

A Chinyanja, Ciyao and Chitumbuka Conception of Malaria

Mzati Nkolokosa

University of Malawi

mzati5@gmail.com

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Abstract

This paper explores an African conception and understanding of malungo, the Chinyanja name for malaria. Regarding the cause, symptoms, treatment and prevention of malaria, the dominant Western paradigm is at variance with the Malawian experience of malungo. Malawian indigenous ways of knowing and doing, including treatment and prevention of malungo, derive from centuries of experience that produced an independent epistemology that Western science rejects as myths and misconceptions. For the past four decades, researchers have reported low knowledge of malaria in Malawi while using the term malungo during data collection. Anchored in anti-colonial theory and hermeneutics, this paper reviews the 2017 Malawi Malaria Indicator Survey and discusses malungo from the African epistemology perspective. The paper further suggests that malaria and malungo be studied through Western and African lenses to understand whether or not the two are one or different conditions. A clear understanding of malungo and malaria as one or two conditions would lead to developing competent interventions.

Keywords

Malaria,
Malungo,
Language,
Malawi,
African epistemology

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Introduction

This paper explores a Malawian perspective of malungo, the Chinyanja name for malaria. First, the paper proposes that malungo and malaria could be different conditions with different causes and management but similar symptoms. Next the paper discusses the centrality of language to the study of the conception

of diseases on the premise that any language anchors a people's epistemology (Cakata, 2020, p. 115). Finally, the article recommends that conversation is better than conversion (Nyamnjoh, 2015, p. 2). This implies that there should be a conversation between malungo and malaria, between different disease perspectives, not a total conversion of one perspective to another. According to Nyamnjoh (2015, p. 3), a body of knowledge is born inadequate or incomplete; it is understood to undertake a journey of self-activation in the process of cultivation or domestication through relationships and interactions with other bodies of knowledge. Nyamnjoh echoes Molande (2006, p. 101), who posits that cultures "undergo moments of rewriting in their dialogical encounter with other cultures." (For a discussion of the relationship between culture and knowledge production, see Mkhize, 2004; Mkhize, 2018; Nwoye, 2015; Nwoye, 2017; Nyamnjoh, 2012, Ramose, 1999; Ratele, 2016.)

According to the Ministry of Health in Malawi (2022), malaria is endemic throughout the country and is a significant public health problem, with an estimated six million cases annually. The disease is a leading cause of morbidity and mortality, especially in children under five and pregnant women. Malaria accounts for about 34% of all outpatient visits and 18% of all hospital deaths in Malawi. In addition, malaria is a significant contributor to the poor health indicators in Malawi. Malawi's workforce is estimated to lose about 15-25 days a year due to malaria, with families spending about 28% of their yearly income to treat malaria. The Ministry of Health in Malawi, therefore, has developed the following strategies to reduce the burden of malaria to a level of no public health significance: (a) malaria case management, (b) integrated malaria vector management (IVM) which involves the provision of long-lasting insecticide-treated nets, indoor residual spraying and larviciding, (c) malaria prevention during pregnancy, (d) social and behavioural change communication to promote positive behaviours and treatment adherence, and (e) monitoring and evaluation (Ministry of Health, 2022). Given the interventions underway in Malawi, researchers consider the cases higher than expected. Consequently, knowledge of malaria has been singled out as an essential

tool in the fight against the disease (Sixpence et al., 2020, p. 9; Okiro et al., 2014, p. 46; Munthali, 2005, p. 129).

This paper is, therefore, a call to a conversation between bodies of knowledge and between cultures, a dialogue between malaria and malungo. Such a call requires an epistemic disruption, a departure from the norm or the acceptable, which is the study of African knowledge through the Western lens, or the study of malungo through the lens of malaria, to the un/acceptable new, the study of African knowledge through an African lens. Consequently, in addition to the African lens, I also disrupt the Western epistemic rules that dictate the structure of knowledge dissemination, called academic writing. Here, I present an African epistemology of malungo in an African manner; thus, the paper is written in a conversational style, which is the African way of knowledge dissemination through stories that are “eaten” with figures of speech (Cakata, 2020, p. 115; Akinde, 2008, pp. 8-11; Shame, 2010, p. 109; Achebe, 1958, p. 11). I will, therefore, analyse figurative language, the storeroom of African knowledge, and end the paper with ethics, in which a reflective ethical dilemma is posed for listeners, readers in this case.

This paper is structured as follows: Firstly, I reflect on the anti-colonial and hermeneutics as theories that anchor the paper. Secondly, I discuss what malaria researchers label as myths and misconceptions from Malawian participants in malaria research and propose that these could be causes of malungo, not malaria since questionnaires ask about malungo, not malaria. In the third and final section, the paper suggests that malaria and malungo could be different conditions, with similar symptoms but different causes and preventive measures.

Theoretical Frameworks

The anti-colonial theory and hermeneutics are two theoretical anchors of this paper. The anti-colonial theory questions the nature of traditionally accepted colonial experiences and consequences. Primary to the anti-colonial theory is the realisation that the encounter between the coloniser and the colonised was characterised by various forms of violence (Fanon, 1963, p. 38; Fanon, 1967, pp.

58-61; Ngugi, 1987, p. 2), including epistemological violence (Nyamnjoh, 2012, p.132; Cakata, 2020, p. 115). For Ngugi and others, imperialism's greatest evil was that the colonised social and cultural fabric was destabilised, and their ways of knowing and languages devalued (See also, Fanon, 1963, p. 38). Perhaps the main aim of the anti-colonial theory, in this regard, is to offer a critical analysis of the colonial and neo-colonial agendas embedded in social and cultural institutions to make sense of the current lived realities of the colonised (Nyamnjoh 2015, p. 3; Mkhize & Ndimande-Hlongwa, 2014, p. 11).

The anti-colonial theory, therefore, rejects the idea that Western knowledge traditions are universal and calls on African researchers to be critical of social and power relations embedded in the production, organisation, validation and dissemination of knowledge (Ngugi, 1987, p. 2). According to Nyamnjoh (2015, p. 7), it is in one's interest and the interest of others to acknowledge that being and becoming is an eternal process of incompleteness; and this, in many ways, is central to the anti-colonial theory, i.e., western bodies of knowledge are incomplete just as African bodies of knowledge are incomplete. Therefore, bodies of knowledge need to seek growth from conversations with each other. A language's place in knowledge production and dissemination is central to the discussion and anti-colonial theory. For example, the devaluation of African languages undermines how we relate with the coloniser. Cakata (2020, p. 115) points out the critical importance of language in expressing one's identity and world. She notes that the coloniser had a deliberate intention and policy to empty the African mind and fill it with everything Western.

However, the anti-colonial theory does not mean an uncritical or nostalgic acceptance of local knowledge. On the contrary, the theory accepts conversation, rejects Western attempts at conversion, agrees with the force of argument, and rejects the Western idea of force. The anti-colonial theory argues that all bodies of knowledge are incomplete and inadequate and rejects the West's imposition of its ways of being and knowing "as if they were the one best way of being human and being modern" (Nyamnjoh, 2015, p. 2).

The anti-colonial theory's call for a careful engagement with knowledge is also the goal of hermeneutics. In general, hermeneutics is concerned with the interpretation and understanding of texts, both written as well as non-written texts. As Mkhize and Hlomangwe (2014, p. 12) put it, "To understand the whole, one needs to understand its constituent parts. Similarly, the constituent parts need to be understood with reference to the whole." It is evident that understanding, from a hermeneutic point of view, is historical and perspectival. Using one particular worldview as their only point of departure, colonialism and neo-colonialism have sought to erase the contributions of the colonised to knowledge production and their languages. It is through language, including living language or orality, "that humanity can dialogue with one another and come to a consensus about a new future" (Nabudere 2011, p. 90). The recognition and scientific development of African languages, the primary communication medium for most of Africa, are critical to anti-colonial theory and hermeneutics. In the context of this paper, I use the anti-colonial theory and hermeneutics to call for the recognition of an emic understanding of malungo in the Chinyanja and Ciyao languages of Malawi.

Malawi Malaria Indicator Survey of 2017

The Government of Malawi, through the Ministry of Health, conducts the Malawi Malaria Indicator Survey (MMIS) once every five years. The latest MMIS at the time of writing this paper was dated 2017. The Government of Malawi uses information collected during the surveys for policymaking and programme management, designing and evaluating programmes and strategies for improving the health of the country's population (MMIS, 2017). The MMIS, therefore, attracts interest from experts, especially those in public health (see Sixpence et al., 2020). One of the key aims of the 2017 survey was to assess knowledge of malaria among women of reproductive age (MMIS, 2017, p. 51). In addition, the MMIS (2017, p. 52) reports that human behaviour, including knowledge, could play a vital role in reducing malaria transmission and infection. Other studies in Malawi have determined that ignorance of malaria symptoms results in delayed treatment, often degenerating into fatal emergencies (Oyekale, 2015, pp. 521-522). Therefore,

researchers recommend teaching women of reproductive age about malaria as an effective way of managing the disease in Malawi.

Sample Design

The Malawi Malaria Indicator Survey (2017, p. 1) was a nationally-representative household survey that followed a two-stage sample design to allow for estimates of key malaria indicators for the whole country, for urban and rural areas, and each of the three administrative regions. First, 150 clusters were selected from enumeration areas (EAs) of the 2008 Population and Housing Census. Of the 150 clusters, 60 were in urban areas, while 90 were in rural areas. The second stage of sampling involved the systematic selection of households. Twenty-five households were randomly selected from each EA from a national sample size of 3,750. The questionnaires were in English, Chinyanja and Chitumbuka. Some results are presented in Table 1.

Knowledge about the cause of Malaria

In the MMIS (2017, pp. 117-118), a question was asked, “what do you think is the cause of malaria?” Respondents provided the following answers: (1) mosquito bites, (2) eating immature sugarcane, (3) eating cold nsima, (4) insufficient sleeping, (5) eating contaminated food, (6) drinking dirty water, (7) getting soaked in the rain, and (8) cold or changing weather.

Knowledge about common symptoms of malaria

In the MMIS (2017, pp.117-118), a question was asked, “what signs and symptoms would lead you to think that a person has malaria?” Respondents provided the following answers: (1) fever, (2) feeling cold, (3) headache, (4) vomiting, (5) diarrhoea, (6) dizziness, (7) loss of appetite, (8) body ache or joint pain, (9) pale eyes, (10) salty-tasting palms, (11) feeling weak, and (12) refusing to eat or drink.

Knowledge about preventive/protective measures

In the MMIS (2017, pp. 117-118), a question was asked, “how can someone protect themselves against malaria?” Respondents provided the following answers: (1) sleeping under a treated net, (2) sleeping under an insecticide-treated mosquito net, (3) using a mosquito net, (4) taking preventive medication, (5) spraying house/rooms with insecticide, (6) clearing weeds around house/rooms, (7) using mosquito coils, (8) cutting grass around the house, (9) avoiding stagnant waters (puddles), (10) keeping surroundings clean, (11) burning leaves, (12) avoiding drinking dirty water, (13) avoiding eating bad food, (14) putting screens on windows, and (15) avoiding getting soaked in the rain.

Why “wrong answers”?

I will now attempt to explain the “wrong answers,” such as “eating immature sugarcane causes malaria”, which the MMIS (2017) did not attempt to investigate. The survey occurred in the local language, Chinyanja, in southern and central Malawi (MMIS, 2017, p. 2), where malaria is translated as malungo. This signifies that research assistants asked about malungo, and research participants answered about malungo and could have been right about malungo. The answers on causes, symptoms and prevention of malungo suggest that the condition is a collection/family of physical disorders that may or may not include malaria. It seems researchers go to rural areas to get wrong answers, and it is unnecessary to understand people’s perspectives. An established research finding divides high and low-level knowledge into educated and uneducated, rich and poor, and urban and rural. A study by Kamdaya et al. (2021), for example, assessed household knowledge, practices and perceptions of mosquito larval source management (LSM) in Mwanza, rural Malawi, and determined that educated people with high socio-economic status have a high level of knowledge about malaria while the uneducated, crop farmers and poor households have a low level of knowledge about malaria. In the following sections, I will attempt to explain the “wrong answers” in the MMIS 2017.

Meeting of English and Ciyao

This paper aims to demonstrate that one reason for high-level and low-level knowledge findings is the question of language that is not interrogated in studies on knowledge about diseases in Malawi. The meeting of English and Malawian languages is well represented by the arrival of Dr David Livingstone at Chembe (what he renamed Cape Maclear) in the Nankumba area in Mangochi. Livingstone first set foot on the shores of Lake Malawi in 1859. He visited Chembe, a place he renamed Cape Maclear after his friend Sir Thomas Maclear, the Astronomer Royal. Residents still tell the story of Livingstone's visit to Chembe up to this day. As Livingstone's boat neared the beach, Village Headman Madothi ran away and hid under a baobab tree that still stands today. The people of Chembe say that the village headman ran away because he thought the boat had carried slave buyers. We see three issues at the meeting of the West and Africa at Cape Maclear. One, Livingstone came with a position of power. His aides carried guns.

Secondly, Livingstone assumed a position of intellectual superiority. He renamed the place Cape Maclear. Three, we see confusion at the meeting of two languages, English and Ciyao. Livingstone named the body of water he saw in Mangochi, Lake Nyasa. It seems that Livingstone likely asked the people of Mangochi the following question: what is the lake's name? To the question, people answered *Nyasa*. The word *nyasa* is Ciyao for the lake. The people might have thought Livingstone had asked, "What is this?" By naming the lake, Lake Nyasa, Livingstone goofed because Lake Nyasa means "Lake Lake" in English, "Nyanja Nyanja" in Chinyanja, and "Nyasa Nyasa" in Ciyao. The name Lake Nyasa demonstrates the confusion and lack of consultation between English and Malawian languages at the first meeting. Based on such confusion and lack of consultation, I propose that there might have been similar challenges at the first meeting between malaria and malungo.

Disregard for local languages

As Mfuno-Mwanjakwa (2016, p.4) puts it, “Each language is an expression of a unique worldview and the initial system of signification that one encounters is critical to subsequent developments – intellectual or otherwise.” The consistent responses of “eating immature sugarcane” and “being soaked in the rain” as causes of malungo should not be called low knowledge levels. Instead, researchers should investigate the condition called malungo from Chinyanja and Ciyao perspectives/worldviews in line with Mfuno-Mwanjakwa’s (2016, p.4) suggestion that “a particular people’s universe is not all the universe there is out there; hence it is enriching to be exposed to other [bodies of knowledge] besides one’s own.” Malaria is not all that is out there about what Malawians call malungo (see Table 1). Therefore, it would be necessary for researchers to understand malungo from a malungo/Malawian perspective.

Idioms and metaphors

Some MMIS (2017) responses were idioms and metaphors that should not be taken literally. Chinyanja speakers use idioms and metaphors to depict a worldview unique to the language. For example, the response that malungo is caused by eating immature sugarcane is a metaphor for stopping people, especially children, from eating immature sugarcane, thereby denying the crop a chance to grow fully. However, immature sugarcane is not the only metaphor for food and disease. Chinyanja speakers also say eating roast maize at the same time as green maize causes cheeks to swell. This is a metaphor for warning against being careless with food and should not be construed as a failure to understand the cause of cheek swelling.

Table 1: *The Causes and Symptoms According to MMIS*

Cause	Symptom	Chinyanja Emic Explanation
Eating immature sugarcane		Eating immature sugarcane as a cause of malungo should be understood as a metaphor to warn children and young people from harvesting and eating immature crops. Sugarcane is a crop that demands patience until complete maturity. Unfortunately, researchers in Malawi have taken immature sugarcane as literal instead of understanding the phrase as a metaphor.
Eating cold nsima	Vomiting Diarrhoea Dizziness	Nsima is eaten hot, at least warm, but never cold. With poor food storage facilities, nsima was supposed to be eaten hot. On the other hand, cold nsima could be a victim of flies and other insects, thus causing a person to suffer from diarrhoea and vomiting, for example.
Insufficient sleeping	Headache Feeling weak	It is common knowledge that inadequate sleep, accompanied by a headache, weakens one.
Eating dirty food	Feeling cold, Headache, Vomiting, Diarrhoea, Dizziness Loss of appetite	The people of Malawi understand that contaminated food causes disease. The symptoms listed here should remind us that malungo could be a family of conditions and not necessarily or exclusively malaria.
Drinking dirty water	Feeling cold, Headache, Vomiting, Diarrhoea, Dizziness, Loss of appetite, Body ache or joint pain, Pale eyes, Salty-tasting palms, Feeling weak, Refusing to eat or drink	Dirty water has the potential to cause diarrhoea, as ably suggested in the study.
Getting soaked in the rain	Feeling cold	I remember being soaked in the rain while walking home from primary school. I felt cold and shivered, even after the rains. I had to warm myself with fire at home. The cold and shivering are what people refer to as malungo.
Cold or changing weather	Feeling cold	In a country where people do not have enough warm clothing even for the shortest winter, cold weather is a cause of shivering called malungo.

Ciyao, Chinyanja and Chitumbuka Perspectives of Malungo

The MMIS (2017, p.16) determined that women with secondary education and higher education were more likely to own a radio and television that enabled higher knowledge of malaria than those who did not own a radio or television. Furthermore, the study concluded that women with secondary and higher education resided in wealthy households, had seen or heard malaria messages, and were from Tumbuka ethnic groups, urban or northern region dwellers. In addition, rural women demonstrated less knowledge than urban women because rural settings face barriers to information. Finally, the MMIS (2017) determined that Yao women from southern Malawi “were more likely to have lower knowledge of malaria” as they were less likely to be educated because of cultural factors. However, the findings were inadequate because language, critical to knowledge production and dissemination, was not considered during the analysis. Therefore, I will interrogate the question of language to demonstrate why knowledge of malaria is highest among women of the Tumbuka ethnic group and lowest among women of the Yao ethnic group.

Ciyao

Malungo is a Ciyao word for knees. When one among the Yao people is ill, the question is asked, *akubwala chichi?* (What are they suffering from?). The answer could be *ndetemu sya m'malungo* (shaking in the knees) or *kutetemela kwa m'malungo* (shaking in the knees). The shivering/shaking is understood to originate from or take place in the knee joint. I propose that malungo in Ciyao could be a short form for *ndetemu sya m'malungo* or *kutetemela kwa m'malungo*. Ciyao word malungo is associated with fever and not necessarily or exclusively malaria. Thus, a question about causes, symptoms and signs of malungo to a Yao respondent evokes *ndetemu sya m'malungo* or *kutetemela kwa m'malungo*, not solely or necessarily malaria. Unsurprisingly, researchers in Malawi determine the lowest knowledge levels of malaria among Yao women because they understand the questions about malungo in Ciyao, as *ndetemu sya m'malungo*, not as exclusively or necessarily malaria. Mosquitoes are not necessarily part of the Ciyao perspective of malungo.

Therefore, when Ciyao speakers mentioned being soaked in the rain, for example, as a cause of malungo, they were right about malungo from a Ciyao perspective.

Chinyanja

I am a Chinyanja speaker who grew up among the Yao people of Balaka in Southern Malawi, and I can claim to understand why Ciyao speakers and Chinyanja speakers provided somewhat similar answers in the MMIS of 2017. There are some similarities between malungo in Ciyao and Chinyanja. Speakers of Chinyanja use the term ‘malungo’ to mean a person’s body joints, similar to the understanding of Ciyao speakers, although malungo is Ciyao for knees. Chinyanja speakers also use the term ‘malungo’ to refer to a disease that causes shivering, affects joints and is associated with fever. The mosquito is not necessarily part of the Chinyanja perspective of malungo. Therefore, when Chinyanja speakers mentioned being soaked in the rain, for example, as a cause of malungo, they were right about malungo from a Chinyanja perspective.

Chitumbuka

Chitumbuka is regarded as a regional lingua franca in northern Malawi (Moyo, 2012). Malaria is ‘phungu’ in the Chitumbuka language. However, the Chitumbuka word ‘phungu’ is no longer used daily. A study on managing malaria in rural Malawi, Rumphi, concluded that while old men and women referred to malaria as ‘phungu’, most young men and women neither knew nor used this term. Instead, they referred to malaria as “malaria” in Chitumbuka and English. Young men and women said they always used the word malaria – everyone understands it. Even health workers said they used malaria (Munthali, 2005, p. 130). However, if one were to say ‘phungu’ to a Tumbuka person below 50, the word would take its Chinyanja meaning, *phungu wa nyumba ya malamulo* (member of parliament). I can speculate that the Chinyanja word ‘phungu’ has replaced the Chitumbuka word ‘phungu’ at two levels.. First, at independence in 1964, Malawi inherited a language-in-education policy in which Chinyanja, Chitumbuka and English were the media of instruction (Kishindo, 2001). The policy was changed at the Malawi Congress

Party (MCP) convention of 1968 when English and Chichewa were declared official languages. In addition, Chichewa was declared a national language, and all other languages were to be used privately. During classroom instruction, teachers in northern Malawi preferred the term ‘malaria’ to ‘malungo’; consequently, both ‘phungu’ and ‘malungo’ were not in daily use among students in the region since 1968.

Second, the term ‘phungu’ has become more associated with Chinyanja, a Member of Parliament, than Chitumbuka. This is where the study of language becomes critical to understanding disease perspectives. Since the name for malaria in Chitumbuka is malaria, a study about malaria in northern Malawi is more likely to evoke malaria knowledge than in the southern region, where the term malungo means something different from malaria. Therefore, the use of the English name ‘malaria’ and not the Chitumbuka name ‘phungu’ explains, in part, the finding of the highest knowledge levels of malaria among women of the Tumbuka ethnic group living in northern Malawi.

Conclusion

I conclude this paper with a moral consideration, as with African folk stories, which leaves an ethical question for reflection (Shame, 2010, p. 124; Cakata, 2020, p. 113). The moral question is often without a question mark and one that attracts different responses. Consequently, this conclusion is also an invitation to various ethical considerations. There seems to be a yawning gap between what Chinyanja and Ciyao speakers know (what they practice and experience about malungo in their environment) and what the Ministry of Health expects them to know about malaria. It is this yawning gap that compels me to conclude with ethics. It was unethical for Livingstone to give Chembe the name Cape Maclear. It was also unethical for him to name Lake Nyasa, meaning “Lake Lake”. It remains unethical for Malawian researchers, who in this case have adopted a quasi-colonial stance on disease conception, to describe Chinyanja and Ciyao perspectives of malungo as having low knowledge levels. Such a description results from researchers’ failure to appreciate that local languages are knowledge production and dissemination

centres. Research ethics should include respect for people's knowledge through their lens and language. As argued by Mfunne-Mwanjakwa (2016), every language is a worldview it is and may have something to teach to the other languages, much as it may also have something to learn from. As such, for a more prosperous and better understanding of the universe, every language must be accorded its rightful place and status among the polity of languages. I have compared the conception of malungo in the Chinyanja and Ciyao languages and malaria in the English language to determine whether or not the three conditions, i.e., the Chinyanja language malungo, the Ciyao language malungo and the English language malaria, are one. Researchers need to learn from people and not necessarily dismiss local knowledge as low-level knowledge. Once researchers begin to learn from people, and the people begin to see that their knowledge is respected, the journey towards developing malaria interventions that are competent, appropriate and sensitive shall have begun.

I will end this paper the way we end knowledge dissemination in Chinyanja folklore by saying *mbatata yanga* (my potato) and letting the reader say *yapselera* (it has burnt). In other variations, the narrator says *ntbano yangayo* (my folk story), and the audience responds, *yapselera* (it has burnt). The audience/listener is the last to speak in every knowledge dissemination by folklore, signifying the death of one narrator and the birth of another. The ethics of knowledge production and dissemination among Chinyanja speakers is that every person is a centre of knowledge production, and people should give each other turns to disseminate knowledge. Consequently, knowledge dissemination among Chinyanja speakers is a process that does not come to an end. One tells a folklore, another tells a similar or different folklore, one tells a proverb, and another describes a similar or a counter-proverb. So, the dissemination goes on and on and on. From such discussions, folklore and proverbs adapt to different experiences at different times and places. In addition, the audience/listener has the final say on the knowledge disseminated (*yapselera*). The next narrator puts their potato (knowledge) on the fire (audience) to continue the dialogue. Malaria researchers in Malawi have been speaking for decades. It is time to pause and say, *mbatata yanga* (my potato) and

let study participants answer, *yapselera*. Next, the researchers should walk into Chinyanja and Ciyao languages and learn from within to appreciate different perspectives of malungo because in these languages is nestled the understanding of malungo, not narrowly malaria.

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Conflict of interest

There is no conflict of interest

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