

LINGUISTIC CHALLENGES IN THE FIGHT AGAINST HIV AND AIDS: AN ANALYSIS OF DOCTOR-PATIENT DISCOURSE IN KENYAN HEALTH CENTERS

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Abstract

The language question has received little attention in the fight against HIV and AIDS in Kenya, yet language has a very fundamental role to play if progress is to be made in responding to this pandemic. The language barrier can completely hinder progress especially in Doctor-patient communication whereby a patient suffering from HIV or AIDS, or indeed any other disease, cannot communicate directly to the doctor in the language he is most competent in. This problem is most prevalent in multilingual nations like Kenya, where knowledge of either the national or official language is the preserve of an educated minority. In linguistically heterogeneous areas, doctors or clinical officers normally require the services of a nurse or close family member for interpretation. This in itself denies the patient the confidentiality they require and may lead to miscommunication or misrepresentation of the ideal picture to either the doctor or the patient. It may also encourage the culture of silence since the patient may shy away from revealing certain personal details related to their condition in the presence of a third party. This has implications for the efficacy of the entire communication process and limits or prevents access to effective treatment for health issues.

This paper looks at doctor-patient discourse in some selected health centres in Kenya with a main focus on some of the problems encountered by patients in communicating to doctors and how doctors deal with the language barrier problem in the treatment of HIV and AIDS. It aims at highlighting how linguistic barriers can slow down the efforts made in responding to this global pandemic and makes suggestions on how to manage doctor-patient discourses in a multi-ethnic and multi-lingual setting for efficient communication, especially in the prevention, care and treatment of HIV and AIDS.

Introduction

Discourse on language matters is often considered esoteric and of marginal interest by members of the intellectual elites worldwide... And indeed, on first sight, language appears to have little or nothing to do with the 'real' and burning problems of economic development, spread of HIV/AIDS, and poverty alleviation. Browsing through the major documents relating to the African Renaissance and NEPAD, for instance, one is struck by the observation that 'language' is a word that practically never occurs even in the most important and fundamental papers and speeches! (Wolff, 2006: 3)

The above statement clearly indicates the neglect of the language question in issues of national importance and national development in many multilingual nations in Africa,

and Kenya is no exception. But as Mugambi (2001) clearly shows, language cannot be left out in any discourse on development:

Language plays a central role in all aspects of development. Development implies communication of thoughts, feelings, facts, opinions, observations, knowledge, and all manner of individual and communal expression. Literacy is essential if people are to interpret correctly issues that affect them politically, constitutionally, and in Education. People need to use language(s) that will enable them comprehend and make decisions on matters relating to health and hygiene, agriculture, civic education, economic welfare and also matters pertaining to other aspects of their social well being. (3)

In light of the above statement, it is unfortunate that many issues, including the issues of HIV and AIDS, have often been discussed with little or no attention being given to the role of language. Language is fundamental in the dissemination of information that would ensure the success of both prevention and treatment of any disease including this global pandemic. This paper seeks to find out the extent to which linguistic issues act as barriers in the fight against HIV and AIDS in Kenya by looking at how doctors and patients communicate in selected health centers in Eldoret town.

The information used in this paper is based on a series of interviews with some selected doctors, nurses and counsellors in Voluntary Counselling Centres (VCTs) in Eldoret town of Uasin Gishu district. Eldoret is a relatively cosmopolitan town with people from four major language groups well represented, namely, the Kalenjin, the Kikuyu, the Luhya and the Luo. However the Kalenjin form the largest linguistic group in the region. The interviews were conducted with a doctor from the Luo community, one Kenyan of Indian origin and another from the Luhya community. A nurse from the Kikuyu community and a counselling officer from the Kalenjin community were also among those interviewed.

Communication: The key to fighting HIV and AIDS

The role of communication in the fight against HIV and AIDS cannot be overemphasized. Communication is the key to understanding issues relating to HIV and AIDS and is instrumental in inducing behaviour change both in people living with HIV (PLHIV) and other members of the society to check both the infection and spread of the disease. This is particularly important in light of the fact that “since

there is no vaccine and no cure for AIDS, education about prevention and care is very important. The only way to stop the spread of the disease is for everybody to understand how it spreads and then to avoid being exposed.”¹ Effective education is therefore a key to fighting the epidemic and this can only be achieved through the communication of relevant honest and complete information on HIV and AIDS. This underscores the importance of using a language that is well understood by the people if education is indeed to be effective. Unfortunately, in Kenya, for example, English continues to be used as the main language of communication in matters relating to HIV and AIDS, despite the fact that only about 17% of the population speak or use English effectively (Angoya, 2002). It would therefore be correct to argue that majority of the Kenyan population do not receive adequate education on this pandemic. One argument might be that Kiswahili is understood by more people than those who understand English but this is normally with varying degrees of competence and intelligibility. This means that the two languages that are largely used for education on HIV and AIDS are not languages which majority of Kenyans are competent in. Therefore, although the literacy rate in Kenya is high, at 85.1% (CIA world fact book), the lack of adequate proficiency in the two official languages of the country remains a barrier to effective education.

The role of communication in the response to HIV and AIDS has long been recognized and it has led to the introduction of the notion of ‘AIDS communication’. Communication approaches used to address HIV and AIDS range from those focusing on information for individuals to those concerned with broad social and environmental factors for change. One of the approaches, behaviour change communication (BCC), involves the development of tailored messages and approaches in order to develop, promote and sustain individual, community and societal behaviour change. BCC takes cultural difference and audience reception into consideration and employs a variety of communication channels. It can enhance knowledge, ensuring that people are given the basic facts about HIV and AIDS in a medium that they can understand and relate to.

The immediate question that comes to mind is how effective communication can be in a multilingual context, especially where a majority of the population does not understand the main language(s) of official and, or national communication. Wolff

argues that “since human communication is largely through the use of language(s), linguistic issues become inseparable from issues related to development” (15). If linguistic issues are indeed inseparable from development, so are they to issues relating to the prevention and treatment of HIV and AIDS, which in several ways affect development. It is therefore of paramount importance that communication to people either infected or affected by HIV and or AIDS be in a language that they will understand and identify with. For the majority of the Kenyan population, that language would be the mother tongue. This underscores the importance of promoting the local languages and using them to address the issue of HIV and AIDS. Without such an approach, the efforts made to fight this pandemic may fail to achieve their maximum effect.

Bodomo (1996) clearly captures the importance of local languages with the story of some agricultural extension officers and their experiences on one of their first field trips. He narrates how these young African experts graduated from one of the universities in Africa and were ready to impart new farming technologies to rural farmers in various areas of their country. ‘On the very first day of their jobs they came to terms with one issue which had apparently been neglected in the course of their training: language, that most important tool of communication. In spite of all the academic theorizing about sharing new technologies with the indigenous people, apparently nobody ever thought that these scholars were going to start working with people, the majority of who did not communicate in their language of education, in the language in which all the wonderful theories of agricultural extension were propounded’ (31). The officers in this story might as well have been graduates of a medical school in Kenya, who after completion of their training realised that their usefulness to the local people would be limited by a language barrier. However, this does not mean that none of the doctors speak any of the local languages. The problem normally arises when the graduates are sent to work in areas where their local language is not spoken by the majority of the people living that particular area.

In the last few decades, research has shown that there are a host of cultural, economic, and linguistic barriers that limit or prevent access to effective treatment for health issues. In Kenya, one area where language may be a major barrier in the response to HIV and AIDS is in the delivery of health services. This is normally the case in

situations where a patient cannot communicate in either English or Kiswahili and neither do they speak or understand the local language of the nurse or doctor. He therefore cannot directly communicate with them in order to obtain treatment. The services of an interpreter may then be sought, whereby either another nurse or close family member may be requested to ask the patient their problem and then translate what they say to the doctor. One of the major problems with such a practice is that those asked to interpret obviously have no training in the art of interpretation and may themselves not be very competent in the language which they have to translate from or into.

This is demonstrated by a story by a nurse in one health centre in Eldoret town. Her patient was a 26 year old young mother from the rural area who could only communicate in very elementary Kiswahili in addition to her mother tongue. The communication problem was so acute that she had to send the patient home to return with her spouse. On her return, the patient brought her husband who had to act as an interpreter. He turned out to be half literate but could speak and understand Kiswahili. Although the nurse counselled the patient through her husband, she had the feeling that the explanation the patient was getting was not as effective as she would have wanted it to be. There was certainly a communication gap between her and her patient.

The lack of a common language of communication between the doctor and his patient is very crucial in handling sensitive aspects of any disease, where direct communication would be very fundamental. One doctor who was interviewed admitted that she is normally reluctant to attend to some patients when she realises that they cannot speak English. Although her case is somewhat unique, being a Kenyan of Indian origin, she is much more competent in English than in Kiswahili and English is therefore the main language of communication in her clinic. She narrated to me how on one occasion she nearly turned back a ten-year old girl who had been raped. The girl did not speak English and her Kiswahili was also minimal. For such a sensitive topic, the doctor admitted that she would have preferred to counsel the patient directly but this could not have been possible due to the language problem. Although she attended to the patient, it was not to her satisfaction and certainly not to that of the patient. The entry of a third party certainly interfered with

the entire communication process in addition to putting the patient in a vulnerable position, after she had already had the harrowing experience of rape at her tender age. This shows that language indeed does limit access to proper health care for many Kenyans. In this case, however, the problem did not lie entirely with the patient since it was actually the doctor who did not have competence in Kiswahili. But even if she did, there would still have been a problem since the patient's knowledge of Kiswahili was minimal.

The problem of language also means that some patients do not approach certain doctors for treatment. This is because of the fear of the inability to communicate in the language understood by the doctor. They might also be afraid of not getting the appropriate treatment or prescription. For HIV or AIDS patients, the lack of a common language of communication with the health provider would be a major hindrance to seeking health care or treatment. Since HIV and AIDS already carry some kind of stigma in the society, a patient might feel even more stigmatized by his inability to communicate with the doctor which would mean his using a third party to interpret for him or her. It would therefore be ideal if patients suffering from HIV or AIDS would be able to directly communicate in the languages they best understand. This underscores the importance of incorporating the local languages into the campaign against HIV and AIDS as a matter of policy.

As in many multilingual nations in Africa, English is the main language of education in Kenya. However, it is not the language of everyday communication for majority of the population, whose competence in the language is also very minimal or non-existent. This entails the translation of material from English into the languages of the people during the provision of health care services. Over the years, medical writers have had to write for multilingual audiences. Comprehensibility across languages and cultures is reached either by translation into the target readers' native languages or by writing in a language common to all members of the audience. In most cases, this language is usually English. However, there are different degrees of proficiency in English especially in non-native settings. As a result, the writing of texts that may be translated and writing for a non-native-speaking audience requires particular expertise and cultural awareness on the part of the medical writer.

Despite the amount of care taken in writing medical texts used by non-native speakers of English, the task of translating information received in English into local languages, including Kiswahili is a tall order for many medical personnel. While English is the language of education for all medical personnel in Kenya, Kiswahili is the main language of communication in health centres especially in urban settings. This was confirmed by 90% of the nurses and doctors interviewed within Eldoret municipality. But the levels of proficiency in Kiswahili vary greatly from those of English, with majority of those interviewed admitting that they are more comfortable using English compared to Kiswahili. One of my informants, a nurse, confided in me that she faces a lot of difficulty in translating information from English to Kiswahili during counseling. This is especially problematic due to the lack of one-to one equivalents between English and Kiswahili. Due to her confessed lack of fluency in Kiswahili, she admitted that she may not always use words or expressions that capture exactly what she would have said had she used the language of education, i.e. English.

She also admitted that certain English terms are difficult to translate and that others when translated into Kiswahili acquire certain connotations which are absent in their English equivalents. One of the examples given to illustrate the problem of translatability of terms is the term Anti-Retroviral-drugs (ARTs). This term is translated into Kiswahili as “madawa za Ukimwi”. This translation is problematic because while the English term basically refers to medication that can slow down and even reverse the progression of HIV infection by reducing the multiplication of the virus thus delaying the onset of AIDS by twenty years or more, the Kiswahili one seems to condemn one as already having AIDS since “ukimwi” refers to the full blown condition. Other terms that are problematic in translation include terms like ‘abstain’ which translates into Kiswahili as ‘kutofanya’ (as given to me by the nurse) but which patients don’t seem to take very kindly when told what to do to avoid infection or re-infection.

Another problem of translation is that the choice of near equivalents to terms may give either an exaggerated or less informing version of what the patient intends to inform the doctor or vice versa, since communication from the doctor to the patient also has to go through the same kind of process. Of all the doctors and nurses interviewed, 70% confirmed that they normally require interpretation for some of

their patients. However, for some, the fear of not getting every detail of what the doctor tells them leads them to ask for someone to translate for them. One doctor felt that although most patients can speak and understand Kiswahili, some patients feel as though they are missing out on certain details from the doctor or that the doctor isn't getting exactly what their condition is and that they may therefore not get the correct prescription. They therefore request that someone who speaks their local language assists them to make complete sense of the doctor's diagnosis and prescription. This implies that although English and Kiswahili may be used by a certain percentage of the Kenyan population, not all people have confidence in their expressive or comprehension abilities in these languages. For this category of people, the local languages are their first choice in communication on matters that they consider to be of central importance to their well being.

In Kenya, English and Kiswahili are the official languages. The new constitution under chapter 2 section 7 (2) declares Kiswahili an official language together with English. However, Kiswahili retains its previous status as a national language (1). English remains the main language of instruction in schools and tertiary institutions (Although this might change with the elevation of Kiswahili to official status). This means that it is the main language of training for medical staff and since the majority of Kenyans, especially those who haven't gone through formal education do not understand English, medical personnel attending to such patients need to use either Kiswahili or the mother tongues. But while it may be easy to communicate in these languages on the ordinary day to day issues, it becomes a problem when the use of certain medical terms is involved. This implies that special training is required for the medical personnel in the area of language and particularly in the translation of medical terms from English to either Kiswahili or the mother tongues. This would ensure that the appropriate terms are used in all health centres. With the elevation of Kiswahili to official status, one can only hope that more attention will be given to its growth and development in order to make it

Language, Communication and Culture

Levine (1984) acknowledges the integral relationship between communication and culture. Haslet (1989) quotes Schefflen (1974) who defines communication as "an organized, standardized, culturally patterned system of behaviour that sustains,

regulates and makes possible human relationships” (20). Culture on the other hand, is “an inherited system of ideas that structures the subjective experience of individuals” (ibid). It refers to shared ways of life, with sharing on both the concrete level and the cognitive level, which includes language and other symbols. There is therefore an integral relationship between language, culture and communication. Language and culture cannot be separated since language is the vehicle through which culture is expressed. Haslet (1989) argues that for humans, culture and communication are acquired simultaneously: Neither exists without the other (20). The language question in the fight against HIV and AIDS is therefore, no doubt, tied to the cultural question as well. There are certain cultural expectations that dictate what is permissible as far as language use is concerned. As Haslet (1989) indicates, ‘different cultures have differing degrees of openness with respect to communication’. For instance, taboo words exist in each culture, with unspoken rules and regulations on which words should not be used. Some of the areas which contain taboo words are those to do with death, bodily functions, certain wild animals and parts of the body. During counselling sessions to people living with HIV or AIDS (PLWH), as well as during the diagnosis and treatment of the same, one requires a great deal of expertise to ensure that words or expressions considered taboo by a particular community are not used.

One of the nurses interviewed confessed that while she has no problem using English terms that refer to the reproductive organs, she finds it difficult to mention the same in Kiswahili or mother tongue. She feels as though the English terms are not as harsh as their equivalents in the local languages. But such a feeling has more to do with cultural expectations than with the harshness or softness of the terms in question. In many cultures, it is considered taboo to mention the reproductive body organs, hence the unease felt by the nurse and no doubt by the patients involved. The nurse indicated that the mention of some terms during counselling leads to the patient feeling embarrassed especially if the partner or a family member is present as an interpreter. Such feelings of embarrassment certainly do influence the concentration by the patient to what the nurse or doctor is saying. Language therefore ultimately becomes a barrier in this effort to explain issues pertinent to the prevention or treatment of HIV and AIDS due to the cultural aspects with which it is inherently connected.

Gillies (2004) argues that dealing with HIV/AIDS is one of the major ethical challenges facing the world today and that an expanded discourse on ethics, divided into three levels, can help give a fuller understanding of all aspects of the HIV/AIDS pandemic. The levels are: (1) micro level (doctor-patient relationship); (2) meso level (civic and public health ethics); and (3) macro level (ethics of international relationships). At the micro level, the four principles of respect for autonomy, beneficence, non-maleficence and justice apply to HIV patients, as to any other. He believes, however, that the overwhelming demand for medical care and the lack of doctor availability in developing countries seriously limits their application.

Autonomy is reflected by respecting confidentiality and human dignity and by ensuring that HIV testing is performed with informed consent. He concurs that medical personnel have a duty to help patients and to avoid harm and that they should discuss the balance between benefit and harm with each individual patient, where possible. However, the practice of these principles is obviously hindered by the overwhelming demand for medical care, and the lack of capacity, including doctor time and doctor availability in developing countries. Another major hindrance to the practice of these principles is the linguistic barrier in multilingual nations where majority of the citizens are only competent in their ethnic languages. As already discussed, the lack of a common language between the doctor and the patient automatically leads to the principle of confidentiality being interfered with.

In answer to the question whether he felt that Language affected his communication with his patients, the first doctor interviewed began by admitting that “communication is the biggest problem we in this profession have”. When asked to elaborate, he narrated a rather sad story. A man whom the doctor suspected was aged between 30 and 35 once visited his clinic unaccompanied, and had explained to the doctor all that he felt. Using a mixture of both English and Kiswahili, the doctor held a long discourse with the patient, at which the patient simply nodded. The doctor then suggested that he performs certain tests on the patient, one of which was going to be an HIV test.

When the results came, the doctor discovered that the patient was indeed HIV positive. He therefore sat the patient down and explained to him what the results had

shown. However, the doctor noted that there was no reaction by the patient to indicate that he knew the implications of the outcome of the tests. The doctor nevertheless counselled the patient and informed him how to avoid re-infection as well as how to keep to the prescribed medication. Finally the patient rose up to leave the doctor's chamber, but on reaching the door, he turned to the doctor and shockingly asked "Daktari, na hii positive ni nini?" ("Dr. and what is this thing called 'positive'"). It was at that time that the doctor realised that the patient had understood nothing of what he had been talking to him about for the last nearly half hour that he had been in his clinic.

This story is a clear indication of the way in which language can be a major barrier to comprehension of important details that have to do with either the diagnosis or treatment as well as follow up of a patient. The doctor's explanation to the reaction of the patient was that apparently, he did not want to show the doctor that he did not understand English very well, so he kept nodding as though to indicate that he understood everything and therefore not "annoy" the doctor. This sentiment was echoed by another doctor whose argument was that many patients who do not understand English would normally not admit immediately since they do not want to "offend the doctor" and instead wear a blank look on their faces simply gazing strongly at the doctor. It is such a gaze that indicates to the doctor that the patient does not understand what he is telling them and at that point a third party is brought in. We must however also acknowledge the fact that many doctors are also not competent in the local languages of the communities in which they work and their knowledge of Kiswahili is also limited. For instance, in this case perhaps if the doctor had a Kiswahili word or expression to explain the concept of being "positive", the patient would have understood him better and therefore it would not have been necessary to involve a third party.

The multilingual situation in Kenya makes language choice a very sensitive issue in the delivery of health services. Schmied (1991) has argued that Kenya has what he calls "a trifocal" language situation with the local languages functioning as languages of local identity, used by family members and very close friends, Kiswahili being the language of interethnic communication, used by people who belong to different ethnic communities, and English as the official language. The choice of language can

indicate the amount of distance between the participants in a conversation. The use of English, for instance, is normally considered an indication of greater social distance between people. This presents a challenge to health providers who can only use English. One such doctor who was interviewed indicated that at least 20% of her patients do not understand English, which requires her to use Kiswahili which she is not very competent in. The other 90% of doctors and nurses interviewed indicated that Kiswahili is the major language they use in their clinics and that majority of their patients also prefer to use Kiswahili. The lack of competence in Kiswahili by trained professionals in Kenya is indeed very common, much as it is ironical since Kiswahili is an official and national language of the country. It is a phenomenon observed even among top political leaders, including members of parliament who cannot communicate very effectively in Kiswahili. This means that certain policies need to be put in place to encourage the use of Standard Kiswahili in professional circles.

The preference of Kiswahili by patients echoes the story of the agricultural extension officers who, having received their education in English realise that they need a different language in the field, either Kiswahili or mother tongue. In the same way, most of the nurses and VCT counsellors felt linguistically inadequate in counselling or attending to patients who only understood little Kiswahili or only their mother tongues. One way of solving this problem would be to employ medical personnel who are competent in the local language of the community. However, due to the limited number of trained medical personnel in the country, it would not be possible to have enough doctors from every ethnic community to work in their respective “catchment areas”. Therefore, at the moment, the only solution to the language barrier is the use of interpreters. 95% of the informants agreed that they require interpreters quite often and that they mostly use family members of the patient.

Although the use of an interpreter makes communication between the patient and the doctor possible, it comes with its own limitations. To begin with, the person required to act as an interpreter may not be competent enough in the language being used. For instance, they may be illiterate which restricts the kind of information they pass on to the patient, thus creating a communication gap. One doctor admitted that the use of an interpreter reduces the rapport between the patient and the doctor.

The fact that interpretation can be a hindrance to effective communication became apparent during my interviews with a number of nurses and doctors in health centres in Eldoret town. One nurse actually felt that communication between her and a patient through a third party was only 50% effective, while the majority of the health service providers felt that it was 70% effective. This means that the lack of a common language of communication between the patient and the doctor which leads to the entry of a third party can indeed slow down the progress in the treatment of HIV and AIDS. A young VCT counsellor interviewed actually confided in me that when he has to counsel a patient through a third party, he normally leaves out some details due to the tedious process of having to communicate to his patient through an interpreter. He also strongly felt that the patient often leaves out some important information when he does not communicate directly to the health care provider.

Another shortcoming of interpretation has to do with the ethical question. Every patient has a right to privacy and one of the requirements of every doctor is to ensure confidentiality with the information the patient gives. In the presence of a third party, there can be nothing confidential any more between the patient and the doctor. Although the patient normally consents to the presence of the third party, this might result in the patient feeling inhibited from giving certain details of their disease, particularly those which they would consider too personal.

Conclusion

This paper has looked at different ways in which language becomes a barrier in the provision of health care services in Kenya. It has shown that doctor-patient discourse is particularly affected by the lack of a common language of communication between the doctor and the patient. One way which may be used to reduce the language barrier would be to develop nonverbal and other more indirect communication skills which may be more culturally appropriate. It can also be argued that more resources are needed to develop, evaluate and replicate linguistically accessible and culturally appropriate HIV prevention interventions especially for local communities in the country.

The language question needs to be given more attention in the training and recruitment of medical personnel. This means that it should not be sufficient to speak English in order to be employed as a medical practitioner and it might also be necessary to evaluate a person's competence in Kiswahili before they are considered for employment especially in government medical centres. The government needs to introduce a policy that requires doctors and nurses sent to work in rural areas to learn the respective languages of the communities they are assigned to work with. This is a practice that is common in some religious institutions where training in the language of the target population is offered to those sent to work with the local communities. It is therefore clear that language policy should be flexible to accommodate rural and regional, local national or international interests and needs.

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