LANGUAGE MANAGEMENT IN FAMILY PLANNING DISCOURSES AT MACHAKOS LEVEL 5 HOSPITAL, KENYA

MAITHA JULIANA NDUNGE

C50-10311-2016

A THESIS SUBMITTED TO THE SCHOOL OF HUMANITIES AND SOCIAL SCIENCES IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS IN APPLIED LINGUISTICS OF MACHAKOS UNIVERSITY

OCTOBER 2019

DECLARATION

This thesis is my original work and has not been presented for a degree in any other university.

Sign: ……..Date: ……

MAITHA JULIANA NDUNGE REG. NO: C50-10311-2016

This thesis has been submitted with our approval as university supervisors:

Sign:…….…….. Date:……..

PROF GEOFFREY MAROKO

Department of Linguistics and Languages,

Machakos University.

Sign:…..……. Date:……..

DR. LARRY NDIVO

Department of Linguistics and Languages,

Machakos University.

DEDICATION

To the Almighty God

ACKNOWLEDGEMENTS

First and foremost, I give thanks to God for giving me the strength I have needed to work on this thesis to completion. I am greatly indebted to my supervisors Prof Geoffrey Maroko and Dr. Larry Ndivo for their invaluable help and encouragement that made me to accomplish this work. To my classmates Dorothy, Bernedette, John and Patrick, I acknowledge and appreciate your positive criticism especially during our seminerial presentation during our course work. I could not have chosen a better group of people to accompany me on this journey, thank you all!

The nature of my study demanded that I access as much as possible naturally occurring data. For this reason, I would like to particularly than Machakos Level 5 Family Planning Department staff and service seekers who went out of their way to allow me to observe and record their interactions. I will forever be indebted to you all for making this research happen. Finally, I cannot forget my wonderful family: my husband Francis Kaula; my children, Victor Mwendwa, Glory Mutheu, Gideon Kaula and Caleb Ngumbau who have been a great source of encouragement during this journey. I particularly thank my husband for the moral and financial support he has provided throughout the duration of my studies. Thank you all.

ABSTRACT

In Kenya and particularly Machakos County, there is low prevalence of family planning uptake which stands at 49.7%. Family Planning (FP) is not only a health issue but also a cultural and linguistic concern. Therefore, lack of attention to culture and linguistic aspects in communication can negatively impact on the quality of FP services offered and thus contraceptive uptake. The study sought to analyse the language problems in family planning discourses at Machakos Level 5 Hospital. The study was motivated by previous studies in other countries that show that existence of language barriers affect uptake of family planning services. The study employed qualitative research design. The study was guided by Neustupny and Jernudd (1987) Language Management Theory (LMT) and supplemented with Grice (1975) Cooperative Principle and Leech (1983) Politeness Theory. The study was guided by four research objectives: to identify service related language problems at Machakos level 5 Family Planning Department; to analyse how language problems are evaluated; to assess adjustment strategies to the language problems; and to analyse mechanisms for the implementation of the adjustment strategies. The study randomly sampled 20 service seekers and purposively included 15 service providers. The researcher observed 13 service seeker – service provider interactions that were recorded. An interview schedule guide was used to administer interviews to all the 15 service providers and 15 service seeker that were recorded which were later transcribed. Document analysis checklist was used to analyse written family planning materials. The recorded data was transcribed and analysed. The study findings show that Cooperative Principle and Politeness Theory maxims are violated and the deviations are evaluated negatively leading to language problems. This study demonstrated that language problems led to six undesirable consequences: miscommunication; dissatisfaction with services; poor service delivery; hindering access to family planning services; increased sense of vulnerability; and failure to seek consent. Further, the study established that there are various adjustment design strategies that are designed to mitigate the language problems. At simple management level, these strategies include; avoidance, pre-interaction management, code switching among others while at organized management level, there are written materials in place. The study noted that there are mechanisms of implementing the adjustment designs selected. For example, at the micro level, participants became rude, others came along with their relatives for interpretation services and providers made use of their colleagues while at the macro level; the written materials such as charts were seen pinned on notice boards and clients were issued with leaflets and brochures. The study concluded that Machakos Level 5 Hospital does not provide adequate language services despite existence of language problems. Further, the study concludes that service providers lack cultural and linguistic competency to offer culturally sensitive healthcare and recommends the facility to offer language services. Based on these findings, the study recommends: training of medical staff to equip them with interpersonal communication skills that take care of linguistic and cultural diversity; Machakos Level 5 Hospital to provide professional interpretation and translation services; and Machakos Level 5 Hospital to translate family planning materials into Kikamba and Swahili.

TABLE OF CONTENTS

CONTENTS **PAGE**

LIST OF FIGURES

OPERATIONAL DEFINITION OF TERMS

Adjustment Strategy: In Language Management Theory (LMT), is the communicative plan devised to remove a negatively evaluated norm.

Evaluation: In LMT, evaluation is the process of assessing and judging a deviation from a norm subjectively- on whether the deviation is positive or negative.

Family planning services: These include contraceptive services for clients who want to prevent pregnancy and to space births.

Implementation: In LMT, is the strategy that is put in place to ensure the devised adjustment design is able to remove the language problem.

Language barrier: The absence of communication between people who speak different languages.

Language problems: Refers to a negatively evaluated norm. In this study they refer to deviations from Cooperative Principle and Politeness Theory Maxims.

Language management: In this study, language management refers to language management process outlined by Neustupny and Jernudd (1987) Language Management Theory.

Noting: Is a process of identifying a deviation from an established norm in language management.

Service Provider: Any staff member who is involved in providing family planning services to a client.

Service seeker:	Refers to a client who is seeking family planning services at Machakos Level 5 Hospital.

ABBREVIATION AND ACRONYMS

AIDS	:	Acquired Immuno Defiency Syndrome
CP	:	Cooperative Principle
CPR	:	Contraceptive Prevalence Rate
DPHC	:	Division of Primary Health Care
FP	:	Family Planning
GoK -	:	Government of Kenya
HIV	:	Human Immuno-Deficiency Virus
HTC	:	HIV Testing and Counseling
KHSSP	:	Kenya Health Sector Strategic and Investment Plan
KNBS	:	Kenya National Bureau of Statistics
LMT	:	Language Management Theory
MCIDP	:	Machakos County Integrated Development Plan
MoH -	:	Ministry of Health
MTP II-	:	The Second Medium Term Plan
NACOSTI	:	National Commission of Science, Technology and Innovation.
SDG	:	Sustainable Development Goals.
UN	:	United Nations
WHO	:	World Health Organization

CHAPTER ONE

INTRODUCTION

1.0 Introduction

This chapter covers the background to the study, statement of the problem, objectives of the study, research questions, research assumptions, rationale of the study, significance of the study, and scope and limitations.

1.1 Background to the Study

Kenya is a developing country which comprises of 43 tribes who speak different languages (Kenya National Bureau of Statistics, 2010). The Constitution of Kenya (2010), Article 7, states that Kiswahili and English are co-official languages. Under the same article, the State is required to promote and protect the diversity of languages of the people of Kenya. Furthermore, it is expected to promote the development and use of indigenous languages. Such steps are critical because language is important as a tool of communication and it can be used to address key societal issues such as access to health care and education.

The Kenya's Patients' Charter provides that the patient has an individual right "to be treated with respect, confidentiality, dignity and consideration regardless of age, gender, religion, race or ethnicity" (Ministry of Health, 2013). The Patient Charter has encouraged more people to seek health services from public hospitals. In Kenya, health services are provided through a network of over 4,700 health facilities countrywide with the public sector accounting for about 51% of these facilities. The public health sector consists of: the National Referral Hospitals; the County Level 5

Hospitals; the Sub-county Level 4 Hospitals; Health Centers; and Dispensaries (Wanjau, Wangari & Ayonde, 2012).

The importance of good communication between health care providers has long been recognized. Language has been described as medicine's most essential technology – the principal instrument for conducting its work (Bowen, 2015). Literature on patient health care provider communication indicates, in addition to effects on patient satisfaction, that there is a relationship between the quality of communication and specific health outcomes (Stewart, et al, 1999., Stewart, et al 2000, Teutsch, 2003, Williams, Weinman & Date, 1998). Three basic communication processes have been identified as associated with improved health outcomes: amount of information exchanged, patient's control of dialogue, and rapport established (Kaplan, Greenfield & Ware, 1989). Research has established that when bilingual clinicians are fluently communicating with patients in a language they understand, the healthcare improves (Rodgers, 2010).

Press (2003) as quoted in Ulrich, Quan, Zimring, Joseph and Coudhary (2004) argues that good communication tends to be the single important factor affecting overall satisfaction with care across different patient categories. Physicians' communication bahaviours are important contributors to patients' satisfaction in the out patients setting (Williams et al., 1998; Steward, 2018). Indeed, effective communication is vital in hospital contexts for health providers to offer effective care and ensure that all information about care is grasped by the patients/clients. However, sometimes there are barriers to effective communication which include: differences in language, gender and cultural differences, low health literacy among others. Culture affects

one's understanding of a word or sentence, even those who share a common native language may not have a common culture (Arungwa, 2014). Clients may have questions regarding care, but they might be uncomfortable expressing them, therefore, it is important that the service provider uses words and phrases that the client comprehends (Akacho, 2014). Communication is imperative to promote the ethical responsibility of autonomy and protect the client's right to make informed decisions (Davies, 2008).

Where there are multilingual societies, it is assumed that the existence of the multiple languages lead to multiple language barriers. Language barriers impede communication by creating a strong potential for misunderstanding (Pillay, 2005). Public health campaigns on family planning methods may face resistance if they are not language-specific (Alali & Jinadu, 2002; Haile, 2000). Machakos level 5 hospital is an example of the language situation in urban Kenya. This study investigated whether there are any communication challenges encountered by Family Planning (FP) service providers and seekers at Machakos Level 5 Hospital.

In order to minimize difficulties in providing healthcare services to clients with different cultural backgrounds, healthcare professionals need cultural competence, (Belintxon & Lopez, 2014). Cultural competence is the ability of providers and organizations to effectively deliver health care services that meet the social, cultural and linguistic needs of patients (Betancourt, Green & Carrillo, 2002). Language and cultural issues have significant impact on health outcomes and quality and when not addressed by healthcare organizations they can impede service delivery (Smedley, Still& Nelson, 2002). From the foregoing, it is clear that communication challenges

are bound to emerge from linguistic and cultural barriers and whenever they happen they tend to impede effective service delivery. Out of the recognition and appreciation that communication is a process, there is therefore, the need for language management in order to put in place strategies aimed at removal of language problems.

One of the approaches in which the communication process occupies a central position is Language management Theory (Kimura, 2014). The study is premised on the Language Management Theory (LMT) advanced by Jernudd and Neustupny (1987) which aims at removal of language problems whenever they occur in discourses. Proponents of LMT such as Nekvapil (2016) claim that the theory is grounded on two main processes that can be distinguished: (a) the generating of utterances (communicative acts) and (b) utterance management (management of communicative acts). The former is language use while the latter is language management. In this way, LMT brings the two processes together into a unified framework emphasizing that managing language is an integral part of language activities (Lanstyak, 2014). Language management is thus an activity directed either at language itself or at communication. The agent of such an activity can either be an institution or an individual in a particular interaction. Therefore, language management can take place at micro-level which is simple management of a particular phenomenon or it can be organized at the institutional level (Nekvapil, 2009).

Jernudd and Neustupny (1987) claimed that language management is a process that can be divided into four phases: noting the deviation from the norm; evaluating the

deviation positively or negatively; designing an adjustment design; and implementing the suggested adjustment design to eliminate the problem noted. Noting a deviation from a norm is one of the most important processes of LMT because all the other three processes depend on how the noted norm is evaluated (either positively or negatively). In the current study, deviations from norms were noted from violation of Grice (1975) Cooperative Principle and Leech (1983) Politeness Theory maxims. This study is based on the narrative that cultural and linguistic problems arise whenever there are two participants, in a conversation, from different socio-cultural and linguistic backgrounds. For instance, a Kamba from Kitui interprets some Kikamba words differently from a Kamba from Machakos and a Luo may make a verbatim translation of a Swahili word from his dholuo language which may be offensive to a Kamba.

According to statistics given by National Cohesion and Integration Commission (2016), Machakos County comprises of many ethnic diversities such as Akamba (92.9%), Agikuyu (3.2%), Abaluyha (0.7%), Luo (0.7%), AMeru (0.7%), Kalenjin (0.3%), Abagusii (0.3%), Taita (0.1%) and other Kenyans (1.1%). From this data, it is evident that Machakos County has a diversity of ethnic and cultural differences and this is likely to bring about language barriers in the delivery of FP services at Machakos Level 5 Hospital. The study therefore addressed language barriers in communicating with culturally and linguistically diverse service seekers in providing FP services in Machakos Level 5 Hospital. The study on one hand reviewed the cultural and linguistic diversity of the service seekers who visit the FP department. On the other hand, it identified the specific language barriers, their impacts on

service delivery and explored strategies used to overcome the communication barriers and their implementation.

1.2 Statement of the Problem

Contraceptive use is a human right and is identified as a priority in the National Reproductive Health Policy (MOH, 2007). Contraceptive Prevalence Rate (CPR) stands at only fourty six percent (46%) (Kenya Family Planning Costed Plan, 2012). If Kenya is to realize the United Nations (UN) Sustainable Development Goals (SDGs), the Kenya Vision 2030 and be in line with the Constitution of Kenya (2010), there is need to upscale uptake of family planning. At Machakos County, CPR stands at 49.7 percent (Machakos County, 2015). Various efforts including financing, improvement of infrastructure and medical supplies have been used to improve FP services at Machakos Level 5 hospital (Machakos County, 2016). However, family planning is not only a health issue but also a cultural and linguistic one yet these latter dimensions have not been given adequate attention by both linguists and policy actors.

This study is based on the narrative that cultural and linguistic problems arise whenever there are two participants, in a conversation, from different socio-cultural and linguistic backgrounds. For instance, a Kamba from Kitui interprets some Kikamba words differently from a Kamba from Machakos and a Luo may make a verbatim translation of a Swahili word from his dholuo language which may be offensive to a Kamba. In case this is a medical exchange, the client may feel culturally offended and therefore may decline some services, although both are communicating in a common language. This study therefore sought to address

cultural and linguistic aspects in family planning discourses with a view of addressing some of the barriers hindering CPR which remains low.

1.3 Research Objectives

The objectives of this study were to:

1. Identify service related language problems at Machakos Level 5 Hospital Family Planning Department.
2. Analyse how the language problems are evaluated by both service providers and service seekers at Machakos Level 5 Hospital Family Planning Department.
3. Assess adjustment strategies devised to remove language problems occurring at Machakos Level 5 Hospital Family Planning Department
4. Analyse mechanisms for the implementation of the adjustment strategies designed to remove language problems occurring at Machakos Level 5 Hospital Family Planning Department.

1.4 Research Questions

The study sought to answer the following questions:

1. What service related language problems are noted at Machakos Level 5 Hospital Family Planning Department?
2. How are the language problems evaluated by service providers and service seekers at Machakos Level 5 Hospital Family Planning Department?
3. What adjustments strategies are designed to mitigate the language problems at Machakos Level 5 Hospital Family Planning Department?

4. Which mechanisms are used to implement the adjustment strategies at Machakos Level 5 Hospital Family Planning Department?

1.5 Research Assumptions

The study was guided by the following assumptions:

1. There are typical service related language problems in Machakos Level 5 Hospital Family Planning Department that affect delivery of family planning services.
2. Language problems in Machakos Level 5 Hospital Family Planning Department are negatively evaluated.
3. There are various adjustment strategies at personal and organizational level designed to solve language problems at Machakos Level 5 Hospital Family Planning Department.
4. There are several mechanisms used in implementing adjustment strategies at Machakos Level 5 Hospital Family Planning Department.

1.6 Rationale of the Study

Family planning service providers just like other health care providers, work with diverse service seekers with challenges of language barriers. To overcome these challenges, they tend to use tools such as family and ad-hoc interpreters which could result in improper interpretation. Kenya Ministry of Health New charter of (2013) on Patients' Protection requires the health care provider to use an easy-to-understand language when providing service to service seekers in hospitals. The use of plain language is common in health care provision, but the cultural diversity in language

use is mostly overlooked. For instance, a word or a phrase may have different meaning depending on the ethnic background and may be interpreted differently.

Research done in Morocco has indicated that language barriers hinder provision of health care services including FP services (Westoff & Bankole, 1998). In the Kenyan context, no research has focused on identifying language barriers in FP service provision. To bridge this research gap the current study identified language barriers in the provision of FP services at Machakos Level 5 Hospital. The results will, hopefully, provide a framework for the Ministry of Health (MoH) and Machakos County Department of Health to develop hospital language policy for managing language in FP clinics.

Studies have shown that service seekers in hospitals gain satisfaction when there is good interpersonal communication with health care providers (Steward 2018 & Williams et al, 1998). Proper language skills can help FP service seekers' emotions to open up and express their needs, hence an increase in contraceptive use prevalence. The language used in the information guides and during counselling session has sometimes led to ineffective service provision in hospitals because it lacks the cultural and linguistic aspect which could influence these services (Smedley, 2003). This research focused on solving such a problem by assessing and mitigating adjustment strategies to the language problems.

While various efforts including financing, hiring more medical professionals, improvement of infrastructure and medical supplies have been undertaken to improve FP services at Machakos Level 5 Hospital, CPR remains low at 49.7 percent

(Machakos County, 2015; Machakos County, 2016). However, family planning is not only a health issue but also a cultural and linguistic one. Therefore, lack of attention to culture and linguistic aspects in communication can negatively impact on the quality of communication. Evidence suggests that there is need for language to be managed in a "bottom – up" approach (Nekvapil & Sherman, 2009; Kimura, 2014; Nepkavil, 2015; Nekvapil, 2016). In other words, the actual language situation should inform the strategies that are to be put in place to address any language problems within an organization. In Machakos County, it is evident that there is ethnic and cultural diversity between the service providers and service seekers and there is therefore a probability that a second language is used during medical exchanges which can impede on effective communication. This study is therefore justified in that it aims at giving a linguistic approach to addresss a social problem (low uptake of contraceptioves).

In Machakos Level 5 Hospital FP department, there is no evidence on whether there are language problems that emerge whenever a service seeker is being served by a provider and also, little is known of the kind of language strategies put in place, if any. There was need therefore, for a study to identify whether there are language problems experienced at the FP department, how they impact on service delivery, and what strategies are designed; both at personal and organization level, and how are they implemented.

1.7 Significance of the Study

The study findings could be used by the national government Ministry of Health policy makers in order to identify language needs in hospitals' family planning

departments and probably develop a language policy that is informed by the actual language needs. The study findings might also be used by the county governments department of health policy makers so as to understand the magnitude of language challenges in hospital settings and probably inform provision of language services. Machakos Level 5 Hospital can find the results useful in addressing specific language challenges the study findings has exposed. The findings of the study may also be useful to FP service providers to understand how their communication behaviours affect satisfaction and the quality of services they offer and probably work towards bridging their communication skills gap. The findings of the study will also make special contribution to the existing body of knowledge and address existing research gaps. Researchers in this field of applied linguistics might utilize the results of this study as part of secondary data in enhancing future studies.

1.8 Scope and Limitations

The study falls within the area of language planning and management. Under this, one can study language selection, language standardization, language of instruction, mother tongue in education and monolingualism, bilingualism or multilingualism. Numerous studies have been done on language standardization, use of mother tongue in education among others. This study confined itself to language problems and management. This was because language is the expression of human communication through which information is shared and is key to service delivery, but little research had focused on language management in provision of FP services. Language issues are many, including but not limited to discourse, politeness, communication in multilingual and intercultural contact situations, and speech therapy among others. The current study has focused on the linguistic and cultural language problems and

their management. This was because these problems are prevalent in interpersonal communication and there are few studies on this area.

In a health care facility, there are many departments which include: the outpatient, emergency, laboratory, pharmacy, medical and administration. The data of the study was collected from the family planning department. This was because high fertility strains budgets of poor families in developing nations reducing resources to feed, educate and provide healthcare to children and therefore, there is need for family planning programs (Nancy & Charles, 1988). Language is a resource which can be utilized in awareness campaigns and FP service delivery. The diverse views which were obtained have exposed the challenges associated with FP services at the Machakos Level 5 Hospital facility. The area of the study was Machakos Level 5 Hospital in Machakos County. This hospital was chosen because it is a referral hospital situated in Machakos town and serves clients from diverse linguistic and cultural backgrounds.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.0 Introduction

This chapter covers the review of literature related to this research and the theoretical framework underpinning this study. It highlights the gaps in the existing knowledge and shows how the current study intends to fill these gaps. The review is organized in six sub-sections namely: family planning policies in Kenya; service related language problems; evaluation of language problems on service delivery; adjustment strategies to language problems; mechanisms for the implementation of adjustment strategies; review of related studies; and theoretical framework that discusses language management theory, violation of cooperative principle maxims and violation of politeness theory maxims.

2.1 Family Planning Policies in Kenya

World Health Organization (WHO, 2010) defines family planning as the ability of individuals and couples to anticipate and attain their desired number of children, the spacing and the timing of their births. Contraceptive services include consideration of a full range of approved contraceptive methods (Singh & Darroch, 2012). Strengthening FP services is key to improving health, human rights, economic development and population growth (Speidel, Thomas & Harper, 2014). Improving the quality of care in FP services is paramount to improving use of Family Planning (FP) services in developing countries (Blanc, Curtis & Croft, 2002; Arends & Kessy, 2007).

Several decades after the introduction of modern family planning methods, Kenya's population is still growing and is projected to exceed 60 million by 2025 (Ochako, Mbondo, Aloo & Kaemenyi, 2015). The growing number of clients needing services is a challenge to the continued success of FP in Kenya. Kenya's average annual population growth rate of 3.8% (1969-1989) implies greater numbers of women of reproductive age needing reproductive health services, including contraception. About 7.5 million women aged 15 to 49 were enumerated in the 1999 Census. This number is projected to increase to between 11.4 million and 11.7 million in 2020, depending on the pace of fertility decline. Therefore, one challenge is continuing to serve users while contacting and convincing resistors. Another challenge is continuing a commitment to quality of care while seeking ways to pay for future needs. To meet these challenges, The National Reproductive Health Policy of 2007 has useful provisions that seek to enhance access to family planning services in Kenya.

The Kenya Reproductive Health policy promotes community based distribution of FP to expand access to FP services and distribution of contraceptives in marginalized areas (Reproductive Health Policy, 2007). Despite having an enabling policy environment to promote universal access to reproductive health, there still exists disconnect between policy and contraceptive prevalence rate. As a result, the country has not been able to address population growth as it has always projected.

For instance, the total mistimed and unwanted pregnancies among all women (15–49 years) remain relatively high at 26% and 17% respectively (Remare & Cathherine, 2012). According to Kenya Demographic and Health Survey 2014 report, there has

been an overall decline from 8.1 births per woman in the mid-1970s to 4.6 in 2008 which has further fallen to 3.9 in 2014 (Kenya National Bureau of Statistics, 2015). However, this rate is still higher compared to global fertility rate of 2.5 (United Nations Department of Economic and Social Affairs, 2015). Ensuring that family planning service seekers receive good quality services is important from an ethical point of view and because non-use and discontinuation are related to low levels of service quality (KNBS; ICF Macro, 2010). In 1991, the Division of Primary Health Care (DPHC), MoH, published guidelines to improve quality and consistency in reproductive health services. This widely used publication was revised in 1997 and became the Reproductive Health/ Family Planning Policy Guidelines and Standards for Service Provider (GoK, 1997). These guidelines equip FP service providers with the tools required to provide consistently high-quality, client-sensitive professional services. National Family Planning Guidelines for Service Providers emphasizes improving access to quality FP services (KNBS; ICF Macro, 2010).

Family planning is a central pillar of Kenya's reproductive health programme and wider national health priorities as outlined in the Kenya Health Sector Strategic and Investment Plan 2014-2018, the National Reproductive Health Policy (2007) and the National Reproductive Health Strategy (2014-2018). The National Family Planning Guidelines for Service Provider (2010) incorporates the most up-to-date information on the Medical Eligibility Criteria for the use of various contraceptives as published by the World Health Organization (2009). The current study sought to place language as a central focus in achieving medical eligibility criteria of enabling FP service seekers to choose a suitable contraceptive method (World Health Organization 2015).

The Kenya Health Sector Strategic and Investment Plan (KHSSP) July 2012- June 2017 aims to support the achievement of the objectives of the Kenya Vision 2030. The second medium term plan (MTPII) for health (2013-2017) indicates that the women of reproductive age receiving FP services should increase from 45% (2013) to 80% by (2017). Despite this, as at December 2018, FP uptake in Machakos was at 49.7% (Department of Trade, Economic Planning and Industrialization, 2015). The study investigated how a linguistic approach can be applied in order to upscale CPR in Machakos Level 5 Hospital and the County in general.

Unmet need remains relatively high implying a significant population is not accessing the right contraceptives. Myths and misconceptions on side effects have been identified as a significant barrier to contraceptive uptake and is partly fueled by cultural beliefs (Akacho, 2014; Ministry of Health, 2017). In order to overcome these myths and misconception so as to upscale CPR, there is need for FP seekers to be provided with the right information whenever they visit FP clinics. In a country with diverse cultural population of service seekers and service providers, the health professionals administering services should be culturally competent in order to improve the quality of the medical interactions.

In the medical domain, communication represents a fundamental clinical skill that involves the establishment of the therapeutic relationship, understanding the patient's perspective, exploring thoughts and emotions, and guiding them towards improving their health (Chichirez & Purcarea, 2018). The importance of communication between providers and patients has long been recognized as medicine’s most essential technology for conducting its work (Bowen, 2015). Previous research

(Stewart, et al, 1999; Stewart, et al 2000; Press 2003; Teutsch, 2003) has shown that there is a relationship between the quality of communication and specific patient health outcomes. For instance, whenever there is communication breakdown between provider-seeker due to the use of unintelligible linguistic varieties; or when poor translation or interpretation is used, the quality of the health service may be compromised (Bowen, 2000). In spite of consistent international evidence of the risks of language barriers to quality of care and patient satisfaction, there is little research in Kenya that explores whether there are cultural and linguistic problems in family planning departments and how they influence access to contraceptives. This study, sought to address that gap.

2.2 Service Related Language Problems in Hospitals

There is a growing realization that language is one of the critical components in the delivery of any health service (Ainworth-Vaughn, 2001; Fleischman, 2001). All health care delivery processes demand linguistic interaction between a service provider and a client. Whenever there is communication breakdown between them due to the use of unintelligible linguistic varieties; or when poor translation or interpretation is used, the quality of the health service may be compromised (Bowen, 2000; Bowen, 2015). Language allows patients/ clients and care-providers to make their intentions known, and if problems in linguistic encoding interfere in this process, there may be important consequences (Cameron & Williams, 1997). Communication challenges lead to failure to ensure confidentiality or obtain informed consent in provision of health care services (Bowen & Kaffert, 2000). Confidentiality and informed consent are main pillars in provision of FP services. This study was designed to identify potential linguistic barriers during interactions

between FP service providers and service seekers, for example cultural expressions which have different meanings and their impact on health care provision.

The challenges to health services posed by linguistic diversity have been extensively described (Flores, 2005; Smedley, 2003). Miscommunication in the healthcare sector can be life-threatening. Language discrepancies may result in increased psychological stress and medically significant communication errors for already anxious patients. People from different cultural groups describe pain and distress quite differently: culturally-specific terms, expressions, or metaphors can be difficult to navigate even when language competence is high (Ryder, 2011).

Some religious denominations have been documented to be controversial in advocating against the use of modern contraceptive. For example, in Kenya the Roman Catholic Church advocates for abstinence or use of natural methods for FP as the use of modern methods is against the church's religious beliefs (KNBS ICF Macro, 2010). The Muslims maintain that all forms of contraceptives violate God's law and intentions (Poston, 2005). From the foregoing, it can be argued that religion may be a hindrance to FP contraceptives uptake.

In Morocco, a research done on FP noted that misinformation and fear of side effects reduced access to contraceptives (Westoff & Bankole, 1998). Fear of side effects can be overcome through good communication and information, especially through community based distribution programmes (Omondi-Adhiambo, 1999). This study identified adjustment strategies of overcoming language barriers in provision of FP services, hence improving communication which promotes contraceptive use.

A study by Casterline (2001) reveals a significant relationship between a woman's level of education and contraceptive use. Educated women tend to marry later, have fewer children and use contraceptives more (Caldwell & Caldwell, 2003). The current study hypothesized that a high level of education promotes contraceptive use since the enlightened individuals have the language to express themselves and make informed consent on which FP method is appropriate for them and that the inverse is true. In most African societies, discussing sexual matters is a taboo subject for men and women; consequently they may feel uncomfortable discussing reproductive health issues such as contraceptive use (Drennan, 1998). This study investigated whether there are any communication challenges in FP service provision and the strategies used to overcome them.

One major challenge is that no systematic collection of patient/ client language data currently exists in the Kenyan hospitals, making it difficult to plan efficiently for professional support mechanisms to monitor healthcare quality for family planning clients. This research attempted to fill this knowledge gap by assessing and collecting data on linguistic diversity, and identifying the service related language problems of clients seeking family planning services at Machakos Level 5 Hospital. The outcome will address the use of proper language skills that can help FP service seekers' emotions to open up and express their needs, and this will probably increase the CPR.

2.3 Evaluation of the Language Problems

A lack of attention to language barriers can lead to poor communication, a poor therapeutic alliance, suboptimal quality of care, and poor health outcomes (Divi,

Koss, Loeb & Schmaltz, 2007; Ku & Flores, 2005; Yeo, 2004; Bischoff, Bovier & Rrustemi, 2003). Proper linguistic skills are required by FP service providers to capture the correct health information from FP service seekers in order to maintain good quality data in hospitals which improves quality of care. Potentially, such good quality data might be used to track adoption of interventions of contraceptives and their effects over time.

Communication challenges have been found to be associated with: increased time spent in the emergency department (Hampers et al., 1999) and decreased general satisfaction with care (David & Rhee, 1998). Hu and Covell (1986) found that the percentage of patients describing their care as more than adequate was almost twice as high for English speaking than non-English speaking patients. To improve the health of non-English speaking patients, the health providers need to understand more about them by use of proper professional language as well as the community local language. The mastery of occupation's professional language as well as the community's local language in the event of performing duties is key to the providers overall satisfaction and efficiency.

There is evidence that communication challenges may result in increased use of expensive diagnostic tests, increased use of emergency services and decreased use of primary care services, and poor or no patient follow-up when such follow-up is indicated (Greising, 2006). Patients face significant barriers to health promotion and disease prevention programs: there is also evidence that they face significant barriers to first contact with a variety of providers. Arhin (2000) indicates that there is a

general pattern of lower use of many preventive and screening programs by those facing language barriers.

Communication with patients is vital to delivering service satisfaction because when hospital staff take the time to answer questions of concern to patients, it can alleviate many feelings of uncertainty (EFP, 2006). In addition, when the medical tests and the nature of the treatment are clearly explained, it can alleviate their sense of vulnerability (Friedman & Kelman, 2006). Effective communication in a hospital set-up requires proper linguistic skills and an understanding of the service seeker's local languages. This study investigated challenges of communication needs of diverse population at Machakos Level 5 Hospital.

Dehlendorf, Levy, Kelley, Grumbach and Steinaner, (2012) research suggests that women value an intimate, friend-like relationship with their clinicians when discussing their family planning options/during contraceptive counselling. Language barrier can affect the contraceptive counseling session and lead to a client making a wrong decision on the method and type of contraceptive to use. This research sought to fill this knowledge gap by identifying language barriers affecting healthcare provision of family planning services at Machakos Level 5 Hospital.

2.4 Adjustment Strategies to the Language Problems

In order to address communication challenges, language services need to be integrated into organizational routines. Although this has been successfully accomplished in a number of hospitals in the USA, several studies identify institutional barriers (Greenhalgh, Voisey & Robb, 2007; Regenstein, 2007; Divi et

al., 2007). Some of these hospitals have built an in-house capacity to provide language services using medical interpreters (Flores et al, 2003). However, as language services programs grow, hospitals are increasingly challenged to determine whether their programs are providing high-quality language services to their patients. This study aimed at gathering data in Machakos Level 5 Hospital to estimate the actual demand for language services in the FP department and to determine whether the adjustment strategies being used are effectively meeting that demand.

The importance of professional interpreters for ensuring adequate communication with limited English-speaking patients has been well-established (Karliner et al., 2007; Loutan, 1999). However, in many contexts, healthcare providers continue to rely on bilingual colleagues or the patient's family or friends to provide linguistic assistance. This is worrisome because these strategies have been shown to be associated with a number of problems related to poor quality communication and care and breaches of confidentiality (Elderkin, Silver & Waitzkin, 2001). The reliance on untrained interpreters may be simply a result of limited access to trained interpreters or may reflect a deeper resistance at both the individual and the institutional levels to call on professional interpreters when language barriers are encountered.

Use of interpreters has been abused, for example some studies indicate that some hospitals use children and ad-hoc interpreters, a worrisome practice identified in USA (Flores, 2006; Lee, 2006). Ad-hoc interpreters are unlikely to have had training in medical terminology and confidentiality; their priorities conflict with those of patients and sometimes inhibit discussion on sensitive issues (Flores, 2005). The

current study investigated the adverse effects if any are available of ad-hoc interpreters in provision of FP services at Machakos Level 5 Hospital.

Narayan (2014) writing a paper on language barriers to healthcare in India notes that there is need to address language barriers to healthcare in India. He singles out three interventions which include: the ways in which language barriers affect health and healthcare; the efficacy of interventions to overcome language barriers; and the costs of language barriers and efforts to overcome them. He stresses that there is a need to address such barriers in health worker education and clinical practice. He recommends strategies to overcome the language barriers to include hiring multilingual healthcare workers, providing language training to health providers, employing in situ translators or using telephone interpretation services.

A study done in South Africa on 'language as a barrier to care for Xhosa-speaking patients' (Levin, 2006) found out that language and culture are major barriers to health care and majority of health professionals could not speak any of the indigenous African languages. He recommended that interpreters should be made widely available, and doctors should be educated on how best to utilize their services. The current research built on this recommendation by first identifying whether there are interpreter services in place at the FP department at Machakos Level 5 Hospital and to establish their effectiveness.

2.5 Mechanisms for the Implementation of the Adjustment Strategies

Many health care providers do not provide adequate interpreter services because of the financial burden such services impose (Radcliffe & Anderson, 2001; Graham,

2001). However, these providers fail to take into account both the consequences of not providing the services and the potential cost benefits of improving communication with their patients. Language barriers are a major obstacle in providing effective health services (Bischoff, 2003; Murphy, 2004). This research anticipated that Machakos Level 5 Hospital encounters a number of challenges during implementation of the language service measures. This study collected data on the number of language services encountered in the FP department, examined the adjustment strategies and their implementation and has recommended potential means of overcoming the communication challenges. Language services encountered in research were taken to mean single interaction among an interpreter, a FP client, and a health care provider.

There is evidence on the positive effect of health professional training to improve communication skills across culture and language (Beach et al., 2005). Unfortunately, health care professionals and staff face competing demands for the limited time they have for educational activities and receive mixed messages on communication priorities. Most hospital staff and health professionals in Kenya would benefit from training that addresses both the delivery of culturally and linguistically appropriate FP services. Kenyan public hospitals need support and encouragement to develop strategies that enable appropriate access to clients preferred language in FP services delivery. This study examined the appropriate mechanisms for the implementation of adjustment strategies in solving language barriers in hospitals. Its key concern was to understand the linguistic diversity and identify potential means of overcoming the communication challenges in FP health care delivery.

Hospitals cannot provide adequate and appropriate language services to their clients if they do not create mechanisms to screen for limited English speaking clients and record clients' preferred spoken language for health care services. The type of interpreting support provided differs significantly in terms of the healthcare systems concerned, the demographic make-up of communities, and the type of services provided (Schulze et al., 2003). The current study has provided information of the FP clients' linguistic diversity at Machakos Level 5 Hospital and the preferred language per linguistic group, age and literacy level to ensure high quality, patients-centered care for all service seekers.

In the Netherlands, the Ministry of Health forbade the use of non-professional interpreters, and healthcare workers who do so can be sued (Dickover & Bot, 2007). In Switzerland they developed a set of standards for the provision of linguistically and culturally appropriate health care (Saladin, 2007). In a survey by Saohatse (1998) at Chris Hani Baragwanath hospital in South Africa, it was found that language problems are common due to lack of interpreters and inability of most doctors to speak an African language. Limited literature exists in studies on the impact of interpreter services in provision of FP health care in Kenya. However, based on the available literature from other regions, we are able to identify that there are challenges facing interpretation services in hospitals. The purpose of this study was to carry out field research in a hospital to understand current practice and develop recommendations that would assist health care providers in dealing with the challenges of health care delivery to a diverse population.

2.6 Review of Related Studies

There have been attempts to investigate how language problems hinder patient-doctor communication. This study reviewed studies that were undertaken in medical settings. However, majority of these studies looked at how language problems hinder effective communication and thus impact on quality of healthcare. The studies reviewed show that there has been little or no effort to use language management approach as outlined by Neustupny and Jernudd (1987) in order to link simple language management and organized language management.

Ali and Watson (2018) conducted a qualitative descriptive study on the impact of language barriers on provision of care to patients with limited English proficiency in the United Kingdom. Using individual interviews and focus group discussions, data were collected from 59 nurses working in tertiary care hospitals in England. The study results identified communication as the most important aspect of care provision and an essential component of a nurse's professional role regardless of the clinical area or specialty. The study findings further showed that language barriers were the biggest obstacles in providing adequate, appropriate, effective and timely care to patients with limited English proficiency. On the adjustment strategies put in place to overcome the language barriers, the study found out that use of professional interpreters was useful; however, the limitations associated with use of interpretation service, including arrangement difficulties, availability and accessibility of interpreters, convenience, confidentiality and privacy related issues and impact on the patient's comfort were mentioned.

De Moissac and Bowen (2018) conducted a mixed method study on the impact of language barriers on quality of care and patient safety for official language minority Francophones in Canada. They employed an online paper-based on 21-question survey that had both closed and open-ended questions. They similarly conducted interviews in French that were audio recorded and partially transcribed. Results of their findings showed that most of the OML Francophones believed language barriers had contributed to poorer quality of care and increased risk of adverse events for themselves, family members, or friends and some perceived inequity in quality of care received; others reported increased stress.

For instance, the researchers quoted a participant service provider who had this to say, “His mother had bad odours coming from her lower body, but because she had problems expressing herself in English, the doctor diagnosed it as an infection. When she passed away shortly after, they found she had cancer of the uterus, which had remained untreated.” This narrative demonstrates that language barrier can lead to miss-diagnosis. Further, when confronted with language barriers, 51.5% of all survey respondents reported doing the best they could without linguistic assistance; this percentage increased to 68.3% for LEP participants. Furthermore, 20% of all participants reported not seeking health services when these were not available in French for fear of not understanding or being understood. Few (3%) requested formal interpretation services. These findings emphasize language barriers can hinder access to healthcare services.

Evidence from a case study conducted by Qanbar and Saqer (2019) on language miscommunication in the healthcare sector conducted in United Emirates shows how

miscommunication between a doctor and patient can expose patients' to fatal risks. In this case, the patient who was a Pakistan and was being treated for a knee injury in a United Emirates Hospital could not speak English, except very few words. All the translators were busy and the doctor decided to proceed taking medical history alone using a mix of simple English and Urdu words he knew. He could get some information and the location of the pain. However, when he asked the patient about having any drug allergies or a relevant significant past medical history, the patient did not seem to understand the questions and said no and he therefore decided to give the patient a Diclofenac injection for pain relief.

One of the nurses who could speak Urdu came to give him the injection and asked him whether he had any drug allergies or if he was asthmatic. The patient stated that he was asthmatic and that he once had a reaction to one of the pain medications. The nurse withheld the drug and immediately informed the doctor. The medication was changed to paracetamol. Later, the doctor informed the patient about the miscommunication through the nurse. The patient was upset and infuriated because his life was put at risk. The doctor apologized and told the patient that it was his right to have a translator. This case study presents what actually happens when there are language barriers between a provider and service seeker. It points to the need to not just provide language services (like the interpreters), but to provide adequate services that are able to address the language demands. For instance, although this hospital had translation services, the study found that they were sometimes overwhelmed and doctors resulted to working alone.

Similarly, studies in Africa conducted in medical settings similarly show language barriers have significant effect on the quality of healthcare outcomes. For instance, Khadidja (2012) carried out a sociolinguistic study of communication and language barriers in Algerian health care settings. The study aimed at establishing the linguistic and communication problems caused by language differences between doctors and patients. She found that in medical settings, due to language variation and language differences communication problems are becoming pronounced and deserve investigation. The research used an ethnographic approach which focused on examining doctor-patient communication at macro-level. The current study was not only interested in investigating language problems but took a global approach of investigating socio-linguistic and socio-cultural language problems.

Kamwendo (2004) did a research on language policy related communication problems at Mzuzu Central Hospital (MCH) in Malawi. His approach was concerned with what languages are used, the problems that come up with use of such languages and how the problems are solved. He found out that several forms of language gaps do exist and are filled by use of ad-hoc interpreters in the form of nurses, support staff and other parties. The current study adopted the discourse based approach of language management that involves noting deviations, evaluating them and devising adjustment strategies and their implementation so as to advise on development of a bottom-up health language management policy.

Levin (2004) carried a study on Red Cross War Memorial Children's Hospital (RCH) in Cape town. The study was to identify barriers to optimal care for Xhosa speaking parents at RCH and he assessed the possibility of language problems to

health care for this group. He found out that language barriers cause great difficulties for Xhosa speaking parents of children at RCH. Parents were dissatisfied with communication between themselves and their doctors and blamed their linguistic limitations. The study used the questionnaire method to collect data while the current study used several data collection instruments including: audio recording, observation, interview and document analysis. This was important because language management proposes that there is need to gain access to naturally occurring data and therefore, these various data collection methods were essential.

There is limited research done in Kenya on language barriers in hospitals. Data reviewed by Chen, Dutta and Maina (2014) highlights critical gaps regarding the quality of healthcare services in Kenya and they identified inadequate infrastructure as a major barrier. Kungu (2016) established that ineffective communication channels affected the delivery of good quality healthcare services at the National Spinal Injury Referral Hospital in Kenya. This study investigated how ineffective communication due to lack of paying attention to language problems could be a hindrance to provision of family planning services in a bid to upscale the uptake of contraceptives.

2.7 Theoretical Framework

This study is based on Language Management Theory (LMT) and further employs Cooperative Principle and Politeness theory maxims to identify communicative norms that are analysed using LMT.

2.7.1 Language Management Theory

The study is premised on the Language Management Theory (LMT) advanced by Jernudd and Neustupny (1987). The theory has several tenets but this study restricted itself to two. The first is the simple and organized management whereby simple management (discourse based) is the management of problems as they appear in individual communication acts. For example, when we switch to another language variety or begin to speak slowly because we note our communication partner does not understand us. Organized management (institutional management) is performed by institutions.

The second tenet of the theory is its processuality. The theory views language problems not as a product or entity, but as a process. According to the theory, there are two main processes which can be distinguished: (a) the generating of utterances (communicative acts) and (b) utterance management (management of communicative acts). The management process follows all or some of the following stages: (i) deviations from norms are noted; (ii) the noted deviations are evaluated (or not evaluated); (iii) (correction) adjustment designs are selected to remove the deviations (or not selected); and (iv) the adjustment designs are implemented (or not implemented). All the other processes of LMT depend on whether a deviation from a norm is noted.

The first process of LMT is *noting* of deviation from an expected norm. The theory is premised on the preposition that in language use, for example, when two people are involved in a conversation; there is a likelihood of deviations from expected norm(s). The deviations can arise from grammatical errors, pronunciation, misspelling a word,

cultural norms (for example where culture dictates how elderly people are to communicate with the youth or taboo topics that are not to be discussed) or social norms (where different age sets or people from different social background interpret a word to give it different meaning), among others. Language Management Theory was advanced in order to take care of language problems that emerge in actual language use. This study aimed at exposing cultural and linguistic problems, and to achieve this, violation of cooperative principle and politeness theory maxims provided a framework for noting norm deviations.

Evaluation is the second process among the four LMT processes of language management. In the context of LMT, the initial stage is when an individual notes something in his/her own or the intelocutor's utterance. The process can cease at this stage or it can continue into phase two, that is, evaluation. If the process transits from phase one (noting), the speaker evaluates the deviation from the language or communicative norm positively or negatively. If the deviation is evaluated negatively, it is understood in LMT as inadequacy; and in case the interlocutors have no routine solution at their disposal to overcome such inadequacy, and provided this phenomenon is of recurrent nature, LMT classifies it as a problem. However if the phenomenon noted is evaluated positively, it is referred to as gratification. The language management process can end at this point (gratification) or it can continue into the next phase called adjustment design.

The focus of LMT is to remove language problems. Designing an adjustment strategy to a negatively evaluated norm is the third phase of Jernudd and Neustupny (1987) Language Management Theory. When a deviation from norm is noted in

phase one and evaluated negatively in phase two, the process can continue into adjustment design phase. At this stage, the speaker may, for instance, start to think about re-wording her/his utterance to manage the single interaction. In simple management, individuals may also devise other adjustment strategies such as code switching, avoidance strategies, identifying their own interpreters such as relatives or professional colleagues as interpreters.

According to the theory, organizations and institutions are also involved in language management in what is referred to as organized management. When organizations pay attention to language problems, they may devise adjustment strategies designed to eliminate the language problems. Such organized language management activities may include: the organization designing written materials that are translated in a language that addresses the local language needs; may hire professional interpreters and translators; and may provide language services to its staff in order to address potential language problems that may impede effective communication.

In line with LMT, adjustment design strategies devised in phase three should always be implemented in order to eliminate language problems noted in phase one. This is because an adjustment design can be as good as dead if it is not implemented. Implementation of an adjustment strategy can be at both micro (individual) and macro (organization) levels. Activities that may be implemented at micro management level, for instance, during single interactions, may include: a speaker switching to another familiar language whenever s/he encounters difficulties in communicating in certain language (code switching); the speaker may choose to remain silent or murmur something that may be inaudible (avoidance strategy); the

speaker may request for an interpreter; the speaker may look for difficult words from the dictionary, just to mention but a few.

At macro level, organizations may: provide translated written materials for further clarification; issue notices on language policies; provide language assistance through in-house professional translators and interpreters; and offer language training services. This theory guided noting of language problems, analysing how language problems are evaluated, assessing adjustment strategies that are designed at simple and organised management levels, and analysing implementation of adjustment strategies designed to eliminate language problems noted. The study further employed Cooperative Principle and Politeness Theory Maxims to identify deviation of cultural and linguistic norms that set in motion language management process.

2.7.2 Violation of Cooperative Principle Maxims

In order to establish how cultural and linguistic norms are deviated in LMT, this study employed Cooperative Principle maxims that when violated can lead to deviation of expected norm. Paul Grice formulated the Cooperative Principle and introduced it in pragmatic theory. Grice (1975) theory deals with understanding of the utterance meaning. The principle describes how people achieve effective communication in common social situations (Li, 2015). For instance, how listeners and speakers act cooperatively and mutually accept one another to be understood in a particular way. The principle states, “Make your contribution such as is required, at the stage at which it occurs, by the accepted purpose or direction of the talk exchange in which you are engaged.”

The cooperative principle is divided into four maxims of conversation, called the Gricean maxims. The four maxims include: maxim of quantity; maxim of quality; maxim of relation; and maxim of manner (Wang & Peng, 2015). The maxims prescribe rational principles that ought to be observed by people in conversations if they are to achieve effective communication. The maxims are discussed as follows:

a). Quantity maxim

According to Runqing (2014), the maxim states a) Make your contribution as informative as is required; b) Do not make your contribution more informative than that is required. In fulfilling maxim of quantity, Khoyi and Behnam (2014) emphasize that the speaker should be as informative as it is required and therefore should not give too little information or too much. They also opine that conversations should not be crowded with ineffective words. Maxim violation of quantity occurs when a speaker/writer gives more or less information than the situation requires (Adriani, Hamzah and Havid, 2013). The violation of quantity maxim means speaker does not provide enough information or provide less information than its actual need in the conversation.

1. A: Machakos University is in which town in Kenya?
2. B: It's in Machakos town.
3. C: It's in Lower Eastern.

In this conversation, B gives adequate information. Speaker C does not give the precise location of the university because lower eastern has several towns and therefore violates the quantity maxim. It can be argued that the norm is to provide adequate information to the information need of a speaker. Similarly, in analysing discourses, the study looked at whether speakers provided adequate information to each other and any violation was used as a basis of noting deviations from expected

norms for analysis using LMT.

b). Maxim of quality

According to Liu (2017), the maxim states a) Do not say what you believe to be false; b) Do not say that for which you lack adequate evidence. The requirement of quality maxim is to make a contribution that is true. For example:

1. A: What causes flu?
2. B: A virus.
3. A: Can antibiotics treat it?
4. B: Yeah but I don't know how that works because it isn't bacterial infection, but many people treat it that way anyway.

In line 2, B observes the maxim. He does not provide what he believes to be false. However, when asked on whether antibiotics can treat a viral infection in line 3 by A, he responds in the affirmative but his further explanation confirms he does not give adequate evidence of his claim. It can therefore be concluded that B in line 4 violates the expected norm established by the quality maxim of giving accurate information. Similarly, in analysing discourses, the study looked at whether speakers provided accurate information to each other and any violation was used as a basis of noting deviations from expected norms for analysis using LMT.

c). Maxim of Relation

Grice defines the maxim of relation as follows: "I expect a partner's contribution to be appropriate to immediate needs at each stage of the transaction" (Li, 2015). The relevance of an answer needs to be inferred on the basis of information in the context. For example:

1. A: Where is my pen?
2. B: It's in your locker
3. C: I can assist you with my pen.

B's contribution abides by the maxim of relevance, since a direct and appropriate answer to the question is given. On the other hand, C violates the maxim by not giving a relevant answer to the question posed by A. Similarly, in analysing discourses, the study looked at whether speakers provided relevant information to each other and any violation was used as a basis of noting deviations from expected norms for analysis using LMT.

d). Maxim of Manner

According to Liu (2017), the maxim of manner states that states: a) Avoid obscurity of expression; b) Avoid ambiguity c) Be brief (avoid unnecessary prolixity); and d) Be orderly.

1. A: Where was the teacher when class ended?
2. B: She left class and went to the staffroom.
3. C: She prefers departmental offices to staffroom. She may be in either of them.

In this example, B is clear, brief and orderly and thus observes the maxim of manner. On the contrary, C is ambiguous and therefore violates the maxim of manner. Similarly, in analysing discourses, the study looked at whether speakers provided clear, brief and orderly answers to each other and any violation was used as a basis of noting deviations from expected norms for analysis using LMT.

2.7.3 Violation of Politeness Theory Maxims

In order to establish how cultural and linguistic norms are deviated in LMT, this study employed Politeness Theory maxims that when violated can lead to deviation of expected norm. Geoffrey Leech (1983) formulated the politeness principle with conversational maxims similar to those formulated by Paul Grice in 1975. According to Leech, Politeness Principle seeks to minimize the expression of impolite beliefs.

Politeness can be regarded as some kind of social norm determined by the convention of the community. Politeness theory has been evolving. For example, Brown and Levinson's in 1987 improved Leech theory (1983) and introduced the notion of face (Al-Hindawi & Alkhazaali, 2016). They defined face as ''the public self-image'' that must be maintained by others in communication. However, the present study restricted itself to Leech politeness theory (1983). Leech proposed six maxims, namely Tact Maxim, Generosity Maxim, Approbation Maxim, Modesty Maxim, Agreement Maxim, and Sympathy Maxim.

a). Tact Maxim

According to Leech (1983), tact maxim states: 'Minimize cost to other, maximize benefit to other. For example:

1. A: It's rather chilly, would you mind taking a cup of tea?
2. B: That's a great idea.
3. A: But wash the glass, Ok? And the plate also!
4. B: No please, I do not need your cup of tea please.

Speaker A utterance in line one implies that taking tea is of benefit to B and thus, observes the tact maxim. However, looking at the next utterance in line three, A was insincere in his offer. After taking tea, A wanted B to clean the glass and plates. Therefore, it can be assumed that A violated the tact maxim because speaker A did not minimize the cost to the hearer B and also, did not maximize the benefit to hearer B. Similarly, in analysing discourses, the study looked at whether speakers minimized cost and maximized benefit to each other and any violation was used as a basis for noting deviations from expected norms for analysis using LMT.

b). Generosity Maxim

Generosity maxim refers to minimize benefits to self and maximize cost to self

(Muchiri, 2014). An example of generosity maxim is as follows:

1. A: Can I go and print for you?
2. B: Yeah, I will appreciate.
3. C: Will you pay the taxi so that we take the assignment to the lecturer?
4. B: No. I can just print for myself.

In line one, A implies that cost of the utterance is to himself while the benefit is for B and thus, generosity maxim is adhered to. In line three, A intends to spend less money but he wants B to spend more on the taxi. Therefore, A does not want to minimize benefit to self as well as maximizing cost to self. Generosity maxim is therefore violated in line three. Similarly, in analysing discourses, the study looked at whether speakers were seen to minimize benefit as well as maximizing cost to themselves and any violation was used as a basis of noting deviations from expected norms for analysis using LMT.

c). Approbation Maxim

According to Maharani (2017), approbation maxim refers to: minimize dispraise of others and maximize praise of others. This maxim is used to avoid saying unpleasant things about others, especially to the hearer. The example is given below:

1. A: Your performance was great
2. B: Oh thanks!
3. C: But next time avoid cheating, this performance is beyond your ability!

In the example, A gives a good comment about B's performance. He is congratulating B and thus maximizing praise of other and therefore obeys the dictates of the approbation maxim. However, C seems to suggest that B must have cheated in the examination and goes ahead to mock B's intellectual ability. This utterance tends to maximize dispraise of B and minimizes praise of B as well and thus violates the approbation maxim. Similarly, in analysing discourses, the study looked at whether speakers minimized dispraise as well as maximized praise of

others and any violation was used as a basis of noting deviations from expected norms for analysis using LMT.

d). Modesty Maxim

According to Maharani (2017), in the modesty maxim, the participants must minimize praise of self and maximize dispraise of self. Modesty maxim usually occurs in apologies. An example is as follows:

1. A: Please accept this small gift as a price for being the best student in your class.
2. B: Thank you a lot. I feel appreciated.
3. C: In my time, I led the class but with higher marks, how are you leading with such low marks? The standards must have gone down!

In this conversation, A maximizes dispraise of himself by using "small gift" and therefore it obeys the modesty maxim. However, C seems to suggest that when he was in the same class, he used to lead with higher marks than what B had scored and goes ahead to suggest that B ought not to have led with such comparably low marks. This utterance violates the modesty maxim in that C maximizes praise of self. Similarly, in analysing discourses, the study looked at whether speakers minimized praise as well as well maximized dispraise of self and any violation was used as a basis of noting deviations from expected norms for analysis using LMT.

e). Agreement Maxim

According to Maharani (2017), agreement maxim refers to: minimize the expression of disagreement between self and other and maximize the expression of agreement between self and other. An example is given below:

1. A: Nairobi is a difficult city to live in.
2. B: True but there are few places like Muthaiga and Karen that are nice to live.
3. C: Oh no, Nairobi is far better than the many cities I have travelled such as Mumbai, Mogandishu….

From the example, B actually does not agree that all parts of Nairobi are difficult to live in. However, he does not express his disagreement strongly to be more polite. In this case, B's answer tries to minimize his disagreement using partial agreement, *"true but.."*. However, C by using the praise, "Oh no.." at the beginning, he maximizes the disagreement between himself and C and therefore violates the agreement maxim that demands a speaker to minimize disagreements between self and other. Similarly, in analysing discourses, the study looked at whether speakers made efforts to reduce disagreements and enhance the level of agreements in their conversations and any violation of this criteria set by this maxim was used as a basis of noting deviations from expected norms for analysis using LMT.

f). Sympathy Maxim

According to Muchiri (2014), sympathy maxim refers to: minimize antipathy between self and other and maximize sympathy between self and other. In this case, the achievement being reached by other must be congratulated. On other hand, the calamity that happens to other must be given sympathy or condolences. An example is as follows:

1. A: The thugs badly injured my father.
2. B: I am terribly sorry to hear about your father.
3. C: But he used to be a village bully; he must have got his match!

In this conversation, B's statement is an emotional expression which expresses the sympathy for misfortune of A. This expression shows the solidarity between the speaker and the hearer. However, C seems to celebrate the calamity that happens to A's father and thus violates the symphathy maxim that demands that calamity that happens to other must be given sympathy. Similarly, in analysing discourses, the study looked at whether speakers sympathetic to each other and any violation was

used as a basis of noting deviations from expected norms for analysis using LMT.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter deals with the research methodology that was used to carry out the study. It includes: the research design, study area, study population, sampling procedure and sample size, piloting, instruments of data collection, data collection methods, data analysis and presentation, and the ethical considerations that were followed in this study.

3.1 Research Design

This study adopted qualitative research design. According to Creswell (2014), qualitative studies involves purposeful sampling, collection of open-ended data, analysis of text or pictures, representation of information in figures and tables, and personal interpretation of the findings. This study purposively sampled service providers and family planning written materials and therefore conformed to a qualitative research design. Creswell (2014) asserts that qualitative researchers tend to collect data in the field at the site where participants experience the issue or problem under study. He emphasizes that qualitative researchers collect data themselves through examining documents, observing behavior, or interviewing participants and do not tend to use or rely on questionnaires or instruments developed by other researchers. The researcher observed and recorded service seeker – service provider discourses and interviewed participants and further sampled family planning written materials at Machakos Level 5 family planning department.

Morse (1991) in Makori (2015) contend that qualitative research design relies on multiple forms of data, such as interviews, observations, documents, and audiovisual information rather than relying on a single data source. He further posits that qualitative research design is suitable when the nature of the phenomenom may not be suited to quantitative measures. In line with this recommendation, this study adopted qualitative approach because a study on language use requires data to be collected in its natural setting as much as possible. Fairbrother, Nekvapil and Sloboda (2018) claim that research in language management under LMT should focus on actual language use wherever possible. They observe that there is need to gain access to naturally-occurring data. For that reason, the current study adopted qualitative research design and employed qualitative data collection approaches such as observation, interviews, audio recording and reviewed written materials.

3.2 Study Area

This study was carried out in Machakos Level 5 Hospital located in Machakos town, in Machakos County. The County borders Murang'a, Embu and Kiambu counties in the North. It borders Nairobi and Kajiado counties in the west, Makueni County in the south and Kitui County in the East. The hospital was upgraded to a level 5 facility in 2015. The hospital is the only referral facility in the lower Eastern Region and it therefore offers specialized services such as antenatal, antiretroviral therapy, curative inpatient and outpatient services and family planning among others. According to the Kenya Population and Housing Census report (2009), the county has a population of 1,098,584. It covers an area of 62,082 km^2. The average household size is four persons (Kenya National Bureau of Statistics, 2010). The local people are mostly Akamba (92.9%) who speak Kikamba but there are also ethnic

groups such as the Agikuyu (3.2%), Abagusii (0.3%), Luo (0.7%), Taita (0.1%), Kalenjin (0.3%), Maasai (0.7%), Abaluhya (0.7%) just but to mention a few (National Cohesion and Integration Commission, 2016). Due to this ethnic diversity, the research area therefore provided a rich study site to study language management in the context of diverse cultural and linguistic backgrounds.

3.3 Study Population

The current study was carried out in the FP department at Machakos Level 5 Hospital. The study population comprised of all the FP service providers, all FP service seekers and all FP written materials at Machakos Level 5 Hospital FP department. The service seekers were both men and women and service providers included counsellors, social workers, clinical officers and gynecologists. The written material population included charts, drug leaflets and brochures.

3.4 Sampling Procedure and Sample Size

The researcher made several visits to the FP department on separate dates, different days and time. At the facility reception, the researcher through simple random technique identified FP seekers that were included in the study. In total, 20 service seekers were included. Sampling for service providers was purposive and depended on professionals who served the sampled service seekers. In total, 15 service providers were sampled and they included: 3 social workers, 3 counselors, 8 nurses and 1 gynaecologyst. The study further sampled hospital written materials using purposive sampling technique and went for only materials with FP content. Included in this category were 2 charts, 2 drug leaflets and 2 brochures. Patton (2002) observes that purposive sampling involves the identification and selection of

information rich cases.

3.5 Piloting

Before the actual data collection, piloting was conducted to test the content validity of data collection instruments. According to Kothari and Gaurav (2014), testing for validity enables a researcher to ascertain whether data collection instrument content is measuring what it is expected to measure. Piloting was done in this research so as to ensure that the questions were relevant, clear and understandable. During piloting, it was noted that some questions were ambiguous and others were irrelevant and tended to prolong the duration of the interviews to the disadvantage of clients who had taken a lot of hours in the facility. After the interviews, irrelevant and ambiguous questions were removed.

3.6 Materials and Methods

Fairbrother, Nekvapil and Sloboda (2018) claim that research in language management under LMT should focus on actual language use wherever possible. They observe that there is need to gain access to naturally-occuring data. The current study employed observation of service encounters, interviews and sampled hospital written materials so as to understand language management at both simple and organized levels. Service seekers were sampled at the reception using simple random technique. The researcher first introduced herself to the service seekers and stated her mission in the facility. Participants were informed that they would be observed while receiving their FP services at various service points and their conversations would also be recorded. They were assured of their anonymity and voluntary participation was sought.

The researcher moved with the client to the first service point which was the HTC room. Services offered at this point are HIV counseling and testing. The researcher started recording the interactions and filling the observation schedule as soon as the interactions between the provider and seeker began. The researcher then moved with the seeker to the FP room where she recorded the interaction and observed what was happening as she filled the observation schedule. In most of the interactions, it was noted that seekers were unwilling to engage the providers fully and this tended to stretch the sessions longer (24 minutes) than the successful interactions (15 minutes). After the FP room, the researcher led the seekers to a room she had been allocated for interviews. Most of the seekers complained that they had spent a lot of time at the facility and as a result, the researcher ensured the interviews were shorter (on average, 5 minutes) and they were also recorded.

3.6.1 Observation

In line with the methodological requirement of LMT, the current study employed observation method to observe service seeker-service provider interactions that were also recorded using digital voice recorder. The Sony ICD-PX240 recorder that was used has an internal memory of 4 GB and has four different recording speeds, each with respective recording length of time. Observation schedule was used to guide the observation process. The schedule consisted of five item-columns that were to be observed and recorded (see appendix 1). While seated at some far end, the researcher made notes on: phatic communication; nature of conversation; turn taking between the provider and seeker; intonation; and evaluated the service encounters. The researcher observed and recorded 20 interactions at the HTC room which took an average of 20 minutes and another 20 observations at the FP room that took an

average of 25 minutes.

3.6.2 Interviews

The study also employed post service interview that involved interviewing the service seekers and service providers after their service encounters. The interviews were guided by an interview guide which consisted of semi structured questions (see appendix II and III). Questions on bio-data of respondents were structured and were uniformly asked to all participants while the other section consisted of questions that were randomly asked differently to different participants depending on the researcher's information need. The interviews were recorded to be transcribed later for analysis. In total, there were 30 interviews: 15 for service seekers at the allocated room and 15 for service providers at their service rooms. Five service seekers insisted they had spent a lot of time at the facility and therefore declined to be interviewed.

3.6.3 Document Analysis

In connection to language management, researchers have made use of many different natural data sources in their analysis (Fairbrother, Nekvapil & Slobada, 2018). The current study used document analysis checklist to sample written materials at Machakos Level 5 Hospital. The checklist consisted of 6 items that were to be analysed (See appendix IV): type of document to be analysed; brief description of the type of document; organization structure of the document; target audience for the document; language use in the document; and evaluation of whether the document had succeeded in conveying the message. The study sampled 2 charts, 2 drug leaflets and 2 brochures. In total, 6 document analysis checklists were used to evaluate the 6

documents that were sampled. Data was recorded on the checklist against each evaluated document.

3.7 Data Analysis and Presentation

The study employed qualitative approach to data analysis. Recorded data were transcribed and translated into English where necessary. Data for the four study objectives was qualitative and was anlysed thematically through content analysis. In objective one, violation of Cooperative Principle and Politeness Theory maxims provided a framework for identifying (noting) norm deviation that set in motion analysis based on the other three LMT processes, that is, evaluation, adjustment design, and implementation of adjustment strategies. In other words, the researcher looked (or observed) at whether violations of the maxims were noted by speakers in their conversations, how they were evaluated (whether negatively or posively), the adjustment strategies that were designed and how they were implemented. Interview data was used to strengthen researcher's narratives. Similarly, hospital written materials were also analysed thematically through content analysis.

3.8 Ethical Considerations

Kothari and Gaurav (2014*)* suggest that researchers should consider ethical issues during planning, conducting, and reporting of research in order to protect the interests of the public, the subjects of research, and the researchers themselves. Ethical issues in this study were two fold: the need to seek authority to conduct research which is a legal requirement in Kenya; and the need to recognize participants' right to privacy, dignity and confidentiality. To address these ethical concerns, the researcher obtained a research permit from National Commission of

Science, Technology and Innovation (NACOSTI) prior to data collection. Participants were issued with Informed Consent Forms (See appendix IV) and they were guaranteed of their confidentiality and anonymity. Additionally, the audio files were encrypted with a password and the transcribed materials were stored in a safe and locked. The researcher will destroy the study materials through burning after six months of writing this thesis.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATIONS AND DISCUSSION

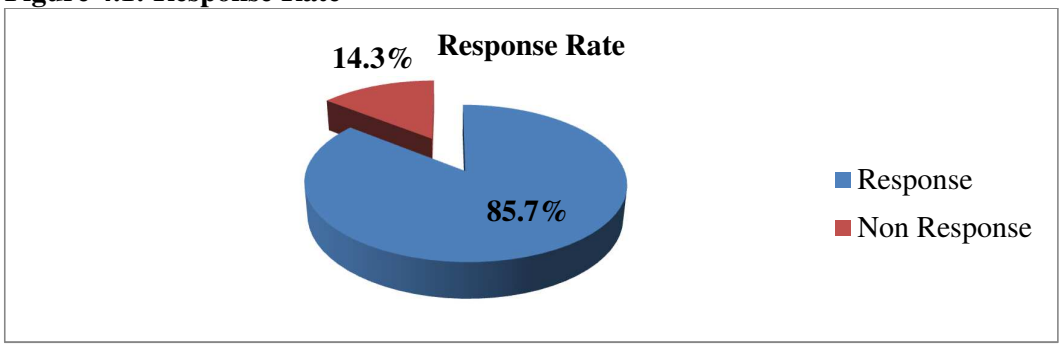
4.0 Introduction

This chapter summarizes and discusses the results of the research based on the objectives and aims of the study and in relation to the literature review. Here, the researcher attempts to interpret, explain, compare and discuss the findings under the study objectives.

4.1 Response Rate

The study involved 15 service providers and 20 service seekers totaling to 35 respondents. Figure 4.1 provides the information.

Figure 4.1: Response Rate



Source: Researcher 2019

Not all the included service seekers participated fully in the study; out of the sampled 20 service seekers, 5 declined to be interviewed at various points and were therefore excluded from the study. Therefore, out of 35 targeted participants; 30 participated fully in the study. This constitutes 85.71% response rate.

4.2 Respondents' Demographic Information

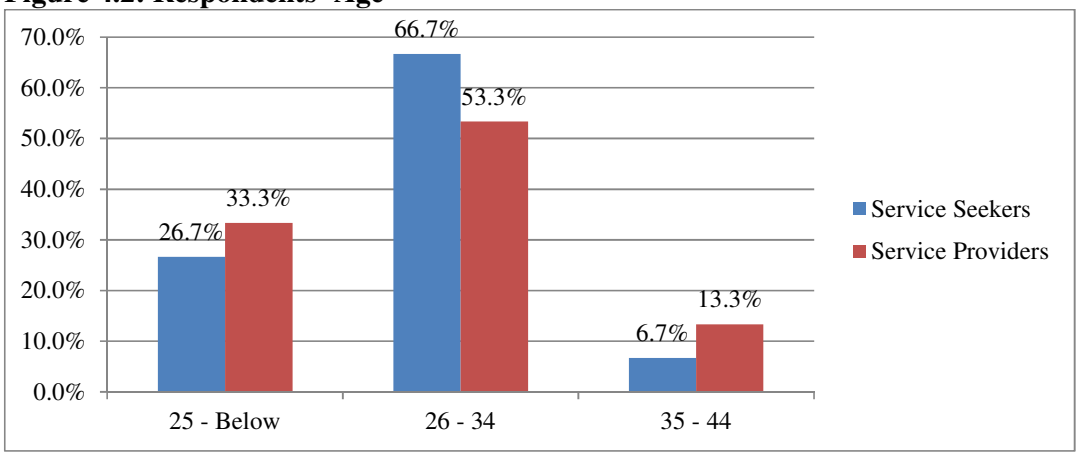
The study collected demographic information of both service seekers and service

providers. The data collected included information on age, level of education, professional status and ethnicity.

4.2.1 Respondents' Age

The study probed respondents' age distribution. Figure 4.2 gives information on respondents' age.

Figure 4.2: Respondents' Age



Source: Researcher 2019

The results show that majority (66.7%) of service seekers are aged between 26 and 34 years. Almost a quarter (26.7%) of service seekers are below 25 years. Cumulatively, nearly 9 in every 10 service seekers are below 34 years. This confirms that the fertile age is 34 and below. Only, 1 (6.7%) of service seekers are aged above 35 years. From these findings, it can be argued that the majority of service seekers are young mothers who might be competent in speaking Sheng' (Machakos being cosmopolitan), Swahili or English.

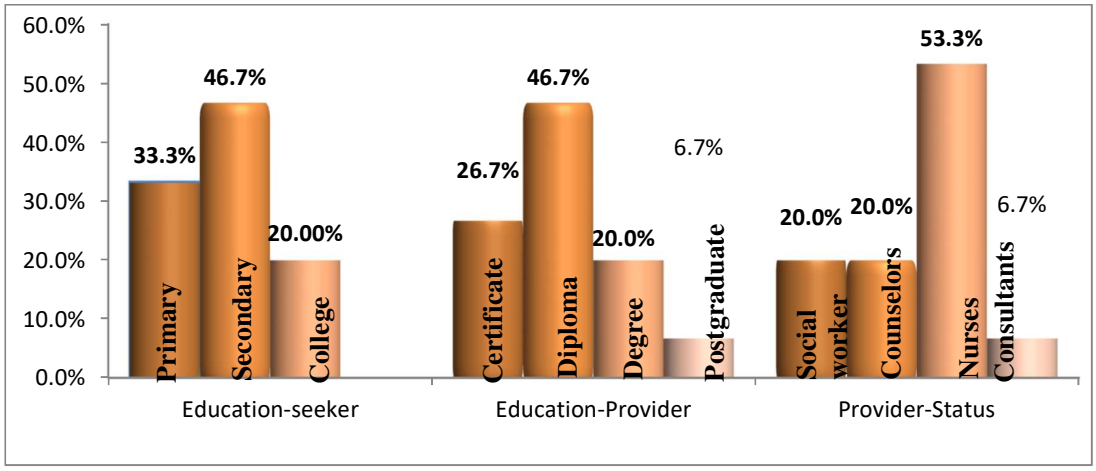
Similarly, the results show that majority (53.3%) of service providers are aged between 26 and 34 years of age. Further, the results show that a third (33.3%) of service providers are 25 years and below. Cumulatively, nearly 9 (86.6%) of every

10 service providers in Machakos Level 5 are aged 34 years and below. It can therefore be inferred that majority of service providers are young and equally serve young service seekers. It can be concluded that majority of service seekers and service providers are in the same age set and are likely to code-switch in their conversations.

4.2.2 Respondents' Level of Education and Service Providers' Professional Status

The study collected information on service seekers' level of education and information on service providers' level of education and their professional status. Figure 4.3 gives the information.

Figure 4.3: Respondents' Level of Education and Service Providers' Professional Status



Source: Researcher 2019

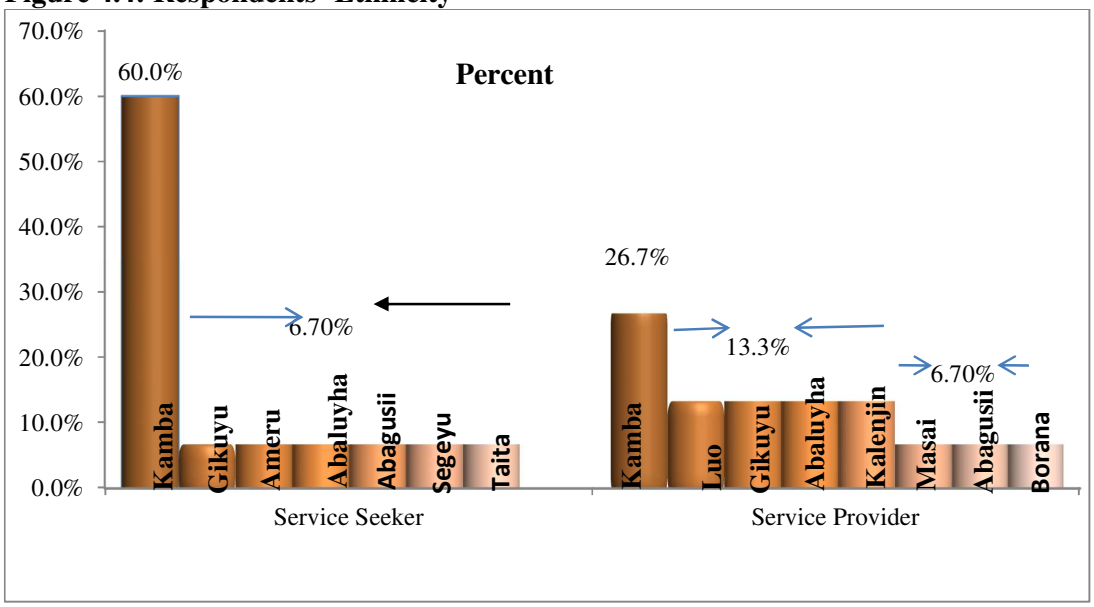
The results of the study indicate that majority of service seekers have attained post primary education as indicated by 46.7% who have attained secondary and 20.0% who have attained college education. However, nearly a third of service seekers have only attained primary education. This could mean that there might be a significant population that does not have a good grasp of both Swahili and English spoken and

written languages given that the study did not inguire which primary class level the participants reached. The study results also show that majority (46.7%) of service providers are diploma holders. Further, the results show that majority (53.3%) of professionals in charge of the FP department are nurses.

4.2.3 Respondents' Ethnicity

The study sought to establish the ethnicities of service seekers and service providers. Figure 4.4 presents the results.

Figure 4.4: Respondents' Ethnicity



Source: Researcher 2019

Results show that majority (60.0%) of service seekers are Kamba while 40.0% of the rest of service seekers are from 6 other ethnic tribes at 6.7% each. Results also show that majority (26.7%) of service providers are of Kamba decent. Luo, Gikuyu, Abaluyha and Kalenjin constitute each 13.3% while Masai, Abagusii and Borana represent each 6.7%. It can be concluded that 6 out of 10 service seekers whose first language is Kamba are likely to be offered FP services by 7 out of 10 non-Kamba speaking service providers exposing a high likelihood of a language barrier.

4.3 Language Problems in FP Settings

This study is based on Jernudd and Neustupny (1987) Language Mangement Theory that claims language management is a process that begins with noting of deviation of a norm (Nekvapil, 2015). Fairbrother, Nekvapil and Sloboda (2018) maintain that LMT while noting deviation from a norm does not solely focus on the grammatical features of a language, but also pays attention to sociolinguistic and sociocultural features. According to Nekvapil (2016), the first step in LMT involves noting the deviation from the norm. In the current study, deviations from norms were noted from violation of cooperative principle and politeness theory communication maxims (Wang & Peng, 2015; Khoyi & Behnam, 2014; Muchiri, 2014; Li, 2015; Maharani, 2017; Liu, 2017). The maxims stipulates the communication needs that must be satisfied by speakers and any deviation means that the norms established by the maxims are violated leading to communication problems.

4.3.1 Language Problems Based on Cooperative Principle

Cooperative Principle formulated by Paul Grice in 1975 describes how people achieve effective conversational communication (Li, 2015). He proposes that participants in a conversation obey a general Cooperative Principle (CP), which is expected to be in force whenever a conversation unfolds: “Make your conversational contribution such as is required, at the stage at which it occurs, by the accepted purpose or direction of the talk exchange in which you are engaged.” (Liu, 2017). Cooperative principle has been divided into four maxims, called the Gricean maxims. According to Li (2015), the Gricean maxims explain the link between utterance and what is understood from them. The four maxims are: maxim of quantity, maxim of quality; maxim of relation; and maxim of manner (Wang & Peng, 2015). Violation of

the maxim is what LMT would note as a deviation from norm. Common language problems that may arise from violation of cooperative principle maxims may mean that speakers may give: less information than required; inaccurate information; irrelevant information; and ambiguous explanations.

a) Giving Less Information than Required

The maxim of quantity states that "try to make your contribution as informative as is required for the current purpose of the exchange, do not make your contribution more informative than is required" (Runqing, 2014). In fulfilling maxim of quantity, Khoyi and Behnam (2014) emphasize that the speaker should be as informative as it is required and therefore should not give too little information or too much. Maxim violation of quantity occurs when a speaker/writer gives more or less information than the situation requires (Adriani, Hamzah and Havid, 2013). In text 1, this maxim is violated:

Text 1: Extract 2

9. A: *Umewaikosa kupata your menses?* (Have you ever failed to receive your menses?)
10. B: *Si kupata hizo vitu ni kaawaida* (I thought receiving periods is normal)
11. A: *Ni kawaida, but mimi nilikuwa nataka kujua kama ushaikosa* (Its normal but I wanted to establish whether you have ever failed to receive your periods)
12. B: *Eeh* (Yeah)

In text 1, A's opening utterance is a yes/no question which receives too much ineffective words as an answer by participant B. This is a violation of quantity maxim which requires a participant to make a contribution that is as informative as is required for the current purpose of the exchange (Khoyi & Behnam, 2014). In the context of LMT, it can be argued that when A openly mentioned "menses', B noted that as a deviation from a cultural norm. It can be argued that B did not want to

discuss matters “menses”, probably due to A using a culturally insensitive terminology “menses” which is subject considered a taboo in many cultures (Fortier, 2013). As a consequence, B evaluates that norm deviation negatively and gives little information, hence deviating from the expected norm of precision (quantity maxim). If a speaker violates the maxim of quantity, he/she does not give the listener enough information to know what is being talked about, because he/she does not want the listener to know the full picture (Adriani, Hamzah and Havid, 2013).

Further, a similar scenario is observed in text 2 in line 24 and 25.

Text 2: Extract 13

24. A: *Eeh, sasa unaonaje tukiweka kitu long term kama coil ndio next ukikuja ufike menopause umalizane na hizi family planning kama hii ni ya five years* (Eeh, would you consider this 5 year method that can sort your FP concerns upto menopause)
25. B: *Nitajua tu* (I will know)
26 A: *Mbona umesema hivyo hapana kwa coil. Tueleze tu ndio tujue kwa nini? Unafikiria nini ama uliambiwa inafanya aje? Unajua iko na the same hormone, by the way yenye iko kwa depo ndio iko hapa, miligrams ndio inadiffer coil iko na? (rudely) as in tufunze. Ama hizi unajua mtu anakuanga na reason maybe nilitumia ikanidhuru ndio sitaki*. (why are you declining coil, tell us your reservations. What are you thinking about? Or what were you told about its side effects? Do you know it has the same level of hormone? Does coil have any? (rudely), tell us. Or just tell us why you prefer your current method?)

In text 2, A’s opening utterance is a yes/no question which receives inadequate answer from B. This is a violation of quantity maxim which requires a participant to make a contribution that is informative (Runqing, 2014). From LMT perspective, it can be seen that speaker A noted that speaker B in line 24 did not provide adequate information she required and it seems that she evaluated that negatively. In LMT, a speaker notes a deviation from a norm and if the deviation is evaluated negatively, it is classified as an inadequacy that sets in motion a process to remove the problem (Kimura, 2014; Nekvapil, 2016). This process can be observed in line 26 where speaker A is seen trying to press B for more information, although impolitely and contrary to patients’ rights charter that dictates a patient has a right to be served with

dignity (Ojwang, Ogutu & Matu, 2010; Ministry of Health, 2013). Khoyi and Behnam (2014) argue that a speaker may give less information so as to advance his/her hidden agenda. From this view, it can be deduced that speaker B in line 25 had a hidden agenda of avoiding the medic from imposing "FP methods".

b) Giving Inaccurate Information

Giving inaccurate information can be as a result of flouting cooperative principle maxim of quality. The maxim refers to "make your contribution one that is true, do not say what you believe to be false, do not say that for which you lack adequate evidence" (Liu, 2017). The violation of quality maxim refers to offer false message deliberately or say something which one does not have enough evidence (Li, 2015). Based on this criterion, the study evaluated whether the conversation in text 3 between the service provider and service seeker flouted the maxim of quality.

Text 3: Extract 13

40. A: *Inaweza kuwa haikudhuru saa hii lakini ukifikisha 50 unaanza kupata hizo cancer zenye tunaongelelea… kama ya matiti, cervix.* (It may not affect you for now but it may be a predisposing factor to cancers like breast or cervical cancer when you hit 50)
41. B: *Kwa hivo hizi family planning methods zenye ziko na hormones ndizo zinacause cancer? Mbona wanaume upata cancer na huwa hawatumii hizi madawa* (So you mean hormonal FP methods cause cancer? But there are men who still get cancer and they do not use these FP contraceptives)
42. A: *Cancer ucausiwa na vitu mob na causes zingine bado hazijulikani* (There are many things that cause cancer but others remain unknown)
43. B: *Kwa hivo hauko sure kabisa kama one of the cause ni hizi madawa?* (So you are these contraceptives cause cancer?
44. A: *Currently zijaona any medical evidence inasuggest so.* (I have not come across any medical evidence suggesting so)
45. B. (Silence). *Na kwa hivyo above 40 which is the best method.* (At 40, what's the best method?)
46. A: *Non hormonal na hiyo coil ndio nilikuwa na kuuliza umesema hapana kwa coil, ndio tumeona your reactions, tunauliza tuelezee……* (No-hormonal like the coil I was telling you and you reacted….just tell us what was the reason we move on……)

In text 3, A intimates that hormonal FP methods can cause some types of cancer but

it later emerges that she had no adequate medical evidence. This is a violation of quality maxim which requires a speaker "to make contribution that is true, not false, or one which he/she lacks adequate evidence" (Liu, 2017). The context of this conversation is in a FP room. Just before line 40, speaker A had tried to persuade speaker B against a depo method by trying to outline the possible side effects. On her part, speaker B was against speaker A's medical narratives of severe side effects. For example, contrary to speaker A's assertion that the depo method can delay pregnancy for long, speaker B indicated that she was able to stop using the drug and conceive within a short period. With limited convincing options, speaker A invoked her professional power and deliberately scared B by falsely alleging that hormonal methods can cause cancer. It can be seen that speaker B *notes* a deviation from the expected *norm* of providing accurate information. She evaluates this negatively and she is seen pelting A with a series of direct questions in order to press her to clarify whether her assertion is based on medical evidence.

Text 3 illustrates the first process of language management within the framework of LMT that Jernudd and Neustupny (1987) claimed involves noting of a deviation from norm (Nekvapil & Sherman, 2009; Kimura, 2014; Nekvapil, 2015; Nekvapil, 2016). According to CDC (2014), providers should give accurate information to the client about risks and side effects of the methods under consideration so as to enable the client make a decision on safer FP method. Providing false information to a client that one lacks adequate evidence does not only flout the maxim of quality but also the fundamental principle of quality which aims at improving health outcomes in a manner that is consistent with current professional knowledge (Institute of Medicine, 2010).

Similarly, quality maxim was violated in text 4 below:

Text 4: Extract 6

17. A: *Hii ya three months yenye unadungwa uliambiwa madhara?* (This is for three months, were you told of the side effects?)

18. B: *Eeh* (Eeh)

19. A: *Kama gani?* (like which one?)

20. B: *Inaweza change pressure* (Can increase your pressure)

21. A: *Eeh* (Eeh)

22. B: *Inaweza ongeza weight* (Can increase your weight)

23. A: *Inaweza ongeza kilo. Haukuambiwa ukitaka kupata mtoto inaweza kukawia* (It can increase weight, were you not told if you want to get a baby it will take long?)

24. B: *Hapana* (No)

25. A: *Hukuambiwa hivyo?* (Were you not told that?)

26. B: *Labda niliambiwa lakini sikusikia* (May be I was told but I didn't get it.)

27. A: *Hukusikia hiyo? Sawa hii inaweza ongeza kilo, inaweza change period zako but sasa shida yake ni kuwa inaffect fertility, time unataka kupata mtoto wa pili ina delay, unaweza ngoja miezi sita, miaka kumi ukigoja mtoto mwingine* (You did get it? Okay this one can increase your weight, change your periods but also affects fertility so that, when you want to get your second child it can take long)

Given that speaker B claims to have been told of all possible side effects of depo method in her previous FP clinic, speaker A expects B to have been told that the method can delay conception but to his surprise, B gives an inaccurate answer. This is a violation of quality maxim which requires a speaker to make contribution that is true (Li, 2015). In this interaction, simple language management seems to be on course. For example, after being pressed hard in line 25, speaker B seems to have *noted* in line 26 that she had lied and negatively evaluates that utterance act. She (speaker B) decides to clarify that she may have been told but it escaped her attention, possibly to remove the deviation. In LMT, when a deviation from norm is noted and negatively evaluated, as in the present case, the other processes of

evaluation, designing an adjustment strategy and implementing the strategy are set in motion to eliminate the negatively evaluated norm (Fairbrother, Nekvapil & Slobada, 2018).

c) Providing Irrelevant Information

The maxim demands that the speaker should give relevant information (Wang & Peng, 2015). According to Liu (2017), the maxim of relation refers to the conversation between the speaker and the hearer being closely related to the topic in a specific context. This implies that the speakers should try as much as possible to remain within the topics they are conversing on because switching to other related topics will flout the relation maxim. However, this does not usually happen because in most instances during conversations, speakers usually bring in other unrelated issues (Li, 2015). In text 5, this maxim is violated:

Text 5: Extract 11

1. A: *Habari yako?* (How are you?)
2. B: *Nataka sindano* (I want the injection)
3. A: *Hakuna sindano, unless ununue pale inje, unawezaa jaribu njia ingine?* (Injections are out of stock unless you buy from the pharmacy, can we offer something different and available?)
4. B: *Hapana, nataka shindano mimi* (no, I just want the injection)
5. A: *Sasa unless uende ununue pale inje ukuje tukudunge.* (For now you can only buy from the pharmacy and come for an injection.)
6. B: *Naeza tumia pill?* (Can I use pills?)
7. A: *Ama unaweza tumia pills at least for a month, labda by then zitakuwa zimekuja mtoto ako na wiki gapi?* (Alternatively you can use the pills for now before we get more medical supplies. On a different note, how many months does the child have?

In text 5, speaker B returns greetings with an irrelevant answer about what she wants. Therefore, B deviates from the expected norm of returning greetings with greetings. It can be inferred from the foregoing that B, obviously aware of her language limitations, had devised a language management strategy similar to what Neustupny (2004) refers to as pre-interaction management process. It involves noting a deviation from norm, evaluating it, devising an adjustment design and implementating it in

anticipation of potential problem in a future interaction. Speaker B seems to have a fixed mind on what to tell A at the first instance.

As a result of flouting the relation maxim, it is noted that the CDC (2014) guidelines are not followed step-wise. In lines 3, 5 and 7, A becomes a passive provider and the roles are interchanged with B assuming an active role. As a consequence, A does: not seek medical history of B to identify methods that are safe; does not confirm B's pregnancy intentions; and does not inform B about all contraceptive methods that can be used safely. The maxim could have also been flouted due to language cultural issues. It seems B had anticipated deep interrogation against her cultural beliefs that may hold that family planning topics are taboo. In a subsequent interview, speaker B confirms this researcher's position:

R: *Umekaa kipindi kidogo na dakitari na nikama umekuja kama umejipanga na njia yako ya kupanga uzazi (I have noticed your session with the provider was short and its like you had a predetermined method).*

B: *Venye nimelelewa, hii mambo ya family planning huwa sipendi kuichangia saana. Huwa nasikia ikiwa ni mambo chafu.* (Family planning topics do not go down well me. I consider it a dirty topic for discussion at length)

From this follow up interview, it can be seen that speaker B had come ready with her preferred FP method just to avoid discussing a topic she considers a taboo.

The maxim of relation is also violated in text 6 below:

Text 6: Extract 12

91. A: *Tukigojea matokeo ukiwa na swali unaweza kuniuliza* (You can ask any question as we wait for the results).
92. B: *Kwa nini watu wasikia ubaridi?* (why do people experience coldness?)
93. A: *Watu wasi……..* (People experience…)
94. B: *(Interrupts) wasikia ubaridi dhidi wanapokuwa na hiyo maradhi.* [(interrupts) HIV patients experience coldness]
95. A: *Uh! (pause) saa zingine nimekueleza wakati mwili hauna kinga ya kutosha…..* [uh! (pause) I have just explained that it is when the immune system is very low]
96. B: (Interrupts) wasikia ubaridi saa zote? [(interrupts)] they experience coldness all through?]
97. A: *Si, lazima akiwa anasikia baridi ni pengine kama kinga ya mwili imeenda chini*

ya kuzuia maradhi eeh … (pause) ndio pengine anaanza kusikia hivi hivi. Na (pause) Family Planning umepanga kuanza lini? {It's not mandatory to feel cold maybe your immunity level has gone down … (pause) that is when you start feeling funny. And (pause) when are you starting Family Planning?}

98. B: *(silence) naona ni vyema ni discuss hayo maneno na daktari next room juu nilikuwa nakuja kusaidiwa.* (I think those are issues are I need to discuss with FP provider in the next room because I had come to be helped)
99. A: *Yeah hao ndio ma expert wa hizo, pole lakini hiyo ilikuwa by the way.*(Yeah because they are the experts in FP, it was just a by the way question)
100. B: *Eeh* (Eeh)

As part of HIV prevention intervention measure, HIV Testing and Counselling (HTC) is a component of family planning services in Kenya. Line 97 presents an ordinary HTC session where a service provider allows the client to ask questions related to HIV after presenting HIV related information. Speaker B is curious to know why HIV positive patients experience coldness. Provider A explains in line 97 that the situation can be attributable to the body having low immune system due to the effects of HIV when it is at an advanced stage. This conversation is expected in a HTC pre-test session. However, it is noted that A asks B when she was planning to start FP just within line 97 which is completely unrelated to HTC services. In view of the fact that the three primary components of HIV testing and counselling (HTC) are the pretest session, the HIV test, and the post-test session, it can be argued that the question A puts to B on when she will be starting FP is irrelevant to the current setting. Therefore, it can be concluded that the maxim of relation was flouted in this particular conversation which demands that the speaker utterances should remain within the current context (Li, 2015).

d) Ambiguous Explanations

The maxim of manner dictates that the speaker should avoid obscurity of expression, ambiguity and that the speaker should try as much as possible to be brief and orderly (Li, 2015). According to Liu (2017), in people's daily conversation, communication

between the two sides or one side can express some extended meanings with vague, ambiguous or lengthy discourse to realize interpersonal communication. To avoid this, physicians should guide their patients thinking and joining activities actively by using accurate or clear explanations. Use of obscure and ambiguous expressions or words violates the manner maxim (Liu, 2017).

Text 7: Extract 9

30. B: *Umesema hizo pills zina last for how long?* (How long do the pills last?)
31. A: *Unameza kila siku tu moja moja.* (You swallow one daily.)
32. B: *Mmh (not satisfied)* {Mmh (not satisfied}
33. A: (*shouting) namaanisha unatumia dawa kila siku hadi ubadilishe njia ingine. Kila siku, si ati kwa muda fulani unaacha*. [(shouting) my point is that you take the pills for as long as you are not on any other method. Daily, not for sometime and you stop].
34. *Uh mmh*. (uh mmh).
33. A: *Halafu tuko na sindano ya miezi mitatu kila baada ya miezi mitatu unakuja unadungwa sindano sawa.* (We also have a three month injection whereby you come for if after every three months)

In text 7, B's opening utterance is a statement which seeks clarity on time frame which receives ambiguous answer from A. This is a violation of manner maxim which dictates that the speaker should avoid obscurity of expression and ambiguity. From LMT perspective, it can be seen that speaker A noted in line 31 that she did not provide clear information as sought by speaker B. Speaker A seems to have evaluated the deviation negatively. In LMT, a speaker notes a deviation from a norm and if the deviation is evaluated negatively, it is classified as an inadequacy that sets in motion a process to remove the problem (Kimura, 2014; Nekvapil, 2016). This process can be observed in line 33 where speaker devises and implements an adjustment strategy of self correction to remove the problem.

Looked from another angle, it can be argued that the service seeker is also observed to be involved in simple language management. For example, in line 30, speaker B is seeking clarity on how FP drugs should be taken. Going by her murmurs "mmh", it

can be inferred that she noted a deviation from norm in line 31 where speaker A provided unclear answer. She seems to have evaluated the deviation from the norm negatively and designs an adjustment strategy of murmuring just to show the provider that she was not satisfied with the answer in the hope that the ambiguity would be clarified. This finding is consistent with Ojwang, Ogutu and Matu (2010) study on nurses' impoliteness that showed which distorted information was one of the undesirable strategy used by nurses in Kenya.

The maxim of manner is further flouted in subsequent discourse that takes place at HTC room.

Text 8: Extract 1

13. A: *Mwezi wa sita. Ni sawa inakuanga muhimu kujua hali yakonampenzi wako sababu inaweza pengine ako na virusi na hajakuambukiza so kujua hali yake ni kitu muhimu. Nitakuuliza maswali kwa kifupi. Ningependa nijue unaelewa nini kuhusu HIV? Unaelewa kama nini HIV?* (In June, it is good to know the HIV status of your partner because he/she may be infected but you are not. Let me ask you some questions briefly. I would wish to know how you understand HIV, what is HIV?)
14. B: *(Silence) Ni uh ugonjwa tu uh bad* {(Silence) It is uh just a bad uh sickness}

Prior to line 13, A speaker was inquiring the last time speaker B and her husband were tested. Speaker B indicated it was in June. While continue with the HTC session, speaker A repeats speaker B's "June statement" and goes on state so many other things in a disorderly manner. In text 8, A's utterance in line 13 is ambiguous, unclear and disorderly and thus violates the manner maxim which requires a speaker to: avoid ambiguity; be brief; be clear; and be orderly (Li, 2015). It seems speaker A *notes* the ambiguity in his statement, "*Ningependa nijue unaelewa nini kuhusu HIV?"* and evaluates the deviation from the norm negatively so that he designs and implements an adjustment strategy of clarifying the ambiguity in the statement "*Unaelewa kama nini HIV?"*

Fairbrother, Nekvapil and Sloboda (2018) assert that a speaker only pays language attention in LMT to a negatively evaluated norm with an aim of removing the problem. The service seaker B on the other hand is seen to be involved in simple language management. For example, in line 14, speaker B appears to have *noted* the ambiguity in speaker A's utterance and evaluated it negatively. She designs and implements an adjustment strategy of going into silence and murmuring unclear words "uh" probably to protest the ambiguity. It can therefore, be concluded that there is simple language management by both the provider and the seeker.

4.3.2 Language Problems Based on Politeness theory

Leech (1983) politeness theory has six conversational maxims similar to those formulated by Paul Grice that sets norms of conversations. Leech proposed six maxims, namely Tact Maxim, Generosity Maxim, Approbation Maxim, Modesty Maxim, Agreement Maxim, and Sympathy Maxim. Flouting of these maxims offends the politeness principle.

a) Use of Stigmatizing Language

Tact is characterized by sensitivity in dealing with others or by a keen sense of what to do or say in order to maintain good relations with others and avoid offense. Actions may be evaluated in terms of what is assumed to be its cost or benefit to the speaker or the hearer. According to Muchiri (2014), the tact maxim states "minimize cost to other and maximize benefit to other" In text 9, it is noted that tact maxim is violated.

Text 9: Extract 7

9. A: *Sawa huwa tunarudia tena mama akikuja kuanza clinic ya mtoto. (pause) tunataka tuakikishe tumekinga mtoto asikuje kupata virusi sawa sawa.*

Humewahi pimwa na mzee. (OK. We normally do it again when a mother brings the child to clinic for the first time to ensure we protect the child from contracting HIV virus. OK. Have you ever been tested with your husband?)

10. B: *Bado* (Not yet)
11. A: *Tangu muoane hamjawahi pimwa pamoja?* (Since you got married, you have never been tested together?)
12. B: *Hapana.* (No)
13. A: *Kwa hivyo hujui hali yake?* (So you do not know his status?)
14. B: *Hapana* (No)
15. A: *Okay, usibabaike saana HIV prevalence is going down in Kenya na watu wengi tunapima tunapata hawana. But it is important umkumbushe mpimwe.* (Okay let that not bother you a lot; HIV prevalence is low in Kenya infact many tests we conduct here turn negative. But it is important you convice him for a test.)

The conversation captures an ordinary HIV pre-testing session. Normally, the session involves: information on the benefits of knowing one's HIV status; benefits of couple testing; an explanation of the HIV testing process; and the need for consent for the HIV test (National AIDS & STI Control Programme, 2010). The session also involves asking questions so as to enable the provider to get accurate information that may predispose a client to HIV exposure and probably devise a suitable counseling approach. The provider can still achieve all these while taking note of the need to save the seekers face through observing the tact maxim. In line 9, A explains the benefits of the post-natal HIV testing to B. Still on the same line, A further inquires from B whether she has ever undergone couple testing with her husband. In line 10, B answers in the negative. Oblivious of the emotional cost to B, A still repeats and re-emphasizes the same question in line 11.

The impact is observed in line 12 when B, appears tensed and still replies in the negative. In line 13, A's inquisitive behavior continues when he asks B whether she does not know of her husband's HIV status. From a professional point of view, A ought to have inferred from B's response that she could not have been aware of her husband's HIV status given that they had not been tested together. Therefore, it was

unjustified for A to continue subjecting B to emotional burden of not knowing her HIV status and this amounted to flouting the tact maxim. The established norm by Leech's tact maxim is to reduce the cost (burden) on others but in this case, it is noted that A is increasing the emotional cost on B and thus deviating from this norm.

Further, in the same conversation line 19, A continues to violate the tact maxim.

Text 10: Extract 7

19. A: *So unatarajia matokeo ikuwe aje sababu hujawahi pimwa na mzee?* (So, what results do you expect now that you've not been tested with your husband?)

20. B: *Ikue tu poa* (to be just okay).

21. A: *Kwa bahati mbaya ikibadilika?* (And in case the results turn positive?)

22. B: *(silence) Nitatafuta tu namna.* (I will get a way out)

By trying to suggest that there is a high likelihood of the HIV tests results to be positive, the speaker is trying to add more emotional burden on the choice of B accepting to be tested or even declining the test. This defies the requirement of tact maxim that stipulates that costs are to be minimized and benefits are to be maximized. Ordinarily, the speaker ought to show B how getting tested is more beneficial than stigmatizing the testing process. In the absence of adequate pre-test clinical counseling, like in the present case, the act of asking such a question would be regarded as stigmatizing. Line 22 demonstrates that speaker B has noted that speaker A is insensitive and evaluates that deviation negatively. Silence and "Nitatafuta namna" statement indicates that speaker B is trying to show speaker A that she is being offended by her insensitive questions. Nekvapil (2015) claims that when a speaker notes and evaluates a deviation from a norm negatively, s/he gives the deviation language attention aimed at designing and implementing a strategy to remove the problem.

b) Use of Insensitive Language

According to Maharani (2017), the norm in sympathy maxim is to minimize antipathy between self and other and maximize sympathy between self and other. The achievement being reached by other must be appreciated and the calamity that happens to other must be given sympathy or condolences. Muchiri (2014) says that sympathy is found where one feels that he or she cares about and is sorry about another's trouble, grief or misfortune. The sympathy maxim accounts for compassion between self and other. Any deviation from this established norm leads to impoliteness. In text 11, this norm is deviated.

Text 11: Extract 9

80. B: *Nitakuja tu mueke hio Implanon* (I will come for the Implanon)
81. A: *Lini?* (When?)
82. B: Next month *(Next month)*
83. A: *Sa between now and next month unataka kutumia njia gani?Uunaweza tumia tembe au unaweza tumia* (So between now and next month which method do you wish to use? you can use the pill or you can use……)
84. B: *(interrupts) Pill, lakini pill si uaffect mtu as in tuseme as in between now and next month nitumie hizo pills na nikija mniweke Implanon* {(Interrupts) pill, does it not affect someone, let's say between now and next month I can use it, then I come for Implanon.}
85. A: *Haina shida* (No problem)
86. B: *Eeh* (Eeh)
87. A: *Eeh ukitumia pills kutoka now mpaka next month ukiwa ready ukitaka implant tunasimamisha hio tunaweka Implanon. Eeh.* (You can use the pill from now upto next month and when ready come for the Implanon.)
88. B: *Mmh* (Mmh)
89. A: *Yah, lakini ni vizuri ujikinge* (Yah, but its good you protect yourself.)
90. B: *Sawa* (Okay)
91. A. *Because ukipata mimba na mtoto hajakua? Utazaa mwingine tena mwaka ujao kama huyu hajaanza hata mwaka mmoja si ndio?* (What if you conceive and the baby is still small or you deliver another one next year before this one is a year old)
92. B. *(laughs and folds her eyes with palm) mmh* {(laughs and wraps her eyes with palm) mmh}
93. A: *Sasa ni muhimu so ni wewe kuchagua mi nakufunza halafu unaamua* (So it's important you choose a method as mine was just to inform you.)
94. B: *Eeh* (Eeh)

According to CDC (2014), if a client chooses a method that is not available on-site or during the visit, the client should be provided with another method to use until she or

he can start the chosen method. In this case, B is not on any FP method but after counseling, she prefers the Implanon method (in line 80) but she is only ready for it in another month's time (in line 82). Speaker A gets concerned in line 83 that B is exposed to imminent pregnancy and encourages her to use pills for the time being. In line 84, B is convinced to use the pills temporarily although with reservations on the side effects. It is in line 91 where A deviates from the established norm of showing sympathy to B when she says, 'What if you conceive and the baby is still small…". In line 92, B laughs and folds her eyes with the palm. This act suggests that A could have mentioned something that may have been embarrassing to her. When she was followed up for an interview, she told the researcher that where she comes from, a woman with very many toddlers of almost same age is viewed negatively as being sexually irresponsible. Wang and Peng (2015) opine that some topics are considered a taboo and are therefore avoided in different cultures. It can therefore be concluded that the maxim of sympathy has been violated.

Similarly, in text 12, it is to be noted that A uses impolite language that defies the maxim of sympathy proposed by Leech.

Text 12: Extract 6

1. A: *Habari ya leo mum. Mtoto ana wiki gapi?* (How are you mum, how old is the baby?)
2. B: *Miezi tano na wiki mbili* (Five months and two weeks)
3. A: *Miezi tano na wiki mbili*. Mbona umekuja family planning kama umechelewa ulikuwa unatumia method gani? (Five months, two weeks! Why have you delayed coming for family planning? Which method have been using?)
4. B: *Three months* (Three months)
5. A: *Ya three month, sindano ama dawa ya kumeza?* (Three months injection or pill?)
6. B: *Sindano* (injection)
7. A: *Sindano ah uko na watoto wangapi?* (Injections ah how many children do you have?)
8. B: *Mmoja* (one)

9. A: *Mmoja (Surprised) mbona uliamua sindano? Ndio ulale tu na starehe?* {One (surprised) why then did you choose the injection or you wanted a convenient method?}
10. B: *(Embarassed) Ndio inafaa* {(Embarassed) It's suitable for me}
11. A: *Eeh ndio inafaa?* (Eeh that's good?)
12. B: *(Silence) Mmh* (Silence) Mmh)

In this discourse, A is surprised by B's choice of depo method which according to her should not be used by young mothers who still want to conceive in future. In line 9, A probes B why she preferred the depo method and innocently/ignorantly uses the phrase "so that you can sleep comfortably". It is observed in line 10 that B is embarrassed by that statement. While A could have used the phrase innocently to mean depo gives B the comfort of not worrying about conceiving, in some other cultures, the phrase is used to refer to a sexually loose woman. Therefore, A emerges as a speaker who does not care or feel sorry about B's trouble, grief or misfortune and therefore deviates from the established norm of trying to reduce the calamity that happens to others.

Within the framework of LMT as advanced by Jernudd and Neustupny (1987), Language management is a process that goes through four phases that are triggered by a speaker noting and evaluating a deviation from a norm negatively in order to pay language attention. Proponents of LMT claim that speakers in conversations are involved in simple language management whenever they note, evaluate a deviation from a norm negatively and choose to pay language attention (Nepkavil, 2016). For example, the service seeker after noting a deviation from norm in line 9 is seen implementing an adjustment strategy of being rude in line 10.

Similarly, speaker A is also seen in line 11 to have noted and evaluated a deviation from norm negatively when speaker B answered rudely, and designs and implements an adjustment strategy of repeating B's rude utterance. Matsuoka and Poole (2015)

observe that healthcare professionals are expected to acquire communication skills that might lead to mutual trust and a therapeutic, supportive relationship between themselves and their patients. It is observed in text 12 that the medic lacks linguistic skills to probe the service seeker and deliver services in a therapeutic and supportive atmosphere.

c) Dignity Violation

According to Maharani (2017), the approbation maxim states that: minimize dispraise of other while maximizing praise of others. This maxim advises that if one cannot praise an individual then it is better to side step the issue or to give a minimal response through the use of euphemisms for example or by being silent. It is noted in text 13 that the norm established by this maxim is flouted.

Text 13: Extract 8

59. A: *Sawa tutaangalia tuone vile unaendelea. Hakuna usaha?, Hakuna kitu yeyote?Damu bado inatoka huko chini?* (Ok we shall check and see how you are doing. No pus? I mean do you have any fluids? Is the vagina bleeding still?)

60. B: *(Embarrased) Iliisha.* {(Embarrased) It's over}

61. A: *Iliisha, mtoto ananyonya vizuri?* (Is it over? Is the child suckling well?)

62. B: *(Silence)* (Silence)

63. A: *So vile ulifikisha mwezi ulikuwa umeanza kupanga uzazi?* (So, now a month is over have you begun FP?)

64. B: *Bado* (No)

65. A: *Bado hujaanza? So tulikuwa tunataka tukimalizia utatoka hapa twende tuanze kupanga uzazi ndio at least huyu ni mtoto wa gapi?* (You have not started? So when we clear you here, you will proceed to FP at least, this child is a born?)

In text 13, A's opening phrase of *"Hakuna usaha"* and *"damu bado inatoka uko chini"* are unpleasant and insensitive to speaker and thus violates the approbation maxim. The phrases are *noted* and negatively evaluated by speaker B to be culturally

offensive. This can be implied from speaker B's body language where she is seen embarrassed in line 60. Speaker B is seen to be involved in simple language management. For example, in line 62, speaker B devises and implements an adjustment strategy of remaining silent probably to avoid the culturally offending topic.

Similarly, it also observed that speaker A has *noted* that the subject is culturally offending to speaker B. She seems to have negatively evaluated the deviation and designs and implements an adjustment strategy of avoidance by switching to different topic in 63. Further, in line 65, it can be argued that A shows dispraise to B by rebuking her for not having started FP. This can be implied from the way she puts her statement in the negative, *"bado hujaanza kupaga uzazi?"* Statements put in the negative usually expose a negative evaluation and are spiteful especially when they are put as a question statement. Therefore, A deviates from the established norm by Leech (1983) approbation maxim of minimizing dispraise of others while maximizing praise of others probably due to the provider lacking communication skills.

Similarly, approbation maxim is also flouted in the conversation below:

Text 14: Extract 10

1. A: *Jina lako?* (What's your name?)
2. B: *Kasuma* (Kasuma)
3. A: *Kasyuma?* (Kasyuma?)
4. B: *Kasuma* (Kasuma)
5. A: *Namba yako ya simu* (Your phone number?)
6. B: *071 (interrupted)* {071 (interrupted)}
7. A: *(shouting) uongee kwa sauti 0701…….eh* {(shouting) talk loudly 0701…… eh}
8. B: *(loudly)0050230* {(loudly) 0050230}

This interaction starts unconventionally with A not bothering to establish a rapport

with the client (B) which is the norm in most cultures and is a sign of politeness. In an unequal encounters such as nurse – patient, the actor in a superior position in this case the nurse, would be expected to greet patients, exchange pleasantries and accommodate the patients in order to make them at ease.

According to Ojwang, Ogutu and Matu (2010), if the nurse does not practice these traits of expected polite friendliness, then the right to be treated with dignity and respect would have been violated. This can be taken to mean that violation of approbation maxim has dignity violation dimensions. In line 6, while giving her phone number, B is interrupted by A who subsequently, in line 7, shouts and demands B to talk loudly. Subdued, B thereafter shouts loudly her phone number. The substance of this whole interaction paints a picture of a provider who is rude and does not observe patients' dignity rights as envisioned by the Patient Health Charter (Ministry of Health, 2013). It can be concluded that A did not minimize dispraise of B and thus flouted the approbation Maxim. Kimura (2014) notes sometime a speaker may note and evaluate a deviation from a norm negatively but fail to pay attention, as is the case here.

d) Rudeness

Agreement implies a situation in which people share the same opinion. According to Maharani (2017), the agreement maxim promotes harmony between self and other stating: minimize disagreement between self and other; and maximize agreement between self and other

Text 15: Extract 12

109. A: *Kwa hivyo ukipata mashinda huji kushauriwa?* (So, when you get problems you never come for consultation?)

110. B: *Eeh, nilishindwa mimi nikaona hii dawa mbaya* (Eeh, I was unable and I thought the method was bad)
111. A: *Nikujifanya mjuaji unajua na hujui?* (That's adopting a know it all attitude)
112. B: *Sijasema nikipata shida huwa siwezi kuja kusaidiwa.* (I have not indicated that I can't seek help)
113. A: *Lakini ulipopatatwa na shida hukuja* (But you proved you can't)
114. B: *(silence).* (silence).

By insinuating that B does not bother to seek medical advice (line 109) when she encounters medical challenges, A is increasing the likelihood of a conflict (disagreement). Such an act can be construed to promote a disagreement deviating from the norm of minimizing disagreement. By further using the phrase *"nikujifanya mjuaji unajua na hujui"* speaker A is increasing disagreement and thus flouts the agreement maxim. The impact is seen being felt in line 112 where speaker B is seen building up a tension when she alleges, *"sijasema nikipata shida siwezi kuja kusaidiwa."* Speaker B goes into silence in 114 implying that she has noted and evaluated the incidence negatively and designed and implemented an adjustment design of avoidance. This speech act shows that while speaker B is paying attention to language in simple language management, speaker A despite noting that he is brewing conflict has ignored paying attention to the deviation. This is not uncommon in simple language management because Fairbrother, Nekvapil and Sloboda (2018) posit that a speaker may note a deviation from a norm and evaluate it negatively but still ignore paying attention to the deviation.

Similarly, the maxim is again violated in the text below:

Text 16: extract 1

28. A: *Umetoka huko. Sawa nowadays huwa ni routine* (You have come from counseling room. Ok Nowadays it is routine)
29. B: *(interrupt) mmh.* {(interrupt) mmh}
30. A: *Kabla ujatibiwa popote unakuwa unajulishwa hali yako ya HIV. So tukikosa kupima unamaanisha hautaki kuudumiwa leo?* (Before you are treated you

are informed about your status, so if I do not test you do not want to be attended today?)

31. B: *Sikujua nakuja kupimwa* (I did not know that I was to be tested)

It is noted in line 28 that A is informing B who is against a HIV test that it is a normal procedure in the facility. B seems to have been offended by the phrase, "…routine" and she interjects interlocutor A with a murmur. This shows that B is completely disagreeing to be tested. However, in line 30, A further worsens the disagreement already being experienced by threatening her that she will not receive further services unless she is tested. This linguistic act increases the level of disagreement which is against the established norm by Leech agreement maxim of promoting harmony between self and other through minimizing disagreement between self and other while maximizing agreement between self and other (Maharani, 2017).

All this disagreement can be traced to the provider's failure to explain that it is the norm in the facility for all FP clients to undergo mandatory HIV test at the beginning of the conversation. For example, Ogutu et al (2010) noted that some nurses were too forceful and too determined, not caring whether the patient was ready for the medical procedure. They added that the most recurrent complaints in hospitals in Kenya is that nurses in charge do not bother to explain procedures. This also violates the patients' right to be informed unconditionally as promised in the Kenyan Charter of Patients' rights (Ministry of Health, 2013).

Generally, it can be concluded that there are Politeness Theory Maxims that are violated more than others. For instance, service providers tended to violate tact maxim more often leading to use of stigmatizing language. Sympathy maxim was also highly flouted by service providers leading to use of insensitive language.

Approbation maxim was less flouted leading to dignity violation. Agreement maxim was another most flouted maxim by service providers leading to rudeness.

4.4 Evaluation of Language Problems on Service Delivery

Jernnudd and Neustupny (1987) in Nevkapil (2016) outlined the process through which language in use is managed. Jernnudd and colleague claimed that language in use is monitored by the speaker and the hearer and compared with norms that they possess, deviations being noted; deviations from norms are evaluated and thus inadequacies being established; corrective strategies are selected, thus corrective adjustments may be carried out; and the process is completed when corrections have been implemented. Deviation from norms noted in step one can be evaluated negatively by the speaker. In this case, deviations can impact negatively on the quality of communication and therefore impact on service delivery. In this study, deviations from communication norms under Leech's (1983) politeness theory and the Cooperative Principle were evaluated negatively and led to undesirable consequences as discussed below.

a) Miscommunication among Participants

It was observed that use of culture insensitive phrases during service seeker – provider interactions led to communication breakdown.

Text 17: Extract 8

59. A: *Sawa tutaangalia tuone vile unaendelea. Hakuna usaha? Hakuna kitu yeyote? Damu bado inatoka huko chini?* (Ok we shall check and see how you are doing. No pus? I mean do you have any fluids? Are you still bleeding?)

60. B: *(Embarrased) Iliisha.* {(Embarrased) It's over}

61. A: *Iliisha, mtoto ananyonya vizuri?* (Is it over? Is the child suckling well?)

62. B: *(Silence)* (Silence)

In text 17, A's opening phrase of *"Hakuna usaha"* and *"damu bado inatoka uko chini"* are unpleasant and insensitive to speaker B and thus violates the approbation maxim. The phrases are *noted* and negatively evaluated by speaker B to be culturally offensive. This can be implied from speaker B's body language where she is seen embarrassed in line 60. Speaker B is seen to be involved in simple language management. For example, in line 62, speaker B devises and implements an adjustment strategy of remaining silent. It can therefore be concluded that deviation from communication norm may lead to complete communication breakdown.

b) Dissatisfaction with Services

Good communication tends to be the single important factor affecting overall satisfaction with care across different patient categories (Ali & Watson, 2018). In text 2, extract 13; this study noted that B gave inadequate information, an act that violated quantity maxim. In line 24, A tried to convince B on the benefits of coil method. It was noted that in line 25, B gave inconclusive answer when asked to consider the coil method. As a consequence, infuriated A made a forceful explanation and probed further on why B was not making a decision so as to be able to give adequate information in line 26. Similarly, in text 18 of the same extract (extract 13), the same language problem (quantity maxim violation) would return to haunt B in line 45 below. A is seen ventilating her anger on B because she did not give adequate information when she was earlier asked to.

Text 18: Extract 13

45. B: (Silence). *Na kwa hivyo above 40 which is the best method.* (So what is a better method for those with 40 years and above?)
46. A: *Non hormonal na hiyo coil ndio nilikuwa na kuuliza umesema hapana kwa coil, ndio tumeona your reactions…. tunauliza tuelezee* (No-hormonal like the coil I was telling you about then you reacted….just tell us)
47. B: *Mmh uh (silence)* (Mmh uh (silence).
48. A: *Ati?* (what?)
49. B: *Nitaenda na nikirudi nitakuwa decided.* (Next time I will come decided)

The statement, *"non-hormonal na hiyo coil ndio nilikuwa na kuuliza umesema hapana kwa coil, ndio tumeona your reactions, tunauliza tuelezee…… ."* shows speaker A ventilating her anger." In line 47, speaker B uses phrases such as *"Mmh uh"* and goes into silence. This conversational act shows speaker B found speaker A's behavior offensive. When asked what she meant in line 48, she cuts the FP counseling session discussion and indicates that she will come to the facility some other time when decided. This act confirms that she was not satisfied with the services she received from speaker A. Physicians' communication bahaviours are important contributors to patients' satisfaction in the out patients setting (Williams, et al. 1998).

On the follow up interview, the service seeker was probed on whether she was satisfied with the services she received at the hospital.

R: *Umeridhika na huduma ulizozipata kwa hii hospitali?* (Were you satisfied with the services you received?)
B: *Hapana, kwanza imenistress, nikafeel niko down na kama sijashugulikiwa poa* (No, I felt stressed up, demoralized and ignored)
A: *Mbona?* (why?)
B: *Hio kusomewa na nurse kama mtoto akiniulizia vitu sitaki kujibu haikunifurahisha* (The aspect of being lectured by the nurse like kid when I withheld some information sucks)

Responses from B are indicative that she is not satisfied with the services she received from the facility. This study has established that some of the linguistic problems can be traced to flouting of Leech (1983) politeness maxims. It is therefore important to note that service seekers have a face to save and any face threatening act may lead to dissatisfaction with FP services.

c) Poor Service Delivery

Language problems can lead to poor quality of healthcare (Yeo, 2004; Bischoff, Bovier & Rrustemi, 2003). In most of the service provider – service seeker sessions, it was noted that services had a predetermined choice of a depo, a method that service providers insisted has more health effects compared to other FP methods. It appears that most of the service seekers, aware of their language limitations, had devised a strategy of enquiring beforehand, a FP method just to ensure their sessions lasted for a shorter period. This denies the service seekers the professional advice that would be offered by experts should they give them an opportunity for meaningful FP counseling. However, existence of language problems noted could be a major hindrance leading to service seekers preferring more harmful FP methods.

Text 19: Extract: 11

1. A: *Habari yako?* (How are you?)
2. B: *Nataka sindano* (I want the injection)
3. A: *Hakuna sindano, unless ununue pale inje, unawezaa jaribu njia ingine?* (Injections are out of stock unless you from the pharmacy, can we offer something different and available?)
4. B: *Hapana, nataka shindano mimi* (no, I just want the injection)
5. A: *Sasa unless uende ununue pale inje ukuje tukudunge.* (For now you can only buy from the pharmacyand come for an injection.)

In the conversation, B returns greetings with an irrelevant answer of what she wants. Therefore, B deviates from the expected norm of returning greetings with greetings and thus flouts relation/relevance maxim. This linguistic strategy is what Neustupny (2004) refer to as pre-interaction management process. It involves noting a deviation from norm, evaluating, adjustment design and implementation in anticipation of potential problem in a future interaction. Flouting relevance maxim denies the service seeker the professional advice that would be offered by experts should they give them an opportunity for meaningful FP counseling.

Similar incidence was noted in extract 7 where the service seeker revealed that she

got the wrong information from a previous FP visit suggesting language problems may be recurrent and hence the need for organized language management attention:

Text 20: Extract: 7

37. A: *Unaanza lini? Umepanga kuanza lini FP?* (When are you beginning? When are you starting FP?)

38. B: *Mtoto akifisha six months* (When the baby gets to six months)

39. A: *Eeh umeolewa? Nani alikuambia hiyo ya six months?* (Eeh. Are you married? Who told you about that one of six months?)

40. B. *Niliambiwa huku clinic* (I was told here during clinic.)

41. A: *Ukaambiwa hivyo. Hapo uliadanganywa ukaambiwa six months? Na ukipata mimba ingine kabla ya hio six months ifike? Utafanya nini?* (That is what you were told. You were cheated about six months. What if you conceive before the six months? What will you do?)

42. B: *Sikuambiwa siku ile ninaweza anza, eeh.* (I was not told the date I should start. Eeh)

In line 37, A asks B when she is starting her FP method. She says she is planning to start after six month a time period she believes she cannot conceive. The provider enquires who gave her the wrong information in line 39 prompting B to reveal that she was advised at the clinic. In line 41, A doubts the validity of the claim insisting the information was grossly incorrect. Speaker B seems to have experienced a communication problem in her previous visitation to the clinic because in line 42 she further reveals that she was not informed when she should start her FP. In this interaction, it is clear that when a language problem emerges, service seekers often get the wrong information and this can lead to poor services.

d) Hindering Access to FP Services

Arhin (2000) indicates that there is a general pattern of lower use of many preventive and screening programs by those facing language barriers.

Text 21: Extract 1

33. A. *Leo uko tayari kujua hali yako?* (So tell me if you are ready to know your status.)
34. B. *(silence) Hapana* {(Silence) No}
35. A: *Huwa hatulazimishi watu. Na ukienda huko mbele ukose kutibiwa?* (We never force people. What if you proceed then you are not treated?)
36. B: *Nitaenda nyumbani* (I will go home.)

In line 34 B going into silence exposes an underlying stigmatization that can be reduced through effective pre-HIV testing. However effective counseling requires the counselor to possess extraordinary linguistic skills. Instead of A showing empathy to B, she commits a face threatening act that offends Leech (1983) sympathy maxim. It can be seen that B feeling threatened employs an avoidance adjustment strategy of declining the service. It can therefore be concluded that language problems can lower access to health services.

Bauer (2017) claims that providing culturally and linguistically appropriate health services is essential to delivering equitable care and thus increasing access to health care services. One service seeker who declined any of the FP methods after counseling session was interviewed:

> R: *Mbona umekataa kuchangua FP ata kama ni gani na dakitari amekuelezea haina nyingi* (Why didn't you choose any of the FP methods and the provider outlined several?)
>
> B: *Sasa unajua mimi nilikuwa nataka hiyo sindano but venye dakitari amenielezea iko na madhara nyingi ata mtu anaweza kukosa mtoto. Sasa hii imenitia wonga nikaconfirm zile rumour husema hizi vitu za kupanga uzazi zinaweza fanya mtu akose mtoto.* (I had come for the depo but according to the provider, it can cause severe side effects like making one barren. This has scared me and made me to confirm a long held believe that contraceptives can make one not to get a child)

From the interview, B claimed that the provider persuaded her against depo by outlining more severe side effects such as the possibility of failing to conceive. Coincidentally, B comes from a social background that holds the notion that contraceptives can make one barren. Rumors and myths about contraceptives can increase fear of side effects of FP services and thus negatively impact on access.

Fortier (2013) observes that cultural beliefs hinder women from accessing family planning, and eliminating social stigma may require innovative approaches different from other health care services. It can therefore be concluded that B could have encountered a provider who lacks linguistic cultural competency.

e) Increased Sense of Vulnerability

Communication with patients is vital to delivering service satisfaction because when hospital staff takes the time to answer questions of concern to patients, it can alleviate many feelings of uncertainty (EFP, 2006). In addition, when the medical tests and the nature of the treatment are clearly explained, it can alleviate their sense of vulnerability (Friedman & Kelman, 2006).

Text 22: Extract 3
17. A: *Ni ya miaka gapi?* (It's for how many years?)
18. B: *Five years* (Five years)
19. A: *Ni mbali utatolewa 2020?* (It will take a long time, will be removed in the year 2020)
20. B: *Uh!* (Uh!)

Just before line 17, the client had reported that she was on jadelle. She had complained that she was experiencing severe side effects from a 5 year jadelle. In line 19, it can be seen that A is using insensitive words (it will take a long time..). The impact of these insensitive words to B is felt in line 20 where she says *"uh"* an act which can be inferred to mean she is traumatized.

f) Consent may not be sought

Other service seekers decried that their consents were not sought when service providers took tests to confirm their HIV status.

R: *Ni changamoto zipi ulizozipata ulipokuwa ukipokea huduma kutoka kwa dakitari ambaye si wa kabila lako?* (What challenges did you encounter when receiving FP services from a healthcare provider who was not from your linguistic background?)
B: *Nilikasirika kwa sababu sikuulizwa ruhusa nikipimwa hali yangu ya HIV. Wakati*

> *mwingi dakitari alikuwa anaongea vitu sielewi inabidi na nyamaza. Lakini haingefaa achukulie kunyamaza kwangu nikama nimempea ruhusa ya anipime*. (I got bitter because my HIV testing consent was not sought. The fact that I wasn't responding to most of the questions the nurse posed to me shouldn't have been assumed I gave consent)

Communication is imperative to promote the ethical responsibility of autonomy and protect the client's right to make informed decisions (Davies, 2008). Connected to this, through this follow up interview, it is clear that there are instances where service seekers consent to HIV testing is not sought by providers.

4.5 Adjustment Strategies

The focus of LMT is to remove language problems in discourses. Designing an adjustment strategy to a negatively evaluated norm is the third phase of Jernudd and Neustupny (1987) Language Management Theory (Nekvapil, 2016). In simple management, individuals may devise adjustment strategies such as code switching, avoidance strategies and pre-interaction management among others. On their part, organizations may devise adjustment strategies that are aimed at removing language problems in what LMT recognize as organized language management (Kimura, 2014). Such strategies may include: employing professional interpreters and translators; designing staff training courses, developing written material, translating written materials and developing language policy among others. This study examined adjustment strategies that are designed at simple and organized levels in Machakos Level 5 hospital FP department.

4.5.1 Simple Language Management Adjustment Strategies at Machakos Level 5 hospital

Language Management Theory assumes that a speaker is able to note a deviation

from a norm and evaluate the deviation from the norm either positively or negatively. When deviations are evaluated positively, it means the utterance act meets the communication needs. But when the deviation is evaluated negatively, it means the speaker has noted a language problem and pays language attention by designing an adjustement strategy aimed at removing the problem. This section will look at how language problems are occurring in single interactions and how speakers are designing adjustment strategies aimed at removing the problems.

a) Avoidance

Avoidance is an adjustment strategy that involves a speaker changing or switching to a different topic to divert a discussion from an ongoing subject. Avoidance strategy is being employed in this conversation:

Text 23: Extract 4

31. A: *Umewaikosa kupata your menses?* (Have you ever failed to receive your menses?)
32. B: *Mmh (Inaudible)* {Mmh (Inaudible)}
33. A: *Sema ndio ama la?* (Yes/no?)
34. B: *Na iko na the same hormone kama Implanon?* (Does it have same hormone like Implanon?)

In text 23, it can be seen that speaker B noted speaker A's use of the word "menses" and evaluated the deviation negatively. It can be inferred that the term "menses" may be culturally offensive to speaker B who chooses to utter inaudible words, an act that confirms she is not comfortable with the topic and this violates the quantity maxim. Speaker A notes speaker B is not giving adequate information, evaluates that negatively and decides to direct the conversation in a "yes/no" answer. On her part, now forced to a culturally offensive topic, speaker B chooses to divert the topic in line 34 to avoid the topic. This exerpt presents a classic example of two speakers involved in simple language management where both are noting and evaluating a

norm negatively and designing an adjustment strategy.

b) Pre-Interaction Management

Nekvapil and Sherman (2009) define pre-interaction management as a language management process done in anticipation of a future interaction or more precisely, in anticipation of a potential problem in future interaction. They explain that it involves noting (anticipating) a deviation from a norm, evaluation, adjustment design and implementation. Text 24 presents a case where a service seeker seems to have visited the facility and had already decided on her preferred FP method:

Text 24: Extract 11

1. A: *Habari yako?* (How are you?)
2. B: *Nataka sindano* (I want the injection)
3. A: *Hakuna sindano, unless ununue pale inje, unawezaa jaribu njia ingine?* (Injections are out of stock unless you from the pharmacy, can we offer something different and available?)
4. B: *Hapana, nataka shindano mimi* (no, I just want the injection)
5. A: *Sasa unless uende ununue pale inje ukuje tukudunge.* (For now you can only buy from the pharmacyand come for an injection.)

In text 24, B returns greetings with an irrelevant answer of what she wants. Therefore, B deviates from the expected norm of returning greetings with greetings and thus violates the relation maxim. The maxim demands that the speaker should give relevant information (Wang & Peng, 2015). It appears that speaker A notes the deviation from the norm and chooses not to pay attention. Fairbrother, Nekvapil and Sloboda (2018) claim that a speaker may note and evaluate a deviation from a norm negatively and still choose not to pay attention to language management. Despite speaker A's insistence that the injection is out of stock, speaker B remains steadfast that she had come for an injection. It can therefore be concluded that B was aware of her language limitations and had already identified her FP method of choice probably to avoid long FP counseling sessions.

The study also established that service seekers come along with their relatives and especially their husbands to solve their language problems, albeit few:

1. R: *Naona uko na Personal Assistant* (I can see you have a personal assistant)
2. B: *(laughing) Hapana huyu ni my husband (*(laughing) No, he's my husband}
3. A: *Isipokuwa wewe na mama mwingine, sijaona hawa wengine wakikuja na mabwana zao* (save for you and another mother, I have not seen other clients come with their husbands)
4. B: *Wah, mtu nikujipanga kivyake.Unajua kama leo nilikuwa nataka kuchange method yenye natumia then juu sometimes unapata daktari mwenye upenda kuongea kizungu nyiingi nikaona ni vizuri nikuje na bwana anisaidie zenye zitanipita (laughing)* {It's a my strategy. You know today I wanted to change my method and you know sometimes we are served by service providers who have a higher preference for English, I decided to come with my husband to offer some language assistance}

This service seeker told the researcher that she had anticipated to encounter language problems and decided to come with her husband to offer language assistance. This is a case of a pre-interaction management.

c) Rudeness

Further in extract 6 line 9, A violated Leech (1983) sympathy maxim. The norm in sympathy maxim is to minimize antipathy between self and other and maximize sympathy between and other. It was observed during the discourse that the researcher was allowed to observe the seeker when embarrassed, became assertive probably to re-assert the value of her decision.

Text 25: Extract 6

9. A: *Mmoja (Surprised) mbona uliamua sindano? Ndio ulale tu na starehe?* {One (surprised) why then did you choose the injection or you wanted a convenient method?}

10. B: *(Embarassed) Ndio inafaa* {(Embarassed) It's what is good for me.}

11. A: *Ndio inafaa* (It's what suitable)

12. B: *(Silence) Mmh* {(Silence) Mmh}

13. A: *Mbona sio hii unaweka kwa mkono na inakupatia kinga kwa siku mob una avoid kuja kuja clinic saa yote ni dawa the same.Walikuambia hizi zingine na ukapenda hii?* (Why not have the one inserted on your hand as its long term and avoid coming here many days. They told you about the other methods and you chose this?)

14. *Ni vile huwa naogopa kuwekwa* (It's because I am scared of the insertion process).

In line 9, A probes B why she preferred the depo method, and innocently/ignorantly uses the phrase "so that you can sleep comfortably". It is observed in line 10 that B is embarrassed by that statement. While A could have used the phrase innocently to mean depo gives B the comfort of not worrying about conceiving, in some other cultures, the phrase is used to refer to a sexually loose woman. Therefore, A emerges as a speaker who does not care or feel sorry about B's trouble, grief or misfortune and therefore deviates from the established norm of trying to reduce the calamity that happens to others. Proponents of LMT claim that speakers in conversations are involved in simple language management whenever they note, evaluate a deviation from a norm negatively and choose to pay language attention (Nepkavil, 2016). For example, the service seeker after noting a deviation from norm in line 9 (embarrassed) is seen implementing an adjustment strategy of being rude in line 10 probably to re-assert her decision and compensate for her injured ego and therefore stop A from embarrassing her further.

Similarly, speaker A is also seen in line 11 to have noted and evaluated a deviation from norm negatively when speaker B answered rudely, and designs and implements an adjustment strategy of repeating B's rude utterance. This utterance act seems to have infuriated B and she murmurs *"mmh"* probably to protest A's irresponsible behavior. Speaker A notes that she has offended speaker B and designs an adjustment strategy of reducing the tension by illucidating the benefits of other FP methods over the injection in line 13. We see this strategy eliminates the tension that was building up because speaker B relaxes and responds well in line 14. Fairbrother et al (2018) posit that language management can sometime be a cyclic process.

Similarly, another seeker who is against HIV testing despite provider's persuasion uses the same strategy of rudeness in the conversion below that happens in HTC room. The problem can be traced to the provider's failure to explain that it is the norm in the facility for all FP clients to undergo mandatory HIV test at the beginning of the conversation.

Text 26: extract 1

28. A: *Umetoka huko? Sawa nowadays huwa ni routine* (Have you come from there? Ok Nowadays it is routine)
29. B: *(interrupt) mmh.*{(interrupt) mmh}
30. A: *Kabla ujatibiwa popote unakuwa unajulishwa hali yako ya HIV. So tukikosa kupima unamaanisha hautaki kuudumiwa leo?* (Before you are treated you are informed about your status, so if I you, you will not be attended today?)
31. B: *Sikujua nakuja kupimwa* (I did not know that I was to be tested)
32. A: *Si nimeona umeandikiwa room 9. So imekuwa routine. Tunataka kusaidia watu wajue hali yao ya HIV. Mwenye anajipata ako nayo tunamsaidia sawa sawa, so uniambie kwa leo huko tayari kujua hali yako?* (I can see its indicated you come to room 9. It's the routine as we wish to let people know their status so that incase one is infected he/she can be helped. So tell me if you are ready to know your status?)
33. B: *(silence) Hapana* {(silence) No}
34. A: *Uwa hatulazimishi watu. Na ukienda huko mbele ukose kutibiwa?* (We never force people. What if you proceed then you are not treated?)
35. B: *Nitaenda nyumbani* (I will go home)

It is noted in line 28 that A is informing B who is against a HIV test that it is a normal procedure in the facility. Speaker B seems to have been offended by the phrase, "…routine" and she interjects interlocutor A with a murmur. This shows that B is completely disagreeing to be tested. However, in line 30, A further worsens the disagreement already being experienced by threatening her that she will not receive further services unless she is tested. This behavior corresponds to what Ogutu et al (2010) observed that some nurses were too forceful and too determined and failed to explain medical procedures at the beginning of medical session. Further in line 33 and 35, B maintains her rudeness and threatens to forgo any service should the test be a mandatory pre-requirement.

d) Code Switching

Code switching is an adjustment strategy that is employed by a speaker within a discourse when s/he faces language difficulties and switches to a more familiar language to overcome the language challenge. This is evident in extract 1 line 14 that was observed by the researcher

Text 27: Extract 1.

13. A: *Mwezi wa sita. Ni sawa inakuanga muhimu kujua hali yako nay a mpenzi wako sababu anaweza pengine kuwa ako na virusi na hajakuambukiza so kujua hali yake ni kitu muhimu. Nitakuuliza maswali kwa fupi. Ningependa nijue unaelewa nini kuhusu HIV. Unaelewa kama nini HIV?* (In June. It is good to know the HIV status of your partner because he/she may be infected but you are not. Let me ask you some few questions briefly. I would wish to know how you understand HIV, what is HIV?)
14. B: *(Silence) Ni uh ugonjwa tu uh bad.* {(Silence) It is uh just a bad uh sickness}

It can be seen that be B is laboring trying to look for a word to respond to A's question. She first goes into silence then she uses *uh* repeatedly probably to give her time to figure out the best word to use and finally switches to English. In a follow up interview, a service seeker was pressed to explain some of the adjustment strategies she employs.

> R: *Unapopatwa na changamoto za mazugumzo unafanya nini?* (When faced with language problem what do you normally do?)
> B: *Huwa natumia Sheng', Swahili ama English…uh.. bora nipate kitu cha kusema.* (I normally switch to Sheng', Swahili or English…uh.. so long as I get some few words to express myself with)

It is thus clear that code switching is used by patients at Machakos Level 5 hospital as an adjustment strategy. The facility is located in a cosmopolitan town, it is common to hear residents use Swahili and English.

The researcher was also keen to observe adjustment strategies employed by the service providers. Machakos Level 5 hospital has no language policy; all service

providers more often than not switch from Swahili to English and vice versa.

R: When faced with language problem what do you normally do?
B: I switch to Swahili or English especially when I am explaining medical terminologies.

From this follow up interview, it is similarly clear that the service providers equally employ code switching as an adjustment strategy during their individual interactions with service seekers.

e) Medical Colleagues as Interpreters

In many contexts, healthcare providers continue to rely on bilingual colleagues or the patient's family or friends to provide linguistic assistance (Karliner et al., 2007). This study probed service providers on whether they experience language barriers and how they solve them:

R: In your job, do you usually encounter language problems?
A: Eeh but the problem is not so severe because most of the service seekers are able to communicate in Swahili, Sheng' or a bit of English and in extreme cases, we seek help from within ourselves (colleagues).

The above discussion was interested in establishing how service providers solve language problems at simple management level. From the interview, it emerges that there are few cases of communication challenges because most of the service seekers are able to communicate either in Swahili or a little of English. In a survey by Saohatse (1998) at Chris Hani Baragwanath hospital in South Africa, it was found that language problems are common due to lack of interpreters and inability of most doctors to speak an African language. From the quantitative data attained at Machakos Level 5 Hospital, majority (26.7%) although less than a third, of service providers were Kamba while the rest were Luo (13.3%), Kikuyu (13.3%), Luyha (13.3%), Kalenjin (13.3%), Maasai (6.7%), Borana (6.7%) and Gusii (6.7%). These service providers are supposed to serve a population that consists of Akamba people

(60.0%), Gikuyu (6.7%), Meru (6.7%), Luyha (6.7%), Gusii (6.7%), Segeyu (6.7%) and Taita (6.7%). Although figure 3.3 showed that majority (67.7%) of the service seekers had attained post primary education, there are 33.3% who indicated that their education level is primary. Therefore, there is a high likelihood of a language problem resulting from a semi-literate service seeker served by a provider from another ethnic background.

In conclusion, during the researcher's observation and post service interviews, the study noted that there are simple management adjustment strategies that are more often designed to remove language problems than others. These strategies include: avoidance; rudeness; and code switching. On the other, pre-interaction management and use of colleague medical interpreters were designed, although, at a less extent. During the study period, the researcher did not observe service providers seeking language help from among other colleagues, although during post service interviews it was confirmed.

4.5.2 Organised Language Management

When organizations pay attention to language problems, they may devise adjustment strategies designed to eliminate the language problems that usually occur at simple management level (Kimura, 2014; Nekvapil, 2015). Such organized language management activities may include: the organization designing written materials that are translated in a language that addresses the local language needs; may hire professional interpreters and translators; and may design language training materials. In Machakos Level 5 hospital, there are various FP written materials that are offered to service seekers for reference in their own time which include package leaflets and

brochures for Jadelle, Intra Uterine Contraceptive Device (IUCD), Depo-provera and Implanon. These materials are packaged by manufacturers of various FP medicines and FP devices. There are also FP counseling aids such as charts that enable the provider to explain and demonstrate various FP methods and devices. These include well labelled charts for family planning methods, charts for Sexually Transmitted Infections (STI), Family Planning model charts, charts for cervical cancer, and HIV results interpretation charts.

In single service seeker – provider interactions, it was observed that service providers give out written materials probably to bridge language gaps. For example, in this interaction where the service seeker was declining a FP method after FP counseling, the provider seems to acknowledge the seeker requires more information probably to make up her mind. She devises a strategy of issuing her with a package leaflet. It is observed in line 45 that B is not able to make a decision on the choice of FP method after A elucidates several of them.

Text 28: Extract 13

45. B: (Silence). *Na kwa hivyo above 40 which is the best method.* (So what is a better method for those with 40 years and above?)
46. A: *Non hormonal na hiyo coil ndio nilikuwa na kuuliza umesema hapana kwa coil, ndio tumeona your reactions, tunauliza tuelezee……* (No-hormonal like the coil I was telling you about then you reacted….just tell us we move on……)
47. B: *Mmh uh (silence)* (Mmh uh (silence).
48. A: *Ati?* (what?)
49. B: *Nitaenda na nikirudi nitakuwa decided.* (Next time I will come decided)
50. A: *So enda udiscuss na mzee ufikirie halafu utaenda nah ii (hands her a leaflet) uone kila kitu about depo ndio uende usome. Jina unaitwa?* [So go and discuss the matter with your partner and read this leaflet (hands her a leaflet) to understand more about depo. What is your name?]

In line 50, the provider hands speaker B a depo leaflet and insists that she should read in order to understand more about depo. These written materials are described in

the next section.

a) Jadelle Brochure

The Jadelle brochure describes what Jadelle implants are and what they are used for, what a client needs to know about Jadelle before using them, how to use Jadelle, possible side effects, how to store Jadelle and contents of the pack and other information. The brochure is written in English and translated into other two foreign languages but not in Swahili or other local language. The brochure has 31 pages but this study was interested in pages 2 and 12 (See Appendix VI, C). It is also noted that the Jadelle brochures are written in a medical language that may be difficult to an ordinary service seeker to comprehend even with language aids such as dictionary. For example, on when not to use Jadelle, the brochure says one should not use it when, "are allergic to levonorgestrel and uses the term, 'migrane, migrane attacks":

> **Do NOT use Jadelle Implants if you:**
> **-**are allergic to levonorgestrel or any of the other ingredients in jadelle implant (listed in section 6)
> **Warning and Precautions**
> Talk to your doctor before using or while you are using jadelle implants, if any of the following symptons occur:
> - Migraines or increase in the frequency of migrane attacks

The researcher could not find the term "levonorgestrel" in ordinary English dictionary suggesting that the term could only be found in a medical dictionary. It can therefore be inferred that when these materials are written in a language that provides less information to the seeker, they flout the quantity maxim and they may therefore be ineffective as language supplements. It seems that the materials are targeting international audience which speaks English and is not customized to address local language needs. This could indicate a failure on the side of Machakos Level 5 hospital FP department to translate the material in a language that targets its audience. It

means the facility may not be paying attention to language management processes as advised by Jernudd and Neustupny in their Language Management Theory (Nepkavil, 2015).

b) Depo-Provera leaflet

Depo-provera is an injectable contraceptive that stops women from getting pregnant. Its leaflets describe how depo-provera works, who can be given depo-provera, when can injection begin, what to do when one wants to get pregnant, information on its safety and how long can one continue using it. The leaflet is written in simple English devoid of medical jargon. The same information written in English is also translated into Swahili: The contents of the two leaflets were sampled and presented (See Appendix VII, B):

English Version	**Swahili Version**
INFORMATION ABOUT DEPO-PROVERA **HOW DOES DEPO-PROVERA WORK** Depo-provera acts in many ways to prevent you from getting pregnant, it stops your egg from ripening, it prevents the sperm from reaching the egg and also prevents any attachment to the womb. These combined methods make this contraceptive very effective.	***SINDANO DEPO-PROVERA*** ***JINSI INAVYOFANYA KAZI*** • *Hufanya ukuta wa mji wa mimba kutoruhusu yai kukaa kukua* • *Huzuia kupevuka yai* • *Hutengeneza ute mzito kwenye shingo ya mji wa mimba, hivyo kuzuia mbegu za kiume zisiingie kwenye mji wa mimba ili kutunga mimba.*

The material avoids medical jargons even when explaining biological processes. For example, use of, “it stops your egg from ripening” can be inferred to be simple English words easy to understand. It seems that the manufacturer targets Kenyan or the larger East African market audience that speaks Swahili. For example, the material has been translated into Swahili version, *“ hufanya ukuta wa mji wa mimba kutoruhusu yai kukaa kukua”* At one point, through observing the service provider – service seeker interactions, the researcher was concerned that the method of choice of many service seekers was Depo-provera. It was noted that providers provided the

leaflets to the service seekers. It can be concluded that the method may be preferred due to its leaflets using simple easy-to-understand language as opposed to other written materials from other manufacturers. The current study concludes that drug manufacturing companies are also involved in organized language management.

c) Charts

The researcher observed that there are other FP materials in form of charts. These include: well labelled charts for family planning methods; charts for Sexually Transmitted Infections (STI); Family planning model charts; and HIV results interpretation charts. The researcher observed that the charts are provided by the Ministry of Health an indication that this could be a national language management strategy in health facilities by the national government. The current study sampled a chart that shows various FP methods. This chart is written in English and is also translated into Swahili titled,"*Do you Know Your Family Planning Choices or Je, Unajua Chaguo Lako la Mbinu za Kupanga Uzazi?"* (See Appendix VII, A).

English Chart	**Swahili Chart**
Injectable Contraceptives • Effective and safe. • One injection every 3 months (13 weeks) • May be able to get the injections outside the clinic, in the community.	***Mbinu za kuzuia mimba kwa sindano*** • *Inafanya kazi kwa ufanisi na kwa haraka* • *Sindano za DMPA huchomwa mara moja kila miezi mitatu (wiki 13).* • *Unaweza kuchomwa sindano nje ya zahanati, katika jamii.*

The chart shows various family planning methods. The English version is written in simple language devoid of medical jargons. The same chart has been translated into Swahili showing existence of organized language management.

4.6 Mechanism for Implementation of Adjustment Strategies

The study noted that there are language problems experienced at Machakos Level 5

hospital that impact on the FP services delivery. To respond to the language challenges, the study found that there are adjustment strategies, albeit few and ineffective, that are employed by either the service provider or the service seekers. This part shows how these adjustment strategies are implemented to overcome the language problems.

4.6.1 Simple Language Management Practices of Service Seekers and Providers

Nekvapil and Nekula (2006) observe that a speaker may plan and finally implement the adjustment strategy. For example, a speaker may bring along an interpreter when he/she anticipates encountering a language problem in a simple management process. This study found out that some service seekers usually visit FP clinics with their husbands to help in interpretation.

a) Avoidance

Avoidance is an adjustment strategy that involves a speaker changing or switching to a different topic to divert a discussion from an ongoing subject. Avoidance strategy is being employed in this conversation:

Text 29: Extract 4

31. A: *Umewaikosa kupata your menses?* (Have you ever failed to receive your menses?)
32. B: *Mmh (Inaudible)* {Mmh (Inaudible)}
33. A: *Sema ndio ama la?* (Say yes/no?)
34. B: *Na iko na the same hormone kama Implanon?* (Does it have same hormone with Implanon?)

In text 29, it can be seen that speaker B noted A's use of the word "menses" and evaluated the deviation negatively, as indicated by murmuring something which is not clear. It can be inferred that the term "menses" may be culturally offensive to speaker B. It can be argued that speaker B decides to avoid the offending topic. The

avoidance strategy is implemented in line 34 when speaker B switched to a different topic, all demonstrating a classic example of simple language management. Speaker A is also involved in language management. Speaker A *noting* that she has been given unexpected response she prompts B on the options to choose from *"Sema ndio ama la"* This is an aspect of simple language management although not avoidance strategy.

b) Pre-Interaction Management

In two of the observations, the researcher noted that the service seekers were accompanied by their husbands who were also involved in the FP discussions. For example, the speaker noted a situation where the service seeker had to be helped by her husband in replying a provider question. The researcher was keen to establish whether coming with their husbands was a deliberate pre-interaction strategy to overcome language challenges.

1. R: *Naona uko na Personal Assistant* (I can see you have a personal assistant)
2. B: *(laughing) Hapana huyu ni my husband (*(laughing) No, he's my husband}
3. A: *Isipokuwa wewe na mama mwingine, sijaona hawa wengine wakikuja na mabwana zao* (save for you and another mother, I have not seen other clients come with their husbands)
4. B: *Wah, mtu nikujipanga kivyake.Unajua kama leo nilikuwa nataka kuchange method yenye natumia then juu sometimes unapata daktari mwenye upenda kuongea kizungu nyiingi nikaona ni vizuri nikuje na bwana anisaidie zenye zitanipita (laughing)* {It's a my strategy. You know today I wanted to change my method and you know sometimes we are served by service providers who have a higher preference for English, I decided to come with my husband to offer some language assistance}

This service seeker told the researcher that she had anticipated to encounter language problems and decided to come with her husband to offer language assistance. From the foregoing revelations and the researcher's observation, it is clear that some seeker anticipate encountering communication challenges and designing an adjustment strategy of coming with their relatives that is implemented whenever they find communication challenges.

c) Rudeness

Further in extract 6 line 9, A violated Leech (1983) sympathy maxim. The norm in sympathy maxim is to minimize antipathy between self and other and maximize sympathy between and other. It was observed during the discourse that the researcher was allowed to observe, that the seeker when embarrassed became rude probably to re-assert the value of her decision.

Text 30: Extract 6

9. A: *Mmoja (Surprised) mbona uliamua sindano? Ndio ulale tu na starehe?* {One (surprised) why then did you choose the injection or so that you can sleep comfortably.}

10. B: *(Embarassed) Ndio inafaa* {(Embarassed) It's what is good for me.}

11. A: *Ndio inafaa* (It's what is good)

12. B: *(Silence) Mmh* {(Silence) Mmh}

13. A: *Mbona sio hii unaweka kwa mkono na inakupatia kinga kwa siku mob una avoid kuja kuja clinic saa yote ni dawa the same.Walikuambia hizi zingine na ukapenda hii?* (Why not have the one inserted on your hand as its long term and avoid coming here many days. They told you about the other methods and you chose this?)

14. *Ni vile huwa naogopa kuweka* (It's because I am scared of the insertion process).

In line 9, A probes on B why she preferred the depo method and innocently/ignorantly uses the phrase "so that you can sleep comfortably". It is observed in line 10 that B is embarrassed by that statement. It is seen that speaker B notes and evaluates the embarrassing statement negatively. She designs an adjustment strategy of being rude probably to warn speaker A not to continue injuring her dignity. The adjustment design is implemented in line 10 when speaker B re-asserts her position by saying, *"Ndio inafaa."* On the other hand, speaker A is also being seen to be involved in language management. She appears to have noted speaker B became rude in her reply in line 10 and devises an adjustment strategy that is implemented by repeating the phrase she considers rude in question form *"ndio inafaa?"* It can be seen that both the seeker and the provider design and implement

"rudeness" as a strategy.

Similarly, another seeker who is against HIV testing despite provider's persuasion uses the same strategy of rudeness in the conversion below that happens in HTC room:

Text 31: extract 1

28. A: *Umetoka huko?. Sawa nowadays huwa ni routine* (Have you come from there? Ok Nowadays it is routine)
29. B: *(interrupt) mmh.*{(interrupt) mmh}
30. A: *Kabla ujatibiwa popote unakuwa unajulishwa hali yako ya HIV. So tukikosa kupima unamaanisha hautaki kuudumiwa leo?* (Before you are treated you are informed about your status, so if I do not test you do not want to be attended today?)
31. B: *Sikujua nakuja kupimwa* (I did not know that I was to be tested)
32. A: *Si nimeona umeandikiwa room 9. So imekuwa routine. Tunataka kusaidia watu wajue hali yao na HIV. Mwenye anajipata ako nayo tunamsaidia sawa sawa, so uniambie kwa Leo uko tayari kujua hali yako?* (I can see its indicated you come to room 9. It's the routine as we wish to let people know their status so that incase one is infected he/she can be helped. So tell me if you are ready to know your status?)
33. B: *(silence) Hapana* {(silence) No}
34. A: *Uwa hatulazimishi watu. Na ukienda huko mbele ukose kutibiwa?* (We never force people. What if you proceed then you are not treated?)
35. B: *Nitaenda nyumbani* (I will go home)

It is noted in line 28 that A is informing B who is against a HIV test that it is a normal procedure in the facility. B seems to have been offended by the phrase, "…routine" and she interjects interlocutor A with a murmur. It can be seen that speaker B notes use of "routine" to be the provider's arrogance to recognize that she has a right to make a medical decision. She seems to evaluate this norm of been forced to undergo medical procedures against her wish negatively and designs an adjustment strategy of being rude. Speaker B implements her strategy by protesting in non-verbal expressions, *"Mmh"* probably to remind speaker A that she has a right to make a decision. In the entire conversation, both the seeker and the provider are seen designing and implementing rudeness as a simple management strategy.

d) Code Switching

Implementation of code switching is evident in extract 1 line 14:

Text 32: Extract 1.

13. A: *Mwezi wa sita. Ni sawa inakuanga muhimu kujua hali yako na ya mpenzi wako sababu anaweza pengine kuwa ako na virusi na hajakuambukiza so kujua hali yake ni kitu muhimu. Nitakuuliza maswali kwa fupi. Ningependa nijue unaelewa nini kuhusu HIV. Unaelewa kama nini HIV?* (In June. It is good to know the HIV status of your partner because he/she may be infected but you are not. Let me ask you some few questions briefly. I would wish to know how you understand HIV, what is HIV?)
14. B: *(Silence) Ni uh ugonjwa tu uh bad.* {(Silence) It is uh just a bad uh sickness}

It can be seen that be B is laboring trying to look for a word to respond to A's question. She first goes into silence then she uses *uh* repeatedly probably to give her time to figure out the best word to use and finally switches to English. Using English word "bad" while previously using Swahili words is implementing code switching adjustment strategy. In a follow up interview, the service seeker had this to say:

R: *Unapopatwa na changamoto za mazugumzo unafanya nini?* (When faced with language problem what do you normally do?)
B: *Huwa natumia Sheng', Swahili ama English…uh.. bora nipate kitu cha kusema.* (I normally switch to Sheng', Swahili or English…uh.. so long as I get some few words to express myself with)

It is thus clear that code switching is used by patients at Machakos Level 5 hospital. The facility is located in a cosmopolitan town and it is common to hear residents use Swahili and English interchangeably within the hospital and along Machakos town streets.

Code switching is also quite common with medics at the facility while delivering services. The researcher was also keen to understand adjustment strategies implemented by the service providers. Machakos Level 5 hospital has no language policy; all service providers more often than not switch from Swahili to English and vice versa.

R: When faced with language problem what do you normally do?
B: I switch to Swahili or English especially when I am explaining medical terminologies.

From this follow up interview, it is similarly clear that the service providers equally design and implement code switching as an adjustment strategy during their individual interactions with service seekers.

e) Medical Colleagues as Interpreters

Research has shown that healthcare providers rely on their bilingual colleagues to provide linguistic assistance (Karliner et al., 2007). The excerpt is a follow up interview with a service provoder: :

R: In your job, do you usually encounter language problems?
A: Eeh but the problem is not so severe because most of the service seekers are able to communicate in Swahili, Sheng' or a bit of English and in extreme cases, we seek help from within ourselves (colleagues).

The above discussion was interested in establishing how service providers solve language problems at simple management level. This service provider told the researcher "..we seek help from within ourselves." This shows that the adjustment strategy of seeking help from colleagues is implemented at Machakos Level 5 hospital.

4.6.2 Organized Language Management at Machakos Level 5 hospital

Nekvapil and Sherman (2009) posit that organizations put in place strategies that are aimed at the removal of problems in a number of interactions. This organized language management is typically manifested through implementation of corporate language, through administering language courses for staff, through preparing or translating written materials that can be pinned on notices or given to clients, hiring interpreters and translators among others. The study sought from healthcare

providers whether the facility provides languages services through follow up interviews

In Machakos Level 5 Hospital, there are various FP written materials which include package leaflets for Jadelle, Intra Uterine Contraceptive Device (IUCD), Depo-provera and Implanon. These materials are packaged by manufacturers of various FP medicines and FP devices. There are also FP counseling aids such as charts that enable the provider to explain and demonstrate various FP methods and devices. These include well labelled charts for family planning methods, charts for Sexually Transmitted Infections (STI), Family planning model charts and charts for HIV results interpretation. The next sessions discusss how FP written materials are implemented.

a) Jadelle Brochures

On how Jadelle brochures are implemented to solve language problems as an organized language management strategy, the leaflets are issued by the service providers to service seeker after the FP session. The providers told the researcher that they are aware that service seekers do not fully comprehend much of what they offer.

b) Depo-Provera Leaflet

Depo-provera leaflet is written in simple English devoid of medical jargon (Seee Appendix VII, B). The same information written in English is also translated in Swahili. It seems that the manufacturer targets Kenyan or the larger east African market audience that speaks Swahili. It was noted that providers provide the leaflets to the service seekers. The current study concludes that drug manufacturing companies are also involved in organized language management though at Machakos

Level 5 hospital FP department, giving the leaflets to seekers can be argued to be implementation of organized language management.

c) Charts

The researcher observed that there are other FP materials in form of charts. These includes: well labelled charts for family planning methods; Family planning model charts; and HIV results interpretation charts. The researcher observed that the charts are prepared by the Ministry of Health an indication that this could be a national language management strategy in health facilities by the national government. On how they are implemented, the researcher observed that there are two charts: one for family planning methods; and another one for FP demonstration kit pinned inside FP room. There is another chart on family planning methods at the family planning notice board code-named *"Family Planning Corner"* (See appendix VIII, A) At the HTC room, there is a chart on HIV related topics displayed inside the room. Displaying the charts can be viewed as implementation of organized language management at Machakos Level 5 hospital FP Department.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter presents the summary, conclusions and recommendations based on the four objectives. This study was based on Jernnud and Neustupny (1987) Language Management Theory which claims that language management is a process that begins with *noting* a deviation from a norm*, evaluating* the deviation either positively or negatively*, designing adjustment strategy* and *implementing* the selected adjustment strategy (Fairbrother et al., 2018). The four processes formed the four objectives of the current study.

5.1 Summary of Key Findings

The first objective of the study was to identify *(note)* service related language problems at Machakos Level 5 hospital in the Family Planning Department. To achieve this, Grice's Cooperative Principle (CP) and Leech's Politeness theory were employed to provide the framework for noting deviations from norms that were evaluated negatively. The study found out that all the four Gricean Maxims of the Cooperative Principle were flouted leading to language problems. On the other hand, four of the six politeness maxims were found to have been violated. Therefore, this study was able to identify eight (8) language problems at Machakos Level 5 Hospital.

The second objective of the study was to analyse how language problems are evaluated by both service providers and service seekers. To achieve this, Language Management Theory proposed by Jernnud and Neustupny (1987) was used to

provide the evaluation criteria (Nekvapil, 2015). In this study, deviations from communication norms under Leech's (1983) politeness theory and the Cooperative Principle were evaluated negatively and led to six (6) undesirable consequences: miscommunication among participants; dissatisfaction with services; poor service delivery; hindering access to FP services; increased sense of vulnerability; and consent was not sought in HIV testing.

The third objective sought to assess adjustment strategies *(adjustment design)* that are often employed to mitigate language problems experienced in Machokos Level 5 Hospital. Adjustment strategies designed at simple management level are: pre-interaction management strategy that involves seekers coming with their relatives to interpret; rudeness; code-switching; and medical colleagues as interpreters. At the organized language management level, only written materials are designed. They include: package leaflets and brochures for various contraceptives methods and charts.

The fourth objective was to analyse *(implementation of adjustment design)* mechanisms for implementing the adjustment strategies identified in objective three. At simple management level, the study found out that speakers implemented all the five (5) adjustment designs that were identified: service seekers avoided some offensive topics, service seekers used husbands whenever they faced language problems; others became rude; others switched from Swahili-English and vice versa to implement code-switching; and service providers requested language help from their medical colleagues. At the organized language management level, contraceptives' leaflets and brochures were issued to service seekers and charts were

displayed in notice boards and inside service rooms.

5.2 Conclusions

This study was able to identify eight (8) language problems that emerged during service seeker – service provider interactions. Service seekers tended to provide inadequate information and irrelevant information while service providers tended to be rude, impolite and insensitive. The study concludes that service seekers perceive family planning a taboo subject to discuss while service providers lacked social and cultural competencies to offer services in a diverse socio-cultural background. The study demonstrated that deviation from norms are negatively evaluated and led to six (6) undesirable consequences: miscommunication among participants; dissatisfaction with services; poor service delivery; hindered access to FP services; increased sense of vulnerability; and consent was not sought to test HIV. The study concludes that language problems can lead to poor quality healthcare services that can lead to low contraceptive uptake.

The study was able to show that there is simple language management and organized management at Machakos Level 5 hospital. Adjustment strategies designed at simple management level are: pre-interaction management strategy that involves seekers coming with their relatives to interpret; rudeness; code-switching; and medical colleagues as interpreters. At the organized language management level, only written materials are designed. They include: package leaflets and brochures for various contraceptives methods and charts. Even though the study exposed several language problems that emerge at the hospital during seeker-provider interactions, the study concludes that the facility does not pay adequate attention to language problems

experienced. For example, all the written materials are prepared by exterrnal organizations and most of them are not translated.

At simple management level, the study found out that speakers implemented all the five (5) adjustment designs that were identified: service seekers avoided some offensive topics, service seekers used husbands whenever they faced language problems; others became rude; others switched from Swahili-English and vice versa to implement code-switching; and service providers requested language help from their medical colleagues. The study concludes that adjustment strategies designed and implemented by both the service seeker and providers may not be adequate to eliminate language problems noted at the facility. At the organized language management level, contraceptives' leaflets and brochures were issued to service seekers and charts were displayed on the notice boards and inside service rooms. The study concludes that the facility is not designing and implementing superior strategies that can eliminate language problems. For example, there are no professional interpreter and translator services and there are no language training courses to equip the providers with language competencies to offer services in a diverse socio-culural and linguistic background. The study further concludes that existence of language problems at Machakos Level 5 Hospital FP Department and subsequent lack of attention by the facility to the problems could be one of the reasons why contraceptives uptake remains relatively low.

5.3 Recommendations

i.) The study results showed that there are service related language problems at Machakos Level 5 Hospital Family Planning department which can be

assumed to be prevalent in other service points at the facility. Based on this, the study recommends training of medical staff to equip them with interpersonal communication skills that takes care of linguistic and cultural diversity. This is important because language and culture are inseparable.

ii.) The study found out that service seekers use relatives as interpreters and service providers sought interpretation help from among other colleagues. This study recommends Machakos Level 5 hospital hospital to provide professional interpretation services.

iii.) The study results showed that organized language adjustment strategies such as written materials were inadequate due to the language they are written in. The study recommends that Machakos Level 5 hospital translates FP materials into Kikamba and Swahili.

iv.) The study found out that FP written materials target only women. The study recommends that any FP written material should be designed to target both men and women.

5.4 Suggestions for Further Research

i. Given that the study was conducted in a peri-urban hospital setting, it is suggested that a similar study to be conducted in a complete rural and complete urban setting.

ii. The study was conducted in a Level 5 health facility, it is suggested that a similar study to be conducted in a level 1 (possibly in Turkana) and a level 8 (possibly Kenyatta National Hospital) so as to get the typical language

management practice that are put in place to enable the Ministry of Health to develop a bottom-up National Health language Management Policy.

iii. It is also suggested a similar study to be replicated in other service industries such as hotels among others so as to understand language management practices in Kenyan service industries so as to address quality of services.

iv. It is also suggested a similar study to be replicated in other hospital departments such as maternity, mental health among others to as to understand whether there issues that require language management.

v. It is also suggested that a similar study should be replicated in theses and projects' defense sessions in order to understand language problems that arise between defense panelists and candidates so as to enable universities develop appropriate policies for guiding such sessions.

REFERENCES

Adriani, K. G. D., Hamzah & Havid, A. (2013). Comparision of the Maxim Violation found in Action and Drama Movies. *E-Journal English Language and Literature 1*(2): 69-78.

Afzali, K. (2013). Character revelation and dialogue interpretation through Politeness theory and conversation analysis in dramatic discourse: The case of Woody Allen's Death Knocks, *Journal of Language and Literature Education, 2*(6), 43-54.

Akacho, E. N. (2014): *Factors Influencing Provision of Healthcare Service Delivery in Kenya. A Case of Uasin Gishu District Hospital in Eldoret (Unpublished University Thesis*). Nairobi. University of Nairobi.

Ainsworth – Vaughn, N. (2001). *The discourse of medical encounters*. In: D. Schiffrin, D. Tannen & H.E. Hamilton (eds) Handbook of discourse analysis. Backwell publishers.

Alali, A.O., & Jinadu, B.A. (2002).*Health communication in Africa; contexts, constraints and lessons*. New York. University press of America Inc.

Ali, P. A. & Watson, R. (2018). Language barriers and their impact on provision of care to patients with limited English proficiency: Nurses' perspectives. *Journal of Clinical Nursing*, 27 (5-6).

Al-Hindawi, F. H. & Alkhazaali, M. A. R. (2016). A critique of politeness theories. *Theory and Practice in Language Studies*, 6(8), 1537-1545.

Archin – Tenkorang, D. (2000). Mobilizing resources for health. The case for users fees on micro-economics and health. Geneva. World Health Organization.

Arends-Kuenning, M., & Kessy, F. L. (2007).*The impact of demand factors, quality of care and access to facilities on contraceptive use in Tanzania*. *J BiosocSci,* (39), 1-26.

Arungwa, O. (2014): Effect of communication on nurse-patient relationship in orthopaedic hospital, Igbobi. *West Africa Journal of Nursing*, 25(2), 37-39.

Bauer, T. K. (2017). Bridging the language gap: Overcoming language barriers in health care. [Weblog]. *GHDonline*. Retrieved from https://www.ghdonline.org/language-barriers/discussion/how-does-limited-proficiency

Barnett, B. (1998). Client preferred method choices. *Family health international*, 19(1), 14-18.

Beach M. C., Price, E. G., Gary, T. L., et al. (2005). Cultural competency; a systematic review of health care provider educational interventions. *Med care.*43(4), 356-373.

Belintxon.M., & Lopez de Dicastillo, O. (2014). *The challenges of health promotion in a multicultural society*: A narrative review. *AnsistSanitNavar*. 37(3), 401-9.

Betancourt. J.R., Green, A. R., & Carrillo, J. E. (2002) *Cultural competence in healthcare; emerging frameworks and practical approaches*. New York.

Bischoff, A., Bovier, P., Rrustemi, I., et al. (2003). Language barriers between nurses and asylum seekers; their impact on symptom reporting and referral rates. *SocSci Med,* (57), 503 – 512.

Bischofe, A. (2003). *Caring for migrant and minority patients in European hospitals: A review of effective interventions*. Basel. Institute for Migrants Friendly Hospitals.

Blanc, A.K., Curtis, S.L., Croft, T. N. (2002). Monitoring contraceptive continuation: Links to fertility outcomes and quality of care. *Stud FamPlann*; (33), 127 – 140.

Bowen, S.,& Kaufert, J.M. (2000). Measuring the costs' using case studies in the evaluation of health interpreter services. *MMIA News,* 3, 2-5.

Bowen, S. (2000). *Language barriers in access to health care*. Ottawa, Ontario, Health Canada.

Bowen, S. (2015). The impact of language barriers on patient's safety and quality of care. Retrieved from http://www.reseausantene.ca/wp-content/uploads/2018/05/Impact-language-barrier-qualitysafety.pdf

Caldwell, J. C., & Caldwell, P. (2003). *The fertility translation in sub-saharan Africa*. Human sciences research council.

Cameron, R., & Williams, J. (1997). Sentence to Ten Cents: a case of relevance and communicative success in non-native-native speaker interactions in medical settings. *Applied Linguistics,* 18(4), 416-445.

Casterline, J. (2001). *Diffusion process and fertility transition. In diffusion processes and Fertility translation. Selected perspectives (eds) casterline*: 1-38. Washington. National Academic press.

Centre for Disease Control and Prevention (2014). *Providing quality family planning services: recommendations of CDC and the U S. Office of population affairs*. Author. Retrieved from https://www.cdc.gov/mmWr/preview/mmwrhtml/rr6304a1.htm

Chen, A., Dutta, A., & Maina, T. (2014). *Assessing the quality of primary health care services in Kenya, PETS-Plus*.

Corbin, J., & Strauss, A. (2008).*Basics of qualitative research: Techniques and procedures for developing grounded theory (3rd ed.)*. Thousand Oaks, CA.

Creswell, J. N., & Plano-Clark, V. L. P. (2006). *Designing and conducting mixed methods research.* London. SAGE.

Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches – 4th ed*. London, United Kingdom. Sage publications.

Dale, J. Hu, Ruth, M., & Covel. (1986). Health care usage by Hispanic outpatients as a function of primary language. *West J. Med*, 144(4),490-498.

Davies, M., Elwyn, G. (2008). Advocating mandatory patient 'autonomy' in healthcare: Adverse reactions and side effects. Health Care Analysis. *PubMed,* 1(2).

David, R. A. & Rhee, M. (1998). The impact of language barrier to effective healthcare in an under-served urban Hispanic community. *Mount Sinai Journal of Medicine,* 65, 393-397.

De Moissac, D. & Bowen, S. (2018). Impact of language barriers on quality of care and patient safety for official language minority Francophones in Canada. *Journal of Patient Experience*. 6.

Dehlendorf, C., Levy, K., Kelley, A., Grumbach, K., & Steinauer, J. (2012). Women's preferences for contraceptive counseling and decision making. Contraception. *[PubMed]*

Dickover, D. W., Bot, H. (2007). Patterns of communication through interpreters. *J Gen Intern Med. Jun;* 22(6).

Divi, C., Koss, R. G., Schmaltz, S. P., & Loeb, J. M., (2007). Language proficiency and adverse events in US hospitals: a pilot study. *Int J Qual Health Care,* 19, 60-67.

Drennan, M. (1998). Reproductive Health new perspectives on Men's participation. population reports*, Series J*. 46(36).

Elderkin-Thompson, V., Silver, R.C., & Waitzkin, H. (2001). When nurses double as interpreters: A study of Spanish-speaking patients in a US primary care setting. *SocSci Med,* 52, 1343-1358.

Fairbrother, L., Nekvapil, J. & Sloboda, M. (2018). *Methodology in Language Management*. Peter Lang, GmbH.

Fleischman, S. (2001). *Language and Medicine*. In: D. Schiffrin, D. Tannen & H.E. Halmiton (eds). The handbook of discourse analysis. Blackwell publishers.

Flores, G. (2005). The impact of medical interpreter services on the quality of health care: a systematic review. *Med Care Res Rev,* 62:255-299.

Flores, G. (2006). *Language barriers to health care in the United States*. *The New England Journal of Medicine*, 355 (3), 229 – 31.

Flores, G. Laws, M. B., Mayo, S. J., *et al. (2003)*. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics,* 111, 6-14.

Fortier, L. (2013). Cultural barriers to family planning.Girls Globe. [Web log]. Retrieved from https://www.girlsglobe.org/2013/11/14/cultural-barriers-to-family-planning

Friedman, J. N., & Kelman, J. J. (2006). *Public sector incentives and inertia effort*. Harvard university. Cambridge (MA)-working paper.

Golegane, G. (2018). Group work and classroom interaction in communication and study skills classes (css) of the University of Botswana. *Theory and Practice in Language Studies,* 8(12), 1595-1604.

Graham, J. D. (2001). *Assessment of cost and benefits associated with the implementation of Executive Order* 13166.

Greenhalgh, T., Voisey, C., Robb, N. (2007). Interpreted consultations as 'business as usual'? An analysis of organizational routines in general practices. *Social Health*, 29, 931-954.

Greising, C. H. (2006). *Patients with limited English proficiency*: Results from a national survey. Brief of Hasnain-Wynia, R., Yonek, J., Pierce, D., Kang, R., & Greising, C. H. (2006, October), Hospital language services for patients with limited English proficiency: Chicago.

Grice, H. P. (1975). *'Logic and conversation'* In Cole, P. & Morgan, J. (eds.). New York. Academic Press.

Haile, SiduGuerny, J., & Stloukal, L. (2000). *Provision of reproductive health services in sub-Saharan Africa, lesson, issues, challenges and the overlooked rural majority*.

Hampers, L. C., Cha, S., Gutglass, D. J., et. al. (1999). Language barriers and resource utilization in a pediatric emergency department. *Pediatrics*, 103, 1253-1256.

Institute of Medicine. (2010). *Future directions for the national health care quality and disparities reports.* Washington, DC: The National Academies Press.

Jaccard, J. (2010). *Careful, current, and consistent: tips to improve contraceptive use*. Washington, DC. National Campaign to Prevent Teen Pregnancy.

Jernudd, B. H., & Neustrupny, J. V. (1987). *Language planning: for whom*? In Lorne Laforge (ed), Proceedings of the international colloquium on language planning, 69-84. Quebec: Les Presses de L'Universite Laval.

Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). *Towards a definition of mixed methods research. Journal of Mixed Methods Research*. 1, 112-133.

Kamwendo, G. H. (2004). *Language policy in Healthcare services*: A sociolinguistic study of a Malawian referral hospital. M.A. Thesis (unpublished).

Kaplan, S. H., Greenfield, S., & Ware, J.E., Jr. (1989). Assessing the effects of physician patient interactions on the outcomes of chronic disease. *Medical Care,* 27 (3).

Karliner, L. S., Jacobs, E. A., Chen, A. H., & Mutha, S. (2007). *Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature*. Health Serv Res, 42, 727-754.

Kenya National Bureau of Statistics (KNBS) and ICF Macro. (2010). *Kenya Demographic and Health Survey 2008-09*. Calverton, Maryland: KNBS and ICF Macro.

Kenya National Bureau of Statistics, (2015). *Kenya Demographic and Health Survey 2014*, Nairobi. Author.

Kenya National Bureau of Statistics. (2010). *Kenya Demographic and Household Survey*. Nairobi. Author.

Khadidja, B. (2012). *A socio linguistic study of communication and language barriers in Algerian healthcare settings* (*Unpublished M.A Thesis).*

Khoyi, A. M. & Behnam, B. (2014). Discourse of law: analysis of cooperative principles and speech acts in Iranian law courts. *Asian Journal of Education and e-Learning,* 2(4).

Kimura, G. Ch. (2014). Language Management as a cyclical process: A case study on prohibiting Sorbian in the woekplace. *Slovo a Slovesnost,* 75(4), 255-270.

Kothar*i, C. R.* & Gaurav, G. *(*2014*). Research methodology,* (3rdEd). New Dheli. Age International Publishers.

Ku, L., Flores, G. (2005). Pay now or pay later: providing interpreter services in health care. *Health Aff (project Hope),* 24, 435 – 444.

Lee, K. C., Winickoff, J. P., Kim, M. K., Campbell, E.G., Betancourt, J. R., Park, E. R., et al. (2006). Resident physicians' use of professional and non professional interpreters: A national survey, *JAMA*, 296(9).

Leech, G. (1983). *Principles of Pragmatics*.Retrieved from http://www.ebook3000.com/Principles-of-Pragmatics_105339.html

Lester, F. (2005).On the theoretical, conceptual and philosophical foundations for research in mathematics education, *ZDM,* 37(6), 457-467.

Levin, M. E. (2004). *Language differences as an access barrier for Xhosa speaking patients at a children's hospital in Cape Town*. mmed Thesis.

Levin, M. E. (2006). Language as a barrier to care for Xhosa-speaking patients at a South African paediatric teaching hospital. *South Afri Med.* 96 (10), 1076-1079.

Li, Q. (2015). The application of cooperative principle in oral English learning. *International Journal on Studies in English Language and Literature,* 3(1), 39-48.

Liu, L. (2017). Application of cooperative principle and politeness principle in class question-answer process. *Theory and Practice in Language Studies,* 7(7), 563-569.

Louis, l. (1999). The importance of interpreters to ensure quality of care for migrants. *International Journal of Public Health,* 44(6), 245-247.

Kothari, *C. R.* & Gaurav, G. (*2014*). *Research Methodology, (3rd Ed).* New Dheli. Age International Publishers.

Machakos County (2016). *Fiscal Strategy Paper*. Machakos. Author.

Machakos County (2015). *Machakos County Intergrated Development Plan*. Machakos. Author.

Maharani, S. A. I. (2017). Politeness maxim of main character in Secret Forgiven. *Jurnal Bahasa Lingua Scientia,* 9(1), 1-14.

Makori, P. M. (2015). Turn taking and topic shift among adult men and women of Abagusii community in Nyamira County (Unpublished M. A Dissertation). Nairobi. Kenyatta University.

Matsuoka, R. & Poole, G. (2015).Politeness Strategies in Healthcare communication at "difficult times": A pragmatic analysis in manga discourse in nurse Aoi. *Journal of Pan-Pacific Association of Applied Linguistics,* 19(2), 89-109.

Ministry of Health (2007). *National Reproductive Health Policy*. Nairobi. Author.

Ministry of Health (2013). *The Kenya National patients' rights charter*. Nairobi. Author.

Muchiri, P. (2014). *Understanding politeness through a sequence: the case of an interview (Unpublished Master's Project).* Nairobi. Kenyatta University.

Murphy, S. (2004).*Communicating with limited English proficiency (LEP) patients*: question of health-care access. *Journal of Medical Practice Management*, 20, 23–7

Nancy, M. B. & Charles, C. G. (1988). Fertility and poverty in developing countries. *Journal of Policy Modeling,* 10(1).

National AIDS and STI Control Programme, (2010). *National guidelines for HIV testing and counselling in Kenya*. Nairobi. Ministry of Public Health and Sanitation.

Narayan, L. (2014). Addressing language barriers to healthcare in India. *The National Medical Journal of India*, 26, 236-8.

Nekvapil, J. (2004). Language biographies and management summaries. In H. Muraoka (Ed.), Language management in contact situations (3, pp. 9–33). (Report on the Research Projects No. 104). Chiba: Chiba University, Gradual School of Social Sciences and Humanities. Retrieved from http://languagemanagement.ff.cuni.cz/en/node/352#2004

Nekvapil, J. (2006). From language planning to language management. *Sociolinguistica*, 20, 92 104.

Nekvapil, J. & Nekula, M. (2006). On language management in multinational companies in the Czech Republic. *Current Issues in Language Planning*, 7(2–3), 307–327.

Nekvapil, J. & Sherman, T. (2009). Pre-interaction management in muiltinational companies in Central Europe. *Current Issues in Language Planning*, 10(2), 187–198.

Nekvapil, J. (2012). Some thoughts on "noting" in language management theory and beyond. *Journal of Asian Pacific Communication,* 22(2), 160-173.

Nekvapil, J. & Sherman, T. (2014). Jazykový management a teorie jazykového managementu: úvodní poznámky [Language management and Language Management Theory: Introductory remarks]. *Slovo a Slovesnost*, 75(4), 245–254.

Nekvapil, J., & Sherman, T. (Eds.). (2015). The language management approach: Perspectives on the interplay of bottom-up and top-down. [Special issue]. *International Journal of the Sociology of Language*, 232, 1–214.

Nekvapil, J. (2016). Language management theory as one approach in language policy and planning. *Current Issues in Language Planning*. 17(1):1-12.

Ochako, R., Mbondo, M., Aloo, S.,& Kaemenyi, S. (2015). Barriers to modern Contraceptive methods. *Public Health,* 15(118).

Ojwang, B. O., Ogutu, E. A. & Matu, P. M. (2010). Nurses' impoliteness as an impediment to patients' rights in selected Kenyan hospitals. *Health and Human Rights,* 12(2). Retrieved https://www.hhrjournal.org/2013/08/nurses-impoliteness-as-an-impediment-to-patients-rights-in-selected-kenyan-hospitals

Omondi – Adhiambo. (1999). *Fertility change, family planning and the impact of CBD in Siaya district, Kenya.* A study report for ministry of health GTZ reproductive health project, Kenya.

Patton, M.Q. (2002). *Qualitative research and evaluation methods*. 3rd safe publications; Thousand Oaks. C.A.

Payne, A. (2006). *A Handbook of CRM; Achieving excellence in customer management*. Amsterdam, Butterworth.

Poston, L. (2005). Islam. N. C Manning & Zuckerman P. (eds) *sex and religion,* 181-197.

Radcliffe, Anderson E. (2001).*Comments on policy guidance on the prohibition against national origin discrimination as it affects persons with limited English proficiency*.written communication to Carol Brown, office of civil rights.

Regenstein, M. (2007). Measuring and improving the quality of hospital language services: insights from the speaking together collaborative. *J Gen Intern Med.* 2, 356 – 9.

Remare, R. E. & Catherine, K. (2012). Physical access to health facilities and contraceptive use in Kenya: Evidence from the 2008-2009 Kenya Demographic and Health Survey, *African Journal of Reproductive Health,* 10(3).

Republic of Kenya (2004). *Demographic health survey of (2003).* Nairobi. Government printer

Rodgers, A. (2010). *Eliminating health disparities strengthening data on race, ethnicity, and primary language in the United States*. Retrieved from http://www.cdc.gov.richs.data

Runqing, L. (2014). *New Linguistics Course*. Beijing: Foreign Language Teaching and Research Press.

Ryder, A. G., Ban, L. M., & Chentsova-Dutton, Y. E. (2011).Towards a cultural-clinical psychology. *Socpersonal psychol compass*, 5 (12), 960-75.

Saladin, P., Buhlmann, R., Dahinden, D., Gall Azmat, R., Ebner, G., & Wohnhas, J. (2007).*Diversity and equality of opportunity*. *Fundamentals for effective action in the microcosm of the health care institution*. Bern: FOPH – Federal Office of Public Health, in collaboration with H+ Swiss Hospital Association.

Saohatse, M. C. (1998). Communication problems in multilingual speech communities. *South African journal of African languages,* 18(4), 111-117.

Schulze, B., Nowak, P., Krajic, K., Trummar, H. &Pelikan, J. M. (2003). *Improving interpreting in clinical communication pathway for implementation and evaluation.* Vienna. Ludwig Boltzmann Institute for the Sociology of Health and Medicine.

Singh, S. & Darroch, J. E. (2012). *Adding it up: cost and benefits of contraceptive services*. New York. Guttmacher Institute.

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2003).*Unequal treatment. Confronting racial and ethnic disparities in health care*. Washington: The National Academies Press.

Sparrow, R. (2005).*Dead culture: The case of cochlear implants; the journal of political philosophy*. 13(2), 135 -152.

Speidel, J. J., Thomas, K. M. J. & Harper, C. C. (2014). Family Planning; Much progress but still far to go. *Solution* 4, 54-61.

Spolsky, B. (2004). *Language policy*. Cambridge, Cambridge university press.

Steward, M. A. (2018). Stuck in the middle: The impact of collaborative interprofessional communication on patient expectations. *Shoulder Elbow,* 10(1), 66-72.

Stewart, M., Brown, J. B., Boon, H., Galajda, J., Mcredith, L., & Sangster, M. (1999). Evidence on patient – doctor communication, cancer prevention & control: CPC – prevention and controle ER cancerologie; *PCC,* 3(1), 25-30.

Stewart, M., Brown, J. B., Donner, A., McWhinney, I. R., Oates, J., Welton, W. W., & Jordan, J. (2000). The impact of patient centred care on outcomes. *The Journal of Family Practice*, 49 (a), 796-804.

Teutsch, C. (2003). Patient – doctor communication. *The medical clinics of North America*, 87(5), 115-1145.

Tucker, P. B. (1998). Deaf culture, cochlear implants & elective disability. *The Hastings center report*, 28(4), 6-14.

Qanbar, A. W. & Saqer, A. O. (2019). Language miscommunication in the healthcare Sector: A Case Report. *Journal of Patient Safety and Quality Improvement*, 7(1), 33-35.

Ulrich, R., Quan, X., Zimring, C., Joseph, A. & Coudhary, R. (2004). *The role of the physical environment in the hospital of the 21st century: A once in a lifetime opportunity*. Center for Health Design.

United Nation Department of Economic and Social Affairs (2015). *World Fertility Report, 2015*. New York. Author.

Wang, M. & Peng, Y. (2015). A Pragmatic study of Chinese and Western linguistic politeness. *International Conference on Social Science and Technology Education,* 1(2), 192-197.

Wanjau, K., Wangari, M., & Ayonde, E. (2012). Factors affecting provision of quality in publichealth sector – A case study of Kenyatta National Hospital. *International Journal of Humanities and social sciences,* 2, 13.

Westoff, C. F., & Bankole, A. (1998). The time dynamics of unmet need: An example from Morocco. *International Family Planning Perspectives,* 24 (1), 12-14.

Williams, S., Weinman, J., & Date, J. (1998). Doctor – patient communication and patient satisfaction. *A Review, Family Practice,* 15(5), 480-492.

Wilson-Stronks, A., Lee, K. K., Cordero, C. L., et al. (2008). *The joint commission*; one size *does not fit all: Meeting the health care needs of diverse populations*. Oakbrook Terrace, IL.

World Health organization. (2009). *Promoting sexual &reproductive health for persons with disabilities*: WHO/ UNFRA guidance note.

World Health Organization. (2010). *Trends in maternity mortality*. Geneva. Author.

World Health Organization. (2015). *Improving access to quality care in family planning*: *Medical eligibility criteria for contraceptive use*.1st ed. Geneva, Switzerland, Author.

Yeo, S. (2004). Language barriers and access to care. *Annu Rev Nurs res;* 22, 59-73.

Zhang, C. (2017). A study on the application of the cooperative principle in business English letters. *Advances in Computer Science Research,* 59, 1139 – 1144.

APPENDIX I: OBSERVATION SCHEDULE FOR SERVICE ENCOUNTERS

Phatic communication	Nature of the conversation –Q/A	Turn taking pattern between provider and service seeker	Intonation	Evaluation of the service encounters

APPENDIX II: INTERVIEW GUIDE FOR SERVICE SEEKERS

Section I: Service related language problems

1. What is your age?
2. What is the highest level of education?
3. Which languages do you speak fluently?
4. Which languages have you heard being used in this facility?
5. Which language(s) would you prefer to receive medical services in?
6. Have all your communication needs been satisfactorily met in all communication events in this hospital? Yes/ No
7. If No, which specific communication needs have not been satisfactorily fulfilled?
8. Which strategies have you used to solve these communication problems?
9. Give suggestions on how to solve the language problems.
10. Which family planning (FP) written materials have you received in this facility in the recent past?
11. In which language(s) were they written?
12. Did you find the information understandable?
13. If No what was difficult to understand?
14. What means did you employ to understand the materials?
15. What recommendations do you make to the hospital regarding preparations of such materials?

Section 2: Analysis of Language Problems

1. What are some of the challenges you have had while receiving services in this facility?
2. How did these challenges affect you?

3. What did you do about them?
4. What did the hospital do about them?
5. Have you ever raised a complaint concerning the services you receive? YES/ NO
   If yes, describe the nature of the complaint.
6. How was the complaint solved? Was the solution given satisfactorily?
7. Suggest recommendations on how such language challenges can be solved.
8. Does the gender of the health provider make you fear mentioning some medical issues? Why?

Section 3: Adjustment strategies

1. What challenges do you encounter when receiving FP services from a healthcare provider from a different region?
2. Give the techniques you will use to overcome such challenges.
3. How effective are these technques? Give other strategies that can be used to solve the language problems?
4. When you are in the process of receiving services and a communication barrier is noted. Who seeks for the strategy to overcome the problem?
5. Do you feel comfortable in such a case?
6. Give suggestions on how these challenges can be improved?
7. Have you ever required any help in communication in the FP? What kind of help did you get and were you satisfied?
8. Are there written materials in this facility that are supposed to give you information?
9. How effective are they in passing the intended message?
10. Do you understand them clearly?

11. What assistance would you like the hospital to offer you?

Section 4: Mechanism for implementation of adjustment strategies

1. In case you are receiving FP services and a communication problem crops up, how do you solve it?
2. What kind of language services do you look for?
3. How do you get these language services?
4. Does the hospital offer such language services?YES/NO
5. How available are such language services?
6. Have you ever required the services of an interpreter when seeking services in this facility? What were the reasons?
7. Who provided the interpretation?
    - Your service provider
    - Another staff
    - Another service seeker
    - A relative
    - Other (specify)
8. Where you satisfied with the interpretation you got? YES/ NO
9. If no, what challenges did you face in communicating FP issues to the healthcare provider through an interpreter?
10. Give suggestions on how interpretation should be improved in this facility.

APPENDIX III: INTERVIEW GUIDE FOR SERVICE PROVIDERS

Section 1: Service related language problems

1. What is your age?
2. What is your highest educational level?
3. What is your professional status in this hospital?
4. What is your first language?
5. What other languages do you speak fluently?
6. Which languages are used in this hospital?
7. What is the language policy in this hospital?
8. Which languages do you use when offering services to your clients? Why?
   i) The first most common language
   ii) The second most common language
   iii) The third most common language
   iv) Other language(s) specify----
9. What are your communication challenges when dealing with the following categories of service seekers?
   a) Visually impaired
   b) Deaf
   c) Dumb
   d) Mentally challenged
   e) Close relatives
   f) People from other linguistic backgrounds
   g) People with strong religious beliefs
   h) People with strong attachment to their culture
10. How do you deal with these problems?

11. How does the hospital deal with such challenges?
12. Give your suggestions on what can be done?
13. How can your suggestions be implemented?
14. Which documents/materials do you use to supplement your FP services?
15. Which audience do you target?
16. In which languages are these materials written?
17. Do the service seekers find the materials helpful?
18. Have the service seekers raised any language related concern about them? YES/ NO
19. What is the concern?
20. When you discovered the materials were not helping them, what did you do?
21. What has the hospital done about them?
22. Has the hospital come up with a policy to address these language problems?
23. How effective has the policy been?

Section 2: Analysis of language problems

1. What challenges do you encounter when serving a service seeker whose language you do not understand?
2. How do you solve this problem?
3. How effective have been the strategies you employ?
4. What assistance does the hospital offer concerning these problems?
5. Suggest other ways in which these challenges can be solved?
6. How can these strategies be implemented?
7. How do the language problems evident in the facility affect your work?
8. How do you deal with them?

9. How effective has your strategy in dealing with them been?
10. What assistance have you received from the hospital?
11. Has it been effective?
12. Give other strategies you think can solve these problems?
13. What are your recommendations concerning their implementation?

Section 3: Adjustment plan/ strategies

1. In your view what are the main communication problems you face as you work in this facility? How do you solve these communication problems?
2. How effective do you think your mechanisms have been?
3. What other strategies can be applied to solve the language problems?
4. Give recommendations on how their strategies can be implemented?
5. What assistance does the hospital give you?
6. Does the hospital have a policy guide on these communication problems? Describe it
7. How effectively has the policy addressed the challenges?
8. You have met a service seeker who is deeply rooted in culture. How do you deal with the language problems?
9. Do you think the strategies can be used to solve the problems?
10. What other strategies can be used to solve the problems?
11. How can they be implemented?
12. Did the hospital give any assistance?
13. Is there a policy guide in the hospital on how to deal with such challenges?
14. Give suggestions on how these challenges can be solved.

Section 4: Mechanism for implementation of strategies

1. What assistance does the hospital give you when you encounter a communication barrier with a service seeker?
2. How do you get this assistance?
3. How adequate is the assistance?
4. What is the policy of the hospital concerning this kind of assistance?
5. What is your input concerning the same?
6. Have you ever requested for anyLanguage related assistance while dealing with a service seeker? What was your experience(s).
7. Who offered you the assistance?
8. How effective was it?
9. Suggest how this can be improved
10. Have you ever been requested by your colleague service provider to assist him/her understand what their client was saying? Give your experience(s)?
11. Incase you note that your gender is the source of communication barrier with a service seeker, how do you solve this?
12. What are your general comments on communication problems and their solutions in this facility?

APPENDIX IV: HOSPITAL DOCUMENT ANALYSIS CHECKLIST

Document	**Comment**
Type of document	
Description of the type of document	
Organization structure of the document	
Target audience – what evidence is there?	
Language use in the document	
Evaluation of the document – Is the document effective in conveying the message?	

APPENDIX V: CONSENT FORM

Dear Respondent,

My name is Juliana Ndunge Maitha and I am a postgraduate student at Machakos University. I am conducting a study on "**Language Management in Family Plannning Discourses at Machakos Level 5 Hospital, Kenya"** as part of fulfillment of the requirements for the degree of Master of Arts in Applied Linguistics.

I am supposed to sample service seekers and service providers to participate in the study. The study intends to understand language problems that occur when service provider is attending to service seeker. I will therefore be required to observe a service seeker being offered family planning services and record the conversations. Thereafter, I will interview the service provider and service seeker. You have been sampled as one of the respondents in this study.

This form therefore seeks your consent to participate in the study. Your confidentiality and anonymity will be guaranteed and the research findings will be used for academic purposes only. You are free to terminate your participation at any stage of the data collection process. This will not affect in any way you or any services you may be receiving here at Machakos Level 5 Hospital.

I have fully understood the contents of this statement and willingly agree to take part in this study

Signature …….. Date …….

APPENDIX VI: RESEARXH PERMIT

Permit No : NACOSTI/P/18/96105/24920
Date Of Issue : 14th September,2018
Fee Recieved :Ksh 1000

THIS IS TO CERTIFY THAT:
MS. JULIANA NDUNGE MAITHA
of MACHAKOS UNIVERSITY, 543-90100
MACHAKOS,has been permitted to
conduct research in *Machakos County*

on the topic: *ANALYSIS OF LANGUAGE PROBLEMS IN FAMILY PLANNING DISCOURSES AT MACHAKOS LEVEL 5 HOSPITAL*

for the period ending:
13th September,2019

.....
Applicant's
Signature

.....
Director General
National Commission for Science, Technology & Innovation

APPENDIX VII: EXTRACTS

DATA FROM MACHAKOS LEVEL FIVE FAMILY PLANNING DEPARTMENT

EXTRACT 1
HIV Counseling and Testing Room

1. A: Eeh. Mimi naitwa Jane (sic). I am a counselor najulisha watu kuhusu HIV. Kuwajulisha hali yao na pengine (pause) mwenye anaitaji usaidizi wangu zaidi anapata sawa sawa shika mtoto vizuri. Naweza jua majina yako?
2. B: Ruth.
3. A: Ruth, sawa karibu umekuja clinic yako ama ya mtoto?
4. B: Yangu
5. A: Ya family planning.Ok. Hapa kwa hii room huwa tunafanya mambo na Hiv na tunajaribu kuangalia jinsi tunaweza saidia watu incase mtu kwa bahati mbaya amepata HIV asije kuanza kudhoofika so once tunapata mtu pengine ako nayo tunamsaidia.Sawa sawa. So nitakuuliza maswali kwa kipufi ndio tuweze kufikia kukutest. Mwisho ulipimwa HIV lini?
6. B: (Silence) last year
7. A: Last year which month?
8. B: Kama mwezi wa sita
9. A: Mwezi wa sita. Eeh, umeolewa? Na mzee mshapimwa pamoja
10. B: Eeh tulipimwa pamoja?
11. A: Mwisho ilikuwa lini?
12. B: Hiyo siku
13. A: Mwezi wa sita. Ni sawa inakuanga muhimu kujua hali yakonampenzi wako sababu inaweza pengine akona virusi na hajakuambukiza so kujua hali yake ni kitu muhimu. Nitakuuliza maswali kwa kifupi. Ningependa nijue unaelewa nini kuhusu HIV. Unaelewa kama nini HIV?
14. B: (Silence) Ni uh ugonjwa tu uh bad.
15. A: Ugonjwa mbaya. HIV haikuangi ni ugonjwa, inakuanga tu ni condition vile tuseme leo unaweza kuwa hauna shida ya pressure na leo ukuje upimwe upatikane na shida ya pressure sawa. HIV inakuanga ni virusi ambayo ikiingia kwamwili inaenda kuattack your immunity system ama kinga ya mwili.Kinga ya mwili huzuia mwili wako magonjwa. Tuseme kama jirani yako ako na TB, kama mwili wako uko na kinga ya kutosha hautapata TB.Sawa. So hii virus ikiingia kwa mwili huwa si ati inakuletea magonjwa. Inaattack your immunity system.Sawa sawa. So wakati mwili hauna kinga ya kutosha kuzuia magonjwa unawezakupata magonjwa, malaria na mangonjwa ingine inatokelezea sababu mwili hauna nini? Hauna kinga.So umeelewa HIV madhara ambayo inayoleta kwa mwili wako? Hio virusinaleta madhara mengi kwa mwili wako. Ina attack kinga ya mwili nawakatimwili hauna kinga ndio tunaanza kupata magonjwa. Kwa hivyo unaelewa HIVni virus sawa sawa.Kuna njia ambazo mtu anaweza pata virusi kama gani?.....
16. B: (Interrupts) sharp objects
17. A: Pia kushare sharp objects kama kutumia sindano pamoja na mtu ambaye ako na virusi. Itawezakukuambukiza virusi. Pia unaweza kuongezwa damu ambayo haikuangaliwa hali ya HIV na pengine huyo mtu alikuwa na virusi mwenye alipeana hio damu. Mwenye ataongezwa hio damu ataambukizwa ukimwi. sawa. Mama anaweza kuambukiza mtoto. mama amepata mtoto na akiwa hajui hali yake, akijifungua na anyonyeshe mtoto anaweza

kumuambukiza. Pia wakati kumehappen kuwa na accident, gari imepata accident watu wameumia na kwa hio yeye pia ameumia ameshed blood so wakati watu wamepata vidonda na hio damu ya mwenye ako na Hiv 'icome incontact na vidondavengine anaweza kuwaambukiza Hiv. Umeelewa? So.Tumefika hapo sijuhi kama uko na swali. Umeelewa njia ambazo mtu anaweza pata virusi. Umeelewa HIVni nini? Kutoka leo utakuwa ukisema ni ugonjwa.

18. B: Hapana
19. A: Unakumbuka kuinterprete matokeo? Utajua kusoma matokeo? sawa nitakukumbusha. Tukipima tunatarajia matokeo mawili either kuwa positive ama ikuwe negative. Sokama ni positive itaweza kuchora laini mbili ukiangalia kwa hii chart like hiyo ya kwanza imechora laini mbili kumaanisha positive na ikichora laini moja ina maanisha ni negative ama hauna virusi pia inaeza chora laini hapo chini ama ikose kuchora laini yoyote kumaanisha hiyo process haijakuwa complete na tunairudia so uko tayari kupimwa? Kuona matokeo yako
20. B: Leo?
21. A: Mmh (yes)
22. A: Tunapima hapa na ujue matokeo leo leo
23. B: Siku ingine
24. A: Siku ingine. Ukifika hapa ulikuwa umetoka room?
25. B: Room 1
26. A: Room7?
27. B: Sijaenda room 7
28. A: Umetoka huko. Sawa nowadays uwa ni routine……
29. B: (Interrupts) mmh..
30. A: Kabla ujatibiwa popote unakuwa unajulishwa hali yako ya HIV. So tukikosa kupima unamaanisha hautaki kuudumiwa leo?
31. B: Sikujua nakuja kupimwa
32. A: Si nimeona umeandikiwa room 9. So imekuwa routine. Tunataka kusaidia watu wajue hali yao na HIV. Mwenye anajipata ako nayo tunamsaidia sawa sawa, so uniambie kwa
33. Leo uko tayari kujua hali yako?
34. B: (silence) Hapana
35. A: Huwa hatulazimishi watu. Na ukienda huko mbele ukose kutibiwa?
36. B: Nitaenda nyumbani
37. A: Ni nini haswa unafeel unaogopa?
38. B: Hakuna. Sasa mimi sijajitayarisha
39. A: Utaeza endelea tu na room 7 basi

EXTRACT 2
FAMILY PLANNING ROOM

1. A: Habari ya asubuhi
2. B: Iko sawa
3. A: Umekuja clinic yako ama ya mtoto?
4. B: Yangu
5. A: Uko kwa family planning method yeyote?
6. B: Nilikuwa nimedungwa ile shindano ya three months.
7. A: Mbona ukachangua shindano? iko na yeyote?

8. B: Hapana
9. A: Umewaikosa kupata your menses?
10. B: Si kupata hizo vitu ni kaawaida
11. A: Ni kawaida, but mimi nilikuwa nataka kujua kama ushaikosa
12. B: *Eeh*
13. A: Ungeprefer method ngani?
14. B: Nataka sindano
15. A: Umekuwa ukitumia sindano kwa miaka migapi?
16. B: Miaka tano
17. A: Kuna shida yoyote? Kilo haiongezeki?
18. B: Uh! Imeongezeka
19. A: Haijaongezeka. Si unaona iko pale. Ulianza ukiwa kilo 84 na leo uko 85. Uko sawa
20. B: (Laughs) eeh
21. A: Unasema hakuna shida?
22. B: Pressure imekataa(laughs)
23. A: Ati imekataa. Ajahauamini imekataa? Bp imekataa kabisa?
24. B: eeh
25. A: Umpeleke wapi?
26. B: Room 1

EXTRACT 3
FAMILY PLANNING ROOM

1. A: Uko kwa nini? Jadelle?
2. B: Eeh
3. A: Sawasawa hebu tuone, unasikia?
4. B: Yah!
5. A: Zinakuanga mbili zote mbili ziko? Unaeza feel kama umekaa hivi ama juu ya nini……
6. B: He he ….
7. A: Haha. Nauliza kaa unaweza feel juu ya nguo. Utazifeel tu mbili hebu jaribu. Umefeel yote mbili? Ni hiyo tu kuna shida yoyote?
8. B: Hakuna shida, may be circulation ya blood tu haifiki kwa kichwa
9. A: (Laughs) kwani uko na headache.
10. B: Hakuna headache. Ni dizziness. Nasikia kuanguka, nasikia kutapika, nasikia kaa kuna kitu kimekataa kufika mahali
11. A: Inakusumbua? Kuna shida mahali?
12. B: (Laughs)
13. A: Unakuja kutolewa sasa?
14. B: Hapana
15. A: Uliwekwa lini?
16. B: Mwezi wa kumi 2015
17. A: Ni ya miaka gapi?
18. B: Five years
19. A: Ni mbali utatolewa 2020?
20. B: Uh!

21. A: (laughs) Utafukuzwa na mzee? A: Utatoa wakati utafeel unataka kupata mtoto. Uko na miaka migapi?
22. B: Saa hii niko naa (pause)……I think 30
23. A: Namba ya simu
24. B: 0712 222 450
25. A: Unaishi wapi?
26. B: Naishi kwa D.C
27. A: Sasa utaenda tu. Tutatoa 2020. Lakini kabla ya hapo unaweza kuja ukipata shida yoyote.

EXTRACT 4
FAMILY PLANNING ROOM

1. A: Sasa
2. B: Poa sana. Nakuja kutoa depo
3. A: Unatoa kwa nini? Unatoa mbona?
4. B: Si…. imeisha wakati wake
5. A: Tuweke ingine ama? Ama unataka kuconcieve? Mmh….. Tutaeka ingine ….. Ama utaconceive?
6. B: Tutaongea. (laughs)
7. A: Tutaongea za kutoa?(laughing)
8. B: Eeh….
9. A: Haya sawa
10. B: Wakati umeisha
11. A: Lakini umekuwa sawa. Imekupeleka vizuri
12. B: Eeh……. But ilikuwa na bleedings sometimes on and off
13. A: (interrupts) but…….
14. B: Haikuwa mbaya
15. A: Unasikia uchungu?
16. B: Sisikii..
17. A: Umeamua kutoa ama kubadilisha method?
18. B: Nilikuwa nataka kubadilisha
19. A: Kubadilisha? Uende kwa njia gani? Ama hiyo bado.
20. B: Mtanieleza zile ziko ndio nijue.
21. A: Tukueleze zile ziko.
22. B: Yah!
23. A: Kuna njia nyingi za kupanga uzazi pamoja na hiyo ulikuwa unatumia.
24. B: Mmh….
25. A: Tuko na coil, coil haina hormone yoyote, inaweza chukua miaka kumi na mbili. Hizo njia ulikuwa ukitumia ziko na hormones, ulikuwa unadungwa hormones, unameza hormones, unawekwa hormones.
26. B: Mmh……
27. A: Unawekwa hormones kwa mwili
28. B: Mmh…..
29. A: Sawa. Hiyo hormone insaidia mayai isitoke
30. B: Mm
31. A: Umewaikosa kupata your menstrual?
32. B: Mmh (Inaudible)
33. A: Sema ndio ama la

34. B: Na ikona the same hormone na implano?
35. A: Hio iko na the same hormone, zile tembe tunapeana ziko na extra hormone.
36. B: Mm
37. A: Sawa. Kuna natural method, ya kuhesabu kuanzia siku yako ya kwanza ya kuona damu ya mwezi (pause) Kuna siku tunaziita safe days….. Pia kuna condom.
38. B: Mm
39. A: Ya kwanza sikuwa nimekuambia side effects. Kuna discomforts.
40. B: (Interrupts) mm…….
41. A: Hiyo ingine iko na side effect ya spotting, kuumwa na klichwa but ni side effect ukiona zikisidi utarudi hospitali.
42. B: Mm……
43. A: Swali yoyote
44. B: Na depo
45. A: Depo iko na the same price kama ile ya coil.
46. B: Na side effect yake pia…..
47. A: Kuumwa na kichwa. Kichwa inaweza uma
48. B: Mm
49. A: Yes. Unaweza kosakuona damu yako ya mwezi
50. B: Na nikikosa kuona? Na pia ninaweza kuona?.....
51. A: (Interrupts) it is how it occurs. Damu ya mwezi inaweza kuonekana na ile sperm haiwezi kufertilize mayai. Those are the two ways it works. Nimeweka hizo pamoja kwa sababu ziko na the same effects na ni hormonal. Uko na swali yoyote?
52. B: Ni kama sina swali
53. A: Unajua si tunakuambianga tu hizo vitu nimekueleza uchaguzi ni wako.
54. B: Na hiyo depo tunalipia?
55. A: Ikiwa hapa ni free but it is out of stock.
56. B: Mmh
57. A: So tunaomba wenye wanakuja kuchukua depo waende pale nje wanunue….
58. B: Wacha niende ninunue pale chemist nikuje munidunge
59. A: Ni sawa kama umeamua hivo.
60. B: So otherwise mtu anaweza enda kwa hospitali ingine andungwe tu ya serikali
61. A: Yah! (silence) So long as ako nayo anaweza dungwa.
62. B: Sawa na si ni hivyo tu ni nimeshukuru
63. A: Sawa wacha tukutume room9
64. B: Eti
65. A: Nataka uende room9
66. B: (Interrupts) room 9!
67. A: Room 9. Uko na receipt Evelyne?
68. B: Yah!
69. A: Sawa.
70. B: Karibu.

EXTRACT 6

FAMILY PLANNING ROOM

1. A: Habari ya leo mum. Mtoto ana wiki gapi?
2. B: Miezi tano na wiki mbili
3. A: Miezi tano na wiki mbili.Mbona umekuja family planning kama umechelewa ulikuwa unatumia method gani?
4. B: Three months
5. A: Ya three months? Sindano ama dawa ya kumeza
6. B: Sindano
7. A: Sindano uko na watoto wangapi?
8. B: Mmoja
9. A: Mmoja (Surprised) mbona uliamua sindano? Ndio ulale tu na starehe?
10. B: (Embarassed) Ndio inafaa
11. A: Ndio inafaa
12. B: (Silence) Mmh
13. A: Mbona sio hii unaweka kwa mkono na inakupatia kinga kwa siku mob una avoid kuja kuja clinic saa yote ni dawa the same.Walikuambia hizi zingine na ukapenda hii?
14. B: Ni vile huwa naogopa kuwekwa
15. A: Uliambiwa mdhara ya hii?
16. B: Hio ni gani?
17. A: Hii ya three months yenye unadungwa uliambiwa madhara?
18. B: Eeh
19. A: Kama gani?
20. B: Inaweza change pressure
21. A: Eeh
22. B: Inaweza ongeza weight
23. A: Inaweza ongeza kilo. Haukuambiwa ukitaka kupata mtoto inaweza kukawia
24. B: Hapana
25. A: Ukuambiwa hivyo?
26. B: Labda niliambiwa lakini sikusikia
27. A: Hukusikia hiyo? Sawa hii inaweza ongeza kilo, inaweza change period zakobut sasa shida yake ni kuwa inaffect fertility, time unataka kupata mtoto wa pili ina delay, unaweza ngoja miezi sita, miaka kumi ukigoja mtoto mwingine……
28. B: (Interrupts) nikitafuta mtoto!
29. A: Compared to hii iko na hormones nyingi so kwa maoni yangu, though the choice bado ni yako kaa unataka kupata, mtoto baada ya three months unaendea kitu long term. Unaweka na kusahau hiyo story. Inaweza kukupatia kuzunguzungu, unaweza umwa na kuchwa, unaweza kuwa na spotting, inaweza interfere na period cycle yako.Kwa wengine periods zinaenda zinapotea, wengine kila mwezi utakuwa unapata periods but for thefirst 2-3 months ikiisha shika kwa system yako na bado ni the same hormone na depo.Na incase ikudhuru in any way itarudi tu ni kutoa tunatoa na kila kitu inarudi normal.
30. B: Inawekwa aje?

31. A: Unasukumia hapa ndani. Mwikali nifungulie hiyo ni muonyeshe ya chini so hii ni ile ya kitambo. So ni kakitu kama hii sa dawa iko hapo ndani ndio inasukumiwa ndani ya ngozi. Basi ni kakitu kadogo kana kaa hivi
32. B: Sasa hii ndio unanidunga nayo?
33. A: But unagandishwa hakuna uchungu yoyote
34. A: Uchungu tu ni kama ya ile sindano ya kawaida
35. A: Juu inagandishwa.ikiiasha gandishwa ni hivyo hakuna uchungu wowote
36. B: Maybe niende nifikirie ndio next time nichange.
37. A: Sawa unaeza enda ufikirie halafu next time ukikuja uamue ni hii juu itafunguza siku zako za kuja huku. Unaenda unaweka halafu unasahau.
38. B: Sawa
39. A: Uko na swali yoyote. Hii si chungu by the way usiogope
40. B: Inakaa ya ngomb'e
41. A: Halafu by the way hii haidhuru maziwa
42. B: Halafu pressure
43. A: So unaweza enda fikiria next time ukuje umeamua.

EXTRACT 7

HIV COUNSELING AND TESTING ROOM

1. A: Mtoto ako na miezi gapi?
2. B: Ako na mwezi na two weeks
3. A: Ndio mara ya kwanza kumleta clinic.Mara ya mwisho yako kupimwa HIV ilikuwa lini
4. B: Naweza kumbuka kweli?
5. A: Mara ya mwisho yako kupimwa HIV ilikuwa lini?
6. B: Mwezi wasaba
7. A: Mwezi wa saba?
8. B: Eeh
9. A: Sawa huwa tunarudia tena mama akikuja kuanza clinic ya mtoto. (pause) tunataka tuakikishe tumekinga mtotoasikuje kupata virusi sawa sawa. Humewahi pimwa na mzee.
10. B: Bado
11. A: Tangu muoane hamjawahi pimwa pamoja?
12. B: Hapana
13. A: Kwa hivyo hujui hali yake?
14. B: Hapana
15. A: Okay, usibabaike saana HIV prevalence is going down in Kenya na watu wengi tunapima tunapata hawana. But it is important umkumbushe mpimwe.
16. B: Naona
17. A: So kujua hali yake ni kumleta mpimwe pamoja asiende kupimwa nje na akuambie nimepimwa niko sawa sawa nakupima pamoja na unaona matokeo ndio uatakuwa umeakikisha kabisa mtoto akiendelea kunyonya ako safe ni sawa.
18. B: Eeh
19. A: So unatarajia matokeo ikuwe aje sababu hujawahi pimwa na mzee?
20. B: Ikue tu poa
21. A: Kwa bahati mbaya ikibadilika?
22. B: (silence) Nitatafuta tu namna.

23. A: Eeh sawa. Incase kama tunapata mama amepata virusi, huwa tunamuanzisha matibabu na pia tunaendelea kuangalia mtoto incase kama atakuwa amepata hio ugonjwa pia yeye tunamuanzisha matibabu lakini kama bado hajapata kuna dawa ambayo huwa tunapeana, tunapea mtoto ya kuzuia hata akiendelea kunyonya ukute hawezi kuambukizwa hizo virusi. Uko sawa
24. B: Sawa
25. A: Mm So uko tayari nikupime tuangalie vile hali iko?
26. B: Haina shida
27. A: Sawa sawa utakaa pale tutoe damu. Jina lako? Nipatie majina tatu
28. B: Redempta Mbatha Joel
29. A: Uko na miaka gapi?
30. B: 20……..23
31. A: Niambie your date of birth
32. B: 17th July 1994
33. A: Namba yako ya simu
34. B: 0723 220 20
35. A: Umeanza clinic
36. B: Bado
37. A: Unaanza lini? Umepanga kuanza lini FP
38. B: Mtoto akifisha six months
39. A: Eeh umeolewa? Nani alikuambia hiyo ya six months?
40. B: Niliambiwa huku clinic
41. A: Ukaambiwa hivyo. Hapo uliadanganywa ukaambiwa six months? Na ukipata mimba ingine kabla ya hio six months ifike? Utafanya nini?
42. B: Sikuambiwa siku ile ninaweza anza, eeh.
43. A: Mama akijifungua baada ya mwezi mmoja unaanza FP sawa.
44. B: sawa
45. A: Baada ya hio mwezi moja unaweza pata mimba vile sasa mwezi imeisha …..two weeks eeh, ama umeambia mzee mtakaa hio miezi sita…
46. B: (laughs) bado sijamuambia
47. A: Eeh so ni vizuri ujipange, mtoto akidungwa utampeleka apumzike ni vizuri. Ushai itumia ama ndio itakuwa mara ya kwanza.
48. B: Ndio itakuwa mara ya kwanza
49. A: Eeh so ni vizuri upitie pale wakupe ushauri utawaambia unataka kuanza family planning watakueleza…….
50. B: (Interrrupts) eeh
51. A: Zile njia ambazo unaeza changua sasa yenye itakupendeza sawasawa.
52. B: Eeh
53. A: Ee usikae ukuje kujipata umepata mimba ingine mtoto hata hajafikisha miezi tatu…….. nne sawa ndio
54. B: Eeh
55. A: Sawasawa sasa naona matokeo iko sawa iko negative ukiona imechora laini hapo ikiwa positive inachoranga laini mbili so kama ni moja ni negative. Sawa lakini sijasema mzee usimlete (laughs) utaenda umuongeleshe umwambie utamuongelesha vile mnaongea sini sawa.
56. B: Eeh
57. A: Kwa hivyo ukimalisha room 3 uende room 7 ndio mtoto adungwe
58. B: (Interrupts) akadungwe ha! Room 7 uambiwe mambo ya family planning.
59. A: Uh! room 7 uambiwe mambo ya family planning
60. B: .Eeh

61. A: Eeh sawasawa
62. B: Sawa
63. A: Sawa

EXTRACT 8

FAMILY PLANNING ROOM

1. A: Mtoto ni wangapi
2. B: Wa kwanza
3. A: Wa kwanza
4. B: Eeh
5. A: Mtoto ako na miezi ngapi?
6. B: Six weeks
7. A: Mwezi moja na six weeks.Uh! Mwezi moja na two weeks. Sawasawa.Sasa hii clinic ya leo tuna kufania kitu ya kwanza ni kuangalia hali yako naya mtoto.Halafu kuna zile chanjo tutapea mtoto.
8. B: Eeh
9. A: Na imeandikwa wapi? Nisaidie hii alipewa wapi? Sawas awa. Za leo mtoto atapewa chanjo nne.
10. B: Eeh
11. A: Chanjo ya kwanza ni polio alipata ile ilipeanwa ya campaign?
12. B: Hapana
13. A: Hio hakupata? Polio inazuia ugonjwa wa kupooza tutamueka kwa mdomo…….
14. B: (Interrupts) eeh.
15. A: Kuna ile tunaita roda hio nayo ni ya kuzulia kuhara…. mwaka moja atapata chanjo mbili saa hii na akiwa miezi mbili na robo.
16. B: Eeh
17. A: Sawa chanjo za kudungwa atapata mbili, atapata moja kwa mguu ya left hio inazima magonjwa kadhaa kuna eye tunaita Hepatitis B, ingine tunaita Influenza, ingine tunaita aje (pause) Diphtheria, inazuia magonjwa matano halafu kunaile ingine nitapeana mguu ya right ni ya kuzuia Pneumonia unajua Pneumonia ni nini?
18. A: Eeh Kyambo,
19. B: Eeh kyambo, sawa
20. A: Hii ndio inaitwa roda ndio ya kuzuia kuhara nikimpea usinyonyeshe mtoto immediately sawa.
21. B: Mm
22. A: Umpe dakika kumi na tano ama nusu saa kabla ujamnyonyesha sawa sawa.
23. B: Mm
24. A: Alikuwa amenyonya saa hii?
25. B: Eeh
26. A: Mpee tu pole pole anyonye
27. B: Yeye anyonye?
28. A: Eeh yote (silence) akimaliza utaniambia nishikie hapo kwa goti.
29. B: Mm
30. A: Shikilia hapo utamgeuza na hio side ingine. Shikilia tu hapo. Hiyo dawa nimempea anaweza pata rash ama joto kwa mwili. Incase atapata joto utampunguza nguo lakini ikizidi ukiona haishi utamrudisha hospitali

sawasawa. Ukiona amepata rash ni kawaida halafu kuna umuhimu wako wa kuja hizo clinic zingine uakikishe hiyo siku tumekuandikia umemrudisha clinic hata ikipita siku moja na ujamleta usiogope utamleta…….. unamrudisha.

31. B: Mm
32. A: Sawa
33. A: Utamleta tu hiyo siku
34. B: Sawa
35. A: Nimekumalizia. A: Kuna information nataka kukupea kuhusu uja kizito baada ya kujifungua 6wks. Unaitwa nani?
36. B: Redempta
37. A: Unaishi wapi?
38. B: Katheka Kai
39. A: Namba yako ya simu
40. B:0720 190
41. A: Uko na miaka gapi?
42. B: 22
43. A: Mtoto alizaliwa tarehe gapi?
44. B: Ishirini mwezi……..
45. A: (Interrupts) Kijana au msichana
46. B: Msichana
47. A: Ulimsalia hospitali au nyumbani?
48. B:Hospitali
49. A: Ukamzaa normal au CS?
50. B: CS
51. A: .CS, hebu toa ulimi inje tuone? Matiti ziko sawa
52. B: Eeh
53. A: Ama kunashida yoyote kwa matiti?
54. B: Mm…..
55. A: Kubleed ulibleed sawa? Shida yoyote kwa tumbo.Kidonda?
56. B: Imeheal
57. A: Imepona kabisa?
58. B: Eeh
59. A: Sawa tutangalia tuone vile unaendelea. Hakuna usaha, hakuna kitu yote. Damu bado inatoka huko chini.
60. B: Iliisha
61. A: Iliisha mtoto ananyonya vizuri.
62. B: (Silence)
63. A: So vile ulifikisha mwezi ulikuwa umeanza kupanga uzazi?
64. B: Bado
65. A: Bado hujaanza? So tulikuwa tunataka tukimalizia utatoka hapa twende tuanze kupanga uzazi ndio at least … huyu ni mtoto wa gapi?
66. A: Wa kwanza
67. B: At least inakuwezesha kujipanga kama huyu ni wa kwanza, ukipata mwingine soon unaona huyu bado anataka kunyonya, huyu pia ako hapo mnasumbuania sumbuana si ndio at least inakuwezesha kupanga watoto wako vizuri sawa.
68. B: Sawa

69. A: .So kuna wenye uanza na wiki nne but ideal ni at six weeks so leo tukikuanzilizia hapa after chanjo za mtoto we pia tutakupeleka room 7 uende uanze kupanga uzazi si ndio.
70. B: Ndio
71. A: At least ujipange mwingine asikuje before huyu…like amfuate haraka haraka plus we mwenyewe anakupatia time, si ukiwa na mimba ulikuwa unamiss vitu nyingi sawa, at least mwili wako upate nguvu damu irudi kama kawaida ndio za ushike mimba ingine si ndio.Unasema hauna shida yoyote.
72. B: Sina shida yoyote.
73. A: Kama vile amekuambia mtoto anaweza pata joto anaweza pata rashes lakini ni normal but ukiona kama joto imekuwa too much ndio unafanya nini?
74. B: Ninamrudisha
75. A: Mzee anaitwa nani?
76. B: Joseph Muendo
77. A: We mwenyewe unaitwa?
78. B: Benedetta mbatha
79. A: Sawa twende nikupeleke room 7. Halafu isipokuwa clinic mtoto alikuwa na shida ingine yoyote?
80. B:Hapana

EXTRACT 9
FAMILY PLANNING ROOM

1. A: Karibu mama kwenye clinic yetu ya family planning.
2. B: Asante
3. A: Eeh so nataka kukufunza kuhusu haina za family planning zile tuko nazo
4. B: (*interrupts)* eeh
5. A: Si ndio
6. B: Eeh
7. A: Njia za kupanga uzazi. Haina ya kwanza tuko na yenye inaitwa coil……
8. B: (interrupts) Eeh
9. A: So coil……
10. B: (interrupts) Eeh
11. A: Ni aina ya njiaya kupanga uzazi amabyo tunaweka kwenye mwili wako
12. B: Eeh
13. A: (demonstrates) Tunaweka kwenye njia ya uzazi, so the coil enyewe inakaa hivi sawa, so ndio inakaa ndani ya mwili halafu hizi ni strings zitakuwa zinaonekana hapa za kumonitor so inaweza kukuprotect kwa muda wa miaka kumi na miwili, sawa.
14. B: Mm
15. A: Sawa unaweza kutoa wakati wote unataka kutoa side effects ni unafeel tu, utafeel uncomfortable ndani ya miwili wako unajua kuwa kitu imewekwa si ndio …….
16. B: Mm
17. A: Utafeel discomfort kidogo saa ile inawekwa unafeel tu discomfort lakini haina side effects nyingi si ndio.
18. B: Mm
19. A: Hii ni aina ya kwanza ya family planning
20. B: Mm
21. A: Halafu aina ya pili tuko na (pause) implant ya five years na 3 years sawa.
22. B: Mm

23. A: Hiyo iko na hormones sasa hiyo inaweza kufanya uongeze kilo upunguze kilo uumwe na kichwa saa zingine maybe unaspot.
24. B: Mmh
25. A: Yah, so hio ni implano, kuna ya 3yrs na five years. Sawa unawekewa kwa mkono wa kushoto.
26. B: Mmh
27. A: Halafu tuko na tembe, tembe tena ni hormonal iko na side effects kaa the same na implano sawa.
28. B: Mm
29. A: So tembe unameza moja kila siku muda ambao umeamua mwenyewe wewe kaa ni jioni saa moja utakula kila saa moja jioni sawa.
30. B: Umesema hizo pills zina last for how long?
31. A: Unameza kila siku tu moja moja. Yah.
32. B: Mmh (not satisfied)
33. A: Halafu tuko na sindano ya miezi mitatu kila baada ya miezi mitatu unakuja unadungwa sindano sawa.
34. B: Mmh
35. A: So kwa hii sindano iko na side effects; inaweza kudhuru lakini si lazima ikudhuru but inaweza kudhuru
36. B: Mm
37. A: Ya kwanza kichwa inaweza kuuma mara ya kwanza, inaweza chelewesha kupata mimba, siku ile unataka before kupata ianachelewa kidogo inaitwa secondary fertility sawa, halafu tena inaweza fanya siku zako za mwezi zikuwe nyingi, sawa halafu unaeza umwa na kichwa unaweza feel dizzy, backpains, Yah, sa hio ni sindano.
38. B: Mm
39. A: Unadungwa moja baada ya miezi tatu uko na watoto wangapi?
40. B: Mmoja
41. A: Moja, so kaa uko na mtoto mmoja bado unapanga kuwa na wengine?
42. B: (laughs) Bado
43. A: Ok, sawa, so tuone halafu tukuwe na condom hizo za wanaume so ni wewe uchangue njia ambazo unaitaji na kaa una swali yote unaweza uliza.
44. B: Mm. Na implant umesema ni five years?
45. A: Yah kuna ya miaka mitano naya miaka mitatu eeh
46. B: Sawa
47. A: Yah so we ndio unachangua mi hata sikuwa naitarajia leo
48. B: Mi hata sikuwa naitarajia leo.
49. A: He……
50. B: Eeh
51. A: Mtoto ako na siku ngapi?
52. B: Ako na six weeks.
53. A: Six weeks sa si unajua ni muhimu kupanga uzazi, eeh ni muhimu. mbona tupange uzazi...
54. B: Nitakuja tu
55. A: Mbona ni muhimu tupange uzazi?
56. B: (Laughs) usipate mtoto hivi karibuni
57. A: Halafu tena kuspace watoto ndio uweze kuwalea vizuri si ndio
58. B: Eeh
59. A: So haukuwa unatarajia kupanga uzazi leo?
60. B: Sikuwa natarajia leo

61. A: Eeh
62. B: Eeh
63. A: So unakuwa unatumia njia gani kujikinga?
64. B: (Laughs) maybe hio implano
65. A: Implano
66. B: Eeh
67. A: Okay, so unataka uweke lini implano
68. B: Mm……
69. A: Unataka uweke lini
70. B: Nitakuja next month
71. A: lakini si unajua ukuanza kunyonyesha kutoka saa hii ukiwa na week sita, umeona damu yako ya mwezi?
72. B: Mm…….. Bado
73. A: Bado, so saa hii uko na risk ya kushika mimba kwa sababu unajua ukinyonyesha mtoto continuously inasaidia kukingaa usipate mimba. So saa hii unaweka damu yako at risk unaweza pata mimba wakati wowote so that's why ukikuja clinic ukiwa na six weeks unaambiwa ufanye nini, (pause) upange uzazi
74. B: Eeh
75. A: Because kitu yote ikifanyika unaweza pata mimba ukilala na mwanaume unaweza pata mimba.
76. B: Eeh
77. A: So that is why uliambiwa ni muhimu upange uzazi na lazima utuambie unatumia njia ingine gani usipate nini?
78. B: Mimba
79. A: Yah
80. B: Nitakuja tu mueke hio implano
81. A: Lini
82. B: Next month
83. A: Sa between now and next month unataka kutumia njia gani? unaweza tumia tembe au unaweza tumia ……
84. B: Pill, lakini pill si uaffect mtu as in tuseme as in between now and next month nitumie hizo pills na nikija mniweke implano
85. A: Haina shida
86. B: Eeh
87. A: Eeh ukitumia pills kutoka now mpaka next month ukiwa ready ukitaka implant tunasimamisha hio tunaweka implano.
88. B: Mmh
89. A: Yah, lakini ni vizuri ujikinge sawa
90. B: Sawa
91. A: Because ukipata mimba na mtoto hajakua? utazaa mwingine tena mwaka ujao kama huyu hajaanza hata mwaka mmoja si ndio?
92. B: (laughs) mm
93. A: Sasa ni muhimu so ni wewe kuchagua mi nakuafunza halafu unaamua
94. B: Eeh,
95. A: Sawa
96. B: Na hizo pills ni nyinyi mnatupea ama unanunua?
97. A: Sa, kwa sababu mtoto ni six weeks ninakupea
98. B: Sawa
99. A: So umeamuaje

100. B: Mm
101. A: Umeamuaje
102. B: Si nimekuambia btw now na next month nitumie hizo pills na nikikuja ni exchange ni nini implano.
103. A: Sawa, so ni mtoto wa kwanza.
104. B: Eeh
105. A: Unaitwa nani
106. B: Benedetta mbatha
107. A: Miaka ngapi
108. B: 24
109. A: Unaishi wapi
110. B: Katheka kai
111. A: Utarudi next month. Numba ya simu
112. B: 0720 211 290
113. A: Asante
114. B: Karibu

EXTRACT 10
FAMILY PLANNING ROOM

9. A: Jina lako
10. B: Kasuma
11. A: Kasyuma?
12. B: Kasuma
13. A: Namba yako ya simu
14. B: 071 (interrupted)
15. A: (shouting) uongee kwa sauti 0701…….eh
16. B: 0050230
17. A: Uko na miaka ngapi?
18. B: 23
19. A: Ulizaa mtoto lini?
20. B: 28 mwezi wa nane 2018
21. A: Nyumbani ama hospitali
22. B: Hospitali
23. A: Ulizaa kawaida ama ulipasuliwa?
24. B: Kawaida
25. A: Matiti iko na shida?
26. B: He?
27. A: Matiti iko na shida
28. B: Hapana
29. A: Ulibleed sana baada ya kupata mtoto
30. B: Hapana
31. A: Na uliongezewa njia?
32. B: Hapana.
33. A: Damu ya uzazi imeacha kutoka?
34. B: He?
35. A:Mtoto ako na shida yoyote?
36. B: Hapana
37. A: Umepitia room 9 ukikuja hapa?
38. B; Ndio

39. A: Catherine, ukitoka hapa utaenda room 7. Room 7 ni ya kupanga uzazi. Mtu akifikisha six weeks baada ya kupata mtoto ndani ya hospitali so,lazima upange uzazi hata kama hutaki kuanza saa hii uende hio room sawa.
40. B: sawa
41. A: Catherine
42. B: Eeh
43. A: Jina ya mzee anaitwa nani.
44. B: Muthama
45. A: Eti Muthama? Jina ya mzee wako, jina zake mbili
46. B: Justus Muthama
47. A: Catherine (silence) nimekuandikia siku ya kurudi, utarudi huku tarehe 17th mwezi wa kumi. sawa
48. B: Mwezi wa ngapi?
49. A: Umempea namba gani?

EXTRACT 11
FAMILY PLANNING ROOM

1. A: Habari yako?
2. B: Nataka sindano
3. A: Hakuna sindano, unless ununue pale inje, unawezaa jaribu njia ingine
4. B: Hapana, nataka shindano mimi
5. A: Sasa unless uende ununue pale inje ukuje tukudunge.
6. B: Naeza tumia pill?
7. A: Ama unaweza tumia pills at least for a month, labda by then zitakuwa zimekuja mtoto ako na wiki gapi?
8. B: Six
9. A: Six weeks, unaeza anza na tembe ukishamaliza kama zitakuwa zimekuja sawa uta……. Utadungwa.
10. B: Sawa
11. A: So, utatumia tembe? Ushawahi tumia?
12. B: (silence)
13. A: (Excitedly) Kwa hivyo unajua vile zinamezwa
14. B: Yah
15. A: Hio yenye umepimwa nini ….. Iko wapi? Nisaidie. Umepimwa hali yako?
16. B: Ndio
17. A: Imeandikwa wapi? Huku mbele (silence) Damu ya mwezi imerudi?
18. B: Hapana
19. A: So, nitakupatia tu moja.
20. B: Mm
21. A: Uko na miaka gapi Catherine?
22. B: 23
23. A: Namba ya simu
24. B: 0715 200 2..
25. A: Unaishi wapi?
26. B: Mumbuni
27. A: Utarudi hapa (pointing)

EXTRACT 12
HIV TESTING AND COUNSELLING ROOM

1. A: Mi naitwa Rebecca (sic).
2. B: Mm
3. A: Mshauri wa afya, sawa sawa mambo ya HIV. Eeh
4. B: Eeh
5. A: I hope unaelewa HIV ni nini?
6. B: Ni maradhi
7. A: Ni maradhi ya aina gani?
8. B: Virusi
9. A: Virusi kama vile umesema HIV ni virusi. So karibu. Hapa tunaangalia wamama wakianza clinic ya watoto tunataka tuakikishie ya mtotokwamba, akiendelea kunyonya hatapata virusi kwa mama. Mshawahi pimwa na mzee?
10. B: Mmh.
11. A: Kupimwa na yeye?
12. B: (Interrupts) eeh kupima na yeye (pause)
13. A: Sio ile ya aende kupimwa….
14. B: (Interrupts) peke yake.
15. A: Pamoja mwisho ilikuwa lini?
16. B: Tarehe shirini na tatu mwezi wa nane
17. A: Ishirini na tatu mwezi wa…..
18. B: Mwezi wa nane
19. A: Yah ni vizuri kujua hali ya mpenzi wako. Unaeza pata mmoja ako na virusi ndio sababu tunakinga mtoto. sawa. So nitakuuliza maswali kwa kifupi unaelewa HIV ni nini. Umeniambia ni maradhi nani virusi vile umesema. HIV ni virusi.
20. B: Mm
21. A: Haikuangi ni maradhi haswa. Inakuwa kamdudu. Ako ka virusi kakiingia kwa mwili huwa kanaenda kuaribu ile kinga ya mwili. So ile madhara hii virusi inaleta ni kuaribu kinga ya mwili sawa.
22. B: Mm
23. A: So, kuna njia ambazo mtu anaweza pata virusi ni kama gani
24. B: Damu
25. A: Damu
26. B: Mimi najua tu damu
27. A: Eeh. Unajua damu ikifanya nini?
28. B: Ikichanganyikana
29. A: Eeh, tuseme pengine niko na kidonda inatoka damu na pengine nikuwe na hizo virusi unaweza pata ukiwa na kidonda. Pia mama anaweza kuambukiza mtoto kupitia kunyonya kama saa hii ndio tunaangalia.
30. B: Eeh
31. A: Pia kupitia sindano kwa wale wanatumia dawa za kulevya. Na pia unaweza kupata kupitia kufanya kimapenzi na mtu ako na virusi pengine ujatumia kinga.
32. B: Mmh
33. A: Sawa sawa so kwa sasa unatarajia matokeo. Hakuwaaje kwa sababu mwezi wa nane ulikuwa sawa na sasa…..
34. B: (interrupts) itakuwa sawa tu
35. A: Eeh. Na kwa bahati mbaya ikiweza kubadilika?
36. B: Haina shida
37. A: Utakuwa tu tayari kukubali matokeo vile imekuja?

38. B: Eeh
39. A: Ok sawa sawa. Hio ni kitu muhimu
40. B: Eeh
41. A: Unakumbuka kusoma….kusoma majibu
42. B: Eeh
43. A: Eh. Tukipima uwa tunatarajia matokeo mara mbili. Inaweza kuwa kuna virusi ama hakuna. Sawa
44. B: Eeh
45. A: So ukiangalia hapa kuna hii chart inatusauidia kuangalia
46. B: Eeh
47. A: Tukiweka damu hapa chini uwa inachora laini kulingana na vile kuna shida ama hakuna.
48. B: Eeh
49. A: Ukiangalia hii ya kwanza inachora laini mbili kumaanisha kuna virusi
50. B: Eeh
51. A: Sawa, ukiangalia hii ya pili utaona kuna laini moja tu kumaanisha hakuna. So uko na swali kabla hatujaendelea?
52. B: Na mbona huwa nasikia ina dalili sabini na mbili
53. A: Iko na? Signs
54. B: Sabini na mbili ambapo ikipita hizo nini uwa haina …. Hauna iyo maradhi
55. A: Mm Ikipita inamaanisha hauna
56. B: Eeh hauna.
57. A: Mm
58. B: Hizo signs zo…….ote upite na pengine bado unaugua tu na hauna hiyo maradhi.
59. A: Mm (laughs) Uh! Si lazima mtu akiwa na HIV aonyeshe, akuwe na dalili niko nayo. Naweza kuwa tu niko very health.
60. B: Eeh
61. A: Lakini wakati kinga imeenda chini, kinga ya mwili kuzuia usipatwe na magonjwa kwa mfano kinga ya mwili inakuanga kama vile ukijenga boma unaweka fence, ndio watu wasipitie pale. Si ndio?
62. B: Eeh
63. A: Ha, kinga ya mwili inakuanga hivo hivo.
64. B: Eeh
65. A: Mwili wako uko na kinga uko na fence ya kuzuia usipate magonjwa. Nikiwa naTB inakuzuia usipate sawa.
66. B: Eeh
67. A: So, wakati hio kinga imeenda chini ndio hizo virus zinaendanga kuharibu hizo kinga za kuzuia magonjwa. So wakati fence imeenda chini naweza kupitia uko juu. Si ndio?
68. B: Eeh
69. A: Ndio unapata mtu anaweza pata hizo magonjwa. Si lazima nikipimwa saa hii niwe na HIV ama niwe na magonjwa.
70. B: Eeh
71. A: So, inatengemea kama hali ya kinga iko juu utaonekana tu uko sawa.
72. B: Eeh
73. A: Umeelewa, so, kaa uko tayari tupime utakaa kwa hiyo kiti tutoe damu
74. B: Eeh
75. A: Niambie majina zako
76. B: Mwanaisha

77. A: Niambie majina tatu
78. B: Mwanaisha Ismail Kataba
79. A: Miaka uko na gapi?
80. B: 32
81. A: Your date birth
82. B: Mwezi wakuzaliwa.
83. A: Eeh yako, unaweza kumbuka?
84. B: February
85. A: Unaweza kumbuka tarehe na mwezi
86. B: Hapana
87. A: Sawa, niambie namba yako ya simu.
88. B: 0710 101
89. A: Umeolewa?
90. B: Eeh
91. A: Tukigojea matokeo ukiwa na swali unaweza kuniuliza.
92. B: Kwa nini watu wasikia ubaridi?
93. A: Watu wasi……..
94. B: (Interrupts) wasikia ubaridi dhidi wanapokuwa na hiyo maradhi.
95. A: Uh! (pause) saa zingine nimekueleza wakati mwili hauna kinga ya kutosha…..
96. B: (Interrupts) wasikia ubaridi saa zote.
97. A: Si, lazima akiwa anasikia baridi ni pengine kama kinga ya mwili imeenda chini ya kuzuia maradhi eeh … (pause) ndio pengine anaanza kusikia hivi hivi. Na (pause) Family Planning umepanga kuanza lini?
98. B: (silence) naona ni vyema ni discuss hayo maneno na daktari next room juu nilikuwa nakuja kusaidiwa.
99. A: Yeah hao dio ma expert wa hizo, pole lakini hiyo ilikuwa by the way.(Yeah because they are the experts in FP, it was just by the way question)
100. B: Eeh (Eeh)
101. A: Sawa nilikuwa tu naulizia tu
102. B: But generally Family Planning imenishida.
103. A: Mbona?
104. B: Nilijaribu Shindano ikanishida
105. A: Eeh
106. B: Maana mgongo uliniuma nikashindwa na kusimama. Nilipoacha ndio niko na mimba ya huyu mtoto. Na mwenye anafuatwa na huyu ako na miaka tisa.
107. A: Na ulienda hospitali?
108. B: Hapana
109. 109. A: Kwa hivyo ukipata mashinda huji kushauriwa?
110. B: Eeh, nilishindwa mimi nikaona hii dawa mbaya
111. A: Nikujifanya mjuaji unajua na hujui?
112. B: Sijasema nikipata shida huwa siwezi kuja kusaidiwa
113. A: Lakini ulipopatatwa na shida hukuja
114. B: (silence).
115. A: So, ile ungefanya ungerudi tena uwaeleze wakushauri sababu kama saa hii unaeza pata mimba kama huyu hajafikisha miezi tatu.
116. B: (Laughs)
117. A: (Excited) utafanya nini saa hio, mimba ndio hii mtoto ndio huyu. So ni vizuri uta …. Ukipitia room 7 watakushauri vile utafanya, unaweza tu jaribu haina ingine uone vile utajipanga pia siku hizi maisha imeenda juu.
118. B: (Laughs) maisha ni magumu.
119. A: Mtoto hajui baba anajuanga mama. So wakati hauna kitu cha kumpatia ndio utaona shida.

120. B: Kabisa
121. A: Eeh, utapitia hio room 7
122. B: Mm
123. A: Uweze kuangalia hio….kuna haina nyingi unaweza tumia sio sindano. So unaweza kujitunza na ako katoto kasije kupata shida baadaye. So utaenda room 3 mtoto apewe hio chanjo na room 7 utapata wenye wanaweza kushauri hio Family Planning, eeh.
124. Sawa

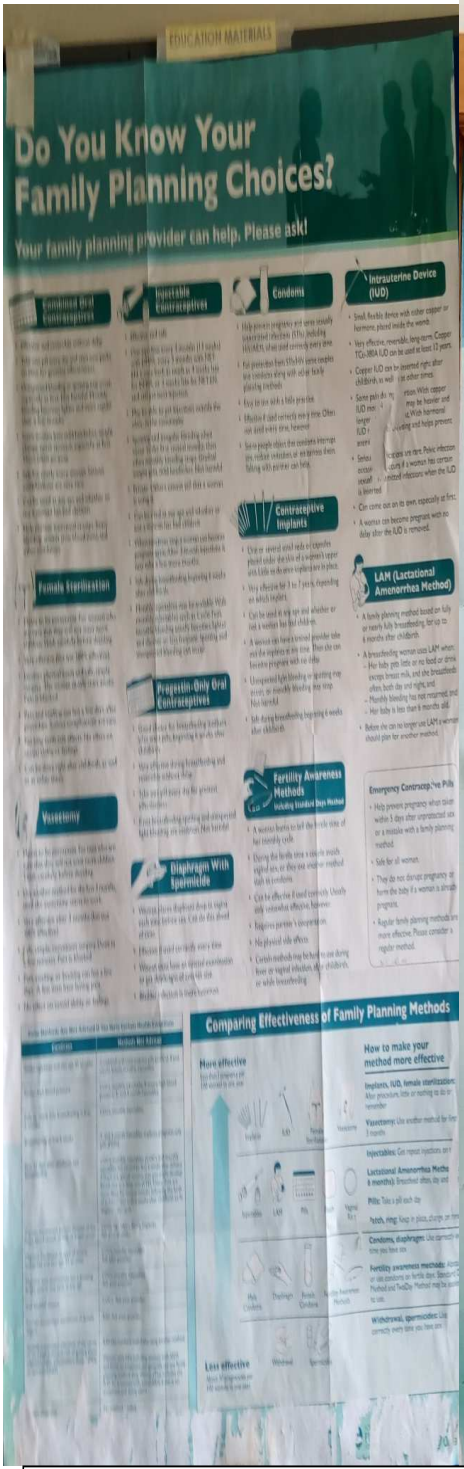
EXTRACT 13
FAMILY PLANNING ROOM

6. A: Uko kwa method gani?
7. B: Depo
8. A: Mbona usichukue method ingine unaeka na unasahau? Mmh uliambiwa madhara ya depo.
9. B: Too much bleeding.
10. A: Hospitali?
11. B: Eeh.
12. A: Eight years, mbona ningeendelea ile method ya 5 yrs, eight years unaekwa na unasahau na ni the same hormone……. The same hormone. Na bado kuna coil na haina hormone yoyote na inakuprotect upto 20 years.
13. B: Mmh
14. A: Mbona ukachoose tu depo.
15. B: Sikuambiwa madhara ya depo
16. A: Period zinakuja kila month? Uko na watoto wagapi?
17. B: Three
18. A: Three, miaka?
19. B: 40
20. A: 40, unataka kupata mtoto mwingine?
21. B: Eeeh
22. A: Uh!Eeh, uko sure?
23. B: Na?
24. A: Eeh, sasa unaonaje tukiweke kitu long term kama coil. Ndio next ukikuja ufike menopause umalizane na hizi Family Planning kama hii ni ya five years.
25. B: Nitajua tu.
26. A: Mbona umesema hivyo hapanakwa coil. Tueleze tu ndio tujue kwa nini? Unafikiria nini ama uliambiwa inafanya aje. Unajua iko the same hormone, by the way yenye iko kwa depo ndio iko hapa, miligrams ndio ina differ coil iko na (rudely) as in tufunze. Ama hizi unajua mtu anakuanga na reason maybe nilitumia ikanidhuru naona sitaki.
27. B: Wajua tangu nilianza kutumia depo nilipatanga tu period kawaida.
28. A: Hawa watoto wengine ulipata tu ukitumia depo.
29. B: Eeh
30. A: Uliacha depo ukapata immediately.
31. B: Eeh
32. A: Ulikaa for how long?
33. B: Mm. Nilikaa kitu almost a half a year.
34. A: Half a year si unaona. Ndio ile unaweza pata mtoto.
35. B: Sina plan ya mtoto
36. A: But hatutaki upate mtoto.

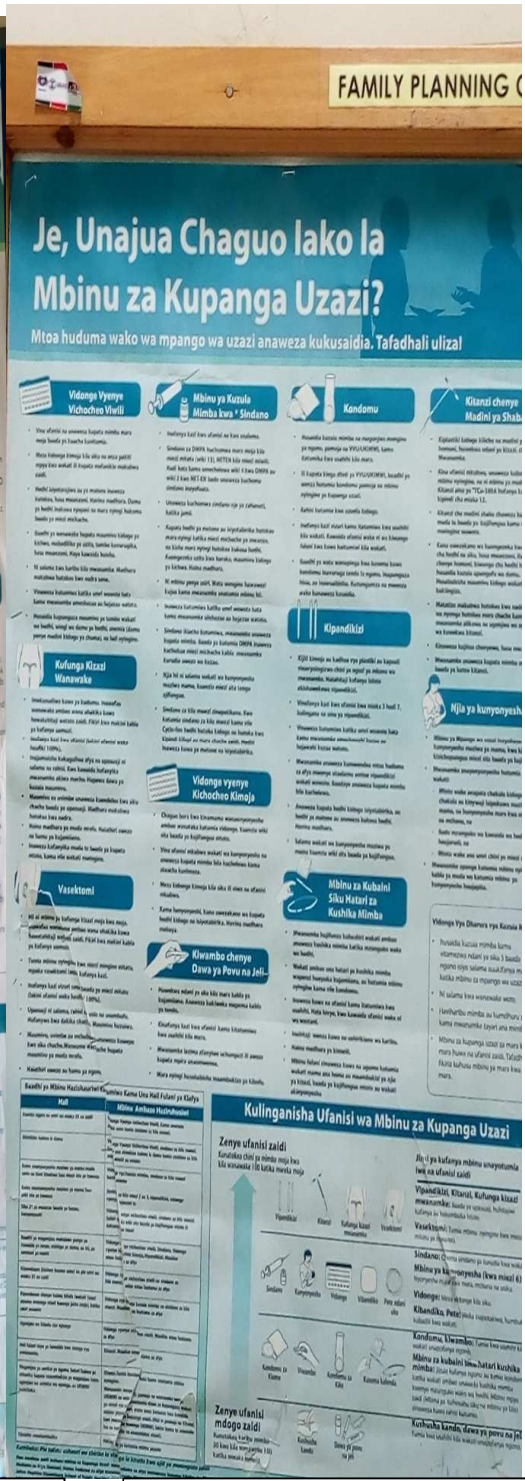
37. B: Mi sitaki mtoto.
38. A: Unajua kitu tuna kuprotect nayo? Iyo sindano tunakudunga inaongezea hormone na hormones iko na madhara yake kwa mwili, the more your age advance… si unaona wanawake wanachanga kupata period. Inaonyesha hormones zimeenda kureduce. Lakini saa hii unakujia sindano tunakuongezea hormones. Na hizo hormones will naturally inaisha so wakati tunakuongezea hizo hormones especially above 40 kupredispose kuwa na cancer. Hizo cancer unaweza kuwa na cancer. Unaongezea hatari yako ya kupata cancer sawasawa.
39. B: Eeh
40. A: Inaweza kuwa haikudhuru saa hii lakini ukifikisha 50 unaanza kupata hizo cancer zenye tunaongelelea… kama ya matiti, cervix.
41. B: Kwa hivo hizi family planning methods zenye ziko na hormones ndizo zinacause cancer? Mbona wanaume upata cancer na huwa hawatumii hizi madawa
42. . A: Cancer ucausiwa na vitu mob na causes zingine bado hazijulikani
43. . B: Kwa hivo hauko sure kabisa kama one of the cause ni hizi madawa?
44. . A: Currently zijaona any medical evidence inasuggest so.
45. . B. (Silence). Na kwa hivyo above 40 which is the best method
46. . A: Non hormonal na hiyo coil ndio nilikuwa na kuuliza umesema hapana kwa coil, ndio tumeona your reactions, tunauliza tuelezee……
47. B: Mmh uh (silence)
48. A: Ati?
49. B: Nitaenda na nikirudi nitakuwa decided.
50. A: So enda udiscuss na mzee ufikirie halafu utaenda na hii (hands her leaflet) uone kila kitu about depo ndio uende usome. Jina unaitwa?
51. B: Mary
52. A: Namba ya simu
53. B: 07…….
54. A: Unaishi wapi?
55. B: Mumbuni
56. A: Sawa.

APPENDIX VIII: FAMILY PLANNING DOCUMENTS

A) FAMILY PLANNING CHARTS

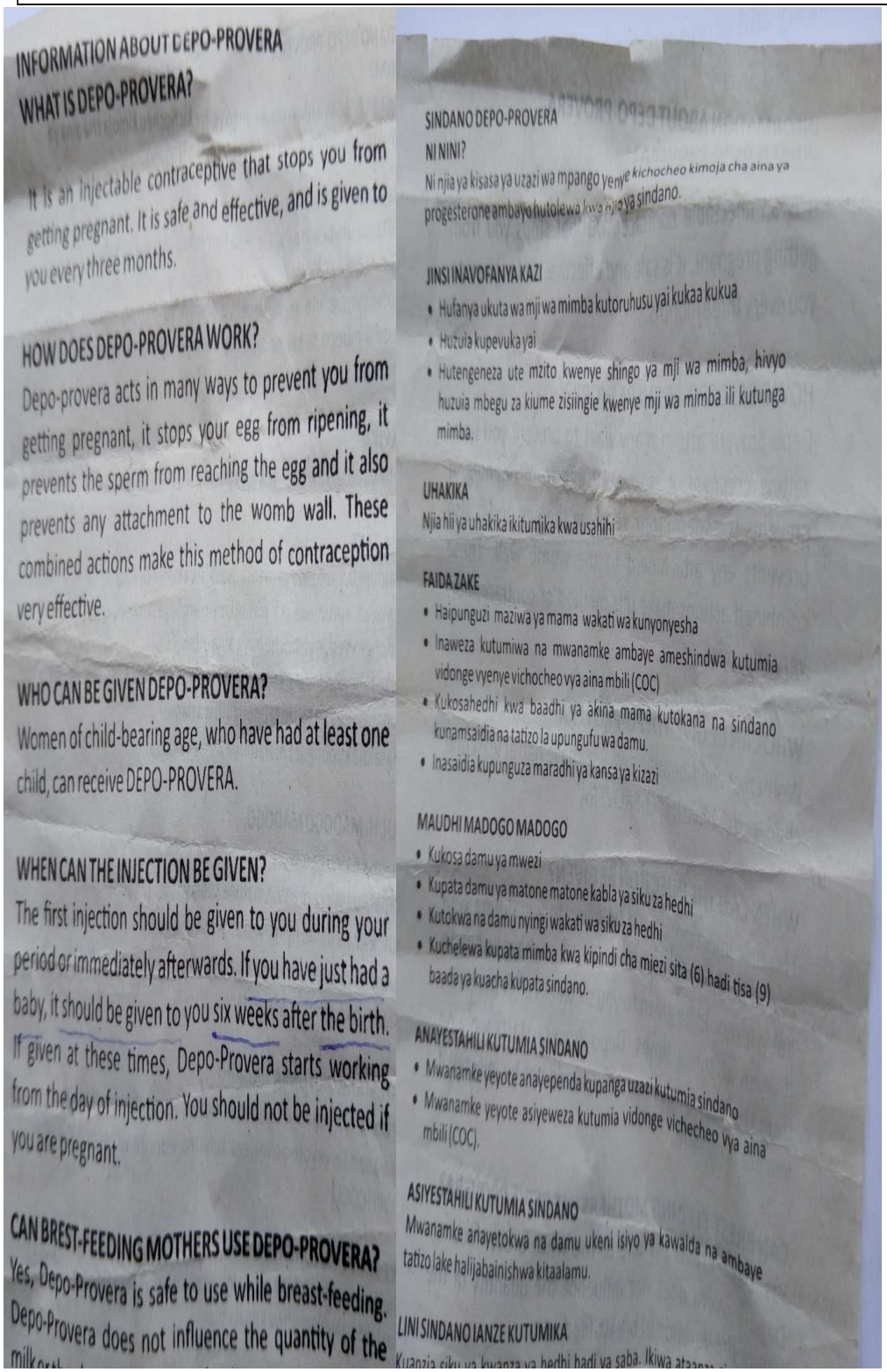


FAMILY PLANNING NOTICE BOARD



RECEPTION NOTICE BOARD

B): DEPO-PROVERA: FRONT AND BACK SIDE



INFORMATION ABOUT DEPO-PROVERA

WHAT IS DEPO-PROVERA?

It is an injectable contraceptive that stops you from getting pregnant. It is safe and effective, and is given to you every three months.

HOW DOES DEPO-PROVERA WORK?

Depo-provera acts in many ways to prevent you from getting pregnant, it stops your egg from ripening, it prevents the sperm from reaching the egg and it also prevents any attachment to the womb wall. These combined actions make this method of contraception very effective.

WHO CAN BE GIVEN DEPO-PROVERA?

Women of child-bearing age, who have had at least one child, can receive DEPO-PROVERA.

WHEN CAN THE INJECTION BE GIVEN?

The first injection should be given to you during your period or immediately afterwards. If you have just had a baby, it should be given to you six weeks after the birth. If given at these times, Depo-Provera starts working from the day of injection. You should not be injected if you are pregnant.

CAN BREST-FEEDING MOTHERS USE DEPO-PROVERA?

Yes, Depo-Provera is safe to use while breast-feeding. Depo-Provera does not influence the quantity of the

SINDANO DEPO-PROVERA NI NINI?

Ni njia ya kisasa ya uzazi wa mpango yenye kichocheo kimoja cha aina ya progesterone ambayo hutolewa kwa njia ya sindano.

JINSI INAVOFANYA KAZI

- Hufanya ukuta wa mji wa mimba kutoruhusu yai kukaa kukua
- Huzuia kupevuka yai
- Hutengeneza ute mzito kwenye shingo ya mji wa mimba, hivyo huzuia mbegu za kiume zisiingie kwenye mji wa mimba ili kutunga mimba.

UHAKIKA

Njia hii ya uhakika ikitumika kwa usahihi

FAIDA ZAKE

- Haipunguzi maziwa ya mama wakati wa kunyonyesha
- Inaweza kutumiwa na mwanamke ambaye ameshindwa kutumia vidonge vyenye vichocheo vya aina mbili (COC)
- Kukosahedhi kwa baadhi ya akina mama kutokana na sindano kunamsaidia na tatizo la upungufu wa damu.
- Inasaidia kupunguza maradhi ya kansa ya kizazi

MAUDHI MADOGO MADOGO

- Kukosa damu ya mwezi
- Kupata damu ya matone matone kabla ya siku za hedhi
- Kutokwa na damu nyingi wakati wa siku za hedhi
- Kuchelewa kupata mimba kwa kipindi cha miezi sita (6) hadi tisa (9) baada ya kuacha kupata sindano.

ANAYESTAHILI KUTUMIA SINDANO

- Mwanamke yeyote anayependa kupanga uzazi kutumia sindano
- Mwanamke yeyote asiyeweza kutumia vidonge vichecheo vya aina mbili (COC).

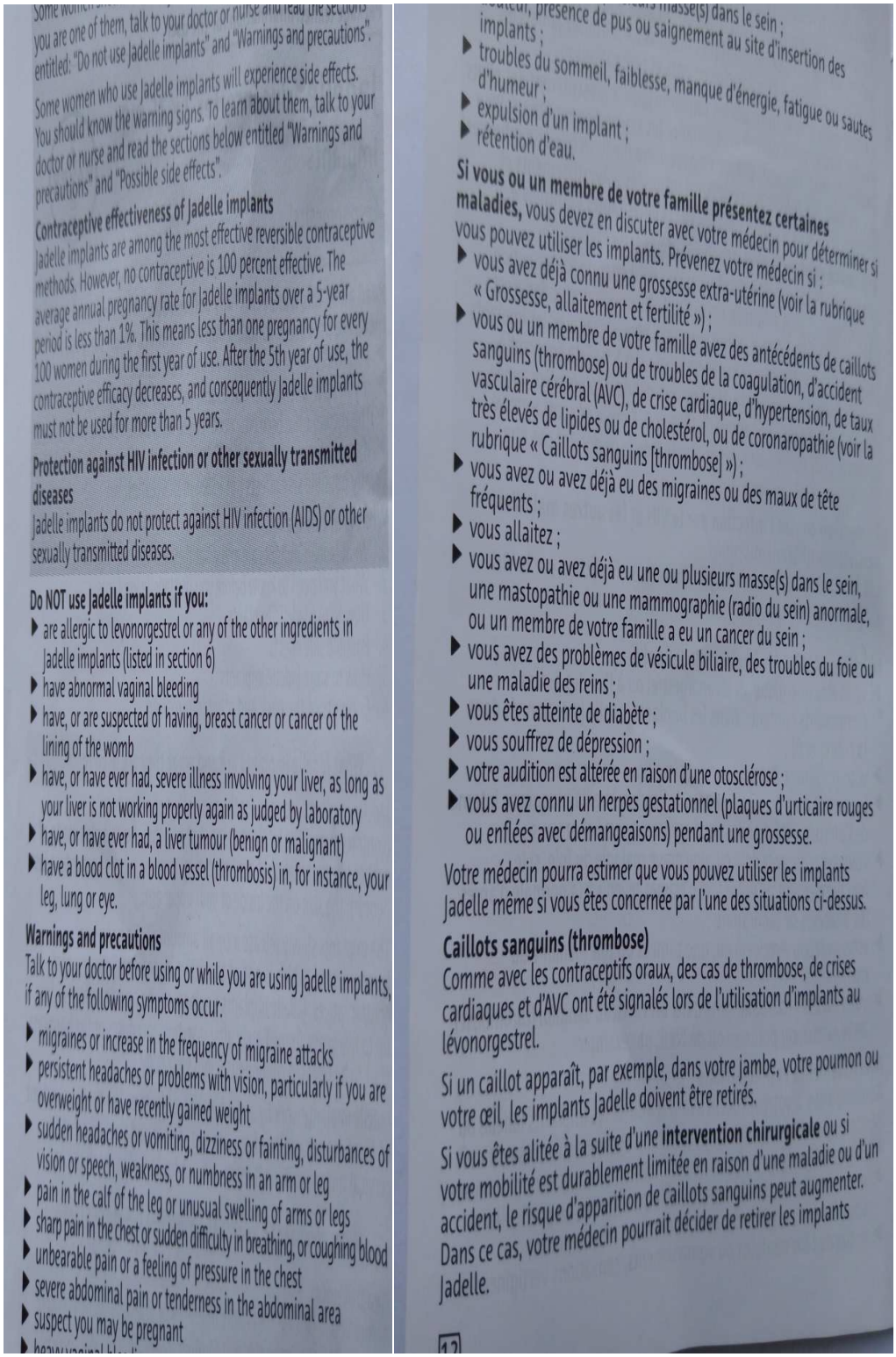
ASIYESTAHILI KUTUMIA SINDANO

Mwanamke anayetokwa na damu ukeni isiyo ya kawaida na ambaye tatizo lake halijabainishwa kitaalamu.

LINI SINDANO IANZE KUTUMIKA

Kuanzia siku ya kwanza ya hedhi hadi ya saba. Ikiwa ataa

C) JADELLE: PAGE 2 AND PAGE 12



you are one of them, talk to your doctor or nurse and read the sections entitled: "Do not use Jadelle implants" and "Warnings and precautions".

Some women who use Jadelle implants will experience side effects. You should know the warning signs. To learn about them, talk to your doctor or nurse and read the sections below entitled "Warnings and precautions" and "Possible side effects".

Contraceptive effectiveness of Jadelle implants
Jadelle implants are among the most effective reversible contraceptive methods. However, no contraceptive is 100 percent effective. The average annual pregnancy rate for Jadelle implants over a 5-year period is less than 1%. This means less than one pregnancy for every 100 women during the first year of use. After the 5th year of use, the contraceptive efficacy decreases, and consequently Jadelle implants must not be used for more than 5 years.

Protection against HIV infection or other sexually transmitted diseases
Jadelle implants do not protect against HIV infection (AIDS) or other sexually transmitted diseases.

Do NOT use Jadelle implants if you:
- are allergic to levonorgestrel or any of the other ingredients in Jadelle implants (listed in section 6)
- have abnormal vaginal bleeding
- have, or are suspected of having, breast cancer or cancer of the lining of the womb
- have, or have ever had, severe illness involving your liver, as long as your liver is not working properly again as judged by laboratory
- have, or have ever had, a liver tumour (benign or malignant)
- have a blood clot in a blood vessel (thrombosis) in, for instance, your leg, lung or eye.

Warnings and precautions
Talk to your doctor before using or while you are using Jadelle implants, if any of the following symptoms occur:
- migraines or increase in the frequency of migraine attacks
- persistent headaches or problems with vision, particularly if you are overweight or have recently gained weight
- sudden headaches or vomiting, dizziness or fainting, disturbances of vision or speech, weakness, or numbness in an arm or leg
- pain in the calf of the leg or unusual swelling of arms or legs
- sharp pain in the chest or sudden difficulty in breathing, or coughing blood
- unbearable pain or a feeling of pressure in the chest
- severe abdominal pain or tenderness in the abdominal area
- suspect you may be pregnant

douleur, présence de pus ou saignement au site d'insertion des implants ;
- troubles du sommeil, faiblesse, manque d'énergie, fatigue ou sautes d'humeur ;
- expulsion d'un implant ;
- rétention d'eau.

Si vous ou un membre de votre famille présentez certaines maladies, vous devez en discuter avec votre médecin pour déterminer si vous pouvez utiliser les implants. Prévenez votre médecin si :
- vous avez déjà connu une grossesse extra-utérine (voir la rubrique « Grossesse, allaitement et fertilité ») ;
- vous ou un membre de votre famille avez des antécédents de caillots sanguins (thrombose) ou de troubles de la coagulation, d'accident vasculaire cérébral (AVC), de crise cardiaque, d'hypertension, de taux très élevés de lipides ou de cholestérol, ou de coronaropathie (voir la rubrique « Caillots sanguins [thrombose] ») ;
- vous avez ou avez déjà eu des migraines ou des maux de tête fréquents ;
- vous allaitez ;
- vous avez ou avez déjà eu une ou plusieurs masse(s) dans le sein, une mastopathie ou une mammographie (radio du sein) anormale, ou un membre de votre famille a eu un cancer du sein ;
- vous avez des problèmes de vésicule biliaire, des troubles du foie ou une maladie des reins ;
- vous êtes atteinte de diabète ;
- vous souffrez de dépression ;
- votre audition est altérée en raison d'une otosclérose ;
- vous avez connu un herpès gestationnel (plaques d'urticaire rouges ou enflées avec démangeaisons) pendant une grossesse.

Votre médecin pourra estimer que vous pouvez utiliser les implants Jadelle même si vous êtes concernée par l'une des situations ci-dessus.

Caillots sanguins (thrombose)
Comme avec les contraceptifs oraux, des cas de thrombose, de crises cardiaques et d'AVC ont été signalés lors de l'utilisation d'implants au lévonorgestrel.

Si un caillot apparaît, par exemple, dans votre jambe, votre poumon ou votre œil, les implants Jadelle doivent être retirés.

Si vous êtes alitée à la suite d'une **intervention chirurgicale** ou si votre mobilité est durablement limitée en raison d'une maladie ou d'un accident, le risque d'apparition de caillots sanguins peut augmenter. Dans ce cas, votre médecin pourrait décider de retirer les implants Jadelle.

12