Publications of the Institute for Asian and African Studies 6

LANGUAGE POLICY IN HEALTH SERVICES:

A SOCIOLINGUISTIC STUDY OF A MALAWIAN REFERRAL HOSPITAL

Gregory Hankoni Kamwendo

Helsinki 2004

Gregory Hankoni Kamwendo

LANGUAGE POLICY IN HEALTH SERVICES:
A SOCIOLINGUISTIC STUDY OF A MALAWIAN REFERRAL HOSPITAL

ACADEMIC DISSERTATION

To be publicly discussed, by due permission of the Faculty of Arts of the University of Helsinki, in auditorium XII, Unioninkatu 34, on the 13th of November, 2004, at 10 o'clock

Publications of the Institute for Asian and African Studies 6

ISBN 952-10-0495-9 (printed)
ISBN 952-10-0496-7 (pdf)

ISSN 1458-5359

Helsinki University Printing House
Helsinki 2004

ACKNOWLEDGEMENTS

This dissertation marks the end of a long academic journey that started when I registered as a part-time Ph.D. student at the University of Malawi. The immense pressure of work at the University of Malawi's Centre for Language Studies (where I worked as Senior Research Fellow and Deputy Director), the paucity of relevant and up to date literature, and the lack of adequate access to computer and Internet facilities all impacted negatively on my academic work

After nearly two years of seeing no real light at the end of the tunnel, salvation came from Harri Englund. He generously took me on board his project, "Translating Human Rights in Africa" - a project based at the Institute for Asian & African Studies at the University of Helsinki, and funded by the Academy of Finland. Under the new arrangement, I transferred my Ph.D. work from the University of Malawi to the University of Helsinki, and Harri Englund became my new supervisor.

With funding from Harri Englund's project, I was able to conduct fieldwork at the Mzuzu Central Hospital from April to August 2002. In September of the same year, I moved to the University of Helsinki where the Academy of Finland, through Englund's project, paid my salary for two full years. I am most grateful to the Academy of Finland for its generosity.

I should also acknowledge with gratitude the financial support I received from GTZ whilst I was in Malawi. With funds made available by GTZ, I was able to make a one-week orientation visit to my research site (Mzuzu) in December 2001. Through GTZ's funding, I was also able to present papers at a number of international conferences outside Malawi. I highly commend GTZ for supporting scholarship in African languages.

I have had opportunities to attend courses within and outside the University of Helsinki. For example, I benefited immensely from two courses on human rights/language rights which were offered by the Institute for Human Rights at the Åbo Akademi University in Åbo/Turku. I thank the Director and staff of the Institute for Human Rights at Åbo for giving me eye-opening short courses. I also thank Norfa for funding my participation in those courses through its Mobility Scholarship.

I would also like to express my gratitude to the Nordic Africa Institute for the support it has given me. I was a beneficiary of a Study Grant during the month of February 2003. Through this grant, I was able to conduct library research at the Institute's library in Uppsala, Sweden. The Nordic Africa Institute came into the picture again in October 2003 when it funded my participation at the Nordic Africa Days Conference.

I would also like to register my profound gratitude to the University of Helsinki (the Rector's Grant) for providing me with monthly salaries from August to October 2004. I should also acknowledge with gratitude that I was a beneficiary of the Chancellor's Travel Grant that enabled me to attend an international conference at Linköpings University, Sweden, in June 2004.

In Harri Englund I had a dedicated, resourceful and time-conscious supervisor. He ably captained the 'ship' and steered it into safety. I would like to echo the saying that if I have seen far, it's because I stood on the shoulders of a giant, and that giant is no other than Harri Englund. Without him, I would not have made it. *Zikomo kwambiri achimwene Harri. Mulungu akudalitseni*.

I would also like to express my profound gratitude to the two pre-examiners, Professor H. Ekkehard Wolff (Leipzig University, Germany) and Professor Karsten Legère (Göteborg University, Sweden) for giving me valuable and highly constructive comments. These two

eminent scholars are, in no way, responsible for errors that remain in the thesis. I take full responsibility for that.

My Custos, Professor Arvi Hurskainen deserves thanks for a job well done. The support and encouragement he gave me during my two years' stay at the University of Helsinki will always be remembered with appreciation.

There are many other institutions and individuals who gave me a helping hand, but due to space limitations, it is impossible to mention them all. However, within this space constraint, I wish to acknowledge the generous support I received from the following institutions and individuals: first, staff and clients of the Mzuzu Central Hospital for generously giving me data. Without their support and co-operation, I could not have made it. I also thank other institutions and individuals who gave me data in one way or another; and in this regard, I wish to recognise the special contributions made by Mr. A. Thole of the Mzuzu Museum, Mr Heinz Kaposa of the National Archives Office in Mzuzu, and others. I also thank Professor Al Mtenje (my Director of the Centre for Language Studies, for creating a conducive atmosphere under which I was able to purse my academic goals); Pascal Kishindo (a fine language scholar, a former thesis supervisor, a colleague and a friend); Matthews Mugala (my hard-working and cooperative research assistant); Frank Nantongwe Jr. and Matthews Msokera (the men who computerised data from the questionnaires); Tarcizius Nampota (a friend who has now turned into a brother); Joachim F. Pfaffe, Wanjiku Janet Ng'ang'a (a very supportive colleague from Kenya) and Sergei Repin (I happily shared an apartment with him in Vantaa).

I am thoroughly convinced that if I have survived and succeeded in this world, it is partly due to the support and loving care I have received, and continue to receive, and will continue to receive, from my dear wife Yasinta (Juliet). She has been the solid rock on which I have stood during moments of frustration and despair. Her contributions towards the successful completion of the dissertation are too many to cite here. It is to Juliet and our beloved three "guests" - Tamanda Agatha Kamwendo, Titus Kamwendo and Martin Cleophas Kamwendo - that I dedicate this dissertation.

LIST OF ABBREVIATIONS

ABC	African Bible College
AFORD	Alliance for Democracy
AIDS	Acquired Immunodeficiency Syndrome
AIIC	International Association of Conference Interpreters
CA	Conversational Analysis
CASAS	Centre for the Advanced Studies of African Society
CDA	Critical Discourse Analysis
CCAP	Church of Central African Presbyterian
CHAM	Christian Health Association of Malawi
CLACA	Chitumbuka Language & Culture Association
CODESRIA	Council for the Development of Economic and Social Research in Africa.
EAP	English for Academic Purposes
EFL	English as a Foreign Language
ESL	English as a Second Language
EMP	English for Medical Purposes
ESP	English for Specific Purposes
EU	European Union
FGD	Focus Group Discussion
FTA	Face Threatening Act
GDP	Gross Domestic Product
GTZ	Deutsche Gesellschaft fur Technische Zusammenarbeit
HIV	Human Immunodeficiency Virus
IMF	International Monetary Fund
JCE	Junior Certificate of Education
KCN	Kamuzu College of Nursing
LCH	Lilongwe Central Hospital
L1	First Language
MACRO	Malawi Aids Counselling and Resource Organisation
MANEB	Malawi National Examinations Board
MBC	Malawi Broadcasting Corporation
MCP	Malawi Congress Party
MCH	Mzuzu Central Hospital

MSCE	Malawi School Certificate of Education
NAC	Nyasaland African Congress
NEPAD	New Partnership for Africa's Development
NGO	Non-Governmental Organisation
NIB	National Intelligence Bureau
OAU	Organisation of African Unity
OPD	Out Patient Department
OSCE	Organisation for Security and Co-operation in Europe
PSI	Population Services International
PSLC	Primary School Leaving Certificate
QECH	Queen Elizabeth Central Hospital
ROC	Republic of China (Taiwan)
SADC	Southern African Development Community
SPSS	Statistical Package for Social Sciences
TB	Tuberculosis
TBA	Traditional Birth Attendant
TMP	Tumbuka for Medical Purposes
TUM	Teachers' Union of Malawi
UDF	United Democratic Front
UMCA	Universities Mission to Central Africa
UN	United Nations
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
US/USA	United States/United States of America
VD	Venereal Disease
WHO	World Health Organisation
ZCH	Zomba Central Hospital

ABSTRACT

Gregory Hankoni Kamwendo: Language Policy in Health Services: A Sociolinguistic Study of a Malawian Referral Hospital

During the first three decades of independence, Malawi, like many other African countries, had an official policy that eschewed the country's linguistic and cultural diversity in the name of nation building. Whilst examining how Malawi's transition to liberal democracy has affected its language policy, this sociolinguistic study contributes to comparative scholarship on linguistic and minority rights in new democracies.

In Malawi, research and discussion on linguistic pluralism have so far been confined to the domains of education, broadcasting and parliament. This study expands the scope of the discussion to include the domain of health services. The focus of the study is on language use at the Mzuzu Central Hospital in the linguistically complex Northern Region. The study presents detailed analyses of language use, linguistic and non-linguistic barriers to communication and the provision of language services at the hospital. Data were collected through questionnaires, observations, interviews with key informants, focus group discussions, archival research and audio-recordings of client-service provider interactions.

The study argues for a carefully contextualised approach in which historical, political, social and economic forces are understood to shape linguistic phenomena. As such, the study shows the importance of domain- and context-specific language policy and questions common assumptions in the literature on linguistic and minority rights. In this particular context, Tumbuka, the regional lingua franca rather than mother tongues should be recognised and developed. Courses should be offered to service providers who lack competence in the regional lingua franca.

TABLE OF CONTENTS

Acknowledgements iii
List of Abbreviations v
Abstract vii
PART I: Contextualising Language Policy
CHAPTER 1: Introduction to the Study 1
1.1. Preamble 1
1.2. The Research Problem 3
1.3. Objectives of the Study 3
1.3.1. Patterns of Language Use and Choice 3
1.3.2. Barriers to Communication 4
1.3.3. Language Policy and Language Services 4
1.3.4. Language Rights and the Delivery of Health Services 4
1.3.4.1. Health, Language and Human Rights 4
1.4. The Research Site 6
1.5. Research Strategy 7
1.5.1. Fieldwork 7
1.5.2. Research Clearance and Ethics 8
1.5.3. Research Orientation 10
1.5.4. Sampling 12
1.5.4.1. Random Sampling 12
1.5.4.2. Non-Random Sampling 13
1.5.5. Qualitative and Quantitative Methods 14
1.6. Methods of Data Collection 17
1.6.1. Questionnaire Survey 17
1.6.1.1. Questionnaire for Clients 17
1.6.1.2. Questionnaire for Service Providers 17
1.6.1.3. Analysis of Questionnaires 18
1.6.2. Observations 18
1.6.3 Interviews with Key Informants 19
1.6.4. Focus Group Discussions 19
1.6.5. Audio Recordings of Client-Service Providers Verbal Interactions 20
1.6.6. Archival Research 20
1.7. Fieldwork Challenges and Constraints 21
1.8. Sociolinguistics in a Hospital Setting 22
1.9. Significance of the Study 23
1.10. Conventions and Key Terms/Concepts 29
1.11. Organisation of the Thesis 32
CHAPTER 2: Malawi: Politics, Language and Health 35
2.1. Introduction 35
2.2. The Making of Modern Malawi: Political and Socio-Economic Situation 35
2.2.1. The Missionary/Colonial Era 35
2.2.1.1. Language Policy/Planning 38
2.2.2. The Banda Era 41
2.2.2.1. Language Policy/Planning 42
2.2.2.2. The Democratic Transition 49
2.2.3. The Post-Banda Era 49

2.2.3.1. Directives on Languages of Radio Newscasts 51
2.2.3.2. From the Chichewa Board to the Centre for Language Studies 52
2.2.3.3. Directive on Mother Tongue Instruction 53
2.2.3.4. From Chewa to Nyanja: Change of Name 54
2.2.3.5. Language Associations 55
2.2.3.6. Language, Identities and Politics of Recognition 56
2.3. Current Demographic Trends 57
2.4. Poverty and Inequality 58
2.5. Education and Literacy 60
2.6. Health Indicators 61
2.7. Provision of Health Services 62
2.7.1. Provision of Western Medical Services 62
2.7.2. Alternative Medical Systems 63
2.7.3. Traditional Birth Attendants 65
2.8. The Northern Region: A History of Identity Politics 65
2.8.1. Ethnic Consciousness and Regionalism 65
2.8.2. Dissidence and Political Activism 66
2.9. "The Dead North" 67
2.10. Health Services in the Northern Region 68
2.11. Mzuzu: the Research Site 69
2.11.1. The Capital of the Northern Region 69
2.11.2. Mzuzu Central Hospital 70
2.11.2.1.The Politics of Development 70
2.11.2.2. A State-of-the-Art Hospital 70
2.11.2.3. Referrals and Non-Referrals 71
2.11.2.4. Hospital Personnel 72
2.12. Summary and Conclusions 72
CHAPTER 3: Theoretical and Analytical Orientation 79
3.1. Introduction 79
3.2. A Hospital as a Site of Sociolinguistic Study 79
3.2.1. The Speech Community 79
3.2.2. Discourse Community 82
3.2.3. Community of Practice 83
3.3. Discourse Analysis in the Health Domain 85
3.4. Language Policy/Planning 86
3.4.1. Language Policy/Planning: History, Definitions and Scope 86
3.4.2. Status and Corpus Planning 87
3.4.3. The Canonical Model of Language Planning 88
3.4.4. Centralized and Decentralized Language Planning 89
3.4.5. Language Planning Ideologies 90
3.4.6. Endoglossia and Exoglossia 91
3.4.7. Sociolinguistic Data and Language Planning 93
3.4.7.1. Sources of Sociolinguistic Data: A Critique 93
3.4.7.2. Data on Language Use: Household Communications and Health Services 96
3.5. Linguistic Human Rights 102
3.5.1. Linguistic Human Rights: An Introduction 102
3.5.2. Importance of Linguistic Human Rights 103
3.5.3. Linguistic Diversity, Language Rights and Politics of Recognition 105

3.5.4. Personality and Territoriality Principles of Language Rights 106
3.5.5. The Linguistic Human Rights Paradigm: A Critique 107
3.6. Language Services 109
3.6.1. Interpretation and Translation 110
3.7. Summary and Conclusions 111
PART II: The Findings
CHAPTER 4: Patterns of Language Use Within and Outside the Hospital 115
4.1. Introduction 115
4.2. The Sociolinguistic Landscape of Mzuzu City: An Overview 116
4.3. Clients' Responses 119
4.3.1. Clients' Demographic Characteristics 119
4.3.2.1. Categories of Clients 119
4.3.1.2. Sex of Clients 121
4.3.1.3. Age of Clients 122
4.3.1.4. Clients' Nationalities 122
4.3.1.5. Clients' Highest Educational Levels 123
4.3.1.6. Clients' Residential Districts 124
4.3.1.7. Dominant Languages of Clients' Residential Districts 125
4.3.1.8. Clients' Ethnic Identities 126
4.3.2. General Patterns of Language Use 127
4.3.2.1. Mother Tongues 127
4.3.2.2. Other Languages Spoken 129
4.3.2.3. The Need for Learning Tumbuka 130
4.3.2.4. Frequency of Language Use 132
4.3.3. Hospital-Based Patterns of Language Use 136
4.3.3.1. Frequently Used Language(s) 136
4.3.3.2. The Best Language(s) for Hospital Transactions 137
4.3.3.3. Language and Staff Posting 137
4.3.3.4. Language Requirements for Foreign Personnel 137
4.3.3.5. Language and Health Education Literature 139
4.4. Service Providers' Responses 140
4.4.1. Service Providers' Demographic Characteristics 140
4.4.1.1. Professional Status of Service Providers 140
4.4.1.2. Sex of Service Providers 140
4.4.1.3. Nationalities of Service Providers 141
4.4.2. Linguistic Repertoires of Service Providers 141
4.4.3. Language(s) of Service Providers' Interactions with Clients 142
4.4.4. Language and Staff Posting 143
4.5. The Hospital's Linguistic Landscape 145
4.5.1. Language(s) of Hospital Administration and Client Services 145
4.5.2. Language(s) of Signs, Notices and Health Education Literature 146
4.5.2.1. Language(s) of Signs and Notices 146
4.5.2.2. Language(s) of Health Education Literature 147
4.6. Summary and Conclusions 148
CHAPTER 5: Communication Barriers at the Mzuzu Central Hospital 150
5.1. Introduction 150
5.2. Multilingualism at the MCH: a Problem and a Resource 150
5.2.1. The Use of Lingua Francas 150
5.2.2. Networks of Linguistic Support 153

5.2.3. Breaking Local Language Barriers: Perspectives from Service Providers 155
5.3. Minority Languages: Some Special Cases 161
5.3.1. The Case of Swahili 161
5.3.2. The Languages of Karonga and Chitipa 161
5.4. The Use of English: Bridge or Barrier? 163
5.4.1. The Bridging Role of English 163
5.4.2. Problems with Chinese Service Providers' English 163
5.5. Illiteracy 166
5.6. Facework in Health Care Communication 168
5.7. Comparing and Contrasting the MCH with South Africa's Multilingual Hospitals 174
5.8. Summary and Conclusions 176
CHAPTER 6: Language Services and Language Rights 179
6.1. Introduction 179
6.2. Interpretation 179
6.2.1. Need and Use of Interpreters 180
6.2.1.1. Service Providers' Views 180
6.2.1.2. Clients' Views 185
6.2.2. Selection and Training of Interpreters 186
6.2.3. Problems with MCH's Interpretation Services 187
6.3. Availability of Translated Materials 189
6.4. Language Courses for Health Service Providers 191
6.4.1. Options 193
6.4.1.1. Option 1 193
6.4.1.2. Option 2 194
6.4.1.3. Option 3 194
6.5. Other Language Services 195
6.5.1. Language Services for the Visually Impaired and the Deaf 195
6.5.2. The Use of Visuals 195
6.6. NGOs, Donors and Linguistic Rights 195
6.7. The Conundrum of Linguistic Rights 197
6.8. Some Recommendations on Language Services 198
6.9. Summary and Conclusions 200
CHAPTER 7: Language Policy and Planning in Health Services 202
7.1. Introduction 202
7.2. Language Policy and Planning in the Health Domain 202
7.2.1. Current Status of Language Policy and Planning 202
7.2.2. Language Planning at the MCH 206
7.2.3. Corpus Planning 208
7.2.3.1. Corpus Planning by the MCH 208
7.2.3.2. Norm Selection: Towards Standard Tumbuka 208
7.2.3.3. Codification 210
7.2.3.4. Elaboration of Function 212
7.3. Language Planning Ideologies 214
7.3.1. Internationalisation 214
7.3.2. Vernacularisation 216
7.3.3. Linguistic Pluralism 216
7.3.4. Linguistic Assimilation 217

7.4. Territoriality versus Personality Principles in Language Planning 219
7.4.1. The Personality Model of Language Planning 219
7.4.2. The Territoriality Model of Language Planning 220
7.5. Summary and Conclusions 223
PART III: Conclusions
CHAPTER 8: Summarising and Concluding the Thesis 227
8.1. Preamble 227
8.2. Summary of the Findings 228
8.3. Suggestions for Further Research 229
8.4. Concluding Remarks 230
References 231
PART IV: Appendices
Appendix I: Map of Africa 260
Appendix II: Map of Malawi 261
Appendix III: Questionnaire for Clients 262
Appendix IV: Questionnaire for Service Providers 266
Appendix V: Focus Group Discussion Checklist 268

LIST OF TABLES

Table 1.1: Catchment Population, Beds and Personnel at Malawi's Central Hospitals 2003 13
Table 1.2: Out-Patient Services at Malawi's Central Hospitals 2002 13
Table 1.3: In-Patient Services at Malawi's Central Hospitals 2002 13
Table 1.4: Direct Obstetric Deaths at Malawi's Central Hospitals, January 2002-June 2003 25
Table 2.1: The Least Livable Countries in Africa 59
Table 2.2: Performance in English: Malawi School Certificate of Education 1987-97 60
Table 2.3: Lowest Life Expectancy in Africa as of 2002 61
Table 2.4: Government Health Institutions in Northern Malawi 69
Table 2.5: Bed Occupancy in Central Hospitals 2002 71
Table 3.1: Speech Community and Community of Practice: Similarities and Differences 84
Table 3.2: Languages of Household Communication: National Distribution 97
Table 3.3: Languages of Household Communication: Northern Region 97
Table 3.4: Languages of Household Communication: Chitipa District 98
Table 3.5: Languages of Household Communication: Karonga District 99
Table 3.6: Languages of Household Communication: Likoma Islands 99
Table 3.7: Languages of Household Communication: Nkhata Bay District 100
Table 3.8: Languages of Household Communication: Rumphi District 100
Table 3.9: Languages of Household Communication: Mzimba District 101
Table 3.10: Languages of Health Services: Northern Region Teachers 101
Table 3.11: Languages of Health Services: Northern Region Parents/Guardians 102
Table 3.12: Languages of Health Services: Northern Region Pupils 102
Table 4.1: Mzuzu: Languages of Household Communication 118
Table 4.2: Categories of Clients 119
Table 4.3: Clients' Ages 122
Table 4.4: Clients' Highest Educational Levels 123
Table 4.5: Clients' Residential Districts 125
Table 4.6: The Dominant Languages of Clients' Residential Districts 126
Table 4.7: Clients' Ethnic Identities 127
Table 4.8: Clients' Mother Tongues 128
Table 4.9: Tumbuka as a Mother Tongue versus Ethnic Identity of Speaker 128

Table 4.10: Chewa as a Mother Tongue versus Ethnic Identity of Speaker 129
Table 4.11: Tonga as a Mother Tongue versus Ethnic Identity of Speaker 129
Table 4.12: Other Languages Spoken by Clients 130
Table 4.13: The Need to Learn Tumbuka 130
Table 4.14: No Need to Learn Tumbuka: Justifications 131
Table 4.15: Tumbuka: Frequency of Use 132
Table 4.16: Chewa: Frequency of Use 132
Table 4.17: English: Frequency of Use 133
Table 4.18: Rank 1 of Frequency of Language Use 133
Table 4.19: Rank 2 of Frequency of Language Use 133
Table 4.20: Rank 3 of Frequency of Language Use 133
Table 4.21: Rank 4 of Frequency of Language Use 134
Table 4.22: Highest Educational Level versus Frequency of Language Use (English) 134
Table 4.23: Highest Educational Level versus Frequency of Language Use (Chewa) 135
Table 4.24: Highest Educational Level versus Frequency of Language Use (Tumbuka) 135
Table 4.25: Most Frequently Used Language at the MCH 136
Table 4.26: Second Most Frequently Used Language at the MCH 136
Table 4.27: Languages of Clinical Interviews 136
Table 4.28: Best Language for Hospital Transactions 137
Table 4.29: Should Language Determine Staff Posting? 137
Table 4.30: Local Language(s) Requirement(s) for Foreign Personnel 138
Table 4.31: Access to Health Education Literature 139
Table 4.32: Language(s) of Health Education Literature 140
Table 4.33: Professional Status of Service Providers 140
Table 4.34: Sex of Nurses and Patient/Hospital Attendants 141
Table 4.35: Service Providers' Nationalities 141
Table 4.36: Mother Tongues of Service Providers 141
Table 4.37: The Most Commonly Used Language in Client versus Service Provider Interactions 142
Table 4.38: Second Commonly Used Language in Client versus Service Provider Interactions 142
Table 4.39: Third Commonly Used Language in Client versus Service Provider Interactions 143
Table 4.40: Other Languages Commonly Used in Client versus Service Provider Interactions 143
Table 4.41: Language and Staff Posting 143
Table 4.42: Themes of Health Education Posters 148
Table 4.43: Language(s) of Health Education Posters 148
Table 5.1: Shared Vocabulary, Different Meanings: Chewa and Tumbuka 160
Table 5.2: Too Embarrassing Topics to be Discussed Through Interpreters? 169
Table 5.3: Does Interpretation Erode Privacy? 170
Table 5.4: Should Reproductive Health Education Carry Explicit Language? 170
Table 5.5: Verbal Strategy when Referring to Reproductive Organs and/or Excreta Functions 171
Table 6.1: Is it important for Service Providers to Speak Client's Language(s)? 181
Table 6.2: When Service Provider Does Not Understand Client's Language 184
Table 6.3: Involvement in Interpretation 185
Table 6.4: Ever Used an Interpreter? 185
Table 6.5: Full Time Interpreters at the MCH? 185

PART I: CONTEXTUALISING LANGUAGE POLICY

CHAPTER 1

INTRODUCTION TO THE STUDY

1.1. PREAMBLE

Research on language use in hospital-based interactions between clients and service providers cuts across many academic disciplines. There is a growing realisation that language is one of the critical components in the delivery of any health service, be it the provision of therapy and curative drugs on one hand; or the provision of health education, on the other hand (see, for example, Cicourel 1981; Fitzpatrick et al 1992; Pugh 1996; Drennan 1998; Crawford 1999; Ainsworth-Vaughn 2001; Fleischman 2001; Candlin & Candlin 2002; Youdelman & Perkins 2002; amongst others). All health care delivery processes demand linguistic interaction between a service provider and a client. Whenever there is a communication breakdown between a client and a service provider due to the use of unintelligible linguistic varieties; or when poor translation or interpretation is used, the quality of the health service may be compromised. This, for example, can lead a physician into making poor diagnosis and/or inappropriate prescriptions. In some unfortunate cases, loss of life can be the final result. Ong et al sum up the critical role of language in health services as follows: "While sophisticated techniques may be used for medical diagnosis and treatment, inter-personal communication is the primary tool by which the physician and patient exchange information" (Ong et al 1995: 903). Cameron and Williams also articulate the same view as follows:

> Although we may think that the primary tools of medicine are technological, the most fundamental tool, upon which all use of technology depends, is that of language. Language allows patients and care-providers to make their intentions known, a crucial step in the process of identifying a problem, investigating how long it has existed, exploring what meaning this problem may have, and setting in action a treatment strategy. Thus if problems in linguistic encoding interfere with this process, there may be important consequences (Cameron & Williams 1997: 419; see also Ngqakayi 1994: 22).

It should, therefore, be understandable why the provision of language services such as translation, interpretation and the use of plain language is now considered to be crucial to language rights-centred health services in multicultural and multilingual contexts. Linguistically inclusive language services ensure that certain groups of people are not denied access to quality health services due to some linguistic barriers. Some of these linguistic barriers are illiteracy, the lack of proficiency in the language(s) used by the service provider or the inability to understand a written text that has been phrased in highly technical language. All persons in the world are entitled to health as one of their basic human rights (see Dupuy 1979; Exter & Hermans 1999; Toebes 2001; Evans 2002). It is therefore imperative that appropriate language policies be put in place to facilitate the enjoyment of the right to health.

Health service institutions that cater for linguistically heterogeneous groups of people pose some linguistic challenges to the service providers. To this end, institutional language policies and language practices become important tools for ensuring that communication problems are minimised, if not eradicated entirely. Research whose goal is to determine the

extent to which language policies and language practices facilitate the delivery of health services then becomes necessary and relevant. The current thesis is concerned with language planning as a branch of applied linguistics whose goal is to solve language problems (Kaplan & Baldauf 1997; Grabe 2002). "Virtually every organisation, from the multinational corporation to the local 'mom- and-pop' corner convenience store, engages in some form of language policy formulation" (Kaplan & Baldauf 1997: 12).

That language planning research is necessary in institutions operating in multilingual contexts has been confirmed by sociolinguistic studies carried out, for example, in South African hospitals (Saohatse 1997, 1998, 2000; Drennan 1998; Crawford 1999); the Malawian parliament (Matiki 2001a); South African prison services (de Klerk & Barkhuizen 2002); and the South African defence force (de Klerk & Barkhuizen 1998). Such studies enable us to document the institutional language policies that are in place. In addition, we are also able to determine the extent to which actual language practices conform to the official policy. Furthermore, these studies enable us to evaluate the prevailing institutional language policies and practices in terms of the extent to which they facilitate inter-institution and intra-institution communication. It is important to stress that no institution operates without a language policy. The language policy of an institution can come in either overt or covert manner. That is, a de jure language policy refers to an explicitly outlined policy whereas a de facto language policy tends to be implicit. The absence of a written language policy does not imply that there is no policy at work.

It has been demonstrated in a number of ways that language policy and planning for hospital communication is a critical aspect of health service delivery. One key question is whether due consideration is given to the language factor during the recruitment of medical personnel. Some countries have local language competence tests for in-coming (foreign) medical staff such as doctors and nurses. The provision of interpretation services in some of the multilingual hospital contexts further confirms the centrality of the language factor in health service delivery. It is against this background that the United States of America's Executive Order number 13166 of 2000 calls for the improvement of access to health services for people with limited proficiency in English; thus requiring that all federal government funded health service institutions should provide free language services to their clients (see Perkins 1999; Perkins et al 1999; Youdelman and Perkins 2002). President Clinton issued this Executive Order in line with the requirements of Title VI of the Civil Rights Act. That members of linguistic groups who are not proficient in the official language(s) of a health service delivery system are disadvantaged has also been documented in other parts of the world such as in the United Kingdom (Pugh and Jones 1999), in Australia (Lo Bianco 1987); and in South Africa (Saohatse 1997, 1998, 2000; Drennan 1998; Crawford 1999).

From the hospital-based language policy/practice studies surveyed in the literature, it is clear that a multilingual health service institution's overall planning should also include language planning. In this thesis, I argue that one of the challenges of studying specific institutional language planning in health care delivery is to realise that different health service institutions within the same country may have different language-in-communication needs and problems. Focussing on national level language planning ignores the peculiarities of certain specific institutions. Thus, case studies enable us to identify institution-specific language needs and problems. This thesis, therefore, is a response to Fishman (1984: 41) who raised the following concern about language planning:

> The level of language planning that has thus far received the lion's share of attention is that which pertains to the nation as a whole or target populations which are, at least theoretically, distributed throughout the country. Microanalysis

> of language planning (in a particular plant, school, agency, for example) has not yet received the attention it deserves.

Since the time Fishman made this remark to this date, there have been many examples of microanalysis of language planning as Kaplan and Baldauf (1997) attest.

1.2. THE RESEARCH PROBLEM

Linguistic barriers to effective communication in health service-providing institutions become very pronounced in multilingual settings. Urban referral hospitals in Africa often attract clients from a wide diversity of linguistic and cultural backgrounds. A regional referral hospital situated in the linguistically heterogeneous city of Mzuzu in Northern Malawi offered me the right conditions for studying communication problems that may be induced by the presence of several languages. Another relevant point to make here is that the employees of the hospital also come from a diversity of linguistic backgrounds, both Malawian and non-Malawian. The majority of the doctors at the hospital are expatriates from the Republic of China (Taiwan), Egypt, Palestine, the United States of America and the United Kingdom. With the exception of the American and British doctors, the rest of the doctors do not have English as their first language. In the so-called non-English-speaking countries, English is not the main language of doctor-patient interaction. The extent to which doctors from such countries are able to use English effectively as a lingua franca in the hospital context in Malawi was, therefore, part of my research agenda.

The Medical Council of Malawi stipulates that one of the grounds for granting a work permit to a foreign medical practitioner in Malawi is his/her ability to speak English fluently. This policy mistakenly presupposes that English is the main language of doctor-patient interaction in Malawi. The mistake is based on the official classification of Malawi as an English-speaking country and a member of the Anglophone group. The label Anglophone country, which Malawi carries, masks the fact that only a tiny minority of the population has competence in the language (see Mazrui & Mazrui 1998 for a critique of the Anglophone designation). Local languages, therefore, remain the principle media through which service provider-client communication takes place.

1.3. OBJECTIVES OF THE STUDY[1]

The purpose of my study was to identify language policy-related communication problems at the Mzuzu Central Hospital. More specifically, the purpose of the study was addressed by four objectives. The underlying motives of each of the four objectives are outlined below.

1.3.1. Patterns of Language Use and Choice

The first specific objective was to identify patterns of language use and choice among service providers and clients of the hospital. This objective was aimed at generating the following information:

i. Demographic characteristics of the respondents such as age, sex, education, place of birth, current place of residence, nationality, and ethnic identity;
ii. Mother tongues;
iii. Fluency in other languages (i.e. degrees of bilingualism or multilingualism);
iv. Frequency in the use of Chewa, English, Tumbuka, and other languages;
v. Languages used in service provider-client communication;
vi. Linguistic considerations during the recruitment, licensing and posting of staff;
vii. Languages of health literature.

1.3.2. Barriers to Communication

The second specific objective was to identify linguistic and non-linguistic barriers to communication which exist at the hospital. In any event of communication problems or barriers to communication, there should be strategies that could be used to overcome the barriers. This objective, therefore, sought the following information:

i. Identification of linguistic barriers to communication;
ii. Strategies for overcoming the linguistic barriers;
iii. Identification of non-linguistic barriers to communication;
iv. Strategies for overcoming the non-linguistic barriers;
v. Impact of language and communication problems on the quality of health service delivery.

1.3.3. Language Policy and Language Services

The fourth objective was to audit the provision of language services at the MCH. Through this objective, data on the following issues were collected:

i. Identification of the language services that are available at the hospital;
ii. Identification of the providers of the various language services;
iii. The professional competence of the providers of the language services;
iv. Problems with each language service;
v. Possible means of improving each language service;
vi. Identification of linguistic groups that are in need of language services;
vii. Use of visuals to facilitate communication;
viii. Use of translation and interpretation;
ix. Language courses for hospital personnel;
x. The official position of the Ministry of Health on hospital-based language services;
xi. The stipulations of the Medical Council of Malawi on language use in the delivery of health services.

1.3.4. Language Rights and the Delivery of Health Services

My fourth and final objective was to situate the overall findings of the study into the language rights paradigm within language policy and planning framework. This specific objective takes into consideration the human right to health[2] (Dupuy 1979; Exter & Harmans 1999; Toebes 2001; Evans 2002) as well as patients' rights (Leenen et al 1993; Leenen 1994).

1.3.4.1. Health, Language and Human Rights.

States cannot guarantee good health but they can create environments in which good health can be enjoyed. It is against this background that the Constitution of Malawi places the State under the obligation "to provide adequate health care, commensurate with the health needs of Malawian society and international standards of health care" (Malawi Government 1995a: chapter 3). In addition, Malawi as a signatory to the Universal Declaration of Human Rights, automatically adopted the declaration's position on the human right to health. Commenting on the interface between the right to health and other human rights, Eze says:

> A look at the categories of human rights and their contents will reveal their interdependence and interrelation. Put differently, the right to health presumes the enjoyment of other rights without which the right to health will become meaningless. Thus the right to an adequate standard of living, the right to education, the right to social security, the right to participate in cultural life and enjoy the benefits of scientific progress and the right to work may all be regarded as directly relevant to the promotion and protection of the right to health (Eze 1979: 79).

In a situation of inadequate health facilities as is the case in Malawi, the human right to health can be compromised. The right to health has three angles, namely the declaration of the right to health as a basic human right; second, the prescription of standards aimed at meeting the health needs of specific groups of people; and thirdly, the prescription of ways and means of implementing the right to health. There are now several international instruments enunciating the right to health. Article 25 of the Universal Declaration of Human Rights of 1948 states that:

> Everyone has the right to a standard of living adequate for the health and well being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or lack of livelihood in circumstances beyond his control.

Secondly, the International Covenant on Economic, Social and Cultural Rights, in its Article 12, recognises the right of everyone to the enjoyment of the highest attainable standards of physical and mental health. The article also lays down the broad strategies for implementing the right to health. The right to health care is a social right. Social rights are taken as part of the fair participation of citizens of a country in the available social goods; and one of the social goods is health service. Thirdly, the Declaration on Social Progress and Development of 1969, in its article 10, calls for "the achievement of the highest standards of health and the provision of health protection for the entire population, if possible, free of charge." Fourthly, the International Covenant on Civil and Political Rights (Article 6, paragraph 1) stipulates that "every human being has the inherent right to life. Law shall protect this right. No one shall be arbitrarily deprived of his life." In addition, Article 7 of the same declaration says, "no one shall be subjected to torture or cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation."

There are some guiding principles for the right to health, namely: the availability of health services, financial, geographical and cultural accessibility, quality, and equality (see Toebes 2001). The first principle, availability of health services, can be exemplified by the establishment of the state-of-the-art Mzuzu Central Hospital (see chapter 2) as the main referral hospital for the Northern Region of Malawi. This referral hospital has made it possible for the Northern Region to access hospital services that were previously either inaccessible or partially accessible. With reference to the second principle, financial, geographical and cultural accessibility, I would say that the Mzuzu Central Hospital serves the Northern Region as a geographical area as chapter 2 will point out. The services offered at the hospital are financially affordable (see section 2.11.2.3 in chapter 2). Culturally, the services offered by the hospital are acceptable. Despite the fact that Malawians also use "traditional medicine," Western medicine offered by the MCH and other health institutions is not culturally inappropriate. Very often, there is a tendency for some patients to draw on both "traditional medicine" and Western medicine. The quality principle is satisfied by the fact that

the MCH offers high standards of services (see section 2.11.2.2 in chapter 2). Finally, there is the principle of equality which states that health services must be accessible to everyone. Though Toebes (2001) does not include the question of language in this principle, I have found it necessary to make the inclusion. Language, as later chapters of the thesis and other studies elsewhere indicate, is one of the critical factors that determine the accessibility of health services, yet the debate on the right to health, especially from a legal point of view, is often made without reference to the role of language. This thesis corrects that anomaly. The thesis also discusses the interconnectedness between language, the right to health and other human rights.

As it provides health services, the MCH has to ensure that there is equality and non-discrimination in clients' access to these services. As Article 21 (paragraph 2) of the Universal Declaration of Human Rights stipulates, "everyone has the right to equal access to public services in his country." The provision of language services ensures that language does not exclude certain individuals or groups of individuals from enjoying equal access to hospital services. For example, non-English-speaking clients should not be excluded from benefiting from the services of an expatriate doctor who does not speak a local language. The same should also be true of a speaker of a minority language, for example, someone from Karonga or Chitipa who does not speak any of the hospital's lingua francas such as Tumbuka or Chewa. The right to non-discrimination comes under the theme of equality in Article 20 of the Constitution of Malawi:

> Discrimination of persons in any form is prohibited and all persons are under any law, guaranteed equal and effective protection against discrimination on grounds of race, colour, sex, language, religion, political and other opinion, nationality, ethnic or social origin, disability, property, birth or other status.

This provision is also available in Article 2 of the Universal Declaration of Human Rights. It can be seen that the provision of language services aims to ensure that language does not excluded certain segments of society from enjoying health services and human rights. It is also important to bear in mind the legal perspective of human rights, which talks about the interdependence and indivisibility of human rights (see Eide & Rosas 2001; Koji 2001).[3]

One should not assume that the question of linguistic human rights in language policy and planning is an easy and straightforward matter. A very important caution is sounded by Paulston: "Linguistic human rights is also easy to say, far more difficult to define, and quite another to put into practice" (Paulston 1997a: 187). The findings of my study, which are discussed from chapter 4 to 8, bear testimony to Paulston's cautious words. In chapter 3, under the section on linguistic human rights (section 3.5), I present a critique of the linguistic human rights paradigm (see also other critiques in Brookes & Heath 1997; Paulston 1997a, b; Blommaert 2001). Linguistic human rights is a field that has produced more questions than answers. Whilst the current interest in linguistic human rights in Malawi is largely concerned with the education domain as chapter 2 will show, my study extends linguistic human rights and language policy/planning to a different and little-explored area in Malawian sociolinguistics - the health domain. The thesis argues that domain-specific analyses of language policy/planning enable us to see the futility of recommending one language plan in the hope that it would fit all public domains in a country like Malawi.

1.4. THE RESEARCH SITE

I conducted my study at the Mzuzu Central Hospital which is situated in Northern Malawi. This hospital is the newest and largest referral hospital in Northern Malawi. As such, the hospital's catchment area is the whole Northern Region. Going by the 1998 population census

of Malawi, (National Statistical Office, 1998) and other sources such as Kayambazinthu (1998) and Centre for Language Studies (1999), the Northern Region is the most linguistically heterogeneous region. While Tumbuka is the regional lingua franca, other prominent languages and/or dialects exist in Northern Malawi, for example, Tonga, Ngonde, Lambya, Nyakyusa and Swahili. Both the Malawian and foreign personnel at the hospital are also linguistically mixed. Given the linguistic heterogeneity of the hospital's catchment area, it was decided that the study should determine the extent to which such a linguistic profile created communication problems between the hospital's service providers and their clients. In a study conducted at the Baragwanath hospital in South Africa, Saohatse (1997, 1998, 2000), noted that linguistic heterogeneity caused serious communication problems between service providers and their clients.

It was Saohatse's (1997) study that finally set me on the road to planning my own work. I was intrigued to note that the MCH and the Baragwanath hospital (Saohatse's research site) shared some similarities. Both were key referral hospitals, Baragwanath being ten times lager in bed capacity than the MCH. Secondly, both hospitals served a multilingual clientele and also had personnel who came from a wide diversity of linguistic backgrounds. Thirdly, both Malawi and South Africa had changed their political landscapes in 1994. For Malawi, the change meant the installation of a multiparty system of government after 30 years of one-party rule. In South Africa's case, 1994 was the year when the African National Congress formed and led the first multiracial government. In both countries, language policy reforms had become necessary in order to put them in line with the new political dispensations (see Langtag Report 1996 for the case of South Africa and Kamwendo 1997 & 1998; Kayambazinthu 1998 and Kishindo 1998a, for the case of Malawi). As demonstrated by various contributors to Legère & Fitchat (2002), the whole Southern African region has since the early 1990s, with the demise of one-party regimes and the end of Angolan and Mozambican civil wars, intensified efforts to research on the role of language in a democratic political dispensation. One argument running through Legère & Fitchat (2002) is that local languages in Southern Africa and elsewhere in Africa have a crucial role to play in the democratisation process. This is the case since the vast majority of the citizens can effectively communicate only through local languages, and not through metropolitan languages such as English and Portuguese. It therefore becomes necessary to examine the role of the current language policies with reference to specific domains such as education, the judiciary, health, the mass media and others.

1.5. RESEARCH STRATEGY

1.5.1. Fieldwork

Fieldwork involves an extended period of interaction between the researcher and the researched. This means that the researcher stays in the environment in which his/her informants and/or phenomena are located. Though the origins of fieldwork are closely associated with anthropology, its use has been extended to other disciplines. For example, dialectology and other studies within and outside sociolinguistics use fieldwork. This contrasts with the work of the theoretical linguist who may choose to be his/her own informant if he/she is a native or fluent non-native speaker of the language that is under investigation. Alternatively, the theoretical linguist can use one or more native speakers as his/her informants. Fieldwork, on the other hand, is a personal experience that involves the use of various types of data collection methods.

I conducted fieldwork from April to August 2002. I engaged the services of a research assistant. He was a 20-year old man. His highest educational qualification was the Malawi

School Certificate of Education (equivalent to the British Ordinary Level). I found him to be qualified to carry out the duties of a research assistant for two reasons. First, he came from Karonga in the Northern Region itself. In this case, the research assistant was an 'insider' in cultural and geographical senses, whilst I was an 'outsider' in both senses since I come from the Southern Region of Malawi. Second, the research assistant was fluent in English, Chewa (the national lingua franca), Tumbuka (the lingua franca of the Northern Region), Lambya and Nyiha.[4] Such a multilingual research assistant was well placed to handle the linguistic heterogeneity prevailing among the informants to whom he administered the questionnaire. Having a research assistant who spoke the major languages of the region and also being someone who was culturally close to the people was a strategy that was aimed at minimising problems of cultural and linguistic differences between the data collector and the informants. To the Northern Region clients, he was one of their own. Since the majority of the respondents in the clients' category came from the Northern Region, I assigned to the research assistant the task of administering the clients' questionnaire in order to exploit his linguistic and cultural proximity to the informants. His second duty was to provide me with interpretation if and when I needed it.

On my part, I performed the following tasks. I supervised the completion of the service providers' questionnaire. Second, I conducted all the interviews with key informants. Third, I made relevant observations of the patterns of sociolinguistic behaviour at the MCH as well as in the city. Fourth, I conducted archival research at two institutions within Mzuzu. These institutions were the Mzuzu branch of the National Archives of Malawi and the secretariat of the Chitumbuka Language and Culture Association (CLACA). Fifth, I supervised the research assistant daily. One of my daily routines was to review each day's work, pointing out the major findings as well as noting problematic issues that needed to be resolved. I had instructed the research assistant to make relevant observations and record them in his research diary. Prior to the beginning of the fieldwork, I had trained the research assistant in fieldwork techniques. I also had oriented him to the objectives of the study. Before the start of the fieldwork, I undertook a one-week orientation visit to the hospital in December, 2001. This exercise enabled me to achieve the following objectives. First, I introduced myself and my research topic to the director of the hospital. By this time, the research clearance had not yet been granted. I used the visit to acquire some basic details about the hospital such as the staffing situation, and departments where I could make observations and/or audio recordings etc. I also used the orientation visit to acquaint myself with the hospital's physical geography as well as its regulations and routines. Thirdly, I discussed my project with some of the professional staff. From these discussions, I was able to readjust my proposed plan of work.

1.5.2. Research Clearance and Ethics

I took a number of steps to ensure that my study satisfied the required ethical standards. The first step was to acquire a research clearance from the Ministry of Health. The Ministry has a research committee that is charged with the task of reviewing and clearing all health science research projects in Malawi. The standing requirement is that an applicant for a research clearance must submit 15 copies of his or her research proposal. The submission had to be accompanied by a fee of 500 Malawi Kwacha (about 4 Euro). The researcher is under obligation to furnish the Ministry of Health with at least one copy of the research report or publication. Since I am a member of the teaching staff at Chancellor College at the University of Malawi, my application for the research clearance had to be submitted through the Research and Publications Committee of the college. The chair of the College Research and Publications Committee cleared my proposal for onward submission to the Ministry of Health. The Ministry, thereafter, granted me the research clearance without any reservations.

My second task was to ensure that ethical fieldwork practices were followed. The ethical research standards were centred around the autonomy of the informants, respect for the informant, veracity (truthfulness), beneficence (to do good to the informant), non-maleficence (to do no harm to the informant), and the protection of the confidentiality and privacy of the informants. These are the rights of the hospital-based informants as enshrined in the Nuremberg Code of 1947 and the Helsinki Declaration of 1957 (see Kendrick 1995). Upon meeting a prospective informant, the first step was to request him/her to take part in the study. The research assistant and/ or I would give a brief overview of the study. The description of the study was always done in such a way that neither too much nor too little information was made available to the would-be-informant. What was needed was information that was just enough to make the informant comfortable and knowledgeable (Cameron et al 1997; Wolfram & Fasold 1997). I feared that giving away too much information would have led some of the informants to present responses that they thought the researcher wanted to hear. It is for this reason that Cameron et al (1997) have argued that "it is not considered unethical for the researchers to protect their own interests in various ways. They are permitted, for example, to be less candid about the ultimate purpose of their research. Many research designs require that the investigator conceals their goal" at least in some ways (Cameron et al 1997: 147).

On the other hand, not telling the informant about the nature of the research that he/ she is about to participate in is unethical. The informant has the right to know what the research is about so that he/she can decide whether or not to participate. Whilst the research assistant and I would kindly encourage prospective informants to take part, we did not use coercion since it is unethical. We upheld the wishes of the informants totally. For example, one of my key informants, a Malawian citizen of Asian origin, refused to have his interview audio-taped. I, therefore, interviewed him without audio-recording the interview as per his wishes. As soon as the interview was over, I recalled the informant's main points and recorded them in my research diary. Whilst there was only one case of refusal to be audio-recorded, there were many cases of clients (patients or guardians) who refused to respond to the questionnaire which was administered by the research assistant.

Some of the out-patients and guardians were elusive. They claimed that they did not have the time for the questionnaire since they were on a queue for clinical examination or treatment. Others said that they had to go home without delay so that they could rest, hence they had no time for the questionnaire. Some guardians mentioned that they were too busy with caring for their patients. Other guardians said that the conditions of their patients were so critical that they could not respond effectively to a questionnaire during those depressing moments. They were psychologically too unstable to give meaningful responses to the questionnaire. There were a few rude respondents who openly said that their main business at the hospital was to receive medical treatment or to provide care to their patients, and not to be subjected to the 'unprofitable' business of answering a researcher's questions. But on the whole, such bald on record refusals were rare. The majority of the refusals to take part in the study were mitigated (cf. Brown & Levinson 1987). That is, people opted for less face-threatening refusals.

Upon reaching a particular section or department of the hospital, the research assistant and I would meet the in-charge. The purpose was to seek his/her approval that the study to be conducted in his/her area of control. We followed this procedure in order to ensure that we maintained a harmonious relationship with the gatekeepers. It was important to make the gatekeepers realise that we acknowledged and respected their authority. Despite the fact that the study had been cleared at the highest level (the Ministry of Health headquarters) and that the hospital director had been informed accordingly, it was still important not to descend upon the various departments or sections of the hospital. The success or failure of any study is, to

some extent, determined by the degree of co-operation and assistance a researcher receives from the officials on the ground. In all the cases, the relevant departmental or sectional heads granted approval without problems. Once an informant had accepted to be interviewed, we assured him/her that all the information provided by him/her would be treated in strict confidence. Informants were also assured that the study's report would not identify them by name but through the use of pseudonyms.[5] In this thesis, I follow Feagin's use of pseudonyms that preserve informants' "ethnicity and other essential traits, so that someone with a German name would be given a German pseudonym, and the same style of naming" (Feagin 2002: 33).

The research assistant and I also adhered to the principle of non-maleficience as follows. Before asking for an informant's consent for an interview, the health condition of the informants was thoroughly considered. Amongst the patients, we interviewed only those who were not critically ill and were able to speak fluently. The critically ill and those who were either very young or very old were left out. It was deemed unethical to interview critically ill patients (see also Saohatse 1997). In addition, very young or very old people sometimes tend to give responses that do not make much sense.[6] The exclusion criteria also included overt psychiatric illness, and lack of co-operation (cf. Baker et al 1996) as well as prior enrolment in the study.

The research assistant and I also had respect for the hospital's norms and regulations. They were strictly followed in order to forge a harmonious relationship with the authorities. Whilst academic freedom is enshrined in the Constitution of Malawi (Malawi Government 1995a), I felt that I had the duty to exercise social responsibility (see Mamdani & Diouf 1994) by ensuring that my study did not disrupt the hospital's established routines. For example, we could only enter the wards during visiting hours. This meant that outside the visiting hours, we were unable to access in-patients for interviews. During that time, we turned to interviewing guardians, out-patients and key informants.

1.5.3. Research Orientation

My study employed the case study approach. The most outstanding strength of the case study approach lies in the fact that I was able to make an in-depth examination of the language-in-communication situation at one institution. The aim of the study was not to generalise the findings across all Malawian hospitals, but to document in a detailed manner the linguistic situation and its communication problems at one specific institution. Malawi's other three referral hospitals are located in linguistic contexts that are different from the MCH. For example, the Lilongwe Central Hospital is located in an area that is predominantly Chewa-speaking. The Zomba and Queen Elizabeth Central Hospitals are located in the Southern Region where Chewa is again the lingua franca. It is, therefore, understandable why the findings from the MCH cannot be generalised across the board.

The use of the case study approach has both strengths and weaknesses. Hartley (1994) mentions at least three strengths of the case study approach. First, the approach is useful for understanding certain social behaviours and processes within their natural contexts. The second strength of the case study approach is that it is well suited to research whose goal is not to study typicality but unusualness. The linguistic situation at the MCH is so unique that it cannot be expected to be found at the other three central hospitals, namely Lilongwe, Zomba and the Queen Elizabeth. The third strength is that case studies are good for generating hypotheses and new theory. By concentrating on one institution, I was able to observe and document sociolinguistic behaviour that could have otherwise remained hidden in a large-scale survey involving several hospitals. In response to the charge that the findings thus obtained cannot be generalised, I argue that the linguistic landscape of Malawi's three regions

is so varied that generalisations must be treated with caution. One of my contributions to the debates on language rights is precisely to show how claims about 'empowering' minority languages may be unwarranted if they are not supported by substantial empirical research.

Case studies can use either qualitative or quantitative methods or a combination. The objectives of the current study necessitated a combination of qualitative and quantitative methods of data collection and analysis in order to capture the complex realities of the sociolinguistic situation of the hospital's communication practices. The same argument has also been used to justify the study's triangulation of theoretical frameworks. The combination of the methods is a realisation of the fact that qualitative and quantitative methods are best treated as being complementary rather than antagonistic (see Bogdan & Biklen 1992; Creswell 1994; Duff 2002; Saville-Troike 2003). In the use of ethnographic and sociolinguistic survey methods of data collection and analysis, the study was guided by Hoffman's (1991) position that:

> Research which combines data collected through interviews, questionnaires and records of actual observation should prove particularly attractive. If the results achieved by each method are kept separate till the end of the study, then compared with each other and found to be consistent and mutually corroborating, such research can be said to have high validity. But statistical analysis is not usually employed in this kind of anthropological research, and the main emphasis remains the observer's intensive involvement with the communities they are studying; any statistical data that are collected may be used only as supplementary material (Hoffman 1991: 183).

When qualitative and quantitative methods are combined, as is the case with the current study, the outcome is data which represent one of the following three trends. The first possibility is that there may be a pre-eminence of qualitative data over quantitative data. The second possibility is that there could be a pre-eminence of quantitative data over qualitative data. Thirdly, equal weight could be accorded to qualitative and quantitative data. The current study is largely based on qualitative data, and this therefore gives the study the label, qualitative sociolinguistic study (cf. Johnstone 2000). Given the largely qualitative nature of the study, I adopted the following qualitative research principles (Bogdan & Biklen 1992; Janesick 1998). I, as the researcher, was the main research instrument. I observed the language situation, conducted interviews, engaged in other modes of data collection and then interpreted the findings. The study also demanded a focussed understanding and appreciation of the linguistic situation of not only the hospital environment but also the city of Mzuzu. The linguistic situation at the Mzuzu Central Hospital has to be understood within the larger context of the Northern Region's sociolinguistic, political and economic landscape. That is why in chapter 2, I provide the social, political, economic and linguistic background information on not only the Northern Region but also the whole Malawi. Secondly, the study was not guided by any set of hypotheses. Rather, it was guided by a set of research questions that arose out of my objectives. Thirdly, as a case study, my study of language use at the hospital was holistic and descriptive. Fourthly, analysis of data has been an ongoing process that commenced during the fieldwork. An inductive mode of analysis was employed. That is, I connected small pieces of evidence to form the whole. During the fieldwork, I was able to adjust my research design in line with the changing conditions at the research site. I therefore maintained a flexible but carefully monitored approach to the fieldwork.

1.5.4. Sampling

Sampling refers to the process and criteria under which informants and/or institutions are selected as sources of data. The first concept that I want to discuss here is population. This concept refers to all individuals who fall into the categories of one's research. In my study, the population consisted of all the clients and service providers at the MCH. By clients, I mean patients, that is, out-patients and in-patients as well as the patients' guardians. The service providers comprised doctors, clinicians, nurses, technicians and patient attendants and other categories of support staff. Thirdly, there were key informants drawn from within and outside the MCH.

A sample population, on the other hand, refers to those individuals that are selected from the population so that they can furnish the researcher with relevant data. A sample is a portion or subset of the larger group that is known as the population. A sample population should be representative enough to inspire confidence in the results of a study. One way of classifying sampling procedures is to use the dichotomous notions of random versus non-random sampling. It is to these two classifications that I now turn.

1.5.4.1. Random Sampling

Random or probability sampling refers to the process of selecting informants for a study in such a way that all elements within the larger group have equal chances of being selected. This is employed in statistically grounded studies in order to come up with a sample population that is representative. Random sampling can be subdivided into simple random sampling, quasi-random sampling, stratified random sampling and random multi-stage cluster sampling. The simple random requires that the researcher should use a sampling frame. Then a table of random numbers is used for selecting a sample. In stratified random sampling, the aim is to order the population into different strata such as age, gender and social class. The researcher then selects the informants randomly within each stratum, usually through the use of quasi-random sampling. Random sampling works on the basis of a sampling frame. This is a list of all members of the population from which a researcher can draw his/her sample. However, there are situations when the sampling frames do not exist at all (see Bulmer 1993; Ward 1993). Writing about the situation in some Third World countries, Bulmer observes that often there are "no sampling frames, no census tracts with home addresses, no comprehensive directories of who's where. If any of these exist, they are likely to be unreliable" (Bulmer 1993: 91).

There was an absence of patients' sampling frames in my study. I was unable to get some of the much needed hospital statistics (such as Tables 1.1, 1.2 and 1.3) until more than a year after the fieldwork had been conducted at the hospital. During the fieldwork, I was, therefore, unable to establish the sampling frame for this population whose size and composition changed daily. It was practically impossible then to have a list of all out-patients. With in-patients, the situation was not easy either. Officially, the hospital has a maximum capacity of 300 beds. However, when I contacted the hospital administration, I learnt that not all the beds were being used, meaning that the hospital had less than 300 in-patients (compare with Table 1.1). Precise figures could also not be given about out-patients, live discharges and deaths. It then became impossible for me to come up with a realistic sampling frame for the in-patients. The case for the service providers was not different. For example, a senior nursing administrator was unable to give me the exact number of nurses. She attributed this to constant fluctuations in the numbers due to transfers, resignations and to some extent, deaths. She simply told me that the population of nurses at the hospital was between 80 and 90 (compare with Table 1.1).

Table 1.1: Catchment Population, Beds and Personnel at Malawi's Central Hospitals 2003

Hospital	Population	Beds	Doctors	Nurses	Clinical Officers	Techn.	Admin. Person.
MCH	1,412,659	262	10	89	18	19	51
LCH	4,613,958	623	32	256	55	40	66
ZCH	1,978,831	332	4	112	26	24	27
QECH	3,040,337	872	13	265	22	19	72
Total	11,045,785	2,089	59	722	121	102	216

Source of Table 1.1: Malawi Health Information Bulletin

Key

Techn.: Technicians
Admin. Person.: Administration Personnel
MCH: Mzuzu Central Hospital
LCH: Lilongwe Central Hospital
ZCH: Zomba Central Hospital
QECH: Queen Elizabeth Central Hospital

Table 1.2: Out-Patient Services at Malawi's Central Hospitals 2002

Hospital	OPD Visits	% of C. Popul.	Aver. Monthly OPD Visits	Aver. Daily OPD Visits
MCH	56,068	4	6,457	307
LCH	148,808	3	16,719	796
ZCH	102,925	5	10,364	494
QECH	160,246	5	19,364	922
Total	468,047	4	52,904	2,519

Source of Table 1.2: Malawi Health Information Bulletin

Key

OPD: Out-Patient Department
C. Popul.: Catchment Population
Aver.: Average

Table 1.3: In-Patient Services at Malawi's Central Hospitals 2002

Hospital	Admissions
MCH	11,043
LCH	41,209
ZCH	23,507
QECH	72,650

Source of Table 1.3: Malawi Health Information Bulletin

1.5.4.2. Non-Random Sampling

Non-random sampling derives from targeting a particular group of research subjects. This type sampling is frequently used in ethnographic research, action research, case study research and in situations where there is no desire to generalise the findings (see Cohen et al 2000). Some of these conditions apply to my study. First, my study was largely ethnographic, supplemented by a survey. Secondly, my study employed the case study approach. Since I had adopted the case study approach, I did not expect to generalise the findings to Malawi's other three central hospitals. Bulmer (1993: 97-98) observes that in disciplines such as sociology, anthropology and political science, non-random or non-probability sampling is

more common than random or probability sampling. He attributes this trend to indefinite populations, unavailable sampling frames, small budgets, and lack of time and pressure for results. The decision on whether or not to adopt random or non-random sampling will be determined, first of all, by the type of data or measurements one wants to get. For example, when the aim of a study is to get a deeper understanding of the language situation at an institution (as was the case with my study), then the representatives of the sample becomes of less importance and the most suitable sampling strategy is the non-random or non-probability type. Probability sampling is suitable for studies that intend to test empirical hypotheses. Quantitative researchers tend to think and work randomly and statistically whilst qualitative researchers think purposively and conceptually about sampling. The important point to make here is that there are occasions when random sampling is either impractical or unnecessary.

In non-random sampling, the chances of selection for each element in a population are unknown. Examples of non-random sampling include convenience sampling, quota sampling, and purposive sampling and snowball sampling. I will briefly outline the major features of each of these categories. Convenience sampling is also known by other names such as opportunity sampling and accidental sampling. This involves the selection of the nearest individuals to serve as informants. This group of individuals is easy to contact because it is highly accessible to the researcher. The next category, quota sampling, sets out to represent proportions found in the wider population. It gives the proportional weighting among selected factors that reflect their weighting in which they can be found in the wider population. The goal is to meet the number of relevant characteristics of the quota. The third type, purposive sampling, is the handpicking of the cases that are included in the sample on the basis of their typicality. In this way, a sample is built up in such a manner that it satisfies the specific objectives of a study.

Fourthly, snowball sampling starts with the identification of one or two informants. Then these informants lead the researcher to more informants who possess similar traits. Like a rolling snowball, the sample gets larger and larger as time goes. Snowball sampling is particularly useful when the researcher is trying to study difficult-to-get populations for which a sampling frame is not available. Examples of such difficult-to-get populations are drug traffickers, illicit commercial sex dealers and secret society members. The snowball sampling technique has its strengths and weaknesses. With good connections with the initial informants, a researcher can get extra informants whom he or she could not have openly accessed on his or her own. The weakness of the technique is that the researcher gets in touch with those who belong to the network of his or her initial informants. Those members who lie outside the network of one's initial informants are left out, hence their views are not recorded (see Cohen et al 2000).

1.5.5. Qualitative and Quantitative Methods

I start by discussing the essential characteristics of qualitative research. Bogdan and Biklen (1992) mention five characteristics of qualitative research. First, in qualitative research the researcher is the key instrument in the natural setting that gives him/her masses of data. He or she makes observations and interprets them. Qualitative research, therefore, demands a high degree of interpretive ability on the part of the researcher. Second, qualitative research yields words or pictures and not numbers. To this end, this type of research is said to be descriptive. In my study, these kinds of data were collected through interviews with key informants, focus group discussions, partly from the two questionnaires as well as observations. Since the study combined qualitative and quantitative methods, I was able to get numbers from some of the questions in the two questionnaires. The third characteristic of qualitative research is that it is concerned with process rather than simply with outcomes or products. The fourth

characteristic is that qualitative research calls for inductive analysis of data. The researcher does not search for evidence in the data to confirm or disconfirm a hypothesis. Instead, grounded theory is the guiding principle. Themes, patterns and categories emerge from the data, rather than being imposed on the data. The fifth characteristic is the interest in getting the informant's views. This means getting what an informant thinks or believes and this is said in his/her own words.

Critics of qualitative methods have mentioned a number of what they perceive to be weaknesses. First, it is claimed that qualitative research is unscientific since it is alleged to be full of bias, lacks the rigours of quantitative studies, and also lacks measures of validity and reliability (Silverman 2001). It has been argued that qualitative research is full of unquantifible data and therefore, such data cannot be subjected to a statistical analysis. It is argued that without statistical analysis, a study loses its scientific flavour. However, it should be mentioned that figures alone do not make much sense unless they are explained qualitatively. Furthermore, mere figures do not render a study scientific (Bogdan & Biklen 1992). Further doubts about the strengths of qualitative research are linked to the idea of the generalisability of the findings. However, not all studies are concerned with generalisation of findings. Another criticism levelled against the use of qualitative research is that it is a personal experiment that cannot be reproduced, and thus cannot claim having any kind of scientific status. However, it is still possible to employ specific methods in order to have the findings of fieldwork reproduced, falsified or verified.

Some sceptics have wondered how the researcher's opinions, prejudices and other biases can be kept out of qualitative research and its interpretations. A response to this accusation is that the researcher should let the data speak for themselves. The researcher should endeavour not to make claims that are not supported by the available data. Another criticism is that qualitative research means that the researcher immerses him/herself in naturally occurring data and that the study has no structure. This criticism becomes unfounded when we consider what Silverman (2001) advocates: "Doing qualitative research should offer no protection from rigorous, critical standards that should be applied to any enterprise concerned to sort fact from fancy" (Silverman 2001: 12). Whilst qualitative research is flexible, that is, it is not rigidly segmented, this does not mean that it has no structure. The point is that the structure of a qualitative study is adjusted in accordance with the prevailing conditions.

Bodgan and Biklen (1992) assert that qualitative research is a rigorous activity whose goal is to achieve validity and reliability. This runs contrary to the view that qualitative research lacks the means of enhancing the validity of the findings. Validity refers to the extent to which an account faithfully represents the social phenomena to which it refers (Hammersley 1990, 1992; Bogdan & Biklen 1992; Silverman 2001). In trying to enhance the validity of my findings, I followed the five suggestions made by Silverman (2001) as follows. First, I used the refutability principle. I subjected the findings to many tests. The second strategy was the use of the constant comparison method, inspecting and comparing all the data fragments that arise in a single case. Third, I used the deviant case analysis. This was an attempt to seek out and address all deviant cases. Fourth, I used the comprehensive data treatment. This was done in order to dismiss the criticism that in some cases of qualitative research, the findings are based on subjectively selected and probably biased sample case studies that tend to fit the analytic argument. My fifth strategy was the use of appropriate tabulations. Where necessary, quantitative measures were used in my study. For example, the questionnaires targeted at clients and service providers respectively produced some quantitative data (see the results discussed in chapter 4).

Reliability is another important aspect of any research finding. This refers to the extent to which there is consistency between two or more researchers in assigning instances to the same category (Hammersley 1990, 1992). Or to put it the other way, can any two researchers working independently on the same setting come up with the same findings? According to Bogdan and Biklen (1992), we should view reliability as a fit between what researchers record as data and what actually happens in the setting. To demonstrate that findings are reliable, a researcher has to show the procedure used and that categories have been used in a consistent manner. The mere use of quantitative methods is no guarantee that a study is adhering to scientific principles. There is nothing inherently less scientific in qualitative methods either. Weaknesses in the findings of can come from elsewhere. Johnstone (2000) identifies five sources or types of such weakenesses. The first weakness is inadequate amount of evidence on which conclusions are made. The second weakness is the inadequate variety of evidence. The third weakness is faulty interpretative status of evidence - the researcher fails to understand what the data suggest or mean. The fourth weakness is inadequate disconfirming evidence. The fifth weakness is inadequate discrepant case analysis. The problem here is that inadequate attention is given to apparent exceptional cases.

The analysis of the qualitative data in my study followed Tesch's (1992) principles. The first principle is that analysis was treated as an ongoing process. It was carried out throughout the research process. There was no specific time allocated to data analysis. The second principle is that analysis of qualitative data is systematic and comprehensive but it avoids rigidity. This principle requires discipline, an organised mind and perseverance. The analysis ended only after new data no longer generated new insights. Thirdly, I adopted the principle that though data were divided into relevant and meaningful units, an attempt was made to connect all the parts to the whole. Fourthly, data segments were categorised. These categories were made out of the data and not imposed on the data. Of course, initially I had to have tentative categories of the data. The fifth principle is that categories for sorting commonalities among the data are tentative and preliminary. They remain flexible throughout. The sixth principle is that analysis is done in an eclectic way. There is no fixed formula or the "right" way. Every researcher must exercise his or her own intellectual creativity and imagination in order to come up with a workable style of analysis. The seventh principle says that qualitative data analysis is not mechanistic. It involves intellectual craftsmanship and a lot of methodological knowledge and competence. The eighth principle is that the main intellectual tool in qualitative data analysis is the researcher's ability to make meaningful and relevant comparisons and contrasts among the data by trying to look for meaningful patterns. The ninth principle is that the final outcome of qualitative data analysis is the emergence of a large and consolidated picture of a situation.

Strict adherence to the qualitative-quantitative divide is not helpful. It is better to see qualitative and quantitative methods as complementing each other rather than fiercely opposing one another. Rather, the study objectives and the kind of data being sought should dictate which approach can be followed. For instance, a questionnaire that asks both fixed choice and open-ended questions is an example of how both qualitative and quantitative data can be collected within one instrument. In my study, the two questionnaires followed this approach. The combination of qualitative and quantitative methods added rigour, breadth and depth to the study. Saville-Troike observes that:

> While ethnography has tended to be identified exclusively with qualitative approaches, many practitioners today are recognising the need to extend the boundary to include quantitative data in ethnographic descriptions" (Saville-Troike 2003: 8).

Also, Saville-Troike observes that:

> Although an ethnographic approach is quite different from an experimental one, quantitative methods may prove useful in some aspects of data collection, especially when variable features of language use are being explored. Qualitative methods are essentially techniques for measuring degree of consistency in behaviour, and the amount and nature of variation under different circumstances (Saville-Troike 2003: 8).

It is also important to be aware of the caution that Hartley makes:

> There is nothing about a method per se which makes it weak or strong. The argument about method depends on two factors. First, the relationship between theory and method; and the second, how the researcher attends to the potential weakness of the method (Hartley 1994: 208).

1.6. METHODS OF DATA COLLECTION[7]

1.6.1. Questionnaire Survey

1.6.1.1.Questionnaire for Clients

A questionnaire was administered to clients. This questionnaire (see Appendix III) was targeted at out-patients, in-patients and guardians. The respondents were selected through the use of convenience sampling. The researcher assistant, who administered this questionnaire, asked the questions and then recorded the responses. The questionnaire was in English but the research assistant was equipped with Chewa and Tumbuka versions as well. In this way, the research assistant was free to use any of the three languages, depending on the preference of the respondent. I used the researcher-completed questionnaire approach because of the following reasons. First, the research assistant was able to clear up respondents' misunderstandings of some of the questions. Secondly, the research assistant was able to gather supplementary information about personal characteristics and the environment that could be valuable in the interpretation of the results. I had instructed the research assistant to record at the end of the questionnaire any details he felt were unique or important. Thirdly, the research assistant had full control over who actually responded to the questionnaire. In contrast, in the case of mailed questionnaires, the researcher has no control over who actually completes them. The researcher cannot tell whether or not the respondent completed the questionnaire with the assistance of some other people. The researcher-completed questionnaire has its problems too. First, the way the data collector asks questions and records the responses is very crucial. Unless the data collector is properly trained and carefully supervised, he/she can end up with inaccurate and/or incomplete data. The second problem is that researcher-completed questionnaires involve interviewing and sometimes interviewer bias can set in. This refers to the tendency on the part of the interviewer to lead the respondent towards certain answers.

1.6.1.2. Questionnaire for Service Providers

The second questionnaire (see Appendix IV) was targeted at service providers. Initially, I had planned to administer this questionnaire. I had planned to interview each respondent and record his or her responses accordingly. The plan was changed upon realising that the service providers' busy schedule could not allow me to cover a significant number of the service providers within the fieldwork period. I therefore opted for the respondent-completed

questionnaire approach. Saohatse (1997) had employed the same approach in her study of the language situation at the Baragwanath hospital in South Africa.

Given that all service providers had gone through formal education and were therefore literate in English, I assumed that they would be able to complete the questionnaire on their own. Of course there are advantages as well as disadvantages for using this approach. It turned out that the advantages outweighed the disadvantages. In general, the respondents showed reasonable understanding of all the questions. There was fear that there would be a low response rate. This did not happen. There was a high degree of co-operation. Of the 90 questionnaires that were distributed, 79 fully completed ones were returned. This represented a return rate of 87.7 %. Of course there was no control over who actually completed the questionnaire. By using a self-completed questionnaire, I was able to save time. Secondly, I was able to avoid interviewer bias. Thirdly, the approach gave the respondents more time to think deeply about their responses, thereby increasing the validity of those responses that required the respondent to check the information or to think about his/her answer.

1.6.1.3. Analysis of Questionnaires

The use of open-ended questions in a questionnaire has implications for the analysis. Open-ended questions become difficult to taxonomise and quantify on this basis. However, not all the time do we need quantifiable data. There are occasions when researchers prefer non-quantifiable data. In that case, open-ended questions allow respondents to present deeper and more personal views about a particular issue than what a closed question can yield. The fact that closed questions have predetermined categories of responses means that the respondent is constrained in terms of what he/she can say. Open questions, on the other hand, allow respondents to make some illuminating views, which the researcher could not have anticipated. The analyses of the two questionnaires were computerised. Data were first cleaned and then fed into a computer. They were afterwards analysed using the Statistical Package for the Social Sciences (SPSS). Frequency as well as relevant percentages were obtained. In addition, cross-tabulations between certain variables were made where necessary.

1.6.2. Observations

The observation of the linguistic situation in a particular area is one of the widely used techniques in sociolinguistic surveys. It was one of the data collection methods that were used in the East African Language Surveys that covered Zambia, Kenya, Uganda, Tanzania and Ethiopia (Polomé 1982: chapter 5). The use of ethnographic techniques in these surveys included direct observation of language use in diverse social contexts in order to supplement and validate quantitative survey instruments. I followed the same approach in that I observed language use in several places within the MCH such as the pharmacy, the registration point, queues outside examination rooms, queues outside treatment rooms, and the interactions in the corridors of the hospital. Observation of sociolinguistic phenomena was not restricted to the hospital. I continued to make observations in the city since the hospital is part of the city. I observed language behaviour on the public transport network, at the market, at banks, the post office, the motel where I was staying, and leisure and entertainment places. I used these observations to verify the responses that the informants had given about their patterns of language use in domains outside the hospital. In the East African Language Survey (Polomé 1982), researchers made a careful survey of the notices posted in the administrative buildings as sources of data on language use. At the MCH, I adopted the same technique. I therefore made a survey of administrative notices posted on notice boards, health education posters and departments' sign posts to identify patterns of language use.

All the observations were recorded in my research diary which I carried with me all the time. The research diary included the following details: reactions or comments, new ideas on how to proceed with the study, literature reviews and comments and/or insights from the literature, frustrations, new findings, daily reflections or reviews of work done, tentative interpretations, names and addresses of possible informants or other persons likely to assist in data provision. The diary enabled me to reflect on the data collection process. Information contained in the diary was also useful during the writing up of the thesis.

There were some limitations on observations. It was practically impossible to observe all the sections of the hospitals. In addition, some areas had restricted access.[8] The restricted places included wards for patients who were under intensive care. Another limitation was that it was impossible to observe everything. Some sociolinguistic behaviour and patterns may have gone unnoticed. Another problem was the observee bias (also known as the Hawthorne effect). This refers to the invalid observations that result from the fact that the subject knows that he or she is under observation. I minimised this problem by being as little intrusive as possible.

1.6.3. Interviews With Key Informants

Key informants were also a source of data. By key informants, I mean people who are knowledgeable about particular issues. These are people whose insights were useful for me as a researcher to understand a particular situation. The key informants were drawn from a wide range of sources, both within the hospital and outside. At the hospital, key informants included administrators, service providers such as doctors and nurses, and support staff such as patient/hospital attendants. Some of the key informants were drawn from media practitioners, the Chinese medicine clinic based in Mzuzu, health NGOs such as Banja la Mtsogolo and the Malawi Aids Counselling and Resource Organisation (MACRO) and some well-informed residents of Mzuzu. The majority of the interviews with key informants were audio-recorded. Other key informants were contacted by post and in some cases by e-mail. The search for key informants continued even after the end of the fieldwork. The non-random sampling technique of purposive sampling was used to identify the key informants. A total of 21 key informants were identified and interviewed. They were identified in accordance with my study's objectives since the informants were found qualified to shed light on some key issues. All the interviews were transcribed and translated into English, where necessary. The analysis involved a search for emerging themes and then relating them to the objectives of the study

1.6.4. Focus Group Discussions

Focus groups discussions (FGDs) were also used in collecting qualitative data. A well-conducted focus group discussion allows the researcher to obtain a wide range of responses as a result of a wide range of experiences coming from the group. Secondly, for some participants, the presence of peers may give them individual confidence. For others, the presence of peers may inhibit their free and open participation in the discussions. There are also other problems that are associated with the use of focus groups as a means of collecting data. The method is time-consuming, hence it was difficult to organise FGDs at the MCH since both clients and service providers were busy with their own activities. In addition, the method is also resource-demanding. For example, the researcher may need flipcharts, pens, a comfortable setting, drinks and snacks, and even some payments. Another problem is that some particularly talkative participants may dominate the discussions, thereby sending the less talkative individuals into silence.

Two FGDs (see Appendix V) were conducted at the hospital. The first one involved nurses. The second one involved patient/hospital attendants. Both FGDs were based on the following topics: the identification of languages that are commonly used by patients at the MCH; how service providers handle cases of patients whose language(s) they do not understand; and how interpretation works at the hospital. Before transcribing the FGDs, I listened to the tapes several times in order to capture the relevant emerging themes. The transcriptions, if not in English, were then translated into English. I also kept the original language version. The next step was to search for emerging themes and then relate them to the study's objectives.

1.6.5. Audio-Recordings of Client-Service Provider Interactions

Though the study does not fall into the discourse analytic tradition, I noted that it was still important to make audio recordings of client-service provider interactions. The intention was to examine transcripts of these interactions in order to answer some of the questions posed under each of the study's specific objectives. The recordings were made through the use of a mini recorder that had an in-built microphone. Before each recording, consent was sought from the informant(s). In some places, such as the registration point, the paying point and the pharmacy, there was a problem of background noise. However, the recordings in the examination rooms did not pose this problem. Another problem was that I was not allowed to be present in the examination room given that some patients would have felt uneasy in the presence of a non-medical person. I missed the visual component of the interaction. I was not able to observe how both the clients and service providers used body language. The analysis of the audio-recorded interactions took the following format. The first step was to listen to a tape several times. The next step was to transcribe the recordings and where necessary, to translate them into English. Equally important was that I listened to the tapes several times in order to identify the relevant sociolinguistic behaviour.

1.6.6. Archival Research

Archival research is one of the methods of data collection used in qualitative research. The kinds of documents that can be accessed and then analysed are many. It all depends on the subject and objectives of a particular study. Among the commonly analysed documents are autobiographies, personal letters, memos, diaries, minutes of meetings, policy documents, letters to the editor, yearbooks, personal files and news releases (Bogdan & Biklen 1992). During the fieldwork, I searched for both non-official and official documents that had the potential of providing me with the relevant information about the health services situation as well as the language situation in Malawi. In Mzuzu, I searched for documents at three locations, namely the hospital itself, the CLACA secretariat and the regional office of the National Archives of Malawi. At the hospital, I examined posters, notices of various types and health cards (also known as health passports). At the CLACA secretariat, I examined minutes of meetings. In addition, I was also able to access copies of correspondence between CLACA and government ministries/departments regarding the status and use of Tumbuka. Thirdly, I was also able to access and examine manuscripts of Tumbuka textbooks. I also accessed press cuttings that featured language issues, especially those written about Tumbuka. I was also shown copies of the surviving Tumbuka books that were part of the school curriculum before the 1968 removal of the language from the education sector. At the National Archives, my aim was to trace some relevant documents about the past use of Tumbuka. I was able to access official correspondence on the past use of Tumbuka in education.

There were a number of official documents that I consulted. With reference to language planning and language policy, I examined the Constitution of Malawi (Malawi Government 1995a) in order to find out its language-related stipulations. I also examined the Draft Language Policy on Education as well as the Draft Cultural Policy. Another important document is the country's Vision 2020 report.[9] I was, therefore, interested to find out what the Vision says about language planning and language policy. Strangely, the Vision is silent on language policy matters. It is as if language has no important part to play in national development. This is an unfortunate omission because Africa's language problems have a bearing on national development.[10]

Since language policy and planning on the one hand, and politics on the other hand, are closely connected (see Blommaert 1996a, b; 1997a), I found it important to establish what the political parties' views were. Since Malawi has more than ten parties, I limited my examination to the three main parties that have been represented in parliament since 1994. These parties are the United Democratic Front (the ruling party since 1994), the Malawi Congress Party (the ruling party from independence in 1964 to 1994) and the Alliance for Democracy (AFORD). I examined each party's previous election manifestos in order to establish their respective positions on the country's language policy. In the case of the United Democratic Front, I examined its 1993 manifesto (UDF 1993a), the 1999 manifesto (UDF 1999) and the party's draft policy on education and culture (UDF 1993b). As for the Malawi Congress Party, I examined its 1993 and 1999 manifestos (Malawi Congress Party 1993, 1999). In the case of AFORD, I was able to access part of its manifesto, with reference to the arts and culture, through a critique done by Chimombo and Chimombo (1996).

In order to get national, regional and district statistics on literacy and languages of household communication, I examined the most recent population census report (National Statistical Office 1998) as well as previous census reports. For a historical background to the early post-independence language policy and planning, I examined speeches made by Dr Hastings Kamuzu Banda (the country's first president) as well as debates in parliament (for example, Malawi Government 1966). For the latter, I examined the *Hansard*, the official verbatim record of parliamentary proceedings. Another key historical document is the compilation of the 1968 Malawi Congress Party resolutions (Malawi Congress Party 1985) regarding the official languages of Malawi. The resolutions have since 1968 up to this day served as Malawi's language policy. The examination of documents was not limited to language policy matters only. Given that the study focussed on language policy in the health sector, I found it important to examine key government documents on the health policy. Among these key documents were *Health Policy Framework* (Malawi Government 1995b), *The Bakili Muluzi Health Initiative* (Malawi Government 1999a), *To the Year 2020: a Vision for the Health Sector in Malawi* (Malawi Government 1999b), and the national health plan for the period 1999 to 2004 (Malawi Government 1999c).

1.7. Fieldwork Challenges and Constraints

My presence (as well as the presence of my research assistant) raised some suspicions at the beginning. For example, the research assistant and I were suspected of being journalists who wanted to write stories about services at the hospital. To those who are uncomfortable with journalists, we were unwelcome visitors. Others thought that we were inspectors from the Ministry of Health headquarters. But these suspicions died down quickly. One reason could be that the hospital authorities had communicated to staff informing them about the study. Secondly, my research assistant and I always explained what we were doing whenever someone was not in the know. We also carried the research clearance letter with us all the time. Whilst the suspicions surrounding me and my research assistant died down quickly at

the hospital, the same was not the case outside the research site. At the motel where I stayed for nearly five months, some people suspected me of being a member of the National Intelligence Bureau (NIB). This suspicion was triggered by my behaviour. I carried with me notepads and documents all the time. People would see me taking down notes. They would also find me asking questions about language and other related issues. Another suspicious behaviour was that I had no office in Mzuzu, yet every day I claimed to be going to my workplace. I could be found at the hospital, the Mzuzu University and other institutions such as the CLACA secretariat, the National Archives, radio stations, among other places. People also wondered how I could afford to pay for accommodation and meals for close to five months. These were all signs of a secret agent. To make matters worse for my case, my arrival in Mzuzu in April 2002 had coincided with the State President's visit to the city and the Northern Region. I was suspected of being part of the President's intelligence network. So I wore different labels. To some, I was an academic researcher. To others, I was a government spy.[11]

Access to an institution as a research site can sometimes be a problem. Sarangi (2002) notes that negotiations for access to different professional sites can be time-consuming and frustrating. In some cases, clearance comes "after exhausting and frustrating negotiations with the relevant bureaucratic bodies" as was the case when Barkhuizen and de Klerk (2002: 164; see also de Klerk & Barkhuizen 2002) set out to study the sociolinguistic situation at a South African prison. In my case, access to the research site was not a problem. What was a problem was to access some service providers. They had such a heavy workload and busy schedule that arranging for interviews was difficult and time-consuming. For example, on one occasion, I had to wait for slightly over an hour before I could interview a doctor whom I had selected as one of the key informants. I had made an appointment for the interview. However, at the agreed time, the doctor had to attend to an emergency. I had to wait. Patience and perseverance were required on my part. If I had lost my patience and gone away, I would have lost this key informant's views. In another case, a previously scheduled interview with another doctor had to be shifted to the following day because of unforeseen pressing demands on the doctor.

Audio recording of some of the interactions at the hospital was problematic. The examination room interactions were well recorded. They were noise-free. However, noisy backgrounds in open spaces like the registration point, the pharmacy and the paying point had a negative effect on the quality of recordings. There was, however, no way I could have controlled the background noise.

Conducting a sociolinguistic study at a hospital demands that the researcher, who is professionally an outsider (cf. Sarangi 2002), should come to grips with how the new Community of Practice (Lave & Wenger 1991; Wenger 1998) works. To this end, I had to familiarise myself with not only some of the basic medical registers but also some of the norms of the medical culture. This process also meant reading about the new Community of Practice. Of course the idea is not to specialise in hospital issues. But a general appreciation of how things are done in medicine and why they are done in certain ways enables the researcher to make accurate interpretations out of his/her data. Trying to understand and appreciate a new professional context can be very demanding.

1.8. SOCIOLINGUISTICS IN A HOSPITAL SETTING

I am aware of the fact that the question of language and communication in health services has attracted the attention of researchers from a wide range of disciplines (see, for example, Ainsworth-Vaughn 2001; Fleischman 2001). Therefore, different topics have been investigated using different theoretical orientations and methodologies. There are indeed

several approaches to the sociolinguistic examination of language use in hospital communication. Two of these approaches are the discourse-analytic approach (Todd & Fisher 1993; McGroarty 2002) and the language policy and planning approach (for example, see Saohatse 1997, 1998, 2000). The discourse analytic approach actually comprises many approaches that come under the common name, discourse analysis. Such approaches to the analysis of discourse include pragmatics, ethnography of communication, conversational analysis and critical discourse analysis (see Cameron 2002). In the discourse analytic approach, audio and/or video recordings of service provider (normally a doctor) and client interactions are made. The researcher then examines the actual transcripts of the service provider-patient communication. The researcher may, for example, be looking for ways in which particular styles of language are used, and the effects of the style, the content of the communication, traces of communication breakdown and other issues. My study's approach was concerned with what languages are used, what problems come with the use of such languages, and how the language problems are solved. Christian (1988: 197) regards language planning as "an explicit and systematic effort to resolve language problems and achieve related goals through institutionally organised intervention in the use of and usage of languages."

In her sociolinguistic study at the Baragwanath hospital in South Africa, Saohatse (1997) took the hospital as a heterogeneous speech community. Yet she did not critically assess the strengths and weaknesses of using the concept of speech community. I attach the label speech community to the Mzuzu Central Hospital in a more cautious manner than Saohatse (1997) because of the realisation that the notion is very slippery (see Saville-Troike 2003). Various competing definitions and descriptions of the notion of speech community exist (see, for example, Bloomfield 1933; Hocket 1958; Gumperz 1962, 1968; Lyons 1970; Labov 1972; Hudson 1996; Patrick 2002). A detailed critique of the notion of speech community is given in chapter 3. In addition to the use of the notion of speech community, I also see the existence of a specific Discourse Community within the larger Mzuzu Central Hospital speech community. This Discourse Community (Swales 1990) is made up of health service professionals such as doctors, clinicians, nurses and clinical technicians. These professionals belong to a particular Discourse Community because they have similar "professional orientations as well as a shared set of rhetorical norms and conventions" (Saville-Troike 2003: 145). The notion of Discourse Community is built around mutual dependence of language use and membership within a particular group. "The people feel connected by virtue of their shared discourse and work that the discourse enables them to do" (Bizzell 1994: 395). Whilst Saohatse (1997) categorised nurses and doctors as belonging to smaller speech communities within the larger speech community (i.e. the hospital), I treat nurses and doctors as belonging to profession-based Discourse Communities, or Communities of Practice. In chapter 3, I discuss how the concepts of Discourse Community and Community of Practice are better labels for describing the MCH than the commonly known and used concept of speech community.

1.9. SIGNIFICANCE OF THE STUDY

At this stage, it is important to pose the question raised by Sarangi (2002) in relation to a researcher's motivation in conducting a particular study: Does our motivation for a given research topic or problem align with what the professional group sees as worth investigating? To gauge the degree of seriousness with which language and communication skills are treated in the training of health professionals within the University of Malawi, I contacted the College of Medicine and the Kamuzu College of Nursing. The former trains doctors whilst the latter trains nurses and midwives. Whilst the Kamuzu College of Nursing has a section on

Language and Communication Skills located within the Department of Basic Studies (see also Kamanga 1990), the same is not is not true of the College of Medicine. Within the University of Malawi, the College of Medicine is the only one among the five constituent colleges which has no Department of Language and Communication Skills. The Department of Community Health at the College of Medicine offers elements of doctor-patient communication skills course (Chiwoza Bandawe-Personal Communication). A then final year student at the College of Medicine **(**Kwame Chiwaya-Personal Communication) confirmed this arrangement. I asked the librarian of the college whether his college stocked materials on language and communication skills. The librarian replied that communication was a peripheral area, and that greater attention was given to the acquisition of publications and other library materials for the core areas of medicine (Ralph Masanjika-Personal Communication).

Prior to the start of my study at the Mzuzu Central Hospital, the Department of Language and Communication Skills at Chancellor College at the University of Malawi had made two claims about service provider-patient communication. The first claim was that there was a public outcry that medical personnel in Malawi do not have good communication skills. Secondly, it was claimed that hospital staffs are not formally trained in communication skills. The department then suggested that this was one of the areas on which it could offer research consultancy services (Chancellor College 2001). In chapter 6, I discuss the inadequacies, for example, of the current language and communication skills curriculum at the Kamuzu College of Nursing in preparing prospective nurses for the communication realities existing in the hospitals.

The lukewarm attention paid to the greater incorporation of communication skills into the training of Malawian doctors echoes the assertion made by Waitzkin that:

> Practitioners have often paid lip service to doctor-patient communication, have felt that it is someone else's problem and have immersed themselves in the technical challenges of practice. The common assumption has been that communication is either too obvious or too mysterious to justify much detailed attention (Waitzkin 1984: 2446).

The situation elsewhere, at least in the West, is that of an increased interest in health services communication. There is, for instance, an increased interest in communication studies in medical curricula (see, for example, Sarangi 2002). Academic interest in health service related communication studies, dominated by the discourse analysis approach, has attracted researchers from a wide range of disciplines such as linguistics, medical anthropology, medical education, medical law and ethics, health psychology among many others. This diversity of disciplines has been accompanied by a diversity of research themes and methodologies. The increase in the coverage of this topic especially in discourse-related journals such as *Discourse and Society; Language in Society; Journal of Sociolinguistics* and others demonstrates further interest in health communication. Specialist journals such as *Journal of Health Communication, Health Communication, Social Science and Medicine* and others continue to give a good coverage of the subject. The creation of research centres, such as the Cardiff University's Health Communication Research Centre, is a further indication of the seriousness which communication in the health sector is now receiving. The fact that some of the research projects at Cardiff are now receiving funding from agencies which previously would fund biomedical research only further strengthens the increasing importance of health service communication studies. As Candlin puts it:

> When the Wellcome Trust and the Leverhulme Trust in the UK, the Australian Commonwealth National Health and Medical Research Council, and the World

> Health Organisation get serious about healthcare communication, then the message is very clear (Candlin 2000: 22).

When I applied for a research clearance from the Ministry of Health, a senior officer told me that it was for the first time that the ministry's research committee had to clear a study that focussed on hospital-based communication and language policy/planning. That was not the end of the story. The question of the relevance of the research came up. At the hospital itself, one of the informants wondered why I was conducting a study on language at the hospital when the country had more pressing health problems that needed research attention. One of the likely so-called pressing problems at the MCH would have been that the hospital had registered the highest direct obstetric deaths amongst all the central hospitals in Malawi during the period between January 2002 and June 2003 (see Table 1.4).

In response, I argued that my study was significant in a number of ways. First, this is the first time that a sociolinguistically oriented study has examined language policy and language practices in a Malawian hospital. The study, therefore, breaks new academic ground by focussing on the underresearched health domain.[12] Since the advent of pluralist politics in Malawi in 1994, language policy/planning research has largely concentrated on the education domain (see, for example, Centre for Language Studies 1999; Kamwendo et al 1999; Mchazime 2000; Pfaffe 2000, 2001, 2003). This dominance of language education policy confirms the claim by Kaplan & Baldauf (1997) that in some countries language policy is almost synonymous with language-in-education policy. A recent departure from this research trend is Matiki's (2001a) doctoral research that focussed on the language policy in the legislature. Matiki's study asked whether Chewa and/or other local languages can be introduced in parliament to assist those members of parliament who have problems in following the proceedings through English. Another equally important domain of language use is the judiciary. Whilst there have been concerns about the quality of court interpretation, no sociolinguistic research has been conducted in this area (see Kishindo 2001a on the concerns about the quality of the court interpretation service).

Table 1.4: Direct Obstetric Deaths at Malawi's Central Hospitals, January 2002-June 2003.

Hospital	Cases	Deaths	% Deaths
MCH	595	140	24
LCH	918	72	8
ZCH	1,055	26	2
QECH	6,367	108	2

Source of Table 1.4: Malawi Health Information Bulletin

The health domain therefore was found to be a neglected area of sociolinguistic research. The domain had been partially covered by the educationally oriented sociolinguistic survey of the Centre for Language Studies (1999) in Northern Malawi. The survey's treatment of the health domain was very limited - it had only one question on health. The purpose of this language survey was to determine the acceptability, relevance and practicality of using Tumbuka as a medium of instruction in Northern Malawi. Apart from language use in education, the survey sought to find out people's preferences of languages to be used in public domains such as religion, radio, newspapers, parliament, social work and hospitals. The only question concerning the health domain asked the respondents to cite the language that they would prefer to use at a hospital (see chapter 3, Tables 3.10, 3.11, and 3.12). Other studies on communication in the health domain include Uta's (1993) doctoral research which focussed

on the dissemination of health education information. Chilowa and Munthali's (1997, 1998a, b) study on immunisation also had one question on language use. The current study, therefore, picks up some of the sociolinguistic questions that the earlier non-sociolinguistic studies had partially addressed or did not address at all.

The current study set out to answer some important questions in relation to the earlier studies mentioned above. The questions include: what issues were overlooked by the studies of Centre for Language Studies (1999), Chilowa and Munthali (1997, 1998a, b) and Uta (1993)? What then, has the present study done to address the deficiencies of these studies? Or in what ways is the current study an extension and improvement of the earlier studies? To begin with, the Centre for Language Studies (1999) asked respondents to state the language(s) they would prefer to be used at clinics. Respondents, therefore, mentioned their preferences. While it is one thing to report about language(s) one would prefer to use at a clinic, what language(s) one actually uses when at the clinic may be different from the preferred language(s). My study did not ask what languages are preferred but asked what languages are actually used. I then proceeded to use observations and other data collection techniques to verify the responses. In the case of Chilowa and Munthali (1997, 1998a, b), it was not a study that set out to ask sociolingustic questions. The study was focussed on how effectively or ineffectively the child immunisation programme was being implemented in some districts. The study had only one language question. Uta's study[13] was not sociolinguistically oriented either, despite the fact that it did ask some language- related questions. Uta's study did not focus on any hospital whilst my study is based on fieldwork at a major referral hospital. Secondly, Uta's study was conducted in a rural setting in Southern Malawi where the dominant languages were Chewa and Yao. My study on the other hand, draws on both rural and urban patients who use the Mzuzu Central Hospital. The hospital's catchment area is predominantly Tumbuka-speaking. Apart from Tumbuka, there are a number of other languages in use in the catchment area of the hospital.

It is also important to mention that the current study contributes to the sociolinguistic understanding of Northern Malawi. The region's sociolinguistic features were under-researched during the first thirty years of Malawi's independence. The reason was not a lack of researchers but the academically restrictive climate of the Banda dictatorship (see Vail & White 1991: chapter 8; Kamwendo 1995; Mkandawire 1997; Kerr & Mapanje 2002; Zeleza 2002).[14] Under the Banda regime, any research that had questions on the effectiveness of Chewa as a means of nation-wide communication or attitudes to the national language was deemed undesirable and regarded as a threat to national unity. I have four cases of evidence to support the claim that language studies were a delicate and politically unfavourable topic during the Banda regime. The first case is that the Banda regime did not allow the Ford Foundation-sponsored East African Language Survey to take place in Malawi. The survey took place in Tanzania, Uganda, Kenya, Ethiopia and Zambia. According to Professor Lupenga Mphande, as cited by Kayambazinthu (1995: 2):

> Professors Whiteley and Thomas Gorman agreed with the Malawi Government to include Malawi in the East and Central African Language Survey. However, when Malawi spontaneously adopted Chichewa as a national language, the government withdrew its commitment on grounds that the survey would interfere with the country's language policy.

My own personal communication with Professor Mphande is an elaboration of the account cited above. According to Mphande (e-mail communication with the present author, 7th November, 2002), Professor Gorman went to Malawi and met President Banda in the company of Dr Zimani Kadzamira, a fomer Principal of Chancellor College.[15] It was at that

meeting that Banda refused to permit the survey to take place in Malawi for "it would disrupt his carefully crafted Chichewa language policy."[16]

The second case of evidence is the fact that after Malawi's 1966 census, subsequent censuses held in 1977 and 1987 did not have sociolinguistic questions. It was after the demise of the Banda regime that the census in 1998 featured sociolinguistic questions. The fear during the Banda era was that a census would reveal a sociolinguistic reality that would challenge the granting of official status to Chewa alone amongst all the local languages. In the 1998 census, two language-related questions were asked. First, the respondents were asked to mention the language(s) they used for communication in the households. The second question was on literacy. Those who claimed to be literate had their answers placed into seven language categories as follows: English only; Chewa only, other language only; English and Chewa; English and other; Chewa and other; and, English, Chewa and other. The census referred to literacy as the ability to read and write amongst those members of the population who were five years old and above.

The third case comes from Uledi-Kamanga et al (1992). In their listenership survey of the national radio, the Malawi Broadcasting Corporation, the researchers failed to address the language factor in a satisfactory manner. The survey did not raise the question on whether or not people wanted more local languages to be introduced onto the then bilingual radio. Since the elevation of Chewa to national language status in 1968, the radio had broadcast in Chewa and English only until 1994. When the new government came into office in 1994 after the first post-independence multiparty elections, more local languages were introduced for use in newscasts. The fourth case comes from Uta's (1993) doctoral research on the dissemination of health education materials. He noted that though language was an important aspect of health information dissemination, his respondents "were generally reluctant to discuss the question of plural languages. Debate on the use of other languages in official communication is a sensitive topic which most people prefer not talk about" (Uta 1993: 76). These restrictions led to the paucity of accurate and reliable data on Malawi's language situation. With the demise of the one-party state and its restrictive tendencies towards academic freedom, the ground is now clear for "open" research (Kayambazinthu 1998) into Malawi's multilingualism and multiculturalism. The new constitution provides for academic freedom (see Malawi Government 1995a). In addition, Malawi adopted the Kampala Declaration on Intellectual Freedom and Social Responsibility in 1994.[17]

In their critique of academic freedom in the post-Banda era, Kerr and Mapanje (2002) criticise Malawian academics for not taking full advantage of the new political climate to venture into research topics that were prohibited by the Banda regime. The two critics point out that such research worthy topics include the history of the nation (especially resistance to colonialism), the economics of rural exploitation, class formation and non-Chewa language and culture. In the case of language studies, my sociolinguistic research at the Mzuzu Central Hospital is one example of moving into what Kerr and Mapanje (2002: 88) call "non-Chewa language and culture" areas. This study would not have been cleared under the Banda era for two or more reasons. First, the location of the study, the Northern Region, was regarded as the home of rebels or dissidents (see chapter 2 of this thesis). Secondly, the Northern Region, with the support of the Livingstonia Mission, had fought successfully against the colonial government's desire to make Nyanja the sole local language with official status. After the demotion of Tumbuka from official circles in 1968, the Banda regime would not have tolerated sociolinguistic research on Tumbuka and other Malawian languages. The fear was that such research would have come up with findings which would have gone against the sacred political ideology of the time (i.e. one nation, one language; see also McCracken 2002).

At present, there could be other academics within Malawi who may have the desire to conduct research in what I call "liberated fields," but limited resources often frustrate them. For example, the low funding given to the University of Malawi by the government has resulted in reduced expenditure on research. Those who are fortunate to get research funding from external sources have to satisfy the donors' research agenda. Two examples from the Centre for Language Studies at the University of Malawi will illustrate the problem of funding. The first case is the Centre for Language Studies' (1999) sociolinguistic survey. The original aim of the Centre for Language Studies was to conduct a countrywide sociolinguistic survey because the country has never had such a survey before. The interested donor, the German Technical Co-operation Agency (GTZ), made it clear that they could only fund a smaller survey whose focus was on the mother tongue instruction. In order to meet the donor's condition, the survey was reduced to four languages, namely Yao, Tumbuka, Sena and Lomwe.

The second case of donors dictating the research agenda involves a radio listenership survey (Centre for Language Studies & Malawi Broadcasting Corporation 2001), whose proposal had been jointly worked out by the Centre for Language Studies and the Malawi Broadcasting Corporation. Since the last listenership survey (Uledi-Kamanga et al 1992) had been conducted during the one-party rule when it was politically unacceptable and dangerous to ask certain questions, the time was now ripe to take advantage of the prevailing atmosphere of academic freedom by conducting a follow-up survey. Though the relevance of such a study was appreciated by all the funding agencies from whom funding was solicited, they all declined to fund the project on grounds that the study was either too expensive or that the study did not lie within their areas of research interest. An important point to make here is that certain research areas seem to be of no immediate interest to some of the funding agencies operating in Malawi. Language happens to be one of such areas. GTZ has so far been the only consistent and reliable source of financial and technical support for the Centre for Language Studies' research activities on mother tongue education. It is well known that GTZ and other German aid agencies have also been in the forefront in supporting the study and development of African languages for many years in other parts of Africa (see Abdulaziz 2002).

It is my hope that my study will inform policy and decision making in the health sector. Ideally, relevant consultations and research inform policy. The reality in Malawi and other African countries, however, is that language policy decisions are often made for political gains, and as such, research findings and recommendations are often ignored. This point will be elaborated in chapters 2 and 3 where I discuss language planning in Malawi. Some scholars (e.g. Bamgbose 1991; Nzyuko 1996; Ngugi wa Thiong'o 2003) have criticised African academic researchers for not disseminating their findings widely. The language in which the research findings are couched has also been criticised:

> Researchers tend to be more comfortable sharing their world with their academic peers. They receive figures from the field (rural areas), they work on the figures and produce magnificent reports in codes, but these figures mean nothing to the field - they are written for peers in the academia. Researchers appear to be far removed from the field in distance and language (Nzyuko 1996: 227).

I will address this dissemination problem by depositing a copy of my thesis at the Ministry of Health headquarters as stipulated in the research clearance letter. I will donate other copies of the thesis to the Mzuzu Central Hospital's library as well as key libraries in Malawi, namely the National Archives, the National Library Service, the Medical Council of Malawi, the Mzuzu University and the University of Malawi's College of Medicine, the Kamuzu College of Nursing and Chancellor College. I also plan to serialise a summary of the thesis in the local

press, preferably in three languages, English, Chewa and Tumbuka. These summaries will be free from academic jargon in order to enhance comprehension. Should the situation allow, a radio feature would be another effective way of disseminating my findings to the larger non-academic audience.

1.10. CONVENTIONS AND KEY TERMS/CONCEPTS

At the outset, it is important to spell out some of the key conventions and the use of sociolinguistic terminology in this thesis. A convention adopted in this thesis is that China shall mean the Republic of China (ROC), which is also known as Taiwan.

Chewa, the national language of Malawi since 1968, is also known by the name Nyanja in other countries within Southern Africa such as in Mozambique (see Lopes 1998; Gadelii 2001), Zambia (see Heine 1970; Kashoki 1978, 1999) and elsewhere. In the current thesis, I shall maintain the name Chewa, which is still preferred in most Malawian contexts, bearing in mind that we are talking basically about the same language. In 1999, Malawi attempted to revert to the name Nyanja, but as section 2.2.3.4 will show, this change has not been successful. Officially, the language continues to be called Chewa.

Another convention is connected with the recommendation made in 1927 by the International Institute of African Languages and Cultures that all names of languages should be used in their uninflected forms. However, this recommendation has not always been faithfully followed. For instance, the language called Nyanja is often cited as Cinyanja or Chinyanja; whilst Chewa is officially cited as Chichewa. The current practice in Malawi is to use the prefixes *Chi-* or *Kya-* depending of the language in question. In this thesis, however, I will comply with the recommendations of the International Institute of African Languages and Cultures, hence I will refer to African language names without the use of prefixes. However, prefixes will be maintained if they appear in direct quotations, or if they are part of a conventional name, for example, the Chichewa Board, or the Chitumbuka Language and Culture Association.

Though Malawi and her neighbours share what are known as transborder or cross-border languages, they do not share common orthographic conventions. For example, in Malawi, they write Chiyao whilst in Mozambique (see Lopes 1998; Gadelii 2001) they use the spelling Ciyao, dropping the **h.** From a linguist's point of view, Malawi's use of the **c** and **h** combination is incorrect, but the first President, Dr Kamuzu Banda (see Kishindo 2001b), imposed this practice upon Malawi. Efforts to correct the situation are being undertaken. For example, the Centre for Language Studies at the University of Malawi proposed a revision of the Chewa orthography in which one of the issues raised was the **ch** combination. In addition, the Centre for Language Studies also revised Tumbuka and Yao orthographies, but the implementation of the orthographies has not taken place yet. At the regional level, the Centre for the Advanced Studies of African Society (CASAS) has formulated a harmonised orthography for all the languages of Malawi, Mozambique and Zambia (see Banda et al 2002; Banda 2002; Mtenje & Kamwendo 2002). The three countries have not yet ratified the harmonised orthography. In the absence of ratification, different orthographic principles continue to exist for the same language in different countries.

Just like other disciplines within the social sciences, sociolinguistics uses terms whose meaning can be elastic. For example, terms such as mother tongue, national language, minority language, and second language are some of the slippery terms which are defined differently by different authors (Adams 1975; Brann 1994; Kaplan & Baldauf 1997; Legère & Fitchat 2002: xv). Very often there is a lack of one standard way of defining a term. Referring to the social sciences in general, Adams observes that there is a:

> Tendency of many social scientists to give multiple meanings to words, often without even defining the words concerned. One author may even assign two or more meanings to the same term without giving any clue that he is using the word in a different way (Adams 1975: 526).

Adams then accounts for this terminological confusion:

> The way in which theories are developed is one potential cause of linguistic confusion. Often different writers begin their work from the same point and as they are using similar terms, the meanings of these terms will gradually drift further apart. On the other hand, as has already been mentioned, researchers who belong to different schools of thought and who subsequently study their subject from different perspectives will often use different terms to describe the same concept (Adams 1975: 526).

Language planning, a sub-discipline on which this thesis is based, has its own share of confusing terminology. For this thesis, the starting point is whether or not the terms language planning and language policy can or should be used interchangeably. Following Kaplan & Baldauf (1997) and others, I adopt the view that the two terms do not mean exactly the same thing, hence they should not be used interchangeably. This issue will be elaborated in the subsequent chapters. As far as language planning is concerned, Kaplan and Baldauf (1997: 14-26) note that there are at least four types of definitions that are associated with the sub-discipline's terminology or concepts. The definitions can be political (i.e. government definitions), social (i.e. definitions reflecting the broader view of the community), educational (i.e. definitions constructed from an educational perspective), and popular definitions (i.e. definitions which operate at the level of popular imagination). The significance of all this is that sociolinguistic terms are not always defined from a linguist's perspective. It is for this reason that the thesis will attempt to clarify how certain key concepts are used and defined.
The term national language will feature frequently in the thesis. I employ it in line with the current usage in Malawi. Chewa is the national language. It is the language that serves as a symbol of national identity. Chewa also happens to be an official language. I am also aware that the term national language can be used in more than one way. For example, Brann (1994) notes that:

> The term 'national language' has been, and is being, attributed in turn, and in different polities and circumstances, to the territorial languages of a given polity (chthonolects); to the regional languages representing the second order of geographical allocation (choralects); to the inter-ethnic or majority ethnic languages, serving as a language-in-common or community language throughout a State (demolect); and finally to the central language used for the government's official acts and records, also often serving as a symbol of the language-nation-state (politolect) (Brann 1994: 133).

By official language, I mean a language that is used in an institution's business. The institution can be governmental or non-governmental. At the governmental level, Chewa and English are the main official languages, with the latter taking the higher functional load.

I use the term local languages to refer to what others (e.g. Brann 1994) may call national languages. I have opted not to use the term national language to avoid creating confusion since the term national language is accorded to Chewa only in Malawi. I am using the term local language without implying that the concerned languages are 'inferior' in some way.

Another set of key terms is minority versus majority language(s). The European Bureau for Lesser-Used Languages views a minority language as one that "differs and is distinguished from the dominant language of a State and is spoken and/or written within a certain territory, by a smaller number of persons" (cited in Nic Shuibhne 2002: 49). Pandharipande (2002), on the other hand, argues that a minority language can be defined on the basis of its functional load and functional transparency. The functional load of language refers to the ability of a language to function successfully in one or more domains. The more domains a language covers, the higher the functional load the language is said to have. Functional transparency, on the other hand, refers to the autonomy and control that a language commands in a particular domain, whether or not the language shares functions in a particular domain with other languages.

The notion of minority languages is generally difficult to delimit in sociolinguistics. It is generally understood in two senses. In the first sense, a minority language is defined in terms of the numerical strength of its speakers. The second sense of a minority language is the lack of official status of a language in a given polity. In most of the cases, the categorisation of languages as minority is based on the numbers of speakers, but sometimes it is based on other considerations such as literary, political or education status. In the case of the MCH's minority languages, both perspectives apply. Srivastava (1984) observes that:

> Literally speaking, the term minority stands for the smaller in number of two aggregates that constitute a whole. However, this statistical definition of minority neither tells anything about the social status of a minority group vis-à-vis the majority group in a given society, nor does it reflect its attitude towards the majority group and vice-versa... A definition of minority can include in this orbit even the elite and dominant section of society which, in spite of being far smaller in number, happens to wield power and has access to resources which are not available to the subordinate but majority population group (Srivastava 1984: 189).

In Malawi's case, English is the most important and prestigious language socio-economically and politically though it is spoken/used by a minority of the population. Bamgbose (2000a: 14-15) has noted that sometimes "a single minority language taken by itself may appear to be small and perhaps inconsequential, but when all the so-called minority languages are taken together, the picture that emerges is that of a sizeable proportion of the population." In the thesis, the fluidity of the majority/minority language distinction will be demonstrated.

Another commonly used term in the thesis is mother tongue. This is one of the many sociolinguistic terms that defy single and clear-cut definitions. Skutnabb-Kangas (2000), for example, offers four ways of defining a mother tongue. The first definition is that a mother tongue is the language one learnt first. It is the language in which one has established the first long-lasting verbal contacts. This definition is based on origin. Second, a mother tongue can be defined as the language one identifies with as a native speaker. It may also be the language one is identified with as a native speaker by others. The basis of this set of definitions is identification. Third, on the basis of competence, a mother tongue can be defined as the language one knows best. The fourth way of defining a mother tongue is based on function. In this regard, a mother tongue is the language one uses most (Skutnabb-Kangas 2000: 106). In the thesis, this elasticity of the term mother tongue is maintained since it is not always clear as to what is meant when someone claims that a particular language is his or her mother tongue.

I also define a few key non-sociolinguistic concepts, which are of paramount importance to the overall discussion. These terms are health, health services, service providers, and clients. The thesis adopts the World Health Organisation's definition of health, cited by Evans (2002: 198) as "a state of complete physical, mental and social well-being."

In this thesis, a health service provider shall mean a man or woman who provides people with preventive and curative drugs as well as health-related information. These include doctors, nurses, dentists and other health professionals. Given the existence of "traditional" medicine as a complement to Western medicine in Malawi, practitioners in the former are also fit to be called health service providers. I also extend the definition of health service providers to include support staff such as patient and hospital attendants since they place a crucial role in providing non-professional support services to the professionals.

Health services shall mean the provision of counselling, preventive and curative drugs as well as the provision of health related information. Health services in Malawi include Western medicine, Oriental Medicine and "traditional medicine." The beneficiaries of the health services are called clients. In the thesis, clients shall be used as an umbrella term that covers categories such as out-patients, in-patients and guardians. In Malawi, patients are normally expected to have guardians. These guardians provide patients with non-clinical care such changing and washing linen and clothes, cooking food (i.e. when the hospital does not provide food), and observing the condition of the patient. It is guardians who normally report to the doctor daily about the progress in the patients' health, especially when the patient is too ill to speak about his/her condition. A patient without a guardian, therefore, leads a very miserable life.

1.11. ORGANISATION OF THE THESIS

The forthcoming chapters of the thesis are as follows. In chapter 2 (Malawi: Politics, Language and Health), I give a historical, political, social and economic overview of Malawi, tracing trends from the missionary/colonial era up to the post-colonial era. The chapter introduces the reader to Malawi, the Northern Region (where the study was conducted), Mzuzu city (where the MCH is located) and finally the hospital itself. In chapter 3, I present the study's theoretical and analytical orientation. From chapter 4 to 7, I discuss various themes in connection with the findings. The findings of the study are discussed as follows: Patterns of Language Use Within and Outside the Hospital (chapter 4), Communication Barriers at the MCH (chapter 5), Language Services and Language Rights (chapter 6), and Language Policy and Planning in Health Services (chapter 7), and Summary and Conclusions of the Thesis (chapter 8).

NOTES

[1] I should acknowledge that Saohatse (1997) had earlier conducted a related study at the Baragwanath hospital in South Africa. In order to show the similarities and differences between her study and my own study, I reproduce Saohatse's objectives as follows:
i. To identify problems caused by the use of many languages at Baragwanath hospital;
ii. To find solutions to these communication problems;
iii.To identify language varieties that occur at Baragwanath hospital;
iv. To describe each variety in different speech communities; that is, the variety used in conversation between: doctors and doctors; doctors and nurses; doctors and patients; nurses and nurses; nurses and patients; nurses and visitors; patients and visitors; as well as the function of the particular language variety in every situation above;
v. To describe the attitudes towards each variety by the various speakers (Saohatse 1997: 44-45).

[2] There are some terminology problems surrounding health as a human right. For example, the literature presents four perspectives, namely: the right to health, the right to health care, the

right to health protection, and health rights (see Toebes 2001). At the United Nations level, the most often used term is the right to health, which should not be mistaken as the right to be healthy. The right to health can be found, for example, in: Article 25 of the Universal Declaration of Human Rights; Article 12 of the International Covenant on Economic, Social and Cultural Rights; Article 12 of the Convention on the Elimination of All Forms of Discrimination Against Women; Article 24 of the Convention on the Rights of the Child; and Article 11 of the European Social Charter.

[3] Koji (2001: 918), for example, notes that "the realisation of each human right requires other human rights and, in this sense, all human rights are indivisible."

[4] Lambya and Nyiha are two of the minority languages of Northern Malawi.

[5] Whilst researchers strive to maintain the anonymity of their informants, the latter may sometimes dislike the practice. For example, van der Geest (2003) conducted an anthropological study in Ghana. He carefully protected his informants' identities by giving them pseudonyms. When he returned to his informants some years later, he noted that they were disappointed with his published works because they had not mentioned them by name. The Ghanaian informants felt that the use of pseudonyms had rendered them invisible. They, therefore, gave him the consent to use their real names in future publications. This situation, however, does not apply to my study.

[6] For instance, during a sociolinguistic survey of Tumbuka (Centre for Language Studies 1999), "it was noted that pupils from the lower classes usually did not provide reasonable and meaningful answers. The subjects in this category were too young to understand and appreciate the research questions. So the research team opted for senior pupils" (Centre for Language Studies 1999: 22).

[7] cf. Fishman et al (1971: 295) who advocate the use of the following data sources in studies of language policy/planning: government reports and other documents, archival materials, newspaper accounts, structured and semi-structured interviews with key informants, and the use of questionnaires. This approach is highlighted in section 1.6 in this chapter.

[8] It is not only hospitals that have restrictions in terms of the areas that can be accessed by researchers. Sociolinguistic researchers studying language policy and planning in South African Prison Services (Barkhuizen & de Klerk 2002; de Klerk & Barkhuizen 2002) were allowed to make their observations only around the public-access areas of a prison. This is a common research constraint associated with studies conducted in institutions that are sensitive or security-conscious.

[9] This document outlines the kind of Malawi its citizens would like to have by the year 2020.

[10] Whilst this is the case, language continues to be sidelined in Africa-wide programmes such as the New Partnership for Africa's Development (NEPAD). This is a programme whose goals are to free Africa from poverty, and to enhance sustainable development. Bamgbose has observed that "so far, there is no specific mention of language" in NEPAD's framework (Bamgbose 2003: 43).

[11] Another Malawian researcher (Munthali 2001), who conducted medical anthropology fieldwork in his own home area in Rumphi in the same Northern Region, was also suspected of being a member of the Criminal Investigation Department of the Police. Elsewhere, sociolinguists' fieldwork behaviour has also attracted suspicions. In the USA, for example, Wolfram & Fasold (1997: 104-105) have noted that: "Even if we present our purpose for interviewing in a straightforward manner, we must realise that informants can easily become suspicious of our motives. It is sometimes difficult for informants to believe we are simply interested in speech. We have, on occasion, been suspected of being everything from a tape recorder salesman to FBI agents."

[12] To the best of my knowledge, this is the first Malawian sociolinguistic study of language use in the health service domain.

[13] The objectives of Uta's (1993) study stand in marked contrast to my study's objectives, namely:

i. To identify and analyse problems which are found to hamper the effective communication of health information to rural populations,
ii. To identify the sources which people perceive to be their trusted sources of health information,
iii. To match the characteristics of information provided in (i) above with the information-seeking patterns of the population in (ii) above,
iv. To review the hypothesis that radio health messages are often ignored because they are badly timed or are in a wrong language,
v. To validate the need for packaging and/or repackaging of some information in forms which rural communities can use effectively,
vi. To assess the levels of AIDS and bilharzia awareness among rural Malawian population (Uta 1993: 1-2).

[14] For a broader picture of academic freedom in Africa, see Mamdani and Diouf (1994).

[15] Chancellor College is the main constituent college of the University of Malawi.

[16] It has to be mentioned that even in Tanzania, where the survey was allowed to take place, some restrictions were put in place. For example, "the study of Swahili as a national language was not to be questioned; any systematic linguistic study of the local vernaculars was discouraged" (Polomé 1982: 61). In addition, Polomé says that some parts of the country were not accessible. Actually the survey team's entry into the islands of Pemba and Zanzibar was restricted, probably on political grounds best known to the authorities. Another restrictive tendency was that the survey team was required to get the support and clearance of the local branch leadership of the Tanganyika African National Union (now called *Chama cha Mapinduzi*). Legère (2002a) acknowledges the fact that the current political climate in Tanzania accommodates research on languages other than Swahili as testified by an ongoing language survey.

[17] The adoption of the Declaration took place at Malawi's first national conference on academic freedom which was held in Mangochi from 17th to 20th October, 1994, under the sponsorship of the Council for the Development of Economic and Social Research in Africa (CODESRIA) (see Kamwendo 1995 for a review of the conference).

CHAPTER 2

MALAWI: POLITICS, LANGUAGE AND HEALTH.

2.1. INTRODUCTION

Malawi, previously known as Nyasaland during the British colonial rule, is a small landlocked country situated in Southern Africa (see Appendices I and II). The country shares borders with Zambia to the west, Tanzania to the north and northeast and Mozambique to the east, south and southwest. Administratively, Malawi is divided into three regions, namely the Northern Region, the Central Region and the Southern Region. Each region is made up of administrative districts.

This chapter presents an overview of Malawi's history, socio-political and economic status. Such an account is important in this study of language policy/planning since it offers a context within which the findings can be appreciated and interpreted. Politics and power during both colonial and post-colonial Malawi have shaped language policy/planning. This interface between politics, ideology and power on one hand, and language policy/planning on the other, is demonstrated in this chapter. I subscribe to the view that "politics, power, ideology and other concepts that were hitherto strictly off limits to self-respecting linguists are relevant, sometimes even crucial in explaining linguistic phenomena of various types and sizes" (Blommaert 1997a: 6).

2.2. THE MAKING OF MODERN MALAWI: POLITICAL AND SOCIO-ECONOMIC SITUATION

I have found it meaningful to divide Malawi's socio-political history into three phases, namely: the missionary/colonial phase, and the post-independence phase which has been sub-divided into the Banda and post-Banda eras. The missionary/colonial era begins in the 1860s with the arrival of Scottish Christian missionaries. As has been the case elsewhere in Africa, these missionaries acted as harbingers to colonial rule.[1] In terms of both the nationalist phase and the post-colonial history of Malawi, the name Hastings Kamuzu Banda (Short 1974) features prominently. He led the country to independence in 1964. Under his thirty years of one-party rule, Malawi witnessed some of Africa's worst autocratic tendencies and gross violations of human rights (see Africa Watch 1990). Banda dominated the politics as well as the day-to-day running of Malawi. He directed policy on almost every aspect, language included. Because of the enormous influence Banda has had on Malawi, I have found it useful to divide Malawi's post-colonial history into the Banda era (from 1964 to 1994) and the post-Banda era (from 1994 to the present day). Though Banda[2] ceased to be president in 1994 following an electoral defeat in the first post-independence multiparty general elections, and died later on 25th November in 1997, his legacy refuses to die.

2.2.1. The Missionary/Colonial Era

The introduction of education and English in Malawi has been traced to the pioneer Scottish Christian missionaries, and later to the establishment of British colonial rule. The Scottish missionaries persuaded the British government to establish colonial rule in the land that later came to be called the Nyasaland protectorate. The coming of missionary work to Nyasaland was a direct response to a call for evangelisation and the replacement of slave trade with

legitimate and morally unquestionable trade. The Scottish missionary explorer, Dr David Livingstone, had made this call. Between 1858 and 1863, Livingstone made four journeys to Central Africa as part of his Zambezi river expedition. During the expeditions, he noted the existence of Arab-led slave trade and the non-existence of missionary activity in the area surrounding Lake Nyasa. Following these visits to the country, an appeal for the stamping out of slave trade and its replacement with legitimate trade was made. Livingstone also called upon Scottish missionaries to open up missionary work in the region. Two developments followed Livingstone's appeal. The first response came from missionary groups, and the second response came from the commercial sector. The first missionary group to set out for the region was the Universities Mission to Central Africa (UMCA), which arrived in 1861. The UMCA first established itself at Magomero (see White 1987) in the south of Nyasaland, and later moved to the Likoma Islands on Lake Nyasa. This is the church that is now known as the Anglican Church.

The second group of Scottish missionaries arrived in Nyasaland in 1875. This was the Free Church of Scotland. Members of the church first arrived at the mouth of the Zambezi. The team then sailed inland on the Zambezi river through the Shire river using a steamer called the Ilala. In the present-day Malawi, members of the mission sailed on the Shire all the way up to the Lake Nyasa where they established the first station at Cape Maclear. The Cape Maclear area was found to be unhealthy due to malaria and other diseases. Within a space of five years, many missionaries had died of malaria and other tropical diseases. Another problem was that the area was sparsely populated because it lay on the slave trade route. It was therefore decided that the mission be shifted to a healthier environment. The shift was made and Dr Robert Laws, the leader, moved the station northwards along Lake Nyasa (now Lake Malawi). Bandawe then became the new mission site. Since all the supplies for the missionaries came from Scotland by water, it was again found necessary to settle near the lake (Vail & White 1989). The mission was located among the lakeshore Tonga. This missionary group later moved into the interior of Northern Nyasaland and then spread its influence and operations across the region. The mission was named Livingstonia in memory of David Livingstone.[3]

In 1876, a third positive response was made to Livingstone's call for missionary work in Africa. The response came from the Established Church of Scotland that set up its first station at Kabula, the site of the present-day city of Blantyre. The site of the mission was named Blantyre after David Livingstone's home village in Scotland. The mission's first converts were the Mang'anja. The mission, therefore, adopted the Mang'anja dialect of Nyanja as its medium of evangelisation and education. From Kabula, the mission later extended its stations to other parts of what is now Southern Malawi. Some of the notable stations were opened at Mulanje and Domasi. The Established Church of Scotland is today what is known as the Blantyre Synod of the Church of the Central African Presbyterian (CCAP).[4]

Other missionary groups such as the Roman Catholic Church and the protestant Dutch Reformed Church came later on the scene. The contributions of the missionaries to Malawi's socio-political and economic development are enormous. First, the missionaries helped in stamping out slave trade and restoring order.[5] Secondly, the missionaries did not only evangelise but also opened up the first schools. Apart from teaching local languages, these schools also introduced the teaching of the English language. The establishment of colonial rule in 1891 strengthened the position of English. Till 1925, education was entirely in the hands of missionaries. Up to the current date, some of the most prominent schools are still owned by the churches. The mission-educated Africans found themselves taking up various positions in both the colonial and post-colonial civil service. Thirdly, some of the missionaries, especially the Livingstonia Mission, produced some of the pioneer African

political activists who agitated for independence from Britain. Dr Hastings Kamuzu Banda, Malawi's first president, was also a product of a mission school that was run by the Livingstonia Mission (see McMaster 1974; Short 1974). In addition to education, the missionaries also introduced Western medicine to Malawi. For example, Dr Laws of the Livingstonia Mission was a medical doctor as well as a reverend. So the missionaries were not only interested in healing the soul but also the body.[6] What is most relevant for a sociolinguist is that in the fulfilment of their tasks, missionaries placed great emphasis on the use of local languages. The golden principle was to use the local languages to carry out evangelisation, education and other tasks. Missionaries then took a very active role in the development of the local languages in an activity we now call language planning. In terms of language planning, the Livingstonia Mission was important in its "support of the regional lingua franca Tumbuka against colonial administration and the national lingua franca Nyanja helped to establish the major divisions that are still felt today" (Schmied 1996: 302). (See section 2.2.1.1 below).

As I mentioned earlier, Dr David Livingstone's call also received a positive response from the commercial sector. To this end, a group of traders from Glasgow in Scotland established a trading company known as the African Lakes Corporation (also known locally as Mandala). The company started its operations under the management of the Moir brothers, Fredrick and John. These were followed by the arrival of planters in the Southern Province who opened up tea, coffee and tung estates.[7] The planters later entered the Central Province where they majored in tobacco production. The arrival of the planters created wage labour. The mining industries of Northern and Southern Rhodesia and South Africa created another market for Malawian labour (see, for example, McCracken 1977b). These economic activities can be seen as the realisation of Livingstone's dream about the replacement of slave trade with legitimate trade and other economic activities.

British colonial rule started on 4th May in 1891 in what was then known as the British Central Africa Protectorate. Sir Harry Johnston was made Commissioner General. The name of the protectorate was changed to Nyasaland Protectorate on 6th July 1907. The name Nyasaland is traced to the days of the Scottish missionary and explorer, David Livingstone. The word *nyasa* means lake in Yao, one of the Bantu languages of Malawi. When Livingstone reached a great lake, he asked the locals (Yaos) about the name of the lake. The locals did not have a name for the lake: it was simply *nyasa* (the lake). Livingstone took it that the name of the lake was *nyasa* and recorded so in his diary. From then on, this third largest lake in Africa has been known as Lake Nyasa.[8] When colonial rule came into being, the area surrounding the lake region was named Nyasaland (the land of the lake).

In 1915, the colonial government faced an uprising, popularly known as the Chilembwe rebellion. The uprising was a demonstration of Africans' grievances[9] against the injustices of the colonial rule. In 1944, the Nyasaland African Congress (hereafter NAC) was formed with the aim of pressing for an end to colonial rule. In 1953, Nyasaland became part of the Federation of Rhodesia and Nyasaland. The other partners in the federation were Northern Rhodesia (now called Zambia) and Southern Rhodesia (now called Zimbabwe). Some of the leaders in the NAC, like Henry Masauko Chipembere and Kanyama Chiume felt that they lacked the maturity and charisma to lead the party. They, therefore, started to persuade Dr Banda, who was then practising medicine in Britain, to come back home and take up the leadership of the party. In 1958, the NAC formally invited Dr Hastings Kamuzu Banda to assume the leadership of the party (Short 1974; McMaster 1974). Banda,[10] a Malawian medical doctor who had lived outside Malawi for over forty years, returned on 6th July 1958. Banda mounted a strong campaign against the Federation of Rhodesia and Nyasaland. Following some waves of civil unrest that made Nyasaland ungovernable, a state of

emergency was declared on 3rd March 1959. The NAC was banned and some of its leaders, including Banda, were detained. Whilst Banda was in detention, the Malawi Congress Party (hereafter MCP) was formed by Orton Chirwa and his associates in September 1959. The Malawi Congress Party was simply the NAC under a new name. Upon his release from Gweru prison on 1st April 1960, Banda took over the leadership of the Malawi Congress Party. On 6th July 1964, Malawi became independent and Banda became its Prime Minister.

2.2.1.1. Language Policy/Planning

In this section, I discuss the language policy/planning situation during the missionary/colonial era. The primary aim of Christian missionaries was not to provide Africans with formal education but to spread Christianity. It became clear to the missionaries that they could not carry out evangelisation whilst the targeted communities remained illiterate. The first schools were, therefore, set up with the goal of equipping African converts with literacy skills. Each mission adopted as its medium of evangelisation and education the dominant language or dialect of its sphere of influence. The pioneer missionaries, then, had a double mission of conversion - converting the local people to Christianity and the local languages into a written mode (see also Welmers 1974). Since this thesis is based on a study that was conducted in the Northern Region of Malawi, I will devote the larger part of this section to a discussion of the role of the pioneer missionaries in language planning activities in that region.

Whilst the Livingstonia Mission is renowned for its development and promotion of Tumbuka as the lingua franca of the Northern Region, in the Southern and Central Regions, different dialects of Nyanja were promoted by different missionaries. In the case of Nyanja, the missionaries found themselves working with one of the three dialects of the language. These dialects were Mang'anja in the southeast, Chewa in the centre, and Nyanja in the northeast (Heine 1970). The Established Church of Scotland which had set up its headquarters at Kabula (Blantyre Mission) found that Mang'anja was the dominant dialect within its sphere of influence. The Mission therefore reduced this dialect into writing. One of the Blantyre Mission's remarkable contributions to the development of Nyanja came in 1892 with the publication of David Scott's *A Cyclopaedic Dictionary of the Mang'anja Language Spoken in British Central Africa.* Another Blantyre missionary, Alexander Hetherwick, revised and enlarged the dictionary. The new edition of the dictionary, which was published in 1929, took the title *Dictionary of the Nyanja Language.* The Dutch Reformed Church settled in the Central Region where the lingua franca was the dialect of Nyanja known as Chewa. The UMCA, because of its interest in the Lake Nyasa area, promoted the dialect of the lake area. The UMCA produced not only religious but also secular works using the Likoma dialect of Nyanja (see Mwiyeriwa 1978 for missionaries' contribution to the growth of the vernacular literature of Malawi).

As for the Livingstonia Mission, its first station was Cape Maclear in the Southern Region. The initial language of missionary work was Nyanja. Dr Robert Laws, the mission leader, and his group had thought that they would be able to use Nyanja when they shifted the mission to the northern end of Lake Nyasa. When the Mission opened up its first station in the Northern Region among the Tonga at Bandawe, they found a new language. It was Tonga. Further into the interior, the Livingstonia Mission "encountered a Babel of linguistic confusion" (Vail & White 1989: 153) that consisted of Nyiha, Lambya, Sukwa, Ngonde, Tumbuka, Ngoni and others. The most predominant language was Tumbuka. The missionaries then realised that Nyanja was not the most effective medium of evangelisation and education. They, therefore, abandoned their earlier plan to use Nyanja. With the passage of time, missionary work extended into the interior among the Ngoni and their subjects, the

Tumbuka. In the interior, the main language turned out to be Tumbuka, the language of the conquered. For missionary work to succeed in this area, the Livingstonia Missionaries turned to Tumbuka as the medium of evangelisation. In order not to lose the Tonga, the first converts, missionary work in Tongaland continued in Tonga whilst inland, the medium changed to Tumbuka (Vail & White 1989).

In order to win the hearts of the Ngoni ruling class and others who still maintained their mother tongue, the Livingstonia Mission, found it necessary to include Ngoni on the list of languages of missionary work. But Ngoni was not a widely used language. Though it was the language of the Ngoni conquerors, their subjects were not forced to adopt it. The defeated groups such as the Tonga and the Tumbuka maintained their respective languages. Whilst the Ngoni were able to maintain their traditional customs, they were not able to keep their language alive. They adopted Tumbuka, the language of their subjects (see Tew 1950; Vail & White 1989). By 1900, Chingoni was becoming moribund. The fact that the Livingstonia Mission turned to Tumbuka as its main language of work bears testimony to the fact that Ngoni was not a language of wider communication. In order to increase chances of winning converts among the reluctant Ngoni, the Livingstonia Mission did use Ngoni to some extent, mainly to cater for the Ngoni ruling class who still had the language. The Mission brought in some Zulu-speaking evangelists from South Africa in order to improve communication with the Ngoni. By 1890, 250 copies of a translation of Harry's catechism in Ngoni were available. At the same time, 500 copies of St. Mark's Gospel had been translated into Tonga and another 500 copies had been made available in Ngoni. The missionary Elmslie is also reported to have worked on the grammar and lexicon of Tumbuka and Ngoni (McIntosh 1993).

In 1918, the status of Tumbuka[11] came under a threat when the move towards making Nyanja the official language in Nyasaland started. Some junior officers in the colonial government revived the idea that the language should be given official status and that it should be taught in all the schools. The then governor, Sir George Smith, is said to have rejected the idea. The governor's fear was that the policy would unite people of different ethnolinguistic origins against colonial rule. This was undesirable for colonial interests, and therefore, the divide-and-rule tactic of encouraging a number of lingua francas (e.g. Nyanja in the Southern and Central Regions and Tumbuka in the Northern Region) had to continue (Vail & White 1989). The Nyanja case took a different course when Sir Shenton Thomas became governor of Nyasaland. Unlike former Governor Smith, the new governor was not a divide-and-rule enthusiast. His goal was to streamline the administration of Nyasaland and the language policy was one tool for achieving this objective. He argued that Nyanja as the official language would bring about two benefits. First, the government would save money in that it would invest in only one language. This was in line with the view that monolingualism is economically less costly than multilingualism. The second benefit was that such a policy would unite the protectorate in that people of divergent ethnolinguistic backgrounds would take Nyanja as their rallying point.

Determined to see Nyanja fulfil the two aims of unity and cost reduction, the Advisory Committee on Education made a formal proposal that Nyanja should be made a medium of instruction throughout Nyasaland not later than class 4 in both government and assisted schools. The latter meant schools that were run by the churches. A threatening condition was attached to the new policy. The government made it clear that any institution that opted to disregard the policy would not receive government aid. This condition was made in the hope that there should emerge full compliance with the language policy directive. This agrees with the assertion by language planning scholars that language planning is generally a government-dominated activity and that governments have "the power to legislate and the ability to enforce incentive structures (and disincentive structures) to enforce planning decisions"

(Kaplan & Baldauf 1997: 5). The colonial government was using its financial aid as a weapon to force unwilling missionaries into submission.

The Livingstonia Mission was not ready to bow to this pressure. On 15 July 1933, the Mission issued four grounds on which it found the new language policy unacceptable. The first argument was that the people themselves opposed Nyanja. Therefore, it was not good to impose a rejected language upon the people. Secondly, by not being close to the peoples' daily linguistic interactions, Nyanja would be a hindrance to effective learning. The best medium for instruction was Tumbuka because it was much closer and better understood than Nyanja. The third argument against Nyanja was that it was not the language of higher culture and linguistic value. The people were more interested in learning through Tumbuka and then move on to learn English, a language of high socio-political and economic value. Fourthly, the Livingstonia Mission argued that it had invested heavily in Tumbuka teaching and learning materials as well as in human resources. With the adoption of Nyanja, the Livingstonia Mission doubted that it could successfully get such materials and human resources for the new language.

When a new governor, Sir Herbert Young, went to the Northern Province to persuade the Livingstonia Mission and the people to accept the new language policy, he was greeted with stiff resistance. This resistance came not only from the Livingstonia Mission but also from some of the articulate African graduates of the Mission. When the governor met Ngoni leaders, their spokesperson, Charles Chinula declared that "Chinyanja is not wanted in this Chitumbuka-speaking area" (Vail & White 1989: 165). The governor's meeting with Tumbuka leaders produced another anti-Nyanja stance. One of the highly respected Tumbuka elites, Levi Mumba, argued that time was not yet ripe for Nyasaland to have a lingua franca. At the appropriate time, so Mumba argued, that language would have to be English and not Nyanja (Vail & White 1989). The Ngoni and the Tumbuka had spoken with one voice in defence of Tumbuka. That Levi Mumba and Charles Chinula were bold enough to voice opposition to the colonial language policy is a reflection of the critical thinking that the Livingstonia Mission had inculcated in its students.

Since different missionaries worked under different language situations, it then naturally follows that different language policies were followed. There was, therefore, no united stand against the Nyanja proposal. Whilst the Livingstonia Mission was vehemently against the proposal, other missions welcomed the policy. For example, the Roman Catholic Church, the protestant Dutch Reformed Church and other churches that were working in the predominantly Nyanja-speaking areas raised no objection to the government's proposal. In the very sphere of Livingstonia Mission's influence, in the northern tip of the Protectorate (present-day Karonga), Ngonde speakers, who had all along objected to Tumbuka influence, saw this as an opportunity to rid themselves of the language of their Tumbuka overlords. Ngonde speakers despised the Tumbuka-speaking and mission-educated Henga who had settled in their area. To the Ngonde, the Henga were refugees. The Ngonde, therefore, welcomed Nyanja as a replacement of Tumbuka. The Ngonde paramount chief, Peter Mwakasungula, supported the Nyanja proposal (Vail & White 1989; McCracken 2002). The Ngonde had been unhappy all along after the Livingstonia Mission had discontinued using Ngonde for evangelisation and education, and had instead adopted Tumbuka (see Kalinga 1985). Backed by this support, Governor Harold Kittermaster ordered the implementation of the policy.

The Livingstonia Mission's fighting spirit refused to die. The Mission appealed to the Colonial Office in London. A sympathetic ear was given to the Livingstonia Mission's concerns. Considering that the Livingstonia Mission had contributed significantly to the protectorate's education, the Colonial Office reasoned that it was unwise to break off ties with

such an important partner. The Colonial Office then advised the governor and his administration "to hold another conference and to impose no policy against the Mission's wishes" (Vail & White 1989: 165). The governor complied with the orders from London and convened the conference. Levi Mumba took the occasion to dismiss any future reissue of the Nyanja proposal, adding that the use of the language as a medium of instruction in the Northern Province "would interfere with the mental development of the children" (Vail & White 1989: 165). The dispute was over. The government had been defeated. The Livingstonia Mission continued with its Tumbuka policy. In 1947, Tumbuka and Nyanja were given official status despite the fact that the former "was spoken by a small fraction of the population" (Vail & White 1989: 166). Tumbuka held this position till 1968. It is interesting that during the Banda era, it was politicians from the Tumbuka-speaking Northern Region who led the move to relegate Tumbuka from official domains (see section 2.2.2.1 in this chapter).

2.2.2. The Banda Era

Soon after the attainment of independence, Malawi had a cabinet crisis (Short 1974; Baker 2001). This was a situation during which some of the members of the cabinet disagreed with Banda over a number of issues such as foreign policy and the process of Africanising the civil service. Upon leaving the cabinet, the rebel ministers fled into exile.[12] One of the former ministers, Yatuta Chisiza, attempted an armed invasion of Malawi but Malawian soldiers quickly killed him. After the cabinet crisis, Banda tightened his grip over Malawi and ruled the country in a very dictatorial manner, coupled with gross violation of human rights (Short 1974; McMaster 1974; Africa Watch 1990).

In 1966, Malawi attained republican status and Dr Banda became the first president. At the end of his first five-year term of office, the MCP pushed for an amendment of the constitution to make Banda president for life. On 6th July 1971, Banda was sworn in as Life President. This constitutional amendment consolidated Banda's authoritarianism. Open criticism of Banda's dictatorial tendencies was crushed ruthlessly through the use of the secret service, the Malawi Young Pioneers (a paramilitary wing of the MCP) and other institutions of torture. The Banda regime set up a very oppressive censorship system that muzzled press, literary, art and academic freedoms (see Mapanje 1988; Vail & White 1991: chapter 8; Mkandawire 1997; Kerr & Mapanje 2002; Zeleza 1996, 2002). This oppressive atmosphere, coupled with the outlawing of opposition parties, created a culture of silence and forced obedience (Africa Watch 1990) as well as the culture of hero-worshipping and praise-singing (Vail & White 1991: chapter 8).

The Academia was deprived of its critical and objective voice. Critical academic expatriates were given deportation orders on grounds that their ideas were subversive and dangerous to the political stability of the country. Academics of local origin who took a critical socio-political stance were either jailed or forced to flee into exile. Courses taught at the then only university, the University of Malawi, were carefully scrutinised to ensure that the so-called subversive disciplines or topics were not on offer. The media too was heavily censored, and it was generally sunshine journalism that became the order of the day. The biting teeth of the media had been taken off. The religious denominations also went into silence and failed to speak on behalf of the oppressed. It was not until 8th March, 1992 that the Catholic Church broke its long silence and voiced its concern over the country's socio-economic and political problems through a pastoral letter[13] (see, for example, Newell 1995; Forster 1997; Schoffeleers[14] 1999a). (See section 2.2.2.2 for a discussion on the political impact of the pastoral letter).

2.2.2.1. Language Policy/Planning

In this section, I focus on language policy/planning during the Banda era. Two significant developments that occurred in this era were the official demise of Tumbuka and the consolidation of Nyanja (later called Chewa) as the national language. The process of consolidating the status and prestige of Chewa was accompanied by the definition of what Banda perceived to be the "correct" Chewa. Between 1964 and 1994, Malawi's language planning was engineered by the then Life President, Dr. Hastings Kamuzu Banda. He asserted so great an influence on language planning that the final outcome was largely his personal views rather than views from language experts or policy makers. He was the unquestionable language planner and language policy maker during the period 1964 to 1994. During this period, language planning and language policy were guided by the desire to use a single national language (Chewa) as "a unifying agent in an ethnically and linguistically divided country" (Kishindo 1998a: 252). When Malawi attained independence from Britain on 6th July 1964, the country retained the colonial language policy. The policy maintained English as the main official language. Tumbuka and Nyanja were also retained as the supporting official languages. On the national radio, three languages were used, namely English, Tumbuka and Nyanja. The same three languages were also used in the school curriculum. The enthusiasm for Tumbuka was so strong that Austin Mkandawire translated Shakespeare's *Julius Caesar* into Tumbuka.[15]

At a time when the situation in the education sector was very encouraging for the development and promotion of Tumbuka, the Malawi Congress Party was making plans to relegate Tumbuka from official domains. The first proposal towards promoting Nyanja at the expense of Tumbuka came from a Tumbuka-speaking politician of Ngoni origin. As early as 1963, the regional chairman of the Malawi Congress Party in the Northern Region, McKinley Chibambo, had suggested that Nyanja should be made the national language (see Malawi Government 1966; Short 1974; McCracken 2002). Chibambo had used the slogan "one Kamuzu (Banda), one flag, one nation, one language and one party" (McCracken 2002: 86). At that time, Malawi had attained self-rule but not full independence. The then Prime Minister, Dr Hastings Kamuzu Banda, is said to have rejected Chibambo's proposal on grounds that Nyanja had to undergo standardisation into "real" Nyanja before it could play the role of national language.

The idea of making Nyanja the national language resurfaced in parliament in 1966. Yet another politician from the Northern Region revived the idea. A junior cabinet minister, Flax Musopole, presented the language policy proposal during his contribution to a debate on the amendment of the Malawi Broadcasting Corporation Act. The bill under debate sought to give the Minister of Development and Planning more powers over the day-to-day running of the national radio station. The bill itself had nothing to say about the language policy. However, Musopole diverted the debate to language policy (see Malawi Government 1966: 494-495; and also McCracken 2002). He unambiguously proposed that Nyanja should be the sole national language. After him, several members of parliament spoke in support of the proposal. The majority view was that Tumbuka should be removed and that Nyanja should become the sole local language in use on the national radio. Aleke Banda,[16] then the Minister responsible for the Malawi Broadcasting Corporation, cleverly and without angering the then Prime Minister Dr Banda, acknowledged the desire to remove Tumbuka from the radio broadcasts. He hinted, however, that in some non-Chewa-speaking areas, the proposed policy could face some problems:

> Now I would like to point out one problem on this point that, while we reduce the use of Chitumbuka and increase that of Chinyanja, I think I would also like to mention here that it may be necessary in certain special circumstances for us to do some broadcasting in one of the local languages for special reasons. In some local areas, for example, we may find that it is almost impossible for some of the people to understand what we are saying in English or Chinyanja or Tumbuka and, therefore, perhaps we should say it in the language which people can understand. Perhaps I shouldn't say very much at the moment, but there are one or two particular areas which I have in mind where this rule may be an exceptional (Malawi Government 1966: 501).

But Aleke Banda could not convert his party colleagues to his side since the latter were determined to demote Tumbuka. Before the parliamentary debate, the question of making Nyanja the sole national language had been raised during informal discussions at a Malawi Congress Party convention. The subject had been dropped in response to a voice of disapproval made by some party representatives from the Northern Region (McCracken 2002).

In 1968, Chibambo chaired the annual MCP convention. It was at this convention that Tumbuka's official status was removed. The convention, guided by the desire to forge national cohesion and unity, passed two resolutions regarding the language policy. The first resolution adopted Nyanja as the national language of Malawi. Secondly, the convention resolved to change the name of the national language to Chewa. The third resolution stated that "Chichewa and English should be the official languages of the state of Malawi and that all other languages would continue to be used in private life in their respective homes" (Malawi Congress Party 1985: 6). Though these resolutions never made any direct reference to Tumbuka, they automatically meant that Tumbuka's official status had been taken away. The name Chewa was originally a referent to a dialect of Nyanja spoken by the Chewa of Central Malawi. It was claimed to be Banda's mother tongue and Banda believed that his dialect was the "best." He condemned the other variants of Nyanja or Chewa. He was particularly not happy with the dialects that were influenced by the missionaries and the Southern Malawi dialects (see Malawi Government 1966). By becoming the national language, Banda's dialect had turned into what linguists call a dialect with an army and a navy. In other words, Banda's dialect had assumed political, economic and other powers. This was a big blow to those people in the Northern Region who had hoped that the advent of independence would create a climate for further development and promotion of Tumbuka. Whilst during the colonial era, the Livingstonia Mission had rallied people in protest against the colonial government's decision to make Nyanja the national language, the church could not do the same in the wake of the MCP resolutions. The cost of daring to oppose the MCP government was just too high for the church or any individual.

As mentioned earlier, it is intriguing to note that the move to relegate Tumbuka was first proposed by a Northerner, Chibambo, and then later revived in very strong terms by another Northerner, the militant 'General' Flax Musopole. McCracken (2002) offers some possible explanations for the behaviour of these two Northern Region politicians. First, it is possible that the two were compelled by Banda's dictatorial powers to tow his line. They may have acted out of fear or out of the desire to please Banda. Coming after the cabinet crisis of 1964 in which the majority of the rebel ministers were from the Northern Region, one can interpret Musopole and Chibambo's stand as a way of demonstrating their loyalty to Banda. Another possible explanation is that given that Chibambo and Musopole were holding ministerial posts, failure to push through the language policy could have led to the loss of

their lucrative ministerial posts. They were, therefore, ready to trade in the Northern Region's lingua franca with ministerial positions. Another possible scenario is that the debate in parliament that was ignited by Musopole "was a piece of staged theatre, involving the use of a nationalist hero to lay the foundations for a piece of controversial legislation" (McCracken 2002: 87). One more possible explanation could be that Musopole was just in line with the nationalist ideologies of the time. It is important to note that at that time, Nyerere's leadership in neighbouring Tanzania had embarked on the promotion of Swahili as the national language and symbol of national unity. This could have influenced the national language stance taken by Chibambo and Musopole.[17]

That Musopole and Chibambo, in their support for Nyanja, were merely showing their honest convictions is yet another possibility. It is important not to forget that Musopole did not come from a Tumbuka-speaking background. He spoke Tumbuka as second language. As for Chibambo, he was linguistically Tumbuka but ethnically Ngoni. Could it be that since the Ngoni had lost their language and had instead acquired Tumbuka, the language of their subjects, Chibambo did not have strong emotional attachments to Chitumbuka? It is also interesting to note that during the debate in parliament in 1966, it was only Aleke Banda, a native speaker of Tonga, who attempted to defend Tumbuka. It is surprising that a native speaker of Tonga was busy defending what is traditionally a rival language. All this points to the importance of the caution McCracken (2002) makes. That is, we need to be on our guard against simplifying the complex mosaic of politicised identities and languages of the Northern Region.

Writing about the 1968 language policy, Kishindo (1998a: 254) claims that it is "difficult to gauge the extent of non-Chichewa-speaking people's resentment to this policy because in Banda's Malawi, dissent was prohibited." I have two reactions to this claim. My first reaction is to argue that it is possible, to some extent, to gauge the degree of resentment. I have two incidents that demonstrate the anger with which the policy was greeted in the predominantly Tumbuka-speaking Northern Region. First, Schmied (1996) claims that angry protestors set ablaze Malawi Broadcasting Corporation facilities in the Northern Region. What was exactly destroyed and how the government reacted remain unknown. Secondly, Vail and White (1991: 317, endnote 27) mention a song of protest sung at one of Banda's political rallies. In the song, some people from the Northern Region protested against Tumbuka's loss of official status. Unfortunately, Vail and White do not give an account of Banda's reaction to this song. My second reaction to Kishindo's claim is to agree with him that the protests against Tumbuka's relegation did not bear fruit in the wake of the heavy-handed administration of the MCP.

In an earlier fieldwork, whose findings appear in Kamwendo (2002a), my informants told me that the Banda regime ruthlessly handled all those who harboured and demonstrated the anti-Chewa stance. My informants also claimed that MCP and government agents set some of the Tumbuka books on fire. The church community, especially the Livingstonia Synod of the CCAP and the Mzuzu Diocese of the Catholic Church, continued to use Tumbuka as their official language throughout the Banda era. When the Catholic bishops issued their historic pastoral letter of 1992, three languages (English, Chewa and Tumbuka) were used. Some commentators have remarked that the use of Tumbuka in the pastoral letter was a sign of the church's rebellion against the official language policy. This is not a correct interpretation because the Catholic Church and the Livingstonia had never at any time abandoned Tumbuka as one of their official languages. The Bible Society of Malawi (BSM), as a translator and publisher of the Bible or its portions, was also left free by the Banda regime to publish in any language of its choice.[18]

In the preface to the reprint of Turner's (1996) trilingual Tumbuka, Tonga and English dictionary, Alex Chima says that he had:

> Fears that Chitumbuka, together with so many other Malawian languages, was doomed to vanish, driven into final extinction by a conscious government policy of nationalising one language. While I agree that such a policy may have economic and other attractions, its rigid enforcement has struck me, with many other Malawians, as a sad, being dangerously monoculturalist and ethnocidal. This could have become a tragic case of indeed cultural extinction and the elimination of a people's right to function in their own language and culture (Chima 1996: iii).

I take this to be too extreme a view. I see two problems here. First, Chima talks of linguistic and cultural extinction as if the link between culture and language were so easy to understand.[19] Does the loss of a language lead to cultural loss as well? The Ngoni lost their language in Malawi but they did not lose their culture. If language and culture were one and the same thing, we should have seen cultural extinction among the Ngoni, but this has not happened. Is this not the reason why we should not rush into equating language and culture? Another problem with Chima's claim is that Chewa's devastating effect on Tumbuka has been exaggerated. Also exaggerated is the extent to which people could or could not use Tumbuka after the passing of the 1968 MCP resolutions. Tumbuka and other languages were not banned, strictly speaking. They were simply not accorded official status. The use of such languages went unprohibited in all non-official circles. Language extinction would only occur when a language is no longer being passed on from generation to generation. This, however, was not the case with Tumbuka. The fact that the language was removed from the media and the education domains was not a recipe for language extinction as Chima and others like to put it. In my view, Kamchedzera's account is more acceptable:

> Malawians could use languages of their choice under the MCP. Banda himself, who always made his public speeches in English only, had a Chitumbuka interpreter whenever he addressed meetings in the Northern Region. However, it was the compulsory teaching of Chichewa and the implied unimportance of other languages that some Tumbuka speakers resented (Kamchedzera 1994: 59).

The relegation of Tumbuka from official status and the subsequent intensification of the Chewa policy did not result in an acute language shift from Tumbuka into Chewa. I have argued elsewhere (Kamwendo 2002a: 148) that "of all the indigenous languages apart from Chichewa, it (Chitumbuka) was the one that continued to be spoken and used most widely even during the darkest years of the Banda regime." My argument draws support from three sources. First, when one examines the 1966 population census (National Statistical Office 1966), one finds that by that time Tumbuka was the fourth most widely used language. Chewa, Lomwe and Yao occupied the first, second and third position respectively. Thirty-two years later, the 1998 census report (National Statistical Office 1998) shows that Tumbuka has risen one step up and is now the third most widely used language. The first position remains under Chewa/Nyanja whilst Yao has taken the second position, displacing Lomwe (see Lomwe's new position in Table 3.2 in chapter 3). This means that whilst Lomwe speakers have undergone a massive language shift towards Chewa, Tumbuka speakers have acquired Chewa but they have not lost their language. That the acquisition of Chewa did not lead to language (Tumbuka) loss can be explained by the fact that there is a high degree of language loyalty and pride.

The second support for my argument is taken from Kayambazinthu (1998). She notes that in a survey she had carried out in 1991 in Karonga and Rumphi districts, Tumbuka "was highly used both as a home language and an interethnic language" (Kayambazinthu 1998: 424). Thirdly, I refer to the Centre for Language Studies' (1999) survey. According to teachers who were asked to mention the language most spoken by pupils at their schools, Tumbuka was mentioned by 51.4 % of the teachers in Karonga, 100 % of the teachers in Rumphi, 94 % of the teachers in Mzimba and 4 % of the teachers in Nkhata Bay. My special attention is on Mzimba and Rumphi given that traditionally these are the core Tumbuka-speaking districts. The evidence I have submitted so far indicates that Tumbuka is a vibrant language, and that language loss is not a serious issue. The available empirical evidence contradicts the claim that the language policy of the Banda regime almost led to Tumbuka's extinction.

I also argue that the Banda regime acted in an ambivalent manner towards Tumbuka. Whilst the regime had removed the language from official domains and had even harassed pro-Tumbuka elements, there was, however, some degree of partial tolerance towards Tumbuka. That Banda allowed Tumbuka interpretation at his political rallies was in itself an admission that Tumbuka was a regional lingua franca. Given that during the one-party era, the line separating the party from the government was thin, I argue that Tumbuka had retained some traces of official recognition as evidenced by its use at presidential rallies. I have argued elsewhere (Kamwendo 1998) that apart from the use of Tumbuka interpreters at Banda's rallies, the various languages of Malawi were used in songs of praise for President Banda's so-called wise, dynamic and foresighted leadership. Banda never protested against the use of Tumbuka in those songs of praise. Whilst the national radio followed a bilingual policy (English and Chewa), the radio was open to songs in any Malawian language. A programme called *Nyimbo za M'maboma* (songs from the districts) is one example. The programme featured traditional songs sung in local languages. My argument here is that whilst the Banda regime had placed emphasis on a one language, one nation policy, there was some degree of tolerance towards Tumbuka in official circles. There was also some degree of tolerance for non-Chewa cultural elements although officially the Banda regime used to portray the Chewa culture as the national culture (see Vail & White 1989; Africa Watch 1990; Forster 1994). As McMaster (1974) observes, Banda, using:

> The terminology of the matrilineal society, cast himself as the *Nkhoswe* no.1, the maternal uncle to whom societal decisions were referred. This use of Chewa imagery is a good example of Dr Banda's projection of Chewa traditions and language onto the whole of Malawian society, a projection which has not always been greeted with wholehearted enthusiasm by members of other tribes such as the Ngoni and the Tumbuka (McMaster 1974: 66).

Though Banda had the tendency to portray Chewa practices as the core Malawian culture, non-Chewa cultural practices were never discontinued by the government. For example, ethnically based dances such as *Beni* among the Yao, *Tchopa* among the Lomwe and *Malipenga* among the Tonga, for example, were not stopped in favour of Chewa's *Gulewamkulu.* Ethnically based marriage customs were also left intact. That Banda proclaimed Chewa supremacy is true, but his regime did not force the non-Chewa to turn into Chewas. If some did, it was their own choice. It is not uncommon for some members of the minority group(s) to seek to align themselves with the dominant group(s).

After the 1968 elevation of Chewa, a number of steps were taken to further improve the status and potential of the language. For example, the University of Malawi was advised to offer Chewa courses. Initially the name of the teaching department was called the Chichewa

Department. The name of the department was later changed to Chichewa and Linguistics. Banda himself, as Chancellor of the university as well as honorary professor of Chewa, gave a number of public lectures on Chewa. Banda had championed as the highest authority on Chewa.[20] Though he had no training in Linguistics, he made a number of pronouncements on Chewa, some of which went contrary to linguistic principles (see Kishindo 2001b). Moreover, Banda never spoke Chewa spontaneously in public. He always had an interpreter to convey his speeches into Chewa or other local language(s). This is only one of the paradoxes of his personality - the apparent pride in Chewa culture and language and, at the same time, the evident inability to converse in Chewa. This paradox fuelled popular suspicions that perhaps Banda was not a Malawian at all (see Englund 1996). Banda's views on Chewa became, in any case, the 'manual' for the Chichewa Board, a language academy-like institution that was charged with the task of conducting the corpus planning activities. Banda and the Chichewa Board policed Chewa very strictly as Zeleza testifies:

> While no writer could escape the long harsh hands of the censors, those who wrote in the national language, Chichewa, had to contend with additional demands from the Chichewa Board, and the Life President himself that correct Chichewa be employed. Never mind that in his infinite wisdom, the Life President never saw it fit to talk to his beloved people in Chichewa. He spoke to them in English through an interpreter. But as the omniscient leader, he periodically banished words from Chichewa and imposed new ones from the recess of his forgotten youth. And the mass media and the nation would purge wrong words from the vocabulary, and in complying, each one of us fell further into silence, surrounding a part of ourselves, of our language, our ability to tell stories to a contemptuous, cynical power (Zeleza 1996: 12).

Another creative writer, Steve Chimombo, confirms Zeleza's account. Chimombo complains that his own Chewa play *Wachiona Ndani,* which had been published in 1983, became so popular that he thought it would be included in the school syllabus. This did not happen. Instead, works by ethnically Chewa writers from Banda's home region (the Central Region) were preferred. Chimombo was later told informally that his play could not be included on the school syllabus because "it was not in the accepted Chichewa dialect" (Chimombo 1995: 28). He had written the play in the Zomba dialect (Southern Malawi Chinyanja dialect) which Banda and the Chichewa Board did not approve of. A frustrated Chimombo argued that the characters in his play "were native Chinyanja speakers and could not have been expected to speak or even know the Central Chichewa dialect. But I was arguing to myself and no one appreciated the literary aesthetics of having characters speak their own dialects" (Chimombo 1995: 28). Indeed on several occasions, President Banda had expressed his dislike of the Chewa or Nyanja spoken in the Southern Region. For example, in a 1966 speech in parliament, Banda had said that "the kind of Chinyanja you hear in the South is not Chinyanja at all. *Yaonised* Nyanja, modernised Nyanja" (Malawi Government 1966: 499). He further argued that even in the heartland of the "correct" Nyanja or Chewa (the Central Region), the bad influence of the Southern Region dialects was noticeable.

After the elevation of Chewa to national language, Banda established the President's Fund (Kalinga 1998). The purpose of this fund was to support the study of Chewa, English and Malawian history. Kalinga claims that in reality not much money was made available for historical research or the encouragement of the better use of English. It is Chewa that benefited most. The big boost for Chewa came in 1972 when the Chichewa Board was set up as a statutory body to prescribe correct usage of the language. Following the tradition of language academies of the West, the Board's overall tone was prescriptive. In specific terms,

the Board had three functions. The first function was to provide the national dictionary of the Chewa language. The second task was to provide Chewa orthography rules. Thirdly, the Board was tasked with the general development of the Chewa language. Banda was the final decision-maker in the Chichewa Board's tasks. He had to vet the orthography rules and all the entries for the dictionary. In the process, the compilation of the dictionary dragged given that approval had to be sought from the President even on purely technical matters. The orthography too suffered in the sense that Banda prescribed rules that were at variance with linguistics (Kishindo 2001b). Another problem with the Chichewa Board was that its staff was ill equipped to handle the tasks before them. The professional staff:

> Were largely non-linguists, who for one reason or another had some reputation for being native speakers of the language, by virtue of zeal, occupation, or commitment, were held to be suitable agents. This is not to say that these were no suitable qualifications at the time, or that some people had not, at some stage or other, received linguistics training, but rather linguistic considerations were rarely involved in what was after all, largely a political operation (Kishindo 2001b: 282).

Though Dr Banda portrayed himself as the leading promoter of Chewa, the language policy pursued at his own Kamuzu Academy, an elitist private school modelled on Eton, a British grammar school, pointed to the opposite direction. The school, which admitted the cream of Malawi's youths, followed a curriculum that strongly emphasised the study of English and classical languages (Latin and Greek) and history. Chewa was not amongst the subjects studied, thus creating the impression that it was unfit for such a top class school. This was nothing but a denigration of Chewa by its own so-called honorary professor. Dr Banda had on many occasions spelt out his conviction that no person could claim to be truly educated when he/she had no knowledge of Greek and Latin. It was against this background that the University of Malawi was forced to set up a Department of Classics (see Kishindo 1998a). It was not only local languages that were barred from the Kamuzu Academy, but also local teachers (teachers of Malawian origin). Banda emphasised that he did not want any *mutu bii* (black head) to teach at his academy, thus degrading Malawian teachers, some of whom were more qualified than the white teachers who were hired from Britain and elsewhere. The staff recruitment policy as well as the language curriculum of the Kamuzu Academy cannot escape from being seen as products of cultural and linguistic imperialism. As Ngugi wa Thiong'o has observed, one of the impacts of imperialism is that people "want to identify with that which is furthest removed from themselves; for instance, with other peoples' languages rather than their own" (Ngugi wa Thiong'o 1986: 3; see also Ngugi wa Thiong'o 1993). The mentality of degrading what is local and glorifying what is foreign can also be noted in the post-Banda era where the mother tongue instruction has been described as an impediment to the acquisition of competence in English (see section 2.2.3.3 in this chapter; also see Williams (1996, 1998) for a study in Malawian and Zambian schools that found that mother tongue instruction had no negative effect on the acquisition of literacy in English).

The language policy of the Banda era can be summed up as follows. The policy strongly supported English as the main official language. Secondly, in relation to local languages, the Banda regime implemented a language promotion regime (cf. Kymlicka & Patten 2003a, b) that favoured Chewa at the expence of the other languages. The language tolerance regime (cf. Kymlicka & Patten 2003a, b) was largely in the field of religion where publishing religious literature in languages other than Chewa was permissible. Apart from this religious domain-specific language tolerance regime, other public domains such as education and the mass media could not use a local language other than Chewa. The political atmosphere was not even conducive to grassroots efforts to develop and promote their own languages (see

section 2.2.3.5 of this chapter for a discussion on language associations in the post-Banda era).

2.2.2.2. The Democratic Transition

The voice of the Catholic Church, through its 1992 pastoral letter, has been marked as the first internal open criticism of the follies and injustices of the Banda regime. This letter opened the way for other voices of dissent. These voices of dissent were supported by the winds of political change, under the banner of multipartyism, which were blowing across the African continent in the early 1990s. Events that followed the release of the pastoral letter showed that the letter was a true catalyst for political reforms. First, students at the University of Malawi marched in the streets in support of the bishops' letter.[21] The students openly demanded the introduction of multipartyism. The demand for political change was carried forward by Chakufwa Chihana, a trade unionist. On 6th April 1992, on his return from Zambia where he had attended a meeting[22] on political reforms in Malawi that had been organised by exiled political parties, Chihana was arrested at the Lilongwe International Airport. He was charged with the possession of seditious literature.[23]

Initially, Banda ruthlesslessly resisted the calls for political reforms. Many political reformists were either detained or harassed in other ways. Alarmed by Banda's gross abuse of human rights and the general prevalence of bad governance, the international donor community froze its aid package to Malawi. The West, which had supported Banda during the Cold War for his anti-Communism stand, and his policy of non-military confrontation against the then apartheid regime in South Africa (see McMaster 1974; Short 1974), was disappointed with Banda's human rights abuses. The Western donors, then, decided to part ways with their ally (see Newell 1995; van Donge 1995). Opposition groups operating from outside Malawi joined hands with internal underground movements in the fight against the autocracy. It was during this period that two pressure groups, the Alliance for Democracy (AFORD) and the United Democratic Front (UDF) were formed. The two groups took the form of pressure groups since at that time, the constitution provided for only one party, the MCP. AFORD was the first to be formed. Since AFORD was led by Chihana who comes from the Northern Region, and its leadership structure was dominated by Northerners, the MCP was quick to call it a "Northern affair" (see van Donge 1995: 246). The pressure groups campaigned vigorously for a referendum to decide whether the country was to remain a one-party state or not.

On 14th June 1993, a referendum was held and nearly two-thirds voted in favour of a change to the multiparty system of government (see Dzimbiri 1994). Following the results of the referendum, the constitution was amended to legalise the formation of political parties. The former pressure groups legally turned into political parties. Exiled politicians returned home in response to an amnesty. The ground was now set for the first post-independence multiparty general elections. The elections took place in a peaceful, free and fair manner in 1994. In the presidential elections, Bakili Muluzi of the UDF won.

2.2.3. The Post-Banda Era

The post-Banda era covers the period from 1994 to the present. The post-Banda era has been dominated by the UDF. The party and Bakili Muluzi won both the 1994 and 1999 elections. In the former, Muluzi's UDF took 85 of the parliamentary seats whilst Banda's Malawi Congress Party won 56 seats and AFORD took 36 seats (Kaspin 1995; Posner 1995; Osei-Hwedie 1998). The 85 seats taken by the UDF, however, did not give the party the two-thirds majority to enable it to pass legislation on its own. The UDF then found it necessary to form a coalition government with AFORD in which Chihana was appointed the Second Vice-

President. AFORD withdrew from the coalition in June 1996, accusing the UDF of being corrupt. Despite the official withdrawal of AFORD from the coalition government, some of its members decided to stay on in the cabinet.

The second post-independence multiparty elections were held in 1999. This time, the MCP and AFORD formed an electoral alliance whilst the UDF did not make any (see Ott et al 2000). Muluzi was returned to power, but the MCP/AFORD electoral alliance and other opposition parties accused the UDF of rigging the elections. The election results were challenged in court, but the opposition lost the case. Angered by the alleged rigging by the UDF, the predominantly pro-MCP/AFORD alliance Northern Region witnessed some political violence. The victims were mainly Southerners (because of their strong support for the UDF). Some Southerners were physically harassed whilst others had their property destroyed. They were told to go "home" since they were "strangers" in the North. In the Southern and Central Regions, cries of *nawonso Atumbuka adzipita kwawo* (let the Tumbuka also go home) were also heard.[24] The politics of belonging (cf. Geschiere & Gugler 1998; Nyamnjoh & Rowlands 1998) was at work. Once again, the ethnicised politics of the post-Banda era became very visible. The results from both the 1994 and 1999 elections, and the politically motivated violence that erupted after the 1999 elections, simply confirmed that for politicians, the region of origin had acquired a new importance as a power base in national politics (cf. Geschiere & Gugler 1998; Nyamnjoh & Rowlands 1998).

Since 1994, the UDF has been strengthening its grip over Malawi, leading to fears that the country was set to slide back into the one-party rule. The unsuccessful attempts by the UDF to amend the constitution in order to allow President Muluzi to seek a third term of office is one example of how the UDF had tried to manipulate Malawian politics. In addition to the opposition political parties and human rights organisations, many of the churches (Ross 2004) also campaigned against the infamous third term bid. Since the 1992 pastoral letter, the voice of the church in political matters has continued to gain strength. The church community sees itself as "midwives of democracy at the close of the one-party rule of Kamuzu Banda", also as "protectors of the democratic values in Malawi" (Ross 2004: 98). Whilst the majority of the churches spoke openly against the presidential third term bid, the Moslem community's condemnation of the bid was lukewarm. This is explained by the fact that Muluzi is a Moslem.[25]

In 2000, Brown Mpinganjira, one of the founding members of the UDF, lost his cabinet post and was later brought to court to answer charges of corruption. He was acquitted by a court of law. He then formed his National Democratic Alliance, a pressure group that later registered as a party. Mpinganjira's claim was that the corruption charges were fabricated in order to punish him for challenging Muluzi's secret plan to seek a third presidential term of office. In 2002, Mpinganjira was vindicated when the UDF tried to amend section 83(3) of the Constitution of Malawi (see Malawi Government 1995a) which stipulates that the president can only have two five-year terms of office. On 4th July 2002, Khwauli Msiska of AFORD moved a private member's bill on the said amendment. The bill was narrowly defeated: 125 voted in favour, 59 voted against, and 5 abstained (Ross 2004). The result was that the bill was three votes short of the required two-thirds majority. The UDF tried to bring back the bill, but realising that it would be defeated again, the bill was withdrawn.

The third multiparty elections were held in May 2004. The UDF presidential candidate, Bingu wa Mutharika won in what were largely controversial elections. The opposition claimed that there had been vote rigging. Due to the divided nature of the opposition, some opposition parties agreed to form a government of national unity in which the UDF is the leading party. The MCP and other opposition parties opted to challenge the election results in court.[26]

2.2.3.1. Directives on Languages of Radio Newscasts

The UDF government's first language policy reform affected the national radio. Having been in office for barely a month, on 25th June, 1994, President Muluzi issued a directive on the reinstatement of Tumbuka on the national radio station (see Kamwendo 1997, 1998; Kishindo 1998a). The Malawi Broadcasting Corporation was caught unawares by the directive. The station was therefore forced to hurriedly start broadcasting news in Tumbuka. The reactions to this policy development were mixed. On one hand, there were people who felt that the President's main aim was to appease the Northern Region that at that time had been won by AFORD in the presidential and parliamentary elections. To gain popularity, and to show that he was more accommodating than the previous (Banda) regime, Muluzi made the directive. By correcting a mistake made by the previous regime, he hoped that he would be able to get his government supported by the Northern Region.

Whilst Tumbuka speakers rejoiced on the return of their language to the national radio, some quarters among Tumbuka speakers claimed that the Tumbuka of the radio was "bad." The language on the radio was described as town Tumbuka that had been heavily influenced by Chewa. These concerns were expressed at the launch of the Chitumbuka Language and Culture Association (CLACA) on 2nd July, 1994, when it was noted with concern that there is "poor usage of the written and spoken Chitumbuka." One of the clearest purist tones appears in the minutes of a CLACA meeting held on 17th May 1996. The meeting:

> Noted that the Tumbuka written and spoken today leaves a lot to be desired. This could be addressed by the use of the print and electronic media; persuade the Malawi Broadcasting Corporation to introduce Chitumbuka programmes reflecting traditional social settings like weddings, beer parties etc. People in Blantyre should be discouraged from being involved in such programmes since their Chitumbuka is not as good.

From the CLACA minutes referred to above, it can be also noted that it is in the villages and not in urban areas where "good" or "real" Tumbuka is perceived to exist, hence the proposal that Blantyre-based Tumbuka speakers should be banned from participating in radio programmes. This is certainly an act of linguistic exclusion based on an obsession with linguistic purism (see Thomas 1991 and Brunstad 2003 for a detailed account of linguistic purism).

Probably reacting to the claim that the Tumbuka used on the national radio was not good enough, the Tumbuka section at the Malawi Broadcasting Corporation had a meeting at the broadcasting house in Blantyre on 25th September 1996. The meeting proposed that the Malawi Broadcasting Corporation should have a special Tumbuka language teaching programme called *Tisambizgane Chitumbuka*. (Let us teach each other Tumbuka). Participants in the programme would be "genuine Tumbuka speakers."[27] These so-called "genuine" speakers of Tumbuka would authoritatively discuss various aspects of Tumbuka. Judging from the earlier CLACA statements, these so-called "genuine" speakers of Tumbuka would exclude those speakers that are based in urban areas. To this date, this programme has not yet been put on the Malawi Broadcasting Corporation network. The programme would have been similar to what was in place during the Banda era when the national radio used to run two Chewa programmes. These programmes were *Chichewa cha kumudzi* (Chewa of the village) and *Tiphunzitsane Chichewa* (Let us teach each other Chewa). It should be noted that even in the case of Chewa during Dr Banda's era, it was believed that it was in villages and not in towns where "good" Chewa was spoken; hence the title *Chichewa cha kumudzi*.[28]

Another policy directive in connection with the national broadcaster was issued on 15th November 1996. This government directive introduced Yao, Sena and Lomwe as additional languages of newscasts on the state-run radio's first channel (see Kishindo 1998a). But this was not going to be the end of the directives on language policy because on 13th September 1997, President Muluzi directed that Tonga should become one of the languages of newscasts on the national radio. This directive came as a response to a Tonga chief who had asked the President to consider directing the Malawi Broadcasting Corporation to offer newscasts in Tonga. The "new" languages are not used in any full-length programme, except for Tumbuka, which has at least two full-length programmes. The "new" languages are used for 5-minute newscasts. The content of the newscasts is the same for all the languages. Whilst the addition of five languages as media of newscasts on the national radio can be seen as a progressive act of linguistic pluralism, one cannot fail to notice some problems surrounding the policy. First, the languages were introduced on the radio without the support of any needs analysis. As such, there is a lack of objective criteria on which the five languages were selected, and why the other languages were not selected (see Patten 2001 for a discussion on the problems of official recognition of languages in linguistically plural societies). In the absence of empirical evidence in support of the recognised languages, political gain cannot be ruled out as the main reason behind the new language policy. Secondly, none of the languages is standardised, and there have been hesitations and fluctuations in the use of certain words.[29]

2.2.3.2. From the Chichewa Board to the Centre for Language Studies

On 31st July 1995, Cabinet directed the dissolution of the Chichewa Board. The Cabinet further mandated the University of Malawi to set up a Centre for Language Studies to replace the dissolved Chichewa Board (Kamwendo 1999). The news of the dissolution was received with mixed feelings. On the one hand, it was argued that in the new dispensation of political pluralism, it was not fitting to have a statutory body whose research focussed on one language only. There was a need for a multilingualism-friendly institution. The second argument advanced by those who supported the dissolution of the Chichewa Board was that the Board was so politicised that professionalism was sometimes compromised. By ignoring the views of professional linguists, Dr Banda wrongly prescribed technical decisions on Chewa. Thirdly, the professional staff of the Chichewa Board lacked the professional training and competence with which to carry out their duties. The in-coming Centre for Language Studies, being part of the University of Malawi, was an assurance that the quality and performance of researchers would be improved. There were others, however, who resented the dissolution of the Chichewa Board. They criticised the dissolution as simply a politically motivated decision aimed at lowering the status and prestige of Chewa. This was seen as another way of undermining what Banda had put in place. The anti-dissolution feelings were so high among the Chichewa Board's staff that some of them deleted from the computer a part of the Chewa dictionary that the Chichewa Board had been working on for many years. One story has it that the deletion was ordered by the head of the Chichewa Board. It has been claimed that the alleged deletion was meant to frustrate the in-coming Centre for Language Studies.

The Centre for Language Studies started its work on 1st April 1996 (see Chancellor College 1995; Kamwendo 1999). The Centre was charged with the task of fulfilling seven objectives. These objectives are: establishing orthographic principles of Malawian languages; developing descriptive grammars of Malawian languages; compiling lexicons of Malawian languages; teaching Malawian languages to foreigners; promoting and preserving Malawian languages; providing translation, interpretation and editing services to institutions and individuals at a fee; and promoting research in language studies. This mandate is wide and

can only be fulfilled in a context of sufficient resources. This, however, has not been the case. The Centre has since its inception been largely underfunded by government. The institution has also not been able to generate its own substantial income due to the low marketability of the language industry in Malawi. Whilst the Centre has been involved in several mother tongue-related projects, it has not been possible to enter other areas. As for donor support, the German Technical Co-operation Agency known as GTZ is the only donor agency that has over the years supported research at the Centre. The support from GTZ should not be seen as a direct support towards the development of Malawian languages as such. The interest of GTZ lies in the use of local languages in the education domain (see also Abdulaziz 2002; Brock-Utne 2002). In order to fulfil that goal, GTZ has had to support corpus planning activities since all the local languages, with the exception of Chewa, lag behind in this respect (see chapter 7 for a discussion on government and donor financial support for corpus planning of Tumbuka. See also chapter 6 (section 6.6) for a discussion on the role of NGOs and donors in the promotion of linguistic rights).

2.2.3.3. Directive on Mother Tongue Instruction

On 28th March, 1996, the Secretary for Education issued a directive that from then onwards, grades 1 to 4 should be taught through mother tongues (see Kamwendo 1997, 2000, 2001a; Kayambazinthu 1998; Kishindo 1998a). Part of the directive read as follows:

> With immediate effect, all standards 1, 2, 3 and 4 classes in all our schools will be taught in their own mother tongue or vernacular language as a medium of instruction. English and Chichewa will, however, continue to be offered as examinable subjects in the primary curricula. In the past, Chichewa was used as both a medium of instruction and a subject, making it very difficult for beginners to grasp ideas. However, English will continue as a medium of instruction beginning in standard 5. [30]

Reactions to the announcement were largely negative. Various criticisms were raised in the mass media, especially in the print media. First, it was argued that no local research had been conducted to determine the relevance, practicality and acceptability of the policy. Critics warned that it should not be cheaply assumed that what has worked elsewhere can also work in Malawi. The second criticism was that apart from a lack of local research, there were no consultations with the relevant stakeholders. The policy came in a top-to-bottom style, and not in line with the new political dispensation in which consultation and transparency are preferred. Third, it was feared that the policy would strengthen ethnic loyalties at the expense of national unity. Fourth, there was concern that there were no teaching materials for the many languages involved. In addition, the production of such materials in the many languages would be an economic burden. Fifth, some critics argued that what Malawi needed most was better teaching of English. Such critics feared that the mother tongue policy would lead to a further deterioration of the already declining standards of English. In a country in which competence in English tends sometimes to be equated with education (Matiki 2001b; Kamwendo 2003), the policy became a big concern to many a parent and/or teacher.[31] The sixth criticism was that Malawian languages lacked the appropriate terminology with which to teach science and technology, hence English would be the best option as a medium of instruction. Another criticism was that the policy was a revival of the infamous *kwanunkwanu*[32] directive which the Banda regime had made earlier (see Kathewera 1999).

As Bamgbose (1991, 2000a), Kaplan & Baldauf (1997) and others have argued, in African language planning, the education domain gets the most attention. The situation in

Malawi during the post-Banda era is not different. Whilst there have been some language policy changes in at least two domains, that is education and the media, it is the former that has attracted the most attention in terms of research and debate. For example, the country has since 1999 (with the exception of 2002) had an annual symposium[33] on language policy in education. With the exception of the first one, which was jointly funded by GTZ and UNESCO, the rest of the symposia have been funded solely by GTZ through its Basic Education Programme.

Five years have lapsed since the draft language policy was submitted to the Ministry of Education, but Cabinet has not yet approved the new language-in-education policy. This raises a number of questions. For example, has the government silently withdrawn the mother tongue policy in the wake of its political unpopularity? Was Malawi's mother tongue instruction merely a window dressing affair aimed at pleasing international donors and organisations such as UNESCO (cf. UNESCO 1953, 2002)? Or is this yet another case of what Bamgbose (1991) calls declaration without implementation? Since the UDF presidential candidate, Bingu wa Mutharika, won in the May 2004 elections, it will be interesting to see how his administration will handle the language question. In his failed attempt to win the presidency through the then United Party in 1999, Mutharika had pledged to elevate the status of local languages to the point of using them in parliament.

2.2.3.4. From Chewa to Nyanja: Change of Name

On 22nd January 1999 the Ministry of Education announced the change of the name of the national language from Chewa to Nyanja:

> This is to inform you that with immediate effect, Chichewa is replaced by Chinyanja in the school curriculum. Please let all schools in your division be informed of the change. You are, therefore, requested to take note of the changes and make necessary adjustments to your records and inform all schools in your division.[34]

As expected, there were mixed reactions to the proposed change of the name. Kathewera (1999) argues that the 1968 decision to change the name from Nyanja to Chewa was reached at then sole political party's annual convention. Since the convention drew participants from all corners of Malawi, Kathewera then argues that the 1968 decision represented the true wishes of Malawians. He argues that since the change of the name was agreed upon at a "big forum" (Kathewera 1999: 111), then the name-changing process was democratic. The UDF-led government's attempt to change the name of the language in 1999 is undemocratic because it was not decided at a national forum. Kawale (2000: 141), like Kathewera, is also of the view that the change to Chewa was justified because "a political convention composed of people from different ethnic groups decided to call it Chichewa." What both Kathewera and Kawale, who, incidentally are from the Chewa ethnic group of the Central Region and also native speakers of Chewa, miss is the fact that long before the convention, Banda had shown the desire to call the language by the name Chewa. In many of his speeches, he made use of the name Chewa, and not Nyanja (see, for example, Malawi Government 1966). The convention merely endorsed Banda's wishes. There is nothing democratic about a convention whose participants, out of fear, endorsed the President's wishes. In fact Kathewera weakens his argument by acknowledging that some delegates may have voted in favour of the change of the name out of fear.

Related to the attempted change of the name of the national language is the notion of language ownership. I am sceptical of Kawale's (2000) claim that the Chewa "own" the

Chewa language, hence they should have the right to decide on its name or orthography. My view is that as Malawi's national language and one of the major lingua francas in neighbouring countries, Chewa is no longer an ethnically based piece of property. There are also non-Chewas for whom the language is the mother tongue (see the findings in Table 4.10, chapter 4). Apart from that, there are also many other second language speakers or users of this lingua franca. If consultations have to be made regarding a policy matter affecting Chewa, it is not only the Chewa who should be consulted. The spectrum of stakeholders is much wider. To further weaken Kawale's argument about the Chewa "owning" the Chewa language, one can also ask the big question: Who owns English? Is it the English people who are based in England? While there is no doubt that the English language was originally "owned" by the English people, the same cannot be said to be true now. The language has spread extensively globally, leading to the rise of local or indigenised varieties.[35] Now the non-native speakers of the language outnumber the mother tongue speakers. No specific group of people can realistically claim to own English. The same can be said about Chewa.[36] All matters pertaining to Chewa are of national concern and sometimes they can even be of international concern given that Chewa is a cross-border or pluricentric language. It is, therefore, not appropriate to look at Chewa in very narrow terms from a Chewa ethnic perspective.

2.2.3.5. Language Associations

One of the benefits of the political pluralism that came in 1993 is the freedom to form associations.[37] Previously during the Banda era, it was illegal to form political parties or ethnically based cultural and/or linguistic associations. The Banda regime feared that those who had political motives could hijack cultural and linguistic associations.[38] The first language and culture association to be formed in the post-Banda Malawi was the Society for the Advancement of Chiyao. It consisted of intellectuals and journalists. Initially, Pascal Kishindo, a linguist at the University of Malawi, had wanted to form clubs that would discuss orthography and creative writing in the local languages of Malawi (Kayambazinthu 1998). This initial idea was then expanded into the Society. One of its goals was to draft a bill that would be tabled in parliament seeking the declaration of Yao as one of the optional subjects in the school curriculum. The Society also intended to establish a Yao Cultural Centre that would work towards teaching and preserving Yao culture. The Society then began to lose its original objectives as some Yao politicians started to use it to satisfy their political motives. Upon realising this, the founder, Pascal Kishindo, withdrew. There was no one else to keep the Society alive. It withered without achieving any of its objectives.

In 1998, an association known as the Abenguni (or Ngoni) Revival Association was formed in Northern Malawi. It had three objectives. The first objective was to revive the language that is not being passed on to future generations. That Ngoni is moribund is well documented in the literature. For example, writing in 1968, historian Wills noted the disappearance of the Ngoni language. He noted that the Ngoni now "speak the tongues of the people they conquered, Tumbuka, Chewa, Mang'anja and Yao" (Wills 1964: 68). The second objective was to bring unity to the Ngoni of Central and Northern Malawi. Thirdly, the association aimed at fostering Ngoni identity. The association then began teaching Zulu, a variant of Ngoni (Kayambazinthu 1998). Kishindo (2002: 221) has remarked that "the futility of the exercise can be likened to flogging a dead cow."

The Chitumbuka Culture and Language Association (CLACA) is a very active association in the Northern Region. It was formed in 1994 with the aim of preserving the culture and language of the Tumbuka (see Kamwendo 2002a). Upon realising that there is no

standard orthography of Tumbuka, CLACA members took the initiative to revisit the existing orthographies with the aim of producing a standard orthography. Although the revision of the orthography was not guided by relevant scientific principles from Linguistics, the effort remains laudable. This case of CLACA's work on the orthography echoes Chumbow's assertion that in Africa, sometimes language planning is carried out by "amateurs and well-meaning enthusiasts without relevant training and with no sense of orientation" (Chumbow 1987: 15). The product of such endeavours is normally shoddy and CLACA's orthography was no exception. The orthography project was later boosted by the technical guidance that was offered by the Centre for Language Studies of the University of Malawi. There is now a draft Tumbuka standard orthography that has adopted the principles that had been advanced by Banda et al (2002).

The second task that CLACA has undertaken is to lobby the government to reintroduce Tumbuka in schools. In other parts of Malawi, no lobbying for the mother tongue policy has been done. Since Tumbuka had a long history of being used in schools before the 1968 policy change, it is not surprising that there is enthusiasm for the mother tongue policy in this region. The Chitumbuka Language and Culture Association (CLACA) has not only been lobbying for the implementation of the policy but has also made proposals on the textbooks. The Teachers' Union of Malawi (TUM) had suggested that subject content books which were written in Chewa should be translated into Tumbuka and other relevant languages. This suggestion was rejected by CLACA "because Chichewa books had a culture which was different from Chitumbuka culture e.g. *gule wamkulu*."[39] CLACA then wrote to the Ministry of Education on 20th May 1996 making clear its stand on the translation of books:

> All Tumbuka books should not be reprinted at random but after the approval of the Association for Tumbuka Language and Culture. We want the orthography which is generally acceptable to appear in the readers today. These should not be literal translations of Chichewa teaching materials.

In the light of CLACA's concerns about cultural or linguistic purity, it is worthwhile to consider the following questions posed by Felix Banda: "Is there anything like a pure (stable) language, or a pure (stable) culture? Isn't linguistic shift a natural and inevitable consequence of language contact?" (Banda 2001: 198).[40]

Since language change is inevitable, one can therefore question the usefulness of CLACA's attempts to arrest language change or what it considers to be the corrosive effect on Tumbuka culture of books translated from Chewa. We live in a world in which translation[41] is one of the main means of transferring information from one language to another. If people were to worry about the so-called corrosive effect of translation, the world would have not been able to spread a lot of valuable information. I take CLACA's obsession with the corrosive effect of Chewa translations to be misguided. The Ministry of Education received another letter from CLACA recommending books for the proposed mother tongue instruction programme: "We know the ministry has a big task of finding proper and relevant books that would not contradict with the Tumbuka culture and it is in this regard that we want to recommend the types of books to be used."[42] This matter is yet to be resolved by the Ministry of Education.

2.2.3.6. Language, Identities and Politics of Recognition

It is important to realise that the Northern Region is a region with competing identities, both linguistically and ethnically. Whilst at the highest level (regional level), the people of the region would generally identify themselves with the regional lingua franca, Tumbuka, it is not

uncommon to see the same people, at another level, identify themselves with other languages (their mother tongues). For example, some of the members of CLACA are also members of the Abenguni Revival Association. The Ngoni, for instance, find themselves to be ethnically Ngoni but linguistically Tumbuka. In trying to learn Ngoni through the revival efforts, these people are attempting to regain their lost linguistic identity.

A Tonga chief, whose language has a very high mutual intelligibility with Tumbuka, requested the State President to authorise the use of Tonga on the national radio, giving further testimony to the presence of competing/multiple identities. For the Tonga, Tumbuka is for regional identity, whilst Tonga is closer to home since it is a marker of their ethnic identity. By requesting the President to give Tonga airtime, the Tonga did not mean that they were unable to understand Tumbuka newscasts. They were simply trying to assert their 'other' identity. The use of Tumbuka by the CCAP and the Mzuzu Diocese of the Roman Catholic Church in the Northern Region has also sparked identity-seeking behaviour. For example, I have noted elsewhere (Kamwendo 2002a) that Ngonde-speaking congregations of the Catholic Church have asked for the liturgy to be shifted from Tumbuka to their language. The CCAP has also received a similar request for a change of the church's language policy in Nkhata Bay, Karonga and Chitipa. Of course, in some cases there might be communication breakdown when Tumbuka is used. However, in other cases, the call for changing the language policy is, as I have mentioned earlier, a way of declaring another identity. McCracken's (2002: 87) question is pertinent: "How useful is it to conflate 'northern' and 'Tumbuka' identity, as has so frequently been done?" This question will appear in this thesis in different forms to remind the reader of the ethnic and linguistic complexity of the Northern Region.

2.3. CURRENT DEMOGRAPHIC TRENDS

The 1998 population census report put Malawi's population at 9.9 million. Out of this total population, 4.9 million were males whilst 5 milllion were females. This then translates into 51 % of the population being female. Since the previous population census conducted in 1987, the population has been growing at the rate of 2 % per year. The 1998 figures translate into a population increase of 24 % covering the period 1987 to 1998. The Northern Region registered the highest population growth rate of 2.8 %. The Central and Southern Regions had 2.4 % and 1.4 % growth rates respectively. Despite this, the overall national picture shows that the Northern Region recorded 12 % of the national total (the lowest); whilst the Central Region and the Southern Region registered 41 % and 47 % of the national total respectively (see National Statistical Office 1998).

Of the total population enumerated in 1998, 14 % lived in urban areas; with the remainder (86 %) living in the rural areas. It is reported that 11 % of the population lived in four urban centres, namely the cities of Blantyre, Lilongwe, Mzuzu and the municipality of Zomba; whilst only 3 % lived in the remaining urban centres. The urban population had grown from around 850,000 in 1987 to around 1.4 million in 1998. This represents a yearly urban population growth rate of 4.7 % and an increase of 68 % for the period 1987-1998 (National Statistical Office 1998). The 1998 census report puts the national population density at 105 per square kilometre. The Northern Region is the least densely populated; with 46 persons per square kilometre. The Southern Region, on the other hand, registered the highest density, with 146 persons living per square kilometre. The Central Region, whose population density is 113 persons per square kilometre, follows the Southern Region. At district level, Rumphi in the Northern Region has the lowest population density, with a figure of 27. Likoma Islands (with 449 persons per square kilometre), Blantyre (389) and Chiradzulu (307)

were the most densely populated districts recorded in the census report (National Statistical Office 1998).

2.4. POVERTY AND INEQUALITY

Malawi is one of the poorest countries in the world. The first post-independence government of Banda and the MCP did not, however, openly admit this fact. Banda and the MCP, unfortunately, painted a rosy but inaccurate economic picture of Malawi. Banda often claimed that Malawians had what he called the three key essentials of life: self-sufficiency in food, good clothing, and houses that did not leak when it was raining (see also Chinsinga 2002). Despite this rhetoric, a situational analysis of living standards which was jointly conducted by the government of Malawi and the United Nations found that 60 % and 65 % of the rural and urban populations respectively lived below the poverty line (Malawi Government & United Nations 1993). When Muluzi and the UDF formed the first post-Banda government in 1994, poverty alleviation[43] was chosen as the main economic policy (see UDF 1993). The government opted for a free market economy and promised to create a conducive environment in which people could generate income through businesses. The poverty alleviation programme has not benefited the majority poor. Ironically, it is the affluent or those belonging to the ruling party, the UDF, who have had access to credit facilities and lucrative business contracts (see Chinsinga 2002).

The poverty situation in Malawi has continued to worsen since the release of the Malawi Government and the United Nations (1993) report. According to the Malawi-European Union Strategy Paper for 2001-2007:

> Not only are the majority of Malawians grindingly poor but the benefits of past growth and development efforts have affected but a few, such that the 'Gini' coefficient has actually worsened from 0.48 in 1968 to 0.62 in 1995 and 0.88 in 1998, reflecting one of the most unequal distributions of wealth and income in the world (p. 12).

The groups most affected by poverty include the landless, the land-constrained smallholder farmers, tenant farmers, *ganyu* labourers (piece-meal labourers), women (especially those heading households), the elderly and the infirm, and children, especially orphans. The HIV/AIDS pandemic is the major factor responsible for the rise in the number of orphans (see Malawi-European Union Country Strategy Paper). Two-thirds of Malawians live below the poverty line. Malawi, according to the 2003 Human Development Index, is on position 14 among Africa's 25 "least liveable countries" as indicated in Table 2.1. On the worldwide level, Malawi ranked 162 out of 175 countries on the 2003 Human Development Index.

Table 2.1: The Least Liveable Countries in Africa

POSITION	COUNTRY
1	Sierra Leone
2	Niger
3	Burkina Faso
4	Mali
5	Burundi
6	Mozambique
7	Ethiopia
8	Central African Republic
9	Democratic Rep. of Congo
10	Guinea-Bissau
11	Chad
12	Angola
13	Zambia
14	Malawi
15	Cote d'Ivoire
16	Tanzania
17	Benin
18	Rwanda
19	Guinea
20	Senegal
21	Eritrea
22	Mauritania
23	Djibouti
24	Nigeria
25	Gambia

Source of Table 2.1: see www.undp.org/hdr2003

The majority of Malawians suffer from chronic food insecurity. According to the Malawi-European Union Strategy Paper, over 50 % of the rural households cultivate less than one hectare, and 25 % cultivate less than a half hectare. In the end, 55 % of the rural population suffers from chronic food insecurity. Frequent droughts have also contributed to food shortages. Furthermore, the removal of government subsidies on agricultural inputs has made it impossible for the majority to apply chemical fertilisers to their crops, thus reducing the quality and quantity of yields. Droughts, resulting into food shortages and low levels of agricultural exports, have recently had a negative effect on the health of the economy. In addition, HIV/AIDS, corruption and a general lack of fiscal discipline have also contributed to the worsening of the economic situation. In 2002, Denmark, one of the major donors, closed its embassy in Malawi and froze its aid package. Denmark justified its action by citing high level corruption, political interference with the judiciary, and a culture of political intolerance. The International Monetary Fund (IMF), the World Bank and other donors also froze their assistance to Malawi.[44]

2.5. EDUCATION AND LITERACY

The national literacy rate is 58 %. In terms of the sexes, males have a 64 % literacy rate whilst the rate for females is 51 % (National Statistical Office 1998). The imbalance is as a result of the tendency of families to invest in boys' education rather than girls'. In addition, girls have a higher school dropout rate due to early pregnancies and/or marriages, and the demand for them to attend to domestic chores such as cooking and taking care of siblings. In terms of the regions, the highest literacy rates were recorded in the Northern Region during the 1998 population census. The region recorded a literacy rate of 72 %; and the Central Region came second with 57 %; whilst the lowest rate, 55 %, was recorded in the Southern Region (National Statistical Office 1998). The Northern Region, due to the head start in education given to it by the Scottish Christian missionaries, has had a vibrant culture of literacy and education for a long time (see McCracken 1977a, 1994, 2002).

Pre-school is mainly confined to urban centres and it is not compulsory. The majority of the children enter primary school without having attended pre-schools. Primary school education, which has been free since 1994, runs for eight years. The medium of instruction in grades 1 to 4 is Chewa, the national language. English takes over as the medium of instruction from grade 5 onwards. It is also important to mention that English is offered as a subject throughout the whole eight years of primary education (Kayambazinthu 1998; Kamwendo 2001a). A proposal to introduce more local languages (dominant languages of a school's catchment area) was made in 1996 but the policy still remains unimplemented due to a number of problems (see Kishindo 1998a). One of the resentments levelled against the proposed language policy is that in some quarters, the policy is seen as an obstacle to the mastery of English. At the moment, Malawian standards of English are reported to be in decline, resulting in a drop in students' performance in the national examinations (for example, see Table 2.2). This poor performance in English has also been witnessed at the University of Malawi (see Kamanga 1990).

Table 2.2: Performance in English: Malawi School Certificate of Education 1987-97

YEAR	DISTINCTION	CREDIT	PASS
1997	0.13	13	71
1996	0.19	14	68
1995	0.13	12	55
1994	0.40	13	56
1993	0.22	37	71
1992	0.18	27	60
1991	0.17	32	70
1990	0.37	39	7
1989	0.30	38	81
1988	0.30	38	80
1987	0.62	38	90

Source of Table 2.2: Kayambazinthu (1998: 406) citing the Malawi National Examinations Board (MANEB).

At the end of grade 8, a national primary school leaving examination is taken. Few students are selected into the secondary school system. Secondary education runs for four years. Students who pass the Malawi School Certificate of Education and satisfy the university entry requirements are then selected. Malawi has two government-financed universities, the

University of Malawi and the Mzuzu University. There is one private university in Malawi. This is the Livingstonia University, established by the Livingstonia Synod of the CCAP.[45] There are also other proposals, coming especially from the church community, to establish more private universities.

The education sector faces a number of challenges and problems. To begin with, the free primary education programme suffers from a number of problems. First, there is no legal framework for obliging parents/guardians to send their children to school. This means that primary school education is free but not compulsory. Secondly, there are delays in starting schooling and high non-enrolment and dropout rates due to poverty and the need of the children to join the labour force (see United Nations 2001a). Thirdly, there is an acute shortage of qualified teachers, aggravated by insufficient teacher training facilities and high attrition rates due to unattractive terms of employment and HIV/AIDS deaths. Fourthly, generally the teaching environments are poorly supplied with teaching and learning materials. The scarcity of basic learning and teaching resources is also true of secondary and tertiary levels of education. For example, the country's two public universities lack up-to-date library materials and computer facilities (see Kerr & Mapanje 2002 for the case of the University of Malawi). Another challenge for the Ministry of Education is to improve access to tertiary education. Less than 1 % of Malawians who are aged between 18 and 23 enter tertiary education institutions.[46]

2.6. HEALTH INDICATORS

Malawi has one of the lowest health service capacities in the sub-Saharan Africa. Among the key health indicators of any country are life expectancy and maternal mortality. HIV/AIDS stands out as the most serious threat to the health of Malawians. Other health-threatening diseases or situations are tuberculosis, malaria and malnutrition/hunger-related illnesses. Life expectancy is between 38 and 39 years (see Table 2.3). The HIV/AIDS pandemic has lowered the life expectancy. According to the Malawi-European Union Strategy Paper, life expectancy in Malawi has decreased from 45.6 in 1992 to 39.3 in 1998. Further drops in the life expectancy have been predicted. The maternal mortality (per 100,000 live births) is 1,120. In the case of under-five mortality (per 1,000 live births), the figure is 189. The total fertility rate (children/woman/lifetime) is 6.3 (see National Statistical Office 2001).

Table 2.3: Lowest Life Expectancy in Africa as of 2002

POSITION	COUNTRY & YEARS
1	Mozambique (31.3)
2	Botswana (32.3)
3	Zambia (35.2)
4	Lesotho (36.9)
5	Angola (37.0)
6	Malawi (38.0)
7	Zimbabwe (39.0)
8	Rwanda (39.3)
9	Swaziland (39.5)
10	Ethiopia (41.2)

Source of Table 2.3: U.S. Census Bureau, International Database

As for HIV/AIDS, the nation-wide sero-prevalence rates rose from 2 % in 1985 to 16 % in 2001, with the highest infection rates being registered among the most productive 15-49 age

groups and 31 % among women attending urban antenatal clinics. HIV/AIDS is, therefore, one of the major burdens on the economy. Should the current rates of HIV/AIDS infection remain unchecked, it is projected that life expectancy could drop to 33 years by the year 2010 (see Malawi-European Union Strategy Paper).

2.7. PROVISION OF HEALTH SERVICES[47]

2.7.1. Provision of Western Medical Services

Health services are provided by the Government of Malawi through the Ministry of Health and private/non-governmental organisations. Various churches provide health services under the umbrella of the Christian Health Association of Malawi (hereafter CHAM). According to Uta (1993), CHAM is the second largest provider of health services in Malawi, amounting to 20 % of the national total. There also exist privately owned clinics that are run by companies, educational institutions, the Police, the Army, non-governmental organisations (NGOs) and private practitioners. Malawi's health care delivery system is decentralised and operates at district, regional and national levels. At community level, health services are provided by health centres and rural hospitals. This is referred to as the primary level of health service delivery. Then there are district hospitals to cater for the district level. This makes up the secondary level of health service delivery. The tertiary level comprises four central hospitals that act as regional and/or national referral hospitals.

The health services in Malawi are crippled by a number of problems. In a nutshell, the Malawi Vision 2020 sums up the problems as: the majority of the population having no access to health services, weak management systems at all levels of health care services, inadequate financing of health services, poor linkages between Western and "traditional medicine," high infant mortality and maternal mortality, widespread malnutrition among children, poor quality of services, and high incidence of HIV/AIDS (Malawi Vision, 1997). One of the major problems not cited in the Vision is the lack of qualified and experienced personnel as well as a high rate of brain drain (see Lwanda 1995, 2002a, b; Muula & Broadhead 2001). Under funding is another big setback for the health services in Malawi. Hospitals are thus unable to meet in full their financial obligations. Essential services such as ambulances are not easily provided. Even when the ambulances are in good running order, there is sometimes no money for the purchase of fuel. Another serious problem in the Malawian health service is the under supply of drugs. The shortage of drugs is attributed to the low levels of funding which the Ministry of Health receives from the Treasury. However, this is not the only cause of there drug shortage. There have been numerous cases of hospital personnel either stealing essential drugs or using them in their private practices or selling them to private hospitals. Corruption, which has gone untamed by the UDF-led government, has not left the health sector untouched. It is not only drugs that are stolen and sold away for profit but also clinical equipment and hospital utilities such as beds, mattresses and linen (see United Nations 2001a).

Over-crowding in government hospitals is a common sight. It is not unusual for two patients to share a single bed. Some patients have to sleep on the floor. Patients suffering from different diseases are mixed in one overcrowded ward. The overcrowding is further worsened by the fact that patients' guardians also sleep in the same wards. The scenario is one in which the ward becomes a place where a patient is most likely to contract new diseases. Another problem is that some of the hospitals do not provide food, bedding and patients' uniforms. Under normal circumstances, government hospitals are supposed to provide patients with free food, bedding and uniforms. Over the years, however, government hospitals have gradually been losing the capacity to provide these services. Even where these services are still being

offered, their quality may not be good. Another problem is that of inadequate levels of medical specialists. Therefore, a doctor becomes a jack of all trades but a master of none. Recounting his personal experiences of working at the main referral hospital in Lilongwe, the capital, a Scotland-based Malawian doctor, John Lwanda, notes that at the hospital, he was one of the only two medical specialists available. The expertise of doctors is undeniably overstretched.[48]

At independence in 1964, Malawi had no school of medicine unlike its former partners in the Federation of Rhodesia and Nyasaland, namely Zambia and Zimbabwe. As such, Malawi's medical training needs were catered for in Europe and America under sponsored scholarships. The majority of the Malawians who qualified as medical doctors opted not to serve in Malawi (see Muula & Broadhead 2001; Lwanda 2002b). The reasons for the reluctance to return home by the Malawian doctors were many, but the major ones were economic and political in nature. Economically, the newly qualified doctors found the remuneration packages offered to them in Malawi to be much lower than what the West could offer. Some of the doctors had married in their host countries and could not dream of taking their families to Malawi where the standards of living and conditions of service were much lower.

Lwanda (2002b) laments the fact that despite being a medical doctor himself, President Banda did very little to improve the conditions of service for Malawian doctors. It also took a long time before Malawi could establish its own medical school. Whilst Banda was quick to establish Malawi's own university after one of year of independence, the medical school opened much later in 1991. In that year, the medical school admitted students who had had their prior studies in basic medical studies and a clinical year in the United Kingdom and Australia (Muula & Broadhead 2001). This group graduated in 1992. In 1999, the first group of locally trained doctors graduated. Since its inception, the school has so far produced 134 doctors; four of whom have died, and another four left Malawi through either marriage or the search for better opportunities abroad. The majority of these graduates are still pursuing their postgraduate studies outside Malawi. Though Muula and Broadhead (2001) argue that with the demise of the Banda autocracy, Malawian doctors would now opt to work at home, I think the two authors take a very simplistic view that ignores the fact that the remuneration packages are still low and unattractive. The poor handling of the welfare[49] of Malawian doctors by the Malawian government is another factor that encourages both internal and external brain drain.

2.7.2. Alternative Medical Systems

Whilst talking about health care, I am mindful of the fact that in Malawi, as well as in other African countries, people tend to receive health care from both "traditional" and Western modes of health systems. This is what I call an eclectic approach i.e. trying to get the best out of both "traditional" and Western medicines. The former refers to health services rendered by traditional healers or the so-called "African doctors" (Last & Chavunduka 1986; Good 1987). The adoption of the term doctor is significant in the sense that it tries to put them in positive light as opposed to terms like witch doctor. Some of the healers claim that they are as good as the Western-trained medical professionals. As such, they expect to be treated with respect. There is a clash and/or misunderstanding between traditional healers and Western medicine professionals.

There is a tendency to regard "traditional medicine" as unscientific and primitive (Eze 1979). The legacy of negativism towards "traditional medicine" was inherited from the colonial and pioneer missionary times. "Traditional medicine" was treated with spite. Good

notes that "these perceptions are reinforced by the still-powerful and pervasive syndrome of witchcraft and sorcery beliefs that continue to form the basis for explaining much illness and misfortune in contemporary Africa" (Good 1987: xii). For example, despite the wide publicity given to the transmission of HIV/AIDS, there is a belief in some Malawian circles (see Forster 1998) and elsewhere (see Yamba 1997 for a Zambian case study) that witchcraft is behind the spread of HIV/AIDS. As Geschiere (1997) and Moore and Sanders (2001a, b) observe, modernity has not led to a decline in the belief in witchcraft. Belief in witchcraft remains vibrant in many parts of Africa, including Malawi (see, for example, van Dijk (2001) on witchcraft cleansing conducted by some Pentecostal faith believers in Malawi).

It has been claimed that certain illnesses can only be cured through the use of "traditional medicine." Such illnesses include those caused by witchcraft and spirit possession.[50] Even when faced with illnesses whose causes cannot be attributed to witchcraft and/or evil spirits, Western medicine on its own does not and cannot meet all the health needs in Africa. As such, there is a need for medical pluralism (Good 1987), that is, the acceptance that traditional healing systems can and should complement the biomedical system (Msonthi 1985, 1986; also see various contributions to Last & Chavunduka 1986). Msonthi (1985: 41) cites the World Health Organisation (WHO) as saying that it is interested in developing positive links between "traditional medicine" and biomedicine as evidenced by the following aims: (i) to promote the integration of proven valuable knowledge and skills in "traditional" and Western medicine; (ii) to foster a realistic approach to "traditional medicine" in order to promote and further contribute to health care; and (iii) to explore the merits of "traditional medicine" in the light of modern science in order to maximise useful and effective practices and discourage harmful ones.

There is an attempt by traditional healers in Malawi to see themselves as belonging to a noble profession whose goal is the same as that of the Western-trained medical professionals - to cure illnesses and save human life (see Msonthi 1986). The traditional healer, therefore, has adopted some of the practices of the Western-trained medical practitioners. For example, some traditional healers now have in-patient facilities at their clinics. Second, it is not uncommon for the healers to advertise their services in the print and electronic media. In these advertisements, the traditional healers generally talk about the type of illnesses they claim to cure. Some of the traditional healers are peripatetic, hence they use the advertisements to announce their mobile clinic schedules. There are more of such advertisements on the national radio than the print media given that the former reaches a much wider audience.

Within the category of traditional healers are those who claim that they heal with the assistance and guidance of the ancestral spirits. A noteworthy case is that of Billy Chisupe, who in 1995 claimed that through a dream, the spirits had shown him how to make a herbal concoction that can cure HIV/AIDS (Probst 1999; Schoffeleers 1999b; Forster 2001). The concoction, which was locally known as *mchape*[51] (literally, that which cleanses), attracted people of all walks of life, for example: the clergy, politicians, businesspersons, civil servants, children and students. It is estimated that between 250,000 and 300,000 people went to take Chisupe's concoction (Probst 1999; Schoffeleers 1999b). Despite the large numbers of people Chisupe attracted to his place, today there is no scientifically tested proof that his concoction can cure HIV/AIDS. Chisupe himself has accused the government and the scientific community of undermining him and discrediting his efforts. He also sees racism in the whole affair, claiming that if the "cure" had been discovered by a white person, favourable support and a positive media attention would have been given to that person (Probst 1999; Schoffeleers 1999b).

2.7.3. Traditional Birth Attendants

In Malawian rural areas where maternity clinics are not available, home-based child delivery is conducted by government-approved Traditional Birth Attendants (hereafter TBAs) or *azamba,* as they are locally called in Chewa (see Msonthi 1985). This practice of integrating TBAs into the Western mode of maternity practice is also in existence in other African countries such as Zimbabwe (see Rowley 2000). The shortage of nurses and midwives as well as the traditional belief about the importance of home-based child delivery is one of the reasons why TBAs are used. In Malawi, the TBAs are normally given refresher courses by the certified midwives. The TBAs are always encouraged to refer complicated cases to hospitals without delay. As expected, there is always mistrust between the certified nurses and midwives on one hand, and the TBAs on the other. In Zimbabwe too, Rowley (2000) has established that the traditional midwives feel underrated by their Western-trained counterparts.

2.8. THE NORTHERN REGION: A HISTORY OF IDENTITY POLITICS

2.8.1. Ethnic Consciousness and Regionalism

The Ngoni intrusion into the Northern Region in the 19th Century was an important historical development. The various Nguni groups started to move out of present-day Natal (South Africa) and Swaziland in the early 19th Century. Of particular importance to Malawi are two groups, one which was under the leadership of Zwangendaba, and the other, belonging to Maseko. Both groups crossed the Zambezi river in 1835. The Zwangendaba group split, with one group settling at Chipata (in Zambia), another in Mzimba (in Malawi) and another in the Rovuma Valley in Tanzania. The Maseko group settled in Dedza and Ntcheu, along the current Malawi-Mozambique border area. Around 1855, the Ngoni of Zwangendaba group, under the leadership of Mbelwa, defeated the Tumbuka and Tonga in present-day Northern Malawi. When the Ngoni entered present-day Northern Malawi, the region was not only inhabited by the Tumbuka but also Tonga, Lambya, Ngonde, and others. The Ngoni themselves were not homogeneous either. Their group had within it non-Ngoni peoples that had been captured during the trek from Natal towards the present-day Malawi region. The Ngoni were slow to adopt Christianity and education. This was in contrast to their subjects, the Tumbuka, who were quick to accept the religion and education brought by the Livingstonia Mission. The Ngoni, on the other hand, had fears that Christianity would have a negative impact on their military prowess and expansionist ambitions.

Elsewhere, for example in Zimbabwe, missionaries have been accused of "inventing" ethnic groups and languages (see Ranger 1989, 1993; Chimhundu 1992). In the Zimbabwean situation, Chimhundu, a linguist, says that:

> What started off as translation for evangelisation by individual churches, and later became a search for a common system of writing for the whole Shona-speaking area, ended up with the creation of five or six regional dialects associated with what has now come to be generally regarded as separate tribes (Chimhundu 1992: 87).

In Malawi, similar accounts have been given. For example, Vail & White (1989) argue that the Livingstonia Mission cultivated ethnic and regional consciousness among the people of the Northern Malawi. I have already discussed how the Livingstonia Mission promoted Tumbuka as a source of regional identity for all the peoples of the Northern Region (see section 2.2.1.1).

Writing specifically about the situation in then North Nyasa district (the present-day districts of Chitipa and Karonga), Kalinga (1985) argues that the educational policies pursued by the Livingstonia missionaries in that area contributed to the emergence of ethnic consciousness. Kalinga observes that Reverend Matthew Faulds, who was the head of the Karonga Station of the Livingstonia Mission, favoured Ngonde pupils. The favouritism encouraged the belief that the Ngonde "were superior to other peoples of the district" (Kalinga 1985: 63). The Ngonde were thus encouraged to believe that they were different from the others, and that they deserved special treatment. Among the Tumbuka, missionaries also encouraged ethnic consciousness. For instance, Thomas Cullen-Young (Forster 1989) encouraged the writing of Tumbuka histories, aimed at demonstrating that they were different from the other groups (see Kalinga 1985; Vail & White 1989).

Some scholars (e.g. Chirwa 1994/95) have argued that the demarcation of Malawi into the Northern, Central and Southern Regions has promoted an imagined sense of separateness in the minds of the people. People living in the regions imagine that they are different. Government and party structures that operate at national, regional and district levels have further consolidated the separateness of the regions. Past and present political leaders have tended to reinforce regionalist feelings. For example, whilst the first President Banda used to urge Malawians not to think in terms of their regions or ethnic groups, he never failed to remind his audiences that he was a Chewa from Kasungu. Such a declaration went against the spirit of erasing regionalistic feelings. In the post-Banda era, politicians from all the parties have in one way or the other shown regionalistic tendencies through either their deeds or discourse.[52]

Northerners have for a long time been accused of being regionalistic, displaying what is known as the *wakwithu* syndrome.[53] Regionalistic tendencies were noted in the early days of MCP rule. There had been complaints that most of the high positions within the MCP and the civil service had been occupied by Northerners. Furthermore, there were allegations that Northerners tended to favour one of their own. For example, Kanyama Chiume was accused of favouring Northerners in the award of scholarships for study abroad (see Short 1974). The accusations continued as some Northerners, who headed public institutions, were alleged to have packed the institutions with Northerners (see Africa Watch 1990; Chirwa 1994/95). Even in the post-Banda era, allegations of the continuation of the *wakwithu* syndrome have not disappeared. For example, during Chihana's first appointment as Second Vice-President, there were allegations that he had packed the Ministry of Water Development with Northerners. Those in authority tend to distribute favours to those with whom they share a district or a region or a language. The motive is to gather ethnic support.

2.8.2. Dissidence and Political Activism

The Livingstonia Mission contributed to the cultivation of a culture of dissidence and political activism in the Northern Region of Malawi. The Livingstonia Mission in Northern Malawi set up the most comprehensive and advanced educational system. The Livingstonia Mission's Overtoun Institute attracted students not only from Nyasaland but also from some parts of neighbouring Tanzania (then Tanganyika) and Zambia (then Northern Rhodesia). As a centre of academic excellence, the institute is remembered for producing critical-thinking graduates and excellent non-native speakers of English. There is a general agreement among scholars of Malawian missionary/colonial history that the Livingstonia Mission "provided northern Nyasaland with an educational head start that was to survive, regionally, at least to the 1920s and, nationally, until the present day" (McCracken 1994: 3; see also McCracken 1977a and various contributions to Thompson 1994a). McMaster (1974: 12) makes the same point: "The

regional educational disparity thus created had a lasting effect on the political development of the territory; for example, the first proto-political organisations were set up in the Northern Region."

The earliest forms of dissidence were portrayed by the Livingstonians (to borrow Thompson's 1994b label for Livingstonia's graduates) and they were targeted at the Mission itself. For instance, Charles Domingo, dissatisfied with the Livingstonia Mission, joined the Seventh Day Baptists where he became a minister. Elliot Kenan Kamwana became the charismatic leader of the Watchtower movement. Yesaya Zerenji Mwasi was another prominent Livingstonian minister who broke away. He formed his Black Man's Church of God. Charles Chinula followed suit and founded the Eklesia Lawanangwa (Church of Freedom). These cases prove that Livingstonians were not docile followers of the Mission but were people with independent minds and freedom of action (see McCracken 1977a; 1994). Dissidence by Livingstonians was also shown through their writings.[54]

The involvement of the Livingstonia Mission in the encouragement of political activism amongst Livingstonians was first openly shown in 1912 when Dr Laws engineered the formation of the first political association in Nyasaland. This was the North Nyasa Native Association. Livingstonians such as Levi Mumba and Charles Chinula played a very active and distinguished role in articulating the political aspirations of the colonised Nyasas. Chinula, at one point, rose to the position of Vice-President of the Nyasaland African Congress. Mumba, a very articulate spokesperson on a number of issues and a respected politician, was responsible for the formation of the Representative Committee of the Northern Province Native Associations and in 1942, and later, the Nyasaland African Congress (see McCracken 1994). The active involvement of Northerners in party-based politics was noticed in both the Nyasaland African Congress and its successor, the MCP (see Short 1974; McCracken 2002).

After the 1964 cabinet crisis, the Northern Region of Malawi produced the highest number of Banda's so-called enemies or rebels such as Kanyama Chiume, Orton and Vera Chirwa (see, for example, Short 1974; McMaster 1974; Vail & White 1989; Africa Watch 1990). It is small wonder, therefore, that the Banda regime regarded the region as the home of dissidents, rebels, confusionists and disgruntled elements, to use the labels that were used in reference to those who held views different from Banda's. Even among Northern Region students who were studying at the University of Malawi, the spirit of dissidence was alive. For example, after the 1968 Biafra war of secession in Nigeria, some Northern students at the University of Malawi had predicted that "Northern Malawi is going to be the next Biafra" (Vail 1989: ix, preface).[55]

2.9. "THE DEAD NORTH"

The Northern Region has since the colonial days been the most economically underdeveloped region. It is this situation which led the colonial officials to label the region in negative economic terms as the "Dead North" or *chigawa chakufwa* (Tumbuka: the dead region). The region was simply *ku thengele* (Tumbuka: bush). Despite having had an excellent education system established in the North by the Livingstonia Mission, the region lagged behind the other two regions in terms of economic advancement. The European plantation economy was largely confined to the Southern Region. Because of a significant presence of the European planters, traders and colonial officials in the Southern Region, it is not surprising that the region developed at a faster rate than the North. The growth of the towns of Limbe and Blantyre into key commercial centres, and the establishment of the colonial capital in Zomba, contributed to the unequal development of the three regions. Even in terms of infrastructure

such as roads, telecommunications and others, the Southern Region was ahead of the other two regions.

McCracken (1977b) has examined the role of missionaries in the underdevelopment of the Northern Region. He has posed some important questions, for example: Did the Livingstonia Mission have "no influence on the way in which the economy was structured or the form that it subsequently took?" Secondly, "how far, in particular, was the apparent 'deadness' of Northern Malawi in the twentieth century a consequence of Livingstonia's impact?" (McCracken 1977b: 196). He argues that the Livingstonia Mission transformed the Northern Region into a labour-exporting reservoir instead of developing it into a commercial agriculture-based economy. McCracken goes on to give details of how the Livingstonia Mission had turned itself into a labour bureau, recruiting labourers who went to work as porters in commercial companies and as farm labourers in the Southern Region. The Tonga, for instance, found their way to the Southern Region. White (1987), for example, mentions the presence of Tonga labourers in the Southern Region plantations in the early twentieth century. Later, men from the Northern Region went to Southern Rhodesia and South Africa as migrant workers.

The socio-economic underdevelopment of the Northern Region continued during the Banda era. Banda concentrated his development projects in his home region, the Central Region (see, for example, Short 1974; McMaster 1974; Vail & White 1989; Chirwa 1994/95). Banda moved the capital from Zomba to Lilongwe in 1975; and also established various agricultural development schemes in the Central Region. The Southern Region and the Northern Region were second and last respectively in terms of allocation of development projects. Despite his constant claims that he had developed Malawi "beyond recognition," the Northern Region's underdevelopment was clearly recognisable at the end of Banda's rule in 1994. Though Banda granted city status to Mzuzu, there was little that was practically done to match the new status. At the time Mzuzu was granted city status in 1989, it had few social and economic amenities. For example, the city and indeed the whole Northern Region had no government referral hospital. The Saint Johns' Hospital of the Catholic Church located within the city itself and the Livingstonia Synod's hospital at Ekwendeni (some 20 kilometres away) largely provided the city's medical services. Compared to cities like Lilongwe (in the Central Region) and Blantyre and the municipality of Zomba (both of which are in the Southern Region), Mzuzu found itself as the least developed in terms of social and economic facilities. Whilst the Banda regime accused the colonial government of neglecting the development of the "Dead North", the same accusation has been directed at the Banda regime as well (see, for example, Vail & White 1989; Chirwa 1994/95; McCracken 2002). For example, the rail line was confined to the Southern and Central Regions; and this situation has not changed up to this date. Another case is that the then sole national university[56] had, and continues to have, its campuses confined to the Southern and Central Regions.

2.10. HEALTH SERVICES IN THE NORTHERN REGION

Just like elsewhere in Malawi, health services in the Northern Region are provided by the government, CHAM and private practitioners. In terms of government hospitals and other health institutions, the Northern Region has one central hospital, the MCH. The MCH has a catchment population of 1,412,659 (Malawi Health Information Bulletin). Secondly, each district, with the exception of the Likoma Islands, has a district hospital. District hospitals act as referral hospitals at district level. Table 2.4 gives the overall picture of government hospitals and other health institutions in the Northern Region per district.[57]

Table 2.4: Government Health Institutions in Northern Malawi

District	Centr. Hosp.	Dist. Hosp.	Heal. Cent.	Dispe.	Mater.	Rural Hosp.	Hosp.	Ment. Hosp.
Chitipa	-	1	7	2	-	1	-	-
Karonga	-	1	9	2	1	2	-	-
Likoma	-	-	-	-	-	-	-	-
Mzimba	1	1	24	5	-	4	3	1
Nkhata Bay	-	1	12	-	-	2	-	-
Rumphi	-	1	16	-	-	2	1	-
Total	**1**	**5**	**68**	**9**	**1**	**11**	**4**	**1**

Source of Table 2.4: see the Ministry of Health's website: www.malawi.gov.mw/health/hilist.htm

Key

Centr. Hosp.: Central Hospital
Dist. Hosp.: District Hospital
Heal. Cent.: Health Centre
Dispe.: Dispensary
Mater.: Maternity
Rural Hosp.: Rural Hospital
Ment. Hosp.: Mental Hospital

As can be noted from Table 2.4, Mzimba district has the highest number of health centres, dispensaries, rural and other hospitals in the Northern. This is not surprising since Mzimba is the largest district in the Northern Region.

2.11. MZUZU: THE RESEARCH SITE

2.11.1. The Capital of the Northern Region

The beginnings of the present city of Mzuzu can be traced to the mid-1900s. The settlement started off as a tung plantation. The end of the First World War saw the rising prices of tung oil. This trend meant that there was a higher demand for the product. The tung oil industry in Nyasaland had started in the Southern Province. Due to population pressure in the Southern Province, land for the tung industry became inadequate. It was then decided that new tung plantations be opened up in the sparsely populated Northern Province. A Charles Boardman was tasked with setting up the new tung industry. He erected his headquarters at the site of the present-day Mzuzu (Williams 1969). It is this settlement which over the years has grown into an administrative as well as commercial centre, now with city status. The city status was granted to Mzuzu in 1989. Mzuzu is no longer *thengele* (bush), but *msumba* (city). The 1998 population census of Malawi put the city's population at 86,980 (National Statistical Office 1998). One consequence of the city's growth is that the population consists of a diversity of Malawians from other districts and regions. In addition, there is also a small population of Asian businesspersons. Trade opportunities in Mzuzu have also attracted not only Malawians from the other two regions but also other African nationals. The biggest contingent of foreign traders is that of the Swahili-speaking Tanzanians who are locally known as *Taifas* (Swahili: *Taifa* means nation).

Today *msumba wa Mzuzu* (the city of Mzuzu) is not only the regional headquarters for government departments but also several non-governmental bodies. The city is the headquarters of the Anglican Diocese of Northern Malawi, the Mzuzu Diocese of the Catholic Church, and the Livingstonia Synod of the CCAP. Mzuzu also hosts three important language-related activities. First, the Bible Society of Malawi has a Tumbuka Bible translation project based in Mzuzu. Second, the Mzuzu Museum acts as the interim secretariat

for a language association known as the Chitumbuka Language and Culture Association. The third important language activity-taking place in Mzuzu is the existence of the Abenguni Revival Association, which is also known as the Mzimba Heritage Association.

2.11.2. Mzuzu Central Hospital

2.11.2.1. The Politics of Development

The Mzuzu Central Hospital is currently one of the major development projects in Malawi attributed to the UDF government's development agenda.[58] It should be mentioned that the hospital project came amidst the anti-UDF feeling which led to its disastrous performance in the Northern Region in the 1994 elections. The UDF had failed to win a single seat in the power base of AFORD. The hospital project was portrayed by the UDF as a clear testimony of its commitment to spread development to areas that had been neglected by the MCP government. Furthermore, the UDF wanted to demonstrate its desire to spread development projects even to areas where it had no parliamentary seats. The establishment of the second national university in Mzuzu followed the hospital project. The other projects included the establishment of a tobacco auction floors and the building of a branch of the High Court of Malawi. All these development projects, most welcome in a region that had been largely excluded from the MCP's development agenda, gave the UDF the opportunity to show that it, more than the previous government, was responsive to the Northern Region's development needs. In the process, the UDF expected to receive the much-needed recognition as the governing party.[59]

For the construction of the MCH, the UDF government sought technical and financial assistance from Taiwan.[60] That the government of Taiwan was ready and willing to fund the hospital project came as no surprise because since the Banda era, Malawi has been one of the few African countries that maintained diplomatic relations with Taiwan. Banda's dislike of Communism led Malawi to adopt a policy of shying away from having diplomatic ties with the then communist countries such as the former Soviet Union, mainland China and the then East Germany, just to mention a few (see Short 1974: 206-8, on Malawi's choice between mainland China and Taiwan). After the demise of the MCP regime, the new government strengthened its relations with Taiwan by opening an embassy in Taipei. At the United Nations, Malawi voiced its support for an end to the isolation of Taiwan. Malawi also supported Taiwan's bid to join the World Health Organisation.[61]

2.11.2.2. A State-of-the-Art Hospital

The Mzuzu Central Hospital caters for the all the six districts of Northern Malawi, namely: Mzimba, Nkhata Bay, Likoma Islands, Rumphi, Karonga and Chitipa. The hospital also caters for some parts of the Central Region such as Dwangwa. The hospital has a 300-bed capacity. President Muluzi officially opened the MCH on 11th November 2001. The hospital was funded and constructed to the tune of 14 million US Dollars. The Chinese Medical Mission to Malawi includes the provision of the state-of-the-art hospital equipment, drugs and medical personnel. A Chinese doctor heads the Medical Mission.

When I first visited the MCH in December 2001, I was quick to notice that the hospital was unique. The hospital was starkly different from other government hospitals. First, the hospital buildings and the surrounding premises were clean. The foul smell that is common in other government hospital was simply not there. Second, unlike other hospitals, there was no overcrowding in the wards at the MCH (see also Table 2.5). There was one patient to a bed, and no sharing of a single bed by two patients. Neither was there any case of patients sleeping

on the floor. Third, there was a foreign medical mission - the Chinese Medical Mission - that provided some of the hospital's specialists. In many government hospitals, specialists/consultants are rare. Fourth, there were no reports of drug shortages at the MCH. Fifth, all the systems (e.g. water, electricity etc) were in working condition. This was a big contrast to some government hospitals that have technical problems with water, sewage and electricity systems. At the MCH, there was evidence of adequate and effective maintenance work.[62]

Table 2.5: Bed Occupancy in Central Hospitals 2002

Hospital	Bed Occupancy %
MCH	74
LCH	93
ZCH	99
QECH	65

Source of Table 2.5: Malawi Health Information Bulletin

The MCH offers general out-patient treatment, in-patient treatment, and specialist treatment. The hospital has up-to-date equipment for the laboratory, x-ray department, physiotherapy department, the dental unit and operation theatre. The hospital is also able to offer surgery that is not available at other hospitals. For instance, the MCH offers plastic surgery.[63] In 2002, there were also plans to establish an open-heart surgery theatre and a dialysis centre. Previously, the Lilongwe Central Hospital had the country's only dialysis centre. Another unique aspect of the hospital, by Malawian standards, is that it has a library. The library offers Internet facilities, thus allowing health service providers at the hospital to access various types of information. In addition to the up-to-date facilities, qualified and experienced medical personnel from the Chinese Medical Mission support the hospital. Since its opening, the MCH has had a wide range of medical expertise offered by the Taiwanese. Some of the areas of Taiwanese expertise that the MCH has so far enjoyed are: nursing, radiology, pharmacy, orthopaedics, dentistry, pathology, obstetrics and gynaecology, surgery of various types (e.g. general surgery, breast surgery, digestive surgery etc).

2.11.2.3. Referrals and Non-Referrals

The MCH receives referrals from all the six districts of the Northern Region as well as Dwangwa in the Central Region. The highest number of referrals comes from government health centres and private hospitals located within the city of Mzuzu. Apart from attending to referrals from government and CHAM hospitals, the MCH also attends to out-patients from within Mzuzu city and other areas. All referred patients receive free services unless they opt for the private paying-wards. Non- referred patients are required to pay for consultation, diagnosis, drugs, and laboratory services. In case of admission, a non-referred patient pays 300 Malawi Kwacha (about 2 Euro) per night in the side ward and 150 Malawi Kwacha (about 1 Euro) per night in the common wards. The payment is due at the time of discharge.

All patients at the MCH use what are called health passports. This is a booklet that contains a patient's general health profile i.e. the diseases one has suffered from in the past and the treatments one has received. In the absence of patients' computer database, the health passport becomes a handy documented history of one's health. I found three types of passports in use at the MCH. The passports are physically distinguished from each other by colour. The yellow passport is for girls aged 5 and above, and child-bearing women. The

orange passport is for children under the age of 5. The blue passport is for boys aged 5 and above, all men and non-child-bearing women.

2.11.2.4. Hospital Personnel

A hospital director who is a Malawian doctor heads the MCH. A mission director who is also a medical doctor heads the Chinese Medical Mission. This joint administration is a result of the technical co-operation under which Taiwan funded the construction of the hospital, provided equipment and continues to provide staff and drugs. At the time of my fieldwork, expatriate doctors (rather than Malawian doctors) were in the majority at the MCH, a feature that is common in Malawi. The breakdown of the composition of the doctor population at the MCH is as follows: three Malawians, three Chinese, one American, three Britons, four Egyptians and one Palestinian (Dr. Haji Juma-Personal Communication). Malawi's heavy reliance on expatriate doctors comes in the wake of the presence of many qualified Malawian doctors working in the Diaspora. The reliance on expatriate doctors brings in a linguistic problem (the inability of the expatriates to speak local languages), and chapters 4 to 7 will highlight this problem.

With the unfavourable doctor/patient ratio in Malawi and the heavy reliance on expatriate personnel as mentioned earlier, clinical officers and Medical Assistants become a substitute for doctors. The clinical officer or clinician is a service provider who comes after a doctor. His/her training is more advanced than that of a medical assistant. A clinician receives a patient's medical history, makes a diagnosis out of it and then prescribes treatment. More complicated cases are referred to specialists (i.e. doctors). Clinicians with relevant experience and qualification can upgrade to the level of a doctor through training that is obtainable at the College of Medicine within Malawi as well as abroad. At the time of my fieldwork, the MCH had 17 clinicians, according to the Hospital Administrator. Nurses and midwives made up the largest category of professional staff at the MCH. They provide nursing care and the administration of drugs. At the time of my fieldwork, the MCH had a nurse/midwife population of 84. Another category of the MCH staff is what is known as paramedics. These are also known as technicians. They include pharmacy assistants, radiology assistants, dentist assistants and laboratory assistants. Technicians undergo the basics of medical training before they specialise in their fields. There were 13 technicians at the MCH at the time of my fieldwork. As for support staff, they come in various categories. Examples include ambulance drivers, security personnel, catering staff, clerical staff, and hospital/patient attendants. In the present study, attention was paid to hospital/patient attendants because they interact with patients and other clients more directly than the other categories of support staff. A total of 105 hospital/patient attendants were recorded at the time of the fieldwork. While patient attendants take care of patients, hospital attendants perform tasks such as cleaning. But in reality, the actual duties of the two categories of support staff are not easy to distinguish.

2.12. SUMMARY AND CONCLUSIONS

In this chapter, I have presented a historical, political, socio-economic and sociolinguistic background to the making of modern Malawi and its Northern Region. This account serves as the context (cf. Duranti & Goodwin 1997) within which the findings of the study can be appreciated and analysed. I have discussed three eras of Malawi's history - the missionary/colonial era, the Banda era and the post-Banda era - and outlined the major socio-economic, political and language policy/planning developments that took place in each era. Special attention has been paid to developments in the Northern Region during the three eras. I have also highlighted the current state of economic development in the Northern Region,

especially with special focus on Mzuzu city, the regional capital. It is within Mzuzu city that the ultra-modern Mzuzu Central Hospital is located.

NOTES

[1] See McCracken's (1999) review of some of the major works that discuss the profound contributions of Christianity towards the making of modern Malawi.

[2] Banda was referred to as the "Father and Founder" of the nation. Note that Tanzania's founding President, Julius Nyerere, was called *Baba ya Taifa*, the Swahili title whose English translation is "Father of the Nation."

[3] Livingstone himself died in 1873 at Chitambo in present-day Zambia. In that country, there is now a town called Livingstone, named in honour of the Scottish missionary explorer.

[4] The current CCAP comprises three synods: the Blantyre Synod (formerly the Established Church of Scotland), the Nkhoma Synod (formerly the Dutch Reformed Church) and the Livingstonia Synod (formerly the Livingstonia Mission of the Free Church of Scotland).

[5] For example, the first group of the UMCA missionaries at Magomero (White 1987) went into physical confrontation with slave dealers, freeing some of the captured slaves in the process. Later, the Mission opted for a non-physical confrontation in its anti-slave trade campaign. On the other hand, the Blantyre Mission (the Established Church of Scotland) had pursued a policy of non-physical confrontation with the slave dealers from the beginning.

[6] Note, for instance, that when the UMCA arrived at Magomero in 1861, Horace Waller, one of its members, started offering medical services though he had no medical training or experience (White 1987: 40). See also King and King (1997) for a comprehensive history of Western medicine in Malawi.

[7] One of the prominent plantation owners was Alexander Low Bruce, a son-in-law to Dr David Livingstone. Alexander Bruce died in 1893, leaving his assets in Malawi to his two sons, David Livingstone Bruce and Alexander Livingstone Bruce, "in the hope and expectation that they will take an interest in the opening up of Africa to Christianity, Commerce and Civilisation on the lines laid down by their grandfather David Livingstone" (White 1987: 82).

[8] When the name of the country changed to Malawi, the lake was given the same name. Tanzania, however, continues to use the name Lake Nyasa. The lake has been at the centre of a border dispute between Malawi and Tanzania. See Mayall (1973) for a detailed account of the border dispute.

[9] One of the major grievances was the brutality with which European plantation managers, such as William Jervis Livingstone (a distant relation to Dr David Livingstone) treated Africans. The labour tenancy system, *thangata*, was also strongly resented. In the Chilembwe uprising, William Jervis Livingstone was beheaded. Colonial government soldiers later killed Reverend John Chilembwe, the leader of the uprising. A number of Chilembwe's followers were executed whilst others fled into hiding (see White 1987).

[10] Hastings Kamuzu Banda was the second Malawian to qualify as a medical doctor. The pioneer was Daniel Malikebu.

[11] The discussion here is mainly based on Vail & White's (1989) essay, especially the section entitled 'Language Policy and the Creation of Northern Regionalism,' (pages 164-166).

[12] After the cabinet crisis, many Malawians, who were victims of Banda's political purges, sought asylum in the neighbouring countries of Tanzania and Zambia. This development angered Banda, who in turn accused the two countries of harbouring rebels who wanted to overthrow his government. See, for example, Mayall (1973) on the soured relations between Malawi and Tanzania; and also see Short (1974) on Malawi's strained relations with both Tanzania and Zambia.

[13] The pastoral letter was read during mass in all the Catholic parishes on 8th March, 1992.

[14] Schoffeleers (1999a) provides the most comprehensive discussion of the 1992 pastoral letter. He gives a very rich historical background to the letter. As he reminds his readers, the 1992 pastoral letter was not the first confrontation between the Catholic Church and the MCP. In 1960, Archbishop Theunissen had encouraged the formation of the Christian Democratic Party as a rival to the MCP. This development had angered the MCP leadership, leading to strained relations between the Church and the MCP.

[15] The translation took the title of *Sobero la Julius Kesare.* It was first published in 1967 (see Kamwendo 2002a). Prior to this, the then Tanzanian President, Julius Nyerere, had translated the same play into Swahili.

[16] Aleke Kadonaphani Banda is not a relation of Dr Hastings Kamuzu Banda.

[17] In his speech in parliament (Malawi Government 1966), Musopole made references to Tanzania as a model which Malawi could emulate: "And Tanganyika (Tanzania), a country which is very big, I don't know how many times Malawi can go into Tanganyika, but there, there is one language - Swahili - only one language. But Malawi although small as it is, why has it two or three or ten languages?" In addition, Kanyama Chiume, one of the ministers who had rebelled against Dr Banda during the cabinet crisis in 1964, admitted to me in an interview (14th March, 2001) that he fully supported Banda's policy of one nation, one language. He was, however, worried that the post-Banda language policy could erode national unity and, instead, encourage ethnic loyalties. Chiume was a staunch admirer of Julius Nyerere (McCracken 2002), and Nyerere's influence on him as regards the language policy cannot therefore be ruled out.

[18] For example, Kawale (2000) mentions that the Bible Society of Malawi produced a Tonga Bible in 1987 and a Ngonde Bible in 1992.

[19] The exact link between language and culture is yet to be established as noted by Titscher et al (2000: 91): "It is uncontested that language exists in a cultural context, but it remains open how the relationship is to be specified: Does language function as the expression of culture, and is it determined by the non-linguistic features of culture? Are linguistic and non-linguistic components of culture different in principle from one another? Or does language have a determining influence on culture as an organisational principle of the material world (Sapir-Whorf hypothesis)?" See also Gumperz & Levinson (2000) on further discussion on the linguistic relativity thesis.

[20] See Aleke Banda's praise of Dr Banda's enviable authority on Chewa in Malawi Government (1966).

[21] By this time, the bishops had been threatened with death by the MCP. The death threats were issued at an extraordinary MCP convention held on 11th March, 1992, in Lilongwe. See also Newell (1995) and Schoffelleers (1999a).

[22] The theme of the meeting was "Prospects for Democracy in Malawi" (see Newell 1995). See also Kalipeni's (1992) discussion on the prospects of political reforms and democracy in Malawi.

[23] The literature comprised a copy of the pastoral letter and his own speech on political change. In December 1992, Chihana was sentenced to two years imprisonment. In March 1993, the Supreme Court upheld Chihana's conviction but reduced his sentence to nine months with hard labour. He was released a few days before the June 14th 1993 national referendum.

[24] Note the use of the designation Tumbuka to anyone who comes from the Northern Region. In a related manner, the three main political parties were ethnicised as follows: UDF as *chipani cha Achawa* (the party of Achawa). Achawa is a pejorative term for the Yao. Muluzi is a Yao. The MCP, by having its stronghold in the Chewa-dominated Central Region, was branded *chipani cha Achewa* (the party of the Chewa), and AFORD was called *chipani cha Atumbuka* (the party of the Tumbuka).

[25] According to the 1998 population census (National Statistical Office 1998), 80 % of the enumerated persons claimed to be Christians whilst 13 % claimed to be Moslems, and the

remainder were either non-believers or belonged to traditional religions. See also Forster (1997) on religion and the presidency in Malawi and Tanzania.

[26] For a detailed account of the 2004 elections, visit www.sdnp.org.mw.

[27] Minutes of Tumbuka briefing at Malawi Broadcasting Corporation, Blantyre, 25th September, 1996.

[28] cf. During her fieldwork in Malawi, Ribohn (2002) was constantly told that she had to go to the villages since it was where "real" or "genuine" culture could be found. The village, as a rural area, is said to have "pure" culture.

[29] One example from Tumbuka is whether *wakutumbikika* or *wakuchindikika* should be used for the title *honourable*. In Lomwe, at first the word *enthawi* was used for referring to *time*, but it was later dropped in favour of *elukuluku.*

[30] See Secretary for Education's Letter, Reference IN/ 2 / 14, dated 28th March, 1996.

[31] See, for example, articles by D. D. Phiri, "How Much English Should We Know?" *The Nation,* 13th August, 2002. Phiri remembers the "good old days" when Malawian students were fluent in the English language, and laments the fall in the English language fluency as well as education standards. See also L. D. Nsapato, "English Speaking Fluency Nose-diving." *Weekend Nation*, 14-15 September, 2002. Nsapato blames too much use of Chewa as being responsible for the fall in fluency in the English language. Some parents have responded to the situation by sending their children to the so-called "English only" schools in order to "improve" the children's language skills (see Kamwendo 2003). The insatiable demand for English medium schools has also been noted in Tanzania. Brock-Utne, for example, mentions an opposition party leader who had vowed that if he became president of Tanzania, he "would see to it that children started learning English from day one of grade one in primary school" (Brock-Utne 2002: 18).

[32] *Kwanunkwanu* simply meant each person had to go back to his or her region or district of origin. See, for example,"Teachers to Teach in Own Regions," *Daily Times,* 14th February, 1996. The Banda regime had directed that teachers should teach in their regions of origins. Banda gave the infamous directive after he had alleged that teachers from the Northern Region were deliberately trying to destroy the education system whenever they taught away from their home region. Banda had alleged that teachers of Northern Region origin taught diligently when working in their home region. They, however, worked less committedly whenever they were posted outside their home region. Banda claimed that the motive of the Northerners was to sabotage the education system in the Central and Southern Regions so that in the end, the Northern Region would excel in national examinations (see Africa Watch 1990).

[33] The first symposium took place from 7th to 11th March, 1999 (see Kamwendo et al 1999). The most significant outcome of this symposium was a draft policy on language in education. The draft policy was submitted to the Ministry of Education for government's consideration for approval. The second symposium took place from 25th to 28th October, 2000. Its theme was Local *Languages in Education, Science and Technology* (see Pfaffe 2000). The third symposium, which took place in 2001, had the theme of *Cross Border Language Co-operation* (see Pfaffe 2001). There was no symposium in 2002. The fourth national symposium on language policy in education was held in April 2003, under the theme of *Implementing Multilingual Education* (see Pfaffe 2003). The fifth symposium was held jointly with the 3rd conference of the Association for the Development of African Languages in Education, Science and Technology (ADALEST) from 30th August to 3rd October 2004. The theme was *Making Multilingual Education a Reality*.

[34] The decision to revert to the former name of the language was announced through a circular letter from the Secretary for Education and addressed to all Divisional Education Managers.

[35] See Stroud (1999) for the appropriation of Portuguese in post-colonial Mozambique, and the transformation of Portuguese into a bona fide Mozambican variety.

[36] In Zambia, ethnically oriented ownership of language is also a contested issue. Members of certain ethnic groups argue that they "own" certain radio programmes since they are broadcast

in "their" languages. Kashoki has argued that the use of the seven local languages on the public radio "does not mean or imply that programmes in these languages are intended only, or specially, for the Cewa, Tonga, Bemba, Lunda, Lozi, Kaonde or Luvale. On the contrary,... anybody, whatever his mother tongue background, who speaks or understands any of the seven languages is welcome to listen to that language. The intention is to make the seven languages as much as possible 'national' properties, or national lingua francae" (Kashoki 1990: 35-36).

37 That multipartyism has allowed the creation of elite associations has been witnessed in other parts of Africa (see Geschiere & Gugler 1998) such as in Cameroon (see Nyamnjoh & Rowlands 1998).

38 President Mogae of Botswana has also raised such a fear. With the proliferation of ethnically based language and culture associations in Botswana, President Mogae fears that some people might be using the associations "to separate themselves from others in order to mobilise for political purposes" (Werbner 2002a: 128). It is not uncommon that the so-called language and culture associations go beyond what their names suggest. That is, whilst they claim to seek more cultural and linguistic rights, the associations may also be seeking political rights. In the end, the associations look like political pressure groups or even political parties. For example, the language and culture association for the Wayeyi of Botswana has not only demanded linguistic and cultural rights (Nyati-Ramahobo 2000), but also land and political rights (Nyati-Ramahobo 2002; Werbner 2002a, b). For instance, the association is pressing for the government's recognition of its newly created paramount chief. In addition, the Wayeyi want their paramount chief to be admitted into the House of Chiefs. Another demand is that the Wayeyi should no longer be under the rule of the Batawana chieftainship. These examples from Botswana show that language and cultural associations have the potential of becoming politicised.

39 Minutes of CLACA meeting, 17th May, 1996.

40 See the same argument in Kontra (1999).

41 Ngugi wa Thiong'o argues that "through translations, the different languages of the world can speak to one another. European languages have always communicated with one another such that today it is possible to read nearly all the classics of Russian, French or German literature and philosophy in any of those languages, thanks to the art of translation. But there is very little mutual translation between African languages and, say, English and French" (Ngugi wa Thiong'o 1993: 40).

42 Letter to the Ministry of Education from CLACA, dated 24th October 1996.

43 Initially called poverty alleviation but later changed to poverty reduction.

44 In late 2003, the IMF resumed, on a small scale, its assistance programmes subject to further periodic reviews. This scenario does not impact positively on the poverty reduction programme.

45 In the mid 1920s, Dr Robert Laws, then the head of the Livingstonia Mission, had planned to set up the first university college in Central Africa. Following his replacement by W. P. Young as head of the Mission in 1927, the university plan was abandoned (McCracken 1994: 7).

46 See www.malawi.gov.mw/educ

47 Currently, the delivery of health services in Malawi is being guided by the objectives outlined in the 1999-2004 health plan (Malawi Government 1999c). The objectives of this 5-year plan are as follows: (i) to provide better quality health care to all families; (ii) to have health services to the general population strengthened, expanded and integrated; (iii) to have an increase in efficiency and equity in resource allocation; (iv) to have an increase in access to health care facilities and basic services; (v) to improve the quality of human resources; (vi) to strengthen the collaboration and partnership in the health sector; and (vii) to have an increase of overall resources in the health sector. In addition, the Bakili Muluzi Health Initiative (Malawi Government 1999a) focuses on ensuring the availability of basic essential drugs among the rural populations within walking distance to their homes.

48 Note, for example, Lwanda's experiences: "I visited district hospitals, imagine the buzz and scariness of arriving there knowing you would be consulted on any medical subject from

malaria through diabetes to an x-ray appearance suggestive of a blastomycosis" (Lwanda 1995: 2). As Mlombe put it, postgraduate training, which allows a doctor to specialise, is not a luxury as some people in Malawi wrongly think. He says that in Western medicine, "no single person can treat and manage every possible human ailment;" and he sarcastically adds "except may be Malawi's clinical officers and graduates of the Malawi College of Medicine," see www.malawihere.com/views.asp? id=417.

[49] For example, in December 2002, the only eye specialist at the Queen Elizabeth Central Hospital in Blantyre went on strike to protest against government's failure to pay and house him. In addition, doctors are frustrated by shortages of drugs and the lack of the necessary hospital equipment (see Lwanda 2002a, b).

[50] For a discussion on traditional cures for spirit possession in Malawi, see for example, the case of *nantongwe* among the Lomwe (see, Boeder 1984; White 1987: 182-90) and *vimbuza* among the Tumbuka (see Vail & White 1991: chapter 7).

[51] This *mchape* should be distinguished from the *mchape* of the 1930s. The latter was a herbal concoction which, when consumed, would only kill those who were witches. The 1930 *mchape* cleansed society, ridding it of witches. See, for example, White (1987: 188-89).

[52] For example, in 1996, the late Kampunga Mwafulirwa (an AFORD Member of Parliament) made a speech in the presence of President Muluzi at Wowve in which he accused the president of not developing the Northern Region. The speech also carried some regionalistic remarks. This is just one of the many examples of regionalistic speeches.

[53] *Wakwithu* (Tumbuka) means "someone from home (*kukaya*)." It has been noted by non-Northerners that the moment someone speaks Tumbuka or shows other Northern identity such as a name, a fellow Northerner's reaction is likely to be: "*Mwana wakwithu! Kukaya ni nkhu?"* (Child of my home! Where do you come from i.e. which part of the Northern Region?).

[54] For example, Charles Domingo, in *The African Sabbath Recorder*, was very critical of the conduct of the missionaries and the colonial government. Dissidence was also depicted in some unpublished materials, such as letters of protest written to the Mission Council. In 1921, for instance, Yesaya Chibambo, wrote a letter in which he protested against the conditions in the mission employment (see a detailed discussion of the Livingstonians' protest literature in Thompson 1994b).

[55] After the first multiparty general elections in 1999, the secession talk was also heard in the Northern Region, apparently as a sign of frustration with Chihana's failure to win the presidency.

[56] The five constituent colleges of the University of Malawi are located as follows: Chancellor College (Zomba, Southern Region), the Polytechnic (Blantyre, Southern Region), the College of Medicine (Blantyre, Southern Region), Kamuzu College of Nursing (Lilongwe, Central Region), and Bunda College of Agriculture (Lilongwe, Central Region).

[57] Note that Likoma District came into being on 5th November 1999. The district comprises Likoma and Chizumulu Islands. Prior to 5th November, 1999, Likoma and Chizumulu Islands were part of Nkhata Bay district. The Anglican Church runs the St. Peter's Hospital on the Likoma Islands. There is no government hospital.

[58] That the Banda regime later realised its neglect of the development of health services in the Northern Region is suggested by the 1993 MCP manifesto. In that manifesto, the Malawi Congress Party made a pledge that its next government would build a referral hospital in Mzuzu (Malawi Congress Party 1993). Unfortunately for the MCP, it did not have the opportunity to translate its electoral pledge into reality because the party failed to win the 1994 multiparty general elections. The United Democratic Front government then picked up the referral hospital project proposal and negotiated for financial and technical assistance from Taiwan.

[59] The extent to which the UDF has gained support in the Northern Region because of these projects is beyond the concerns of this thesis. However, it can be pointed out that the UDF's performance in the Northern Region during the second multiparty general elections held in 1999

was not impressive either. The party only managed to win one parliamentary seat on the Likoma Islands, and history repeated itself as AFORD took the largest number of seats. AFORD took 28 seats whilst the MCP and UDF took four and one seat respectively (see relevant chapters in Ott et al 2000; Englund 2002a). These electoral performance results show clearly that since the advent of the multiparty system of government in 1994, the Northern Region has been an AFORD power base. However, during the 2004 elections, AFORD performed badly and lost its parliamentary dominance in the Northern Region.

60 The assistance which Malawi receives from Taiwan is part of the latter's relentless efforts in seeking allies and international recognition. As a politically isolated state, Taiwan hopes that by forging close ties with African states, it can get the much-needed diplomatic and international recognition. Most vulnerable to this ploy are the economically weak African countries such as Burkina Faso, the Central African Republic, Guinea Bissau, Liberia, Gambia, Niger, Malawi and Swaziland (see Payne & Veney 2001).

61 See A. Mchulu, "Malawi Lobbies UN on Taiwan," The *Nation*, 21st August, 2003.

62 See, for example, United Nations (2001a: 17): "Many health centres are housed in old buildings that are deteriorating due to lack of maintenance, have no piped water and no communication facilities." The Lilongwe Central Hospital has had no running elevators for a long time. This has created serious mobility problems to the extent that guardians who cannot manage to carry the sick relatives on their back or a stretcher are forced to hire vendors (who sell commodities around the hospital) to carry the patients for a fee. See George Ntonya, "Vendors Carrying Patients at Lilongwe Central Hospital," *The Nation*, 13th April, 2004.

63 See P. Msowoya's article, "Rats Nip Off Baby's Nose," in *The Nation*, 30th December, 2003, in which a surgeon at the MCH mentioned the availability of expertise and equipment for plastic surgery.

CHAPTER 3

THEORETICAL AND ANALYTICAL ORIENTATION

3.1. INTRODUCTION

In this chapter, I discuss the theoretical and analytical orientation of the study. The chapter is divided into the following sections. In section 3.2, I present the hospital as a site for sociolinguistic analysis, focussing on three competing theoretical constructs, namely the speech community (section 3.2.1), the Discourse Community (section 3.2.2), and the Community of Practice (section 3.2.3). The next section, 3.3, focuses on discourse analysis. Various discourse analytic approaches have been, and continue to be used in the study of language and communication in health care delivery. Although my study is not based on the discourse analytic approach, it is still important to highlight the contributions of this approach towards the study of health service-based language and communication. I have also drawn some insights from the discourse analytic approach that I have found to be relevant in the analysis of my findings.

In view of the fact that my study focuses on language policy and planning issues at a hospital, I discuss various aspects of language policy and planning such as the history, definitions and scope of the concept (section 3.4.1); status and corpus planning (section 3.4.2); the canonical model of language planning (section 3.4.3); centralised and decentralised language planning (section 3.4.4), language planning ideologies (section 3.4.5); endoglossia and exoglossia (section 3.4.6); sociolinguistic data as input for language planning (section 3.4.7); sources of sociolinguistic data: a critique (section 3.4.7.1); relevant data on language use in household communication in Northern Malawi and preferred languages of health service delivery in the same region (section 3.4.7.2). In section 3.5, I discuss the interface between linguistic human rights and language policy/planning. In section 3.6, I focus on language services during the provision of health care. I summarise and conclude the chapter with section 3.7.

3.2. A HOSPITAL AS A SITE OF SOCIOLINGUISTIC STUDY

3.2.1. The Speech Community

In her study of the language situation at the Baragwanath Hospital in South Africa, Saohatse (1997, 1998, 2000) employed the notion of the speech community. She took the hospital as a speech community:

> The data collected for this study indicate that various smaller groups (or speech communities) such as doctors, nurses and patients, who belong to different groups, can be defined within a larger speech community such as the Baragwanath Hospital speech community (Saohatse 1997: 63).

Initially, I had intended to follow Saohatse's approach in designating my study site, the Mzuzu Central Hospital, as a speech community. Having critically examined the literature, I changed my approach. I now hold the view that the application of the notion of a speech community to a hospital setting is problematic in a number of respects. I find the constructs Discourse Community and Community of Practice, though not free from their own problems, to be better suited than the speech community in explaining the language and communication

situation at the MCH. I will, first of all, define and discuss the speech community and then show its inadequacy. I will also bring Saohatse's use of the construct into the critique.

The concept of the speech community has been debated for many decades now, but it still remains one of the most controversial constructs in sociolinguistics. A number of definitions have attempted to explain the concept, but there is still no single universally agreed definition. "This is in great part because there is not a clear notion of what a community is" (Figueroa 1994: 56). The problematic nature of the concept of the speech community is finely captured by Patrick (2002: 573) when he admits that he can "neither offer a new and correct definition nor reject the concept (both misguided efforts), nor exhaustively survey its applications in the field (an impossibly large task)." Whilst some scholars have found the speech community to be a concept "too difficult to explore" (Patrick 2002: 574), others have even given up trying to explore it further and have opted to reject the notion altogether. Others have found it meaningful, in certain contexts, to supplant the speech community with the concept of the Community of Practice (see, for example, Holmes 1999; Saville-Troike 2003). Though the speech community is fraught with many difficulties, some scholars still use it as if "it were either unproblematic or, at any rate, necessary" (Patrick 2002: 574). The speech community is also problematic in the sense that in actual practice, it is difficult to indicate its precise boundaries. One can, therefore, talk about Detroit and New York in the USA as separate speech communities. At the same time, one could also talk of African American and European American speech communities within New York or Detroit. One can also, therefore, talk of smaller speech communities existing within larger speech communities.

Figueroa (1994), Saville-Troike (2003) and others note that the criteria for deciding whether a unit is to be called a speech community or not are varied. It has been noted that the criteria for determining a speech community include shared language use (Lyons 1970); shared rules of speaking and interpretation (Hymes 1972); shared attitudes and values regarding language forms and use (Labov 1972); and sociocultural understandings and presuppositions with regard to speech. Hudson (1996) has critiqued various definitions of the speech community. In his critique, Hudson regards the terms speech community and linguistic community as having the same meaning. Our first definition comes from Bloomfield (1933: 42) who says that "a speech community is a group of people who interact by means of speech." Hudson (1996: 25) observes that Bloomfield's definition "leaves open the possibility that some interact by means of one language, and others by means of another." Bloomfield also acknowledges the difficulty, if not the impossibility, of determining who belongs to the same speech community. Lyons offers another definition of a speech community. He says a speech community refers to "all people who use a given language or dialect" (Lyons 1970: 326). This definition implies that speech communities may overlap as in the case of bilinguals since, by definition, they use more than one language or dialect. Hudson (1996: 24) adds, "it is possible to delimit speech communities in this sense only to the extent that it is possible to delimit languages and dialects without referring to the community that speaks them." Hockett (1958: 8) offers the third definition as being "each language defines a speech community: the whole set of people who communicate with each other, directly or indirectly, via the common language." Hudson (1996: 24) remarks that Hockett's definition implies that "if two communities both spoke the same language but had no contact with each other at all, they would count as different speech communities."

John Gumperz offers two definitions of a speech community. His first definition (Gumperz 1962) is cited by Hudson (1996: 25) as "a social group which may be either monolingual or multilingual, held together by frequency of social interaction patterns and set off from the surrounding areas by weaknesses in the lines of communication." Later,

Gumperz (1968) issued another version of his definition which Hudson (1996: 25) cites as being "any human aggregate characterised by regular and frequent interaction by means of a shared body of verbal signs and set off from similar aggregates by significant differences in language use." William Labov, one of the leading figures in the variationist school of sociolinguistics, makes his contribution as follows:

> The speech community is not defined by any marked agreement in the use of language elements, so much as by participation in a set of shared norms; these norms may be observed in overt types of evaluative behaviour, and by the uniformity of abstract patterns of variation which are invariant in respect to particular levels of usage (Labov 1972: 120).

As it can be noted from the discussion so far, definitions of the speech community have ranged from very simple ones like Bloomfield's (1933) and Lyons' (1970) to more complex ones (e.g. Gumperz 1962, 1968). It has also been noted that the boundaries between speech communities are not clear, leaving us wondering whether indeed we can objectively identify a speech community. Who determines what constitutes a speech community? Is it the linguist (an outsider) or the person who perceives him/herself to belong to such a community? Hudson (1996: 28) doubts whether "the notion of speech community is helpful at all. The construct may in fact mislead us by implying the existence of 'real' communities 'out there', which we could discover if only we knew how." He goes on to caution that:

> The sociolinguistic world is not organised in terms of objective 'speech communities,' or social types such as 'Londoner' and 'American'. This means that the search for a 'true' definition of the speech community, or for the 'true' boundaries around some assumed speech community, is just a wild goose (Hudson 1996: 29).

Like Patrick (2002), Hudson (1996) is not ready to either reject all the past definitions of the speech community or offer new and better definitions. He says that the definitions:

> Are all 'correct', since each of them allows us to define a set of people who have something in common linguistically - a language or dialect, interactions by means of speech, a given range of varieties and rules for using them, a given range of attitudes to varieties and items (Hudson 1996: 27).

For Saohatse (1997, 1998, 2000), her study site (a hospital) was a speech community that was made up of smaller speech communities such as nurses, doctors and patients. However, Saohatse did not provide the criteria she had used in coming up with these speech communities. For example, what makes nurses and doctors belong to two distinct speech communities? Are these professional or language-based communities? There is a need to come up with clear characteristic features of a speech community and then apply them to a hospital situation. If the features of the speech community fit the hospital situation, then we can confidently designate a hospital as a speech community. This has not been done in Saohatse's case. I am, therefore, of the view that she imposed the construct of a speech community on her research site. In the light of the critique presented so far, it appears to me that the speech community is not an appropriate construct for describing and explaining the language situation at the MCH. There is a need, therefore, to search for a more workable construct. To this end, Saville-Troike (2003) suggests as follows:

> The use of the speech community as a basic social unit for study has been criticised by some because of its implicit acceptance of existing social/political boundaries and categories as legitimate entities. One alternative is a more

> complex model of 'nested' speech communities reflecting expanding fields of individual's interactions and networks (Saville-Troike 2003: 17).

For Saville-Troike, one alternative is the use of the construct called the Community of Practice whilst the other alternative is the construct called Discourse Community. It is to these two constructs that I now turn. First, I consider the case of a Discourse Community.

3.2.2. Discourse Community

According to Swales (1990), members of a Discourse Community share at least six things. First, members of a Discourse Community share a common language. There is a need to qualify this talk of a common language. Reference is being made here to a common professional language, and not to a common language in the ordinary sense. In the case of a hospital situation, health professionals share a common register. This linguistic variety is unique to their profession. This register is called medicalese (see Maclean & Maher 2001). Secondly, members of a Discourse Community share a body of knowledge. Indeed this is the case with the health service providers at the MCH. They have acquired this body of medical knowledge through their various programmes of professional training as doctors, nurses, clinicians and clinical technicians. Thirdly, members of a Discourse Community have a distinct group culture. As members of the health care community, nurses, doctors and clinicians have distinct ways of doing things. Fourthly, an acceptable code of behaviour is what members of a Discourse Community share. This is true for the MCH. Various clinical codes of conduct govern the way health service providers carry out their duties. There are even professional bodies such as the Nurses and Midwives Council of Malawi and the Medical Council of Malawi which license members and also ensure that appropriate professional standards of conduct are maintained.[1] Fifthly, members of a Discourse Community have a common goal or interest. The common goal of all the service providers at the MCH is to save human life and reduce suffering. The sixth point is that members of a Discourse Community share a common physical environment. The common physical environment in the current case is the hospital. The MCH is a physical structure separated from the other structures in Mzuzu city. As can be seen, the MCH qualifies to be called a Discourse Community on the basis of its service providers' attributes.

Taking the above description of the Discourse Community as my point of departure, I now proceed to explain why in the context of the MCH, I find the notion of Discourse Community to have stronger explanatory power than the speech community. To start with, I argue that the construct of the Discourse Community enables me to draw boundaries between service providers and clients at the MCH. Service providers can be said to belong to what I would roughly call the Medical Discourse Community. Clients are not members of this community. One of the advantages of using the construct of the Medical Discourse Community is that the boundaries are much clearer here than in the case of speech communities. Through professional training, doctors, clinicians, nurses and other professionals qualify as members of the Medical Discourse Community. Given the lack of professional training, clients lie outside as non-members of the Medical Discourse Community. Within the Discourse Community, there are both core and peripheral members. The core members of the Medical Discourse Community are doctors, clinicians, nurses and other categories of professionals. Support personnel such as patient/hospital attendants are, in my view, peripheral members of the Discourse Community because they do not have professional training. Because of their close contacts with the core members of the Discourse Community, support personnel pick up some rudiments of professional practice, but this is not enough to enable them to become core members. The Medical Discourse Community is

characterised by diversity. There are numerous specialities. Some service providers are doctors whilst others are nurses or technicians and so on. Even among doctors, there are also many specialities. To this end, we can talk of nurses as belonging to a smaller Discourse Community within the larger Discourse Community of medicine. Doctors can also be said to belong to yet another smaller Discourse Community within the larger Discourse Community. The distinguishing feature here is the professional expertise given that here we are dealing with profession-based Discourse Communities.

I sum up the discussion presented so far as follows. Whatever type of Discourse Community one is talking about, the key point remains that members are bound together by their special use of language. Members of a Discourse Community have a common discourse or a particular way of using language. Therefore, different Discourse Communities produce, use and interpret texts in different ways. Discourse Communities are characterised by a sharing of sets of common interests, common professional values and common purpose (Swales 1990).

3.2.3. Community of Practice[2]

In this sub-section, I discuss the suitability of using the Community of Practice as a construct for describing and analysing language and communication at a hospital. The notion of the Community of Practice is gradually becoming a widely cited theoretical and methodological basis of inquiry. This construct is used in a manner that is closely related to the speech community and the Discourse Community. The concept of a Community of Practice was propounded by Lave and Wenger (1991; see also Wenger 1998). For Eckert and McConnell-Ginet, a Community of Practice is:

> An aggregate of people who come together around mutual engagement in an endeavor. Ways of doing things, ways of talking, beliefs, values, power relations - in short, practices - emerge in the course of this mutual endeavour. As a social construct, a Community of Practice is different from the traditional community, primarily because it is defined simultaneously by its membership and by the practice in which that membership engages (Eckert & McConnell-Ginet 1992: 464).

From Eckert and McConnell-Ginet (1992, 1999) and Meyerhoff (2002), we also learn that a Community of Practice is an aggregate of people who are united by a common enterprise. These people develop and share ways of doing things. Furthermore, they share beliefs and practices. This aggregate of human beings that we call a Community of Practice can grow out of either a formal or informal activity. An academic department, a gang of drug users, a church choir and a secretarial pool are all examples of Communities of Practice. The notion of Communities of Practice is also applicable to professions.

According to Wenger (1998), there are three crucial dimensions of a Community of Practice. The first dimension is that of mutual engagement. This means that there is regular interaction among members of a Community of Practice. They meet either formally or informally to discuss matters of mutual interest. At the MCH, there is regular interaction amongst the various categories of service providers. This interaction is conducted through face-to-face encounters or written communication as in the case of patients' records. The second dimension of a Community of Practice is that there is a joint enterprise. Members of a Community of Practice have a shared goal or mission. As a hospital, the mission of the MCH is to cure patients' ailments, thus reducing human suffering and saving lives. The third dimension of a Community of Practice is a shared repertoire. Like any other profession, the medical profession boasts of its own register. At the MCH, one easily notices this register

even on notices and signs, for example, terms such as examination room, dressing room, radiology (i.e. x-ray) and many others. Members of a Community of Practice share linguistic resources such as specialised terminology and linguistic routines.

The Community of Practice as a construct bears some similarity with the earlier discussed construct, the speech community. It is important to clearly outline the differences and similarities between these two constructs. Furthermore, it is also important to see what the Community of Practice as a construct can do which the other construct cannot do. In other words, with reference to the MCH, how is the concept of the Community of Practice more helpful in the analysis of the language situation than the speech community? To begin with, the emphasis of a Community of Practice is on "practice." The focus is on what members do. The question is: What practices or activities indicate that people belong to one group? The practices or activities of the group include discourse and interaction patterns. In addition, becoming a member of a Community of Practice involves gaining control of the discourse appropriate to that group. Within a Community of Practice, individual members will differ. Some people will be core members whilst others will be peripheral members. "The basis of this variation lies in how successfully an individual has acquired the shared repertoire, or assimilated the goals(s) of the joint enterprise, or established patterns of engagement with other members" (Holmes & Meyerhoff 1999: 176).

According to Holmes and Meyerhoff (1999), there are certain similarities and differences between a speech community and a Community of Practice. Table 3.1, adapted from Holmes and Meyerhoff's (1999: 179), summarises those similarities and differences.

Table 3.1: Speech Community and Community of Practice: Similarities and Differences

SPEECH COMMUNITY	COMMUNITY OF PRACTICE
Shared norms and evaluations of norms are required.	Shared practices are required.
Shared membership may be defined externally.	Membership is internally constructed.
Nothing to say about the relationship between an individual's group and personal identities.	Actively constructed dependence of personal and group identities.
Non-teleological.	Shared social or instrumental goal.
Nothing to say about maintenance or (de)-construction of boundaries.	Boundaries are maintained but not necessarily defined in contrast with out-groups.
Acquisition of norms.	Social process of learning.

The picture that has been painted about the professional Community of Practice or a professional Discourse Community is that of homogeneity. In the case of my study site, I am aware of the fact that complete homogeneity in the characteristics and ways of doing things among service providers at the MCH is impossible. As chapter 4 shows, service providers are characterised by diversity in a number of aspects such as nationality and race, professional status, sex, mother tongues, and other features. With these attributes, it is therefore unrealistic to expect all service providers at the MCH, as members of one Community of Practice, to act or verbally interact in a uniform manner. Despite variations in terms of members' characteristics, all members of the Community of Practice share a common purpose - to deliver health services.

3.3. DISCOURSE ANALYSIS IN THE HEALTH DOMAIN

Discourse analysis is an umbrella term encompassing a wide range of approaches. There is no single way of doing discourse analysis. The various approaches to discourse analysis continue to have overlaps, and in some cases, fuzzy lines of demarcation. Initially, discourse analysis was applied to language teaching. The situation has changed since the application of discourse analysis now goes into many disciplines such as medicine (for example, Aronsson & Satterlund 1987; Ainsworth-Vaughn 1992; Ong et al 1995; Candlin 2000; Sarangi 2002; Candlin & Candlin 2003), law and human rights (e.g. Englund's 2004 study on interactions at a Malawian legal clinic), political science and others.

The name Conversational Analysis (hereafter CA) gives the misleading impression that this discourse analytic approach is about informal talk (i.e. conversations) only. The reality is that CA is also applicable to formal or institutional kinds of talk such as courtroom proceedings, medical interviews and classroom interactions (see Hutchby & Wooffitt 1998). CA lies at the interface between sociology and other disciplines in the social sciences such as linguistics and social psychology. The aim of CA is to do a systematic analysis of talk. CA investigates the levels of social order that could be revealed in every day practice of talk. The main assumption is that talk is an ordered and structurally organised phenomenon.

In a study of laughter in doctor-patient interaction, Haakana noted that there were two categories of laughter. There was laughing alone (one interactant laughed whilst the other party did not laugh). The other category of laughter is known as laughing together. Laughing together is a sign of social intimacy. Haakana confirmed previous studies' conclusion that patients laugh more than doctors do. It was also noted that patients use laughter to accompany delicate talk. Though Haakana (2002) does not link laughter in delicate talk to face management (Goffman 1967; Brown & Levinson 1987), I argue that laughter acts as one way of saving face.

Another discourse analytic approach that has been widely applied to the health domain is Critical Discourse Analysis (hereafter CDA). Fairclough (1995) stands out as the leading proponent of CDA. Several schools exist within the CDA approach but all of them share the common view that CDA is a type of discourse analysis with an attitude. That means CDA is never politically neutral (see Wodak & Meyer 2001). CDA focuses on social problems such as domination, control and discrimination that are embedded in language use. Language as a social practice is also a medium through which power, control and domination are facilitated. CDA, therefore, aims at exposing such inequalities. Analysis is conducted at three levels, namely text analysis, analysis of discursive practices and analysis of social practices. In non-clinical contexts, for example, it has been observed that men generally tend to dominate in mixed-sex verbal interactions. Men, for example, interrupt women more than women do to men. Male dominance has been attributed to the socially powerful position men enjoy at the expense of women (see, for example, Zimmerman & West 1975).

Even in clinical settings where normally the doctor is the dominant figure in doctor-patient interaction, it has been shown that male patients dominate when the doctor is a woman. In her study, West (1984) found that male patients interrupted female doctors more frequently than male doctors. Ragan (2000) cites studies conducted by Todd (1993) and West (1993) as confirming the male dominance in mixed-sex doctor-patient interactions. Freidson (1961) has described doctor-patient communication as being an unequal encounter, with the doctor, by virtue of his/her expertise, having more power than the patient. Freidson's model, therefore, sees the doctor as having superordinate power whilst the patient has subordinate power. But the findings from the study of mixed-sex patient-doctor interactions in which male patients dominate over female doctors challenge the commonly held view in CDA that it is the doctor who has more power than the patient. CDA, therefore, takes the doctor's power for

granted. Since doctors have the professional expertise that the ordinary patient does not have, a common feeling is that doctors know what is in the best interest of their clients. Doctors, therefore, listen and respond to patient's stories selectively. Doctors are simply interested in specific sections of these stories, which can help them to make proper diagnosis and prescription of treatment. In other words, doctors ignore the extraneous issues contained in patients' stories (Mishler 1984). Ragan (2000) notes that power and authority vested in the doctor render the patient powerless and passive. Patients are limited in their ways of asking questions. The doctor ignores assertiveness in a patient, especially when the doctor is male and the patient is female:

> When women do engage in question-asking, for example, caregivers frequently ignore their questions or cut them off-manoeuvre which communicate that such assertiveness is dispreferred and which function to augment women's passivity and silence in their health care interactions (Ragan 2000: 273).

3.4. LANGUAGE POLICY AND PLANNING

3.4.1. Language Policy/Planning: History, Definitions and Scope

Various definitions of language planning have been put forward. Though they are phrased differently, they all point to the common goal of solving communication problems. For the purpose of this thesis, I adopt Crystal's (1992) definition. He defines language planning as "a deliberate, systematic, and theory based attempt to solve communication problems of a community by studying its various languages or dialects, and developing an official language policy concerning their selection and use" (Crystal 1992: 220).[3]

Language planning can be conducted at various levels, be it at national or regional or institutional levels. The current thesis is based on a study of institutional language planning - language planning at a major referral hospital in Northern Malawi. The objectives of my study lie within Crystal's definition of language planning in the sense that the study, first of all, identified the patterns of language use at the hospital. Then the study proceeded to identify linguistic and non-linguistic barriers to communication that exist at the hospital. This was followed by the identification of the language facilitation services that the hospital offers in response to communication problems.

Language planning is often discussed together with the concept of language policy. Language policy too has been variously defined. For our current purposes, I adopt Bamgbose's (1991: 111) definition of language policy as "a programme of action on the role or status of language in a given community." Whilst some scholars regard language planning and language policy as being synonymous, others tend to treat the two terms as being very distinct. For example, Cooper (1989) sees language policy as an outcome of language planning. Gottlieb (1995: 1-2) specifies the difference between the two concepts by defining language planning as the act of "consciously engineering language change;" whilst language policy refers to the "specific strategies formulated and implemented by the planners to achieve their objectives." Following Gottlieb (1995), I take language planning[4] and language policy to be related but not synonymous concepts.

Language planning has a long history. But during the 1960s, the focus of language planning was largely on the developing or the newly independent nations. The process of decolonisation, resulting in the creation of new nations, came with language problems that had to be solved (see Blommaert 1996b; Ricento 2000; Tollefson 2002). This focus on language problems[5] of the new or developing nations was even reflected in the titles of Rubin and Jernudd's classic - *Can Language be Planned? Sociolinguistic Theory and Practice for*

Developing Nations, and in Fishman et al's (1968) *Language Problems of Developing Nations*. Ricento (2000) has analysed language planning according to three phases of its historical development. The first stage, which he calls early work in language planning, flourished in the 1960s. Three central elements of this phase were decolonisation and state formation; secondly, the predominance of structuralism in the social sciences; and thirdly, the belief that language problems could be solved through planning. Language was seen as a resource that had to be planned in order to harness its potential (see Rubin & Jernudd 1971).

Ricento's (2000) second phase of language planning roughly covers the period from the early 1970s to the late 1980s. There was no abrupt break with the early phase since some of the themes of the first phase were continued. What is particularly significant about this phase is that there was a serious re-examination of language planning models that had been formulated in the first phase. There was an admission that some of the earlier models were not effective. Unlike the earlier phase, the second phase was characterised by a growing realisation amongst language planning scholars that socio-economic and political factors cannot be separated from language planning. There was an acknowledgement that language planning is fundamentally political (Tollefson 2002). That is, the technical side of language planning has to be understood and analysed within a particular political atmosphere; and that political ideologies are a powerful force in language planning (see, for example, Blommaert 1996a, b; 1997a, b; 1999a).

Ricento's (2000) third phase of language planning runs from the mid-1980s to the present day. Whilst it is difficult to characterise this phase since it is still in its formative stage, it is possible to mention some of the major issues that have surfaced so far. Certain political events in the world have put new demands on language planning. Such events include the devolution of the Soviet Union and the evolution of new states and identities in Europe, the repatriation of former colonies such as Hong Kong, and the enlargement of the European Union. Relevant to my study's context, I should add that the demise of single-party authoritarian regimes in Africa (Malawi included), and their replacement by multiparty governments, has also given a new political dimension to language planning in Africa. The new culture of democracy has heightened the politics of recognition (see Englund & Nyamnjoh 2003), and language rights have come to occupy a visible position in the politics of recognition. Language planning is now regarded as being "important for all states, not only developing ones" (Tollefson 2002: 422; see also Ricento 2000). Language policy/planning is both multi- and inter-disciplinary but much of it is grounded in sociolinguistics or the sociology of language.[6] The current thesis, whilst drawing insights from political theory (e.g. Patten 2001; Kymlicka 2003a, b) as well as legal perspectives (e.g. de Varennes 1996, 1999a, b; 2001a, b; Packer 1999; Dunbar 2001; Nic Shuibhne 2002), has its foundation in sociolinguistics/sociology of language.

3.4.2. Status and Corpus Planning

Language planning has been categorised into status planning and corpus planning. Status planning refers to the status given to any language in formal domains and beyond. This is the process that determines what language(s) shall work in what domains. Corpus planning, on the other hand, is the selection and codification of norms such as in the writing of grammars, the development and standardisation of orthographies, and the compilation of dictionaries. This is the technical empowerment of a selected language or dialect. The objective of corpus planning is to enable a language or dialect to carry out effectively the functions that have been allocated to it. Some scholars make a sharp distinction between status planning and corpus planning. Other scholars, such as Williams (1992), Daoust (1997) Kaplan and Baldauf (1997), do not see the need to draw too sharp a dividing line between the two concepts given that

there is a close connection between status and corpus planning. For instance, Kaplan and Baldauf observe that:

> It is, in fact, virtually impossible, in practice, to separate the two activities. The fact is that any change in the character of a language is likely to result in a change in the use environment, and any change in the use environment is likely to induce a change in the character of the activities which make up the language planning process (Kaplan & Baldauf 1997: 28-29).

In the case of Malawi, corpus planning of all the languages, with the exception of Chewa, is in its very elementary stages. The prospects and challenges that lie ahead of the corpus planning of Tumbuka, the main lingua franca for my study site, will be considered in chapter 7. The literature on corpus planning cautions against looking at corpus planning from the technical side only. That is, it is not only technical expertise of linguists that is required in corpus planning. As Fishman observes:

> Technical expertise alone never seems to be sufficient since there are always habits and attitudes and values and loyalties and preferences, not only in the target populations, but also among the planners themselves. Thus the only truly sociolinguistic study of codification and elaboration must be no more socially innocent than is the study of language policy decision making (Fishman 1974b: 19; see also Ansre 1974; Fishman 1983).

My proposed case for the corpus planning of Tumbuka in chapter 7 agrees with Fishman's claims.

3.4.3. The Canonical Model of Language Policy/Planning

The canonical model of language planning (see various contributions to Rubin & Jernudd 1971, especially Rubin 1971a, b) is characterised by a process of identifying language problems through some form of fact-finding. Once the language problems have been identified, a plan is devised on how to cope the problems. The plan includes expected outcomes. A language policy decision is then made. This then is followed by the implementation of the language plan. There is evaluation at various stages of the plan. Rubin's (1971a) model is the best representative of the canonical model of language planning. Despite being popular, the canonical model has come under criticism. Of direct relevance to my study is the critique which has come from African sociolinguists (e.g. Bamgbose 1987, 1991, 2000a; Chumbow 1987) who argue that the model is at variance with what is normally perceived to be language policy/planning in Africa. These scholars argue that often policy decisions are not supported by any fact-finding exercise.

Bamgbose (1987, 1991, 2000a) and Chumbow (1987) maintain that the canonical model takes language planning as a government-authorised and/or controlled activity, thereby making the activities of non-governmental institutions, such as missionaries and individuals, invisible. In Africa, there has been, and there continues to be, significant contributions to language planning made by non-governmental institutions and even individuals (e.g. Kamuzu Banda's role in Chewa's status and corpus planning which was discussed in chapter 2). Despite the significant and commendable contributions non-governmental bodies have made and continue to make towards language planning in Africa, the canonical model does not recognise such contributions simply because language planning is defined as a government-controlled activity. This is a weakness. Further support for the role of non-governmental efforts has come from the South African language planner Alexander (1992) who declares that he has no doubt in his mind that, "at the very least, non-governmental attempts to change

the status of a language, whether or not they are successful in the long run, ought to be accepted as attempts at language planning" (Alexander 1992: 147).

The third criticism of the canonical model of language planning is that it forces language planning into the narrow mould of economic planning. Bamgbose (1987) argues that it is an oversimplification to treat language as a commodity or resource that can be planned in the manner economists do. He argues that whilst economic behaviour is largely predictable, language behaviour is, however, less predictable. Fourth, Bamgbose claims that the canonical model of language planning is idealistic and Eurocentric. The model, Bamgbose argues, assumes an ideal situation in which language planning is rational and systematic. In reality, the contrary is often true, especially in Africa where arbitrary decisions on language policy frequently take place. In addition, the model assumes that the democratic channels of language planning which take place in Europe (or the West in general) apply all over the world. But this is hardly the case. In Africa, for example, initial fact-finding or commissions of inquiry recommendations or democratic legislation have not supported a number of language policies. Decrees or directives of the "with immediate effect" type are legion in Africa, and Malawi is no exception as I pointed out in chapter 2. Despite the undemocratic manner in which solutions to language problems are arrived at in many African countries, one cannot, however, deny that language planning does take place. Fifth, Bamgbose (1987) argues that though the literature on the canonical model talks of status and corpus planning, there is a bias in favour of corpus planning. The result is that status planning is rendered invisible. Corpus planning, then, tends to be treated as language planning proper. If one follows this view to the letter, then most of what happens in Africa, by virtue of being largely concerned with status planning, should not be considered to be language planning at all. But Bamgbose (1987) argues that it is wrong to hold such a view since status planning is part of language planning.

Bamgbose says that the canonical model of language spells out the distinction between "what is planning proper and what is not." He adds that "what is not planned is a happening" (Bamgbose 1987: 10). Proper language planning implies that there is a rational and systematic attempt to solve language problems. Such a process starts off with the identification of the problems, formulation of strategies to overcome them, implementation of the language problem-solving mechanisms, and the constant evaluation of the process. Any attempt taken to solve language problems which is not guided and supported by these steps, no matter undertaken by whom and in what circumstances, falls short of being considered as language planning. Such a language problem-solving exercise is best described as language treatment. I will return to this subject in chapters 6 and 7.

3.4.4. Centralised and Decentralised Language Planning

"The language planning process may be analysed with reference to the organisation of the decision-making systems that deal with language problems" (Tollefson 1981: 176). This perspective has led to the formulation of centralised and decentralised modes of language planning. The main concern here is "the degree of local initiative involved in the formulation and implementation of a national plan and to the scope (local, regional, national) of the intended outcomes of the plan)" (Tollefson 1981: 176). Centralised language planning is characterised by a dominance of the central government in the setting up of priorities and the establishment of goals for the distribution of resources. The focus of the central government's planning efforts is the entire national population and not merely a portion of it. Decentralised language planning, on the other hand, is characterised by language planning decisions that are arrived at and implemented by local agencies. This contrast should not make one think that there is a sharp dividing line between centralised and decentralised language planning. In

reality, it is not unusual for some language planning done at the central government level to have been initiated or demanded by lower levels of the administrative hierarchy.

3.4.5. Language Planning Ideologies

It has already been mentioned that language planning is not simply based on linguistic considerations alone. The process of language planning is in fact an interplay of various social, cultural, economic and political considerations. Ideologies play a major role in shaping language planning directions (see Cobarrubias 1983; Christian 1988; Blommaert 1996a, b; 1997a, b; 1999a). Cobarrubias (1983) has proposed a taxonomy of language planning ideologies. This taxonomy comprises four ideologies, namely linguistic pluralism, linguistic assimilation, internationalisation, and vernacularisation. Reagan (1986: 6) argues that it is important that we should not draw too sharp lines between the four categories of language planning ideology. His view is that language planning ideologies can co-occur. It is possible to have one polity that exhibits more than one language planning ideology.

The first language planning ideology that I discuss is linguistic assimilation. The goal of linguistic assimilation is to have one dominant language that is used in official domains. The other languages are ignored and given no official recognition. Sometimes these unrecognised languages may even become targets of eradication efforts. The Russification process in the former Soviet Union, the Chewasation programme in Malawi during the Banda era (see chapter 2, especially section 2.2.2.1), the Swahilisation process in Tanzania and the Hellenization of Macedonia in Greece are some notable examples of linguistic assimilation. This ideology assumes that everyone, regardless of their linguistic origin and linguistic capabilities, should adopt the dominant language of the society in which they live.

In the second ideology, linguistic pluralism, the equality of official language status is given to two or more languages. For instance, French and English are official languages in both Cameroon and Canada. Belgium, on the other hand, has French, Flemish and German as its official languages. In Finland, Finnish and Swedish are the official languages. An extreme case of linguistic pluralism is South Africa's post-apartheid language policy that has adopted eleven official languages. During the apartheid era, the official languages were English and Afrikaans. Whilst the new South African language policy has been hailed as one of the most progressive in the world in terms of its support for linguistic pluralism (e.g. Bamgbose 2000a), the reality on the ground remains one in which a hegemony of English exists. I also extend the linguistic pluralism ideology to Malawi. There are some elements of linguistic pluralism in Malawi's current language policy because the state-run Malawi Broadcasting Corporation presents newscasts in English and six local languages, namely Chewa, Yao, Tumbuka, Tonga, Sena and Lomwe. From 1964 to 1994, the national radio used Chewa and English only. There has been an attempt in Malawi to extend the linguistic pluralism ideology to the education domain. I am referring here to the 1996 directive on mother tongue education that I discussed in section 2.2.3.3 in chapter 2.

The third language planning ideology is internationalisation. This ideology refers to the granting of official status to an international language. This may not be the language spoken by the majority. It is a common practice in post-colonial Africa to have the ex-coloniser's language such as English, French or Portuguese serving as the official language of the State. It is argued that the adoption of such a language gives citizens the means with which to interact with the outside world because the selected languages are media of wider communication. The position of English as the main official language of Malawi falls within the internationalisation ideology. This policy traces its origin to the British colonial rule, which run from 1891 to 1964.

Vernacularization, the fourth language planning ideology, refers to a situation where an indigenous language is developed and made to function in domains such as education, the mass media and government services. Examples of vernacularisation include Hebrew in Israel, Malay in Malaysia, Tok Pisin in Papua New Guinea, Quechua in Peru and Swahili in Tanzania. In Malawi, one can also see traces of vernacularisation when Chewa is brought into the picture. Chewa is the only local language that is used as a medium of instruction in primary grades 1 to 4. It also serves as a subject of study all the way from primary school to university level. Chewa also enjoys the longest literary tradition amongst all the local languages (see Made et al 1976; Mwiyeriwa 1978). After English, Chewa is the mostly used language in official domains. This situation makes Malawi carry some elements of the vernacularisation ideology.

3.4.6. Endoglossia and Exoglossia

The concepts of endoglossia and exoglossia have also been used to describe language planning and language policy situations in Africa. Bell (1976) uses the term endoglossia to refer to situations under which an indigenous language is chosen to function in official domains. The commonest argument against endoglossia in Africa is that due to the presence of many languages, those people whose language(s) is/are not selected for official functions may become resentful, leading to conflicts. It is argued then that in order to avoid the social and political tensions that come with endoglossia, a neutral language should be selected to serve in official domains. In many cases, African nations have opted for the ex-coloniser's language. The continued use of exoglossic language policies has led to the view that Africa's political independence has not been accompanied by linguistic liberation (see Mazrui 1993; Mazrui & Mazrui 1998). Other scholars (e.g. Ngugi wa Thiong'o 1986, 1993; Phillipson 1992) have described this linguistic situation as linguistic imperialism. Examples of this exoglossic language include, for example, English in Malawi, Portuguese in Mozambique and French in Senegal serving as official languages of those countries respectively.

When Mozambique attained its independence from Portugal in 1975, it was noted that there was no dominant local language that could have served as the national language. Frelimo, the party that formed the first post-independence government in Mozambique, realised that throughout the liberation struggle, it had used Portuguese as its lingua franca. Portuguese was then the language that was deemed to have the greatest potential of bridging people of different language groups. At independence, it was thought that national unity would be jeopardised if one of the local languages were given the national or official language status. The Frelimo government hoped to forge national unity through Portuguese, an ethnically neutral language (see Lopes 1998; Stroud 1999). As Stroud puts it, "Portuguese, the language of oppression during the colonial times was appropriated by the Frelimo movement;" and turned into an instrument of nation building (Stroud 1999: 346).

In post-apartheid South Africa, the two former official languages, Afrikaans and English, have been retained as official languages. Nine Bantu languages, as new official languages, have joined them. English and Afrikaans have not received equal treatment in the post-apartheid era. Because of its past ties with the architects of apartheid, Afrikaans remains stigmatised as the language of the racist oppressors. English, on the other hand, though it was also a colonial language, is portrayed in positive light and is the language needed most by black South Africans. Bamgbose has recorded some of the positive labels that have been attached to English as being, for example, "the language of unification and liberation," "the language of freedom," "the vehicle for ideologies of freedom and independence," and "the symbol of liberal values and liberation" (Bamgbose 1998: 5-6).

The exoglossic language policy in Africa has led to the division of the continent into linguistic zones such as Francophone, Lusophone and Anglophone. These labels have been criticised for masking the fact that the majority of Africans have no competence in these languages (for example, see Schmied 1991 for the case of English). It is the elite, who are a minority, who command competence in the ex-colonisers' languages. Whilst people may claim to be able to speak or write in English, the actual levels of competence in those two skills is another thing. Even the completion of the eight-year primary and four-year secondary education is no guarantee in Malawi that one's competence in English would be reasonable. Some African countries have decided to adopt a mixture of exoglossic and endoglossic policies. For example, Tanzania has Swahili and English working in official domains. Malawi too has a mixture of exoglossic and endoglossic policy in that it has English as the main official language, which is supported by Chewa. Malawi's mixture of exoglossic and endoglossic language policies is characterised by "an asymmetrical coexistence between the two official languages in which English has established a clear hegemony over Chichewa" (Matiki 2001b: 201).

The role that English plays in Malawi and at the MCH in particular has to be understood within the context of the status the language holds. In Malawi, English serves as a Second Language (ESL). This ESL position refers to a situation where English performs important functions in official domains in a country where the language is not natively spoken. This contrasts with the English as a Foreign Language (EFL) situation. This refers to a situation where English is not the commonly used language in official domains. According to Kachru's (1985, 1986) model of language diffusion, there are three circles of English. The first circle, which is called the inner circle, consists of varieties that constitute English in the minds of its native speakers. The inner circle includes Australia, Canada, New Zealand, Britain and the United States of America. The second circle of English, called the outer circle, is made up of all those non-indigenous varieties of English that have been modified by the local conditions. The outer circle mainly comprises the former colonies of Britain and the Unites States of America. Malawi's ESL position lies within the outer circle. The final circle is what is called the expanding circle. This consists of countries where English has an EFL status, as is the case in Taiwan, Japan, Finland, Egypt and others. The existence of the three circles of English has implications on intercomprehensibility. The fact that there are several varieties of English or the "new Englishes" as Kachru (1985, 1986) calls them, means that there are differences among the various users of these varieties in terms of pronunciation, grammar, the lexicon, collocations, idioms and discoursal and stylistic strategies. These differences are likely to cause cross-cultural incomprehension or misunderstandings (cf. Thomas 1983). This is a topic that will be expanded on in chapter 5 where I discuss communication barriers that exist at the MCH.

In conclusion, it is important to point out that the decision whether to adopt endoglossia or exoglossia or a combination of the two is motivated by the differing political ideologies of the parties or liberation movements that formed the first post-colonial governments. For example, in Tanzania, the *ujamaa* philosophy, which was advanced by Julius Nyerere's Tanganyika African National Union, was the force behind Swahilisation (see Blommaert 1997a). In Mozambique, Frelimo's political ideology favoured the use of Portuguese in the building of the post-colonial nation whilst the opposition Renamo movement favoured the use of local languages (Stroud 1999). In Malawi, whilst internationalisation was adopted, as evidenced by the use of English as the main official language, Chewa was identified as one of the cornerstones of the Malawi Congress Party's nation-building programme (see Timpunza-Mvula 1992). Factors that influence the selection of official languages in the various polities

are not the same across the board. It is important, therefore, to turn to a country's history and politics in order to appreciate how and why particular language policies were adopted.

3.4.7. Sociolinguistic Data and Language Planning

3.4.7.1. Sources of Sociolinguistic Data: A Critique

Ideally, language policies need to be informed by accurate and up-to-date information provided by research. However, that is not often the case. A common trend in Africa is that policy decisions on language and/or other issues are made without the backing of any empirical evidence (see Chumbow 1987). As Ferguson (1966) notes, emotional issues such as tribal, regional and religious identification, national rivalries and the preservation of elites notoriously influence decisions on language policy. Policy decisions may even go against all evidence of feasibility. This, however, does not mean that researchers should abandon collecting empirically sound data concerning a country's language situation. Language surveys are one way through which language information is accumulated. As I mentioned in chapter 1, Malawi has never had a full nation-wide language survey. Instead, there have been a few isolated small-scale language surveys (e.g. Kayambazinthu 1995; Matiki 1996/97; Centre for Language Studies 1999, 2001a).

Language surveys can produce immense amounts of valuable language data. Amongst the many issues on which language surveys can provide data are: degrees of multilingualism - what other languages apart from mother tongues people speak; attitudes people have towards languages and language policies; domains in which a language is used; the demographic strength of the speakers of a language; the geographical spread of speakers of a language; the internal varieties of a language (dialectology); the degree of standardisation of a language; the constitutional or official support a language has; patterns and degrees of language maintenance, language shift, language death and language revival. The specification of the number of languages spoken in a country is often too difficult a question to answer given the lack of a uniform yardstick for classifying a linguistic variety as either a language or a dialect (for the case of Mozambique, see Lopes 1998 and Gadelii 2001; for Zambia, see Kashoki 1978).

In the absence of a comprehensive national sociolinguistic survey, census data remain the best available source of data Malawi has. There are some problems that are associated with the use of population censuses as sources of language data. I will draw some examples from Malawi and elsewhere. Some of the problems have to do with the way the data are collected. For example, in a population census there is no provision for verifying a respondent's claim that he/she speaks or understands a particular language. Neither is there a way of verifying one's claims about literacy. Even if one really speaks a language, the sociolinguist would be interested in knowing the level of proficiency. For example, is the respondent's language proficiency excellent, good, average or poor? In language surveys, attempts can be made to test a respondent's claims about his/her ability to speak or write a language. For example, in the Centre for Language Studies' (1999) survey on Tumbuka, vocabulary and comprehension tests were given to respondents to check on their claimed language proficiency. Without such tests, one cannot be sure about the respondent's claims. Respondents have been known to overreport or underreport their language competencies for various reasons.

The validity of mother tongue declarations in a census can also be problematic. For example, some respondents may identify themselves with a major and prestigious language and yet they do not speak it, thereby concealing their real mother tongue (cf. Kubchandani 2001). In situations when certain ethnic groups have low self-esteem, or when their language

is depicted in negative terms or stereotypes, such a group may decide to conceal their linguistic identity. In Malawi, there is the case of the Lomwe, some of whom have been reluctant to reveal their mother tongue due to stigmas or negative stereotypes attached to their language. For example, the Lomwe were associated with wild behaviour (Galligan 1975; Boeder 1984; White 1987), witchcraft and strange eating habits, which included the eating of snakes. When the Lomwe entered the present-day Malawi from the then Portuguese East Africa (now called Mozambique), their language, comprising several variants, was incomprehensible to the locals. Due to intermarriages with the Nyanja and Yao-speaking peoples, and having the desire to gain employment in the predominantly Nyanja-speaking plantations in the Southern Region, the Lomwe gradually underwent language shift towards Nyanja, and to some extent Yao. Because of the negative stereotypes, some of the Lomwe began to hide their identity.[7]

Another discomfort for the Lomwe was the pejorative name, Ngulu. Following pressure from the Alomwe Tribal Association, which was led by Lewis Mataka Bandawe, the colonial government banned the use of the name Ngulu in 1945 (see Price 1952; Soka 1953; Galligan 1975; and White 1987). The Lomwe avoided speaking their language in public for fear of being mocked. Their language had become embarrassing. Given the low value and loyalty they attached to their mother tongue, the Lomwe did not have the pride to pass on the language to future generations. This led to a gradual language death. Kamchedzera (1994) claims that one of the reasons for language death among the Lomwe is that their language has sounds that are very difficult to learn. I do not subscribe to this view since there is no language which is intrinsically too difficult to be learned. The social-psychological issues of low self-esteem, negative stereotypes, low language loyalty and the desire to switch to an economically rewarding lingua franca (Nyanja) can best explain the language shift and death among the Lomwe.

The question of what counts as a language or a dialect is another problematic issue in Malawi's censuses. For example, the 1966 census indicated that there were 476,306 speakers of Lomwe (representing 14.5 % of the total national population). The same report mentioned that there were 74,466 speakers of Khokhola (representing 2.3 % of the national population). Whilst the census treated Lomwe and Khokhola as two separate languages, evidence from other sources (e.g. Soka 1953; Boeder 1984; Grimes 1996; Centre for Language Studies 1999, 2001a) indicate that Khokhola is one of the many dialects of Lomwe. Turning to the Northern Region, the site of my study, both the 1966 and 1998 censuses indicate that the region is the most linguistically heterogeneous region, especially in the two districts of Chitipa and Karonga. As it will become clear later in the thesis when I discuss my findings, the linguistic complexity of these two districts, especially that of Chitipa, is characterised by the language versus dialect puzzle. One of my informants called Chitipa "a confused district," apparently referring to the district's confusing linguistic complexity. This geographical area has not been subjected to thorough dialectological studies that can resolve the language/dialect puzzle (cf. Walsh & Swilla 2001). Commenting on the language situation in Chitipa, Kayambazinthu says that her informants reported that the district has up to thirteen languages. She notes that "this might be an exaggeration or confusion on the differences between languages and dialects" (Kayambazinthu 1995: 13).[8]

Ngoni, a moribund language, is another problematic issue found in the census data. Both the 1966 and 1998 censuses have figures for Ngoni, and yet research has continued over the years to show that the language is dead. The 1966 census recorded 37,480 speakers of Ngoni. These speakers of Ngoni were located in Mzimba, Dedza and Ntcheu districts. In the 1998 census report, 74,198 speakers of Ngoni were identified in Malawi (see Table 3.2 in section 3.4.8.2 in this chapter). Yet as early as 1936, Read (1936) had noted that Ngoni was

dying out. It was a language that was confined to the elderly, with very poor transmission to the next generation. Later studies (Tew 1950; Wills 1964; Pachai 1973; Moyo 1995; Mtenje & Soko 1998; Kishindo 1995, 2002) have confirmed that Ngoni is a dead language. The sociolinguistic reality is that there has been an acute language shift among speakers of Ngoni in favour of Tumbuka (in the case of the Ngoni of Mzimba in the Northern Region) and Chewa in the case of the Ngoni of Dedza, Ntcheu and Southern Malawi. Ngoni only survives in songs, royal praises and in the speech of a few old people. What is then regarded as Ngoni in the two censuses is actually Tumbuka (i.e. Tumbuka that has heavy influence from Ngoni) or Chewa of Dedza that has a peculiar Ngoni accent. Kayambazinthu (1995: 16) rightly notes that the Ngoni have "remained ethnically Ngoni, linguistically they became either Chewa or Tumbuka and their language had a significant impact on the languages they mixed with, leading to distinct dialects." Moyo (1995) also notes that the Mzimba dialect of Tumbuka is sometimes called Ngoni, apparently because of the heavy borrowing this dialect has made from Ngoni. Grimes (1996) also observes correctly that in some contexts in which the Ngoni live, the name Ngoni[9] is also used as an alternate name for Chewa. Writing about the Central Region Ngoni, Pachai (1973: 187) says: "I found that the language of Ntcheu natives (Maseko Ngoni) was entirely Chinyanja. A few natives could understand Zulu."

Another problem with censuses and even language surveys is what name a language or dialect takes in a particular area (see also Blommaert 1999b on language naming). Some languages carry different names in different areas. In Malawi, as mentioned earlier, the national language has since 1968 been known as Chewa, while other countries in the Southern African region maintained the name Nyanja for the same language. In the post-Banda Malawi, there have been attempts to revert to Nyanja, but the implementation has not been successful. This, however, does not mean that the name Nyanja is unpopular in Malawi. In the 1998 census, some people claimed that they speak Nyanja (basically Chewa). These people consider their language to be Nyanja whilst Chewa is that which is spoken by the Chewa of the Central Region. The bottom line is that all these people speak one language (of course with different dialects). In Zambia, there has also been a debate as to whether to call the language Nyanja or Chewa, especially in the wake of Malawi's 1968 change of the name of the language. Kashoki (1999) says that during the colonial period in Northern Rhodesia (now Zambia), both official and unofficial views went in favour of the name Nyanja. At present, Zambian popular convention continues to favour the use of the name Nyanja.

The *Ethnologue* (Grimes 1996) is another source of language data. The *Ethnologue* is more elaborate in its coverage than population censuses. For example, the former supplies information on the status of a language, location of the speakers of the language, dialects and their names, linguistic affiliation, literacy, degrees of bilingualism, details about Bible translation, speaker numbers and alternate names for a language. But like other sources, the *Ethnologue* has its own share of weakenesses or problems. Legère, for example, is critical of this source, arguing that it is "not recommended as a reference material beyond a very elementary level: it contains errors, misinterpretations and improperly researched data - including estimates of numerical strength and glossonyms - which fail to adequately reflect the actual linguistic situation" (Legère 2002a: 165). As for Malawi, I have the following concerns about the *Ethnologue* data. First, the publication states that Nyanja (Chewa), Tumbuka and English are Malawi's "national or official languages." To begin with, the terminology used here is wrong, at least with regard to the current usage in Malawi. English, and to some degree Chewa, and Tumbuka to a much lesser extent, are official languages. Tumbuka is not a national language, at least as far as the term national language is used in Malawi (cf. Brann 1994). The title national language applies to Chewa only as mentioned earlier.

The second concern is over the sources of data that the *Ethnologue* has relied on. Use has been made of books written by Pachai (1973) and Boeder (1984). The problem is that the two works are history and not sociolinguistics books. As such, much as they may deal with language issues in some way, their treatment obviously lacks sociolinguistic perspectives. Whilst there is a significant volume of works on the language situation in Malawi that has been published by language scholars over the years (see, for example, the references section of this thesis), the *Ethnologue* has not attempted to quote from such more authoritatively and up-to-date works by competent language scholars.

The third concern I have to register is that whilst the 1998 census is the latest one with data on language, the *Ethnologue* continues to use the outdated 1966 census data. Fourth, the *Ethnologue* claims that there are 15 languages in Malawi and that all are living languages. The reality on the ground is that Ngoni and Zulu are not living languages as I have already pointed out. Fifth, the *Ethnologue* classifies Khokhola as a distinct language, following the 1966 census, yet recent studies (Centre for Languages Studies 1999, 2001a) indicate that this is a dialect of Lomwe. Sixth, Afrikaans is mentioned as one of the 15 languages of Malawi.[10] Whilst I accept that there are some speakers of Afrikaans, my guess (supported by observations made in Malawi) is that their numerical strength is so insignificant to warrant an entry. Unfortunately, the *Ethnologue* does not provide the number of speakers. The eighth problem with the data is that Malawi's literacy is placed between 25% and 41%. This is wild guesswork. The 1998 census put the national literacy rate at 58 %. The census report adds that literacy rate had increased from 42 % recorded in 1987 (National Statistical Office 1998). These inaccuracies confirm Legère's (2002a) serious doubts about the accuracy and usefulness of using language data that are contained in the *Ethnologue.* Whilst it is argued that language planning should be guided by language data, it is important that sources of such data should be of unquestionable quality. Planning language with the support of flawed data sources is obviously unhelpful.

3.4.7.2 Data on Language Use: Household Communications and Health Services

The special focus of this sub-section is on language use data for the Northern Region of Malawi in two domains, namely household communication and health care delivery. I draw the data from two sources: the 1998 population census (for national, regional and district distributions of languages of household communication) and Centre for Language Studies (1999) for languages preferred for use in hospitals in Northern Malawi. As Table 3.2[11] shows, the 1998 census found that out of a total of 9,933,868 persons who were enumerated at the national level, Chewa emerged as the most widely used language of household communication, followed by Yao and Tumbuka. In Table 3.2, unlike elsewhere in the thesis, I have deliberately not combined the figures for Chewa and Nyanja in order to highlight the significant numerical strength of respondents who opted for the Nyanja label as opposed to the Chewa label. In this regard, the final figure for Chewa in Table 3.2 is actually a combination of Chewa and Nyanja, which comes to 69.98 % - almost 70 %.

Table 3.2: Languages of Household Communication: National Distribution

Language	Number of Speakers	% Enumerated Population
Chewa	5,679,482	57.17
Nyanja	1,272,205	12.81
Yao	999,024	10.06
Tumbuka	939,109	9.45
Sena	264,172	2.66
Lomwe	241,000	2.42
Tonga	165,654	1.67
Other Languages	105,343	1.06
Ngonde	84,000	0.85
Ngoni	74,198	0.75
Lambya	44,385	0.45
Nyakyusa	24,824	0.25
Senga	19,959	0.20
English	17,479	0.18
Portuguese	2,458	0.02

At the Northern Regional level, 1,233,560 persons were enumerated. Table 3.3 shows the dominance of Tumbuka as a language of household communication. The category labelled "other languages" has a particularly strong showing in the Northern Region. The sources of this strong presence of the "other languages" are two districts, Chitipa (see Table 3.4) and Karonga (see Table 3.5). Tumbuka is a minority language at the national level (Table 3.2) whilst the same language has a majority status at the regional level (Table 3.3). Tables 3.4 to 3.9 show that within the Northern Region, the majority status of Tumbuka is not unchallenged. There are some areas within the Northern Region where Tumbuka does not enjoy a majority status, and this has also been confirmed by Centre for Language Studies (1999). The implication of the data contained in Tables 3.4 to 3.9 is that my study site, the Mzuzu Central Hospital, was a site where speakers of Tumbuka (a regional majority language) as well as speakers of other languages (minority languages) converge.

Table 3.3: Languages of Household Communication: Northern Region

Language	Number of Speakers	% Enumerated Population
Tumbuka	793,610	64.33
Tonga	128,296	10.40
Other Languages	82,586	6.69
Chewa/Nyanja	77,624	6.29
Ngonde	76,154	6.17
Lambya	39,879	3.23
Yao	9,915	0.80
Ngoni	4,189	0.34
Lomwe	2,102	0.17
Nyakyusa	835	0.07
Sena	543	0.04
Senga	317	0.03
English	27	0.002
Portuguese	26	0.002

The 1998 census also gathered data for languages of household communication at district level. Language data for each of the six districts of the Northern Region are presented from Table 3.4 to Table 3.9. In Chitipa district (see Table 3.4), the so-called linguistically "confused" district, 126,799 persons were enumerated. Chitipa stands out as having the highest level of the "other languages" category in the Northern Region.

Chilowa and Munthali (1997), in their study of immunisation in Chitipa, found that Tumbuka was the main language used by health service providers to educate mothers on immunisation in that district. But in some parts of Chitipa, such as Kapenda, the use of Tumbuka turned out to be a linguistic barrier since Lambya was the commonly used language there. Within Chitipa, it was noted that the language of education on immunisation varied from area to area. Apart from Tumbuka and Lambya, Sukwa and Ndali were also used in certain areas of Chitipa. These experiences confirm the existence of linguistic heterogeneity in Chitipa district.

Table 3.4: Languages of Household Communication: Chitipa District

Language	Number of Speakers	% Enumerated Population
Other languages	65,264	51.47
Tumbuka	29,517	23.28
Lambya	29,127	22.97
Chewa/Nyanja	1,917	1.51
Ngonde	514	0.41
Nyakyusa	160	0.13
Tonga	97	0.08
Lomwe	53	0.04
Ngoni	41	0.03
English	27	0.021
Portuguese	26	0.020
Senga	22	0.017
Yao	18	0.14
Sena	16	0.12

In the case of Karonga (Table 3.5), 194,572 persons were enumerated. Though Tumbuka is the majority language in Karonga, its majority status is weaker than that of Mzimba (see Table 3.9) and Rumphi (see Table 3.8). The Karonga data show a very strong challenge to Tumbuka as evidenced by a rather narrow margin separating the numerical strengths of the Tumbuka and Ngonde speakers.

Table 3.5: Languages of Household Communication: Karonga District

Language	Number of Speakers	% Enumerated Population
Tumbuka	81,033	41.65
Ngonde	70,972	36.48
Nyakyusa	16,423	8.44
Other Languages	14,168	7.28
Lambya	5,466	2.81
Chewa/Nyanja	4,974	2.56
Tonga	513	0.26
Yao	496	0.25
Ngoni	171	0.09
Lomwe	130	0.07
Senga	87	0.05
Sena	74	0.04
English	65	0.03
Portuguese	0	0

The Likoma Islands, with a population of 8,074, shows a predominance of Chewa despite being classified as a Northern Malawi district (see Table 3.6). The dominance of Chewa/Nyanja on the Likoma Islands is not a new phenomenon. It is something that dates back to the missionary/colonial era. During that period, the UMCA developed and promoted a Nyanja variant, commonly spoken along the shores of Lake Malawi, the so-called lake Nyanja (see Heine 1970). It is this variant which is spoken on the islands (see Mwiyeriwa 1978 for UMCA's publications in Nyanja). Given the wide use of Nyanja on the Likoma Islands, it is not surprising that the islands were treated by the Banda regime as a special case - a Nyanja-speaking enclave located in a predominantly Tumbuka-speaking region. It was in this regard that in 1966, the Minister of Education directed "that day secondary schools in the Northern Region should take Tumbuka up to Junior Certificate. This ruling does not apply to Likoma Day Secondary School where Nyanja will be taken up to Junior Certificate."[12] Likoma is therefore, geographically as well as linguistically, an island in the Northern Region.

Table 3.6: Languages of Household Communication: Likoma Islands

Language	Number of Speakers	% Enumerated Population
Chewa/Nyanja	5,594	69.28
Tonga	2,305	28.55
Tumbuka	132	1.63
Yao	23	0.28
Ngonde	10	0.12
English	5	0.06
Other languages	5	0.06
Nyakyusa	0	0
Lomwe	0	0
Ngoni	0	0
Sena	0	0
Senga	0	0
Lambya	0	0
Portuguese	0	0

In Nkhata Bay (see Table 3.7), 164,761 persons were enumerated. The majority language was Tonga. The Centre for Language Studies' (1999) survey has also supported the non-dominance of Tumbuka in Nkhata Bay.

Table 3.7: Languages of Household Communication: Nkhata Bay District

Language	Number of Speakers	% Enumerated Population
Tonga	118,114	71.69
Tumbuka	31,869	19.34
Chewa/Nyanja	10,001	6.07
Other languages	1,495	0.91
Ngonde	1,181	0.72
Yao	605	0.37
Lambya	553	0.34
Nyakyusa	305	0.19
Lomwe	229	0.14
Ngoni	157	0.09
English	115	0.07
Sena	110	0.066
Portuguese	19	0.011
Senga	8	0.004

In Rumphi, 128,360 persons were enumerated. The dominance of Tumbuka use is highly pronounced in Rumphi as Table 3.8 shows. Rumphi, according to this table, has the highest number of persons in the Northern Region who claimed to use Tumbuka as a medium of household communication in the Northern Region.

Table 3.8: Languages of Household Communication: Rumphi District

Language	Number of Speakers	% Enumerated Population
Tumbuka	115,261	89.80
Chewa/Nyanja	7,018	5.47
Ngonde	2,718	2.11
Lambya	1,732	1.35
Yao	1,690	1.32
Other languages	714	0.56
Tonga	364	0.28
Lomwe	256	0.20
Ngoni	177	0.14
English	132	0.10
Nyakyusa	114	0.09
Sena	76	0.06
Senga	51	0.04
Portuguese	16	0.012

Mzimba (Table 3.9), the district in which Mzuzu city and the MCH are situated, has the highest enumerated population (610,994) in the Northern Region.[13] The district is also the second highest in terms of the use of Tumbuka as a language of household communication.

Table 3.9: Languages of Household Communication: Mzimba District

Language	Number of Speakers	% Enumerated Population
Tumbuka	535,798	87.69
Chewa/Nyanja	48,120	7.88
Yao	7,083	1.16
Tonga	6,903	1.13
Ngoni	3,643	0.60
Lambya	3,001	0.49
Other Languages	940	0.15
Ngonde	759	0.12
English	491	0.80
Sena	267	0.43
Nyakyusa	258	0.04
Portuguese	189	0.03
Senga	149	0.02

In a sociolinguistic study of the Northern Region (Centre for Language Studies 1999), three categories of clients (teachers, parents/guardians and pupils) were asked about the language(s) they would prefer health service providers to use when serving their clients. The dominant view of the teachers in four of the five districts that were sampled (see Table 3.10) was that Tumbuka should be the language of health services. Although Malawian teachers must be able to teach English and other subjects through English, they predominantly opted for local languages as media of health services. Thus, despite being able to speak and write English, the majority of the teachers felt that they could best interact with health service providers in a local language.

Table 3.10: Languages of Health Services: Northern Region Teachers (Figures in %)

District	Eng.	Chewa	Tum.	Tonga	Ngonde	Sukwa	Ndali	Lam.	Nyiha
Chitipa	5.9	23.5	29.4			11.8	11.8	11.8	5.9
Karonga	1.4	26.4	46.6	1.4	13.9	1.4	2.8	1.4	1.4
Rumphi		37.5	62.5						
Mzimba	19.4	15.3	61.1		1.4		1.4		
Nkhat.		44.0	28.0	28.0					

Key

Nkhat.: Nkhata Bay
Tum.: Tumbuka
Lam.: Lambya
Eng.: English
Ban.: Bandia

Parents' and guardians' most preferred language for use in health services in the Northern Region was also Tumbuka (see Table 3.11). Just like in the case of teachers (Table 3.10), parents' support for Tumbuka was not uniform across the four districts that were sampled. The lack of a majority status for Tumbuka for Nkhata Bay in Table 3.11 is consistent with the 1998 census report (see Table 3.7) which indicated that the district is not a core Tumbuka-speaking area.

Table 3.11: Language of Health Services: Northern Region Parents/Guardians (Figures in %)

District	English	Chewa	Tumbuka	Ngonde	Tonga	Swahili
Karonga	1.0	18.4	54.1	24.5		
Rumphi		14.7	82.7			1.3
Mzimba	4.5	15.7	76.9			
Nkhata Bay	2.4	43.7	26.2		26.2	

Source of Table 3.11: Centre for Language Studies (1999: 37)

School pupils in the Northern Region (see Table 3.12) gave responses that showed a majority preference for Chewa in Nkhata Bay, consistent with the preferences of teachers (see Table 3.10) as well as parents and guardians from the same district (see Table 3.11 for the parents' and guardians' preferences).

Table 3.12: Languages of Health Services: Northern Region Pupils (Figures in %)

District	Eng.	Chewa	Tum.	Ngonde	Tonga	Lam.	Ndali	Sukwa	Ban.
Karonga	7.3	52.0	34.3	5.6	0.4	-	-	-	-
Chitipa	6.8	37.9	28.8	0.8	-	2.3	3.8	17.4	1.5
Rumphi	2.3	20.7	77.0	-	-	-	-	-	-
Mzimba	11.0	37.6	50.7	-	-	-	-	-	-
Nkhat.	8.2	60.5	12.3	-	17.3	-	-	-	-

Source of Table 3.12: Centre for Language Studies (1999: 49).

Key

Nkhat.: Nkhata Bay
Tum.: Tumbuka
Lam.: Lambya
Eng.: English
Ban.: Bandia

3.5. LINGUISTIC HUMAN RIGHTS

3.5.1. Linguistic Human Rights: An Introduction[14]

Chen (1998) defines language rights as "the rights of individuals and collective linguistic groups to non-interference by the State, or to assistance by the State, in the use of their own language, in perpetuating the use of the language and ensuring its future survival, in receiving information and state-provided services in their own language, and in ensuring that their exercise of other lawful rights, particularly fundamental human rights (e.g. the right to vote, the right to a fair trial, the right to receive education, the right to employment), will not be handicapped or subject to discrimination for linguistic reasons" (Chen 1998: 49). With regard to the role of the State in language rights matters, Chen (1998) identifies two perspectives. The first perspective is about language rights that only require the State to abstain from interfering with their exercise. This perspective is also known as the tolerance-oriented rights (see Kymlicka & Patten 2003a, b). Examples of such rights include the right to use a particular language in the running of a business, meeting or religious service. The Constitution of Malawi, for example, provides that "every person shall have the right to use the language and participate in the cultural life of his or her choice" (Malawi Government 1995a: chapter IV). This constitutional provision entails that the State does not interfere with or limit a person's language choice and use.

The second perspective of language rights refers to rights that require the State to take positive action and to expend public money in order to enable the rights to be realised. This perspective is also known as the promotion-oriented rights (see Kymlicka & Patten 2003a, b). Examples include situations when the State provides services in some selected languages. For instance, the Constitution of Malawi grants that every person, who is detained, including a sentenced prisoner, shall be informed of the reason for his or her detention in a language that he or she understands. In addition, the State is duty bound to provide the accused with interpreters during trial should the situation demand so. The State, at its expense, also has to provide a detainee with reading and writing materials which he or she requires.

The emergence of the linguistic human rights paradigm in sociolinguistics has largely been advanced by the work of Phillipson (1992, 1998); Skutnabb-Kangas (2000); Skutnabb-Kangas and Phillipson (2001). The growing academic interest in language rights has led to an increased number of publications and conferences covering the subject. In terms of publications, it is important to mention that some international journals have had special issues devoted to language rights.[15] There now exists a number of international human rights instruments (such as charters, conventions, covenants, declarations and national constitutions) which have provisions for the protection of language rights, especially those of the minorities. The Universal Declaration of Human Rights acts as the point of departure for these language rights instruments.[16] Despite having these human rights instruments guaranteeing the protection of language rights, the violation of language rights continues. One cause of this is the way the human rights instruments are phrased. Skutnabb-Kangas (1998, 2001) and Skutnabb-Kangas & Phillipson (2001) argue that most language rights clauses are vaguely phrased and contain many opt-outs, hence giving some States excuses for not adhering to the clauses in full. The second drawback is that there are no clearly stipulated measures to force States to comply in full with the language rights provisions. “The real problem is that violation does not easily attract penalties “ (Bamgbose 2001: 641). Thirdly, the social, political and economic realities in each country are different; and the extent to which countries will respond to language rights matters will vary from country to country. Fourth, the degree of peoples’ awareness of their language rights varies across countries. Some people are conscious of language rights whilst others are not (see, for example, Englund 2000, 2001, 2004, on the human rights awareness situation in Malawi).

A related issue is the extent to which people feel that language rights are as important as any other human right. Within the international documents on human rights, it has been noted that “language is given a much poorer treatment than other central human characteristics” (Skutnabb-Kangas & Phillipson 2001: 547). Skutnabb-Kangas has also claimed that “if languages were given positive rights, the clauses or articles about them would create obligations and contain demanding formulations and States would be firm duty holders and be obliged to act in order to ensure the specified rights” (Skutnabb-Kangas 2001: 210). But as Bamgbose (2001) observes, the lack of political will on the part of the ruling elite is one of the major barriers to the enforcement of linguistic human rights. A further weakness is that some of the documents on linguistic human rights are not legally binding. One outstanding example is the Universal Declaration on Linguistic Rights (Personal Communication with Fernand de Varennes).

3.5.2. Importance of Linguistic Human Rights

The question of language rights is attracting the attention of scholars from many disciplines. Since the subject cuts across mainly two major disciplines, i.e. sociolinguistics or the sociology of language on one hand, and law, on the other, it is not surprising that the two disciplines take a leading role in addressing language rights issues (see, for example,

contributions in Kontra et al 1999a). This multidisciplinarity is stressed by Skutnabb-Kangas et al (2001), in response to Blommaert's (2001) claim about the existence of a linguistic human rights paradigm: "If there is a paradigm in the making, it is an eminently multidisciplinary one. Salvation will never come from sociolinguistics alone" (Skutnabb-Kangas et al 2001: 144). The argument continues: "But sociolinguistics can hopefully forge a powerful synthesis of the insights from all these disciplines, while remaining abreast of cutting-edge developments in the sociology of language and micro-sociolinguistics" (Skutnabb-Kangas et al 2001:145).

The crucial question to pose at this point is: Why are language rights important? Why is there now an increased interest in language rights? Some justifications have been put forward. First, it has been argued that language rights are linked to some of the world's conflicts. Therefore, finding solutions to language rights problems contributes to conflict resolution (de Varennes 1996; Packer 1999; Dunbar 2001; Holt & Packer 2001; Kymlicka & Patten 2003a, b; Patten & Kymlicka 2003). The end of communism in Eastern Europe and the upsurge of ethnic tensions in Central Eastern Europe have alerted the world about the link between language rights (and other rights) on one hand, and ethnic dissatisfaction or tensions on the other hand, which have led to some wars. For example, the Organisation for Security and Co-operation in Europe (OSCE) (Holt & Packer 2001) derives its interest in language matters from a conflict prevention perspective. The protection of the rights of persons belonging to national minorities constitutes a key element in the work of the OSCE. The linguistic rights of persons belonging to national minorities have emerged as the most common sources of disputes in many OSCE states. Issues surrounding language rights can be highly charged since they link up with matters of identity and sovereignty. Until quite recently, there was not much attention paid by international law to language rights. The entry into force of the Council of Europe's Charter for Regional or Minority Languages on 1st March in 1998 marked the first international human rights instrument "directed solely at the question of language" (Dunbar 2001: 90).

The second justification for the increased interest in language rights is connected to the fear of the depletion of linguistic diversity. Concerns have been raised about language endangerment. In view of this threat, some scholars (e.g. Skutnabb-Kangas 1998; Dunbar 2001) are of the view that language rights have the capacity to check the depletion of linguistic diversity. Thirdly, language rights have become very prominent in countries where the democratisation process is gaining ground. For example, language rights have featured highly in the post-apartheid era in South Africa[17] (see Langtag Report 1996; Bamgbose 2000a) because of the new political dispensation which seeks to address the inequalities and injustices of the previous regime. Fourthly, language rights and other human rights have now become part of the criteria for assessing entry into regional blocs such as the European Union (EU) and the North Atlantic Treaty Organisation. Certain standards in the observance of language rights are demanded before a State can be accepted into the European Union (Nic Shuibhne 2002; Ozolins 2003: 17). Fifthly, it has been argued that the enjoyment of certain human rights is dependent on language rights. de Varennes (1996; 1999a, b; 2001a, b) has argued that language is linked to the enjoyment or the non-enjoyment of a number of rights, for example, the right to non-discrimination, the right to fair trial, the right to access to information, and the right to freedom of expression. The right to non-discrimination in access to public services such as health care is dependent on language policies and practices that can ensure that linguistic barriers are broken down. These barriers can be broken down by the provision of appropriate language services (see chapter 6 of this thesis where I discuss language services and language rights in relation to the provision of hospital services at the MCH).

The question of whether language rights are an integral part of human rights is crucial. As de Varennes (2001b) observes, it is sometimes mistakenly believed that the rights of minorities or language rights in general, are part of a new generation of rights, or are collective in nature. For de Varennes, such a view is both unfortunate and erroneous. It is unfortunate since it considers language rights as less deserving than the so-called real human rights. It is wrong since it fails to understand the actual sources of these rights. de Varennes' argument is that language rights are not an exception to, or a weaker type of human rights. That language rights are sometimes treated as a weaker form of human rights is linked to the tendency to create a hierarchy of international human rights. As Meron (1986: 1) observes, "the quest for a hierarchy of international human rights continues unabated." Meron further observes that "claims of hierarchical status are also raised as to the relationship among rights belonging to the so-called first generation (civil and political rights), second generation (economic, social and cultural rights, e.g. the rights to peace, development and protected environment)" (Meron 1986: 2). Meron (1986) observes that it would appear that some human rights are more important than others. "But except in a few cases (e.g. the right to life or to freedom from torture), to choose which rights are more important than other rights is exceedingly difficult. It is fraught with personal, cultural and political bias" (Meron 1986: 4).

3.5.3. Linguistic Diversity, Language Rights and Politics of Recognition

Akinnaso (1994) claims that the first generation of African leaders had neglected civil, political and language rights because such rights were perceived to be potentially subversive. Building strong nation states against a background of ethnic and linguistic diversity was high on the agenda of the pioneer leaders of post-colonial Africa. As Englund (2003: 9) puts it, "nation building was the altar at which ethnic and linguistic diversity was to be sacrificed." In Malawi, for example, the country adopted a one nation, one party, and one language policy as a way of consolidating national unity (see chapter 2, especially section 2.2.2.1). Tanzania adopted a similar policy, with Swahili as the official and national language. The Swahilization programme was regarded as the cement of national unity within the *Ujaama* socialist paradigm. It is, therefore, not surprising to note that the authorities discouraged the official recognition of other local languages. Botswana, a multilingual and multicultural country, also followed the same trend towards nation building. The first post-independence government favoured homogeneity and fostered it through the retention of English as the official language and Tswana as the national language. The government's Tswanification or Tswanalisation, a majoritan process of cultural nationalism, "left virtually no space in the public sphere for the country's many non-Tswana cultures, unless recast in a Tswana image" (Werbner 2002b).

A single local language with national language status was not the only tool for cultivating national unity. Single-party systems of government were another strategy that was employed by African rulers who faced "the task of building nations out of competing modes of belonging and identification" (Englund 2003: 2). This scenario prompted Bamgbose to observe that in Africa:

> It seems we are obsessed with the number ONE. Not only must we have one language; we must also have a one-party system. The mistaken belief is that such oneness of language or party would achieve socio-cultural cohesion and political unity in our multiethnic, multilingual and multicultural societies (Bamgbose 1994: 36).

Language planning, therefore, cannot be regarded to be politically neutral. The whole process was guided by political-ideological motives (Blommaert 1997b). The major ideology was what Cobarrubias (1983) calls assimilation, that is, the integration of speakers of different

languages into a united nation of Tanzania with Swahili as their national lingua franca. In the case of Malawi, whether or not the Chewa only language policy has united Malawians is, however, open to debate (see Short 1974; Vail & White 1989; Timpunza-Mvula 1992). However, what is beyond doubt is that the policy strengthened the power of Chewa as the national lingua franca. The language has permeated into areas that were traditionally non-Chewa-speaking (Kayambazinthu 1998; Centre for Language Studies 1999). This has improved communication among people of different linguistic backgrounds (see, for example, the discussion in chapter 4).

Akinnaso (1994) distinguishes between what he calls the language as a right perspective and the right to language perspective. The language as a right perspective refers to the rights of individuals and groups to have their languages developed and used for certain purposes in certain contexts (see Akinnaso 1994). This includes the right to education through the mother tongue; the right to legal and clinical services through a language the client understands most; and other language-related rights. The demand for these rights has been on the increase since the adoption of plural political systems that started in the late 1980s and early 1990s. The culture of democracy has given rise to the politics of recognition (Werbner 2002a, b; Englund & Nyamnjoh 2003) in multilingual and multicultural nations. In Botswana, for example, the politics of recognition has led the Wayeyi to demand the use of Yeyi in pre-schools and the early grades of primary education (see Nyati-Ramahobo 2002). In addition, the Wayeyi have also asked for the use of Yeyi in adult literacy programmes. These Wayeyi demands have been made against a background of Tswana and English hegemony.

I now turn to the right to language perspective. The right to language perspective refers to the right of individuals and groups to access the state's official or dominant language(s). This right enables people to access the language(s) of socio-economic and political importance. In the African context, these languages are usually the ex-colonisers' languages such as English, French and Portuguese. For one to make headway politically, socially and economically, the acquisition of these ex-colonisers' language is a prerequisite.[18] Akinnaso (1994), Chen (1998) and others have drawn a distinction between individual language rights and communal or collective language rights. As an example of individual language rights, Chen cites the right of an accused person to be informed of the details of his/her charge in a language he/she understands. Chen's example of a collective right is the right of a group to ensure the survival of its language and to be able to transmit the language to future generations.

3.5.4. Personality and Territoriality Principles of Language Rights

The personality and territorial principles of language rights (Patten 2003; Patten & Kymlicka 2003; Reaume 2003) help to identify how an individual can access public services in a multilingual country. The personality principle refers to the right to receive public services in a particular language (s) in a country, region or any other locality. Citizens are able to enjoy the same set of language rights in accessing public services no matter where they are in a country. In other words, it is the language rights that follow an individual wherever he or she opts to live in a particular country. Canada (with two official languages, French and English) and South Africa (with eleven official languages) are examples of countries that put emphasis on the personality principle. In Canada, for example, federal government services are available in English or French anywhere in the country subject to the proviso that there be reasonable level of demand of services in that particular language (Patten 2003; Patten & Kymlicka 2003; Reaume 2003). The territoriality principle, on the other hand, refers to a situation where "language rights should vary from region to region according to local conditions" (Patten 2003: 297). The language rights one can enjoy depend on the region of the

country where one finds him/herself. Belgium and Switzerland have been cited as good examples of countries that follow the territoriality principle. Belgium, for example, is divided into four language districts. Each language district recognises a distinct set of language rights.

It is important to mention that there is no rigidity in a country's use of the personality and territoriality principles. It is possible to have varying degrees of the two principles at work in one country. Canada is one example. Whilst Canada has an English/French bilingual public services policy, thus putting it in the personality principle tradition, the same country also has elements of the territorial model, formulated by Bill 101 of 1977 which gives some degree of autonomy to Quebec (Boran 2001). In Quebec, about 83 % of the residents are French-speaking, according to the 1990 census. Whilst the French-speaking population is a majority in Quebec, it is a minority at national level, with only 23 % (May 2001). Finland too exhibits elements of both the personality and territoriality principles: the autonomous Åland Islands have Swedish as the language of public services (Hannikainen 1993), thereby establishing the territoriality principle. On mainland Finland, on the other hand, the personality principle is illustrated by the Finnish/Swedish bilingual public services policy.

3.5.5. The Linguistic Human Rights Paradigm: A Critique

Whilst the Linguistic Human Rights paradigm, championed by Tove Skutnabb-Kangas and Robert Phillipson, has been gaining ground among scholars of different persuasions, the paradigm comes with some controversies and/or problems. To begin with, the quality of the work of the proponents of the linguistic rights paradigm has been put under the microscope. For example, one of the main issues in Blommaert's (2001) critique is that the work of the linguistic human rights scholars is generally shoddy.[19] This is so because political activism is done at the expense of scholarship. Bamgbose echoes this criticism. In fact, Bamgbose challenges the advocates of the linguistic human rights paradigm to "admit that, in addition to being scholars and analysts, they are also political activists" (Bamgbose 2001: 642). As Blommaert (2001) argues, there is nothing wrong with the political activism that goes with the linguistic rights paradigm, but such activism should not be done at the expense of critical and objective analysis.

Another problem with the linguistic human rights paradigm is the failure to recognise that the implementation of language rights instruments is never easy. Blommaert (2001) takes the Asmara Declaration on African languages as one product of the linguistic human rights discourses that is phrased in a rosy language but is difficult to implement in real life. In the same spirit, whilst reviewing a book edited by Skutnabb-Kangas, Joshua Fishman remarks that "the tower of 'shoulds' and 'oughts' and 'must' that Tove Skutnabb-Kangas assembles may strike the reader as being naively idealistic and pie-in-the-skyish" (Fishman 1998: 415; see also Paulston 1997a, b, for the idealism argument). The idealism associated with the linguistic human rights paradigm is also reflected in the naively phrased clauses of the Universal Declaration on Linguistic Rights. As an example, Bamgbose cites Article 25 of the Declaration:

> All language communities are entitled to have at their disposal all the human and material resources necessary to ensure that their language is present to the extent they desire at all levels of education within their territory: properly trained teachers, appropriate teaching methods, textbooks, finance, buildings and equipment, traditional and innovative technology.

Bamgbose then reacts to this clause as follows: "It is unrealistic to expect all languages to be used at all levels of education" (Bamgbose 2001: 640). Relevant to my study is the question:

Can the MCH officially offer language services in all the languages spoken by its clients? Chapters 4 to 8 address this tricky question.

Linguistic human rights scholars, especially Skutnabb-Kangas, tend to put it as if everyone needs and aspires for mother tongue education as a human right. Yet when asked to make choices, some people reject mother tongue education. For example, the majority of the pupils in the Northern Region of Malawi were found to have generally rejected Tumbuka as a possible medium of instruction. Instead, they opted for English and Chewa. Parents, guardians and teachers, on the other hand, were in favour of Tumbuka (Centre for Language Studies 1999). This is a clash which the linguistic human rights paradigm has to settle: Whose account matters? Is it the learners' or the teachers' or the parents'? Scholars of linguistic human rights assume that mother tongue education is beneficial, but this is not always the case, especially from an economic point of view. A mother tongue may facilitate the acquisition of knowledge but the language may turn out to be economically less rewarding. For instance, the Northern Malawian pupils did not see the economic benefit of learning via Tumbuka, a language that attracts less economic benefits than either English or Chewa. Annamalai (1998: 33) has noted that the State has the duty to formulate and implement a language policy for education, but he admits that sometimes "there is a potential for conflict in this area between the interests of the individual and the interests of the State." He argues that it is up to individuals to decide on what aspects of the language-in-education policy are in their best interests. As can be noted, it is a difficult task for the State to satisfy the varying interests of all its citizens. Language policy in education, then, remains one of the most controversial areas within the language rights debate (see, for example, Skutnabb-Kangas 2000). Another worrying point about mother tongue education is that all one hears are success stories. Evidence for unsuccessful stories is hidden or only partially made available. In addition, the success stories are always attributed to the use of the mother tongue, thus forgetting the other factors (e.g. learning and teaching resources) which may have contributed to the success of the teaching/learning process.

Within the linguistic human rights paradigm, there is the general assumption that mother tongue education is an empowering process. Yet history has evidence that mother tongue education can be used for disempowering certain people. For example, the apartheid regime in South Africa used the mother tongue education policy in the black homelands in order to restrict Africans' access to the socio-economically and politically empowering English language. Brookes and Heath give an example of economic exploitation that can be assisted by the use of the right to mother tongue:

> Economic rights and land tenure issues, as well as mineral and oil rights, may lead nations to grant linguistic rights and even encourage education in minority languages in order to ensure lack of access to information and legal rights by particular groups (Brookes & Heath 1997: 199).

Therefore, there is nothing inherently empowering or disempowering in any language - it all depends on what one intends to achieve with the use of a language. Yet proponents of the linguistic rights paradigm often ignore this reality when they proclaim the emancipatory and empowering nature of mother tongue education.

In his critique of the linguistic human rights paradigm, Blommaert (2001) reminds us about the importance of looking not only at inter-language inequalities but also intra-language inequalities. The latter become very conspicuous when the process of standardisation is conducted. Standardisation is obviously a way of giving power and prestige to one language variant amongst many. It thus creates inequalities and hierarchies (Blommaert 1999b) amongst variants of language. By granting a group the right to function in their mother tongue

in public domains, one has not only to think about the language but the variant that goes with that public recognition. Inability to use that variant of power and prestige can be disempowering. Thus, it has been argued (see Brookes & Heath 1997; Blommaert 2001) that lack of linguistic rights can prevent equality but full linguistic rights cannot lead to full equality either.

Proponents of linguistic human rights call for the revitalisation of minority languages in order to check the depletion of linguistic diversity. They, therefore, call on states to ensure that all languages are maintained. Reacting to this call, one would say that such a call is tantamount to ignoring the fact that some speakers of the minority languages have no wish to maintain their original tongue(s) for one reason or another. What the linguistic rights scholars fail to notice are the "economic incentives that may be behind the desire of a group to replace its ancestral tongue with another, while still claiming identity as a people" (Brookes & Heath 1997: 199). The same argument has been extended by Bamgbose (2001) who observes that whilst governments can formulate language policies that support the growth of minority languages in order to check language shift or death, the final determiners of the fate of any language are its speakers. If speakers of a minority or marginalised language want to maintain it, it will be maintained. Government can only complement the efforts of the speakers of the language. A telling Malawian example is Tumbuka, which despite having been proscribed by the Banda regime, is still well maintained.

Pennycook (1998) argues that often language rights are discussed from a Western view of human rights. The Western view of human rights and language rights is then applied universally. Pennycook argues that we need to seek ways by which language rights can be decided according to a notion of self-definition. Any notion of language rights should be drawn from what the community in question perceives to be their language rights. Paulston (1997a: 189) neatly stresses this view with her assertion that "Courtney Cazden has somewhere discussed the happening of child erasing a blackboard: it may be in punishment, it may be a reward, it may be the routine of that particular classroom, but until you have an emic understanding, you will not understand what is happening." She claims that the significance of this emic understanding is often ignored in the discussions of linguistic human rights.

In their review of Skutnabb-Kangas and Robert Phillipson's edited book, *Linguistic Human Rights: Overcoming Linguistic Discrimination*, Brookes and Heath (1997) point out that neither continents nor countries/regions share the same socio-economic, political and sociolinguistic conditions. In view of this, it is worrying that Skutnabb-Kangas and Phillipson's book tends to offer "all-embracing theories and recommended policies... that try to encompass a topic so diverse and complicated as language use and language rights" (Brookes & Heath 1997: 198). In the light of this caution, the findings of my study at the MCH cannot, and should not, be generalised as being applicable to other hospitals beyond the Northern Region. The language policy proposals that I make in chapter 7, for example, are specifically hospital-based, arising out of an analysis of the sociolinguistic situation at the MCH. Furthermore, the policy proposals are specific to the health domain, thus other domains such as education also need their own context-specific analyses before coming up with relevant language policy proposals.

3.6. LANGUAGE SERVICES

I adopt the Langtag Report's (1996) definition of a language service as any action taken by government and other agencies to facilitate communication within multilingual contexts in order to ensure access, equity and participation. Language service provision is also known as language mediation, thus language service providers are language mediators. In addition to the term language mediators, some authors (e.g. Valdes & Angelelli 2003) also refer to

interpreters and/or translators as language brokers. It is worth noting that the terms language facilitation services and language assistance services are used interchangeably with the term language services. With reference to the MCH, language services refer to activities such as interpretation and translations. The overall goal of language services is to reduce or minimise linguistic barriers in communication. This then means that language services are a component of language planning since they provide solutions to communication problems that are of a linguistic nature. I maintain a clear distinction between interpretation and translation. Gile (1998: 41), for example, draws some useful distinctions between translation and interpretation. The most fundamental distinction is that since translators deal with written language, they have the opportunity to refine their work. Interpreters, on the other hand, do not have the opportunity to refine their work since they deal with spoken language.

3.6.1. Interpretation and Translation

The literature on interpretation talks about consecutive and simultaneous interpretation. To begin with, simultaneous interpretation occurs when individuals receive an immediate oral interpretation of a speech into a second language. This mode of interpretation is used in meetings, seminars and conferences. As can be deduced from the description, this mode of interpretation is not meant for hospital settings. On the other hand, in consecutive interpretation, the interpreter alternates with the speaker at regular intervals. This occurs in courts and other public institutions. This is also called community interpreting (see Wadensjö 1998; Schweda-Nicholson 2002; Valdes & Angelelli 2003). The term community interpreting itself is not free from contention. According to Schweda-Nicholson (2002), there is no agreement over the use of the term community interpreting. To some, it is an umbrella term that includes interpreting in courts, medical settings, and social services.

The crucial question is: Who is best qualified to interpret? There are those who argue that as long as one is a bi-/multilingual, then one can interpret. This view is based on the premise "that interpreting ability is a natural consequence of bilingualism" (Valdes & Angelelli 2003: 69). This is the view that holds at the MCH given that anyone who claims to be bi-/multilingual is called upon to interpret (see chapters 5, 6 and 7 in this thesis). The other view is that bi-/multilingualism on its own is not enough. It is argued that whilst natural aptitude is a prerequisite to becoming an interpreter or translator, training can tremendously improve one's performance. Whilst this view is appreciated by some of the service providers I interviewed, the absence of the trained interpreters compels them to use whoever is available. They considered having an untrained interpreter to be, in some instances, better than having no interpreter at all. In addition, sometimes service providers have to use their professional experience to fill the gaps left by the untrained interpreter.

From a professional point of view, the International Association of Conference Interpreters (hereafter-AIIC) has laid down some standards based on language proficiency. To this end, the AIIC rates an interpreters' languages as A, B, or C. The A language(s) refer to native tongue(s) of the interpreter or language(s) of which he or she has native or near-native command. The interpreter can work into as well as out of the A language. As for the B language(s), these refer to non-native language(s) of which the interpreter has sufficient command but not at the same level as an A language. Interpreters can work into as well as out of their B language(s). The C language(s) are passive languages. Interpreters work from a C language into their A or B language, but do not interpret into a C language (Gile 1998:41; Valdes & Angelelli 2003).

Among scholars of interpretation, the notion of assessment of the quality of interpretation is also problematic. Different scholars and practitioners of interpretation advocate different yardsticks. For example, there is a view that assessment of quality

presupposes a theory of interpretation involving the relationship between source and target text in the form of equivalence, adequacy, fidelity, ideational clarity, linguistic acceptability or terminological accuracy, and the perceptions of this relationship by individuals who make use of the interpretation services (Valdes & Angelelli 2003). A related method of assessing the quality of interpretation is one that is based on the users' perceptions - what are the interpretation beneficiaries' expectations, perceptions and reactions concerning the language service?

In translation, the goal is to provide semantic equivalence between the source language and the target language. This means that translation is not simply a menial and clerical task but also an intellectual discipline. The professional translator is not a luxury but a must in various professions such as law and medicine. There are several theoretical types of translations. For example, the pragmatic translation focuses on the accuracy and knowledge of a subject whilst the aesthetic translation aims at preserving emotional and stylistic equivalence of literary works. In ethnographic or sociolinguistic translations, the aim is to preserve the social-cultural contextual meanings of texts. Linguistic translation means conveying the meaning in quite a literal manner. The approach that is taken will depend on the aim of the translation. It is, however, not unusual to have a mixture of these theoretical approaches to translation.

Bandia (1998) observes that there is a low level of the professionalization of translation and interpretation in Africa. In some countries, remarkable progress has been achieved. He cites two success stories. The first one is the Nigerian Association of Translators and Interpreters that is active both locally and internationally. For example, the Nigerian association organises annual conferences to promote the study and practice of interpretation and translation. It also encourages local training initiatives as well as seeking legal protection and recognition of its members. The second success story is that of the Tanzanian Organisation of Translators (Swahili: *Chama cha Watafsiri*) which is the powerhouse for Swahili translations in Africa.

3.7. SUMMARY AND CONCLUSIONS

The aim of this chapter was to present the study's theoretical and analytical orientation. As a sociolinguistic study of hospital-based language use - language policy and language practices, three possible theoretical constructs - the speech community, Discourse Community and Community of Practice - were offered. In the final analysis, the Community of Practice was adopted for the description and analysis of health service providers' language use at the hospital.

In the chapter, I also pointed out that the study of language use in medical settings has largely been conducted from a discourse analytic framework. This involves audio- and/or video recording of verbal and even non-verbal interactions that take place between service providers and clients. The analysis is based on the transcripts of the interactions. The themes that have been explored or can be explored are varied - inequalities in client-service provider communications (e.g. Ragan 2000), gender inequalities in client-service provider communications (e.g. West 1984, 1990, 1993; Todd 1993), topic transition in doctor-patient interview (e.g. Ainsworth-Vaughn 1992), politeness in doctor-patient communications (e.g. Aronsson & Satterlund 1987, 1989), a wide range of issues related to interpretation (e.g. Hatton 1992; Hatton & Webb 1993; Haffner 1992; Drennan 1998; Wadensjö 1998; Bolden 2000; Davidson 2000, 2001; Elderkin-Thompson et al 2001; Drennan & Swartz 2002; Bischoff et al 2003) and so on.

Other studies of language use in medical settings have tended to focus on the policies and practices that are in place. These studies have shifted attention from analyses of

transcriptions of interactions to the examination of what languages are used in the medical setting, by who, when, where, why and with what communicative efficiency/problems (see, for example, Saohatse 1997, 1998, 2000). My study lies in this tradition. It is based on the language policy/planning approach. To this end, the chapter has discussed language planning from various angles, for example, the status versus corpus planning dichotomy, the canonical model of language planning and its critique, language planning ideologies and sociolinguistic data as a type of input in language planning. In the chapter, I have also addressed the issue of language rights - how they can be incorporated into language planning and the practical difficulties of implementing some of the language rights. Finally, I have discussed language services as mechanisms through which the language gap can be reduced. Interpretation is the most common language service in medical settings.

NOTES

1 For example, the Malawian print media had reported about the following cases that had been brought to the attention of the Medical Council of Malawi. First, the Council had confisticated a machine from a private clinic following claims made by the clinic that the machine could "kill the deadly HIV virus that causes AIDS." (See McDonald Chapalapata, "Doctor in Trouble Over AIDS Cure Machine," *The Nation*, 20th January, 2004). The second case involved Dr Hetherwick Ntaba, who had attended to and escorted President Muluzi's sick mother to a South African hospital. Dr Ntaba had been out of practice for too long; and according to section 5(1) of the Medical Practitioners and Dentists Act, a practitioner who has been absent from practice for more than three years shall not be eligible for a private practice licence unless he/she has undergone full clinical orientation at an approved hospital for not less than six months. Dr Ntaba, however, did not satisfy this clause (see Caroline Somanje, "Ntaba faces Med. Penalty," *Malawi News*, 1-7 November, 2003).

2 According to Professor Heidi Hamilton (personal communication), scholars tend to use the concepts of Community of Practice and Discourse Community to refer to "approximately the same entities." She, however, believes that there are some areas of contrast between the two concepts.

3 See Cooper (1989) for a discussion of at least twelve definitions of language planning.

4 I should also point out that amongst some language planning scholars, the terms language development, language engineering, language management, language regulation, language policy and language planning are used synonymously (see Karam 1974; Cooper 1989: 29). Amongst all these terms, the most widely used and conventionally accepted is language planning, and it is this term that I use in this thesis.

5 Note that the collocation between language problems and language planning is reflected in one of the major journals of the field, *Language Problems and Language Planning*.

6 For a discussion on the dividing line(s) between sociolinguistics and the sociology of language, see Hudson (1996).

7 Some of the Lomwe changed their names in order to hide their identity.

8 The decision to call a linguistic variety either a language or a dialect is never easy. It is not uncommon that in making such a decision, linguistic criteria can be overtaken by political, historical and cultural criteria (see Chambers & Trudgill 1998).

9 The Ngoni problem is not confined to Malawi alone but also extends to neighbouring Zambia as well (see Kashoki 1978). Despite the fact that Ngoni is a dead language, Zambia's 1969 census had a surprisingly large showing for the language. Kashoki describes and interprets the Zambian situation as follows: "Linguistically the Ngoni today may be divided into two main groups: the Tumbuka-speaking of Magodi and the Nsenga-speaking of Mpezeni. Although there are some Ngoni who speak Cewa (Nyanja), as well, these do not form the bulk of the Ngoni population as

is reflected in the census. There is one probable explanation. In Zambia, it is popularly thought that all Nyanja-speaking peoples are Ngonis, so that the Cewa, the Nsenga and others normally resident in the Eastern Province consider themselves Ngoni" (Kashoki 1978: 23).

[10] Note that on the most extreme side, Williams (1996: 186) cites an unpublished mimeo by a Mr W.K. Sichinga of the National Statistical Office, Malawi, as saying that there were 35 indigenous language varieties in Malawi.

[11] Tables 3.2 to 3.9, showing languages of household communication, have been constructed out of data which were extracted from National Statistical Office (1998).

[12] See Circular letter dated 20th January 1966 reference 3/12/volume11/26, under the title "Day Secondary Schools Syllabus-Tumbuka."

[13] The other districts in the Northern Region had the following enumerated populations: Karonga (194,572), Nkhata Bay (164,761), Rumphi (128,360), Chitipa (126,799), and the Likoma Islands (8,074) (see National Statistical Office 1998).

[14] Three terms, language rights, linguistic rights, and linguistic human rights are commonly used synonymously in the literature. "Language rights and linguistic rights usually do mean the same thing" (Paulston 1997b: 75). However, linguistic human rights is slightly different. "Its awkward stylistic tautology - if it is linguistic it must, of course, already be human - derives from the attempt to link language with human rights, i.e. to reframe the issues of language rights in terms of human rights" (Paulston 1997b: 76). Since generally many writers tend to use the terms language rights, linguistic rights, and linguistic human rights as synonyms, I will follow the same trend while of course acknowledging that linguistic human rights has a slightly different dimension.

[15] Examples include: Issue 127 (1997) of *The International Journal of the Sociology of Language;* Volume 20 Issue 1, (1998) of *Language Sciences;* Volume 6 Number 3 (1999) of the *International Journal on Minority and Group Rights;* Volume 3 Number 1 (2001) of *MOST Journal on Multicultural Societies;* Volume 3 Number 2 (2001) of *MOST Journal on Multicultural Societies;* and Volume 105 Number 4 (2003) of *American Anthropologist.*

[16] Some of the international human rights instruments that in some way(s) address the language rights include:

i. The Universal Declaration of Human Rights of 1948;
ii. The International Labour Organization Convention number 107 of 1957;
iii. The Unesco Convention Against Discrimination in Education of 1960;
iv. The Convention on the Rights of the Child of 1989;
v. The Declaration on the Rights of Persons Belonging to the National or Ethnic, Religious and Linguistic Minorities of 1992;
vi. The Draft Declaration on the Rights of Indigenous Peoples of 1993;
vii. The European Convention on Human Rights of 1950;
viii. The Charter of Paris for a New Europe;
ix. Document of the Moscow Meeting of the Conference on the Human Dimension of 1991;
x. The Treaty of the European Union of 1992;
xi. The European Charter for Regional or Minority Languages of 1992;
xii. Framework Convention for the Protection of National Minorities of 1994.

[17] Whilst South Africa has, at least on paper, one of the best multilingual policies, there are concerns that there is a lack of political will to put the human rights-friendly language policy into practice (see Brock-Utne 2002, Bamgbose 2003, Wolff 2003b). Even in President Thambo Mbeki's widely proclaimed African Renaissance scheme (see Wolff 2003a, b), there is an "inadequate representation of the language issue and the role of the indigenous African mother tongues in education and development, both of the individual and society in general" (Wolff 2003b: 2).

[18] In Malawi, for example, one's desire to participate in parliamentary politics can be severely hampered if he or she has no command of English (see Matiki 2001a). This is the case because

the constitution provides that one of the qualifications of a Member of Parliament is the ability to speak and write English (Malawi Government 1995a).

19 Reviewing Robert Phillipson's *Rights to Language,* a festschrift to mark Skutnabb-Kangas's sixtieth birthday, Bamgbose complains about the quality of the contributions to the edited book. He notes that the book has 47 chapters authored by 51 contributors. A further 20 invited contributors were unable to make their submissions. Bamgbose describes the editor's goal as being "too ambitious", resulting in "the unfortunate effect of making several authors produce brief, less than adequate expositions of their topics" (Bamgbose 2001: 639).

PART II: THE FINDINGS

CHAPTER 4

PATTERNS OF LANGUAGE USE WITHIN AND OUTSIDE THE HOSPITAL

4.1. INTRODUCTION

In this chapter, I discuss patterns of language use within and outside the Mzuzu Central Hospital. Whilst the main interest of this chapter is focused on language use within the MCH, I have not ignored language use in the out-of-the hospital domains. I have done this in order to obtain a broader picture of the language situation. Since the MCH does not lie in a sociolinguistic vacuum, it would not have made much sense to discuss the hospital's language situation without making references to Mzuzu city or the Northern Region or even the national sociolinguistic situation. The main source of the data that are discussed in this chapter is a questionnaire survey that was conducted amongst the MCH's clients and service providers. Other relevant data have been drawn from interviews with key informants, observations that were made within and outside the MCH, and some audio recordings of verbal interactions between clients and service providers.

The chapter is organised as follows. In section 4.2, I present an overview of the sociolinguistic landscape of Mzuzu city. In the next section, 4.3, I discuss clients' responses to a questionnaire. This section addresses three topics. The first topic is clients' demographic characteristics which I discuss in section 4.3.1. I discuss the second topic, clients' general patterns of language use, in section 4.3.2. The issues at the centre of the discussion here are clients' mother tongues, other languages spoken by clients, and the frequency of language use with reference to Tumbuka, Chewa and English. The third topic is hospital-based language use, which I discuss in section 4.3.3. The discussion on hospital-based language use focuses on the hospital's frequently used languages (section 4.3.3.1), clients' best language(s) for transacting hospital business (section 4.3.3.2), whether or not the Ministry of Health should consider the language factor when posting staff to various hospitals (section 4.3.3.3), language requirements for foreign (expatriate) health personnel (section 4.3.3.4), and the language(s) of health education literature (section 4.3.3.5).

In section 4.4, I discuss service providers' responses to their questionnaire. This section addresses four topics. The first topic is demographic characteristics of the service providers (section 4.4.1). The demographic characteristics comprise professional statuses of service providers (section 4.4.1.1), sex (section 4.4.1.2), and nationality (section 4.4.1.3). The other topics that I discuss in 4.4 are linguistic repertoires of service providers (4.4.2), the language(s) of service providers' interactions with clients (4.4.3) and, whether or not language considerations should determine staff posting (4.4.4).

In section 4.5, I discuss the hospital's linguistic landscape. The main instrument of data collection used here was observations. I consider two topics in this section, namely language(s) of hospital administration and clients' services (section 4.5.1) and the languages of signs, notices and health education literature (section 4.5.2). Finally, I conclude and summarise the chapter with section 4.6.

4.2. THE SOCIOLINGUISTIC LANDSCAPE OF MZUZU CITY: AN OVERVIEW.

Mzuzu city, with a population of 86,980 (National Statistical Office 1998), is linguistically diverse (see Table 4.1). Being located in a predominantly Tumbuka-speaking area, it is not surprising that Tumbuka is the mostly widely used language in daily interactions. The Tumbuka greeting *muli uli* (How are you?) or its other version, *muli makora*? (Are you all right?) is more common than the Chewa greeting, *muli bwanji?* (How are you?). But within this dominant use of Tumbuka in various forms of verbal interaction in the city of Mzuzu, one still hears other languages being spoken here and there. *Muli mampha?* (Are you fine?), a Tonga greeting is not uncommon since the city borders with Nkhata Bay, a predominantly Tonga-speaking district. One linguistically rich spot within the city is the main market. Since the market draws traders from various parts of the country, and even some from outside Malawi (especially Tanzania), one hears languages such as Yao, Chewa (in its various accents and dialects, reflecting the varying origins of the speakers), various languages of the Northern Region and also Swahili. Walking through residential areas such as Luwinga, Nkholongo, Mapale, Salisbury, Chimaliro, Moyale, Kaning'ina and others, the dominant language that one hears remains Tumbuka.

There are certain areas where one feels as if he or she was in Tanzania or any other Swahili-speaking country. The so-called Taifa market offers such a linguistic situation. This is a market that was specially designated for Tanzanian vendors. It is a market well known for attracting patrons from various districts of Malawi. The market is famous for offering a wide range of manufactured goods such as electronics, clothes and houseware. The market is also reputed for its fair pricing. Most of the market vendors speak Swahili amongst themselves and/or with their clients. Some of the Swahili speakers have acquired Tumbuka and/or Chewa, but their accents betray them. Apart from the Taifa market, there are certain residential areas that are populated by Swahili-speaking people. These are high-density residential areas where Malawians have built houses, some of which are rented out to the Tanzanians. Chibavi and Chibanja residential areas are where most of the Swahili-speaking persons reside. Those *Taifas* on short-term vending visits to Mzuzu stay in rest houses. Since it is not rare to hear speeches in Swahili in Mzuzu, one of my key informants, an expatriate service provider at the MCH, pointed out that it was difficult for her to use Kiswahili "to backbite others" since there was bound to be someone nearby who would know the language. In other words, Swahili in Mzuzu is losing its power to exclude "the other" as more and more Malawians have basic understanding of the language.

Not everyone who speaks Swahili in Mzuzu is a Tanzanian (see also section 4.3.1.4). During my fieldwork, I learnt that Malawians who conduct trading activities between Malawi and Tanzania have had to learn Swahili. Knowledge of Swahili helps them to conduct their trading activities in the Swahili-speaking Tanzania with efficiency. Whilst in Tanzania, Malawian traders have to bargain for fair prices of goods. Success in the bargaining exercise is facilitated by competence in Swahili. It is not only in the Tanzanian *dukas* (Swahili for shops) where Malawian traders need competence in Swahili. Knowledge of Swahili is also critical when travelling without official travel documents. One has to negotiate his/her way through the Tanzanian border posts. My informants said that some of the traders who operate between Malawi and Tanzania engage in illegal cross-border trade - they evade custom duties and some of them even have no passports. If one has no passport, but is able to speak Swahili, then it becomes less difficult to negotiate with the immigration officials. Without the knowledge of Swahili, the whole process of the clandestine transportation of goods, bypassing custom officials, becomes impossible. It is against this background that Malawian traders are motivated to learn Swahili.

Whilst talking about the dominance of Tumbuka in social and other interactions in Mzuzu, it is important to mention that this dominance is confined to oral communication. The written modes of communication, such as road signs, business names, commercial advertisements and secular literature, rarely use Tumbuka. For example, there is no Tumbuka newspaper in Mzuzu. The two dailies that reach the city, *The Nation* and *The Daily Times*, are exclusively monolingual (English). The two dailies[1] are published and printed in Blantyre in the Southern Region. During the time (i.e. 1992-93) when the country was preparing for the national referendum that was to decide whether or not the one-party political system was to be maintained in Malawi, a number of independent newspapers were established. Whilst the predominant medium was English, and to some degree Chewa, these papers used to devote at least a page or two to the then unofficial languages such as Tumbuka, Yao and others (see Chimombo & Chimombo 1996; Chimombo 1997; Kishindo 1998a). For example, *The New Voice* published in Tumbuka. After the referendum and the subsequent inauguration of the post-Banda era, the use of these "small" languages in newspapers ceased. This coincided with the death of many of the papers. The dominant language in the print media continues to be English, whilst Chewa is used to a lesser extent. Even in creative writing, the liberalised political atmosphere has not created a boom for Tumbuka works (see Chimombo 1995, 1997). Going into Mzuzu's bookshops, one sees a sign of a drought of Tumbuka secular literature. Religious literature in Tumbuka is, however, slightly more available than secular literature. The main producers of this literature are the churches, and the Livingstonia Synod of the CCAP takes a leading role here. A visit to the bookshops in Mzuzu will undoubtedly enable an individual to get hold of a Tumbuka Bible or *Sumu za Chiuta* (hymns) or the Catholic missal and other pieces of religious literature.

There are a number of reasons why creative writers, newspaper publishers and others are not using Tumbuka in a significant way. That subject is beyond the concerns of the current thesis. However, from a language corpus planning point of view, I argue that some interventions are necessary before Tumbuka can be used effectively as a medium of creative writing and journalism. So far, what the post-Banda government has done is to remove the restrictions that were placed on Tumbuka by the 1968 MCP convention resolutions. In effect, it means that no language is barred from being used in official domains in any way. This amounts to status planning. What has been neglected, however, is corpus planning. As a language that has assumed an official status through its use on the radio and possibly later as a medium of instruction in junior primary schools, one cannot expect it to fulfil its new tasks without first undergoing some internal developments. The importance of corpus planning, which Bamgbose (2000a: 22) stresses below, is applicable to Tumbuka's case:

> For a language to be used in domains in which it has not previously been used or for its use even in customary domains to be expanded, there will be a need to engage in language development, which may cover a wide range of activities, including devising and reforming of orthographies, preparation of grammars, compilation of dictionaries, and vocabulary expansion.

In addition to the lack of a boom in Tumbuka secular literature, there is also a lack of a vibrant Tumbuka music industry. One of the benefits of the post-Banda political dispensation has been the freedom of expression in the fine and performing arts, and music is no exception. Many bands have been formed since the demise of the one-party system of government. Music is now becoming a lucrative business. But Tumbuka's own contributions (*sumu za mu Chitumbuka*: Tumbuka songs) to the Malawian music industry is very negligble.[2] The dominant language of this music industry is Chewa. This Chewa music is well patronised in Mzuzu.

Despite being a predominantly Tumbuka-speaking city, Mzuzu experiences a weak Tumbuka voice in the electronic media that serves it. When you turn on the radio in Mzuzu, you are mostly likely to have English or Chewa as the language on the air. The national radio, as mentioned in chapter 2, broadcasts mainly in English and Chewa, with some *makani mu Chitumbuka* (news in Tumbuka). The national radio has a studio in Mzuzu, but only a handful of programmes in Tumbuka are broadcast live from this studio. A music request show, involving the studios in Mzuzu, Lilongwe and Blantyre cities, is broadcast every Sunday. The announcers in Blantyre and Lilongwe present the programme in Chewa whilst the Mzuzu announcer presents his/her contributions in Tumbuka. There is also a health education programme focussing on HIV/AIDS, *Njatose* (literally: "it is for all of us," meaning that the HIV/AIDS problem is for all of us to solve). This Tumbuka programme is produced in Mzuzu and then delivered to the main studios in Blantyre for national broadcasting. As can be noted so far, the space occupied by Tumbuka on the national radio is very minimal. Mzuzu, and the Northern Region as a whole, despite being predominantly Tumbuka-speaking, have to tune in to a Chewa and English-dominated national radio.

The demise of the Banda regime has seen Malawi change from a one-radio to a multi-radio country. The liberalisation of the political system has also been accompanied by the liberalisation of the airwaves, leading to the establishment of several private radios.[3] Mzuzu has one of these private radios, the African Bible College (ABC) radio. It broadcasts spiritual programmes in Chewa, Tumbuka and English, but the overwhelming majority of the programmes are in English. The radio's sole announcer said that the dominance of the English programmes was due to the fact that it was cheaper to get pre-recorded programmes from the USA than produce them locally and in local languages. The ABC radio in Mzuzu, therefore, is elitist since its dominant language, English, only serves the minority English-using population of Mzuzu (see Table 4.1). This radio is weak in its evangelisation task since its medium of broadcast is not in line with the commonly proclaimed missionary principle of spreading the Gospel through the dominant language(s) of the targeted area(s).

Table 4.1: Mzuzu City: Languages of Household Communication

Language	Population: Raw Figures and %
Tumbuka	55,459 **(63.76 %)**
Chewa	19,241 **(22.12 %)**
Tonga	4,534 **(5.21 %)**
Yao	2,267 **(2.61 %)**
Ngonde	1,921 **(2.22 %)**
Lambya	1,613 **(1.85 %)**
Other	668 **(0.77 %)**
English	383 **(0.44 %)**
Ngoni	299 **(0.34 %)**
Lomwe	220 **(0.25 %)**
Nyakyusa	145 (**0.17 %)**
Sena	70 **(0.08 %**)
Portuguese	47 **(0.05 %)**
Senga	42 **(0.048 %)**

Source of Data for Table 4.1: National Statistical Office (1998).[4]

4.3. CLIENTS' RESPONSES

4.3.1. Clients' Demographic Characteristics

The relevant demographic characteristics that I discuss in this section are clients' categories, sex, age, nationality, highest education levels, residential districts, dominant languages of residential districts, and ethnic identity. Where necessary, I cross tabulate a demographic characteristic with a relevant aspect of language.

4.3.1.1. Category of Clients

In all, 478 clients responded to the questionnaire. Table 4.2 summarises the composition of the clients. The table shows that there are no significant differences in the numerical strength of each of the three categories of respondents. The numerical strength of each category is linked to the respondents' accessibility to the investigator. The least accessible category was that of the in-patients. The main reason was, as mentioned in chapter 1, that this category of respondents could only be interviewed during the hospital's official visiting hours. On the other hand, out-patients and guardians were more accessible to the investigator. These two categories of clients could be interviewed at any time and place, depending of course on each individual's particular circumstances as pointed out earlier in chapter 1.

Table 4.2: Categories of Clients

Category of Respondents	Frequency	Percentage
Out-patients	171	35.8
Guardians	163	34.1
In-patients	144	30.1
TOTAL	**478**	**100**

I included guardians as respondents because despite not being patients themselves, they do play an active discourse role in the interaction between patients and the service providers. To illustrate that guardians are not necessarily passive in clinical interactions, I present some scenarios I obtained from the MCH. The first scenario is based on a paediatric clinical case - a mother/guardian taking a baby to the hospital.

Scenario I: A Mother as a Spokesperson for a Baby

Since babies cannot give their own accounts of their illnesses, it is the mother or guardian who explains the health conditions to the service provider. The guardian becomes the spokesperson for the baby. To illustrate this, I cite the following segment of a dialogue between a Tumbuka-speaking mother and a clinician in which the former spoke on behalf of her baby:

Clinician: *Mwana uyu wachita vichi?* (This child, what's wrong with him/her?)

Mother: *Chikhoso. Mwana uyu wali ni chikhoso. Wakhosomolanga.* (A cough. This child has a cough. He/she is coughing.)

Clinician: *Wayamba uli?* (When did he/she start?)

Mother: *Wakayamba sabata yamala.* (He/she started last week.)

Clinician: *Thupi likuwotcha?* (Is the body hot?)

Mother: *Yayi* (No)

In contrast to this scenario, the child in scenario II challenges the widely noted powerful discourse role of the mother or guardian in paediatric clinical encounters. The child does not depend on her mother to construct her illness.

Scenario II: An Unusual Paediatric Clinical Encounter

The second scenario involves a talking-child as opposed to the non-talking babies. The case I describe below is exceptional in the sense that it is very rare for a four-year old to give her own medical narrative independently of the mother/guardian. The background to this case is that the mother had gone to the hospital for two reasons. First, she had gone to the hospital with a cough problem. After her clinical interview, she introduced her daughter as another patient. Her daughter, Olga, complained about stomach pains. Part of Olga's clinical interview, entirely in Chewa, went as follows:

Clinician: *Muli bwanji chemwali?* (How are you, sister?)

Child: *Ndili bwino.* (I am fine.)

Clinician: *Dzina lako ndani?* (What is your name?)

Child: *Olga* (Olga)

Clinician: *Olga, chikukuvuta ndi chiyani iweyo?* (Olga, what is troubling you?)

Child: *M'mimba.* (Stomachache)

Clinician: *M'mimba! Mwayamba liti m'mimbamo?* (Stomachache! When did the stomachache start?)

Child: *Lero* (Today)

Clinician: *Lero lomwe? Kodi iwe Olga, ukumatsekula m'mimbamo? Mukumapweteka makamaka mbali yake yapati? Talodzapo.* (Today? Olga, do you have diarrhoea? Which part of the stomach is painful? Point at that part.)

Clinician: *Apapo?* (Here?)

Child: *Eee* (Yes)

Clinician: *Chimbudzi ukupanga bwinobwino?* (Are you opening bowels normally?)

Oga: *Eee* (Yes)

Clinician: *Olga, kodi uli ndi zaka zingati?* (Olga, how old are you?)

Child: *Foolo* (Four)

Clinician: *Unayamba sukulu? Sunayambe? Udzayamba liti, Olga? Olga, ndiye ndakulembela mankhwala kuti ukamwe. Good girl! Good girl!* (Have you started school? You haven't started? When will you start, Olga? I have prescribed some medicine for you. Good girl! Good girl).

It is important to speculate here that the mother did not step in probably due to the mild nature of her daughter's illness. If the child had been suffering from a more serious illness, the mother would have obviously taken a more active discourse role.

Scenario III: Guardian Speaking on Behalf of Adult Patient

The third scenario depicts an adult serving as a guardian for another adult. Sometimes when a patient is too ill to communicate sensibly, the guardian provides the necessary details during history taking. But the patient discussed below was able to talk normally. She could have given her account on her own, but her husband decided to take over. In this example, a man had escorted his pregnant wife to the hospital. She had vaginal bleeding. After some introductory greetings between the clinician and the patient, the husband stepped in and spoke on behalf of his wife. The language of interaction was Tumbuka. It is of special interest that the clinician succumbed to the husband's verbal dominance and addressed all the history-taking questions to him, and not the patient. The wife stayed quiet in the background. The gender inequalities in verbal interaction were obviously at play here, with the husband as *mutu wa banja* (Chewa: the head of the family), assuming leadership and dominance (cf. Zimmerman & West 1975 on mixed-sex verbal interactions). The husband took himself to be more eloquent than his wife, thus rendering her verbally invisible in the clinical interview:

Husband: *Wakageza pa 23 July (*She had her menstruation on 23 July).

Clinician: *August wandageza, na September uno? (*She didn't have periods in August, and this September?)

Husband: *Mmmm* (confirms with Mmmm)

Clinician: *Sono ndopa zikufuma chomene?* (So she is bleeding heavily?)

Husband: *Mmmm* (confirms with Mmmm)

Clinician (to patient): *Kwelani pa bedi apo timuoneni.* (Climb on that bed so that I can examine you)

Clinician: *So kufuma 1997, watolaponso nthumbo ili yonse?* (So since 1997, has she ever been pregnant?)

Husband: *Yayi* (No)

Clinician: *Pakwamba uku nthena?* (Is this the beginning?)

Husband: *Mmmm* (Yes)

Clinician: *Wakuwagonekapo m'chipatala nyengo inyake?* (Has she ever been hospitalised before ?)

Husband: *Yayi* (No)

Scenarios I and III are aimed at justifying the inclusion of guardians as respondents to the questionnaire. As these two scenarios show, any study of hospital-based communication in Malawi would be incomplete if it focussed on patients only. In addition to being spokespersons for patients, some guardians also play the role of interpreters (see especially chapters 5 and 6).

4.3.1.2. Sex of Clients

There were 271 female clients who served as respondents. This figure represents 56.7 % of the sample population, a slightly higher figure than in the 1998 population census report (National Statistical Office 1998) which indicated that females made up 51 % of the total enumerated population of Malawi. It is important to mention that apart from being patients in the own right, women also appear at the MCH in other roles. One role is that of a mother who

brings a sick child to the hospital. In Malawi, childcare is predominantly a woman's domain. As such, it is rare to see a man taking a sick child to a hospital. Another role that women play at the MCH is that of being patients' guardians. These are typical features of Malawi's gendered society. It is from this perspective that the dominance of women in the clients' category should be understood. The majority of the patients' guardians are female. For example, all the guardians who responded to the questionnaire were female. In other contexts, however, such as interviews, observations and audio recordings of client versus service provider interactions, male guardians were noted (see, for example, scenario III in section 4.3.1.1). However, male guardians were, on the whole, smaller in number.

4.3.1.3. Age of Clients

The age of a respondent is an important aspect in any sociolinguistic survey. When the respondent is too young or too old, the possibility that their responses may not be sensible or meaningful is high. Efforts were therefore made to leave out respondents who were either too young or too old. In the analysis of the data, respondents have been divided into four age groups. Table 4.3 is a summary of the age groups.

Table 4.3: Clients' Ages

Age Group	Frequency	Percentage
10-19	55	11.5
20-29	207	43.3
30-39	123	25.7
40 and above	93	19.5
TOTAL	**478**	**100**

4.3.1.4. Clients' Nationalities

One of the questions asked clients to identify their nationalities. I am using the term nationality in the same way as was the case in the 1998 population census in Malawi (National Statistical Office 1998) - to refer to a person's country of origin. A person's nationality has implications for his or her linguistic repertoire. Certain languages are associated with particular nationalities. For example, one normally expects a Malawian national to be able to speak Chewa,[5] Malawi's national language, and a Tanzanian national to be able to speak Swahili. Of course there may be exceptions to these expectations, but the argument here is that there are some general sociolinguistic trends that can be predicted on the basis of an individual's nationality. An individual's linguistic repertoire is, therefore, in some ways influenced by nationality. The question of nationality was also asked in order to determine the extent to which the MCH caters for both Malawians and non-Malawians. Other Malawian hospitals, especially those located in the border zones, are known to cater for both Malawians and nationals of the neighbouring countries.[6]

All the 478 respondents claimed to be Malawians. The fact that no single respondent claimed to be a non-Malawian is questionable since Mzuzu has a large group of Tanzanian vendors. Interviews with key informants at the MCH itself pointed to the fact that patients of foreign nationality, especially the Swahili-speaking Tanzanians, were some of the most linguistically problematic clients at the hospital. My strong suspicion is that the non-Malawian clients cheated on their nationality for fear of being repatriated since most of them are illegal immigrants. The underreporting of foreigners' nationalities is also suspected in the 1998 census report (National Statistical Office 1998) where it is indicated that out of Mzuzu

city's population of 86,980 persons, only 77 persons (0.09 %) declared themselves as non-Malawians. By making simple head counts of the non-Malawians, especially Tanzanians, whom I found in Mzuzu, the census figure suggests a case of underreporting. The non-Malawians may have wrongly suspected that the survey was one way of trying to identify illegal immigrants, an exercise that is not unusual in Mzuzu. Since in Malawi there are no government-issued national identity cards, and only a small segment of the population has passports, the Immigration Department faces an uphill task in identifying Malawians and non-Malawians.

Using language as a way of determining who is a Malawian and who is a non-Malawian can sometimes be unreliable.[7] Whilst it is easy to designate a person who speaks a Malawian language with a foreign accent as a non-Malawian, there are some cases which can be tricky. Cross-border languages sometimes conceal the nationality of an individual given that the languages cannot be pinned down to one specific country. For example, using Swahili to determine an individual's nationality fails completely given that this is a major lingua franca covering many African countries. In the case of Malawi and Tanzania, one finds that people on the Malawian side of the border speak Swahili just as well as Tanzanians across the border. International borders do not control language use. Conversely, language or dialect boundaries do not coincide with territorial boundaries. The situation I have described so far makes it sometimes difficult to determine an individual's nationality on the basis of the language they are speaking.

4.3.1.5. Clients' Highest Educational Levels

Respondents were also asked to mention their highest educational levels. Like other cases of self-reports, the results produced by this question have to be treated with caution given that the possibility on the part of some of the respondents to wish to appear to be more educated than what they actually were cannot be ruled out. The results of the responses to the question revealed that only 3.6 % of the respondents in Table 4.4 claimed to have attained no level of formal education at all. The small number of respondents who had no education can be explained historically. That the Northern Region has since the days of the pioneer Christian missionaries' education had high education levels has already been pointed out in the previous chapters (see also McCracken 1977a, 1994; Short 1974; Vail & White 1989; Thompson 1994a). The high affinity for education, which the pioneer Christian missionaries cultivated in the Northern Region, continues to be sustained. Education has always been a priority amongst the various ethnic groups of the Northern Region.

Table 4.4: Clients' Highest Levels of Education

Highest Educational Level	Frequency	Percentage
No Education	17	3.56
Below PSLC	134	28.03
PSLC	144	30.13
JCE	116	24.27
MSCE	63	13.18
Diploma	1	0.21
First Degree and Above	3	0.63
TOTAL	**478**	**100**

It is significant to note that the general trend noticeable in Table 4.4 is that as the educational levels increase, the number of people attaining such levels tends to diminish. The final picture

that emerges is more or less that of a pyramid. At the top of the pyramid are the highest educated persons and these are a minority. At the base of the pyramid are the majority who are either semi-educated or not educated at all. But the pyramid that emerges from the data in Table 4.4 is one that has a narrow base. This pyramid structure of the Malawian education system is due to unequal educational opportunities.[8] Only the fortunate few reach the top of the educational ladder (cf. Ngugi wa Thiong'o 1986: 12). The superiority of the Northern Region in education attainment levels was also indicated in the 1998 population census (National Statistical Office 1998). The Northern Region's superiority in education levels was also pointed out to me in a number of formal and informal discussions I had with key informants and others. One key informant, an Asian, ruled out language problems at the MCH during interactions between clients and expatriate service providers. He argued that although the expatriate service providers were not competent in any Malawian language, such a situation was not a linguistic barrier because there were "many educated people" in the Northern Region. The implication was that the educated people would comfortably communicate with the English-speaking expatriate service providers. But despite this educational superiority enjoyed by the Northern Region, English has not achieved what my informant claimed as later sections of this chapter and section 5.4 in chapter 5 show. That an individual has been to school does not automatically make him or her have competence in English. A very critical factor here is the level of one's education since Malawi does not belong to Kachru's (1985, 1986) inner circle of speakers of English where English is acquired naturally.

The level of education has direct relevance to the acquisition and the frequency of use of certain languages (see, for example Table 4.22 in this chapter). In Malawi, where English has an ESL (English as a Second Language) status, education is the route through which the language is learned. Schmied (1991) has noted that there is a correlation between the level of competence in English and one's level of education. Normally the case is that the higher levels of education entail high levels of competence in English. However, this correlation can be questioned given that currently there are reports about falling standards of competence in English even among Malawian university graduates (see Kamanga 1990; Kayambazinthu 1998; Matiki 2001b; Kamwendo 2003). It is also through the school system that non-Chewa-speaking pupils acquire Chewa. The Malawian school system, then, cultivates biliteracy (English and Chewa) in the learner (see Williams 1996, 1998). Since no local language other than Chewa is offered in schools, it follows that literacy skills in Chewa are transferred to other local language contexts when either reading or writing. It is also the case that since Chewa is the only local language that has a standardised orthography, it is not unusual to find people writing other local languages using the Chewa orthography (see also Kishindo 1998b).

4.3.1.6. Clients' Residential Districts

Respondents were also asked to name the district where they resided. A district has a bearing on the language(s) one is in contact with or is able to speak. Certain districts are known for the existence of particular languages such that it is possible to make some intelligent predictions about the language(s) a resident is likely to speak. The question also enabled me to determine the degree to which the MCH, as the regional referral hospital, takes in-patients from various districts. The results of responses to the question on residential districts (see Table 4.5) showed that the majority of the respondents were residents of Mzuzu city.[9] This is a very significant point because it demonstrates that despite being a regional referral hospital, the MCH draws its clients from the six districts unequally. Since Mzuzu city is administratively under the jurisdiction of Mzimba district, it then means that the overall

percentage for the district should be 84.1 %. This dominance of the Mzimba-based clients has linguistic implications. The numerical inferiority of the representation of other languages of the Northern Region (Table 4.6) such as Tonga, Ngonde, Lambya, Sukwa, Ndali and Nyiha also serves as an indication of the low frequency in the use of these languages at the MCH. This has implications on the language planning proposals, in line with minority language rights, which are discussed in chapter 7. It is also important to bear in mind that the findings of the study apply to the Mzuzu Central Hospital only, and not all the other hospitals of the Northern Region.

But why does the Mzimba district contribute the majority of the MCH's clients? This can be explained in a number of ways. First, Mzuzu city, which contributes the majority of the clients lies within Mzimba district itself. Second, many parts of Mzimba district are closer to the MCH than are districts such as Karonga and Chitipa. Third, the road conditions and the availability of ambulances and fuel also regulate the volume of referrals that can be made to the MCH by the district hospitals. For example, Karonga and Chitipa district hospitals have poor road connections to Mzuzu, and also experience shortages of fuel and ambulances. Mzimba district hospital, on the other hand, is well connected to Mzuzu by a tarmac road that is in a good condition. Fourth, it is only cases that require specialist care which are referred to the MCH by the district hospitals. Other cases that are considered to be 'normal' are handled within the district hospitals.

Table 4.5: Clients' Residential Districts

Residential District	Number	Percentage
Mzuzu	341	71.3
Mzimba	61	12.8
Rumphi	32	6.7
Nkhata Bay	28	5.9
Karonga	8	1.7
Chitipa	4	0.8
Lilongwe	1	0.2
Zomba	1	0.2
Kasungu	1	0.2
Nkhotakota	1	0.2

The data in Table 4.5 agree with what I gathered from an interview with the hospital administrator. In the interview, the administrator had indicated that the majority of the clients at the MCH are referrals from within the Mzuzu city and Mzimba district. The fact that the MCH does not draw referrals uniformly from all the six districts comprising its catchment area means that the hospital's language use cannot be said to be a full representation of all the other health institutions in the region.

4.3.1.7. Dominant Languages of Clients' Residential Districts

As a follow-up to the question on respondents' residential districts, clients were asked to mention the dominant language(s) of their residential districts. A significant majority, 91.8 % (see Table 4.6) claimed that Tumbuka was the dominant language of their residential areas. Given that only 3 (0.6 %) of the respondents claimed to reside in districts outside the Northern Region, and that the remaining 99.4 % were actually resident in the Northern Region itself, it can be noted that this study confirms earlier results (e.g. Kayambazinthu

1995, 1998; National Statistical Office 1998; Centre for Language Studies 1999) that Tumbuka is the most widely spoken language in the Northern Region of Malawi.

Table 4.6: The Dominant Language(s) of Residential Districts

Language	Frequency	Percentage
Tumbuka	290	60.7
Chewa	80	16.7
Tonga	56	11.7
Ngonde	24	5.0
Lambya	13	2.7
Yao	4	0.8
Sukwa	4	0.8
Ndali	3	0.6
Nyiha	2	0.4
Lomwe	1	0.2
Sena	1	0.2

4.3.1.8. Clients' Ethnic Identities

Edwards (1985: 6) points out that ethnicity can be thought of as a sense of group identity deriving from real or perceived common bonds such as religion, race and language. As it has been pointed out in chapters 2 and 3, Malawian languages have their origins in particular ethnic groups. Caution was made on the dangers of simplistically equating an individual's claimed ethnic group with the ability to speak the ethnic group's associated language(s). There are particular cases, however, under which the identification of an individual's ethnic group is a helpful mechanism through which some reasonable predictions can be made about language maintenance, shift and loyalty. There are certain sociolinguistic trends that are closely associated with particular ethnic groups. It is also important to mention that ethnic groups all over the world differ in terms of the degrees of importance they attach to language as a marker of their ethnic identity. For some ethnic groups, language is at the core of their identity whilst for other groups, language is not perceived to be a critical ingredient of their ethnic identity (see May 2001). In the current study, the majority of the clients claimed to be ethnically Tumbuka. Table 4.7 summarises the results.

The ethnic composition of the sample population shown in Table 4.7 points to the ethnic heterogeneity of the MCH's catchment area. From the table, the following were the Northern Region-based ethnic groups: Tumbuka, Tonga, Nkhonde, Lambya, Ngoni, Ndali, Namwenga, Sukwa and Nyiha. The Ngoni are a special case since they occupy parts of each of the three regions of Malawi. The existence of more than one ethnic group in the sample consolidates McCracken's (2002) argument that it is incorrect to conflate the Northern Region into one ethnic group, namely that of the Tumbuka. There is a tendency in both the Southern and Central Regions to refer to anyone from the Northern Region as a Tumbuka (*Mtumbuka*). There is no doubt that the Tumbuka are the majority in the Northern Region, but what is erroneous, especially with regard to language, is the view that anyone who speaks Tumbuka must be a Tumbuka ethnically, or that every Northerner speaks or understands Tumbuka (see Tables 4.9, 4.10 and 4.11 for cross-tabulations of mother tongue versus ethnic identity).

Table 4.7: Clients' Ethnic Identities

Ethnic Identity	Frequency	Percentage
Tumbuka	294	61.5
Tonga	56	11.7
Chewa	51	10.7
Ngoni	24	5.0
Ngonde	18	3.8
Lambya	14	2.9
Yao	6	1.3
Lomwe	3	0.6
Ndali	3	0.6
Namwenga	3	0.6
Sukwa	2	0.4
Nyika	2	0.4
Mang'anja	1	0.2
Sena	1	0.2
TOTAL	**478**	**100**

4.3.2. General Patterns of Language Use

4.3.2.1. Mother Tongues

Before I present the results on the question about the other languages existing in respondents' linguistic repertoire, it is important to mention that data for these questions come from self-assessments of language competence or ability. Self-assessments have to be treated with caution since "knowing a language" is very subjective. What "knowing a language" means is hard to pin down. Even some people who speak 'some English' are said not to know English. A case in point is a nurse (service provider 28) who indicated in her questionnaire that "we have other doctors from China who do not even know English." My understanding of this statement is not that the doctors were completely without any knowledge of English, but rather that their competence in English was too low for them to work effectively in the new environment in which English was a lingua franca. As Schmied (1991: 29) has observed, respondents "may really not be able to tell objectively, since they cannot know what degree of proficiency is considered a minimum requirement by the interviewer." There is also a possibility of bias in some of the answers to questions on the ability to speak English given that knowledge of "English in particular is normally seen as a status symbol, a sign of importance, influence and education" (Schmied 1991: 29).

In Table 4.8, it can be noted that Ngonde, Lambya, Sukwa, Ndali and Nyiha can be categorised as minority languages in the numerical sense. Even in the other sense of minority languages (i.e. the functional role), these languages are also in the minority category since they do not carry any degree of official status in Malawi. The ranking of the languages in Table 4.8 agrees with the results of the 1998 population census (National Statistical Office 1998) and Centre for Language Studies (1999) which identified Tumbuka as the most dominant language in the Northern Region (see also Table 3.3 in chapter 3).

Table 4.8: Clients' Mother Tongues

Language	Frequency	Percentage
Tumbuka	294	61.5
Chewa	84	17.6
Tonga	52	10.9
Ngonde	20	4.2
Lambya	14	2.9
Yao	4	0.8
Sukwa	4	0.8
Ndali	3	0.6
Nyiha	2	0.2
TOTAL	**478**	**100**

Continuing with the discussion on the extent to which the equation between mother tongues and ethnic identity can be valid, and having noted previously that there is a tendency in the Northern Region to call *Mchewa* any Chewa-speaking person, I found it relevant to cross-tabulate mother tongues and ethnic identity. This process of cross-tabulation was done for the three major mother tongues that have been listed in Table 4.8. The aim of the cross-tabulation was to test the validity of Kashoki's (1982: 139) claim that languages, including African languages, have the capacity "to recruit speakers from within the social group immediately associated with the given language as well as from outside that group." Kashoki's point is that some African languages have ceased to be ethnically-based. Instead, they are used for both inter- and intra-ethnic communication (see also Kashoki 1990: 34-47).

First, let us consider the case of Tumbuka as the most dominant mother tongue for the clients sampled (see Table 4.8). When the 294 mother tongue speakers of Tumbuka were analysed, it was noted that not all of them had claimed Tumbuka to be their ethnic identity. It was noted that five ethnic identities, namely Tumbuka, Yao, Sena, Lomwe and Tonga, were in varying degrees linked to the mother tongue speakers of Tumbuka. Whilst of course the majority of the Tumbuka mother tongue speakers were Tumbuka by ethnicity, one observes in Table 4.9 that the one-to-one correspondence between mother tongue and ethnic group could not be obtained.

Table 4.9: Tumbuka as a Mother Tongue versus Ethnic Identity of Speaker

Ethnic Identity	Tumbuka as a Mother Tongue (Frequency)	Tumbuka as a Mother Tongue (%)
Tumbuka	259	88.10
Tonga	25	8.50
Yao	6	2.04
Lomwe	3	1.02
Sena	1	0.34
TOTAL	**294**	**100**

In the second case, I cross-tabulated Chewa as a mother tongue with ethnicity. In Table 4.10, it can be noted that two ethnic identities, Chewa and Tumbuka, share unequally the status of Chewa mother tongue speakers. The fact that 38.55 % of the mother tongue speakers of Chewa in Table 4.10 are non-Chewa, render Kawale's (2000) assertion that the Chewa "own" the Chewa language hollow. In his argument, Kawale had said that it is the Chewa who

should be consulted on corpus and/or status planning issues concerning the Chewa language because they are the "owners" of that language.

Table 4.10: Chewa as a Mother Tongue versus Ethnic Identity of Speaker

Ethnic Identity	Chewa as a Mother Tongue (Frequency)	Chewa as a Mother Tongue (%)
Chewa	51	61.45
Tumbuka	32	38.55
TOTAL	**83**	**100**

The third set of cross-tabulation, between mother tongue and ethnic identity, was done for Tonga. Again, the trend for Tonga was that one could not equate the language as a mother tongue with Tonga ethnic identity as Table 4.11 shows. There is no total ownership of Tonga by those claiming to be Tonga ethnically.

Table 4.11: Tonga as a Mother Tongue versus Ethnic Identity of Speaker

Ethnic Identity	Tonga as a Mother Tongue (Frequency)	Tonga as a Mother Tongue (%)
Tonga	27	51.92
Ngonde	18	34.62
Lambya	7	13.46
TOTAL	**52**	**100**

There is a consistent finding in the three cases of cross-tabulations between mother tongue and ethnic identity (Tables 4.9, 4.10 and 4.11). This finding is that there is no one-to-one correspondence between a mother tongue and the ethnic group from which the language has its origin. This is, of course, not to deny the existence of the other consistent pattern - that the majority of the mother tongue speakers are actually members of the ethnic group in which the language has its base. Tables 4.9, 4.10 and 4.11, therefore, challenge the view that a linguistic group is the same thing as an ethnic group. Language does not always reflect ethnic identity.

4.3.2.2. Other Languages Spoken

Respondents were then asked to mention other languages they spoke. By other language(s), I meant languages in addition to the mother tongues. The majority 64.4 % cited Chewa as their other language (see Table 4.12). The fact that the majority of the clients, drawn from predominantly Tumbuka-speaking areas, had cited Chewa as their second language pointed to the inroads Chewa has made into its non-core areas. This has been possible due to the existing language policy. Since 1968, Chewa has been the only local language, which in addition to English, is taught in schools and also used in the mass media. In addition, anyone who has been to school, therefore, must have been exposed to English and Chewa. The spread of Chewa across Malawi is also partly due to the national radio's language policy. The radio is the most dominant instrument of the Malawian mass media. Since Chewa has largely dominated this medium, it follows that it has spread the language even to non-Chewa-speaking persons, thus reducing chances of monolingualism. Whilst talking about the Tumbuka/Chewa bilingualism, it is relevant not to ignore the existence of passive or receptive bilingualism (see Romaine 1989). This is a situation whereby a Tumbuka native speaker has no productive control over Chewa but is still able to understand utterances in it. In some

cases, the person may even be able to speak the language to some extent. This situation was observed on many occasions within and outside the MCH.

Table 4.12: Other Languages Spoken by Clients

Language	Frequency	Percentage
Chewa	309	64.6
Tumbuka	67	14
English	33	6.9
None	24	5.0
Tonga	11	2.3
Ngonde	6	1.3
Lambya	5	1.0
Ndali	4	0.8
Swahili	4	0.8
Sena	2	0.4
Nyakyusa	1	0.2
French	1	0.2
Nyiha	1	0.2
Sukwa	1	0.2
No Response	1	0.2
TOTAL	**478**	**100**

4.3.2.3. The Need for Learning Tumbuka

Realising that Tumbuka is the major lingua franca of Mzuzu, respondents were asked whether or not they felt there was a need on their part to learn this language. For those who spoke the language, as native or non-native speakers, such a need did not exist. It was only those who did not speak the language that the need to learn the language could either be felt or could not be felt. The results of the responses to the question were as follows. For the majority 93.9 % (see Table 4.13), there was no need to learn the language (see Table 4.14 for their justifications).

Table 4.13: The Need to Learn Tumbuka

Need to learn Tumbuka	Frequency	Percentage
Yes	29	6.1
No	449	93.9
TOTAL	**478**	**100**

For the minority 6.1 % of the respondents who said they needed to learn Tumbuka, the justification was that since they live in a Tumbuka-dominated area, knowledge of the language would make them more communicatively agile. Whilst they were still able to communicate through Chewa, they felt that the addition of the regional lingua franca to their linguistic repertoires would immensely improve their communication efficiency.

The majority group in Table 4.13 (those who did not need to learn Tumbuka) was broken down into two categories (see Table 4.14). The breakdown was aimed at identifying the reasons why they gave a NO answer to the need to learn Tumbuka. As Table 4.14 indicates, the majority of those who said NO said so because they already spoke the language. This group comprises mother tongue speakers and second/third language speakers of

Tumbuka. This is a very important result because it shows that the overwhelming majority has some knowledge of Tumbuka in the form of mother tongue or second or third language competence. On the other hand, the minority (0.67 %) said that they did not have the need to learn Tumbuka because they did not like the language. This is certainly a case of language attitude. Language attitudes play a significant role in second language acquisition.[10] I am using the term second language acquisition to refer to the acquisition of any language after the first language. The respondents who did not like Tumbuka could have had a negative attitude towards the second language. It was this negative attitude which significantly reduced their motivation[11] or desire to learn the second language.

Table 4.14: No Need to Learn Tumbuka: Justifications

Reason	Frequency	Percentage
Already knew the language	446	99.33
Dont like the language	3	0.67
TOTAL	**449**	**100**

But what did the respondents mean when they said they did not like Tumbuka? Liking or not liking a language is a socio-psychological behaviour. From a linguist's point of view, there is nothing intrinsic in any language that should make an individual either like or not like a particular language. As linguists say, all languages are equal before them. When people say that they like or do not like certain languages, they display their personal evaluative attitudes. The target of this evaluation may not be the language alone, but also the speakers of the language. As Bamgbose (2000a: 4) has said, "if we don't like a group, we tend to transfer our negative feelings about that group to their language." Similarly, Fasold notes that whilst some language attitude studies are primarily concerned with attitudes about language, "the definition of language attitudes is broadened to include attitudes towards speakers of a particular language or dialect" (Fasold 1984: 148; see also Edwards 1985; Hudson 1996). It is difficult to like a language whose speakers you do not like. Attitude towards speakers of the target language is said to be one of the important factors regulating the degree of to which a second language is successfully acquired (see Schumann 1978; Ellis 1986). [12]

Whilst it has been argued that a positive attitude towards the target language group is likely to facilitate the acquisition of the new language, some researchers have noted that it is not only attitude that is critical in second language acquisition. It has been claimed that "necessity may overpower attitude" (Edwards 1985: 146). That is, even if one has a negative attitude towards the target language group and its language, if there is a practical need for acquiring that language, an individual will be compelled to learn the language. The minority in my study who said that they did not like Tumbuka, and therefore saw no need to learn it, may not have seen the learning of the language as a pressing practical necessity. Since one can still survive in the Northern Region to some extent (in communication terms) whilst using Chewa could be the reason why they did not feel compelled to learn Tumbuka. If the situation were such that there were no lingua francas such as Chewa and English, the dislike of Tumbuka would have been overtaken by the practical necessity of being able to speak the language. The length of stay and the nature of business one is engaged in are also factors that can determine whether or not one learns the new residential area's language. For example, the longer one stays in an area, the more the chances are that they will eventually learn the language. Of course, there are exceptional cases of people living for many years in certain areas without acquiring any language(s) of the area. Secondly, the business in which an individual is engaged will influence the learning of the new area's language(s). Service

providers at the MCH indicated through interviews and questionnaires that since that they could be posted to any part of Malawi, one of their pressing needs was to learn the language(s) of their new area(s) in order to facilitate their work (see also section 5.2.3 in chapter 5).

4.3.2.4. Frequency of Language Use

Clients were also asked about how frequently they used Tumbuka, Chewa and English on a daily basis. The notion of frequency was pre-coded on the questionnaire under four categories, namely: NONE, RARELY, OFTEN, and ALL THE TIME. There was no way of obtaining an objective view of what each of the four categories meant. What RARELY or OFTEN or ALL THE TIME meant varied from person to person.

Tumbuka: Frequency of Language Use

In the case of Tumbuka, the OFTEN category was rated the highest (see Table 4.15). This result is consistent with the fact that the study took place in a predominantly Tumbuka-speaking area. The low percentage (6.7 %) for the NONE AT ALL category is also consistent with the finding that 6.1% of the respondents in Table 4.13 needed to learn Tumbuka.

Table 4.15: Tumbuka: Frequency of Use

Frequency of Use	Number	Percentage
None at all	32	6.7
Rarely	41	8.6
Often	385	80.5
All the time	20	4.2

Chewa: Frequency of Use

When the frequency of use of Chewa was worked out (see Table 4.16), the OFTEN category (like in the case of Tumbuka in Table 4.15) attained the highest percentage. However, the majority strength of the OFTEN category for Tumbuka is higher than that of Chewa. This can be explained by the fact that the majority of the clients had Tumbuka as their mother tongue, and it is only natural to expect them to have the highest frequency of language use in this language. It is also significant to note that a small minority (5.0 %) did not use Chewa at all. This means that Chewa was used by the majority of the clients, thus fulfilling its role as a national lingua franca. In addition to the varying frequencies in the use of Chewa, there was also undoubtedly varying levels of competence in the language.

Table 4.16: Chewa: Frequency of Use

Frequency of Use	Number	Percentage
None at all	24	5.0
Rarely	177	37.0
Often	266	55.6
All the time	11	2.3

English: Frequency of Use

In the case of English (Table 4.17), clients rated their frequency of language use as follows. The NONE category was rated highest. 55.2 % of the clients indicated that they did not at any

rate use English in their daily activities. In addition, the ALL THE TIME category had 0 %, meaning that no single respondent claimed that they used English all the time daily. The findings in Table 4.17, showing the majority being unable to use English, cast doubts on the validity of the designation of Malawi as an English-speaking country. Furthermore, the findings expose the inappropriateness of not enforcing a local language proficiency requirement for the non-Malawian health service providers.

Table 4.17: English: Frequency of Use.

Frequency of Use	Number	Percentage
None at all	264	55.2
Rarely	58	12.1
Often	156	32.6
All the time	0	0

As another way of illuminating the categories of frequency of language use, I discuss the frequencies in Tables 4.18, 4.19, 4.20 and 4.21 through a ranking system. The category ALL THE TIME is the highest possible category of frequency of language use. I, therefore gave it rank number 1. Table 4.18 shows the percentages each of the three languages (English, Chewa and Tumbuka) scored on this category. Again, Table 4.18 confirms the wide use of Tumbuka, followed by Chewa.

Table 4.18: Rank 1 of Frequency of Language Use

Language	Percentage
Tumbuka	4.2
Chewa	2.3
English	0

The second highest category of frequency of language use is called OFTEN. In Table 4.19, the same pattern that was obtained in Table 4.18 appears here.

Table 4.19: Rank 2 of Frequency of Language Use

Language	Percentage
Tumbuka	80.5
Chewa	55.6
English	32.6

The third highest category of frequency of language use is RARELY. In Table 4.20, Tumbuka turns out to be the least rarely used language. This again, is consistent with the earlier results that had indicated Tumbuka as the most widely used language.

Table 4.20: Rank 3 of Frequency of Language Use

Language	Percentage
Chewa	37.0
English	12.1
Tumbuka	8.6

The lowest category of frequency of language use is NONE AT ALL (see Table 4.21). The results in Table 4.21 clearly demonstrate that English is a numerically minority language

despite the fact that it has the highest functional load in official domains. What this result means is that the language policy in Malawi, like in other post-colonial African countries where an exoglossic language functions as an official language, marginalises the majority of the people. Apart from being unable to have direct (non-interpreted) interactions with the English-speaking expatriate doctors, the majority of the clients were also unable to decipher information from the health literature that was written in English.

Table 4.21: Rank 4 of Frequency of Language Use

Language	Percentage
English	55.2
Tumbuka	6.7
Chewa	5.0

Table 4.22: Highest Educational Level versus Frequency of Language Use (English)

	None at all	Rarely	Often	**TOTAL**
No education	17			**17**
Below PSLC	135			**135**
PSLC	112	27		**139**
JCE		31	85	**116**
MSCE			69	**69**
Diploma			1	**1**
First degree or above			1	**1**
TOTAL	**264**	**58**	**156**	**478**
PERCENT	**55.23**	**12.13**	**32.64**	**100**

In Table 4.22, the highest education levels were cross tabulated with three frequencies of English use - none at all, rarely, and often. It can be noted here that the majority (who do not use English at all) are confined to the three lowest levels of educational qualification - no education at all, below PSLC and PSLC. This result makes sense because, for example, those without education cannot be expected to use English since education is the only route to the acquisition of English in Malawi. Those below PSLC and even the majority of those at the PSLC level have been exposed to English, but they lack a firm grounding in the language. This lack of a firm grounding in English can also be explained by the fact that apart from the school and work domains elsewhere English is not widely used (see, for example, English as a language of household communication in Tables 3.2 to 3.9 in chapter 3). There is therefore no conducive environment outside the school to nurture a growing competence in English. In the same Table 4.22, it can also be noted that those who claim to use English rarely are a minority of the PLSC and the JCE respondents. For those who claim to use English often, the minimum educational qualification is the JCE. These results are plausible. They indicate that higher levels of educational attainment are associated with higher frequency of the English language use.

Table 4.23: Highest Educational Level versus Frequency of Language Use (Chewa)

	None at all	Rarely	Often	Always	TOTAL
No education	17				**17**
Below PSLC	7	128			**135**
PSLC		49	90		**139**
JCE			116		**116**
MSCE			60	9	**69**
Diploma				1	**1**
First degree or above				1	**1**
TOTAL	**24**	**177**	**266**	**11**	**478**
PERCENT	**5.02**	**37.03**	**55.65**	**2.30**	**100**

In Table 4.23, highest levels of education were cross tabulated with the four categories of frequency of Chewa use - none at all, rarely, often and always. Since Chewa is taught in schools, it is not surprising that all those who claim to have no education and all those below PSLC are the same individuals who also claim not to use Chewa at all. That those below PSLC do not use Chewa is consistent with the Centre for Language Studies' (1999) finding that generally pupils in the Northern Region entered the primary school with poor grounding in Chewa. It therefore means that the more years of schooling an individual has, the more one is exposed to Chewa. Those who have not gone beyond the junior classes of the primary school have not been exposed to Chewa in a significant way, and it is therefore only normal to expect them not to have the confidence and/or competence of using the language. Just like in the case of English in Table 4.22, the results in Table 4.23 also show that those who claim to use Chewa often have the PSLC as their minimum educational qualification. In fact the majority in the OFTEN category are above PSLC level.

Table 4.24: Highest Educational Level versus Frequency of Language Use (Tumbuka)

	none at all	rarely	often	always	TOTAL
No education	17				17
Below PSLC	15	41	79		135
PSLC			139		139
JCE			116		116
MSCE			51	18	69
Diploma				1	1
First Degree or above				1	1
TOTAL	**32**	**41**	**385**	**20**	**478**
PERCENT	**6.69**	**8.58**	**80.54**	**4.18**	**100**

When the highest educational levels were cross tabulated with the Tumbuka frequency of use, the results indicated in Table 4.24 were obtained. We have to bear in mind here that for the majority of the respondents, Tumbuka is the mother tongue. The minority 6.69 % who claim to use no Tumbuka at all are confined to the no education at all and below PSLC categories. Despite the fact that Tumbuka is not offered a subject of study in primary schools, it remains the most widely used language within schools in Northern Malawi (Centre for Language Studies 1999). In some cases, teachers use Tumbuka in order to facilitate the teaching/learning process. This is why in 1996, when the mother tongue instruction policy

was proposed, the Ministry of Education mentioned that it was aware that in some non-Chewa-speaking areas, teachers actually taught through the dominant local languages, and not Chewa. That is why the mother tongue instruction proposal received its warmest reception in the Northern Region (Centre for Language Studies 1999; Mchazime 2000). Under this situation, one should expect the school to help the non-Tumbuka-speaking pupils to gain competence in the language despite the fact that officially the language is not part of the curriculum.

4.3.3. Hospital-Based Language Use.

4.3.3.1. Frequently Used Language(s)

Clients were asked to mention what they found to be the most frequently used languages at the MCH. As Table 4.25 shows, the overwhelming majority of the respondents cited Tumbuka. In the case of Ngoni, the strong suspicion is that the respondent meant Tumbuka since the former is dead; and that there is a tendency among some ethnically Ngoni who speak Tumbuka to call their language Ngoni. The fact that Tumbuka is the most dominantly used language at the hospital agrees with the results discussed earlier in the chapter.

Table 4.25: Most Frequently Used Language(s) at the MCH

Language	Frequency	Percentage
Tumbuka	474	99.2
Chewa	3	0.6
Ngoni	1	0.2

A related question asked clients to mention the second most frequently used language in the delivery of services at the hospital. The overwhelming majority 99.2 % mentioned Chewa (see Table 4.26). This result is consistent with earlier results from the same questionnaire as well as observations of actual interactions.

Table 4.26: Second Most Frequently Used Language at the MCH

Language	Frequency	Percentage
Chewa	474	99.2
Tumbuka	3	0.6
English	1	0.2

Further evidence in support of the finding that Tumbuka and Chewa were the first and the second most widely used languages in service provider-client interactions was obtained from audiotaped clinical interviews. I listened to a total of 36 clinical interviews, involving two Malawian clinicians, both of whom were able to use Chewa and Tumbuka competently. As Table 4.27 shows, the majority of the interviews took place through Tumbuka.

Table 4.27: Languages of Clinical Interviews

Language of Interview	Frequency	Percentage
Tumbuka only	19	52.77
Chewa only	11	30.55
Tumbuka & Chewa	6	16.66
TOTAL	**36**	**99.98 (100)**

4.3.3.2. The Best Language(s) for Hospital Transactions

Clients were asked to refer to their own linguistic capabilities and then mention the language that they felt was their best medium of communication at the hospital. As Table 4.28 indicates, the majority said that the language is Tumbuka whilst the minority view was that the best linguistic medium of hospital communication was Chewa. These results have significant implications on service providers' linguistic capabilities as well as the hospital's overall language policy. The results mean that for service providers to work efficiently at the MCH, competence in Tumbuka is essential. The MCH is linguistically unique among Malawi's four central hospitals. The MCH is the only one that has Tumbuka as the most widely used language of client-service provider interaction. The other three central hospitals in Blantyre, Lilongwe and Zomba have Chewa as the dominant language of hospital interactions.

Table 4.28: Best Language for Hospital Transactions

Language	Frequency	Percentage
Tumbuka	421	88.1
Chewa	56	11.7
Tonga	1	0.2

4.3.3.3. Language and Staff Posting

On the posting of health services personnel, clients were asked whether or not the posting of staff should be based on their ability to speak languages of a particular area/hospital. The overwhelming majority said NO as Table 4.29 indicates (see also service providers' responses to the same question in Table 4.40).

Table 4.29: Should Language Determine Staff Posting?

Language to determine staff posting?	Frequency	Percentage
YES	6	1.3
NO	467	97.7
Not Applicable	5	1.0

A follow-up question asked respondents to justify the answers that have been recorded in Table 4.29. Given that this open-ended question was answered by both clients and service providers, and that their responses were almost the same, I have combined and summarised the responses (see section 4.4.4).

4.3.3.4. Language Requirements for Foreign Personnel

There was also a question on the local language competencies for expatriate staff. As mentioned in the earlier chapters, Malawi relies heavily on expatriate doctors. Clients were, therefore, asked whether foreign medical practitioners should satisfy a local language competence requirement before they could be permitted to practise in Malawi (see Table 4.30). An overwhelming majority said NO. Some countries require foreign medical staff to demonstrate proficiency in the dominant local language before they can be licensed to practise. For instance, all core English-speaking countries require that foreign medical professionals must have competence in English. Even in some of the non-English-speaking countries, local language competence requirements exist for health service providers.

Table 4.30: Local Language Requirements for Foreign Personnel

Any Local Language Requirements?	Frequency	Percentage
NO	447	93.5
YES	26	5.4
No Response	5	1.0

As a follow-up question, clients were asked to justify the responses they had made in Table 4.30. First, I consider the justifications behind the minority 5.4 % of the respondents who were in favour of a policy that would require foreign medical staff to demonstrate proficiency in local languages before they are permitted to practise in Malawi. Their justifications can be summarised as follows. First, such a policy would ease communication problems between expatriate staff and their clients since there would be use of a common language. That means problems that come with the use of interpreters would not be eradicated. The uneducated, who rely on the English-speaking individuals to give them interpretation services, would be able to interact directly with the expatriate service providers, thereby increasing efficiency and client satisfaction. As it will be pointed out in the forthcoming chapters on barriers to communication (chapter 5) and language services (chapter 6), there are numerous gains to be made out of direct (non-interpreted) interaction between a health service provider and his or her client. From the arguments made by some respondents, an analogy was created between a health service provider and a missionary. The former heals the body whilst the latter heals the soul. In the task of healing the soul, the pioneer missionary gave a high priority to the acquisition of the local language(s):

> From the beginning, it had always been difficult for the missionary to remain totally aloof from those whom he was trying to convert. He had to learn the vernacular, not only well enough for ordinary communication, but also to a sufficient standard to translate the Bible (Forster 1989: 2).

By extension, one would expect a health service provider to have some understanding of the language of the people he or she is serving. For the missionary, both integrative and instrumental motivation led him or her to acquire languages of his or her area of duty. Even diplomats and foreign students/researchers have also used instrumental motivation to learn new languages in the hope that such additions to their speech repertoire would help them to carry out their work more efficiently.

The majority view (93.5 %) in Table 4.30 was that there was no need to demand local language competence among foreign medical staff as a condition for granting them the permit to practise. Six arguments in support of this view have been identified. The first argument was that giving such local language requirements would act as a restriction to those foreign professionals who wanted to work in Malawi but were not interested in language learning, or did not have the knack for learning new languages. If the foreign medical staff decided not to come to Malawi due to the language conditions, then it is Malawi that would suffer most given that it is in dire need of qualified and experienced staff. To make Malawi attractive to foreign medical staff, the current policy of demanding proficiency in English should be maintained. This policy does not ask for too much since English is the main international lingua franca. However, to ask a foreigner to learn a Malawian language as a condition for his or her being allowed to a practise in the country could be asking for too much. What the proponents of this view fail to recognise is that it is not unusual to have some jobs that demand certain local language competencies. These requirements are normally set when there

is evidence that without the stipulated language competence, an employee would be communicatively disadvantaged as he/she carried out his/her duties.

The second argument was that if there was a need for foreign staff to learn local languages, then they could learn them whilst on the job. What was not specifically mentioned, however, was how the language learning process was going to be accomplished, whether formal tutoring or natural acquisition models were to be followed. The third argument was that the language problem was a minor issue in Malawi's health sector. In other words, Malawi's linguistic communication situation is not so complex and problematic to warrant such an expatriate staff licensing policy. This argument is weak in the light of the finding that the majority of the clients do not use English at all. Fourth, it was argued that interpreters could always assist whenever an expatriate staff meets a non-English-speaking client. Other respondents even posed the question: "What are interpreters there for?" This question assumed that there are established positions for interpreters at the MCH, yet this is not the case. At the MCH, just like in hospitals in other African countries such as South Africa (Saohatse 1997, 1998, 2000; Drennan 1998; Crawford 1999), Cameroon (Robinson 1996) and Zambia (Chanda 2003) just to mention a few, interpretation is conducted on an ad hoc basis. The fifth argument is that language learning for the foreign medical staff would be time-consuming. The expatriate staff would 'waste' time in learning language whilst patients needed their services. This argument echoes what Welmers (1974: 193) had noted among missionaries who doubled as health service providers: "Medical personnel typically see such a pressing need for their immediate technical service that they find it impossible to take time off to learn a language." Finally, it was also felt that it would be costly to offer language courses to hospital staff.

4.3.3.5 Language and Health Education Literature

Access to health service includes access to health education literature. This literature comes in various forms such as booklets, leaflets and posters. At the MCH, such literature normally features topics such as disease symptoms and signs, methods of prevention and cure. A question was then put to clients as to whether they had access to health education literature. As indicated in Table 4.31, the majority 57.3 % said that they had access to such literature.

Table 4.31: Access to Health Education Literature

Access to Literature	Frequency	Percentage
YES	274	57.3
No	204	42.7

A follow-up question asked respondents to mention the language(s) in which the health education literature was written. Responses to the question revealed that health literature came in three languages, namely: English, Chewa and Tumbuka. The picture that emerges in Table 4.32 is that of a ranking order in which English, Chewa and Tumbuka take first, second and third positions respectively as the languages in which health education literature is written. That English occupies the top position is not surprising given that the bulk of health literature comes from international organisations such as the World Health Organisation and others. There have been attempts to present health education literature in the national language, Chewa, over the years. No other local language has since 1968 been a medium of health education literature. With the liberalisation of the language policy that started in 1994, there have been attempts to use other local languages as media of health education literature. However, the dominance of Chewa over the other local languages continues. The volume of

health education literature written in languages other than Chewa is very low, and Tumbuka is one good example. When I visited MACRO's office in Mzuzu, for example, I learnt that their literature handouts, which were in English and Chewa, had run out. But my informant was optimistic that the next batch of the literature handouts would include a third language - Tumbuka. This was obviously a realisation that the inclusion of Tumbuka literature would increase the accessibility of the literature to the targeted populations in the Northern Region.

Table 4.32: Language(s) of Health Education Literature

Language	Frequency	Percentage
Not Applicable	207	43.3
English	126	26.4
Chewa	102	21.3
Tumbuka	43	9.0

4.4. SERVICE PROVIDERS' RESPONSES

4.4.1. Service Providers' Demographic Characteristics

4.4.1.1. Professional Status of Service Providers

In all, 79 service providers responded to the questionnaire. In terms of their professional status, the majority of the service providers were nurses/midwives. The second largest group was that of patient/hospital attendants. As can be noted from Table 4.33, the nurses/midwives when combined with hospital/patient attendants amounted to 72.1 % of all the service providers who responded to the questionnaire.

Table 4.33: Professional Status of Service Provider

Professional Status	Frequency	Percentage
Nurse/Midwife	32	40.5
Attendant	25	31.6
Clinician	7	8.9
Doctor	4	5.1
Dentist	3	3.8
Technician	3	3.8
Anaesthetist	2	2.5
Radiographer	2	2.5
Pharmacy Assistant	1	1.3

4.4.1.2. Sex of Service Providers

The question on the sex of the service providers revealed that the majority were women. Women dominate when we combine the nurse/midwife and hospital/patient attendants' categories. These two occupations - dealing with care - lie in what is generally perceived to be a woman's domain in Malawi. For example, for a long time in Malawi, nursing has been an all-women occupation until quite recently when male nurses have started entering the profession. Despite the new shift, the prototypical Malawian nurse still remains a female one (see Table 4.34).

Table 4.34: Sex of Nurses and Patient/Hospital Attendants

Professional Status	Sex	Percentages
nurses/midwives	male= 2 female= 30 **TOTAL = 32**	male = 6.25 female = 93.75 **TOTAL = 100**
hospital/patient attendants	male = 14 female= 11 **TOTAL = 25**	male = 56 female = 44 **TOTAL = 100**

4.4.1.3. Nationalities of Service Providers

The question of nationality was also asked (see Table 4.35). Unlike in the case of the clients where I strongly suspect that some of them had lied about their nationalities, such was not the case with the service providers. The non-Malawian service providers had no reason to hide their nationalities given that all of them were working in Malawi legally.

Table 4.35: Service Providers' Nationalities

Nationality	Frequency	Percentage
Malawian	72	91.1
Chinese	4	5.1
Tanzanian	1	1.3
Egyptian	1	1.3
British	1	1.3

4.4.2. Linguistic Repertoires of Service Providers

Two questions were asked about the service providers' linguistic repertoires. The first question asked the service providers to mention their mother tongues. Given that Table 4.35 shows that the majority 91.1 % had declared Malawian nationality, it is only normal to expect the majority of the mother tongues to be languages that are spoken in Malawi. The majority 49.4 % declared Tumbuka as their mother tongue whilst 21.5 % claimed Chewa as their mother tongue (see Table 4.36).

Table 4.36: Mother Tongues of Service Providers

Mother Tongue	Frequency	Percentage
Tumbuka	39	49.4
Chewa	17	21.5
Tonga	7	8.9
Ngonde	4	5.1
Chinese	4	5.1
Swahili	1	1.3
English	1	1.3
Lomwe	1	1.3
Ndali	1	1.3
Lambya	1	1.3
Ngoni	1	1.3
Arabic	1	1.3
Sena	1	1.3

No Malawian claimed English to be his or her mother tongue, thereby confirming the claim that the acquisition of the English language in Malawi is made through the school system. There was one respondent who claimed that Lomwe is his or her mother tongue. Had the questionnaire had a provision for the inclusion of names of the respondents, I would have contacted the respondent to ask him or her some follow-up questions. One of my aims would have been to verify the respondent's claimed competence in Lomwe. The case of mother tongue Lomwe speakers is interesting since the language has been described as a dying language and that the Lomwe have undergone an acute language shift towards Chewa. Another interesting result is that of the single respondent who claimed that Ngoni was his or her mother tongue. This result is questionable since Ngoni is a dead language as has been mentioned in chapter 3. Just like with the case of Lomwe, it would have been more helpful if I had had the opportunity to verify the respondent's claimed L1 facility in Ngoni.

4.4.3. Language(s) of Service Providers' Interactions with Clients

Service providers were asked to mention the language(s) that they commonly used in their interactions with clients at the MCH. The question was split into four parts. The first part of the question asked the service providers to indicate, what in their view, was the first commonly used language. The majority 68.4 % of the respondents cited Tumbuka (see Table 4.37).

Table 4.37: Most Commonly Used Language of Client versus Service Provider Interaction

Language	Frequency	Percentage
Tumbuka	54	68.4
Chewa	17	21.5
English	8	10.1

That Tumbuka was cited as the mostly commonly used language in client-service provider interactions is also supported by evidence from other data sources. First, my observations of language use around the various sections of the hospital support the view that Tumbuka is the most widely used language of client-service provider interaction. Second, clients' responses to their own questionnaire also confirm the case of Tumbuka. The third source of support evidence comes from the interviews I conducted with some key informants.

Then service providers were also asked to mention what they considered to be the second most commonly used language of client-service provider interaction. The majority 64.6 % felt that that language was Chewa (see Table 4.38). Again, this result is consistent with the results obtained from the clients' questionnaire responses and observations of language use around the hospital.

Table 4.38: Second Most Commonly Used Language of Client versus Service Provider Interactions

Language	Frequency	Percentage
Chewa	51	64.6
Tumbuka	18	22.8
Don't Know	4	5.1
English	3	3.8
Tonga	3	3.8

The third part of the question asked respondents to mention what they would rank as the third commonly used linguistic medium of hospital interactions. The majority of the service providers mentioned English as Table 4.39 shows.

Table 4.39: Third Most Commonly Used Language of Client versus Service Provider Interactions

Language	Frequency	Percentage
English	43	54.4
Tonga	18	22.8
Don't Know	10	12.7
Chewa	4	5.1
Tumbuka	3	3.8
Lambya	1	1.3

As for the expatriate service providers, the use of English in interaction with clients is quite obvious given that all the expatriate members of staff, with the exception of one, are not competent in the local languages. They, therefore, communicate through English. They either communicate in English directly with their English-speaking clients or use interpreters in the case of the non-English-speaking clients.

The final part of the question asked service providers to mention what they considered to be the other widely used languages. The majority 48.1 % said that they did not know (see Table 4.40).

Table 4.40: Other Languages Commonly Used in Client versus Service Provider Interactions

Language	Frequency	Percentage
Don't Know	38	48.1
English	13	16.5
Tonga	13	16.5
Ngonde	8	10.1
Lambya	3	3.8
Swahili	2	2.5
Yao	1	1.3
Bemba	1	1.3

4.4.4. Language and Staff Posting

Like the clients, the service providers were asked whether or not staff should be posted only to areas or hospitals whose languages they speak. The question was asked with the aim of finding out whether the posting of health service providers should take into consideration the facilitation of communication between clients and their service providers. In response to this question, the majority gave a NO answer (see Table 4.41).

Table 4.41: Language and Staff Posting

Language to Determine Staff Posting?	Frequency	Percentage
YES	12	15.2
NO	62	78.5
No Response	5	6.3

A follow up question asked the respondents to give reasons for their responses cited in Table 4.41. I consider here two categories of responses, that is those who said YES and those who said NO. The minority view had said that the posting of health service providers should take into consideration an individual's competence in the language(s) of the new duty station. Such a policy would ensure that there is efficient communication between service providers and their clients since linguistic barriers to communication would have been greatly reduced due to the use of a common language. The service provider would be able to discharge his or her duties more efficiently than is the case when he or she has to use interpreters. As service provider 11 put it in a questionnaire response, "communication problems become erased and enhances patient/doctor relationship."

One of the service providers who came from the Southern Region, Mr Chigamba, was so frustrated with the language situation at the MCH that at the time I had an interview with him, he was on the verge of seeking a transfer. Mr Chigamba, an English/Chewa bilingual, did not speak Tumbuka. Unlike other service providers from the Southern and Central Regions who had made personal efforts to learn Tumbuka, Mr Chigamba, due to his negative attitude towards the new community, had not mastered the language (see also case 2 in section 5.2.3 in chapter 5). He believed that the Northern Region people were hostile to people from the other two regions. He cited what he called the derogatory term *Achewa* that is used by some Northerners to refer to those people who speak Chewa and not Tumbuka:

> *Kunoko ukati usayankhule* language *yawo* automatically you hear *kodi awa ndi Achewa* because everyone who doesn't speak Tumbuka they just call *Mchewa* (Here when you don't speak their language, you automatically hear them say: Is this one a Chewa?) The word is completely derogatory. How do you work effectively in a society where people do not...

Mr Chigamba was very firm in his support for a staff posting policy that takes into consideration the language factor:

> When they are doing postings, more especially in the health department, they should consider where they are posting a person. Is that place going to be convenient to him in terms of language? Because language as a means of communication is a very important tool which is supposed to be considered. Yes, the person has been trained but is he going to deliver in terms of language? Where you have got language problems, I don't think you can deliver.... Or you might deliver but the people may not be satisfied.

The majority view in Table 4.41, however, was that posting should not be regulated by linguistic considerations. The current policy whereby civil servants and other personnel are posted to any part of the country, without considering their ability to speak the dominant languages of those areas, should continue. The MCH service providers advanced the following arguments in favour of the maintenance of the current staff posting policy. First, it was noted that posting staff on the basis of their linguistic competencies would be going against the current policy, which has been in use for many years, and has worked well. Secondly, there was fear among some respondents that posting staff in accordance with their competently spoken languages would in some cases mean that civil servants work in their home district or region. This could promote regionalism and ethnic loyalties at the expense of national cohesion. The idea of working among "my own people" with whom one shares a language and/or ethnicity was not seen to be politically healthy. As service provider 16 (a nurse/midwife) put it: "As a service provider, one has to care for anyone regardless of colour,

creed or language or race." This is a pointer to the importance of non-discriminatory practices in healthcare delivery.

The third ground for the rejection of the proposed posting policy was that it could not be practically implemented. There was no guarantee that each linguistic zone would have enough qualified personnel. The policy would mean some areas would have more personnel than others. This is exactly what happened in 1989 when the Banda regime ordered that teachers must teach in their own home regions. The Northern Region, for example, was flooded with teachers whereas the other two regions were understaffed. The fourth argument was that such posting would mean that civil servants would be tied to one region for their entire length of duty, thus limiting their freedom of movement. It was felt that the current flexible posting of staff enabled civil servants to experience life in different parts of the country. In the process, the civil servants also learnt new languages. Others said they would not like to work permanently in their home districts for fear of being disturbed by relatives from the extended family who seek various forms of assistance. The fifth argument was that the linguistic situation in Malawi was not so complex as to warrant such a posting policy.

The sixth argument was that the existence of lingua francas such as Chewa, Tumbuka and even English, dismantled some of the linguistic barriers to communication. Service provider 8, (a clinician) for example, observed that: "As a country/nation, we have a national language which is widely known and as part of the world, we are blessed with an international language like English." Another argument was that being posted to different area enables a service provider to undergo different clinical experiences. Such enrichment of professional experience cannot be adequately achieved if a service provider is confined to one duty station. For example, the state-of- the-art medical equipment that is available at the MCH is not available at other hospitals. By being posted to the MCH, one therefore has a chance to experience using such equipment. The overall majority view was that Malawi already has an acute shortage of health service providers, and adjusting the posting of staff on linguistic grounds would only worsen the situation.

4.5. THE HOSPITAL'S LINGUISTIC LANDSCAPE

There are several ways of drawing up a comprehensive picture of an institution's linguistic landscape. By linguistic landscape, I am referring to issues such as: What languages are in use at the institution? Who uses which languages, and in what situations? One way of documenting the linguistic landscape of the MCH was to observe language use. To this end, I observed language use in both oral and written modes of communication.

4.5.1. Language(s) of Hospital Administration and Client Services

Upon arriving at the MCH, one sees that the major signs are in English. Even the signpost of the hospital is in English. If you telephone the MCH, the switchboard operator answers in English. If you look at files or forms, you find that they are all in English. This would give the impression that all the administrative work of the MCH is conducted in English. Yet the reality is that oral aspects of administrative work are done in a variety of languages, depending on the interlocutors' linguistic capabilities and/or preferences. It is only the paper work that is done in English. I give here two examples of official encounters - where normally one would have expected English to be used. I had selected the hospital administrator as one of my key informants. My knock on his door was greeted with the standard response (in English): "Come in!" When I got in he non-verbally invited me to take a seat. I immediately introduced my agenda in English, and he responded in English. But as the interaction went on, he recognised me as one of the lecturers he had seen during his student days at the University

of Malawi. At this point, the interaction began to switch between Chewa and English. I conducted my interview in this bilingual mode whilst making my notes in English exclusively.

My second case of an administrative encounter was when I met the acting director of the hospital, a medical doctor. I followed the formalities by meeting his secretary first, who informed her boss about the purpose of my visit. When I walked into the office, the acting director welcomed me in Tumbuka: *"Njilani"* (Come in, please). He then proceeded with *muli uli?* (How are you?) to which I responded in Tumbuka. But I changed the medium of communication immediately into English since I felt my competence in Tumbuka could not have allowed me to address my agenda adequately.

Given that English is the official language of Malawi, the same policy applies to the MCH. First, English is the official language of the hospital's correspondence. This includes both internal and external correspondence. My own observation of official memoranda from the hospital administration to staff members is that they were all in English. Whilst some official oral communication can take place in a local language, the recording in the written form is done in English. Secondly, all the records of the hospital are maintained in English. The list includes patients' records. Thirdly, whilst medical examinations can be conducted through a local language, the recording of the history, the diagnosis and the prescription were done in English.

4.5.2. Language(s) of Signs, Notices and Health Education Literature

4.5.2.1. Language(s) of Signs and Notices

The language(s) used in written signs at any institution can be used as some indication of the language policy in use in that context. I am talking of some indication because the signs may not give the complete linguistic picture. Whilst the language(s) used in signs on buildings and roads and public notices may not tell the full story about language use in a particular locality, they nevertheless give hints or indicators which a researcher can follow up more closely. When I first arrived at the MCH, my first task was to walk around the hospital in order to note what language(s) is (are) used in signposts, notices and hospital documents. My other task during the walk around the hospital was to note the languages that were used in conversations. I carried out the observations before I had started to use other techniques of data collection such as questionnaire surveys and interviews. In using this approach, I was following previous sociolinguistic studies (e.g. Spolsky et al 2000; Kamwangamalu 2000) in which the identification of the language used in public signs and notices contributed to the understanding of the language policy and language use of a particular situation.

I identified and examined a variety of written signs and established the frequently used languages. The written signs include those identifying offices or departments by name. Signs that were written in English identified all departments and/or sections and offices. To begin with, a big signpost that welcomes the visitor to the hospital is in English. Examples of signs written in English include the identification of the administration offices, admissions, examination, matron, nurse station, dental clinic and many others. It is important to mention that not only was English used in the signs under discussion but medical register was also used. For example, the section labelled radiology is simply the x-ray department, if we use ordinary language. Another example is the use of terms such as dermatology for skin, ophthalmic for eye department and the abbreviation OPD to stand for Out-Patient Department, among many others.

The use of the medical register is an indication of the existence of a Community of Practice (Lave & Wenger 1991; Wenger 1998) or a Professional Discourse Community (see

Swales 1990). The use of occupation-specific abbreviations such as OPD is one of the characteristics of a Community of Practice. For non-members of the Community of Practice, such as patients, the medical register is difficult to understand. But according to my findings at the MCH, the use of the medical register around the hospital premises did not in any way hamper patients' access to hospital services. The fact that a department, for example, is called radiology and not called x-ray (to use a commonly employed term) did not pose as a communication problem to patients. Furthermore, none of the patients complained about the use of medical register in patients' records being unfathomable. Since Malawi generally has an oral culture, most of the directions at the hospital tend to be given out by word of mouth. Patient/hospital attendants and other personnel guide patients to appropriate service points. This means that the inability to understand what the medical terms on office doors mean is not a handicap to one's ability to receive clinical services at the MCH. Like in the other domains of life in Malawi where English is used, there are always some people who act as literacy brokers (see also the notion of networks of linguistic support in section 5.2.2 in the next chapter).

Whilst the professional departments and/or sections are labelled exclusively in English, notices about non-professional matters come in English with translations into one or more local languages. Such notices include directions to public toilets, general information for patients, and some cautions. For example, the notice one sees the label main entrance accompanied by a Tumbuka version, *pakunjilira.* Given that the MCH is located in a predominantly Tumbuka-speaking area, the use of the language in some of the notices is self-explanatory. The out patient section is labelled *kwakuwonela balwali*, whilst toilets are labelled *chimbudzi.* There are also cases of multilingual notices. Two outstanding ones were *DOOR CLOSED,* which came in three languages as *palibe njira* (Chewa), *palije nthowa* (Tumbuka) and *pangali njira* (Yao). Another warning: "Sitting or staying on the grass is strictly prohibited," came in both Tumbuka and Chewa versions. It is significant to note that whilst signs and notices on strictly professional matters came in English only, those concerning the non-professional matters came in English, with translations into local languages. There is no doubt that language hierarchies (Blommaert 1999b) are at work here as English, a higher level language, is used for covering professional matters whilst Tumbuka and Chewa, the lower hierarchy languages, are for covering the non-professional matters.

4.5.2.2. Language(s) of Health Education Literature

The Ministry of Health and other organisations such as health NGOs run health education programmes. The health education programmes cover a variety of topics. As of now, the most topical issues are the HIV/AIDS pandemic, reproductive health and family planning. These and other health-related topics are addressed through various channels of communication. These communication channels include face-to-face talks between a health educator and members of the public, radio programmes, use of dramatists (cf. Kerr 1985) and musicians, and the use of the print media. It is, therefore, a common practice to find hospitals and other health service points display health educational posters. The situation at the MCH is not an exception. Given that posters are a communication medium, I took an interest to examine the following issues. First, I wanted to identify the topics or themes that the posters addressed. My second interest was to identify the language(s) in which each poster came. In all, I sampled twenty-one different posters. I have arranged the posters according to the following themes: safe motherhood/family planning/reproductive health, HIV/AIDS, TB and OTHER. The majority of the posters covered some aspect of the HIV/AIDS (see Table 4.42).

Table 4.42: Themes of Health Education Posters

Theme of Poster	Frequency	Percentage
HIV/AIDS	6	28.57
Motherhood/Family Planning	5	23.81
TB	3	14.28
Other	7	33.33

Turning to the language(s) in which the posters had been written, I noted that in all, four languages had been used. These languages were English and three local languages, Chewa, Tumbuka, Yao. Out of the twenty-one posters, the majority were written in Chewa only (see Table 4.43).

Table 4.43: Languages of Health Education Posters

Language(s)	Frequency	Percentage
Chewa	14	66.66
English	5	23.81
Chewa & English	1	4.76
Chewa, Yao, Tumbuka & English	1	4.76

From the above presentation, it can be noted that at the time of the fieldwork, Chewa was the dominant language in health education posters that were found at the MCH. The second mostly commonly used language was English. It is important to notice the gap between the two languages. Chewa posters amounted to 66.66 % whilst English posters amounted to 23.81 % of all the posters. That the majority of the posters come through Chewa can be explained by the fact that since 1968, Chewa has been the national language of Malawi. Since that time, the government and NGOs have been using Chewa to communicate with the population at large. The assumption has been that since Chewa is the national lingua franca of Malawi, then communicating health education through the language would pose no problem throughout the country. But Uta's (1993) study revealed that since most of the printed health education materials were in English, they posed as a communication barrier to large sections of the Malawian population.

4.6. SUMMARY AND CONCLUSIONS.

In this chapter, it has been noted that the MCH is a zone of convergence for a number of languages. A consistent result emerging from a wide range of data used in the chapter is that Tumbuka is the most widely used language at the MCH, followed by Chewa. This result has implications on service providers. It means that for service providers to work without serious language barriers, knowledge of Tumbuka first, and then followed by Chewa, is essential.

NOTES

[1] In most cases, these papers arrive in Mzuzu a day or two late. The exceptions are the days when Mzuzu receives flights from Lilongwe.

[2] I am, however, aware of some musicians, especially those working on gospel music, who have produced Tumbuka albums. The Katawa Singers of Mzuzu and the gospel singer, Wambali Mkandawire, are some notable examples.

[3] At the time of my fieldwork (2002), at least ten private radios were operating in Malawi. The majority of the radios were stationed in Blantyre, the commercial hub of Malawi. Secondly, the majority of the radios focused on spiritual matters: Radio Maria (stationed in Mangochi and run by the Mangochi Diocese of the Catholic Church), Radio Islam (based in Blantyre), Radio Calvary (based in Blantyre), TransWorld Radio (based in Blantyre), and the African Bible College Radio (with studios in Mzuzu and Lilongwe). Dzimwe Community Radio is based in the Nankumba Peninsula in Mangochi. MIJ Radio, Capital FM and Power 101 are based in Blantyre and they focus on news and entertainment. Private radio stations are free to choose their language(s) of broadcast.

[4] I am most grateful to Mr Jameson Ndawala, Head of the Demographic and Social Statistics at the National Statistical Office, Zomba, Malawi for retrieving the data for Table 4.1 for me.

[5] It should be mentioned here that the inability on the part of Dr Banda (the first president of Malawi) to speak Chewa, his mother tongue, strengthened the speculation that he was not a Malawian. The speculation was further strengthened by Banda's refusal to eat *nsima,* the main staple food for Malawians (see Englund 1996: 112-3). The UDF presidential candidate in the May 2004 elections (who is now the President of Malawi), Bingu wa Mutharika, also had his Malawian nationality questioned owing to the many years he had spent outside Malawi. But some analysts came to Mutharika's rescue. They argued that his "Ngulu accent" of Chewa (i.e. a Lomwe accent of the national language) is a very firm indication that he is a Malawian.

[6] For example, on the Malawi/Zambia border area, Malawians and Zambians share social facilities such as schools and hospitals. To cite one specific case, "in Mzigawa area, Zambians of Chikoka and the surrounding villages at the far east of Chadiza district, find it easier to get medical attention from Mchinji Hospital in Malawi some three kilometres away," see Nebert Mulenga, "Fear Grips Zambia-Malawi Border Settlers," *The Times of Zambia,* 19th March, 2004.

[7] Eades et al (2003) have questioned the Australian government's so-called language analysis that is used to determine the nationalities of refugee claimants.

[8] There are a number of factors that make it difficult for the majority to reach the upper levels of education in Malawi. One of the factors is a high school drop-out which is caused by early marriages/pregnancies, a lack of interest in school, and frequent repetitions. Economic hardships also make it difficult, if not impossible in some cases, for some individuals to proceed beyond basic education. Some people are also unable to attain higher education simply because there are few institutions that offer such level of education.

[9] Technically, Mzuzu city is located within Mzimba district. In order to avoid masking the individual picture of Mzuzu city, I have presented the data for Mzuzu and Mzimba separately.

[10] Some scholars draw a sharp distinction between language acquisition as being natural and untutored whilst learning is a formal and tutored activity. Other scholars (e.g. Ellis 1986) use the two terms interchangeably, arguing that there is so much overlap between the two linguistic processes that it is only reasonable to regard language acquisition and language learning as equivalents. This is the view that I have adopted in this thesis.

[11] Motivation to learn a second language can be either instrumental or integrative. Instrumental motivation refers to the desire to learn a language for purposes of attaining wider communication, broader interaction and access to new knowledge/information. On the other hand, integrative motivation is the drive to learn a new language in the hope of integrating into the society in which the language is predominantly spoken (Schumann 1978; Ellis 1986).

[12] See Schumann's (1978) acculturation model which says that acculturation is a major causal variable in second language learning.

CHAPTER 5

COMMUNICATION BARRIERS AT THE MZUZU CENTRAL HOSPITAL

> *To be good at anything, one must be able to speak well, correctly, with authority, to speak convincingly. As a physician, I knew that I must be able to evaluate a patient's symptoms, diagnose properly, treat properly, and then be able to communicate well with authority, so that they, the patients, would follow my instructions precisely.*
>
> Dr Hastings Kamuzu Banda, the first president of Malawi

5.1. INTRODUCTION

The above quote from the late Dr Banda, a medical doctor who later turned into a politician (see Short 1974), is a pointer to the importance of barrier-free communication in the health services domain. This chapter focuses on various aspects of communication barriers - things that prevent service providers and/or clients from being "able to communicate well," to borrow from Dr Banda's quote above. I define a communication barrier as anything that can bring about a complete or partial blockage of communication. A communication barrier can be linguistic or non-linguistic, or a combination of the two. For example, face-related communication barriers (see section 5.6) are a combination of linguistic and non-linguistic issues. In this chapter, I address three themes that are linked to language and communication barriers that exist at the Mzuzu Central Hospital. First, I identify these barriers. Secondly, I discuss the impact of the communication barriers on the delivery of health services at the hospital. Thirdly, I relate the language and communication barriers at the MCH to the overall language policy/planning situation in Malawi.

In this chapter, I discuss the communication barriers at the MCH under five broad themes as follows: multilingualism (section 5.2), minority languages (section 5.3), the use of English (section 5.4), illiteracy (section 5.5) and facework (section 5.6). In section 5.7, I compare and contrast the MCH with some South African hospitals (e.g. Saohatse 1997; Drennan 1998; Crawford 1999) in terms of communication barriers. I summarise and conclude the chapter with section 5.8.

5.2. MULTILINGUALISM AT THE MCH: A PROBLEM AND A RESOURCE

5.2.1. The Use of Lingua Francas

It can be tempting to see the existence of several languages at the MCH as a problem. This boils down to treating the multiplicity of languages as a barrier to effective communication. In fact, Saohatse (1997, 1998, 2000) in her sociolinguistic study at the Baragwanath hospital in South Africa attributed many of the hospital's communication problems to the multiplicity of languages in use. But according to the evidence gathered at the MCH, multilingualism is not only a problem but also a resource. Particularly useful in the context of multilingualism as a resource is the existence of lingua francas. These lingua francas can help to narrow the language gap. As was pointed out in chapter 4, Tumbuka and Chewa, as endoglossic languages, and English as an exoglossic language, are the main lingua francas, to varying degrees, at the MCH. This point is summed up correctly by service provider 27 (a nurse):

> Being a central hospital, it serves patients of different languages, and also some of the staff are from abroad, hence for one to work comfortably, has to understand and speak English as the official language and Tumbuka and Chichewa as common languages in Malawi.

The situation at the MCH is, however, different from Saohatse's (1997, 1998, 2000) study site, the Baragwanath hospital in South Africa. The absence of a common language or lingua franca that the majority could use for communication contributed significantly to the communication problems at the Baragwanath hospital. One has to refer to the different histories of South Africa and Malawi to appreciate the absence of a countrywide lingua franca and the presence of a countrywide lingua franca in the two countries respectively. Unlike South Africa, Malawi has since the missionary/colonial days had one major lingua franca (Chewa/Nyanja). The position of the lingua franca was, as it has been mentioned in chapter 3, further strengthened during the Banda era in the post-colonial phase of Malawi's political history. This lingua franca has permeated into what were initially non-Chewa-speaking areas. In some cases, the result has been language shift in favour of Chewa. Given this scenario, it is not surprising that Chewa is the second mostly widely used language at the MCH as chapter 4 has indicated.

The situation in South Africa, on the other hand, is historically different. The context of South Africa's lack of a national lingua franca is the then apartheid policy. Due to its previous apartheid system, South Africa did not adopt a national lingua franca, but thrived in the promotion of separate and antagonistic ethnolinguistic identities among the black population. Each ethnic group was encouraged to promote its own language. The learning of other ethnic groups' languages was discouraged, and so was free movement. The separate development scheme was part of the divide-and-rule colonial strategy. Hostilities between the various ethnic groups led to the cultivation of negative attitudes to other languages and their speakers. After the demise of the apartheid political system in 1994, the new South Africa, unlike Malawi, found itself without a language that is spoken widely across the whole country either as a mother tongue or a non-native tongue. No language in South Africa is spoken by at least half of the entire population. However, like in Malawi, the majority of the South African population lacks competence in the main official language, English.[1]

The importance of English as a link between local and expatriate service providers on one hand, and also between expatriate service providers and the minority English-using clients on the other hand, becomes more pronounced when we consider the fact that all the expatriate service providers, with the exception of one (see case study 3 in section 5.2.3), have no local language competence. In chapter 4, it was noted that 55.2 % of the clients claimed not to use English at all in their daily undertakings. Since all the expatriate doctors have no local language competence, it means that the majority of the clients have no direct (i.e. non-interpreted) interactions with the expatriate doctors. It also happened that the expatriate doctors were in the majority at the MCH. English as a communication barrier between the majority of the clients and the expatriate service providers also mirrors the socio-economic gap existing between the two groups. Doctors, by virtue of their profession and expertise, occupy a superior position in relation to their clients. This inequality is further increased when it is only the doctor who has access to what Blommaert (2001) would call a "power language" - which is English in this case. The expatriate doctor, as a professional, employs "the voice of medicine" (Mishler 1984) through the use of a higher hierarchy language - English, whilst the patient speaks through a lower hierarchy language - a local language (see Blommaert 1999b on language hierarchies). As it will be mentioned in

chapter 6, the voice of the non-English-speaking patient can get lost or distorted through the process of interpretation.

Since the majority of the clients speak Tumbuka and find it to be their best medium of hospital-based transactions, the inability to speak Tumbuka on the part of a service provider can be a serious linguistic barrier. Whilst Chewa is the national language, it should not be assumed that its capacity to break language barriers is uniform across the country. This is especially evident when non-Tumbuka-speaking service providers meet clients who come from the remote rural areas where Chewa is not widely used. For those who have never been to school, or those who have never lived in a Chewa-speaking environment, the use of the national language can be a formidable language barrier. As the Chewa/English bilingual service provider, Mr Chimalizeni, noted upon being posted to the MCH, knowledge of Chewa was necessary but not enough. Mr Chimalizeni had started working at the MCH in November 2001. This was his first posting to a Tumbuka-speaking area. His previous postings had been to Blantyre, Chiradzulu and Kasungu - all being Chewa-speaking districts. At the time of the interview, Mr Chimalizeni had worked at the MCH for about one and a half years. Whilst he had made an effort to learn Tumbuka, his competence in the language was still low:

> The problem here is Tumbuka, I have not yet.... I am just learning to speak Tumbuka. I am getting difficulties because other people are coming from typically the villages. They don't know Chichewa and English, and I am learning (Chitumbuka) from them.

From Mr Chimalizeni's statements, one can deduce the strong potential of education and urban residency in giving an individual the capacity to overcome some linguistic barriers. I first consider the potential of education. Although Chewa is not a common mother tongue in the Northern Region, residents of the Region are able to acquire the language through education as well as travel to, and/or settlement in the Chewa-speaking areas. The current education policy makes Chewa a compulsory subject from the primary school up to the secondary school level. This policy makes everyone, irrespective of whether or not they come from a Chewa-speaking background, learn the language. This is how some Northerners have learnt Chewa. This policy is part of the linguistic assimilation (Cobarrubias 1983) that was put in place by the Banda administration in 1968. Whilst this education policy has led to the acquisition of Chewa by some Northerners, there has been no provision for non-Northerners to acquire Tumbuka, on the other hand. This is the case because the current language-in-education policy makes Tumbuka neither a subject of study nor a medium of instruction. Making Tumbuka one of the subjects of study at both primary and secondary levels can increase the spread of the language. More Malawians would access the Northern Region's lingua franca. In this way, the language-in-education policy could help to break down the language barrier which the non-Northerner health service providers and others face when they work at the MCH or other health institutions that are located in the Tumbuka-speaking areas.

I now consider the urban residency and its potential to increase the capacity of an individual to overcome the multilingualism-induced communication barriers. The observation by Mr Chimalizeni that some clients coming from remote villages could not speak or use Chewa as a lingua franca at the hospital confirms the view that the village is a place where there is minimal language contact, or the place where languages are "pure." This "purity" is a result of the non-use of other languages. So in the case of Mr Chimalizeni's village-based clients, their daily activities are conducted almost entirely in Tumbuka. On the other hand, residents of urban areas such as the Mzuzu city have more interactions with people who do not speak Tumbuka. This increases the chances of the Tumbuka native speakers of learning other languages and/or increasing their fluency in lingua francas such as Chewa.

Competence in the two main local lingua francas of the MCH - Tumbuka and Chewa - is a valuable asset on the part of service providers. It gives them the opportunity to switch between Tumbuka and Chewa from one interview to another, or within the same interview, depending on the client's preferences or linguistic abilities, thereby reducing communication barriers. This linguistic flexibility was noted among the service providers as illustrated by the case discussed below. A patient with a leg injury had walked into a clinical interview room. When the clinician greeted him in Tumbuka, he responded without any language problems. But it was when the clinician started the history-taking that the patient realised that his level of competence in Tumbuka could not allow him to express his problem fluently. He therefore signalled his inability to continue with Tumbuka. A switch into Chewa was then made to break the language barrier:

Clinician: *Chikusugza ni vichi?* (What is the problem?)

Patient: *lundi* (leg). (patient explains but it is inaudible).

Clinician: *Lundi ili likuchita uli?* (This leg, what is it doing?)

Patient: Switches to Chewa (very inaudible).

The clinician then realises that the patient cannot sustain a Tumbuka interaction:

Clinician: *Oh! Ndimwe a Chewa.*[2] (Oh! You are a Chewa). Then switches into Chewa: *Ndiyankhule zoti tidzimvana. Eeee, tafotokozani, mwati munatani?* (Let me now speak in a manner that we should understand each other. Can you explain, what happened?)

Patient: *Ndinavulala apa....* (I got injured here).

Whilst the patient can be said to know both Chewa and Tumbuka, his competence in the two respective languages was undoubtedly unequal (cf. Romaine 1989). It would appear that Chewa was his better medium for the clinical interview. The language barrier created by the patient's inability to proceed with the clinical interview in Tumbuka was rescued by the fact the service provider also spoke Chewa. Had the service provider not been able to speak Chewa, the clinical interview would have been communicatively problematic.

5.2.2. Networks of Linguistic Support

Linguistic competencies amongst various hospital interactants were varied. No one could claim to know all the languages that were spoken at the MCH. But when various individuals' linguistic competencies were pooled together and utilised for the benefit of those who lacked certain language competencies, multilingualism ceased to be a problem. Instead, multilingualism became a resource usable in the networks of linguistic support. Within the MCH, there were networks of linguistic support which both clients and service providers utilised whenever they faced communication barriers. Since there were no institutionally provided interpreters at the MCH, interpretation was conducted on an ad hoc basis. This then means that staff, patients, guardians and others could be asked to assist with interpretation whenever necessary.

The networks of linguistic support operated in various ways: first, amongst service providers; second, among clients; and third, between service providers and clients. My first two illustrations belong to the service provider versus service provider network of support. First, I cite the case of service provider 72 who was a clinician. He had competence in four languages, namely Chewa (his mother tongue), English, Tumbuka and Yao. At one point, he used his competence in Yao to assist a non-Yao-speaking clinician who was attending to a

Yao-speaking patient: "My colleague had a Yao patient,[3] so he is a Tumbuka and he called me to assist him."

The second example of service provider versus service provider network of linguistic support is taken from service provider 15, a nurse. She recalled a situation during which she sought interpretation from a colleague. She also recalled another situation when it was her turn to assist a colleague with interpretation: "Somebody from Chitipa who spoke Chilambya, I didn't communicate, so I asked a clinician to interpret, and somebody who spoke Chitonga, I was there to interpret to the doctor." Service provider 48 (a patient attendant) notes that "there is no problem on language because in this hospital, there is so many people who speak different language. So I can talk to someone to interpret."

My third example of linguistic support involves two clients and a service provider. During ward rounds, a clinician met a monolingual Swahili speaker. A communication barrier set in immediately since the clinician did not know Swahili. But the linguistic barrier was overcome through the linguistic support that was rendered by another patient: "A patient on the other bed was my interpreter and I was assisted in that way," recalled service provider 73, a clinician.

The presence of multilingual health service providers is an asset as service provider 25 (a nurse) put it: "The fact that staff that's working at this hospital is fluent in many languages that the patients who come here speak, communication is not bad. Patients are helped and their concerns addressed." The same view was expressed in a slightly different way by service provider 31 (a nurse) who observed that: "At our hospital, since we're many and from different areas of the country and it is a big hospital, if there is barrier on communication, we just ask anyone who knows that language to interpret" (cf. Davidson's 2001 'grab-the-janitor' school of interpretation). The fact that the workforce represents almost all the Malawian languages reduced the communication problems. More importantly, there was, among both staff and clientele of the MCH, the willingness to assist each other with language services. There was always hope that someone within the hospital could be called upon to assist with interpretation. But this arrangement had its own problems. First, it was not easy to know who among the staff or clients had competence in what language. It was not easy to locate ad hoc interpreters for all the languages. Second, those members of staff who were asked to interpret had to abandon whatever they were doing so that they could offer interpretation. Thus, certain professional activities suffered whilst the responsible members of staff were serving as interpreters elsewhere. Third, the process of looking for interpreters was sometimes time-consuming, leading to a delayed treatment of a patient.

I did not obtain evidence of open hostility or reluctance towards offering interpretation services. This was in contrast to South Africa where nurses and other service providers consider interpretation as an extra burden for which they are not financially rewarded. The result is that they either refuse to offer the service, or they offer it grudgingly, leading to a sub-standard type of interpretation. Crawford (1999) and Saohatse (1997) have documented this reluctance towards offering interpretation among South African nurses and other health service providers. Crawford (1999:30) observes that:

> On busy days, chaos rules. There is an atmosphere of continual crisis management, which raises the stress levels considerably between doctors and nurses. Doctors become agitated because they need someone to interpret quickly, and nurses may be unable to drop their own work and respond immediately. Since they are not rewarded for this largely unnamed though highly skilled work, there is much friction and resentment.

At the MCH, on the other hand, there were no chaotic scenes involving those in need of interpretation and those who were expected to offer the interpretation (see also section 5.7). It is also significant to mention that a lack of extra remuneration for service providers who also act as interpreters is not a practice confined to South Africa alone.[4]

The situation whereby multilingual service providers at the MCH assist each other with interpretation to reduce the linguistic barriers to communication supports Langtag Report's (1996) view that in a multilingual society, knowledge of more than one language is an asset.[5] Bischoff et al (2003: 504) observe that linguistically adequate health care can be achieved when health professionals are "proficient in several languages, and are used as a bilingual resource when dealing with patients from other cultural and linguistic backgrounds." One of such unusual polyglots was Mrs Kameme of the MCH. She was a patient attendant who came from Chitipa district. She spoke eight languages, namely Ndali/Sukwa (her mother tongue), Ngonde, Tumbuka, Chewa, Nyiha, Yao, English and Swahili. Half of her linguistic repertoire comprised what may be called Northern Region languages, namely Ndali/Sukwa, Ngonde, Nyiha and Tumbuka. With varying levels of competencies in eight languages, Mrs Kameme had a rare communicative versatility. By being able to speak four of the languages of the Northern Region's so-called Babel, Mrs Kameme was able to reach out to a linguistically diverse clientele.

A possible way through which service providers at the MCH and elsewhere could extend their linguistic repertoires was the existing staff posting policy. For example, Mrs Kameme, through a posting to Salima, learnt Yao. Some years later, she was able to use her competence in Yao to overcome language barriers at the MCH. As one informant put it, the existing staff posting policy was advantageous in the sense that an individual could learn new languages whose competence may be useful in both the short and long terms. For example, Mrs Kameme was able to communicate well with Yao-speaking patients in a Tumbuka-dominated environment. The same can also be said about service providers who have acquired Tumbuka whilst working at the MCH. Their competence in Tumbuka will always be handy even in non-Tumbuka-speaking areas. From this perspective, the current staff posting policy can be seen to work towards reducing language barriers at national level since staff have opportunities to expand their linguistic repertoires.

But the potential of the current posting policy to encourage individuals to acquire new languages (i.e. languages of the new duty stations) has to be treated with caution. Whilst some individuals, such as Mrs Kameme, take the initiative to learn the language(s) of their new duty stations, others do not. The motivation to learn a new language in whatever environment follows individual differences (see case studies in section 5.2.3. below). Even amongst missionaries, who are generally perceived to be mostly in favour of acquiring local languages, cases of the lack of interest in acquiring those languages are not unusual (see Welmers 1974).

5.2.3. Breaking Local Language Barriers: Perspectives from Service Providers.

The networks of linguistic support that I discussed in section 5.2.2. cannot be relied upon permanently. A preferable situation would be where a service provider is able to achieve linguistic independence - that is, to be able to communicate with some of the clients directly through their own language(s). With reference to the MCH, knowledge of Tumbuka on the part of the service provider is a right step towards seeking language concordant clinical situations.[6] Whilst knowledge of Tumbuka on the part of a service provider will not eliminate all the linguistic barriers, it is at least a significant linguistic capacity since Tumbuka is the most widely used language at the hospital. Theoretically, one would have expected all the non-Tumbuka-speaking service providers, both local and expatriates, to take practical steps to

learn Tumbuka. But not all service providers have taken the practical steps towards learning the majority language of their clientele despite being aware of the benefits of language concordance clinical interactions. The key point that emerges from the MCH is that it is not automatic that a service provider learns the dominant language of his or her new duty station. There is an interplay of factors that motivate an individual to decide whether or not to acquire Tumbuka. Individual differences play a critical role here. I have four case studies to support this argument - the first two cases involve Malawians who came from non-Tumbuka-speaking backgrounds, and the other two cases focus on expatriate service providers.

I use cases 1 and 2 as a contrastive pair. In case 1, Mr Katola was positively motivated to acquire Tumbuka, the language of the majority of his clients. In case 2, in contrast, Mr Chigamba was psychologically unprepared to invest in the language-learning process. This juxtaposition consolidates the point I made in section 5.2.2 that the current civil servants' deployment policy cannot be assumed to be a factor that automatically leads to additive bilingualism in the concerned individuals.

In case 3, Dr Matata, an expatriate service provider of East African origin, whose mother tongue was Swahili, spoke Chewa and some elementary Tumbuka. However, her departmental colleague, Dr Tsui (a Chinese), whilst admitting that he had serious language problems with his only link with Malawians - English - did not even attempt to learn Tumbuka. One can therefore say that Dr Matata was a special case amongst the expatriate service providers. Generally, the typical expatriate doctor at the MCH (see case 4 below) does not know the languages of his or her clients, and has to rely on the helping hand of ad hoc interpreters (see the same trend in South African hospitals: Saohatse 1997, 1998, 2000; Drennan 1998; Crawford 1999). The language gap at the MCH can also be discussed against the background of the doctors' brain drain (Muula & Broadhead 2001; Lwanda 2002b) which has adversely affected Malawi. Had there been no serious brain drain, Malawi would have been less dependent on foreign doctors. In so doing, Malawian doctors would have created more language concordant clinical situations. This is not to say that Malawian doctors would not need language brokering. The point is that Malawian doctors would need language brokering at a much lower level than their expatriate counterparts.

Case 1: Mr Katola

Mr Katola, a clinician, came from the Central Region of Malawi. His mother tongue was Chewa. At the time of the interview, he had spent two years at the MCH and was able to conduct all his clinical work through Tumbuka without any need for language assistance in the form of interpretation. When he first arrived at the MCH, he spoke Chewa and English only. The Tumbuka-dominated work environment led him into learning the language. What scholars of second language acquisition (e.g. Ellis 1986) have called instrumental motivation towards the acquisition of a second language can be detected in Mr Katola's account:

> The situation has really forced me, especially my nature of work. It's like I am here and these are the kind of people I am dealing with. Some of them don't even know Chichewa or English and you are forced to say your broken Tumbuka till you get through with it.

Mr Katola further observed that his early days at the MCH were communicatively problematic:

> It was terrible. Actually I should say it was even funny because somebody says that, you get the point but now how to respond.... You find even people laughing at you. But all along, it was tough anyway, but I accepted it and I think that's what

> has helped me so much that I should be in a position to speak and listen much of Tumbuka this time.

Whilst Mr Katola was prepared to go through the hardships of second language learning (such as being laughed at by the competent speakers of the target language), Mr Chigamba (see case 2) was not prepared to make that kind of investment in second language learning. This shows a stark contrast between the two service providers in the way they treat the cost-benefit analysis of second language learning. The cost of second language learning comes in various forms. For example, in some cases one has to pay fees for a language course. Social-psychological problems such as the fear of making mistakes in the target language and even Mr Katola's experiences of receiving ridicule from competent speakers of the target language can also be included under the costs of second language learning. Most people learn a second language when the benefits of doing so outweigh the costs (see also Laitin 1992). The benefits of learning Tumbuka were easy to notice. For example, Mr Katola was able to discharge his duties more freely than his colleague, Mr Chigamba. Through the acquisition of Tumbuka, Katola had been communicatively empowered in his professional duties. Mr Katola, backed by his experiences at the MCH and elsewhere, strongly spelt out the importance of language in medical practice:

> It's very important. And it's the most important tool in the medical field because as you know we are not *asing'angas.*[7] We are not people who take things out of the blues. We really get what somebody has said. From there that's where we base our medical interference, medical investigations and the like. Otherwise, if there is no communication, it's very difficult for that patient to be assisted appropriately. So communication is very important in the medical field.

Mr Katola's view cited above strongly points to the critical role of language in health care delivery. Whilst modern science and technology have given the medical profession sophisticated equipment for examining a wide range of ailments in the human body, that has not led to the diminished importance of language. Physical medical examinations cannot be meaningful if they are not accompanied by the patient's own narratives about his or her illness. History taking, physical examinations and laboratory tests are some of the ways through which diagnosis can be reached. Of all these mechanisms, history taking is by far the most widely used (see also Chanda 2003). Physical examinations and laboratory tests simply build upon the foundations that history taking can initially establish.

Case 2: Mr. Chigamba

Mr Chigamba was a service provider who came from the non-Tumbuka-speaking Southern Region. He was a Chewa/English bilingual. Unlike his workmates who also came from non-Tumbuka-speaking backgrounds (e.g. Mr Katola in case 1) and made serious efforts to learn Tumbuka, he did not. Mr Chigamba felt socially rejected by the host community, and thus had no sufficient motivation to learn the language of what he perceived to be a hostile group. Since he did not speak Tumbuka, he had to rely on interpreters when he met clients who spoke neither Chewa nor English. Despite receiving interpretation assistance from colleagues and others, he was of the view that the language barrier impacted negatively on how he discharged his duties:

> I feel like I am not working because whatever the message which I have to relay to the patient, that message has to come from me as someone who knows what I am doing. So when I have to involve may be an attendant... it's sort of an embarrassment.

What Mr Chigamba was worried about here can be linked to power relations. To account for Mr Chigamba's case, I take into consideration the critical discourse analysis point of view that language is a social practice through which power, control and domination are exercised (see also Fairclough & Wodak 1997; Wodak & Meyer 2001). The literature on client versus health service provider interactions notes that such communicative encounters are unequal (see, for example, Freidson 1961; Mishler 1984; and West 1984, 1990, 1993). The service provider, by virtue of his/her professional expertise, assumes the powerful position whilst the client, by virtue of his or her lack of professional expertise, is the less powerful partner in the discourse encounter.

The inclusion of a third party (an interpreter) changes the balance of power. The interpreter, who may or may not have medical professional expertise, becomes another powerful party in the interaction. Since the service provider has no linguistic power, he surrenders part of his initial authority to the interpreter. Interpreters wield a lot of power (Davidson 2000) since they possess what both the client and the service providers need - an understanding of the other's language. The service provider and the client become more or less at the mercy of the interpreter. For Mr Chigamba, his overall power was reduced by his lack of linguistic power. In some cases, the one who holds the linguistic power (the interpreter) may even be a junior to the service provider, yet the service provider cannot do without him/her. In Mr Chigamba's case, such juniors included patient/hospital attendants, a category of staff which under Lave & Wenger (1991) and Wenger (1998) would be placed on the periphery of the medical Community of Practice. The notion of knowledge as power (see also Thetela 2002) was at work here. Mr Chigamba had medical knowledge (power) but lacked the knowledge of the language of the client (thus lack of linguistic power). It was this sharing of power with a non-professional in what was supposed to be a professional encounter that made Chigamba feel that it was some "sort of an embarrassment." Of course how people react to this loss or sharing of power with an interpreter will vary according to personalities and other circumstances.

In contrast to Mr Chigamba, other non-Tumbuka-speaking service providers, who had to solicit the assistance of ad hoc interpreters, did not feel that their professional power had been weakened by the presence of a third party in the client-service provider interactions. In fact, they found interpretation to be an empowering exercise - something that facilitated their work. This was the dominant view among both local and expatriate service providers who had to seek interpretation from colleagues and/or other parties. For example, an expatriate dental surgeon mentioned that the language barriers at the MCH had never frustrated her:

> To be honest with you, I have never been frustrated because always I am having some help from the other therapists. When I am stuck, I don't force myself to understand where I don't understand. When I don't understand, I just call somebody to interpret for me.

Mr Chigamba's frustrations with the language situation at the MCH do not represent a majority perspective. The problem with Mr Chigamba was his inability to make maximum exploitation of the linguistic networks of support that existed at the hospital.

Case 3: Dr Matata

I now consider the case of Dr Subujuwa Matata, an expatriate. When she first came to Malawi, Dr Subujuwa Matata was posted to the Lilongwe Central Hospital where she worked for two years. Whilst in Lilongwe, she acquired Chewa. Since both Chewa and her mother tongue, Swahili, are Bantu languages, her learning of Chewa was smooth. When she was

posted to the MCH, she noted that her knowledge of Chewa was less useful in communication. Though Chewa is the national language, the MCH is located in a Tumbuka-speaking area. So she had to learn the dominant language of the area, Tumbuka.

Dr Matata believed, and rightly so, that she had an edge over other expatriate staff as far as the language and cultural barriers were concerned. Culturally, she did not experience a big social-cultural gap between Tanzania (her home country) and Malawi. This observation by Dr Matata can be linked to the acculturation model of second language acquisition which I introduced in chapter 4. According to the model, "second language acquisition is just one aspect of acculturation and the degree to which a learner acculturates to the target language group will control the degree to which he acquires the second language" (Schumann 1978: 34). It is also important to note that Dr Matata received her professional training through the medium of English. Secondly, she came from an ESL country. This meant that the problem of communicating through with English, which negatively affected expatriates from the non-English-speaking countries, did not apply to her.

Unlike other expatriates, Dr Matata spoke at least one local lingua franca, Chewa, and also had partial competence in Tumbuka. Whenever she met a non-English-speaking patient, she first tried to communicate with him or her using Chewa. Whenever Chewa failed, and Tumbuka was required, she would call someone to interpret since her own competence in the latter was limited. Her Chinese colleague in the department (Dr Tsui), on the other hand, had both cultural and linguistic barriers to overcome. First, for the Chinese, Malawian culture was extremely alien to them. Secondly, the Chinese expatriate had inadequate competence in English (see section 5.4 in this chapter). In addition, the Chinese expatriate had no competence in any local language. Dr Matata regarded herself to be in a linguistically better position than her Chinese colleague:

> Chichewa, Chitumbuka, they are also Bantu languages. So most of the words that are found in Chichewa, Chitumbuka they are also found in Kiswahili. So I have a big advantage, far much than him; and him coming from Taiwan makes things worse because English is not even mostly spoken there. So on the language part, I think I am much better than him.

Between Chewa and Tumbuka, Dr Matata was of the view that:

> Chichewa is much easier to me than Tumbuka and sometimes I fail to differentiate the two. When I try to speak Chitumbuka, I mix Chitumbuka and Chichewa. It's not easy for me to differentiate. But I find myself speaking Chichewa easier than Chitumbuka.

But Dr Matata's argument that she found Chewa and Tumbuka easy to learn because of vocabulary similarity with her mother tongue (Swahili) needs to be treated with caution. Whilst it is true that some Malawian languages, especially Chewa, have borrowed some lexical items from Swahili, it does not always follow that there is a complete semantic equivalence between the concerned lexical items. Some Chewa words are spelt the same way as in Swahili but have different meanings: for example, *malaya* (prostitute in Swahili; garment in Chewa), *duka* (as a noun: shop in Swahili; piece of broken brick in Chewa; as a verb: to get cut in Chewa), and *mwalimu* (teacher in Swahili; a Moslem official or Islamic teacher in Chewa). A more detailed analysis would actually show how languages may share lexical items but not exact semantic values. A few examples from Tumbuka and Chewa (see Table 5.1) should suffice to emphasise the caution that I have made about shared lexical items that have different semantic values in the two respective languages.

Table 5.1: Shared Vocabulary, Different Meanings: Chewa and Tumbuka

WORD	TUMBUKA MEANING	CHEWA MEANING
kusambira	to learn	to swim
makani	news	argument-liking behaviour
koma	to kill	(i) to be sweet (ii) but
chiponde	deceased	peanut butter
tiwerenge	let us go home	let us read
gunda	to make love	to hit or bash something

Case 4: The Typical Expatriate at the MCH

As I mentioned earlier, the typical expatriate health service provider at the MCH has no local language competence. The crucial question here is: Why is this the case? There is no simple answer, but one has to take into consideration several factors. The first factor is that the policy of the Medical Council of Malawi makes it possible for the expatriate to do without having to learn a local language. The policy actually creates an escape route for the expatriate service provider since the current legislation (see chapter 7) does not take local language competence as one of the conditions for licensing non-Malawian medical practitioners.

Another way of explaining the reluctance of expatriate service providers to learn local languages is the low esteem Malawians, as hosts, have towards their own languages. To speak English is so highly treasured that there is a mistaken belief in the erroneous equation: English = education. As such, expatriate health service providers, being highly trained in their profession, are taken as individuals who should not lower their prestige and rank by speaking a local language. The adage "charity begins at home" rings true here. When the host community has no pride in its own languages, it should not be difficult to see why expatriate service providers tend to follow suit.

Thirdly, some expatriate service providers see their stay in Malawi to be for a short time. Some may, therefore, not consider it profitable to start learning a local language which they can only use for a short time, and probably will not be able to use it again elsewhere (unless they go to work in a neighbouring country with which Malawi shares cross-border languages). Fourthly, the existence of local staff who are prepared to act as language brokers for the expatriate service provider can also act as a way of weakening the foreigners' motivation to learn local languages. If someone can interpret, then some people would not find it worthwhile to learn the language. For instance, Welmers (1974) gives an example that has parallels at the MCH. Welmers notes that some missionaries to Africa, because of the availability of European language-using local counterparts, decide to preach through interpreters, thus reducing the practical need for learning the local language(s). The lack of formal language learning facilities is one of the reasons behind the expatriate service providers' inability to speak local languages (see chapter 6, section 6.4 on language courses). But individual motivation or interest in learning the local languages should not be ignored. Even in the absence of officially arranged language courses, it is still possible to learn a local language. A good example here is the case of Dr Matata that I have discussed above in case 3. The use of privately arranged language teachers is therefore an option for those who are highly motivated. An expatriate service provider (a native speaker of English) who had engaged the services of a private Tumbuka language teacher demonstrated this at the MCH.

5.3. MINORITY LANGUAGES: SOME SPECIAL CASES

My focus in this section is on minority languages that are located in one specific zone of the Northern Region - Karonga and Chitipa districts. These are minority languages whose sociolinguistic reality has not yet been grasped by language researchers. These minority languages are unique at the MCH because it is not easy to identify a speaker who can serve as a language broker between service providers and the minority language-using clients. The frequency in the occurrence of these minority languages is very low at the MCH.

5.3.1. The Case of Swahili

Swahili is spoken in Malawi largely in Karonga and Chitipa districts. These two districts lie on the border with Tanzania. Karonga and Chitipa districts are famous for their linguistic complexity. The two districts are part of what has been called the Lake Tanganyika-Lake Nyasa Corridor (see Walsh & Swilla 2001). This corridor is demarcated as:

> The area located between Lakes Nyasa and Tanganyika. These languages include Pimbwe, Rungwa, Fipa, Rungu, Mambwe, Wanda, Namwanga, Lambya, Malila, Nyiha, Safwa, Nyakyusa, Ndali and Wangu. Several of these languages straddle international borders and are found in either three or two countries, namely Malawi, Tanzania and Zambia (Walsh & Swilla 2001: 275).

As has been mentioned in previous chapters, the largest non-Malawian language-speaking community in Mzuzu is that of the Swahili speakers. The actual numerical strength of this community has not been officially documented. Even the 1998 population census does not give any indication of how many people claim to speak Swahili, yet this is a conspicuously used language in Mzuzu as well as along the Malawi/Tanzania border areas.[8] One can only assume that Swahili speakers, especially in Chitipa and Karonga are included in the language category known as OTHER (see Tables 3.4 and 3.5 in chapter 3). Despite the fact that Swahili is Africa's most dominant lingua franca (see Bandia 1998, for example), and that Tanzania which is one of the centres of this pluricentric language shares a border with Malawi, the language has no official recognition in Malawi. The lack of official recognition of Swahili in Malawi denies the country the opportunity of accessing a major African lingua franca. As I argue elsewhere (Kamwendo 2001b), this is one of the weaknesses of the language policy that was put in place by the Banda administration and continues to exist up to now. Despite the fact that since 1994, Malawi has had a government that enjoys good relations with Tanzania, there has been no move towards making Swahili a subject of study at any level of education.

5.3.2. The Languages of Karonga and Chitipa

The seriousness of this linguistic barrier was underlined by the fact that between some of the so-called Karonga and Chitipa languages on one hand, and Tumbuka on the other hand, there is little mutual intelligibility. According to Ms Chirwa, though she spoke two of the Northern Region's most widely used languages (Tumbuka and Tonga), the languages of Karonga and Chitipa were a big communication barrier for her and other service providers. The languages were simply unintelligible:

> *Koma pali zilankhulo zina monga Chinkhonde. Ndiziyankhulo zoti m'mene ndilili ineyo palibe ndimamvapo. Chinkhonde ndi language yovuta. Mwina pa chipatala panonso ndi ochepa amene amayimva. Ndiye kunoko ku X department tili ndi mwayi kuti alipo ena amene ali a ku Karonga kaya Chitipa. Ndi amene timawatsogoza pa munthu ameneyo kuti athane naye.*

> (But there are other languages like Chinkhonde. These are languages that I do not understand. Chinkhonde is an unintelligible language. Maybe even at this hospital only a few understand the language. So in here in XXX department we are lucky to have some people from Karonga and Chitipa. These are the people we assign to handle patients who speak those languages).

Another key informant, clinician Katola, held the view that whilst the current practice in the civil service of posting employees to any part of Malawi was good, he however, noted that there are some exceptionally problematic districts:

> You are talking of districts like Chitipa whereby they have got so many languages. You find that somebody from the other side of Chitipa *boma*[9] cannot communicate with fellow Chitipian who is on the other side of the boma. Now, what about you who is just a stranger in the district? It's rather very difficult. Now it's like if there are 21 languages, you are forced to know all the 21 languages.

Mr Katola's accounts of the linguistic complexity of Chitipa need to be treated with caution. Mr Katola's account was a common story that I was repeatedly told whenever I asked about the language situation in Chitipa. There was an element of exaggeration and lack of sociolinguistically valid empirical evidence. For example, all the informants talked about Chitipa's "many languages," and some even gave numbers. But none of the informants was able to list down the "many languages." There was a failure to name the languages. Very often the vague label "languages of Chitipa" (Chewa: *ziyankhulo za ku Chitipa*) was used. In some cases, the "same language" could be counted twice if it has more than one name. One case here is Ndali, which is also known as Sukwa.

When I asked Mr Katola about patients from Chitipa, he acknowledged that they caused communication problems to most of the service providers:

> Yes, we have several coming from Chitipa and that's the problem we are having. Unfortunately, there are very few guys from Chitipa at this institution whereby if you have to interact with the patient, you have to call this other Chitipa resident or Chitipa citizen to interpret.

When I asked Katola as to whether the MCH does receive Swahili-speaking patients, his reply was: "Yes, mostly that's a component of Chitipa and Karonga patients. Most of them they come either speaking Ngonde or Swahili and they are really difficult to communicate with."

That some people from either Karonga or Chitipa know no Tumbuka should not be surprising. Some people have never moved out of their areas of birth. Such people are unlikely to meet other people who speak a language or languages other than their mother tongue. Those people from Karonga and Chitipa who have had a chance to travel and work or attend school elsewhere have had the opportunity to learn other languages. One of my key informants, Mr Simfukwe who came from Chitipa, revealed that when he was selected to pursue his secondary school education at Livingstonia, it was the first time that he had come into contact with a Tumbuka-speaking community. He recounted how surprised people were at Livingstonia Secondary School in Rumphi to find an individual from the same Northern Region who could not speak Tumbuka. He also remembered how students from Chitipa, due to their ability to speak Swahili, and not Tumbuka, were described as being pompous.

Ms. Chirwa cited a similar case about her secondary school days on the Likoma Island. One of her schoolmates was a young man from the Songwe area in Karonga who was initially unable to speak Tumbuka. He spoke Ngonde and Swahili. These accounts narrated by my informants at the MCH should caution us against taking the Northern Region as a linguistically and even culturally homogeneous area. The cultural and linguistic dominance of

the Tumbuka should not mask the fact that this is a region in which several linguistic identities exist. Again, McCracken's (2002) worry about collapsing all the Northern Region's linguistic identities into one (Tumbuka) is relevant here. What remains undocumented empirically is the nature of the similarities and/or differences amongst the two districts' linguistic varieties, as well as the extent to which speakers of these languages have acquired Chewa and Tumbuka as lingua francas. The question of attitudes towards Chewa and Tumbuka is also important. For instance, are people genuine when they say they do not speak Tumbuka, or is it just a case of pride in communicating through their language? These are some of the questions that a Chitipa or Karonga-based study of language use in hospitals could try to pose. The current study has therefore acted as a pointer to areas that could be pursued in future research (see also chapter 8 for suggestions for further research).

5.4. THE USE OF ENGLISH: BRIDGE OR BARRIER?

5.4.1. The Bridging Role of English

It is important to mention at the very beginning that English can act as either a bridge or a barrier to communication at the MCH. As a linguistic bridge, English enables local staff and expatriate staff to communicate, thereby rendering insignificant the fact the interlocutors have different mother tongues. Local staff sometimes find English to be the language of communication among themselves for various reasons. For instance, local staff who do not share a common local language find it convenient to communicate through English. The topic under discussion may also influence the choice of English. For example, due to the scientific nature of some of the discussions focusing on the medical profession, local service providers find English to be the most appropriate linguistic medium to handle such a topic. The service providers, as members of one Community of Practice, are able to discuss and understand medical issues through a major international language of medicine - English (see also Maher 1986). On the other hand, to those who have partial or no competence in English, the language tends to be a barrier to communication.

Some of the expatriate staff of the MCH come from EFL environments, for example the Chinese and the Egyptians, whilst others come from native English speaker-dominated environments as in the case of the British and Americans. The MCH, therefore, is a convergence point for the various varieties of English. Inter-variety intelligibility or comprehensibility is varied. This is typical in situations whereby a language is pluricentric (see also Clyne 1992a, b). As has been observed, the English language is not a monolith, but a language that exists in many clearly distinguishable varieties. In some cases, the inter-variety comprehensibility is so low that communication breakdowns occur. For a foreigner who meets an African or other new variety of English for the first time, it may take him or her "some time to get used to their pronunciation and usage, whereas other Africans are said to be able to understand more easily, because intelligibility is a subjective skill dependent on experience" (Schmied 1991: 29). The distinctive character of a particular variety of English can be shown at various levels of linguistic description such as pronunciation, grammar, vocabulary, meaning and discourse styles (Schmied 1991).

5.4.2. Problems with Chinese Service Providers' English

All the Chinese service providers at the MCH have English as a Foreign Language (see Chia et al 1998; Tsao 1999). There is evidence to the effect that the variety of English spoken by the Chinese caused some problems of comprehension among Malawians at the MCH. The inevitable L1 (Chinese) interference into English, and the fact that English is not the official

language in Taiwan gives the variety of English of the Chinese speakers some distinct lexical and phonological features. One of my Chinese key informants at MCH, Dr Tsui, mentioned that though English is used in medical training in Taiwan, the out-of-the-classroom and hospital environments offer minimal opportunities for the use of English. Since there is minimal use of English in Taiwan in general, those Taiwanese intending to work outside their country have to learn English or beef up their low levels of competence in English. To this end, Dr Tsui noted that "before we came to Malawi, we had to learn English first." Though English is not an official language in Taiwan, a study conducted by Chia et al (1998) found that both faculty and medical students view English as an important language for both medical studies within and outside Taiwan as well as a medical career outside Taiwan (cf. Eggly et al 1998 on the relationship between English language proficiency and success as an international medical resident). [10]

My interviews with two of the Chinese service providers confirmed their English language problems. Both interviewees confessed their lack of a solid command of the English language. In addition, both looked uncomfortable with their language competence. Dr Tsui was an English/Chinese bilingual, with his competence in Chinese taking the upper hand in his verbal repertoire since it was his mother tongue. During the interview, I could see that Dr Tsui was struggling to communicate through English. The confession he made about his lack of fluency in his only medium of communication with Malawians was very informative: "the most important language I cannot speak very good. Sometimes we have to discuss very deep problem, very serious problem. I have to consider some...and try to speak and sometime I cannot speak out. That's my problem."

Since service providers not only have to communicate with clients but also have to talk or consult among professional colleagues, Dr Tsui's language problems raise concerns about his ability to contribute to professional decision making. At a hospital that has a handful of doctors, it is a professional handicap to have a fully qualified doctor who is unable to communicate effectively. Dr Tsui noted that whenever there was no one to offer him interpretation, "if a patient cannot speak English, then they won't refer to me. They won't see me." At other times, "I tell the assistant to work with me and he can do the translation." This meant that the expertise of Dr Tsui was under-utilised because of language barriers. The fact that expatriate service providers have to communicate with clients through English in a largely non-English-speaking environment has already been classified as a language barrier. To be added to this list is the inability to communicate effectively through English as exemplified by the Chinese expatriates.

Ms. Tsao was another Chinese expatriate that I interviewed. When I interviewed her, I noted that she was nervous, but was slightly more confident than Dr Tsui. It was clear that Ms. Tsao was uncomfortable with her competence in English. At the time of the interview, she had spent only one month in Malawi. She was bilingual - English and Chinese. Responding to a question on what communication problems she faced at the MCH, she cited two problems. Ms. Tsao's first problem was what she called the Malawian accent of English. As a way of solving this problem of the Malawi accent of English, she normally asked her interlocutors to speak more slowly. She claimed that Malawians speak English "very fast." I also realised in the previous interview with another Chinese, Dr Tsui, that I had to speak very slowly for him to understand. So when Ms. Tsao complained that Malawians speak "very fast" in English, I was not surprised. Her second problem was her inability to speak Tumbuka. It is significant that she realised that for her to communicate well with the majority of the clients at the MCH, she needed Tumbuka, and not Chewa or English. When I asked Ms. Tsao to comment on the language and communication problems of the hospital, she said: "I hope the hospital can provide Tumbuka class." It is important to note here that she mentions

Tumbuka and not Chewa. This is further evidence of the centrality of Tumbuka in communication between service providers and clients at the MCH.

Through an interview with a key informant, Mr Chigamba, I also learnt about a Chinese expatriate service provider who had severe language barriers. The language barriers were so acute that Mr Chigamba felt that they marred his otherwise respectable professional competence. The expatriate's setback was that his proficiency in English was too low to allow him to communicate meaningfully with colleagues and clients. The expatriate was later replaced. It was not clear whether his replacement was due to his linguistic deficiency or the replacement was simply a routine exercise. Whatever the reason was for his replacement, one thing that is clear is that the professional had an English language deficiency which negatively affected his discharge of duties. Mr Chigamba described the case of the expatriate as follows:

> You know the Chinese have got a problem in English. Our first XX had problems in English. So it was looking like though he doesn't know his job. In general, to say the least, he didn't assist us a lot. But the one we are having at least she did her education through English, so communication is not a problem for her.

Another Malawian service provider, Mr Katola, confirmed that on arrival at the MCH, some of the expatriate staff from the non-English-speaking countries had serious problems with English, but "most of them now are so far familiar with English." The implication here is that on their arrival, the expatriates had a much lower level of competence in English. Since the situation in Malawi has forced them to use English daily in all their transactions, their fluency had improved. Mr Katola elaborated: "Yes, they had problems with English. Some of them could get you speaking in English but for them to speak out in English, it was a problem." It is clear that the expatriates' comprehension of English was better than their production. This is a common universal linguistic trend. Mr Katola described his initial experiences in interacting with Chinese expatriates:

> It's like you have to feel in the patches. There, I think what he has said here means A, B, C, D. But otherwise communication at the beginning was somehow a problem for some of us for who it was our first time to interact with such a society. It was really a kind of problem but they are friendly people. They are well mixing guys. So it didn't take a long time to really know their language, I mean their weaknesses.

A Malawian service provider, a radiology technician (service provider 63), also described how difficult it was for him to understand the English of the Chinese, and also how difficult it was for the Chinese to comprehend Malawian English:

> Communication breakdown was there at first as we are of different nationality. We could not get what our friends meant and vice versa. For example, Chinese English was a problem and our English was so fast for them and it could take a long time to understand what each one of us was trying to convey.

In the words of another Malawian, a patient attendant (service provider 62), the Chinese and other doctors spoke "deep English" which she hardly understood. As a result, she resorted to asking a nurse to explain to her what the doctor meant. Normally when Malawians talk of someone having used "deep language", they refer to vocabulary that is not known to them. In the case of the patient attendant, it may not be that the English of the Chinese was difficult to understand, but that the Chinese had used some vocabulary that she did not know.

The problem of the intelligibility of the non-Malawian varieties of English was also mentioned in service providers' questionnaire responses. For example, problems

comprehending non-native varieties of Egyptian and Chinese English featured prominently. This prompted service provider 73, a Malawian clinician, to propose that the Government of Malawi should treat English language competence more seriously when recruiting expatriate staff, especially those coming from non-English-speaking countries. He advised that: "The government should try as much as possible to send expatriate doctors who know English for better communication and management of patients at this hospital." This recommendation presupposes, very correctly for that matter, that some current expatriates' English language competence was so low that it was a barrier to effective communication. Whether the Government of Malawi can take a stricter stance towards the English language competence remains a difficult thing given that there is an acute shortage of doctors and other medical staff.

It is not only clients who suffer when a hospital has service providers whose poor language proficiency makes them unable to communicate effectively. In the case of the MCH where some local staff are supposed to learn from the more experienced expatriates, the former's goals are frustrated when they cannot meaningfully communicate with the senior professional colleagues from whom they are supposed to learn new skills. Acquisition of new clinical skills is not only done through observations, but also through questions, answers, clarifications or even lectures. This is where the importance of being able to effectively pass on intelligible information becomes crucial.

Miscommunications between Malawians and the expatriate staff are part and parcel of the communication breakdowns that are associated with interactants using different varieties of English and coming from different cultural backgrounds. In such cases, cross-cultural pragmatic failure (Thomas 1983) is not a rare occurrence. But with the passage of time, the two parties learn to understand each other's communicative styles and use of language. Non-native speakers of English coming from different parts of the world bring with them some distinct differences in lexical items, phonological productions, choice of vocabulary and many others (see Frank 2000).

The Taiwanese practise medicine in Malawi without competence in any local language. Some of them even lack adequate competence in the main international language of medicine i.e. English. The Government of Malawi, it would seem, turns a blind eye to the language deficiencies of these expatriates. The feeling one gets is that it is the expatriates' professional knowledge and skills that matter most, and not their language fluency. As a country that is desperately in need of qualified medical personnel, there is a tendency to receive human resource assistance without a critical look. According to the findings of my study, it would be prudent to have these Taiwanese medical personnel take remedial English courses before they are posted to Malawi. If they cannot learn a local language, then at least their competence in English should be high enough to enable them to engage in meaningful communication. Meaningful competence in English on the part of the expatriate service providers is significant for a doctor's interactions with medical, nursing and other colleagues and is an essential ingredient of team building.

5.5. ILLITERACY

I agree with Bamgbose's (2000a) claim that illiteracy is a linguistic barrier to communication. Illiterates are denied access to information that has been packaged in the written form. Literacy is generally said to have liberating or empowering capacities in that the literate are able, on their own, to access information which they would not have accessed, or they could only have accessed through intermediaries. Due to illiteracy, some people are unable to access written information, thus their right to access to information is not honoured. In the

Constitution of Malawi (Malawi Government 1995a), Article 37 stipulates that "every person shall have the right of access to all information held by the State or any of its organs at any level of Government in so far as such information is required for the exercise of his rights." Health education that comes through posters, pamphlets, leaflets and other forms that I discussed in chapter 4 contains vital information. For instance, the literature may carry information about signs and symptoms of diseases, modes of disease spread, prevention and cure. Such information is important for every citizen to use in the maintenance of his or her good health. If a citizen is denied access to such vital information due to illiteracy, then he/she is not able to access information that would have enabled him/her to enjoy the right to health.

At the MCH, whilst the majority of the clients claimed to have some degree of education, it cannot be claimed that they all have equal competencies in literacy. Generally speaking, the trend is that the more one is educated, the more literate one becomes. But not every literate person can read everything. The key issues here are the language(s) of literacy and the notion of literacies. First, we have to consider the question of language. Those who are educated but have a poor grounding in the English language, for example, will obviously be unable to decipher the information written in English that is found at the hospital, but on the other hand, be able to read information available in the local languages. The point is that people are never simply literate, but they are literate in specific languages, and have specific degrees of literacy competencies.

The question of literacies is also important because different literate environments have different demands on the reader. Many clients I interviewed at the MCH, who were competent in English, claimed that they could not understand prescriptions written in English. It is not that the prescriptions were written with the use of rare vocabulary, but only that ordinary words had been used in a special way - medical jargon - which turned out to be unfathomable to the medically uninitiated. This is one reason why at the hospital's pharmacy, the pharmacy assistants repeated verbally the directions for taking each drug despite the fact that some of the clients were educated enough to read on their own. The idea was not to assume that every educated person had appropriate functional health literacy. For example, in the interaction between a pharmacy assistant and a certain patient, it was clear that the patient was educated enough to carry out communication in English. The pharmacy assistant at some point even switched into English from Tumbuka. But as you will notice in the excerpts below, the pharmacy assistant still gave the apparently educated patient Tumbuka verbal instructions about the times when to take the medicine. He did not assume that the educated patient would be able to read and understand the instructions on his or her own:

Pharmacy assistant: ***Aaa! I have found it!*** *Kamoza na mulenji, kamoza na muhanya, kamoza namise* (Aaa! I have found it! One in the morning, one in the afternoon, one in the evening).
Patient: *Sono awa?* (What about these ones?)

Pharmacy assistant: Awa tilije. Muwererenso kwa a dokotala akamusinthileni, **if not, then** mwamugula ku Chirani. Ku Chirani kula, **there is a prescription point. They read this one. It will be six times seven, forty-two, forty-two tabs,** Brufein palije. (This medicine we don't have. You should go back to the doctor so that he can change the prescription, if not, then you buy the medicine at Chirani. At Chirani, there is a prescription point. They read this one. It will be six times seven, forty-two, forty-two tabs. We don't have Brufein)

There are a number of strategies that are followed in order to break down the barrier to information which illiteracy poses. One strategy is the use of audio-visual communication media such as video and television. For example, both MACRO and Banja la Mtsogolo use videos to transmit health education messages to their audiences. Banja la Mtsogolo's outreach

programmes in the Northern Region, which are administered from Mzuzu, use local drama groups (cf. Kerr 1985). According to the Banja la Mtsogolo informant (Mr Pindani), in order to ensure that there are no language barriers, drama groups that are hired to dramatise health education issues are required to use the dominant language of a particular area. In other words, there is no one language-for-all policy. For example, whilst the Banja la Mtsogolo outreach programmes in Mzuzu were conducted through Tumbuka, health education drama in Karonga had to be staged in Ngonde and not Tumbuka since the former is the commonly used language there. This points to another important issue that this thesis wants to emphasise - the fact that while at the MCH, the use of the minority languages such as Ngonde is not widespread, in other areas, the same languages have large concentrations of speakers. It is when the minority language speakers are found in significant concentrations, and the demand for the use of the language is high, that authorities have to take steps to ensure that health services are provided in that language (cf. Chilowa & Munthali's 1997 immunisation study in Chitipa district).

Another obstacle to health literacy in local languages is that currently, the school system in Malawi cultivates literacy in only one indigenous language - Chewa. What happens is that people are innovative in the sense that they transfer the Chewa literacy skills to the other languages. But this is far from being simple and easy. In the absence of standard orthographies and standard grammars, it is difficult to write in the minority languages of Malawi (see an elaboration of this point in chapter 7). One can therefore say that minority language literacy is almost non-existent in Malawi. It is therefore not surprising that the health literature that is available at the MCH is hardly packaged in the local minority languages.

Another way of overcoming illiteracy is the use of face-to-face communication in pairs or groups. For instance, at the MCH nurses/midwives talked to groups of women about safe motherhood and other relevant topics. In predominantly literate societies, such information would have been passed on to clients in the form of printed materials. This mode of communication was said to be good at facilitating dialogue between the health educators and their clients. But when it comes to certain so-called sensitive topics, the notion of face (Goffman 1967; Brown & Levinson 1987) may or may not be a barrier to communication. This is the topic of discussion in section 5.6 below.

5.6. FACEWORK IN HEALTH CARE COMMUNICATION

Health care communication is a site that is rich in Face-Threatening Acts (FTAs). In this section, I explore the link between facework, communication efficiency and communication barriers. Ordinarily, Grice (1975) would expect any two or more interactants to speak sincerely (observing the maxim of quality), relevantly (observing the maxim of relation), and clearly (observing the maxim of manner) while providing sufficient information (observing the maxim of quantity). In the clinical context, however, the service provider or client may not honour these conversational maxims in the interest of attending to face needs.

In order to establish whether health care communications have some FTAs that determine what can be said (as well as how it can be said) or what cannot be said, clients were asked whether there were some clinical issues which they considered to be too embarrassing to discuss with the service provider through an interpreter. The majority of the respondents in Table 5.3 claimed to have nothing that was too embarrassing to discuss through an interpreter. This can be interpreted in a number of ways. First, it could be the case that the interpreter is another health service provider, for example, a nurse or a clinician or a patient attendant. In such a case, the interpreter is a trusted person. He or she is one of the regular health care

givers, thus he or she can be trusted and no topic can be too embarrassing to relay through that individual. After all, the interpreter is one of the medical staff who is expected to observe the ethics of medical confidentiality.

Yet there are times when non-medical staff such as relatives, one's own children, other patients or even total strangers may be called in to interpret. Under such circumstances, studies conducted elsewhere (e.g. Haffner 1992) have shown that some patients become uncomfortable to discuss certain topics through such interpreters.[11] Whilst interpretations conducted by the non-clinical staff have been questioned or shunned in other contexts, it would appear that clients at the MCH care little about interpreters' confidentiality in general. This is understandable given that if one is not proficient in the language of the service provider, then interpretation is inevitable. Even if an ailment is embarrassing, the embarrassment can be suspended in order to achieve a higher goal. This higher goal is the cure of the ailment. It would be counterproductive to go to a hospital and then opt not to use interpreters simply because one's ailment is embarrassing. Of course, a patient with an embarrassing issue may still use an interpreter but in a manner that aims at shielding him/herself from embarrassment. For instance, an embarrassed client may withhold some of the details of his or her embarrassing case (cf. Gricean maxim of quantity); or he/she may not tell the whole truth (cf. maxim of quality); or the account may be given in an indirect style so as to conceal certain embarrassing portions (cf. maxim of manner).

Table 5.2: Too embarrassing topics to be discussed through an interpreter?

Response	Frequency	Percentage
Yes	10	2.1
No	463	96.9
No Response	5	1.0

A follow-up question asked respondents who had given a YES response in Table 5.2 to mention the embarrassing topics. The topics have largely revolved around reproductive health and HIV/AIDS. For example, some clients mentioned that they would be embarrassed or uncomfortable to discuss their HIV-positive status with a service provider through an interpreter. In a society in which people with HIV/AIDS are stigmatised, it is understandable why sensitive clients would not welcome interpreter-mediated communication. AIDS is a shameful disease and it is associated with immorality, thus threatening the positive face of those who have the disease.[12] Other topics that some clients would be too embarrassed to discuss in an interpreter-mediated communication with a service provider are reproductive health issues such menstruation, child delivery and infertility. These FTAs should be appreciated in the cultural context of Malawi where public and/or direct talk (straight talk) about matters pertaining to reproductive health is generally avoided. Shying away from open discussion of these TFA-loaded topics is not confined to Malawi only.[13]

There was also a question on whether or not interpretation erodes the right to privacy (see Table 5.3). This question links up well with the question of confidentiality. The majority view in Table 5.3 is that interpretation does not erode the right to privacy. Whether the clients understood what privacy and confidentiality (from a human rights perspective) meant is difficult to tell.

Writing from a human rights legal perspective, Gruskin & Hendriks (2000) admit that it is difficult to give a very precise definition of privacy, but in their view, privacy is taken to be "the entitlement of individuals to live their own lives free from outside intrusion" (p. 223).

Whilst medical confidentiality is generally one of the cornerstones of medical practice all over the world, it is not unheard of that some medical practitioners have been found to have made unlawful or unconsented disclosures of patients' confidential matters (see Gruskin & Hendriks 2000 for doctors' disclosure of patients' HIV-positive status). When patients feel or fear that hospital interpretation erodes their right to privacy, they may be hesitant to use it, or may use it in such a way that they do not disclose personal details that would lead to loss of confidentiality.

Table 5.3: Does interpretation erode privacy?

Response	Frequency	Percentage
Yes	11	2.3
No	461	96.4
No Response	6	1.3

I take privacy to encompass what Brown and Levinson (1987) call negative face and positive face. The former is the human desire to be left alone or to have territorial freedoms. On the other hand, positive face refers to the human desire to be appreciated, or loved, or praised or liked. It follows then that normally human beings would not like to have their positive face damaged through, for example, the leakage of private and confidential information. For example, (with reference to Table 5.3) if a patient is diagnosed as being HIV-positive and this is relayed to him or her through an interpreter who later leaks the same information to the public, then the privacy of the patient has been breached.[14]

Lack of adherence to Grice's (1975) maxim of manner can lead to some communicative inefficiency. By not adhering to this maxim, a speaker fails to convey information in a clear and unambiguous manner. To this end, clients were asked whether they supported the view that explicit language should be used in reproductive health education. In response, the majority gave an affirmative answer (see Table 5.4). This result is surprising since there is a general discomfort about discussing HIV/AIDS and reproductive health issues openly in Malawi. The result in Table 5.4, showing the majority being in favour of the use of explicit language, is obviously at variance with what happens in Malawi. My interpretation of the result is that the respondents simply wanted to give responses that would please the researcher. They wanted to create a positive image for themselves as people who were open-minded and ready to talk openly about health issues that haunt their society.

Table 5.4: Should reproductive health education carry explicit language?

Response	Frequency	Percentage
Yes	460	96.2
No	13	2.7
No Response	5	1.0

A related question asked clients to justify the YES or NO responses that were given in Table 5.4. For those who gave a YES answer, the justification of use of explicit language was that it was easier to understand than implicit language. For example, Thomas (1995) argues that indirectness can be risky and costly in the sense that it may take time before an interlocutor understands the intended meaning, and sometimes the speaker's intended meaning may be lost entirely. I will cite an example which Mr Katola, one of the clinicians at the MCH, experienced. Whilst giving her history, a female patient told Mr Katola (in Tumbuka) that

"*nili na sugzo kumaso"* (I have got a problem on my face). The clinician examined the patient's face and found that it had no lesion or any other worrying development. He told the patient that she was fine, but the patient kept on insisting that she had a problem with her face. The clinician was confused. Realising that the clinician was unable to decipher her verbal indirectness, she physically pointed at her genitals. That was when Mr Katola realised that the 'face' was a euphemistic expression for the genitals. Whilst Tumbuka and indeed all Malawian languages have exact words for the genetalia, it is culturally a taboo to mention them in a direct way.[15] The most culturally appropriate way to refer to genitalia is through the use of indirect verbal strategies.

As Table 5.4 shows, there were some respondents who rejected the use of explicit language and argued that such a practice borders on obscenity. They went further to argue that young people could indulge in immoral sexual behaviour as a result of having been influenced by the explicit language of the reproductive health education. The straight talk approach, a recent development in Malawi, is said to be in conflict with cultural norms. The only culturally accepted contexts for open talk about sex are the initiation ceremonies for young men and women. Since these are closed cultural ceremonies, the elders have no worry about open talk on sex and other related topics.

Clients were also asked about the verbal strategies that they used in client-service provider communication when making references to reproductive organs and/or excreta functions. They were asked to choose from three options, namely: direct reference, indirect reference and not mentioning the organ or function at all. The direct reference strategy corresponds to Brown and Levinson's (1987) bald on record strategy. This means a non-euphemistic reference is made to sex or excreta organs. The indirect strategy has been well articulated by Obeng (1997). He distinguishes four types of verbal indirectness, namely the use of metaphors and proverbs, innuendo, circumlocution and evasion. The majority of the respondents said they use the direct verbal strategy (see Table 5.5).

Table 5.5: Verbal Strategy When Referring to Reproductive Organs and/or Excreta Functions.

Verbal Strategy	Frequency	Percentage
Direct Reference	340	71.1
Indirect Reference	133	27.8
No Response	5	1.0

Though Table 5.5 gives the impression that clients predominantly used the direct verbal strategy when making references to the reproductive organs, evidence given by service providers at the MCH and other health care institutions as well as evidence collected from a focus group discussion with some clients and the examination transcripts of clinical interviews show a general tendency to go for various forms of indirectness. For example, in a focus group discussion with clients, there was unanimity that the clients use direct verbal strategies. But when they were pressed to give examples, no one gave any. They simply and vaguely said *"timatchula"* (Chewa: we mention), without giving any concrete example.

Even service providers do not go for direct references to reproductive organs. For example, a male patient had complained to a male clinician about urinal problems. When the time came for the clinician to conduct a physical examination of the urinal organ, he avoided the use of the word *mbolo* (penis) and instead used a vague expression *kumusiku* (down there). Below is part of the clinical interview, conducted in Chewa:

Clinician: *Mukufuna kundiuza kuti mumakodza magazi tsiku liri lonse?* (You want to tell me that you pass bloodstained urine every day?)

Patient: *Mmmm* (yes).

Clinician: *Mumamva kupweteka mukamakodza?* (Does it pain when you urinate?)

Patient: *Eeee* (yes).

Clinician: *Muli ndi zilonda kumusiku?* (Do you have sores down there?)

Patient: *Ayi kulibe zilonda zili zonse* (No, there are no sores).

It is important to note that despite the fact that the above was a same-sex clinical interview, there was still an attempt to avoid direct references to the urinal organs. Instead, an indirect reference *kumusiku* was used, and the patient understood what it meant. The same approach can also be detected in the excerpts (in Chewa) below in which a woman discloses to a male clinician her urinal problem:

Patient: *Ndikamakodza ndikumamva kupweteka. Mkodzo ukupweteka potuluka.* (When I urinate, I feel pain. The urine is painful when it is coming out).

Clinician: *Kuyambila liti?* (Since when?)

Patient: *Kuyambila dzana la Mulungu.* (Since Sunday).

Clinician: *Mikodzoyo ikumaoneka bwanji?* (What does the urine look like?)

Patient: *Nthawi zina ya **yellow**, nthawi zina yoyela*. (Sometimes it's yellow, sometimes it's white).

Clinician: ***Apart from** mikodzoyo kupwetekako, palinso china chomwe mukumva kupweteka?* (Apart from the pain when urinating, do you have other pains?)

Patient: *Ndikumvanso kuyabwa nthawi zina kumusiku.* (It sometimes itches down below).

Clinician: *M'mimba? Mukumva kupweteka chili chonse m'mimba?* (How about the stomach? Do you have any pain there?)

Patient: *Ayi, simukupweteka.* (No, there is no pain).

Clinician: *Mukakhalira limodzi ndi abambo, mukumamva chili chonse?* (When you stay together with your husband, you feel any pain?)

Patient: *Sindikumvanso kupweteka, olonso mabala, ayi. Koma kuyabwaku.* (I feel no pain, no bruises. It's just the itching).

Again, there is use of indirect references to genitalia here. For example, the patient refers to her vaginal area, which itches, as *kumusiku* (down below), and avoids a direct reference. When the clinician wants to find out whether the patient feels pain when having sex with her husband, he avoids the expression *kugonana* (to sleep together) and opts for the indirect form *kukhalira limodzi ndi abambo* (staying together with the husband). Since the two clinical interviews that I have discussed are both FTAs, it is easy to notice the mutual desire on the part of the clinician and the patients to maintain each other's positive face by avoiding direct references to genitalia. This is in contradiction to the claims made by the majority in Table 5.5.

Discussions with some service providers, for example clinician Mr Katola of the MCH, service provider Mr Pindani of Banja la Mtsogolo outreach programme and Ms Manda of MACRO, revealed that there is a general tendency for the clients to be embarrassed by direct

mentioning of sex or excreta organs. The situation is more critical in mixed-sex interactions. On the whole, men were said to be less shy than women.[16] Even what the service providers called direct reference was not actually direct but rather the use of euphemistic forms of references. One good example is the use of the Chewa word *chida* (organ) instead of the bald on record form, *mbolo* (penis). It would appear that what is known as calling a spade a spade is relative. What is direct or indirect reference to sex or excreta organs will vary from person to person depending on a host of factors

Since the radio and health NGOs had been criticised in Malawi for being too explicit in their coverage of HIV/AIDS and reproductive health issues, I interviewed some key informants from the state-run MBC, two private radio stations, and two health NGOs i.e. MACRO and Banja la Mtsogolo. The aim was to find out each institution's policy regarding the use of explicit/implicit language in reproductive health and HIV/AIDS education. To start with, MBC runs its programmes on HIV/AIDS on the policy of calling a spade a spade. When I inquired from Capital FM, a privately owned radio station based in Blantyre, my informant told me that they also follow the straight talk approach when addressing HIV/AIDS issues. The situation changed when it came to a spiritual radio station, TransWorld Radio. A key informant from the radio said that they avoid explicit language and opt for euphemistic expressions to avoid causing offence. This response should be understood within the context that this is a spiritual radio, and as such, the tendency is to treat straight talk as bordering on immorality. Open discussion of sexual behaviour and intimate anatomy is a taboo in the religious circles. In addition, some religious denominations are uncomfortable with radio and print media advertisements on condoms. It is argued that condom promotion promotes sexual promiscuity.

The position of MACRO was outlined by Ms. Manda who said:

> When it comes to HIV/AIDS, in fact we call a spade a spade. There is no need of hiding. We have to mention the organs by their names. If we hide (in HIV/AIDS), it means we are not helping the client. The client cannot get the real message. So we talk about sensitive issues as they are, even in public when we go out into communities or in the counselling room, we feel free to talk about sensitive issues without hiding. Of course sometimes may be the client feels uncomfortable but then during the course of counselling or discussions, then they get used and we reach the point of understanding.

Mr Pindani, a key informant from Banja la Mtsogolo, echoed the views cited above: "We have to call a spade a spade and it includes mentioning sex organs." When I pressed him to give examples of how the organs are referred to in the local languages, his response showed that there is an attempt to go for veiled references to the sex organs rather than the more bald on record references. For example, the penis would be called *chida* (Chewa word for weapon or equipment) or *chiwalo chobelekela cha abambo* (man's organ for reproduction), and not the bald on record *mbolo* (penis). For women, there is reference to *chiwalo chobelekela cha amayi* (the organ for reproduction in women) or *kutsogolo kwa amayi* (the front of a woman), and not the bald on record *nyini (*the vagina). The Banja la Mtsogolo informant admitted that the use of veiled terms can sometimes cause misunderstandings since, for example, someone can take *kutsogolo kwa amayi* (a woman's front) in a literal sense. He added that during HIV/AIDS talks, demonstrations do help to clarify meaning. It was also mentioned that the discussion becomes sensitive when the audience is of mixed-sex. In such mixed-sex groups, women tend to be more uncomfortable than men in making references to sex organs.

I also examined the directions of condom use which come with the Chishango brand of condoms. Population Services International (PSI) markets the Chishango condoms in Malawi.

At the MCH, I saw a number of posters urging people to use *chishango (*apparently in Chewa, *chishango* means a shield or protector). The condom as *chivikiliro* (Tumbuka: protector) was also popular in radio jingles on HIV/AIDS. In the packet containing Chishango condoms was an instructional leaflet. In the leaflet, I noted that there was again the avoidance of direct references to the genitalia. Instead, vague references were used, probably in the interest of face considerations. For example, there was no mention of *mbolo* (penis) but simply *chida or chiwalo* (organ). Let us examine this instruction, as an example:

> *"Musavale kondomu pokhapokhapo chiwalo chanu chitadzuka ndipo chisanakhudze maliseche a mkazi."* (Do not put on the condom until your organ is erect and has not touched the woman's nakedness).

In the above instruction, there is avoidance of the more common expression *kutota* for an erection, and instead *kudzuka* (to wake up or stand up) is used. The man is cautioned against having his organ touching the woman's *maliseche* (nakedness). *Maliseche* is vague and too general. It is can mean thighs (*ntchafu*), or the vagina (*nyini*) or the buttocks *(matako*). Whilst what the condom manufacturers had in mind here was specifically the vagina, they were at pains to mention it directly in the vernacular as *nyini.* In the process, clarity is sacrificed through the use of the vague referent, *maliseche.* This example of condom use discourse agrees with my earlier argument that the so-called straight talk is not always straight.

The post-Banda political atmosphere has ushered in some degree of open talk about HIV/AIDS. The official policy is to break the culture of silence. Whilst breaking the culture of silence is being called for, one also sees a continued existence of the desire to maintain the culture of silence. For example, rarely is a death of a family member attributed to HIV/AIDS even when it is well known to have been the cause of the death. It has become a standard practice in Malawi to talk of someone as having died "after a long illness", where the long illness is actually a euphemistic reference to HIV/AIDS-related illnesses. There is a slow move towards some openness that is characterised by veiled talk about HIV/AIDS. In other words, there is a tension between silence and veiled talk on one side and straight talk on the other hand. I have argued in this section that this tension is caused by the desire to attend to face needs. HIV/AIDS is a face-threatening topic, and as such when it is addressed, FTA redressive measures have to be taken. One of the measures is to avoid the topic altogether (i.e. avoid doing the FTA). But this is impossible given the serious threat to human life that HIV/AIDS poses. The 'softer' option seems to talk about HIV/AIDS through the use of various verbal indirectness strategies. It is abundantly clear from the discussion so far that health service providers' talk about HIV/AIDS and reproductive health issues in Malawi involves walking a tight rope between achieving clarity and accuracy of information while at the same time avoiding being offensive and disrespectful to the societal moral norms.

5.7. Comparing and Contrasting the MCH with South Africa's Multilingual Hospitals

In this section, I compare and contrast the communication barriers that exist at the MCH with the situation at multilingual hospitals in one African country, South Africa.

In the discussion on the South African situation, I mostly rely on Saohatse's (1997, 1998, 2000) sociolinguistic study of the situation at the Baragwanath hospital in Johannesburg as the main case study. The discussion is complemented by references to other South African studies such as Drennan's (1998) examination of interpretation services in psychiatry hospitals and Crawford's (1999) sociolinguistic study at some Cape Town hospitals. My aim is to compare and contrast the language and communication problems at the MCH with those

obtaining in South Africa. In this way, I attempt to demonstrate how each country's unique sociolinguistic and political situation impact on communication in the delivery of health services. It is important for me to justify my choice of South Africa as a case for comparison and contrast with the MCH. First, it is the only country, to my knowledge (as far as the African Sociolinguistics literature is concerned), that has had some notable sociolinguistic studies conducted in multilingual health service delivery institutions. Secondly, the interplay between language and human rights is one of the cornerstones of South Africa's post-apartheid language planning/language policy (see, for example, Langtag Report 1996; Bamgbose 2000a).

In order to appreciate the language and communication problems that the MCH and the Baragwanath face, one has to consider the size of the institutions and their catchment areas. The Baragwanath is the largest referral hospital in South Africa. It caters for a population of about 3 million. The hospital has a bed capacity of 3,000. In terms of its catchment area, the Baragwanath hospital serves as both a national and international hospital. Foreign referral cases normally come from Mozambique, Malawi, Botswana, Zimbabwe and Lesotho. The fact that the hospital draws its clientele from both within and outside South Africa adds to the linguistic heterogeneity of the hospital (see Saohatse 1997, 1998, 2000). South Africa has a number of immigrants from both African and non-African countries. In South Africa, therefore, one is confronted with a representation of the major languages of the world. As South Africa's largest hospital, the Baragwanath has become the microcosm of South Africa's linguistic complexity. The country is very mixed in racial, linguistic, cultural and political terms, hence it is called the rainbow nation. The MCH, on the other hand, carries a less complex linguistic and cultural composition than the Baragwanath. This is the case because the MCH mainly caters for clientele from the Northern Region of Malawi. It is neither an international nor a national hospital. It is also smaller in size than the Baragwanath. Whilst the MCH does receive cases of linguistic minorities who are unable to speak any of the lingua francas, the frequency of such cases is very low.

Both the Baragwanath and the MCH have multilingual workforces. In addition, both hospitals have significant numbers of expatriate staff. The general tendency at both hospitals is that the majority of the expatriate staff do not speak the local languages which are mostly used by the patients. The expatriate staff at both hospitals use English to communicate with either other staff or patients. At both hospitals, the exclusive use of English by the expatriate staff is one of the main linguistic barriers in client-service provider communication since the majority of the clients do not speak the language. Out of 1118 patients that Saohatse interviewed at the Baragwanath, a significant majority, 75 %, claimed that they did not understand English. That means only 25 % of the patients understand English. The analysis of the questionnaire that was administered to clients at the MCH shows that 55.2 % said that they use no English at all in their daily undertakings (see Table 4.17 in chapter 4). None of the clients at the MCH said they use English all the time. These figures from the two hospital indicate that English is not the patients' most widely used language. English is therefore a minority language at both hospitals. Thus, the expatriate staff require interpretation in order to communicate with most of the patients.

Whilst both hospitals require interpretation services, the volume of this service is different in each situation. The Baragwanath, being larger in size, and catering for a more linguistically diverse clientele, demands a larger volume of interpretation than the MCH. Both hospitals have no established positions for interpreters. The situation in other South African hospitals is also the same as verified by Drennan (1998) and Crawford (1999). Interpretation is, therefore, conducted on an ad hoc basis.

Another situation that heightens the language and communication problems at the Baragwanath is discrimination against speakers of certain languages. Some nurses at the Baragwanath were said to be reluctant to assist patients who spoke a language different from theirs (Saohatse 1997). This kind of behaviour, was however, not recorded at the MCH. Whilst it is true that Malawians are ethnically divided in terms of political affiliation and voting patterns as shown during the 1994 and 1999 multiparty general elections (see Chirwa 1994/95; Kaspin 1995; Osei-Hwedie 1998; Ott et al 2000), this has not resulted in service providers refusing to serve patients from other ethnic groups. There was evidence at the MCH, on the other hand, of the role of the service provider being that of service to every member of the nation irrespective of their ethnic group. This view can be noted from the statements made by some of the service providers through questionnaire responses and interviews. Service providers were asked whether or not they agree with the proposal that posting of health personnel should be language-determined. That is, staff should be posted to areas whose languages they can speak. Since languages are closely tied to ethnicity, this means working among ethnic groups whose language(s) one understands, and also the possibility of working among one's own ethnic or language group is very high. Both service providers and the clients rejected this proposal. For example, amongst the clients, the majority of them, 97.7 % rejected the proposal. When the same question was put to service providers, the majority of them, 78.5 % said that posting should not be language-determined. Relevant to our present discussion are the grounds on which the proposal was rejected. One of the grounds for going against the proposal is the fear that such a proposal, if implemented, would compel service providers to work amongst their own ethnolinguistic groups. It is feared that such a policy would promote ethnic loyalty at the expense of national loyalty.

5.8. SUMMARY AND CONCLUSIONS

In this chapter, I have identified and discussed the following linguistic barriers to communication existing at the MCH: multilingualism, the use of English as a medium of communication, minority languages, illiteracy and facework. Whilst some of these factors may not be inherently barriers to communication, certain prevailing conditions can turn them into communication barriers. For example, interpretation is generally expected to work as a bridge to communication. However, poorly conducted interpretation can end up being a barrier rather than a bridge to communication. On the basis of the findings presented in this chapter, I have argued that the notion of communication barriers is not static. That is, a communication barrier is not a barrier under all situations. For instance, in this chapter, I have argued that the use of English as a medium of communication at the MCH oscillates between being a bridge to communication and being a barrier to communication, depending on the angle from which one examines the situation. In the case of local and expatriate service providers at the MCH, English is not a barrier but a bridge to communication. It is, in short, a lingua franca that enables individuals who have no common mother tongues to communicate effectively. For the non-English-speaking clients at the MCH, on the other hand, English is obviously a barrier to communication. To such a group, English is an instrument for effecting social exclusion (cf. Bamgbose 2000a). This is the double-edged nature of English. This situation points to the contextually specific nature of the notion of communication barriers that this chapter has discussed.

NOTES

[1] The latest population census of South Africa, 2001, reported that 8.2 % of the population claimed to speak English. The figure represents a drop from 8.6 % in 1996, according to *Cape Times*, 9th July, 2003.

[2] Notice the clinician's reference to the patient as a Chewa (*Mchewa*) and not as a Chewa-speaking individual. This is consistent with what was pointed out in chapter 4 about the tendency to attach an ethnic group to a person on the basis of the language he or she speaks. Also refer to Mr Chigamba's experiences in chapter 4 (section 4.4.4) regarding the use of the label *Mchewa*.

[3] This was a predominantly Yao-speaking patient who could not even speak Chewa competently, thus the Tumbuka mother tongue speaker clinician could not use Chewa to communicate with the patient. That is why the Yao-speaking clinician was brought in as a language broker.

[4] Even in the United States, nurses in multilingual health care centres have complained about the heavy demands interpretation places on their "regular duties without additional compensation" (Elderkin-Thompson et al 2001: 1355)

[5] For instance, a sociolinguistic study in the South African engineering industry has noted the predominant use of English in official domains against a background of a large black workforce that is not proficient in the language. Hill and van Zyl (2002) have noted that black engineers who have multilingual competencies are an asset. They are being used by management "to translate forms, handbooks and training manuals for workers and to liase with the public. They are also helping workers by representing them to management and by voicing grievances" (Hill & van Zyl 2002: 34).

[6] According to Bischoff et al (2003: 504), language concordant consultations refer to situations where the patient and the service provider speak the same language. Language discordant consultations, on the other hand, refer to situations where the patient and the service provider have no language in common.

[7] Some of the *asing'anga* (traditional healers) claim that they can tell a patient's problems without the patient him/herself saying anything. Some of them also claim to have 'videos' which enable them to 'to see' those bewitching the patient.

[8] See, for example, James Mphande's article, "Karonga man drops album" in *The Nation,* 18th August 2003. In the article, a Karonga-based musician (Promise Msiska) talks about his 10-track album that comprises Chewa, Tumbuka and Swahili songs. He justified his language choice as follows: "I used Chichewa because it's spoken countrywide, Tumbuka is my mother tongue, and Swahili came on public demand because of some people I stay with in Karonga cannot understand Chichewa."

[9] The Chewa term *boma* (a borrowing from Swahili) means government or a district headquarters. Its usage in this particular context refers to a district headquarters.

[10] The term resident refers to one of the stages in the development of a doctor's career:
Stage 1: medical student.
Stage 2: houseman/intern (intern= US usage).
Stage 3: registrar/resident (resident= US usage).
Stage 4: consultant/attending (attending= US usage).

[11] For example, Haffner (1992) cites the case of a Latino American woman who had gone to a US hospital three times and yet felt too uncomfortable to reveal to the clinician that she had a rectum problem. This was because on those three occasions, her son had acted as her interpreter. It was on her fourth visit that she was lucky to have access to a hospital interpreter and she loosened up and made the revelations about her rectum problem.

[12] It is not only in Malawi where an HIV-positive status is an FTA. Note that in Uganda, for instance, born-again Christians tend to regard people with AIDS as "sexual sinners" (Seidel 1990: 78).

[13] Such behaviour has also been observed in other parts of the world, for example among Latino American communities in the USA (see Garces 2002, 2001); Tanzania (Mutembei et al 2002); Uganda (see Seidel 1990); Israel (see Solomon 2001); Zimbabwe (see Kesby 2000), and elsewhere. In these societies, even among married partners, there is generally a culture of lack of open discussion about sex. Even the teaching of the human reproductive system during science lessons in schools is sometimes a rather uncomfortable topic for some teachers. For instance, in a study investigating problems encountered when teaching primary school science in Zomba urban schools in Southern Malawi, Juliet Kamwendo et al (2003) found that one of the problems was that some teachers were uncomfortable to teach the human reproductive system. As a result, the topic is not taught well since some teachers skip certain aspects of the topic. According to Juliet Kamwendo (personal communication), the human reproductive system is classified as "*topic yochititsa manyazi*" (an embarrassing topic), especially when teaching primary school pupils who are generally young.

[14] See Gruskin & Hendriks (2000) on the limitations to the right to privacy of HIV-positive persons - the right to privacy is not absolute.

[15] For example, in Uganda, it has been observed that local languages such as Runyankole lack socially appropriate terms for human genetalia which health service providers can employ in public talks/demonstrations on how to use condoms. What exist in the local languages are the crude and socially inappropriate names for genitalia (Seidel 1990). The same problem led UNFPA in Malawi to fund a joint MBC/Centre for Language Studies study of the most socially acceptable local language terms for reproductive health.

[16] Hatton and Webb (1993) mention that some interpreters, especially the young and inexperienced, said that they felt uncomfortable to interpret in venereal disease clinics. One female interpreter lamented: "When you're translating for males, there are times that they stare at you and you feel very uncomfortable, very embarrassed because you're mentioning parts of their bodies. That's the only thing that I don't like about translating, when I'm translating for males in the VD clinic...they expect you to say things like it's nothing and it is something for us because I get embarrassed" (Hatton & Webb 1993: 144).

CHAPTER 6

LANGUAGE SERVICES AND LANGUAGE RIGHTS

6.1. INTRODUCTION

Chen (1998: 45) has argued that: "If there had not been any Tower of Babel - if there were only one language in the world today, then there would be no need and no place for the concept of language rights." With respect to language services, I would argue that if there had not been any Tower of Babel - if there were only one language (with no variants) in the world today, then perhaps there would have been no need for language services or language mediation. Before I mention the topics of discussion for the current chapter, it is important to spell out the justification for language services at the MCH. The critical importance for the service provider and his or her client to be able to communicate through a common language has already been spelt out in the previous chapters. Furthermore, previous chapters have also shown that there are a number of occasions at the MCH when communication between a service provider and a client has to be rescued by an interpreter. Language services, therefore, aim at narrowing the language gap.

In this chapter, I have arranged the discussion as follows. First, I discuss interpretation, the main language service at the MCH, in section 6.2. A related language service, translation, is discussed in section 6.3. Another language service that has been suggested by some of my study's respondents is the provision of language courses to service providers. I discuss this topic in section 6.4. In section 6.5, I discuss language services that I have categorised as OTHER. In section 6.6, I discuss the role of NGOs and donors in the promotion of language rights in Malawi. As mentioned earlier in chapter 3 (section 3.5), the implementation of language rights is not an easy matter. In this regard, I devote section 6.7 to a discussion on the conundrums of linguistic rights. The last section, 6.8, carries the summary and conclusions of the chapter.

6.2. INTERPRETATION

The Constitution of Malawi (Malawi Government 1995a) grants the right to interpretation services to the justice system only. The implicit assumption is that without interpretation, there would be miscarriage of justice. Of course, there is evidence to support the importance of having interpretation services in the justice system in multilingual Africa (see some examples cited in Brock-Utne 2002). What is problematic, however, is that by providing for interpretation in the judicial domain only, to the exclusion of other public service domains, the constitution creates the wrong impression that this language service is not important in the other domains. But as chapters 4 and 5 have so far shown, the MCH cannot do without interpretation. The MCH is just one of the many contexts in the public services domain where interpretation is regularly required. I should also point out that there are no documented official guidelines on interpretation at the MCH. Despite the absence of official guidelines, the MCH still offers ad hoc interpretation through networks of support that exist between service providers and clients.

Although sometimes the terms interpretation and translation are used interchangeably (e.g. Hatton 1992; Hatton & Webb 1993), I take the more widely held view that whilst both translation and interpretation are concerned with the conversion of messages from one language into another, the two activities are very distinct. For this reason, interpretation shall

mean the act of converting oral messages into another language whilst translation shall mean the conversion of written messages from one language into another (see Haffner 1992; Valdes & Angelelli 2003). Anyone who performs the task of interpreting or translation shall be called interpreter or translator respectively, irrespective of whether or not they have received professional training in that field. I am using these 'loose' definitions of interpreter and translator because if I were to use the more strict definitions (e.g. Perkins 1999), then no one at the MCH would qualify as an interpreter.

According to what I call a more strict definition, interpreters are "persons who have received some training in medical interpretation and the ethics of interpreting. This does not include friends or family members (particularly adolescents) unless they have received such training" (Perkins 1999: 1). This definition does not apply satisfactorily to the MCH where anyone with the ability to speak the languages of the interlocutors can act as an interpreter. I am also aware of a special way in which the term interpretation is sometimes used in the medical Community of Practice. As Davidson observes, "in medical settings interpretation means something other than 'oral translation'; it is understood, by institutional insiders, that physicians interpret diseases and disease processes, which is the heart of medicine" (Davidson 2001: 173). It is for this reason that some medical practitioners talk of translation rather than interpretation.

I should point out that in the current study, my main goal was to collect data on interpretation from clients' and service providers' perspectives (Valdes & Angelelli 2003), i.e. how each of the two categories viewed interpretation as it was conducted at the MCH. To this end, relevant data were collected through clients' and service providers' questionnaires as well as interviews with key informants. Through these methods, I have been able to ask the following questions: Under what circumstances was interpretation required? Which linguistic groups were mostly in need of interpretation? Who provided the interpretation service? How effective/ineffective was the interpretation as a bridge to communication? What this study has not done, however, is to conduct a discourse analysis of interpreter-mediated communication between service providers and their clients. This option is mainly applicable to studies that follow the discourse analytic approach, for example, Davidson (2000, 2001) and Bolden (2000). In such studies, it is the interpreter-mediated communication itself that becomes the focus of the analysis (see also chapter 8 for suggestions for further research).

6.2.1. Need and Use of Interpreters

6.2.1.1. Service Providers' Views

The inability on the part of a service provider to speak a patient's language is a linguistic barrier to communication. This barrier can be removed by the use of interpreters. But interpretation itself can sometimes turn out to be another communication barrier if it is not well handled. This is not to suggest that interpretation is not an efficient way of breaking linguistic barriers to communication. The argument here is that whilst interpretation can break down communication barriers between interactants who do not share a common or bridging language, the ability to communicate directly without the need for interpretation has its own merits which should not be overlooked. I would argue that as the first option, client-service provider interaction should be direct (i.e. communication without the use of interpreters). Interpretation should only be used when direct interaction is not possible. The service providers at the MCH were, therefore, asked whether it was important for them to be able to speak the language of their clients. The vast majority of the responses were YES (see Table 6.1).

Table 6.1: Is it important for service providers to speak clients' language(s)?

Response	Frequency	Percentage
Yes	72	91.1
No	7	8.8
TOTAL	**79**	**99.9 (100)**

It is significant to note that the overwhelming majority of the service providers held the view that it was important for them to share a common language with their clients. This is a sound solution for breaking language barriers. As a follow-up question, the service providers were asked to justify their responses. The main reason that was cited in support of the YES position in Table 6.1 was that if a service provider speaks the language of his or her client, communication problems are minimised. At the same time, it was recognised that speaking a common language does not necessarily mean that communication problems between interlocutors can be eliminated completely. There could be some problems that may be linked with inadequate command of the target language or use of different variants of the same language.

Some service providers went on to elaborate on the importance of speaking the patient's language as being the fear of getting faulty interpretation. Faulty interpretation has its roots in more than one factor. Inadequate command of a language can cause faulty interpretation. Another possible cause could be the tendency to leave out or edit what one of the interactants has said. This boils down to an interpreter who "cannot say exactly what the patient is complaining about," a point made by one of the nurses (service provider 28). Service provider 69, a trainee technician who had no competence in the hospital's mostly used language, Tumbuka, but spoke English, Chewa and his mother tongue, Sena, had to rely on interpreters whenever he met Tumbuka-speaking patients who spoke neither Chewa nor English. From his experiences, he claimed that "when you use interpreters, you cannot get exactly what the patient wanted to talk to you." Another form of faulty interpretation was to put words into the mouth of either the service provider or client as service provider 33 (a nurse) claimed. She said: "If you speak the language of your patient, it makes it easier to solve your patient's problem because an interpreter can easily say what a patient hasn't said."

Some studies have documented the existence of conflict between service providers and interpreters due to the fact that service providers, usually doctors, accuse "the interpreter of censoring or inadequately translating the patient's reply" (Kaufert & Koolage 1984: 285; see also Saohatse 1997, 1998, 2000; Crawford 1999). Interpreters are also known to act as editors (see Crawford 1999; Bolden 2000). The view that interpreters can act as editors seriously questions the popularly held metaphor which designates an interpreter's work as being "that of a 'voice box' or a 'translating machine'. According to this view, each utterance in language A is transformed by the interpreter into an equivalent in language B" (Bolden 2000: 390). But as the service providers at the MCH have observed, and research in other countries has also shown (e.g. Kaufert & Koolage 1984; Saohatse 1997; Crawford 1999; Bolden 2000; Davidson 2000, 2001), interpreters decide what to say and what to leave out. In so doing, interpreters do not always convey unaltered messages.

In the context of taking interpreters as linguistic mediators who bridge the communication gap, I raised the question as to whether it was necessary for the interpreter to have some medical background. The dominant view that emerged from my interviews with the service providers was that an interpreter who had some medical professional background was a better facilitator of communication between a service provider and a client. For example, Mr Chimalizeni, a service provider at the MCH who served as one of my key informants, was of the view that an interpreter with "medical training can explain better

because he knows the problem and can really interpret well rather than someone who just knows that language." Another key informant, Dr Matata, strongly emphasised that knowledge of language(s) involved in an interpreted interaction is not enough. The interpreter, above his or her language proficiency, needs to be well informed of the field whose discourse he or she is handling. She noted that:

> If I understand my field of work, a patient might fail to express himself properly but you know I have knowledge of what really that patient is suffering from, I can help that patient tell whatever he wanted to tell or say. If you don't understand the background of the field of work, in this case XXX, you might start interpreting in your own language in such a way that you mislead the one you are interpreting to.

The point raised by Dr Matata above is important considering that if interpretation is not handled competently, it can actually widen, rather than narrow, the language gap between a service provider and his or her client. The same view has also been documented in studies conducted in other countries' medical contexts.[1]

A minority of the service providers in Table 6.1 did not see the importance of service providers' ability to speak a common language with their clients. For example, it was argued that in some contexts there was no need to get into interaction with the patients. Laboratories were cited as one of such contexts. A laboratory technician argued that the language problem or the need for interpretation did not arise in his case since he did not need to interview patients. All he needed to do was to get the patients' specimens, be it blood, urine or stool. What this service provider and others who subscribed to this view missed is the fact that a laboratory technician still has to talk to patients. For example, he or she may have to give instructions to a patient on how and when to collect specimens. Or the patient may want to get clarifications on the instructions he or she has received from the laboratory technician. It is, therefore, not correct to see the job of a hospital laboratory technician as having nothing to do with verbal interactions with patients. What has been noted in actual observations, however, is that laboratory technicians' interactions with patients are less intensive than is the case with clinicians. This is the case because whilst clinicians have to conduct history taking, which can sometimes be long and language-intensive, the same is not expected of technicians.

When patients have the so-called "straightforward medical problems" (Baker et al 1996) - such as a laceration or a sprained ankle - clinicians find little or no need for an interpreter, or a common language with the patient. This view was also advanced in the patient/hospital attendants' focus group discussion. It was pointed out that some accident victims come to the hospital unconscious or are simply unable to speak. There is, therefore, no opportunity to have a clinical interview with such patients. Physical examinations take the upper hand. Through processes such as x-raying, a patient's injuries may be identified and then treated. These are special and rare cases when talk is temporarily suspended.

A service provider in the dentistry section, a dental therapist, had argued that if a tooth is rotten, it is can always be seen with the naked eye. A dentist does not have to be told that there is a rotten tooth. It means that even if there is no common linguistic medium of communication between the therapist and the patient, the former will still be able to make a diagnosis and treatment prescription. A senior colleague of the dental therapist, however, dismissed this view, arguing that even when it is clear that a client has a rotten tooth, some questions may still have to be asked by the therapist which the patient has to answer. History taking cannot be declared irrelevant. That means the service provider has to be able to speak the client's language. If that is not possible, an interpreter has to be used.

When I visited the physiotherapy department, I asked the service providers about their experiences with regard to the importance of communicating with patients either directly or

through interpreters. My intention was to find out whether it was necessary for service providers to communicate directly with such patients since it was easy to see what physical problems the latter had anyway. One patient attendant whom I met whilst she was helping a patient to do some body exercises, provided an informative example of the importance of direct as opposed to mediated communication between a service provider and a client. The patient attendant noted that although she could see that the patient's problem was either an injured arm or leg, she still had to ask the patient about how, where and when the injury was sustained. In addition, she also needed to know which areas of the injured arm or leg were most painful. It was pointed out by my informant that during such body exercises, she had to take great care to ensure that the patient was not harmed. She would, for example, ask the patient: *ndikatele, mukumva kupweteka?* (When I do like this, you feel some pain?), just to ensure that the body-fitness exercises were not harmful. She could not have simply directed the body exercises without talking to the patient, or by simply communicating through gestures. Relying on signs/body language can be misleading and problematic. The role of intelligible verbal communication, therefore, remained paramount in physiotherapy. The scenarios I have presented so far point to an essential point - the service provider has either to be able to speak a common language with his or her client, or use an interpreter in the absence of a common language.

Who needs interpretation at the MCH? Or, when is interpretation required at the MCH? Both service providers and clients at the MCH do have occasions when they need interpretation. Clients interact with two types of service providers, local service providers and expatriates. It is not only expatriate service providers, as a result of being foreigners, who need interpretation at certain times. Even some service providers of Malawian origin also find themselves in need of interpretation. For the expatriate staff, English is their sole medium of interaction with clients and fellow service providers. A nurse or any other local member of staff has to be around to help with interpretation whenever expatriate doctors are making ward rounds. For instance, a patient attendant (service provider 53) said that in her department: "We have a white doctor who doesn't understand Chichewa, I can say vernacular languages. So I go with her to interpret. I become a bridge between the two. So there are no difficulties because I interpret to both of them." The same practice also applies when expatriate doctors are working in examination rooms and other sections of the hospital.

Whilst theoretically one would think that local health service providers face no linguistic barriers in their daily work, the reality points to the opposite direction. Given that the most widely used language when dealing with clients is Tumbuka, local service providers who do not speak Tumbuka find themselves in need of interpretation. The situation becomes more complicated by the fact there are some clients who speak minority languages such as those spoken in Karonga and Chitipa. Even some of the Tumbuka-speaking service providers do not understand these languages. Here too, interpretation is needed.

Whenever a service provider was faced with a situation in which he or she had to serve a client whose language he or she did not understand, the mostly frequently adopted language facilitation strategy was to seek interpretation as Table 6.2 shows. This result is consistent with the dominant view in the health communication literature that interpretation is the standard solution for overcoming language barriers. The second most widely used strategy was for the service provider to switch to other language(s) in the hope that the client would understand at least one of them. To illustrate this strategy, I use examples extracted from service providers' accounts. First, I draw on an example cited by service provider 51, a patient attendant. She said that if, for example, a client spoke Swahili (a language that she did not speak), she would switch into Tumbuka. If that did not work, she would go for English. For those speaking either Ngonde or Lambya, she would try to switch them into Tumbuka, the

regional lingua franca. A Chewa-speaking patient attendant (service provider 58) gave another scenario whose communication strategy with clients would go as follows: "First, I ask a patient if she/he understands Chichewa. If yes, communication is very easy. But if it is not, I talk Chitumbuka." This particular service provider had the advantage of trying more than one language because she spoke five languages, namely Chewa, English, Lomwe, Tumbuka and Tonga. As can be noted, this strategy of trying out as many languages as possible on the client worked well for multilingual service providers. The strategy did not work satisfactorily for those service providers who had only one or two languages in their linguistic repertoire. This strategy simply demonstrates the power of the multilingual individual to break linguistic barriers.

The third strategy was the use of gestures or signs. The following account given by an expatriate radiographer (service provider 67), a native speaker of English who did not speak any local language, is quite illuminating: "Often an examination can be carried out using signs, gestures and expressions. When further communication is needed, one of the department's patient attendants or other member of staff translates[2] as required." Responding to the question whether it was important for service providers to speak a common language with their clients, the expatriate radiographer was of the view that "it is important though not always essential. The degree to which it is important will depend on the procedure being undertaken and how flexible the doctor/clinician is." These are very important observations as they point to the fact that not all hospital procedures need verbal communication at the same level. In some cases, the lack of a common language between a service provider and his or her client does not prevent the execution of certain procedures.[3] What can suffer, however, is the quality of the procedures or treatment.

Another strategy was to use the patients' documents. This applied to in-patients. For example, one of the nurses said that when she failed to know more about a patient due to lack of a common medium of linguistic communication, she would resort to reading the patient's records to know his or her medical history. But this does not take one far enough since it only applies to patients who have medical records. In the case of a newly arrived patient, this strategy cannot work since the patient has no records which the service provider can read and then be able to understand the patient better. Even when medical records are available, they cannot be a substitute for actual client-service provider interaction. Records, for example, cannot respond to questions about the current conditions of health. As Table 6.2 shows, speech still remains the most direct and reliable means of communication between a service provider and his or her client(s).

Table 6.2: When a Service Provider Does Not Understand a Client's Language

Strategy	Frequency	Percentage
Seek interpretation	58	73.4
Try another language	7	8.9
Use gestures	4	5.1
Use patients' documents	3	3.8
Never been in such a situation	1	1.3
No response	6	7.6

Service providers were also asked whether they had ever been involved in the interpretation process in any way. The involvement here refers to being either a provider or beneficiary of the language service. As Table 6.3 shows, the majority had been involved in interpretation in some way. Table 6.3 shows that service providers were not only on the receiving end of

interpretation services, but that they were also actively involved in the provision of the same service to the others who needed it.

Table 6.3: Involvement in Interpretation

Response	Frequency	Percentage
SP* interpreted	28	35.4
SP received interpretation	33	41.8
No involvement in interpretation	18	22.8

Note: SP* stands for Service Provider.

6.2.1.2. Clients' Views

Clients were asked whether or not they had ever used an interpreter at the MCH. The majority claimed that they had never used an interpreter. The minority who had used interpretation comprised clients who were non-speakers of English, non-speakers of Tumbuka and/or Chewa, especially those from Karonga and Chitipa, and some foreigners.

Table 6.4: Ever Used an Interpreter?

Response	Frequency	Percentage
Yes	53	11.1
No	425	88.9

I then engaged in quality assessment of the interpretation services offered at the MCH. My aim was to determine whether or not clients were satisfied with the interpretation they had received. I did not get an assessment with a critical tone. It appeared that the respondents were unable to detect faults or shortfalls in the language service. Clients were generally positive about the language service they received. As long as someone interpreted for them, it was assumed that everything had gone on well. It was as if the interpreter had rescued them, hence there was no need to critique his or her performance. Service providers, on the other hand, were more critical of the interpretation. This critical tone of the service providers can be detected in various sections of this and other chapters.

The majority of the clients made a recommendation that the MCH should have full time interpreters (see Table 6.5). Even though the majority had earlier indicated that they made no use of interpretation, they still felt that it would be appropriate to have full time interpreters. Whether they understood the implications of having full time interpreters is something we cannot say with finality.

Table 6.5: Full Time Interpreters at the MCH?

Response	Frequency	Percentage
Yes	413	86.4
No	60	12.6
No Response	5	1.0

The minority view was that there was no need for full-time interpreters at the MCH. Respondents justified this position is a number of ways. For example, some felt satisfied with the current arrangement of interpretation, hence they saw no need for engaging full-time interpreters. This view is reflected, for example, in the views of a nurse (service provider 40) who remarked that "generally communication at this hospital is made simpler by ourselves

(hospital staff) and guardians." This point is significant in the sense that despite the absence of posts for interpreters, language services were still made available. It was also argued that should there be resources for new posts, then those posts should be earmarked for the more directly relevant staff categories such as nurses and clinicians. In the context of the networks of linguistic support that existed at the hospital, the establishment of interpreters' posts would be a luxury.

6.2.2. Selection and Training of Interpreters.

The unwritten policy for selecting interpreters was that whoever claimed to speak the two languages concerned would be asked to interpret regardless of his or her training, expertise or other considerations. The language proficiency of those who interpreted was hardly taken into consideration when such individuals were asked to interpret. In some cases, service providers were actually aware that the language proficiency of the interpreter was not good enough, but in the absence of a better interpreter they still used that poor interpreter. Take, for instance, this revelation by a technician (service provider 68): "The other day, I came across a patient who was a Tanzanian, who could hardly understand Malawian languages. I had to use an interpreter, who was originating from Karonga and could know a little communication in Swahili." For this interpreter, Swahili was so passive a language in his linguistic repertoire that under a carefully controlled interpretation mechanism, he/she should not have been allowed to interpret.

With regard to the training of interpreters, Malawi is lagging behind. Justice Unyolo of the Supreme Court of Malawi (now the Chief Justice) had asked the vice-chancellor of the University of Malawi on the possibility of the university launching a degree course specialising in interpreting. The vice-chancellor sent this request to the Director of the Centre for Language Studies, who in turn sent it to other language departments for their consideration. So far no action has been taken on the Judge's request. The request implies that there are some concerns about the quality of the court interpretation. Matiki (2001b: 211) notes that "interpreters in Malawi are not given adequate training." For the majority, there is no formal training but learning the art whilst on the job.

I noted that translation and interpretation are not included in the training of medical doctors, nurses and other health personnel in Malawi. This was evident, for instance, in the syllabuses of the Language and Communication Skills programme at the Kamuzu College of Nursing (KCN) at the University of Malawi. The highest institution for the training of nurses did not train its students in how to interpret or how to use interpreters, and yet interpretation is the most sought language service in medical contexts as the results in Tables 6.2 and 6.3 indicate. The language and communication skills courses which the KCN offers are mainly geared towards equipping the trainee nurses with language skills for their academic work at the college. I have selected one course outline to exemplify the absence of study objectives that aim at equipping students with hospital communication skills. The selected course was offered to second year students and it was entitled English Language and Communication (code: EN 201). This course, scheduled for semester 1, run for 3 hours per week for 11 weeks. The course was aimed at assisting students in the development of communication skills that were needed for effective learning/studying and as practitioners in nursing. The course outline added that "emphasis is placed on the major study skills in reading and writing as well as for effective participation in other modes of learning such as lectures, tutorials, seminars." The specific objectives of the course were listed as:

i. To demonstrate scholarly reading and writing skills,
ii. To make effective use of study skills,
iii. To participate in effective oral communication,
iv. To demonstrate public speaking techniques and skills.

One clear problem with the above-cited course is its emphasis on English as the medium of academic work. This is basically English for Academic Purposes (EAP) course. There is little focus on the out-of-the-lecture room life i.e. the hospitals where the nurses will eventually work. Such an EAP course would have been more meaningful if, apart from acting as an academic tool, could also teach practical skills such as interpretation and some aspects of the sociolinguistics of hospital communication.

It is important that both long and short-term measures be taken to ensure that a cadre of well-trained translators and interpreters is available. As a short-term measure, tertiary institutions could start offering courses in translation and/or interpretation. In order to cater for the long-term needs of Malawi, the training of translators and interpreters should commence at the pre-tertiary level. To this end, the proposal is that some elements of translation and interpretation should be introduced into the primary school curriculum (see also Ngugi wa Thiong'o 1993: 39-40). As students enter secondary schools, more advanced aspects of translation and interpretation could be introduced. In this way, students would be better prepared to handle the professionally oriented courses at the tertiary level of education. The current syllabus of secondary school education almost ignores translation except in one subject - Chewa. The end of secondary school education Chewa examination (a national examination) carries one question and it asks students to translate a passage from English into Chewa, and not vice versa. The examination for the English language subject, on the other hand, has no translation question.

6.2.3. Problems with MCH's Interpretation Services

To begin with, there was no official recognition of the language gap at the MCH. As a consequence, there were no guidelines on how to proceed with patients who faced language barriers. This lack of recognition of language problems at the MCH was evident in the interviews I had with both service providers and senior administrators. For example, in an interview I had with a senior nursing officer, I was told that whilst the hospital did face some language problems, they were generally few and isolated. The language problems, so she argued, were not serious enough to warrant the creation of posts for interpreters. She noted that the majority of the patients spoke Tumbuka and/or Chewa, with the former taking the larger share. She argued that even those patients who claimed that they could not speak Chewa were still served by Chewa-speaking service providers. The result was the service provider and his or her client speaking Chewa and Tumbuka respectively, but still be able to understand one another. As far as the nursing officer was concerned, real problems crop up when patients from Chitipa come. But even with those patients, it was always possible to get an ad hoc interpreter. The overall impression was that I was looking for language problems where there were none. If the problems were there, then the dominant insiders' view was that the language problems were of insignificant magnitude. There was simply a general belief in the power of the multilingual capacity of the service providers and their clients to solve the problems of linguistic diversity at the hospital.

I noticed at the MCH a lack of trained interpreters. It cannot simply be accepted as self-evident that if someone is multilingual, then they can interpret. In order to render an effective service, especially in health care where human life is at stake, a hospital interpreter must be competently trained for the job. Whilst it is true that some people are naturally good at

languages and interpretation, hospital interpretation puts extra demand on the interpreter. Such demands include knowledge of the medical culture and its terminology as well as knowledge of medical confidentiality. It is for this reason that some service providers (such as expatriate service provider 5) normally opted for a fellow health service provider to serve as an interpreter because he or she "knows the ethics" of clinical situations.

Whilst almost anybody with the appropriate language facility can interpret at the MCH under ordinary circumstances, there are some special cases when this arrangement becomes problematic. Counselling is one of such encounters. Particularly problematic was HIV/AIDS and family planning counselling. This delicate situation was summed up by service provider 8, a clinician: "Working with a patient through an interpreter is only smooth when dealing with minor cases as opposed to confidential matters like HIV or cancer counselling because you need to have a special, confidential interpreter." As I mentioned in chapter 5, these subjects carry so high a level of FTA that the presence of an interpreter in the counselling session could threaten the confidentiality and privacy that is required. In such cases, interpretation is only allowed on condition that the client brings his or her own trusted person to interpret. Or the client may have to give consent that the service provider can use a hospital-based person to interpret.

Whilst professionals such as nurses and clinicians, who sometimes offer interpretation services, are conversant with medical culture, its terminology and ethics, the same cannot be said to be true of non-professionals such as visitors, other patients, minors or hospital support staff such as cleaners. One weakness with medical staff who offer interpretation is that if they have never been trained in the art of interpretation, or if their language competence is not of high standard, their output may not be as good as that which a trained interpreter would have offered. However, it is obvious that in the absence of a trained interpreter, a nurse or a clinician is a better option than a non-medically trained person such as a cleaner, another patient, a guardian or a minor.

The absence of a staff language bank is also a problem. By a staff language bank, I mean a list of all the hospital's staff members and the languages they can competently speak or read or write. In the absence of this list, it is difficult to tell what linguistic resources or competencies are available in the workforce. Another problem with interpretation has to do with delays that happen when getting the appropriate person to interpret. Sometimes it takes a long time to source a person who can interpret. This is the case particularly with the minority or the rarely spoken languages. The client is left untreated as time is wasted during the search for someone to interpret.

It is important to be on guard against falling into the temptation of making unrealistic expectations as to what a government can do about language services in public institutions such as hospitals. There is the danger of expecting too much, as is sometimes the case with linguistic human rights advocates. This is the case because there are always limits on the availability of staff members who can interpret for certain languages, and there are also limits on non-staff members who may by chance happen to be around when the interpretation is needed. Even if the hospital had posts for full time interpreters, it would not be possible to satisfy the needs of all language groups. No country, not even the richest, has the resources to provide all its public services in all the languages spoken within its jurisdiction (see also de Varennes 1996). I return to this and other problematic assumptions associated with linguistic rights in sections 6.6 and 6.7 in this chapter.

6.3. AVAILABILITY OF TRANSLATED MATERIALS

It should be remembered that translation makes it possible for people to enjoy the right to access to information (see Article 37 of the Constitution of Malawi). Article 19 of the Universal Declaration on Human Rights is about the right to seek, receive and impart information regardless of frontiers. Health education posters that are placed at the MCH (which I discussed in chapter 5) disseminate information on health matters. They belong to health education literature. For this literature to be accessible, it must be in languages that are accessible. Given that the majority of the clients are more at ease with local languages than English, translation into the local languages is one way of making the literature widely accessible. Translation enhances people's enjoyment of the right to information. Without translation, the right to information becomes less of a reality.

My observations and other evidence gathered from data sources such as questionnaires and interviews with key informants point to the fact that translation is a much less common language service than interpretation. In fact translated materials are not commonly found at the MCH. In some cases, it is even difficult to tell whether the material is a product of translation or not. One can only be sure about translation having taken place if more than one version of the same text appears. In some cases, it is easy because more than one version of text appear side by side. Official records of the hospital are kept in English and there are no local language translations. The records include office files and patients' charts. In addition, official correspondence within the MCH and outside is made in English. Another area that is left untranslated into local languages is professional titles and names of departments or sections. Keeping professional titles and names of departments in English could mean that there are no appropriate equivalents in local languages. This is true in most of the cases. Another possibility is that the use of English is supposed to symbolise the high status function of the domain. As for low status functions such as warnings or posters on symptoms and signs of diseases, Chewa or other local languages are used in translation. Translation of health care discourse into Malawian languages cannot be done satisfactorily without bringing terminology development into the picture (see the elaboration on this point in chapter 7, section 7.2.3.4).

Even in the political dispensation in which the use of Tumbuka in official domains is no longer proscribed, translations into Tumbuka have not been done to a considerable extent at the MCH. One possible reason for this state of affairs is that translation is more demanding than interpretation. Whilst interpretation is basically free since the hospital does not hire professional interpreters, the same does not apply to translation. In order to have a document translated, a competent individual or institution has to be hired to do the job. Secondly, the demand for interpretation is on the spot. For example, a client who does not speak a common language with a service provider necessitates the use of an interpreter. On the other hand, it is not always easy to tell whether a translation is needed unless one conducts a needs analysis or an individual actually asks for a translated version of a document. Without a clear idea about the demand for translation, there is the danger of making translations that are in actual fact not made use of at all. In addition, one can never be certain that people care to read the translated materials. This should be appreciated within the context of Malawi's lack of a reading culture (see Malawi Government's Draft Cultural Policy).

Another consideration with translation at the MCH is: Into what language(s) are materials to be translated? Although theoretically, a linguistic pluralism type of language planning (Cobarrubias 1983) in a democratising multiethnic and multilingual society should ensure that public information is made available in as many languages as possible to ensure maximum diffusion of information, the reality is that this is often practically impossible. First,

it is impossible to do so on economic grounds (e.g. see Nic Shuibhne 2002 for the EU's grossly expensive translation service). Secondly, the fact that significant numbers of mother tongue speakers of some of the minority languages do speak the dominant languages (Tumbuka and Chewa) makes it economically not viable to translate into every language. Another constraint could be having languages that have not been standardised both lexically and orthographically. This is true for all local languages in Malawi except Chewa. It is important to adopt a standard dialect which all speakers would have ease of understanding, otherwise an obscure or rarely used dialect stands in the way of the comprehensibility of translated materials. It is against this background that we find a low volume of translations into Tumbuka at the MCH.

Should the MCH decide to formalise language services and make posts available for language practitioners, there would be no immediate need to have translators. It will be a waste of resources since the demand for translators is almost non-existent. After all, most of the translated materials such as the health education were not commissioned for translation by the MCH. Most of the literature comes from the Ministry of Health, whilst the other literature comes from both local and international health bodies such as the World Health Organisation. Since the MCH does not require a significant level of translation on a regular basis, it is best to use the services of institutions such as the Centre for Language Studies or freelance interpreters whenever the demand arises.

The question of specialisation in translation (as well as specialisation in interpretation) has not yet taken root in Malawi. For example, the Centre for Language Studies, which offers translation services, sometimes has to sub-contract native speakers of Lomwe, Sena, Tonga, and other languages to make translations. This raises questions about quality assurance since some of the translators have never studied linguistics/languages or translation. Such individuals are sometimes hired on the basis of being native speakers. In a related case, Englund (2001) has examined the translation of human rights literature from English into Nyanja/Chewa. Though Englund's article is specifically about human rights discourse, some of the issues he raises also apply to the translation of health literature and other discourses into Malawian languages. He notes that with human rights literature, translations are done in a "haphazard manner, with little or no co-ordination between NGOs and between the translators they use." He further notes that the translators range from:

> Secondary school teachers to qualified lawyers to professional linguists at the Centre for Language Studies in the University of Malawi. While the University houses the most competent linguists, NGOs show little consistency in enlisting its services, but nor, on the other hand, is it obvious that its linguists have the time for the kind of research that the translation of a new discourse would require (Englund 2001: 305).

The translation of health care discourse into Malawian languages follows the pattern mentioned in relation to the human rights discourse. In addition, there is a lack of standard health care terminology.

As Bandia (1998) has observed, freelance interpretation and translation can be lucrative, hence the observation by Englund (2001) that even that even those not specialised in language studies enter the field to make money. It was argued earlier in this chapter that for one to be a good medical interpreter, he or she must have fluency in the concerned language as well as a fair knowledge of the medical discourse. The same argument is applicable to the translation of health-related materials. Knowledge of the languages is not enough.

6.4. LANGUAGE COURSES FOR HEALTH SERVICE PROVIDERS

Some service providers suggested that one way of reducing the linguistic barriers at the MCH was to provide language courses to both local and expatriate staff. Such courses would improve the communicative ability of the service providers as they discharge their duties. This view agrees with Kornbeck (2001) who argues that language training for prospective and practising social workers is a neglected topic in the literature on social work. In the case of the MCH, both local and expatriate service providers can take Tumbuka language courses. However, the two groups cannot have a uniform course since they come from different linguistic and cultural backgrounds. For the local service providers, they may already have the basics of the target language. Secondly, being locals, they are more in touch with Tumbuka-speaking individuals than the expatriates. Since expatriates have less exposure to the local languages than the local service providers, the proposal being advanced below is targeted at expatriate service providers. It is assumed that with good motivation, local service providers should be able to learn the dominant local language of their new duty station in a natural way.

There are some important questions to consider with regard to the provision of language courses at the MCH: Which languages should be taught? Is it both Chewa and Tumbuka; or Chewa alone; or Tumbuka alone? Out of these three options, I would argue, on the basis of the findings of the current study, that a Tumbuka language course is the most fitting for the MCH. I justify the selection as follows. In chapter 4, the predominant use of Tumbuka at the MCH was documented in several ways. For example, 61.5 % of the clients cited Tumbuka as their mother tongue. Secondly, 99.2 % of the clients rated Tumbuka as the first most widely used language in the delivery of the hospital's services. There is, therefore, no doubt that knowledge of Tumbuka by a service provider would greatly reduce his or her linguistic barriers when communicating with clients. The selection of Tumbuka as the language to be taught to the MCH's foreign service providers is similar to what I call the pioneer missionary model of language learning.[4] According to this model, pioneer missionaries always learnt the dominant language(s) of the area they were working in.

The Chewa language course option would be less helpful than the Tumbuka option. As it has already been mentioned, Tumbuka is so predominant at the MCH that Chewa can rightly be called a minority language. Whilst at national level Chewa is the majority language, it is a minority language at regional level in the Northern Region. The relevance of the Tumbuka course option is also supported by accounts given in chapter 5 by service providers who come from either the Southern Region or Central Region. These service providers have had to learn Tumbuka in order to enhance their communicative power. Given that language courses demand time, human, financial and other resources, the best option is to offer a Tumbuka language course to the MCH's staff on the spot.

It is important that expatriate service providers be exposed to a language course that also features culture-based styles of communication. Sullivan (1991) stresses the importance of this linguistic and cultural knowledge. His word of advice is that:

> Health professionals, if they are to effectively communicate with their patients, must be fluent in more than one culture. We must carefully study African perspectives in a search for additional avenues for assistance, particularly in the training of African physicians. This requires sensitivity to cultural differences, and an awareness of appropriate language and behaviour in discussing health care practices (Sullivan 1991: 3).

Some international organisations, which send volunteer personnel to Malawi, conform to Sullivan's view. For example, the American Peace Corps volunteers (some of whom work in

the health sector) take an intensive orientation during which they learn a local language and cultural aspects of Malawi. Crawford (1999: 38) rightly remarks that "familiarity with the culture and world view of the patient is clearly part of speaking the patient's language, but this more holistic approach has thus far not been characteristic of second-language teaching or of medical training." Even if the expatriate service provider has to operate through interpreters, it is still important that he or she should try to understand the culture-specific communicative styles and norms of his or her clients. Health service providers have to be respectful of and responsive to their clients' cultural and linguistic backgrounds.

There is divided opinion on the importance and relevance of local language courses for expatriate health service providers. One view supports such courses whilst the other view does not support them. What benefits, if any, come with expatriate service providers' knowledge of a local lingua franca? It is important to remember that talk is a major ingredient of medical care. As Saohatse (1997: 165) rightly observes, "showing willingness to speak the patient's language, (however badly) gives the patient more confidence." According to one expatriate service provider (service provider 5) at the MCH, when a doctor, especially a foreign doctor, speaks no local language, "patients do not feel that you are part of them." This is an important point, especially as it comes from an expatriate doctor. Indeed it is true that the language one chooses to speak brings him/her either closer or further away from the people one is working with. Speaking a common language with one's clients is a positive face sub-strategy (Brown & Levinson 1987) because people may feel that they have a language which even foreigners find worth learning. Perceptions vary, of course. Some people welcome foreigners who attempt to learn their languages whilst others do not.

An expatriate doctor (service provider 76) said: "If I know the language which patients use, I can find their problems easily and immediately." This is indeed true. Such a service provider does not have to waste time searching or waiting for an interpreter. Knowledge of the patient's language enables a service provider to avoid most of the problems that come with interpretation. One of the Egyptian doctors based at the MCH (service provider 75), who did not speak any local language, acknowledged the importance of being able to speak one of the local languages commonly used by clients at the hospital. The reason he gave was that it was "very important to get a more accurate history, thus reaching accurate diagnosis easily and saving time and money." Indeed time is wasted whilst looking for interpreters. Another reason for service providers' desire to speak the language(s) of their clients was the creation of a communicative climate that was conducive to the building of good rapport: "For the patient to feel comfortable with you and to explain fully her/his problems," as service provider 26, a nurse, observed. A clinician (service provider 7) made his case as follows: "The patient should feel at home because with pain and speaking the language which is not of the patient, then the patient can't express himself/herself fully."

At the MCH, some expatriate doctors have expressed willingness to take local language courses if they are organised for them. For example, a Chinese doctor (service provider 76) expressed the wish that "hospital should open the language course to teach local languages such as Chitumbuka and Chichewa." It is interesting that the two languages the Chinese doctor mentioned are indeed the most suitable languages as this and previous chapters have shown. Another Chinese service provider (number 38) hoped that "the hospital can provide a Tumbuka class." Ideally, as service provider 27 (a nurse) noted, if one is "to work comfortably, has to understand and speak English as official language and Tumbuka and Chichewa." Another nurse (service provider 16) had the following view: "I think we have so many languages in the region, some of them minor ones. It would be better if at least one language, say Tumbuka, was used basically by anyone. Then there would be no problem with

communication at the hospital." This service provider was actually pointing to the importance of Tumbuka as a regional lingua franca.

If there was a deliberate policy to reward those civil servants who gained competence in a local language of their duty station, that policy would have contributed to the reduction of language barriers which some service providers face at the MCH. Kashoki (1990), for example, mentions that in the colonial public service in the then Northern Rhodesia (now Zambia), the district commissioner and other officials were promoted or paid more if they mastered one or more local languages. Kashoki finds this to be a positive aspect of colonial policy as it encouraged civil servants to learn the languages of their areas of operation, hence removing language barriers in their work. In colonial Malawi, the government required civil servants to take a test in Nyanja (Kayambazinthu 1998: 409). Currently in Mozambique, Lopes (1998) says that it is an official requirement for government officials to learn the language(s) of their duty station.[5]

A Tumbuka course meant to equip service providers with linguistic competence for hospital interaction should aim at having a clinician, for example, who by the end of the course should be able to use Tumbuka to perform the following clinical tasks:

i. to greet a patient;
ii. to learn about the patient's reasons for coming to the hospital;
iii. to conduct verbal or physical examinations, or both;
iv. to share relevant information with the patient;
v. to detail further courses of action, such as prescription of drugs or referral;
vi. to close the consultation.

Apart from clinicians, other service providers should also be able to conduct various hospital communications through Tumbuka.

6.4.1. Options

It should be noted that the proposed Tumbuka language courses for expatriate health service providers are not general purpose in orientation. The aim is not to cultivate general fluency in a local language but to bring about a certain degree of fluency that would enable expatriates to carry out some of the clinical tasks with non-English-speaking clients without the use of interpreters. Even when an interpreter is used, the assumption should be that the service provider has some knowledge of the local language that would enable him or her to follow how the communication is being interpreted. Supported by such knowledge, service providers would critically follow interpretation, and probably be in a position to press the interpreter for clarifications. The course should, therefore, be modelled on English for Medical Purposes (EMP) or English for Specific Purposes (ESP). The notion of ESP refers to language programmes that are designed for groups and/or individuals who have an identifiable purpose and clearly specified language needs. In the case of the MCH, the course could be called Tumbuka for Medical Purposes (TMP).

The modalities of teaching a local language to expatriate health service providers are another topic that warrants a careful consideration. There are a number of options with regard to the provision of local language courses to expatriates at the MCH. Some of the options are as follows:

6.4.1.1. Option 1

Under this option, the learning of Malawian languages should commence before the expatriate personnel arrive in Malawi. This option has the advantage of giving the expatriate

some basic knowledge of the local language which would act as a foundation for further language learning whilst they are in Malawi. The setback is that learning opportunities may not be easily available in all countries and for all Malawian languages. Whilst there are some books and even some web pages which can assist the learners Chewa, I am not aware of any such language learning aids for Tumbuka. Secondly, some foreign researchers intending to conduct their research in Malawi try to get a Malawian to teach them Chewa or other local language(s). The problem with this approach is that not every Malawian, including native speakers, can be a good language teacher. In addition, there are countries where Malawians are simply hard to find. This then means that there is a need for institutions such as the Centre for Language Studies to consider offering language courses at a fee through the Internet (see Ashford 2001 on the technologisation of the teaching of Swahili). This would mean that learners would not have to rely on physically present language tutors only.

6.4.1.2. Option 2

According to this option, expatriate staff learn the local language(s) whilst they are in Malawi. Several alternatives are available. For example, expatriate staff can undergo a language and culture orientation course before they assume their responsibilities at the MCH. As mentioned earlier, the American Peace Corps volunteers in Malawi, for example, use this approach. The problem with this arrangement is that some may argue that it delays the use of the much-needed professional expertise of the service providers. It is argued that you cannot keep the scarce human resource locked in language learning when hospitals have an acute shortage of qualified and experienced staff. Countries that are keen to see that health service providers have direct (non-mediated) communication with their clients have tried the pre-service language course option. This part of the option means that expatriates do not go into professional work as soon as they arrive in Malawi since they have to take some time to learn the required local language.

Another alternative is to have the expatriate health service providers learn the language as they practise their profession. That means they do not have to take some months off in order to focus on language learning. As soon as they arrive at the MCH, they can assume their posts and then also have language lessons daily. The lessons could be arranged privately or formally. Another way of language learning is to do with the use language learning aids such as electronic and printed materials. These aids include video and/or oral/aural tapes, glossaries, grammar summaries, phrase books and CD-ROM disks. This option avoids the time-wasting argument that was raised in the paragraph above.

6.4.1.3. Option 3

The use of common phrases is one more option in language learning. This alternative means that expatriate service providers learn the most commonly used phrases, expressions and words. Saohatse (1997) has given this as one of the options for doctors who want to learn African languages at the Baragwanath hospital in South Africa. In Zambia, this language learning strategy is also used at the University Teaching Hospital (Chanda 2003; and also personal communication). The Zambian model, for example, consists of a list of commonly used phrases between doctors and clients made from the seven official languages of that country. The phrases cover greetings; general instructions such as inviting a patient to come closer; soliciting patient's personal information such as name and age; physical examination questions; social and medical history; obstetrics; medication; how to take medicines; time of taking medicines; counting; days of the week; months and other relevant topics. The same approach could be adopted for Tumbuka at the MCH.

6.5. Other Language Services

6.5.1. Language Services for the Visually Impaired and the Deaf

Whilst we are discussing language services, we should not forget that there is a minority who have disabilities that need special language services. I am referring here to people with hearing disabilities (the deaf) and those who are visually impaired (the blind). The frequency of the appearance at the MCH of individuals belonging to such a group is very low, hence they do not feature prominently in the various forms of the study's data. But their presence, no matter how infrequent it can be, creates a problematic scenario since the MCH does not have the appropriate language services for such impairments. Whilst the visually impaired are easier to handle as far as oral communication with service providers is concerned, it is the deaf who are a more serious problem.

The deaf have developed sign language. Contrary to some beliefs, sign language is a fully-fledged language that exhibits the complexities that non-signing languages have. Despite this reality, many language scholars fail to include sign languages on the list of languages of the world. This invisibility of sign languages is even translated into a lack of statistics on sign language communities. Whilst the actual number of Malawians who sign is not known, one thing is clearly known - there is a lack of sign language interpretation services in public domains. The MCH is no exception. It was mentioned by some of the service providers at the MCH that they use sign language in order to communicate with deaf clients. However, this is not the conventional sign language. What the service providers call sign language basically amounts to the use of gestures and pointing. Sign language users, like the visually impaired, belong to minority groups, and so far not much has been done in Malawi to address the language barriers of these groups.

6.5.2. Use of Visuals

One way of overcoming the problem of illiteracy at the MCH was to use visuals. These visuals have the capacity to convey a message that would otherwise have been communicated through the word of mouth. For instance, in addition to the label men's or women's toilet, there was a picture of a man or woman on the door respectively. Whilst the site of the toilets, for instance, may be easy to identify, the sex-based demarcations may not be easy to identify if one is either illiterate or if the label is in a language an individual does not understand. Therefore, the use of the pictures helps in arriving at the correct site. I also noted that on some doors to certain offices or sections, pictures or diagrams were posted which gave clues to what an office or department was all about. For example, the eye specialist's office was signposted as such, and also accompanied by a picture of a human eye. When I went to the pharmacy department, I noted some drawings on drug sachets. The sachets containing pills or capsules also had diagrams showing times of the day: morning, afternoon and evening when medicine was supposed to be taken. For those who are illiterate, the diagrams on the sachets are a communication strategy that stands in for the written word.

6.6. NGOs, Donors and Linguistic Rights

In this section, I discuss the role of local human rights NGOs and donors in supporting and bringing awareness about linguistic rights. In many societies which are undergoing the process of democratisation, human rights NGOs see one of their tasks as being that of educating and sensitising people on human rights (cf. Englund 2000, 2001, 2004; Alfredsson

2001). “Knowledge of human rights is a prerequisite for individuals and groups so that they can reasonably expect and demand respect for their rights and freedoms” (Alfredsson 2001: 273). This situation applies to Malawi. Since the demise of the one-party authoritarian rule of Banda in 1994, there has been an increased interest in safeguarding human rights. This has resulted into the establishment of a number of human rights NGOs. Religious faiths such as the CCAP and the Roman Catholic Church have also found it important to establish their own institutions that cater for human rights. In their work, NGOs depend on donor support. Not only do donors support human rights NGOs, but also sometimes donors can and do directly demand that certain human rights be observed, or else a country risks facing a withdrawal of donor aid.

First, I should mention that there is no human rights NGO in Malawi that is solely devoted to linguistic rights. This, in my view, is a weakness because language touches on all aspects of human life. Particularly important is the fact that language has a bearing on the enjoyment or non-enjoyment of certain human rights as the review of the literature (chapter 3) has maintained. Even when human rights NGOs are not directly involved with linguistic rights issues, one would still expect them to tackle language issues that come up. This has not been forthcoming in Malawi. The current trend in Malawi is that human rights NGOs are mainly interested in political and civil rights. This preoccupation with civil and political rights is done at the expense of economic, social and cultural rights.[6] Linguistic rights are part of cultural rights, thus they belong to the economic, social and cultural rights regime. The preoccupation with civil and political rights has created the unfortunate situation whereby there is no civic education on language-related human rights issues. This is a serious concern in a country in which many people need to have their minds decolonised (cf. Ngugi wa Thiong’o 1986) because of their blind worship of English and the degradation of local languages. For example, amongst my respondents at the MCH, there was no strong objection to the current policy in Malawi that allows foreigners to practise medicine without local language competence (see chapter 4). Even the majority who speak no English at all did not appear to be worried with how interpreted interaction with an English-using expatriate service provider can be disempowering. The general mood I noted at the MCH, especially among the clients, was that of lack of awareness of language rights. Such awareness can be raised by, among other facilitators, human rights NGOs.

Courts of law are one avenue through which human rights abuses, including those involving language rights, can addressed. To the best of my knowledge, no one in Malawi has since the demise of the one-party system of government in 1994 challenged a language policy or practice in a court of law. On the other hand, various political moves or practices have been challenged quite successfully in the courts. I take this as a further sign of a lack of awareness of section 15 (2) of the Constitution of Malawi (Malawi Government 1995a):

> Any person or group of persons with sufficient interest in the protection and enforcement of rights shall be entitled to the assistance of the courts, the Ombudsman, the Human rights Commission and other organs of government to ensure the promotion, protection, and redress of grievances in respect of those rights.

The observance of good governance and the rule of law, under which human rights are protected, has been one of the conditions tied to donor support for young democracies in the developing world. Malawi is no exception. Whilst donors have emphasised various aspects of good governance and the respect for human rights in Malawi, language rights have been glaringly absent from their agenda. Of course some donors have funded the translations of certain key documents into local languages to enable the masses to receive information

necessary for the exercise of their rights (e.g. see Englund 2000, 2001, 2004). But the same donors, with the exception of GTZ of Germany, have not directly funded projects aimed at elevating the status and capacity of local languages. Whilst, for example, many donors are interested in supporting the right to education, they remain uncommitted to supporting the right to mother tongue education. Here again, it is only GTZ (see Kamwendo et al 1999; Pfaffe 2000, 2001, 2003; Mchazime 2000) which is supportive of the local language education initiative.

On the other hand, the British government, through the British Council, supports and promotes English, sometimes at the expense of the local languages. The British Council, through its support for English, aims at making people see "the benefits of English... and the drawbacks with their own languages", so that in the end, people can aim at learning English, according the 1983-84 British Council annual report cited in May (2001: 201). The French embassy in Malawi, on the other hand, is only interested in the promotion of French, and not local the languages.

I should also mention that some people in Malawi have been sceptical of GTZ's support for local language development. Some have argued that at a time when standards of English continue to go down, it was unwise for GTZ to support local languages. Others have argued that in supporting the development of local languages, and not English or even German, GTZ has no interest in seeing Africans or Malawians, for that matter, acquire the international language(s) of socio-economic and political power. To this end, references are made to the history of South Africa where the apartheid regime used mother tongue instruction not to empower but to disempower the blacks. Others have even referred to Germany's own colonial past - its exclusionist approach that denied the colonial subject any access to the language of power, the language of the colonial master (see Mazrui 1993). Ironically, it is this policy that contributed significantly to the development of Swahili as an official language in the then German colony of Tanganyika (now Tanzania).

In the absence of any language rights awareness, misconceptions about GTZ's support for the local language initiative become difficult to erase. It is intriguing to note that whilst people may not appreciate the importance of mother tongue instruction in breaking communication barriers in the classroom, the same people are quick to demand that HIV/AIDS education or human rights literature should be provided to them through their own languages for easy understanding. In my view, the mother tongue education policy is also applicable to other domains such as health. For instance, in both health care and education, the efficiency and quality of the service depends on the reduction of the language gap. Both education and health care are language-intensive activities whose success is in some ways dependent on the degree of language concordance.

To conclude this sub-section, it can be said that both human rights NGOs and donors in Malawi are generally not supportive of local language development (see Mazrui 1997 on the World Bank's double standards on the promotion of African languages). There is also a lack of sensitisation on language rights - an exercise which human rights NGOs are best equipped to carry out.

6.7. THE CONUNDRUM OF LINGUISTIC RIGHTS

First, the linguistic human rights paradigm, as championed by Skutnabb-Kangas and other others, is in my view obsessed with educational linguistic rights at the expense of language rights in other equally important sectors such as health services and justice. Skutnabb-Kangas (for example, Skutnabb-Kangas 1998, 2000, 2001) has clearly declared that for her, educational linguistic rights are the most important of all language rights. In this way,

Skutnabb-Kangas naturally engages in the hierarchisation of language rights, thus some language rights are deemed by her to be more important than others. On the basis of my study at the MCH, I argue against the creation of such a hierarchy. In health services, we are dealing with language as a communication medium in the process of giving treatment (thereby promoting the right to life). A patient who is unable to speak a common language with the service provider is more disadvantaged than a pupil who is not familiar with the language of classroom instruction. Whilst instruction can be suspended until an appropriate linguistic medium is made available, and no fatal consequences can emerge, the same cannot be always true for medical treatment.

Secondly, Blommaert (2001), in his critique of the linguistic human rights paradigm, makes reference to the problem of what a language is. He claims that "the equation of 'language' with 'language' names is, however, obviously, problematic" (Blommaert 2001: 135; see also Stroud (2001) and Dunbar (2001) on the same criticism). After knowing what a language is or what languages exist, we will then be in a position to determine: How many and through which languages can the MCH offer professional interpretation? In the current study, the notion of language and dialect, especially with reference to linguistic varieties found in Karonga and Chitipa, has been problematic. The language versus dialect boundary is fuzzy, and as such, it would be difficult to decide on which linguistic variety or varieties should be recognised as media of health service provision.

Thirdly, it has to be stressed that language rights have to be practised in a particular situation that has its own political, economic and practical realities, some of which may stand in the way of partial or full realisation of the language rights. For example, we do not live in a world of unlimited resources. As such, priorities have to be set on what can be achieved. In this context of meagre financial, human and technical resources, the MCH has no full-time professional interpreters. Even in the case of the Western democracies, which are economically advanced, it is an economic burden to provide language services to a linguistically heterogeneous population of minority language speakers.

That anyone can be called to interpret is not weighed against human rights at the MCH. The general feeling towards ad hoc interpretation at the MCH is in line with Crawford's (1999: 29) view that it does not amount to "abrogating the patients' rights." It is only when HIV/AIDS counselling comes into the picture that the human rights angle of interpreted counselling is raised. In my interviews with key informants, the concern about the human rights aspects of interpreted HIV/AIDS counselling was consistently pointed out to me at the MCH, MACRO and Banja la Mtsogolo. The emic understanding of linguistic human rights (Paulston 1997a) is an important issue here - What constitutes a violation of linguistic human rights, and according to whom? Does the 'victim' view the event as a violation of his or her linguistic human rights or not?

There are also limitations on what can be translated and what cannot. Consideration has to be given to the most widely used texts so that the less used or the rarely used are not translated. Unless there is an in-house translation team, the hiring of outsiders to do the job can be expensive, hence the need to translate strictly on the basis of a reasonable demand or need.

6.8. Some Recommendations on Language Services

First, I propose some recommendations with regard to the provision of language services at the MCH. The first recommendation is that if language services are to be conducted in a co-ordinated manner, the problem of the language barrier(s) has to be officially recognised by the management of the MCH. In turn, an officer should be tasked with looking after language and

communication matters. Such an office holder could be called Communications Officer. It is important to note that for the language issue to be taken seriously at public institutional level such as the MCH, the executive branch of government should designate a department that would be in charge of all language matters at the national level.

Second, the MCH should draw up a set of guidelines on how interpretations will be handled at the hospital. It is also essential that a language code of conduct for the MCH be developed taking in consideration the hospital's sociolinguistic landscape, needs and priorities. This would constitute what Kaplan & Baldauf (1997) call micro language planning. Thirdly, patients' records need to contain language issues: languages they are able to speak and/or write; and their interpretation requirements. Such data will be useful in the compilation of patients' language profiles, thus creating a quantified measure of the needs for interpretation, and the languages involved. That data bank has implications on whether the MCH has to create posts for interpreters. Such posts will have to be created on the basis of genuine need. The volume of patients requiring such language services will determine the level of the need for the service. As of now, we only hear that it is clients from Karonga and Chitipa who create the most serious linguistic problems. But the volume of demand for minority language services is too low to warrant full time interpreters. The best that can be done for the minority language users at the MCH is to encourage them to continue relying on the networks of linguistic support.

Third, the MCH should aim at creating staff's language profiles or what Ehresman et al (n.d.) calls employee data bank. That is, what languages do staff speak; and where are the staff located (department or section)? The idea is that in the absence of trained interpreters, the MCH can utilise the available human resources. In that way, the data bank would help in the planning and execution of language services. There will also be need to motivate or reward such staff. As of now, hospital staff who interpret have not asked for monetary rewards, but it cannot be assumed that it will be like that forever. It is, therefore, recommended that the Government of Malawi, through the Ministry of Health, should seek ways of motivating staff to acquire new languages, especially those of their new duty stations. The goal of this additive bilingualism approach is that knowledge of some of the major languages used at the MCH will help in breaking down the language barriers, and improve efficiency and productivity of the MCH in the long run. In this regard, it may be necessary to attach monetary incentives (see Baker et al 1996).

One point that is clear from the discussion is that the professionalisation of language facilitation services at the MCH and indeed in the whole of Malawi is still in its early stages of development. Whilst there are individuals and institutions that offer translation, interpretation, editing and language courses, there is no professional body that regulates language practitioners. In the absence of a regulatory body for the language industry, one finds that, for example, interpreters and translators are not professionalised and registered to ensure that those in the trade can be held accountable for their actions. This is in contrast with other professions. For example, we have the Medical Council of Malawi, the Nurses and Midwives Council of Malawi, the Law Society of Malawi and the Media Council of Malawi. In the absence of such a regulatory body for interpreters and translators, there is no one who takes care of quality assurance. One is, therefore, left with no clear indication as to what extent Malawian translators and interpreters adhere to internationally accepted standards of their profession. Every profession has to be guided by a set of ethics. For translation and interpretation, the principles of the code of ethics include confidentiality, fidelity (accuracy) and neutrality. The professionalisation of interpretation (see Wadensjö 1998) involves the existence of training programmes, the development of systems of certification, and the setting up of professional associations.

That the language industry is only beginning to grow can be explained historically. During the Banda era, the language industry in Malawi was more or less confined to language teaching in schools and colleges. Only Chewa amongst all the local languages was part of the language industry. To this end, those who specialised in Chewa found employment mainly as teachers. A few went into the state-controlled national radio and the then state-controlled print media. The demise of the Banda regime has been followed by a new political dispensation in which linguistic pluralism (Cobarrubias 1983) is the main guiding principle. The new political dispensation has witnessed a growing need for translation into local languages. In the field of health, the catastrophic HIV/AIDS pandemic and reproductive health and/or family planning have been some of the most favourite topics for translations into local languages. As I noted in chapter 5, the situation at the MCH shows that despite the rhetoric of linguistic pluralism in information dissemination, Chewa remains the main local language into which information is translated.

A significant point arising out of the current chapter is that of the state of the language industry or language profession in Malawi. With the new political dispensation, the need for language services has been on the increase. In areas such as translation and interpretation, what is needed is not only professionalisation but also specialisation. Relevant to the current thesis is the observation that medical interpreters and translators:

> Need both knowledge of the subject and knowledge of the special language used in the field (both the source special language and the target special language). They can no longer afford to be simply generalists who possess wide general knowledge and are willing to translate in any domain (Roberts 2002: 440-441).

6.9. SUMMARY AND CONCLUSIONS

In a democracy, the State is duty-bound to ensure that all persons have equal access to public services and these services include health services. To this end, linguistic barriers to individuals' access to health services should be taken care of by language services. The MCH is located in a region that is characterised by both linguistic and ethnic diversity. The provision of language services in one or two languages and not other languages of the hospital's catchment area may be questioned. Why have other languages been left out? In planning for effective communication and the removal of language barriers at the MCH, it should be realised that at no point can all language groups be satisfied. What is important to distinguish is whether a call for the use of a certain language is made on genuine grounds for bridging the communication gap, or the demand for the language is just a camouflage for other demands. In a democracy, demands for language and other human rights have to be watched carefully for there may be some individuals or groups who may use the rights to further their own political or other ambitions. The practical challenge in a democratising country like Malawi is, therefore, attending to issues of linguistic diversity.

In the provision of language services, the MCH takes into consideration its resources. As de Varennes (1996: 88) has observed, "any State language preference invariably favours some and disadvantages other. It must again be emphasised that this is an unavoidable situation, since no State has the resources to provide all of its services in every language spoken within its jurisdiction."

The key point that runs throughout all the chapters of the thesis is that language can act as an aid or barrier in decision making in the health care system. As Candlin (2000) observes, the health care system is moving towards new types of partnership between the service provider and the client. For instance, at present the issue of informed consent is very critical.

In addition, there is a move towards joint decision-making. All these require that service providers and their clients should communicate more effectively. In the absence of a common linguistic medium of communication, then language services should be sought. Without language services, certain rights of the patient stand at the risk of being breached.

NOTES

[1] For example, with special reference to the role of language and interpretation in psychiatry in multilingual South African hospitals, Drennan and Swartz observe that:
"One could characterise the mental health practitioner as the instrument by which this raw material is converted into meaningful medical or psychiatric data. Of course, when the data are presented in a language the clinician does not understand, then this conversion is impossible without an interpreter. But if the interpreter does not have psychiatric training of some sort, this introduces a source of interference or distortion in the receiving and processing of the raw data. In this way, the extent of the interpreter's psychiatric insight and grasp of psychiatric concepts places tremendous constraints on the quality of the access to a patient's mental state a clinician is likely to achieve" (Drennan & Swartz 2002: 1856).

[2] Note the radiographer's use of the verb 'translates' to mean interpretation. Answering another question in the same questionnaire, he said: "I often ask patient attendants to assist in interpreting for me." He uses the verbs 'interpret' and 'translate' interchangeably.

[3] In some cases, service providers are able to diagnose a problem even when they are unable to communicate with the patient. For instance, some problems affecting external body organs, unlike internal organs, are easy to diagnose. Vote Somba shared with me the following experience he had in Karonga at a Banja la Mtsogolo Clinic. A male patient, who spoke only Swahili, had turned up to seek treatment for a sexually transmitted disease. As a researcher, Vote Somba wanted to interview the patient, but he failed because the patient spoke none of the researcher's three languages: English, Chewa and Yao. When the patient met the clinical officer, the two parties could not find a common linguistic medium of communication. The clinical officer simply examined the patient's sex organs and using past experience, prescribed treatment (Personal communication with Vote Somba, Chancellor College Library, Zomba, Malawi, and 23rd October, 2001.

[4] cf. the then practice at the Livingstonia Mission where newly arrived missionaries had not only to learn the language of their new environment, but had also to take language competence tests (see Forster 1989).

[5] cf. Two of the resolutions of the Second International Conference on the Role of African Languages in Education, Science and Technology focus on language use in the workplace. Resolution 3.4 says: "Employers are to be sensitised to the benefits of using African languages in the workplace", whilst resolution 3.5 states that employers have "to be urged to require competence in at least one African language from all employees," cited in Pfaffe (2003) and Wolff (2003a).

[6] Eide & Rosas (2001: 3) have noted that "civil and political rights have attracted much attention in theory and practice while economic, social and cultural rights have often been neglected."

CHAPTER 7

LANGUAGE POLICY AND PLANNING IN HEALTH SERVICES

7.1. INTRODUCTION

In this chapter, I focus on some aspects of language policy and planning as they relate to the MCH and the Malawian health domain as a whole. As early as 1971, Rubin and Jernudd and other contributors to their book, *Can Language Be Planned?*, had made it clear that language planning is a problem-solving enterprise. Rubin, Jernudd and their associates took language as a societal resource that can and should be planned in the interest of solving language problems. In the case of a public service institution like the MCH, the goal of institutionally based language planning is to seek ways of ensuring that language, as a communication resource, is used in ways that facilitate the delivery of health services in an efficient and non-discriminatory manner. With regard to the MCH's linguistic situation that I have so far described in this thesis, it is clear that there are some identifiable language problems that have to be solved. But does the MCH have a plan that lays out solutions to the identified language problems? Second, if the language plan does exist, does it offer options as solutions to the language problems, having taken into consideration the cost-benefit analysis (cf. Thorburn 1971) of each alternative solution? Third, does the plan, if it exists, outline strategies through which the language solutions could be implemented? Finally, are there evaluation mechanisms within the language plan? These questions, which this chapter attempts to answer, form the core of the canonical model of language planning (Rubin 1971a, b). With the aid of these guiding questions, I demonstrate in the chapter the extent to which language planning can be said to take place or not take place at the MCH. Here, I am referring to the notions of language planning versus "unplanned" language planning (Kaplan & Baldauf 1997; Eddington 2002); planning versus non-planning or language treatment (Bamgbose 1987).

In this chapter, I focus on the following topics. First, in section 7.2, I discuss various aspects of language policy and planning in relation to the health domain in Malawi in general and the MCH in particular. In line with this objective, section 7.2.1 focuses on the current status of language policy and planning whilst sections 7.2.2 and 7.2.3 discuss status planning and corpus planning respectively. In section 7.3, I apply Cobarrubias' (1983) taxonomy of language planning ideologies, consisting of internationalisation (section 7.3.1), vernacularisation (section 7.3.2), linguistic pluralism (section 7.3.3) and linguistic assimilation (section 7.3.4). In section 7.4, I consider the extent to which modified versions of the personality model (section 7.4.1) and the territoriality model (section 7.4.2) of language policy and planning could be applied to the MCH, the Northern Region and the national level. I conclude the chapter with section 7.5.

7.2. LANGUAGE POLICY AND PLANNING IN THE HEALTH DOMAIN

7.2.1. Current Status of Language Policy and Planning

In order to discuss comprehensively language policy and planning issues with reference to the MCH (micro level) and the Malawian health domain in general, we cannot avoid considering language planning at the macro (the national level). As Kaplan and Baldauf (1997) have observed, whilst many of the theories and analyses of language policy and planning have over

the years been applied to macro situations (at the national and supranational levels), there is now a new trend towards applying the same theories and analyses to micro-structural language problem situations. The MCH fits into this micro-level situation of language planning studies.[1] My first task is to pose the following two important questions: First, does Malawi have a comprehensive and documented language policy? Second, if such a policy exists, does it have a component that addresses the interests of the health domain? In answering the first question, it can be argued that Malawi does not have a clearly articulated and documented national policy on language. What can be said to be Malawi's language policy consists of the resolutions on English and Chewa which were passed at the 1968 MCP Convention.

Even the end of the one-party state era has not brought about much clarity on the language policy. The policy remains vaguely stated, with a few modifications[2] of the 1968 MCP resolutions. The constitution, as Kayambazinthu (1998) has correctly observed, remains silent on what the official and national language(s) are.[3] However, the silence of the Constitution of Malawi on the official language does not mean that there is no official language. Malawi is not alone in this respect since the USA, for example, does not mention the official language in its constitution and yet every day practice shows that English is the official language of the USA. The multiparty political dispensation in Malawi, guided by the principle of unity within linguistic diversity (see UDF 1993a, b; 1999), has been characterised by a series of language policy directives issued by the state president and government officials rather than "a well wrought language policy" (Kishindo 1998a: 264).[4]

To answer the second question, I would say that Malawi's health domain has a covert rather than an overt language policy. This means that the language policy for the health domain is not visibly clear since it is not articulated in any policy document. We are, however, able to piece together a series of statements in order to deduce the language policy.[5] In addition, the observations of language practices at the MCH have also contributed to my working out what the language policy for the MCH could be. Despite the absence of a language policy document,[6] there is no doubt that there is a language policy in place. As language planning scholars (e.g. Bamgbose 1991; Kaplan & Baldauf 1997) have argued, there is no institution or country that runs without a language policy. In this regard, it is essential to remember that Bamgbose (1991) regards African language policies as generally being characterised by avoidance, vagueness, arbitrariness, fluctuation and declaration without implementation. In the case of the health domain in Malawi, one would say that avoidance and vagueness apply.

I now elaborate on these two characteristics of the language policy i.e. avoidance and vagueness. To begin with, the avoidance strategy is generally fuelled by "the feeling that language matters are not urgent and can be solved at any time; therefore there is no need to hurry to make any statements of policy" (Bamgbose 1991: 12). My experiences during the study, starting from the research proposal formulation, research clearance up to the actual execution of the study at the MCH, convince me that Bamgbose's claim is applicable to Malawi. For example, the major policy documents on the delivery of health services in Malawi (for example, Malawi Government 1995b; 1999a, b, c) make no mention of any language policy nor do they give general guidelines on language use. This is an indication that in the health domain, language policy is not given a high priority unlike in the education domain where it is a hotly contested issue[7].

The picture I have given so far on the lack of mention of language matters in key health policy documents and the surprise with which my research topic was met by both government officials and other people (including those in the Academia) depicts the low value that is attached to language issues in the health domain. It is no big surprise, therefore, that there is

no language policy document for this public service sector. There seems to exist the belief that language is one of those non-essential aspects in the delivery of health care, hence there is no need to formulate a policy as of now. It can wait whilst other more important aspects of health service delivery receive policy attention.[8] The avoidance of formulating a language policy for health services can act as an escape from some commitments. In the absence of a clearly articulated language policy, the Ministry of Health and its hospitals, the MCH included, are not officially committed to any language plan. As a result, should the Ministry of Health be accused of not doing enough about language services in the health care system, it can always respond by arguing that there is no policy in the first place; and that once a policy is formulated and put into implementation, the mentioned problems will be taken care of.

Vagueness of the language policy with reference to the Malawian health domain can be detected as follows. First, since English and Chewa are the country's main and auxiliary official languages respectively, it is assumed that the same policy would be adopted in other sectors, including the health sector. In contrast, the roles of English and Chewa are unambiguously spelt out in the education domain (see Kamwendo 2001a). What specific role(s) the two languages have to play in the health sector remains unstated. Second, the vagueness of language policy is also reflected in the laws of Malawi regarding the licensing of medical personnel. The Medical Council of Malawi issues licenses to medical and dental practitioners in line with the provisions of the Medical Practitioners and Dentists Act Number 17 of 1988. According to the Act, the Medical Council may refuse to register an applicant if in its opinion, the applicant, not withstanding that he or she is otherwise qualified, is not fit to be registered because of his or her:

i. physical or mental health; or
ii. the fact that he or she is not of good character and reputation; or
iii. that he or she does not have adequate knowledge of the English language (emphasis added).

It can be noted that requirement iii. on English language competence is vague. The Act does not specify what "adequate knowledge of English" amounts to and how it is determined or assessed. How strictly the Medical Council follows the language requirement is also unclear. The accounts given in chapter 5 about the Chinese expatriate service providers who could not fluently speak English raise doubts about the Medical Council's strictness in adhering to the language requirement. If the Medical Council were very strict, perhaps some of the MCH's expatriates who have poor English proficiency would not have been allowed to practise. Or perhaps such expatriates would have been required to upgrade their English language proficiency as a condition for granting them licences.

There is also a problem of the lack of an integrated approach to language planning and policy formulation in Malawi. As it has been pointed out earlier in the thesis, language planning in post-Banda Malawi has been largely concerned with the education domain where the major bone of contention has been the mother tongue education proposal. There has been no attempt to have a language planning regime that is inclusive of all the domains. This lack of an integrated approach to language planning has led to isolated domain-specific planning, with little or no attempt to link together the language planning efforts of various domains. The problem is that the Ministry of Education, which has dominated language planning in Malawi so far, can only plan for its own jurisdiction and not others, no matter how close they may be.[9] What has been ignored is the fact that language planning in the education domain has implications for other domains. When certain languages are chosen as media of instruction in schools, that is a matter of status planning. But much more is needed. Corpus planning is of critical importance as section 7.2.3.1 argues. Corpus planning activities such as the

standardisation of a language and its orthography do not affect the education domain only but every other domain. For example, when a standard dialect is adopted, and when a standard orthography for Tumbuka is finally put in place, it is not only the education sector that will use them.

It has been observed (see Chumbow 1987, for example) that one of the problems of language planning situation in Africa has been the uncoordinated manner in which the exercise is conducted. In the case of Malawi, there is a lack of a central agency to give direction to the process of language planning. In contrast, South Africa, for example, until recently used to have the Department of Arts, Science, Technology and Culture as the government's co-ordinator of language policy and planning matters. [10] Though this department seemed to be co-ordinating language policy matters, the reality was a situation under which "different departments of government making policy without reference to one another," as Bamgbose (2003: 55) has observed. Unlike Malawi, South Africa has a constitutionally provided language rights watchdog. This is the Pan South African Language Board (PanSLAB), which is a permanent body established in terms of the constitution as a proactive agent and watchdog over linguistic rights. In contrast, Malawi has no constitutionally provided language rights-specific watchdog. Of course the Constitution of Malawi (Malawi Government 1995a) provides for the existence of human rights/justice-protection bodies such as the Human Rights Commission, the Law Commission, the Office of the Ombudsman. There are also a number of non-governmental human rights agencies in Malawi that contribute to the promotion, protection and enforcement of human rights either directly or indirectly (e.g. see Englund 2000, 2001, 2004). There has been no visible interest in language rights matters that has been shown by these human rights bodies. Whilst there is a Centre for Language Studies in Malawi (see Kamwendo 1999; as well as section 2.2.3.2 of this thesis), the institution is more of a language research and consultancy centre than a policy-directing organisation. As such there is a need to establish a language policy monitoring and guiding broad-based body similar in composition and mandate to the South African Language Board (see Kawale 2000 for the proposal on the creation of a language board in Malawi).

I regard my study at the MCH as belonging to studies of micro language planning. These are studies that focus on the language planning situation in specific institutional contexts such as the health services.[11] My study at the MCH has some contributions to make towards language planning, if we take Rubin's (1971a, b) language planning model in which there are four stages, namely fact-finding (research); the formulation of goals, means of achieving the goals, and the articulation of expected outcomes; implementation; and feedback and/or evaluation. Barkhuizen & de Klerk (2002) point out the role of sociolinguistic studies in providing feedback and/or evaluation to language policy makers. I regard my study as one that satisfies the goals of the fact-finding stage as well as the evaluation stage of language planning. The identification of language problems that exist at the MCH is the first step towards language planning (Rubin 1971a, b). Any language planner working on the MCH language situation can, therefore, use my study's findings as a contribution to his/her fact-finding phase of the language planning exercise. My study also acts as an evaluation of the current language policy and practices at the MCH. This is the case since through fact-finding, I have been able to gather relevant information about the language practices (which constitute an institutional language policy); and I have also been able to assess the strengths and weaknesses. This information will become useful should policy makers and/or administrators wish to modify the existing language practices and policy at the MCH.

Modifications to existing practices become more credible when they are supported by relevant research findings since they reflect the realities on the ground, and are geared

towards solving identifiable language problems. The evaluation stage is essential. It is this mechanism that informs planners about what aspects of the language policy are working well and which are not, and why. Any living institution has to periodically subject itself to a review process. Language policies are not exempted from this requirement. In the context of the prevailing political atmosphere in Malawi where language policy matters are a less sensitive topic politically than was the case during the one-party dictatorship, it is important to carry out periodic reviews of language policies and practices. This will ensure that language policies are not out of touch with the prevailing political, economic and social realities.

7.2.2. Language Planning at the MCH

The notion of language planning presupposes the existence of language problems for which solutions have to be found. We notice that language problem solving at the MCH takes places in both formal and non-formal ways. Some language problems have their solutions outside the MCH. For example, problems of language development (corpus planning) such as the non-existence of a standard variety of Tumbuka, the lack of a standard orthography, the lack of medical terminology in Tumbuka for use by the medical Community of Practice, the lack of an authoritative grammar and lexicographical materials such as dictionaries and glossaries. As the chapter will later argue, these language problems cannot be solved by the MCH. They require the intervention of the State and language specialists. In the previous chapters, there has been evidence that some language problems do exist at the MCH (see chapter 5), and that there are attempts to solve those problems, for example, through interpretation and translations (see chapter 6).

One way of examining MCH's language planning is to consider status and corpus planning. At the MCH, status planning has involved the allocation of functions to languages as follows. First, the administrative machinery of the hospital runs on a clear language policy. In line with the national policy in Malawi, English is the official language at the MCH. High-status administrative written communication is conducted in English whilst a small proportion of the written administrative communication comes through Chewa and/or Tumbuka. The latter consists of what may be termed low-status communications. Secondly, when we turn to client-service provider interaction, there are no prescribed languages. There is what I would call a laissez-faire approach.[12] The languages that are used in any client-service provider interaction depend on the interacting parties' linguistic repertoires, and the language which the two are most at ease with. Each service provider is left to decide on his/her own in terms of how to handle each case of interaction. In some cases, within a single interaction, the interlocutors may switch between two or more languages.

Interpretation, the most widely used language service at the hospital, is also conducted without any clearly stipulated policy. The same is also true of other language services such as translation and the use of visuals (to assist those who cannot read). This situation at the MCH amounts to what is known as "unplanned language planning" (Kaplan & Baldauf 1997; Eggington 2002). It is argued that "unplanned language planning" may involve language modifications effected by accident; or by a laissez-faire attitude towards a language situation; or by an ad hoc solution to immediate language problems. This is exactly what obtains at the MCH as previous chapters have indicated, thus confirming the existence of some elements of "unplanned language planning." The interpretation that occurs at the MCH is indeed a good example of "unplanned language planning." It happens just by sheer luck that a person claiming to have the needed linguistic competencies agrees to interpret. The lack of a plan for

interpretation services is rescued by the unplanned provision of interpretation by service providers, patients, guardians and other volunteering individuals.

However, the use of the term "unplanned" language planning is not free from controversy. For example, Eggington (2002: 404) admits that the term "might appear to be an oxymoron." It is due to its contradictory character that I prefer to use the term language treatment instead. Here, language treatment shall refer to all attempts to tackle language problems, no matter by whom and in what circumstances. However, these attempts at providing solutions to language problems do not conform to the planning model that was outlined in chapter 3 (see section 3.4.3). As a result, such language problem-solving activities at the MCH do not qualify to be called language planning. The appropriate term to use here is language treatment, and not even "unplanned" language planning since the latter is less meaningful due to its contradictory nature.

Since every human being speaks competently at least one language as a minimum, then all human beings are involved in language treatment, especially at micro or local level. Often individuals engage in language treatment in various ways without realising that what they are doing is part of language treatment. A guardian or a visitor to the hospital who interprets for a Tumbuka-speaking client and an expatriate service provider is doing an act of language treatment since he or she is involved in a language problem-solving activity. One expatriate service provider, a native speaker of English, said that he is often called upon to edit non-native speakers' written English. That too is an act of language treatment. When a literate individual helps an illiterate person to read the latter's medicine-taking directions, that again is an act of language treatment. Such activities cannot be recognised as language planning efforts despite the fact that they constitute attempts at solving language problems. For an activity to be recognised as language planning, it has to satisfy the central tenets of the language planning model (see Rubin & Jernnud 1971).

In the literature on language policy and planning (for example, Rubin & Jernudd 1971; Bamgbose 1987, 1991; Chumbow 1987; Kaplan & Baldauf 1997; and others), language planning is often referred to as a government-authorised, long-term, sustained and conscious effort to alter functions of languages in a society with the goal of solving communication problems. As far as the MCH is concerned, such a description or definition of language planning does not apply. The above description says that language planning has to be government authorised, but some of the language problem-solving activities (e.g. interpretation) that occur at the MCH are not controlled or even monitored by government. Neither does government prescribe who should or should not interpret. Those individuals in communicative situations make decisions about who should interpret. These individually-initiated/controlled language problem-solving activities are certainly aspects of language treatment. Some of the activities of language problem-solving may not be long term and sustained as the above-mentioned definition of language planning demands. Take the case of a Swahili-speaking patient who interprets for another patient. The interpreting patient, much as he or she is solving a communication problem, is not providing a long-term and sustained solution. This is a short-term solution. He or she may or may not be there the following day to offer the same interpretation. The experiences I have cited so far in relation to solving communication problems should make us realise that the language services at the MCH largely amount to language treatment and not language planning.

7.2.3. Corpus Planning

7.2.3.1. Corpus Planning by the MCH?

Strictly speaking, MCH has a very diminished role in corpus planning. In other words, there is minimal evidence of activities that are meant to modify the language itself in order to make it capable of carrying out its functions. It is status planning rather than corpus planning activities that are more visible at the MCH. Of course one can argue (for example, Bamgbose 1991) that translations are products of corpus planning. Whilst this is true, what is significant is that the MCH is not involved in the production of most of the translations. Most of the translated literature is produced elsewhere and simply displayed at the MCH. It has been mentioned that very often corpus planning activities involve the use of specialists such as translators, lexicographers and terminologists. These specialists belong to language institutions such as language academies, university departments of linguistics/language studies and others. On the other hand, hospitals and other public service institutions are merely consumers of the corpus planning products that come from such specialist institutions. Assigning functions to language in an institution is something that can be done easily without any demand for special skills. In addition, language function allocation is a must, otherwise there would be chaos.[13] But corpus planning, on the other hand, is too specialist-oriented (see Ansre 1974) to be handled by any layperson or non-language-specialised institution. At the national level in Malawi, there has been more of status planning than corpus planning. Whilst it is easy for politicians and/or government officials to declare language policies, it is harder to engage in corpus planing activities that seek to develop the selected languages. Corpus planning is not only too specialist oriented as I have earlier said, but it is also a financially demanding activity. One example of an expensive corpus planning activity is the compilation of dictionaries.

As later sections of this chapter will show, one of the proposals in this thesis is that Tumbuka should be granted more room in official domains than is the case at the moment. For Tumbuka to gain the necessary capacity to work well in its new role(s), standardisation of the language is required. Under the process of standardisation, a language passes through some stages of development. Hudson (1996), for example, identifies the stages as norm selection, codification, elaboration of functions, and acceptance.

7.2.3.2. Norm Selection: Towards Standard Tumbuka

Norm selection is the identification of a language variant that can serve as the standard. The variety that is selected becomes the basic standard. It is this basic standard that has to undergo the process of development. Two options are normally available in the selection of the basic standard. One option is to adopt one of the existing variants as a standard. Instead of selecting one language variant for standardisation, an alternative is the creation of a composite of various dialects.[14] In the case of Tumbuka, it would mean a distillation of the various dialects. On paper, this may appear to be an efficient way of avoiding the promotion of the hierarchisation of a language's several variants. It is a way of treating the variants as equal. One problem with this approach, as it happened with Shona in Zimbabwe (Chimhundu 1992), is the feeling by some people that the product of dialect distillation is "artificial." It is not the "real" language. Whilst from a linguist's perspective, all variants of a language are equal, and that there is no such a thing as "superior" or "inferior" forms, the situation is different from the point of view of the ordinary speakers of the language.

Whilst Tumbuka is yet to be standardised, and no decision has been made as to how the standard is to be arrived at, there is at least research evidence (Centre for Language Studies

1999) pointing to a majority preference for the Rumphi variant. This variant was noted by the majority of the survey's informants to be the "best" or the "purest." The Rumphi variety is variously positively described as *Chitumbuka chiwemi* (the real Tumbuka) or *Chitumbuka chapachanya* (top-notch Tumbuka). For the linguist, the idea of the "best" or "purest" language variant does not make sense. But when it comes to the politics of standardising a language, the evaluative labels that people attach to variants of a language become very important. The labels indicate what people are prepared to accept as the standard variety of their language. Going against the wishes of the language speakers can sometimes attract resentment.[15] Whilst Rumphi is generally characterised as "the home" of Tumbuka, the specific Rumphi variant which would serve as the standard Tumbuka is something that has to be identified.

Language standardisation, as a way of empowering a language and its speakers, entails providing that empowerment to one particular language variant, and not the other variants (see Blommaert 1999b, 2001). It follows then that the selected variant acquires power and prestige. Those speakers whose dialect is not chosen may feel excluded or even disempowered just like when one language amongst many is given official recognition. There is no doubt that standardisation ultimately leads to hierarchisation amongst variants of a language.

Some language variants are valued more than others (see Blommaert 1999b). During my fieldwork, this phenomenon was confirmed in various ways. First, I have already pointed out in chapter 2 about CLACA's dislike of what may be called urbanised Tumbuka. The dislike for the urbanised Tumbuka was confirmed by one of my key informants, an announcer from the Malawi Broadcasting Corporation, as follows:

> Actually, you know, we have been too much into Chichewa-speaking. In primary school, Chichewa was like our national language. So most of us, we haven't actually lived in our home areas for so long. It is as if the Tumbuka we speak, those people in the villages, would actually criticise you as speaking very shallow Tumbuka.[16]

The tone of the informant is one of admission that her variant of Tumbuka is not "the best." A retired broadcaster of Tumbuka newscasts (who was very popular in the 1960s) lamented before me that there was "no Tumbuka" on the radio "these days." He then went on to tell me that in his days, "real" Tumbuka used to be broadcast on the MBC. This is nothing but nostalgia for what he perceived as the golden past when standards of Tumbuka broadcasting were high. My informant's linguistic prejudice, in fact dialectal prejudice to be precise, was demonstrated by his claim that during his time, the "best" Tumbuka was broadcast on the radio. His did not hide his pride in having been part of those "good old days" of Tumbuka broadcasts. This is what Bamgbose (1998) has called positive linguistic prejudice. On the other hand, my informant from the MBC shows what Bamgbose (1998) has called negative linguistic prejudice - she negatively evaluates her own variant of Tumbuka. The norm for the evaluation is rural Tumbuka.

During the fieldwork, I also learnt that it is not only urbanised Tumbuka that is devalued. There are certain varieties that are believed to be peripheral, and as such they are deemed to lack purity. For instance, in my discussions with the retired radio announcer I have referred to above, he made reference to the African Bible College radio that broadcasts spiritual programmes targeted at Mzuzu city. My informant dismissed the radio station's Tumbuka, arguing that the announcer was not a "real Tumbuka speaker." When I interviewed the announcer in question, it transpired that he was not a native speaker of Tumbuka. He was a native speaker of Ndali from Chitipa, and as such, he did not speak the "real" Tumbuka. It

follows that his variant of Tumbuka is among those that are deemed to be unsuitable for selection as a norm for standardisation. It is not only attitudes towards variants which are crucial when deciding on which variant to standardise, but also how widely or narrowly a variant is understood outside the area where its speakers are located. When a variant cannot be understood, the usual reaction on the part of those who failed to comprehend was to say that it was "not Tumbuka."[17]

To conclude this sub-section, it can be said that people evaluate their own dialects and/or languages as well as dialects and languages of other people. The result is that some dialects or languages are rated higher or lower than others. Tumbuka variants are not exceptional in this respect. Though this evaluation is meaningless from a linguist's point of view since there is no language that is intrinsically inferior or superior, such evaluation is not entirely meaningless in language planning. The importance of the evaluations can be summed up as follows: "Language planners must include such evaluations in the planning process if they propose to forecast successfully the outcomes of their efforts" (Rubin 1971b: 307).

7.2.3.3. Codification

After the identification of the appropriate Tumbuka variant for standardisation, the next step will be codification. Though this is a purely technical process, normally handled by linguists and other language specialists, the actors in the process cannot afford to ignore non-linguistic factors. As Ansre has noted, all activities associated with language standardisation are regulated by factors that are "predominantly socio-historical and not strictly linguistic" (Ansre 1974: 369-370; see also Fishman 1974b: 19). The codification of Tumbuka, which was initiated during the missionary/colonial era, was discontinued during the Banda era because of the emphasis on the one language, one nation policy (see chapter 2). Whilst the Asmara Declaration has claimed that "colonialism created some of the most serious obstacles against African languages and literatures" (reproduced in Blommaert 2001: 132; see also Wolff 2003: 175-177), this claim is not entirely valid in the case of Tumbuka and other Malawian languages.

In chapter 2, I showed how Tumbuka, with the support it had received from the Livingstonia Mission, thrived in both status and corpus planning. Paradoxically, it is the post-colonial state, both the Banda era and the post-Banda era that has not invested meaningfully in the corpus planning of Tumbuka. Whilst the Banda era had no room for the development of any language other than Chewa, the post-Banda era has, at least on paper, pledged to support multilingualism. But in reality, the post-Banda era has not taken any concrete steps towards corpus development of the languages. The post-Banda era has been more concerned with policy decisions (see chapter 2) which have not been accompanied by the necessary development of the languages in question. There is ample evidence (e.g. Made et al 1976; Mwiyeriwa 1978) that both literary and corpus planning activities of Malawian languages (Chewa excluded) registered more gains during the missionary/colonial era than in the post-colonial era. It is, therefore, not correct to accuse colonialism, as the Asmara Declaration does, of always having worked against the development of African languages. Of course one has to be aware that in some cases, (e.g. during the apartheid era in South Africa), African languages were promoted by the colonial regime for a sinister goal - to consolidate the apartheid system.

One has to remember that for a long time since the decolonisation of Africa started in the 1960s, there has been a persistent call for the elevation of the status of African languages, with the desire that they should take over the functions performed by the ex-colonisers' languages. This call has come in various forms like language plans and declarations such as

the then Organisation of African Unity's Language Plan of Action of 1986 (reproduced in Bamgbose 2000a: 119-126; Wolff 2003a: 162-168), the Accra Resolutions on the Promotion of African Languages in Education of 1996 (see Unesco 2002), the Harare Recommendations on Language Policy in Africa of 1997 (see Unesco 2002), the Asmara Declaration on African Languages of 2000 (reproduced in Blommaert 2001; Wolff 2003), Resolutions of the First International Conference on African Languages of 2000 (see Pfaffe 2003; Wolff 2003), and Resolutions of the Second International Conference on African Languages (Pfaffe 2003; Wolff 2003).

Despite the existence of these and other declarations, little positive action has been taken by the various states. The key reason behind the underdevelopment of African languages is simply a lack of political will on the part of governments (see Bamgbose 2000b). The common excuse for not investing in African languages is that financial resources are inadequate. Though this is generally a genuine reason, sometimes it is used as a convenient excuse to cover up a lack of commitment. This translates into linguistic research not being "a priority area of spending for most governments" (Bamgbose 2000b: 20), and Malawi is not an exception in this regard as it has already been pointed out. For our current purposes, codification of Tumbuka will focus on three main areas, namely: orthographical developments, lexicographical developments, and the production of grammatical norms.

As pointed out in chapter 2, Tumbuka now has a draft standard orthography that was formulated by the Centre for Language Studies in conjunction with CLACA and other stakeholders. The fact that there now exists a draft standardised orthography of Tumbuka does not mean that the job has been completed. The most daunting test is the extent to which the various stakeholders, prominent amongst whom are the native speakers, will accept the orthography. One way of increasing the chances of the acceptance of the orthography was that the Centre for Language Studies involved CLACA members and other stakeholders in the revision of the orthography. In this way, the politics of inclusion was meant to make the whole process participatory. It was a strategy that was aimed at buying the support of the language pressure group. Though the pressure group does not represent the views of every native speaker of Tumbuka, and does not have the full legitimacy to speak on behalf of the so-called "owners" of the language, it was still a good tactical decision to involve CLACA. This meant that there was at least some form of grassroots involvement. However, more could have been done to involve increased participation. Whilst the number of people attending the workshops could not have gone beyond a certain limit because of financial and other practical constraints, members of the wider community could have been invited to submit written comments or suggestions for the improvement of the draft version of the orthography. This could have been achieved had the draft orthography been widely circulated.

Since the culture of language ownership exists among some speakers of Tumbuka, it was significant that "the owners" of the language took part in the revision of the orthography. It has been argued by Bamgbose (1991: 136) that orthographical reforms "must have the backing of some authority, preferably governmental, which can engineer its acceptance." The role of CLACA in this regard cannot be dismissed. Despite the involvement of some significant representatives of "the owners" of the language in the revision exercise, resistance to change or non-acceptance of the standard orthography cannot be ruled out. Whilst some of the people may not have scientifically valid grounds for rejecting the new orthography, the rejection may stem from the fact that the revised orthography departs from a tradition they have been associated with for many years. Others feared that a revision of an orthography would lead to the dismantling of the work they have assembled after many years of hard work.[18]

Orthographies are not simply technical, they are also part of the social-political and historical life of the people who use them. For some people, an orthography is a tool for creating boundaries and identities. For example, some of the participants at workshops on the standardisation of the Tumbuka orthography had complained that some users of Tumbuka wrote the language with the use of the Chewa orthography. This amounts to what Brunstad (2003) calls orthographic purism. An example is the name *Chibanja* that is sometimes spelt as *Chiwanja.* The version of the spelling that has a w is an example of Chewa orthography's intrusion into Tumbuka. Tumbuka purists argued that the use of b gives a Tumbuka identity. It should also be noted that when Malawi, under President Banda, adopted its own orthography of Chewa (Nyanja), the orthography became a national identity for Malawi. For example, to spell the name of the language as Chewa was a mark of a Malawian identity whilst the spelling Cewa was deemed to be a marker of a non-Malawian identity.

Having considered the status of orthographical development, I now turn to lexicographical development. Lexicographical development[19] refers to the production of dictionaries, both general purpose and specialist one, as well as glossaries. Currently, the only Tumbuka dictionary available in Malawi is the trilingual Tumbuka, Tonga and English general-purpose dictionary (Turner 1996). One of my key informants, an announcer at a private radio in Mzuzu, was not even aware of the existence of the trilingual dictionary: "We don't have any Tumbuka dictionary. Most of those books were burned in those days." Of course the alleged burning of some Tumbuka books during the Banda era (see also Kamwendo 2002a) does not justify the existence of merely one Tumbuka dictionary. It is just that at the time when Tumbuka books were being banned and burned, there was only one Tumbuka dictionary in print. There is, therefore, a need for a contemporary bilingual (English and Tumbuka dictionary) of a general-purpose type as well as a bilingual medical dictionary or glossary of medical terms.

Another area that needs development is the grammar. There is no revised authoritative grammar of Tumbuka at the moment. What is important to stress here is that since Tumbuka was used for education for many years before it was discontinued in 1968, there are several grammar textbooks from the old system that are still available. During the fieldwork, I saw a small collection of Tumbuka texts, readers included, which are being kept at the CLACA secretariat. This means that there is no need of trying to invent the wheel. What is required is to assemble all these texts and revise the grammar accordingly. A combination of linguists and native speakers could work to conduct the revision of the grammar of Tumbuka.

7.2.3.4. Elaboration of Function

As a language that has to assume new roles in new domains, Tumbuka has to undergo what is known as the elaboration of function. This process involves equipping a language with the necessary terminology or vocabulary that would enable the language to perform its functions in various domains. Lexical expansion is a critical component of language development in Africa since on many occasions, the non-use of African languages in certain official domains is justified on the grounds that the vocabulary is inadequately prepared to serve in such domains (see, for example, Ngugi wa Thiong'o 2003). Ngugi wa Thiong'o argues that it should not be forgotten that even the English language had to overcome similar claims of inadequacy as a medium of scientific thought in the presence of the then language of science, Latin. He also cites Tanzania where Swahili has achieved significant levels of terminological development. He then challenges African intellectuals to commit themselves seriously to the corpus development of African languages.

In my view, Ngugi wa Thiong'o misses the crucial point that most language scholars based in Africa work in environments of shrinking resources (see Kerr & Mapanje 2002 on Malawi's case) and little government and/or donor financial and technical support. In addition, there is a lack of political will towards the development of African languages. New terminology has to be created through borrowing from other languages or word coinage using the language's internal resources. The question of borrowing can be controversial sometimes since language purists may not favour it if it is done extensively. In chapter 2, I indicated the concerns of CLACA with regard to borrowing. There is a need for a deeper investigation into the Tumbuka native speakers' attitudes towards borrowing: Is the general attitude positive or negative towards borrowing? Which languages are preferred and which languages are not preferred, and why?

At the MCH, there is evidence of medical terminology being borrowed from English into Tumbuka. A few examples in four areas will be used here to illustrate the borrowing from English into Tumbuka. The four areas that will be considered here are: diseases, medicines, medical equipment/infrastructure and medical personnel. Borrowing from English in the medical domain can be accounted for in a number of ways. First, English is the main international language of medicine (Maher 1986), and it is the language through which medicine was introduced in Malawi (see King & King 1997 on the history of Western medicine in Malawi). It is the language that the medical Community of Practice uses and it is also the official language of Malawi. Second, in some cases, no local equivalent exists because the concept perhaps did not exist in "traditional" Malawian medicine. In other cases, a local equivalent may be available but individuals may prefer to borrow from English given the high prestige English enjoys in the so-called English-speaking African countries.

Below, I illustrate borrowing from English in the health services discourse:

1. Diseases: Sometimes it so happens that a service provider may fail to find an appropriate term for an ailment. There is the temptation, therefore, to switch to English, a language that has a more straightforward and appropriate term. An example here is the situation when a clinician was explaining to a female patient in Tumbuka. He got stuck and had to resort to English: *"Tinganene wali na....tinene Chitumbuka vichi?* **Anyway**,.. **infection**...(We can say that the patient has... how can we say in Tumbuka? Anyway, infection...)

A female patient complains about having *chimfine* (a running nose). The clinician, before prescribing the relevant drug, explains the cause of *chimfine* as follows: *Chimfine ndi nthenda imodzi mwa matenda amene amayambidwa ndi tizilombo tomwe timatchedwa ma* ***virus*** (...it is one the diseases caused by viruses)

2. Medicines: The common tendency here is to use the English names of the medicines, for example: asprin, panadol, amoxlin etc.

3. Medical Equipment/Infrastructure/Professional Designations

i. *famase* (pharmacy): After diagnosis, a clinician prescribes treatment. He then says to the patient: *"Sono murutenge ku* ***pharmacy*** *kuti mukapoke mankhwala. Muzele apa. Yewo chomene."* (Now, you will go to the pharmacy to collect the medicine. Pass through here. Thank you very much).

ii. A female client enters the clinician's examination room. She is coming from the laboratory. The clinician welcomes her: *"Khalani pa mpando amama. Mwawelako ku* ***lab****?"* (Have a seat, madam. So you have come back from the lab?).

iii. Another case of the use of the borrowed word, lab, is when a patient complains to the clinician that he feels pain when urinating, and that his urine is always mixed with blood. The clinician wanted a laboratory examination of the patient's urine,

and therefore advised him as follow: *"Ine ndidzafuna choyamba kuti mikodzo yanu itawunikidwa ku **lab.** Mwamva?"* (I will first of all require that your urine be examined at the lab. Have you understood?).

iv. When Ms. Chirwa was asked about her job, she responded: *"Ndikugwira **as patient attendant** kuno ku **physiotherapy**"* (I am working as a patient attendant here at the physiotherapy department).

v. *dokotala* (doctor): a female patient attendant meets a male clinician in the corridor and greets him: *"Muli bwanji a dokotala?"* (How are you, doctor?). This is a mark of respect. Of course, the patient attendant, being a member of staff at the hospital knows who is and who is not a doctor.

vi. Upon being asked about the duties she performed at the MCH, Ms. Sakwata said: *"Ndine **hospital attendant** wa mu **department** inoyo"* (I am the hospital attendant of this department). She went on to explain the duties of a patient attendant: *"Ndikati patient **attendant**, timathandiza ma **patient**"* (When I say patient attendant, I mean we help patients).

It should be mentioned that vocabulary enlargement is always an on-going activity. Even the so-called "developed" languages such as English have to keep on expanding their vocabulary in order to be able to cater well for the fast-developing fields such as science and technology.

When everything is said and done about a standard variant of Tumbuka, acceptance is the final test. Standard variants, a standard orthography, grammar and terminology have to be accepted by the users. This, therefore, means that attitudes and preferences of the speakers/ users of the language are of paramount importance. The importance of a participatory approach in the development of Tumbuka has been emphasised. This is particularly important when some groups among the native speakers can be very possessive about the language. As Eddington (2002: 407) rightly argues, "resistance to a plan develops from segments in society that had been overlooked in the planning process."

7.3. LANGUAGE PLANNING IDEOLOGIES

7.3.1. Internationalisation

As Cobarrubias (1983) has argued, language policy and planning is guided by certain ideologies. At this juncture, it is worth examining the extent to which Cobarrubias' taxonomy of language policy and planning ideologies works at the MCH. First, I consider the notion of internationalisation.[20] At the MCH, internationalisation is evidenced by the fact that English is the official language of the institution as well as the whole Malawi. The goal of the internationalisation ideology in the health sector in Malawi is obviously to ensure that health professionals are in touch with their counterparts in other parts of the world. Through the use of English as the main international lingua franca of medicine and health, Malawians receive professional training, access professional information, and are able to use medical products such as medicines and equipment whose directions of use are written in English. The use of English also allows free flow of medical personnel around the world and the MCH is one beneficiary of this trend. For instance, the hospital itself is run with technical assistance from the ROC. The language of reaching the memorandum of understanding between the Government of Malawi and the ROC is English. The ROC medical personnel who work at the MCH under the bilateral technical agreement between the ROC and Malawi use English to communicate with other service providers and clients. There are also non-Chinese expatriates working at the MCH, and they too use English to communicate with both fellow service providers and clients. The internationalisation ideology links together individuals who, if they

were to use their respective mother tongues, would have been unable to communicate and work together effectively.

The internationalisation ideology, like any other language scheme, has strengths and weaknesses. The main strength is that which I have already pointed out: the MCH is able to benefit from the contributions made by expatriate staff (who do not speak Malawian languages) simply because there is English which is a bridging language. Having said that, I should mention that internationalisation is a weak instrument for reaching out to the majority of the clients. As it has pointed out in previous chapters, English is a minority language not only at the MCH but also in Malawi as a whole. As such, English is unable to function as the main lingua franca at the MCH, especially in interactions involving clients and service providers. Whilst English is an effective lingua franca amongst service providers (since they are educated), the use of the same language between service providers and clients leaves most clients in need of interpreters. This is not a Malawi-specific problem. This is a general problem all over Africa where internationalisation as a language policy ideology is in place. Internationalisation, whatever its descriptive label, be it Francophone Africa (see Robinson 1996), Lusophone Africa (see Lopes 1998; Gadelii 2001), or Anglophone Africa (see Schmied 1991), has left the majority of the citizens in a state of linguistic disempowerment (see also Laitin 1992; Mazrui & Mazrui 1998).

There is a weakness in the Medical Council of Malawi's use of the internationalisation ideology in the medical practitioners' licensing. The Medical Council falls into the trap of assuming that a practitioner (especially an expatriate) is linguistically adequately prepared to work in Malawi as long as he or she has reasonable fluency in English since Malawi is one of the so-called English-speaking countries. The choice of English for this requirement makes sense mainly in the administrative domain where it is the main language, and not in the client-service provider interaction domain. The internationalisation ideology ceases to make sense when one considers that English is not a majority language. This contrasts with other countries that prescribe certain local language competence conditions for licensing foreign service providers. The common trend is that the prescribed languages are official and also the most dominantly used in society. Therefore, it makes sense to demand that foreign health service providers should demonstrate fluency in these languages before professional licences are issued. The problem in Malawi is that internationalisation on its own is too weak an instrument of communication in the health and other domains. As the situation at the MCH has shown, it is the vernaculars which are the predominantly used media of interaction between clients and service providers, a combination of vernacularisation (endoglossic policy) and internationalisation (exoglossic policy) would produce better results on the ground.[21] For the MCH, this would mean that the expatriate has to demonstrate not only competence in English but also competence in Tumbuka or even Chewa; or any other relevant local language(s).

At the MCH, internationalisation has led to the creation of two classes of Malawians - those who speak and read English (the haves), and those who are unable to speak and read in English (the have-nots). The non-English-speaking clients are reduced to a state of dependency. They have to depend on language brokers. As they are dependent on language brokers, the communication process is far from being complication-free. The problems that come with interpreted communication which have already been spelt out in the previous chapters are worth remembering. Proponents of the internationalisation ideology of language policy and planning tend to argue that Malawi needs English because it is the window through which the country communicates with the international community. This argument is valid for the minority elite who has to communicate with the international community in business, politics and other endeavours. But for the ordinary Malawian, the use of the

internationalisation language policy and planning ideology in health service provision is a communication problem rather than a solution. By not actively encouraging expatriate service providers to acquire local languages, policy makers fail to learn from the success stories of pioneer missionaries who were supported by vernacularisation, and not internationalisation, in their evangelical work.

7.3.2. Vernacularisation

I now consider vernacularisation as a part of Cobarrubias' (1983) language policy ideology. Given that it is the vernaculars and not English that dominate at the MCH, it is worthwhile to think of how vernacularisation can be improved at the hospital. This vernacularisation has to work in conjunction with internationalisation and not in opposition to vernacularisation. As Bamgbose has correctly clarified, "the emphasis on the need for African languages must not be taken to mean that imported languages such as English and French do not have an important role to play in post-colonial African countries" (Bamgbose 1998: 10). Abandoning internationalisation would mean that the MCH and Malawi as a whole would lose the benefits of internationalisation that I mentioned earlier. To ignore vernacularisation, especially when vernacularisation is used in conjunction with internationalisation is to miss a golden opportunity in the reduction of linguistic barriers to communication.

For the MCH, an increase in vernacularisation could mean a number of things. It can mean an increase in the use of Tumbuka and Chewa in written communications such signs, notices, health literature such as posters and pamphlets. It could also mean the provision of local language courses to expatriates as proposed in chapter 6. If vernacularisation is to become a reality, it must be motivated by some special incentives. In this regard, chapter 6 proposed monetary incentives for staff who engage in additive bilingualism, especially in the acquisition of languages that would directly and positively contribute to efficiency in client-service provider interactions. Vernacularisation in the spoken mode is certainly more important than vernacularisation in the written mode since evidence at the MCH points to the dominance of the oral medium in client-service provider interactions.

The vernacularisation ideology is traceable in interpretation and translation since in the majority of the cases the vernacular is the target language. For example, translation has in almost all the cases had English as the source language and the vernacular as the target language. With interpretation, it is either a vernacular versus another vernacular, or it is the case of English versus a vernacular. The biggest component of the oral communication that takes place between service providers and clients is conducted through vernaculars, thus emphasising the centrality of the vernaculars in the delivery of health services.

7.3.3. Linguistic Pluralism

Linguistic Pluralism is the third of Cobarrubias' language planning ideologies. I consider this ideology at two levels. These are individual and institutional levels. I start with the institutional level. The MCH, as a public institution, has to conform to government policy in whatever aspect one can think of. One would therefore expect the MCH's language practices to reflect Malawi's drive towards linguistic pluralism. As already mentioned, the MBC has adopted linguistic pluralism, especially with regard to newscasts, and the schools may also start working on the same principle once the mother tongue education programme goes into the implementation stage. The arguments that have been made in favour of linguistic pluralism in the mass media and education domains can also apply to the health domain.[22] At the MCH, however, there is little movement towards linguistic pluralism. For example, English remains the official language, and local languages have not entered the administrative

domains of the hospital in any significant way. It is a question of a handful official notices coming in either Tumbuka or Chewa or both, and nothing more than that. English remains the language of hospital records as well as both internal and external official communication.

One can, therefore, say that linguistic pluralism, which was initiated in 1994 as a part of the post-Banda multiparty political dispensation, has not yet been firmly established at the MCH and other public service institutions. Not much has changed since the demise of the one-party state. English and Chewa remain the main languages, in that order, of official domains, and the MCH is no exception. What has changed, however, is that since 1994, the UDF-led government has, in contrast to the previous government, been following a tolerant language regime. The State has not attempted to restrict the use of languages other than English and Chewa in various domains. For example, the use of Tumbuka in health literature by any organisation is not restricted. In addition, the State has allowed both staff and clients of the hospital to interact in any language(s) they find fit for the transaction at hand.[23] The State, however, has not been engaged in promotion-oriented language regime. This means that the state has not taken active and practical measures to promote, for instance, the use of Tumbuka at the MCH.

Opponents of linguistic pluralism may argue that implementing a pluralist language policy at the MCH would be an expensive task. This is indeed true. The EU's expensive language service network (see May 2001; Nic Schuibhne 2002) needs to be remembered when linguistic pluralism is being sought. However, my view of linguistic pluralism at the MCH does not emulate the EU's extensive language services programme. My view of linguistic pluralism is one that is guided by cautious and objective criteria. First, not all languages of Malawi or the MCH's catchment population can be officially recognised. In the context of diminishing resources, it would make a lot sense, in economic and practical senses, to adopt Tumbuka to serve in conjunction with English and Chewa as the working languages of the MCH. In this proposal, linguistic pluralism means taking the three lingua franca as the working languages of the hospital.[24]

Individual service providers differ in terms of their linguistic repertoires' sizes. As chapter 5 exemplified, some service providers are more multilingual than others are. Whilst the more multilingual service providers have proved to be an asset as language brokers at the MCH, there is no deliberate official attempt to increase the number of staff who possess multiple linguistic competencies. Whilst in some countries there are deliberate policies of hiring staff who possess specified linguistic competencies, that scheme has practical and political problems of implementation in Malawi. Since government is the largest employer in Malawi, an employment policy that is based on local language competencies is bound to have a significant negative impact on an individual's employment opportunities. The policy would limit certain people's chances of getting employed. To avoid this problem, I have proposed that through the award of special monetary incentives, staff should be motivated to learn the languages of their new duty stations.

7.3.4. Linguistic Assimilation

Linguistic assimilation, as a language policy ideology, is built around the belief that every individual should effectively function in the dominant language of an area. In the case of the MCH, that language is Tumbuka. Malawian service providers are implicitly expected to learn the language of their new duty station in order to facilitate communication. Whilst clients, some of whom may not be living in Mzuzu or the Northern Region as such (for example, short time visitors who fall ill and have to receive medical attention at the MCH), are generally not expected to show some degree of linguistic assimilation, there is an unwritten

expectation that Malawian service providers should learn the dominant language. The pressure to learn the dominant language is placed more on local service providers than expatriates. There seems to be some excuse given to the expatriates for not speaking the local languages. The local service provider who does not speak the dominant language looks odd, unpatriotic and finds life difficult not only at the workplace but also in his or her out-of-workplace interactions since the dominant language has to be used anyway. Those who fail to assimilate become frustrated, as was the case with Mr Chigamba in chapter 4. I should point out here that assimilation in this current context does not mean abandoning one's mother tongue and/or other languages. It simply means adopting the dominant language of the new environment in order to avoid linguistic and even social exclusion.

The linguistic environment around a newly arrived individual puts pressure on him or her to assimilate, even if that means making a few simple utterances likes greetings or offering thanks in the new language. My own experience at the MCH was that in the majority of the cases, I was talked to first in Tumbuka. If the subject matter was not complicated, I could carry on with the conversation in Tumbuka. When I could not proceed with Tumbuka, I would switch into either Chewa or English. With frequent daily repetitions of the demands on my ability to speak Tumbuka, I gradually found myself gaining fluency in the target language as time went by. I had to speak the language, even when it was not particularly crucial for my work. I had to be "one of them" by showing a positive interest in their language. Even when conversing with individuals, who were also fluent in both Chewa and English, it became customary for me to speak some Tumbuka.

One visible consequence of an assimilation attitude is the insensitivity of the speakers of the dominant language who consider those who do not speak it to be a bother. Sometimes non-speakers of Tumbuka are left out in a conversation. I recall a day when I turned up at one of the MCH's departments to conduct interviews with some service providers. All the service providers, with the exception of only one, were speakers of Tumbuka - as either native or non-native speakers. Whilst the majority kept the medium of the discussion in Tumbuka, the lone non-Tumbuka speaker tried hard to bring the discussion into either English or Chewa. It was an interesting linguistic tug of war. The Tumbuka speakers took it for granted that if one is in the Northern Region, especially working there, then they must know Tumbuka. Thus, there was little room to accommodate the needs of the lone non-Tumbuka speaker.

Another perspective of linguistic assimilation is what I would call official. This amounts to the official expectations of the MCH or government with regard to linguistic assimilation. With reference to expatriate service providers, evidence gathered at the MCH shows that there is no deliberate policy requiring them to speak a local language. The Ministry of Health maintains a laissez-faire policy, leaving it up to individuals to decide whether it is in their best interest to learn a local language or not.

When Cobarrubias (1983) formulated the taxonomy of language policy and planning ideologies that I have been employing in this section, he did not rule out the likelihood of further elaboration or development of the taxonomy. The taxonomy was by no means meant to be exhaustive. To this end, Reagan (1986) has argued that ideologies could co-occur, support each other, and could also be ranked according to degrees of dominance. With evidence obtained at the MCH, I attempt to exemplify Reagan's claims. First, the existence at the MCH of health education literature and some notices in both English (representing internationalisation) and local languages (representing vernacularisation) is a confirmation of the claim that language policy ideologies can co-occur. Secondly, with reference to degrees of dominance, it has already been mentioned that whilst internationalisation is the dominant ideology in the administrative machinery of the hospital, it is vernacularisation that dominates

the client-service provider communication. This shows that a single language planning ideology does not regulate the MCH.

7.4. TERRITORIALITY VERSUS PERSONALITY PRINCIPLES IN LANGUAGE PLANNING

In this section, I attempt to apply language policy and planning models based on the personality and territoriality principles (see Boran 2001; Patten & Kymlicka 2003; Kymlicka & Patten 2003a, b; Reaume 2003; Rubio-Marin 2003) to the situation at the MCH, the Northern Region and Malawi as a whole. The aim is to assess how the two principles can facilitate access to public services. Provision of any public service in more than one language should be sensitive and responsive to some practical realities such as the number of speakers, levels of demand for the use of a language, territorial concentration of minority languages, the state's available resources, type(s) of language services being requested in the mentioned language(s) and the relative ease or level of difficulty in responding to the demand. There may also be other critical considerations.

In my application of the personality and territoriality principles to language policy and planning in Malawi, I am proposing that Tumbuka should be another national language, with equal status to Chewa. The situation would be as it was before the 1968 MCP resolutions were passed i.e. when Chewa and Tumbuka were the two local languages that had official status. I justify the proposal for a two-national language policy on the ground that Malawi basically has two-lingua franca zones (Kayambazinthu 1998) - Chewa in the Central and Southern Regions and Tumbuka in the Northern Region. With this proposal for two national languages, it would then mean having three official languages, namely English (the main official language), Chewa and Tumbuka.

7.4.1. The Personality Model of Language Planning

Since the personality model of language policy and planning allows a person carry his or her language rights across the country, in the case of Malawi it would mean that a Tumbuka speaker would, for instance, have the right to access health services in his or her language at any publicly-funded hospital in any district in any region in Malawi. A Chewa-speaking patient would also be able to access health services through Chewa at any hospital in any region where he/she happens to be. This would mean, for instance, that public institutions would offer services in three languages: English (the main official language), Chewa (the dominant language of the Southern and Central Region) and Tumbuka (the dominant language of the Northern Region). What does this model mean in practice? It would mean that since we have proposed a two-national language policy (resulting into three official languages), these three languages would be the official languages of the hospital. Service providers would be expected to deliver their services in any one of the three languages, and clients would have the right to demand to receive health care through any one of the three official languages anywhere in Malawi. As can be noted, the personality model aims at promoting and respecting linguistic pluralism.

According to the proposed personality model, a hospital will offer its services in any of the three languages if there is sufficient demand for it. For example, at the MCH, the demand for the use of Tumbuka is very high as pointed out in chapter 4. But one may ask, how high a level of demand can be said to be sufficient enough to warrant the use of a language in health services at a particular hospital? Some cut off point has to be agreed upon.[25] Whilst the MCH offers a high demand for the use of Tumbuka in client-service provider interactions, the demand for the same language outside the Northern Region will obviously be very low. An example I can cite here the case of the predominantly Yao-speaking areas in Southern and

Central Malawi (see Centre for Language Studies 1999: 16) where only 1 % of the respondents preferred to receive health services through Tumbuka. Even within the Northern Region, the demand for the use of Tumbuka as a medium of health services will vary from district to district, and from area to area within the same district as Chilowa and Munthali's (1997, 1998a, b) studies have shown. The language data (in terms of the languages of household communication) which I presented from Table 3.2 to Table 3.9 in chapter 3, can also be used to give an approximate indication of the volumes of demand for Tumbuka.

Whilst our personality model is able to cater for the commonly sought media of hospital communication, it leaves the question of linguistic minorities unattended to. As pointed out in the critique of the linguistic human rights paradigm (chapter 3), it is important that language planning in multilingual contexts, such as Northern Malawi, be devoid of utopian thinking. Kymlicka and Patten (2003a) have an important point to make in this respect. They point out that the linguistic human rights paradigm fails "to confront the fact that language policies inevitably involve privileging a limited set of languages, and that the goal of a theory of linguistic rights must therefore be able to provide standards for evaluating the decision about which languages to privilege in which contexts" (Kymlicka & Patten 2003a: 11). Indeed, Bamgbose is right in saying that in the selection of languages of public services and language planning in general, "there is no way one can avoid some advantage being conferred by numbers" (Bamgbose 1998: 6).

7.4.2. Territoriality Model of Language Planning

The principle of territoriality, whether in its stronger version or weaker version, demands some form of decentralised language planning. The structure of government, that is, whether there is a centralised or decentralised government structure, has some tangible effects on language planning (see Tollefson 1981). It is said that in a unitary state, the central government will be better able to enforce its will on language policy matters than a federal state's central government. Under the stronger version of the territoriality model (Boran 2001), Tumbuka by virtue of being the most widely used language in the Northern Region, would attain official status, enjoying this status at the expense of both Chewa and English. The policy would emphasise the role of Tumbuka more than Chewa since the former is the dominant language in the Region. Other policies, which are aimed at making the Northern Region officially a Tumbuka-speaking territory, would be put in place. Public service institutions such as hospitals would also adopt a Tumbuka promotion plan. For instance, the health literature that is targeted at the Northern Region would be mostly in Tumbuka, thus reducing the functional load of both English and Chewa. The linguistic picture at the MCH would change accordingly, for example, with Tumbuka featuring more prominently in notices, signs and other written communication. The hospital itself could also make efforts to offer Tumbuka language courses to expatriate staff so that they gain competence in the regional official language.

This version of the territoriality language planning model has both merits and demerits. I will start with the merits. The model will give Tumbuka more official recognition than is currently the case. Language planning would run on the basis of a decentralised structure, with the regional authorities making some of the key decisions. Secondly, the model would also give the regional authorities opportunities to accommodate a region's interests and priorities. This arrangement, for example, would take care of the complaints that the central government is not doing enough to promote Tumbuka, and that Chewa continues to dominate in official domains as was the case during the one-party state era.

One of the demerits of the model is that it gives too much power of language decision making to the regional authorities. Though decentralisation is taking place in some government ministries and departments, the central government may not wish to give away much power that could lead to some loss of central government control over certain areas. Language is one of the tools which politicians desperately want to control and manipulate for their own interests (see, for example, Francis & Kamanda 2001 in the case of Sierra Leone; and in the case of Malawi, see Kayambazinthu 1998; Kishindo 1998a; Moyo 2001). As such, politicians would be reluctant to lose central government control over such an important tool of political manipulation. Related to this is the fear that giving extended powers to regional authorities would create a fertile ground for secession (see Boran 2001). Others would argue that a centralised language policy making mechanism has the capacity to promote unity and national cohesion, creating policies that foster a sense of belonging to one state such as the use of Chewa as a national language whilst at the same time accommodating other languages in the official domains.

I now go to the weaker version of the territoriality model (see Boran 2001). Under this version, the Northern Region and its public service institutions such as the MCH would enjoy substantial but partial autonomy over public policy, which includes language policy. This means that the central government would still retain control over other issues. Under this model, Tumbuka, Chewa and English would serve in various capacities. Given the current level of economic and political development in Malawi, this seems to be more workable than the stronger version. Malawi does not have the necessary political and economic structures to sustain the stronger version of the territoriality model.[26] Another problem that the territoriality model would have to grapple with is the linguistic diversity within the Northern Region itself. The MCH itself has given evidence of minorities whose languages cannot be understood by some service providers. The question would be what the territoriality model would do to the minority languages: Would it promote them alongside Tumbuka, or only promote the dominant language? According to the findings, there is a very low demand for the use of minority languages at the MCH. The MCH does not have a high concentration of minority language-using clients. These circumstances do not warrant a policy that should promote the minority languages. I have to emphasise that this conclusion is applicable to the MCH only. The situation in hospitals in other districts of the same region could be different.

The on-going decentralisation programme in the Government of Malawi could be used as a stepping stone for the formulation of language policies that are appropriate to the Northern Region. A model that Malawi's language planners and other policy makers could consider is the post-apartheid language policy in South Africa. This language policy recognises eleven official languages (Bamgbose 2000a; Kamwangamalu 2000; Langtag Report 1996). With respect to the use of the official languages by the national and provincial governments, Bamgbose (2000a: 127) quotes the South African Constitution as stipulating that:

> The national governments and provincial governments may use any particular official languages for the purpose of government, taking into account usage, practicality, expense, *regional circumstances* (emphasis added) and the balance of the needs and preferences of the population as a whole or in the province concerned; but the national government and each provincial government must use at least two official languages.

The South African constitution also empowers municipalities to "take into account the language usages and preferences of their residents" (Bamgbose 2000a: 127). A decentralised language policy of Malawi, modelled on the South Africa case, would be as follows. English

would continue to serve as the main official language and Chewa as the national language. In each region, a regional lingua franca would be chosen. The choice would fall on the most frequently and most widespread language of wider communication. In the case of Southern and Central Regions, the regions could also consider granting official the status to other languages used in the region. Decentralisation can bring benefits in terms of encouraging local initiative and resting responsibility in local decision-makers but should not be based against national interests. Unity within linguistic diversity can still be achieved where decentralisation does not result into emphasising regional loyalties or interests at the expense of national loyalty or interests.[27]

According to Francis and Kamanda, centralised and top-down language planning:

> Alienates the target beneficiaries from the language planning itself. It excludes 'views from below'; the language and literacy needs of the grassroots as they themselves perceive those needs. This could be achieved through making the planning process more decentralised and participatory/bottom-up (Francis & Kamanda 2001: 240).

In this decentralised language planning process, even institutions such as the Mzuzu Central Hospital would be able to formulate and implement language policies that are unique to their institution. This, however, does not mean doing away with language policy as given by the central government. For example, under this decentralised language planning, the MCH could consider having an increased volume in the use of Tumbuka in health education literature and signs that are found at the hospital.

As we discuss the territoriality model of language policy and planning, we need to note that what may be demanded may be more than language rights. People may really be after full sovereignty and self-determination rather than language rights. Secondly, we have to think of the extent to which this model has the capacity to promote national unity, respect and tolerance for linguistic diversity as espoused by the United Democratic Front's manifestos (United Democratic Front 1993a, b; 1999). Thirdly, one also has to consider what role Chewa, the national language, would play in that model. Would it be excluded or would Chewa be accommodated; and if so, to what extent and in what contexts? The territoriality model could also allow the Northern Region to reduce the feeling that it is always marginalised (see Kishindo 1998a on complaints that Tumbuka does not have adequate airtime on the national radio).

It is clear that each of the two models has its merits and demerits. Secondly, the models cannot be applied to Malawi without modification. The models need to be modified so that they can fit into the local political, social and economic environment. In reality, one finds tendencies towards combining aspects of personality and territoriality principles. Eclecticism is therefore essential in this respect. There are no easy solutions to language planning matters and what works in one polity cannot be transferred wholesale to another polity and be expected to work successfully. What I have done in this section is merely to propose and argue for a particular version of the territoriality model of language policy and planning for the Northern Region (which is the MCH's catchment area). This means giving Tumbuka more official functions in the Northern Region in particular since the region is predominantly Tumbuka-speaking. As it has been shown in the previous chapters, there are certain large concentrations of speakers of certain languages in each of the three regions. For the Southern and Central Regions, Chewa is the lingua franca whilst for the Northern Region, it is Tumbuka. These language concentrations should be the basis for a multilingual policy in Malawi (cf. Bamgbose 2003).

7.5. SUMMARY AND CONCLUSIONS

Linguistic diversity is either celebrated as an invaluable cultural asset or a costly and divisive phenomenon (Nic Shuibhne 2002: 1). In a country of meagre resources as is the case with Malawi, there is no doubt that the economic costs of managing linguistic diversity cannot be ignored. The management of linguistic diversity has become more demanding in the multiparty era than was the case in the one-party authoritarian rule. In the one-party era, there was no space for the politics of linguistic recognition by non-native speakers of Chewa. Demanding non-Chewa language rights was tantamount to working against national cohesion and unity. The advent of political pluralism and the culture of democracy, on the other hand, have ushered in new demands on the management of linguistic diversity.

The provision of public services such as health care is one arena where language rights feature. My special interest in this regard is on the MCH's management of linguistic diversity. This chapter concludes that the MCH, as a referral hospital for a linguistically heterogeneous catchment area, has to grapple with "the tricky question of accommodating language rights and multilingualism" (May 2001). Whilst the MCH has to engage in linguistic pluralism as it serves its clients, it cannot afford to serve in all the languages of its catchment area.[28] A measure of selectivity has to be applied. A pragmatic and realistic mode of linguistic pluralism has to be followed. In this mode of selective multilingualism (cf. Nic Shuibhne 2002), I have proposed that Tumbuka should be used officially in conjunction with English and Chewa. This will mean, for instance, an increased use of Tumbuka in health literature, sign-posting, and some deliberate efforts being made to have non-Tumbuka-speaking service providers learn Tumbuka.

Yet the choice of Tumbuka may not go uncontested, especially in a region where the politics of linguistic and ethnic identity (as discussed in chapter 2) is very ripe. The question of minorities has to be brought into the picture here. By giving public recognition to Tumbuka, it is not being suggested that minority languages are unimportant. But we are concerned here with the low volume of demand for the use of minority languages at the MCH. In any case, when minority language-speaking patients - who cannot use any of the hospital's lingua francas turn up, the networks of linguistic support that I have referred to in the previous chapters can always be relied upon. The networks of support may not always work perfectly, but they offer the best option in the current situation of low frequency of minority language-speaking patients at the MCH.

The importance of domain-specific language planning has been highlighted in this chapter. Each domain has its own unique demands and problems. Even within one domain, health care for example, there are bound to be differences in what are perceived to be hospital-specific language problems. This underlines the importance of institution-specific language planning studies such as the current one.

NOTES

[1] It is interesting to note that one of the examples cited by Kaplan and Baldauf about micro-situation of language planning is about "the use of native minority languages by nurses and other employees in majority language hospitals, the use of minority languages by hospital patients in majority language hospitals, doctor-patient communication in situations in which participants are native speakers of different varieties or languages, and other applications in the health delivery fields" (Kaplan & Baldauf 1997: 118)

[2] The policy modifications are the introduction of five languages on the MBC as media of newscasts and the proposal on mother tongue instruction in junior primary schools.

[3] In contrast, South Africa's post-apartheid constitution is very clear, granting eleven official languages, see Langtag Report (1996). It is also worth noting that the predecessor to the African Union, the Organisation of African Unity (OAU), had in its Language Plan of Action called on each Member State to have a "clearly defined language policy", cited in Bamgbose (2000a: 122).

[4] See Moyo (2001) who is also concerned with the post-Banda language planning which is driven by the desire to make political gains.

[5] Eggington cites a US study on language policy and planning in an urban school district that had found that there was no formal plan for addressing the needs of minority language students. According to one administrator, the district's language policy was "fairly clear", but when the researcher asked him to produce it, he was unable to do so, having realised that the language plan simply consisted of "just kind of memos" (Eggington 2002: 413).

[6] Many institutions in Malawi do not have language policy documents, but this does not stop them from pursuing particular language policies.

[7] See, for example, the arguments for and against mother tongue education as documented by Kamwendo (1997), Kayambazinthu (1998) and Kishindo (1998a).

[8] Note that even in the education domain where the medium of instruction has been a hot issue since the 1996 directive on mother tongue education, government has been footdragging towards the consideration and possible approval of the Draft Language-in-Education Policy. The draft policy document was presented to the Ministry of Education in 1999 for onward submission to the Cabinet. At the time of writing the thesis, the draft policy document had not yet been tabled at the Cabinet level. This was one of the concerns raised at the 4th national symposium on language policy in education (see Pfaffe 2003).

[9] One example was when the Ministry of Education announced a change of the name of the national language from Chewa to Nyanja. The other sectors, for example the MBC, did not follow suit. This is an indication of an uncoordinated language policy formulation.

[10] Bamgbose (2003: 15) proposes that an inter-ministerial committee could take charge of co-ordinating and streamlining language policies. Bamgbose's proposal is in response to the split of the Department of Arts, Culture, Science and Technology into two departments on 1st August, 2002: Department of Arts and Culture and the Department of Science and Technology.

[11] Examples of such studies in the health sector include Saohatse (1997); Drennan (1998); Crawford (1999); Chanda (2003). Other studies have focussed on prison services (for example, de Klerk & Barkhuizen 2002; Barkhuizen & de Klerk 2002), the mining industry (for example, Hill & van Zyl 2002), the defence forces (for example, Barkhuizen & de Klerk 2000; de Klerk & Barkhuizen 1998).

[12] cf. Kayambazinthu (1998) who has described the missionary/colonial period running form 1875 to 1918 as being characterised by a laissez-faire phase of unplanned or uncoordinated language planning during which each missionary group pursued its own language policy in education and evangelism.

[13] As Rubio-Marin (2003) has remarked, the State can afford to be religiously neutral by not embracing any official religion, but it cannot guarantee perfect linguistic neutrality. That is, some language or languages has or have to be assigned certain roles.

[14] Ansre (1974) has, for instance, noted the failure in West Africa to produce standard Ibo out of the various dialect clusters of the language. And in colonial Malawi, the missionaries who worked on different dialects of Nyanja attempted to translate the Bible into what they called "Union Nyanja." But this had its own problems: "This form, however, could not gain a foothold because the contrast between the groups of dialects had already deepened far too much. The Mang'anja users looked upon the work as the "Chewa Bible", and the users of Chewa, on their

part, complained that Mang'anja was represented in it much beyond its merits" (Heine 1970: 62).

15 For example, when it was decided that the Ki-Unguja dialect of Zanzibar be the norm for the standardisation of Swahili, speakers of the rival Mombasa dialect walked out of the meeting room in protest (see Ansre 1974).

16 A Xhosa-speaking nurse in South Africa, who acted as an interpreter between Xhosa-speaking patients and English-speaking doctors, referred to patients from the rural areas as "speaking that deep, deep Xhosa which we don't know because we are grown up here" (Crawford 1999: 33). *Here* meant urban areas**.**

17 Whilst working at the Centre for Language Studies, I had a colleague, a native speaker of Tumbuka, who was in charge of the Tumbuka section. He came from Embangweni in Mzimba. He, therefore, spoke the Mzimba variant of Tumbuka that has heavy influence from Ngoni. Two incidents surrounding his variant will be used here to illustrate the problems with variants whose mutual comprehensibility is low. First, after he had translated a research questionnaire into Tumbuka, I heard that during the use of the questionnaire in the field, some native speakers of Tumbuka had complained that they did not understand the language very well. Others said that the questionnaire was not in Tumbuka at all but Ngoni. This, of course, was not true. The fact was that the questionnaire was in a Tumbuka variant that had Ngoni influence. The second incident involved an expression that my colleague had put into the questionnaire for a sociolinguistic survey (Centre for Language Studies 1999). Under a language comprehension test, he asked respondents to provide the meaning of the expression: "*lulimwe likawvala mgonda* " (literally, the tongue has worn some underwear). Before setting off for the fieldwork, I had asked him what *mgonda* meant, to which he had responded by saying that *mgonda* was a kind of underwear for men. He went on to explain that the expression *lulimwe likawvala mgonda* simply meant being tongue-tied. When we asked this question amongst those who spoke the same variant as my colleague, they answered without showing any concern with the social appropriateness of the expression. However, non-speakers of my colleague's variant told us that *mgonda* was an offensive word. To them, *mgonda* was a traditional underwear for women, something equivalent to monthly period pads. We quickly abandoned the face-threatening expression. Fortunately, this happened during the pilot phase of the sociolinguistic survey. From a sociolinguistic point of view, it was a lesson for the research team to be careful about the variant adopted for use in research and other communications.

18 One example I noted whilst attending the Tumbuka orthography review workshops in Mzuzu was the worry expressed by a reverend who was a member of the Bible translation team. His worry was that the revised orthography would mean starting all over again with the Bible translation, something he felt would not be easy to accomplish. As Bamgbose (1991) has observed, a revised orthography stands more chances of being accepted than a completely new one. In the case of Tumbuka, it was a matter of revising an already existing orthography, and not creating a new one. Though the proposed reforms are minimal, some people, for their own reasons, may still find it difficult to part with the old orthography.

19 Leroy Vail, in a letter dated 22nd September, 1994, addressed to Mr Michael Gondwe, then secretary of CLACA, mentioned that with "the support of Msgr. Roche and the Rev. Nkhoma of the CCAP's Livingstonia Synod, I am currently deeply at work on producing the first published dictionary of the lakeside Tonga language." This dictionary has not been published, probably owing to the death of Leroy Vail. As for Nyakyusa, there is a trilingual dictionary, Nyakyusa-English-Swahili, compiled by a Norwegian, Knut Felberg, and published by Mkuki na Nyota in Tanzania in 1996. This is the first ever dictionary for Nyakyusa, a cross-border language shared by Malawi and Tanzania (see Walsh & Swilla 2001 for a detailed discussion on Nyakyusa).

20 Note that internationalisation has the same principles as those advanced in exoglossic language policies.

[21] A similar proposal has been made by Matiki (2001a) concerning the language policy of Malawi's parliament. He has argued that a Chewa/English bilingual policy (vernacularisation combined with internationalisation) would increase the level of comprehension and the quality of debates in parliament. He cited Tanzania's use of Swahili as a medium of parliamentary debates as a success story in that it has liberated members of parliament from the burden of struggling to communicate through a medium in which they are not firmly grounded.

[22] The argument has been that in a linguistically heterogeneous society, the use of only one language as a medium of either school instruction or radio broadcasts can be a linguistic handicap to those individuals for whom the language in question is not a commonly used one.

[23] Note the controversial language rule that exists in some private schools where all pupils must speak English in and outside the classroom.

[24] Concern has also been raised about the implementability of post-apartheid South Africa's eleven official languages. Webb (1996: 85) comments on the situation as follows: "Pluralism does not necessarily imply that all state functions have to be performed in all the eleven languages at the same time. A sensible and practical approach to policy formulation is to accept the strategy of functional differentiation" (see also Bamgbose 2000b).

[25] The report on the Vienna seminar on the linguistic rights of national minorities (Siemienski 1999) also grappled with the notion of "significant numbers" which would warrant the right of linguistic minorities to use their language in public services. The question was asked: What proportion of the population constitutes a significant number? There was an agreement that a 20 % of the population of a given locality or region would constitute a significant proportion warranting the public use of a minority language (Siemienski 1999: 353).

[26] cf. the stronger version of the territoriality model that is practised on the Åland Islands, an autonomous province of Finland, where Swedish is the language of public services, and concerted efforts are taken to restrict the use of the Finnish in public services. See Hannikainen (1993) for a more detailed discussion, from an international law perspective, of the language policy of the Åland Islands.

[27] For example, the Nigerian situation encourages pupils to learn through their mother tongues and English, and in addition, they are required to learn at least one of the country's three major languages: Igbo, Yoruba and Hausa (see Akinnaso 1994).

[28] Note that even the strong proponents of the linguistic human rights paradigm, Skutnabb-Kangas et al (2001), refrain from claiming that "all languages should be institutionally equal, with equal money, broadcasting hours in the media, books and grammars. That would be fatuous. The Draft Universal Declaration of Linguistic Rights, handed to UNESCO in Barcelona in 1996, was rejected by most states in its initial form precisely because it contained similar naive demands" (Skutnabb-Kangas 2001: 146).

PART III: CONCLUSIONS

CHAPTER 8

SUMMARISING AND CONCLUDING THE THESIS

8.1. PREAMBLE

Luke and Baldauf (1990) have pointed out that it is important to relate aspects of historical, social, political and economic forces to the shaping of language planning. The practice of finding solutions to, and making decisions on language problems, which is known as language planning, was initiated in the MCH's catchment area, the Northern Region, by the Livingstonia Mission from the 1870s onwards. In my study of the language situation at the MCH, I have found it helpful to pay attention to how history, at both regional and national levels, has shaped the language situation. In this way, I have been able to use the past in order to understand the present. In short, my language policy research at the MCH was not only concerned with institutional language policies and/or practices, but also with the historical processes that have influenced and continue to influence the linguistic behaviour of the hospital's service providers and clients (cf. Ricento 2000).

Secondly, I have in a number of cases employed a comparative/contrastive approach in my discussion. That is, I have compared and contrasted health service delivery at the MCH with non-Malawian multilingual health service delivery situations in Zambia (Chanda 2003), South Africa (e.g. Saohatse 1997; Drennan 1998; Crawford 1999), the USA (e.g. Ehresman n.d.; Perkins et al 1999; Perkins 1999; Youdelman & Perkins 2002), and others. In the process, I have highlighted comparable and/or contrastive language problems and their solutions. This approach has confirmed the view that different contexts demand different solutions to their language problems. Even if the problem is the same across more than one polity, language policy makers and language planners have to consider the local political, social and economic realities when formulating solutions to the language problem.

Thirdly, we live in a world in which costs and benefits are usually attached to plans or actions, and language planning is not exempted from this cost-benefit analysis (see Thorburn 1971; and also Kaplan & Baldauf 1997). One major problem with this approach is the difficulty of attaching monetary value to the benefits of certain language policies or choices. Whilst in this thesis I have not engaged in a rigorous money-oriented cost-benefit analysis of the language planning situation at the MCH, I have nonetheless shown in non-monetary terms the costs that are associated with certain language plans or actions, and the benefits can accrue from them. It is also important, in my view, to acknowledge that cost-benefit analysis in language policy and planning has often been discussed from an economical angle, thus ignoring other forms of cost-benefit. For example, putting in place a policy that ensures that health service providers only serve in areas whose language(s) they speak can have both economic and political costs. Economically, the policy entails training enough health personnel for each language group, something that is practically impossible and also an economic tall order. The other cost of the staff posting policy is political. For instance, some would argue that the policy would be politically costly in the sense that it would strengthen regional loyalties at the expense of national loyalties - something that may not be in the interest of the national unity enthusiasts.

Some of the key language planning-related issues that are worth considering under the cost-benefit analysis are:

i. the costs and benefits of having a multilingual workforce at the MCH;
ii. the costs and benefits of posting health service providers to duty stations on the basis of their ability to speak the dominant language(s) of the area;
iii. the costs and benefits of a deliberate policy of having expatriate service providers learn to speak at least Tumbuka and/or other local languages;
iv. the costs and benefits of local service providers who have to learn the dominant language(s) of their new duty stations;
v. the costs and benefits of having full time trained interpreters at the MCH;
vi. the costs and benefits of an increase in the translation of health literature and other written messages at the MCH into Tumbuka and/or other local languages.

8.2. SUMMARY OF THE FINDINGS

The study has established that the majority of the clients of the MCH come from Mzimba - a predominantly Tumbuka-speaking speaking district. It is therefore the case that Tumbuka is the most widely used language at the MCH. The second mostly widely used language is Chewa. Whilst Chewa is a majority language (in both functional and numerical terms) at the national level, it is a minority language at the MCH. Whilst Chewa can be termed as a numerically significant minority language at the MCH, the other minority languages (those of the Northern Region included) have very low frequencies of use.

Whilst English is the language whose competence the Medical Council of Malawi demands from non-Malawian medical and dental practitioners, this language is not a significant medium of client-service provider interactions since less than half of the clients claimed to be able to use it. The language requirement stipulated by the Medical Council of Malawi gives the false impression that medicine can be effectively practised in Malawi through the English medium, in line with the status of Malawi as a so-called English-speaking country. The study has exposed the inappropriateness of such a designation as well as the linguistic handicap created by not having legislation that compels expatriate health service providers to demonstrate fluency in one major Malawian language before they can be licensed to practice. The typical expatriate at the MCH has no local language competence, and has to rely on ad hoc interpreters when he/she meets non-English-speaking clients.

It is clear from the study that various forms of "language gaps" (Drennan & Swartz 2002: 1854) - the absence of a common language between a health service provider and a client - do exist at the MCH. The most pronounced language gap is between expatriate service providers and the majority 55.2 % of the clients. This gap refers to the use and non-use of English by the expatriate service providers and the majority of the clients respectively. Currently, this language gap is being filled by the use of ad hoc interpreters in the form of nurses, support staff and other parties. To further narrow the language gap between service providers and clients, I have (in chapter 6) proposed Tumbuka for Medical Purposes courses for both local and expatriate service providers. Another proposal has been that service providers be given refresher courses on how to make appropriate use of interpreters. A related proposal has been that interpretation, being the standard way of minimising language gaps in medical settings, should be a component of health service providers' professional training. Furthermore, to motivate staff to learn the language (s) of their new duty stations, it has been proposed that a language allowance be payable to those who learn a new language and pass an appropriate test in it.

The study has also noted that for the MCH, the presence of multilingual staff and clients is both a problem and a resource. As a problem, multilingualism brings language barriers. However, through networks of support, the MCH is able to use the various linguistic competencies of both staff and non-staff to narrow the language gap. The use of lingua francas such as Tumbuka, Chewa and English was also noted to have significant power in breaking down communication barriers.

I also considered the question of language rights with reference to language services. Whilst minority language speakers, especially those from Karonga and Chitipa, do create some linguistic barriers to communication, it was found that the frequency of such speakers was very low to warrant special language services.

8.3. SUGGESTIONS FOR FUTURE RESEARCH

No study can claim to be exhaustive. The current one is no exception. I have obviously merely scratched on the surface of some topics. Such topics need to be explored in greater depth. One of such topics is interpretation. Since this study was not based on the discourse analytic tradition, further studies could revisit the interpretation problems that were identified through the use of non-discourse analytic methods. This will involve collecting large amounts of audio-recorded hospital communication which can be transcribed and then analysed.

Another piece of unfinished business has been the minority languages of Chitipa and Karonga. In the previous chapters, the linguistic picture of Chitipa and Karonga districts has been that of Tower of Babel of the Northern Region of Malawi. However, this linguistic picture should not be taken as valid unless there is ample empirical evidence to lend support to it. My own study did not involve fieldwork in Karonga and Chitipa and, therefore, cannot be used to support the Babel thesis. Previous studies, such as Centre for Language Studies (1999), did not go far enough to examine the presence of language varieties and degrees of mutual intelligibility. Given that in some circles, there has been a tendency to associate Africa with extensive multilingualism and the Towel of Babel,[1] and some dubious estimates of the number of languages have been made, we need to be careful with the case of Karonga and Chitipa in Malawi. In this regard, I apply Blommaert's (1996b: 12) critical questions about Africa's Tower of Babel to the Karonga/Chitipa case as follows: Where does the Tower of Babel that has been claimed for Karonga and Chitipa come from? Secondly, how do we reach the language numbers that have been cited in previous chapters? Thirdly, through what criteria have the languages of Karonga and Chitipa been identified and catalogued? These critical questions should compel interested scholars to engage in fieldwork that can explain the language puzzle of the Karonga/Chitipa area.

One of the assignments during the proposed fieldwork would be to test the degree of intelligibility amongst the linguistic varieties spoken in the two districts (cf. proposals by Walsh & Swilla 2001). Whether two or more linguistic varieties are called same language matters very little as far as communication is concerned. What matters most is whether there is mutual intelligibility among the linguistic varieties, and if so, to what degree. Language names are mere labels which do not go far to tell us whether speakers of the two or more labels can understand each other or not. The danger is that some of the linguistic labels conceal the notion of mutual intelligibility. There is a need, therefore, to collect data from various speech forms and examine the following items:

i. lexicon - to what extent do speech forms share a core vocabulary, and semantic values?
ii. phonological features - in what ways are speech forms different or similar?

iii. syntactic features - in what ways are speech forms similar or different? An examination of the following syntactic features: question formation, tense marking, negation, and imperatives.

It would also be worthwhile to conduct a sociolinguistic study of Chitipa and Karonga district hospitals and other health service institutions in the two districts. The study would be modelled on the current study. Such a study would enable us to follow up some of the issues which the MCH study as well as Chilowa and Munthali's (1997) have raised.

8.4. CONCLUDING REMARKS

As we conclude the thesis, it is important to remind ourselves of the goal(s) of language planning, especially with reference to the situation at the MCH. One goal is to solve language and communication problems. In the case of the MCH, we are talking about a case of trying to provide health services in a linguistically accessible manner to a linguistically diverse clientele. We have noted that language planning as a problem-solving enterprise cannot succeed in the absence of relevant and accurate information. The problem-solving nature of language planning is research-based. The findings of the current study have the potential of assisting policy makers and/or language planners in formulating and evaluating various alternatives for solving language problems so that in end the most optimal policy decisions are reached (cf. Rubin & Jernudd 1971).

The study has confirmed that the MCH has a catchment area that is linguistically heterogeneous. Because of the close link between linguistic heterogeneity and communication barriers, one may be quick to view the situation at the MCH as highly problematic. Whilst it is true that linguistic heterogeneity of the hospital's catchment area does cause some communication barriers, the overall assessment leads to the conclusion that a lingua franca is an important communication bridge. As Legère has observed about Africa's multilingualism, "a common medium of communication is normally always found at the provincial/regional or national level, and even transnationally" (Legère 2002b: 12). In the case of the MCH, such a common medium of communication is Tumbuka.

Whilst Tumbuka is a minority language at the national level, at the MCH the opposite is true. Even at the regional level, the predominant use of Tumbuka has been confirmed by other studies (Kayambazinthu 1995, 1998; National Statistical Office 1998; Centre for Language Studies 1999) that Tumbuka is the majority language in the Northern Region. It is in this regard that one of my proposals (see chapter 7) is that Tumbuka's functional load in official domains should be increased. This proposal is backed by the argument that in areas that are inhabited by significant numbers of speakers of a particular language, and where there is sufficient demand, public services be provided in that language (see various contributions to Packer 1999). At the MCH, there is evidence that speakers of Tumbuka are in majority at the hospital, and that there is sufficient demand for services in Tumbuka.

NOTE

[1] A number of scholars have pointed out that Africa's multingualism is sometimes exaggerated, especially by the West. It is as if communication in Africa is never smooth due to interlocutors not understanding each other's language(s). In contrast, Legère argues that "the so-called language problem of Africa is often projected onto the continent from overseas" (Legère 2002b: 12). Writing earlier, Chimhundu (1992: 88) had claimed that missionaries and colonial officials had created "an exaggerated multi-ethnic, multi-lingual and multi-tribal picture" of Africa.

REFERENCES

Abdulaziz, M. (2002) “The German Contribution to the Study of African Languages.” In: I. Rissom (Ed) *Languages in Contrast.* Bayreuth African Studies Series, 51, pp. 115-126.

Adams, R. (1975) “Pulling the Minds of Social Scientists Together: Towards a World Social Science Information System.” International Social Science Journal. 27 (3): 519-531.

Africa Watch (1990) Where Silence Rules: The Suppression of Dissent in Malawi. NewYork: Human Rights Watch.

Agnew, S. & M. Stubbs (Eds) (1972) Malawi in Maps. London: London University Press.

Ainsworth-Vaughn, N. (1992) “Topic Transition in Physician-Patient Interviews: Power, Gender and Discourse Change.” Language in Society. 21: 409-426.

Ainsworth-Vaughn, N. (2001) “The Discourse of Medical Encounters.” In: D. Schiffrin, D. Tannen & H. E. Hamilton (Eds) Handbook of Discourse Analysis. Blackwell Publishers.

Akinnaso, F. (1994) “Linguistic Unification and Language Rights.” Applied Linguistics. 15 (2): 139-168.

Alexander, N. (1992) “Language Planning from Below.” In: R. K. Herbert (Ed) Language and Society in Africa: The Theory and Practice of Sociolinguistics. Johannesburg: Witswatersrand University Press, pp. 143-149.

Alfredsson, G. (2001) “The Right to Human Rights Education.” In: A. Eide, C. Krause & A. Rosas (Eds) Economic, Social and Cultural Rights. 2nd Edition. London: Martinus Nijhoff Publishers, pp. 273-288.

Annamalai, E. (1998) “Language Choice in Education.” Language Sciences. 20 (1): 29-43.

Ansre, G. (1974) “Language Standardisation in Sub-Saharan Africa.” In: J. A. Fishman (Ed) Advances in Language Planning. The Hague: Mouton, pp. 369-389.

Aronsson, K. & U. Satterlund (1987) “Politeness Strategies and Doctor-Patient Communication: On the Choreography of Collaborative Thinking.” Journal of Language and Social Psychology. 6: 1-27.

Aronsson, K. & U. Satterlund (1989) “Cats, Dogs and Sweets in the Clinical Negotiation of Reality: On Politeness and Coherence in Paediatric Discourse.” Language in Society. 18: 483-504.

Ashford, R. (2001) “Technology and the Potential Spread of Kiswahili.” In: J. S. Mdee & H. J. M. Mwansoko (Eds) Kiswahili 2000 Proceedings. Dar es Salaam: Institute of Kiswahili Research, pp. 144-157.

Baker, D; R. Parker, M. Williams, W. Coates & K. Pitkin (1996) “Use and Effectiveness of Interpreters in an Emergency Department.” Journal of American Medical Association. 275 (10): 783-788.

Baker, M. (Ed) (1998) Routledge Encyclopedia of Translation Studies. London: Routledge.

Baker, C. (2001) The Revolt of the Ministers: The Malawi Cabinet Crisis, 1964-1965. London: I. B. Tauris.

Baldauf, R. & A. Luke (Eds) (1990) Language Planning and Education in Australasia and the South Pacific. Clevedon: Multilingual Matters.

Baldauf, R. (2002) “Methodologies for Policy and Planning.” In: R. Kaplan (Ed) The Oxford Handbook of Applied Linguistics. Oxford: Oxford University Press, pp. 391-403.

Bamgbose, A. (1987) “When is Language Planning not Planning?” Journal of West African Languages. 17 (1): 6-14.

Bamgbose, A. (1991) Language and the Nation: The Language Question in Sub-Saharan Africa. Edinburgh: Edinburgh University Press for International Africa Institute.

Bamgbose, A. (1994) “Pride and Prejudice in Multilingualism and Development.” In: R. Fardon & G. Furniss (Eds) African Languages, Development and the State. London: Routledge, pp. 33-43.

Bamgbose, A. (1998) “Language as a Resource: An African Perspective.” Paper Presented at a Workshop on the Role of African Languages in Democratic South Africa, 5-6 March 1998, University of Pretoria, South Africa.

Bamgbose, A. (2000a) Language and Exclusion: The Consequences of Language Policy in Africa. Hamburg: Lit.

Bamgbose, A. (2000b) “African Language Use and Development: Aspirations and Reality.” In: H. Ekkehard Wolff & Orin D. Gensler (Eds) Proceedings of the 2nd World Congress of African Linguistics. Köln: Rudiger Köppe, pp. 19-32.

Bamgbose, A. (2001) Review of: Robert Phillipson (Ed) Rights to Language: Equity, Power and Education; and M. Kontra, R. Phillipson, T. Skutnabb-Kangas and T. Varady (Eds) Language, A Right and a Resource: Approaching Linguistic Human Rights. In: Language in Society. 30 (4): 639-643.

Bamgbose, A. (2003) “Language and the African Reinassance: Lessons From the South African Experience.” In: H. Ekkehard Wolff (Ed) Tied Tongues: The African Renaissance as a Challenge for Language Planning. Hamburg: Lit, pp. 39-60.

Banda, Felix. (2001) Review of: African Voices: An Introduction to Languages and Linguistics in Africa. In: South African Journal of African Languages. 21 (2): 197-202.

Banda, Felix. (Ed) (2002) Language Across the Borders: Harmonisation and Standardisation of Orthographic Conventions of Central African Languages. Cape Town: Centre for the Advanced Studies of African Society.

Banda, Felix; Vincent Chanda, Gregory Kamwendo, Marcelino Liphola, Carlos Manuel, Lazarus Mithi, Al Mtenje, Armindo Ngunga & Silvester Simango (2002) A Unified Standard Orthography for South-Central African Languages: Malawi, Mozambique and Zambia. Cape Town: Centre for the Advanced Studies of African Society Monograph Series.

Bandia, P. (1998) “African Traditions.” In: M. Baker (Ed) Routledge Encyclopedia of Translation Studies. London: Routledge, pp. 295-304.

Barkhuizen, G. P. & V. de Klerk (2002) “The Role of Xhosa in a South African Prison: The Situation is Leading You.” Journal of Multilingual and Multicultural Development. 23 (3): 160-174.

Batibo, H. M. & B. Smieja (Eds) (2000) Botswana: The Future of Minority Languages. Berlin: Peter Lang.

Batibo, H. M. (2002) “Integration and Ethnic Identity: A Critical Dilemma for the Minority Language Speakers of Botswana.” In: I. Mazonde (Ed) Minorities in the Millennium: Perspectives from Botswana. Gaborone: Lightbooks for the University of Botswana & the International Centre for Contemporary Cultural Research, pp. 89-96.

Bell, R. T. (1976) Sociolinguistics: Goals, Approaches and Problems. London: B. T. Batsford Limited.

Bischoff, A; P. Bovier, R. Isah, G. Francoise, E. Ariel & L. Louis (2003) “Language Barriers Between Nurses and Asylum Seekers: Their Impact on Symptom Reporting and Referral.” Social Science and Medicine. 57: 503-512.

Bizzell, P. (1994) “Discourse Community.” In: A. C. Purves (Ed) Encyclopaedia of English Studies and Language Arts. New York: Scholarstic, pp. 395-397.

Blommaert, J. (Ed) (1996a) The Politics of Multilingualism and Language Planning: Proceedings of the Language Planning Workshop Held at the Political Linguistics Conference, Antwerp, December 1995. Antwerp Papers in Linguistics. 87.

Blommaert, J. (1996b) “The Politics of Multilingualism and Language Planning: Introduction.” In: J. Blommaert (Ed) The Politics of Multilingualism and Language Planning: Proceedings of the Language Planning Workshop Held at the Political Linguistics Conference, Antwerp, December 1995. Antwerp Papers in Linguistics. 87: 3-26.

Blommaert, J. (1997a) “Introduction: Language and Politics, Language Politics and Political Linguistics.” Belgian Journal of Linguistics. 11: 1-10.

Blommaert, J. (1997b) “Ideology and Language in Tanzania: A Brief Survey.” In: R. K. Herbert (Ed) African Linguistics at the Crossroads: Papers from Kwaluseni. Köln: Rudiger Köppe, pp. 501-510.

Blommaert, J. (Ed) (1999a) Language Ideological Debates. Berlin: Mouton de Gruyter.

Blommaert, J. (1999b) “The Debate is Closed.” In: J. Blommaert (Ed) Language Ideological Debates. Berlin: Mouton de Gruyter, pp. 425-438.

Blommaert, J. (2001) “The Asmara Declaration as a Sociolinguistic Problem: Reflections on Scholarship and Linguistic Rights.” Journal of Sociolinguistics. 5 (1): 131-142.

Bloomfield, L. (1933) Language. New York: Holt, Rinehart & Winston.

Boeder, R. B. (1984) Silent Majority: A History of the Lomwe in Malawi. Pretoria: Africa Institute of South Africa.

Bogdan, R. C. & S. K. Biklen (1992) Qualitative Research for Education. 2nd Edition. Boston: Allyn and Bacon.

Bolden, G. A. (2000) “Towards Understanding Practices of Medical Interpreting: Interpreters’ Involvement in History Taking.” Discourse Studies. 2 (4): 387-419.

Bonanno, M. (1982) “Women’s Language in the Medical Interview.” In: R. J. Di Pietro (Ed) Linguistics and the Professions. Norwood: Ablex, pp. 27-38.

Boran, I. (2001) “Autonomy as a Remedy for Language Conflicts: Negotiating Territoriality and Identity.” Language Problems and Language Planning. 25 (3): 237-257.

Brann, C. M. B. (1994) “The National Language Question: Concepts and Terminologies.” Logos. 14: 125-134.

Brock-Utne, B. (2002) Language, Democracy and Education in Africa. Discussion Paper Number 15. Uppsala: Nordic Africa Institute.

Brookes, H. & S. B. Heath (1997) Review of: T. Skutnabb-Kangas & R. Phillipson, editors: Linguistic Human Rights: Overcoming Linguistic Discrimination. In: International Journal of the Sociology of Language. 127: 197-208.

Brown, P. & S. Levinson (1987) Politeness: Some Universals in Language Usage. Cambridge: Cambridge: Cambridge University Press.

Brunstad, E. (2003) "Standard Language and Linguistic Purism." Sociolinguistica. 17: 52-70.

Bulmer, M. & D. P. Warwick (Eds) (1993) Social Research in Developing Countries: Surveys and Censuses in the Third World. UCL Press.

Bulmer, M. (1993) "Sampling." In: M. Bulmer & D. P. Warwick (Eds) Social Research in Developing Countries: Surveys and Censuses in the Third World. UCL Press, pp. 91-99.

Cameron, D; E. Frazer, P. Harvey, B. Rampton & K. Richardson (1997) "Ethics, Advocacy and Empowerment in Researching Language." In: N. Coupland & A. Jaworski (Eds) Sociolinguistics: A Reader. Basingstoke Macmillan, pp. 145-162.

Cameron, D. (2002) Working with Spoken Discourse. London: Sage.

Cameron, R. & J. Williams (1997) "Sentence to Ten Cents: A Case of Relevance and Communicative Success in Non-native-native speaker Interactions in Medical Settings." Applied Linguistics. 18 (4): 416-445.

Campbell-Kibler, K.; R. J. Podesva, S. J. Roberts & A. Wong (Eds) (2001) Language and Sexuality: Contesting Meaning in Theory and Practice. CSLI Publications.

Candlin, C. (2000) "Reinventing the Patient/Client: New Challenges to Health Care Communication." The Cardiff Lecture 2000, Cardiff University, United Kingdom.

Candlin, C. (Ed) (2002) Research Practice in Professional Discourse. Hong Kong: City University of Hong Kong Press.

Candlin, C. & S. Candlin (2003) "Health Care Communication: A Problematic Site for Applied Linguistics Research." Annual Review of Applied Linguistics. 23: 134-154.

Carabine, D. & L. Ssemusu (Eds) (2002) Ethnicity in an Age of Globalisation. Nkozi: Uganda Martyrs University Press.

Cassell, C. & G. Symon (Eds) (1994) Qualitative Methods in Organizational Research: A Practical Guide. London: Sage.

Centre for Language Studies (1999) Sociolinguistic Surveys of Four Malawian Languages: With Special Reference to Education. Zomba & Lilongwe: Centre for Language Studies, University of Malawi & GTZ.

Centre for Language Studies (2001a) Chilomwe: Some Considerations for Bible Translation in Malawi. A Study Commissioned by the Bible Society of Malawi.

Centre for Language Studies (2001b) Towards the Standardisation of the Chitumbuka Orthography. Report Submitted to GTZ/MIITEP, Lilongwe, Malawi.

Centre for Language Studies & Malawi Broadcasting Corporation (2001) Malawi Broadcasting Corporation Listenership Survey: With Special Reference to Democratisation. A Research Proposal.

Chambers, J. K. & P. Trudgill (1998) Dialectology. 2nd Edition. Cambridge: Cambridge University Press.

Chambers J. K, P. Trudgill & N. Schilling-Estes (Eds) (2002) The Handbook of Language Variation and Change. Oxford: Blackwell.

Chancellor College, University of Malawi (1995) Proposal for the Establishment of a Centre for Language Studies. Paper Reference CC/2/1/3/1.

Chancellor College, Language and Communication Skills Department (2001) Income Generating Activities: A Proposal.

Chanda, K. L. (2003) "Patient-Doctor Communication During History Taking: A Case for the University Teaching Hospital, Lusaka." A Proposal for an M.A. Degree in Communication for Development, University of Zambia.

Chebanne, A. (2002) "Minority Languages and Minority Peoples: Issues on Linguistic, Cultural and Ethnic Death in Botswana." In: I. Mazonde (Ed) Minorities in the Millennium: Perspectives from Botswana. Gaborone: Light Books for the University of Botswana & the International Centre for Contemporary Cultural Research, pp. 47-55.

Chen, A. H. Y. (1998) "The Philosophy of Language Rights." Language Sciences. 20 (1): 45-54.

Chia, H-U; R. Johnson, H-L Chia & F. Olive (1998) "English for College Students in Taiwan: A Study of Perceptions of English Needs in a Medical Context." English for Specific Purposes. 18 (2): 107-119.

Chilowa, W. & A. C. Munthali (1997) A Study of Vaccination Culture, Social Demand for Immunisation and Practices of Vaccination Regimes: The Case of Nthalire in Chitipa District. Zomba: Centre for Social Research, University of Malawi.

Chilowa, W. & A. C. Munthali (1998a) A Study of Vaccination Culture, Social Demand for Immunisation and Practices for Vaccination Regimes: The Case of Ntchisi District. Zomba: Centre for Social Research, University of Malawi.

Chilowa, W. & A. C. Munthali (1998b) Immunisation in Malawi. Amsterdam: Het Spinhuis.

Chima, A. (1996) "Preface." In: W. Y. Turner, Chitumbuka/Chitonga/English Dictionary. Blantyre: Central Africana Limited.

Chimhundu, H. (1992) "Early Missionaries and the Ethnolinguistic Factor During the Invention of Tribalism in Zimbabwe." Journal of African History. 33 (1): 87-101.

Chimombo, S. (1995) "Nothing Changed for the Writer." Wasi. 6 (3): 28-30.

Chimombo, S. (1997) "Non-Publishing in Minority Languages." Wasi. 8 (3): 18-19.

Chimombo, Steve & Moira Chimombo (1996) The Culture of Democracy: Language, Literature, the Arts and Politics in Malawi, 1992-1994. Zomba: Wasi Publications.

Chinsinga, B. (2002) "The Politics of Poverty Alleviation in Malawi." In: H. Englund (Ed) A Democracy of Chameleons: Politics and Culture in the New Malawi. Uppsala: Nordic Africa Institute, pp. 25-42.

Chirwa, W. C. (1994/1995) "Regionalism, Ethnicity and the National Question in Malawi." Southern Africa Political and Economic Monthly. December/January, pp. 59-62.

Chiwome, E. M. & Z. Gambahaya (Eds) (1998) Culture and Development: Perspectives from the South. Harare: Mond Books.

Christian, D. (1988) “Language Planning: The Views from Linguistics.” In: F. J. Newmeyer (Ed) Linguistics: The Cambridge Survey: Language: Socialcultural Context. Volume 4. Cambridge: Cambridge: Cambridge University Press, pp. 193-209.

Chumbow, B. S. (1987) “Towards a Language Planning Model for Africa.” Journal of West African Languages. 17 (1): 15-22.

Clyne, M. (Ed) (1992a) Pluricentric Languages: Differing Norms in Different Nations. Berlin: Mouton de Gruyter.

Clyne, M. (1992b) “Pluricentric Languages: Introduction.” In: M. Clyne (Ed) Pluricentric Languages: Differing Norms in Different Countries. Berlin: Mouton de Gruyter, pp. 1-9.

Cobarrubias, J. (1983) “Ethical Issues in Status Planning.” In: J. Cobarrubias & J. Fishman (Eds) Progress in Language Planning: International Perspectives. Berlin: Mouton de Gruyter, pp. 41-85.

Cobarrubias, J. & J. Fishman (Eds) (1983) Progress in Language Planning: International Perspectives. Berlin: Mouton de Gruyter.

Cohen, L; L. Manion & K. Morrison (2000) Research Methods in Education. 5th Edition. London: Routledge.

Cole, P. & J. Morgan (Eds) (1975) Syntax and Semantics: Speech Acts. New York: Academic Press.

Cooper, R. L. (1989) Language Planning and Social Change. Cambridge: Cambridge University Press.

Coulmas, F. (Ed) (1984) Linguistic Minorities. Berlin: Mouton de Gruyter.

Coulmas, F. (Ed) (1997) The Handbook of Sociolinguistics. Oxford: Basil Blackwell.

Coupland, N. & A. Jaworski (Eds) (1997) Sociolinguistics: A Reader. Basingstoke Macmillan.

Coupland, J. (Ed) (2000) Small Talk. London: Pearson Education.

Cicourel, A. V. (1981) “Language and Medicine.” In: C. A. Ferguson & S. B. Heath (Eds) Language in the USA. Cambridge: Cambridge University Press, pp. 407-429.

Crawford, A. (1999) “We Can’t Understand the White’s Language: An Analysis of Monolingual Services in a Multilingual Society.” International Journal of the Sociology of Language. 136: 27-45.

Creswell, J. (1994) Research Design: Qualitative and Quantitative Approaches. Thousand Oaks, C A: Sage.

Crystal, D. (1987) The Cambridge Encyclopedia of Language. Cambridge: Cambridge University Press.

Crystal, D. (1992) Encyclopaedic Dictionary of Language and Languages. Oxford: Blackwell.

Daoust, D. (1997) “Language Planning and Language Reform.” In: F. Coulmas (Ed) The Handbook of Sociolinguistics. Oxford: Basil Blackwell, pp. 436-452.

Davidson, B. (2000) “The Interpreter as Institutional Gatekeeper: The Social-Linguistic Role of Interpreters in Spanish-English Medical Discourse.” Journal of Sociolinguistics. 4 (3): 379-405.

Davidson, B. (2001) “Questions in Cross-linguistic Medical Encounters: The Role of the Hospital Interpreter.” Anthropological Quarterly. 74 (4): 170-178.

de Klerk, V. (Ed) (1996) Varieties of English Around the World: Focus on South Africa. Amsterdam: John Benjamins.

de Klerk, V. & G. Barkhuizen (1998) “English in the South African Defence Force.” English World-Wide. 19 (1): 33-60.

de Klerk, V. & G. Barkhuizen (2002) “English in the Prison Services: A Case of Breaking the Law?” World Englishes. 21 (1): 9-22.

de Varennes, F. (1996) Language, Minorities and Human Rights. The Hague: Martinus Nijhoff.

de Varennes, F. (1999a) “The Existing Rights of Minorities in International Law.” In: M. Kontra et al (Eds) Language: A Right and a Resource. Budapest: Central European University Press, pp. 117-146.

de Varennes, F. (1999b) “Equality and Non-Discrimination: Fundamental Principles of Minority Language Rights.” International Journal on Minority and Group Rights. 6(3): 307-318.

de Varennes, F. (2001a) A Guide to the Rights of Minorities and Language. COLPI Paper Number 4. Budapest: The Open Society.

de Varennes, F. (2001b) “Language Rights as an Integral Part of Human Rights.” MOST Journal on Multicultural Societies. 3 (1). www.unesco.org/most

Denzin, N. K. & Y. S. Lincoln (Eds) (1998) Strategies of Qualitative Inquiry. London: Sage Publications.

Di Pietro, R. J. (Ed) (1982) Linguistics and the Professions. Norwood: Ablex.

Drennan, G. (1998) Language and the Role of Interpreting in South African Psychiatry. Unpublished PhD Thesis, University of Cape Town, South Africa.

Drennan, G. & L. Swartz (2002) “The Paradoxical Use of Interpreters in Psychiatry.” Social Science and Medicine. 54 (12): 1853-1866.

Duff, P. A. (2002) “Research Approaches in Applied Linguistics.” In: R. B. Kaplan (Ed) The Oxford Handbook of Applied Linguistics. Oxford: Oxford University Press, pp. 13-23.

Dunbar, R. (2001) “Minority Language Rights in International Law.” International and Comparative Law Quarterly. 50: 90-120.

Dupuy, R-J. (Ed) (1979) The Right to Health as a Human Right. The Netherlands: Sijthoff & Noordohoff.

Duranti, A. & C. Goodwin (Eds) (1997) Rethinking Context: Language as an Interactive Phenomenon. Cambridge: Cambridge University Press.

Dzimbiri, L. B. (1994) “Notes on Recent Elections: The Malawi Referendum of June 1993.” Election Studies. 13: 229-234.

Eades, D; H. Fraser, J. Siegel, T. McNamara & B. Baker (2003) “Linguistic Identification in the Determination of Nationality: A Preliminary Report.” Language Policy. 2: 179-199.

Eastman, C. (1983) Language Planning: An Introduction. San Francisco: Chandler & Sharp.

Eckert, P. & S. McConnell-Ginet. (1992) “Think Practically and Look Locally: Language and Gender as a Community-based Practice.” Annual Review of Anthropology. 21: 461-490.

Eckert, P. & S. McConnell-Ginet. (1999) “New Generalisations and Explanations in Language and Gender Research.” Language in Society. 28: 185-201.

Edwards, J. (1985) Language, Society and Identity. Basil Blackwell.

Eggington, W. G. (2002) “Unplanned Language Planning.” In: R. Kaplan (Ed) The Oxford Handbook of Applied Linguistics. Oxford: Oxford University Press, pp. 404-415.

Eggly, S; J. Musial & J. Smulowitz (1998) “The Relationship Between English Language Proficiency and Success as a Medical Resident.” English for Specific Purposes. 18 (2): 201-208.

Ehresman, C. J; C. Abboud & R. C. Bowman (n.d) A Study of the Language Interpretation Services at Omaha Hospitals. Unpublished Document.

Eide, A; C. Krause & A. Rosas (Eds) (2001) Economic, Social and Cultural Rights. 2nd Edition. London: Martinus Nijhoff Publishers.

Eide, A. & A. Rosas (2001) “Economic, Social and Cultural Rights: A Universal Challenge.” In: A. Eide, C. Krause & A. Rosas (Eds) (2001) Economic, Social and Cultural Rights. 2nd Edition. London: Martinus Nijhoff Publishers, pp. 3-8.

Elderkin-Thompson, V; R. Cohen Silver & H. Waitzkin (2001) “When Nurses Double as Interpreters: A Study of Spanish-Speaking Patients in a US Primary Care Setting.” Social Science and Medicine. 52: 1343-1358.

Ellis, R. (1986) Understanding Second Language Acquisition. Oxford University Press.

Englund, H. (1996) “Between God and Kamuzu: The Transition to Multiparty Politics in Central Malawi.” In: R. Werbner & T. Ranger (Eds) Postcolonial Identities in Africa. London: Zed Books.

Englund, H. (2000) “The Dead Hand of Human Rights: Contrasting Christianities in Post-Transition Malawi.” The Journal of Modern African Studies. 38 (4): 579-603.

Englund, H. (2001) “Chinyanja and the Language of Rights.” Nordic Journal of African Studies. 10: 299-319.

Englund, H. (2002a) (Ed) A Democracy of Chameleons: Politics and Culture in the New Malawi. Uppsala: Nordic Africa Institute.

Englund, H. (2002b) From War to Peace on the Mozambique-Malawi Borderland. London: Edinburgh University Press for the International African Institute.

Englund, H. (2003) “Introduction: Recognising Identities, Imagining Alternatives.” In: H. Englund & F. Nyamnjoh (Eds) Rights and the Politics of Recognition in Africa. London: Zed Books, pp. 1-29.

Englund, H. (2004) “Towards a Critique of Rights Talk in New Democracies: The Case of Legal Aid in Malawi.” Discourse and Society. 15 (5): 527-551.

Englund, H. & F. Nyamnjoh (Eds) (2003) Rights and the Politics of Recognition in Africa. London: Zed Books.

Evans, T. (2002) “A Human Right to Health?” Third World Quarterly. 23 (2): 197-215.

Exter, A. & H. Hermans (Eds) (1979) The Right to Health in Several European Countries. The Hague: Kluwer Law International.

Eze, O. C. (1979) “Right to Health as a Human Right in Africa.” In: R-J. Dupuy (Ed) The Right to Health as a Human Right. The Netherlands: Sijthoff & Noordohoff, pp. 76-93.

Fairclough, N. (1995) Critical Discourse Analysis. London: Longman.

Fairclough, N. & R. Wodak (1997) “Critical Discourse Analysis.” In: T. A. van Dijk (Ed) Discourse and Social Interaction. London: Sage, pp. 258-284.

Fardon, R. & G. Furniss (Eds) (1994) African Languages, Development and the State. London: Routledge.

Fasold, R. (1984) The Sociolinguistics of Society. Oxford: Basil Blackwell.

Feagin, C. (2002) “Entering the Community: Fieldwork.” In: J. K. Chambers, P. Trudgill & N. Schilling-Estes (Eds) The Handbook of Language Variation and Change. Oxford: Blackwell, pp. 20-39.

Ferguson, C. A. (1966) “On Sociolinguistically Oriented Language Surveys.” The Linguistic Reporter: Newsletter of the Centre for Applied Linguistics. 8 (4): 1-3.

Ferguson, C. A. & S. B. Heath (Eds) (1981) Language in the USA. Cambridge: Cambridge University Press.

Figueroa, E. (1994) Sociolinguistic Metatheory. Oxford: Pergamon Press.

Fishman, J. A; C. A. Ferguson & J. Das Gupta (Eds) (1968) Language Problems of Developing Nations. New York: John Wiley & Sons.

Fishman, J. A.; J. Das Gupta; B. Jernnud & J. Rubin (1971) “Research Outline for Comparative Studies of Language Planning.” In: J. Rubin & B. Jernudd (Eds) Can Language be Planned? Sociolinguistic Theory and Practice for Developing Nations. Honolulu: The University Press of Hawaii, pp. 293-305.

Fishman, J. A. (1965) “Who Speaks What Language to Whom and When?” La Linguistique. 2: 67-88.

Fishman, J. A. (Ed) (1974a) Advances in Language Planning. The Hague: Mouton.

Fishman, J. A. (1974b) “Language Planning and Language Planning Research: the State of the Art.” In: J. A. Fishman (Ed) Advances in Language Planning. The Hague: Mouton, pp. 15-33.

Fishman, J. A. (1983) “Modelling Rationales in Corpus Planning: Modernity and Tradition in Images of the Good Corpus.” In: J. Cobarrubias & J. A. Fishman (Eds) Progress in Language Planning: International Perspectives. Berlin: Mouton de Gruyter, pp. 107-118.

Fishman, J. A. (1984) “Language Modernisation and Planning in Comparison with other Types of National Modernisation and Planning.” In: C. Kennedy (Ed) Language Planning and Language Education. London: George Allen & Unwin, pp. 37-54.

Fishman, J. A. (1998) Review of: T. Skutnabb-Kangas (Ed) Multilingualism for All. In: Language in Society. 27 (3): 413-415.

Fitzpatrick, M. A; T. Edgar & V. Freimuth (1992) "Communication, Language and Health: An Overview." Journal of Language and Social Psychology. 11 (1 & 2): 1-8.

Fleischman, S. (2001) "Language and Medicine." In: D. Schiffrin, D.Tannen & H. E. Hamilton (Eds) The Handbook of Discourse Analysis. Blackwell Publishers, pp. 470-502.

Forster, P. G. (1989) T. Cullen-Young: Missionary and Anthropologist. Hull: Hull University Press.

Forster, P. G. (1994) "Culture, Nationalism, and the Invention of Tradition in Malawi." The Journal of Modern African Studies. 32: 477-497.

Forster, P. G. (1997) "Religion and the State in Tanzania and Malawi." Journal of Asian & African Studies. 32 (3-4): 163-184.

Forster, P. G. (1998) "Religion, Magic, Witchcraft and AIDS in Malawi." Anthropos. 93: 537-554.

Forster, P. G. (2001) "AIDS in Malawi: Contemporary Discourse and Cultural Continuities." African Studies. 60 (2): 245-261.

Francis, D. J. & M. C. Kamanda (2001) "Politics and Language Planning in Sierra Leone." African Studies. 60 (2): 225-244.

Frank, R. A. (2000) "Medical Communication: Non-native English-Speaking Patients and Native English Speaking Professionals." English for Specific Purposes. 19: 31-62.

Freidson, E. (1961) Patients' Views of Medical Practice. New York: Russell Sage.

Gadelii, K. E. (2001) "Languages in Mozambique." Africa and Asia: Göteborg Working Papers on Asian and African Languages and Literatures. Department of Oriental and African Languages, Göteborg University. 1: 6-12.

Galligan, T. (1975) "The Ngulu Penetration into Nyasaland 1892-1914." In: R. J. MacDonald (Ed) From Nyasaland to Malawi: Studies in Colonial History. Nairobi: East African Publishing House, pp. 108-123.

Garces, C. V. (2001) "Integrating Cross-Cultural Research in Translation or How to Produce Effective Texts: The HIV/AIDS Case." Across Languages and Cultures. 2 (1): 15-30.

Garces, C. V. (2002) "Translation and Stereotypes as Cultural Facts: A Case Study, AIDS and the Latino Community in the USA." Babel. 48 (4): 289-304.

Geschiere, P. (1997) The Modernity of Witchcraft: Politics and the Occult in Postcolonial Africa. Charlottesville & London: University Press of Virginia.

Geschiere, P. & J. Gugler (1998) "The Urban-Rural Connection: Changing Issues of Belonging and Identification." Africa. 68: 309-319.

Gile, D. (1998) "Conference and Simultaneous Interpreting." In: M. Baker (Ed) Routledge Encyclopedia of Translation Studies. London: Routledge, pp. 40-45.

Gingras, R. (Ed) (1978) Second Language Acquisition and Foreign Language Teaching. Arlington, VA: Centre for Applied Linguistics.

Goffman, E. (1967) Interactional Ritual: Essays on Face to Face Behaviour. Garden City, New York: Doubleday.

Good, C. M. (1987) Ethnomedical Systems in Africa: Patterns of Traditional Medicine in Rural and Urban Kenya. New York: The Guilford Press.

Gottlieb, N. (1995) Kanji Politics: Language Policy and Japanese Script. London: Kegan Paul International.

Grabe, W. (2002) "Applied Linguistics: An Emerging Discipline for the Twenty-First Century." In: R. B. Kaplan (Ed) The Oxford Handbook of Applied Linguistics. Oxford: Oxford University Press, pp. 3-12.

Grice, H. P. (1975) "Logic and Conversation." In: P. Cole & J. Morgan (Eds) Syntax and Semantics: Speech Acts. New York: Academic Press, pp. 41-58.

Grimes, B. (Ed) (1996) Ethnologue: Languages of the World. Dallas: Summer Institute of Linguistics.

Gruskin, S. & A. Hendriks (2000) "The Right to Privacy: Some Implications for Confidentiality in the Context of HIV/AIDS." In: T. S. Orlin, A. Rosas & M. Scheinin (Eds) The Jurisprudence of Human Rights Law: A Comparative Interpretative Approach. Åbo: Institute for Human Rights, Åbo Akademi University, pp. 223-252.

Gumperz, J. (1962) "Types of Linguistic Community." Anthropological Linguistics. 4: 28-40.

Gumperz, J. (1968) "The Speech Community." International Encyclopaedia of the Social Sciences. London: Macmillan, pp. 381-386.

Gumperz, J. & D. Hymes (Eds) (1972) Directions in Sociolinguistics: The Ethnography of Communication. New York: Holt, Rinehart & Winston.

Gumperz, J. & S. C. Levinson (Eds) (2000) Rethinking Linguistic Relativity. Cambridge: Cambridge University Press.

Haakana, M. (2002) "Laughter in Medical Interaction: From Quantification to Analysis and Back." Journal of Sociolinguistics. 6 (2): 207-235.

Haffner, L. (1992) "Translation is not Enough: Interpreting in a Medical Setting." The Western Journal of Medicine. 157: 255-259.

Hammersley, M. (1990) Reading Ethnographic Research: A Critical Guide. London: Longman.

Hammersley, M. (1992) What's Wrong With Ethnography? Methodological Explorations. London: Routledge.

Hannikainen, L. (1993) Cultural, Linguistic and Educational Rights in the Åland Islands: An Analysis in International Law. Publication Number 5 of the Advisory Board for International Human Rights Affairs.

Harlech-Jones, B; I. Mbise & H. Vale (Eds) (2001) Guardian of the Word: Literature, Language and Politics in SADC Countries. Windhoek: Macmillan.

Hartley, J. F. (1994) "Case Studies in Organisational Research." In: C. Cassell & G. Symon (Eds) Qualitative Methods in Organisational Research: A Practical Guide. London: Sage, pp. 208-229.

Hatton, D. C. (1992) “Information Transmission in Bilingual, Bicultural Contexts.” Journal of Community Health Nursing. 9 (1): 53-59.

Hatton, D. C. & T. Webb (1993) “Information Transmission in Bilingual, Bicultural Contexts: A Field Study of Community Health Nurses and Interpreters.” Journal of Community Health Nursing. 10 (3): 137-147.

Heine, B. (1970) Status and Use of African Lingua Francas. Munich: Weltforum.

Heine, B. & D. Nurse (Eds) (2000) African Languages: An Introduction. Cambridge: Cambridge University Press.

Henry, I. C. & G. Pashley (Eds) (1995) Community Ethics and Health Care Research. Mark Allen Publishing Limited.

Herbert, R. K. (Ed) (1992) Language and Society in Africa: The Theory and Practice of Sociolinguistics. Johannesburg: Witswatersrand University Press.

Herbert, R. K. (Ed) (1997) African Linguistics at the Crossroads: Papers from Kwaluseni. Köln: Rudiger Köppe.

Hill, P. & S. van Zyl (2002) “English and Multilingualism in the South African Engineering Workplace.” World Englishes. 21 (1): 23-35.

Hockett, C. (1958) A Course in Modern Linguistics. New York: Macmillan.

Hoffman, C. (1991) An Introduction to Bilingualism. London: Longman.

Holmes, J. (Ed) (1999) Language in Society. Special Issue on Communities of Practice in Language and Gender Research. 28 (2): 171-320.

Holmes, J. & M. Meyerhoff (1999) “The Community of Practice: Theories and Methodologies in Language and Gender Research.” Language in Society. 28: 173-183.

Holt, S. & J. Packer (2001) “OSCE Developments and Linguistic Minorities.” MOST Journal on Multicultural Societies. 3 (2). www.unesco.org/most

Hymes, D. (1972) “Models of the Interaction of Language and Social Life.” In: J. Gumperz & D. Hymes (Eds) Directions in Sociolinguistics: The Ethnography of Communication. New York: Holt, Rinehart & Winston.

Hudson, R. A. (1996) Sociolinguistics. 2nd Edition. Cambridge: Cambridge University Press.

Hutchby, I. & R. Wooffitt (1998) Conversational Analysis. Cambridge: Cambridge University Press.

Janesick, V. J. (1998) “The Dance of Qualitative Research Design.” In: N. K. Denzin & Y. S. Lincoln (Eds) Strategies of Qualitative Inquiry. London: Sage Publications, pp. 35-55.

Johnstone, B. (2000) Qualitative Methods in Sociolinguistics. New York: Oxford Publishing Company.

Kachru, B. (1985) “Standards, Codification and Sociolinguistic Realism: The English Language in the Outer Circle.” In: R. Quirk & H. Widdowson (Eds) English in the World: Teaching and Learning the Language and Literatures. Cambridge: Cambridge University Press, pp. 11-30.

Kachru, B. (1986) The Alchemy of English: The Spread, Functions and Models of Non-Native Englishes. Pergamon Press.

Kalinga, O. J. M. (1985) “Colonial Rule, Missionaries and Ethnicity in the North Nyasa District, 1891-1938.” African Studies Review. 28 (1): 57-72.

Kalinga, O. J. M. (1998) “The Production of History in the 1960s: The Legacy of Sir Harry Johnston, The Influence of the Society of Malawi and the Role of Dr Kamuzu Banda and His Malawi Congress Party.” African Affairs. 97: 523-549.

Kalipeni, E. (1992) “Political Development and Prospects for Democracy in Malawi.” TransAfrica Forum. 9 (1).

Kamanga, Thandie. (1990) “Teaching English for Academic Purposes (EAP): Fundamental Issues and Recurrent Problems.” In: A. C. J. Pongweni & J. Thondhlana (Eds) The Role of Linguistics in Communication for Development: Proceedings of the Second Linguistics Association for SADCC Universities Conference Held at the University of Zimbabwe, 2-5 September 1987. Harare: University of Zimbabwe, pp. 48-53.

Kamchedzera, G. (1994) “Language: Malawi after Banda.” BBC Focus on Africa Magazine, July-September, pp. 58-59.

Kamuzu College of Nursing. (1999-2000) Mzake ndi Mzake: Peer Group Discussions for AIDS Prevention Project in Malawi. Faculty/Students Research Project.

Kamwangamalu, N. M. (2000) “A New Language Policy, Old Practices: Status Planning for South African Languages in a Multilingual South Africa.” South African Journal of African Languages. 20 (1): 50-60.

Kamwendo, Gregory H. (1995) “Towards Academic Freedom in Malawi: The National Conference on Academic Freedom.” Southern African Political and Economic Monthly (SAPEM), February 1995, p. 50.

Kamwendo, Gregory H. (1997) “Language Policy in Malawi.” Zimbabwe Journal of Educational Research. 9 (2): 202-215.

Kamwendo, Gregory H. (1998) “Towards Linguistic and Cultural Liberalisation in Malawi.” In: E. M. Chiwome & Z. Gambahaya (Eds) Culture and Development: Perspectives from the South. Harare: Mond Books.

Kamwendo, Gregory H. (1999) “Centre for Language Studies: An Overview.” Malilime: Malawian Journal of Linguistics. 1: 41-46.

Kamwendo, Gregory H. (2000) “Interfacing Language Research with Policy: The Case of Language in Education in Malawi.” Nordic Journal of African Studies. 9 (2): 1-10.

Kamwendo, Gregory H. (2001a) “Malawi’s Approach to Language in Education: A Review of Key Issues.” In: R. Trewby & S. Fitchat (Eds) Language and Development in Southern Africa: Making the Right Choices. Windhoek: Gamsberg Macmillan, pp. 86-93.

Kamwendo, Gregory H. (2001b) “Rethinking the Status of Kiswahili in Malawi.” In: J. S. Mdee & H. J. M. Mwansoko (Eds) (2001) Kiswahili 2000 Proceedings. Dar es Salaam: Institute of Kiswahili Research, pp. 103-108.

Kamwendo, Gregory H. (2002a) “Ethnic Revival and Language Associations in the New Malawi: The Case of Chitumbuka.” In: H. Englund (Ed) A Democracy of Chameleons: Politics and Culture in the New Malawi. Uppsala: Nordic Africa Institute, pp. 140-150.

Kamwendo, Gregory H. (2002b) “Linguistic and Ethnic Identity Among the Lomwe of Malawi.” In: D. Carabine & L. Ssemusu (Eds) Ethnicity in an Age of Globalisation. Nkozi: Uganda Martyrs University Press, pp. 113-127.

Kamwendo, Gregory H. (2003) “Is Malawi Guilty of Spoiling the Queen’s Language?” English Today: The International Review of the English Language. 19 (2): 30-33.

Kamwendo, Gregory H.; A. Mtenje & B. Sandhaas (Eds) (1999) Towards a National Language Policy for Education: Proceedings of a National Symposium on Language Policy Formulation. Lilongwe & Zomba: GTZ & Centre for Language Studies, University of Malawi.

Kamwendo, Juliet; A. Dolozi & L. Mteleka (2003) “Problems in the Teaching of Primary Science: Views From Zomba Urban Teachers in Malawi.” Poster Presentation, 11th Annual Southern African Association for Research in Mathematics, Science and Technology Conference, Swaziland, 11-15 January 2003.

Kaplan, R. B. (Ed) (2002) The Oxford Handbook of Applied Linguistics. Oxford: Oxford University Press.

Kaplan, R. B. & R. B. Baldauf (1997) Language Planning: From Practice to Theory. Clevedon, Avon, UK: Multilingual Matters.

Karam, F. X. (1974) “Toward a Definition of Language Planning.” In: J. A. Fishman (Ed) Advances in Language Planning. The Hague: Mouton, pp. 103-124.

Kashoki, M. E. (1978) “The Language Situation in Zambia.” In: S. Ohannessian & M. E. Kashoki (Eds) Language in Zambia. London: International Africa Institute, pp. 9-46.

Kashoki, M. E. (1982) “Rural and Urban Multilingualism in Zambia: Some Trends.” International Journal of the Sociology of Language. 34: 137-166.

Kashoki, M. E. (1990) The Factor of Language in Zambia. Lusaka: Kenneth Kaunda Foundation.

Kashoki, M. E. (1999) Loanwords in Silozi, Cinyanja and Citonga. Ndola: Mission Press.

Kaspin, D. (1995) “The Politics of Ethnicity in Malawi’s Democratic Transition.” The Journal of Modern African Studies. 33: 595-620.

Kathewera, R. E. M. (1999) “Change of Terminology and Medium of Instruction in Standards 1-4: A Reaction.” In: G. Kamwendo, A. Mtenje & B. Sandhaas (Eds) Towards a National Language Policy for Education: Proceedings of a National Symposium on Language Policy Formulation. Lilongwe & Zomba: GTZ & Centre for Language Studies, University of Malawi, pp. 107-115.

Kaufert, J. M. & W. W. Koolage (1984) “Role Conflict Among ‘Culture Brokers’: The Experiences of Native Canadian Medical Interpreters.” Social Science and Medicine. 18 (3): 283-286.

Kawale, W. R. (2000) “Orthography Formulation in the Malawian Languages.” In: J. Pfaffe (Ed) Local Languages in Education, Science and Technology: Proceedings of the Second National Symposium on Language Policy Formulation. Lilongwe & Zomba: GTZ & Centre for Language Studies, University of Malawi, pp. 130-149.

Kayambazinthu, E. (1995) Patterns of Language Use in Malawi: A Sociolinguistic Investigation into Selected Areas. Unpublished PhD Thesis, La Trobe University, Australia.

Kayambazinthu, E. (1998) “The Language Situation in Malawi.” Journal of Multilingual and Multicultural Development. 19 (5 & 6): 369-439.

Kendrick, K. (1995) “An Ethic of Care in Nursing Research.” In: I. C. Henry & G. Pashley (Eds) Community Ethics and Health Care Research. Mark Allen Publishing Limited, pp. 61-74.

Kennedy, C. (Ed) (1984) Language Planning and Language Education. London: George Allen & Unwin.

Kesby, M. (2000) “Participatory Diagramming As a Means to Improve Communication about Sex in Rural Zimbabwe: A Pilot Study.” Social Science and Medicine. 50: 1723-1741.

Kerr, D. (1985) “Community Theatre and Public Health in Malawi.” Journal of Southern African Studies. 15 (3): 468-485.

Kerr, D. & J. Mapanje (2002) “Academic Freedom and the University of Malawi.” African Studies Review. 45 (2): 73-91.

King, M. & E. King (1997) The Story of Medicine and Disease in Malawi: The 130 Years since Livingstone. Blantyre, Malawi (Unnamed Publisher).

Kishindo, P. J. (1993) “Linguistic Diversity and National Unity.” UDF News. 1 (44): 8.

Kishindo, P. J. (1995) “Endangered Languages: An Example of Chingoni.” Africana Marburgensia. 28 (1 & 2): 46-58.

Kishindo, P. J. (1998a) “Politics of Language in Contemporary Malawi.” In: K. M. Phiri and K. R. Ross (Eds) Democratisation in Malawi: A Stocktaking. Blantyre: CLAIM/Kachere Book No. 4, pp. 252-280.

Kishindo, P. J. (1998b) “On the Standardisation of Citumbuka and Ciyao Orthographies: Some Observations.” South African Journal of African Languages. 18 (4): 85-91.

Kishindo, P. J. (2001a) “Language and the Law.” In: The Lamp.

Kishindo, P. J. (2001b) “Authority in Language: The Role of the Chichewa Board in the Prescription and Standardisation of Chichewa.” Journal of Asian and African Studies. 62: 261-283.

Kishindo, P. J. (2002) “Flogging a Dead Cow? The Revival of Malawian Chingoni.” Nordic Journal of African Studies. 11 (2): 206-223.

Kloss, H. (1969) Research Possibilities on Group Bilingualism: A Report. Quebec: International Centre for Research on Bilingualism.

Koji, T. (2001) “Emerging Hierarchy in International Human Rights and Beyond: From the Perspective of Non-derogable Rights.” The European Journal of Law. 12 (5): 917-941.

Kontra, M. (1999) “Some Reflections on the Nature of Language Rights and Its Regulation.” International Journal on Minority and Group Rights. 6(3): 281-288.

Kontra, M; R. Phillipson, T. Skutnabb-Kangas & T. Varady (Eds) (1999a) Language: A Right and a Resource. Budapest: Central European University.

Kontra, M. et al (1999b) “Conceptualising and Implementing Linguistic Human Rights.” In: M. Kontra et al (Eds) Language: A Right and a Resource. Budapest: Central European University, pp. 1-21.

Kornbeck, J. (2001) “Research Note: Language Training for Prospective and Practising Social Workers: A Neglected Topic in Social Work Literature.” The British Journal of Social Work. 31 (2): 307-316.

Kubchandani, L. (2001) “Linguistic Census.” In: R. Mesthrie (Ed) Concise Encyclopaedia of Sociolinguistics. Amsterdam: Elsevier, pp. 648-650.

Kulemeka, A. (1995a) “Rethinking the Language Issue.” Moni. 31 (353): 7 & 10.

Kulemeka, A. (1995b) “Rethinking the Language Issue.” Moni. 31 (354): 19 & 22.

Kymlicka, W. & A. Patten (2003a) “Language Rights and Political Theory.” Annual Review of Applied Linguistics. 23: 3-21.

Kymlicka, W. & A. Patten (Eds) (2003b) Language Rights and Political Theory. Oxford: Oxford University Press.

Labov, W. (1972) Sociolinguistic Patterns. Oxford: Blackwell.

Laitin, D. (1992) Language Repertoires and State Construction in Africa. Cambridge: Cambridge University Press.

Langtag Report (1996) Language Plan for South Africa. Pretoria: State Language Services.

Last, M. & G. L. Chavunduka (Eds) (1986) The Professionalisation of African Medicine. Manchester: Manchester University Press.

Lave, J. & E. Wenger (1991) Situated Learning: Legitimate Peripheral Participation. Cambridge: Cambridge University Press.

Leenen, H; J. Gevers & G. Pinet (1993) The Rights of Patients in Europe: A Comparative Study. WHO Regional Office for Europe, Deventer & Boston: Kluwer.

Leenen, H. (1994) “The Rights of Patients in Europe.” European Journal of Health Law. 1: 5-13.

Legère, K. (2002a) “The Languages of Tanzania Project: Background, Resources and Perspectives.” Africa and Asia: Göteborg Working Papers on Asian and African Languages and Literatures. Department of Oriental and African Languages, Göteborg University. 2: 163-186.

Legère, K. (2002b) “Language and Democracy in the SADC Region: Focus on Namibia.” In: K. Legère & S. Fitchat (Eds) Talking Freedom: Language and Democratisation in the SADC Region. Windhoek: Namibia, pp. 11-37.

Legère, K. & S. Fitchat (Eds) (2002) Talking Freedom: Language and Democratisation in the SADC Region. Windhoek: Gamsberg Macmillan.

Lo Bianco, J. (1987) National Policy on Languages. Canberra: Australian Government Publishing Service.

Lopes, A. J. (1998) “The Language Situation in Mozambique.” Journal of Multilingual and Multicultural Development. 19 (5 & 6): 440-486.

Luke, A. & R. Baldauf (1990) “Language Planning and Education: A Critical Reading.” In: R. Baldauf & A. Luke (Eds) Language Planning and Education in Australasia and the South Pacific. Clevedon: Multilingual Matters, pp. 349-352.

Lwanda, J. (1995) “Letter from Malawi.” HOOLET: The Magazine of the Royal College of General Practitioners. Glasgow, Scotland, 7th October 1995.

Lwanda, J. (2002a) “Tikutha: The Political Culture of the HIV/AIDS Epidemic in Malawi.” In: H. Englund (Ed) A Democracy of Chameleons: Politics and Culture in the New Malawi. Uppsala: Nordic Africa Institute, pp. 151-165.

Lwanda, J. (2002b) “Doctoring the Brain Drain: The Medical Case of Malawi.” African Issues. 30 (1): 47-51.

Lyons, J. (1970) New Horizons in Linguistics. Harmondsworth: Penguin.

MacDonald, R. J. (Eds) (1975) From Nyasaland to Malawi: Studies in Colonial History. Nairobi: East African Publishing House.

Maclean, J. & J. C. Maher (2001) “Medical Language.” In: R. Mesthrie (Ed) Concise Encyclopaedia of Sociolinguistics. Amsterdam: Elsevier, pp. 256-259.

Made, S. M; M.V. Mangoche-Mbewe & R. Jackson (1976) 100 Years of Chichewa in Writing, 1875-1975. Zomba, Malawi.

Maher, J. C. (1986) “The Development of English as an International Language of Medicine.” Applied Linguistics. 7 (2): 206-218.

Malawi Congress Party (1985) Convention Resolutions: 1965-83. Blantyre: Blantyre Print.

Malawi Congress Party (1993) Manifesto. Blantyre: Blantyre Print.

Malawi Congress Party (1999) Reconciliation, Reconstruction and Development. Blantyre: Blantyre Print.

Malawi Government (1966) Hansard: Official Verbatim Report of the Debates of the 3rd Session of the 5th Meeting of Parliament (9th March 1966). Zomba: Government Printer.

Malawi Government (n.d) Draft Cultural Policy for Malawi.

Malawi Government (1995a) Constitution of the Republic of Malawi. Zomba: Government Printer.

Malawi Government (1995b) Health Policy Framework. Lilongwe: Ministry of Health and Population Services.

Malawi Government (1999a) The Bakili Muluzi Health Initiative. Lilongwe: Ministry of Health and Population Services.

Malawi Government (1999b) To the Year 2020: A Vision for the Health Sector in Malawi. Lilongwe: Ministry of Health and Population Services.

Malawi Government (1999c) Malawi National Health Plan 1999-2004. Lilongwe: Ministry of Health and Population Services.

Malawi Government (2002) Education for All: Language Policy (for Education) in Malawi. Draft Version as of April 2002.

Malawi Government-European Union Country Strategy Paper and Indicative Programme for the Period 2001-2007.

Malawi Government & United Nations (1993) Situational Analysis of Poverty in Malawi. Zomba: Government Printer.

Malawi Health Bulletin. Performance Data Analysis of Tertiary Care Facilities. Special Issue: 2002 Calendar Year and 2002-2003 Fiscal Year.

Malawi Vision 2020 Document. (1997) Lilongwe: National Economic Council.

Mamdani, M. and M. Diouf (Eds) (1994) Academic Freedom in Africa. Dakar: CODESRIA.

Mapanje, J. (1988) "Censoring the African Poem: Personal Reflections." In: K. H. Petersen (Ed) Criticism and Ideology: Second African Writers' Conference, Stockholm, 1986. Uppsala: Scandinavian Institute of African Studies, pp. 104-111.

Matiki, A. J. (1996/97) "Language Shift and Maintenance: Social Determinants of Linguistic Change among the Lomwe People." Journal of Humanities (Malawi). 10 & 11: 1-25.

Matiki, A. J. (2001a) Language Planning and Social Change: A Study of Linguistic Exclusion and the Legislative Process in Malawi. Unpublished PhD Dissertation, University of New Mexico, USA.

Matiki, A. J. (2001b) "The Social Significance of English in Malawi." World Englishes. 20 (2): 201-218.

Mayall, J. (1973) "The Malawi-Tanzania Boundary Dispute." The Journal of Modern African Modern Studies. 11 (4): 611-628.

May, S. (2001) Language and Minority Rights: Ethnicity, Nationalism and the Politics of Language. London: Pearson Education.

May, S. (2003) "Misconceiving Minority Language Rights: Implications for Liberal Political Theory." In: W. Kymlicka & A. Patten (Eds) Language Rights and Political Theory. Oxford: Oxford University Press, pp. 123-152.

Mazonde, I. (Ed) (2002) Minorities in the Millennium: Perspectives from Botswana. Gaborone: Lightbooks for the University of Botswana & the International Centre for Contemporary Cultural Research.

Mazrui, Alamin. (1993) "Language and the Quest for Liberation in Africa: the Legacy of Frantz Fanon." Third World Quarterly. 14 (2): 351-363.

Mazrui, Alamin. (1997) "The World Bank, the Language Question and the Future of African Education." Race and Class. 38 (3): 35-48.

Mazrui, Ali & Alamin Mazrui (1998) The Power of Babel: Language and Governance in the African Experience. Oxford: James Currey.

McCracken, J. (1977a) Politics and Christianity in Malawi 1875-1940. Cambridge: Cambridge University Press.

McCracken, J. (1977b) "Underdevelopment in Malawi: The Missionary Contribution." African Affairs. 76 (303): 195-209.

McCracken, J. (1994) "Livingstonia in the Development of Malawi: A Reassessment." In: T. J. Thompson (Ed) Bulletin of the Scottish Institute of Missionary Studies. 10: 3-12.

McCracken, J. (1999) "New Perspectives on the History of Christianity in Malawi." Journal of Religion in Africa. 29 (4): 486-493.

McCracken, J. (2002) "The Ambiguities of Nationalism: Flax Musopole and the Northern Factor in Malawian Politics, c. 1956-1966." Journal of Southern African Studies. 28 (1): 67-87.

McGroarty, M. (2002) “Language Uses in Professional Contexts.” In: R. B. Kaplan (Ed) The Oxford Handbook of Applied Linguistics. Oxford: Oxford University Press, pp. 262-274.

McIntosh, H. (1993) Robert Laws: Servant of Africa. The Handsel Press & Central Africana.

McMaster, C. (1974) Malawi: Foreign Policy and Development. London: Julian Friedmann Publishers.

Mchazime, H. (2000) Feasibility and Acceptability of Piloting Chitumbuka as a Medium of Instruction in Northern Malawi. A Consultant’s Report Submitted to GTZ/MIITEP, Lilongwe, Malawi.

Mdee, J. S. & H. J. M. Mwansoko (Eds) (2001) Kiswahili 2000 Proceedings. Dar es Salaam: Institute of Kiswahili Research.

Meron, T. (1986) “On a Hierarchy of International Human Rights.” The American Journal of International Law. 80: 1-23.

Mesthrie, R. (Ed) (2001) Concise Encyclopaedia of Sociolinguistics. Amsterdam: Elsevier.

Meyerhoff, M. (1999) “Sorry in the Pacific: Defining Communities, Defining Practices.” Language in Society. 28: 225-238.

Meyerhoff, M. (2002) “Communities of Practice.” In: J. K. Chambers, P. Trudgill & N. Schilling-Estes (Eds) The Handbook of Language Variation and Change. Oxford: Blackwell, pp. 526-548.

Mishler, E. G. (1984) Discourse of Medicine: Dialectics of Medical Interviews. New Jersey: Ablex.

Mkandawire, T. (1997) “The Social Sciences in Africa: Breaking Local Barriers and Negotiating International Presence.” African Studies Review. 40 (2): 15-36.

Moore, H. L. & T. Sanders (Eds) (2001a) Magical Interpretations, Material Realities: Modernity, Witchcraft and the Occult in Postcolonial Africa. London: Routledge.

Moore, H. L. & T. Sanders (2001b) “Magical Interpretations and Material Realities: an Introduction.” In: H. L. Moore & T. Sanders (Eds) Magical Interpretations, Material Realities: Modernity, Witchcraft and the Occult in Postcolonial Africa. London: Routledge, pp. 1-27.

Moyo, T. (1995) “Language Contact and Language Change: The Case for chiTumbuka in Northern Malawi.” South African Journal of African Languages. 15 (4): 186-191.

Moyo, T. (2001) “Language and the Politics of Invention of Culture and Tradition in Malawi.” In: B. Harlech-Jones, I. Mbise & H. Vale (Eds) Guardian of the Word: Literature, Language and Politics in SADC Countries. Windhoek: Gamsberg Macmillan, pp. 128-140.

Msonthi, J. (1985) “Traditional Birth Attendants in Malawi: Their Role in Primary Health Care and Development.” Society of Malawi Journal. 38: 40-44.

Msonthi, J. (1986) “Government, Associations and the University: Liaison in Malawi.” In: M. Last & G. L. Chavunduka (Eds) The Professionalisation of African Medicine. Manchester: Manchester University Press, pp. 99-115.

Mtenje, A. & B. Soko (1998) “Oral Traditions Among the Northern Malawi Ngoni.” Journal of Humanities (Malawi). 12: 1-18.

Mtenje, A. & G. H. Kamwendo (2002) “On the Harmonisation of Orthographies: the Case for Ciyao, Citumbuka and Cilomwe.” In: Felix Banda (Ed) Language Across Borders:

Harmonisation and Standardisation of Orthographic Conventions of Central African Languages. Cape Town: Centre for the Advanced Studies of African Society.

Munthali, A. C. (2001) “Doing Fieldwork at Home: Some Personal Experiences Among the Tumbuka in Northern Malawi.” The African Anthropologist. 8 (2): 114-116.

Mutasa, D. (2000) “Language Policy and Language Use: An Uneasy Marriage.” South African Journal of African Languages. 20 (3): 217-224.

Mutembei, A. K; M. A. C. Emmelin, J. L. P. Lugalla & L. G. Dahlgren (2002) “Communicating about AIDS-Changes in Understanding and Coping with the Help of Language in Urban Kagera, Tanzania.” Journal of Asian and African Studies. 37 (1): 1-16.

Muula, A. & R. Broadhead (2001) “The First Decade of the Malawi College of Medicine: A Critical Appraisal.” Tropical Medicine and International Health. 6 (2): 155-159.

Mwiyeriwa, S. S. (1978) Vernacular Literature of Malawi 1854-1975: An Annotated Bibliography. Zomba: National Archives of Malawi.

National Statistical Office (1966) Malawi 1966 Census Report. Zomba: National Statistical Office.

National Statistical Office (1998) Malawi 1998 Census Report. Zomba: National Statistical Office.

National Statistical Office (2001) Malawi Demographic and Health Survey. Calverton, Maryland, USA.

Newell, J. (1995) “‘A Moment of Truth?’ The Church and Political Change in Malawi, 1992.” Journal of Modern African Studies. 33 (2): 243-62.

Newmeyer, F. J. (Ed) (1988) Linguistics: The Cambridge Survey: Language: Socialcultural Context. Volume 4. Cambridge: Cambridge University Press.

Ngqakayi, N. (1994) “Unhealthy Language Practices: The Need for New Policy.” Bua. 9 (3): 22-24.

Nic Shuibhne, N. (2002) EC Law and Minority Language Policy: Culture, Citizenship and the Fundamental Rights. The Hague: Kluwer.

Nyamnjoh, F. & M. Rowlands (1998) “Elite Associations and the Politics of Belonging in Cameroon.” Africa. 68: 320-337.

Nyati-Ramahobo, L. (2000) “Linguistic and Cultural Domination: The Case of the Wayeyi of Botswana.” In: H. Batibo & B. Smieja (Eds) Botswana: The Future of Minority Languages. Berlin: Peter Lang, pp. 217-234.

Nyati-Ramahobo, L. (2002) “From a Phone Call to the High Court: Wayeyi Visibility and the Kamanakao Association’s Campaign for Linguistic and Cultural Rights in Botswana.” Journal of Southern African Studies. 28 (4): 685-709.

Nzyuko, S. (1996) “Does Research Have any Role in Information/Education/Communication Programs in Africa? An Insider’s View.” Journal of Health Communication. 1: 227-229.

Obeng, S. G. (1997) “Language and Politics: Indirectness in Political Discourse.” Discourse and Society. 8: 49-83.

Ohannessian, S. & M. E. Kashoki (Eds) (1978) Language in Zambia. London: International Africa Institute.

Ong, L; C. de Haes, A. Hoos & F. Lammes (1995) “Doctor-Patient Communication: A Review of the Literature.” Social Science and Medicine. 40 (7): 903-918.

Orlin, T. S, A. Rosas & M. Scheinin (Eds) (2000) The Jurisprudence Human Rights Law: A Comparative Interpretative Approach. Åbo: Institute for Human Rights, Åbo Akademi University.

Osei-Hwedie, B. (1998) “The Role of Ethnicity in Multi-Party Politics in Malawi and Zambia.” Journal of Contemporary African Studies.16 (2): 227-247.

Ott, M; K. M. Phiri & N. Patel (Eds) (2000) Malawi’s Second Democratic Elections: Process, Problems and Prospects. Blantyre: CLAIM for the Kachere Series.

Ozolins, U. (2003) “The Impact of European Accession Upon Language Policy in the Baltic States.” Language Policy. 2: 217-238.

Pachai, B. (Ed) (1972) The Early History of Malawi. London: Longman.

Pachai, B. (1973) Malawi: The History of the Nation. London: Longman.

Packer, J. (Ed) (1999) International Journal on Minority and Group Rights. (Special Issue on the Linguistic Rights of National Minorities) 6 (3): 281-387.

Pandharipande, R. V. (2002) “Minority Matters: Issues in Minority Languages in India.” MOST International Journal on Multicultural Societies. 4 (2). www.unesco.org/most

Patrick, P. L. (2002) “The Speech Community.” In: J. K. Chambers, P. Trudgill & N. Schilling-Estes (Eds) The Handbook of Language Variation and Change. Oxford: Blackwell, pp. 573-597.

Patten, A. (2001) “Political Theory and Language Policy.” Political Theory. 29 (5): 691-715.

Patten, A. (2003) “What Kind of Bilingualism?” In: W. Kymlicka & A. Patten (Eds) Language Rights and Political Theory. Oxford: Oxford University Press, pp. 296-321.

Patten, A & W. Kymlicka (2003) “Introduction: Language Rights and Political Theory: Context, Issues and Approaches.” In: W. Kymlicka & A. Patten (Eds) Language and Political Theory. Oxford: Oxford University Press, pp. 1-51.

Paulston, C. B. (1997a) “Epilogue: Some Concluding Thoughts on Linguistic Human Rights.” International Journal of the Sociology of Language. 127: 187-195.

Paulston, C. B. (1997b) “Language Policies and Language Rights.” Annual Review of Anthropology. 26: 73-85.

Payne, R. J. & C. R. Veney (2001) “Taiwan and Africa: Taipei’s Continuing Search for International Recognition.” Journal of Asian and African Studies. 36 (4): 437-450.

Pennycook, A. (1998) “The Right to Language: Towards a Situated Ethics of Language Possibilities.” Language Sciences. 20 (1): 73-87.

Perkins, J. (1999) Language Access Questionnaire for Managed Care Contractors that Receive Federal Funding. National Health Law Programme, USA.

Perkins, J; H. Simon, F. Cheng, K. Olson & Y. Vera. (1999) Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities. National Health Law Programme, USA.

Petersen, K. H. (Ed) (1988) Criticism and Ideology: Second African Writers' Conference, Stockholm, 1986. Uppsala: Scandinavian Institute of African Studies.

Pfaffe, J. F. (Ed) (2000) Local Languages in Education, Science and Technology: Proceedings of the Second National Symposium on Language Policy Formulation. Lilongwe & Zomba: GTZ & Centre for Language Studies, University of Malawi.

Pfaffe, J. F. (Ed) (2001) Cross-Border Languages Within the Context of Mother Tongue Education: Proceedings of the Third National Symposium on Language Policy. Lilongwe & Zomba: GTZ & Centre for Language Studies, University of Malawi.

Pfaffe, J. F. (Ed) (2003) Implementing Multilingual Education: Proceedings of the Fourth National Symposium on Language Policy and Language Policy Implementation. Lilongwe & Zomba: GTZ & Centre for Language Studies, University of Malawi.

Phillipson, R. (1992) Linguistic Imperialism. Oxford: Oxford University Press.

Phillipson, R. (1998) "Globalising English: Are Linguistic Rights an Alternative to Linguistic Imperialism?" Language Sciences. 20 (1): 101-112.

Phiri, K. M. & K. R. Ross (Eds) (1998) Democratisation in Malawi: A Stocktaking. Blantyre: CLAIM/Kachere Book No. 4.

Polomé, E. C. (1982) Language, Society and Paleoculture: Essays by Edgar C. Polomé. Stanford: Stanford University Press.

Posner, D. (1995) "Malawi's New Dawn." Journal of Democracy. 6 (1): 131-141.

Price, T. (1952) "The Name Anguru." Nyasaland Journal. 5 (1).

Probst, P. (1999) "Mchape 95, or, the Sudden Fame of Billy Chisupe: Healing, Social Memory and the Enigma of the Public Sphere in Post Banda Malawi." Africa. 69 (1): 109-137.

Pugh, R. (1996) Effective Language in Health and Social Work. Cheltenham.

Pugh, R. & E. Jones (1999) "Language and Practice: Minority Language Provision within the Guardian and Litem Service." The British Journal of Social Work. 29 (4): 529-545.

Purves, A. C. (Ed) (1994) Encyclopaedia of English Studies and Language Arts. New York: Scholastic.

Quirk, R. & H. G. Widdowson (Eds) (1985) English in the World: Teaching and Learning the Language and Literatures. Cambridge: Cambridge University Press.

Ragan, S. L. (2000) "Sociable Talk in Women's Healthcare Contexts: Two Forms of Non-Medical Talk." In: J. Coupland (Ed) Small Talk. London: Pearson Education., pp. 269-287.

Ranger, T. (1989) "Missionaries, Migrants and the Manyika: The Invention of Ethnicity in Zimbabwe." In: L. Vail (Ed) The Creation of Tribalism in Southern Africa. London: James Currey, pp. 118-150.

Ranger, T. (1993) "The Invention of Tradition Revisited: the Case of Colonial Africa." In: T. Ranger & O. Vaughan (Eds) Legitimacy and the State in Twentieth-Century Africa. London: Macmillan, pp. 62-111.

Ranger, T. & O. Vaughan (Eds) (1993) Legitimacy and the State in Twentieth-Century. London: Macmillan.

Read, M. (1936) “Tradition and Prestige among the Ngoni.” Africa. 9: 435-484.

Reagan, T. (1986) “Language Ideology in the Language Planning Process: Two African Case Studies.” South African Journal of African Languages. 6 (2): 94-97.

Reaume, D. G. (2003) “Beyond Personality: The Territorial and Personality Principles of Language Policy Reconsidered.” In: W. Kymlicka & A. Patten (Eds) Language Rights and Political Theory. Oxford: Oxford University Press, pp. 271-295.

Ribohn, U. (2002) “‘Human Rights and the Multiparty System Have Swallowed Our Traditions’: Conceiving Women and Culture in the New Malawi.” In: H. Englund (Ed) A Democracy of Chameleons: Politics and Culture in the New Malawi. Uppsala: Nordic Africa Institute, pp. 166-177.

Ricento, T. (2000) “Historical and Theoretical Perspectives in Language Policy and Planning.” Journal of Sociolinguistics. 4 (2): 196-213.

Rissom, I. (Ed) (2002) Languages in Contrast. Bayreuth African Studies Series. Number 51.

Roberts, R. P. (2002) “Translation.” In: R. B. Kaplan (Ed) The Oxford Handbook of Applied Linguistics. Oxford: Oxford University Press, pp. 429-442.

Robinson, C. D. W. (1996) Language Use in Rural Development: An African Perspective. Berlin: Mouton.

Romaine, S. (1989) Bilingualism. Oxford: Basil Blackwell.

Ross, K. R. (2004) “Worrisome Trends: The Voice of the Churches in Malawi’s Third Term Debate.” African Affairs. 103: 91-107.

Rowley, C. T. (2000) “Challenges to Effective Maternal Health Care Delivery: The Case of Traditional and Certified Nurse Midwives in Zimbabwe.” Journal of Asian & African Studies. 35 (2): 251-263.

Rubin, J. (1971a) “Evaluation and Language Planning.” In: J. Rubin & B. Jernudd (Eds) Can Language be Planned? Sociolinguistic Theory and Practice for Developing Nations. Honolulu: University Press of Hawaii, pp. 217-252.

Rubin, J. (1971b) “A View Towards the Future.” In J. Rubin & B. Jernudd (Eds) Can Language be Planned? Sociolinguistic Theory and Practice for Developing Nations. Honolulu: University Press of Hawaii, pp. 307-310.

Rubin, J. & B. Jernudd (Eds) (1971) Can Language be Planned? Sociolinguistic Theory and Practice for Developing Nations. Honolulu: University Press of Hawaii.

Rubio-Marin, R. (2003) “Language Rights: Exploring the Competing Rationales.” In: W. Kymlicka & A. Patten (Eds) Language Rights and Political Theory. Oxford: Oxford University Press, pp. 52-79.

Sacks, H. (1992) Lectures on Conversation. Volumes 1 & 2. Oxford: Blackwell.

Saohatse, M. C. (1997) African Language Varieties at Baragwanath Hospital: A Sociolinguistic Analysis. Unpublished PhD Thesis, University of South Africa.

Saohatse, M. C. (1998) “Communication Problems in Multilingual Speech Communities.” South African Journal of African Languages. 18 (4): 111-117.

Saohatse, M. C. (2000) “Solving Communication Problems in Medical Institutions.” South African Journal of African Languages. 20 (1): 95-102.

Sarangi, S. (2002) “Discourse Practitioners as a Community of Interprofessional Practice: Some Insights from Health Communication Research.” In: C. Candlin (Ed) Research and Practice in Professional Discourse. Hong Kong: City University of Hong Kong Press.

Saville-Troike, M. (2003) The Ethnography of Communication: An Introduction. 3rd Edition. Blackwell Publishers.

Schiffrin, D; D. Tannen & H. E. Hamilton (Eds) (2001) Handbook of Discourse Analysis. Blackwell Publishers.

Schmied, J. (1991) English in Africa: An Introduction. London: Longman.

Schmied, J. (1996) “English in Zimbabwe, Zambia and Malawi.” In: V. de Klerk (Ed) Varieties of English Around the World: Focus on South Africa. Amsterdam: John Benjamins, pp. 301-321.

Schoffeleers, M. (1999a) In Search of Truth and Justice: Confrontations Between Church and State in Malawi, 1960-1994. Blantyre: CLAIM.

Schoffeleers, M. (1999b) “The AIDS Pandemic, the Prophet Billy Chisupe, and the Democratisation Process in Malawi.” Journal of Religion in Africa. 29 (4): 406-441.

Schumann, J. (1978) “The Acculturation Model for Second Language Acquisition.” In: R. Gingras (Ed) Second Language Acquisition and Foreign Language Teaching. Arlington, VA: Centre for Applied Linguistics.

Schweda-Nicholson, N. L. (2002) “Interpreting.” In: R. B. Kaplan (Ed) The Oxford Handbook of Applied Linguistics. Oxford: Oxford University Press, pp. 443-456.

Seidel, G. 1990. “Thank God I Said No to AIDS: On the Changing Discourse of AIDS in Uganda.” Discourse and Society. 1 (1): 61-84.

Short, P. (1974) Banda. London: Routledge and Kegan Paul.

Siemienski, G. (1999) “Report on the Vienna Seminar on the Linguistic Rights of National Minorities, 27-28 February 1998.” International Journal on Minority and Group Rights. 6 (3): 351-358.

Silverman, D. (2001) Doing Qualitative Research: A Practical Handbook. London: Sage.

Skutnabb-Kangas, T. (1998) “Human Rights and Language Wrongs - A Future for Diversity?” Language Sciences. 20 (1): 5-27.

Skutnabb-Kangas, T. (2000) Linguistic Genocide in Education or Worldwide Diversity and Human Rights? London: Lawrence Earlbaum.

Skutnabb-Kangas, T. (2001) “The Globalisation of (Educational) Language Rights.” International Review of Education. 47 (3 & 4): 201-219.

Skutnabb-Kangas, T. & R. Phillipson (2001) “Discrimination and Minority Languages.” In: R. Mesthrie (Ed) Concise Encyclopaedia of Sociolinguistics. Amsterdam: Elsevier, pp. 545-550.

Skutnabb-Kangas, T.; R. Phillipson & M. Kontra (2001) “Reflections on Scholarship and Linguistic Rights: A Rejoinder to Jan Blommaert.” Journal of Sociolinguistics. 5 (1): 143-155.

Soka, L. D. (1953) Mbiri ya Alomwe. London: Macmillan.

Solomon, H. (2001) “Skirting Around: Towards an Understanding of HIV/AIDS Educational Materials in Modern Israeli Hebrew.” In: K. Campbell-Kibler; R. J. Podesva, S. J. Roberts & A. Wong (Eds) Language and Sexuality: Contesting Meaning in Theory and Practice. CSLI Publications, pp. 225-247.

Spolsky, B; H. Tushyeh, M. Amara & K. de Bot (2000) Languages in Bethlehem: The Sociolinguistic Transformation of a Palestinian Town. NIRP Research for Policy Series 6. Amsterdam: Royal Tropical Institute.

Srivastava, R. N. (1984) “Linguistic Minorities and National Languages.” In: F. Coulmas (Ed) Linguistic Minorities. Berlin: Mouton, pp. 99-114.

Stroud, C. (1999) “Portuguese as Ideology and Politics in Mozambique: Semiotic (Re) Construction of a Postcolony.” In: J. Blommaert (Ed) Language Ideological Debates. Berlin: Mouton de Gruyter, pp. 343-380.

Stroud, C. (2001) “African Mother Tongue Programmes and the Politics of Language: Linguistic Citizenship Vs Linguistic Human Rights.” International Journal of Multilingual and Multicultural Development. 22 (4): 339-355.

Stubbs, M. (1972) “Home Language and the National Language Understood.” In: S. Agnew & M. Stubbs (Eds) Malawi in Maps. London: London University Press, pp. 72-73.

Sullivan, L.W. (1991) “Africa’s Health Needs and the US Assistance.” TransAfrica Forum. 8 (2).

Swales, J. M. (1990) Genre Analysis: English in Academic and Research Settings. Cambridge: Cambridge University Press.

Tesch, R. (1992) Qualitative Research: Analysis Types and Software Tools. New York: The Falmer Press.

Tew, M. (1950) Peoples of the Lake Nyasa Region. London: Oxford University Press for the International African Institute.

Thetela, P. (2002) “English and the Bilingual Court Proceedings in Lesotho Courtroom Discourse: Linguistic or Legal Disempowerment, or Both?” In: K. Legère & S. Fitchat (Eds) Talking Freedom: Language and Democratisation in the SADC Region. Windhoek: Gamsberg Macmillan, pp. 125-141.

Thomas, G. (1991) Linguistic Purism. London: Longman.

Thomas, J. (1983) “Cross-Cultural Pragmatic Failure.” Applied Linguistics. 4 (2): 91-112.

Thomas, J. (1995) Meaning in Interaction: An Introduction to Pragmatics. London: Longman.

Thompson, T. J. (Ed) (1994a) Bulletin of the Scottish Institute of Missionary Studies, 10.

Thompson, T. J. (1994b) “Speaking for Ourselves: The African Writers of Livingstonia.” In: T. J. Thompson (Ed) Bulletin of the Scottish Institute of Missionary Studies, 10: 24-35.

Thorburn, T. (1971) “Cost-Benefit Analysis in Language Planning.” In: J. Rubin & B. Jernudd (Eds) Can Language be Planned? Sociolinguistic Theory and Practice for Developing Nations. Honolulu: University Press of Hawaii, pp. 253-262.

Thorne, B. & N. Henley (Eds) (1975) Language and Sex: Difference and Dominance. Rowley, MA: Newbury House.

Timpunza-Mvula, E. S. (1992) “Language Policies in Africa: The Case for Chichewa in Malawi.” In: R. Herbert (Ed) Language and Society in Africa: The Theory and Practice of Sociolinguistics. Johannesburg: Witswatersrand University Press, pp. 37-47.

Titscher, S; M. Meyer, R. Wodak & E. Vetter (2000) Methods of Text and Discourse Analysis. London: Sage.

Toebes, B. (2001) “The Right to Health.” In: A. Eide, C. Krause & A. Rosas (Eds) Economic, Social and Cultural Rights. 2nd Edition. London: Martinus Nijhoff Publishers, pp. 169-190.

Todd, A. D. (1993) “Exploring Women’s Experiences: Power and Resistance in Medical Discourse.” In: A. D. Todd & S. Fisher (Eds) The Social Organisation of Doctor-Patient Communication. Nordwood, NJ: Ablex, pp. 267-285.

Todd, A. D. & S. Fisher (Eds) (1993) The Social Organisation of Doctor-Patient Communication. Norwood, NJ: Ablex.

Tollefson, J. W. (1981) “Centralized and Decentralized Language Planning.” Language Problems and Language Planning. 5 (2): 175-188.

Tollefson, J. W. (2002) “Limitations of Language Policy and Planning.” In: R. B. Kaplan (Ed) The Oxford Handbook of Applied Linguistics. Oxford: Oxford University Press, pp. 416-425.

Trewby, R. & S. Fitchat (Eds) (2001) Language and Development in Southern Africa: Making the Right Choices. Windhoek: Gamsberg Macmillan.

Tsao, F. (1999) “The Language Planning Situation in Taiwan.” Journal of Multilingual and Multicultural Development. 20 (4 & 5): 328-375.

Turner, W. Y. (1996) Chitumbuka/Chitonga/English Dictionary. Reprinted with a New Preface. Blantyre: Central Africana Limited.

Uledi-Kamanga, B. J; G. Mills & A. J. Nazombe (1992) Malawi Broadcasting Corporation Radio Listenership Survey. Zomba: Centre for Social Research, University of Malawi.

United Democratic Front (UDF) (1993a) Towards a Better Malawi: Manifesto. Place of publication not indicated.

United Democratic Front (UDF) (1993b) Draft Policy on Education and Culture.

United Democratic Front (UDF) (1999) Eradicating Poverty: Our Goal. Blantyre: United Democratic Front.

UNESCO (1953) The Use of Vernacular Languages in Education. Paris: Unesco.

UNESCO (2002) Language Policies in Africa: InterGovernmental Conference on Language Policies in Africa: Final Report. 17th - 21st March 1997, Harare, Zimbabwe.

United Nations (2001a) Common Country Assessment for Malawi. Lilongwe: United Nations System in Malawi.

United Nations (2001b) Third United Nations Conference on the Least Developed Countries: Country Presentation for Malawi. Brussels, 14th - 20th May, 2001.

Uta, J. J. (1993) Health Communication to Rural Populations in Developing Countries: With Special Reference to Malawi. Unpublished PhD Thesis, Loughborough University of Technology, United Kingdom.

Vail, L. (1972a) “Suggestions Towards a Reinterpreted Tumbuka History.” In: B. Pachai (Ed) The Early History of Malawi. London: Longman, pp. 148-167.

Vail, L. (1972b) “Noun Classes of Ndali.” Journal of African Languages. 2 (3): 21-47.

Vail L. (Ed) (1989) The Creation of Tribalism in Southern Africa. London: James Currey.

Vail, L. & L. White (1989) “Tribalism in the Political History of Malawi.” In: L. Vail (Ed) The Creation of Tribalism in Southern Africa. London: James Currey, pp. 151-192.

Vail, L. & L. White (1991) Power and the Praise Poem: Southern African Voices in History. London: James Currey.

Valdes, G. & C. Angelelli (2003) “Interpreters, Interpreting, and the Study of Bilingualism.” Annual Review of Applied Linguistics. 23: 58-78.

van der Geest, S. (2003) “Confidentiality and Pseudonyms: A Fieldwork Dilemma from Ghana.” Anthropology Today.19 (1): 14-18.

van Dijk, T. A. (Ed) (1997) Discourse and Society. London: Sage.

van Dijk, R. (2001) “Witchcraft and Scepticism by Proxy: Pentecostalism and Laughter in Urban Malawi.” In: H. L. Moore & T. Sanders (Eds) Magical Interpretations, Material Realities: Modernity, Witchcraft and the Occult in Postcolonial Africa. London: Routledge, pp. 97-117.

van Donge, J. K. (1995) “Kamuzu’s Legacy: the Democratisation of Malawi: or Searching for the Rules of the Game in African Politics.” African Affairs. 94: 227-257.

Wadensjö, C. (1998) Interpreting as Interaction. London: Longman.

Waitzkin, H. (1984) “Doctor-Patient Communication: Clinical Interpretations of Social Scientific Research.” Journal of the American Medical Association. 252: 2441-2446.

Walsh, M. T. & I. N. Swilla (2001) “Linguistics in the Corridor: A Review of Research on the Bantu Languages of southwest Tanzania, north east Zambia and north Malawi.” Journal of Asian and African Studies. 61: 275-302.

Ward, M. (1993) “Missing the Point: Sampling Methods and Types of Error in Third World Surveys in Identifying Poverty Issues.” In: M. Bulmer & D. P. Warwick (Eds) Social Research in Developing Countries: Surveys and Censuses in the Third World. UCL Press, pp. 125-142.

wa Thiong’o, Ngugi (1986) Decolonising the Mind: The Politics of Language in African Literature. London: James Currey.

wa Thiong’o, Ngugi (1993) Moving the Centre: The Struggle for Cultural Freedoms. London: James Currey.

wa Thiong’o, Ngugi. (2003) “Europhone or African Memory: the Challenge of the Pan-Africanist Intellectual in the Era of Globalisation.” Keynote Address Delivered at the 30th Anniversary Celebrations of the Council for the Development of Social Science Research in Africa (CODESRIA), Dakar, Senegal, 10th December 2003.

Webb, V. (1996) “Pluralism and Language Planning in a Democratising Context in South Africa.” In: J. Blommaert (Ed) The Politics of Multilingualism and Language Planning: Proceedings of the Language Planning Workshop Held at the Political Linguistics Conference, Antwerp, December 1995. Antwerp Papers in Linguistics. 87: 72-92.

Welmers, W. E. (1974) “Christian Missions and Language Policies in Africa.” In: J. A. Fishman (Ed) Advances in Language Planning. The Hague: Mouton, pp. 191-203.

Wenger, E. (1998) Communities of Practice. Cambridge: Cambridge University Press.

Werbner, R. & T. Ranger (Eds) (1996) Postcolonial Identities in Africa. London: Zed Books.

Werbner, R. (2002a) “Conclusion: Citizenship and the Politics of Recognition in Botswana.” In: I. Mazonde (Ed) Minorities in the Millennium: Perspectives from Botswana. Gaborone: Light Books for the University of Botswana & the International Centre for Contemporary Cultural Research, pp. 117-135.

Werbner, R. (2002b) “Introduction: Challenging Minorities, Difference and Tribal Citizenship in Botswana.” Journal of Southern African Studies. 28 (4): 671-684.

West, C. (1984) “When the Doctor is a Lady: Power, Status and Gender in Physician-Patient Dialogues.” Symbolic Interaction. 7 (1): 87-106.

West, C. (1990) “Not Just Doctor’s Orders: Directive Response Sequences in Patients’ Visits to Women and Men Physicians.” Discourse and Society. 1 (1): 85-112.

West, C. (1993) “Ask me no Questions...: An Analysis of Queries and Replies in Physician-Patient Dialogues.” In: A.D. Todd & S. Fisher (Eds) The Social Organization of Doctor-Patient Communication. Norwood, NJ: Ablex, pp. 127-160.

White, L. (1987) Magomero: Portrait of an African Village. Cambridge: Cambridge University Press.

Williams, E. (1996) “Reading in Two Languages at Year Five in African Primary Schools.” Applied Linguistics. 17 (2): 182-209.

Williams, E. (1998) Investigating Bilingual Literacy: Evidence from Malawi and Zambia. London: DFID Education Research.

Williams, G. (1992) Sociolinguistics: A Sociological Critique. London: Routledge.

Williams, S. G. (1969) “The Beginnings of Mzuzu: With Some Biographical Notes of Some Vipya Tung Project Managers.” Society of Malawi Journal. 22: 46-50.

Wills, A. J. (1968) History of Central Africa. London: Oxford University Press.

Wodak, R. & M. Meyer (Eds) (2001) Methods of Critical Discourse Analysis. London: Sage.

Wolff, H. Ekkehard & Orin D. Gensler (Eds) (2000) Proceedings of the 2nd World Congress of African Linguistics. Köln: Rudiger Köppe.

Wolff, H. Ekkehard (2000) “Language and Society.” In: B. Heine & D. Nurse (Eds) African Languages: An Introduction. Cambridge: Cambridge University Press, pp. 298-347.

Wolff, H. Ekkehard (Ed) (2003a) Tied Tongues: The African Renaissance as a Challenge for Language Planning. Hamburg: Lit.

Wolff, H. Ekkehard (2003b) “Convener’s Introduction: The Vision of the African Renaissance.” In: H. Ekkehard Wolff (Ed) Tied Tongues: The African Renaissance as a Challenge for Language Planning. Hamburg: Lit, pp. 1-19.

Wolfram, W. & R. W. Fasold (1997) “Field Methods in the Study of Social Dialects.” In: N. Coupland & A. Jaworski (Eds) Sociolinguistics: A Reader. Basingstoke Macmillan, pp. 89-115.

Yamba, B. (1997) “Cosmologies in Turmoil: Witchfinding and AIDS in Chiawa, Zambia.” Africa. 67: 200-223.

Youdelman, M. & J. Perkins (2002) Providing Language Interpretation Services in Health Care Settings: Examples from the Field. National Health Law Programme, USA.

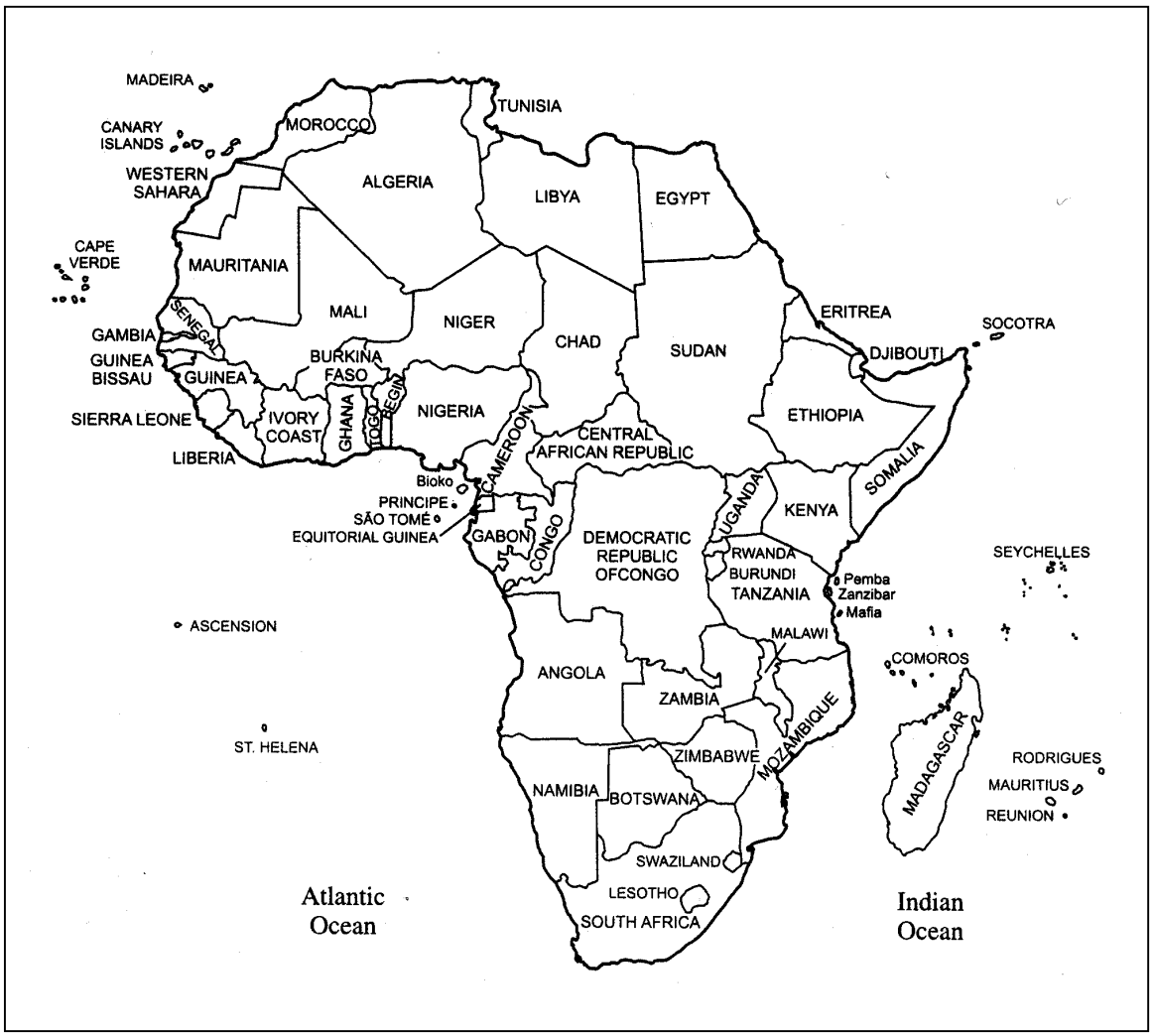
Zeleza, P. T. (1996) “Banishing Words and Stories: Censoring in Banda’s Malawi.” CODESRIA Bulletin. 1: 10-14

Zeleza, P. T. (2002) “The Politics of Historical and Social Science Research in Africa.” Journal of Southern African Studies. 28 (1): 9-23.

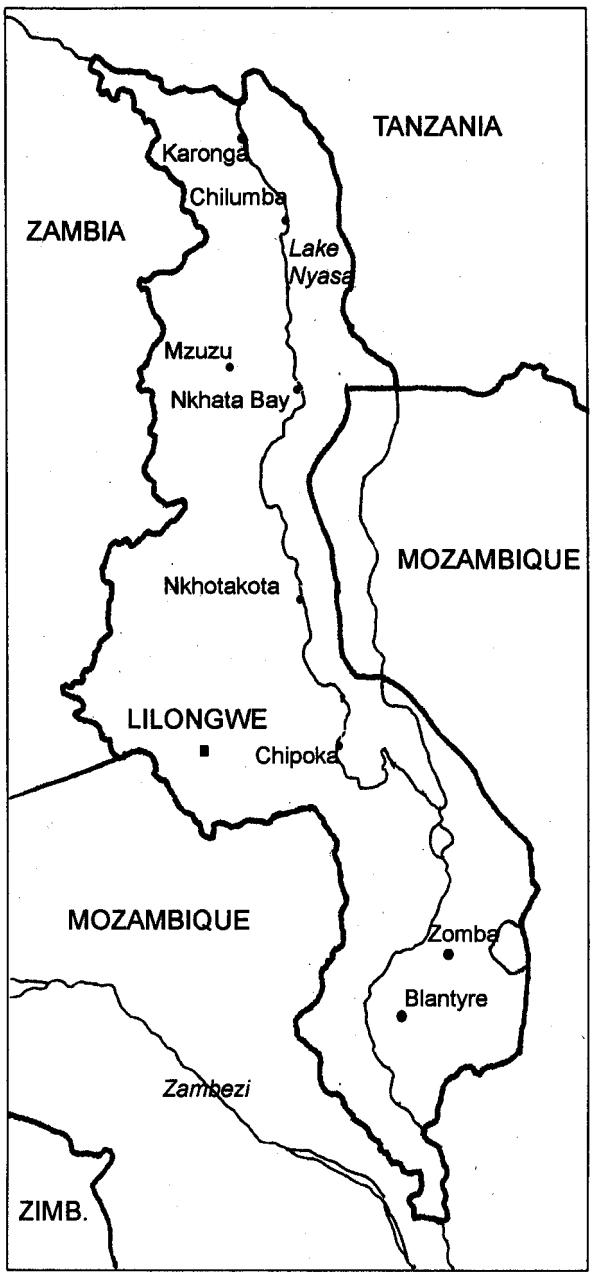
Zimmerman, D. & C. West (1975) “Sex Roles, Interruptions and Silences in Conversation.” In: B. Thorne & N. Henley (Eds) Language and Sex: Difference and Dominance. Rowley, MA: Newbury House, pp. 105-129.

PART IV: APPENDICES

APPENDIX I: MAP OF AFRICA



APPENDIX II: MAP OF MALAWI



APPENDIX III: QUESTIONNAIRE FOR CLIENTS

Introduction

I am Gregory Kamwendo, a PhD student. I am here to conduct a study of language use in the delivery of health services. I have identified you as a possible respondent to my questionnaire. I, therefore, kindly request you to allow me to ask you a few easy-to-answer questions. Let me assure you that your answers will be treated confidentially. Thank you.

Name of Interviewer:

Date & Time of Interview:

SECTION A: DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

	QUESTION	ANSWER	CODE
1	Status of respondent	1 = service provider 2 = out-patient 3 = in-patient 4 = guardian	
2	Sex	1 = male 2 = female	
3	Age	1 = 10 to 19 2 = 20 to 29 3 = 30 to 39 4 = 40 and above	
4	Highest educational level	1 = none 2 = below PSLC 3 = PSLC 4 = JCE 5 = MSCE 6 = Diploma 7 = First degree and/or above	
5	What is your nationality?	1 = Malawian 2 = non-Malawian	
6	If not Malawian, specify nationality		
7	What is your ethnic group?		
8	In which district do you reside?		

SECTION B: GENERAL SOCIOLINGUISTIC INFORMATION

9	What is the dominant language of your residential district?		
10	What is your mother tongue?	1 = Chewa 2 = Tumbuka 3 = Yao 4 = Sena 5 = Lomwe 6 = Tonga 7 = Ngonde 8 = Lambya 9 = Ndali 10 = Nyakyusa 11 = English 12 = French 13 = Portuguese 14 = Swahili 15 = Other (specify)	
11	What is your second language?	1 = Chewa 2 = Tumbuka 3 = Yao 4 = Sena 5 = Lomwe 6 = Tonga 7 = Ngonde 8 = Lambya 9 = Ndali 10 = Nyakyusa 11 = English 12 = French 13 = Portuguese 14 = Swahili 15 = Other (specify)	
12	If you do not speak Tumbuka, do you now see the need to learn the language?	1 = yes 2 = no 3 = not applicable	
13	How frequently do you use Chewa daily?	1 = none at all 2 = rarely 3 = often 4 = all the time	
14	How frequently do you use Tumbuka daily?	1 = none at all 2 = rarely 3 = often 4 = all the time	
15	How frequently do you use English daily?	1 = none at all 2 = rarely 3 = often 4 = all the time	

SECTION C: HOSPITAL-BASED LANGUAGE USE

16	What is the most frequently used language for service delivery at this hospital?	1 = Chewa 2 = Tumbuka 3 = English 4 = Tonga 5 = Other (specify)	
17	What is the second most frequently used language for service delivery at this hospital?	1 = Chewa 2 = Tumbuka 3 = English 4 = Tonga 5 = Other (specify)	
18	What is your best language for hospital transactions?	1 = Chewa 2 = Tumbuka 3 = English 4 = Tonga 5 = Other (specify)	
19	Have you ever required an interpreter at this hospital?	1 = yes 2 = no	
20	Give reasons for your answer to Q. 19		
21	Who provided the interpretation service?	1 = not applicable 2 = nurse 3 = other staff 4 = Other (specify)	
22	Were you satisfied with the interpretation you received?	1 = not applicable 2 = yes 3 = no	
23	Would you recommend that this hospital should have full time interpreters?	1 = yes 2 = no	
24	Give reasons for your answer to Q. 23		
25	Do you find it embarrassing to relay certain issues to the service provider through an interpreter?	1 = yes 2 = no	
26	If YES to Q. 25, mention the embarrassing topics.	i ---------- ii ---------- iii ---------- iv ----------	
27	Does communication between a client and a service provider via an interpreter erode the client's privacy?	1 = yes 2 = no	
28	Should the posting of hospital staff be determined by individuals' language competence in the dominant language(s) of their prospective duty stations?	1 = yes 2 = no	

29	Justify the answer given in Q. 28 above.		
30	Should foreign health service providers be required to demonstrate competence in a local language before they are licensed?	1 = yes 2 = no	
31	Justify the answer given in Q. 30 above.		
32	Do you support the use of plain language in reproductive health education campaigns?	1 = yes 2 = no	
33	Justify your answer given in Q. 32 above.		
34	When referring to sex organs and excreta functions, which of the following strategies do you use?	1 = direct reference 2 = indirect reference 3 = not mention them at all	
35	Does the sex of the service provider make you forgo mentioning certain clinical problems?	1 = yes 2 = no	
36	Do you have access to health education literature?	1 = yes 2 = no	
37	If YES to Q. 36, in what language(s) is this literature?	1 = Chewa 2 = English 3 = Tumbuka 4 = Lomwe 5 = Tonga 6 = Sena 7 = Yao 8 = Other language(s) (specify)	

APPENDIX IV: QUESTIONNAIRE FOR SERVICE PROVIDERS

Introduction

I am Gregory Kamwendo, a PhD student. My research topic focuses on language use in a hospital setting. You have been identified as one of my respondents. In this regard, I kindly request you to spare a few minutes of your busy schedule to respond to some easy-to-answer questions. In order to enhance your confidentiality, please DO NOT WRITE your name on the questionnaire. I thank you very much for your assistance and co-operation. *Zikomo Kwambiri. Yewo Chomene.*

SECTION A: DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

1. What is your professional status at this hospital? (e.g. nurse, technician etc)

_____

2. How old are you? _____

3. Male or female? _____

4. What is your nationality? _____

SECTION B: LANGUAGE MATTERS

5. What is your mother tongue? _____

6. What other languages do you speak fluently?
i) _____
ii) _____
iii) _____
iv) _____
v) _____
vi) _____

7. What are the most common languages which service providers use when serving patients at this hospital?
i) the first most common language is _____
ii) the second most common language is _____
iii) the third most common language is _____
iv) other languages (specify) _____

8. How do you serve a patient whose language you do not understand?
_____
_____
_____
_____
_____
_____

9 a) Have you ever needed an interpreter to assist you as you worked with certain patients? Describe your experiences. _____
_____
_____
_____
_____

b) Or have you ever been asked by a doctor/clinician/nurse to assist him/her in interpreting what a patient was saying? Describe your experiences. _____
_____
_____
_____
_____

10. Should staff be posted only to hospitals or areas whose main language(s) they speak? Justify your answer. _____
_____
_____
_____
_____

11. In your view, what (if any) are the major language/communication problems you face as you work at this hospital? And how do you solve those communication problems?

	PROBLEM	SOLUTION(S)
i		
ii		
iii		
iv		
v		
vi		
vii		

12. How important is it for you to be able to speak the language(s) of your patient? Justify your answer. _____
_____
_____
_____
_____

13. Finally, please feel free to make any relevant comments on language and communication problems at this hospital. _____
_____
_____
_____
_____

APPENDIX V: FOCUS GROUP DISCUSSION CHECKLIST

1. What languages are commonly used by your clients at this hospital?

2. How do you deal with a patient whose language you do not understand?

3. What sort of language problems do you face here, and how do you solve them?

4. Have you ever served as an interpreter for someone? Or has someone ever served as your interpreter? What were your experiences?

5. Do you think it is important that you, as a service provider, should be able to speak the language(s) of your clients?

6. What is your comment on the role of language in the delivery of health services?