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

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Abstract

The purpose of this paper is to analyse language management strategies in family planning discourses at Machakos Level 5 Hospital, Kenya. Thirteen (13) in situ service seeker – service provider interactions were observed and audio-recorded. Follow-up interviews involving the participants were carried out to seek explanation and clarification for the nature of language management implementation strategies obvious in family planning contexts in the health facility. Furthermore, the complementary information materials offered by the hospital formed a part of the analysis. Guided by tenets of the Language Management Theory, the data was analysed qualitatively. At a simple language management level, the study found that speakers implemented various adjustment strategies which included: service seekers avoiding some offensive topics, service seekers using husbands whenever they faced language problems; others becoming rude; others switching from Swahili-English and vice versa; and service providers requesting for language help from their medical colleagues. At the organised language management level, leaflets on contraceptives, brochures, and charts were issued to service seekers to supplement oral information in the clinic. The outcome of the study will extend the language theory to hospital setting discourses. With improved language management and communication in the family planning department at Machakos Level 5 Hospital, uptake of family planning is expected to rise, leading to a higher quality of life.

Keywords: *Language management, Language Problems, Language Management Theory; Simple Language Management, Organised Language Management.*

1. INTRODUCTION

In the medical domain, communication represents a fundamental clinical skill that involves the establishment of therapeutic relationships, 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 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-seekers 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, 2015).

The Government of Kenya has made a commitment to achieve Universal Health Care (UHC) by the year 2022. The country's strong political commitment to UHC is embodied in the government's big 4 agenda that include healthcare for all as one of the key development priorities. The installation of UHC as a global and country health policy goal has highlighted the need to measure it, and to track progress over time. One of the preventive/promotive indicators is the satisfaction of family planning needs. Therefore, to progress towards UHC countries must advance along at least three lines of action namely expanding priority services, including more people, and reducing out-of-pocket payments.

Long after the introduction of modern family planning methods, Kenya's population is still growing and is projected to exceed 60 million by 2025 (OCHAKO et al., 2015). Although contraceptive use has been identified as a human right and a priority in the National Reproductive Health Policy, the Contraceptive Prevalence Rate (CPR) stands at only 46% (MOH, 2007; MOH,

2012). In order for Kenya to realize the United Nations (UN) Sustainable Development Goals (SDGs), the Kenya Vision 2030 and to be in line with the Constitution of Kenya (2010), there is a need to upscale uptake of contraceptives. According to ETTARH & KYOBUTUNGI (2012) the total mistimed and unwanted pregnancies among all women (15–49 years) remain relatively high at 26% and 17% respectively despite the fact that contraceptives are available in all the public hospitals.

Even though various efforts such as financing, hiring more medical professionals, improvement of infrastructure and medical supplies among others have been undertaken to improve Family planning services at Machakos level 5, uptake remains low at 49.7% (MCIDP, 2015; MACHAKOS COUNTY FISCAL STRATEGY PAPER, 2016). There is a growing realization that family planning is not only a health issue, but also a cultural and linguistic concern. Therefore, the lack of attention to cultural and linguistic aspects in communication can impact on the quality of communication. For instance, in countries with culturally and linguistically diverse populations, like Kenya, the use of a second language by either the patient or the practitioner is common (DEMOISSAC&BOWEN, 2018). Therefore, overcoming language barriers in health-care encounters may represent a challenge. While language planning prescribes language management solutions without considerations for actual language context, proponents (NEKVAPIL & SHERMAN, 2009; KIMURA, 2014; NEKVAPIL & SHERMAN, 2015; NEKVAPILl, 2016) of language management theory argue that there is need for language problems to be managed in a "bottom – up" approach. 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.

This paper is anchored on Language Management Theory (LMT). According to NEKVAPIL (2016), LMT is grounded on the premise that in using language, two main processes can be distinguished: (a) the generating of utterances (communicative acts) and (b) utterance management (management of communicative acts). Language problems that are noted when the utterance is generated may be addressed by employing strategies aimed at eliminating the problem (NEKVAPIL & SHERMAN, 2015). In this way, LMT brings the two processes together into a unified framework emphasizing that the managing language is an integral part of the language activities (LANSTYAK, 2014). This paper is based on the assumption that during interactions, there is a likelihood of occurrence of language problems that require being paid attention by employing appropriate communication strategies to eliminate the problems.

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 (Kimura, 2014). Therefore, language management can take place at micro-level which is the simple management of a particular phenomenon (like an interaction between a family planning provider and a service seeker) or be organized at the institutional level like Machakos Level 5 (NEKVAPIL & SHERMAN, 2015).

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 is language management in hospitals, and specifically, at the family planning departments. The paper examines strategies that are designed and implemented both at individual and organizational levels at Machakos Level 5 family planning Department in line with LMT.

2. THEORETICAL FRAMEWORK

The Language Management Theory (LMT) advanced by JERNUDD &NEUSTUPNY (1987) focuses on actual problems appearing in discourses and its ultimate goal is to remove the problems (FAIRBROTHER et al., 2018). According to LMT, language management is examined as a corrective discourse-based process, which involves the discrimination of two processes which characterize language use. These are: first,

the generation of utterances (communicative acts) and, secondly, utterance management; that is, management of communicative acts (NEKVAPIL, 2006; NEKVAPIL& NEKULA, 2006; NEKVAPIL, 2016). According to NEKVAPIL (2016), the management process follows all or some of the following stages: 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); (iv) The adjustment designs are implemented (or not implemented).

The Language management theory does not only focus on the grammatical features of a language, but also pays attention to sociolinguistic (communicative) features, and sociocultural (interactive) features. For example, FAIRBROTHER, NEKVAPIL and SLOBODA (2018) posit that when people communicate with others, they do not only focus on making accurate sentences or communicate in a way to suit the situation, but they also manage their interactions for broader purposes, such as how to communicate in order to establish friendships, continue business relationships or to maintain their self-image as a competent member of a society.

In the context of LMT, the initial stage is when an individual notes something in his/her own or the interlocutor's utterance (KIMURA, 2014). 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 (NEKVAPIL & SHERMAN, 2015). If the deviation is evaluated negatively, it is understood in LMT as inadequacy; 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 (NEKVAPIL, 2016). However, if the phenomenon noted is evaluated positively, it is referred to as gratification (KIMURA, 2014). The language management process can end at this point or it can continue into the next phase called adjustment design.

The evaluation process of LMT is initiated by conversation interactants noting deviations from norms (NEKVAPIL, 2016). Deviations from norms that are negatively evaluated require being paid attention to in order for an appropriate adjustment design to be devised and implemented to eliminate them at both simple and organized management (NEKVAPIL & SHERMAN, 2015). Proponents of LMT claim that organized management is based on the occurrence of simple management, that is, it resonates with the speaker' noting and evaluating in particular interactions and with their effort to use adequate means to remove such problems or it meets their needs in case of gratifications (SHERMAN, 2010; KIMURA, 2014; NEKVAPIL, 2016).

NEUSTUPNY (1994) formulates that (NEKVAPIL, 2016):

> I shall claim that any act of language planning should start with the consideration of language problems as they appear in discourse, and the planning process should not be considered complete until the removal of the problem is implemented in discourse.

In LMT, there is a connection between macro-level management, such as national, regional and organization-level management referred to as organized management and micro-level discourse management also known as simple management (FAIRBROTHER, NEKVAPIL& SLOBODA, 2018). Organised management refers to a management directed towards language as a system and is performed by institutions or organizations (JERNUDD&NEUSTUPNY, 1987; NEKVAPIL, 2016). It involves a considerable number of participants, extensive theoretical legitimation of stand points; it takes place in a number of encounters and includes communication about management and theorization (NEKVAPIL, 2012; FAIRBROTHER, NEKVAPIL & SLOBODA, 2018). On the other hand, simple management is directed towards micro-level discourses and is generally carried out by individuals in interaction.

The focus of LMT is to remove language problems. Designing an adjustment strategy to a negatively evaluated norm is the third phase of JERNUDD&NEUSTUPNY'S (1987) Language Management Theory (NEKVAPIL, 2012). When deviation from a norm is noted in phase one and

evaluated negatively in phase two, the process can continue into the third phase which is adjustment design (KIMURA, 2014). At this stage, the speaker may start to think about re-wording her/his utterance to manage the single interaction (KOPECKY, 2014; NEKVAPIL, 2016). 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.

NEKVAPIL (2016) asserts that it is not just individuals in everyday interactions who pay attention to language and language use. Indeed, organizations and institutions are involved in organised management. When organizations pay attention to language problems, they may devise adjustment strategies designed to eliminate the language problems (KIMURA, 2014). Such organised language management activities may include: the organization designing written materials that are translated in a language that addresses the local language needs; it may hire professional interpreters and translators; and may provide language services to its staff in order to address potential language problems that impede effective communication.

FAIRBROTHER, NEKVAPIL and SLOBODA (2018) maintain that language management should start with an identification of problems in discourse and its ultimate goal should be the removal of those problems from the discourse. In line with LMT, adjustment design strategies devised in phase three should always be implemented in order to eliminate the language problems noted in phase one. Implementation of an adjustment strategy can be at both micro (individual) and macro (organization) levels (NEKVAPIL & SHERMAN, 2015).

Activities that may be implemented at simple 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 ask for an interpreter; the speaker may look for difficult words in 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.

3. METHODOLOGY

3.1 Study site

The current study was carried out in the family planning department at Machakos Level 5 Hospital located in Machakos town, in Machakos County. The County borders Murang'a, Embu, Kiambu, Nairobi, Kajiado, Makueni and Kitui counties. The hospital is the only referral facility in the lower Eastern Region of Kenya and it therefore offers specialized services such as antenatal, antiretroviral therapy, curative inpatient and outpatient services, family planning among others. 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.

3.2 Population and Sampling

The study population comprised of all the trained family planning service providers, all family planning service seekers and all written materials on family planning at Machakos Level 5 hospital. The service seekers were both men and women and service providers included counsellors, social workers, clinical officers and gynaecologists.

The study, through random sampling technique, identified 13 family planning seekers. 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 counsellors, 8 nurses and 1 gynaecologist. The study further purposively

sampled hospital written materials. Included in this category were 2 Patient Information Charts and 3 Patient Information Leaflets. Purposive sampling method is preferred because it involves identifying and selecting individuals or groups of individuals that are especially knowledgeable about or experienced with a phenomenon of interest (CRESWELL& PLANOCLARK, 2011).

3.3 Data collection procedures

After identifying a family planning service seeker at the reception, the purpose of the study was explained to the respondents. When informed consent was granted, a client would be accompanied to the first service point which was the HIV Testing and Counselling (HTC) room. The interactions were audio-recorded and observation schedule filled as soon as the interactions between the provider and seeker began. A Sony ICD-PX240 recorder was used for audio-recording while a five item-column observation schedule guided the observation process of the family planning activities in the facility. Items on the observation checklist included phatic communication; nature of conversation; turn taking between the provider and seeker; intonation; and evaluated the service encounters.

The seeker would then be taken to the family planning room where the ensuing interaction was audio recorded. On average, each of the 13 audio-recordings lasted 15 minutes. From the family planning room, the family planning service seekers and providers were led to which had been allocated for follow-up interviews. Each follow-up interview took approximately 10 minutes. In total, 13 follow-up interviews were conducted. DEJONCKHEERE&VAUGHN (2019) argue that follow-up interviews present an opportunity for collecting open-ended data and exploring participant thoughts, feelings and beliefs about a particular topic and delving deeply into personal and sometimes sensitive issues.

3.4 Data Analysis Procedures

The mixed method data analysis approach was used. The participants' demographic data was analysed quantitatively through frequencies and percentages and presented in figures. Transcribed audio-recorded data, interviews and documents were organized, sorted out, coded and analysed into themes as per the study objective. Violation of norms provided a framework for identifying adjustment strategies and their implementation.

3.5 Ethical considerations

To place the study reported in this paper within expected ethical standards, the research proposal, data collection instruments and the informed consent form were reviewed, approved and issued with a permit by the National Commission for Science, Technology & Innovation (NACOSTI). Before data collection, all respondents were fully debriefed about the purpose of the study and asked to sign an informed consent form. They were assured of anonymity and confidentiality.

4. RESULTS AND DISCUSSION

This section reports the findings of the study reported in this paper. First, it presents an analysis of simple language management strategies and then organized language management strategies. The generation and implementation of adjustment strategies is a response to negative evaluation of language problems emerging in communicative acts in family planning settings at the facility. Failure to mitigate the effects of language problems would lead to undesirable consequences including poor service delivery and eventual low uptake of family planning services.

4.1 Simple Language Management Strategies

This paper establishes that interactants in family planning contexts at Machakos Level 5 Hospital indeed grappled with language problems which called for the implementation of simple language management strategies. NEKVAPIL and NEKULA (2006) observe that a speaker may plan and finally implement an adjustment strategy to address a language problem. The data in this study revealed a number of adjustment strategies to address language problems such as the interaction between family planning service seekers and service providers progressed. These spontaneous adjustment strategies were avoidance, pre-interaction language management,

rudeness, code-switching, and use of interpreters. The strategies are discussed as follows:

4.1.1 Avoidance

Avoidance is the behaviour that prevents communication by eluding what an interactant develops apprehension to. In the context of this study, it is an adjustment strategy that involves a speaker changing or switching to a different topic to divert a discussion from an ongoing offensive subject. Consider Text 1 below:

Text 1

1. A: *Umewahikosakupata your menses?* (Have you ever failed to receive your menses?)
2. B: *(Inaudibly)Mmh*
3. A: *Semandioama la?* (Say yes/no?)
4. B: *Na ikona the same hormone kamaImplanon?* (Does it have same hormone like Implanon?)

In text 1, it can be assumed that speaker A's use of the word "menses" was evaluated negatively by Speaker B leading her to murmur *Mmh*. When prodded to yes or no, she changes the topic as evidenced in utterance 4. It is plausible to note that the term "menses" is culturally offensive to speaker B especially in a context where several people are listening. For this reason, therefore, Speaker B decided to avoid the offending topic. In a study by TURONTO, NISHIDA&NAKAYAMA (2005), anxiety and uncertainty could be causes of avoidance in communication with strangers from both the same and different cultures.

4.1.2 Pre-Interaction Management

Pre-interaction language management is a strategy for managing problems anticipated in future interactions (NEKVAPIL & SHERMAN, 2009). In two of the observations, the researcher noted that the service seekers were accompanied by their husbands in anticipation of language situations where they could help decipher messages for their spouses. This is evidenced in Text 2.

Text 2

5. A: *Naonaukona Personal Assistant* (I can see you have a personal assistant)
6. B: *(laughing) Hapanahuyuni my husband (*(laughing) No, he's my husband}
7. A: *Isipokuwawewena mama mwingine, sijaonahawawenginewakikujanamabwanazao*(Save for you and another woman, I have not seen other clients come with their husbands)
8. B: *Wah, mtunikujipangakivyake.Unajuakamaleonilikuwanatakakuchange method yenyenatumia then juu sometimes unapatadaktarimwenyehupendakuongeakizungunyiinginikaonanivizurinikujena bwana anisaidiezenyezitanipita (laughing)* (It's a my strategy. You know today I wanted to change my method and you know sometimes we are served by doctors who talk more in English, I decided to come with my husband to offer some language assistance)

In Utterance 8, Speaker B comes along with the husband for language assistance because she had anticipated to encounter language problems. It is presumptive that this strategy arose from communication problems Speaker B may have already experienced and are created and reproduced in anticipation of similar problems in the future.

4.1.3 Rudeness

LEECH (1983) advances the sympathy maxim envisages minimization of antipathy between self and other and maximization of sympathy between self and other. It was observed during provider-seeker interaction that where the sympathy maxim was violated, the seeker resorted to rudeness as a face-saving strategy as illustrated in Text 3.

Text 3

9. A: *Mmoja (Surprised) mbonauliamuasindano? Ndioulaletunastarehe?* {One (surprised) why then did you choose the injection or you wanted a convenient method so that you can sleep around?}

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

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

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

13. A: *Mbonasiohiiunawekakwamkononainakupatiakingakwasiku mob una avoid kuja kuja clinic saa yote nidawa the same.Walikuambiahizizinginenaukapendahii?* (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 huwanaogopakuweka*(It's because I am scared of the insertion process).

In Utterance 9, A probes on B why she preferred the *Depo provera* method and innocently/ignorantly uses the phrase "*ndioulaletunastarehe*". It is observed in Utterance 10 that B is embarrassed by that statement. It appears speaker B interpreted the statement, '*ndioulaletunastarehe*" according to Akamba culture can be interpreted to mean "so that you can sleep around." It is seen that speaker B notes and evaluates the embarrassing statement negatively. Feeling embarrassed, she designs an adjustment strategy of being rude probably to warn speaker A not to continue injuring her dignity. The adjustment strategy is implemented in line 11 when speaker A re-asserts her position by saying, "*Ndioinafaa.*" Speaker A appears to have noted that Speaker B became rude in her reply in Utterance 10 and devises an adjustment strategy that is implemented by repeating the phrase she considers rude in question form (see Utterance 11).It can be seen that both the seeker and the provider design and implement "discourteous language" as a defense mechanism to protect self-esteem and guard oneself against supposed threats or negative consequences. In this way, the defense mechanism works as a strategy to restore the loss-of-face.

4.1.4 Code Switching

One of simple adjustment strategies that were employed participants in family planning interactions was code switching. Code switching occurs when a speaker alternates between two or more languages or language varieties SHARTIELY (2016). In the context of this study, the languages involved were English and Kiswahili. An extract from the study data is presented in Text 4:

Text 4

15. A: *Mweziwasita. Ni sawainakuangamuhimukujuahaliyakonayampenziwakosababuanawezapengi nekuwaakonavirusinahajakuambukiza so kujuahaliyakenikitumuhimu. Nitakuulizamaswalikwaufupi. Ningependanijueunaelewaninikuhusu HIV. Unaelewakamanini 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?)

16. B: *(Silence) Ni uh ugonjwatu uh bad.* {(Silence) It is uh just a bad uh sickness}

Considering the hesitations in B's response, one notices the intra-sentential code-switching from Kiswahili to English. The use of the filler *uh* presents an opportunity to find a suitable expression which in this case is the word *bad*. In Utterance 15, Speaker A uses the English conjunction *so* to link two sentences. In Text 4, it is apparent that code-switching also achieves two purposes: to fulfil a communication need and to express solidarity. The former is driven by complementarity where one language assists another for effective communication in what MYERS-SCOTTON (1993) observes fills the gap of a missing item in the expected language. The latter

occurs where a speaker responds with a switch where the interlocutor has also code-switched.

4.1.5 Interpreters

Research has shown that healthcare providers rely on their bilingual colleagues to provide linguistic assistance (KARLINER et al., 2007). In this study, when a service provider was unable to comprehend a service seeker, they called for interpretation services from their colleagues. In a follow-up interview between the researchers and a service provider, it emerged that providers can seek interpretation services from their colleagues who understand the language of the service seeker. This is illustrated in Text 5:

Text 5

17. **Researcher**: In your profession, do you usually encounter clients with communication problems and what do you do about them?

18. **Service Provider**: 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 among ourselves.

The above discussion was aimed at establishing how service providers address expressive language problems experienced by their clients at the simple management level. As can be noted in Utterance 18, the service provider noted "*….we seek help from among ourselves*." This shows that the adjustment strategy of seeking help from colleagues to act as interpreters is actually implemented at Machakos level 5 Hospital. According to AVERY (2001), the conceptualization of the "interpreter as manager of the cross-cultural/cross-language mediated clinical encounter" defines the primary function of the role as the facilitation of the communication process between two people in order to make possible the goal of the encounter - the patient's well-being.

It is evident from the categories of how language problems are addressed presented above that conscious decisions are needed by the hospital administration to improve communication. In other words, the simple language management strategies discussed here should feed into organized language management efforts by the hospital in what NEKVAPIL & SHERMAN (2009), KIMURA (2014), NEKVAPIL (2016) refer to as the "bottom-up" approach. In the next section, we discuss the organized language management strategies adopted at the hospital.

4.2 Organised Language Management

This paper established that there are adjustment strategies, albeit few and ineffective, that are implemented at organised language management level. NEKVAPIL& SHERMAN (2015) posit that organizations put in place strategies that are aimed at the removal of problems in a number of interactions. This organised 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 (NEKVAPIL, 2016). In Machakos Level 5, there are various family planning written materials which include Patient Information Leaflets (PILs) for such methods as *Jadelle*, *Intra Uterine Contraceptive Device* (IUCD), *Depo-provera* and *Implanon*. These materials are packaged by manufacturers of various family planning medicines and devices. There are also family planning counselling aids such as charts that enable the provider to explain and demonstrate various family planning 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 complementary support materials are described as follows:

4.2.1 Jadelle Leaflets

The leaflet is written in English and translated into other two foreign languages but not in Swahili or other local languages. It is noted that the *Jadelle* leaflets are written in medical jargon that may be inaccessible to ordinary service seekers.

For example, the leaflet advises when it is not right to use *Jadelle*. It says, avoid the method when you:

Text 6

"*…are allergic to levonorgestrel*"

The leaflet also warms users of Jadelle of side effects including:

Text 7

…migraine attacks

If *Jadelle* leaflets are employed to complement face-to-face counselling on family planning methods to adopt, it is difficult to fathom how uneducated users may access the technical expressions in Texts 6 and 7. Though *Jadelle leaflets* are adopted for complementary support information to clients, they may not be effective in conveying the intended family planning information due to technical jargon used. Though earlier research has recommended improvements in patient information leaflets to make them legible, clear and easy to use (RAYNER, 2017), this seems not to have been affected in family planning leaflets.

4.2.2 Depo-Provera leaflet

Depo-provera leaflet was another post family planning service material given out to clients in the family planning clinic. The leaflet is written in simple English devoid of medical jargon. The same information is translated into Kiswahili in the same leaflet. In a follow-up interview with one of the clients, she found the leaflet useful because it was written in two languages as illustrated in text 8:

Text 8:

19. Researcher: Do you understand the information on *Depo-provera* on this leaflet?

20. Client: Inaelewekajuu it communicates in English and Kiswahili. (It is understandable because it is written in both English and Kiswahili)

According to the Kenyan language policy, English and Kiswahili are co-official languages while Kiswahili is additionally recognized as the national language. It therefore helps when written materials meant for the average Kenyan are at least expressed in Kiswahili. It can be noted therefore that patient information leaflets in family planning settings provide standard templates informing users of family planning products on administration, precautions and side-effects. For these materials to work well, the need to be presented in a language accessible to users.

4.2.3 Charts

The researcher observed that there are other family planning materials in the family planning clinic in the form of charts. Three types of these were identified: a well labelled chart on family planning methods; a family planning model chart; and HIV results interpretation charts. Asking a Gynaecologist on the purpose of these materials, he noted they provide more healthcare information to their clients. Consider Text 9 that follows:

Text 9

21. **Researcher**: What purpose do all these illustrations on the walls serve?

22. **Gynaecologist**: You know, we may not say all that a client needs to know. When the options are displayed, the client can quickly make a decision. Further, a client particularly a new one, can quickly understand a method once they see the illustration.

It is evident from Utterance 22 that charts can provide a graphic representation of the family planning methods. Clients need this information to understand the methods better for informed decision-making. Close reading of information on the family planning charts suggests that information provided could help prevent unwanted pregnancies and unsafe abortions besides preventing transmission of HIV and Sexually Transmitted Infections (STIs).

However, though the hospital makes an effort at organized language management, it is apparent

that this is indeed the work of manufacturers of products used to effect family planning. In the Kenyan context, most healthcare interventions are driven by foreign implementing partners who are not in touch with the language requirements of the users. This implies that the charts might not fulfil their communicative purposes. To ameliorate this situation, NEKVAPIL (2016) advises that organisations should support organized language management interventions to address (mis) communication surrounding service delivery. Such organizational interventions are called macro-language management (NEKVAPIL& SHERMAN, 2015)

5. CONCLUSION

This paper has demonstrated that there is a raft of simple and organized adjustment strategies employed to address language problems emerging in the family planning clinic at Machakos Level 5 Hospital. While the simple language management strategies are generated by interactants before, during and after communicative events, organised language management strategies are apparently generated by the manufacturers of family planning products with little or no input by the hospital. The paper therefore concludes that the facility is yet to realize the negative effects language problems characteristic of service provider-service seeker interactions in family planning settings might cause to the projected growth of family planning uptake. Language problems may arise in communicative events coloured by cultural differences, illiteracy, and unskilled family planning service providers. The paper recommends that the Chief Executive Officer of the hospital in collaboration with the head of family planning department need to take deliberate measures to strengthen organized language management strategies in place including the facilitation of translation of Patient Information Leaflets, training of providers on inter-cultural communication and availing interpreters for clients with language challenges. Funding proposals could be channelled to the County Executive Committee members for Health Services and Finance respectively. Perhaps these measures could upscale the Contraceptive Prevalence Rate at not only at Machakos Level 5 Hospital but nationally and move the Country closer to Universal Healthcare status by 2022.

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References

AVERY, M. (2001) *The Role of the Healthcare Interpreter: An Evolving Dialogue*. The National Council on Interpreting in Healthcare. Available from: https://memberfiles.freewebs.com/17/56/66565617/documents/The%20role_of_health_care_interpreter.pdf [15 September 2019].

BOWEN, S. (2015) *The impact of language barriers on patient's safety and quality of care*. Available from: from http://www.reseausantene.ca/wp-content/uploads/2018/05/Impact-language-barrier-qualitysafety.pdf [22 October 2019].

CHICHIREZ, C. M. & PURCAREA, V. L. (2018) Interpersonal communication in healthcare.*Journal of Medicine and Life*.11(2), pp. 119–122.

CRESWELL J. W. & PLANO CLARK V. L. (2011) *Designing and Conducting Mixed Method Research*. 2nd Sage, Thousand Oaks, CA.

DEJONCKHEERE, M & VAUGHN, L.M. (2019) Semi-structured Interviewing in Primary Care Research: A Balance of Relationship and Rigour. *Family Health and Community Medicine*, 7, pp. 1-8.

FAIRBROTHER, L., NEKVAPIL, J. & SLOBODA, M. (2018) *Methodology in language management*. Peter Lang, Berlin, Bern, Bruxelles, New York, Oxford, Warszawa, Wien.

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

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, pp. 727-754.

KIMURA, G. (2014) Language Management as a Cyclical Process: A Case Study on Prohibiting Sorbian in the Workplace. *Slovo a Slovesnost*, 75(4), pp. 255-270.

KOPECKY, J. (2014) Derivation of feminine surnames in Czech as a case of language management. *Slovo a Slovesnost*,75 (4), pp. 271–293.

LANSTYAK, I. (2014). On the Process of Language Problem Management. *Slovo a Slovesnost*,75(4), pp. 325–351.

MYERS-SCOTTON, C. (1993) Common and uncommon ground: Social and Structural Factors in Code Switching. *Language in Society*. 22(4), pp. 475-503.

NEKVAPIL, J. (2006) From language planning to language management. *Sociolinguistica*,20, pp. 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), pp. 307–327.

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

NEKVAPIL, J., & SHERMAN, T. (2009) Pre-interaction management in multinational companies in Central Europe. *Current Issues in Language Planning*, 10(2), pp. 187–198.

NEKVAPIL, J., & SHERMAN, T. (Eds.). (2015) The language management approach: Perspectives o n theinterplay of bottom-up and top-down. *International Journal of the Sociology of Language*, 232, pp. 1–214.

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

OCHAKO, R., MBONDO, M., ALOO, S. & KAEMENYI, S. (2015) *Barriers to modern Contraceptive methods. Public Health,* 15, pp. 118.

RAYNER, T. (2017) Why Patient Information Leaflets Have their Place in Informing Patients about their Medicines. *The Pharmaceutical Journal*. Available from: https://www.pharmaceutical-journal.com/opinion/comment/why-patient-information-leaflets-have-their-place-in-informing-patients-about-their-medicines/20203384.article?firstPass=false [22 October 2019].

ETTARH, RR & KYOBUTUNGI, C. (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,* 16(3), pp. 48-56.

SHARTIELY, N.E. (2016) Code-Switching in the University Classroom Interaction: A Case
Study of the University of Dar es Salaam. *Stellenbosch Papers in Linguistics Plus*. 49, pp. 215-231.