CULTURAL TABOOS AS A FACTOR IN INTERPRETATION IN THE MEDICAL FIELD.THE CASE STUDY OF THE MERIDIAN HOSPITAL

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF ARTS IN INTERPRETATION

BY

FREDRICK ALUCHULA MUNANE

DEPARTMENT OF LINGUISTICS AND LANGUAGES

FACULTY OF ARTS

UNIVERSITY OF NAIROBI

NOVEMBER, 2014

DECLARATION

This thesis is my original work and has not been presented for a degree in any other university or institution of higher learning.

Munane Fredrick Aluchula

Reg. No: C50/64613/2010

Signature_____ Date _____

The thesis has been submitted for examination with our approval as the university supervisors.

By the Supervisors:

Signature _____

Dr. Catherine Agoya Date _____

Signature _____

Dr. Zaja Omboga Date _____

ACKNOWLEDGEMENT

In completing this project I feel indebted to many people.

My first debt of gratitude is to the Almighty God for His unending love and mercies that are new every morning.

My two dear supervisors, Dr. Agoya and Dr. Omboga for the many hours they patiently guided me throughout this journey.

Special thanks to Professor Mutiga, the Centre Coordinator for words of encouragement and genuine concern.

My other lecturers: Prof. Okoth Okombo, Prof. Kithaka Wa Mberia, Prof. Lucia Omondi, Dr. Michira, Dr. Olali, Mr. Gitonga and Caroline.

UN instructors: Mr. Mosslenga, Fernando, Petronila, Lina, Elina, Fatima and Jack.

Carmen, Nick and Kate Davies. Thank you and God bless you all.

To my colleagues: Doris, Evelyn, Elvire, Rufus, Truphosa, Rachel, Raquel, Jean Paul, Koffi and Kadzo; I thank you so much for the encouragement, teamwork, competition and friendship we forged. I know it is for a lifetime.

To my dear and wonderful parents Tabitha Kadenyi and Japheth Ngaywa up in heaven, my siblings : Ben, Margaret, Joyce, Albert, Ken, Rose and Edith plus dear brothers Francis, Douglas and Allan who are up yonder, I say thank you for your love and support.

Special gratitude to Mr. Bernard Ndiege for his assistance. When I needed a speech quickly, he was there for me!

Finally, to my dear wife, Princess Constance Rapando, lovely children: Ethel Kanda, Elvis Seth, Susan Erica, Elleanor Tara and Everett Annan; words sound superfluous and inadequate, but a thank you from the bottom of my heart is all I have for you all. God Bless you all.

DEDICATION

To my entire family, fellow students and the staff and lecturers of the University of Nairobi for the support and encouragement.

LIST OF ABBREVIATION

AIDS	Acquired immunodeficiency Syndrome
AUSIT	Australian Institute of Interpreters and Translators
BRM	Biotherapy/Biological Response Modifier
DNA	Deoxyribonucleic Acid
ECG	Electrocardiography
HIV	Human immunodeficiency Virus
KDHS	Kenya Demographic Health Survey
LEP	Limited English Proficiency
S.L	Source Language
S. T. I	sexually transmitted infection
T. B	Tuberculosis
T.L	Target Language
WHO	World Health Organization

TABLE OF CONTENTS

Declaration i

Acknowledgement ii

Dedication iii

List of abbreviation iv

Table of contents v

List of Tables vii

List of figures viii

Abstract ix

CHAPTER ONE

1.1 Introduction 1

1.2 Background of the Study 1

1.3 Statement of the Problem 5

1.4 Research Questions 6

1.5 Objectives of the Study.. 7

1.6 Hypotheses of the Study 7

1.7 Scope of the Study 7

1.8 Limitation of the Study 8

1.9 Theoretical Framework 8

1.10 Literature Review 11

1.11 Research methodology 21

1.12 Rationale of the Study 23

CHAPTER TWO

DATA OF CULTURAL TABOOS

2.1 Introduction 25

2.2 Taboo words 25

2.3 Diseases that are taken as Taboo 27

CHAPTER THREE

ANALYSIS OF TABOO DISEASES AND INTERVENTIONS

3.1 Lupus 29
3.2 Hemophilia 30
3.3 HIV in Kenya 31
3.4 Taboos brought about by ignorance 35

CHAPTER FOUR

RESEARCH FINDINGS

4.1 Introduction. 39
4.2 Purpose and Scope 39
4.3 Demographic Characteristics of Respondents 39
4.4 Miscommunication between patients and health care providers 44
4.5 Overall Opinion on Effective Interpretation 46
4.6 Extent of the Effectiveness of interpreters on cultural taboos 46
4.7 Training Interpreters with sensitivity to cultural taboos. 47
4.8 Presence of Medical Interpreters of cultural taboos in the medical field. 48
4.9 Extent of how untrained interpreters deal with cultural taboos 49
4.10 Cultural Taboos affect Interpretation 49
4.11 Professional Interpretation 50

CHAPTER FIVE

SUMMARY , RECOMMENDATIONS AND CONCLUSION

5.1 Introduction 51
5.2 Summary of Findings 51
5.3 Conclusions 52
5.4 Recommendations 53

References 54
APPENDIX:Taboo words, diseases, drugs, conditions and body parts. 59

LIST OF TABLES

Table 1 Taboo words 26
Table 2 Taboo diseases 27
Table 3 Body parts that are Taboo 28
Table 4 Target population 40
Table 5 Sampling design 40
Table 6 Overall Response Rate 41
Table 7 Gender of Respondents 41
Table 8 Response Rate by Work Experience 42
Table 9 Level of education of respondents 43
Table 10 Overall Opinion on visitation by doctor of different gender 43
Table 11 Dissatisfaction of patient's clinical encounter 44
Table 12 Miscommunication between Patients and health care provider 45
Table 13 Effectiveness of interpretation. 47
Table 14 Training Interpreters with sensitivity to cultural taboos. 48
Table 15 Presence of Medical Interpreters 48
Table 16 Presence of Medical Interpreters 48
Table 17 Extent of untrained interpreters 49
Table 18 Cultural Taboos affect Interpretation 50
Table 19 Professional Interpretation 50

LIST OF FIGURES

Fig. 1 Gender of respondent 41
Fig 2 Years of service 42
Fig. 3 Dissatisfaction with patient's clinical encounter 44
Fig 4 Miscommunication between patients and health care giver 45
Fig 5 Overall opinions on effective interpretation 46
Fig. 6 Effectiveness of interpretation 47

ABSTRACT

The study focused on how cultural taboos influence interpretation in the medical field. The Meridian Hospital was used as the case study. The hospital has four major departments which are frequently visited by patients which made it easier to collect data. The study also included the miscommunication in hospitals between both the trained and untrained interpreters and their patients and how the presence of medical interpreters is crucial. Moreover it examined some hardships faced in the medical field either due to lack of interpreters or lack of trained interpreters who are sensitive to culture.

The study adopted the Skopos theory to show what needed to be done by interpreters in effectively communicating culturally bound taboo words between medical practitioners and patients. The study employed descriptive and correlation survey design. The study used a sample of 35 patients from the four main departments which were visited by most patients. Stratified random sampling used to select respondents to reflect overall response by the patients from each sampled department. Questionnaires were used to collect data from the selected four main departments. Doctors were also given the questionnaires.

Analysis was done using descriptive statistics such as frequencies, percentages and graphs. Simple random sampling was used to select patients who visited the main departments in Meridian hospital. Descriptive survey design was used to show the nature of the relationships between cultural taboos displayed by patients in the medical field. The data was analyzed using a chi-square and Pearson's Coefficient of correlation. Results revealed that the presence of medical interpreters in the medical field has a positive impact in patient visits and helps them understand various culturally bound taboo words as they are interpreted by either paraphrasing or using euphemisms in order to avoid the stigma associated with some of the diseases.

The findings and recommendations of the study are useful in the efforts towards ensuring that there are trained interpreters in the medical field who will enable the patients to better understand what they are told by doctors. The patients are also to appreciate or do away with some practices in the society that have hitherto caused stigmatization. They also adapt better practices that help in preventing some diseases. Medical practitioners are also better placed to understand why some patients appear hesitant to go to hospital and instead preferred herbal medication.

CHAPTER ONE

1.1 Introduction

Interpreting cultural terms is a very difficult task. This is especially so in the medical interpretation because there are always new terminologies that are coined when new diseases and drugs are discovered. Newmark (1988:94) defined culture as the way of life and its manifestation that is peculiar to a community that uses a particular language as its means of expression. People adapt and believe in culture making it part of them and believe in them. Some aspects of culture become taboo with time. Nida (1964:30) believes in equal importance to both linguistic and cultural differences between the source language (SL) and the target language (TL). He believes that differences between cultures may cause severe complications for an interpreter than do difference in language structure. This makes interpreting of cultural taboos very difficult.

1.2 Background of the Study

While the field of medicine is a science, the disciplines of medical translation and interpreting sometimes have a lot in common with the sciences. These linguists act as diplomats, medical professionals and cultural ambassadors all at once. There are many ways that translation can go wrong and that is why it is important to have qualified, professional medical interpreters and translators guiding you through multilingual medical encounters.

In Southwestern United States, the Navajo have no word for chemotherapy. An interpreter will first have to get the concept of chemotherapy across and communicate the risks and benefits associated with the procedure before the medication can continue. The doctor would be the one to provide the explanation, but through the interpreter who would have to break it down to more culturally familiar concepts. Therefore in addition to knowledge of medical

terminology, language professionals have to be able to properly handle issues of cultural taboos. This is due to the stigma that might accompany some of these diseases and conditions.

In Kenya, some communities still believe that AIDS is a curse that is cast on a person who transgresses some culture. This could also be caused by failing to observe certain taboos in a society. In the Luo community, it is referred to as ‘chira’ which is a curse. For a long time, the stigma associated with this disease prevented the patients from accessing medication. Many patients lost their lives due to this ignorance and adherence to repugnant customs where it was believed that traditional healers would treat AIDS. Some patients believed they could be healed by miracles, sacrifices or by having sex with young children or virgins.

Guo Zibin (1999:117) in his research found out that many elderly Chinese immigrants in the city of New York preferred Chinese-trained doctors and the Chinese traditional doctors than the western trained doctors. They viewed them as medicine dispensers instead of active healers. Language barriers, socio-economic barriers and the fear in differences between expectations and outcomes are among major factors that discouraged the Chinese from being attended to by the western doctors. The Chinese condemn the HIV and AIDs virus and its resulting illness as a disgrace to the family of the afflicted individual. In this case, trained interpreters are highly needed to educate the Chinese to accept the western medicine and to show them the positive side of their treatment since they only know of its side effects.

The VOA (Voice of Africa) news site reported that medical interpreters must often resort to euphemisms when speaking about sexual health including body parts due to African cultural

taboos. The process of communicating necessary medical information while respecting cultural norms is a delicate one and this isn't always easily accomplished.

In Kenya, among the Maasai community women are discouraged from speaking in public and most of the talking is done by their husbands and elders. This makes diagnosis and treatment more difficult because the woman does not explain her ailment herself; hence it is important for doctors and interpreters to be aware of these kinds of considerations. It is even more complicated when culturally bound words or conditions are involved. For example, if a woman is suffering from fistula condition, a sexually transmitted disease or cancer of the breast, it becomes difficult for her to clearly articulate her condition to a medical practitioner.

Common cultural taboos encountered at the Meridian Hospital included female patients refusing to be attended to by male health practitioners. They considered it taboo to be held by hand, to be asked personal questions and to remove their clothes for examination. These taboos are caused by religious beliefs, for example, the Muslim patients preferred to be attended by Muslim doctors. Female Muslim patients would not allow male medical practitioners to touch them or perform any medical procedures on them. Some traditional African churches discourage their members from seeking treatment from hospitals. They pray for divine intervention and threaten to excommunicate any members who go for medical attention in hospital. Some diseases are not openly discussed due to the stigma associated with them. These included HIV/AIDs, cancer, Sexually Transmitted Infections and fistula. This caused a big dilemma to the medical practitioners who handle such cases. These cases were investigated at the Meridian Hospital and how the medical practitioners surmounted them. The study was carried out with a view to finding out why some patients refused to go to

hospital, to discover how the issue of cultural taboos was affecting diagnosis and treatment and to find out how culturally taboo bound words were interpreted at the Meridian Hospital.

1.2.1 Essence of trained interpreters in the medical field

Tebbe (2003: 50) asserts that while many linguists can perform direct translations of simple medical terms and regular conversation, medical translation involves much more than that. It is vitally important to both the practitioner and patient to understand exactly what is being discussed, and that includes a detailed knowledge of medical concepts and the repercussions of diseases and treatments. For example, a recent article in the Tufts Journal stated that the Navajo have no word for chemotherapy. An interpreter would first have to get the concept of chemotherapy across and communicate the risks and benefits associated with the procedure before the conversation could continue. The doctor would be the one to provide the explanation, but the interpreter would have to flag the unfamiliar concept in the first place (Tebbe, 2003: 67).

There are many ways that translation can go wrong. Complacency, haste and emotions are just a few of the complicating factors. That's why it's important to have qualified, professional medical interpreters and translators guiding you through multilingual medical encounters (Tebbe, 2003: 67). In addition to knowledge of medical terminology, language professionals have to be able to properly handle issues of cultural taboos. In an article in the Tufts Journal of 16th February 2011, the VOA news site reported that medical interpreters must often resort to euphemisms when speaking about sexual health — including body parts — due to African cultural taboos. The process of communicating necessary medical information while respecting cultural norms is a delicate one, and this isn't always easily accomplished. Taboos in a conservative, Islamic culture significantly hinder the awareness

and understanding of the mere existence of the disease called breast cancer (Tebbe, 2003: 68). For example, a breast cancer awareness group called Pink Ribbon Pakistan found that they were forbidden to say the word “breast” during a presentation to a Pakistani university. In lieu of the words “breast cancer,” the Pink Ribbon group was reportedly required to use the neutral (and misleading) term “cancer of women” when discussing self-examinations and mammograms. Sadly, when Pakistani women are diagnosed with breast cancer, they often refrain from sharing the information with their families, even their husbands. The word “breast” is associated with sexuality, not health. Furthermore, many consider undergoing a medical screening to be immoral. The study therefore breaks new ground particularly due to the fact that very little research has been done at the Meridian Hospital in particular and in East Africa in general on cultural taboos. This hospital receives patients from all over the East Africa region. The investigation benefits many people among them, the medical practitioners; so as to understand the difficulties some of their patients and the friends or relatives who accompany them face in trying to explain to them their ailments. Most of these arise due to cultural taboos, where for instance a patient with a sensitive ailment might not wish to let the relative or friend accompanying him or her to know about it. The case might be that a daughter or a son has accompanied a parent of a different gender. For interpreters, patients, their relatives and other stake holders such as policy makers, the research will make them adjust the way they handle cultural taboos.

1.3 Statement of the Problem

Interpretation in various fields requires the interpreter to be well versed with the terminology or technical terms used. Interpreters play a key role in the medical field especially with the continuous discoveries of new diseases and medicines and how there are taken by different people from different cultural backgrounds. For instance, a doctor attending to a patient is not

certain that the patient understands perfectly what is being said and the prescribed medicine is what the patient requires. Cultural taboos inhibit free and candid speech. There are possibilities that some patients might not express themselves openly in an intimidating setting like the hospital. Others might feel uneasy talking about the type of disease that is afflicting them .Some may refuse to be examined by medical staff of opposite gender. My research question therefore is: how would appropriate sensitization of interpreters in the medical field effectively equip them with skills to enable them adequately interpret patients' conditions involving cultural taboos so that diagnosis and subsequent treatment is appropriate?

No empirical study has been carried out to determine cultural taboos as a factor of interpretation in the medical field at the Meridian Hospital This gap in research is bridged with this study investigating cultural taboos in interpreting. The findings are of importance as it makes the work of medical practitioners easier especially where culturally bound words are involved.

1.4 Research Questions

The following research questions guided the research process:

1. What are the common cultural taboos encountered during medical interpretation at the Meridian Hospital?

2. How do the interpreters overcome these cultural taboos encountered in the course of their work at the Meridian Hospital?

3. What can be done to make medical interpreting more effective at the Meridian Hospital?

1.5 Objectives of the Study.

The general objective of this study was to investigate cultural taboos that hinder effective interpretation in the medical field.

The specific objectives were;

1. To determine how cultural taboos affect effective interpretation in the medical field.
2. To show how both trained and untrained interpreters deal with cultural taboos.
3. To investigate whether there are medical interpreters sensitive to cultural taboos in the medical field.
4. To determine whether there is miscommunication between patients and health care providers.

1.6 Hypotheses of the Study

The following are the hypotheses of the study:

1. Cultural taboos hinder effective communication in the medical field.
2. Untrained medical interpreters are unable to deal with cultural taboos.
3. The training of medical interpreters with cultural sensitivity can lead to effective interpretation of various terms and diseases in the medical field.

1.7 Scope of the Study

The study mainly focused on cultural taboos as a factor of interpretation in the medical field. The study focused on community interpretation and specifically on the medical interpretation, at the Meridian Hospital which is in a cosmopolitan city, the patients came from different backgrounds both linguistically and economically. The need for sensitivity to cultural

differences was observed. Some patients refused to be treated due to perceived stigma associated with their diseases.

1.8 Limitation of the Study

The study was limited to medical interpretation at the Meridian hospital. Further limitations were due to finances. This limited the researcher to a small area as it was not possible to cover more areas. The study was limited to a period of one month. The Skopos theory was the only theory that was used in the study.

1.9 Theoretical Framework

The study was guided by the following theory:

1.9.1 Skopos Theory

The study will apply the Skopos theory because it is a concept from the field of translation studies. It provides an insight into the nature of translation as a purposeful activity, which is directly applicable to every translation project. It was established by the German linguist Hans Vermeer and comprises the idea that translating and interpreting should primarily take into account the function of both the source text and target text. The function of translation depends on the knowledge, expectations, values and norms of the target reader, who are influenced by the situation they are in and the cultural context. Arising from this, German translation scholars like Reiss (1971) and Vermeer (1978) elevated the purpose which in Greek is Skopos or intended function of the target text to the top-ranking principle governing the process of translation, Vermeer argued that the end justified the means.

Reiss and Vermeer (1984:119) define translation and interpretation as a process of cultural transfer according to a set of hierarchical principles. They hold that the purpose to be fulfilled is largely constrained by the target culture recipients. Therefore, the target text must first and foremost conform to the standard of inter-textual coherence. This means that it must make sense within its communicative situation and culture. Inter textual coherence is therefore put in second place. In this functionalist conception, an interpreter is therefore judged not by the degree of equivalence with the original but the extent to which the target text functions as intended within its socio-cultural context.

Micaela Munoz-Calvo, (2010:2-3) affirms that translators need cultural literacy, communicative language competencies and socio-cultural competencies as well. There are thousands of cultural-bound terms deeply noted in culture. The main arguments against the possibility of translations are the linguistic ones. However promoters of translatability such as Mary Snell-Hornby (1995) remarks rely on the relationship between reality and thought in favor of the former.

The interpreter in the medical field must of essence be an expert in socio-cultural issues of the two languages used more so, if he or she has to interpret cultural taboos or taboo words .A patient is served better if he or she gets the services not as interpreter equivalence but as a communicative event. Ascertaining the function of an original speech or its interpretation should not be limited to the analysis of the text but can and must rely on the socio-psychological data and dynamics of the situation of interaction.

In the Skopos theory, the crucial standard to be met is the degree to which an interpretation is coherent. This means the interpretation is supposed to be understandable, interpretable and

meaningful within its particular situational context in a given target cultural environment. The communicative patterns and expectations within a given culture play a key role in determining whether an interpretation is deemed sufficiently coherent. Chesterman (1996:31) stresses the naturalness of the interpreter's output in the target language. An interpretation should sound like an original rendition; at its best when listeners forget that they are listening to an interpreter rather than the original speaker.

A simultaneous interpretation is expected to be of the communicative rather than semantic, overt rather than covert or instrumental rather than documentary type. The target text would need to be as conventional, that is acceptable, appropriate, informative, and correct and marked and so on by target-cultural standards as the source text within the communicative traditions of the source culture. It is generally expected that a given culture is essentially different from rather than similar to another culture.

Therefore the target text in the source interpretation should be adapted to the communicative patterns text type conventions generally accepted for native texts in the culture in question. I have borrowed from the Skopos Theory (the tenets of the skopos rule, the coherence rule and the fidelity rule) to illustrate in my study how interpreters with cultural sensitivity should assist patients and service providers in effective communication. This would be easier in medical interpretation which is mostly consecutive interpretation where the interpreter listens to a rendition, understands it, decodes it then renders the same to in the Target Language.

1.10 Literature review

1.10.1 Cultural taboos and effective interpretation in the medical field.

The Oxford Advanced Learners Dictionary defines taboo as a cultural or religious custom that does not allow people to do, use or talks about a particular thing as people find it offensive or embarrassing. Tylor's (1871:11) definition of culture includes "knowledge, belief, art, morals, law, customs and any other capabilities and habits acquired by man as a member of society". Culture in a standard view is defined as a complex set of shared beliefs, values and concepts which orient groups to make sense of the world and that is made of the implicit (informal) and explicit(formal).

Critics have identified in this definition various shortcomings that affect the way culture is often perceived in academic settings. Culture seems, in fact, acquired in a process of enculturation, where culture is perceived as a basic text to learn and personalize. It has been noted that nowadays the term "culture" is often included in adversarial and controversial contexts: "culture clash", "culture conflict" and at a different level "culture shock" (Ibid :55) retaining therefore a fairly negative connotation. The concept of "culture shock" that has been widely used in the late 20th century to refer to emotional and intellectual unease in front of unfamiliar meanings and practices could probably best fit intercultural communication in health care settings. In fact, even if potential conflicts on the basis of disagreement over cultural values may arise, intercultural medical interactions are often characterized on a less blatant level, by misunderstandings, is communication that are often concealed or left unspoken. This is another reason why medical interpreters' role in mediating between different perceptions of illness and disease, life and death issues, may reveal itself to be crucial to the successful outcome of cross-cultural medical encounters.

Critics of intercultural communication studies argue that three major difficulties in the field lie in the fact that firstly, their focus is "on problems and difficulties and so "culture" or what we might call the "cultural principle" is used. Therefore, culture is seen as assuming a negative connotation in intercultural studies (ibid.). While assuming that one must be careful in ascribing miscommunication in intercultural settings to a mere list of cultural explanations, that may perpetuate stereotypical views of some cultures and that other crucial theoretical contributions, such as social studies, should be applied in the study of cross-cultural settings, it must be argued that studies in intercultural health care contexts aim at finding possible solutions to achieve mutually shared understanding.

Kaufert and Putsch (1998:513) point out that "the literature about communication has emphasized language and culture as "barriers". However, the discussion of the medical interpreter's roles in health care settings and the proposals of medical anthropology and other social branches to apply a more sensitive and integrative approach between biomedical care and alternative views of illness and healing are all directed towards resolutions that may satisfy both providers and patients expectations. Resistance on the side of biomedical practitioners to accommodate alternative therapies or views on illness and treatment or patients and family's firm supporting of their beliefs led sometimes to dramatic consequences in the most serious cases.

Talking systems and politeness markers must be taken into account when interpreting in cross-cultural settings. In fact, lack of pragmatic, more than linguistic, equivalency represents a deep concern in dealing with some cultures. For instance, in Australian Aboriginal English, "mother" is also "mother's sister", an indication of the fluidity and continuity in aboriginal

kinship 62 systems (Kaufert and Putsch 1998:186). At the linguistic level, many so-called traditional cultures rely more than western cultures on the use of metaphors as descriptive tools of symptoms and illness experiences (Kaufert and Putsch 1998:191). Metaphors are linguistic modes that are highly culture-bound in their communicative and pragmatic effect and they therefore need to be contextualized to be correctly understood and interpreted. More generally, cross-cultural differences in communication modes in health care settings may arise when delicate or even taboo issues such as suicide, contraception, abortion, sexually transmitted diseases, impotence, stigmatized diseases such as leprosy, TB or in some countries even cancer (Kaufert and Putsch 1998:190) must be dealt with. Also organ transplants and blood transfusions are considered violations of cultural beliefs in some cultures.

Besides, description of pain level highly differs from culture to culture, as well as conceptualization over relationships between body, self and culture. Putsch and Joyce (1990:1055) propose a problem orientation model that adapts clinical methods in biomedical practice to cross-cultural care. They argue indeed that biomedical practitioners must consider both biological evidences and illness experiences of patients and their families, in an integrative approach where a patient's individual and cultural values are taken into account not only in determining the nature of his or her problems but also in prescribing solutions. This means that also the use of alternative healing practices must not be disdained by biomedical professionals, but discussed and negotiated together with patients and their families.

As the authors point out, views of "what's wrong" are not universally determined, and often biomedical care does not seem to realize that their orientation is culturally shaped too and

being in a dominant position confronted with minority cultures members, they often run the risk of introducing bias and providing a unilateral and ethnocentric approach. Patients' views are often overlooked as invalid concerns by biomedical professionals, who, relying on their professional, formal knowledge, usually think to be the only ones, who can make sensible medical decisions. Symptoms and life disruptions may call into play either biomedical or popular models of problem-solving or both of them. It is not unusual to find out that, not only minority cultures members, but also other westerners recurred to biomedicine, religion and alternative healing practices to deal with illness (Putsch and Joyce 1990:1056).

In the Kenyan context, herbal medicine is gaining ground and is a much cheaper alternative to Western medicine. Patients for example suffering from prostate cancer would have a medical intervention then go for herbal medicine during the management period rather than go for chemotherapy which is expensive. The role of the interpreter would be to explain this to the doctor using the terminology that the doctor would understand because the herbal terminology might not be understood by the doctor.

1.10.2 Trained interpreters with sensitivity to cultural taboos are more effective.

Flores et al., 2003, say language barriers in the health care industry can lead to misdiagnosis, deferment of care, avoidance of needed services and inconsistency in visits with the risk of errors in health services increasing; there is a greater risk of liability for organization (Flores et al., 2003). For these reasons, the medical profession and civil rights advocates have stressed the need for professional medical interpreters in health care settings in which patients have limited skills.

In the medical profession, interpreters are vital simply because they assist in the communication between the patient and health service providers. Their roles and

responsibilities require them to act as a language and cultural broker in real-time conversation between patient and doctor (Schapira et al., 2008:586-588).

Additionally, Karliner, Perez-Stable and Gildengorin, (2004:175-178) argue that the presence of an interpreter in the medical visit can help decrease the disparity in quality of care and health care access for patients with Limited English Proficiency (LEP). This would be similar to the Kenyan situation, where most patients from the greater East African region (Burundi, Somalia and Ethiopia) or rural areas in Kenya do not necessarily speak English or Kiswahili, the most usual languages of communication in the Kenyan medical field. Good patient-health provider communication is important to ensure quality care and service to all who have healthcare needs. When there are barriers to the communication process between providers and patients, the breakdown can be detrimental to the quality of care, resulting in negative consequences. For doctors serving patients of diverse backgrounds it is essential that they attempt to communicate with sensitivity to cultural and linguistic differences in order to provide the best care possible. Medical interpreters assist in bridging the gap in patient-provider communication. The communication problems that exist between patients and providers do not only involve the exchange of words. Cross-cultural variations contribute to communication and perception differences that greatly impact the patient-provider relationship.

Hudelson, 2004, stated that there are three main areas where patients and providers are likely to differ and these are included:

(i) Cultural beliefs regarding the expectations of roles

(ii) Communication styles

(iii) Perceptions about health and ideas about medicine.

Understanding these differences can help providers be proactive about medical visits. For instance among the Maasai of Kenya, a woman is not expected to speak in the company of men. Should she be accompanied by a male relative to the hospital and have a gynecological problem, this would cause problems due the cultural perceptions of the role a man plays as spokesman. This situation would be further compounded if the interpreter is of male gender. A female interpreter would be better placed to assist the woman in question. However a well trained male interpreter would still perform a professional duty effectively especially if he is well versed with the cultural taboos that make the female patient appear disadvantaged.

1.10.3 Differences in perceptions of the patient's health problem.

Patients may have different beliefs and perceptions from that of the health provider about what causes their illnesses (see example above). Often patients are diagnosed in their home countries and cultures in systems that vary greatly from where they come from. Traditional healers and spiritually related treatment methods are often used. They may approach health and healing very differently than the western model. Problems between patients and providers often arise due to these differing opinions. Interpreters can serve as cultural liaisons and can help explain the differences in perception to the provider and patient. This is especially helpful in situations where certain diagnoses, such as tuberculosis or psychological problems, are highly stigmatized (Hudelson, 2004:311-316). An interpreter's work as a cultural broker is extremely valuable in the treatment planning stage of the medical encounter as they can provide much needed understanding about illness and medications.

1.10.4. Different expectations of the clinical visit.

Hudelson(2004) states that patients may have different expectations of the medical experience depending on where they come from. Some patients may approach Western

medicine with caution and cynicism, believing that the doctor may not be trustworthy. Others may believe that every visit should be absolutely comprehensive, including all lab work, and that the doctor should be in an authoritative role. When faced with a visit that isn't this way patients may believe they are not getting quality service. In these, interpreters can explain the role of the doctor, the goals for the visit and help patients to understand the culture of Western medicine. This helps both the provider and patient in improving the quality and effectiveness of the visit. A doctor who requests a patient's consent to carry out a certain procedure in the Kenyan context may seem in the patient's eyes not to be competent. A request to perform a Caesarian section on a patient needs her consent. She may not necessarily understand this and easily conclude that the medical practitioner is incompetent. An interpreter with cultural knowledge could clarify this for the patient.

1.10.5. Differing communication styles

Cross-cultural communication may be one of the biggest barriers to quality health service. Non-verbal communication, such as gestures and eye contact, can often be interpreted differently in different cultures, causing confusion in the visit. Interpreters can help the provider to understand what may or may not be offensive to certain patients. Another challenge to communication is differences in styles. Medical terminology often doesn't exist in other languages the way it does in English (Hudelson, 2004). Finding ways to express and understand these differences often creates challenges in the medical encounter. Interpreters can bridge these differences by presenting information to each party in a way that is culturally appropriate yet meets the medical standards presented by the provider. It is clear that the cross-cultural differences faced by many providers working with Limited English Proficiency (LEP) patients can lead to communication problems. Medical interpreters serve as a very

important cultural adviser in the medical encounter and can greatly improve the quality of health care for patients with Limited English proficiency.

The response of any society to challenges of sickness is based on its own beliefs and practices. This response in many cases in most developing countries is irrespective of one's educational background or standing in the society. Illness or any form of disease is mainly looked upon as a breakdown in harmony between an individual and his invisible environment or between him and his creator or between him and his ancestors or his enemies (Garber 2000: 54). Illness in these areas therefore is regarded strictly as a misfortune or a curse rather than a health problem.

Taboos may be somehow ambiguous. They may involve a prohibition of certain activities that are not directly spelled out in the formulation of a taboo. For example, among the Luhya community there is a taboo against shaking hand with one's mother-in-law. What was implied in such a taboo was avoidance of any close contact with mother-in-law, which would involve such activities as sitting next to her or embracing her. What was insinuated in that taboo was commonly understood by the members of the tribe? Taboos served as the foundation for laws that were most specific and universal (Garber 2000: 54). Interpreters should be able to understand the taboos in order to correctly interpret information given by patients to the medical practitioners.

Landy (1977: 78) states that medical translation risks apply to more than just patient care. Any part of the medical industry that exchanges information over a cultural or linguistic border is in danger of mistranslation. The Journal of Operations Management published a study that analyzed the difference in quality between drugs produced in the US mainland and

drugs produced in Puerto Rico by the same company. The primary differences were in culture, language and values.

The contribution of cultural studies to the analysis of health care settings consists in the recognition that medicine is a product or part of culture, a concept that has been widely overlooked by social scientists and biomedical professionals, who were prone to consider it as an objective, rational body of scientific knowledge (Carr et al 1997: 56). "Science teaches us that human populations are governed by biological universals that transcend cultural boundaries" however, the construction of meanings about the world, including conceptualizations concerning medicine, illness and disease are deeply shaped by interaction with cultural background, personal experience and discussions with others (Hale 2007:173). Hale further argues that medicine, health care, illness and doctor-patient relationship are all practices and interactions that do not take place in social or cultural vacuums and need therefore, theoretical and methodological tools of research based on sociological and cultural frameworks. Brunnet et al (2003: 271) confirm in their cross-cultural care studies, that Western medicine represents indeed "a subculture with its own history, language, codes of conduct, expectations, methods, technologies, and concerns about the science which supports it", with the result that the gulf between biomedical practitioners and the lay public has dramatically widened.

Hale (2007: 178), asserts that the contribution of cultural studies to the analysis of health care settings consists in the recognition that medicine is a product or part of culture, a concept that has been widely overlooked by social scientists and biomedical professionals, who were prone to consider it as an objective, rational body of scientific knowledge. (Garber 2000: 276). Kaufert and Putsch point out that "the literature about communication has emphasized

language and culture as “barriers” (1998:513). However, the discussion of the medical interpreter’s roles in health care settings and the proposals of medical anthropology and other social branches to apply a more sensitive and integrative approach between biomedical care and alternative views of illness and healing are all directed towards resolutions that may satisfy both providers and patients expectations. In spite of this call for a sensitization in cross-cultural settings, the reality of some case studies in the experience of the authors has evidenced that complex situations could not be resolved simply adopting a more culturally sensitive approach or informing both professionals and patients and families on discrepant cultural beliefs.

Patients may have a different belief about where their illness comes from than that of the provider. Often patients are diagnosed in their home countries and cultures in systems that vary greatly from where they come from. Traditional healers and spiritually related treatment methods are often used and approach health and healing very differently than the western model. Problems between patients and providers often arise due to these differing opinions. Interpreters can serve as cultural liaisons and can help explain the differences in perception to the provider and patient. This is especially helpful in situations where certain diagnoses, such as tuberculosis or psychological problems, are highly stigmatized.

Flores et al (2003) give examples of clinical errors made by untrained interpreters. They included:

(i) Omitting questions about drug allergies

(ii) Omitting questions and remarks about past medical history

(iii) Adding instructions about treatment planning that physicians did not include

(iv) Answering questions for the patient without asking the patient.

1.11 Research methodology

The study was carried out in the Meridian Hospital Ongata Rongai, Kajiado County. The study employed descriptive and correlation design. Descriptive method research design involves the collection of information without changing the environment. The descriptive method was found to be appropriate for the study because it enabled the collection of data from large sample, which is a requirement for data collection at one point in time about opinion or phenomena. The study design was used since the researcher just collected the data in the hospital but did not take any action to advice or comment on the way things were carried out in the hospital to the staff available. The study design was used in checking the relationship of various cultural taboos displayed by people who visited Meridian hospital. The correlation design was also advantageous because it allowed the collection of data of two or more variables on the same group of subjects and computing a correlation coefficient

The population of interest was the staff of Meridian Hospital in four leading departments. The focus was on four main departments which are frequently visited by patients from different cultures, Consultation department, Laboratory department, Ultra sound department and Dental department.

1.11.1 Data collection, procedures and instruments

Both quantitative and qualitative data was obtained for this study by use of self-administered questionnaires with closed and open ended questions to solicit the response on related problems. The questionnaires were pre-tested by sending a sample of four questionnaires to the Meridian Hospital to measure its validity. After the pre-test, the final questions were drawn and administered to the target population. The researcher assured the respondents that

the information provided was for academic purposes only. The questionnaire was divided into the following sections: General information, cultural taboos, trained interpreters, untrained interpreters and training of medical interpreters with sensitivity to culture.

1.11.2 Data Analysis.

After data collection, the questionnaire was coded then data entered into the computer for analysis. The Statistical Package for Social Sciences (SPSS) version 12.0 was used to process and analyze data. Data was subsequently cleaned and edited, synthesized according to emerging issues, variables and the objectives of the study. Qualitative and quantitative data were collected from the respondents. Qualitative data was used in describing the various aspects of the study and in drawing conclusions and recommendations. Quantitative data was analyzed using both descriptive and inferential statistics. Descriptive statistics was used in calculating frequencies, means, and percentages. This enabled the researcher to describe distribution of scores of measurements using a few indices or statistics. The purpose of inferential statistics enabled the researcher to generalize the results from the sample to the population. The inferential statistics used in this study was Pearson-Product Moment Correlation, Means, frequencies, and percentages were used to analyze all the variables to meet the objectives of the study. Data was edited and analyzed using descriptive statistics which included frequency distribution and percentages. Data was presented in tables, percentages and charts.

1.12 Rationale of the Study

The study generated useful knowledge to different categories of people, ranging from medical practitioners, interpreters (both professional and freelance), patients, relatives of patients and students in the field of interpretation since it enabled them to appreciate cultural taboos when dealing with medical interpretation. Doctors and other medical practitioners shall see the need and indeed the importance of having trained interpreters and also be able to appreciate the important role played by these interpreters. The study also recommended that trained and untrained or freelance interpreters should be sensitized on the role they play as mediators in the doctor-patient situations and appreciate the fact that their role is very complicated and could have serious ramifications especially on moral and ethical issues, thus the need to be as professional as possible. The study also generated knowledge for patients on their part to be careful in giving and receiving information through third parties as their very own lives may as well be entirely dependent on these interpreters.

Insights were also obtained in so far as cultural taboos are concerned. Much as most of what is referred to as taboo words are connected to culture, there was need to demystify some of these words because some communities have been held hostage by ignorance. With technological advancement in the medical field, better diagnosis of diseases was expected and more challenges for the interpreters were envisaged. Although Kenya is a hub for the East African region, as far as medical tourism is concerned. Many patients from this region- Uganda, Burundi, Rwanda, Somalia, Sudan access medical care in Kenyan hospitals, yet many of these countries have a very different culture from the Kenyan one. This fact makes the study of interpretation of cultural taboos very necessary. Many do not speak English or Kiswahili, so the cultural taboos emanating from their cultures will not be understood. Since

most of the studies in this area have been carried out in Western European and American contexts, there is a pressing need to address this in the Kenyan context, so that patients from the greater E.A. region access quality healthcare that is not hampered by the lack of /mistranslation due to cultural taboos. Some of the challenges of these studies include; doctors-trained in Western healthcare vs minorities-used to traditional healing/spiritual dimension. There is need for redefinition because in Kenyan context it is the opposite. Western type medicine is mainly accessible in urban areas/cities. Majority of Kenyans first resort to witchdoctors/herbal medicine because the latter is expensive. Redefining the doctor-patient relationship, require the use of interpreters with cultural knowledge.

CHAPTER TWO

DATA OF CULTURAL TABOOS

2.1 Introduction

This chapter is on cultural taboos data that was collected at the Meridian Hospital Ongata Rongai, Kajiado County. It includes diseases and health terminologies which were found to be interpreted wrongly at the Meridian Hospital. The terms are grouped into various categories that are encountered during interpretation at the hospital. Some taboo words were never mentioned due to the fact that they are culturally taboo bound while people from different cultural backgrounds viewed them differently. Some diseases were thought to be brought about by curses and the patients were uncomfortable discussing them. Patients and family members feared the stigma associated with these diseases and conditions and therefore rarely sought medical attention.

2.2 Taboo words

The following are taboo words that are culturally bound, their Kiswahili translation and how they were rendered at the hospital. The main reasons for the variance between the Kiswahili translation and how they were rendered by the interpreter were either linguistic deficiencies or the need to avoid mentioning them directly and instead either using euphemisms or paraphrasing. The interpreter had to use the wealth of cultural experience to bridge the linguistic gap that constantly appeared when these terms were spoken. It is due to the presence of the interpreter that sound diagnosis was done and thus averting a near fatal situation that could arise out of miscommunication.

Table 1 Taboo words

ENGLISH	KISWAHILI	MERIDIAN INTERPRETATION
Mental patient	Mgonjwa wa akili	Mwendawazimu
Leutic	-a kaswende	Ugonjwa wa ngono
Catatonic	Kitatonia	Wenda wazimu wa kuzimia
Genitalia	Manena	Sehemu ya siri ya uzazi
Genital herpes	Tutuko za manena	Ugonjwa wa sehemu za siri
Genital sore	Kidonda cha manena	Kidonda katika sehemu za siri
Anal	-a mkundu	Nyuma
Promiscuous	-a ufuska/-a ukware	Umalaya
Vaginal	-a uke	Sehemu ya siri ya uzazi
Moron	Buzyuu	Aliye na upungufu wa akili/mjinga
Feaces	Choo	Mavi
Vaginal wart	Chunjua	Vipele kwenye sehemu ya uzazi
Drool	Dovuo	Kutokwa na ute mdomoni
Frigid	Hanithi/enye baridi	Baridi/asiyeweza kufanya ngono
Gynecology	Ginakolojia	Uchunguzi wa sehemu za siri
Menstruation	Hedhi	Kwenda mwezini
Fertility medicine	Hoto	Dawa ya kuongeza rutuba ya uzazi.
Hermaphrodite	Huntha	Mtu aliye na sehemu mbili za uzazi.
Sex organ	Kia cha uzazi	Chombo cha uzazi
Handicap	Kilema	Ulemavu
Carcinogen	Kisababisha kensa	Hali iletayo kensa
Gonorrhea	Kisonono	Ugonjwa wa ngono
Intra-uterine-devise	Kitanzi	Chombo cha kuzuia uzazi
Spermicide	Kiuavinyiriri	Dawa ya kuua mbegu za uzazi
Contraceptive	Kizuia mimba	Dawa ya kupanga uzazi
Menopose	Komahedhi	Kutopata hedhi
Coitus	Kujamiiana	Kufanya mapenzi

2.3 Diseases that are taken as Taboo

The table below shows diseases and health terminologies in English and Kiswahili language and the way they were rendered at the Meridian Hospital. They are culturally bound and cause difficulties to render directly. An interpreter who is sensitive to these words would use figurative language to render them[1]. I shall illustrate using the following diseases: lupus, hemophilia and HIV-AIDS.

Table 2 Taboo diseases

Dementia	Kichaa	Kuwa na kichaa
Cerebral palsy	Taahira	Ugonjwa wa ubongo
Syphilis	Kaswende	Ugonjwa wa ngono
Cancer	Saratani	Kensa
Blood pressure	Shinikizo la damu	Ugonjwa wa presha
Venereal disease	Ugonjwa wa ngono	Ugonjwa wa ngono
Leukemia	Lukemia	Kensa ya damu
Fistula	Nasuri	Fistula
Leprosy	Ukoma	Ukoma
Vaginal thrush	Kuvu uke	Ugonjwa wa sehemu ya uzazi

It can be noticed that the interpretation of these diseases was mostly paraphrased or euphemisms were used. This at times led to misdiagnosis because some of the interpretation was not accurate. For example ‘ugonjwa wa ngono’ was a very general term.

[1] The use of figurative language will not be analyzed in this project.

Table 3 Body parts that are Taboo

Most of these words had to be paraphrased.

Penis	Dhakari/Mboo	Mboro
Rectum	Mgoro	Sehemu karibu na mkundu
Vagina	Kuma	Uke
Scrotum	Kende	Kifuko cha mbegu ya uzazi
Cervix	Shingouteresi	Mlango wa mfuko wa uzazi
Clitoris	Kinembe/Kisimi	Sehemu ya uke
Anus	Mkundu	Nyuma
Vulva	Vulva	Vulva

CHAPTER THREE

ANALYSIS OF TABOO DISEASES AND INTERVENTIONS

In this chapter, I will discuss some of these diseases and conditions to illustrate what information an interpreter needs to understand from a medical point of view in order to be able to interpret accurately to a patient and dispel any myths about them being curses. Some diseases are taboo because people are ignorant of the symptoms. Others are medical interventions which people reject due to ignorance for example, family planning and vasectomy.

3.1 Lupus

This is a chronic auto-immune disease that can affect any part of the body. It occurs when the body immune response attacks healthy tissues in the body's organs. Its symptoms are wide and varied and it can therefore mimic many different diseases making diagnosis difficult. It affects several organs including the heart, joints, skins, lungs, blood vessels, liver, kidneys and the nervous system. The typical age group that is affected is between 15 to 35 years. It is more common in women than in men, at the ratio of 9:1 and also affects black people more than any other race. The severity is unpredictable with some patients experiencing mild benign disease while others have severe forms. It is also characterized by flare-ups of the disease, alternating with remission.

Symptoms of lupus

These vary from patient to patient experiencing joint pains and swelling, common symptoms include chest pains when taking a deep breath, fatigue and generally feeling unwell. Other symptoms are fever, hair loss, mouth sores, swollen lymph nodes, skin sensitivity to sunlight

and a “butterfly” rash over the cheeks and bridges of the nose that get worse in sunlight. Other symptoms include headache, numbness, convulsions, vision problems, personality change, abdominal pain, nausea and vomiting, abnormal heart rhythm, coughing blood and difficulties in breathing and patchy skin color or fingers that change color when cold.

Diagnosis

Diagnosis can be complex due to the myriad symptoms that patients can present. Diagnosis must therefore begin with a detailed medical history and a thorough examination, followed by laboratory tests. Testing for lupus includes immunological tests as well as ECG or the heart and chest x-ray and x-ray of the joints. Laboratory tests must include a complete blood count, kidney function test and urinalysis.

Lupus may develop some complications that include kidney failure, heart failure, blood clots, recurrent miscarriages, blood disorders, stroke and blood vessel disease .A patient suffering from lupus may become depressed and feel stigmatized by society. An interpreter in such a scenario would have to more than just the knowledge of the disease and how it presents but must also have cultural knowledge about how it is understood by the community. If it is seen as a curse he has to be able to convince a patient that the detailed medical history and thorough laboratory tests are necessary. Some of the complications arising from lupus such as kidney failure, heart failure or recurrent miscarriages are often seen as arising due to a curse. An interpreter with cultural knowledge can give the correct medical explanation.

3.2 Hemophilia

This is a bleeding disorder that slows the clotting of blood. This is usually as a result of the blood not clotting in order to stop the bleeding. When a person has hemophilia his or her

blood does not clot normally. Even minor injuries can result in severe bleeding .This can lead to injuries to internal organs, loss of blood or irreversible damage to the joints or muscles. Hemophilia occurs in about one out of 5000 males.

3.3 HIV in Kenya

The 2012 Kenya Aids Indicator Survey (KAIS) that surveyed nearly 14000 women and men and 4000 children showed that half of the persons infected with HIV knew they had HIV. However, they were not accessing HIV care and treatment that could prolong their lives and prevent them from infecting others. 7 out 10 people had been tested for HIV at least once in their lifetime. In Kenya, all government health facilities offer free HIV testing and counseling. Only 35% of persons who visited a health facility in the last 12 months offered to take a HIV test. For a long time HIV AIDS was perceived as a curse and patients carried the stigma associated with it. Most of them could not go for testing or access medication. They believed that it could be cured by sleeping with a virgin.

Mental health disorders can be costly to treat, and in addition, carry a stigma in many African cultures. Factors that have characterized mental health in Kenya include the following:

i. Poor or limited allocation of financial resources for mental health.
ii. Lack of an operational mental health policy- it is still in draft form.
iii. Violation of human rights of people with mental illness.
iv. High levels of psycho-trauma as a result of gender- based violence and sporadic politically instigated violence.
v. Inadequate human resources who are inequitably distributed with a bias for urban areas.
vi. Other competing priorities of acute medical conditions for example HIV/AIDS and

malaria.

vii. Low mental health literacy in the communities.

viii. Low selection rate of mental health as a profession.

With all these factors playing a role in mental health a medical interpreter must be very well trained in order to interpret correctly so that a mentally ill patient is neither stigmatized nor sent to a mental institution.

In Kenya, organizations such as Schizophrenia Association of Kenya and Africa Mental Health Foundation have been formed to help the less fortunate in society in getting quality treatment. Schizophrenia is a Latin word meaning 'split –mind'. It is a collection of serious brain abnormalities in which a person interprets reality abnormally. It may cause a combination of delusions, hallucinations and disordered thinking behavior. It is caused by both genetics and the environment. The risk factors that appear to trigger or increase the risk of developing schizophrenia include family history of schizophrenia, stressful life situations, older paternal age, exposure to viruses, toxins or lack of proper nutrition while in the womb and taking psychoactive drugs during adolescence or in young adulthood. This disease is common in children and people above the age of forty five years.

With schizophrenia, there is the fear of being labeled 'mad', thus causing stigma to the patient, relatives and friends. Psychological therapy and medication can help manage the situation. Hospitalization may be required to guarantee safety, adequate sleep, proper nutrition and basic hygiene. Diabetes is another disease that may cause stigma and trauma. Unhealthy diets are linked to top risk factors that cause premature death such as high blood pressure, high cholesterol, overweight and obesity and high blood sugar that is commonly seen in diabetes. Fat around the stomach can significantly impact on blood pressure, blood

cholesterol levels and interfere with the ability to use insulin effectively. Body Mass Index (BMI) and stomach circumference are two standardized methods of measuring ones cardiovascular risk. When people get fatter, the risk of developing type 2 diabetes and high blood pressure significantly rises. Obese people suffer some stigma and trauma. Dr. Cory Couillard writing in the Daily Nation of October 1, 2013 states that statistics show that 58% of diabetes and 21% of ischemic heart diseases can be attributed to a BMI above 21. In children, physical, inactivity contributes to increased risk of heart disease and stroke. Smoking also produces inflammation and damages the lining of blood vessels and increases blood clots and strokes.

Another disease that can lead to one being stigmatized is cancer. Patients suffering from cancer require treatment and management. There are cultural taboos attached to cancer. This is because most cancers are inherited. The symptoms of cancer are diverse depending on the location of the cancer, the size of the tumor and where it is spread. Lymphoma initially exhibits through swelling in the neck, groin or underarms. To diagnose lymphoma, a doctor has to do a complete physical examination including a personal and family medical background. This includes examining some taboo areas or asking taboo questions to the embarrassment of the patient, relatives and friends. The medical interpreter is therefore called upon in such cases to explain the necessity of such examinations and the course of treatment.

Many cultures around the world have developed false beliefs regarding albinism. Albinism is a defect of melanin production that results in little or no color in the skin, hair and eyes. The lack of the pigment that blocks ultraviolet radiation increases the risk of skin cancer. Albinos may also have crossed eyes, light sensitivity, rapid eye movements and functional blindness.

Albinos often face social and cultural challenges, threats, ridicule, discrimination or violence. In Tanzania and Burundi there have been increased cases witchcraft- related killings of albino people because their body parts are used in potions sold by witchdoctors. In Zimbabwe, there is increased HIV infection and rape following a very harmful and false belief that sex with an albino woman would cure a man of HIV. These acts of discrimination, stigma and harm are compounded when the patients have to seek medical assistance. Children born with deformities and twins have been abandoned or killed because they were considered a curse in some African cultures. Grey hair is seen as a sign of ageing. When it appears prematurely for example in the ages between twenty and forty, it could be a medical condition. This could include conditions like vertigo and thyroid diseases which alter the melanin pigment. People who grow grey hair tend to fear visiting doctors as it is stigmatizing. Perhaps the disease that carries the highest stigma is HIV AIDS.A high percentage of HIV positive pregnant women do not attend the mandatory antenatal visits or deliver ion health facilities. The consequence of this is the mother to child infection.

In Kenya, a Ministry of Health report indicates that there are 40,000 traditional herbal practitioners who treat about 2,000 patients annually. The common diseases treated are similar to those treated at government facilities. The major challenges include the diminishing availability of herbs to prepare medicines, lack of facilities for clinics and storage and of equipment to process medicines, non-payment, low level of cooperation with government and officials, low levels of training or skills and competition with quacks. Seventy per cent of people in developing countries rely on traditional herbal medicines. In a country where the doctor-to-patient ratio is15 to 100,000 the need for interpreters to work closely as cultural intermediaries is great. All pharmacists are sufficiently knowledgeable in traditional medicine because it is a mandatory subject in all their undergraduate training in most universities

around the world. However few of them take interest in practicing it because of the stigma that goes with it. This is despite the fact that WHO officially recognized traditional medicine in 2002.

In his Inaugural lecture at the University of Nairobi in 2012, Professor Julius Wanjohi Mwangi said that for a long time herbal remedies had been referred to as alternative treatment but the WHO refer to them as complementary medicines. He asserts that in the past people did not tell their doctors that besides Western medicine they also took herbs. The two do not compete negatively. The interpreter therefore would be required to explain to the doctor about this situation especially to the benefit of patients who feel intimidated by hospital environments and would wish to try allopathic medicine.

The examples of the diseases mentioned above present challenges to the interpreter because in some communities, these are accompanied by stigma and some patients would prefer herbal treatment to western medicine. The interpreter must therefore use his or her cultural experience and linguistic competence to be an intermediary and convey the message to the patients about the need to seek treatment and allay the fears associated with such situations.

3.4 Taboos brought about by ignorance

It is always good to have accurate and professional interpretation in health care area though sometimes this is overlooked as discussed above. Professional interpretation may prevent a lot of damage to the patients or clients. An example of a cultural taboo area that is often misunderstood is in the family planning method of vasectomy. In 2010 a survey by Dr. Charles Ochieng alongside a team of experts from the Nyanza based Winam Safe Parenthood Initiative (WSPI) found that men from the region who were approached to undergo the

procedure rejected it on various grounds, none of which had scientific proof. Some rejected it because it was not part of their culture. Others feared it might affect their virility, while others saw it as a form of castration. Dr. Ochieng states that nearly 95% of the country's healthcare workers are ignorant of vasectomy while less than 5% of the remaining specialists offer the service. An interpreter equipped with knowledge of the Luo culture would explain to these people the importance of this procedure and help in popularizing this as a family planning method without being inhibited by the taboo associated with it.

From this we find that if cultural taboos are not overcome, there are some misconceptions that result, in this case, a good family planning method is discarded whereas it can be effective. It was also noted that even the government tends to direct most of its aid to HIV/ Aids programs. The doctor advised that the government should support male-friendly family planning programs to help debunk the myths surrounding the use of contraceptives as well as clarify their benefits and effects on the psychology of the users. This is why the government should involve interpreters sensitized in cultural taboos so that such misconceptions do not hinder such interventions.

Due to the cultural beliefs associated with this family planning procedure, the country has fewer than ten specialists who can conduct the surgery. Those who do it in private clinics charge about KES.150,000 which is beyond the means of many ordinary people. A person who had undergone the procedure explained that it took him seven years to get a specialist who could perform the operation. He said that he started by visiting a gynecologist who referred him to urologists, saying that they only dealt with women. On visiting the urologists, he was told that they only dealt with problems of the urinary tract and not family planning. Due to his persistence, he was able to have the simple medical procedure carried out on him.

The family was relieved in this case because the wife no longer had to use injections and implants which had brought about complications during the birth of their second child. The wife had suffered abdominal pain, severe headaches, heavy bleeding and almost had a miscarriage. The husband reported that since the operation, his wife had led a healthy, stress-free life.

Another case in Kakamega County is cited where a father of seven insisted that he could not go under the scalpel because he feared that he would become a "lesser man". He feared that his community would mock him. He was also apprehensive that it was risky especially if ones children died. He argued that vasectomy could lead men into extra – marital affairs which could end up breaking up their families.

The above cases show how cultural taboos could hinder family planning. Some women who were interviewed on the issue of vasectomy also opposed it claiming that it was a permanent method and feared that it made men lose their ego. This is despite the fact that the World Health Organization (WHO) has endorsed it as an effective measure in checking population growth in developing countries. A recent Kenya Demographic Health survey (KDHS) report estimated that 48.2% of married men in Kenya had no clue what vasectomy was. Dr. Ochieng argued that this could be increased through public awareness campaigns and also training of more health practitioners and equipping health facilities. This would also be helped more if interpreters sensitive in cultural taboos are also available in these health facilities to help in debunking the myths surrounding vasectomy.

These examples from the Kenyan context show the importance of having trained interpreters who are sensitive to cultural taboos in order to make people understand the importance and

the effect of certain interventions in the society. Interpreting includes other non-verbal cues as well. There is strong gender bias in a certain community that discouraged women from speaking in public (Tebbe, 2003: 75). Neither the doctor nor the interpreter want to alienate the patients and therefore make diagnosis and treatment more difficult, so it's important for them to be aware of these kinds of considerations.

CHAPTER FOUR

RESEARCH FINDINGS

4.1 Introduction.

This chapter presents and discusses the findings of this study based on the objectives and research questions formulated in items 1.4 and 1.5 in Chapter One. The chapter contains findings from specific data analysis procedure. It begins with findings from descriptive statistical analysis mainly frequencies and percentages based on the variables of the study. The latter part of the chapter deals with the tests/cross tabulations using inferential statistical procedures, specifically Pearson Product Moment Correlation. Attempts have been made to discuss the results of this study as they relate to other findings

4.2 Purpose and Scope

The purpose of the data analysis was to analyze the cultural taboos that hinder effective interpretation at Meridian Hospital. The researcher was to identify how trained and untrained interpreters handled them and whether the training of medical interpreters with sensitivity to culture helps in interpretation.

4.3 Demographic Characteristics of Respondents

There were 35 patients drawn from the four main departments in Meridian Hospital as indicated in chapter 1.11 Group characteristics that featured in the study as intervening variables included overall feedback rate, gender of the respondent, work experience, level of education, (dis)satisfaction of patient encountered, and miscommunication between patients and health providers.

Table 4 Target population (Source:Researcher 2013)

Departments	**Population/Frequency**	**Percentage (%)**
Consultation	5	50
Laboratory	1	10
Ultra sound	2	20
Dental	2	20
Total	10	100

Table 5 Sampling design

Department	**Population**	**Sample**	
	Frequency	Ratio	Size
Consultation	50	0.16	8
Laboratory	15	0.3	5
Ultra sound	20	0.85	17
Dental	15	0.3	5
Total	**100**		**35**

Source: Researcher 2013

4.3.1 Analysis of Response Rate

A total of 35 questionnaires were administered in the four main departments. All questionnaires were returned in useful form, coded and analyzed. The overall response rate was 100% as presented in table 5 below.

Table 6 Overall Response Rate

Department	No of Questionnaires	No. Returned	Response Rate
Consultancy	8	8	23%
Laboratory	5	5	14%
Ultra sound	17	17	49%
Dental	5	5	14%
Total	35	35	100

Source: Researcher 2013

4.3.2 Response Rate by Gender

The sample compared 71% and 29% of male and female respectively as tabulated in the table below.

Table 7 Gender of Respondents

Gender	Frequency	Percentage %
Male	25	71
Female	10	29
Total	35	100

Source: Researcher 2013

This can be presented in the pie chart as shown below.

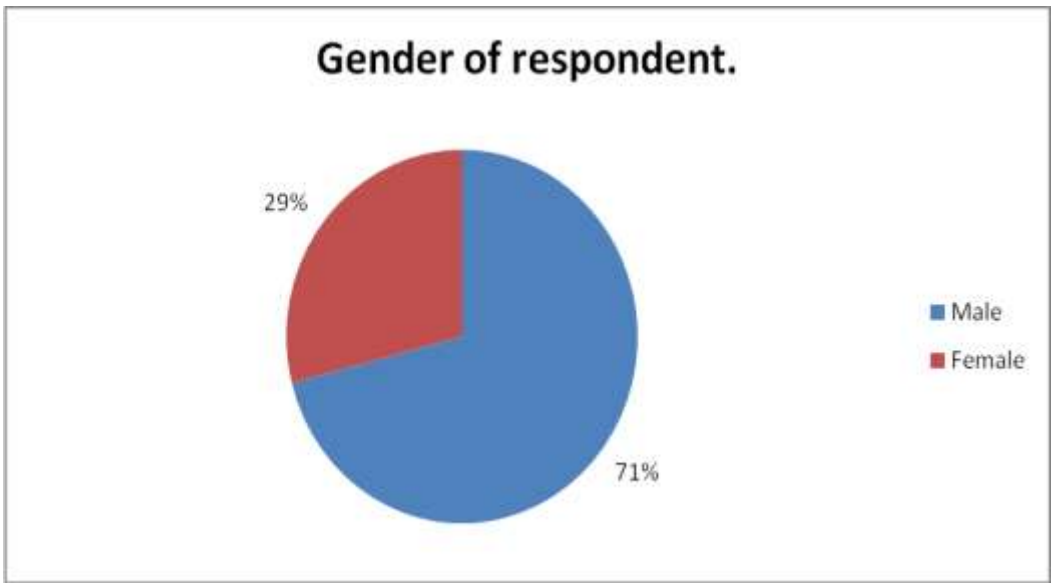


Fig. 1 Gender of respondent (Source: Researcher 2013)

4.3.3 Response Rate by Work Experience

In terms of the level of respondent's work experience, majority indicated to have experience between 5 years and above. This means they were able to carry out interpretation fairly at the Meridian hospital.

Table 8 Response Rate by Work Experience (Source: Researcher 2013)

Variable	*Frequency*	*%*
0-5	8	23%
5-10	11	31%
10-15.	10	29%
15<	6	17%
Total	35	100%

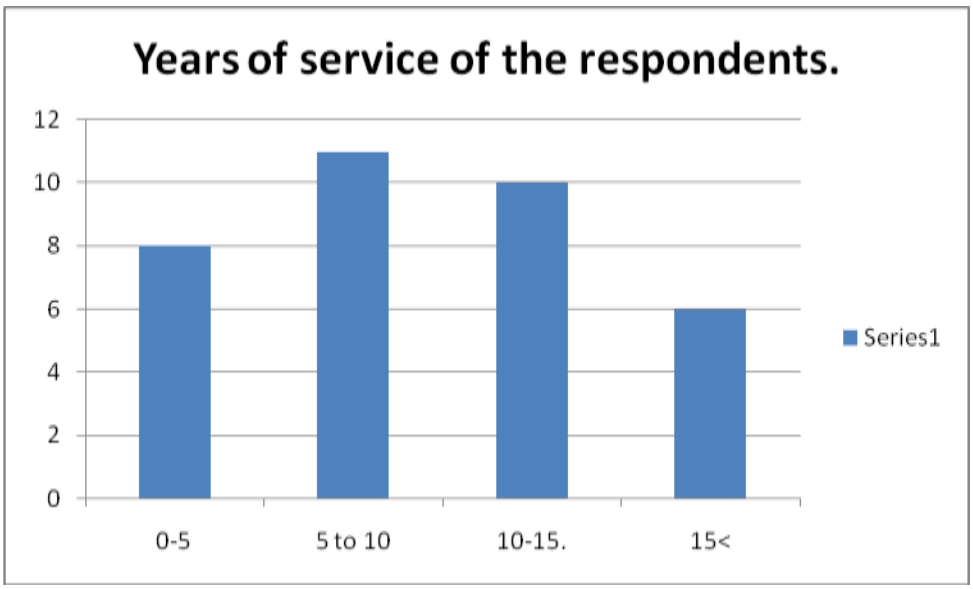


Fig 2 Years of service (Source: Researcher 2013)

4.3.4 Response by Education Level

In reference to level of education, majority of the respondents indicated to have secondary education and above. The low levels of education definitely affect quality of interpretation. See the table shown.

Table 9 Level of education of respondents

Level of Education	Frequency	%
Secondary	6	17%
University	10	29%
Post graduate	15	43%
Others	4	11%
Total	35	100%

(Source: Researcher 2013)

4.3.5 Overall Opinion on visitation by opposite gender doctor

The respondents were asked if patients refused to be attended to by opposite sex doctors or younger doctors and the majority of respondents (73%) said yes and 11% of respondents said no and the rest were not sure, that is 16%.They were also asked if male patients preferred male doctors especially when they had urinary tract and sexual organ infections. There was need to tell them that it was okay to be seen by any doctor or specialist.

Table 10 Overall Opinion on visitation by doctor of different gender

Opinion	Frequency	Percentage %
Yes	26	74%
No	3	9%
Not Sure	6	17%
Total	35	100

(Source: Researcher 2013)

4.3.6 Dissatisfaction of patient's clinical encounter

The respondents were asked whether or not there were situations where patients were visibly dissatisfied by their clinical encounter and the majority, that is 70% of respondents said no and 30% of respondents said yes. This means that generally the way diagnosis or medical information was given was insensitive and blunt in manner. Statement like "you have 6 months to live" and other explanations that give a death sentence cause anger to patients and this should not happen at all.

Table 11 Dissatisfaction of patient's clinical encounter

Opinion	Frequency	Percentage %
Male	10	29%
Female	25	71%
Total	35	100

Source: Researcher 2013

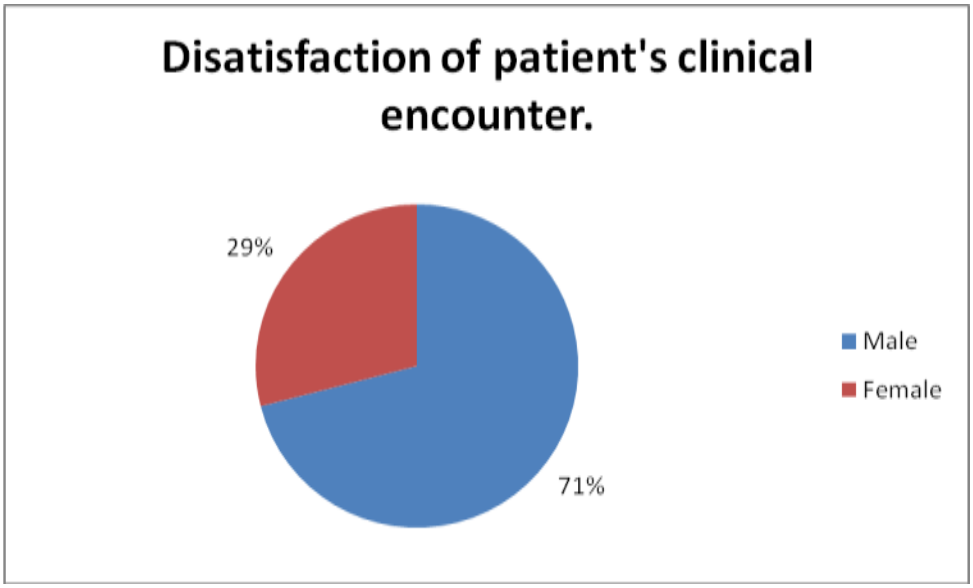


Fig. 3 Dissatisfaction with patient's clinical encounter (Source: Researcher 2013)

4.4 Miscommunication between patients and health care providers

The respondents were asked if they ever experienced a breakdown in communication between patients and the health care providers due to cultural differences such as different

perceptions of causes of illness, symptoms and so on. Majority of respondents, 71% answered in the affirmative and 17% said no and 12% were not sure. This means generally, there's continuing awareness of cultural beliefs and practices and the miscommunication is not always between patients and doctors.

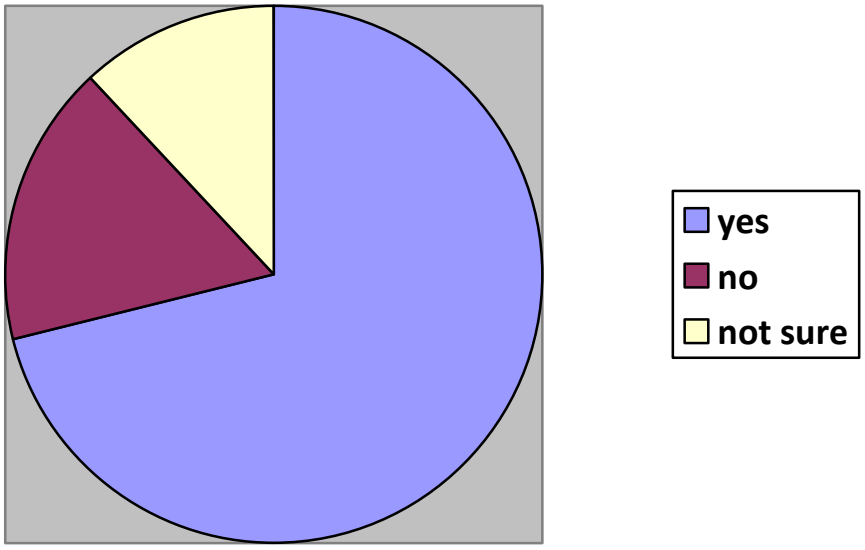
Table 12 Miscommunication between Patients and health care provider

Opinion	**Frequency**	**Percentage %**
Yes	25	71%
No	6	17%
Not Sure	4	12%
Total	35	100

(Source: Researcher 2013)

It can further be shown in the pie chart as displayed below

Fig 4 Miscommunication between patients and health care giver



(Source: Researcher 2013)

4.5 Overall Opinion on Effective Interpretation

The respondents were asked to give their opinion on if they thought Meridian Hospital had good interpreters and the majority indicated that they had fair interpreters of 60%, 20 % indicated not sure and 20% said they had no interpreters.

See the chart below.

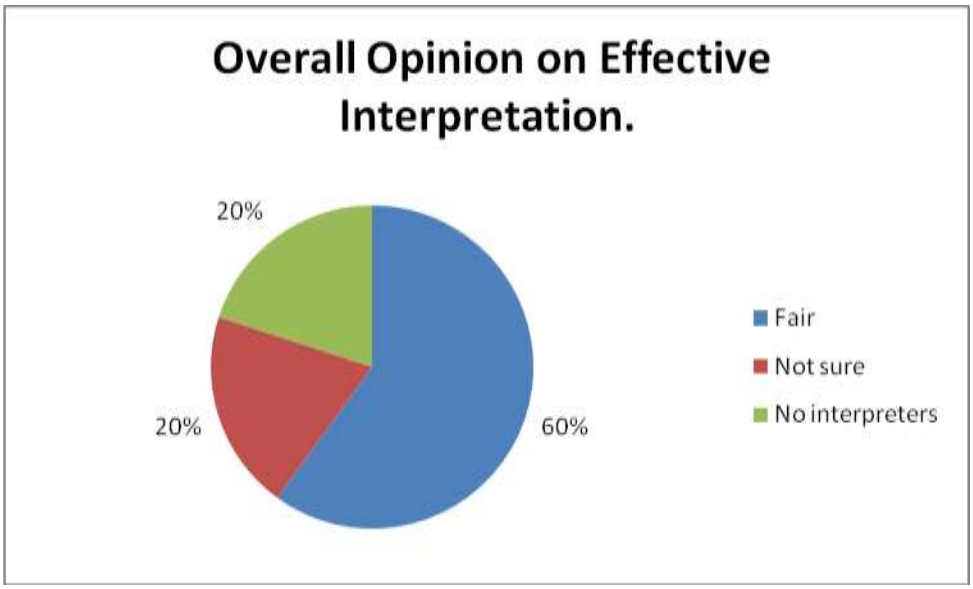


Fig 5 Overall opinions on effective interpretation

4.6 Extent of the Effectiveness of interpreters on cultural taboos

The respondents in a scale of great (5) to low (1) were asked what they thought about the effectiveness of interpretation program in the hospital. Majority of respondents indicated 51%, 29% great and moderate respectively, whereas 20% indicated the interpretation program were low. This information is tabulated in the table 13 as shown.

Table 13 Effectiveness of interpretation.

Variable	Frequency	%
Low	7	20%
Moderate	10	29%
Great	18	51%
Total	35	100%

(Source: Researcher 2013)

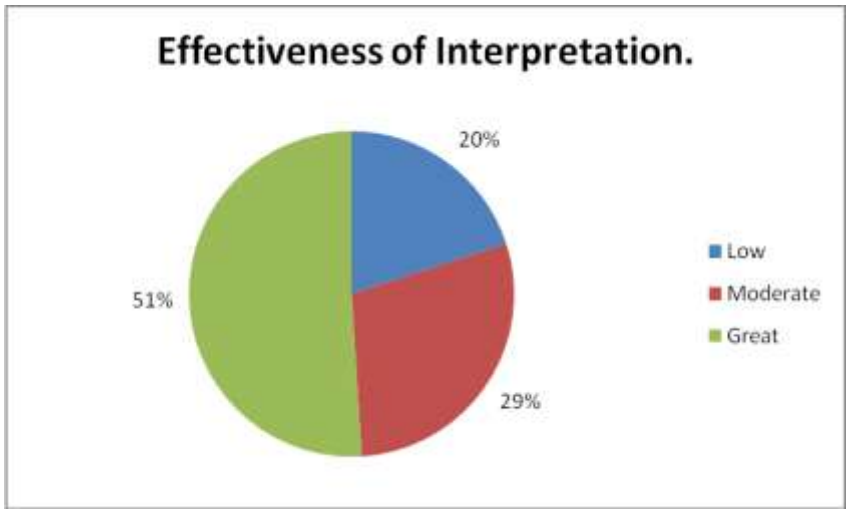


Fig. 6 Effectiveness of interpretation

4.7 Training Interpreters with sensitivity to cultural taboos.

The respondents were asked whether training interpreters with sensitivity to cultural taboos would make interpreters more effective and the majority 80% of respondents answered in the affirmative whereas 14% and 6% of the respondents answered no and not sure respectively. This means that generally the staff appreciates the training of the interpreters. The results are tabulated in table below.

Table 14 Training Interpreters with sensitivity to cultural taboos.

Category	Frequency	Percentage %
Yes	28	80
No	5	14
Not sure	2	6
Total	35	100

(Source: Researcher 2013)

4.8 Presence of Medical Interpreters of cultural taboos in the medical field.

The respondents were asked if the medical interpreters in medical visits could help decrease the disparity in quality of care and majority 89% of the respondents said yes whereas 9% and 3% of the respondents said no and not sure respectively. This means that generally the staff appreciates the presence of Medical interpreters. See the table tabulated below.

Table 15 Presence of Medical Interpreters

Category	Frequency	Percentage %
Yes	31	89
No	3	9
Not sure	1	3
Total	35	100

(Source: Researcher 2013)

Table 16 Presence of Medical Interpreters

Category	Frequency	Percentage %
Yes	33	94
No	2	6
Total	35	100

Source: Researcher 2013

4.9 Extent of how untrained interpreters deals with cultural taboos

The respondents were asked on the extent of untrained interpreters at Meridian hospital in the scale of very high (5) and very low (1) majority 40% of the respondents indicated high and 11 % indicated very high. The rest indicated fairly high and low with 26% and 23% respectively. This means there's a problem with the hospital as training of interpreters is not given enough attention.

The result is tabulated below:

Table 17 Extent of untrained interpreters

Scale category	Frequency	Percentage %
High	14	40
Fairly high	9	26
Low	8	23
Very high	4	11
Total	35	100

(Source: Researcher 2013)

4.10 Cultural Taboos affect Interpretation

The respondents were asked whether cultural taboos affect effective interpretation at Meridian Hospital and the majority 80% of the respondents said less frequent and 14% said frequent and 6% said fairly frequent. This means that there is a problem at Meridian Hospital because the medical staff is not conversant with interpretation. The result is tabulated in the table shown.

Table 18 Cultural Taboos affect Interpretation

Variable	Frequency	Percentage %
Less frequent	28	80
Frequent	5	14
Fairly frequent	2	6
Total	35	100

(Source: Researcher 2013)

4.11 Professional Interpretation

The respondents were asked whether having accurate and professional interpreters can prevent a lot of damage to the patients and majority 86% of respondents said yes and only 14% of respondents said no, none of the respondents was unsure.

Table 19 Professional Interpretation

Option	Frequency	Percentage %
Yes	30	86
No	5	14
Total	35	100

(Source: Researcher 2013)

CHAPTER FIVE

SUMMARY, RECOMMENDATIONS AND CONCLUSION

5.1 Introduction

The chapter gives the summary of the study, how it was conducted, the key findings and the objectives that were attained. It also includes the implications the study is likely to have on the interpretation of cultural taboo as a factor of interpretation in medical field and the recommendations towards improvement. Finally, it provides the various gaps identified in the study that may require further investigations

5.2 Summary of Findings

There were four questions raised namely; cultural taboos, trained and untrained interpreters and trained medical interpreters and whether they affected interpretation.60% of the respondents did agree they had good interpreters at Meridian Hospital with 20% disagreeing and 20% were not sure. However on the extent of the effectiveness of interpreters on cultural taboos, 51% of respondents agreed that they had effective interpreters, while 29% were moderate, and the rest, 20% indicated they had less effective interpreters.

5.2.1 Cultural Taboos affect Interpreters

Most respondents agreed that cultural taboos affect interpretation at Meridian hospital. As to whether the cultural taboos existed, the majority of respondents, 80% indicated they did not exist. As to whether a cultural taboo was well understood, 14% of respondents indicated they were well understood and 6% indicated they were fairly understood.

5.2.2 Training Interpreters

On whether training of interpreters affected interpretation, 80% of the respondents indicated that it affected interpretation. However, only 14% disagreed with the assertion and 6% indicated that they were not sure whether it affected interpretation. On whether the medical staff was well trained to carry out interpretation at Meridian hospital, 61% said yes and 39% said no.

5.2.3 Untrained Interpreters

94% of the respondents agreed that untrained interpreters affect quality of interpretation, whereas 5% of respondent said no. As to the extent of untrained interpreters, 40 % and 23% of respondents indicated high and low respectively, while 26 % indicated fairly high and only 11 % indicated very high.

5.2.4 Medical interpreters

89% of the respondents agreed that medical interpreters are vital to the Meridian Hospital for they help decrease disparity in quality of care whereas 9% negated and 3% were not sure.

5.3 Conclusions

The study showed that Meridian Hospital has interpreters in place. The study also revealed that these interpreters are important for interpretation session. However, these interpreters are not that effective as 20% were of the opinion that the interpreters are either moderate or low.

5.3.1 Cultural Taboos Affect effective Interpretation.

Cultural taboos do affect effective interpretation at Meridian Hospital. However, on the extent to which the cultural taboos are effectively interpreted, 14% responded frequent and 6% responded fairly frequent.

5.4 Recommendations

5.4.1 Training Interpreters

Trained interpreters with sensitivity to cultural taboos make interpretation more effective. Language barriers in the health care industry can lead to misdiagnosis, deferment of care, avoidance of needed services and inconsistency in visits with risks of errors in health services. Therefore in conclusion, we recommend that trained interpreters that are sensitive to cultural taboos should be used in the medical field to enhance effective communication. With this training, they will interpret culturally taboo bound words especially diseases and body parts effectively.

References

Brunnet et al (2003) The Critical Link 3.Amsterdam: John Benjamins

Carr, Roberts, R., S. E., Abraham, D. and Dufour, A. (eds.) (2000) The Critical Link 2.

Flores, G. et al (2003) Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters. PubMed.

Flores, G. (2006) "Language Barriers to Health Care in The United States." New England Journal of Medicine

Garber, N. (2000) "Community Interpretation: A Personal View" in The Critical Link 2.

Guo Ziblin (1994) "Health, medicine, and beliefs: Chinese American elderly in a developing multicultural urban community". *Doctoral Dissertations.* Paper AA195256666

Hale, S. (2007) Community Interpreting, Hampshire, Palgrave Macmillan

Health and the Development of a Three The Critical Link 3.Interpreters in the Community, Amsterdam/ Philadelphia, John Benjamins Publishing company

Health care" in The Critical Link 4: Professionalization of Interpreting in the Community, Amsterdam/Philadelphia, John Benjamins Publishing Company

http://digitalcommons.uconn.edu/dissertations/AA195256666

http://www.pbs.org/indiancountry/challenges/navajo.html [last accessed 27/12/09]

Hudleson, P. (2004) "Improving Patient-Provider Communication. Insights from Interpreters" Family Practice

Interpreters in the Community, Amsterdam/Philadelphia, John Benjamins Publishing Company

Interpreters in the Community, Amsterdam/Philadelphia, John Benjamins Publishing Company

Interpreters in the Community, Amsterdam/Philadelphia, John Benjamins Publishing

Karkner, et al (2004) The Challenges of Understanding and Eliminating Racial and Ethnic Disparities in Health. Journal of General Internal Medicine.

Kaufert, J. M., Putsch, R.W. (1997) "Communication Through Interpreters in Healthcare: Ethical Dilemma as Arising from Differences in Class, Culture, Language and Power" in The Journal of Clinical Ethics, Volume 8, Number 1

Kaufert, J., (1999) "Cultural mediation in cancer diagnosis and end of life decision -making: the experience of Aboriginal patients in Canada" in Anthropology & Medicine, Vol.6. No.3,

Kaufert, J., Koolage, W.W. (1984) "Role conflict among Culture brokers: the experience of Native Canadian Medical Interpreters" in Social Science Medicine Vol. 18, No.3, Great Britain.

Kaufert, J., O'Neil, J. D., (1998) "Culture, Power and Informed Consent: The Impact of Aboriginal Health Interpreters on Decision-Making" in Coburn, D., D'Arcy, C., Torrance, G., Health and Canadian Society: Sociological Perspectives. Third Edition, University of Toronto Press, Toronto Buffalo London

Kaufert, J. Lavallée, M. Koolage, W.W. O'Neil, J. (1996) Culture and Informed Consent: The Role of Aboriginal Interpreters in Patient Advocacy in Urban Hospitals" in Issues in the North, Volume1

Landy, D. (1977) Culture, Disease and Healing. Studies in Medical Anthropology. Macmillan Publishing Co., Inc., New York; Collier Macmillan Publishers, London.

Landy, D. (1977) Culture, Disease and Healing. Studies in Medical Anthropology,

Learned. Challenges in interpreting diabetes concepts in the Navajo language", [last

Link 3. Interpreters in the Community, Amsterdam/ Philadelphia,, John Benjamins

Macmillan Publishing Co., Inc., New York; Collier Macmillan Publishers, London.

Munoz-Calvo, M. Buesa-Gomec, c. ed. (2010). Translation and cultural identity- selected essay on translation and cross cultural communication. London: Cambridge Scholarly Publishers.

Newmark, P.(1988). Textbook of Translation. Oxford Pergamon Press.

Nida, E A (1964). Towards a science of translation, with special reference to principles and procedures involved in the Bible translation. Leiden: EF. Bill.

Putsch,R.W.& Joyce, M.(1990) Dealing with Patients from other Cultures. In H.K. Walker, W.D.Hall &J.W.Hurst. Clinical Methods. London. Bitterworth Publishers

Reiss, K. and H. Vermeer (1984). Groundwork for a General Theory Translation. Tubingen: Niemeyer.

Schapira, et al (2008) "Lost in Translation: Integrating Medical Interpreters into the Multidisciplinary Team." The Oncologist.

Snell-Hornby, M. (1995). Translation studies : An integrated Approach . Amsterdam: John Benjamins BV.

Tebbe, H. (2003) "Training Doctors to Work Effectively with Interpreters" in The Critical Link Angelelli, C., Agger -Gupta, N., Green, C.E., Okahara, L. (2007), "The California Standards for Healthcare Interpreters. Ethical principles, protocols and guidance on roles and intervention in The Critical Link 4. Professionalization of Interpreting in the Community, Amsterdam/Philadelphia, John Benjamins Publishing Company

Tebbe, H. (2003) “Training Doctors to Work Effectively with Interpreters” in The Critical Link 3. Interpreters in the Community, Amsterdam/ Philadelphia, John Benjamins Publishing Company

The Critical Link 1. Interpreters in the community, Amsterdam/Philadelphia, John Benjamins Publishing Company

Turner, G.H. (2007) “Professionalization of interpreting with the community. Refining model” in The Critical Link 4. Professionalization of Interpreting in the Community Amsterdam/Philadelphia, John Benjamins Publishing Company

Tylor, E.B. (1871) Primitive Culture: Researches into the Development of Mythology, Philosophy, Religion, Language, Art and Custom. London John Murray.Albemarle Street

URL: http://care.diabetesjournals.org/content/26/6/1913.full McCabe, M., Morgan, F.,

URL: http://care.diabetesjournals.org/content/28/6/1534.2.full, McCabe, M., Gohdes, D, Morgan

URL: http://hospitals.unm.edu/language/documents/ncihc.pdf [last accessed 05/12/09]

URL: http://navajopeople.org/navajo-legends.htm [last accessed: 04/01/10]

URL: http://tde.sagepub.com/cgi/content/abstract/32/5/714 McCabe, M., Gohdes, D.,

URL: http://www.context.org/ICLIB/IC38/Yazzie.htmChief Justice Yazzie, R.

URL: http://www.ihs.gov/index.cfm[last accessed: 08/01/10]

URL: http://www.ihs.gov/PublicInfo/PublicAffairs/Welcome_Info/IHSintro.asp [last accessed: 08/01/10]

URL: http://www.legendsofamerica.com/NA-NavajoLongWalk.html[last accessed: 07/01/10]

URL: http://www.navajo.org/history.htm [last accessed: 07/01/10]

URL: http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=cm&part=A6682 Putsch, R.

URL: http://www.pbs.org/indiancountry/challenges/trauma.html [last accessed 27/12/09]

URL: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1495335Carrese, J.A.,

URL: http://www.umass.edu/legal/derrico/navajo_childhood.html, Peter D'Errico (2009)

URL: www.ncichc.com[last accessed 05/12/09]

Vermeer, H.J. (2000) Skopos and commission in translational action: in L Venuti (ed.), The translation studies reader. London: Routledge.

Joyce, M., (1990) "Methodology in Cross-Cultural Care. The Disease-Illness Dichotomy"

Wade, D., (2001) Healing ways. Navajo Health Care in the Twentieth Century, University of New Mexico Press

Wamitila, K. W (2013) Kamusi ya Istilahi Mbalimbali. Vide Muwa Publishers Ltd

Wanjohi, J.M (2012) Herbal Medicines: Do they really work?-Inaugural Lecture.

Witherspoon, G. (1977) Language and Art in the Navajo Universe , Ann Arbor, The University of Michigan Press

Wolfe, W. S., (1994) "Dietary change among the Navajo: implications for diabetes" in Diabetes as a Disease of Civilization: the Impact of Culture Change on Indigenous Peoples by Joe, J.R. and Young, R. S. Eds.

APPENDIX: TABOO WORDS, DISEASES, DRUGS, CONDITIONS AND BODY PARTS.

ENGLISH	**KISWAHILI**	**MERIDIAN INTERPRETATION**
Veneral diseases	Magonjwa ya ngono	Magonjwa ya kufanya mapenzi
Manic depressive	Mania sonona	Upweke
Scrotal hernia	Mshipa wa ngiri	Ugonjwa wa makende
Umbilical hernia	Ngiri ya kitovu	Ugonjwa wa kitovu
Leukemia	Leukemia	Kensa ya damu
Elephantiasis of scrotum	Kibuyu	Kuvimba makende
Gynaecologist	mgandamano	Daktari wa wanawake
Vaginism	Mkachouke	Hali ya sehemu ya siri ya mwanamke
Aphrodisiac	Mkuyati	Dawa ya kuongeza nguvu wakati wa kufanya mapenzi.
Female homosexual/lesbian	Msagaji	Shoga wa kike
Gay/male homosexual	Mlawiti	Shoga wa kiume
Perineum	Msamba	Sehemu ya mkundu
Libido	Nyege	Msisimko wa kutaka kufanya mapenzi
Abortion	Mwavyo	Kutoa mtoto kabla siku zake
Infuse	Oama	Kutoa mtoto kwa kuwekea dawa mwilini mwa mzazi
Masturbation	Punyeto	Kucheza na sehemu za kufanyia mapenzi/kujiamsha
Seminal fluids	Shahawa	Maji ya uzazi
Cervix	Shingouterasi	Mlango wa mfuko wa uzazi
Indurate	Shupaza	Kukauka kwa ngozi
Ejaculate	Shusha	Kumwaga mbegu za uzazi
Erect	Simika	Kusimama
Sanitary towel	Sodo	Taulo za wanawake
Obstetrics	Taaluma ya ukunga	Ujuzi wa uzalishaji

Circumcise	Tahiri	Kukata ngozi ya mbele ya mboro
Excreta	Takamwili	Uchafu utokao mwilini
Tampon	Tampuni	Pamba ya wanawake
Sterile	Tasa	Mwanamke asiyeweza kupata mtoto
Obese	Tipwatipwa	Kunenepa mwili kupita kiasi
Clitodectomy	Tohara ya mwanamke	Ukeketaji/kukata sehemu ya uzazi ya mwanamke
Palpate	Tomasa	Kufinya tumbo kukagua kama mwanamke ameshika mimba
Eunuch	Towashi	Mume asiyeweza kuzalisha
Clone	Tumbusha	Kutengeneza sehemu ya mwanadamu kwenye lebu
Virginity	Ubikira	Mtu ambaye hajawahi kufanya mapenzi
Promiscuity	Ufuska	Umalaya
Impotence	Uhanithi	Asiyeweza kuzalisha
Miscarriage	Uharibikaji mimba	Kutoka kwa mtoto kabla siku zake
Endometrium	Ukutauteresi	Ukuta wa mfuko wa mimba
Dwarfism	Umbilikimo	Hali ya kuwa mfupi wa kimo
Euthanasia	Utanazia	Kuuwa mgonjwa asiyekuwa na matumaini ya kupona
Ovulation	Uvizaji	Kutoa mayai ya uzazi ya mwanamke
Contraception	Uzuiajimimba	Kuzuia kupata mimba
Senility	Uzulifu	Hali ya akili kutoimarika
Vulva	Vulva	Sehemu ya nje ya uzazi ya mwanamke
Dysmenorrhea/afterbirth	Zingizi	Kinachotoka tumboni baada ya mtoto kuzaliwa
Hereditary disease	Ugonjwa wa kurithi	Ugonjwa wa ukoo
Diabetes	Kisukari	Ugonjwa wa sukari
Ringworm	Baka	Minyoo

Arthritis	Bwiko	Ugonjwa wa kukosa nguvu kwenye mifupa
Blood pressure	Shinikizo la damu	Ugonjwa wa presha
Convulsion	Degedege/mfafaruko	Ugonjwa wa kukosa fahamu
Pneumonia	Kichomi	Ugonjwa wa kuvimba mapafu
Croop	Kifaduro	Ugonjwa unaosababisha ugumu wa kupumua
Scurvy	Kiseyeye	Ugonjwa wa kukosa vitamin c
Kwashiorkor	kwashokoo	Utapia mlo
Tonsillitis	mafindofindo	Kuvimba sehemu za mashavu
Athelete's foot	mamunyumunyu	Ugonjwa wa vidole vya miguu na nyayo
Acne	Chunusi/kipele	Ugonjwa wa kutoka vidonda kwenye uso
Allergic rhinitis	Mzio wa pua	Ugonjwa unaoathiri pua
Goiter	Kororo/rovu	Uvimbe kwenye shingo
Celebral palsy	Utaahira	Ugonjwa unaoathiri ubongo
Cold/influenza	Mafua	Homa
Dry dermatitis	Machugachuga	Kukauka wa ngozi
Elephantiasis	Mafyega	Uvimbe kwenye miguu
Neck lamp	Kikomwe	Kidonda kwenye shingo
Diptheria	Dondakuu	Kidonda
Croup	Kifaduro	Ugonjwa wa kikohozi kwa watoto

Appendix 2

The following words were not used at the meridian Hospital so I did not get the Meridian Interpretation.

ENGLISH	KISWAHILI
Rheumatism	Duwazi
Vertigo	Gumbizi
Measles	Hasuba
Gout	Jongo
Dieresis	Ugonjwa wa mkojo
Dermatitis	Uwati
Dysentery	Kuhara damu
Epilepsy	Kifafa
Lockjaw	Kachaya
Elephantiasis	Kitakasa/mgonzo
Migraine	Kipandauso
Marasmus	Upozajo
Leprosy	Ukoma
Plague	Tauni
Riverblindness	Usubi
Ringworm	Choa
Sclerosis	Mkacho seli
Scabies	Kipwepwe
Sinusitis	Uvimbebweta
Septicaemia	Uozadamu
Stroke	Kiharusi
Tetanus	Pepopunda
Rickets	Uyabisi
Yaws	Buba
Malnutrition	Utapiamlo/unyafuzi
Whooping cough/pertussis	Kifaduro
Hypoglcaemia(low blood sugar)	Begeo

Eczema/psoriasis	Kiba
Gastric ulcer	Mtuchi
Hypertension(high blood pressure)	Kilumwe
Trachoma	Tongo
Chronic fever	Kidingapopo
Nausea	Jelezi
Mycosis	Maradhikuvu
Threadworm	Mchangouzi
Neurosis	Nyurosisi
Hookworm	Safura
Eye swelling	Sekenene
Tapeworms	Tegu
Hysteria	Umanyeto
Jaundice	Umanjano
Erectile	-a kudusi
Infections	-a kuambukiza
Chronic	-a kudumu
Congenital idiot	Mjinga wa kuzaliwa
Nasal	-a pua
Empathetic	-a shirikali
Hygienic	-a siha
Aural	-a sikio
Toxic	-a sumu
Malignant	Enye kudhuru
Contaminate	Akidi
Anti-partum haemorrhage(apc)	Apiechi
Abnormal	Atilifu
Abnormal pregnancy	Ujauzito atilifu
Bulimia	Umero
False pregnancy	Kibuyumimba
Gangrene	Mti

Pancreatic juice	Maji ya kongosho
Pulmonary valve	Vali nya mapafu
Autonomic nervous system	Mfumo wa neva huria
Central nervous system	Mfumo mkuu wa neva
Anatomy	Anatomia
Rectum	Mgoro
Cranium	Fuu
Amnion	Chupa
Abdomen	Fumbatio

.

Bronchial	-a pafu
Microbal	-a vidubini
Viral	-a virusi
Preventive	Ya kinga
Morphine	Afyuni
Acarina	Akarina
Amenorrhoea	Amenoria
Amoeba	Amiba
Amylase	Amilesi
Androgen	Androgeni
Heterogeneous	Anuwai
Sputum	Balghamu
Coryza	Bombo
Food allergy	Mzio wa chakula
Inoculate	Chanja
Vaccine	Chanjo
Hiccup	Chechevu
Chromosome	Chembeuzi
Pimple	Chungu/chunusi
Obstetrician	Daktari mkunga
Serum	Damaji

Emaciated	Dhoofika
Dysphasia	Disifasia
Diagnose	Dodosa
Induce	Dukiza
Inject	Dunga
x-ray	Uyoka/eksrei
Immunology	Elimukinga
Psychology	Elimunafsi
Hygiene	Elimusiha
Epididymis	Epididimisi
Oestrogen	Estrojeni
Neurosis	Fadhaa
Latent	Fichu
Confabulation	Fidiamawazo
Antibody	Fingo
Antiseptic	Finya
Cartilage	Gegendu
Amputate	Guta
Microscope	Hadubini
Temperature	Hali joto
Temperament	Halitabia
Carbohydrates	Hamirojo
Emotion	Hemko
Emotive	Hemshi
Conceive	Himili
Intelligence quotient	Hisa weledi
Nausea	Jelezi
Grentia violet(GV)	Jivii
Cardiology	Kadiolojia
Catarrh/mucus	Kamasi
Catheter	Katheta
Organ	Kia

Bladder	Kibofu
Appendix	Kidoletumbo
Concussion	Kibondwa
Nausea	Kichefuchefu
Micro-organism	Kidubini
Nucleus	Kiiniseli
Foetus	Kijusi/kilenge
Epiglottis	Kilimi
Cataract	Kingo
Embryo	Kinitete
Contraceptive	Kinzamimba
Safe period	Kipindi salama
Umbilical cord	Kiungamwana
Skeleton	Kiunzi
Still birth	Kivoromoko
Diaphragm cap	Kiwambo
Hysteria	Kiwewe
Post-natal clinic	Kliniki ya wajawazito
Clone	Kloni
Ovarian hormones	Kokwa
Cholesterol	Kolesteroli
Senile	Kongwe
Scar	Kovu
Asphyxia	Kwamopumzi
Constipation	Kuvimbiwa
Blister	Lengelenge
Lymph	Limfu
Lymphadenopathy	Kuvimba tezi la limfu
Lipoma	Lipoma
Prescription	Maagizo
Minerals	Madini
Casualty	Majeruhi

Accoucheuse	Mamamkunga
Neuralgia	Hijabu
Hernia	Ngiri
Flatulence/dyspepsia	Riahi
Frunclulosis	Mbuba
Halitosis	Tombovu
Heartburn	Kiungulia
Kyphosis	Wembezi
Hydrocele	Busha
Herpes zoster	Mkanda wa jeshi
Mortality	Mauti
Iris	Mboni
Ascarid	Mchango
Rapture of muscles	Mchanuko wa misuli
Bone	Mfupa
Temporal bone	Mfupa wa tempula
Agglutination	Mgandamano
Arteriosclerosis	Mkakamoteri
Midwife	Mkunga
Balance diet	Mlo kamili
Stigma	Mnyanyapao
Heart specialist	Mtaalamu wa Maradhi ya moyo
Opthalmia	Mrajua
Drug addict	Mraibu wa dawa za kulevia
Laxative	Msahala/sanamaki
Bone marrow	Msukulo
Allergist	Mtaalamu wa mzio
Anaesthesist	Mtaaalamu wa unusukaputi
Collar bone	Mtulinga
Shin	Muundi
Tumor	Mvimbo

Fracture	Mvunjiko
Convalescent	Mwahueni
Asthenic	Mwembamba
Echolalia/echopraxia	Mwigotendo
Parasite	Ngurukia
Alimentary canal	Njia ya chakula
Premature baby	Njiti
Gallstone	Njivinyongo

Hallucination	Njovi
Chronic illness	Nyondenyonde
Neurology	Nyurolojia
Cyst	Nziba
Infuse	Oama
Pigment	Pigmenti
Breathlyser	Pimakileo
Altimeter	Pimakimo
Dehydrate	Pwea
Premolar	Sagego
Organic psychosis	Saikosisi ogania
Synthesize	Sanisi
Chronic	Sedeka
Protein	Protini
Progesterone	Projesteroni
Phagocyte	Selaji
Cell	Seli
Celebrum	Serebela
Intensive care	Uangalizi shadidi
Cytology	Sitolojia
Cytoplasm	Sitoplazimu
Lint	Sufu ya pamba
Nephrotoxic	Sumu figo

Endotoxin	Sumwilindani
Symptom	Dalili
Exotoxin	Sumwilinje
Psychotherapist	Tabibukalima
Occupational therapist	Tabibuliwaza
Pandemic	Tandavu
Sterilize	Tasisha
Mandible	Taya
Gland	Tezi
Ptyalin	Tialini
Acupuncture	Tibavitobo
Agomphious	Ubogoyo
Pregnancy	Ujauzito
Enuresis	Ufukunyungu
Mortuary	Ufuo
Orthopedics	Ufupaikaji
Resuscitation	Uhuishaji
Curettage	Ukwanguaji
Hospitalization	Ulazwaji
Lethargy	Ulegevu
Metabolism	Umetaboli
Oesophagus	Umio
Surgery	Upasuaji
Lactation	Unyonyashaji
Porosis	Upenyevu
Prevelance	Ushamiri
Drowsiness	Usinziaji
Inflammation	Uvimbeuchungu
Micronutrients	Virutubisho
Panacea	Utatuzi
Atrophy	Usinyaaji
Excretory organs	Vitoatakamwili