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# A Socio-Cultural Analysis of Yoruba Discourse Patterns in Selected Child Welfare Clinics in Southwestern Nigeria

## ANALYSE SOCIO-CULTURELLE DU DISCOURS DE PATTERNS YORUBA DANS CERTAINES CLINIQUES PEDIATRIQUES AU SUD-OUEST DU NIGERIA

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## Abstract
This paper is the report of a study that examined discourse patterns of nurses and mothers at some Child Welfare Clinics (CWCs) in Southwestern Nigeria. It describes and analyzes significant elements of recorded discourse chunks in breastfeeding, ORS/ORT and General cleanliness; as well as discourse strategies employed by interactants of both classifications (nurses and mothers) involved in the socio-linguistic activity, exemplifying how language is used to exercise and buttress relationships in the clinics. The study reveals that communication is primary to effective health care; while both parties were willing to cooperate in order to achieve their main goal. The implication of all these is pointed out while it notes that communication whether in English, the mother tongue or the "father tongue", is crucial and in this case, effective, educative and entertaining. The study concludes that in order to cope with short-staffing, literacy and education constraints, resorting to indigenous Yoruba discourse patterns and discourse modalities is a viable option in the pursuit of the goals of the Primary Health Care (PHC).

**Key words:** Discourse patterns; Primary Health Care; Poverty-related challenges

## Résumé
Ce document est le rapport d'une étude qui a examiné les profils discours dans le discours des infirmières et des mères dans certaines cliniques Child Welfare (CTC) dans le sud ouest du Nigeria. Il décrit et analyse des éléments importants de morceaux enregistrés dans le discours allaitement, SRO / TRO et la propreté générale, ainsi que les stratégies employées par les interactants discours des deux classifications (infirmières et les mères) impliqués dans l'activité socio-linguistiques, illustrant comment le langage est utilisé pour l'exercice et étayer les relations dans les cliniques. L'étude révèle que la communication est aux soins de santé primaires efficaces, tandis que les deux parties étaient prêtes à coopérer afin d'atteindre leur objectif principal. L'implication de tous ceux-ci est souligné mais il observe que la communication soit en anglais, la langue maternelle ou la «langue paternelle», est cruciale et, dans ce cas, efficace, éducative et divertissante. L'étude conclut que dans le but de faire face aux contraintes à court de personnel, d'alphabétisation et d'éducation, de recourir à motifs indigènes discours Yoruba et les modalités de discours est une option viable dans la poursuite des objectifs du PHC.

**Mots-clés:**
Modèles discours; Soins de santé primaires; Liées à la pauvreté des défis

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## INTRODUCTION

### Discourse Patterns
Discourse patterns in Nigeria and indeed, in Africa, usually commence with polite inquiries into the welfare of the person and his family. Such social niceties go a long way, since it shows how thoughtful one could be and also how much of the culture one has imbibed; having been brought up to see greeting as a mandatory social practice (Elegbeleye, 2005; Agyekum, 2008).

In Nigeria, virtually all information dissemination takes place through the electronic media, particularly radio, television and home videos. Women are usually the one's at home to take care of the children, so they end up being probably more exposed to the electronic media than most men. In infancy, girls have more resilience than boys, thus the mortality rate of girls is lower than that of boys due partly to several factors. One of these factors is literacy. A large number of Nigerians are not literate. As a matter of fact, general adult literacy rate declined from 57% to 49% while the women literacy rate declined from 44% to 41% from 1991 – 1999. Indeed, in the Southwest part of Nigeria, it declined from 74% to 55% during the same period. It was also observed that only 31% of women had access to family planning facilities, and 45% of children benefitted from immunization facilities (Hodges, 2001, pp.142-143).

This study was motivated by the experience of a nursing mother who went to the clinic to obtain immunization for her baby and encountered another mother who could neither speak English nor Yoruba, the language of the immediate environment.

## Yoruba Culture and Health Communication Patterns

The Yoruba of southwestern Nigeria have been described as a gregarious people whose communication patterns employ proverbs, folktales, rituals, songs, prayers, pithy sayings and even drumming and singing to enrich the meaning of what they say. This is especially true when speaking their native language, although many of the same characteristics have been carried into their English language usage. The Yoruba often use humour to prevent boredom during long meetings or serious discussions. They believe that when songs, proverbs, folktales, humour, satire, etc are embedded in their messages, such messages are not readily forgotten, particularly since Yoruba is a tonal language where the tone of an utterance determines the meaning of what is said.

People have been known to ignore and even sometimes refuse to assist visitors who did not first offer greetings. Indeed, among the Yoruba, greetings are regarded as a social interaction facilitator and a precursor for enhanced positive results since there is a greeting for virtually every conceivable situation in that language. Abioye and Simpson (2009, p.2) point out the following:

> "eku oko" (for people on board a vehicle);"e ku iroju" (for people in distress); "e ku ijoko" or "e ku ikale" (for people seated); "e ku arojuje" (for people who have lost their appetite or who have reason(such as bereavement) not to enjoy their meal); "e ku rogbodiyan yi"(when there is civil unrest.) There is even a form of greeting for people lazing about (e ku aise o) or (e ku ise) in a satirical sense. It follows, therefore, that the Yoruba would be courteous, friendly, sociable and hospitable on one hand, and caustic, sarcastic and even satirical on the other hand.

Among the Yoruba, communication is essential to survival, hence they say "Eni ba dake, t'ara e a ba dake" (whoever keeps silent in the face of challenges will hardly come by any solution). The culture establishes communication as a concrete ingredient for social, economic, religious and political prosperity. Most times, one's depth of wisdom is also measured in terms of proficiency in communication which must align with the pattern of the people's cultural imperatives.

Yoruba communication pattern is complex and elaborate. It can be verbal or non-verbal. Verbal communication can occur in form of greetings, advice, counsel, instruction, etc, and communication patterns employ proverbs, folktales, rituals, songs, prayers, pithy sayings and even drumming and singing to enrich the meaning of what they say. All these can equally be appropriated non-verbally–instances of these can be observed in gestural communication, dress and facial marks. There are other indigenous communication channels which constitute a blend of the most common traditional media that include music (or more popularly folk music), drama, dance, sign language, drums, and town criers. The *kakaki* (trumpet) usually heralds the arrival of a king, thus, commoners have no business owning it. This gave rise to the pithy saying "ole to gbe kakaki oba, nibo ni yo ti fun?" (the thief that stole the king's kakaki is faced with the dilemma of where to blow the trumpet).

The people braid their hair, wear special clothes and there is also the naming aspect where they give appellation and panegyrics which communicate information. For instance, most men of affluence among the Yoruba wear the *abetiaja* cap; a cap literally called "dog's ears," which is sewn in order to droop like a dog's ears, but is pulled back stylishly from both ears.

With regard to health, for instance, an expression such as "*imo toto b'ori aarun mole, b'oye ti n b'ori oru*" (cleanliness averts ill-health in the same way harmattan provides succour against the scorch of heat) encourages a preventive approach to sensitize the people on the need to maintain a clean and healthy environment in order to avert sickness and also reaffirm the painful experience induced by ill-health as illustrated by the scorch of heat. Their emphasis on preventive measures does not however suggest that the people do not have a primordial health institution – their healing rests on the efficacy of herbs and the formidable experience of the '*onisegun*' (the master of medicine/traditional healer), or the *iya abiye (the traditional midwife)*.

The construction of a communication framework in health discourse today witnesses a blend of the people's indigenous pattern in communication and modern methods of information dissemination. Health communication channels are now structured to meet the familiar mode acceptable to the people. For instance, our data reports a parallel structure in the mode of greeting in hospital discourse that is synonymous with what is applicable elsewhere within the platform of the people's

pattern of communication. The socio-cultural pattern of communication among the people reverberates in health discourse for obvious reasons. First, communication of any sort is more than perfunctory in Yoruba; it reaffirms and enlivens the very fabric of the people's social interaction. Second, the communication pattern in health has to be structured to accommodate the people's style of communication – this is necessary to instill cooperation in such dialogue.

## RESEARCH PROBLEM

Member states and governments of the United Nations made a strong commitment in the year 2000 by which the Millennium Development Goals (MDGs) would be realized by 2015. The MDGs are local and global development goals that would ensure development reaches all nations, thereby significantly eradicating poverty. Goals 4 and 5: "Reduce child mortality" and "Improve maternal health" respectively are the major concern of this study. The three main arms of the media play important roles in the dissemination of information concerning such crucial issues in Nigeria. One of such issues is the National Primary Immunization under the Primary Health Care (PHC) in the country. As a nation, the National Health Policy (1988) set out to achieve "a level of health that will enable all Nigerians to achieve socially and economically productive lives". PHC is the primary tier of the National Health Scheme in Nigeria.

Given the multiplicity of languages in Nigeria, PHC practices must focus on ensuring high quality responses. However, it is evident that language and communication barriers may compromise the quality of instruction in medical discourse (Al-Nahedr, 1995). The crucial role of language in the communication process of the PHC cannot therefore be downplayed, particularly when we note that the lives of millions of women and children depend on mostly, how these women understand and interpret health instructions. In addition, in such a developing country like Nigeria where poverty-related issues abound, and people are hamstrung by stereotypical attitudes and beliefs that are embedded in the culture, access to, and correct interpretation of messages is crucial. This is even more pertinent as Nigeria has been battling with the weight of illiteracy, which does not seem to have improved, for decades. Indeed, Babatunde Fafunwa, a professor and former Minister of Education in Nigeria observes: "A nation that plans to be great, yet remains 50% illiterate, plans what never was and never shall be" (*TELL*, Nov 3, 2008, p.13). Then, there is the general assumption that everybody that comes to the Clinics understands either Yoruba or English. But this is not so, making it pertinent for us to examine discourse patterns in these clinics.

## REVIEW OF LITERATURE AND METHODOLOGY

The relevance of effective hospital or medical discourse has been examined with increasing frequency in literature and the argument has essentially been that some forms of interaction take place in the hospital and in order to understand the contexts, contents and implications of these discourses, experimental studies have been conducted. Such studies have used conversational analysis/ethnomethodology approach to examine their corpus.

According to Taiwo and Salami (2007):

> The term 'medical discourse' is an umbrella name for any form of discourse that takes place within the medical context, usually in hospitals and other health institutions. It includes the kind of discourse that takes place between doctors and patients in the process of trying to diagnose or treat the latter's illnesses during consultations, regular health check-ups, doctors ward round. It also includes health literacy, medical classroom interactions, and so forth.

Manning & Ray (2002) examine how agenda-setting of medical discourse is determined by doctors and patients. Using interviews as basic corpus, the study outlines the relevance of agenda-setting in such contexts. In Nigeria, for instance, in Odebunmi (2006) samples of oral discourses of doctors that highlight diagnostic interactions that may or may not be understood by patients were the main focus. Adegbite and Odebunmi (2006) observe the predominance of doctor-initiated interactions which also point to the fact that doctors usually set the agenda of medical discourse, which in this case, is transactional. Other studies on medical discourse in Nigeria either concentrate on the pragmatic aspects of nurse-patient interactions or doctor-pregnant women interactions (Salami, 2006). Taiwo and Salami (2007) examine the ante natal literacy class organized for expectant mothers to equip them with vital information required for safe deliveries. One of the findings is that the literacy class is not interactive enough in the sense that most of the time; the expectant mothers are usually expected to just listen, thus forming an impetus for the present study. Odebunmi (2008) focused on context of interaction and general pragmatic strategies of diagnostic news delivery in the hospital, using data obtained from doctors and nurses with individual patients in hospitals in southwestern Nigeria. It does not focus on women who may or may not understand instruction in the language of their immediate environment, but who have to struggle to do so because their lives and the lives of their children depend on it. It is also not concerned with child care.

None of these previous studies has to the best of this researcher's knowledge, dwelt on the implications of discourse strategies in Child Welfare Clinics for mothers who can and cannot understand the language of instruction. This is the gap this paper intends to fill. This

research is therefore expected to complement existing studies on hospital interactions and medical discourse on the global scale, fill the existing gap in the literature on language use in medical discourse (not diagnostic news) in Nigeria; and in general, add to the existing literature on medical communication in Africa. The Yoruba of south western Nigeria even have this saying:" *Ara líle loògùn orò*" (Health is wealth). This means when you are well and strong, then you are rich because you will not waste your money on drugs.

For the methodology, the study focuses on Hymes' ethnography of communication (1962) that rests on the planks of the acronym, SPEAKING, where S refers to the physical or abstract setting; Participants are categorized as speakers, hearers and the audience; purposes and goals of the interaction are called Ends; Act sequences refer to the message forms and content; Key is concerned with tone or manner of an act or event; the choice of the channel, mode or form of speech is called Instrumentalities; Norms of interpretation and interaction also matter; while Genre refers to textual categories. Fairclough's (1985) studies on the issue of language and power (which can be determined through discourse) in addition to Hymes' (1962) study have formed the framework for this study. The present study is germane to hospital discourse because it sheds more light on the cultural backdrop that informs the use of particular linguistic items.

To find out how effective communicative events take place in such circumstances, this researcher selected 20 government-owned Child Welfare Clinics in Ado/ Odo-Ota Local Government Area and its environs in Southwestern Nigeria for reasons that include proximity, and level of literacy. The clinics are located in rural and semi-rural areas of Ogun and Lagos States. Five different Health Talk sessions were randomly selected based on the observation that the patterns of these Talks were similar. A session has an average of 80 mothers and usually lasts for about 2-3 hours. The researcher, along with 2 research assistants visited each clinic 3 times over a period of 6 months. Due to constraints of space, only three discourse chunks were selected for analysis- family planning, breastfeeding and general cleanliness.The interactive sessions sought information from these mothers ranging from government's attitude to health care, the pattern of communication and whether this pattern was effective.

## SAMPLE AND RELEVANCE OF THE $CWC_S$ HEALTH TALK SESSION

The sample is made up of all the mothers (107) who brought their children for immunization at the Clinics at different times. It is hoped that the result of this study would throw more light on the interactive process between the mothers and the Health Care Services, particularly the Child Welfare Clinics, at the different hospitals in southwestern Nigeria. However, the Health Talk which usually focused on: exclusive breastfeeding, Introducing baby to solid foods, Immunization and vaccine preventable diseases, Prevention and care of diarrhea in children, Vitamin A deficiency, Foods babies need for healthy growth, etc given to mothers on such days formed the basic corpus for this study.

## FEATURES OF $CWC_S$ HEALTH TALKS

Given the importance attached to Health Care even in developed countries not to talk of a developing economy such as Nigeria, it is not surprising that provision is made for health talks particularly when we note that there is no room for mistakes as a little mistake can become a major life-long challenge or even a fatal mistake; the child's health may seriously deteriorate and even cause a permanent impairment rather than improve, which was the idea in the first instance. Thus, hospitals give health talks to expectant mothers (and some of their spouses) in ante-natal classes i.e. before delivery and these same women in post-natal classes i.e. after delivery. For the latter, which is our focus in this study, they must bring along their babies for physical monitoring, examination and treatment each time they come. They are also advised on how to take care of themselves particularly as regards family planning, as well as how to properly care for their children. It is therefore pertinent that these mothers understand the instructions given to them concerning how they should care for their babies in particular, and their families in general.

## HEALTH TALK PROCEDURE

After hospital cards have been issued out to the respective patients, the nurses usually give the health talk in Yoruba with occasional words interspersed in English. The discourse is usually between the nurses and the mothers who brought their children for immunization. On the several occasions the researcher was involved in surreptitious participant observation, none of the fathers came along with their wives. One of the nurses, in most cases, the most senior one who has been designated to address the women (NIC), stood in their midst and addressed the mothers with a clarion call of:

"*Iyá Ayò Oò*!" (Mother Joy); Mother of the child called Joy.

During the Health Talk, the Nurse–in-charge (NIC) interspersed the talk with questions and there were chorus answers while some of the mothers did not respond. These answers are a sort of reinforcement of what they had been taught. A Christian or Muslim usually says the opening and closing prayers respectively before the talk begins and after it ends. This is because the hospital authorities do not want to appear as favouring a particular religion to the detriment of the other, since religious issues are highly

volatile in the country. Mothers are taught the importance of general cleanliness in their environment, the importance and benefits of immunization, the relevance of family planning, why babies need a balanced diet, etc. Intermittently, the mothers would be rebuked for making too much noise by another clarion or wake-up call of "*Iyá Ayò Oò*!"

Where the noise persisted, they were threatened with "detention" for 1 hour (i.e. they would have to wait an extra hour after the others have left before drugs could be administered to their babies). This noise was largely due to the fact that there is usually limited space provided at any point in time for babies and their mothers. In response to the researcher's questions about whether the mothers actually understand what they are taught, the nurses argued that whatever the mothers did not understand would be reinforced by individual questions, radio and television programmes and even home videos. Then, they sang songs at the end of each topic - prayerful, educative and entertaining songs about the importance of the different aspects of the PHC.

## PRESENTATION, TRANSCRIPTION AND ANALYSIS OF DISCOURSE

Health Talks (discourse chunks) were used to elicit discourse strategies employed and they form the corpus which is recorded, transcribed and analyzed using Hymes' ethnography of communication as well as Fairclough's theory of language and power. The Talk is classified into 5 Steps:

**Step I:** Preamble or introduction;
**Step II:** Exchange of greetings;
**Step III:** Talk (mainly by the nurses);
**Step IV:** Response from the mothers; and
**Step V:** Song.

Thus, once the Talk starts with Steps I and II (which are Preamble and Exchange of greetings), other topics do not require these two steps, however, Steps III, IV and V are quite relevant.

**Health Talk: Texts 1 II&III**

**Step I: Preamble/ introduction**

**NIC:** Ìyá Ayò oò! (Mother Joy); Mother of the child called Joy.

**M.:** Ma!

**Step II : Exchange of Greetings**

**NIC:** E káàrọ o. (Good morning all).

**M.:** E káàrọ ma. (Good morning Ma).

**NIC:** Awon '*daddy*' wa nkọ́? Gbogbo ilé nkọ́ o? (How are our daddies, (ie their husbands) and how are your families?)

**M.:** Gbogbo won wa o. (They are all doing well).

**NIC:** Ekú ìtójú `awọn ọmọ. Ọlọ́run á jẹ́ ká jèrè ọmọ o. (Taking good care of your children. May we reap the fruits of our labour on these children by the grace of God)

**M.:** Ámín. (Amen).

**Step III: Family Planning (Ìf' ètò sí ọmọ bíbí)**

**NIC:** Ìf' ètò sí ọmọ bíbí (*Family Planning*). Lẹ́hìn *41 days* tí ẹ bá bímọ, (41 days after you have given birth), Ewá fún Ìfètò sí ọmọ bíbí (Come here for Family Planning). *Family Planning*: "Ìfètò sí ọmọ bíbí"– kì íṣe pé ká dédé lóyún tí akòfẹ́. (Family Planning- is about not having unwanted pregnancies):

Kí 'yà máa je omo àtì'yá nítorípé a kò f'ètò si. (Where a mother and her children suffer because a pregnancy was not planned).

Kíni Ìfètò sí ọmọ bíbí nṣe o? :(Family planning does what?)

**Step IV: Response from the Mothers**

**M:** Ó nfa ìfẹ́ láàrín tọkọtaya, (It encourages intimacy between spouses), O ndáàbò bòwá lọ́wọ́ àrùn ìbánilòpọ loríṣiríṣi. (It prevents STDs and similar infections).

**Step V: Song:**

Sèsè nínu mi dún, tòri mótifètò si (2ce). (I am so happy because I have planned it)2ce.

Alábẹ́rẹ́ ẹsé ò: óní hóró ẹ sé ò; (The injection option we thank you: We appreciate the tablets too);

Oni fére yí o, ẹ mà sé: tòri móti fètò si. (The condom alternative, we thank you also: all because I have planned it).

## ANALYSIS

**Text 1**

For the physical and abstract Setting, this study is located in CWCs in the southwest of Nigeria where Yoruba is the language of the immediate environment and even the regional language, making it the major language of communication. Because English is the language of education, the average literate Yoruba is bilingual. However, the level of proficiency in both languages is inadequate going by the educational qualifications of the mothers. But this does not take care of mothers who neither speak English nor Yoruba.

In the preamble, (Step I) in Yoruba language '*Ayo*' has dual meanings. It could either be the name of a person (which could either be male or female) as in '*Ayomídé*' – (Joy my come) My Joy has come, and it could just be '*Ayo*' 'joy/happiness'. This is the "signature tune" or wake-up call that tells the mothers to be attentive or to refrain from distractions. The implication here is that children are a source of joy to the mothers in particular and parents and the family in general. This is connected to the fact that in the traditional African society, if a woman does not give birth to children, it is usually seen as her fault. The primary responsibility of a wife is to bear children, particularly male children, to perpetuate the family name. Where this does not happen, then the woman has failed in her responsibilities.

Thus, a woman who has no child is usually perceived

as bitter, cantankerous, unhappy, etc because the source of *joy* in her life is missing. It is assumed that a woman cannot be happy without children. It is also in line with the Yoruba belief that whatever the child turns out to be is largely traceable to the mother- positively or negatively. Since all the mothers came with their bundles of *joy (ayò)*, whether the child is actually named "*Ayò*" or not, for the purpose of the Clinic, all the mothers are thus addressed as "*Iyá Ayò*".

The response is "*Ma*" (short for Madam). The Participants are the (NIC) and the (M). The 'asymmetrical power relations' are very clear here as it depicts who is in charge and who is taking instructions. In this short discourse, words show clearly the difference between the person dominating the discourse and the passive discursant, the giver of instruction/ lecturer (NIC) and the receiver/ student (M); the unequal partners in a discourse situation.

The Ends or goal of the interaction is to achieve an improved health care through family planning, prevent sexually transmitted diseases, and space child birth for the convenience of the family. The Act sequence, message forms and content start with greetings (Step II). The Yoruba, according to Fadipe (1970, p.301) has "…an elaborate code of manners and etiquette…" Thus, it is the custom to exchange greetings bordering on the health and well-being of the family as well as a prayer that God will continue to sustain them, before the actual business starts. It sets the pace for a cordial relationship. Anything short of this is conceived as ill- breeding.

In Steps III, IV and V, the Key is cordial and friendly through the responses but still shows clearly who is in charge. The Instrumentality is verbal, more of listening, some chorus answers and singing. The Norms show the level of shared cultural experiences between NIC and M. For instance, "*Daddy*" is an umbrella term where the meaning of "husband" is embedded in the word 'daddy". The Yoruba believe that not only is the husband the head but he is also the father of the family, the wife inclusive, thus he is addressed as "*Baálé*"- "*Bàbá onílé*" (The father of the household, the father in the house or the man who owns the house). It is therefore not surprising that wives and sometimes women refer to their husbands or other people's husbands as "daddy". Then the Genre is an educative and entertaining discourse text as they all enjoyed the songs.

In the same text, *alábéré* could mean the person administering the injection or the injection option, '*óníhóró*' graphically depicts the small doses in tablet or capsule form while '*onífèrè*' means the trumpeter or the trumpet option. This name is derived from the physical presentation of the condom likening it to a trumpet. Thus, the researcher observed that it was referred to as '*fèrè daddy*' (daddy's trumpet). The underlying meaning of this expression is that only men use the condom and that it is daddy's prerogative. This song also educates the listener about the different family planning options available- injection, tablet/ capsule and condom.

**Text 2: K'a fun omo l'oyan (Breastfeeding)**

**Step III:** Talk (mainly by the nurses)

**NIC ":** Onje wo lo dara ju lati ma fun omo owo? (What is the best food for infants?). **Step IV:** Response: Oyan (Breastmilk).

**NIC:** Kini anfani to wa ninu ka ma fun omo loyan? (What are the advantages of breastfeeding?).

**Step IV: Response:** Ko ki nje komo ki o se aisan. (It reduces illness in children).

O nje ki omo dagba daadaa. (It ensures healthy and steady growth in children).

O nfa ife laarin iya ati omo. (It increases love and affection between mother and child).

**NIC:** A ko fe ki e maa fun omo ni onje inu agolo – *Baby food*. We do not encourage giving infants tinned baby formular).

**Step V: Song:** Sese ninu mi dun, omi kunnu oyan mi (2ce); (I am so happy, because my breast is filled with milk);

Tori mo fomo l'oyan, omi kunnu oyan mi, (Because I breastfeed, my breast is filled with milk);

Tori mo fomo mi loyan mu, omi kunnu oyan mi. (Because I breastfeed my baby, my breast is filled with milk).

In **Text 2**, the Setting and the Participants are the same as in Text 1. In Steps III, IV, and V, the End goals of the interaction are to encourage mothers to breastfeed their babies in order to minimize preventable diseases. The Act sequence, the Key, Instrumentality and the Norms are the same since this text is a continuation of Text 1. The song actually reinforces and reminds the mothers about the crucial need for breastfeeding, the relevance, as well as the advantages. The cohesive ties are exemplified through out the sample discourse chunks as one line is linked to the other through question and answer (NIC: What is the best food for infants?) Response: (Breast milk) in anaphoric and cataphoric situations and the sequence in which the advantages of breastfeeding are listed. The level of interaction in this text is better than in Text 1as we have a question and answer sequence.

**Text 3: Imo toto (General Cleanliness)**

**Step III:** Talk (mainly by the nurses)

**NIC:** "Ona melo ni imototo o? (In how many ways can we describe cleanliness?)

**Step IV: Response:** Ona meta: ara, ounje ati adugbo. (3 ways: physical, food and environment).

**NIC:** Aso ti o ba igba ni ki a maa wo fun omo. (Ensure that children are dressed appropriately to suit the weather).

Ki a paro *nappy* lasiko. (Nappies should be changed frequently).

Ka tanba fun won bi emeta lojumo. (We must wash babies' backsides at least thrice a day).

Ka bu moju si abiya ati orun , ki kokoro ba maa damu won. (Sprinkle special baby talcum powder liberally

around baby's neck and underarms so that they do not get rashes).

Ki a san eso, ata, tumati wa daradara. (Our fruits, pepper and tomatoes must be thoroughly washed).

K'ama lo abefele t'enikan ti lo. (Do not use blades previously used by somebody else, i.e ensure it is a new blade).

Eleyi lewu pupo. (This is very risky).

Ti aba nlo *salon*, ki a mu ilarun dani. (When you go to the *salon*, ensure you go with your own sharp comb).

Ki ama je ki efon ribi kole si l'adugbo wa. (We must ensure that our environment is not mosquito-infested).

K'ase *net* si oju *window* ati enu ona. (Ensure that doors and windows are protected by nets).

K'asi lo *mosquito – treated nets for the child*. (Use mosquito – treated nets for the child).

" T'ara omo ba ngbona, ki lo ye ka se?" (If baby has a fever, what must we do?).

**Step IV: Response:** Ti omo ba ngbona, ki a lo paracetamol fun. (If the baby is running temperature, we should administer paracetamol).

Ki a si fi omi san an lara. (And give baby a cold bath).

**Step III NIC:** "T'ara omo ba gbona ju, o le fa kini o?" (If the temperature is exceptionally high, it can result in what?).

**Step IV: Response:** "O le fa giri". (It can result in convulsion).

**Step III NIC:** Ti o ba to wakati mefa ti ara ko ba bale, e gbee wa. (If symptoms persist after 6 hours, come for treatment).

Bronco – *pneumoneau po lasiko yi*. (Bronco – pneumoneau is rampant now).

Ti oba ri wipe omo nwuko, tete gbee wa. (If you observe that the child is coughing, seek medical attention immediately).

E ma lo agbo ko ma lo di nla si lara. (Do not resort to local/traditional herbs so as to avoid complications).

In **Text 3**, the Setting and the Participants are the same as in Text 1. In Steps III, IV, and V, the End goals of the interaction are to encourage mothers to keep their environments clean and bring up their babies in clean houses in order to minimize preventable diseases. They are equally sensitized on endemic issues like HIV, malaria, pneumonia, cough, etc. The Act sequence, the Key, Instrumentality and the Norms are the same since this text is a continuation of Text 1. There is no song attached to this text. The cohesive ties are exemplified throughout the sample text as one line is linked to the other through question and answer (NIC: If baby has a fever, what must we do?). Response: (If the baby is running temperature, we should administer paracetamol). The relevance of a clean environment and how to take proper care of a child are outlined. This text is similar to Text 1 where a lot of instructions are given.

## RELEVANCE OF LANGUAGE USE IN THE SOCIO-CULTURAL CONTEXT

This study has used the discourse analytic technique of recording, transcribing and analyzing to investigate interaction patterns in CWCs. The media gave prominence to Child Care, child spacing and other issues through the use of posters and stickers in English, Yoruba, Hausa, Igbo (the three indigenous officially recognized languages in Nigeria) and even Pidgin English. But some of the mothers could not read these posters, as such; they had to rely on what they hear from the nurses and the electronic media. Because some of the clinics were in semi-rural areas, low attendance is usually recorded on market days (every 5 or 7 days) where the mothers go to buy and sell. This means some mothers miss their scheduled clinic days and this has serious implications for the children's health. There was no one-on-one interaction, thus the question and answer part of the health talk was done as a group. All these tally with Taiwo and Salami's (2007) observation that the ante-natal literacy class is not interactive enough. Mothers who could not speak Yoruba or English sat beside people who could understand and subsequently interpret for them. They are thus left at the mercy of the interpreter whose level of proficiency is questionable. After the health talk, babies were weighed and the vaccines were administered.

Majority of the women (60%) were traders. From the interactive sessions, it was clear that only a few were actually educated. It was also observed that low level of literacy, unemployment, social, cultural and poverty-related challenges slow down the rate of progress/success of the PHC.

## CONCLUSION AND RECOMMENDATIONS

From the foregoing, it is clear that for Nigeria to move ahead in the 21st Century, it must pay serious attention to not only education, but PHC. The target for the realization of the MDGs is 2015; how this can be done in the next few years depends on the level of commitment by government. Then, concerning communication and interaction, it was clear that although communication took place, it was not between two equal interactants. Thus, the level of interaction was minimal. However, it was observed that the nurses used not just talks but the highly educative and equally entertaining songs rooted in the Yoruba culture to teach, reinforce and remind the mothers of their responsibilities. This would not have been possible in a purely English–medium discourse where some of the diseases, symptoms and expressions have no equivalent in the Yoruba language. The mothers, on their part, observed that the classes were more educative because they could

identify with the traditional Yoruba expressions, culture, songs, beliefs and practices. Some actually wished that learning would be situated in such conditions because it gave them the opportunity to exhibit their singing skills. Thus, we do not foresee an end to this type of discourse pattern.

Government should ensure that the teaching of at least 3 Nigerian languages, apart from one's first language is incorporated into the curriculum for nurses. These languages may be selected from major Nigerian languages apart from the 3 recognized major languages viz Hausa, Igbo and Yoruba. Some of these languages are: Igala, Kanuri, Bini, Efik, Urhobo, Itsekiri, Tiv, etc. Then, the National Policy on Education, Section 3, No 4 (p.13) which reads:

> Government will see to it that the medium of instruction in the primary school is initially the mother – tongue or the language of the immediate community and, at a later stage, English,

should be revised to cater for those who do not speak the language of the immediate community and on whose shoulders a linguistic burden has been placed.

Nurses at such clinics should monitor what has been interpreted into Yoruba or any other language for those who do not speak either of these languages, to ensure that the correct information has been passed across. Finally, immunization is crucial and it saves mothers, children and their families a life time of sorrow, pain and tears if it is administered at the right time and if the information is communicated in the language in which the mothers are most proficient.

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