

Language and Health Services Delivery in North East Nigeria

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Abstract: *Much work remains to be done in terms of improving the health services delivery in Nigeria. Imperative in dealing with the problem of health services delivery is adequate communication. Central to this drive is language. Recognizing the primary importance that people place on their own language fosters the kind of true participation in development that achieves lasting results and greater participation in health programs. Language is a vital tool for the achievement of Health Service provision and utilization in the community. This paper explored the nexus between language and health services delivery in North East Nigeria by looking at the situation in Adamawa State. This study used qualitative methods to gather the data needed. This involved interviews with 80 key informants in 20 public reproductive health programs in Yola, Adamawa State. Additionally, 12 focus group sessions were held between June 2015 and March 2016 across the project area, which comprised of 4 focus group discussion sessions each with male, female and mixed sex respectively. A pre-tested focus group guide was used for data collection. Male and female facilitators conducted discussions separately. The interviews were analyzed for what participants considered as language which either promotes effective communication in reproductive health or language which make people shun participation in community programs. The findings indicates that language is crucial in health service delivery in communities since the use of the right language will promote communication which will enhance community participation, promotion of ownership of programs, act as a motivating impetus in mass participation/usage, demonstrate sensitivity to cultural and religious ethics, enhance community members' self-esteem and image and project sustainability. The paper recommends that languages indigenous to community should be use in health services delivery in communities for great acceptability and patronage.*

1. Introduction

The provision of good health services has been one of the major preoccupations of most governments in developing nations. Health services include all services dealing with the diagnosis and treatment of disease, or the promotion, maintenance and restoration of health. They include personal and non-personal health services. Health services are the most visible functions of any health system, both to users and the general public. Service provision refers to the way inputs such as money, staff, equipment and drugs are combined to allow the delivery of health interventions. Improving access, coverage and quality of services depends on these key resources being available; on the ways services are organized and managed, and on incentives influencing providers and users [1]. A good Health delivery should encourage services utilization. This is important for the health of the citizens, hence, one of the Sustainable Development Goals (SDGs) is good health and wellbeing with the task of ensuring healthy lives and promoting wellbeing for all at all ages. Imperative in dealing with the problem of health service utilization is adequate communication, which is driven by language.

Language is the key to inclusion, understanding, self-expression and identity [2] Language is a unique used as an instrument of communication, cultural integration as well as development in all spheres of life [3]. It was in the realization of the importance and the role language plays in effective communication that in 2010 hundreds of educators, development workers, linguists, government workers and civil society delegates came together at a conference in Bangkok. Convinced that language is a vital tool for the achievement of the MDGs, the conference reported on the many ways in which initiatives that promote local languages are making a real difference to people's lives across Asia and beyond. The conference showcased, in particular, impressive evidence for how early education in the mother tongue improves the lives of children and their communities and participants also reported that recognizing the role of languages is highly

significant for work on all of the MDGs, including tackling maternal and child health and health services utilization in general [4]. The place of language in health service delivery and utilization is key to the achievement of health for mothers and children. Every minute, a woman dies from complications in childbirth. Of the more than half a million women who die from complications in childbirth each year, most come from developing countries [4]. Most of these deaths are preventable, being mainly due to insufficient care during pregnancy and delivery. Many lives can be saved through women receiving better information on, for example, nutrition, the important role of breastfeeding for child health, and how to prevent and treat infections, diarrhea and malaria. Women need to receive health information in a language that is familiar to them and in ways that engage with their cultural context. Recognizing the importance of language in national health policies and strategies is vital to ensure that all people, including marginalized women, are reached.

Researchers have provided a body of evidences on the relationship between language and health services utilization. Research in South-East Asia found that many ethnic minority people identified language as a major constraint to accessing health services [5]. Other studies have observed that language barriers encountered in health care settings may compromise the quality of care for limited English-proficient of patient [6, 7, 8, 9]. Language barriers appear to decrease access to primary and preventive care [10, 11, 12], impair patient comprehension [13, 14], decrease patient adherence [15,16], and diminish patient satisfaction [17,18,19]. The use of trained medical interpreters and professional interpreter services can improve communication [20, 21].

People's languages are vitally important to them. Through language, people communicate, share meaning and experience their sense of individual and community identity. Loss of language and culture is frequently accompanied by large human and social costs, including poverty, poor health, drug and alcohol abuse, family violence and suicide (Romaine, 2010). Recognizing the profound importance that people place on their languages is a core insight for tackling poverty and hunger including their reproductive health and other health services utilization. It is an important part of the move away from "top down" models of development that have been shown not to work, and towards participatory development models called "bottom up", which often do. Properly conducted participatory development brings improved outcomes both in the short- and long term and language is central to achieving this [4] According to one study, development initiatives that sought beneficiaries' involvement through the use of their language achieved 68 percent success,

while those that did not achieved a success rate of just 10 percent [22]. Genuine participation obviously relies on a two-way communication, which means engaging with the languages people actually speak. This requires consideration and planning at the levels of both policy and practice. According to UNICEF [4], Policy makers who understand the vital role of languages help to create better development planning. They are aware that focusing on languages has obvious beneficial results for communications and participation targets. They know that opportunities may be lost when the role of language is forgotten. For example, in a province of Lao PDR, there was much greater participation and enthusiasm among Hmong and Khmu ethnic populations, and a reduction in malaria and diarrhea, after a local primary health care provider worked with local ethnic groups to produce videos, story boards and other health education materials in the local languages [4]. Other studies have reported improved health services as result of understanding of language [23,24].

Indigenous health workers who speak to women in their own languages, and those that promote intercultural approaches to health care, is a vital instrument for effective health services utilization in the communities. In the Philippines, the Muslim Mindanao which is linguistically and ethnically diverse people had and one of the highest reported instances of child and maternal mortality due to improved health utilization. The introduction of one project that recognized the importance of local language and culture for community participation and engagement led to increased uptake by the local community of existing health services and more proactive demands from the community for services [25].

In Viet Nam, women access to reproductive health services increased and decrease in maternal and children death when Programs which used local languages and belief systems were introduced to the remote mountainous parts of the area. Before the introduction of the Program most midwives who worked in the area where non-native who do not understand the language and the culture of the people, which made most the indigenes shy away from using the services. The government understood the problem and eventually trained indigenes to be midwives who understand the language of the people. This eventually paved way for better access to reproductive health services to the people [2].

Ojha, [26] reported how women built on local languages to create a "bridge" to wider opportunities in Thar Desert of India. The women who were embroiderers became more empowered after they were taught in the local language of how to take control and benefits of the local market. After first gaining confidence and knowledge in

communicating about concepts of their trade in their local language, the women decided they needed to become more skilled in the language, needs and practices of buyers. They then learned enough of the second language so they could negotiate for improved payments. The combination of first building capacity in the mother language and then moving on to a “bridge” language brought tangible income benefits, which had the additional effect of improving the health, nutrition and housing of the women and their families. The Philippines Department of Education [27], Shrestha, Pinto, & Ochoa, [28] and Tripura & Rahman [29] have documented the benefits of teaching students in mother languages to include: improvement in quality of education, inclusion of all students in learning, better grades in schools, greater enthusiasm and motivation to learn and better understanding of health related matters in their schools. Pearce, Vijayakumar & Nahar [30] reported that Save the Children and partner found that children learning in the mother tongue significantly outperformed counterparts who were not taught in the mother tongue, in communications, language and literacy and that those children have better understanding of health issues. Tudu and Saleh Uddin, [31] found out in their work that the engagement of community people in their local language, enhanced Program delivery including reproductive health and other health services uptake. Salem, Bernstein, Sullivan, and Lande, [32] found out that Behavioural Change Communication Programs that use local languages have motivated people to visit health clinics, discuss family planning, use contraception, advocate abandonment of female genital cutting, protect themselves against HIV infection, and to get tested for HIV. Amuseghan., Ayenigbara, and Tunde [3] observed that the use of languages alien to people had led to exclusion of people from Programs and benefits. They concluded in their paper that language indigenous to a people be used for community engagement since this will promote inclusion and effective community engagements and participation and increase health services utilization. Kamwendo [33] observed that language in health programming help in the inclusion of disabled such as blinds, deaf and dumb, and displaced people in community programming. According to him if health Programs are not packaged in the language of the people, a particular group may not understand details of health services and this might limit utilization, This is because, those who do not understand will be exclude and that population might even experience deaths. He argued that such linguistic minorities be reached in languages that are familiar to them for effective inclusiveness. Furthermore, he argued that for effective clinical treatment of patients, services

be rendered in language which is familiar to the medical personnel and patients.

For people to enjoy good health, they need to have access to health services such as medical tests, drugs, health education, and others. It is important to stress that health services are provided through some linguistic media. This being the case, there is a need to take a serious consideration of how the language factor impacts on the delivery of health services in multilingual sub-Saharan African countries especially in communities programming. Kamwendo [33] noted that, enormous language planning efforts in Africa have been devoted to the education domain – learning the language as a means of teaching and educating people, thereby neglecting other domain such as health service utilization. In view of the centrality of health to human life and sustainable development, it is worthwhile to give increased attention to language planning in the health domain in sub-Saharan Africa. Health services and community Programs do not operate in a linguistic vacuum. given Language and communication problems sometimes derail the delivery of quality health services. The use of foreign languages (such as English, French, and Portuguese) can sometimes be problematic that these languages are known/used by a minute segment of many a country's population. On the other hand, the use of local languages has its own problems too [34]. To this end, then, how can local and global languages be meaningfully used to deliver and increase of health services utilization in Africa? This paper explored the nexus between language and health services delivery in North East of Nigeria. It highlights some of the linguistic dilemmas, contradictions and other challenges that health workers face as they deliver health services in rural communities. This is with a view of finding out how such languages either encourage or discourage access and utilization of services.

2 Methodology

2.1 Study Design

The study was conducted using qualitative descriptive design. In-depth interviews with individual participants and focus group discussions (FGDs) were used to collect data. FGDs were conducted to complement individual interviews and to examine from a group perspective the phenomenon under study.

2.2 Selection of Participants/ Data Collection Procedures

The study was based on a sample of 80 key informant interviews of persons who attended 20

reproductive health (RH) Programs in Yola, Adamawa State. The informants ranged from NGO practitioners in reproductive and community people who attended reproductive health Programs during the duration of the study. Therefore, the selection of the participants was based on their experience in different Health Programs described by attendance of at least three Program events. Ethical requirement was fulfilled by introduction of the study to organizers of Programs and taking permission before the involvement of any member from a group. Such a member was also briefed and gave verbal consent before the interviews. The facilitators of most of the Programs (20 of them) served as first key interview and recruited three additional persons based on the agreed criteria of experience with reproductive health Programs. The choice of the community members and the other person to be interviewed was based on the Facilitators knowledge of both the community and the persons recommended. The researcher assisted by a note taker conducted all the interviews by listening to answers provided to questions in a guide prepared for the interviews purpose relating to the place of language in health services utilization and how language either help participants benefit from Program or the disadvantages they suffered as a result of language in RH Programs. For Focus Group Discussions' Participants, twelve of the key informants worked with the researcher to organize 4 female and 4 males FGDs and 4 mixed FGD with agreed date set aside in a day that such persons are supposed to appear for Programs. Each FGD has a range of 5-7 participants.

Data were collected from June 2015 and March, 2016 on the role and importance of language in health services utilization in the community including the challenges of language in reproductive health Program. Data relating to personal characteristics of participants were also gathered. The researcher personally conducted the interviews and moderated the FGDs to ensure consistency and reliability in the process including ability to probe in depth. The interviews were also taped –recorded after permission from participants. All participants agreed to be tape – recorded except two of them who only allowed their answers to be taken by the note taker. Interviews were held in a private space free of noise and conducted in mixed of languages including English, Hausa and Fulfude since majorities of the participants speak either Hausa or Fulfude fluently. Sometimes, Pidgin English was used depending on the interviewee. The grounded theory was adopted in

this study which entailed the simultaneous process of data collection, analyses and description (Glaser, 1992; Glaser & Strauss) – This meant transcribing the tape immediately after the interviews and subsequently analyzing the transcriptions. Data analysis involved the researcher reading and re-reading the transcriptions to identify the merging themes with common codes sorted out in the course of reading and re-reading. To confirm the validity and reliability of data, consultation was made with some colleagues who read the transcription and discussed the emerging themes in order to have a common understanding [35]

3 Results

3.1 Background Information on Participants

This section is dedicated to the background of participants who took part in the interviews

3.1.1 Interview:

Eighty interviews were conducted in twenty events were reproductive health programs took place. Though the interviews were not directly conducted during the events, the recruitment of the participants took place during the events and subsequent interviews. The people interviewed were 55% male and 45% female with an average age of 57.5 and 42.5 respectively. A vast proportion of them are married (67.5%). Most of them are Fulanis (41.7%) and Hausas (27.3%). A greater percentage of them are Muslim (62.5) while others are Christian (37.5). The average number of children for male participants in the study is 5.8 and that of female is 4.2.

3.1.2 Focus Group Discussion

Twelve FGDs were conducted having 72 people in all since each FGD was made of six persons. The percentage of male and female was equally divided (50% each) with an average age of 42.6 and 40.7 respectively. A vast proportion of them are married (65.3%). Most of them are Fulanis (41.7%) Hausas (27.8%). A greater percentage of them are Muslim (58.3) while others are Christian (41.7). The average number of children for male participants is 5.3 and that of female is 5.8.

Table

Table 1: Background Characteristics of Participants

Characteristics	In-depths interviews		FGDs	
	Number	%	Number(72)	%(100)
Gender				
Male	44	55	36	50
Female	36	45	36	50
Average Age				
Male	46	57.5	42.6	-
Female	34	42.5	40.7	-
Marital Status				
Single	21	26.4	20	27.8
Married	54	67.5	47	65.3
Divorced	2	2.5	3	4.2
Widowed	3	3.8	2	2.7
Ethnic Group				
Hausa	23	27.3	20	27.8
Fulfulde	33	41.7	30	41.7
Charmba	13	16.5	14	19.5
Bura	11	14.5	8	11.1
Religion				
Christianity	50	62.5	42	58.3
Muslim	30	37.5	30	41.7
Average No of Children				
Female	5.8	-	5.3	-
Male	4.2	-	5.8	-

3.2 The Link between Language and Culture

There are many ways in which language and culture are intimately related. Language, of course, is determined by culture, though the extent to which this is true is now under debate. The findings from the study indicated that there is a strong link between language and culture and that most people perceive that the understanding of the language of a group of people means that those who can speak the language of a people are at home with the culture of the ethnic group, therefore gain greater acceptance during programming in community. Majority of the participants agreed with this position of the connection between language and culture as evident from the statement of these participants:

“Most ethnic groups accept those who can speak their languages. They believe such a person understand their culture and will not be doing anything inimical against the people of the group. The implication of this, is that the officer who can speak the language of a community quickly gain acceptance compare to those who cannot”

Another participant in an FGD offered reason why the people who can speak a language of people understand their cultures:

“If a man or a woman can speak the language of a particular people, it a pointer to the fact that the one who can speak the language is either an indigene or had lived with the people for a long time and in the process understands their way of living and most likely will have respect for the people because the he/she see the community as his/her own and so gaining acceptance becomes easy as result of this link brought about by language”

The immediate attention which an health personnel gets in the community as a result of the link of language and culture could be understood from the comment of a participant who noted:

“The man who can talk in our mother tongue is someone who understands us very

well and so will have respect for our culture. For example, it is common thing that when we sit in communal meeting when youth corpers are sent to us, we are often advised to write in our door post “Ba Shiga” Hausa words for a ban on entry of a particular house. The understanding is that such people do not understand our culture and everything is done to protect them and us.

However if a man speak your language, it connotes a long stay in a place and in the process understands the norms of the place and the tendency to respect them is higher, hence the high level of acceptance of such people in communities”

A female participant gave a famine angle to the link in language and culture as she noted:

“Mace da take cikin halatta taron fadakarwa tace abin mata na mata ne tunda ya shafe harshe (yare) da al’adun jama’a. Mutanen mu anan sunfi bawa mata fifiko in aikin ya shafi harkan mata. Wadanda zasu iya magana da harshensu (yare) akan fi basu fifiko na musamman ta fuskar kiwon lafiya da ya shafi maganan haifuwa. Mata da suka fahimci harshen mu (yare) an fi yarda da su tunda sun sa al’adunmu da yadda mukesa tufafin mu wanda mazajenmu suka yarda da su da yake mu musulmaine. A matsayina na musulma bai kamata ana ganina sa’i-sa’i ba ga mutane sai mijina kawai. Mutane da yake jahilaine, basu fahimci matsayi mu ba, koda yake mutum yakan yi wata magana da harshe (yare) da ya sani, bugu da kari ya kara masa/mata fahimtar al’adu da kuma bazai sha wahala wajen shirya bita (abubuwan buki) a cikin karkara ba. (hausa)”

(Our people here give preference to female people if the project is going to be related to women. Those who can speak the language are given added preference. In reproductive health, females who understand our language are more accepted since they know our culture and dress in a fashion acceptable to our men especially those of us who are Muslims. As a Muslim I am not supposed to be seen casually by any man except my husband. Outsiders in their ignorance never really understand our position hence a person who speaks a particular language, it adds to his/her understanding of the culture and less stress in programming in the community).

3.3 Language as a Tool for Community Inclusion/Integration

The concept of community involvement in improving health outcomes is not new. It is increasingly clear that community support for health and social welfare has unique advantages in its close connection with communities, its ability to communicate through people’s own culture and language, to articulate the needs of communities, and

to mobilize the many resources that community members can bring to the processes of policy and decision making and to service delivery. A dominant theme from the analysis of the data in this study is the role of language as a tool for inclusion of all people in a project area. Due to the promotion of ethnic interest with a particular a geographical unit, some of the people feel they are not part of a project when other language is used to implement such project. This is particular the case of Adamawa State where over 58 difference languages are spoken. All participants including men and women and people of all ages agreed to the inclusive role of language as means a people identify with a project and feel they own a project. Comments from interviews as well as FGDs illustrate this vividly:

“Language is an effective instrument for influencing social cohesion and social inclusion or exclusion depending on how it is deployed. If I hear a person speak my language, I see that such a person identify with me and my people and in this situation, a strong feeling of inclusion and solidarity is engendered and automatic support is generated especially if the content of the speech is harmless. In health service provision and utilization, just like in other projects, speaking the language is a receipt for people’s inclusion in project and acceptance which will promote greater usage”.

An FGD participant stressed the inclusive role of language thus in fulfulde:

“Numu dume feiita nde ardiido (CPED) wari yoola, ndem o urhoboojo boo ndem o woldam e nanoobe Hausaare boo, gannungol soyude famtootiral laatan. Demngal dum laawal famtindirki hakkunde anndube e dabbitoobe anndal Hanko e yimbe maako be njottidi e muunyo ko haundi wadee ko faamaa her mo Allah bangi daraja o habdi no o famtina ngam jahorgal yeeso ndonu mabbe haa joonde nde hoore en ngadata . wolan ko firtata billa kaa sonah damngal. Demngal do wallita hawtuki anndube e fandu anndal en e nanta luttube nderjenyol”

(Think of what would have happened when CPED Project Coordinator first came to Yola, an Urhobo by tribe, talking to people who understand only Hausa. A big problem would have resulted from that scenario but for language. Language is a clearing place for relating and integrating expert and local knowledge. He and his team came with ideas of what is ideal in RH after listening to what

we were doing. He tried to bridge these ideas to make a way forward within acceptable culture during the stakeholders meeting. It was language that solved this problem. Language helps in "mixing" expert and local knowledge which result in the inclusion of a people in a defined locality)

One of the basic difficulties encountered in most community project including reproductive health that communities are not homogenous, unified entities. They are fractured, fractious, complex groups that contain competing interests, factions, groups, loyalties, alliances, feuds, families, faiths, genders, clans, ethnicities. Working in places in which project people have not been able to use a shared language or in which they have not had sufficient contextual knowledge, the project people have made and will continue to make assumptions about various aspects of local dynamics. In some cases, there are some serious tokenism going on or that the so-called representatives were not sanctioned to speak on behalf of the community (Sherry, 1969). The inclusive role of language helps in dealing with this problem as noted by a participant:

"Language is a source of strengthening, a sense of ownership since it enable project to identify competing interest in projects locations and in the process make sure that the project is in the hand of the real stakeholders order than the self-seeking groups. Language also allowed deeper capturing of the needs of the community and greater inclusiveness in a project which enhances the utilization of such services"

Community participation is crucial in health service provision and utilization, success especially in getting all segments of community to be involved and to determine their level and method of involvement. The issue of community identification is common to most spheres of community work, however in the field there are vastly different interests (for example, persons with disabilities, family members, professionals, bureaucrats), who have in turn widely varying needs. The participation of all segments in health services increase utilization and make for the feeling of inclusion [36]. The statement by one of the women participants supports this:

"Language promotes community Identity and feeling of togetherness and oneness and increase participation in community health projects which lead to increase utilization of such services. The communities see services and project as their own and as the one that

identify with them, therefore the feeling of togetherness and oneness are promoted and increase community participation and resultant usage".

As a politically, linguistically, socially and economically marginalized group, the deaf are usually not the targets of information and education on health services including HIV/AIDS and sexuality. Most ethnolinguistic minorities tend to live in geographically marked areas. This is not the same with deaf people [33]. Deaf people are not born in a deaf community. They are scattered across any country among hearing people. Language of sign will help with the inclusion of this group in health services provision and utilization, project as noted by this participant during the FGD:

"Understanding the needs of deaf and dumb will help to deal with their problem in Health projects. We need to talk to them in the language they will understand. We should provide sign language interpretation. If there is no sign language interpretation, there will be serious implications of the absence of the language service and exclusion of this group of persons and low utilization of health services. All human beings are equal and must not be discriminated against on linguistic grounds. What is needed is special arrangements to have information on health services and other health hazards conveyed to them through sign language. This will promote their inclusion and their ability to use the services".

The issue of illiteracy is also critical in health education and programming. The use of reading materials (e.g. bill boards, magazines, pamphlets, posters etc) turns out to be useless when dealing with illiterate people. A community participant's statement lends a voice to this point in fulfulde:

"To a tabkiti tabkaram ma dam njamu ko nanndi bana daadiraagu boonngu e hetol daygol to a wii maraa haaje nii hannju woni sanndol dereji yeenol faago yimbe ladde ngam be njannga be faama a tammi" haaje maa hwubam, ngam maajum a do torra hoore ma tan ngam ko a mari haaje man tokkany no haandi waaree"

(When you run your reproductive health Program, issues such as safe motherhood and family planning and all you do is to give leaflets, books, and posters among others to rural community folks to read and you think your project is making an impact, you are deceiving yourselves. Such Program do not achieve pre-determined results since the targets were

reached with the wrong instruments and you cannot make any meaningful impacts)

A pregnant participant supported the idea that the language, the illiterate understand cannot be written down on paper but in other audible and visual form:

“For the illiterate to be reached with reproductive health information, audiovisual materials such as television and videos with the language of the people, will work well since sound and pictures will be produced by these items. However the problem is that most people do not have these gadgets in the rural communities. The project therefore has to set up a centre where these electronics are available and films produced with the language of the people so as to stimulate their interest and ability to develop interest to use health services”.

3.4 Offensive Health Programs’ Languages

Community Programs in health services provision and utilization face a lot of oppositions in the course of community mobilization and implementation due to community belief system and moral inclinations and interest which may limit the extent of the usage of the health services in the project. Many religious bodies support one form of reproductive practice or the other. For example the Catholic Church will not support any Program promoting abortion and artificial contraceptives. It is from this perspective that this study explored offensive reproductive health language as seen from different participant views. A community woman has this to say:

“I am a traditional birth attendant. How do a stranger come to my own locality and begin to describe my practice as barbaric and out dated just because I am not a medical doctor with certificate. I have been in this trade for decades and I have never lost any woman in the course of my taking delivery of women in my community but go to the so-called hospital and see the rate of mortality of women and children as a result of birth, yet such persons have the audacity to come here that they are better –condemning our trade. Agreed, that there are few things that we are not doing very well and we can collaborate to make them better. That is acceptable and not this outright insults from the white people. This is like a wall between us and will not produced the need result to encourage people to use the services they are promoting”

An obviously bitter Hausa interviewee who is a traditional birth attendant observed:

“Maganai abayyane yake inji wata anguwar-zoma da ta halaci bita (taro). Dan iska wanda ya kira kansa masani akan harkokin yanayin mata da yara kanana ya gayyace ni zuwa wani bita da ya shirya, ya fara zagin “ubansa” bani da kua abin da ya faru akan cewa babu mutunci, ladabi da kuma rashin mutunci (kauyanci). Na ce masa ya shirya wata bita don ya karyata abin da ya fada daga fari cewa yayi shekara biyar a cikin wannan aiki. Ya kada baki yace, a yayin gudanar da aikin bban taba rasa jariri ko uwa ba lokacin karban haifuwar gida ba (gidana). Amma Asibiti kowane rana suna irga mutuwar jarirai ta fuskar karban haifuwa. Ni dasu, wa ya fi? In za’a nuna mana sabuwar hanya da zamu inganta aikin mu, ba za mu ki halattaba, lafazi da suke amfani da shi suyi bita bai dace ba”

(An idiot who called himself knowledgeable in women and children matters invited me the other day to his Program and started abusing “his father” certainly not me by calling what we do as unhealthy, unethical, unsafe and primitive. I told him in that Program to withdraw the statement. In fact he told him that in the last five years of my practice; I have not lost a child or the mother in the delivery room of my house, yet hospital count daily death from child birth. Who is better? If they are to tell us better way of doing our work, I will have no objections language they use in their Program is not just right)

Another community man noted stated this in an FGDs:

“Some organizations are not just good at all. Yes, they are not the friends of our people. You come to my home and tell me that, it is wrong for me to marry many wives and have many children without considering my own reason for my action. The insult is so high that, you are labeled backward because you have two or more wives. When has having one wife now the criterion for development. Are those people having one wife better than those with two or more economically? I am a Muslim who must not question what Allah (God) has for me. Whatever that happened to me is ordained by God. I respect the rights of the people with one wife. However, most of these people with one wife have no regard for our persons. What I am advocating is that every man should be

responsible whether you are having one wife or more”

An Hausa facilitator in one reproductive health Program reported:

“Wata mai gudanar da bita akan kiwon lafiya da ya shafi fannin haifuwa ta taba cewa: “Arewancin Nigeria inda aka turani a matsayin jami’a, na daya na shirya bita akan ka’ide iyali, ina cikin al’umma tare da sarkin gargajiya a cikin wata karamar hukuma cike da himma da kwazo ga sabuwar aikina ya hadu da kuma yandan alumma na karkara da nake in a fara yi musu magana akan kiwon lafiya da ya shafi lafiyar mutane. Mutane sun cika kuma suna suna nitse don jin jawabina. Sai na fara da cewa na zo na yi musu magana akan ka’ide iyali, shine babban sako da nike tafe da shi. Nan da nan naga hankalin dagacin ya tashi ya kira mataimakinsa a fusace ya ce su tafi tun da suna da wani taron da zasu halatta. Ba tare da bata lokaci ba, duk jama’a suka bar wurin suma a fusace. Daga baya wani mutum mai son jama’a ya kirani ya ce abin da nake fama yi ana “zunubi ne” a fahimtarsa laifi ne ayi irin wannan magana a nan. A wannan alkari ya musulmin su suke da rinjaye. Gaskiyar magana ita ce ba wanda yake da karfin hana haifuwa sai Allah, kuma shi yake da umurni cewa ga yawan yayan da mutum zai samu. Daga baya ne na gane cewa maganan ka’ide iyali babban laifi ne a wasu sassar kasar. Yin irin wannan magana a cikin wasu alumma babban laifi ne wanda ya ci a kore mutum ya bar garin”

(I was new to the northern part of Nigeria where I was sent as a Program officer. I was in a community with a traditional ruler in one of the LGAs. Full of zeal for my new work coupled with the acceptance from the community members I was talking to them about the benefits of reproductive health program. I was introduced to them. All along, it has been a good and convivial atmosphere until I mentioned family planning as part of what we came to teach in the community. Suddenly, the District Head became aggressive and called on his assistants to follow him out since he had a meeting to attend. Immediately he left, his entire subjects followed him. It was much later that a friendly person in the community told me my “sin”. According to him, it is offensive for you to talk of family planning in a Muslim gathering. The belief is that it is only Allah (God), as the case may be that has the sole mandate of deciding the number of children a family should have. It was later that I found out that, family planning is a taboo in some areas.

To discuss it in some communities is a punishable abomination).

Another dimension to what community term as offensive in health services provision and utilization has to do with the target and location of the project as a participant puts it:

“As a project person working in the area of reproductive health, you have to be sensitive to the object of your project as well as the location of the project. By object, I mean the target of your project. If your project is for youth, find a way to know the position of the community members on such issues relating to sexuality because most of the community members will become suspicious as soon as they see you talking about sex. This is actually a function of the community the Program is being done. The point I am making is that, you should be very sensitive to the kind of language you use –be careful in choosing your words which some people may consider offensive. People might not use the services if they perceive the language as offences”

A gender coloration too was added by another participant in a FGD:

Wata mai nuna jinsi wata da halitta taron ta kara kokawa: In kai na mijine mai gudanar da bita akan ka’ide iyali a wurin da mata suke, ya kamata ka san irin lafazin da zaka yi ko irin kalmomin da zaka yi amfani da su, dole ya zamanto ya shafi al’adu kuma (harshe) da suka yarda da shi. Kuma ka zama mai la’akari akan irin maganganun da zai fito daga bakinka. (hausa)

(If you are a man facilitating in Program where there are women, mind the language you use. Be sensitive to the community culture and accepted language. Make your language simple and mind the kind of statement you make about community people especially women).

Still a participant who was a facilitator in one Program has this to say:

“Offensive languages during health services Program are many. Sometimes, the display of our comfort with what we know is offensive. For example, I can mention vagina without blinking an eye with a high level of comfort and talk about sex always with the same level of composure. However, during programming in the community, we have to exercise some cautions knowing that communities’ members have a different level of comfort with these

words. If we are not careful, they might just walk out on us and a section of people in the community who see us as vulgar might not be part of our Program”.

A disturbing aspect of community programming in health services is related to offensive Program language is a situation when facilitator become judgemental in addressing community health problem. This is captured from a participant in an FGD:

“We go to communities assuming that the people we are dealing with are primitive and condemn everything about their way of lives and you expect to make progress and convince them to use the new health services in that community. You may not be far from failure if this is your approach to programming in communities. Take for example, you tell communities members that it is primitive to have many children and to marry many wives and that their herbs they are used to are archaic including the traditional midwives who had worked and lived with them for ages. It may sound an exaggeration in my statement, but that is what some of us go out to do in the communities. We have not been exposed to basic ethics of community engagement or maybe we are carried away by sense of what we believed is right and in the process become judgemental of the beliefs and practices of others. The attitude should be that of glass-half-full. This is because there is always something good in community and Program should start by highlighting these things rather than bracket condemnations of the people and their culture”

A voiceless language a participant identify has to do with the way Program officers as well as other field officers carry themselves when they get to a community as found in the statement below:

“You may score 100 percent in terms of the utterances from your mouth in health programming in the community. However, an essential aspect of what you need to succeed in; is that you should follow what you say with the appropriate body language. You may pretend to be at home with the community but your body language says the opposite, it will be very easy for community members in no time to discover the discordant between your words and your body expressions and this will discourage people from taking part in your Program”

3.5 Language that Promotes Community Participation in Health Program.

The right of everyone to the enjoyment of the highest attainable standard of physical and mental health is established in international law. These laws also cover community programming. Discrimination and stigma are generally abhorred in community programming and any language used in programming should avoid the two terms. Programming in community should follow the highest level of ethics in health delivery and relate to environment the Program is being implemented. The paper also explored on the language that the community considered as appropriate in RH Programs: A few statement from participants give credence to what community member see as right language that will enhance participation and utilization of services in Program as noted by this participant.

“Program managers as well as other fieldworkers should see the community as an entity that is already having their own way of doing things which they believe is right. As an outsider who is coming to change some of those beliefs that are already well established, you should work softly with the people. First identify what they have and appreciate them since these have satisfied them for ages. You introduce what you know is right as a new “alternative” to what they already have. Have tried out the new ideas, the community may stick to it and a change of behaviour. Condemning what the community has after your few days’ intrusion will achieve the opposite of your intention”.

Another participant has this to say:

“The approach to having effective language which will gain acceptance in reproductive health Program is that any organization working in the community should speak of the community and her people as knowledge people to learn from. Of course, community members are knowledgeable about their way of life which an outsider is coming to explore. Abusing community members through offensive words which condemn what they believed in should be avoided. Practices that are not in line with modern trends should be appreciated from the point of view of the practitioners and build on what they believe”

An FGD participant noted:

“We should speak to people from the point of those things that appeal to them especially from the point of their religions. Because you are a Christian do not make a Muslim having two or more wives bad. That you marry a wife is not a receipt for making it a guideline of how people should live. What is expected is language of respect and relativism. Program language should promote and respect the culture of their host, enhance their self-esteem and promote participation of greater segments of the community in the project”.

4 Discussion And Conclusion

Data from the study indicates that language matters in health services Program and attempt to make people increase the use of health services, especially if we want to make meaningful progress and achieve our pre-determined objectives in target communities. Majorities of participants agreed that language should be an essential part of planning when we are going to carry out reproductive health Program. The data from the study specifically supported the fact that language can lead to the exclusion of some people from partaking in reproductive health project [3,4]

The data in this study also bear credence to other studies [22,33], who asserted that the use of language indigenous to a community in health services; will enhance community participation. This was evident from the way people spoke about the zeal to participate if their language is used to implement a health Program. Participation in community Program will be enhanced due to the motivation people get, as a result of the use of their language. The motivation comes from the fact that the health personnel as well as facilitator who speak local language most time are indigenes who understand the culture of the people and so appreciate them without being judgmental. Additionally, if the medical personnel are not indigenes of such communities, they might have lived in the communities for such a time that they now come to appreciate the people as their own and so are more sympathetic to community people

The nexus between language and health service utilization was equally found in the identification of the some disabled (e.g. deaf and dumb) as people with special needs in terms of their language. The paper recognized the fact that the disabled just like their able counterpart suffer the same health challenges. While able men and women are pursued with different Programs, the disabled do not enjoy equal treatment in terms of access and utilization of health projects. Deliberate effort must be made to

close this gap through provision of sign language. This agrees with earlier work by [33]. According to the paper by Kamwedo [33], a critical and important role to play in the delivery of health services such as health education, is to design linguistic accepted method of reaching excluded minorities such as visually impaired, the hearing impaired, indigenous peoples, and refugees or displaced groups of people. The notion of linguistic exclusion refers to a situation whereby a segment of a population is left out of RH Program in a community, with language being the main reason for the exclusion. The findings from the work is in line with the work of [37,38] who also recognized the place of the disabled as having a special language. According to them, it is important to stress that sign languages constitute legitimate kinds of human languages since sign languages are fully developed and authentic languages which allow their users to communicate the same complete messages just as spoken languages do. The implication of this is that, for an all-inclusive programming of health with great degree of uptake, provision must be made to address the needs of the challenged persons.

Culture plays a crucial role in community programming. The connection between culture and language is crucial for the success of community Programs since people believed that the understanding of a people's language connotes that such persons also know the cultures and will show respect for them – thereby creating greater acceptability and higher utilization of health services. Finally, for the acceptance of community health services and programming languages which promote participation should be highlighted instead of those that make people abandon health services utilization:

5 Policy Recommendations

In view of the place of language in health service delivery, the paper has the following recommendations:

1. Languages of the immediate environment (local languages) should be mapped before community health service provision so as to increase health acceptability and usage;
2. Health service delivery should always take into consideration the language needs of all segments of their communities including planning for minority groups such as disabled and other excluded persons;
3. Health service involving community Programs should use messages that are well censored and pilot-tested to make them not to be offensive to the target population.

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