Vol. 8 No. 4 (1993, pp. 19-38)

Language, Videos and Family Planning in the South Pacific

By Margaret Winn and David Lucas *

** The authors of this article are Margaret Winn, Consultant on Reproductive Health and Development and Visiting Fellow, School of Medical Education, University of New South Wales, Sydney, and David Lucas, Fellow, Graduate Studies in Demography, National Centre for Development Studies, Australian National University, Canberra.* *They would like to acknowledge with gratitude the South Pacific women who spoke so frankly about this sensitive subject, and thank Family Planning Australia for supporting the project as well as the Australian International Development Assistance Bureau for providing the funding.*

Programme managers must be aware that language may be a substantial barrier to the diffusion of reproductive health knowledge

The provision of information, education and communication (IEC) on family planning has two major objectives: to inform people of the existence of family planning and to educate acceptors on the proper use of methods (Coeytaux and others, 1987). This article looks at the importance of language in IEC activities in the South Pacific, and particularly at the use of language in videos and the development of a lexicon of reproductive health terms in the Melanesian societies of Fiji and Papua New Guinea, and the Polynesian ones of Samoa and Tonga. It also looks at the need to involve community women in the development of an appropriate lexicon of reproductive health terms.

Watkins (1991:191), drawing on European research, suggested that linguistic, cultural and religious factors can influence the speed of the fertility decline in developing countries. Family Planning Australia's work in the South Pacific supports a view that the socio-cultural milieu, and the linguistic expression of it, have an important role to play in influencing family planning practice in countries at different stages of the demographic transition. In Papua New Guinea, there is little evidence of a decline in fertility, and contraceptive prevalence is low. In contrast, Fiji, Samoa and Tonga all have crude birth rates (CBRs) of 30 or less. (McMurray and Lucas, 1990).

Watkins (1991) commented that diffusion of fertility control involves copying behaviour, and can occur from person-to-person contact, as well as from a central source such as the media or family planning clinics. One view is that "linking mass-media approaches with face-to-face contact and readily available services may offer the most effective and efficient approach to increase use of family planning" (Church and Geller, 1989:2). Language is important in both contexts.

Apart from IEC, language is important in KAP (knowledge, attitudes and practice) studies (Ware, 1977). The assumption borrowed from family planning surveys is that knowledge of family planning is a pre-requisite of use. This is implicit in the questionnaire designs for two major series of sample surveys: the World Fertility Survey and the Demographic Health Survey. In both cases, respondents are asked if they have heard of a specific contraceptive method. Only if the answer is "yes" are they asked about use of that method.

Experience in family planning health promotion and education has shown that many factors contribute to contraceptive use, including logic, appeal, incentives and facilitation. Although knowledge about contraceptives and family planning is important, it is not enough to bring about initial contraceptive use or to maintain contraceptive practice.

Successful use of contraceptives requires more than knowledge, it requires talk and action (ESCAP 1974:25-45). Words are necessary to gain access to contraceptives. Clients have to discuss contraceptive method choice with community-based distributors, ask pharmacists for pills, and talk to health workers about sterilization. In addition the way health workers treat clients has an impact on clients' willingness to follow advice and return if they have problems (Liskin and others, 1989:27). A large part of the procedure of treating clients is tied up in communicating with them. Talk between health workers and clients must therefore be understood and acceptable.

Although some contraceptives such as injectables and IUDs can be used without the knowledge of, or discussion with, the male sexual partner, others such as the ovulation method, or natural family planning method, clearly require considerable communication. Successful use of barrier methods requires that sexual partners talk to one another and share responsibility for decision-making (Liskin and others, 1989:26). However, in Papua New Guinea only about half of the respondents in a 1979/80 survey stated that there was actual or possible communication between spouses on the subject of contraception (Agyei, 1988:109).

For a family planning message to be effective, it must be appropriate, that is, noticed, acceptable, believable, comprehensible and relevant. It must also be appropriate for the context in which it is used. It must suit the channel through which it is delivered, whether those channels be interpersonal, mass media or health service ones. The message must suit women's channels as well as men's.

Appropriate family planning language not only allows for an increase in contraceptive knowledge, it can have an effect on family planning attitudes as well. It can reduce negative opinions and increase supportive ones. It can help to make a taboo

subject legitimate for public discussion. It can also assist behavioural goals by increasing discussion between partners about the links between family planning and sexuality, and by fostering the correct use of contraceptives.

Language impinges on and helps to define the tone, approach and emotional setting for the educational message. It can foster many things including fear, which is traditionally used in education about STDs (sexually transmitted diseases) and AIDS (acquired immunodeficiency syndrome); responsibility, which is commonly used in family planning education; pleasure; empowerment; and consensus. The language of reproductive health, which includes the language of family planning and sexuality, needs to foster a range of responses. The choice of reproductive health term used and the manner in which it is used can significantly help or hinder family planning education efforts.

Church and Geller (1991:25) state that, in a television, video or film project, a thorough understanding of the audience is needed to develop an effective message, and this includes gauging rumours. Seniloli (1992:199) noted that, in her Fijian field study, village women heard gossip about the harmful effects of contraception while waiting in the health clinic: thus, they were unlikely to be motivated by the medical personnel to adopt contraception.

One of the factors that hinders successful family planning education is the lack of agreement about what constitutes an acceptable language for that education. Because family planning education requires discussion about things related to sexuality, it is often fraught with linguistic difficulty.

Rogers (1971:102) stated that the "range of discussability" of family planning terms needs to be known; for example, in some cultures, husband and wife could not talk about the condom. Experience in the South Pacific suggests that women want to talk about family planning and sexuality, and want to share contraceptive and sexual decision-making with their sexual partners. At the same time they are inhibited by a culture which places numerous socio-religious strictures on sexuality, which views much sexual behaviour as unnatural and shameful, which discourages an interest in acquiring or publicly discussing sexual knowledge and which has a limited sexuality lexicon. As a consequence, South Pacific women often feel they do not have the confidence, the permission, or the words to initiate a discussion of sexuality. Without an ability to talk freely about reproductive health matters, many women are not obtaining the information and services they want.

To assist these women in the South Pacific, Family Planning Australia undertook a project which, in conjunction with local island communities (and in particular with local island women), assembled a culturally acceptable vocabulary in the Tongan, Samoan, Fijian, Fijian-Hindi and Papua New Guinea Pidgin languages. The resultant lexicon, the *Booklet of South Pacific Reproductive Health Words and Phrases* (Family Planning Federation of Australia, 1992) was used to provide linguistic guidance for the translation of a series of reproductive health education videos and in face-to-face education classes.

It is expected that this development of a lexicon of appropriate reproductive health words and phrases and their use in IEC materials, will have a positive impact on family planning "talk" and ultimately on contraceptive use.

Background to the video project

In 1984,a reproductive health needs assessment was undertaken in Tonga, Fiji, Kiribati and the Solomon Islands. This study of *Women's Reproductive Health Needs in the South Pacific* showed that women throughout the subregion wanted culture-specific, educational resources on a number of subjects including sexuality, family planning, contraception, reproduction and STDs. Pacific women also wanted resources that could be used by themselves, in their own villages, and would therefore not be dependant on health-care worker initiative (Winn and Lloyd, 1985a:81).

When asked what medium would be the most appropriate way to present information on these topics, the women strongly favoured video. They felt that video could present the information in a story-telling style that was in keeping with the Pacific tradition. Video could also overcome a reliance on over-stretched, geographically restricted health educators, whose presentation of topics, when constrained by sexual taboos, has limited effectiveness (Winn, 1992a:19).

Although the distribution of video equipment within the region is uneven, video technology is generally available and accessible. This is in keeping with much of the developing world where the number of video cassette recorders had doubled or tripled in the late 1980s (Church and Geller, 1991:12). In the Pacific, video has the potential to reach wider audiences than television. Television is not available in Samoa or Tonga; in Papua New Guinea and Fiji, transmissions are mostly in English and do not reach the rural areas or smaller towns.

Urban households commonly have videos in their homes, and rural villages can obtain access if given sufficient notice. Even on remote outer islands without electricity, it is not uncommon to see a two-day video marathon, staged by a visiting travelling entrepreneur, with his own generator and audio-visual equipment.

Video technology is inherently interesting, particularly to people who are unfamiliar with it. Pacific people will spend many hours watching videos even if the programmes are in a language they do not understand (Winn, 1989:30). On popular demand, screenings can be repeated, providing audiences with information when it suits them. Video does not require communication between people and therefore can eliminate the embarrassment of having to interact with an educator. Video also has the advantage of reaching both a wide audience through mass screenings or a small private gathering, and all in an entertaining form.

Supporting Pacific women's requests for video resources, the 1984 Study recommended that a series of videos be produced by, for, and in consultation with Pacific women. Four videos were eventually produced: *Better Safe*, a drama about STDs, condom use and male sexual responsibility; *Taboo Talk*, a documentary about women's attitudes to menstruation, sex education and family planning; *AIDS and the South Pacific*, an information video about AIDS transmission and prevention; and *Down There*, a part animated, part documentary video on reproduction and methods of contraception. These videos were designed to be used throughout the Pacific subregion. Since there is only one *lingua franca* covering the whole target area, the videos were produced in English.

English is an official language in all the target countries, and education in English begins in primary school. Fiji, Samoa and Tonga have had universal primary education for decades, and their populations have considerable exposure to English. In Papua New Guinea, primary school enrolment rates are much lower and English is less widely spoken. Pidgin English has been gaining ground over other *lingua francas*, such as Police Motu, which are based on Melanesian languages. Pidgin is used widely in radio programmes. Papua New Guinea has over 700 distinct languages and "Each language brings a strong sense of regional identity, reflected in the wantok (one talk) system of rights and responsibility. While this diversity provides PNG with a rich and vibrant cultural life, it also presents some very real obstacles to national cohesion and development" (AIDAB, 1992:10).

The linguistic situation in Fiji has been described in the report of the 1974 Fiji Fertility Survey. The Bauan dialect of the Fijian language is used in the press and radio and is understood by most Fijians. For Indo-Fijians, there is greater linguistic diversity because the original Indian migrants came from different parts of the Indian subcontinent. A *lingua franca* had evolved: a simplified form of Hindustani, with a Latin as well as a Devnagari script (Fiji, 1976:15).

The project

The videos were filmed in Fiji so that they could most easily include, and thus be representative of, a wide cross-section of South Pacific people - Polynesian, Melanesian and Micronesian, urban and rural, educated and uneducated, young and old, religious and non-religious.

As the project approach was grounded in a "women in development" philosophy, women controlled all aspects of the production, from design to evaluation. Although women's concerns were paramount in content decisions, cultural and religious sensitivities in the subregion were also taken into account.

The position of women in the context of birth control varies considerably within the Pacific. In a field study of a Fijian village, Seniloli (1992:195-6) noted that for almost all the Fijian and Indian couples who had accepted family planning, the wives were the innovators in the decision-making process, often after receiving advice from a physician or nurse. In both communities there was almost total agreement that family planning was the responsibility of women. In Yap in Micronesia, traditional abortion practices were a secret that women did not reveal to men (Workman and others, 1992). For Papua New Guinea, McDowell (1988:20) cited a number of sources to show that men disapproved of women taking action to avoid pregnancy.

When the videos were completed, they were distributed widely through indigenous Family Planning Associations and women's networks, and are now to be found in every South Pacific territory from Papua New Guinea to the Cook Islands.

An evaluation of the video project (Winn, 1989) showed that, although they were very well-received and widely used even by non-English speakers, the videos would have reached a far greater audience if they had been available in local languages. In response, it was decided to follow the same "women in development" approach and produce five vernacular versions (Tongan, Samoan, Fijian, Fijian-Hindi and Papua New Guinea Pidgin) of each of the four English-language videos, a total of 20 videos in all. To assist this major undertaking, the *Booklet of South Pacific Reproductive Health Words and Phrases* was developed, showing the equivalent of 88 English terms in the same five languages.

Throughout 1991, Pacific men and women undertook the long and complex task of debating and agreeing upon a translation for the list of reproductive health terms. These translated terms were chosen on the basis that they would be understood by and acceptable to a majority of language speakers. At the same time, the 20 culturally and linguistically appropriate video translations were developed.

The process used to develop the reproductive health terms and the video texts was novel. The usual practice is to develop the words and then test them on an assembled audience. This project did the opposite, it assembled the audience and gave it responsibility for developing and testing its own words.

In four different countries, a cross-section of national language speakers representing the local community was brought together. Their task was to modify and improve a draft translation (of each of the four scripts), prepared by one of their number. Each group met many times to discuss their particular language translation, paragraph by paragraph, checking for ease of understanding, clarity of message and cultural acceptability. Each national group also debated a translation for the 88 reproductive health terms; these were then incorporated into the *Booklet of South Pacific Reproductive Health Words and Phrases.*

The group represented as wide a variety of national language speakers as possible and included people of different age, sex, education, religion and socio-cultural affiliation. A more expensive alternative might have been focus group sessions of young men, young women, older men and older women. (See Knodel and others, 1984, for example.) This alternative might have been appropriate if the target group were adolescents, or if language use varied in large measure with age.

Each group was not requested simply to assemble a list of acceptable words; rather they had to find acceptable words that were clearly understood by a majority of language speakers. They had to find a linguistic balance between not wanting to offend and making sure people knew what the message was. It was felt that the only way to discover what was culturally and linguistically acceptable was to engage the learners. By canvassing their views, the project could determine what words ordinary members of the society would tolerate and comprehend. All members of the group had an equal role in voicing their opinions about what words could and could not be used. Where the balance was difficult to find, the group had to err on the side of comprehension. Particularly with the advent of AIDS in the South Pacific, there has been a perceptible shift to the view that where survival is at stake, communities cannot be shamed into silence. Nor should they be baffled by language that is too elite, too noble, or too polite to be understood.

Problems of communication

While debating the appropriate words for the booklet and video translations, a number of communication-related issues surfaced. They are noted below.

Articulation of and adherence to cultural taboos

Many South Pacific people consider that cultural taboos render frank, public discussion about sexual matters, at best difficult, at worst almost impossible. A raft of taboos on inter-gender, inter-kinship and inter-generation discussion exist. These "inter" taboos are sometimes complicated by "intra" taboos, making even private discussion problematic.

In the Marshall Islands in Micronesia, sex could not be discussed in mixed company in the same family (Westaway, 1989:4). In Tonga and Fiji, the taboo against cousins of the opposite sex being present during sexual talk means that family planning radio broadcasts avoid explicit information, just in case cousins are inadvertently listening in the same room.

There is no doubt that sexuality taboos are significant and can lead to awkwardness, shame and embarrassment. South Pacific women often talk about (and are regretful of) the difficulty they have in talking to their own daughters about a subject of mutual interest, namely menstruation (Winn and Lloyd, 1985b:33). Family planning charts at health clinics are often the objects of jokes by men (Seniloli, 1992:174-5). Yet although these taboos are significant, they are not insurmountable. To be successful, health education programmes must find ways around them.

Those whose job it is to educate about reproductive health and sexuality look for help to determine an educational approach that will minimize this perceived difficulty. Desiring to be culturally sensitive and respectful of social mores, educators often seek guidance from self-appointed community "spokes-persons" or "gate-keepers".

Implicit in the role of gate-keepers is their position as guardians of community standards. They may foster an idealized view of their community (such as one that is sexually monogamous), and reject tarnishing images (such as the use of anal intercourse as a contraceptive measure) and attempt to protect the community against sullying influences (information about homosexual practice). By judging community attitudes and pronouncing a community position, they delineate the parameters of communication about sexuality. An example is provided by a newspaper report (*Canberra Times*, 6 March 1993:12) which stated that Pacific Islanders "disapprove of explicit references to sex in the media". Thus there were a number of complaints when the *Samoan Observer* published the transcript of a sexually explicit telephone conversation, and the President of the Pacific Islands News Association said that she felt obliged to "censor" the *Samoan Observer* before her children could read it.

Educators who heed the opinions of community gate-keepers will, in the name of cultural sensitivity, censor their sexuality education accordingly. Winn and Lloyd (1985) noted that family planning advertisements on Pacific radio often are not comprehensive or explicit and stress only the economic benefits of having a small family. Rarely would anyone dare challenge the received wisdom about what the community would tolerate by way of explicit material.

Although there are common and strong positions on the use of condoms, the practice of pre- and extra-marital sex and homosexuality, people in all South Pacific societies exhibit a range of divergent attitudes and practices. Sexuality education messages and approaches have to cater for this religious, social, educational, generation and gender diversity. Over-sensitivity to cultural taboos and the design of programmes around judgements of people with an interest in raising community standards rather than in accepting them in all their diversity will unacceptably restrict community access and options.

In societies where there has been little public debate about sexuality, there is a natural tendency to err on the side of caution and restrict sexuality discussion. This has been a feature of much South Pacific education to date. There has been almost no view that this conservative position should be challenged and that it is part of an educator's role to question the prevailing wisdom, to defy the *status quo*, to push at the margins of culture and broaden community understanding. Until this is

done, communication about sexuality in the South Pacific will remain inadequate.

Communication style

The communication style most commonly seen in South Pacific health education settings is one suffused with forthright admonishment and exhortation (Winn and Lloyd, 1985a:19). A contrast can be drawn between an Australian health education setting where one would hear "it is a good idea not to use..." and a South Pacific one with "do not use..."

Health messages in the South Pacific are usually broadcast in a one-way transfer from educators to members of the audience. Warnings are issued, advice is given, a clear picture of action is laid out and people are urged to fulfil their responsibilities. Health education messages are often delivered sermon-like, by people in a position of authority over the audience. A questioning of the content and requests for explanations are not usually part of the interaction. There is little acknowledgment that education is about providing choices and that the learner has life experiences and abilities that are as valuable as those of the educator. The wants, needs, choices and motivation of the learner, as articulated by the learners themselves, are not incorporated into the education process. This devalues the learner and does nothing to contribute to the empowerment sentiments so often lauded as an essential feature of family planning and sexuality education (Winn, 1992b:17).

Problems of language

As well as the aforementioned communication-related issues, a number of language-based issues arose. These are listed below.

Language choice

The case for producing videos in additional languages is related to the need to discuss a topic in a language in which the audience is most comfortable. Research in several countries (Paraguay, Uganda and Cameroon) has shown a preference for the use of a local language instead of a European language (Pish, English, or French) when discussing social or intimate matters. (Ware, 1977:23).

Most parts of the Pacific are multilingual, with English or French being used as a *lingua franca.* Other *lingua francas* have already been mentioned: Hindi in Fiji, and Pidgin and Motu in Papua New Guinea. However, a *lingua franca* is normally a simplified language, used with various degrees of precision and levels of understanding. (Lucas and Ware, 1977:233).

Language context

Language affiliation is not the only factor that defines a person or their place in society and it cannot be presumed to take pre-eminence. Just being a Tongan or Fijian speaker does not determine how you will respond to hearing or reading a Tongan or Fijian word. Socio-economic status, religious connection, educational level and age can have a significant impact on the way people use and respond to language. Developing any translation for a broad cross-section of language speakers is a daunting task, but developing a reproductive health translation, with its inevitable sexuality pre-occupation, poses an even greater challenge.

Caldwell (1974:17) found that, in Western Nigeria, a translation of a survey questionnaire was too literary, so it was revised to be more comprehensible to illiterates. Weiss and Udo (1981:49) found that, in Eastern Nigeria, modest language was needed for female respondents in surveys. Similarly in the Pacific, any translation must sound neither too elitist to the less educated in rural areas nor too patronizing to urban professionals. It must be neither so technical as to be alienating nor so crude as to be offensive.

Different words are used by the same people in different contexts. Pet names for reproductive anatomy and sexual acts which are used by couples in the privacy of the bedroom sound vulgar when used in public. The choice of words for translation must therefore also take into account the contexts in which the translation will be used. This posed particular problems for the development of the 1992 Booklet as all the words in it are out of context.

As public discussion of sexuality is not common in the South Pacific, there is understandably some uncertainty about which words and phrases can be used and in what contexts. Ordinary people do not have the appropriate language tools to talk about sexuality in a way that is comfortable, open and widely understood.

In societies which are highly stratified by class or generation, translation is even more difficult. A bias towards decorousness in language at the expense of understanding is highlighted by a famous but probably apocryphal South Pacific tale. A proper exhortation to "put the condom on the organ" resulted in its placement on the church's musical instrument - obviously to no contraceptive effect. We may laugh at the inappropriateness of the action, but must question the educative and linguistic skill of the exhorter.

Equivalence

In translating reproductive health terms from English into a local language, the problems of conceptual and linguistic equivalence arise. A basic question is whether concepts have any meaning or the same meaning in various cultures. Linguistic equivalence refers to the accurate translation of identical items (Warwick and Liniger, 1975:163, 165). An example is the concept of family planning: if no local expression exists, then one must be invented. One early problem with the Fijian family planning programme was the first Fijian translation of the term included the word *tatarovi* which suggests stopping conception. A subsequent and more acceptable translation, implied control of conception (Hull and Hull, 1973:203).

In the 1992 Booklet, "family planning" was translated with emphasis on planning children, but "birth control" was bluntly translated as *tatarovi*, which may reflect reliance on female sterilization in the Fiji programme. In contrast, the Pidgin translation was either the direct "famili plening" or "spesim pikinini", thus emphasizing the spacing of children which was encouraged in most Papua New Guinean societies (see, for example, McDowell, 1988).

Linguistic equivalence is difficult to achieve when one language is richer than others in certain aspects. For example, the Raroian islanders in French Polynesia have no word for "coconut", instead they have names for the many different kinds of coconut (Danielsson, 1954:128). Conversely, English has a richer vocabulary of terms used to describe family planning methods because many of the innovations in contraception have come from medical research in English-speaking countries (Rogers, 1971:970).

Seniloli (1992:199) found that "vasectomy" was equated with "castration" by Fijian men. The 1974 Fijian Fertility Survey showed no use of male sterilization and in a 1987 sample of clients at an antenatal clinic in the capital city, Suva, only one-fifth of women said they would consider this method as a possible choice (Roizen and others, 1992:33,37).

Wurm (1971:905) has commented that the criticism of Pidgin English as a restricted language is unjustified. Any language may be lacking in labels, but new words can be borrowed from which the concept has been taken. By extension, it could be argued that the educator's role is then to ensure that the new words become understood by the public.

New words

Where there was simply no local word for a term that the project group needed to translate, its members often Anglicized one. For example, there was no Tongan word for tampon, so the group used "tamponi", and as there was no Samoan word for "perineum", the group used "periniume". Although this was sometimes seen as a little distancing and vaguely neo-colonial, on balance most agreed it was a good option.

A particular problem arises when the same word is used to describe two different things. In Papua New Guinea, Hughes (1991:136), in her work among the Huli, found that "condoms and IUDs were not readily distinguishable by women in any group, which may be accounted for by the use of the generic term gumi or rubber which is Pidgin for both devices". When family planning knowledge is low, then it may be necessary to describe a condom as a "rubber" for the men, or "a rubber for a man's penis". When family planning knowledge is at higher levels, as in Fiji, then words such as "condom" or "durex" are more precise. The 1974 Fiji Fertility Survey was able to include the English variants "tube tie" and "vasectomy" to describe sterilization operations in the Fijian questionnaire (Fiji, 1976:514-6). The trade name "durex" for a condom was used in both the Hindi version of the same survey and in the 1992 Booklet. However, there were some disparities between the 1974 questionnaire and the Booklet, suggesting possible changes in usage over time or the existence of alternative terms, which might be added to the Booklet.

Some words have a limited meaning and fail to convey the totality of the concept the translators seek. The usual Fijian-Hindi word for "homosexual" refers only to men, and so anyone wanting to include female homosexuality has to find another word.

When people search for a word, the dictionary is sometimes consulted. With Fijian, only a handful of the 88 terms from the Booklet appeared in one Fijian-English dictionary (see Capell, 1968). In other cases, the sought words are listed, but as none of the group had heard of them before and as the public would not understand them, they could not be used. The Fijian-Hindi word for "anus" comes into this category.

Where the only choice was between a rude word and a highly technical one, the group sometimes chose to use neither, preferring instead to describe the word. In Hindi, the word "vagina" became the phrase *baby wala raasta*, i.e. "the passage through which the baby comes out".

Rude words

As was mentioned previously, where a wide repertoire of sexual activity is proscribed, where many sexual acts are associated with shame and where the acquisition of sexual knowledge is not encouraged, a rich lexicon of sexuality is generally missing. It is not surprising therefore that in the South Pacific people are unfamiliar with, embarrassed by and confused about many sexuality terms.

A limited vocabulary, with the resultant inability to be precise when explaining terms, makes it difficult to educate people about complex and potentially embarrassing things. Whether it is an imprecision that comes from a limited repertoire of terms or whether it comes from widespread use of poetic euphemisms, the end result is the same. The Tongan term "respected parts" for the "genital area" and the Fijian-Hindi expression *lahsun* ("garlic") for "clitoris" cannot guarantee a comprehending audience.

Many words, whether the private pet words of lovers, street slang or highly derogatory swear words, are considered too impolite for utterance in public education. In many languages, there is simply no understood alternative to an impolite word.

The 1992 Booklet reveals considerable differences between the two Polynesian languages, Samoan and Tongan, and the other three languages. For the former, it was necessary to show the polite translation and, where applicable, put the "rude" word into brackets. Approximately one-fifth of the Tongan terms and one-eighth of the Samoan terms had a "rude" alternative. Rude words that may be acceptable in everyday speech may be less acceptable in media messages. However, creating a euphemism may produce a very ponderous result: for example the "rude" Tongan expression for the word "anus" consisted of two words, while the polite alternative comprises 23 words.

Pidgin English tends to be very direct, and the use of rude words did not pose a problem for the Booklet. This however does not mean that communication is any easier in Papua New Guinea. One informant, a former family planning worker, stated that she could not refer to certain parts of the body in any language for fear that people in her home village would find out. Another informant described how a family planning flip-chart prepared in the late 1970s encouraged men to use contraceptives when they "slip waintim" (sleep with) their wives. This euphemism caused confusion in parts of the Highlands since sleeping with one's wife would take place in one's house, whereas, for fear of ritual pollution, intercourse, which could have been translated by the direct (but still acceptable) term "puspusim", would occur in the bush.

The benefits of the translation process

One outcome of using a group to develop the Booklet and video texts was the creation of a pool of potential educators, with both a vested interest in the end-product and an easy familiarity with the once-controversial terms. By discussing each and every word, the group learned very quickly what words were understood and not understood, and which were acceptable and not acceptable to each other. They could then more easily reach a consensus about what particular words to choose for the translation.

By using a community decision-making process, the project was in keeping with the South Pacific consensus tradition. By debating terms in their own language, the group members developed a familiarity with taboo words that made it easier to use them and therefore would make it easier to educate others about sexuality in the future.

Interestingly, this familiarity, born of repeated use, made the translations undertaken towards the end of the project more liberal than the translations at the beginning. A good illustration of this was the Fijian-Hindi group which discussed the reproductive health terms in alphabetical order. At the first meeting, there was great debate about the word for "anus" and the group, erring on the side of caution, deliberately omitted writing the Hindi script for the word they chose. Instead, they used a less offensive term than they would have done had they discussed the word "anus" at the final meeting. In contrast, they discussed the word "vulva" at the final meeting and easily agreed on a rather rude term.

Conclusion

The erosion of taboos about the discussion of sexuality is quite recent in Western countries, so it is difficult to predict the resilience of taboos in the Pacific. The project has shown that - despite taboos, an inadequate vernacular vocabulary with which to work and an initial high level of embarrassment about the subject -Pacific women were able to assemble a booklet of culturally and linguistically acceptable reproductive health terms and carry out successful translations of health videos.

Although the importance of language has been recognized in the context of the diffusion of fertility control (Watkins, 1991), and in developing family planning media messages (Church and Geller, 1989:25), specific examples of language problems encountered in other projects proved hard to find. Reference has been made to the African literature, and it has been shown that translation has presented various problems in multilingual situations in Africa which have parallels in the South Pacific. Thus, the success of videos in local languages in the South Pacific could be replicated elsewhere. Melanesia, Papua New Guinea and the Solomon Islands may represent the greatest challenge because of the multiplicity of languages, and in this respect they can be compared with those high-fertility African countries which have many local languages.

The project also showed that, to develop a lexicon that is both understood by and acceptable to a majority of language speakers, it is necessary to fully consult members of the targeted community. To discover what is culturally and educationally possible, one must engage the learner. To this end, the project used a participatory approach which involved the audience from the beginning.

One lesson from the South Pacific project is that people are often far more willing to accept sexuality information than is generally believed, and they will welcome frank and explicit material if they are given an opportunity to determine the context in

which they receive it. The project's use of video ensured that a wide cross-section of people gain access to reproductive health education. The Pacific women's use of a cross-section of language speakers to debate each word, ensured the development of a resource that is more likely to be appropriate than one produced by an individual translator.

This is not to say that there will not be debate about particular words and disagreement about what is or is not offensive language. Perhaps no single word will suit all people in all circumstances - nor should it. What is needed is a broad reproductive health lexicon, a range of different approaches to the subject and a wide variety of channels for dissemination of information.

This project was the first step in opening up the area for clear examination, in widening public discussion and increasing public knowledge. It is hoped that, as a consequence of the project, people will be moved to argue for language amendments and offer alternative words, because the more this area is examined, the less will be the possibilities for restricting access to knowledge and action. This project gave South Pacific people, and especially South Pacific women, an opportunity to debate the language in which to couch knowledge and action. Only further studies will reveal whether this approach will affect health behaviour and increase contraceptive use.

The main policy and programme implications of the project relate to the desirability of the target audience *determining* project content, rather than, as is the usual practice, simply being consulted about it. In this project, the target audience determined, among other crucial things, the choice of language, the communication medium and the style of presentation. In other family planning and sexuality projects, policy makers and programme administrators, fearing controversy and project failure, are often wary of giving non-expert community people too much say. This project has shown that project success, in fact, was assured by the non-expert community people making all the major decisions.

Programme managers must be aware that language may be a substantial barrier to the diffusion of reproductive health knowledge. Health educators and survey interviewers must be trained to overcome their own inhibitions, otherwise they will fail to communicate and receive information. As Caldwell (1982:583) observed about surveys in Bangladesh, the trainers and interviewers were often more embarrassed than the respondents. Programme managers have a duty to produce more materials in the vernacular and to ensure that advertising campaigns result in key terms becoming part of everyday language.

References

Agyei, William (1988). *Fertility and Family Planning in the Third World* (London, Croom Helm).

AIDAB (Australian International Development Assistance Bureau) (1992). "The voice of a nation", *Focus*, December:10-11.

Caldwell, John (1974). "The study of fertility and fertility change in Tropical Africa. *World Fertility Survey Occasional Papers* 7(May).

_____ (1980). A book review of "Bangladesh Fertility Survey 1975, First Report", *Population Studies*, 34(3): 581-583.

Church, Cathleen and Judith Geller (1989). "Lights! Camera! Action!" *Population Reports*, J38.

Coeytaux, Francine, Taoufik Kilani and Margaret McEvoy (1992). "The role of information, education, and communication in family planning service delivery in Tunisia", *Studies in Family Planning*, 18(4):229-234.

Danielsson, Bengt (1954). *The Happy Island* (London, George Allen and Unwin).

ESCAP (Economic and Social Commission for Asia and the Pacific) (1974). "Husband-wife communication: measurement and correlation with family planning", in: *Husband-Wife Communication and Practice of Family Planning* (Bangkok, United Nations, ESCAP), Asian Population Studies, Series 16:25-45

FPFA (Family Planning Federation of Australia) (1992). *"Booklet of South Pacific Reproductive Health Words and Phrases"*, Canberra

Fiji (1976). *Fiji Fertility Survey 1974* (Suva, Bureau of Statistics).

Hughes, Jenny (1991) "Impurity and danger: the need for barriers and bridges in the prevention of sexually-transmitted disease in the Tari Basin, Papua New Guinea", *Health Transition Review* 1(2):131-141.

Knodel, John, Napaporn Havanon and Antony Pramualratana (1984). "Fertility transition in Thailand: a qualitative analysis", *Population and Development Review* 10(2):297-328.

Liskin, Laurie and Cathleen Church, Phyllis Piotrow and John Harris (1989) "AIDS Education: a beginning", *Population Reports,* L8:25-27

McDowell, Nancy (ed.) (1988). *Reproductive Decision Making and the Value of Children.* (Boroko, Papua New Guinea, Institute of Applied Social and Economic Research).

McMurray, Christine and David Lucas (1990). "Fertility and family planning in the South Pacific", *Islands/Australia Working Paper 90/10,* National Centre for Development Studies, Australian National University.

Rogers, Everett (1971). "Family planning word symbols: semantic problems in diffusion", *Rural Africana,* 14(Spring):97-102.

Roizen, Judith, Rajat Gyaneshwar and Zoe Roizen (1992). "Where is the planning in family planning?" *Demographic Report 3,* Population Studies Program, University of the South Pacific, Suva.

Seniloli, Kesaia (1992). "The socio-economic determinants and cultural dimensions of ethnic fertility differentials in Fiji: the case of two villages in Viti-Levu", Unpublished Ph.D. thesis, Australian National University.

Ware, Helen (1977). "Language problems in demographic field work in Africa: the case of the Cameroon Fertility Survey. *World Fertility Survey Scientific Reports 2* (November).

Warwick, Donald and Charles Lininger (1975). *The Sample Survey: Theory and Practice* (New York, McGraw-Hill).

Walter, Annie (1985). "The body and bodily functions as seen through the vocabulary of anatomy used by the Surimarani (Central Pentecost)", *Ethnographical Notes and Records 2* (Port Vila, ORSTOM).

Watkins, Susan (1991). "More lessons from the past: women's informal networks and fertility". Paper presented at the IUSSP/University of Zimbabwe Seminar on the Course of Fertility Transition in Sub-Saharan Africa, Harare, November.

Weiss, Eugene and A.A. Udo (1981). "The Calabar Rural Maternal and Child Health/Family Planning Project", *Studies in Family Planning,* 12(2):47-57.

Westaway, Jane (1989) "Marshall Islands employs education to reduce high birthrate", *Development,* Wellington, (September):4-13.

Winn, Margaret (1989) "Report on the evaluation of South Pacific reproductive health videos", Family Planning Federation of Australia, Canberra.

_____ (1992a). "Taboo talk: reproductive health videos by Pacific Island women", *Quality/Calidad/Qualite,* The Population Council, New York:19-22.

_____ (1992b). "Family planning education: working with target groups in the South Pacific", *Development Bulletin,* 24(25) Australian National University, Canberra.

_____ and Coral Lloyd (1985a). "Final report on women's reproductive health and family planning in the South Pacific - Tonga, Kiribati and Fiji", Australian Federation of Family Planning Associations, Canberra.

_____ (1985b). "Final report on women's reproductive health and family planning in the Solomon Islands", Australian Federation of Family Planning Associations, Canberra.

Workman, Ann, Randall Workman and Linda Cruz-Ortiz (1992). "Abortion on Guam: demographic trends and fertility data", Isla 1(2):183-198.

Wurm, Stephen (1971). "Pidgin English", in: *Encyclopedia of Papua and New Guinea,* P. Ryan (ed.) 2:902-5, Melbourne, Melbourne University Press.
