

**Translation Practices in a Developmental Context:
An Exploration of Public Health Communication in Zambia**

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ABSTRACT

Translation in Africa has been studied mostly through the prism of postcolonialism and literary studies. Some scholars have argued that this approach restricts translation studies scholarship on and about the continent. The gist of the postcolonial approach lies in the inherent power relations that exist in the inevitable cross-cultural contact arising from colonialism. Of late, some scholars have suggested that it is time to move beyond the post-colony. It is against such a backdrop that this dissertation broaches the study of translation phenomena in Africa from a developmental perspective. This thesis argues that the postcolonial era is not monolithic and that the African condition has evolved over the years. While it acknowledges the legacy of colonialism with all of its devastating consequences, the study understands the concept of the developmental context to offer the perspective of a continent in charge of its own destiny in contrast to the perspective that sees only a victim. Accordingly, this study seeks to explore translation practices within a developmental context and concentrates on one of the most important development issues: health. In line with global health priorities that now approach health from a preventive rather than a curative perspective, health promotion and communication have become central to the development agenda. This dissertation therefore discusses the historical, political, linguistic, socioeconomic, and cultural factors that inevitably affect translation in public health communication in Zambia and, to a lesser extent, the southern African region. While emphasizing the sociological context of the case study, this research takes translation as a cluster concept and a communicative act in order to investigate how translation is practiced. The research involves a contextual analytic exploration of a few selected health communication products. Drawing on Jakobson's three types of translation, descriptive translation studies, and functionalist theories, this dissertation brings to light the importance of intersemiotic translation in societies that are anchored in oral culture.

RÉSUMÉ

La traduction en Afrique est principalement examinée à travers le prisme du postcolonialisme et des études littéraires. Des spécialistes ont critiqué les limites de cette approche qui, s'agissant du continent africain, s'intéresse essentiellement aux rapports de pouvoir inhérents aux contacts interculturels issus de la colonisation. Récemment des voix se sont élevées, affirmant que le moment est venu d'aller au-delà de la postcolonie. Sur cette toile de fond, l'étude aborde les phénomènes de traduction en Afrique dans l'optique du développement : le postcolonialisme n'est pas monolithique et la situation africaine a évolué au fil des années. Sans nier l'héritage de la colonisation ni ses conséquences dévastatrices, l'étude envisage le développement comme un contexte qui offre au continent la possibilité de prendre en charge sa propre destinée par opposition à la condition victimaire où l'approche postcolonialiste tend à la cantonner. L'étude explore des pratiques de traduction qui vont dans le sens de cette émancipation. Elle se concentre sur un des secteurs les plus importants en matière de développement : la santé. Conformément aux priorités mondiales suivant lesquelles mieux vaut prévenir que guérir, la communication et la promotion des pratiques sanitaires sont désormais au cœur des politiques de développement. Les circonstances historiques, politiques, linguistiques, socioéconomiques et historiques qui entourent la communication et donc la traduction en matière de santé publique dans un monde en développement sont discutées en détail. Entendues au sens d'un ensemble flou et comme instances de communication, les pratiques de traduction sont analysées au moyen d'exemples représentatifs en prenant soin de les situer dans leur contexte sociologique respectif. Tout en faisant appel à la typologie de Jakobson (traduction intralinguistique, interlinguistique, intersémiotique), l'analyse se situe dans la lignée d'une traductologie descriptive et fonctionnaliste. Elle fait ressortir l'importance particulière de la traduction intersémiotique dans des sociétés où prévaut une culture de l'oralité.

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Dedication

To the memory of my father, my biggest cheerleader in my doctoral journey, Mulenga Abraham Chibamba

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ABBREVIATIONS AND ACRONYMS

ACALAN	Academy of African Languages
ADHD	Attention-Deficit Hyperactivity Disorder
AHO	African Health Observatory
AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress (Zambian)
ARK	Absolute Return for Kids
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
ATSA	Association for Translation Studies in Africa
AU	African Union
BCAO	British Colonial Administration Office
BCC	Behaviour Change Communication
BSAC	British South Africa Company
BTL	Breakthrough to Literacy
C4D	Communication for Development
CBO	Community-Based Organization
CDA	Critical Discourse Analysis
CDC	Centers for Disease Control and Prevention
CHA	Community Health Assistant
CHAZ	Churches Health Association of Zambia
CHW	Community Health Worker
CIDRZ	Centre for Infectious Disease Research in Zambia
CSH	Communications Support for Health
CSO	Central Statistical Office
CT	Computed Tomography
DA	Discourse Analysis
DFID	Department for International Development
DTS	Descriptive Translation Studies
E-E	Entertainment-education
EPI	Expanded Programme on Immunisation

FBO	Faith-Based Organization
First 1000 MCDP	First 1000 Most Critical Days Programme
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GRZ	Government of the Republic of Zambia
HBC	Home-Based Care
HDI	Human Development Index
HFA	Health for All
HIC	High Income Countries
HIV	Human Immunodeficiency Virus
HPI	Human Poverty Index
IATIS	International Association for Translation and Intercultural Studies
ICTs	Information Communication Technologies
IEC	Information, Education, and Communication
IALC	International Institute of African Languages and Cultures
IMCI	Integrated Management of Childhood Illnesses
IPT	Intermittent Preventive Treatment
IPTp	Intermittent Preventive Treatment in pregnancy
IRS	Indoor Residual Spraying
ITN	Insecticide Treated Net
ITU	International Telecommunications Union
LLIN	Long-lasting Insecticidal Nets
LMIC	Low and Medium Income Countries
LSHTM	London School of Hygiene & Tropical Medicine
LWSSD	Lusaka Water Supply, Sanitation and Drainage project
MCA	Millennium Challenge Account Zambia
MCDMCH	Ministry of Community Development Mother and Child Health
MCP	Multiple Concurrent Partners
MDG	Millennium Development Goals
MGCD	Ministry of Gender and Child Development
MOE	Ministry of Education
MOF	Ministry of Finance
MOH	Ministry of Health

MPI	Multidimensional Poverty Index
MRI	Magnetic Resonance Imaging
NAC	National HIV/AIDS/STI/TB Council
NACAS	National HIV and AIDS Communication and Advocacy Strategy
NASF	National AIDS Strategic Framework
NBTL	New Breakthrough to Literacy
NCD	Non-communicable Diseases
NFNC	National Food and Nutrition Commission
NFNSP	National Food and Nutrition Strategic Plan
NGO	Non-Governmental Organization
OAU	Organization of African Unity
ODA	British Overseas Development Administration
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PANMAPAL	Pan-African Master's and PhD Programme in African Languages and Applied Linguistics
PEPFAR	President's Emergency Plan for AIDS Relief
PLWA	People Living with HIV/AIDS
PMI	United States President's Malaria Initiative
PMTCT	Prevention of Mother-to-Child Transmission
PPP	Public Private Partnerships
PPP	Purchasing Power Parity
PRP	Primary Reading Programme
R & D	Research and Development
R-SNDP	Revised Sixth National Development Plan
SACMEQ	Southern African Consortium for Monitoring Educational Quality
SADC	Southern African Development Community
SAfAIDS	Southern Africa HIV and AIDS Information Dissemination Service
SALALS	Southern African Linguistics and Applied Language Studies
SDG	Sustainable Development Goals
SHARE	Southern Africa HIV and AIDS Regional Exchange portal
SHI	Social Health Insurance
STAAF	Stories Across Africa

STI	Sexually Transmitted Illness
SUN	Scaling Up Nutrition
TB	Tuberculosis
TS	Translation Studies
TTR	Traduction, terminologie rédaction
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIP	United National Independence Party
USAID	United States Agency for International Development
USDHHS	United States Department of Health and Human Services
WHO	World Health Organization
WHO-AFRO	WHO Regional Office for Africa
WSIS	World Summit on the Information Society

INTRODUCTION

This study was first and foremost born out of my interest in translation phenomena in Africa. Having grown up on the continent and experienced first-hand the multilingualism that is part and parcel of African society, I was naturally drawn to the study of translation phenomena in the African continent. As a researcher embarking on my doctoral journey, my curiosity about translation in Africa was further piqued by the apparent absence of it in the field of translation studies (TS) as a whole. Certainly, some important work (Bandia 2008) had already been done within the framework of the postcolonial approach and literary studies, and this had laid a solid foundation for the study of translation phenomena in Africa. Nevertheless, much research remained to be done.

In order to ascertain the place of Africa in TS with a greater degree of certitude, I conducted a preliminary bibliometric survey. The purpose of the survey was to shed light on the presence of scholarship on Africa in the discipline; the survey is therefore not a comprehensive study. I limited the survey to an eleven-year period (2005–2015) and only six journals, namely, *Journal of Translation and Interpreting Studies*, *Meta*, *Target*, *Translation Studies*, *The Translator*, and *TTR (Traduction, terminologie, rédaction)*.¹ My decision to limit the survey to only these journals was motivated by their international reach (for both the national and international titles) and the fact that they are all well-known, peer-reviewed journals dedicated to research and scholarship covering a varied range of specializations in TS (such as translation theory and criticism, translation practice, etc.), and drawing from diverse disciplines such as linguistics and sociology.

¹ The *Journal of Translation and Interpreting Studies* began publishing in 2009. Therefore, the bibliometric information for this journal covers only the period 2009–2015.

In addition, the six journals represent both older (*Meta*) and more recent publications (*Journal of Translation and Interpreting Studies*). To be sure, there are several other scholarly journals that publish articles covering a wide range of translation research that fall outside the purview of the survey. Many of them are restricted to specific geographic regions and sometimes languages, and many often cover a wider range of language-related disciplines, such as linguistics and literature. One such publication that has extensively covered translation scholarship in Africa but was not included in the survey is the journal *Southern African Linguistics and Applied Language Studies (SALALS)*.

The survey reveals that out of the estimated 1,545² articles that were published across the six journals over the period under study, only 30 contributions (representing about 1.94% of all articles published) were on translation in Africa (cf. Appendix 1, Fig 1).

In terms of subjects covered, the 30 articles published on translation in Africa in the six journals over the specified 11-year period were categorized as follows: 20 of the articles were on translation relating to postcolonial or literary studies; 2 were on Bible translation, 1 on linguistics; and 7 on various subject areas including terminology, localization and ICTs (Information Communication Technologies), translation theory, subtitling, cultural translation, visual translation, and court interpretation as illustrated in the pie chart below (cf. Appendix 1, Fig 2). The content of the contributions was determined mostly through reading the abstracts but also through perusing full articles in some cases. Naturally, some articles covered overlapping subject areas and were therefore categorized according to what appeared to be the more prominent theme.

² This figure is based on the average number of articles published per issue of each journal title multiplied by the number of volumes per year and the number of years of publication.

The bibliometric survey confirms that translation phenomena in Africa have been under-researched and that, where they have been studied, it has been mostly through the prism of postcolonial and literary studies. Although the postcolonial approach has been the most prominent and natural angle for the study of translation in Africa due to the legacy of colonialism, it has also somewhat limited the expansion of translation scholarship on the continent.

Some scholars may argue that postcolonialism is a permanent feature of many lands, including the African continent, and that the era after the end of colonialism will always be referred to as the postcolonial era. On face value, this is a valid argument. However, other scholars have recognized the constraints that such a view places upon African translation scholarship and have begun to call for researchers and scholars to move beyond the postcolony (Marais and Feinauer 2017, Tyulenev and van Rooyen 2013, Tymoczko 2007, Susam-Saraeva 2002, among others). These scholars have rightly pointed out that although there can never be any escaping the effects of colonialism, the postcolonial approach should not be the only framework through which translation in Africa should be studied.

I argue, as have other scholars, that the postcolonial era is not monolithic and that the constraints and issues that Africa faced at the time of independence and the few decades following have since evolved. In a much more contemporary African society with new dynamics and new challenges, translation scholarship should also evolve. Statistics reveal that Africa has a very young population. This means that the majority of African citizens today were born after independence (which, for the most part, took place some 50–60 years ago). As a result, many Africans have had different experiences of the postcolonial era. For instance, while the independence fathers resisted the imposition of European languages and used many strategies including translation and writing to resist them, the post-independence generations of Africans

have grown up with European languages and have largely appropriated them and created their own variations of them, as I discuss later.

TS has been criticized for its Eurocentric foundations, and the study of translation in Africa using Western models and approaches tends to curtail creativity and expansion in research.³ Susam-Saraeva (2002) points out that students of translatology interested in Africa tend to gravitate towards postcolonial and literary studies because that has been the “accepted” view of what constitutes translation scholarship in Africa. To this point, Tymoczko (2007: 219) suggests that developing countries would be better served with more appropriate translation training programmes that encompass broader conceptualizations of translation, better-suited to a multilingual continent with a specific context. That said, it should be pointed out that Eurocentrism is not the only problem. The perceived universalism of the theories and models is also problematic.

The Eurocentric positions of TS have not gone unchallenged. In recent times, a growing number of scholars (notably Tymoczko 2007, Marais 2014, among others) have called for the enlarging of the field to accommodate wider conceptualizations of translation. Significantly, Marais (2014) has called for the study of translation phenomena in Africa from the viewpoint of her specific context: the developing world. Although development was born out of colonialism (it was part of the process of decolonization) and it has a symbiotic relationship with postcolonialism, I make a distinction between the postcolony and the developing nation. The major thrust of postcolonialism is the power relations that existed (and still exist) between the colonizers and the colonized. While acknowledging the problems and controversies associated with the concept of

³ The term *Western* is loosely used throughout this study to signify the widely accepted concept of the inherited norms, values and belief systems (mostly based on Christianity) emanating from Europe. They include but are not limited to concepts such as individual freedoms, human rights, and democratic principles of governance. The *West* refers to Europe and includes countries founded by Europeans, notably North and South America, Australia, and New Zealand (Heath 2004; Arowolo 2010).

development, I argue that some of the later conceptualizations, notably the human-centred models such as Amartya Sen's (1999) capabilities approach (which I discuss in greater detail later) provide a more empowering position for Africa. Likewise, TS research on the continent stands to benefit from a more unfettered study of translation phenomena, study that is more relevant to its context.

The central question that this study attempts to answer is this: How is translation practiced in a developmental context? Additionally, it attempts to answer some peripheral questions such as the following: How does this context affect how translation is practiced? Why does it matter how translation is practiced in a developmental context? How is translation practiced in public health communication, and specifically in health promotion in Zambia? What role does translation play in public health communication in Zambia? What is the relationship between translation and communication? What are the socioeconomic and cultural factors affecting translation praxis in public health communication in Zambia? As I explain later, health communication is a wide concept and this study focuses exclusively on communicating health messages to the general public. I chose to focus on health communication due to its growing importance as a tool to fight against disease in the developing world.

I begin Chapter 1 with a brief discussion of the theoretical framework that I draw upon for my study. I then explain the methodology employed for the research, which, in a nutshell, is a case study of translation practices in public health communication in Zambia.

In Chapter 2 I present a brief geographical and historical background of the case study. I follow this with a detailed discussion of the ethno-linguistic background of the country, dating from pre-colonial times. I finish this chapter detailing the language situation and explaining how both colonial and post-independence policies have helped shape the linguistic landscape of the country.

As this study is interdisciplinary in nature, bringing into interaction translation, communication, health, and development, I dedicate Chapter 3 to discussing the concepts of health and development and their relationship in greater detail. I outline the health situation in Zambia, discuss what the major issues are, and present the policies that have been put in place to address them.

Chapter 4 focuses on public health communication in Zambia and the southern African region. I trace the history of public health communication and how it came into prominence globally and in Africa. Then I give an overview of some of the public health communication policies and strategies that have been formulated and implemented in Zambia. The chapter closes with an overview of some public health communication campaigns in southern Africa as well as a discussion of the edutainment model as a translation and communication strategy.

In Chapter 5, I establish a link between translation and public health communication. I discuss some related socioeconomic and cultural factors—which are reminiscent of a developmental context—such as illiteracy, poverty, gender inequality, and some cultural and religious practices.

In the last chapter (Chapter 6), I briefly discuss the importance of context in translation as well as the significance of multimodality and intersemiotic translation. I explore translation practices in public health communication through a contextual analytic assessment of a number of selected health messages directed towards the general public.

In the conclusion, I highlight some salient translation practices and demonstrate how these are connected to the social context of the target audiences. I draw attention to the importance of multimodality and intersemiotic translation in this context. Lastly, I point out that many of the translation practices revealed are only possible when translation is viewed as a broad concept.

In view of the fact that translation phenomena in Africa have, nevertheless, been under-researched, it is hoped that this work will contribute to a better understanding of translation and communication practices as they relate to development and contemporary African society with its specific context. It is also hoped that the study will similarly assist in moving the agenda for Africa in TS beyond the postcolony. While Marais (2014: i) “aims to provide a philosophical underpinning to translation and relate translation to development,” the present study aims to investigate translation praxis in a developmental context. It adds to some of the work that has already been done and continues to be done in greater numbers by TS scholars globally. The ultimate goal is to help increase the visibility of the so-called periphery in TS and to enhance reciprocity in terms of knowledge creation and sharing as opposed to the current centre/periphery dichotomy.

CHAPTER I

TRANSLATION IN CONTEXT: THEORETICAL AND METHODOLOGICAL ISSUES

The focus of this study is translation practices in a developmental context. In the sections that follow, I provide a fair amount of detail to situate the reader in the specific context in which the study takes place and to highlight how this context relates to translation.

1.1 Translation as a function of context

A look at the genealogy of translation studies (TS) reveals how the field has evolved over the years and where this study fits in the field's evolution. Broadly speaking, the prescriptive model and the equivalence paradigm—although long criticized—underpin many theories of translation (Pym 2014). Translation viewed as “language” transfer formed the basis of the work of earlier scholars (linguists), such as Vinay and Darbelnet (1958), Mounin (1963) or Catford (1965). During the same period, however, the “contextual” approach was pioneered by Nida's ethno-cultural model of translating (1959, 1964). Nida's work (which focused on Bible translation) brought a new perspective to the notion of equivalence in translation; that is, it recognized the target context including social practices and beliefs. Nida proposed the concept of “dynamic” or “communicative equivalence” (as opposed to “formal equivalence”) in recognition of the cultural differences between source and target contexts:

The basic principles of translation mean that no translation in a receptor language can be the exact equivalent of the model in the source language. That is to say, that all types of translation involve (1) loss of information, (2) addition of information, and/or (3) skewing of information. (1959: 13)

Since the time of these scholars, TS has gone through a number of “shifts” and “turns” due to factoring in elements other than “language” and (source/target texts) “equivalence”. Both in process- and product-oriented translation studies, attention shifted to the “function” of translated texts in their own *context of communication* (Holz-Mänttari 1984, Vermeer 1978) or in their own (literary) “*system*,” (Even-Zohar 1978). Functionalist theories see translation as a communicative act that does not operate in a vacuum but is determined by the actors involved in the communicative action:

Communication takes place through a medium and in situations that are limited in time and place. Each specific situation determines what and how people communicate, and it is changed by people communicating. Situations are not universal but are embedded in a cultural habitat, which in turn conditions the situation. Language is thus to be regarded as part of culture. And communication is conditioned by the constraints of the situation-in-culture. (Nord 2014: 1)

Either process or product-oriented, functionalist theories emphasize the communicative autonomy of the translated text in its own specific context and the importance of its target-user(s). Functionalist approaches, such as those proposed by Hans Vermeer and Katharina Reiss (1984), and Justa Holz-Mänttari (1984) focus on the purpose or aim of a translation. Vermeer’s Skopos theory (1978, 1989) specifically prioritizes the purpose of a translation from the point of view of the target culture, whereas the equivalence paradigm assumes that the purpose of the source and

target texts are similar (Nord 2014; Pym 2014). As Pym (2014) summarizes, Skopos theory holds that a text can be translated in several different ways depending on the deemed purpose of the translation in a specific target environment.

In modern Western TS, the conceptualization of “context” has evolved from the fuzzy notion of “culture” as a neutral, unified set of worldviews, beliefs and social practices determining how reality is “named” to a “discursive” environment involving representations of otherness and power differentials embodied in narratives. Historic developments such as decolonisation and civil rights movements led to a more complex view of the translation process, which disciplines other than linguistics—mainly semiotics (translation as discourse), anthropology (translation as representation), and sociology (e.g. translation in social systems, agency in translation)—could better help to describe and understand (Brisset 2010).

Significant in this regard are Even-Zohar’s ([1978] 2000) polysystem theory of translation and Toury’s (1982, [1995] 2012) descriptive approach (DTS), which shifted the focus to the context of translation. Following Tynianov’s formalist principle that literature cannot be studied out of its context, polysystem theory of (literary) translation conceived literature as part of a self-regulated literary system. Moreover, polysystem theory positioned literature within the cultural, social, and historical context in which it operates (Gentzler 1993). As opposed to former, prescriptive models, the descriptive approach—reflected in Holmes’ ([1972] 2002) map of TS, initiated by Even-Zohar and further elaborated by Toury (1982)—emphasized the description and explanation of translation products and strategies. Toury (1980) defines translation as a “social behaviour” thus operating under constraints stemming from the self-regulating nature of the social system (e.g. literary, legal, scientific) within which it is performed.

Polysystem theory has been criticized particularly for its strong leanings on Russian formalism (Gentzler 1993), and DTS for its “deterministic” underpinnings (Gentzler 1993, Hermans 1999, Munday 2001, among others). In spite of these (questionable) criticisms, these approaches have been recognized for their important contributions to TS. Even-Zohar’s and Toury’s theories were essentially the precursors to the “cultural turn” as they shifted attention toward the sociohistorical and cultural context of translating:

what the new approach succeeded in doing was to position the study of translation within the study of culture more broadly, highlighting political and socio-economic factors, while continuing to insist on the importance of close textual analysis; in short, creating an approach to translation that was as much concerned with ideology as with philosophical debates about meaning. (Bassnett 2014: 24)

In the wake of the Second World War and the setting-up of international organizations, increased intercultural communication and interaction between nations resulted in increased trade, cooperation, and intercultural exchanges. Translation, therefore, became an important tool to facilitate growing global interactions. Differences in culture between various nations necessitated better approaches to translation than what was being obtained at the time by the merely linguistic approaches. Initiated by Bassnett and Lefevere (1990) towards the end of the 1980s, “the cultural turn” in TS signified a shift towards analyzing translation from a *contextual* point of view (Munday 2001). As a determinant of language, “culture” had always been present in translation models. At the end of the 1980s, “culture” assumed a new meaning as TS jumped on the bandwagon of postcolonialist criticism. It joined the debate on “Otherness” (the colonized, women, and social minorities), which for some time had defined the “crisis of representations” in the humanities.

Echoing the “translation turn” in anthropology, the “cultural turn” in TS shifted attention towards *power differentials* and *ideology* in translation (Bachmann-Medick 2006; Wolf 2002).

Bassnett and Lefevere (1990) argued that translation—which inevitably operates between both the source and target culture—needed to move away from the linguistic approaches of equivalence and faithfulness. In addition, Lefevere’s (1992) notion of translation as rewriting and manipulation (a notion which emanated from what was known as the “manipulation school” following the Leuven meeting in 1976) (Hermans 1985) reinforced the (functionalist) idea that translating across cultures involved a rewriting and manipulation of the source text to suit various purposes (not just that of the target audience as in the case of exported translations) (Bassnett & Lefevere 1990).

As an offshoot of the cultural turn, which was rooted in postcolonial criticism, the “sociological turn” was informed mostly by Pierre Bourdieu’s sociology of domination. It served to explore “agency” in translation and the role of translation in knowledge and cultural transfers. While the cultural turn highlighted the power relations inherent in translating across cultures and focused on translation products, the sociological turn emphasized the role of agents (vs. “the” translator) intervening along the translation process as well as the sociohistorical environment of translators (Brisset 2010; Wolf 2011). Wolf summarized this point as follows:

The insights gained from this newly developed perspective showed, however, that an important feature of the translation process had been not totally ignored, but widely neglected by then: the view of translation as a social practice and consequently the role of translators and other persons involved in the translation process as social agents. (Wolf 2011: 3)

Although not entirely anchored in the salient points of the sociological turn, some aspects of this study still draw from the sociological perspective. For instance, although this study focuses on translation products, it does discuss, albeit briefly, translators as well as agents and agency. A sociological approach could provide a theoretical angle for further research.

As alluded to earlier, the study also draws from Tymoczko's (2007) notion of internationalization. The "international turn," as it is sometimes known, is a push by some scholars (Tymoczko 2007, Susam-Saraeva 2002, Marais 2014, among others) for TS to enlarge its borders as a discipline. As this study demonstrates, there has been very little translation scholarship on Africa (cf. Appendix 1: Fig. 1 & 2). A true enlarging of the discipline means not only conceptualizing translation widely but also enlarging the discipline geographically and hierarchically—as this study seeks to do. Moreover, it means that the problematic binary notions of centre/periphery should no longer be a part of the discipline's vocabulary.

Although they are not necessarily similar, I draw a parallel between the notion of enlarging the field and Marais' (2014) *complexity* thinking in TS. The complexity theory proposed by Morin (2008) has many facets, but the central issue as regards translation is that the complexity theory widens the scope of the study of translation phenomena in the so-called "peripheral" cultures. Complexity theory thinking accepts that systems are complex and that they do not have to be linear and reductionist as most TS theories are. Marais (2014) summarizes this point aptly:

My argument in this section is that the Western scientific project has been dominated by "a paradigm of simplification" (Morin, 2008, p. 3), which "mutilates" (Montuori, 2008, p. ix; Morin, 2008, p. 51) reality by imposing a simple conceptualization on a complex reality. This paradigm attempts to provide simple laws underlying complex reality, which is the

reductionist (and covertly religious) ideal of explaining all of reality by means of one cause.
(19)

In essence, complexity thinking in translation would result in applying context-specific models, approaches, and methodologies in translation scholarship rather than trying to fit a square peg in a round hole. Internationalization and complexity thinking therefore share a common goal: to enlarge the field to include translation practices, models and approaches that are applicable in periphery-specific contexts.

In addition to proposing complexity thinking in TS, Marais links translation to *development* since development, he argues, forms an integral part of what he calls the African context. Although Marais accepts the fact that linking translation to development while proposing a complexity theory approach is problematic, he hopes that his efforts will be seen as worthy of further research by other scholars. He justifies his reasons for undertaking such a task as follows:

So why am I taking the long and arduous route of complexity philosophy to talk about translation and development? Well, I am wondering about the following: If I want to understand a particular context, can I understand it with the logic of another context? Or perhaps what I am asking is whether there is only one kind of logic for understanding the world. (Marais 2014: 9)

Building on his work on a complexity theory approach to translation and development, Marais called for interested scholars to work towards establishing a stronger link between TS theories and development theories. While development theories may not necessarily be applicable to translation phenomena, a parallel can be drawn between the trajectories that both development

studies and TS have taken as disciplines. Both began on Eurocentric paths that have been criticized over the years. Additionally, in the same way that TS has moved from a source-oriented approach to a functionalist one, development studies has moved from a programme-centred approach to a human-centred one (best represented by Nussbaum (2000) and Sen's (1999) capabilities approach), as I discuss later in greater detail (Marais 2017b).

The main objective of this study is to explore translation practices in a developmental context. It is therefore logical to follow the description of the context with a closer look at some concrete examples of public health communications drawn from the area under study. Accordingly, I will later analyze examples of public health communications, highlighting some of the context-specific aspects of the translated messages.

1.2 Contextualizing translation

Context factors in how information of any format is translated and how it is received and interpreted. As we have seen, the notion of context has been conceptualized differently by various translation scholars, from Nida's ethnocultural model of translation (1959) to the "cultural turn" in translation studies (Bassnett and Lefevere 1990), and to applications of sociology of communication (Tyulenev 2012, 2014). In her study on contextualization in translation and interpretation, Baker (2006a) identifies three broad binary categories, among others, of how context in translation has commonly been conceptualized: "(1) cognitive versus social/interactive definitions of context; (2) static versus dynamic models and the shift from 'context' to 'contextualization'; and finally (3) neutral versus power-sensitive definitions of context" (2006a: 322). The first pair of cognitive and social/interactive conceptualizations can be interpreted to

mean that context in translation is based more on the cognitive rather than the environmental context; that is, the context is determined more by the perceptions and beliefs of the target audience than the external social conditions that surround them. In a nutshell, the receptor audience's interpretation of information is based on their *Weltanschauung* or worldview (Baker 2006a; van Dijk, T. A. 2006; Gutt 2000 cited in Baker 2006a; van Dijk 2009). The second category of static versus dynamic notions of context acknowledges the fact that context is not static. It changes constantly depending on the situation and how the involved actors interpret new information and recontextualize it. The last of the categories surveyed by Baker (2006a) highlights the fact that context is not neutral and can sometimes be subject to power relations in the sense that some participants in interpretive actions—by virtue of their positions or the situation—wield more power than others. For instance, depending on the situation, the translator may sometimes frame messages in a certain way in order to push a particular narrative, as is often the case in politics.

Baker (2006a) points out that these categories of context are broad and often overlap. Her survey is important as it serves to emphasize the complex nature of context and the fact that it can be studied and understood in several ways depending on one's purpose. While prescriptive translation studies would be more akin to examining textual and linguistic contexts, descriptive translation studies focus more on extralinguistic contexts (e.g. socio-historical events, social system) because of its target-oriented approach.⁴ Inasmuch as all types of contexts are important and valid points of inquiry in the study of translation, this study does not purport to adhere to only one type of context. Rather, I take a broad approach focussing on analyzing various aspects of selected health messages in relation to their historical, socioeconomic, and cultural contexts, with

⁴ This in line with poststructuralism where the concept of "text" as a self-contained semiotic system was replaced by the concept of "discourse" to acknowledge the importance of subjectivity, dialogism, interdiscursivity, and most of all the role of the historical and social context in the production and reception of any instance of communication.

the overarching theme being that of a developmental context. It is understood that while most of the analysis might focus on extralinguistic contexts of translation such as the ones mentioned above, some of it will inevitably address textual contexts, according to its relevance to specific cases. In short, in accordance with Baker (2006a) and other scholars' broad categories of the conceptualization of context as discussed above, this study also considers a wide array of conceptualizations, including cognitive, social/interactive, dynamic, environmental, etc.

1.3 Discourse analysis and translation

An important development in TS was the recognition, in the 1970s, that translation is about discourse, rather than language (terminology and grammatical structures). Discourse is purposeful and contextual. It involves intersubjective, narrative and argumentative as well as intertextual and interdiscursive constructs (Charaudeau & Maingueneau 2002, Maingueneau 2017). Several scholars have proposed various models of analyzing translation as discourse. From the (functionalist and pragmatic) linguistic models proposed by House (1977) and Hatim and Mason (1989), to models that go beyond text linguistics (Fairclough 1992; Bell 1991; van Dijk 2009, etc.).⁵ Angermuller, Maingueneau and Wodak (2014) point out that discourse can be studied from many different angles and approaches. Beyond text linguistics, pragmatic semantics or the semiotics of discourse, some models are based on practice and society, drawing from social sciences and humanities. What remains true is that context plays an important role, whatever the approach. As Munday and Zhang (2017) aptly summarize, "As a method of analysis, discourse

⁵ Most Anglo-Saxon DA scholarship focuses too much on language and does not take into account discursive constructs. A good example is Paltridge's language-focused model, where texts are not analyzed within their socio-historical contexts (2012). Even when drawing from the more recent Anglo-Saxon narrative theory, Mona Baker (2006b) narrowly focuses on framing devices to highlight ideological manipulations on the part of the translator.

analysis is holistic, dealing with entire constituents of an act of communication. It is a method that studies a discourse in its context of culture, context of situation, its structure and individual constituents” (2017: 4). A point to note here is that societies are made up of several interrelated and interconnected social systems and subsystems that are constantly changing. DA therefore operates within these systems of communication.

1.4 Multimodality and intersemiotic translation

In a bibliometric survey of scholarship on discourse analysis in translation studies, Zhang, Pan, Chen, and Luo (2015) expand on the framework of analysis on the dimensions of context proposed by Hatim and Mason (1989) and add new subthemes to reflect recent studies.⁶ Particularly relevant to this study is that in addition to Hatim and Mason’s (1989) main categories of extralinguistic and linguistic factors, Zhang *et al.* add subthemes under the semiotic dimension to include multimodality and semiosis in translation. O’Halloran, Tan and Wignell (2016) highlight the link between intersemiotic translation and multimodality. They point out that ICTs have accentuated multimodality in intersemiotic translation as they have broadened the array of modes of information exchange and transfer. As a result, citing Kourdis and Yoka (2014) and other scholars, they point out that Jakobson’s (1959) definition of intersemiotic translation has since expanded to include translation from one non-verbal system to another, which has been made possible by multimodality enhanced by new technologies. They call this process resemiotisation. In the same vein, Paltridge (2012) points out that: “When people communicate with each other, thus, it is seldom done by one means of communication alone, that is, language. They most

⁶ The bibliometric survey done by Zhang, Pan, Chen and Luo only included scholarship published on DA in English. It therefore excludes some early (1960s and 1970s) important contributions in French, German and Italian focussing on the semiotics of discourse.

typically draw on a number of modes simultaneously, such as images, gesture, gaze and posture – as well as language” (Machin 2007; Jewitt 2009 cited in Paltridge 2012: 171). Given the multimodal nature of the translation products selected for this study, I use a variety of approaches to explore public health communication taking into account the social and cultural context in which these forms of discourse are used, reflecting different beliefs and views of the world.

1.5 Methodology

The present research is a qualitative, descriptive, and exploratory case study. I chose a case study because it was the method that best lent itself to answer the study’s central and peripheral questions. Responding to the central question “How is translation practiced in a developmental context?” required taking a closer look at translation practices in a specific, limited area (both in terms of geography and subject) within the defined context of study, that is, a developmental context.

Public health communication was chosen as the study’s subject area because health is one of the leading development issues globally and specifically in the geographical area of focus. Within the area of public health communication, the study was restricted to communication intended for the general public and excluded health communication between health care professionals and members of the public.

The essence of a case study is to examine or investigate any given phenomenon through one or more specific cases or examples. The idea is that, by exploring these few cases, some important insights on the phenomenon or phenomena under study will be gained or confirmed. Typically, a

case study will focus on only a few cases, which are studied in significant detail (Gerring 2007). Susam-Saraeva (2009) posits that in TS research

[a] case is a unit of translation or interpreting related activity, product, person, etc. in real life, which can only be studied or understood in the context in which it is embedded. A case can be anything from a translated text or author, translator/interpreter, etc. to a whole translation institution or source/receiving system. (40)

Although a case study focuses on a limited area, its distinct advantage is that it provides for an in-depth analysis of a specific phenomenon and therefore results in qualitative data that is richer and more meaningful. Although not always generalizable, information obtained from a case study can be applicable or transferrable to other cases or can provide a basis for further exploration of an issue.

This study describes in detail the context of a particular case—public health communication in Zambia—and establishes a link between the social context and the practice of translation. I borrow from Geertz’s notion of “thick description”, in turn borrowed from Gilbert Ryle (Geertz 1973; Susam-Saraeva 2009).

Given the central and peripheral research questions enumerated above, I concluded that one of the best ways to observe how translation was practiced or how it behaved in this specific context was to look at the translation products of public health communication. My primary source of information was therefore actual communications of various formats, that is, textual, visual, and audiovisual communications. Once I had identified what types of sources would be my primary sources of information, I set out to collect the data. I first did a preliminary search online to get a

feel for what kind of materials had been produced in public health communication. Drawing on Jakobson's three types of translation (intralingual, interlingual, intersemiotic), I took all health communication messages as translated texts (as I explain in greater detail in Chapter 5). Thus, my data collection was not guided by the language of the health messages but rather by the fact that, regardless of the language of delivery, the messages were based on scientific information adapted for a specific audience. That being said, I was still interested in collecting messages in both English and local languages across various formats to gain a wider understanding of the translation practices under study.

The online search was later supplemented by documentation and health messages obtained either in person or through email from various public health communication organizations. As part of my search, I visited several organizations in Zambia with mixed results. I discovered that, since many public health communication campaigns are donor-funded and target specific, many campaigns are short-term, and many had ceased. Moreover, the organizations running many of the campaigns were specifically set up for targeted short-term projects, and, as such, disbanded after the projects came to an end. These factors made it very hard to obtain health messages and permission to use some of the messages that were readily available online. One of the organizations with which I had a lot more success was the *Afya Mzuri* Resource Centre in Lusaka, which was created to house all the health communication materials and documentation produced from the several campaigns that had run in the country up until that time (2014–2016). Other organizations where I had more success were the Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS), Media365, and *Komboni Housewives* largely because they were still active organizations. My initial method of collection was random but, in the end, availability played an important role in selecting the messages that I retained for the study.

In addition to the primary sources of information, that is to say, the actual health communication messages, I consulted a wide range of secondary documentary sources, such as reports, strategic plans, policy documents, statistical reports, books, journal articles, and the websites of reliable organizations, such as WHO, the World Bank, and UN agencies. The secondary data allowed me to gain a better understanding of the socioeconomic and cultural context of my case study and to be able to give a “thick description” of this context.

After collecting the data, my next step was to analyse the health messages. In view of the series of questions that the study sought to answer and in view of the fact that context was an integral part of the study, a contextual analysis seemed to best fit the bill. Contextual analysis draws from discourse analysis, but it analyzes data in view of its historical, social, cultural, environmental, and political context while offering the flexibility of analyzing textual and other aspects of the object of study (Behrendt 2008). I therefore concerned myself with aspects like the target audience of the message, their culture, religion, beliefs, their literacy levels and levels of education, their living and geographic location, their economic status, their language, etc. I also paid attention to the objective of the message as well as the method by which and medium in which the message was delivered.

CHAPTER II

ETHNOLINGUISTIC BACKGROUND

This study focuses on present day Zambia and will, to a lesser extent, also occasionally refer to the southern African sub-region.

2.1 Geographical and historical background

Situated in the southern part of Africa, Zambia is a landlocked country in a region that many history books classify as Central Africa or, more rarely but perhaps more accurately, as South-Central Africa. In his preface to the fourth edition, Wills (1985) has attributed this misnomer to the fact that most regions were named according to how explorers perceived them upon their “discovery” (vii). By the time they reached the areas surrounding the upper Zambezi or—as they called these areas—the “Interior,” European explorers had already reached most of coastal Africa, settled in what is now South Africa, and penetrated the east African region. For this reason, countries such as Zambia, Malawi, and Zimbabwe are sometimes still referred to as being in Central rather than Southern Africa, despite the fact that, as Wills explained, one needs only to look at the map to understand that these countries are all south of the equator, which traverses Africa at roughly its mid-point.

Zambia covers an area of 752,612 square kilometres, with an estimated population of 15 million as of 2016. Much of this oddly butterfly-shaped country sits on an elevated plateau rising 3000 to 5000 feet above sea level. It is bordered to the north-west by the Democratic Republic of Congo; to the north-east by Tanzania; to the east by Malawi; to the south-east by Mozambique; to

the south by Zimbabwe, Botswana, and Namibia; and to the west by Angola (Roberts, Hobson & Williams 2017; cf. Appendix 2: Fig. 1 & Fig. 2).

It is well documented that much of pre-colonial Africa was characterized by mass migrations of various ethnic and linguistic groups as well as by the existence of some well-established empires, such as Great Zimbabwe, the Luba Empire, and the Lunda Empire amongst many others (Griffiths 2005: 11–12). In short, African societies were, prior to colonization, organized mostly according to tribal groupings and had some form of structure. Wills (1985) has attested:

In due course there developed new forms of tribal organization whose principal characteristics were widely diffused and widely similar: a more advanced and complex social/political structure based on the extended family; the possession, under strict control by the tribal authorities, of artificial furnaces for the working of iron, sometimes copper and even gold; the cultivation of crops, of which millet was the most common [...] (14)

In the late 19th century, Scottish missionary and explorer David Livingstone undertook three expeditions in the central and southern African regions. Although history informs us that prior to this, Portuguese explorers and Arab traders had interacted with this part of Africa, it was largely due to Livingstone's expeditions that the Western world gained better knowledge of the central and southern African interior. Livingstone's explorations, coupled with the establishment of Cecil Rhodes' British South Africa Company (BSAC) in the southern African region, marked the beginning of Great Britain's interest in the area.

This interest culminated in Great Britain's colonization of Zambia (and other countries in the region, namely, Malawi, Zimbabwe, Botswana, South Africa, Swaziland, and Lesotho),

following the Berlin Conference of 1884–1885.⁷ With permission from the British government, the British South Africa Company, which had obtained mining rights from local chiefs, began in 1889 to administer what was initially two separate regions of present day Zambia, namely North-Eastern Rhodesia and North-Western Rhodesia. The two regions were later merged to form Northern Rhodesia in 1911. In 1923, the British South Africa Company relinquished control of the territory, which in 1924 became the British protectorate of Northern Rhodesia and was formally administered by the British Colonial Administration Office (Kambidima 2010: 8). Northern Rhodesia obtained independence from Britain on October 24, 1964 when it officially became the Republic of Zambia.

2.2 Ethnic and linguistic diversity

Scholars have argued about the difference between the terms “ethnic group” and “tribe,” and many have concluded that there is no significant difference between the two. Because the word “tribe” is fraught with colonial baggage, many historians, scholars, and politicians avoid using it and instead prefer the more accepted term “ethnic group.” However, in Africa, it is not uncommon to hear the term “tribe” used in place of “ethnic group.” As MacArthur (2013) elucidated:

While most contemporary historians shy away from the term, due to its imperial roots and primordial implications, “tribe” has rarely represented a problem for self-description within African patriotic discourses. Indeed, the idiom of “tribe” has proved incredibly durable despite the vilification of its twin head “tribalism.” (352)

⁷ In what is known as the “Scramble for Africa,” European countries arbitrarily divided up Africa into 53 countries, without any regard for cultural or linguistic differences.

The question of ethnicity is a complex one. Anthropologists, ethnographers, politicians, and scholars from diverse fields have studied several aspects of ethnicity and its impact on mankind. In some regions, added to this complexity is colonialism and its legacy of division, which makes for some very complicated situations that have often led to long-term conflicts and wars. Ethnicity has indeed threatened the very existence of some nations and has been at the core of social, economic, political, and linguistic turmoil in many others:

Ethnicity is more than skin color or physical characteristics, more than language, song, and dance. It is the embodiment of values, institutions, and patterns of behavior, a composite whole representing a people's historical experience, aspirations, and world view. Deprive a people of their ethnicity, their culture, and you deprive them of their sense of direction or purpose. (Deng 1997: 28)

Even though African nations were a creation of the colonial enterprise, the African leaders of the newly independent states⁸ made a bold decision at the formation of the then Organization of African Unity (OAU) in 1963; they upheld all the pre-colonial states as they had been partitioned by the European colonial powers at the Berlin Conference of 1884–1885. African countries have

⁸ Largely influenced by the Pan-African movement in the United States of America, the Organization of African Unity (OAU) was created on May 25, 1963 in Addis Ababa, Ethiopia and was initially comprised of 32 countries. All 53 African states later became members. Morocco withdrew in 1984. The main purpose of the OAU was to promote unity and solidarity among African states and to fight against colonization and ensure that all African states gained independence and the right to self-determination. It was dissolved in 2002 and replaced by the African Union, whose objective was to be a more forward-looking organization that would focus on the development of Africa and its integration. At OAU summits in the 1990s, African leaders began to look at the possibility of transforming the OAU into an organization that would better respond to the challenges facing African nations in the 20th and 21st centuries. The idea was to move beyond the postcolony and take charge of the continent's development. (African Union n.d., retrieved from African Union website <https://www.au.int>, accessed April 10, 2017)

thus inherited very ethnically, culturally, and linguistically diverse nations, and multilingualism is a common feature of African states across the continent.

The OAU's 1963 decision has, to some extent, mitigated the possibility of more ethnic conflicts on the continent and has provided a channel through which such conflicts are resolved. As Deng (1997) has aptly summarised, the "decision by the Founding Fathers of the Organization of African Unity to respect the colonial borders established a normative principle that has been followed with remarkable success. Secession movements have met with strong resistance from the OAU" (28). That being said, how a country has managed its ethnic and linguistic diversity has often determined its outcome. Some countries have not fared too badly, while others have descended into full-blown, ethnically motivated civil wars or genocide, as in the case of Rwanda in 1994. At the root of ethnic conflict is always the lack of or unequal access to a nation's resources.

According to many sources, Zambia is said to comprise over 70 ethnic and linguistic groups. Almost all are from the Bantu group, which, according to historians, migrated from western Africa during the Bantu expansion and settled in most of the area east of Cameroon, spreading across most of eastern and southern Africa.⁹ Although the official number of languages in Zambia is 72, many of these are not active, and some have even been designated as endangered languages by UNESCO (Christopher 2010). Others may be classified as dialects, although this has been a controversial subject.

Kambidima (2010) has identified three clusters of migration into present-day Zambia according to when these groups arrived and where they came from: the 16th century and earlier from the Great Lakes region; between the 17th and 18th centuries also from the Great Lakes region

⁹ According to some historians, a few might be from the Khoisan group, who are believed to have occupied the territory before being displaced by the Bantu.

and through present-day Democratic Republic of Congo;¹⁰ and the 19th century mostly from present-day South Africa. He has counted 24 ethnic groups in the first cluster, 36 in the second, and 18 in the third. His study gives us insight into the geographical distribution of Zambia's language map. It also provides insight on how the language map, along with colonialism, impacted the statuses of the different ethnolinguistic groups and how some languages came to be more widely spoken than others (4–7).

When the BSAC set up shop in southern Africa, it needed labourers to work in the mines in South Africa and Southern Rhodesia (present-day Zimbabwe). To compel Africans to work in the mines, the Europeans imposed a poll tax on the African population. The only way the Africans could raise money to pay the tax was to seek jobs in the mines. Many young African men from Northern Rhodesia (present-day Zambia) and Nyasaland (present-day Malawi) had to leave their families and community-based lives in the villages and rural areas and travel long distances to look for work in the mines in South Africa and Southern Rhodesia. Later, when the copper mines in Northern Rhodesia's Copperbelt Province opened in the 1920s under British colonial rule, native Northern Rhodesians could get jobs in mines that were closer to home. However, there were still not enough Africans in the areas surrounding the Copperbelt Province to work in the mines, so the colonial authorities encouraged native Zambians from other parts of the country to go and work there. During this time, there was a huge influx of native Zambians from the rural to urban areas. Because Zambia is a landlocked country, a railway was built to transport copper for export through ports such as Dar es Salaam, Beira, Durban, Maputo, Walvis Bay, Nacala, and Lobito Bay. The railway line runs from the mining towns in the Copperbelt Province (Chililabombwe, Chingola,

¹⁰ Most of the 36 ethnic groups in this second wave of migration into Zambia temporarily settled in present-day Democratic Republic of Congo and are thought to have been part of the Luba and Lunda Kingdoms (Kambidima 2010 5–6).

Mufulira, Kitwe, Ndola, Luanshya) through the capital city, Lusaka, to Livingstone on the southern border with Zimbabwe. All economic activity was concentrated in the towns along the railway line, and, as people from the rural areas flocked to these towns to find work, these towns became the country's urban centres (Banda 1996: 110; cf. Appendix 2: Fig. 3).

This urban migration had a significant impact on Zambia's sociolinguistic map, because the people converging in the urban centres were from diverse ethnic groups. Whereas ethnicity was the single most important unifying factor in the rural areas, language became the most important unifying factor in the urban areas. Ethnic groups, such as the Bemba in the northern part of Zambia, migrated to the Copperbelt to work in the mines in greater numbers than did other ethnic groups from other parts of the country. Bemba or ChiBemba thus became a lingua franca on the Copperbelt as well as in Kabwe, another mining town in the Central Province (Posner 2003: 136).¹¹

There were reasons other than the colonial administration's drive to recruit people from the northern part of the country for the influx of northerners to the Copperbelt and Kabwe:

A number of factors having nothing to do with government policies ensured that migrants from the Bemba-speaking heartland would be easy to attract. Poor soils, the presence of the tsetse fly in much of the area, and the great distance that agricultural products had to be transported to the rail line ruled out cash cropping and animal husbandry to earn money to pay taxes. Also, because of the dearth of European settlers in the area, local cash employment opportunities were limited. Thus, to an even greater degree than in most other regions residents of the northeast had few alternatives to labor migration. (Posner 2003: 137)

¹¹ Most Bantu languages add a prefix to the name of an ethnic group to denote the language. In this case, *chi* (or sometimes *ici*) is added to indicate that it is the Bemba language that is the subject of discussion and not the ethnic group. A different prefix is used to designate the people, e.g. *abaBemba* (also *baBemba*) meaning the Bemba people.

2.2.1 Ethnicity and policy

While Zambia's current sociolinguistic landscape was shaped by factors such as the migration patterns of the Bantu peoples as discussed above, it was also molded by policies implemented by both the colonial and post-independence governments. For this reason, the following two sub-sections look at some of the most significant colonial and post-independence government policies surrounding language.

2.2.1.1 Colonial policies

When Christian missionaries first came to Africa, their main mission was to proselytize. The only way they could do this was by learning some of the African languages. They subsequently translated the Bible and produced some Christian literature (such as catechisms) in some of the more widely spoken African languages. In order to teach the Gospel and produce the tools required for the task, the Christian missionaries had to transcribe the African languages they learnt and intended to use in their mission. They also had to produce grammars and dictionaries. Since there were several languages spoken by the African populations across the territory, the Christian missionaries had to be strategic in the way they set up their mission posts. They chose to set up stations in the areas where a significant number of people spoke and understood a common language, whether it was their mother tongue or not. The missionaries would then produce grammars, dictionaries, and catechisms in these languages and use them to proselytize. Moreover, missionaries often used these same languages to teach even neighbouring villages that spoke dialects that were close enough to the chosen language. The effect that these practices had was the further spread of the languages used by the missionaries. In colonial Northern Rhodesia, four languages emerged as the most widely spoken languages in specific geographical areas of the

country: Bemba (ChiBemba) in the north, Nyanja (Chewa or ChiChewa) in the east, Lozi (SiLozi) in the west, and Tonga (ChiTonga) in the south (Posner 2003: 130–131).¹²

Posner (2003) has pointed out that although these four languages are the most widely spoken in the country, they are spoken not only by native speakers but also by a significant number of second-language speakers. Multilingualism in Africa is a necessity, so it is not uncommon for people to speak two or three or more languages. Of the four languages, ChiBemba and ChiNyanja are the most widely spoken to the point where the former is a lingua franca not only in the northern region, but also on the Copperbelt and in parts of the Central Province. Meanwhile, ChiNyanja is a lingua franca in the eastern region of the country and the capital city, Lusaka. It is necessary for most Zambians to learn one of these two languages in order to communicate in most of the urban areas (cf. Appendix 2: Fig. 4 & Fig. 5).

In addition to their primary role as teachers of the Gospel, Christian missionaries were involved in providing education to the native African population. They ran many schools in Zambia until 1925, when the British Colonial Administration Office took over the running of the country. Posner (2003) states that the colonial government then decided to offer education to the African population in only the four most commonly spoken languages: ChiBemba, ChiNyanja, SiLozi, and ChiTonga. They claimed that it would be too complicated to produce the literature needed for teaching in more than just the four languages due to Northern Rhodesia's multiplicity of dialects. Therefore, in 1927, English and the aforementioned languages became the official languages of instruction for African education in Zambia. Even adult literacy classes were

¹² Nyanja or ChiNyanja is more commonly known as Chewa or ChiChewa in Malawi.

conducted in these languages. The growing popularity of education among the African population¹³ made these four languages even more important (Posner 2003: 132).

Perhaps of more significant importance than the formal education sector was popular media because it reached a wider audience. In 1936, to counter anti-government publications from some religious groups (such as the Watch Tower Movement), the colonial government launched a newspaper called *Mutende*, which was published in ChiBemba, ChiNyanja, SiLozi, and ChiTonga.¹⁴ Later, monthly publications that were produced in English by the mining companies for their workers also began to carry some stories in ChiBemba and sometimes ChiNyanja. Meanwhile, the radio too began to have a significant role. Posner summed up the importance of radio broadcasting in language consolidation as follows:

Even more important than newspapers was radio broadcasting. Thanks to the invention and rapid proliferation of the “Saucepan Special,” an inexpensive battery-operated radio set developed specifically for the Northern Rhodesian African population, thousands of Africans had access to radio in Northern Rhodesia by the 1950s. Largely because it knew it had such a big audience of African listeners, the Northern Rhodesian Broadcasting Service was the first radio service in Africa to allocate significant air time - fully 72 percent in 1952 - to programming in vernacular languages. Bemba, Nyanja, Tonga and Lozi were chosen, with English, as the languages of Northern Rhodesian broadcasting. Because radio reached such a large population, the choice of these languages had a critical impact on patterns of language consolidation in the country- more, in all likelihood, than the educational system, which directly touched fewer people. (Posner 2003: 133)

¹³ Enrolment increased from 25% of school-aged children in 1924 to 75% in 1945.

¹⁴ *Mutende* means “peace” in ChiBemba.

2.2.1.2 Post-independence policies

In a bid to promote unity and integration and to discourage tribalism, the independence forefathers, led by first president, Kenneth Kaunda, opted to designate English as the official language of the newly independent state. In addition, they named seven local languages—that is, Bemba, Nyanja, Tonga, Lozi, Kaonde (KiKaonde), Lunda (ChiLunda) and Luvale (ChiLuvale)—as “national languages” to be used in the lower courts and police stations as well as in various fora, such as the media. The seven languages were chosen with the aim of covering all geographical areas of the country and for their status as languages of wider communication (Posner 2005; Marten & Kula 2008).¹⁵

Thus nationalism, unity, and identity were the main drivers of the decision by many African leaders to adopt the European languages of their erstwhile colonial masters as official languages at the time of independence. There are a few exceptions to this. For example, Tanzania’s founding father, Mwalimu Julius Nyerere, chose to adopt Kiswahili, the lingua franca commonly used in East Africa, as the official language of Tanzania alongside English. Nyerere is known to have been a strong advocate for African languages. He even translated two of Shakespeare’s plays, *The Merchant of Venice* and *Julius Caesar*, into Swahili.

Larmer (2011) has criticized scholars of history and social science for ignoring the complexities of forging new nations from disparate groups, complexities that existed for most African nations at the time of independence. He notes that most historians and social scientists, in their enthusiasm about independence, downplayed the arduous task that was synonymous with

¹⁵ Kaonde, Lunda, and Luvale were added to the four languages that were initially used as media of instruction in African schools in the colonial days, mainly because they are all spoken in the North-Western Province, which had no representation among the four languages. It is said that not one of the three languages is more dominant than the other two because the North-Western Province had relatively fewer missionary settlements than the rest of the country, in other words, because there was no external force promoting one language over the others as was the case in the rest of the country (Posner 2005).

nation-building. He points out that, although there had been some unity among the African populations in the run-up to independence, there had also been a lot of differences. People were divided in various factions, mostly along ethnic and linguistic lines, and, for the most part, came together only for the common goal of attaining independence.

Zambia was no exception to this. In the period leading up to independence, there were a few political parties formed by African leaders representing diverse interests. Kaunda's party, the UNIP (United National Independence Party),¹⁶ drew most of its support in the Northern, Luapula, and Copperbelt provinces; in the capital city, Lusaka; and in other urban centres. Another significant political party, namely, the African National Congress (ANC), drew most of its support in the Southern Province (perhaps because it was led by Harry Mwaanga Nkumbula, who was a southerner himself) and had some support in the Western and Central provinces. Meanwhile, in the west, the Lozi people led by their king, the Litunga, wished to secede as the kingdom of Barotseland and to not be part of the independent nation of Zambia.¹⁷ At independence, Kaunda clearly inherited a rather divided nation, and unity inevitably became the cornerstone of his policies.

Politicians and many linguists who have studied various aspects of the language situation in Zambia have emphasized that the decision to make English Zambia's official language was justified by the new nation's evident multiplicity of languages. While this explanation may be true,

¹⁶ UNIP, with Kenneth Kaunda as president, formed the first government of an independent Zambia on October 24, 1964. UNIP and Kaunda remained in power for 27 years. In 1991, Kaunda lost the first multi-party election in Zambia since 1972, when Kaunda had turned Zambia into a one-party state.

¹⁷ During the colonial days, the Lozi managed to keep some form of autonomy through agreements that were signed between their king, the Litunga, and the BSAC and later the British. They were, for example, able to keep a percentage of the tax that was imposed on Africans. To this day, there are still some groups of activists among the Lozi who advocate for secession. It is said that the original Barotseland covered the present-day Western and North-Western provinces of Zambia as well as the Copperbelt Province. It also extended across the border into parts of present day Namibia and Angola and the Katanga Province in the Democratic Republic of Congo. Although the Lozi are the dominant ethnic group in the area, there are also several other ethnic groups in the Western Province and the larger Barotseland area such as the Nkoya and the Mbunda.

it does not tell the whole story, as Larmer (2011) has rightly pointed out. Adopting a supposedly “neutral” idiom—English in this case—as the official language was politically advantageous to Kaunda and UNIP (Larmer, 2011). Given the ethnic, linguistic, and socioeconomic¹⁸ heterogeneity of the country, Kaunda sought to solidify his legitimacy as leader by emphasizing unity and discouraging any talk of ethnic identity and tribalism. To this end, he adopted the national motto “One Zambia, One Nation” and devised a system which he called tribal balancing. This, in effect, allowed him to strategically allocate cabinet and other important government positions in such a manner that every province was represented and no one ethnic group or linguistic community dominated. Larmer (2011) has noted that, although this system appeared to work outwardly in the sense that it avoided open tribal conflict, it didn’t exactly stop ethnic affiliations and sentiments among the population. Like Larmer (2011), Kahombo Mateene, the Organization of African Unity’s head of language policy in the 1980s, rejected the notion that diversity in language was a threat to national unity. He gave the example of India, which, although it is one of the world’s most linguistically diverse countries, has had less conflict than Rwanda, Burundi, and Somalia, which are far less linguistically diverse (Mateene 1999: 165–166). Mateene suggested that the unity card was basically a smoke screen used by politicians to mask the real (political) reasons for their reluctance to recognize diversity.

Perhaps more consequential than the adoption of English as Zambia’s official language was the decision (also made at independence) to make English the main language of instruction in all schools and to have the seven national languages taught as subjects in schools in their respective geographical areas.¹⁹ This decision was clearly a shift from the colonial policies and can be

¹⁸ The country was socioeconomically heterogeneous because some areas had been more developed than others since they were more important and useful to the colonizers.

¹⁹ A team of Australian experts commissioned by UNESCO reviewed the Zambian education system at independence and recommended that Zambia adopt English as a medium of instruction in schools. This

attributed to several factors, including the fact that English and education had become status symbols and were highly sought after:

At the time of independence in 1964, Zambia inherited an exceptionally weak educational profile. According to O'Brien "Zambia had fewer skilled and educated citizens than virtually any other ex-colony". In 1963, there were about 100 university graduates and under 1,000 secondary school graduates. With her sophisticated copper industry Zambia had a great need for skilled personnel. In addition to the shortage of manpower, there was also a general problem which usually accompanies big political changes like independence, namely the desire on the part of the government to do something different from the previous regime. In this case, the government embraced the tenets of the welfare state and quickly introduced a free public school system. In the predominantly illiterate society that Zambia was in the sixties, education was among the most prized social services, especially because it was directly related to upward social mobility, and demand for it was predictably high. (Lungu 1985: 289)

English acquired an "elite" status. It was the language of government and commerce, and its mastery became synonymous with success. Citizens did not need to be persuaded to learn in a foreign language. They did it happily and willingly in the belief that this was what would afford them the opportunity to have a good education and subsequently a good job. In light of this development and with the legacy of colonialism, local languages took a back seat.

It did not take long, however, for the problems associated with the language of instruction to begin to surface. Many studies carried out in the two or three decades following independence revealed that Zambia had a literacy and reading problem. One of the more significant studies commissioned by the then British Overseas Development Administration (ODA) and carried out

recommendation was supported in 1965 by the *Hardman Report*, which was produced by a UK language expert researching the issue of teaching English in primary schools (Linehan 2004: 2).

by the University of Reading in 1993 revealed that a clear majority of students selected for the study had reading skills two levels below their grade in both English and ChiNyanja, the Zambian language chosen for the study.²⁰ In comparison with a similar study that was carried out in Malawi among students whose language of instruction was ChiChewa, the Zambian students fared much worse.²¹ Moreover, the results showed that, although the medium of instruction for the Malawian students was ChiChewa, their English reading skills seemed to meet an acceptable standard and did not seem to be affected by the fact that ChiChewa was their medium of instruction. Another important study, which was commissioned by the Zambian Ministry of Education and conducted by the Southern African Consortium for Monitoring Educational Quality (SACMEQ) in 1995, also revealed very low reading levels among the students tested (Linehan 2004: 3).

The results of these studies were disconcerting. After all, as Matafwali and Adriana (2014: 130) have postulated, several studies the world over have demonstrated that sound literacy skills are the basis of any kind of learning and that the language in which these skills are acquired is of cardinal importance. Study after study has shown that acquiring literacy skills in one's mother tongue or most familiar language not only facilitates the task of gaining literacy but also helps the learner to grasp concepts in other subject areas and even in learning a second language.

To respond to this problem, the Zambian Ministry of Education (MOE) has embarked on several education reforms over the years and has moved from a "status quo" position in the 1970s to a more proactive stance in the last decade. Nevertheless, there is a lack of political will to implement the changes that have been recommended by the myriad studies and advice from linguists and experts. In the 1977 education policy document, the MOE acknowledged that the

²⁰ ODA was superseded by the Department for International Development (DFID) in 1997.

²¹ ChiNyanja and ChiChewa are basically the same language with some regional variations. In Zambia, the language is commonly known as ChiNyanja, and, in Malawi, it is called ChiChewa.

straight-for-English approach that had been adopted at independence had been problematic. However, in a nine-point ramble, the ministry set out to justify why the status quo would be maintained. Reasons for this decision ranged from the impracticality of teaching a child in his mother tongue in a multilingual society such as Zambia to the claim that, since the medium of instruction in higher grades was English anyway, exposing the child to it earlier would be better. Some of the reasons presented, such as the need to develop content and train teachers, were valid, but most did not hold water. A case in point is the idea encased in the following statement from the MOE:

There are certain concepts in Mathematics, Science and Technology, for instance, which cannot be expressed precisely in any of the Zambian languages at the present, simply because such concepts and the technical terms used have no equivalents in the Zambian languages or for which the equivalents are imprecise, inadequate and perhaps completely misleading. (1977: 33)

In 1977, the government was reluctant to make any meaningful changes mostly for political reasons. Due to the status that English had acquired in Zambia and the people's views towards it, the government was unwilling to ruffle any feathers by proposing what they perceived would be an unpopular policy change. Instead, the ministry settled on a meaningless and loose compromise, which would allow teachers to use the seven local national languages to explain some difficult concepts to students provided all the students understood the language the teacher would use.

In 1991, another significant attempt at language policy reformulation came in response to the 1990 World Conference on Education for All in Jomtien, Thailand. The proposed policy, *Focus on Learning*, recommended that the major Zambian languages be adopted as media of instruction in grades 1 through 4. The policy was proposed in 1992 but was still not implemented in 1995. In

1996, an election year, the government of the day made it clear to the MOE that they preferred not to implement the policy as it was. Subsequently, the policy was re-focussed and presented as a literacy policy that allowed basic literacy skills to be taught in the familiar local languages and all the other subjects to be taught in English, as before (Linehan 2004).

While several scholars, researchers, and policy makers have linked education and development, Williams (2011) has pointed out that there doesn't seem to be any proof that the use of European languages as media of instruction in African countries has helped the development agenda. In fact, to the contrary, it has, in his opinion, curbed human development by jeopardizing Africa's chances of producing an adequately educated citizenry. Williams (2011) has posited that the populace in most African countries (Zambia included) has, for the most part, been complicit in aiding politicians to make the wrong policy decisions concerning language. He expresses skepticism about the so-called unifying force of English that is pushed by politicians and charges that it serves only to perpetuate existing inequalities in many African nations:

While opting for English may have succeeded in preventing conflict in the educational arena between competing language groups, and while its dominance in the same arena is largely welcomed by the public, the language has, however, created division between, on the one hand, those who have good access to it, typically members of the reasonably well-off urban groups, and, on the other hand, those who do not, typically the members of poor urban and especially rural groups. (Williams 2011: 7)

He quotes Kayambazinthu (1999: 52), Heugh (1999: 306) and Myers-Scotton (1990) to support his point. On a similar note, Lungu (1985) pointed out that, although services such as education affect the whole population regardless of social status, the elite heavily influence policy decisions in Zambia, and their influence is, of course, based on what is advantageous to them and

not necessarily to the whole population, particularly the less-privileged. Suffice it to say that a local-language-of-instruction policy would benefit mostly those who do not have access to elite schools and the English language; in other words, such a policy would little benefit the elite.

Although politics has played a huge part in language policy decisions in Africa, linguists and researchers have also played a very significant role through advocacy and the provision of scientific data. International organizations and institutions, such as UNESCO and the African Union, have been instrumental not only in influencing policy and decision makers but also in generally increasing the profile of African languages on the continent. After the re-introduction of multi-party politics in Zambia in 1991, the new and successive governments were more open to the idea of local languages as media of instruction in schools. While political will was lacking in the beginning, there was at least some recognition of the importance of such a policy and a more concerted effort to get it implemented.

During this period, the MOE, with the support of some donor agencies, implemented the Primary Reading Programme (PRP). Under this intervention programme, the ministry ran a few pilot projects, such as the New Breakthrough to Literacy (NBTL) course, whose aim was to teach literacy skills in the seven Zambian national languages to first graders in selected schools and regions of the country. Linehan (2004), quoting Kotze and Higgins' (1999) evaluation report on the project, asserted that the "programme was an unqualified success; children in *Breakthrough to Literacy* (BTL) classes were reading and writing at a level equivalent to Grade 4 or higher in non-BTL classes" (4-5).

It was against this backdrop that, in January 2014, the MOE, with the support of the government at the time, finally implemented two policies: the 2012 *Zambia Education Curriculum Framework* and the 2013 *National Literacy Framework*. These policies essentially paved the way

for the introduction of Zambian languages as media of instruction in most schools from grades 1 to 4 with some exceptions (Chishiba & Manchishi 2016). Of course, there have been some problems associated with the roll out of a programme of such magnitude. Not least among the problems is strong opposition from some parts of society. Other challenges include the criteria for exemption as well as inadequate content and suitably qualified teachers. How successful this policy will be and whether it will achieve its intended goals remains to be seen. Meanwhile, Zambia is currently part of a short list of countries²² that have at least some local languages as media of instruction in schools.

2.2.1.3 Continental policies

Although experiences may differ from country to country, it is safe to say that the issue of language policy has been a rather complex one for most African countries:

[...] a major preoccupation for all ex-colonial African countries has been the formulation of national policies (economic, educational, political, social etc.) considered appropriate to their national mode of development. None of these has proved more difficult to achieve than the formulation of language policies that reflect the complex multi-lingual contexts of these countries. (Kashoki 2003: 184)

The multiplicity of languages in Africa, coupled with the hegemony of the former colonizers' languages, especially English, have made for some very complex situations surrounding the formulation of language policies and the related medium-of-instruction policies. English is seen as the language of globalization and upward mobility, so it is not hard to see why African languages have had a hard time competing even among the African population in the post-colonies.

²² The list of countries also includes Tanzania, Malawi, South Africa, and Zimbabwe.

A recent trend in Africa has been a shift in official languages; countries with a European official language other than English (such as French and Portuguese) have adopted English as an official language. For example, in 1994, Rwanda, a former German and Belgian colony, decided to adopt English as an official language alongside French and Kinyarwanda soon after the genocide.²³ In 2008, Rwanda went on to adopt English as a medium of instruction in schools. Burundi is said to be considering similar moves. Meanwhile, Ethiopia and South Sudan have also adopted English as an official language, although they were not colonized by Britain (Negash, 2011). This trend speaks to the inevitable existence of European languages on the African continent.

For the most part, African linguists, scholars, researchers, and policy makers have accepted this inevitability as one of the legacies of colonialism and have decided to use it to the continent's advantage where necessary. This was the logic behind Chinua Achebe's stance on writing in English.²⁴ This has also been the stance of the African Union (AU), more than the OAU before it. Since inception, the AU has been a strong advocate for the promotion and preservation of African languages and has been supported on the international scene by UNESCO. Rather than seeking to abandon European languages, the AU has very clearly pursued revalorizing and promoting African languages alongside the European languages that the continent has inherited and now considers her own.

Over the years, the OAU and the AU have played a significant role in encouraging African countries to adopt language policies that help to preserve and protect African languages and guarantee the rights of citizens to use their own languages to participate in social and civic activities. Scholars such as Mateene (1999) and Kashoki (2003) have emphasized the importance

²³ As a member of the East African Community, Rwanda has also adopted Kiswahili as an official language.

²⁴ Chinua Achebe was one of Africa's most renowned authors.

of recognizing language rights as human rights. Mateene has stressed that “[i]t would be unjust to have citizens learn a foreign language in order for them to gain access to some essential rights, such as justice, medical care, education, and employment” (1999: 165). Kashoki (2003) has cited the OAU’s *Language Plan of Action for Africa*, which was drawn up and adopted in 1986 as evidence of the paradigm shift in the attitude towards language rights as human rights. He has also pointed to the inclusion of language rights in the constitutions of several African countries, such as South Africa, Namibia, Zimbabwe, Malawi, and Mozambique.

Efforts to develop African language policy began as early as 1930, during the colonial era. The International Institute of African Languages and Cultures (IILAC) in London produced the first edition of the *Practical Orthography of African Languages*, whose aim was to harmonize and simplify the orthography of African languages. Thereafter, when African nations began to gain independence and the OAU was formed, several conferences and meetings produced documents mostly centred on harmonization of orthographies and literacy in African languages. The most significant and comprehensive effort in terms of language policy came in 1986 with the *Language Plan of Action for Africa*. The plan recognized the importance of African languages as media of communication and decried the dependence of Africa on European languages. It identified some priorities in terms of language planning, which included encouraging the formulation of language policies in all member states as a priority. Several meetings, charters, and declarations followed, and the efforts continued as the OAU transitioned to the AU.

Of particular importance was the establishing of the African Union Academy of African Languages (ACALAN) in 2006 in Bamako, Mali. ACALAN was initially created by the Malian government in 2001 and was later adopted by the AU as its specialised agency for languages. The

idea behind the creation of ACALAN was to have an agency that would be “mandated to develop and promote African languages” (Bamgbose 2016).²⁵

ACALAN was created because all the efforts and meetings concerning language policy and planning conducted under the auspices of the OAU had yielded very few results; it was clear that a different approach had to be used. The idea was that ACALAN would be given a more significant mandate to lead the development and promotion of African languages, and that this mandate would be supported by policy and a higher level of engagement from member states. ACALAN’s vision and mission as stated on its website is “[f]ostering Africa’s integration and development through the development and promotion of the use of African languages in all domains of life in Africa.” Its core values are to respect the cultural values of Africa while recognizing her cultural and linguistic diversity. ACALAN notes that before colonialism, African languages were the mode of communication among its peoples, despite their diverse languages, cultures, and beliefs. After foreign languages were imposed as part of the colonial enterprise, African languages lost their status and were relegated to a very low rung. In light of these observations, ACALAN seeks to “reposition, revalorize and empower” indigenous languages in Africa and encourage their use in all domains. According to the ACALAN website, one of the main reasons for the failure of past efforts was the lack of a central body to oversee and guide the implementation of all the proposed policies and plans. ACALAN’s purpose is therefore to be the body that would bring together people with the necessary experience and expertise supported by a sufficient level of funding for the task (Bamgbose 2016).

ACALAN hopes not only that African languages will be used more in education and literacy but also that they will be used more in social and political circles as well as in all spheres of life in

²⁵ Available online at <http://www.acalan.org/index.php/en/> accessed May 9, 2017

general. Bamgbose (2016) has supported this idea, positing that indigenous languages can be a powerful tool for development as they encourage more participation by the citizens in the development process. He has given the example of Kenya and Tanzania, where Kiswahili is widely used and where the populace has demonstrated wider participation in the political process.

Operational for almost two decades, ACALAN has worked on numerous projects. As one of the first projects, the 1986 OAU *Language Plan of Action for Africa* was revised by Professors Maurice Tadadjeu and Salam Diakité in 2004 (Alexander 2008: 263). The following six major projects have also been launched and are still ongoing:

- **Stories Across Africa (STAAF)**

This project works to produce collections of stories for children in various languages. The idea is to encourage literacy by collecting old and new folk tales and to adapt, translate, illustrate or rewrite them for the enjoyment of African children.

- **African Languages in Cyberspace**

This project was launched in response to a workshop held in Bamako in 2006 and in response to the second phase of the World Summit on the Information Society (WSIS) in Tunis in 2005. Its objective is to help coordinate the presence of African languages in cyberspace.

- **Pan-African Master's and PhD Programme in African Languages and Applied Linguistics (PANMAPAL)**

Introduced in 2006 in three African universities (the University of Yaoundé 1, the University of Cape Town, and Addis Ababa University), this programme aims to develop a pool of qualified researchers and scholars specializing in different aspects of African languages. The first phase of the project ended in 2010. ACALAN has plans to expand the programme to more countries across the continent.

- **Pan-African Center of Interpretation and Translation / Terminology and Lexicography Project**

These projects were set up to train dictionary and terminology compilers and provide related services.

- **African Linguistic Atlas Project**

This project aims to produce a consolidated and updated linguistic map of Africa based on the information that is already available from some countries and institutions. Although it is well known that over 2,000 languages are spoken on the African continent, information has sometimes been scanty and is often not updated to reflect issues such as which languages are endangered, and which have become extinct (ACALAN 2016; Alexander 2008, 2009).

The present chapter has outlined Zambia's historical and current ethnolinguistic situation, which provides an important context for the study. It highlights the interplay between ethnicity and politics that has shaped the country's sociolinguistic landscape and that is largely responsible for its current linguistic profile. Building upon the ethnolinguistic backdrop that this chapter has provided, the next two chapters will provide a contextual background of the Zambian health environment. As this research focuses on translation practices in public health communication, the next chapters will also shed light on the interaction between language, health, and society.

CHAPTER III

HEALTH AND DEVELOPMENT

Explaining why health is such an important development issue, this chapter gives an overview of the relationship between health and development. It also provides insight into the health sector in Zambia, discusses the main points of Zambia's health policy, and highlights the most important health challenges that impact health communication in the country.

3.1 The development context

At its inception, the World Health Organization (WHO) (1948) defined health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.” Since then, WHO has, through its many activities and programmes, endeavored to work towards the attainment of this health standard for everyone. Although many successes have been scored over the years as evidenced by the eradication of some diseases (e.g. smallpox) as well as by the improvement of health standards and life expectancies, global inequalities in health conditions have continued to exist. It was for this reason that WHO adopted a Health for All (HFA) policy and primary health care approach in the 1970s. The goal was to achieve health for all by the year 2000, and the organization aimed to do so by focusing more on public health than on specific diseases.

At the Alma-Ata International Conference on Primary Health Care in 1978, WHO adopted five resolutions that marked this new approach to international health. The shift was clearly reflected in the resolution which stated that health equity was part of development and social

justice (Koskenmaki, Granziera, & Burci 2009: 25). According to WHO (WHO 1978 in Koskenmaki *et al.* 2009), health is a fundamental human right which directly impacts economic and social development. Moreover, vulnerable groups such as women, children, the poor, and the marginalized should be identified and prioritized. In 1998, the World Health Assembly reaffirmed these earlier declarations about the importance of health in social and economic development.

One of the most important resources that a nation has is its human capital. In fact, economists named human resources as one of the essential parts of economic development (Bloom & Sachs 1998; Savvides & Stengos 2009; Manuelli 2015). For a country's human capital to reach its full potential and function at full capacity, the country's people must be healthy. When a person suffers from a health-related issue, their ability to be productive suffers and adversely affects their livelihood and that of their close family members. When poor health leads to the death of a family's breadwinner, the futures of the surviving members of the family may be seriously affected. In cultures where emphasis is placed on the extended family, the death of a breadwinner may threaten the livelihoods of more than just one family. It follows that, for a nation to obtain maximum benefit from its human resources, it has to invest in the health of the latter. As Bloom and Sachs succinctly put it:

[. . .] investments in health are increasingly recognized as an important means of economic development and a prerequisite for developing countries – and, in particular, for poor people within those countries – to break out of the cycle of poverty. Indeed, there is evidence that investments in health can have positive economic returns. (1998, in Dodd & Cassels 2006: 384)

That health is an important aspect of development holds true whether one adheres to the economic-indicator-based models of development or the human-based models. It is unsurprising then that many scholars have linked health to poverty. People who are poor are more likely to suffer ill health, are disproportionately affected by some health issues (notably communicable diseases), and are less likely to have access to adequate health care. The link between health and poverty is just one of the many reasons why health is such an important development issue. In addition to poverty, other factors—such as low levels of education, the status of women in society, inadequate access to clean air and water, and compromised food security—also predispose the poor to ill health. Meanwhile, poor health can actually lead to bankruptcy and poverty when an individual has to spend large sums of money on health care and when they are unable to provide a decent livelihood for themselves and their family (Dodd & Cassels 2006). It is against this backdrop that UN agencies such as WHO, the United Nations Development Programme (UNDP), the United Nations Children’s Fund (UNICEF), The Joint United Nations Programme on HIV/AIDS (UNAIDS), and the United Nations Population Fund (UNFPA) have made equity the bedrock of their agenda (Dodd & Cassels 2006; Koskenmaki *et al.* 2009).

WHO’s aforementioned shift in focus continued into the 1990s. Coupled with other events (notably the onset of the HIV/AIDS pandemic in the early 1980s), this new approach influenced the work of researchers and scholars; world leaders; other UN agencies; and international organizations, such as The Global Fund and the Bill and Melinda Gates Foundation. With health now at the front and centre of the development agenda and with a focus on equity, heads of state met at the United Nations General Assembly in New York in September 2000. The meeting resulted in the adoption of the “United Nations Millennium Declaration,” whose principal aim was to reduce poverty in the world. This objective was expressed in what were dubbed the eight

Millennium Development Goals (MDGs), which were to be achieved within 15 years. Reflecting the pivotal role of health in development and its potential to reduce poverty, three of the eight MDGs (MDGs 4, 5, and 6) directly focused on health. Meanwhile, the other five MDGs were linked to health in one way or another. The three MDGs that directly focused on health dealt with issues that affect poor people the most. MDG 4's objective was to reduce child mortality; MDG 5's objective to improve maternal health; and MDG 6's objective to combat, amongst other diseases, HIV/AIDS, malaria, and tuberculosis (UNDP 2015).

The 2015 MDG report indicated that there were many successes scored on all three health-related goals, but that the targets were not met, and some regions of the world continue to face the major challenges the MDGs sought to address. For instance, the report stated that HIV/AIDS, malaria, and tuberculosis have all been reduced, but it acknowledged that Africa remains the region most affected by these diseases. In short, the report recognized that more work still needs to be done and that awareness remains one of the best methods of fighting these diseases (UN Economic Commission for Africa 2015).

The 2012 United Nations Conference on Sustainable Development in Rio de Janeiro elaborated 17 Sustainable Development Goals (SDGs), which would continue the work begun by the MDGs. The objective was to “produce a set of universal goals that meet the urgent environmental, political and economic challenges facing our world” (UNDP, 2015). The SDGs came into effect in January 2016 and involve a 15-year plan with a 2030 expected end date. Similar in purpose to the MDGs but wider in scope, the SDGs focus on the most pressing development issues of our time, including health.

Some SDGs are a clear continuation of some MDGs. SDG 3, for example, concentrates on health and well-being. While the UNDP applauds the successes achieved by the health-related

MDGs, it has pointed out that there are still too many children who die before their fifth birthday in some regions of the world, notably in sub-Saharan Africa. It has noted that, in most cases, children die from preventable diseases such as measles, pneumonia, tuberculosis, and diarrhoea. Furthermore, it has observed that maternal mortality rates in sub-Saharan Africa are still far much higher than in other regions of the world and that AIDS accounts for most deaths among teenagers in the region. The UNDP has emphasized that all “[t]hese deaths can be avoided through prevention and treatment, education, immunization campaigns, and sexual and reproductive healthcare. The Sustainable Development Goals make a bold commitment to end the epidemics of AIDS, tuberculosis, malaria and other communicable diseases by 2030” (2017a).

While SDG 3 is the only SDG that directly addresses health, many of the other SDGs also affect health. For example, the main purpose of SDG 6 is to improve access to clean water and sanitation, which, of course, is essential to good health.

To support its work on bringing health to the fore of the development agenda, in 2000, WHO created the Commission on Macroeconomics and Health, whose goal was to study the role of health in global economic development. The report the commission issued confirmed that better health standards among poor populations could indeed have a positive impact on economic development and could help to reduce poverty. In other words, the report established that health was not only an important requirement for economic development but at the same time a product of it. The publication also revealed that although improving the health standards of the marginalized and poor would require a significant amount of funding, the benefits would be significant and would range from improved health to improved economic outcomes (especially in the poorer countries) to improved global security (Koskenmaki *et al.* 2009: 31).

Matlin (2009) points out that, in addition to health moving to the centre of development in the last few decades, there has been a global shift in the health issues that are being highlighted. In particular, he traces the evolution in health research and development (R & D) in the last few decades. The early years were marked by huge disparities in the improvements made by high-income countries (HIC) and low- and medium-income countries (LMIC). HICs benefited from gains made in health R & D; life expectancies soared and very few deaths occurred from communicable diseases, which had been brought under control by the development of vaccines and other preventative methods. Meanwhile, LMICs continued to have a high disease burden. Most deaths in LMICs occurred as a result of communicable diseases or very preventable conditions, such as malnutrition and malaria. The disparity largely resulted from the lack of interest in the tropical diseases that affected mostly LMICs; very little research and funding had been devoted to studying these diseases. However, in the last decade—that is, after the international development community placed a greater focus on equity—more money has been poured into R & D in tropical diseases and health conditions that affect poor countries. One important aspect of this change has been the increased focus on capacity building that encourages local scientists and researchers to investigate problems that most affect their communities, those which are disproportionately affected by ill health.

Recognizing that health is an important indicator of development, the Government of the Republic of Zambia (GRZ), like most other governments, places great emphasis on the health sector. The theme of its Revised Sixth National Development Plan (R-SNDP) is “People Centered Economic Growth and Development” (Ministry of Finance 2014). The plan stated from the outset

that it aimed to achieve the goal laid out in its 2005 plan: Vision 2030.²⁶ That is, the GRZ aimed to make Zambia a “prosperous middle-income country by 2030” (Ministry of Finance 2014). Both the R-SNDP and Vision 2030 articulate the priority areas in health that should be tackled by any sitting government in order to achieve better development indicators and a better standard of living for all. In line with the policy and action plans that resulted from the MDGs, both Zambian publications emphasized availability of primary health care for all and universal health coverage as two of the most pressing health care issues. They also stressed the importance of establishing policies more oriented towards public health and more concentrated on preventative measures as a more efficient way of combating some communicable diseases and epidemics, such as cholera. Moreover, the plans acknowledged inequalities between urban and rural areas, which often record more unfavourable statistics across the board. After identifying significant issues, the documents laid out how they expected to achieve their goals. For instance, one way the GRZ planned to eliminate disparities in access to health care between urban and rural areas was to introduce mobile clinics that would deliver free health care services to poor people in remote areas (GRZ 2006; Ministry of Finance 2014).

3.2 The health sector in Zambia

3.2.1 Improvements in the health sector

²⁶ Vision 2030 is a 25-year plan that was published in 2005 by the Zambian government. Vision 2030 was meant to express a long-term vision and plan for the country. This plan would be supplemented by shorter-term national development plans, which are typically produced every five or so years when either a new president comes into office or an incumbent is given a fresh five-year mandate after a general election. Both Vision 2030 and the national development plans highlight the most important areas of development that the government wishes to follow and the milestones that it wishes to achieve within a specified period. These documents also give an overview of where the nation is in a specific sector and where the government wishes to go in the next few years or decades.

Statistics show that Zambia's health standards have been improving over the past two to three decades. These improvements can be attributed to major health reforms that were initiated in 1991 and have since been continued to some degree or another by the various successive governments.

The years following Zambia's independence in 1964 were marked by massive development projects that included many schools and hospitals being built as a trademark of African socialism.²⁷ However, after the economic crises of the 1970s and 80s, when prices of commodities fell on the world market, many African governments were no longer able to provide necessary social services for their people, and many sectors, like education and health, suffered greatly or even collapsed. In 1991, it was from this collapsed state of the health sector that the new Zambian government in the new multi-party era undertook to improve health services by proposing more funding and major reforms.

3.2.2 Decentralization of administration

One of the most significant features of the new reforms was the decentralisation of health administration. While the Ministry of Health (MOH) still takes the leadership role in all health matters, many administrative functions and financial decisions have been assigned to the district level. The MOH thus has more time to concentrate on matters of strategy and policy. Meanwhile, community engagement and involvement in many health matters has been another strong feature of the decentralised model (African Health Observatory 2010).

²⁷ At the time of decolonization, when pan-Africanism and nationalism were at their height, many African leaders espoused the ideas of an African brand of socialism, which was based on the African traditional principles of sharing. This was the basis of policies such as Ujamaa in Tanzania and humanism in Zambia.

3.2.3 Public and private services

Health services in Zambia are provided mostly by public institutions under the MOH. The National Health Policy states that health delivery will follow the primary health care approach. Services are therefore structured and delivered at the following levels: the community, health posts, health centres, first level or district hospitals, second level or general hospitals, and third level or central/tertiary hospitals (MOH 2012: 9–10).

The private sector is also an important provider of health services. Although the public health care system strives to provide free services, especially to rural areas and to the most vulnerable groups, some services still require the client to assume his or her own expenses. This situation provides for a two-tiered system along class lines. Those with the financial means have access to the best health care, while the poor can access only the most basic care available.

Plans are underway to eliminate or at least reduce such inequalities in health care provision. The government, through the MOH, is currently looking at the possibility of introducing a social health insurance (SHI) scheme for those working in the formal sector. It is also looking at ways of encouraging and engaging the private sector to invest in the health sector in some sort of partnership, as has been done in other African countries in the sub-region, Lesotho and Namibia being two (African Health Observatory 2010).

3.2.4 Improvement in health indicators

Although the statistics show a general improvement of health standards in Zambia, much work remains to be done. Zambia, like other developing countries, still faces many challenges in this area and a very high disease burden in particular. One case in point is the HIV/AIDS pandemic

which practically reversed many of the gains that were made in the early 1990s and which almost derailed the process of reform. At the pandemic's height in the 1990s and early 2000s, there was a reversal in some important health indicators. Life expectancy, for instance, dipped to an all-time low of about 37 years. Although HIV/AIDS remains Zambia's greatest health challenge, much progress has been made and many indicators have since improved. The latest figures from WHO indicate that life expectancy as of 2016 stands at about 60 years.

3.2.5 Focus on mother and child health

In line with its decentralization policy, the government has taken steps to streamline the functions of the health sector by defining two portfolios under health. The first portfolio is general health, and the second mother, neonatal, and child health. While the MOH drives health policy and remains the lead ministry, it is supported by the Ministry of Community Development Mother and Child Health (MCDMCH) in all matters pertaining to the health of mothers and children. In tandem with education, this type of health is recognised as a particularly important aspect of human development. After all, the health of mothers and their children basically sets the tone for the future health status of a nation. This fact was reflected in the MDGs, and the *Zambian government* has recognized its importance through the various policies (e.g. the *Roadmap for Accelerating Reduction of Maternal, Newborn and Child Mortality, 2013-2016*) that it has established to improve the health prospects of mothers and children.

3.2.6 Health infrastructure and resources

Although some serious steps have been taken to improve the health infrastructure in the country (such as the building of more hospitals and expansion of existing ones), there has been a shortage of hospitals and health facilities, notably in the rural areas. In fact, 46% of the families in rural areas live more than five kilometres away from a health service compared to only 1% in urban areas.

Health facilities in Zambia have also consistently faced shortages of equipment and medical supplies due to inadequate funding. Since 2005, the government has made concerted efforts to procure some modern diagnostic equipment, such as magnetic resonance imaging (MRI) and computed tomography (CT) scans. In addition, it has acquired the ability to use molecular diagnostic techniques. However, such equipment is not sufficient and is mainly available at only second and third level hospitals. Consequently, there is congestion and long wait times for specialised services (MOH 2012).

Inadequate infrastructure and equipment impact another problem facing the health care system in Zambia: inadequate human resources. The two provinces that have the highest number of health workers, the Copperbelt Province and Lusaka Province, are the most highly populated and urbanised provinces (MOH 2012). As with other issues, the rural areas are the worst hit by the critical shortage of health workers. The lack of facilities and inaccessibility of the rural areas make them unattractive for health workers. The MOH often lacks the resources necessary to attract health personnel to the rural areas. This shortage of qualified staff compounds the problem of long wait times for patients seeking care (MOH 2012).

Low remuneration also affects health workers in urban areas and sometimes leads to low motivation and morale among the workforce as a whole. In addition to not being sufficiently

rewarded for their work, health workers often must endure working under very difficult circumstances where there is not only a shortage of equipment but also an exceptionally high patient-to-health-personnel ratio.²⁸ For example, in 2010, there were 911 doctors employed in the public sector against a set requirement of 2,300, and there were 7,669 nurses against a requirement of 16,732. The figures are similar for all health workers, regardless of whether they are midwives, dentists, clinical officers, laboratory services technicians, nutritionists, pharmacists, physiotherapists, etc. (MOH 2012).

To exacerbate the staffing problem, there has been an inadequate number of yearly graduates and very high levels of brain drain in the past few decades. In fact, a general shortage of adequately qualified health workers is a chronic issue in Zambia. According to the MOH, this problem has seriously hampered the efforts of the ministry to provide adequate health care services. Meanwhile, the African Health Observatory (AHO) highlights brain drain as an example of the inequities that exist in global health standards when health workers are enticed from rural to urban areas or from developing to Western countries (AHO 2010).

Over the years, many health workers have left Zambia to work under better conditions and for better remuneration. The AHO notes that about 15% of the nurses trained in Zambia between 1992 and 2003 were, at one point, working outside the country. In most cases, health workers are recruited from developing countries to work in Western countries in remote areas that are equally understaffed. In recent years there has also been a trend for highly qualified doctors from the public sector to move to international non-governmental organizations (NGOs) that are addressing health issues within the country (AHO 2010).

²⁸ The ratio recommended by WHO is at least 2.3 doctors per 1000 patients. Zambia's actual ratio is 0.09 per 1000 population (Makasa, Nzala & Sanders 2015).

To mitigate the problem of insufficient numbers of medical staff, the government has put in place measures to increase the number of educational institutions training health workers (MOH 2012). Previously, the country's only medical school was at the public University of Zambia. In the last decade or so, medical schools have opened at another public institution, the Copperbelt University, as well as at private institutions, such as the Lusaka Apex Medical University. In addition, several private nursing schools have also opened. While this is a welcome move, there has been some concern about the quality of graduates that some of these private institutions might produce.

3.3 Health spending

Although the Zambian government allocates a reasonable portion of its national budget to the health sector—8.9% in 2017—the amount of money that this represents falls far short of what is required to significantly improve the health standards of the nation (National Assembly of Zambia 2016). Nevertheless, Savedoff (2003) posits that the health outcomes of a country do not necessarily co-relate with the proportion of its budget a nation spends on health. He points out that, although WHO has proposed a ballpark figure of 5% of a nation's GDP, many other factors must be considered when planning a nation's expenditure on health. For instance, the level of disease burden and the nature of these diseases is certain to heavily influence health expenditure. In short, as Savedoff puts it, everything depends on the “epidemiological profile” of a nation (2003: 2). At the same time, health care is expensive. Even some Western nations inadequately fund their health sector. There are always several other pressing issues that need to be financed, so governments normally concentrate on what they consider to be the most important issues. When it presented its 2017 budget, the Zambian government laid out its priorities in terms of health for

the year. Among the most important priorities were the continuing development of health infrastructure and the introduction of a SHI policy as a step to achieving universal health coverage for all citizens.

3.4 Other players

Donors, or cooperating partners, play a significant role in not only funding but also providing technical assistance and expertise in several areas. In the health sector, WHO encouraged richer countries to set aside a portion of their own budgets for this purpose. This global effort is meant to tackle the world's most pressing health issues, such as the HIV/AIDS pandemic and other epidemics in geographical regions that are often already compromised by other social ills, like poverty, illiteracy, unsafe environments, and even war.

To accomplish most of its policy plans in important socioeconomic development sectors such as health, the Zambian government has depended on a substantial amount of aid from various donors, especially international cooperating partners over the years. For instance, the country is supported by the United States Agency for International Development (USAID) and its many programmes, including the President's Emergency Plan for AIDS Relief (PEPFAR), Saving Mothers, Giving Life, the United States President's Malaria Initiative (PMI), etc. Zambia is also a recipient of health-related aid from the United Kingdom's Department for International Development (DFID); the governments of other countries, such as Sweden, Finland, Germany, Ireland, Canada, and Norway; and international organizations, including various UN agencies, WHO, and The Global Fund, to name a few. NGOs have also been instrumental in providing

assistance in the health sector, as have been religious or faith-based organizations under the Churches Health Association of Zambia (CHAZ).

Of particular note, CHAZ is a grouping of 151 Catholic- and Protestant-run health institutions in Zambia. The association oversees 34 hospitals, 9 nursing and laboratory personnel training schools, 77 health centres, and 31 community-based organizations (CBOs). CHAZ institutions provide about 35% of health care in Zambia and 50% in the rural areas. With a humane approach anchored on Christian values, the association's main thrust is using a preventative strategy in serving rural and marginalized communities. A hallmark of CHAZ's work is the home-based care (HBC) model, which relies on volunteers to provide home-based care services to the sick. CHAZ works in partnership with the MOH, which finances 75% of the operational costs of church health institutions. CHAZ also receives material and technical support from other governments and international cooperating partners (CHAZ 2013).

3.5 Health policy

3.5.1 Important policy documents

The MOH's work is guided by a number of policy documents, which are produced by experts in the area, often with the technical assistance of cooperating partners such as WHO and the appropriate UN agencies. Of specific importance are the *National Health Policy* and the *National Health Strategic Plan*. These publications are normally produced periodically and are meant to cover an average of five years. The general objective of the *National Health Policy* is "to reduce the burden of disease, maternal and infant mortality and increase life expectancy through the provision of a continuum of quality effective health care services as close to the family as possible

in a competent, clean and caring manner” (MOH 2012: 27). The policy identifies several specific objectives and elaborates the standards that would be used to measure them. It also pinpoints the important determinants that affect health. Like the *National Health Policy*, the *National Health Strategic Plan* articulates the nation’s vision for health and the government’s plan on how to achieve it. Another significant document that guides the ministry’s work is the *National Human Resources for Health Strategic Plan*, which focuses on human resources in the health sector.

Meanwhile, the 2012 *National Health Policy* lists several principles that guide all policies on health within a five-year period. Notable among these principles are equity in terms of access and affordability; a primary health care approach; gender sensitivity; and transparency and accountability.

3.5.2 Key health determinants identified in health policy

The *National Health Policy* identifies many key determinants of health. These include:

- **Environment** understood as sanitation, food safety, access to clean water, and good hygiene standards.
- **Nutrition and its effects on health:** Malnutrition is a major problem in Zambia and is responsible for a significant proportion of the deaths of children under five.
- **Health promotion and education:** The ministry recognizes that health promotion and education significantly impact health. Furthermore, it proposes to increase efforts in public health communication.
- **Maternal, newborn and child health:** The ministry aims to reduce maternal, newborn and child mortality rates by increasing access to health care for this group.

- **Communicable diseases:** HIV/AIDS, malaria, tuberculosis, and neglected tropical diseases that get little attention, such as schistosomiasis (bilharzia). Other communicable diseases that are endemic to Zambia include cholera, typhoid, dysentery, and measles.
- **Non-communicable diseases,** which are on the upswing, include mental illness, cancer, diabetes, and cardio-vascular diseases.

There are other priorities that policy highlights as targets in the health system. The *2011–2015 National Health Strategic Plan* enumerates several areas for improvement, such as the following: training, recruitment and retention of health personnel; drug and medical supplies; health infrastructure and equipment; availability of information on health; financing of the health care system; administration of health systems (MOH 2011a).

3.5.3 Implementation of health policy

Zambia's health policy is strongly anchored on the global health initiatives and recommendations of international health organizations like WHO and the UN system. This explains why Zambia was fully engaged in the MDGs and is now also committed to putting policies in place aimed at achieving the SDGs.

Although Zambia's health policies are fairly well defined, their implementation has been hampered by numerous challenges that are a reflection of the problematic socioeconomic structure of Zambian society. Inequalities persist despite the government's emphasis on reducing them in the provision of health services. In particular, inequalities exist between urban and rural areas, between the rich and the poor, and along gender lines. Furthermore, the HIV/AIDS epidemic

undermined the work and the progress that was being made on the MDGs and, although there has been an improvement, the crisis has largely continued to this day (WHO-AFRO 2010).

The challenge for the country is to co-ordinate a holistic, multi-sectoral approach towards human development. For instance, with the help of cooperating partners, the government currently has several water and sanitation projects running. This is an essential step towards the improvement of the health statuses of especially the marginalized groups. Meanwhile, to address all health problems regardless of whether they are mentioned or not mentioned in the government policy documents, MOH stresses the importance of prevention as one of the most effective methods of combating disease (2012).

3.6 Salient issues and challenges

The first point to note about Zambia's epidemiological profile is that it has a high disease burden. (The same can be said about most of sub-Saharan Africa.) There are many factors or determinants that contribute to the high disease burden. Poverty, poor sanitation, poor hygiene, air pollution, poor garbage disposal, and a lack of education are just a few. What follows is a discussion of the most salient health problems that Zambia faces and must address as part of its development process.

3.6.1 Funding

As alluded to earlier, the health sector in Zambia is inadequately funded, and the MOH accepts that funding is currently far below what is required to provide adequate service. A profile of Zambia's health financing produced by USAID, PEPFAR and the Health Policy Project

indicates that, for the past few years, Zambia surpassed the 5% of GDP mark on health spending by government. However, this does not mean very much as the amount actually allocated is relative to the GDP size of a country. For a country like Zambia whose GDP is small at \$21.15 billion in 2015 (World Bank, 2017b), 5% does not add up to very much in actual terms. Notwithstanding this fact, it should be noted that the Zambian government spends more on health than the average LMIC, which devotes about 4.2% of GDP to health (USAID 2016).

One of the targets of the 2001 Abuja Declaration was that African nations would allocate at least 15% of their budget to health by the year 2015. Compared to other LMICs, Zambia has not been too far off target. In 2015, 12.6% of the country's total budget was spent on health while the LMIC average was 6.2%, far below the 15% target. In monetary terms, Zambia's per capita expenditure on health for 2015 was US\$93, of which US\$54 was government funding. Private health insurance accounted for only about 0.5% to 3%.

All in all, 58% of the total health expenditure in 2015 came from government; 34% from external sources, that is, cooperating partners; and the remaining 8% from other sources such as user fees. These statistics for 2015 reflect a general trend; funding for health care mostly comes from the government's budget allocations; then from donor funds that are either tied to specific projects or given to the Zambian government specifically for the health sector; and finally, from user fees.

However, it must be noted that the bulk of user fees were abolished in 2006 because of the government's decision to adopt the WHO-proposed primary health care approach. User fees were abolished first in rural and peri-urban areas to make it easier for people in already marginalized areas to access basic health care. User fees were later abolished in urban areas. That being said, some of the major and higher-level hospitals still run a fee-paying unit that offers better and faster

service. Unfortunately, only a small portion of the population can afford these services and those offered by private health facilities. At present, private health insurance is not very well developed, but plans are underway for the introduction of legislation to support and regulate private and social health insurance policy plans.

While public health institutions are funded by the above-named means, private health facilities are normally funded by the private sector and user fees. It is quite common for employers to have an in-house health facility for the benefit of their workers and families. Most of these facilities are relatively small and offer primary health care with referral services to hospitals if necessary. Bigger and more established employers, like the mining companies, usually run their own fully fledged and often well-equipped hospitals (USAID 2016).

At the time the *2012 National Health Policy* was published, the government was looking at potentially encouraging and setting up mechanisms for Public Private Partnerships (PPP), where the government could partner with the private sector to improve social services (MOH 2012). Information is not readily available as to whether this initiative has come to fruition or is still in progress.

To compound the issues surrounding funding, some funding from donors comes with strings attached in the sense that the ministry does not have flexibility to spend money on what it considers to be priority areas. In other words, funding from donors is often attached to specific causes that matter more to the benefactors. For example, due to its magnitude, the HIV/AIDS pandemic attracted a massive influx of funding. While such a gesture was needed at the peak of the disease, it may not be needed now that the disease has largely been brought under control. There are instead other areas of growing concern, such as the increasing numbers of non-communicable diseases, to which the MOH would like to devote more funding.

The health budget is currently shared between the MOH and the MCDMCH. In 2015, the two ministries received 57% and 42% of the total health budget respectively. Reflecting the magnitude of HIV/AIDS, 20% of the government health budget went to combating the disease. 75% of the total expenditure on HIV/AIDS came from sources other than the government (USAID, 2016).

3.6.2 Communicable diseases

Communicable diseases are the leading cause of morbidity and mortality in Zambia. HIV/AIDS, tuberculosis, and malaria are all among the leading culprits. Meanwhile, cholera also poses another health issue. Although prevalence rates have decreased in the last few years, HIV/AIDS still remains a significant problem for Zambia and is the highest cause of mortality. In 2014, the prevalence rate of HIV/AIDS among Zambians between the ages of 15 and 49 was 13% (down from about 16% at the peak of the epidemic in the early 2000s). Prevalence was higher among women at 15% (down from 18% in 2001) than men at 11% (down from 13%). HIV prevalence was lower among younger people in the 15-to-24 age range, at 7% for females and 5% for males. Prevalence among the population generally increased with age and then tapered off at around the 49-year mark. The 25-to-29 age range had a prevalence rate of 12.9%; the 30-to-34 age range 17.6%; the 35-to-39 age range 21%; and the 40-to-44 age range had the highest prevalence at 22%. In all the age ranges, the prevalence for females was higher than for males. Prevalence rates were also higher in urban areas (18.2%) than rural areas (9.1%). The prevalence rate among the ten provinces of Zambia varied. Unsurprisingly, the two most urbanized provinces had the highest prevalence rates: Copperbelt Province at a rate of 18.2% followed by Lusaka Province at 16.3%. Muchinga Province had the lowest prevalence at 6.4%. For translation and communication

purposes, it is worth noting that when education levels are taken into consideration, the highest prevalence rates were among those with the highest levels of education—14% among those with a secondary school education and 15.3% among those with higher-than-secondary-school education. Relatedly, prevalence rates also increased with wealth (Central Statistical Office 2014). These statistics suggest that people who live in urban areas and who have a higher level of education and a higher income live lifestyles that make them more susceptible to the risky behaviours associated with the spread of HIV/AIDS (Temah 2009: 47). The statistics also may be an indication of how these people are better able to afford good health care. Since they can easily access antiretroviral therapies (ART), they may attach less importance to lower-risk practices that would keep them healthy.

Tuberculosis (TB) is a disease exacerbated by the high prevalence rates of HIV/AIDS. After the outbreak of the HIV/AIDS pandemic, TB cases spiked, and the majority of cases since then have been HIV/AIDS-related. This has made TB a major health concern in Zambia. The government has responded accordingly and has since put in place a national TB programme, which has had a treatment success rate of 86% and has therefore met the WHO target rate of 85%. The prevalence of TB has decreased in the last few years, although it still remains an area of concern due to its interconnectedness with HIV/AIDS. The prevalence rate for TB was 436 per 100,000 population in 2014, down from 524 per 100,000 population in 2000 (AHO 2010; MOH 2011a, 2012).

According to the MOH figures for 2009, 40% of all health facility visits in Zambia were due to malaria. Government interventions have centred on preventive treatment measures which include the use of indoor residual spraying (IRS) and insecticide treated nets (ITN). The

government has also focused on the use of rapid diagnostic tests in all health facilities (AHO 2010; MOH 2011a).

Zambia faces a problem of regular (usually seasonal) cholera outbreaks, which have been reduced in the past decade. Cholera is one of the forgotten infectious diseases. As some scholars have posited, it attracts little worldwide attention, mainly because it affects a small group of people, that is, the poor in developing countries. The number of cholera cases increased dramatically in the early 2000s. A 79% increase of cases worldwide was recorded from 2005 to 2006. 87% of those cases occurred in Africa, with Zambia having her own share of cases. Scientists have established a link between cholera outbreaks and environmental factors such as crowded places with poor sanitation and limited access to clean water (Luque Fernández *et al.* 2009). As a result, outbreaks have generally affected very densely populated areas such as the shanty towns in the capital city, Lusaka. The government response to epidemics has mostly centred on preventive measures, such as encouraging people to chlorinate drinking water and wash their hands. The government has also focused on the setting up of treatment centres in affected areas to prevent the disease from spreading (UNICEF 2016). Although the government makes an effort to contain epidemics, it generally lacks the institutions and mechanisms needed to adequately respond to such emergencies. Its responses are therefore usually slow and not well co-ordinated. Managing cholera epidemics poses a great challenge in Zambia (AHO 2010).

3.6.3 Non-communicable diseases

The bulk of Zambia's high disease burden is due to communicable diseases, which are responsible for most deaths (about 61% in 2015, down from 79% in 2000). Nevertheless, there is a growing incidence of non-communicable diseases, which are the leading cause of mortality

globally. In Zambia, non-communicable diseases were responsible for 29% of all deaths in 2015, up from 15% in 2000 (World Bank 2017a). Statistical data from health facilities has indicated a clear upswing in non-communicable diseases, such as asthma, epilepsy, cancers, diabetes, and hypertension. Non-communicable diseases tend to be associated with certain lifestyles. What people chose to eat, how physically active they are, whether they use tobacco products, and whether they consume too much alcohol are examples of factors associated with non-communicable diseases. At the same time, non-communicable diseases can be hereditary. They may also be due to some risk factors to which some people are pre-disposed. In the past decade, the MOH has set up a non-communicable diseases unit (NCD), which has been tasked with the responsibility of developing a policy and strategy on all matters pertaining to non-communicable diseases. Until 2007, Zambia did not have a single cancer treatment centre. Most cancer cases were dealt with at the biggest hospital in Lusaka, the University Teaching Hospital. If a person was in desperate need and was lucky (or had connections in high places), the government would also refer that person to a hospital in a neighbouring country, usually South Africa, for specialist treatment at great cost.²⁹ To address the rising number of cancer cases, GRZ collaborated with some cooperating partners to build the state-of-the-art Cancer Diseases Hospital at the University Teaching Hospital. It now provides specialist cancer screening, diagnosis, and treatment. Meanwhile, some lower level health institutions screen some types of cancer (such as cervical cancer, which, in sub-Saharan Africa, is most common in Zambia) (Centre for Infectious Disease

²⁹ Although the government would insist that this service is open to all Zambians, public perception suggests the contrary. To this day, it is common practice for Zambian politicians—including the president—to seek medical attention abroad (in South Africa, India, even Europe) for the most minor of health conditions. Two of Zambia's former presidents and many politicians have died in hospitals in Europe (France and the UK in the case of the two presidents) at the tax payers' expense. At the official opening of the Cancer Diseases Hospital in 2007, then president Levy Mwanawasa noted that between 1995 and 2004, only 350 of the 5,000 cases of cancer that required radiotherapy treatment abroad received it at government's cost. The patients represented by the remaining cases died ("Zambia opens first cancer hospital," Lusaka Times 19th July 2007).

Research in Zambia 2015). In addition, the NCD prioritises prevention and early detection measures through health promotion on issues like nutrition, healthy lifestyles, and early screening. (MOH 2011a).

Malnutrition and stunting are other major areas of concern in Zambia. According to the MOH, malnutrition was the cause of 42% of the deaths of children under five. Moreover, the ministry's statistics also show that 45% of Zambian children are stunted due to malnutrition, 15% are underweight, and 5% are wasted (MOH 2011a, 2012). This problem is obviously exacerbated by the country's high levels of poverty, and interventions must take this into consideration.

3.6.4 Mother and child health

Mother and child health is an important development and global health issue. A healthy nation begins with healthy children and healthy mothers. As the Central Statistical Office (CSO) states, "Infant and child mortality rates are important indicators of a country's socioeconomic development and quality of life, as well as its health status" (2014: 109).

Although Zambia's child mortality rates have improved in the past decade, the statistics provided by the MOH and the CSO confirm that they are still far too high. To give an idea of the situation, the under-five child mortality rate dropped from 197 per 1000 live births in 1996 to 168 in 2002 to 119 in 2007 to 75 in 2014 (MOH 2012; CSO 2014). The MOH (2012) has also noted that there has been an insignificant reduction in neonatal mortality rates; neonatal mortality rates account for half of infant deaths, indicating that Zambia's perinatal care is inadequate. Further compounding the precarious condition of mothers and children, determinant socioeconomic factors often affect these demographics more than they do other groups.

Recognizing its very high maternal and child mortality rates, Zambia has been particularly engaged in addressing the issue of mother and child health. In the past decade, the MOH has sought to increase the number of antenatal clinics so that pregnant women can have access to these services as close to their homes as possible. As of 2012, 80% of health facilities had an antenatal clinic. That being said, as of 2012, only 46.5% of deliveries are attended by a health care professional (nurse, midwife or doctor), and only 45% of women who have complications in pregnancy are treated at a facility equipped with the necessary expertise (MOH 2012). Besides increasing the number of antenatal clinics, the MOH has actioned the Expanded Programme on Immunisation (EPI), which seeks to have as many children as possible immunised against dangerous diseases like measles; the Prevention of Mother-to-Child Transmission (PMTCT) of HIV programme, which seeks to reduce the number of infected babies born to HIV positive mothers; and the Integrated Management of Childhood Illnesses (IMCI) programme. The MOH has also worked to improve nutrition among children by, for example, providing vitamin A and iron-folate supplements.

Context plays a very important role in both translation and health communication. While some of the challenges described above are not unique to Zambia, they create a very specific and somewhat complex environment within which translators, communicators, policy-makers, and health professionals must work in order to disseminate health information to the public effectively. It is this particular context that ultimately determines how the vital health messages are packaged, how they are delivered, and how all the involved actors interact with each other to achieve the common goal of communicating health information. By giving an overview of Zambia's

epidemiological profile, this chapter seeks to put into context some of the health communication and translation issues that will be discussed in greater detail in the next two chapters.

CHAPTER IV

PUBLIC HEALTH COMMUNICATION IN ZAMBIA

Health communication is a broad concept that includes communication between patients and health professionals. Citing *Healthy people 2010*, Parrott (2004) has defined health communication as

the art and technique of informing, influencing, and motivating individual, institutional, and public audiences about important health issues. The scope of health communication includes disease prevention, health promotion, health care policy, and the business of health care as well as enhancement of the quality of life and death of individuals within the community. (751)

The present study specifically focuses on public health communication, which targets disease prevention, promotes health, and educates the public. According to Thomas (2006), this is the most apparent form of health communication.

4.1 Evolution of health communication

Globally, the importance of health communication has grown in response to the shifts in global health policies highlighted in Chapter 2. In the United States, health communication praxis has evolved due to, amongst other things, changes in the medical system and a stronger emphasis on the patient as a consumer or client with corresponding rights (Thomas 2006). While health systems differ worldwide, a focus on equity in health care provision and on preventive measures

are some shared reasons for the rise in prominence of health communication. In Africa, global health policies led by WHO and various UN agencies have notably increased the importance of health communication. The strengthened use of health communication as a strategy to combat disease and promote better health is also largely a response to conditions and epidemics (HIV/AIDS and Ebola are notable examples) that have ravaged the continent. The 1986 Ottawa Charter for Health Promotion, which was essentially the product of the first WHO global conference on health promotion, also significantly elevated the place of health communication in health care delivery. The charter defines health promotion as follows

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector but goes beyond healthy life-styles to well-being. (WHO 1986: 426)

4.1.1 The rise of health communication in Africa

Although Africa—perhaps more than other regions of the world—needed to employ health communication to combat disease and promote better health, the continent lagged in this respect and embraced the health communication approach much later than some other regions. Even after the 1986 Ottawa Charter, African countries did not participate in the WHO global conferences on health promotion until the fourth conference, which occurred in Jakarta in 1997. The Global North, on the other hand, had since been developing models, methodologies, and theories to support

health communication practice. By the year 2000, more African countries had taken an interest in health promotion and attended the Mexico City conference in greater numbers. Furthermore, representatives of many African states committed to developing their own health promotion policies and strategies.

In 2000, member states of the WHO Regional Office for Africa requested the latter to produce a regional health promotion strategy. The resulting strategy was adopted by all member states in 2001. The following year, many African countries also adopted WHO health promotion guidelines (Houéto & Valentini 2014). Health communication—and health promotion in particular—became a more and more significant part of regional meetings, and, in 2009, it was an African country (Kenya) that hosted the seventh WHO Global Conference on Health Promotion.

Although many African states committed to developing their own health promotion policies and strategies, many developing countries were heavily dependent on cooperating partners to help finance their health sectors, and many health communication strategies, policies, and campaigns were formulated with the financial and technical expertise of Western donor nations and organizations. Although this was not a bad thing in and of itself, the situation resulted in one-size-fits-all, top-down approaches whose methods were those known and favoured by the donors. Very often, these approaches did not engage the target audiences or take into consideration their specificities or context (Houéto & Valentini 2014; Sanders *et al.* 2008). Recognizing the growing importance of public health communication as a discipline,” Bernhardt (2004) has addressed this issue and highlighted the importance of adopting an “audience-centred philosophy:

Health communication campaigns have sometimes been criticized as paternalistic, and concerns have been raised about the use of 1-way communication from “beneficent” experts to passive audiences. Public health communication recognizes that for programs to be both

ethical and effective, information from and about the intended audience should inform all stages of an intervention, including development, planning and implementation, to ensure that the program reflects the audience's ideas, needs and values. Areas of particular interest include the audience's health literacy, culture, and diversity. Furthermore, public health communication programs rely heavily on formative research and 2-way communication between sources and receivers to ensure that messages are accessed and understood, communities are involved and invested, and programs are modified as needed. (2052)

Although the situation is changing and has improved in recent years, Africa, according to Alali (2002), has lacked the methodology and theoretical backing that is specific to her context in terms of health communication. Meanwhile, the methodologies and theories that have been applied to her were developed for very different contexts. Alali has contended that research on health communication in Africa should not ignore the cultural and behavioural aspects of individuals and societies; instead, it should link these aspects to health. Much research on the subject has failed to do so. Alali (2002) has explained

[...] most of the research aimed at health promotion and disease prevention efforts in Africa appear to be casually-linked to the public's health. Hence, the communication models developed by those who study health issues have not fully addressed the individual and societal factors that interact with public health compliance; neither do their studies create linkages between theory and practical issues in health promotion and disease control in Africa. (27–28)

Alali (2002) has added that many researchers (such as Nwosu, Taylor, and Onwumechili (1995)) have criticized the universalizing of Western research methods, which are inadequate in African contexts. For example, these researchers maintain that Western models of communication center

on the individual while African models focus on the community. Models developed on the basis of individuality are clearly incompatible with a society strongly anchored on the communal.

Like Bernhardt (2004), Alali (2002) has stressed that culture and, he has added, religion are often inextricable from how a society operates and what shapes its belief systems. He has therefore emphasized the importance of understanding and being respectful of the elements that matter to people when formulating health-related messages aimed at urging the populace to change or adjust certain behaviours and beliefs. Interestingly, Alali (2002) has also pointed out that many of the HIV/AIDS campaigns run in Africa have largely failed to improve compliance, as some statistics show.

In Zambia, as in most countries of sub-Saharan Africa, no event made health communication more important than the HIV/AIDS epidemic. Early on, experts in the medical field recognized that prevention was one of the most effective ways of fighting the disease, which at that point had neither cure nor treatment.³⁰ The National HIV/AIDS/STI/TB Council (NAC)³¹ was created in 2002 by an act of Parliament to lead the national response to the disease. The NAC has formulated its strategy around the nexus of prevention and mitigation. In fact, in its 2017–2021 *National AIDS Strategic Framework* (NASF), the NAC states that it aims to place prevention of new infections at the heart of the HIV/AIDS response (NAC 2017). It is hoped that this approach will put the country on the path to achieving the global health targets of the 90-90-90 by 2020³² and to eliminating HIV/AIDS by the year 2030. To achieve this goal, the NAC has developed a prevention strategy.

³⁰ Antiretroviral therapies (ARTs) were developed later, and, although they provide affected persons with a much-improved quality of life and life expectancy, they do not cure the disease. In fact, there remains no cure for HIV/AIDS as of 2017.

³¹ The National HIV/AIDS/STI/TB Council is commonly referred to as the National AIDS Council or NAC, although it also deals with sexually transmitted illnesses (STIs) and tuberculosis (TB).

³² 90-90-90 refers to the UNAIDS target of having 90% of people living with HIV/AIDS (PLWA) knowing their status, having 90% of those who know their status receiving antiretroviral drugs (ARVs), and having 90% of those on ARVs achieving viral suppression by 2020 (UNAIDS, 2014).

Since communication is an important aspect of prevention, the NAC has also formulated a communication and advocacy strategy. As the most challenging health issue the country has faced since the first case was diagnosed in 1988, HIV/AIDS has largely been responsible for increased importance of health communication in Zambia. It is therefore not surprising that most of the health-related information, education, and communication (IEC) materials available in the public domain are targeted at its prevention. Although the majority of health messages target HIV/AIDS, other important health issues (like malaria and maternal and child health) as well as connected social issues (like gender-based violence (GBV)) have also ridden the wave of the health communication era.

4.1.2 Regional collaboration

Countries of the southern African region³³ share similar statistics when it comes to certain aspects of health. For instance, the majority of the countries in the region were among those hardest hit by the HIV/AIDS epidemic. As of 2015, eastern and southern Africa had the highest number of PLWA—an estimated 20.5 million. Eastern and southern Africa also had the highest number of new infections at about 1.1 million and the highest mortality rate resulting from AIDS at 560,000. To put it in perspective, the next most affected region, that is, western and central Africa, had an estimated 7.8 million PLWA, 530,000 new infections, and 430,000 mortalities (UNAIDS 2016: 4). The countries of the southern African region also face similar disease burdens and have high

³³ The southernmost part of the African continent is commonly known as the southern African region, which is generally understood to comprise ten countries: Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe. It must be noted, however, that ‘southern Africa’ does not always refer to these ten countries; depending on their purpose, some sources restrict the number of countries while others include more (Marks 2014).

prevalence rates of communicable and non-communicable diseases. These countries (except South Africa and Lesotho) are also malaria-endemic (Centers for Disease Control and Prevention 2017).

In view of their similar epidemiological profiles and their geopolitical proximity, collaboration has been an important aspect of the region's response to serious health issues. For example, one of the most significant political regional groupings, the Southern African Development Community (SADC), developed the SADC Health Programme in 1997 to coordinate the implementation of global and regional health policies and strategies.³⁴ The programme produced three policy documents, namely, the *Health Policy Framework*, the *SADC Protocol on Health*, and the *Regional Indicative Strategic Development Plan*. The *Health Policy Framework* puts forward policies and strategies in several regional priority areas of health: research, health information systems, health promotion, HIV/AIDS, reproductive health, nutrition, and substance abuse, among others. The *SADC Protocol on Health*, which came into effect in 2004, promotes collaboration on important health issues, such as epidemics and disaster management. Meanwhile, the *Regional Indicative Strategic Plan* places health at the heart of the region's development agenda and specifically addresses HIV/AIDS, other communicable diseases, and non-communicable diseases (SADC 2012).

Reflecting the need for regional collaboration, Article 8 of the *SADC Protocol on Health* (the article addressing health promotion and education) declares

State Parties shall

- a) co-ordinate efforts to prevent diseases and promote the well-being;
- b) formulate and implement appropriate policies with respect to

³⁴ SADC comprises 15 member states: the 10 countries of the southern African region in addition to the Democratic Republic of Congo, Madagascar, Mauritius, the Seychelles, and Tanzania.

- i) mechanisms to co-ordinate regional health promotion and education;
- ii) appropriate guidelines and material for health promotion and education; and
- iii) guidelines on healthy lifestyle and reduction of substance abuse. (SADC 1999: 9)

In line with the protocol, there have been many collaborative efforts to target, through public health communication, the common health issues faced by most countries in the region. It is quite common to see health campaigns developed in one country and implemented in several countries across not just the region, but the continent at large. Indeed, adapted and localized versions of some of the more successful health campaigns have been used throughout the continent. Collaboration has equally been exercised in health communication organizations. For instance, SAfAIDS,³⁵ not only has offices in three capital cities (Harare, Pretoria, and Lusaka) but also implements its programmes in all ten countries of the southern African region. Through multimedia campaigns, SAfAIDS specialises in the collection, storage, and dissemination of information about HIV/AIDS and related socioeconomic and cultural issues (SAfAIDS 2017). Other collaborative efforts, such as the Southern Africa HIV and AIDS Regional Exchange portal (SHARE), have harnessed the increasing uptake of information and communication technologies (ICTs) in Africa to provide a platform for people and organizations to find and share resources germane to the pandemic.

4.2 Health communication policy

The *Zambian National Health Policy* includes health promotion and education as part of its general objective and lists it as one of its specific objectives (MOH 2012: 27 & 29). Through this

³⁵ SAfAIDS was established in 1994.

policy and its various strategy documents, the Ministry of Health has demonstrated the importance that it places on health communication. Accordingly, it has formulated targeted communication strategies for the various areas that it deems as priorities in terms of health service delivery to the nation. These strategies are often the product of consultations between local and international medical specialists and communication experts. There is also significant input from the public and cooperating partners (donors). The strategy documents serve as action plans to implement the numerous policies articulated in the *National Health Policy*.

This study will focus on the three areas of importance that have been highlighted by the MOH: HIV/AIDS; malaria; and maternal, newborn, and child health. It should be noted that some issues overlap across two or all of the three categories. For example, both HIV/AIDS and malaria are important mother and child health issues because children and pregnant women are particularly vulnerable to them. In other words, both are important health issues in their own right, but they take on an added dimension in the context of mother and child health. As a testament to this added dimension, there are specific health programmes that have been put in place to accentuate the protection of pregnant women and young children against malaria, just as there are specific programmes to protect babies born to HIV-positive mothers from being infected by the disease during and after birth.

4.2.1 HIV/AIDS communication strategy

The 2011–2015 *National HIV and AIDS Communication and Advocacy Strategy* (NACAS) stresses the importance of communication: “Communication, guided through successive communication strategies, has been identified as a crucial ingredient to effective responses to the pandemic.” (NAC 2011: 5). Its main objective is to have an “[i]ncreased percentage of the Zambian

population that is informed, engaged, empowered, and positively participating in the national agenda in prevention; treatment, care and support; impact mitigation; and coordination and management of the national response” (NAC 2011: 9). Another important goal of the 2011–2015 NACAS was to fill the lacunas that were identified in the evaluation exercises of previous communication efforts and to address deficiencies in the implementation of the 2005–2010 strategy. Some of the concerns raised were the appropriateness, uniformity, consistency, and veracity of the information made available on HIV and AIDS. According to the NACAS, the conflicting messages that were conveyed to the public had often led to confusion and misinformation (NAC 2011).

Given the current high prevalence rates of HIV/AIDS in the country, the NACAS stresses the importance of not only disseminating accurate information and raising awareness of the disease but also evoking behavioural change to reduce the rate of new infections. The strategy points out that, while the number of deaths due to AIDS has drastically decreased, the rate of new infections has not. The reduction in the number of AIDS-related mortalities can be attributed to the availability of antiretroviral drugs, which have greatly improved the chances of PLWA. The high rate of infection suggests that, although people may be well aware of the disease, they still engage in the same risky behaviours that expose them to the human immunodeficiency virus. The strategy, therefore, rightly recognizes that any communication campaign must both inform the public and evoke behavioural change. In light of this, the strategy identifies two main approaches to communicating with the public about HIV and AIDS: mass communication and interpersonal communication. Mass communication is effective in disseminating information to a wide audience, while interpersonal communication is more effective in evoking changes in behaviour. The latter type of communication reaches fewer people at one time (NAC 2011). People’s

behaviours and attitudes towards many things, including their health, are very often closely linked to their culture, traditions, beliefs, and even socioeconomic circumstances. As a result, influencing behaviour is very difficult. As Arkin, Maibach and Parvanta (2002) have put it: “Realistically, [behavioural change] is difficult to achieve on a population-wide basis because most behaviours are complex. Most people are unwilling to change existing health behaviours without compelling reasons to do so or unless barriers are reduced” (66). This is why extensive knowledge of the target audience’s context is a sine qua non in health communication (and in translation):

Understanding the audience is essential to effect persuasive communication with the general public. As with efforts to inform the general public, audience segmentation, literacy, numeracy, culture, language, and preferred communication channels all need to be considered prior to developing a persuasive message. (Arkin *et al.* 2002: 67)

In addition to serving as the national communication strategy on HIV/AIDS, the NACAS aims to provide guidelines to all of its partners working in communication. It notes that a survey conducted as part of its situation analysis revealed that only 2 of the 11 partners surveyed confirmed having a communication strategy. The most common reason for the lack of a strategy was the shortage of financial and human resources as well as poor coordination among stakeholders. The NACAS thus fills an important gap in HIV/AIDS-related health communication and is an important resource for organizations and institutions involved in communicating health information and encouraging behavioural changes among the population. Besides identifying the communication approaches that can be employed, the NACAS outlines communication channels and tools, such as human communication, mass media, and other ICTs. One channel or a combination of channels could be used depending on the message to be transmitted and the target audience. Finally, the NACAS lists

some of the major issues that need to be addressed through communication and how this can be achieved. It provides a step-by-step guide on how to develop IEC materials and on how to implement, monitor, and evaluate campaigns. It proposes diverse strategies, channels, and tools and gives a detailed explanation of how they work and how to best use them (NAC 2011).

4.2.2 Malaria communication strategy

Malaria is a vector-borne disease that is transmitted by infected female *Anopheles* mosquitoes (WHO 2017). It can be successfully treated with a number of medications, but it very often leads to death if not detected early or treated adequately. Malaria thrives in certain geographic regions and climates and is exacerbated by poor socioeconomic conditions. Malaria is one of the leading causes of morbidity and mortality in Zambia and in endemic countries in sub-Saharan Africa. Global interventions target control of the malaria vector, that is, the mosquito, in order to prevent transmission. The two most common preventive measures used in Zambia are indoor residual spraying (IRS) and the use of long-lasting insecticidal nets (LLIN).

Communication campaigns are thus based on informing the public about the benefits of IRS and LLIN and persuading them to adopt the healthy habits of using these tools. Campaigns also aim at educating people about the symptoms of malaria and encouraging them to seek medical attention as soon as they show any signs of these symptoms (MOH 2011b).

The *National Malaria Strategic Plan* for 2011–2015 enumerates some of the challenges that the MOH faces in managing prevention and mitigation measures against the disease. Challenges include poor health-seeking behaviours among the population; improper use of the nets; communication campaigns with inadequate coverage; limited finances for long-term, durable health promotion activities; high costs of producing and translating IEC materials; high costs of

diffusing messages on radio and television; inadequate IEC materials translated into local languages; and low literacy levels among some sections of the population (MOH 2011b).

The *National Malaria Communication Strategy 2011–2014* is a comprehensive document that supports the objectives of the 2011–2015 *National Malaria Strategic Plan*. It details the country's plan for communicating critical information about malaria to the entire population. It also proposes various techniques and tools that can be employed to encourage the adoption of healthy habits that prevent malaria. It identifies some of the barriers to effective communication as well as proposes solutions to overcome these barriers. For instance, improper use of LLIN has been quite common among certain sections of the population. It has been reported that some people use the free LLIN that have been distributed by the ministry as fishing nets or use them to make curtains and clothing items, such as wedding attire. Similarly, some people have not cooperated with authorities during indoor residual spraying exercises. Another issue is that patients infected with malaria and pregnant women routinely put on intermittent preventive treatment in pregnancy (IPTp) do not comply with their treatment plans. To deal with these issues, the communication strategy proposes communication approaches that will help change public perceptions of malaria and dispel some of the common myths surrounding the disease. It is common for people to develop wrong attitudes and beliefs when correct and suitably-packaged information is lacking. For example, although malaria is endemic in all areas of the country, it is more severe in some regions than others. As a result, many people who live in the hardest-hit areas have come to accept the disease as a part of life that cannot be prevented. Another common myth is that the chemicals used to spray houses and treat nets are ineffective or even harmful to one's health. Some people believe that sleeping under a net can cause them to suffocate or become ill. The communication strategy lists the various channels through which correct information can be diffused to persuade people to

adopt healthy behaviours that can prevent malaria. Some of the suggested channels are radio and television (programmes, advertisements, dramas, etc.), newspapers, posters, calendars, fact sheets, text messages, stickers, T-shirts, leaflets, billboards, public announcements, door-to-door visits, and health talks in schools and other community fora. (MOH 2011–2014).

4.2.3 Maternal and child health strategy: The First 1000 Most Critical Days Programme

Maternal and child health is a broad concept that encompasses several aspects of health care. Accordingly, communication strategies are focused on a single issue or a group of related issues, such as child nutrition or women’s reproductive health. The goal of this section is to give an example of one of the communication policies and strategies pertaining to mother and child health issues. Due to the limited scope of the study, this section will only look at one aspect, that is, nutrition.

Undernutrition has been identified as one of the leading causes of child morbidity and mortality in Zambia. One of the most serious consequences of undernutrition is stunting. Stunting affects the general well-being of children and inhibits their capacity to develop normally both physically and mentally. Stunting also hinders children’s and adults’ productive capacity. As part of the global response to address undernutrition, a group of organizations led by the UN launched the Scaling Up Nutrition (SUN) movement. Its emphasis was on the first 1000 days of a child’s life, which it deemed to be a “window of opportunity” in which interventions could positively influence a child’s health and development (National Food and Nutrition Commission 2012).³⁶

³⁶ The first 1000 most critical days include the period before the child is born, that is, the entire duration of the mother’s pregnancy, up to the child’s second birthday (NFNC 2012).

As a result of the SUN movement, the First 1000 Most Critical Days Programme (First 1000 MCDP) was launched in Zambia in 2013 as a follow-up to the 2011–2015 *National Food and Nutrition Strategic Plan* (NFNSP). The NFNSP lists a number of strategic priorities for the country in terms of nutrition, the first of which is to reduce incidences of stunting among the populace. With support from the SUN Fund and numerous other local and international partners, the GRZ set out to implement the First 1000 MCDP. The plan names communication as one of the important elements that would guide the roll-out of the programme. To this end, a communication strategy was produced that took into account the specific socioeconomic and cultural environment.

The First 1000 MCDP communication strategy and implementation plan emphasizes the significance of the programme and the importance of implementing interventions at the most critical time of a child’s development, that is, from conception until the second year of life. It points out that maternal and child malnutrition accounts for about a third of all child mortalities and that malnutrition “leads to intra-uterine growth retardation and low birth weight” (National Food and Nutrition Commission 2014: 1). In addition to being a significant contributor to infant mortality, undernutrition also contributes to morbidity rates as it increases the chances of illness in children under five. Malnourished children are more susceptible to infections and diseases, such as pneumonia, measles, and diarrhoea—which are all preventable. The First 1000 MCDP put together a package of interventions to achieve the goal of reducing stunting. The communication strategy accordingly focuses on raising awareness and encouraging behavioural change to support the selected interventions. The proposed interventions include encouraging the consumption of iron, folic acid, and vitamin A supplements among the target audience; deworming children regularly and administering zinc when they have diarrhoea; promoting breastfeeding and supplementary feeding at appropriate stages of the child’s development; encouraging appropriate

diets for pregnant women and nursing mothers; promoting the consumption of nutritious, locally available foods that are often ignored; and encouraging better hygiene and sanitation habits (National Food and Nutrition Commission 2014: 4).

The First 1000 MCDP communication strategy states explicitly from the outset for whom it is intended

This Communications Strategy is a national document developed as a guide to implementing partners including NGOs, governmental departments and agencies, faith-based organization[s] (FBOs) community-based organisations (CBOs) and any other institutions implementing nutrition interventions for children up to the age of two years. The Strategy aligns to the Strategic Plan of the NFNC and 1000MCD Strategic Framework, with the aim of ensuring that communication and advocacy activities under the 1000MCD campaign are coordinated and effectively implemented. By coming together under the framework of this Strategy, the organisations will be able to provide a strong and united message. The Communication Strategy provides the opportunity to strengthen the response to stunting in Zambia by eliminating contradictions and mixed messages. (NFNC 2014b: 15)

The programme was to be rolled out in only 14 districts in the country, and the communication strategy chose its channels of communication based on the target audiences in these districts. Because the 14 districts were not homogeneous and because the programme had varied goals (creating awareness, increasing knowledge, encouraging behavioural change), an array of communication channels and tools were selected. Mass media such as community radio and television were chosen for creating awareness and disseminating correct information. Meanwhile, community-centred interpersonal communication was chosen for encouraging behavioural change. Among the communication tools that the strategy proposes are IEC materials,

radio, mobile phones, churches, counselling, community meetings, health and nutrition workers, health talks and community demonstrations, workshops, women's clubs, food fairs, fliers and leaflets, songs and jingles, videos and DVDs (NFNC 2014b).

The strategy enumerates a number of principles that would serve as guidelines for the communications strategies that would be implemented. Among them are target-audience participation to ensure buy-in, cost-effectiveness, and gender and cultural sensitivity of the messages. The strategy also offers a six-step guide for the development of IEC materials. First, the strategy identifies the target audience. Second, it highlights some of the common misconceptions, undesirable practices, and barriers to behavioural change surrounding child nutrition and how these can be overcome through targeted and carefully constructed messages and well-chosen channels. Third, it gives detailed descriptions of each intervention and how it can be addressed in terms of message formulation and delivery. Fourth, it identifies the key messages to be propagated and advises would-be developers on the most important components of the messages, such as the core message, the problems, as well as the proposed solutions and actions to be taken.

4.3 An overview of health communication campaigns in southern Africa

As highlighted above, the countries and sub-regions of sub-Saharan Africa certainly share many features. That being said, sub-Saharan Africa still sports varied socioeconomic and cultural environments, and this variation prevents information from being developed, translated, and disseminated in the exact same ways. Clearly, in such a context, health education and promotion cannot fully rely on the textual paradigm of information dissemination. While the textual paradigm cannot be done away with completely, it must be adapted. Similarly, the textual and interlingual

models of translation must also be modified according to the context. Here, context takes precedence over equivalence and product over process.

4.3.1 The edutainment model as a translation and communication strategy

After many years of an ineffective, top-down approach to health campaigns in sub-Saharan Africa, researchers, scholars, and health professionals began to turn to the entertainment-education model. This model, which is also known as edutainment or simply E-E, is defined as follows:

Entertainment-education (E.E) is the process of purposely designing and implementing a media message to both entertain and educate, in order to increase audience members' knowledge about an educational issue, create favourable attitudes, shift social norms, and change overt behaviour. (Singhal and Rogers 2004: 5)

The model caught the attention of the communication world in the 1980s, but the history of the model begins years earlier. After seeing the impact that a popular Peruvian *telenovela* had on the Peruvian public, Mexican television producer and social scientist Miguel Sabido began to develop a methodology that harnessed entertaining soap operas to change behaviour.³⁷ Using Albert Bandura's social learning theory (also known as social cognitive theory) and Eric Bentley's dramatic theory, Sabido developed a social content communication methodology, now known as the Sabido methodology. Using this methodology, he produced the first ever known television drama on family planning. This drama, *Acompáñame*, ran as a series over several months. At that point (the late 1970s), Mexico had a population growth rate of 3.1% per annum. It dropped to 2.7%

³⁷ The *telenovela* was called *Simplemente Maria* and was televised in 1969.

within a year. Although it is acknowledged that the reduction may not have been entirely due to *Acompañame*, as there had been several other interventions in place at the time, it would be reasonable to conclude that the programme could have contributed to the increased uptake of family planning services and subsequent decline in the population growth rate. Several other *telenovelas* and *radionovelas* followed, and by the 1980s the Sabido methodology and the entertainment-education model had begun to be adopted in other parts of the world. Some of the early adoptions took place in India, Kenya, Brazil, and Tanzania with equally good results. The initial campaigns that modelled Sabido's approach were mostly on family planning, and most countries saw their population growth rates drop (Singhal and Rogers 2004).

The gist of the Sabido methodology is to use a story based on real-life situations with which the public can identify and then, through characters in a television or radio drama series, to demonstrate how beneficial or harmful certain behaviours can be. The audience is invited into the lives of the protagonists and follows them through their vicissitudes and the resulting consequences of their behaviours whether positive or negative. According to the social learning theory, environment influences how people learn. People observe what goes on around them and what other people do. They thus identify some behaviours as good and others as bad. Then they adopt what they believe are good behaviours based on their observations (Schiavo 2014). Entertainment-education is therefore able to change behaviours through stories much more easily than another type of verbal or written message could (PCI Media Impact n.d.).

Entertainment-education has had a greater impact in the developing world than in the developed world. It has therefore been used widely in sub-Saharan Africa. Here, it has the distinct advantage of overcoming some important public health communication barriers, such as illiteracy. I would argue that it also has a strong appeal to the sub-Saharan African region because of the

continent's strong oral tradition. Edutainment is basically the language that many people in oral societies understand; hence it is an effective method of engaging with these societies. Communicators understand this and use the edutainment vehicle even for campaigns that target literate communities in sub-Saharan Africa. Roberto *et al.* (2011) aptly point out: "Because these messages are designed to entertain as well as to educate, key advantages of the entertainment-education strategy include receiver interest and involvement, emotional engagement, and enhancing an audience's willingness to attend to prevention messages." (227)

From a translation perspective, edutainment represents several types of translation. Using edutainment as a vehicle to carry a message means translating a message from the "mega source text" alluded to above. Taking into consideration the socioeconomic and cultural context of a specific target audience, a scientific health message can be weaved into a dramatic art form. In the context of health edutainment in sub-Saharan Africa, translation takes place between the textual scientific information format and the audiovisual format that is edutainment; translation (dubbing or subtitling) takes place between English and local languages for some drama series; and translation, adaptation or localisation takes place where the source language is adapted to suit the local environment (as will be seen in some of the communications analysed in Chapter 6). To close this chapter are examples of health campaigns in the southern African region that used the edutainment model.

4.3.2 Soul City

Launched in 1994, *Soul City* is the showpiece drama series project of the Soul City Institute for Health and Development Communication, an NGO founded in 1992 in Johannesburg, South Africa. Using the edutainment strategy, *Soul City* principally began as a health promotion

campaign inspired by the Ottawa Charter for Health Promotion and targeting the South African population. The year of the programme's launch—1994—was a particularly significant year in the history of South Africa. It officially marked the end of the apartheid era and heralded the beginning of a new democracy, which held the first election where people of all races were eligible to vote. The founders of this NGO were, for the most part, medical doctors who had witnessed the negative impact the inequities of the apartheid era had on the health of a huge portion of the population. Apartheid had basically created a schism in South African society in socioeconomic terms. Economically, South Africa was a rich and developed country with one part of the population living in a developed world and the other, bigger part, of the population living in a developing world with all the problems that go with one (Goldstein *et al.* 2008; Singhal *et al.* 2004; WHO 2009).

For the team at the Soul City Institute for Health and Development Communication, 1994 represented a period of hope when so many changes for the better were taking place. Recognizing the need for health education and promotion, the team, through extensive research and the use of the edutainment vehicle, created *Soul City*. Taking advantage of the very well-developed media infrastructure in the country, they employed multimedia (television, radio, print, etc.) to deliver potentially life-saving health awareness and promotion messages to the South African public. The first season focused on maternal and child health as well as HIV/AIDS prevention. In a compelling story weaved around the lives of the various characters of *Soul City*—a fictitious community in South Africa—messages were reinforced on issues ranging from immunizing one's child to giving water to a child as soon as the child has diarrhoea to pregnant women visiting antenatal clinics to getting tested for HIV/AIDS to dealing with child abuse. *Soul City* became one of the most televised programmes in South Africa and by 1996 was broadcast in several other African

countries, especially those in the southern African region. Later, some of the *Soul City* print materials and other products as well as the campaigns that were produced under the Soul City banner (such as the One Love campaign³⁸) were adapted for other southern African countries, such as Zambia, Namibia, Mozambique, Botswana, Lesotho, Malawi, and Swaziland.³⁹ In 2014, *Soul City* reached its 12th season and has since expanded to address other development and social justice issues, including illiteracy, gender violence, alcohol abuse, and financial literacy (Soul City Institute for Social Justice 2016; Goldstein *et al.* 2008; Singhal *et al.* 2004).

The *Soul City* package comprised the television drama series, which was aired in 13 thirty-minute episodes over 12 themed seasons (1994–2014); 60 fifteen-minute radio programmes transmitted in various South African languages; and full-colour booklets that were printed in the 11 official languages of South Africa. Of all the media used, television was the most expensive. For this reason, only one version was produced but care was taken to include as many languages as possible in the production and to have English subtitles for the international audience. The Soul City brand also produces other print materials, such as training manuals, literacy and adult education materials, and life skills manuals for schools. Soul City is a long-lasting brand that takes advantage of the positive name it has acquired over the years to produce a wide range of communication for development (C4D) materials. The name Soul City is associated with a certain quality and has been supported over the years by various local and international partners (South African government, NGOs, DFID, USAID, PEPFAR, etc.) (Goldstein *et al.* 2008).

³⁸ The main focus of the One Love campaign was to discourage people from having multiple concurrent partners as this was generally understood to be one of the strongest drivers of the high HIV/AIDS prevalence rates in southern Africa. The campaigns were adapted to suit local conditions in each country, and the Zambian version was called “One Love. *Kwasila*.” *Kwasila* in ChiNyanja means “only” or “that’s it.”

³⁹ Swaziland is now known as the Kingdom of eSwatini as of 2018. However, the name Swaziland will be maintained in this study.

The *Soul City* campaign package is an excellent example of translation that takes into consideration the context of the target audience and potential barriers that may be encountered when public health messages are delivered. Soul City has several strategies for ensuring that messages reach as much of the population as possible and that they are distributed as widely as possible, including to the rural areas. Goldstein *et al.* (2008) have indicated that Soul City ensures that even illiterate, low-literacy, and second-language-user audiences are reached by employing strategies such as the edutainment model on both television and radio; simple and clear language expressed in short sentences for print materials; serif fonts in print materials (these fonts are more accessible for low-literacy audiences); a wide range of visual content; easy-to-use content organization that harnesses bullet points, coloured boxes, and tables arranged in short sections; translation of keywords or difficult concepts in local languages; and ways readers can access resources on how to put new knowledge to use.

4.3.3 Other campaigns

Following the success of the edutainment model in sub-Saharan Africa, several campaigns have imitated this approach. While countries like South Africa have a much more developed communications infrastructure, other countries in southern Africa (such as Zambia) have a less developed and less equitable communications infrastructure. For example, although radio is one of the most common channels for health campaigns in the rural areas, there are still some people who do not have access to it. Some campaigns have therefore utilized drama groups to present messages to live audiences in the rural areas. Campaigns have employed drama groups and toured villages to present important health information much in the same way the television drama serials have. In regular edutainment style, the plays often depict some positive role models who learn to

adopt good behaviours in connection with their health. Gausset (2001) has posited that some surveys have shown that drama groups can equally have an impact, as in the case of a drama group used for an HIV/AIDS campaign in rural Zambia. Surveys conducted after the plays and post-play discussions held with members of the audience revealed that there was a higher level of awareness about the disease and stronger indication of behavioural change in some instances.

The aforementioned One Love. *Kwasila!* campaign ran in 2009 and aimed to discourage especially urban married men between the ages of 25 and 50 from having multiple concurrent partners (MCP). It used several channels including the edutainment model. The campaign's flagship was a television drama series called *Club Risky Business*, which centred around three men who exhibited different kinds of behaviours—some of them risky—and the consequences that they faced. Through the practices and experiences of the men, bad and risky behaviours that expose people to infection were discouraged, while good and safe behaviours were reinforced. The One Love. *Kwasila!* campaign also aired a radio drama series also called *Club Risky Business* and an interactive radio talk show featuring public health professionals and some of Zambia's most influential and well-known individuals. Radio and TV advertisements as well as posters and banners were also utilised for the campaign. Additionally, some print materials were produced. These included a booklet called *The Men's Health Kit*, which was meant as a counselling tool for health care providers, and a magazine called *You and Your Relationship*, which focused on warning readers about the dangers of MCP and on giving relationship advice. The campaign even collaborated with some of Zambia's most famous musicians to produce a theme song and a music video (The Communication Initiative Network 2011).

The Safe Love campaign was one of Zambia's best-known campaigns. It had a multi-faceted approach that targeted three topics, namely, multiple concurrent partnerships, condom use, and

prevention of mother-to-child transmission (PMTCT) of HIV/AIDS. The crown jewel of the campaign and the product that probably made it most well-known was the awarding-winning drama series *Love Games*. Beginning in 2013, this series was broadcast on national and regional television (and the Internet) in two 13-episode seasons. In contrast with *Club Risky Business*, *Love Games* follows the story of five young urban women navigating relationships in Zambia's capital city, Lusaka (The Communication Initiative Network 2013). Information on whether producers intended *Love Games* to offer a female-centered alternative to the male-centered story in *Club Risky Business* is not readily available. However, considering that *Club Risky Business* aired before *Love Games*, it was a timely and significant decision to have female protagonists in this particular series. *Love Games* allowed the public to view some of the issues surrounding HIV/AIDS from a different perspective. In fact, the programme helped to bring to the fore some of the gender-related issues in AIDS prevention, that is, the asymmetrical relations between men and women. By so doing, it also helped to empower women in terms of their reproductive health. Because *Love Games* targeted an urban audience, it was broadcast mostly in English. However, translation still played an important role in various ways. For example, it is common practice for urban Zambians to use a fair amount of code-switching in their everyday conversations, and this was clearly depicted in *Love Games*. Subtitles in English were provided for the benefit of international viewers in instances where a Zambian language was used. The local language segments were for the most part in ChiBemba and ChiNyanja for the reasons given in the ethnolinguistic background section of this study. Other languages, such as ChiTonga, were also occasionally used.

In addition to *Love Games*, the Safe Love campaign also created several radio and TV spots called *Mulange One-on-One*. One of the main objectives of these spots was to empower women

to ask their partners to use condoms, a taboo subject in Zambian society.⁴⁰ Another objective was to promote HIV counselling and testing. Still another was to encourage HIV-positive pregnant women to enrol in PMTCT programmes to protect their babies. Like *Love Games*, the *Mulange One-on-One* spots target an urban audience and are transmitted in English. However, the introductory song and part of the title were significantly translated to ChiBemba (Limange *et al.* 2013; The Health Compass n.d.).

The last campaign that will be discussed here, the Komboni Housewives behavioural change intervention campaign, was a collaborative effort of various organizations, such as the Centre for Infectious Disease Research in Zambia (CIDRZ), the MOH, the MCDMCH, and Absolute Return for Kids (ARK). The London School of Hygiene & Tropical Medicine (LSHTM) also provided input on matters relating to research, behavioural change intervention design, and evaluation. The campaign sought to promote positive behaviours among caregivers that would help to reduce the incidence of diarrhoea among children aged five and under in Zambia. The three main behaviours that the campaign promoted were exclusive breast-feeding for the first six months of a child's life; specific hygiene practices, such as regular washing of hands with soap; and the administration of oral rehydration salts (ORS) and zinc to children with diarrhoea. The campaign ran over a period of six months and was targeted at women living in selected low-income areas in Lusaka Province, because the incidence of diarrhoea among children is typically higher in low-income neighbourhoods due to the various population dynamics already discussed (Komboni Housewives 2016a).

Although the campaign did not run a soap opera, it made use of the edutainment vehicle due to its proven efficacy and the dynamics of the target audience. The Komboni Housewives

⁴⁰ *Mulange* in ChiBemba means 'show him/her'.

campaign was multi-faceted and used diverse media to encourage the behaviours described above. Through skits performed at various fora (including community meetings, clinic sessions, and road shows), Komboni Housewives depicted a fictitious group of six women who live in the same community and who make it their business to gossip about other women in the neighbourhood who do not practice (or so they think) the positive behaviours that they pride themselves on practicing. The women have built themselves such a good reputation that other women in the community would love to be associated with them. The reputable women welcome into their group other women whom, they learn, also practice the positive behaviours (Komboni Housewives 2016a).

To summarise, this chapter has introduced public health communication in Zambia as it is currently practiced. It also traced the origins of health communication in the Global North and discussed the reasons that led to its rise and prominence in Zambia and Africa as a whole. The chapter also reviewed health communication policy in Zambia by surveying communication strategies that focused on the three areas chosen for this study, namely, HIV/AIDS, malaria, and maternal and child health. Finally, the chapter gave an overview of some health campaigns in Zambia and southern Africa and discussed how translation is used in the commonly employed entertainment-education model.

CHAPTER V

A SOCIOLOGICAL PERSPECTIVE OF TRANSLATION IN PUBLIC HEALTH COMMUNICATION

Tymoczko (2005; 2007) has problematized the concept of translation; she has pointed out that the definition of the word *translation* is based on Western conceptions of translation and that this tends to emphasize the Eurocentric nature of translation studies as a discipline. She has posited that the definition of translation as a cross-cultural concept must allow for the inclusion of theories, practices, and methodologies from other cultures. This means that conceptions of translation should not be based only on Western ideas and definitions of translation that are anchored on linguistic principles. Instead, conceptions from a target culture should equally be considered, as Toury (1980; 1982 cited in Tymoczko 2005) similarly proposed. Although translation studies has shown some encouraging signs of opening up in the last few decades, most of the current thinking and research about translation is based on Western concepts. Tymoczko has argued that, in order to internationalize the field, translation must be taken as an open or cluster concept which considers aspects of translation that are often ignored because they do not fall under the linguistic and textual conceptions of translation.

5.1 Translation and public health communication

Hatim and Mason (1989), among others, have described translation as “a communicative process which takes place within a social context” (p. 3). In fact, these authors have understood

translation to be “*an act of communication which attempts to relay, across cultural and linguistic boundaries, another act of communication*” (Hatim and Mason 1997: 1) (authors’ emphasis). As evidenced by the various health-related communication strategies and implementation plans surveyed, it is clear that one of the most important objectives of health communication is to elicit a specific, often predetermined response from the target audience. The response is often expected to be a change of perception or behaviour. The task of communicating, therefore, involves finding the best method(s) and identifying the best tools to deliver a message so that it resonates with the audience and draws out the desired response. Language becomes an important aspect of the communication process and translation plays a communicative role.

Easily understood within the cluster concept of translation and the concept of translation as an act of communication, there are, according to Jakobson ([1959]1966), three types of translation: interlingual, intralingual, and intersemiotic (233). Jakobson’s three categories are significant to this study because Zambia and most of the southern African region are societies that are strongly anchored in the oral tradition. Intersemiotic translation provides an important channel for studying translation in non-literate societies. Moreover, some of the socioeconomic and cultural determinants that affect health communication in Zambia inevitably make orality an important point to consider in translating public health messages. The importance of orality is precisely one of the reasons why earlier health promotion campaigns were criticized as paternalistic. Messages created on the basis of literate society principles are unlikely to effectively impact a predominantly non-literate audience. There have been greater efforts in the last decade to produce public health communication that takes into consideration the socioeconomic and cultural environments of target audiences. The literate/non-literate society dichotomy presents a challenge when only Western notions of translation are considered. In this respect, Bandia (2015) has highlighted the

importance of Jakobson's notions of translation in relation to orality: "From a pragmatic perspective, orality can be explored through the study of intra- and interlinguistic or intersemiotic translation practice" (125).

On face value, the Zambian health communication strategies do not appear to give translation prominence as a medium of communication. Nevertheless, translation, taken as a communicative act interacting with the socioeconomic and cultural aspects of the environment within which it is practiced, is implicit in the strategies and is certainly evident in the translation products, that is, the health IEC materials. The fact that translation is almost absent in health policies and strategies in Zambia and is mentioned only in passing in very narrow terms speaks to the hegemony of Western conceptions of translation. On the few occasions where translation is mentioned in the strategies, the reference is clearly to interlingual translation. In practice, it is evident that intralingual, intersemiotic, and even multimodal translation are more commonly used in public health communication since—I would argue, as does Bandia (2015)—these forms of translation are more practical in non-literate and oral societies. That these forms of translation are not addressed as translation in the strategies yet are utilized in practice suggests that they are not conceptualised as translation. It is not unreasonable to conclude that in Zambia the concept of translation is most identified with interlingual translation. Anything outside of translating from one language to another is not considered an aspect of translation but simply part of the communication process. This understanding is in line with the literate and textual views of translation that have been promoted by Eurocentric translation theories and approaches.

As discussed earlier, the language situation in Zambia likely plays a significant role in shaping how translation is viewed and practiced. In other southern African countries (such as South Africa) where local languages have a more defined official language status, interlingual translation

is much more common. Given the status of English in Zambia as the de facto “sole” official language or the first among equals, it is normally assumed that, if someone is literate, they can read and understand English, at least at some level. Most health communication strategies, therefore, are more concerned with delivering health messages to the public in a level of English that can be understood by the majority of the population rather than translating messages into local languages. A case in point was the decision by one of the leading USAID health communication projects in Zambia—the Communications Support for Health (CSH)—to not translate their printed IEC materials:

The logistics of materials distribution is an inherent challenge for any communications project in Zambia and translating print materials into seven local languages would only have further complicated this process. Further, translation frequently would have resulted in the need to redesign materials, taking time away from implementation. Because of this, CSH conducted a desk review on the benefit of print translation and found that previous research in Zambia indicates that most people who can read their local language can read English. CSH therefore made a decision not to translate any print material, although all radio and TV were translated, when possible. (Chemonics International Inc. 2014: 55–56)

In short, the print material (adaptions or intralingual translations) was mostly targeted at literate audiences while other oral-based channels of communication (intersemiotic and multimodal translations) were used for illiterate audiences:

To compensate for this decision, the project used picture-based messages as much as possible and introduced more complex materials, such as the Pregnancy Care Planner and the Growth Reminder Tool, via health workers who could explain the material to a community member.

Additionally, CSH made design files available to partners working in specific areas of the country who wanted to translate materials themselves, as the benefit of translation can extend beyond comprehension to engendering a feeling of ownership. Although translation would never be *inappropriate*, CSH operations research on the use of these materials supported this decision, with users of key Mothers Alive and First 1,000 Most Critical Days, reporting that the pictures on the material were sufficient to facilitate their use. (Chemonics International Inc. 2014: 56) (emphasis in original).

Although the reasons advanced for the preference for intralingual, intersemiotic, and multimodal translation are valid, greater use of interlingual translation even among a low literacy population has some undeniable benefits. When Underwood, Serlemitsos and Macwangi (2007) conducted a survey of Zambian adults' proficiency in reading health communication materials in both English and Zambian languages, their survey results revealed that respondents with a lower level of education preferred receiving—and better understood—printed health materials in Zambian languages than in English. The study also revealed that overall (regardless of their level of education), the respondents better understood information in health communication materials that were written at a fourth-grade level of English than an eighth-grade level. The researchers note that only a small portion of the respondents had a primary level of education and that these were mostly respondents living in rural areas. However, it is this demographic that preferred by far receiving the print materials in their mother tongue or the local language that was spoken in their area and familiar to them. Similarly, this demographic also demonstrated a much higher level of comprehension of health communication in local languages.

From a financial or logistical point of view, it might seem justifiable to produce the bulk of the printed health communication in fourth-grade level English because most people can read and understand it. Nevertheless, there is something to be said about producing IEC materials in local

languages. Although many campaigns make use of non-literate channels of communication (radio, television, pictorial-based materials) to reach lower literacy audiences in rural areas, print materials catered to this audience can be advantageous. Firstly, print materials such as brochures, posters, pamphlets, and leaflets have a longer life span and can be kept for future reference by the target audience. Secondly, printed health communication in local languages can be empowering in the sense that it promotes self-efficacy or belief in one's ability to perform a specific action. This, one might argue, could increase the chance of people acting upon the information they have received. Interestingly, the Underwood *et al.* (2007) survey also revealed that the majority of the respondents with a lower level of education felt that they would benefit from greater access to printed health communication in their local language. In addition, almost half of them reported sharing most of the information that they received from printed health communication in local languages with their less literate friends and family members.

The surveyed literature and strategies on health communication are unequivocal about the importance of involving the target audience in the process of producing IEC or BCC (Behaviour Change Communication) materials. Modern communication methods that seek to move away from the paternalistic practices of communicating health information to the public advocate taking into consideration the target audience's preferred modes of communication. They also advocate empowering methods that promote self-efficacy. In a comparative corpus linguistics study that examined HIV messaging in Germany and Nigeria, Antia and Razum (2012) found that, compared to the messages used in Germany, the messages used in Nigeria lacked strategies promoting empowerment and self-efficacy. Even when they take the different socioeconomic and cultural backgrounds of the two countries into account, these researchers note the much higher use of disempowering and paternalistic strategies in the Nigerian messages. For example, the Nigerian

messages used threatening language, avoided explicit language, and showed a bias towards specific, more culturally acceptable preventive methods, such as the ABC approach.⁴¹ On the other hand, the messages to the German audiences promoted self-efficacy. The content of these messages educated the public about the disease and available options of how to avoid infection. The messages used explicit language that was not threatening.

Studies such as the one carried out in Zambia by Underwood *et al.* (2007) are extremely important in informing communicators about some of the preferences of the target audience. The study suggests that, even when the demographic of functionally literate people residing in rural areas is very small, communicators should strive to incorporate their preferences into the materials being produced in order to avoid further perpetuating the inequalities that already exist between the rural and urban areas. One useful suggestion proposed by Underwood *et al.* (2007) is to provide simple brief summaries that are tailored for the low-literacy rural population, that are written in local languages, and that cover the most important points contained in the regular IECs used for larger-scale distribution.

Notwithstanding the fact that the language of predilection for health communication by both communicators and target audiences in Zambia is English, all three of Jakobson's forms of translation still play a significant role in disseminating public health information. Scholars might argue about the differences between intralingual translation, adaptation, and localization, but the repackaging of highly specialised medical information so that it can be understood by the non-scientist literate and non-literate public involves the act of translating and interpreting on many

⁴¹ The ABC approach refers to three methods of preventing HIV infection: A = abstinence, B = be faithful, and C = use condoms. Although this approach has been criticized by some quarters, it has been credited with having helped to drastically reduce the spread of infection in Uganda from a prevalence rate of 15% in 1991 to 5% in 2001 (Cohen, 2003).

levels. Translating public health communication requires moving beyond the early linguistic and linear ideas of translation which focused on source and target texts and which emphasized equivalence; it requires thinking beyond the conventional ideas of translation. For instance, the source text in public health communication is not always apparent. However, the communicated health message can still be considered a translation or a target text in the sense that it is rendering a message from whatever language or format into another language or format for a specific target audience. Health communication products often stem from specialised information offered by health experts and professionals, and most of this specialized medical information about diseases and epidemics and global prevention and mitigation strategies also originates from the West. In addition, most health communication originates from a printed format (Remington *et al.* 2002; Thomas 2006). In a developmental context such as sub-Saharan Africa, all this information has to be re-packaged into a suitable format or even language for a specific target audience. In short, behind every health communication message is a source text; it may not be apparent, but it exists. The expert information from both scientists and communicators, the information from largely Western sources, and the original printed version of information all form part of the “mega source text” that exists behind every health communication. It is more in this contextual “macro” sense than in a strictly “micro” comparative textual analysis sense that this study seeks to explore translation practices in health communication. In a nutshell, the study focuses more on the contextual aspects of translation practice. It is therefore important to understand the specific context of the case study.

Zambia’s *National Health Policy* separately addresses two important areas of health communication. This first is communication between health care providers and patients, and the second health promotion and education. The MOH’s objective for health promotion and education

is “to provide efficient and effective health education and promotion to empower individuals, families and communities with appropriate knowledge to develop and practice healthy lifestyles.” The MOH (2012) undertakes to “advocate for public policies that support and promote health” and “strengthen health education and promotion” (29). According to the organizational chart of the MOH, the Public Health Unit is responsible for health promotion and education and works with international and local cooperating partners on various health promotions and campaigns (WHO AFRO 2010).

As in the case of Communications Support for Health cited above, it is often the individual health communication programmes, projects, and campaigns that are left to decide whether to translate, what to translate, and how to translate. If they decide to translate any health messages into local languages, the task normally falls to native speakers who have been identified as having a strong command of their mother tongue and the skills required to translate. Those employed for the task include journalists, broadcasters, radio and television anchors specialised in local languages, as well as teachers and educators specialised in teaching and developing curriculum for Zambian languages.⁴² A quick survey of health communication strategies and various health promotion campaigns reveals that health messages conveyed through radio, television, drama, and song are often translated into local languages. However, printed information seems less likely to be translated into local languages. Reflective of Zambia’s linguistic profile, some local languages are translated into far more frequently than others.

⁴² Zambia does not have any formal translation schools.

5.2 Socioeconomic and cultural factors affecting translation and public health communication

One of the most important points to consider when it comes to translation and health communication is the context within which translation takes place. Some of the theories that have informed the fields of translation studies and health communication have tried to take this into consideration. The cultural turn, the sociological turn, and the postcolonial approach are a few examples of how translation studies as a discipline has tried to deal with the importance of context in translation. In health communication, theories such as social cognitive theory, the health belief model, and social support have also tried to link the environment or context to how a person receives health information, how they perceive it, and how they act upon it. Just as communicators study various aspects of their target audience before they decide on the approach and models to use when communicating important health information, translators (who are essentially communicators) also need to be aware of the context of their target audience before relaying health messages to them. Marais' (2014) translation and development concept offers a perspective which conceptualizes translation in interaction with social phenomena in a specific context, that is, the developing world or the Global South. The following sub-sections explore some of the social factors that help to define the notion of a developmental context and that, in one way or another, affect translation in health communication. These factors are, of course, not exclusive to the developing world but they are perhaps felt more acutely in less developed regions. The list of factors explored below is not exhaustive and seeks to highlight only some of the most salient issues vis-à-vis translation and health communication.

5.2.1 Illiteracy

The benefits of literacy cannot be overstated, but what is literacy? Firstly, literacy has often been understood through the problematic binary of literacy versus illiteracy. Secondly, the concept of literacy has varied across time periods, languages, and nations. Literacy has sometimes meant simply the ability to read and write. At other times, it has been equated with the broader and more inclusive concept of not just the ability to read and write but also the ability to assimilate and use information to adequately function in one's environment. In some languages, a literate person is someone who is knowledgeable and well-educated. In other languages, a literate person is anyone who can read, write, and count to any extent (UNESCO 2005). Later definitions of literacy also take into account a person's ability to use the more modern conduits of information, that is, information and communication technologies (ICTs). The United Nations Educational, Scientific and Cultural Organization sums up the concept of literacy as follows:

Beyond its conventional concept as a set of reading, writing and counting skills, literacy is now understood as a means of identification, understanding, interpretation, creation, and communication in an increasingly digital, text-mediated, information-rich and fast-changing world. (UNESCO Institute for Statistics n.d.)

Insofar as technology is an inescapable reality in the modern world, definitions of literacy that encompass technology risk declaring a whole swath of people illiterate just because they live in a world where they do not have access to ICTs. To the extent that the world is increasingly becoming digitized, the digital divide between the developed and developing world continues to be a matter of great concern since the divide perpetuates inequalities between the Global North and South. Although mobile phone use has grown exponentially in Africa in the last decade, the

cost of access to computers and the Internet is still very expensive and hence prohibitive for most of the population. Consequently, definitions of literacy should not suggest that lacking computer skills somehow equates to illiteracy. In the same vein, some scholars have argued that the most common definitions of literacy are problematic in the sense that they are based on Eurocentric notions of literacy—which are based on the text—and are taken to be universal, regardless of the context. In its *Education for All Global Monitoring Report*, UNESCO cites the example of oral expression as a potentially valuable contribution to the process of acquiring literacy skills. For example, in some societies, oral expression can be a powerful tool to encourage women and girls to gain confidence and higher self-esteem (Robinson 2003 cited in UNESCO 2005). Similarly, oral counting and mental arithmetic are valuable skills to have and can be harnessed for literacy skills training. Some adults who would be considered illiterate in other societies are able to do mental arithmetic in their everyday activities, such as in their small businesses, even better than those considered literate (Archer & Cottingham 1996 cited in UNESCO 2005).

Literacy has been directly linked to health by many scholars and researchers. According to UNESCO, “Literacy is also a driver for sustainable development in that it enables greater participation in the labour market; improves child and family health and nutrition; reduces poverty and expands life opportunities” (n.d.). It follows that literacy is also a significant determinant of how people seek, receive, and perceive information about their health. The *Zambia Demographic and Health Survey 2013–14* rightly states:

The ability to read is an important personal asset allowing women and men increased opportunities in life. In addition, knowledge of the literacy level of the population can help programme managers, especially those working in health and family planning, decide how to reach women and men with their messages (Central Statistical Office 2014: 37).

A survey carried out by the CSO to determine literacy levels among the Zambian population confirmed disparities in literacy levels between rural and urban areas, across demographics, as well as along gender lines. 83% of men between the ages of 15 and 49 were deemed literate while only 68% of women in the same demographic were considered literate. Literacy was higher for both men and women in the age demographic of 15 to 24, at 85% for men and 77% for women. Meanwhile, for the 40-to-49 age group it was around 81% for men and 60% for women. This indicates that literacy levels are getting better and that the younger generation has a higher chance of acquiring literacy skills than the older generation.⁴³ The literacy rate in the urban areas was 93% for men and 82% for women, whereas in the rural areas it was 73% for men and 54% for women. The method used to assess the levels of literacy (a reading test of a sentence in one of the seven official local languages given to respondents with less than a secondary school education) suggests that no distinction was made between the functionally and fully literate. This is not a problem in and of itself as it is in line with some of the methods used worldwide. However, it also suggests that the level of education was used as a measure of literacy, which might be problematic because statistics have shown that a small percentage of young people worldwide leave school each year without having acquired the basic literacy and numeracy skills. The survey also confirmed the well-known and already established strong correlation between literacy and economic status. Those in the upper echelons of society posted the highest literacy rates with 98% for men and 93% for women in the highest economic quintile and with 62% for men and 38% for women in the lowest quintile (CSO 2014).

⁴³ Zambia, like many countries in sub-Saharan Africa has a very young population. According to the World Factbook's figures for 2016, 46% of the population is 14 years and below; 20% between the ages of 15 and 24; 28% between 25 and 54; 3% between 55 and 64; and 2% 65 and over (Central Intelligence Agency 2016).

Global literacy statistics show that sub-Saharan Africa has the lowest regional literacy rates in the world; conversely, it has the highest illiteracy rates. In the southern African region, South Africa, Zimbabwe, Lesotho, Swaziland, Botswana, and Namibia have the highest literacy rates; on average, over 90% of the population is considered literate. Zambia follows with a rate of about 80%, while Angola and Malawi have a rate of between 70 and 79% on average. Mozambique has the lowest rate at about 60 to 69% (UNESCO Institute for Statistics 2016).

Literacy and illiteracy rates clearly have a significant impact on health communication and translation practices. Although the linguistic profiles and language policies of countries impact translation practices (as discussed above), literacy rates also partly explain why some translation practices are favoured more in some countries than others. As highlighted above, there is evidence to suggest that interlingual translation is practiced more frequently in South Africa than it is in Zambia—perhaps due to South Africa’s higher literacy rates.

It is worth noting that literacy and illiteracy do not necessarily translate into lower prevalence rates for diseases whose prevention is heavily dependent upon behavioural change. In fact, some of the countries with the highest literacy rates in southern Africa have the highest HIV/AIDS prevalence rates. South Africa has an adult literacy rate of 94% (98% among the youth) with very strong parity between men and women (93% literacy rate for women), but the country has an HIV/AIDS prevalence rate of about 19% for the 15-to-49 age group. Zimbabwe also has a fairly high adult literacy rate (88%) and a high HIV/AIDS prevalence rate (16% for the 15-to-49 age group). On the other hand, Mozambique, which has the lowest literacy rate in the region (in the 60% range), has an HIV/AIDS prevalence rate of around 13% (UNESCO n.d. b; UNAIDS n.d.). In Zambia, HIV/AIDS prevalence rates are consistently lower in rural areas, which traditionally have lower literacy rates. These statistics suggest that when it comes to HIV/AIDS, other

determinants (such as the status of women or culture) drive prevalence rates more significantly or, when combined with illiteracy, exacerbate the situation.

Given the complexities surrounding the definition of literacy, some scholars have suggested that the term be used in relation to the context within which it is applied (health, technology, sciences, arts, etc.) (UNESCO 2005). Kickbusch (2001) thus posited that health literacy is a “discrete form of literacy,” which is “becoming increasingly important for social, economic and health development” and should, therefore, be defined as a separate concept from general literacy (289). She cited a number of definitions that had been proposed by various scholars and organizations for the term “health literacy,” and she noted that the definition given by the United States Department of Health and Human Services takes a health promotion perspective. USDHHS (2000) defined health literacy as the “capacity to obtain, interpret and understand basic health information and services and the competence to use such information and services to enhance health” (cited in Kickbusch 2001: 293). Kickbusch (2001) pointed out that literacy and health promotion are not just about providing information and that involved parties must recognize the power dynamics that are involved in the whole transaction of seeking and disseminating information. Some groups, such as women or the poor and uneducated, are marginalized and do not have the same number of options or the same level of access to services and to information as others do. The goal of health literacy should, therefore, be to empower marginalized populations rather than to emphasize compliance as a measure of the success of programmes.

Cameron, Wolf, and Baker (2011) have discussed the problems associated with low health literacy and the negative impact it can have on health behaviour. Studies have shown that people with not only low literacy, but also low health literacy are more likely to experience poor health. They are more likely to have very limited knowledge of the most basic health issues and are also

more likely to be disposed to psychological behaviours such as shame, stigma, and denial (Parikh *et al.* 1996 cited in Cameron *et al.* 2011). They are also usually less proactive about their health and less likely to engage with their health care providers. Moreover, patients with low health literacy who suffer from chronic conditions fare much worse because they lack the skills to successfully manage themselves and their condition and to follow the instructions of their health care providers.

The literacy figures for the southern African region may not appear to be as dismal as those of other regions (such as West Africa) or those of particular countries (such as Benin, Burkina Faso, Chad, Mali, Guinea, Niger and Gambia⁴⁴). However, the situation in real terms is worse than it appears on paper. The fact that considerable inequalities exist between genders in terms of literacy presents a significant challenge. Information that specifically targets women on specific issues (such as reproductive health) must be packaged in a manner that accounts for the significantly lower level of literacy among women and girls. Other issues that are related to the status of women in a particular society (and which will be discussed in greater detail below) must be taken into consideration when developing messages for this demographic.

Another thing to keep in mind when considering the available literacy statistics is that they are not necessarily classified, meaning that all levels of literacy are included in the total figures. These all-encompassing figures present a problem in the sense that, although 90% of a given population might be labelled “literate,” only half that number might be able to read at a higher-grade level. In short, literacy is not a homogeneous value, and this reality further complicates the process of transmitting health information to the public. To this point, Lum *et al.* (2002) have given

⁴⁴ The latest figures available for these countries indicate that they all have a national literacy rate of less than 50%. Some, such as Mali, have literacy rates for women as low as 22% (UNESCO Institute for Statistics n.d.; Beegle *et al.* 2016).

the example of a literacy survey of adults that was carried out in the United States of America. The survey revealed that 90 million adults, that is 47% of the population at the time could read at only an eighth-grade level or below. In the case of Zambia, Underwood *et al.* (2007) have demonstrated that the majority of Zambians deemed literate could read and adequately understand only material written at a fourth-grade level of English (English not being their mother tongue).

Besides pointing out that literate adults might be able to read and understand at only a certain level, Lum *et al.* (2002) assert that people with low literacy often possess low numeracy skills and find specialised information (such as medical or health care information) challenging to process and comprehend. According to the researchers, the onus is therefore on health communication professionals to “simplify public health information for these audiences. Scientific concepts and technical terms must be introduced slowly and explained clearly and carefully. Great care must be taken when developing messages that contain potentially complex numbers” (50).

Lastly, the existence of more than one language inevitably adds another layer of complexity to the literacy issue. In addition to being simplified, messages may also have to be translated into vernacular languages depending on the target audience. The same literacy considerations mentioned above must be taken into account when translating messages, whatever the model of translation used.

5.2.2 Poverty

The UNDP defines poverty from a number of perspectives, the most common being absolute and relative. In absolute terms, poverty is defined according to the minimum income per day that an average family would need to sustain their basic necessities. Basic needs are defined by individual countries according to their specific social contexts. The World Bank sets the global

poverty line based on a number of economic factors, such as purchasing power parity (PPP). In 2016, the global poverty line was revised to US\$1.90 from US\$1.25. Most developing countries measure poverty according to the global poverty line and use it for planning purposes. In relative terms, poverty is defined according to how wealth is distributed in a given country in relation to its average income. People are considered poor if they fall below the average income that is deemed necessary for them to be able to sustain their livelihoods and participate in society. Many middle- and high-income countries use this method to define poverty. It is widely accepted that the poorer people are, the more they are excluded from participating in society and accessing resources and services (UNDP 2017b; World Bank 2017c).

Although these two perspectives of poverty form the basis for most definitions of the concept, several researchers, scholars, politicians, and organizations have defined poverty differently according to their purposes and beliefs. Poverty can, therefore, be measured in a number of ways according to the purpose or function of the required measurement. In line with its focus as an organization, the World Bank favours the income-based absolute poverty perspective, which it measures using the global poverty line. UNDP, on the other hand, prefers to measure poverty using different development-centred indicators, even though it defines poverty in absolute and relative terms. Along the lines of the Human Development Index (HDI), the UNDP developed the Human Poverty Index (HPI), which measures poverty on the basis of human development. The HPI was used to measure poverty in the Human Development Report from 1997 to 2009 and was replaced by the Multidimensional Poverty Index (MPI) in 2010. Based on Sen's (1999) capabilities approach to development, both the HDI and the MPI measure development and poverty respectively using the same human-centred indicators of health, education, and standard of living (Collin & Campbell 2008; Oxford Poverty and Human Development Initiative 2017). Many

scholars agree that these units of measure are more meaningful in especially developing countries as they measure not just a person's income but also their access, or lack thereof, to opportunities that concern their health, education, and standard of living. These units of measure also account for the social contexts of developing nations and avoid measurements used in developed countries whose contexts are vastly different. For example, it is a well-known fact that many countries in sub-Saharan Africa have been posting impressive GDP growth numbers in the last two decades. However, the national economic growth experienced on paper seldom translates to increased wealth for much of the population, especially the poorest and most vulnerable groups of society. Unlike GDP growth, the HDI and MPI, give a better understanding of the development and poverty situation in real terms.

Poverty is a global problem, and organizations, such as the World Bank and the UNDP, endeavour to eradicate it from the face of the earth.⁴⁵ Both MDG 1 and SDG 1 target poverty reduction. According to the World Bank (2017c), global efforts to reduce poverty have yielded some fruit. In 2010, MDG 1, which aimed to reduce poverty by 50 % between 1990 and 2015, was achieved five years ahead of schedule. Although all regions of the world saw poverty decline in that period, the most significant drop was experienced in China, Indonesia, and India. The reduction in sub-Saharan Africa was minimal compared to other regions. As of 2013, just over 10% of the world's population, that is, about 767 million people were living on less than US\$1.90 a day. About half of these, that is, 389 million people live in sub-Saharan Africa. The majority of

⁴⁵ The methodology and results of organizations fighting poverty (such as the World Bank and many other international NGOs) have been a subject of debate and have been strongly criticized by many groups. Some scholars have accused such organizations of being complicit in perpetuating the problem and profiting from what they call the "poverty industry" (Miller & Fitzgerald 2014).

the world's poorest are young people who live in the rural areas, who have very little education and whose livelihoods depend mostly on agriculture.

The Zambia Human Development Report (UNDP 2016) states that as of 2013, 74.3% of Zambia's total population was living below the international poverty line, which was US\$1.25 a day at the time. Rural areas were hardest hit, recording a poverty rate of 78%, whereas urban areas experienced a poverty rate of 27.5%. The more isolated and rural a region is, the more it is affected by poverty. Moreover, poverty typically affects larger, female-headed families more than it does smaller, male-headed families. 26% of all households in Africa are female-headed. In southern Africa, the figure is much worse at 43% (Beegle *et al.* 2016). Poor people are also typically the least educated and least healthy and lack access to resources and social services (UNDP 2016). In addition, existing inequalities exacerbate the problem of poverty. Statistics show that inequality is highest in southern Africa; seven of the ten most unequal countries in the world are in Africa, and most of them are in southern Africa. Inequality is mostly influenced by geographical location (urban and rural areas) and level of education (Beegle *et al.* 2016).

Several studies have established a correlation between poverty and health. Poorer people are more likely to face health problems, many of which are preventable. For example, cholera has a much higher prevalence rate among the poor. In fact, it occurs almost exclusively among the poor, likely due to their living conditions. The poor often live in shanty towns (slums or 'komboni' as they are commonly known in Zambia), which are always very highly populated, crowded areas that lack access to safe and reliable water supply, adequate and proper sanitation, electricity supply, garbage management services, roads, adequate health facilities, and schools. These conditions, unfortunately, make the shanty towns the perfect breeding ground for cholera, (not to mention

typhoid and malaria). As a result, Zambia and other countries in the region commonly experience cholera outbreaks.

Containing these outbreaks can be very challenging, and experts have noted that prevention provides a better way of dealing with these outbreaks than containment. As the example of cholera suggests, the implications of poverty for health communication and translation are many. First of all, it is important to recognize the significance of health communication and translation as tools to combat diseases (like cholera) that are more prevalent among the poor. Their significance means that messages must be carefully formulated so that they are both acceptable and accessible to this particular target audience. Because the poor are more likely to have high levels of illiteracy, one implication of poverty for health communication and translation is that the language and channels used must be easily understood by people with high levels of illiteracy. Messages to educate the residents of shanty towns must not only use appropriate language and media but also account for the ability of the residents to undertake some of the encouraged behavioural changes. For instance, people may understand that washing their hands is a healthy habit but be unable to do so if they cannot afford to buy soap or if water is scarce in their home and neighbourhood. They may also understand that they can be vaccinated against diseases (such as cholera) but are unlikely to do so if they cannot easily access vaccines in their neighbourhood. Messages must be adapted to the circumstances that the poor unavoidably face.

Messages may also have to take into account certain practices that are common among the local people and that should be discouraged because they could potentially be harmful to people's health. One example in Zambia is funeral ceremonies. During funerals, friends and relatives gather at the house of the deceased and normally leave on only the third day, after the burial. Because cholera is a highly contagious disease spread through contaminated water or food, funerals are a

very risky practice during outbreaks. As a result, gatherings of any kind—including funerals—are strictly forbidden during outbreaks, and health authorities sometimes quarantine affected areas of the city. If a deceased person is suspected to have died from cholera, the authorities safely dispose of their remains, and family members are not allowed to gather for the wake nor even organize a funeral.

The *Zambian National Health Policy* (MOH 2012: 4) has posited that poverty not only impacts the prevalence of infectious diseases but also affects nutrition and fertility. Statistics show that the poor and especially the rural poor are harder hit by malnutrition. Furthermore, poor women and especially poor rural women have a fertility rate that is more than twice that of their more economically well-off and often more educated urban counterparts. The average number of children that women in the lowest economic quintile have compared to those in the highest economic quintile is 8.4 to 3.4. Similarly, the average number of children for rural versus urban women is 7.5 and 4.3 respectively. The women with the most unfavourable circumstances in life are the ones who have the most number of children, which only perpetuates their cycle of poverty. This clearly demonstrates that the less privileged women are the ones most in need of information, education, and services pertaining to reproductive health. However, the issue is not that simple and will be discussed in greater detail below.

5.2.3 Disease burden

As mentioned earlier, the MOH identifies the following health issues as the leading causes of the country's high disease burden: HIV/AIDS; malaria; tuberculosis; diarrhoeal diseases; maternal, neonatal and child health problems; and non-communicable diseases, such as heart disease, diabetes, hypertension, and cancer. These conditions are the leading causes of illness and

death among the Zambian population. Often referred to as the epicentre of HIV/AIDS, southern Africa has a high disease burden largely due to this disease. Aside from the major disease incidences that drive the disease burden up, the interaction of all the socioeconomic and cultural factors discussed here abets a high disease burden and accentuates the need for public health communication.

A high disease burden means that there are many priority areas that require serious and meaningful interventions and preventive measures. It also means that there are many priority areas competing for the very few available resources (financial, human, etc.) that are needed in especially developing contexts. The implications for translation in health communication is that translation is not seen as a priority amid all the other pressing public health issues, such as epidemics. The increased need for health education and promotion as a potentially effective means of reducing the disease burden puts developing nations in a dilemma; they must decide whether prevention or mitigation is more of a priority.

Public health communication, while important, costs money. Zambia, like other nations with few resources, finds itself relying on international cooperating partners in terms of both finances and expertise to launch and run effective health campaigns. Since some issues receive more funding from donors than others, such reliance has resulted in unbalanced coverage of the important health issues that require sensitization and awareness. For example, most public health communication campaigns are on some aspect or other of HIV/AIDS because donors give HIV/AIDS overwhelmingly more attention than other health issues. Reliance on donors has also resulted in inconsistent programme continuity; many campaigns are launched on a short-term basis and often lack follow-up phases because they are tied to some external funding.

5.2.4 Gender disparities

Statistics reveal historical gender imbalances in many aspects of life globally and that gender disparities are worst in developing countries, where, one might argue, gender equality would most improve the livelihoods of the people.

One example of gender imbalance is that women are less likely to be educated than men in many regions of the world. However, international organizations and scholars have extolled the virtues of educating women. In fact, several studies have shown that educating women and girls is beneficial to human development. The longer women stay in school, the better the outcomes for themselves and their children in terms of health and nutrition, education, and general well-being. As the saying goes, educate a woman and you educate a whole nation. Although the benefits of educating and empowering women and girls have been widely studied and accepted by institutions and people in places of authority, gender inequalities persist.

But education is not the only area in which women and girls experience gender imbalance. Women and girls are vulnerable in many ways and are often discriminated against. Nussbaum (2000) aptly summarizes the status of women globally:

Women in much of the world lack support for fundamental functions of a human life. They are less well nourished than men, less healthy, more vulnerable to physical violence and sexual abuse. They are much less likely than men to be literate, and still less likely to have pre-professional or technical education. Should they attempt to enter the workplace, they face greater obstacles, including intimidation from family or spouse, sex discrimination in hiring, and sexual harassment in the workplace – all, frequently, without effective legal recourse. Similar obstacles often impede their effective participation in political life. In many nations women are not full equals under the law: they do not have the same property rights

as men, the same rights to make a contract, the same rights of association, mobility, and religious liberty. (1)

Governments and authorities in many nations, Zambia included, have shown commitment towards eliminating gender inequalities. However, practice often does not match policy. In a patriarchal society where notions about gender are culturally ingrained, it takes more than just policies to change people's attitudes. Nevertheless, policies are a good place to begin to challenge some of the socially constructed narratives and assigned gender roles that shape human society.

In terms of policy, there have been some positive changes in Zambia in the last two decades. The country formulated its first national gender policy in 2000, which was revised in 2014. In 2012, it created the Ministry of Gender and Child Development, whose mandate is to guide the government's gender policy and oversee the implementation of the gender strategic plan. Other positive changes include the formulation and enactment of legislation protecting women, such as the 2011 Anti-Gender Based Violence Act No.1 and the 2007 Matrimonial Causes Act No. 20. There have also been efforts to implement affirmative action policies in sectors such as education, health, and the public service (Ministry of Gender and Child Development 2014a). To summarise, Zambia has come a long way from the days when an abused woman seeking help from the police would be turned away simply because her abuser was her husband and the police had a policy of not intervening in "domestic" matters. Police now have a victim support unit to deal with gender-based violence.

While the policy front paints a pretty picture of the gender situation in Zambia, the statistics show a very different story. One needs only to look at the figures for HIV/AIDS prevalence, illiteracy, education, poverty, employment to know that there is a serious gender inequality

problem in Zambia, as in southern Africa and sub-Saharan Africa as a whole. All the statistics show that women are disadvantaged in many aspects of life. Systemic imbalances are commonplace when it comes to access to services, resources, and finances. Because women are more affected by lower literacy and education, it follows that women also occupy lower positions and earn less than their male counterparts on the job market. According to Carrasco Miro (2016), globally, women earn 30% less than men do. There are also far fewer women in positions of decision-making and authority in both politics and industry. In Zambia, only 18.1% of members of Parliament are women, whereas 81.9% are men (National Assembly of Zambia, 2017). The figures are higher in countries that have introduced gender quota systems (such as Rwanda, Kenya, Tanzania, Mozambique, South Africa, and Namibia).⁴⁶

More disturbingly, women are also victims of both verbal and physical abuse and violence in their homes, their workplaces, and their communities. Poverty and some cultural norms and traditions make women more vulnerable to these vices. The Ministry of Gender and Child Development (MGCD) reported that, in spite of sensitization efforts, incidences of gender-based violence have been increasing. Statistics from the Victim Support Unit show that 11,000 cases of gender-based violence were reported for 2011, while 12,000 were reported for 2012. The latest figures posted on the MGCD website indicate that over 18,000 cases were reported for the year 2015 (MGCD 2014b, 2016). These figures reflect only the number of incidences that were actually reported to the police. Studies have shown that in many cases women do not report cases of

⁴⁶ Although the Zambian Government touts the fact that, for the first time in its history, Zambia has a female vice-president, the country's gender imbalance in Parliament is amongst the worst in the region. In addition, while a female vice-president is a positive move in the right direction which should be applauded, having a woman in the second-highest office in the land does not in and of itself guarantee more gender equality in the nation. In some countries where the gender quotas have been introduced, some sections of society have argued that access to them depends on patronage and political affiliations and that the women selected for these positions do not have a real voice and tend to rubber stamp everything that the men decide. It is argued that the semblance of gender equality has in a way become a tool that Africa's leaders use to pander to donor agencies.

violence and abuse for various reasons, such as intimidation and fear of retribution. Social norms also prevent women from reporting cases of violence, especially if the perpetrator happens to be a member of their family, which is quite often the case. Beegle *et al.* (2016) reported that, according to the 2014 World Bank figures, more than 700 million women the world over are victims of domestic violence (97–100). Africa has the second highest figure after South Asia, with 40% of women who have partners having experienced domestic violence. Beegle *et al.* (2016) also cited the Demographic Health Surveys from 2000 to 2013, which indicated that while tolerance of domestic violence has declined since 2000–2006, Africa still has the highest figure of acceptance of domestic violence—30% of women surveyed as opposed to the 14% average for the rest of the developing world.

The biggest impediment to gender equality in sub-Saharan Africa has been social and cultural norms. Whereas most governments recognize the importance of gender equality to development and have put in place policies and laws to encourage gender equality, citizens have not embraced the idea. An Afrobarometer survey done in 2015 revealed that about 25% of Africans were against equality between men and women (Carrasco Miro 2016). Governments of sub-Saharan African countries have to do more to ensure that laws are enforced and that programmes and policies are followed through. Public health communication is a means through which translators, communication and behavioural change specialists, and governments can become powerful agents to challenge some of the harmful cultural concepts and practices and to encourage wider acceptance of gender equality among citizens.

Gender inequality is a significant determinant of women's health. It impacts how women seek, access, and receive information relating to their health. In some cultures, women require their husband's permission to receive health care. In addition, due to their often low levels of education

and high levels of poverty and illiteracy, women are vulnerable to cultural practices such as early marriages. This, in turn, puts them at risk of maternal mortality because they are forced into motherhood at very young ages (Carrasco Miro 2016). Women in these situations are also more likely not to have access to reproductive health and family planning services and they are more likely to not know about the existence and benefits of these services. Studies have shown that the number of children a woman has does have a bearing—positive or negative depending on the number—on the health and the socioeconomic well-being of both the mother and the child. However, cultural norms that emphasize the role of women as mothers put pressure on women to have more children, sometimes to their detriment.

Marginalised and vulnerable groups of women constitute a specific target audience for potentially life-saving health messages on issues such as reproductive health and child nutrition. Some messages might be directly targeted at women, whereas other messages meant for the general public might have to be adapted specifically for women. The media and channel used are of cardinal importance because the way women access information will undoubtedly vary according to environment, situation, education, culture, and socioeconomic status. Issues of power relations and control (including who makes decisions in homes) must be considered. In some cases, women may not have access to media, such as radio, even if their household owns a set. In homes with very asymmetrical relationships between husbands and wives, it is very conceivable that the woman is not allowed to listen to the radio, let alone turn it on and listen to a programme of her choice. Ideally, all messages should be culturally sensitive while at the same time being gender sensitive. Communicators and translators should take care not to reinforce negative stereotypes about women's and men's roles and statuses in partnerships and in society. Gender-sensitive messages should, for instance, empower women while respecting neutral cultural norms that are

not harmful. They should portray positive images of both women and men (Zaman & Underwood 2003).

At the height of the HIV/AIDS epidemic in the early 2000s, a team of scholars researching in rural Kenya described some of the gender issues observed during their mission. During interpersonal communication meetings attended by both men and women, it was hard to get any opinions or contributions from the women, since very few of them spoke in the presence of the men. However, when the meetings were held separately for men and women, there was a much higher level of participation from the women. It was, unfortunately, also reported that one woman was later beaten by her husband for attending the meeting at all. Another observation was that there were certain subjects, such as family planning, that the women were not comfortable discussing with the scholars and or their husbands. Other issues, such as infidelity, were easily accepted by the women and seldom discussed. The scholars also learnt that, because the women did most of the subsistence farming for their families, they preferred having many children so that they could have more hands to work on their small farms. The women also considered children as a social insurance for themselves later in life. Another thing the scholars learnt was that the social network that the women had formed amongst themselves was a very effective way of getting messages across. In most cases, this verbal social network was used to spread untruths and myths about diseases such as AIDS, but the scholars realised that they could use the same channel to transmit correct information to the women (Friday 2002). Although these examples are from just one country, situations like these are quite common worldwide and they reflect the kind of problems facing women daily and affecting their ability to seek and access health information.

Information taken from the 2005–2013 Demographic and Health Surveys showed that about 46% of husbands in Africa make the final decision concerning the health care of their wives. It

also showed that younger women, poor women, and women who live in the rural areas participated less in their own health care decisions than other women. Although there has been an upswing in women participating in decision-making in domestic, social, and political aspects of life, Beegle *et al.* (2016) note:

The final decision on whether a married woman can visit friends or family lies with the husband alone in 40 percent of African households, compared with 33 percent in the rest of the developing world. Control over a woman's earnings lies fully with someone else in only 10 percent of households. (105)

5.2.5 Digital divide

The digital divide is an expression that has traditionally been used to describe the gap that exists in terms of access to computers and the Internet between the privileged and the underprivileged, the haves and the have-nots. According to J. A. van Dijk (2006),

The digital divide commonly refers to the gap between those who do and those who do not have access to new forms of information technology. Most of these forms are computers and their networks but other digital equipment such as mobile telephony and digital television are not ruled out by some users of the term. (221–222)

J. A. van Dijk (2006) has explained that the term “digital divide” can be rather misleading since the situation has evolved since the term was first coined and used.

At the dawn of the information age, the initial concern was unequal access to the expensive physical equipment and infrastructure that comprised ICTs (hardware, software, network

infrastructure, etc.). The concern was that poorer countries which could not afford the equipment and infrastructure would not be able to keep abreast with the latest developments and would be left behind in the knowledge economy that the world was fast becoming. Although the physical access problem may not be as acute as it was at the outset, other forms of digital divide have since manifested. J. A. van Dijk (2006) has pointed out that the digital divide is reflected in inequalities in social and political participation, acquirement of skills, and capabilities. Similarly, Rhoten (2006) cites former UN secretary general Koffi Annan, who, in a speech given at the World Summit on the Information Society in Geneva, enumerated the different gaps that, in his view, constituted the digital divide. These gaps were the technological divide, content divide, gender divide, and commercial divide. Citing several world leaders who also spoke at the summit, Rhoten (2006) adds to these categories the language divide and the socioeconomic divide (89–90). The various leaders pointed out that a large majority of the sites on the Web were in English or other European languages, which, of course, risked creating a divide for those who were not literate in these languages.

In a highly digitized world, it is clear that technological advances will only increase over the years and decades to come. The use of ICTs is only going to increase. On the one hand, many scholars have touted the benefits of ICTs for development—they can be used in education, health, industry, agriculture, commerce, and services. There is no denying that we live in an information age and that access to information has become a powerful tool for development and for gaining competitive advantage in various sectors of society. On the other hand, several scholars have also criticized ICTs for further perpetuating existing socioeconomic inequalities that have persisted in the world. The very factors that have driven inequality (illiteracy, poverty, gender inequalities, etc.) are the same factors that prevent underprivileged and marginalized groups of people from

benefiting from ICTs. The digital divide exists between the Global North and South, between developed and developing countries, between genders, between other demographics, and between different socioeconomic and geographic segments of the population within countries (Alampay 2009).

The latest figures from the International Telecommunications Union (ITU) confirm the increasing use of ICTs globally. Even regions that have been lagging behind have seen an increased use of ICTs. The increase is more pronounced among young people aged 15 to 24 than it is among the older generation. This is a positive trend as it suggests a narrowing of the divide in years to come. In developing countries, 67% of young people use the Internet compared with 94% of the same age group in developed countries. According to the ITU estimations for 2017, the region with the highest number of mobile cellular phone subscriptions by far is the Asia and Pacific region (4,230 million) followed by the Americas in a distant second (1,145 million), Africa in third (759 million), and Europe, fourth (745 million). To the extent that population has a huge bearing on the figures, the data does give an indication of the degree to which mobile cellular phones have spread globally. What is interesting to note is the growth of mobile cellular phone subscriptions in developing countries in the last two decades. From 87 million subscriptions in 2005 to 759 million subscriptions in 2017, Africa has experienced a significant growth rate. Meanwhile, Europe went from 550 million subscriptions in 2005 to 745 million in 2017. In short, the two fastest-growing regions according to the ITU classifications, are Africa and the Asia and Pacific region, both of which are part of the developing world (International Telecommunications Union 2017).

With the increase in cell phone subscriptions in Africa, mobile broadband subscriptions have gone up significantly from 14 million in 2010 to an estimation of 253 million in 2017. Africa is still lagging behind when it comes to the more expensive fixed broadband subscriptions with only

4 million in 2017 compared to 21 million for the region with the next lowest subscriptions, that is, the Arab states. These statistics clearly show that access to the Internet is still out of reach for most people. The figures also indicate that most people who have access to the Internet in Africa get it through their cell phones, that is, through mobile broadband subscriptions, which are cheaper. From the above figures, it can be concluded that roughly only about a third of all cell phone subscribers in Africa have access to the Internet through mobile broadband subscriptions. That is not to say that only these cell phone subscribers have access to the Internet. In Zambia, Internet cafés are popular, and many people access the Internet through them. Internet cafés, along with commercial, governmental and non-governmental organizations, are able to afford fixed broadband connections. According to the ITU statistics, there are only 21.8 individuals per 100 inhabitants using the Internet in Africa as of 2017, which is the lowest figure among all the regions. The next lowest figures are 43.7 and 43.9 per 100 inhabitants for the Arab states and the Asia and Pacific regions respectively. Africa also has the lowest number of households that own a computer (10.3 per 100 inhabitants compared to 44.4 and 39.1 for the Arab states and the Asia and Pacific region respectively) and that have Internet access at home (18.0 per 100 inhabitants compared to 47.2 and 48.1 for the Arab states and Asia and Pacific regions respectively) (International Telecommunications Union 2017).

More men than women use the Internet in many countries (about two-thirds) worldwide, but the gap is widest in Africa. The data show that the proportion of women to men using the Internet is 13% lower for women globally and 25% lower for women in Africa. In fact, although the ITU figures for Africa indicate a relatively high uptake of ICTs on the continent, there has actually been a 4.3% decrease in the proportion of women to men using the internet in Africa since 2013 (International Telecommunications Union, 2017). Interestingly, the ITU points out that countries

that have achieved gender parity in terms of enrollment in postsecondary institutions of learning have also demonstrated gender parity in Internet use. Africa has not achieved gender parity in postsecondary institutions of learning, and this correlates with gender inequality in Internet usage.

ICTs include a broad range of information and communication technologies, such as telephone, television, radio, computers, and the Internet. ICTs are used for the more traditional method of delivering information through printed material (brochures, leaflets, posters, etc.) as well as for more modern methods of delivering information audibly, visually, and even interactively via the Internet.

Disseminating public health information has been made much easier with the help of ICTs. One of the most significant advantages of ICTs is that they have facilitated the task of information storage and retrieval. ICTs also encourage innovation and increase the possibilities of how messages can be packaged and delivered. Moreover, ICTs have facilitated the task of translating messages into languages and forms that are suitable for the target audience. Translation memories and technologies use ICTs to translate information from one language to another. Translators can also use ICTs to translate information from a textual format to a visual or audio format. ICTs are therefore a powerful medium of translation.

Some forms of ICTs have the advantage of being able to deliver a message to even recipients who are not very familiar with technology. For example, one of the most powerful and effective forms of message delivery in sub-Saharan Africa has been the use of audio and visual forms of ICTs, such as radio, television, or video. The target audience does not need to have any technological skills to watch or listen to a specific message if the required equipment is available (or if interpreters are available for those with visual and auditory challenges). The translators and communicators, on the other hand, need to have the necessary skills to design a message using an

ICT medium. In a nutshell, while inequalities due to the digital divide are real and can be a serious impediment vis-à-vis public health information, ICTs can be useful tools if applied appropriately.

The problem of a digital divide comes in when individuals or nations are unable to access ICTs (such as televisions, computers, and the required connectivity infrastructure) because they are too expensive. The divide equally manifests when some groups of people are cut off from the potential benefits of new technologies because they do not have adequate skills to exploit these tools to their advantage. In as much as ICTs facilitate the dissemination of public health information, the lack of them can also restrict the way in which information can be delivered. For example, in most of rural Africa, the Internet is not an option because of the lack of equipment and infrastructure as well as the lack of skills on the part of the target audience.

Alampay (2009) points out that some scholars have expressed optimism about the chances of the developing world bridging the digital divide through leapfrogging. The development concept of leapfrogging essentially means that, since technology is a fast-developing sector, countries that have been lagging behind can catch up quickly by taking advantage of the continuing technological advances, which make technology cheaper and therefore more accessible. The notion of leapfrogging stems from the idea that developing countries can get onto the technology bandwagon without having to go through all the developmental stages of technology that developed countries had to go through. For instance, in the case of mobile phones, many subscribers in Africa, especially rural Africa, did not have to go through the landline phase but moved directly to cell phones because they were cheaper and more accessible and offered more innovative ways of communicating, such as text messaging. Although this optimistic view paints the ideal situation, the reason why this has not happened on a full-scale should not be ignored. The lack of resources among many competing needs such as health and education have prevented this

ideal. Insofar as ICTs can be used for development, they cannot be fully exploited if the existing barriers of inequality and poverty are not removed. Although the prices of ICTs are falling—consider the \$35 touchscreen laptop developed by the Indian Institute of Technology and the Indian Institute of Science—prices cannot fall low enough for families that live in extreme poverty (Alampay 2009). Until inequalities have been drastically reduced and the digital divide sufficiently bridged to enable everyone to fully exploit ICTs, other more appropriate methods of translating and communicating vital health messages (such as interpreting and interpersonal communication) will have to be used.

5.2.6 Access to health care services

Public health communication is predicated on the availability of health care services that people can easily access in response to the information that is disseminated to them. It would be pointless to run public health communication campaigns if people could not act upon the messages received. In short, before any health information can be designed, generated, and translated into an appropriate format for a specific audience, there must be a health care service available. In fact, according to communication experts, one of the principal requirements of a health message is that it must provide the recipient with information about the next step to take, that is, who to contact or where to go as a follow-up to the message.

However, in spite of the WHO-led global efforts to improve access to health care for all, inequalities persist. Several studies have demonstrated that access to health care is one of the most important issues when it comes to achieving positive health outcomes for people the world over. In most cases, what keeps the poor in developing countries from having healthier lives is access to health care. Many deaths in developing countries including Zambia can be prevented with

improved access to health care. Many children have needlessly lost their lives from conditions, like pneumonia, malaria, or dehydration caused by diarrhoeal diseases, which could have easily been treated at a health facility. Lack of access to health care is a significant driver of high morbidity and mortality rates and it affects the poorest sections of society the most. Lack of access can also discourage people from seeking health information. Access to health care involves many dynamics: physical access and distance to health care facilities; affordability; availability of care, equipment, and human expertise; and acceptability from the perspective of the community (O'Donnell 2007; Peters *et al.* 2008).

The majority of Zambia's population live in the rural areas. However, the rate of urbanization has been quite rapid over the past few decades. The 2010 census revealed that 40% of the total population lived in urban areas, up from 35% in the previous census in 2000 (CSO 2014: 3). The rate of urbanization varies from province to province with some provinces having much higher rates than others. For example, 85% of the residents of Lusaka Province live in the urban areas whereas only 13% of the population in Eastern Province live in the urban areas. As discussed earlier, the urban areas in Zambia are centred along the rail line, which connects them to one another and makes them easier to reach than the more distant rural areas. In recent years, successive governments have made efforts to improve the road network in order to ease access to the rural areas. Nevertheless, connectivity by road, rail, and telecommunications remains problematic.

Rural areas have traditionally been neglected in terms of infrastructure and development during both the colonial and postcolonial eras. As a result, they perpetually lag behind in all areas of life. Statistics show that they are always the hardest hit by socioeconomic issues like poverty and inequality (Peters *et al.* 2008). Health facilities in rural areas are few and far between. People have been known to walk long distances to receive health care because there is no facility nearby

and they do have access to any means of transportation. The health facilities in rural areas are also usually poorly staffed and the worst equipped. Often, there are no emergency response services for people living in the rural areas and the quality of the care they receive is inferior to what is obtained in urban areas. It is no wonder that health facilities in rural areas in developing countries are not utilized as much as those in urban areas; due to the above reasons, people have no incentives to use these services. In addition, lower levels of education, higher levels of illiteracy, and some cultural beliefs and practices all contribute to the low usage of health facilities in rural areas. Studies have shown that rural areas often have the lowest numbers of children immunized as well as the lowest number of women who give birth at health facilities with the attendance of a professional health care worker. Rural areas also have the lowest number of women who use family planning services and, conversely, these areas have higher birth rates (O'Donnell 2007; CSO 2014).

The fact that user fees have been abolished in Zambia and many other countries in sub-Saharan Africa has not necessarily translated into more affordable services for those in rural areas. There is perennial underfunding of the health sector. On top of this issue, an important source of funding has been cut and not replaced, making operations more difficult and increasing shortages of equipment and drugs for especially rural health care facilities. The quality of primary health care provided in rural facilities has not improved and sometimes some of the expenses are passed on to the users. For example, patients have often been asked to pay for their own prescription medication or even simple supplies such as bandages or gloves because the health facility had run out of them. Furthermore, getting to the health institution can also pose a financial problem for users, and this financial burden discourages them from seeking medical attention from a health facility (especially since they would likely face extremely long wait times once they arrive).

Sometimes patients in rural areas are referred to higher level hospitals in the urban areas, and this also constitutes a major expense for them as they must travel long distances to receive care. These trips often mean paying for food and accommodation in the urban area for the family members accompanying the patient to the tertiary hospital (Peters *et al.* 2008).

With regard to acceptability, the lack of education and the existing strong cultural beliefs among rural populations are more likely to lead to a lower appreciation of modern medicine. In Zambia, as in most of sub-Saharan Africa, it is common for especially less educated people to have a higher esteem for traditional medicine and traditional doctors than for modern medicine. Their value for traditional treatment is reinforced by the fact that, in most cases, the traditional doctor is someone from the community and therefore easily accessible compared to the health facility which services their area. An extra incentive for people to seek health care from traditional doctors is the fact that the traditional doctor's fees are also likely to be much lower than prescription drugs (Peters *et al.* 2008). Moreover, it is hard for people living in the rural areas with lower levels of education to appreciate the benefits of health care if these benefits have not been demonstrated to them through better quality and better access to modern health care services. Convincing people of the benefits requires showing them exactly how a particular service can improve their own lives. This is particularly true for people whose beliefs are anchored in traditional medicine, because they often lack an appreciation of the more precise nature of modern medicine, which has more tools to identify a problem and treat it more promptly and adequately. Since they do not understand the value of modern medicine, users often delay seeking attention from medical institutions until they have failed to find a solution through traditional medicine, by which time it is often too late. Unfortunately, the fact that they have sought modern health care too late only reinforces their negative perceptions of modern medicine, because they do not associate their unfavourable

outcomes with their lateness in seeking medical attention (O'Donnell 2007). In short, all the conditions in the rural areas discussed here predispose rural populations to a lower appreciation of primary health care provided through public services. The irony is that poor people in the rural areas who stand to gain the most from health care services are the ones who use them the least. It is regrettable that government institutions are often in a self-defeating cycle when they rightly identify that health education and promotion are important but fail to match the message with the service.

Another reason why it is so challenging for public health communication to engage with rural communities and successfully sell the product of primary health care to them is that rural areas are hard to reach, even for health communicators and translation agents.

Several developing countries have implemented community health worker (CHW) programmes to fill in the gap created by critical shortages of health care workers in rural areas. In Zambia, it is estimated that 40% of the vacancies in the health sector in rural areas remain unfilled. Following the Ethiopian model, Zambia initially began its CHW by recruiting members of rural communities as community health volunteers to perform simple tasks largely centred on health education and promotion. The idea was reinforced by the global health focus on primary health care which sought to provide basic health care as close as possible to citizens within their communities. In the wake of the MDGs, a number of studies as well as guidelines from WHO recommended the scaling up of the CHW programme as an integral part of the health care system and as a way of enhancing sub-Saharan Africa's chances of achieving MDGs 4, 5, and 6. Many countries in sub-Saharan Africa have since established or expanded a form of the CHW programme. For example, all of the countries of eastern and southern Africa have CHWs. In most of these countries, some formal training is offered to the CHWs and, in most cases, they can

perform basic health care interventions, such as rapid diagnostic testing for malaria (Singh & Sachs 2013).

In addition to CHWs, Zambia has community health assistants (CHAs). CHAs are selected from among volunteer CHWs and are put through a one-year training programme (based on the major health issues that the country faces) in addition to the six-weeks training they received as volunteer CHWs. To be accepted into the programme, CHAs must have completed high school (CHWs only need to be literate) and must be residents of the rural community that they are to serve. They must have been nominated by their community leaders and the health care professionals they served under during their time as volunteers. After their training period, CHAs are deployed to serve in their community as employees with a salary from the MOH (which sustains the programme with funding from both GRZ and cooperating partners). They are expected to spend 20% of their time working at the health post assisting the health care professional—usually a trained nurse or clinical officer—in tasks like taking weight and vital signs, making beds, and registering patients. The remaining time (80%) is spent working in the community carrying out health education and promotion activities. They may carry out immunization campaigns or distribute preventive tools, like mosquito nets, vitamin supplements, and prescription drug refills. They are also expected to do home visits, where, for example, they monitor compliance or administer medication to patients who are not able to visit the health post.

CHWs are evidently effective *translation agents* in health communication, since they not only speak the language that their clients speak but also understand their clients' belief systems, and way of life. The MOH (2010) refers to them as “members of communities who work either for pay or as volunteers in association with the local health care system [...] and [who] usually share ethnicity, language, socioeconomic status and life experiences with the community members

they serve” (8). In addition to communicating the language of the people they serve, CHWs also translate specialised health information by explaining how certain medicines should be taken or demonstrating how to install LLINs or how to make oral rehydration salts (ORS) or how to purify drinking water with chlorine. Because they interact closely with the community, they are also able to identify people who require medical attention or counselling and advise them accordingly. Studies have shown that the interpersonal method of health communication can sometimes be the most effective method of influencing people to adopt healthier behaviours (Kumar *et al.* 2014; Perry *et al.* 2017; MOH 2010).

5.2.7 Culture

The notion of culture has had a significant impact on many disciplines in the humanities and social sciences, including translation studies, anthropology, ethnography, and media and communication studies to name but a few. The significance of culture is now a widely accepted fact across disciplines. Of particular pertinence to this study is how culture inevitably shapes the way public health information is disseminated and how translation as part of the process of health education and promotion is also affected by culture.

Health communication as a field uses a number of approaches to deal with cultural diversity. Although care needs to be taken not to form stereotypical images of certain groups of people, the cultural sensitivity approach is useful in that it helps to centre all forms of health communication on the cultural characteristics and norms of the target audience. Dutta and Basu (2011) highlighted the fact that Asian, African, and Latin American cultures tend to construct their concepts of health issues around the family and the community, whereas Western cultures often see health as an individual responsibility. It is also common for people from some cultures to ascribe a significant

amount of importance to issues of spirituality and traditional beliefs. In health communication, cultural sensitivity, which can be referred to by various other terms such as cultural appropriateness or ethnical sensitivity, is defined as:

The extent to which ethnic/cultural characteristics, experiences, norms, values, behavioural patterns, and beliefs of a target population as well as relevant historical, environmental, and social forces are incorporated in the design, delivery, and evaluation of targeted health promotion materials and programs. (Resnicow *et al.* 2000: 272)

Other approaches through which health communication addresses culture are the ethnographic approach, the structure-centred approach, and the culture-centred approach. The ethnographic approach “emphasizes the dynamic nature of culture and seeks to engage the local contexts within which cultural meanings are constituted.” (Dutta & Basu 2011: 332). It deals with health communication in relation to the environment or social structure within which it operates. The social structure refers to all the systems and resources that are available or lacking in the target audience’s environment. The structure-centred approach recognizes that health campaigns alone cannot solve health problems; resolving the issues surrounding the social structure must be part of the solution. The culture-centred approach criticizes the Eurocentric model of health communication which proposes Western solutions and ignores the voices and the agency of the target audience in proposing solutions to their own health problems. The culture-centred approach advocates the inclusion of the ideas and beliefs of the target audience and encourages their participation in formulating campaigns that would be effective (Dutta & Basu 2011).

The approaches discussed above are applicable to translation in health communication. Translators or agents of translation in the dissemination of public health information should ideally

be culturally sensitive. Of course, some cultural practices may present barriers to public health communication. When people's behaviours are anchored in their culture, religion, and traditions, it becomes harder to persuade them to change behaviours that contribute to unfavourable health outcomes. While harmful practices must be addressed, if campaigns seem to only criticize, condemn, and discourage people's cultural practices, they risk having no impact and even alienating the target audience. A useful approach to translation is to incorporate some of the more positive and harmless cultural beliefs into the campaign and to challenge only the harmful practices that counter the purpose of the message. This can be done by focusing messages on the harmful consequences of the practices in question and proposing safer, culturally-sensitive solutions.

Cultural barriers to public health and behaviour change communication include social norms, myths and rumours, cultural beliefs surrounding health, and constructed gender roles and inequalities.

One example of a cultural health barrier is clearly found in the rumours that circulate about the risks of immunization (Kaler 2009). Amongst the African and African American populations, immunization is rumoured to cause sterility. This is not to say that only these populations are susceptible to circulating false rumours about medical interventions; rumours about immunization occur around the world. As Kaler (2009) was quick to point out, among the populace of the Global North, vaccines against diphtheria, measles, mumps and rubella have long been rumoured to cause medical conditions, such as autism and attention-deficit hyperactivity disorder (ADHD).

Although immunization rumours seem to be more prevalent in Africa, according to Kaler (2009), the reasons for this are sometimes anchored in history. Fertility (and conversely infertility) is an important theme in most African societies. Children are often seen as adding to the wealth of a family, especially among rural societies where subsistence farming is a source of livelihood. In

addition, one of the common gender biases assigns women the role of child-bearers, and there is often stigma attached to infertility, which is always blamed on women. Furthermore, it is commonly believed in some societies that one of the missions of the colonial enterprise was to wipe out the African population through vaccines and other medical interventions that would render them sterile.

As wild as some of these rumours may seem, Kaler (2009) has explained that they should not just be dismissed by professionals involved in public health. Efforts should rather be made to understand the origins of the rumours and why they persist. She gave the example of one incidence that seemingly gives credence to some of the rumours surrounding the issue of sterility. It was revealed during the Truth and Reconciliation Commission hearings in South Africa that the apartheid government intended to develop an anti-fertility vaccine that would precisely reduce the birth rate of the African population. The vaccine would be administered under the guise of another vaccine such as yellow fever, and scientists were already actively working on the project under the apartheid government.

The National AIDS Council (2011) identified cultural practices as one of the key drivers of HIV/AIDS transmission. Undesirable practices steeped in culture, such as polygyny and levirate (widow inheritance), propagate the spread of the HIV virus. Socially accepted norms, such as having multiple concurrent partners (MCP) and gender-based violence, are also key drivers of HIV transmission. Recent campaigns against HIV/AIDS have therefore focused on challenging these cultural practices and social norms.

Although the general consensus in global health and its related fields is that some cultural practices constitute a significant barrier to the prevention of HIV/AIDS, some scholars have criticized the framing of cultural practices as key drivers or barriers to the prevention of HIV/AIDS

(Gausset 2001; Fassin 1999). According to these scholars, in the early days when scientists sought to understand the disease better, there were many studies undertaken by various scholars from diverse fields, including anthropology. One of the earliest observations about AIDS was that it affected different sectors of society in different parts of the world. In the West, the gay community and drug addicts were thought to be at highest risk, whereas in Africa, both men and women were at risk, with women being at highest risk. To explain this disparity, anthropologists and other researchers immediately turned to culture to explain why different populations were affected differently. Gausset (2001) and Fassin (1999) both pointed out that, as is often the case, researchers tried to understand and explain the culture of the “other” in Western terms. According to them, the propagation of AIDS in Africa was decontextualized when other important factors, such as the different socioeconomic environments, were not initially considered.

Gausset (2001) decried the double standards that, he claimed, were applied as a basis for intervention programmes, such as public health communication campaigns. He explained that, by focusing on culture as a barrier to be removed in order to arrest the spread of AIDS, public health professionals and communicators neglected what, he says, would be the most effective tool: promoting safe practices to avoid infection. He adds that focussing on culture as the culprit implies that cultural practices are the bad behaviours that are associated with disease. Furthermore, targeting culture often results in negative rather than positive reactions. Such is the case with the controversial explanation given by scientists that basically placed the origins of HIV squarely on the shoulders of Africa and that suggested some primitive cultural practice involving the green monkey. Soliciting some very strong reactions from many African governments, this explanation only served to increase stigma surrounding HIV/AIDS and contribute to denial of the disease's

existence as well as to the code of silence that ensued while the disease ravaged the continent (Fassin 1999; Gausset 2001).⁴⁷

Mannathukkaren (2012) reminds us that culture is intricately linked to power relations and that it can serve as a vehicle for resistance through rumours, gossip, metaphors, folktales, etc. Some cultural practices are used to oppress marginalized groups of society (women, children, widows, orphans or the poor). Many practices that perpetuate gender inequality such as child marriages, property grabbing, and gender-based violence are done under the guise of culture. Such practices must not be tolerated and legislation to discourage them must be enacted. Mannathukkaren (2012) adds that some governments also use culture as an excuse to oppress their people and maintain their power.

5.2.8 Religion

Tied to culture is the concept of religion. Religion influences peoples' attitudes and beliefs about health differently, depending on their religious beliefs. Onongha (2015) has posited that Africans, for the most part, have a different worldview of health and illness. Although there are variations across the continent in terms of religious beliefs, it is widely known that many of these beliefs are based on the power of the supernatural, whether good or evil. As a result, many Africans believe that illness is caused by some supernatural or mystical force. Their beliefs are therefore in stark contrast to the biomedical model, which in general terms is based on the principle that disease originates from natural or concrete phenomena such as germs.

⁴⁷ Former South African president Thabo Mbeki denied the existence of HIV/AIDS for years. Valuable time was lost not dealing with the growing problem in South Africa and thousands of deaths due to AIDS were attributed to Mbeki's inertia during that time.

The Zambian MOH (2012) estimates that “about 80 per cent of the population use traditional and alternative services for their day-to-day health care” (12). The WHO, cited in Onongha (2015), also offers a similar figure; it states that 80% of the African population habitually use traditional medicine as their principal source of health care. Traditional medicine men and women offer solutions that are more in line with the client’s beliefs. This explains many Africans’ predilections for traditional medicine. It also partly explains some of the challenges that health professionals and authorities have in dealing with health problems. When people believe the supernatural is responsible for their illness or whatever misfortune, they externalize the causes of their problems and similarly externalize the solutions. It becomes difficult to convince them that in many cases they play a part in the cause of their illness and that they have a part to play in its solution. This is one of the major challenges of public health communication and this is why cultural sensitivity is important, as it helps find solutions that will work for a specific group of people.

African traditional and religious beliefs are just one side of the coin. On the other side are Christian religious beliefs and their influence on African people’s health beliefs and, by extension, their health-seeking behaviours. The history of Christianity in Africa is closely linked to that of colonialism. The initial wave of Christian missionaries to Africa was comprised mostly of traditional Catholic and Protestant churches. The second wave in the second half of the 20th century was characterised by the growth of the Pentecostal and charismatic movements in many Christian churches (including the Catholic church) in sub-Saharan Africa. (Pentecostal missionaries had been in Africa since the first half of the 20th century, but they had not had the same impact then.) Scholars now speak of the African Pentecostal movement which developed separately from the Pentecostal church (Anderson 2014; Lindhardt 2014).

A common feature of Pentecostalism and the charismatic movement is their emphasis on divine healing and a holistic approach to health, that is, soundness of body, mind, and soul. Scholars have suggested a number of reasons why Africa has proved to be a fertile ground for the Pentecostal and charismatic movements: the doctrine espoused by these movements appeals to Africans as it has some similarities with African traditional beliefs; the much looser dogma of the Pentecostal churches that allows for more participation and seems to embrace cultural diversity is more appealing; and the economic hardships faced by many Africans in the 1980s as a result of the Structural Adjustment Programmes that were imposed on many African countries by the Bretton Woods institutions. In addition, the HIV/AIDS epidemic made them more susceptible to the promises of miracles and healing that were a fundamental part of Pentecostalism. While the reasons for the exponential growth of Pentecostalism and the charismatic movement in Africa south of the Sahara can be debated, what is certain is that these movements have helped shape people's beliefs about their health (Anderson 2014; Lindhardt 2014).

Although faith-based organizations play a significant and positive role in the delivery of health care in Zambia and in sub-Saharan Africa in general, some religious beliefs (especially those related to reproductive health) espoused by these organizations and churches are in conflict with some health messages from secular health authorities, such as the MOH. For example, when it comes to HIV/AIDS prevention, church organizations emphasize abstinence, marital fidelity, and very high moral standards. As a result, they oppose the promotion of condoms as an effective preventive measure. According to conservative Christian institutions and churches, promoting the use of condoms is tantamount to encouraging promiscuity, which defeats their message of abstinence and fidelity. While the George W. Bush administration was one of the biggest donors of HIV/AIDS prevention through PEPFAR, it deliberately distanced itself from any preventive

methods that went against conservative Christian principles. It therefore distanced itself from methods such as the ABC approach, which promoted condom use (Mantell *et al.* 2011).

Health practitioners fear that some religious beliefs undercut important health messages that are disseminated by the health authorities. A recent trend in Zambia and in some other countries in sub-Saharan Africa has been the abandonment of antiretroviral treatments by a small but significant fraction of PLWA in preference for prayers as a path to a cure, according to their beliefs in divine healing (Reid *et al.* 2008; Lusaka Times 4th December 2015). Similarly, some other groups have also refused certain types of medical interventions on account of their religious beliefs. For example, following a strict interpretation of some verses of the Bible, Jehovah's Witnesses generally do not accept any treatment that involves the transfusion of blood or blood products.⁴⁸ Doctors are sometimes faced with very difficult situations where they have to try to be respectful of the patient's beliefs but also put across the advantages of an intervention involving blood. In a number of cases, patients have died after refusing a blood transfusion. Sometimes the courts of law have had to intervene, especially when a minor has been involved. Ethically, medical personnel as well as the law seek to safeguard the rights of a child who cannot intelligently make the decision of refusing a blood transfusion, let alone understand the consequences. Stories abound worldwide of legal battles fought involving Jehovah's Witness parents refusing a potentially life-saving blood transfusion for their child. The refusal of blood transfusions is particularly problematic in some regions of the world, Zambia included, where a spike in non-communicable diseases is attributed to increased incidences of diseases like sickle cell anaemia, a hereditary blood disorder that mostly affects people of sub-Saharan African, Indian, Saudi Arabian and

⁴⁸ It must be noted that while many Jehovah's Witnesses adhere to this principle, not all of them do and some have argued against the strict interpretation that prohibits blood transfusions, albeit covertly for fear of negative consequences from the church authorities and members (Gillon 2000).

Mediterranean ancestry. Patients often require several blood transfusions to manage the disease during the course of their life (Ministry of Health 2011a; World Health Assembly 59 2006).

Outlining the socioeconomic and cultural context within which translation in public health communication takes place, this chapter draws upon Tymoczko's (2007) conceptualization of translation as a cluster concept to highlight the importance of the target culture in translation. Taking Hatim and Mason's (1989; 1997) perception of translation as a communicative process, this chapter has sought to demonstrate that public health communications in developing contexts can be considered translated texts in whatever form they are delivered. This sets up the study for the next chapter, which will discuss and analyse some selected communications.

CHAPTER VI

TRANSLATED HEALTH MESSAGES

As already discussed, the following public health communication messages are all considered translated texts whether a source text has been provided or not. The communications were selected randomly, with the only evident criterion being availability.

6.1 Translation practices in selected health messages

Most of the health campaigns of which the messages below were a product ran in the last decade and the communications were no longer easily available at the time of my data collection. I use Jakobson's (1959) three types of translation to loosely arrange the communications in three broad categories: interlingual, intralingual and intersemiotic translation. These categories are merely a way to logically organize the material and are not meant to strictly classify the individual communications into the respective categories. In fact, it should be noted that some of the messages could very easily belong to more than one category. My decision to place a communication in a specific category is primarily based on the most salient issue highlighted in a given message.

6.1.1 Interlingual translation

Interlingual translation, understood as the transfer of information from one language to another, is what Jakobson (1959) characterizes as 'translation proper.' Of his three types of translation, it is what is most identified with the Eurocentric notion of translation, which assumes the superiority of textuality over orality. While this study does not cover the ratio of translation

types utilized in public health communication, the documentation surveyed certainly supports this hypothesis. In addition, some organizations that have worked in public health communication in Zambia (Chemonics 2014) have confirmed that while translation in general was considered important, textual interlingual translation in health communication was not necessarily a priority, as it was established that most people who could read in their mother tongue could also read and understand English. In addition, a choice often had to be made due to the limited financial resources available. As mentioned above, the increasing influence of multimodality in all forms of communication cannot be ignored.

6.1.1.1 Translating health terminology

One area in which interlingual translation has been pivotal in public health communication is in health terminology. In the wake of the HIV/AIDS pandemic, new terminologies that were hitherto unknown have had to be integrated into everyday language use. In addition, there are some subjects, such as reproductive health, that have always been challenging to deal with in terms of terminology. The challenges stem from the fact that many issues related to reproductive health, including HIV/AIDS, are often perceived as taboo topics by society. As well, in Zambia, as in many other societies, terminology associated with reproductive health is often considered vulgar and shameful and is sometimes even used as curse words. As Mukonka (2008) puts it in his foreword to the revised edition of the *Reproductive health & HIV and AIDS vernacular glossary*:

The words and phrases used in Zambia to describe the human reproductive systems are often regarded as vulgar, disrespectful, uncultured and sometimes simply insulting. This barrier to communication has presented tremendous difficulties to health service providers and

communicators. There was great need for appropriate, consistent and inoffensive Zambian language terminology that could be used in sexual and reproductive health communication. (Mukonka 2008: iii)

Governments in developing countries have inevitably had to integrate some of these taboo topics in their development agendas because many of them are important development issues (e.g. family planning, prevention of HIV/AIDS and STIs) that have to be addressed. As such, it has become increasingly important to have standard language and terminology that is considered appropriate and respectful to use when dealing with reproductive health and HIV/AIDS. In many instances, the lack of standardized language has resulted in derogatory and negative terms and metaphors coined by the public to denote reproductive health and HIV/AIDS-related matters. The use of these negative terms often results in stigma and shame being attached to certain health issues and those who are affected by these issues. This phenomenon is not unique to Zambia but is common in many countries. For example, negative terms evoking death (for example, ‘slow puncture’) are usually used to describe the condition of people who are HIV positive, in reference to the incurable nature of the disease. Furthermore, people also use some of the symptoms of AIDS to describe the disease or the people who are infected. For example, ‘slimming disease’ and similar terms have been used across the continent. Additionally, stigmatizing terms evoking immorality or promiscuity have been used to label affected people in both English and local languages (Chinsembu *et al.* 2011; Horne 2010; Kunda & Tomaselli 2009).

In 2000, the Population Communication Unit of the Zambia Information Services produced a glossary of terms related to reproductive health and HIV/AIDS to be used in all areas of health

communication.⁴⁹ The idea was to establish a more consistent and culturally acceptable repertoire of terms in local languages when it came to reproductive health and HIV/AIDS. Additionally, it was felt that new developments in global health at that time, notably the onset of the HIV/AIDS pandemic, necessitated new standardized terminology in local languages. The glossary was also meant to serve as a guide for all communicators and translators working in the area of public health communication. Therefore, it provides the most commonly used terms in reproductive health and HIV/AIDS in English along with their (dynamic) equivalents in the seven official local languages. The glossary provides terms and their description in English, as well as the corresponding terms and descriptions in the seven local languages. It provides an explanation of how it is organized, who the target audience is and how it can be used:

The first part of this glossary constitutes the English version in two columns, the normative and descriptive. It gives both normative and descriptive translations where possible. The choice to use either the normative or descriptive depends on the type of client or audience one communicates to. Normative is more useful for open and literate groupings. While [sic] descriptive is more useful for semi-literate and traditionalists who are not at ease with direct translations, which they perceive as impolite.

The second part constitutes glossary [sic] in seven languages namely Bemba, Kaonde, Lozi, Lunda, Luvale, Nyanja and Tonga. These are presented in three columns: English terms, normative and descriptive translation. (MOH 2008: iv)

The following are examples of entries in English of the terms Acquired Immuno-deficiency Syndrome, AIDS, and Human Immuno-deficiency Virus, HIV, with their translations in

⁴⁹ The glossary was revised by the Ministry of Health and the Health Communication Partnership in 2008.

ChiBemba and ChiNyanja. The English-only entry figures in the first part of the glossary and provides the normative and descriptive terminologies of the concepts in the first and second columns respectively. The local-language entries, appearing in the second part of the glossary, provide the normative terms in English and the normative and descriptive translations in the respective local languages as shown in Fig. 2 and Fig. 3.

Fig. 1: Glossary entry for AIDS in English

Source: Reproductive health and HIV AIDS vernacular glossary (MOH, HCP 2008: 5)

Acquired Immuno-deficiency Syndrome	A progressive, usually fatal condition (syndrome) that reduces the body's ability to fight certain infections, usually as a result of being infected with HIV.
Human Immuno-deficiency Virus (HIV)	The germ which leads to the development of AIDS

Fig. 2: ChiBemba translation

Source: *Op.cit.*: 14

Acquired Immune Deficiency Syndrome	Kanyunshya / amankowesha	Ubulwele bwa koondoloka
Human Immuno-deficiency Virus (HIV)		Akashishi kaleta ubulwele bwa koondoloka

Fig. 3: ChiNyanja translationSource: *Ibid.*: 51

Acquired Immune Deficiency Syndrome	EDZI	
Human Immuno Virus (HIV)		Kalombo kabweretsa EDZI

These few examples of health terminology reveal some of the translation issues with which translators and communicators are faced when translating health terms for the public, and how they find solutions to them. In the first instance, it can be noted that some terms, such as “Acquired Immune Deficiency Syndrome,” are better translated using a descriptive term. Translation, is, after all, an interpretive act and some difficult-to-understand concepts or untranslatable concepts as some earlier scholars called them, are better served by a descriptive translation involving the use of paraphrasing, adding, “skewing” or borrowing (Nida 1959). The source-language term is itself descriptive although it is often used as an acronym, AIDS. In this case, the acronym cannot meaningfully be replicated in either target language, as it sometimes is in other languages (e.g. French and Spanish with the acronym SIDA), largely because the use of acronyms is not common in either ChiBemba or ChiNyanja. In his study of acronym-nouns in Kiswahili, Asheli (2015, citing Katikiro 2014: 23) observes that the use of acronyms implies textuality. He points out that although Kiswahili uses a significant number of acronyms—largely because it is a written language as well as a spoken one—it is worth noting that some languages that are not written as much as they are spoken may use acronyms far less than predominantly written languages.

As stated earlier, one of the motivations for producing glossaries for reproductive health terminology is to have standardized language that is culturally acceptable and not offensive. On

the one hand, the ChiNyanja translation avoids this problem by borrowing the phonetic version of the term AIDS pronounced in a ChiNyanja tone (edzi) and does not offer a descriptive translation. This can be attributed to the fact that after three decades of dealing with the ravaging effects of AIDS, it is hard to imagine that anybody who calls southern Africa home would not know exactly what AIDS is. Southern Africa, is, after all, known as the epicentre of the disease. It is often said in many countries in southern Africa that if one is not infected with HIV, then they are affected by it in one way or another. With prevalence rates around the 14% mark, it would be hard not to know someone infected or at the very least affected by it. Suffice it to say that people have a very clear picture of what the word AIDS is associated with, as many of them have seen it first-hand or at least heard about it. The ChiNyanja terminology, therefore, borrows the more neutral term from English and sees no point in giving a descriptive translation.

The ChiBemba translation, on the other hand, offers both normative and descriptive terms. While the terms are widely accepted and not considered to be offensive per se, both the normative and descriptive terms have negative connotations. The two normative terms, *kanyunshya* and *amankowesha*, loosely translated allude to something that causes someone to lose weight or stretches them and something that stains, sullies or soils, respectively. The descriptive translation *ubulwele bwa koondoloka*, also translated loosely, means ‘the illness that causes weight loss’ or simply, ‘slimming disease,’ as mentioned above. This attests to the power of language users in society and the influence they have on how language evolves. The most logical explanation as to why these terms with the negative connotations were kept and accepted in ChiBemba is that the terms had probably already been assimilated into public usage and changing them would have likely resulted in confusion. Since the terms do not contain insulting or vulgar language, it was

probably thought best to standardize them as official translations for AIDS. Asheli (2015) summarizes the influence of language speakers:

In my view, speakers are the main stakeholders in determining the direction of change. Those who stick to standards may succeed in controlling things for a period of time. However, the power of language speakers is enormous in determining what the trend is like. It is my humble submission that language standardizers should harmonize their rules with how people speak in a particular language. (57)

It is worth noting, however, that although these terms are accepted and were retained for the glossary, some ChiBemba translators still opt to borrow from the English terms, like their ChiNyanja counterparts, as the translation of the cover of an information toolkit shows below. The initialism HIV and the acronym AIDS are retained in the ChiBemba translation shown in Fig. 5. However, the translations are descriptive in order to enhance their clarity. HIV is introduced with the descriptor *kashishi ka* HIV which means the HIV germ or virus. The same applies to the term AIDS, which is introduced by *Nobulwele bwa* AIDS, meaning AIDS disease or illness. We can deduce from these examples that some scientific concepts that can be adequately explained in local languages and that are well-known by the public are therefore borrowed in some local languages. The choice of whether to use the borrowed terms HIV and AIDS or the recommended translations depends on the translator and the target audience. As the glossary explains, the normative terms are more suitable for literate audiences while the descriptive terms are better suited for the non-literate or low-literacy audiences.

Fig. 4: Cover of an AIDS literacy toolkit (English)

Source: Southern Africa HIV and AIDS information Dissemination Service (2005a)

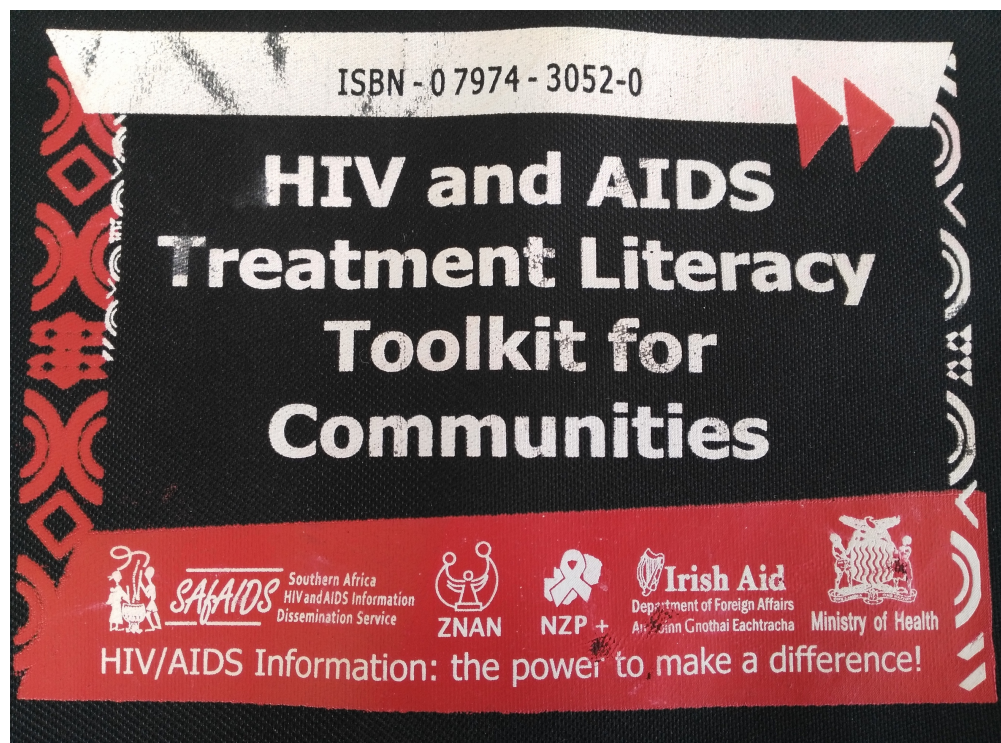
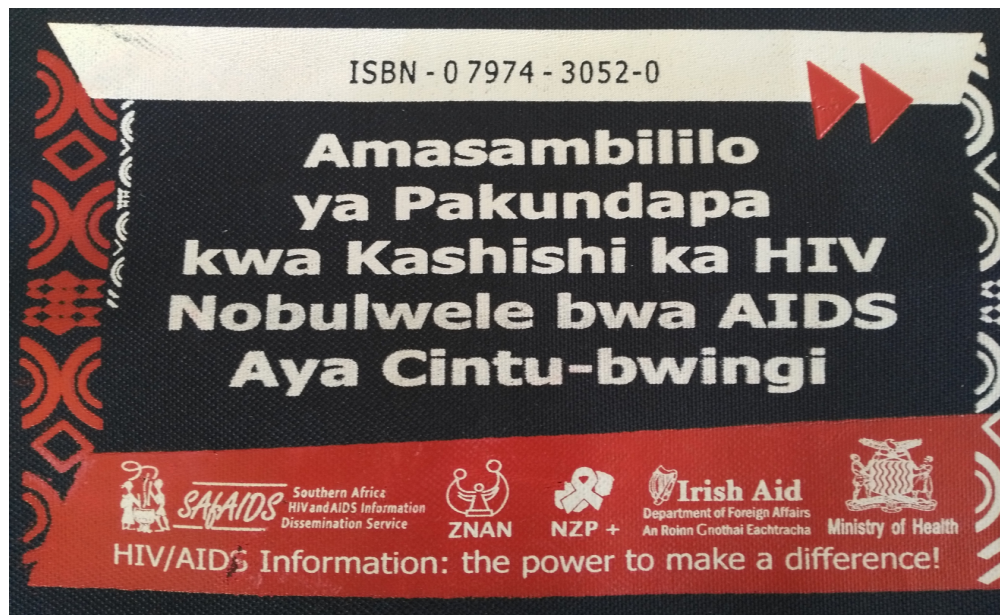


Fig. 5: Cover of an AIDS literacy toolkit in ChiBemba

Source: Southern Africa HIV and AIDS information Dissemination Service (2005b)



Other instances in which translating health terminology was effective are health communication booklets, written predominantly in English for a literate audience. Although the booklets are targeted at a literate audience, care is taken to ensure that even people with lower literacy levels can understand the information. In addition to using simple English in clear and concise sentences, one of the strategies often employed is the translation of only the specialized, complex, or difficult-to-understand concepts into local languages, to facilitate the assimilation of the material. Fig. 6, which is the introductory page of the *One Love Kwasila!* booklet on relationships illustrates this point. Fig. 7 is an example of one of the pages, with some key words translated into the seven official local languages.

Fig. 6: Instructions excerpted from *One Love, Kwasila!* A booklet on relationships

Source: Zambia Centre for Communications Programmes (2009)

Join the OneLove Kwasila campaign!

one love
kwasila!

OneLove Kwasila! is a campaign to reduce the number of people having many sexual partners in order to reduce new infections of HIV. The campaign aims to help people change dangerous social habits and behaviour without blaming them.

It encourages you and I to have safe sex so that we live safer and happier lives. OneLove Kwasila! also aims to change beliefs that encourage people to have more than one sexual partner so that in the long run, the AIDS epidemic can be slowed down.

How about starting a campaign in your town?

You can support the OneLove Kwasila! campaign in many ways:

- Organise a OneLove Kwasila! march.
- Hold OneLove dialogues or debates.

social habits

- misango
- byuubilo bya baantu mu bwikalo
- mikwa ya batu
- viluli yamuchi-handilu
- vilinga vyawathhu vyachiyoyelo
- zinthu zimene anthu akonda kucita
- tulengwa twa ku swagana

Fig. 7: Instructions excerpted from One Love, Kwasila! A booklet on relationships

Source: Zambia Centre for Communications Programmes

one love
kwasila!

How to use this book

You and Your Relationship is a book about relationships. This is not just about HIV. This book is about how we have relationships. It is about how we should treat each other and how we can take care of ourselves and the people we care about.

When reading this book, think about yourself and your partner. You can make choices about the type of life and relationship that you want for yourself, and for your partner.

In Zambia one in every seven people has HIV. So it is important that people talk openly about who they love and what makes them love each other. We also need to talk about sex.

The book gives tips on how you can help build a healthy relationship that is fulfilling to you and your partner. It will also help you to understand why HIV is still spreading in Zambia, and what you can do to prevent HIV in your own life and in your community.

Some of the words in this book may be difficult to understand as they are not everyday words. These difficult words have been underlined. They are translated into Bemba, Kaonde, Lozi, Lunda, Luvale, Nyanja and Tonga in the boxes at the side of the page.

English

- Bemba
- Kaonde
- Lozi
- Lunda
- Luvale
- Nyanja
- Tonga

In this book, there are also different boxes that give you information to help you understand things better. The boxes look like this:

Remember: This box shows important things that we must all remember.

Think about this: This box helps you to think about actions and experiences you have in your relationships.

What people in Zambia say: We asked people from all over Zambia about having more than one sexual relationships. This box shows what they had to say.

6.1.1.2 Toolkits as source documents

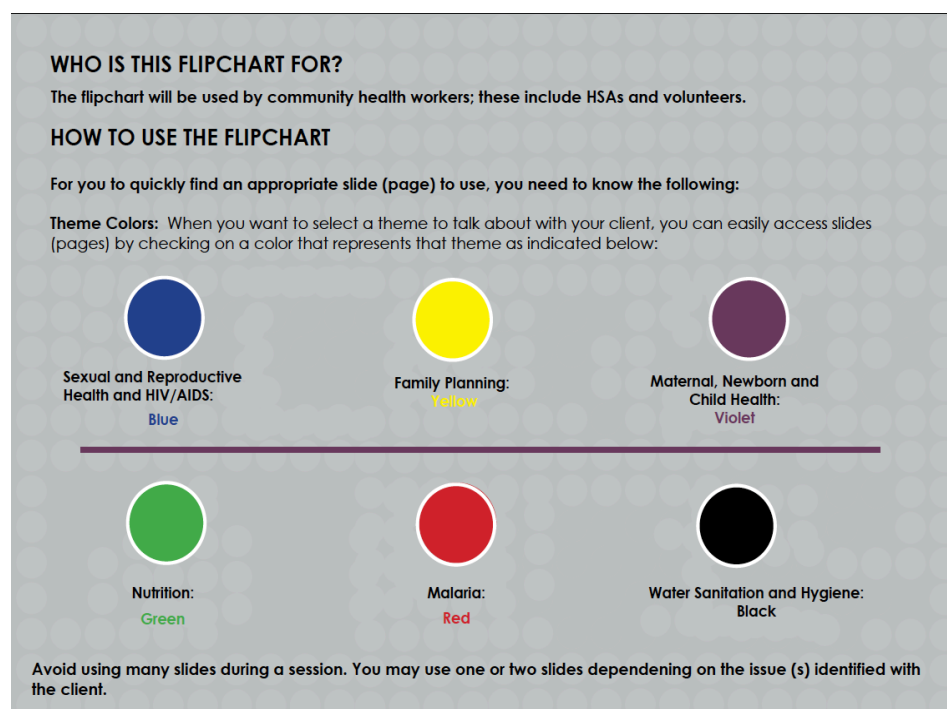
The Community Health Worker (CHW) programme, mostly funded by government departments, NGOs and various donors has been implemented in a number of African countries since the 2000s. CHWs serve as translators of public health information in addition to their work as health promoters and assistants in the communities that they serve. Ministries of health and other global health organizations produce toolkits that serve as source documents for CHWs when they perform their duties. CHWs engage directly with the communities and are therefore able to deliver health messages in the most appropriate form using the toolkits as their source of information. Toolkits are simply packages of health information in various formats depending on the target audience. Toolkits are often translated into local languages so that the CHW can use whichever one is more appropriate for the particular client they are serving. Toolkits normally contain printed material in both English and local languages, as well as information in other formats such as video and audio recordings, picture cards and props that can be used in demonstrations if necessary. Toolkits often contain information for both literate and non-literate audiences. CHWs use the toolkits to interpret information into local languages and initiate a conversation with the client about a specific subject with the aid of pictures, props, and text. All translation types are used either individually or in combination depending on the needs of the client. The screenshots in Fig. 4 and Fig. 5 above, as well as Fig. 8 and Fig. 9 below, are taken from toolkits. The ones in Fig. 4 and Fig. 5 were produced by SAFAIDS and comprise textual and audiovisual information resources (packaged in a briefcase-like bag) meant to provide AIDS literacy to communities to educate them about the essentials of HIV/AIDS. Fig. 8 and Fig. 9 are taken from a multi-faceted health campaign in Malawi, *Moyo ndi Mpamba, Usamalireni!*⁵⁰ The

⁵⁰ *Moyo ndi Mpamba, Usamalireni* in ChiChewa means ‘Life is precious, take care of it.’

toolkit comes in the form of a flipchart and is created in a manner that makes it easy for the CHW to use and understand. Instructions are given in clear short sentences and colour-coded theme cards are used to easily locate and identify information. The information may be delivered interpersonally, that is, one-on-one, or it may be delivered to the whole community or a small targeted group, for instance, mothers of young children, depending on the message.⁵¹

Fig. 8: Flipchart from the *Moyo ndi Mpamba* campaign (English version)

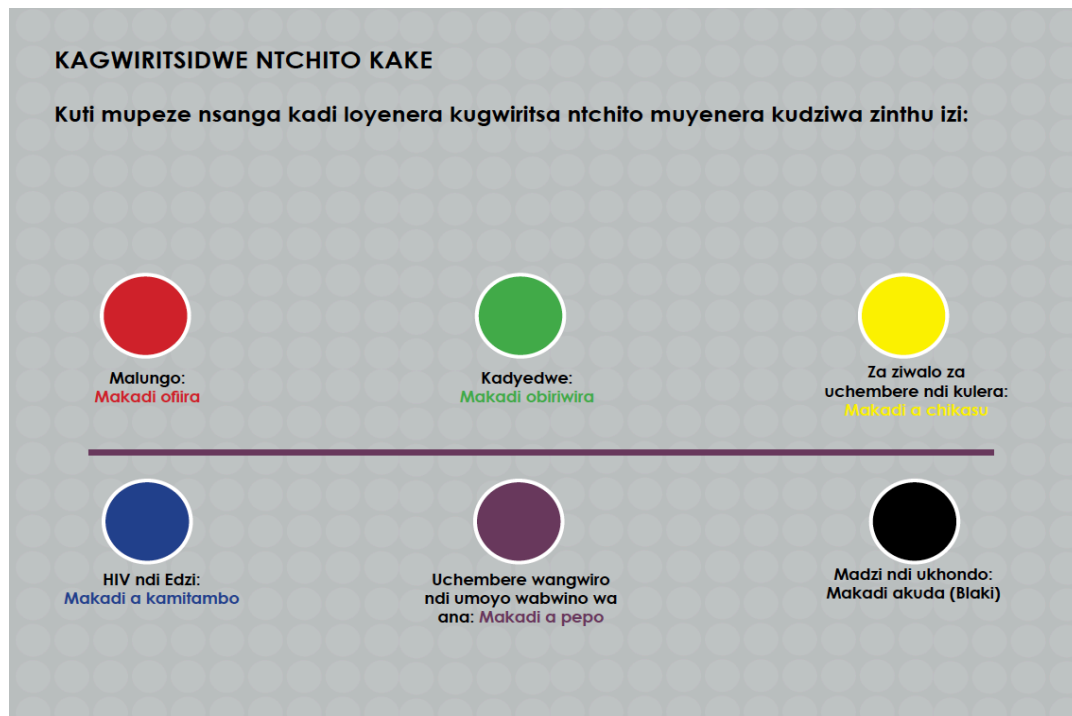
Source: Support for Service Delivery Integration (2016; accessed at K4Health.org)



⁵¹ The *Moyo ndi Mpamba* flipcharts can be accessed online in both English and ChiChewa on the Knowledge for Health website at: <https://www.k4health.org/toolkits/ssdi-communication-toolkit/moyo-ndi-mpamba-community-health-worker-flipchart>.

Fig. 9: Flipchart from the *Moyo ndi Mpamba* campaign (ChiChewa version)

Source: *Ibid.*



6.1.2 Intralingual translation

According to Jakobson (1959: 233), intralingual translation or “rewording” as he calls it, is “... an interpretation of verbal signs by means of other signs of the same language.” There are many reasons that intralingual translation could be necessary, from disparate levels of literacy in any given language among the target audience to linguistic variations within the same language, depending on the diverse regions of the country or the world in which a particular language is spoken. As a result, intralingual translation also plays an important role in public health communication. Though subject to debate, by definition, localization and adaptation can also be considered as intralingual translation. Within the practice of public health communication, in which messages need to be tailor-made for specific audiences, intralingual translation is a useful

tool. Although most of the countries of southern Africa are Anglophone (except for Angola and Mozambique), variations in terms of the usage of English—due to the influence of local languages and the prevalent multilingualism—exist within the region. The same is true for English spoken in other regions of the world, hence the notion of ‘world Englishes’.

6.1.2.1 World Englishes

The field of sociolinguistics increasingly uses the terms World Englishes, Global Englishes and New Englishes to refer to the varieties of English that have developed and spread globally over the years (mostly due to colonialism and globalization) (Crystal 2003). Although European languages were imposed on colonized populations, they have come to be accepted as an inevitable part of the postcolony, after several failed attempts at replacing them with African languages. Because language is dynamic (and because of differences in culture and the presence and influence of local languages), these European languages have evolved over the years, and several varieties of English (and other European languages such as French, Portuguese and Spanish), have developed globally and are classified as World Englishes (Mesthrie & Bhatt 2008).

There have been several studies undertaken in the now well-established discipline of World Englishes, and numerous scholars such as Mesthrie and Bhatt (2008) and Bokamba (2015), among others, have studied the diverse features of some World Englishes on the African continent and in Asia. As can be expected, whether or not to recognize and accept the different variations of World Englishes has been a contentious issue among linguists and scholars alike. On the one hand, some scholars who are more concerned about preserving the purity of the Queen’s language believe that accepting other forms of English would simply be a bastardization of the language (Quirk 1995), while on the other hand, some scholars accept the evolution of language and are open to variations

(Kachru 2017). While many people do not necessarily have anything against lexical variations, as is often evident from the differences in the American, British, Australian, South African or Canadian varieties of English, they often draw the line when it comes to some grammatical variations, which they label as ‘broken English.’ Proponents of World Englishes, however, argue that grammatical variations are often a result of the influence of native languages and cultures, and many of them have undertaken to study these variations to provide some context. Although this study does not particularly concern itself with the intricacies of these grammatical variations, what is of great significance is the fact that there are several types of Englishes, and this is an important factor to consider in translation.

The field of World Englishes often distinguishes between various types of World English, hence the reference to African English, Zambian English, South African English, etc. As alluded to earlier, it is important to note that the majority of the population in Anglophone Africa are L2 speakers of English. This means that many of them began to learn English at the age of about six or even older. Their conception of English is therefore heavily influenced by their native language and their culture, and many Africans happily and creatively take the liberty to ‘bend’ the English language to suit their culture, a notion that renowned African author Chinua Achebe (cited in Bokamba 2015) also justified. This evidently contributes to the formation of numerous neologisms, expressions, and creative linguistic formulations that enter common usage in African English.

One example of ‘bending’ English, as cited by Mesthrie and Bhatt (2008), is the African notion of kinship. In many African cultures, Zambia included, one’s mother’s sisters are commonly also referred to as ‘mothers’ instead of aunties, as is the case in other cultures. Similarly, the brothers of a person’s father are also considered to be that person’s ‘fathers’ and not uncles.

Although there are variations from culture to culture, usually uncles are the cousins of one's parents or the brothers of one's mother. On the flip side, aunties are the sisters of one's father or the cousins of one's parents. To avoid confusion, most African languages will differentiate between a biological father and his brothers or a biological mother and her sisters by indicating their hierarchy in terms of age. It is therefore quite common for Africans to use terms such as my 'small mother' or my 'big mother' in reference to their mother's younger or older sisters, when they speak English. This might, of course, seem quite odd and even nonsensical for native English speakers but is very understandable and relatable in many African cultures. While this type of expression is not normally used in schools, businesses, administration or other formal situations where standard English is the norm, it is commonly used in everyday conversations by the majority of the population. Insofar as only a small portion of the population—mainly the elite who have had access to English from birth—speak English at a native-like or near-native level, it is imperative to consider the majority who do not have this level of English when translating health messages. It is clear that many of the creators of the messages in the public domain have taken this into consideration. *Zambian English* is a safe option because the majority of the population are able to understand it, whatever their socioeconomic background.

6.1.2.2 Malaria animated cartoon series

The Annie Anopheles Malaria Cartoons are a series of short animated cartoon films targeting four different aspects of malaria prevention: indoor residual spraying; treating malaria; intermittent preventive treatment (IPT); and the use of long-lasting insecticidal nets (LLINS). Fig. 10 below is a screenshot taken from the episode focussing on IPT, which is a programme aimed at protecting pregnant women and their unborn babies from malaria. This particular shot presented as a sort of

identification document gives a brief summary of the most important information that the public should know about how malaria is transmitted. It shows an image of a female mosquito and provides very brief notes about the identity of the mosquito and what it does.

Fig. 10: Screenshot of Annie the mosquito

Source: Johns Hopkins CCP (2011b). Video available at: https://www.youtube.com/watch?v=0Dijk9-EiGc&list=PLfR70L-yplF3pGtH99U5GoB5n7hqzj8_D



The gender of the mosquito is an important piece of information that the message intends to convey, since malaria can only be transmitted by the female *Anopheles* mosquito. There are two distinct features that translate the gender of the mosquito to the target audience: The first is the name that the creators chose for the mosquito. Annie is a fairly common feminine name globally, including in Zambia. In addition, the alliteration created with the genus *Anopheles* as the second name (Annie *Anopheles*), makes it easy to remember the name and the gender of the mosquito.

The second, which also serves as a cultural marker, is the headscarf that the mosquito is wearing. In some societies, it may not be uncommon for either gender to wear a headscarf, but in this particular context, a headscarf is normally associated with the feminine gender. Not usually mandatory, headscarves have traditionally been worn by many African women for various reasons including culture, religion, and fashion. Headscarves were initially associated more with older, often rural, women but are increasingly worn by younger, urban women as a fashion statement and empowering ‘taking-back-control’ tool, due to the loaded history of oppression and control associated with headscarves.

Besides the use of the visual cartoon character, the short notes presented in simple, easy-to-understand points also deliver the most important information about the causes of malaria. Apart from the unavoidable key words *species* and *Anopheles*, jargon has been avoided. The language has been broken down into simple, everyday language using analogies such as food to describe how mosquitoes infect people. The identity card shot also provides vital information, including the most likely time that infection takes place, who is most at risk, and the tools that can be used to prevent infection (indoor residual spraying, insecticide-treated nets). In the event that anyone does not understand any or some of this condensed information, the messages are repeated and reinforced in the rest of the short video with the added value of entertainment as the various cartoon characters in the film act out the good and bad behaviours.

While emphasizing the core messages of how to prevent malaria, a clear and important objective of all four episodes of the Annie Anopheles series is to address the myths that are often associated with malaria and mosquitoes in Zambian society. For instance, as discussed earlier, many inhabitants of some of the most malaria-endemic areas of the country have come to accept malaria as a part of life that is unavoidable and that they have no control over. One of the major

objectives of these short, animated films is to educate people about the circumstances that they can actually control and the steps that they can take to combat malaria. The series, through animation and comedy, sets out to dispel what is myth concerning malaria, and provide correct and accurate information that empowers people to protect themselves from the disease.

The episodes address the myths surrounding indoor residual spraying and insecticide-treated nets. Many people refuse to have their homes sprayed with mosquito-killing chemicals because of the myths associated with them. Rumours abound about how dangerous the chemicals are to humans and the negative effects they can have. Aside from addressing the myths, the series also addresses some of the bad behaviours associated with malaria prevention. For example, in some areas of the country where fishing is a major economic activity, mosquito nets are very often converted into fishing nets. One of the episodes of *Annie Anopheles* specifically addresses this issue. The Ministry of Health understands that the success of most malaria prevention programmes is contingent on the cooperation of the public. Communication and translation are therefore key. This series of animated films is the product of repackaged, researched, scientific information about malaria, how it is spread, and how it can be prevented. What the series does is simplify this information for a specific audience, taking into account the socioeconomic and cultural context that may affect how the audience receives the information. The series, therefore, cuts across intralingual, multimodal, and intersemiotic translation. The choice of the modes and channels of transmitting these messages were—as the designers of the messages attest—informed by the sociocultural context of the target audience. A more detailed look at one of the episodes demonstrates this.

Fig. 11: Screenshot from Annie the mosquito

Source: Johns Hopkins CCP (2011a). Video available at:

https://www.youtube.com/watch?v=xrYrW0Wsumk&list=PLfR70L-yplF3pGtH99U5GoB5n7hqzj8_D&index=3



The screenshot in Fig. 11 is from the Annie Anopheles malaria cartoon series that focusses on the importance of seeking treatment early. It is clear from the background of the shot and from the accompanying conversation that the message is targeted at a rural audience. The conversation takes place between a man and his wife about the illness of their young son, Timothy. They discuss his symptoms and weigh their options for treatment before making a final decision. Comically, Annie Anopheles the mosquito tries to influence the man by suggesting options in his mind that initially keep the couple from making the right decision. Below is a transcript of the conversations that take place first between the couple, and later with the nurse at the clinic. In spite of the fact

that the conversations are in (Zambian) English, a few words pertaining to the social and cultural norms of address are in ChiBemba.

While the message is delivered in English, there is a strong use of cultural or identity markers that allows the recipient of the message to identify with the core messages and the characters in the video clip. The most evident cultural marker is the use of commonly accepted norms of address in Zambia. How a person is addressed is a very important aspect of Zambian tradition. Respect for people in positions of authority or older than oneself is a basic ethos of many African cultures. It is therefore common in many Bantu languages to have some sort of language feature such as a prefix added to someone's name or simply to use a title, as a sign of respect. In ChiBemba, the word *ba* is prefixed to someone's name to show respect. It is not generally acceptable to address adults by their first name only. In most cases, if the adult in question has a child, they are first and foremost addressed by the name of their first child with the prefix *bashi* or *bana* (meaning father of or mother of) for men and women respectively. In the Annie Anopheles message transcribed below, the two main characters are addressed as *bashi* Francis and *bana* Francis, which tells us that they probably have an older child named Francis although he does not appear in the video. Only the toddler named Timothy, who is ill, features. In similar fashion, a new layer of respect is added to people who are grandparents. Instead of being addressed by their child's name, they are addressed by their first grandchild's name with the prefix *bashikulu* or *banakulu*, meaning grandfather or grandmother of, respectively (Richards 1968).

In a formal setting where the person being addressed is not known to the addresser, the prefix *ba* can also be used before the profession or position of the person being addressed. By way of illustration, in the cartoon, *bana* Timothy addresses the nurse as *ba* nurse, or more precisely *ba nasi*, the borrowed term of the word nurse in ChiBemba. It is therefore common in professional

circles to address people as *ba* doctor, *ba* teacher, *ba* manager, etc. The latter case indicates a form of politeness as well. The prefix *ba* is also sometimes used to address fairly young people, such as children, as a mark of respect. For example, in many families, the younger children will use it to address their older or oldest sibling(s). Parents will also sometimes use it to address their children when they are older (teenagers or young adults), in recognition of the fact that they are no longer children. The use of first names to address people is normally confined to use among friends and siblings, especially those within a close age-range, or to other very informal settings.

Transcript of Annie Anopheles film on malaria treatment

Annie Anopheles: Hello, I'm Annie, the malaria-carrying mosquito. Ahhhhh! [yawns] After sleeping all day, I sure wake up hungry! I think I'll visit the Phiri home to find something to eat. [Enters the Phiri home and finds a small boy, Timothy, sleeping uncovered and bites him.]

Husband: *Bana* Francis [Mother of Francis], something is wrong with Timothy. He just vomited, he has body hotness, diarrhoea in his nappy, and he keeps touching his head.

Wife: Sounds like malaria *bashi* [father of...]; we should take him to the clinic today.

Annie Anopheles: [Speaking to *bashi* Francis, depicted as a voice in his head] Why go to the clinic? It's so far away and expensive!

Husband: *Bana* Francis, let's go see the traditional healer, he is much closer. We'll save time and money. [He convinces his wife, and they take Timothy to the traditional healer. The scene shows the traditional healer making strange noises over Timothy as his parents watch in the background, stupefied].

The following day:

Husband: *Bana* Francis, Timothy is still not well. He kept me up all night with his crying and vomiting.

Wife: I told you. We need to take him to the clinic for medicine.

Annie: [Whispering in *bashi* Francis' ear] But you already have medicine in your home!

Husband: I have some pills remaining from when I got malaria a few months ago. Let's give him those, it will save us time and money.

Wife: I'm not sure *bashi* Francis. I think we should let the nurse give him the pills.

Husband: Just bring the pills, *bana* Francis.

A few days later:

Wife: *Bashi* Francis, Timothy is still sick, I think he is much worse. We are taking him to the clinic today!

Husband: But— [Speech cut].

Wife: Ah, ah, ah, ah, I listened to you four days ago when you said to take him to the traditional healer...and three days ago when you said to give him your old pills, now it is your turn to listen to me!

At the clinic:

Nurse: Let's start by testing Timothy for malaria.

Annie: [In *bashi* Francis' ear] Testing? I told you not to come to the clinic! He's going to take Timothy's blood! It is going to be used for Satanist rituals! [Last part in a whisper].

Husband: Testing?

Nurse: Yes. I'll take a tiny drop of his blood, put it on the testing stick and it will tell us whether or not Francis [Timothy] [sic] has malaria.

Husband: I don't know if I want you taking his blood, and besides, we don't need a test to tell us Timothy has malaria, he is showing all the signs.

Nurse: It is just a tiny drop of blood. You will see exactly what is done with it. The problem with malaria is that its symptoms are similar to those of many other illnesses. Now we have

fast and accurate tests that can tell us if it is really malaria. If I treat Timothy for malaria when he has the flu, he won't get better. And if I treat him for the flu when he has malaria, it could be deadly.

Wife: That must be why Timothy didn't get better when we gave him your malaria pills, *bashi* Timothy. He must have the flu.

Nurse: Not exactly, it was extremely dangerous to Timothy's health and your health.

Husband: My health?

Nurse: When a person has malaria, they need to finish all the pills. If you stop taking the pills when you start feeling better, the malaria may remain in your body and cause you to get sick again. And what is worse is that the next time you have malaria, the treatment may not work.

Wife: And Timothy's health?

Nurse: When a person begins to show signs of malaria, he or she needs to come to the clinic immediately, within 24 hours. It is especially important for children under the age of five years because their bodies are not strong enough to fight malaria. If you wait to come for treatment, the child may die—and Timothy's condition is very serious right now—and this could have been avoided if you came to see me right away!

Husband: But we did not wait to give treatment.

Nurse: Right, back to your pills. Timothy is a small child. He needs a different amount of medicine compared to a big man like yourself. You could have poisoned him by giving the wrong amount!

Husband: Ohhh!

Nurse: See here, the test shows Timothy is positive for malaria, but I'm going to give him fansidar pills for the malaria, and he must finish all of them, and ORS (oral rehydration salts) is for his diarrhoea. Fansidar pills are used to prevent and treat malaria in pregnant women, but they are also used to treat children for malaria who weigh less than 5 kg. Coartem pills are used to treat malaria in people weighing over 5 kg. But if an adult or a child has severe

malaria, then they must take another medicine called quinine. If his condition worsens, come back here immediately.

Wife: Thank you *ba nasi* [nurse], next time Timothy, Francis, *bashi* Francis or I get malaria, we will come to the clinic at the first signs of illness.

Annie: But!

Nurse: Then, I will test you for malaria.

Annie: But!

Husband: If the test is negative, you will treat our symptoms. If the test is positive you will give us the right medicine and we will... [Video ends]. (Johns Hopkins CCP 2011)

Because some social and cultural norms have been identified as drivers of certain illnesses or societal challenges, many public health communications seek to challenge some of these norms. Messages aim to encourage changes that would be beneficial in combatting disease and to society. Case in point, this particular video tackles male/female relations. The male character of *bashi* Francis initially takes the leading role in deciding how the couple seek treatment for their sick child. However, after a series of bad choices, his wife (who had been right all along) puts her foot down and insists that they take their son to the health facility. Without being offensive, this message shows that women are an important part of the decision-making process in any family. It also shows a positive image of a knowledgeable woman who can make her voice heard. While the challenge of distance in terms of health facilities in rural areas especially is acknowledged, the message also demonstrates why the health facility is still a better and more effective treatment option, even as it takes into account people's beliefs in traditional medicine.

As well, the habit of sharing medicines and ignorance of dosages is addressed. Although the practice of sharing prescription drugs among family members and friends is quite common globally, it might be exacerbated by certain socioeconomic factors, including limited access to

health care; high cost of drugs; low income among some sectors of society; and innocent cultural practices such as a strong belief in sharing as a means of helping those in need. (Beyene, Sheridan & Aspden 2014, 2016). By highlighting the dangers of the practice of medicine sharing, the video discourages this practice and educates the public on the correct way to take medication. Displaying some of the bad behaviours, myths and misconceptions about malaria through the medium of cartoon characters makes it easier for people to identify their own mistakes without feeling patronized or judged. Additionally, the comical, colourful, high-visual-content presentation of the messages, which portray the mosquito as the enemy who encourages bad behaviours, delivers an important health message while entertaining at the same time.

The use of local actors' voices and accents for all the characters in the videos also serves as a strong cultural marker and makes it easy for the Zambian audience to identify with the messages. Many global public health organizations have produced similar messages using audiovisual media. However, many of these messages are of a generic nature and are intended for a wider audience and may not have a specific appeal to particular sectors of society.

6.1.3 Intersemiotic translation

Jakobson (1959: 233) refers to intersemiotic translation as “transmutation.” Whereas he defines the process of intersemiotic translation as “...an interpretation of verbal signs by means of signs of non-verbal sign systems,” this study conceptualizes intersemiotic translation in broader terms, as proposed by O'Halloran *et al.* (2016), among others, as mentioned earlier. I draw on the notion of resemiotisation, which also accommodates translation from one non-verbal sign system to another non-verbal sign system, as illustrated in Fig. 12 and Fig. 13.

6.1.3.1 Translating through images


Numerous international global health organizations, including the WHO, CDC, and UNICEF, often produce generic IEC materials for use worldwide, targeting various health issues. The generic materials produced are sometimes translated and adapted for various audiences by these organizations or by local health authorities with permission from the producers of the materials. Fig. 12 and Fig. 13 are examples of such promotion materials produced by the CDC, based on existing WHO materials. The posters in question are meant to promote and encourage handwashing as a preventive measure of many diseases including diarrhoea and flu. They also teach people the correct way to wash their hands. Information on handwashing worldwide has been well documented, and it is a well-known fact that a significant number of people do not wash their hands regularly or properly for various reasons. The CDC produced different versions of the posters, targeted at specific audiences. By way of illustration, Fig. 13 was produced specifically for an African audience while Fig. 12 targeted an international audience. The posters in Fig. 12 and Fig. 13 target both literate and non-literate audiences. The instructions for handwashing are given in both text and image. The text, in English, uses short clear phrases that can easily be understood by people of a wide range of literacy levels. The images provide a step-by-step guide to correctly wash hands and can also, on their own, adequately deliver the message to non-literate audiences.

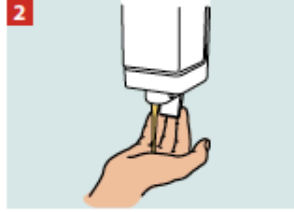
Fig. 12: Instructions for washing hands (English)


Source: Centers for Disease Control and Prevention (CDC 2015)

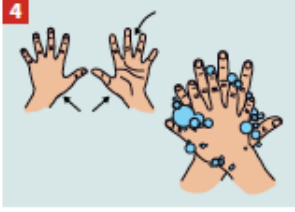
Hand Washing

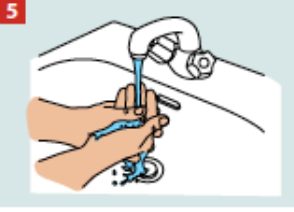
Wash hands with soap and water for 20-30 seconds. If hands are dirty, wash hands with soap and water, not with hand sanitizers, for 40-60 seconds. Use hand sanitizer or chlorinated water, if soap and water are not available.

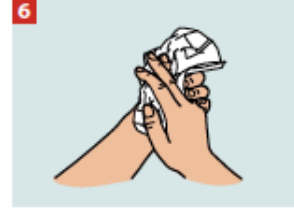
- 


Wet hands with water.
- 

Apply enough soap to cover all hand surfaces.
- 

Rub hands together and scrub everywhere.
- 

Wash the front and back of your hands and in between your fingers.
- 

Rinse hands with water.
- 

Dry hands completely using a single use towel.
- 

Use towel to turn off faucet and throw it away.

When to Wash Hands

- Before, during, and after preparing food
- Before eating food
- Before and after caring for someone who is sick
- Before and after treating a cut or wound
- After using the toilet
- After changing diapers or cleaning a child who has used the toilet
- After blowing your nose, coughing, or sneezing

Adapted from WHO

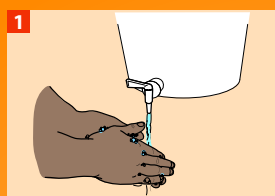
CS 254095-A
February 6, 2015

Fig. 13: Instructions in both images and text (English) targeted at an African audience

Source: Centers for Disease Control and Prevention (CDC 2016)

Hand Washing

Wash hands with soap and water for 20-30 seconds. If hands are dirty, wash hands with soap and water, not with hand sanitizers, for 40-60 seconds. Use hand sanitizer or chlorinated water, if soap and water are not available.



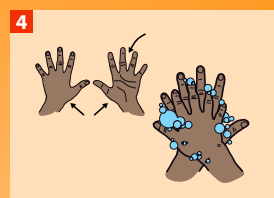
Wet hands with water.



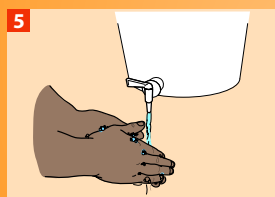
Apply enough soap to cover all hand surfaces.



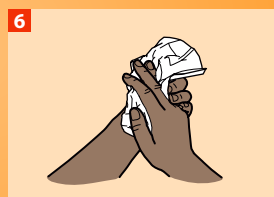
Rub hands together and scrub everywhere.



Wash the front and back of your hands and in between your fingers.



Rinse hands with water.



Dry hands completely using a single use towel or air dry.

When to Wash Hands

- Before, during, and after preparing food
- Before eating food
- Before and after caring for someone who is sick
- Before and after treating a cut or wound
- After using the toilet
- After changing diapers or cleaning a child who has used the toilet
- After blowing your nose, coughing, or sneezing

The different handwashing apparatuses depicted in the images in Fig. 12 and Fig. 13 are a clear indication of the different contexts of the respective target audiences. The poster targeting an African audience shows the image of a bucket tap as opposed to a conventional sink and tap as shown in Fig. 12. In many areas of Africa (especially in the rural and remote areas or the slums and squatter camps in large cities), water supply is erratic, and sinks are not always practical. The availability of a sink normally implies a regular water supply. It is therefore likely that sinks and taps would not be easily available where water is scarce. In view of this reality and in view of the recognition of handwashing as an important part of disease prevention, the bucket tap has increasingly been used in many areas in Africa and the developing world where regular water supply is a challenge. It is quite a normal occurrence, for instance, for households in many African nations to have large containers and jerry cans to store water for use in case of a supply interruption, even in the so-called *kumayadi*.⁵²

It is against this backdrop that the bucket tap, a simple innovation, was created to circumvent the erratic water supply problem. The bucket tap is simply a large bucket with a tight-fitting lid and a tap fitted through a hole near the base of the bucket, to allow it to function as a regular sink tap. The bucket is filled with water and the tight lid helps to keep the water clean and safe. The bucket tap is often mounted on a simple stand and a basin to collect the used soapy water is placed underneath it.

The advantage of the bucket tap is that it can serve as a mobile washing station. It is now often used even in public places that don't have access to a regular water supply, for example at open-air meetings in parks or during water supply interruptions. To be sure, regular sinks are

⁵² The opposite of *komboni* (compound, slums), *kumayadi* is a term used in both ChiNyanja and ChiBemba to mean the wealthier residential areas of cities. The term is taken from the English word *yard*, which was used in the colonial days to describe the residential areas (characterized by bigger houses and large yards) of initially the colonizers and later the educated Africans who were forming the growing middle class soon after independence.

common and available in many areas, and some of the health promotion posters reflect this. However, the bucket tap provides a solution in times and areas where there is no regular water supply. The idea is that the lack of a regular water supply or lack of a sink should no longer jeopardize people's hygiene. The creators of the poster in Fig. 13 clearly targeted an audience that was more familiar with the bucket tap than the regular sink. It is, therefore, appropriate to show images of the apparatus that is more familiar to the audience, rather than one that is not.

Another important point to note is the difference in hues of the hands depicted in both posters. The hands in the general, wider audience poster have a more neutral hue than the ones in the poster targeting an African audience. It clearly makes more sense to depict images that are more familiar to your target audience in order to make it clear for whom the message is intended. People often identify with something that is more familiar to them, and similar to their own reality. The image is therefore translated into an image that is target-audience specific. This particular poster was mostly used during the Ebola crisis in West Africa (CDC 2016).

6.1.3.2 Serials, skits, and spots

The edutainment model discussed in chapter 3 is perhaps the most representative example of multimodal and intersemiotic translation insofar as public-health communication is concerned. Messages are adapted for local audiences using media such as television and radio. In the *Club Risky Business* campaign mentioned earlier, the core message was to get the target audience—urban married men between the ages of 25 and 50 and their female partners aged between 15 and 45—to recognize the risk that having multiple concurrent partners (MCP) represents in regards to becoming infected with HIV. As such, the banner of the campaign, *One Love*, appropriately encouraged men to stick to one partner. Being a regional campaign, the *One Love* banner was used

across the region. However, individual participating countries were free to adapt it for local audiences (UNAIDS and Soul City Institute 2008; Health Communication Partnership Zambia, 2009).

The campaign's designers in Zambia chose to place extra emphasis on the concept of sticking to one partner by adding the ChiNyanja word *kwasila* (that's it), followed by an exclamation mark. The addition of the word *kwasila* essentially localized the banner and turned it into something with which Zambians could identify. In addition, the combination of English and ChiNyanja made the banner even more identifiable because it mirrored common Zambian (especially urban) lingo, which is characterized by heavy code-switching. Speaking in an interview about the conception of *Club Risky Business*, one of the team members also points out the facility of using the banner in whichever local language one wished, for example, One Love, *Chapwa!* (ChiBemba) or One Love, *Kwamana!* (ChiTonga) (Serlemitos 2010). The exclamation mark reflects the way the banner was used as a tagline in radio and television commercials. A series of one-minute "animerts" (animated commercials) (HCP Zambia 2009) constructed around the core messages of the campaign either ended with the tagline 'One Love, *Kwasila!*' or simply *kwasila!*, delivered in an emphatic tone.

From the outset, the campaign designers chose to build the core messaging around raising awareness of the risks associated with MCP, rather than discouraging the practice in and of itself. This decision was made in cognizance of the target audience's context and in order to empower the public to make their own informed decisions. Formative studies in preparation for the campaign revealed that the notion of fidelity was conceptualized differently by different groups of people in the participating countries of the southern African region. In some cultures, the notion of faithfulness was certainly conceived differently than what the dictionary definition of the word would prescribe. Due to a combination of social and cultural norms such as those highlighted in

chapter 4, MCP is perceived in a far less negative light in some regions of the world, and, as such, is not accorded the same level of importance. Indeed, some studies have shown that certain vices including MCP are tolerated more in some societies. This, of course, meant that a message discouraging MCP would be interpreted by the local audience as of paramount importance. The aforementioned formative studies revealed that for many, the concept of faithfulness in relationships amounted more to what would otherwise be defined as taking responsibility for one's family. Many people defined a man's faithfulness as his ability to provide for his family materially and otherwise (UNAIDS, Soul City Institute 2008). The One Love, *Kwasila!* animerts, while possessing an entertainment value, convey an important message using the concept of a network. The highly visual content allows the audience to see and understand just how much they are at risk of contracting HIV due to MCP more than any words could ever express.

The three animerts that were produced each represent the sexual networks of the three protagonists in *Club Risky Business*, namely, David, Sacchi and Charlie Lucky. Although the animerts have a similar beginning and ending, the narrator individually describes the lifestyle and practices of each of the protagonists. As he narrates each story, an animated visual image of the network is traced to show the audience exactly how these networks form and how big they can get, unbeknownst to the individuals who unwittingly find themselves in them. The screenshot in Fig. 14 taken from the animert on David's sexual network illustrates this point:

Fig. 14: David's sexual network

Source: *Media 365* (2010). Available at: <https://vimeo.com/8534658>



In addition to the highly visual content, the three animerts were translated into Zambian English, with the most prominent feature being colloquial terms and expressions that are frequently employed by the target audience. The colloquialisms are usually derived from either Zambian English or one of the local languages, ChiBemba or ChiNyanja in particular, or a combination of both. Most of the terms and expressions used in the animerts pertain to MCP relationships. For example, there are a variety of expressions that are used to refer to extramarital relationships or to the men and women involved in them. Case in point, it is common for people to refer to a married

man's girlfriend or mistress as 'plot two' (the implication being that the official wife is 'plot one'), or side plate, spare wheel, and mini-wife, among others. Other commonly used terms for the men in these extramarital relationships are 'minister of finance,' 'minister of fashion,' or other terms alluding to the specific favours and benefits attached to these relationships (Amin and Clark 2010: 4). The following are transcripts of the three animerts, all displaying a fair amount of colloquialisms, highlighted in italics.

Animert 1: David's sexual network (<https://vimeo.com/8534658>)

Narrator: Hey, do you know where HIV is spreading so fast? In relationships like yours! Here's David, he's married with three kids. He also has three secret *side plates*: Sheila, who is married to a man with a *chi sweet heart*, who also has a *trustee* and a *tycoon*, who has a *spare wheel*, who has also another man! David is also Mimi's *sugar daddy*. Mimi keeps a *player* on the side and another boyfriend who suspects nothing! The *player* has two other girlfriends: one who has an *investor*, who has a wife, who has a *chi young dude*, who has another *honey* and man, the network goes on and on! You see, when we have partners that have other partners and so on, we are all part of a big network of relationships with people we don't even know, let alone trust! And when anyone in the network gets infected with HIV, (more voices join in) it puts everyone at high risk: the bigger the network, the bigger the risk!

Narrator: Do you know your sexual network? Cut your connections to HIV: one love, *kwasila!* (Media365 2010a)

Animert 2: Sacchi's sexual network (<https://vimeo.com/8534704>)

Narrator: Hey, do you know where HIV is spreading so fast? In relationships like yours! Here's Sacchi, he's got a *plot one*, hm, and a *plot two*, who has a *lotion man*, who has two

nkeches, one of whom has a *mudala*, who has a wife, who is a *sugar mummy* to this *ka boy*, who has a *mpopo* and a *guzza* and man the network goes on and on! You see, when we have partners that have other partners and so on, we are all part of a big network of relationships with people we don't even know, let alone trust! And when anyone in our network gets infected with HIV, (more voices join in) it puts everyone at high risk: the bigger the network, the bigger the risk!

Narrator: Do you know your sexual network? Cut your connections to HIV: one love, *kwasila!* (Media365 2010b)

Animert 3: Charlie Lucky's sexual network (<https://vimeo.com/8534576>)

Narrator: Do you know where the risk of HIV is highest? In relationships like yours! Here's Charlie Lucky, a real *Casanova* who is sleeping with Martha, who has a husband, who has other girlfriends. Charlie's also got Sarah and Vera, who has been seeing another man for over a month, ha (laughs), she also has a *minister of finance*, and a *minister of fashion* and another *minister of transport*, in fact, she's got a whole *parliament* going on!⁵³ Each of these guys also have other girlfriends who have other boyfriends who have other girlfriends, and man, the network just goes on and on! You see, when we have partners who have other partners and so on, we are all part of a big network of relationships with people we don't even know, let alone trust! And when anyone in our network is infected with HIV, (more voices join in) it puts everyone at high risk: the bigger the network, the bigger the risk!

Narrator: Which is why Charlie plays it safe! You can't rely on luck for everything. Cut your connections to HIV: use condoms every time, *kwasila!* (Media365 2010c)

Although some of the language used in the animerts is commonly understood in English, like the terms *Casanova*, *player* (also *playa* in this sense), *sugar daddy*, and *sugar mummy*, some

⁵³ In the Zambian system of government, the president can only appoint his cabinet ministers from among the elected or nominated members of parliament (the president can nominate eight non-elected MPs). Therefore, all cabinet ministers are members of parliament; hence, the narrator's comment about Vera having a whole parliament going on because of her numerous 'ministers.'

of the terms are distinctly Zambian. Some terms, such as *mudala*, *nkeche*, *mpopo*, and *guzza*, are in a local language, while others are in English but used in a different context, for example, the terms *investor*, *minister of finance*, and *minister of transport*. Others still are distinctly Zambian because they are used in combination with a local language prefix such as *ka boy*, *chi sweetheart* and *chi young dude*.⁵⁴ The use of these colloquialisms clearly indicates the target audience of these messages. The team of message designers comprising various professionals, including translators, clearly aimed to make these messages resonate with the Zambian public, particularly the specified target audience of married men and their female partners between the named ages. Although *Club Risky Business* was a Zambian production, it was dubbed in Kiswahili for a Tanzanian audience, along with the animerts.

6.1.3.3 The community approach

The *Komboni Housewives* campaign cited in chapter 3 used a wide range of methods to deliver (and translate) the core messages of the campaign to its target audience of mothers and caregivers of children aged five and under living in the compounds or *komboni* of Lusaka, the capital city of Zambia. The campaign, which focussed on the prevention of diarrhoea in children under five, comprised a number of key messages, namely, encouraging exclusively breastfeeding

⁵⁴ *Mudala* in this context means an older man, along the lines of a sugar daddy. *Nkeche*, *mpopo* and *guzza* are all slang words for girl. Words with a financial theme such as *investor*, *minister of finance*, *trustee*, and *tycoon* refer to the men who provide financial benefits to the women with whom they are in relationships. Similarly, terms like *minister of fashion*, *minister of transport* or *lotion man* mean men who buy expensive clothes, are always available to drive their girlfriends to wherever they need to go, or buy expensive cosmetics for them, respectively. *Chi* and *ka* are ChiBemba prefixes usually used to assign values of greatness or smallness to something, respectively. They can be used in numerous contexts to mean various things. For instance, *ka boy* or *ka girl* would mean a young man or young girl respectively. *Chi young dude* would probably mean a good-looking young man with some physical aspect of greatness, e.g. tall, muscular. It could also mean a cool young dude just as a *chi sweetheart* would mean a girl with great attributes such as beauty, kindness, or a great personality. Although *ka* ascribes a value of smallness, it is often used positively as a term of endearment, rather than negatively, e.g. my *ka* niece would mean something along the lines of ‘my sweet little niece.’

babies from birth until the age of six months; teaching mothers how to manage diarrhoea in children at home with ORS and zinc; and handwashing with soap as a means of preventing diarrhoea. Numerous channels were used to deliver the various messages including community radio, women's fora, and road shows. Other channels included ORT (oral rehydration therapy) corner sessions at clinics, where women would be taught the correct way of preparing ORS through demonstrations; skits reinforcing the core messages, performed by the *Komboni Housewives* during road shows and at the women's fora; and videos that were later produced featuring the *Komboni Housewives*. The group of women called the *Komboni Housewives* were actresses engaged by the programme to deliver the messages. The idea behind the formulation of this group was informed by the theory of change. In their process evaluation of the campaign, Greenland, Chipungu, Chilekwa, Chilengi & Curtis. (2017) elucidate that:

The theory of change of the intervention was founded on the insight that people in this populous social context care about their social reputation and seek to avoid becoming the subject of adverse local gossip (the *affiliation* motive [31]) A fictional group of amiable, gossipy local characters known as the *Komboni Housewives* was deployed to suggest that practicing the target behaviours would lead to social approval (the underlying theory of change). The overarching goal was thus to create an environment where mothers would expect that other mothers would notice and approve when they behaved correctly with respect to the four behaviours. Actors playing the *Komboni Housewives* held women's forums in the homes of caregivers of children under-five, facilitated radio call-in programmes during these forums, and co-led road shows featuring a famous Zambian musician. (3)

Clearly, the social context of the target audience was the cornerstone upon which the channels and methods for disseminating the core messages of the campaign were chosen. To begin

with, the reason this particular campaign targeted the *komboni* is that the problem of child morbidity and mortality due to diarrhoea is most severe among residents of the so-called compounds. About two-thirds of the population of Lusaka live in the compounds (Myers 2006, 2016). Typically, the compounds are low-cost, highly populated areas whose residents belong to the low-income bracket of Zambian society. To be sure, although the term *komboni* is used to apply to the collectivity of low-cost, highly populated neighbourhoods, variations do exist within these neighbourhoods. Some are squatter camps with shacks built from tin sheeting where tenants have absolutely no access to social services of any kind, while others are organized low-cost housing neighbourhoods mostly in the peri-urban areas of Lusaka.

Like most postcolonial cities in sub-Saharan Africa, Lusaka neighbourhoods are largely divided by class. The division was initially racial during and soon after colonialism, but it morphed into a class-based division after independence. Lusaka was initially built as a whites-only garden city with lots of open spaces and greenery. However, as the city developed, and the colonial government moved the capital of then Northern Rhodesia from Livingstone in the south to the more central location of Lusaka, there was a growing need for African labourers to work in the light industries that were developing, the administration, and the farms or the homes of the whites. Initially, the white settlers were allowed to build small compounds on their vast farmlands or at the back of their large yards for their African workers. Subsequently, more and more Africans moved to the city whose initial plans had not catered for this eventuality. The result was the mushrooming of many unauthorized compounds with very few or no roads, water and sanitation, electricity, schools, hospitals or other critical services. (Myers 2006, 2016).

After independence, the population of Africans continued to grow and only accelerated at an ever-increasing pace to reach the current (as of 2018) estimated population of about 2 million

inhabitants from just over 100, 000 at independence. Thus, both the colonial and subsequent post-independence governments completely failed to plan for and cater to the growing population of the city. This has resulted in the current situation in which two-thirds of the population in cities live in over-populated residences with hardly any amenities. The post-independence governments tried to tackle the housing problem and built a few medium and better-organized low-cost neighbourhoods with the help of the World Bank. They were, however, never quite able to match the pace of population growth and have never been able to adequately address the problem of decent housing and services in Lusaka and other cities across the country (Myers 2006, 2016).

The situation, of course, resulted in significant disparities in terms of access to services, with a large part of the population facing significantly more health and other social-related problems. Naturally, the elite and higher-income middle class live in the high-cost *kumayadi* while the middle class mostly live in the medium-cost neighbourhoods. The more organized low-cost housing areas that were built by the government are now mostly occupied by the low-medium income groups, and the lowest or no-income groups in many cases are left in the worst of the slums.

As can be expected, education and literacy levels in the compounds are significantly lower than in the richer neighbourhoods. Likewise, the difference in standards of living and the lifestyles of the two types of neighbourhoods are like day and night. For starters, because most of the compounds were not planned, their topography is haphazard with no clear roads or demarcations between houses for the most part. The richer neighbourhoods, on the other hand, are characterized by clearly demarcated yards (usually fenced off by walls), with well planned, structured, and labelled road networks (Myers 2006).

While African society as a whole is based on communal living and the *Ubuntu* philosophy, the sense of community is stronger in the *komboni* than it is in the richer neighbourhoods. Because the houses are much closer together and yards are not well demarcated in the *komboni*, people are forced to live much closer to each other and generally interact (and hence gossip) much more. This clearly had an impact on how the *Komboni Housewives* campaign was designed. The choice of ChiNyanja as the language of delivery was a natural one in view of the target audience. Furthermore, the concept of the group of women (*Komboni Housewives*) monitoring other women in the community played very well with the dynamics of the target audience, in line with the notion of affiliation. As Greenland *et al.* (2017) attest in their study, there was more participation on the part of the audience in the higher populated compounds, as compared to the slightly more affluent ones that generally have more walled yards. The surveys carried out as part of the evaluation also revealed that many of the women cared about what their neighbours thought and said about them if they appeared not to adopt the positive behaviours promoted by the campaign. To this end, the campaign adopted the tagline of *tiku cheking'ani*, which means 'we are watching you' in ChiNyanja, as shown in the poster in Fig. 15.

Fig. 15: Screenshot of *Komboni Housewives*

Source: *Komboni Housewives: Behaviour Change Campaign for Diarrhoea Prevention and Management* (2016b) available at: <https://www.youtube.com/watch?v=jqnGaHXTGg0&feature=youtu.be>



Fig. 15 shows a screenshot of the logo associated with the *Komboni Housewives* campaign. The logo, in ChiNyanja, reads: *Adzimayi bamu komboni: Tiku cheking'ani*, which, translated into English, means ‘compound or *komboni* women or housewives: we are watching you.’ This is taken from the campaign’s promotion video on the use of ORS and zinc for the management of diarrhoea at home. The first point to note is that the term *komboni housewives* in ChiNyanja as a reference to the mothers who are residents of the compounds does not have the same nuanced meaning that it might have in English. In as much as people are well aware of the problems and challenges that are associated with life in the slums, it is not perceived as inappropriate or derogatory to refer to the women who live there as *adzimayi bamu komboni* (compound/*komboni* housewives). In fact,

in this case, the term had a unifying factor in the sense that the campaign designers gave it a positive spin by making it ‘cool’ to be associated with or be considered a part of the *Komboni Housewives*. Being a *komboni* housewife in this sense meant being an enlightened mother or caregiver who practices good behaviours in relation to the health of her children. Likewise, the creators could have chosen any other name for the group, but significantly used the term *housewives* to make it easier for the women they were targeting to identify with the group. Most of the women who live in the *komboni*— although they are usually engaged in some sort of economic activity, for example, growing and selling vegetables or rearing poultry for sale—are not, for the most part, professional women, and are often full-time housewives. As Greenland *et al.* (2017) confirm, the idea behind the affiliation concept was in line with the social context of the target audience.

The campaign capitalized on the strong sense of community of the *komboni* residents in particular and designed a campaign that was community-centred and that would target the whole community, not just individuals. The three videos that were produced all reflect this and illustrate how the whole community gets involved in the health and well-being of one of their own. The promotion video in Fig. 15 opens with the *Komboni Housewives* enjoying a leisurely moment outdoors and talking about a small boy who had recently had a bout of diarrhoea. They discuss the seriousness of the illness and how it has been affecting children in the compound. They wonder how the little boy is doing and express skepticism about his mother’s ability to manage the disease at home. Some of the ladies decide to find out for themselves by paying the family a visit. To their surprise, the mother of the little boy is well informed and knew exactly how to treat her son’s illness with ORS and zinc. The ladies decide to go and inform the rest of the group of how well the little boy’s mother had done and how she had practically saved his life. She is congratulated

and applauded as a real *komboni* housewife, and the clip ends with all the women rejoicing (singing and dancing). The whole film is acted out in a manner that emphasizes and reinforces the core messages about managing diarrhoea with ORS and zinc. The other promotion products of the campaign, that is, the other two videos, the radio adverts, the radio phone-in shows, the road shows, and the interpersonal promotion activities such as the circle of mothers and the ORT corners in clinics all use the community concept as a basis for dissemination. This strategy of meaning-making underscores one of the fundamental differences between how health is approached in individual-based societies and communal ones, as in Africa.

The cultural identifier *tiku cheking'ani* (we are watching you) reflects the kind of code-switching that is part of everyday Zambian language usage. The radical of this expression is taken from the English word *checking* and has been conjugated in ChiNyanja, as is common in Zambian street parlance. Although the word borrowed from English is *checking*, the way it is used in ChiNyanja gives it the sense of *watching*. *Ti* is the personal pronoun used for the first-person plural while *ku* is used for the second person plural. Translating the statement 'we are watching you' in ChiNyanja renders *tiku cheking'ani*. Code-switching and using English words either as they are or conjugated and modified according to the local languages is a common feature of Zambian language use, and the campaign uses this to great effect.

The tagline *tiku cheking'ani* is used across the different modes of communication: the campaign theme song, the videos, and the radio adverts. The transcript of the English version of the radio advert on exclusively breastfeeding in Fig. 16 demonstrates this. The radio adverts were produced in ChiNyanja, ChiBemba and English. The English version was translated for the Zambian English language radio listeners. It uses similar cultural markers as the ones seen in the Annie Anopheles malaria promotion videos discussed above.

Transcript of Komboni Housewives radio advert

Komboni Housewives: EBF

CALL TO ATTENTION: The ring of a bicycle bell. The distant sounds of traffic. A bustling marketplace.

Two KOMBONI HOUSEWIVES share some banter.

FV01: Ah, nxa... Have you heard about that new mother on Chimfwembe Street?

FV02: We buy bread from the same shop, so yes, I see her all the time.

FV01: Well—according to Amake Mwamba, she feeds her poor little baby Maheu and porridge!

FV02: Nxa, nxa, nxa... We should do something. That is *terrible*.

FV01: It's also dangerous. Amake Mumba is a midwife, you know, and according to her, you're supposed to ONLY breastfeed your baby. Here she comes now—isn't that true, Amake Mumba?

FV03: Yes, it is—but who told you that that dear girl feeds her baby such things?

FV01: Well... Amake Thembi heard it from Amake Sidney, who heard it from—

FV03 (laughing): No, no, no—let me assure you. I was at Mwansa's house last night, and all those cartons of Maheu were for her husband's football gathering. She *definitely* knows about exclusive breast-feeding.

FV01: Oh! So, when can you introduce us to her?

Amake Given: Other mothers will honour you, because you only breastfeed your child.

KHs: 'Tiku Cheking'ani.'

END (CIDRZ 2016).

Conventions of address similar to those used in ChiBemba also exist in ChiNyanja. The prefix *a'make* is used in ChiNyanja as a mark of respect in the same way the *bana* prefix, meaning *mother of*, is used in ChiBemba. In the radio advert transcript above, the women address each other by their children's names, namely, *a'make* Mwamba, *a'make* Mumba, *a'make* Thembi, *a'make* Sidney and *a'make* Given. Only *a'make* Mumba (FV03) refers to the new mother who is the subject of the gossip between the two women, FV01 and FV02, by her first name, Mwansa. This indicates that *a'make* Mumba and Mwansa are probably close friends, a fact that is confirmed by the former's seeming 'inside' knowledge of the latter's household and her habits. This is precisely why FV01 asks her to introduce them (FV01 and FV02) to Mwansa, when they learn that she is well informed about exclusively breastfeeding. Furthermore, the English translation also retains other cultural markers such as interjections and references to local foods like *maheu*, a popular fermented drink made from maize (corn) meal.

In concert with *tiku cheking'ani*, the interjection *nxaxaxa* also serves as a tagline. *Nxaxaxa, nxaxaxa*, is basically a disapproving sound along the lines of a "tsk," also produced with a form of dental clicking. The *Komboni Housewives* use this interjection to express their disapproval of some mothers' incorrect practices vis-a-vis the core messages of the campaign. The transcript of the radio advert above and the theme song of the campaign, which is sung in ChiNyanja, demonstrate this. The interjection was also used to elicit responses and encourage participation from the women during the circle of mothers' information sessions. For instance, during the circle of mothers' meetings, the women would call into the radio show and have conversations with the radio show host centred around what they had learned during the meeting. At the end of the show,

as a sign-off, all the mothers would chorus the *tiku cheking'ani* and *nxa, nxa nxa* tagline for the listeners as an encouragement for them to also adopt the positive behaviours.

6.1.3.4 Translating through song

Intersemiotic translation through the medium of song is a popular strategy for disseminating health information. Important health messages are woven into the lyrics of a song, usually performed by local musicians who collaborate with health campaigns to deliver messages. Like the serial dramas, music can entertain as well as educate, and usually has the flexibility of using various languages to do so. Oftentimes, campaigns will work with local artists to produce messages either through music or radio and television spots, or through skits performed at public fora. The *Mulange One on One* series of short adverts on the prevention of HIV/AIDS all used local celebrities to deliver the messages. In the same vein, many southern African countries have at one point or another produced some sort of anthem focussing on one or more health messages. Several of the countries', and sometimes even region's musicians, collaborate on important health issues to spread important messages through song. A case in point is the *Rhythm of Life* health project in which Zambian artists collaborated with a well-known Zimbabwean musician to disseminate key health messages at a music festival of the same name.

Another example of music as a medium of public health communication is the previously alluded to *Moyo ndi Mpamba, Usamalireni* multi-faceted health project out of Malawi. Several key messages touching upon various health issues were united under one umbrella theme that resonated with the public: Life is precious, take care of it. A number of Malawian musicians united

to produce the theme song in ChiChewa, also entitled *Moyo ndi Mpamba, Usamalireni*. A video for the song was produced with English subtitles, as the screenshot in Fig. 16 illustrates.

Fig. 16: From the video for the theme song *Moyo ndi Mpamba*

Source: SSDI-Communication Music4Life (John Hopkins CCP, 2016; accessed at K4Health.org: <https://www.k4health.org/toolkits/ssdi-communication-toolkit/music4life>)



In addition to disseminating health messages, the song also addressed some myths and discouraged certain practices. The key messages disseminated centred on visiting the health centre within a day of falling ill; always sleeping under a mosquito net and not using the nets for gardening; washing hands with soap before eating and at all other necessary times; eating a balanced diet; maintaining healthy standards of hygiene when preparing food; visiting the antenatal clinic by the third month of pregnancy; ensuring babies are vaccinated and taken to the

hospital at the first signs of illness; using condoms to avoid getting infected with HIV/AIDS; avoiding MCP; staying active, etc.

6.1.3.5 Targeting children

The messages in Fig. 17 and Fig. 18 are more of a health and safety issue. They nevertheless fall within the broad spectrum of health and development and provide an interesting perspective insofar as translation is concerned. As well, trauma is a significant contributor to the rate of hospitalizations and mortalities, and these messages warn against the dangers of injury in certain places. The messages were created by Millennium Challenge Account Zambia (MCA), a US-funded organization established to implement the Lusaka Water Supply, Sanitation and Drainage Project (Millennium Challenge Account Zambia, n.d. a). The project aims to improve water and sanitation in the city of Lusaka as an important aspect of health and development. As the Millennium Challenge Account aptly summarizes:

Poor water supply and sanitation has long been regarded as a constraint to inclusive economic growth. Where people do not have access to clean water and sanitation, they are likely to suffer a myriad of complications that affect their health and economic potential. Women and children often spend time drawing water for household use, and time is taken away from economic activities and school. These communities are often susceptible to water-borne diseases, with time and money spent caring for patients. The ill health suffered also limits the productive capacity of individuals. The disease burden limits these residents' potential economic freedom, and as such, the Lusaka Water Supply, Sanitation and Drainage (LWSSD) project is critical in addressing these issues. (Millennium Challenge Account Zambia n.d. b)

The LWSSD project is a five-year multi-faceted programme—nearing completion as of 2018—which includes water and sanitation infrastructure development. A major part of the project was the construction of drainage infrastructure in the city. In some precincts, the construction sites and drainages systems were a potential source of danger to residents, especially children. Recognizing that children are particularly attracted to such places, MCA devised various messages using diverse channels to communicate with the public about the potential dangers of entering the construction sites and drainage systems. Fig. 17 and Fig. 18 below show some of the messages produced that targeted children as well as their parents and caregivers.

Fig. 17: Bilingual poster depicting campaign logo and tagline

Source: Millennium Challenge Account Zambia (n.d. c)



Both messages are visually striking on account of the bright colours used and the campaign mascot (christened Mr. Safety) in the form of a raised palm with a face, symbolizing interdiction. Mr. Safety is appropriately dressed in what appears to be a pair of safety boots for protection while at the construction site. The striking visual content is clearly meant to attract the attention of children, while transmitting a strong message. Even before the words on the messages are read, the image of the raised open palm—universally recognized as a ‘stop’ sign—clearly transmits a strong message: do not enter! Fig. 17 is the campaign logo while Fig. 18 is a poster meant to be displayed near construction sites to warn people not to go beyond the safety barriers.

Fig. 18: Osangena poster warning people not to enter the construction site

Source: Millennium Challenge Account Zambia (n.d. d)



Besides the visual content, both messages contain some text in both ChiNyanja and English to emphasize the point. Both texts include the word *osangena*, which, in ChiNyanja, means ‘do not enter,’ and is the official name of the campaign. Both also include the tagline ‘keep safe, keep

out.’ The word *osangena* is more visible on the logo as it is in a larger font and is strategically placed right next to Mr. Safety the campaign mascot. According to MCA (n.d.), these communications were created for use in the high-density areas in close proximity to the drains under construction; hence the use of the word *osangena*, which everybody could understand and identify with. Most children in these neighbourhoods and their caregivers are likely to speak and understand ChiNyanja. Nevertheless, part of the message is left in English. Although the verbal parts of the message of either language do not mean the same thing, both convey the same message of danger and caution and can be understood in tandem with the raised palm either independently in each language or as a whole bilingual message. This way, chances of the message not being understood by some people are minimized.

The poster in Fig. 18 also has the word *osangena* written on top. However, it has, just below that, the word ‘danger’ in a large, red, upper-case font with an exclamation mark. The word ‘danger’ stands out and is sure to catch the eye because of its size and colour (red, the colour most associated with danger). The goal of this message is to warn of the dangers of entering the construction sites and the gravity of the possible consequences. A clear, direct and concise message in simple English warning people about how they could be seriously injured or even get killed by entering the site follows. The image of a barrier right across the poster also clearly indicates to the audience that they are not to cross the barrier. While the poster is in English, the highly symbolic visuals add a great deal to delivering the message to a wide variety of people with various literacy skills, and specifically to children.

6.1.3.6 Translating through film

A brief overview of the work of the UK-based organization Medical Aid Films will aptly conclude this section on intersemiotic translation. Medical Aid Films was created by three colleagues in the medical field with experience working in low-income countries and refugee camps. Recognizing the need for some simple, practical solutions in the area of maternal and child health, they decided to devise a way of providing life-saving health information that could improve the lives of people in the developing world. To beat illiteracy, poverty, and the lack of access to health services, especially in rural areas, and other barriers presented in this environment, they chose to use the powerful medium of film to educate and disseminate vital health information. Their goal was to create films that would support community health education, working in partnership with diverse government and non-governmental organizations across the globe (Medical Aid Films n.d.).

Given the mission of Medical Aid Films and their target audiences worldwide, translation has inevitably played a significant role in the success of the programme. In the first instance, the repackaging of medical knowledge into the medium of film represents the example of intersemiotic translation as given by Jakobson (1959). The films, which are available on the organization's website, as well as their YouTube channel, use both animation and human narrations accompanied by demonstrations to educate people on a wide range of health issues. On the interlingual front, many of the films have been dubbed into several languages, including ChiBemba. In Zambia, Medical Aid Films works in partnership with the Ministry of Health to diffuse the films, especially to low-literacy and rural communities. Whereas the films do not strictly follow the edutainment model of television and radio serials discussed earlier (they are more along the lines of documentaries), they still have the added value of entertaining while educating at the same time.

Some of the films are produced to specifically serve as training materials for the community health workers working within rural communities. They help provide CHWs with the essential information to share with their audiences. The films are transmitted to the community at health centres, community meetings and other fora. A CHW is often at hand to mediate in the process of meaning-making and further explain any information that the audience did not understand even if it is in a language familiar to them. It should be noted that some health and medical concepts may still be hard to understand even in the same language and may require intralingual translation.

According to health workers in Zambia who have used them, the films have the added advantage of providing visual content, which makes it easier for the audience to retain the information. Some health workers have reported improvements in areas such as antenatal clinic attendance by both men and women after screening the films. Traditionally, pregnant women would visit antenatal or prenatal clinics without their husbands. However, in efforts to encourage gender parity and challenge some of the socially constructed roles of women as child bearers and the only caregivers, men have been encouraged to get involved in the maternal and reproductive health of their spouses. The films encourage and show the attendance of husbands at antenatal clinics, and this has served as a strong encouragement for men to accompany their wives to the clinic and in the process learn about how best they can support their spouses.

One of the challenges reported in showing the films was the non-availability or shortage of the required equipment, especially in remote rural areas. There is not enough equipment for each community to have its own, so it must be passed around from community to community. The films have been particularly popular among rural communities but cannot, unfortunately, be screened as often as desired. Communities instead have to rely on the availability of transportation and equipment, meaning it could take a couple of months before they can have a screening (Medical

Aid Films 2017). Back-translated, the inscription in Fig. 19 reads: “Food for life: what to feed your baby (from six months to two years).”

Fig. 19: Title of a film on child nutrition dubbed in ChiBemba

Source: Medical Aid Films – Films for Life (Whitby 2015) Available at:
<http://www.medicalaidfilms.org/film/ifyakulisha-umwana/>

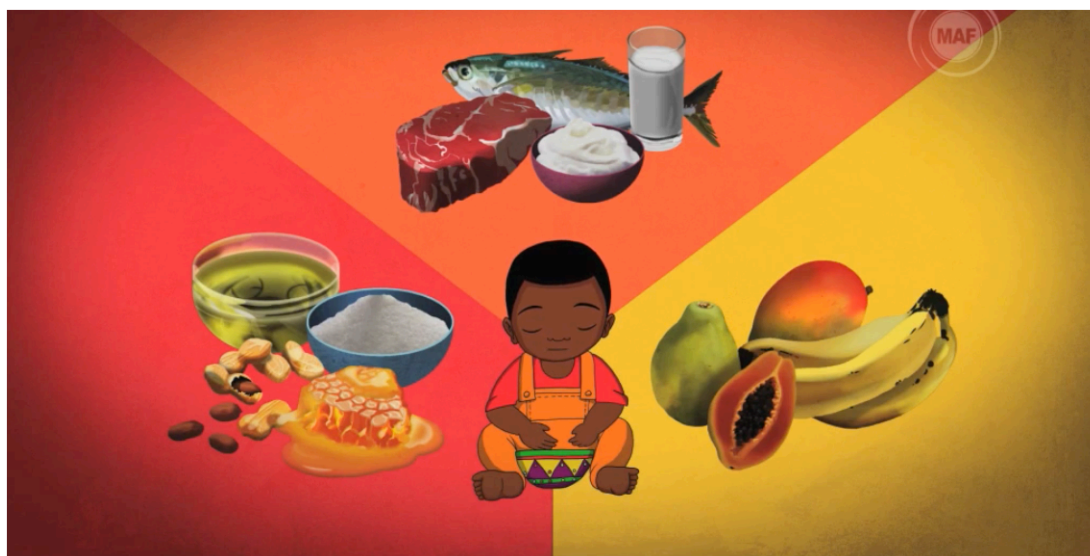


According to the credits, the film was recorded in various locations and dubbed in several languages. The film uses both animation (Fig. 20) and live narrations and demonstrations by real people to educate parents and caregivers about the correct nutrition for their babies to ensure that they grow strong and healthy. It caters to low-literacy audiences and explains with clarity important information like how many times a day and what types of foods a child should be fed at the various stages of life. The film explains what the major food groups are and the importance of eating foods from all the groups (Fig. 20). With respect to affordability, it advises on which local foods can substitute the more expensive ones. It corrects certain myths such as the belief held by

some parents that they should give their babies food of a light consistency because they think it must be easier for their baby to swallow. The film corrects this misinformation, explaining that, in fact, foods of a light consistency deprive the baby of nutrients and could lead to malnutrition. Parents should instead make their babies' food slightly thicker, and simply add some oil to make it softer and easier to swallow. Finally, for the Zambian audience, the film has the added advantage of having the overall narration dubbed in one of Zambia's *linguae francae*, ChiBemba. The locations in which the film was recorded, e.g. the scenes in the market place, are also typical of any African city, which makes it easy to dub this film in various African languages for use in various African countries.

Fig. 20: Screenshot from MAF film on nutrition: food groups for a balanced diet

Source: Medical Aid Films – Films for Life (Whitby 2015);
<http://www.medicalaidfilms.org/film/ifyakulisha-umwana/>



6.2 Summary of findings

The purpose of this study was to investigate translation practices in relation to the socioeconomic and cultural context of the target audience. It is therefore with this in mind that I explored the selected communications as translated texts. To the extent that my analysis focussed on the socioeconomic and cultural context of the target audience, it was still necessary, in some cases, to look at some textual aspects of the communications as they added to the larger picture of the social context.

From the available literature and my investigation of a number of health campaigns within the southern African region, it is clear that translation is an important aspect of health promotion. However, it is often perceived differently across the region. Generally speaking, only interlingual translation or translation proper is perceived as translation. References to translation and translators are usually only made when interlingual translation is implied. The role of intralingual, intersemiotic, and the underlying multimodal translation has often been overlooked, at least, in theoretical terms. A review of the literature reveals that the increased multimodality in public health communication has largely been in response to the hitherto criticized top-down models of health promotion. Consistent with the respective evolutions of the fields that this study intersects, that is, translation studies and development studies, public-health communication has also been criticized for approaching praxis from a one-size-fits-all perspective. Scholars and practitioners now recognize the importance of target-audience-oriented health promotion campaigns that take into consideration the context of the receptor audience. Developments in new technologies have also made it easier to use a variety of channels to package and deliver context-specific messages for audiences. It is therefore not surprising that the developing world context that I have described

in the previous chapters has created a converging point between translation and public health communication.

Other than the most obvious practice of translation, that is, the translation of a (usually textual) document from one language to another, the corpus presented above demonstrates that translation is practiced in numerous ways, for example simply by using a local accent in an audiovisual message or using the local slang that is common in the target community. One strategy that is often applied for literate and urban audiences is the production of code-switched messages where sometimes only the tagline, the name or keywords (or part thereof) of a particular campaign or message are translated into a local language. Examples of this are the *Mulange One on One* ninety-second television spots that deliver the core message in English but are aptly called *Mulange* (show him/her), *Komboni Housewives*, *One Love*, *Kwasila!*, *Moyo ndi Mpamba*, *Usamalireni!*, *Tiku cheking'ani*, *Tikambe Natulande*, and *Osangena*, to name but a few.⁵⁵

The keyword that is translated is often the catchword that you would use to describe the main message if you were to summarize it in one or two words. This draws the audience's attention and ensures that there is no ambiguity as regards the main message. An example of this is the *One Love, Kwasila!* Campaign, which was a regional project. While many people would not have had any problem understanding the words 'One Love', the *kwasila* is basically what drives the point home. In fact, according to one of the designers of the campaign from Media 365, the initial suggestion was to simply call the campaign *Kwasila*, which, the creators believed, would be self-explanatory and would stand on its own. However, the 'One Love' had to be added to ensure that

⁵⁵ The six *Mulange One on One* spots, which were part of the Safe Love campaign, can be accessed at healthcompass.org. An example of one of the spots delivered by one of the cast members of the popular Love Games can be accessed at https://www.thehealthcompass.org/sites/default/files/project_examples/CONDOM_ZEE-Clip1-Medium%20web%20movie.mov. *Tikambe Natulande* is a radio phone-in talk show that provided a platform for young people to talk about reproductive health issues and get expert advice from health professionals. *Tikambe* is a ChiNyanja word that means 'let's talk,' *natulande* also means 'let's talk' in ChiBemba. The programme aired on radio in 2015 and on television in 2016.

the campaign identified with the regional one of which it was a part.⁵⁶ In similar fashion, the *osangena* is also what drives the point of the campaign home. In summary, the localization of a message for, in many cases, literate or semi-literate audiences, is often achieved by using local catchwords and phrases as well as colloquialisms as seen in the One Love, *Kwasila!* animerts.

Habitually, interlingual translation or the rendering of a message in a local language is favoured for rural or very low-income urban communities where illiteracy levels are much higher and education levels much lower. Even where intersemiotic translation takes place, and different media such as radio, film, or sketches are used, the language of delivery is usually a local one. The Medical Aid Films cited above where films produced in English for an African market are dubbed in local languages is just one of many such examples. Other examples are films produced specifically for the Zambian audience, for example the *Mwana Wanga* (My Child) film about the prevention of mother-to-child transmission of HIV/AIDS, produced in ChiNyanja with English subtitles. The soap operas using the edutainment model mentioned previously are also usually adapted into radio drama series produced in the local languages, as this is the most accessible mode of telecommunication for low-income communities.

While this study does not necessarily focus on translator training, some observations can still be made on translators in public health communication in Zambia. Whereas the training of translators is an important aspect of translation and has been studied extensively by some scholars (Kiraly 1995; Orlando 2016; Koskinen 2012; Schäffner & Adab 2000), it is worth noting that the lack of formal translator training programmes in some countries does not necessarily hinder the practice of translation any more now than it did in the past. Bandia's (2005: 959) work on the history of translation in Africa gives us an important overview of how translation was practiced

⁵⁶ Conversation with Mary Phiri, Business Development Director, Media 365, Lusaka 2014.

and who the translators at the time were. He points out that the “professional linguists” who performed translation in ancient times were people who were recognized as gifted linguists and often descended from a long line of linguists. Certainly, many other African countries (e.g. Cameroon, Kenya, Ghana, Mozambique, Senegal, South Africa, etc.) have robust translator training programmes, and with the growing importance of translation, the trend is for more and more schools and programmes to be established. Concerted efforts by regional and continental bodies such as ACALAN (Bamako, Mali) have also contributed to the expansion of translator and language professional training programmes in Africa, as discussed in chapter one. The University of Zambia has in the past offered courses in translation within its language and linguistics department, but it is yet to establish a dedicated translator training programme (as of 2018). Consequently, while it might be common for some countries in the region to have a body of trained translators doing translation work, Zambia and many other countries often have people with other training backgrounds (often connected to languages) practicing translation. Other than in a few cases, for example, the MAF and the *Mwana Wanga* films, where credits were given, translators are often not very visible. Indications are that in some areas, like public-health communication, designers and creators of campaigns are often versatile enough to be able to create and deliver messages in both English and local languages. In cases where they are not, other language professionals or simply people skilled in specific local languages are brought on board.

In other instances of translation requiring knowledge of international languages, for example, at conferences, or for the government and international relations, personnel with the appropriate experience and training—sometimes obtained from outside the country—are employed. Due to Zambia’s geographic position, the international languages that are most sought

after are French and Portuguese.⁵⁷ Although French is not widely spoken among Zambians, there are a significant number of French speakers in the country because of its proximity to the Democratic Republic of Congo (with which it shares its longest border) and the latter's long history of political instability and civil war; over the years, Zambia has received thousands of refugees from the DRC in addition to its many nationals who, due to kinship or for various other reasons, live in Zambia.⁵⁸ Many of these individuals now use their French skills for various jobs within Zambia, including teaching and translation.

The perceived invisibility of translators in Zambia may be attributed to the lack of translator training and hence the lack of recognition for translation as a profession. Nonetheless, taken broadly, that is, in terms of its practice by all those who translate—regardless of who they are (community health workers, agricultural extension workers, communicators, local language broadcasters, and teachers, etc.)—translation and translators are ostensibly agents of cultural and social change. In TS, Kinnunen (2010: 130) uses Kaptelinin and Nardi's (2006) activity theory to conceptualize the agency of, primarily, court interpreters and translators as their “ability and need to act” in the situations in which they work. Likewise, Koskinen (2010: 165) defines agency in translation as “the willingness and ability to act”. Tyulenev posits that “The notion of agency is relevant to T&I studies in two ways: it can refer to translation/interpreting as a social activity and to the translator/interpreter as a social actor” (2016: 17). In public health communication, through the various channels that are used, translation plays an important role in challenging certain cultural practices that are detrimental to the public's health or some sections of it. Campaigns such as *One Love, Kwasila!* demonstrate how translation is used to persuade behavioural change in

⁵⁷ Mandarin has also been gaining traction in recent years in view of China's increased interaction with Africa.

⁵⁸ Several ethnic groups in Zambia trace their origins to the Luba-Lunda Kingdom of Congo. Many Zambian towns and villages are within short distances of the border with DRC and it is not unusual to have extended family members living on either side of the border, a legacy of colonialism.

people. In the larger development agenda that extends beyond health (e.g. agriculture, gender, education), translators also play an important role in improving the livelihoods of communities by influencing how information on important development issues such as improved subsistence agricultural methods for enhanced nutrition is delivered. Clearly, more needs to be done to improve the visibility of translators. Nevertheless, the role of translation and translators is undeniably an empowering one as it is at the nexus of health, education and other critical development issues.

Despite the fact that this study focusses on translation practice in one sector only, namely, public-health communication, some important observations that could apply to other areas can still be made. A clear picture that emerges is one of the pivotal role played by translation (taken in a broad sense) in bringing about social and cultural change in the southern African region vis-à-vis matters of reproductive health. The challenges posed by the HIV/AIDS pandemic fundamentally changed the way reproductive health issues were dealt with. While the countries in the region are not culturally homogeneous, there are many similarities between the cultures. In many of the cultures within the region, reproductive health and sexuality issues are considered taboo topics.

When the earliest cases of HIV/AIDS were diagnosed, and people began to learn more about the illness and how it was spread, it quickly became a topic that no one wanted to discuss. What began as a few cases of a strange disease very quickly turned into a nightmare of epic proportions. It soon became apparent that ignoring the problem was not an option. With the support of global health organizations, governments in the region found themselves in a situation where they had to react. As previously discussed, this began the massive public-health communication drive to combat the disease, and education was the best weapon. In the process, as more scientific information became available, specific drivers were identified, and efforts have now taken on a much broader view. Practices that put people at risk are now more frequently recognized and

challenged. Translation and translators have therefore also played the role of activist alongside other groups in challenging the socially constructed gender roles that put women at higher risk and other issues. Campaigns against early or child marriages, violence against women, and other negative practices are now common. Policies and laws that forbid these practices have also been put in place. Whether these efforts have or will bear fruit is a matter for debate that is beyond the scope of this study. What is important is that with the help of translation, reproductive health issues, HIV/AIDS, and other topics previously considered taboo are increasingly becoming part of the national discourse on health.

In the same vein, translation has also contributed to the drive to improve people's lives regarding many other health-related issues. For instance, there have been several health campaigns targeting better hygiene practices like washing hands and chlorinating drinking water to prevent diarrhoea and cholera, and other diseases. In the recent (beginning in October 2017) cholera outbreak affecting Zambia, Malawi and Tanzania, public- health communication was key in bringing the situation under control. In addition to government interventions, health promotion messages targeting cholera prevention were stepped up (WHO 2017).

In view of *how* translation is practiced in public health communication in this specific context, what comes to mind is a reconstruction or reformulation (akin to the notion of resemiotisation posited by O'Halloran (2016) and others) of a message in a specific culture so that the result is a message that naturally fits within the worldview of that target audience. The source text or information consists of scientific knowledge formulated into messages targeting specific issues pertinent to the social context of the receptor audience. The messages are designed mostly by local professionals (albeit with the support of international experts and donors) who are best suited to understand the intricacies of the local social and cultural context. Although they are from

various professional backgrounds, the local professionals working on major campaigns essentially play the role of linguistic and cultural translators.

CONCLUSION

Tyulenev and van Rooyen (2013) noted that, although many studies of translation in developmental contexts had already been undertaken, many of these were conducted within the realm of postcolonialism. In short, there remained many lessons to be learnt about the behaviour of translation in a developmental context. By researching public health communication in Zambia and the southern African region, this study has offered a glimpse of translation praxis in the context of a developing country.

Because an important goal of public health communication is to influence behaviour change, it is imperative to focus on the target audience in the process of creating meaning and communicating information about health. As Nida ([1964] 2000) and Nida and Tabor (1969) postulated early on, translators have to think about *how* a message will be received in a particular setting and what factors influence the receptivity of the audience. In this case, the relationship between the source text and the target text goes only as far as the factual correctness of the disseminated information. Beyond that, translators and communicators as activists and social change agents have the liberty and flexibility (and the duty) to use whatever tools and channels at their disposal to ensure that the message delivered is understood and resonates with their receptor audience. To do so, they have to understand and identify with the social context and the worldview of their target audience.

Tymoczko (2007) has argued that an enlarged view of translation increases the agency of translators and further empowers them. She has added that viewing translation as a cluster concept liberates translators operating in peripheral cultures from the confines that a Western view of

translation places upon them. Liberated and empowered, translators are able to test and invent new strategies of translation.

Taking translation as a cluster concept and a communicative and interpretive act, this study has shed light on some translation practices in public health communication. Of note is the fact that, while the edutainment model is a well-known and popular communication strategy used in public health interventions, it can also be considered a translation strategy from a translation standpoint. The strategy gives translators and communicators the flexibility to package messages that are target-oriented and that appeal to their audiences. Also noteworthy is the frequent occurrence of intersemiotic translation (the edutainment model, films, images, etc.), which is clearly motivated by the dynamics of the target audiences in this particular context.

It is highly unlikely that the translation products of public health communication (such as the ones presented above) can be evaluated according to some of the Western conventional norms that are based on equivalence. Perhaps, in this case, the best form of evaluation would simply be the accuracy and veracity of the health information relayed, the purpose of the communication, and its compatibility with the target audience context.

Limitations of study

A case study by nature tends to have a narrow focus. My choice of research topic stemmed from my interest in translation studies in the developing world and specifically in Africa. However, as Africa is a large continent comprising 54 countries, it was evident from the outset that the study would be more manageable and meaningful if limited to a specific geographical area. Many African countries belong to the developing world and therefore share many characteristics, but they are also heterogeneous in numerous ways. Although many of the insights

gained from this study may be applicable in other geographical areas, this study refers only to the specific area selected. In addition to limitations in terms of geographical spread, the study was also restricted to only one aspect of a developmental context, namely, public health communication. Lastly, the selected corpus for study also had to be narrowed due to the limited scope of the study. That said, a case study, while having a narrow focus, often provides for a more detailed study of one, albeit limited, subject.

Suggestions for further study

Although it may seem disadvantageous on the face of it, the fact that translation phenomena in Africa have not been studied extensively outside of the ambit of postcolonialism can also prove to be advantageous; the scope for the study of translation in Africa in a developmental context is fairly wide.

For instance, some of the issues arising from the present study that were touched upon but not dealt with extensively could be explored further. Issues such as the empowerment and agency of translators in Africa or issues surrounding translator training or translation as a profession in Africa could be further researched. Tymoczko (2007) proposes that translator training programmes in Africa should be based on and reflect the wider conceptions of translation.

Another interesting area for research is the translation of reproductive health concepts across genders or from a feminist point of view. As alluded to previously, although women are marginalized the world over, sociocultural conditions in the developing world exacerbate the problem for women living in these areas. In my analysis of some of the terminology relating to HIV/AIDS above, I observe, as do other scholars (Chinsebu *et al.* 2011; Kunda & Tomaselli

2009), that negative and shaming terms are used to describe some diseases, especially those related to reproductive health.

A developmental context unites a wide range of issues, all of which could provide interesting avenues for further research in relation to translation phenomena. Sectors such as education, agriculture, the media, economics, or politics could provide some interesting paths for possible research. For example, in a country that only recently adopted the use of local languages as media of instruction in schools, the study of translation in areas such as curriculum development and teacher training could prove useful.

Lastly, as Marais (2017a), Bandia (2015) and Tymoczko (2007) have suggested, there should be more studies exploring issues surrounding semiotics and intersemiotic translation in Africa. The socioeconomic and cultural conditions described above indicate that the semiotic (and multimodal) paradigm is more compatible with a context such as Africa's. Moreover, intersemiotic translation is a much more compatible form of translation in a non-literate, oral society.

Significance of study

On the continent and across the world, there is a growing interest in the study of translation in Africa. When I commenced my research, there was considerably less scholarship on Africa than there currently is. One of the major contributions in the past five years to which I refer extensively is Marais' (2013, 2014) work linking translation and development and proposing a complexity theory approach to translation. Significantly, the last five years have also seen the birth of the Association for Translation Studies in Africa (ATSA), following the International

Association for Translation and Intercultural Studies (IATIS) regional workshop and TS summer school for Africa in August 2014. A collection of articles, *Translation studies beyond the postcolony* edited by Kobus Marais and Ilse Feinauer (2017), resulted from this meeting. In addition, a special issue on translation and development in one of the six journals surveyed above, *The Translator*, is planned for 2019, as is a new ATSA online journal. All in all, there are many reasons to be optimistic about the place of Africa in TS.

It is hoped that this study will add to the growing scholarship of contemporary translation practices in Africa and also contribute to the growth of new avenues of scholarship.

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APPENDIX 1

Figure 1: Articles on translation in Africa published in six TS journals from 2005–2015

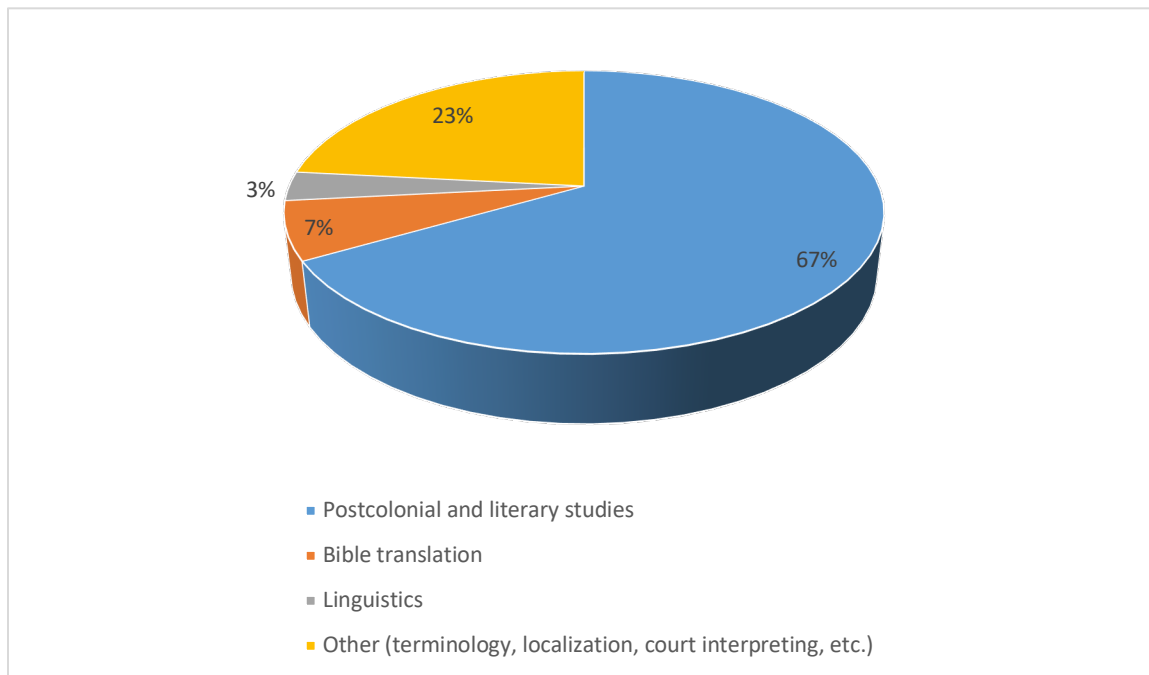
Year of publication	<i>Journal of Translation and Interpreting Studies</i> ⁵⁹	<i>Meta</i>	<i>Target</i>	<i>Translation Studies</i>	<i>The Translator</i>	<i>TTR</i>
2005		1. Bandia, Paul F. (2005), Esquisse d'une histoire de la traduction en Afrique, Vol. 50 (3), p. 957–971 2. Beard, Luna & du Toit, Jacqueline S. (2005), A proactive approach to the translation of bible stories for children, Vol. 50 (4)			Hanna, Sameh F. (2005), Hamlet lives happily ever after in Arabic: The genesis of the field of drama translation in Egypt, Vol. 11 (2), p. 167–192	1. Ramamonjisoa, Patrick (2005), L'étranger prisonnier : écueils d'une traduction passive en situation (post) coloniale, Vol. 18 (2), p. 71–88 2. Kandji, Serigne et al. (2005), Traduire pour l'Afrique. Une approche géo-traductologique, Vol. 18 (2), p. 115–133
2006					1. Cooper, Brenda (2006), Look word talking? Multiple worlds, migration and translation in Leila Aboulela's <i>The Translator</i> , Vol. 12 (2), p. 323–344 2. Bandia, Paul F. (2006), Decolonizing translation: Language, culture and self, Vol. 12 (2), p. 371–378	
2007		Jay-Rayon, Laurence (2007), Traduire les réseaux métaphoriques chez Nuruddin Farah, Vol. 52 (4), p. 839–858				
2008		1. Zougbo, Jean Philippe (2008), Traduire le proverbe: à la recherche de concordances parémiologiques en bété pour la constitution d'un corpus trilingue allemand/français/bété, Vol. 53 (2), p. 310–323				

⁵⁹ The *Journal of Translation and Interpreting Studies* began publication in 2009.

		2. Vakunta, Peter Wuteh (2008), On translating Camfranglais and other Camerounismes, Vol. 53 (4), p. 942–947				
2009		1. Halaoui, Nazam (2009), Acculturation et dénomination des langues africaines, Vol. 54 (3), p. 566–574 2. Antia, Mahamadou & Tamdjo (2009), Terminologie, sécurité alimentaire et santé publique, Vol. 54 (3), p. 575–587		wa Thiong’o Ngugi (2009), Translated by the author: My life in between languages, Vol. 2 (1), p. 17–20	Hanna, Sameh F. (2009), <i>Othello</i> in the Egyptian vernacular: Negotiating the ‘Doxic’ in drama translation and identity, Vol. 15 (1), p. 157–178	
2010		1. Iwuchukwu, Matthew O. (2010), Théorie du sens et sociocritique en traduction littéraire, Vol. 55 (3), p. 529–544 2. Gerbault, Jeannine (2010), Localisation, traduction et diversité sociolinguistique en Afrique subsaharienne : stratégies et perspectives, Vol. 55 (4), p. 817–844			Spiessens, Anneleen (2010), Voicing the perpetrator’s perspective: Translation and mediation in Jean Hatzfeld’s <i>Une Saison de machettes</i> , Vol. 16 (2), p. 315–336	Jay-Rayon, Laurence (2010), Les motifs sonores dans la littérature africaine europhone : exemple et jalons théoriques dans une perspective traductive, Vol. 23 (1), p. 95–122
2011	Marais, Kobus (2011), The representation of agents of translation in (South) Africa: Encountering Gentzler and Madonella), Vol. 6 (2), p.189–206				Kruger, Haidee (2011), Postcolonial polysystems: Perceptions of norms in the translation of children’s literature in South Africa, Vol. 17 (1), p. 105–136	
2012		Kruger, Jan-Louis (2012), Ideology and subtitling: South African soap operas, Vol. 57 (2), p. 496–509			Gamal, Ahmed (2012), Postcolonial translation as transformation: Ahdaf Soueif’s <i>I Think of You</i> , Vol. 18 (1), p. 101–118	El Badaoui, Manal Ahmed (2012), Traduction de quelques faits culturels du français vers l’arabe : retour de l’original à son point d’origine, Vol. 25 (1), p. 133–158
2013			Kruger, Haidee (2013), Child and adult readers’ processing of foreignised elements in translated South African picture books: An eye-tracking study. Vol.		Benmessaoud, Sanaa (2013), The challenges of translating third world women in a transnational context: The case of Mernissi’s <i>Dreams of Trespass</i> , Vol. 19 (2), p. 183–205	

			25 (2), p. 180–227				
2014					Ralarala, Monwabisi K. (2014), Transpreters' translations of complainants' narratives as evidence: whose version goes to court? Vol. 20 (3), p. 377–395		
2015				1. Makutoane, Tshokolo, J. et al. (2015), Similarity and alterity in translating the orality of the Old Testament in oral cultures. Vol. 8 (2), p. 156–174 2. Di Giovanni, Elena & Chelati Dirar, Uoldelul (2015), Reviewing directionality in writing and translation: Notes for a history of translation in the Horn of Africa. Vol. 8 (2), p. 175–190 3. Batchelor, Kathryn (2015), Orality, trauma theory and interlingual translation: A study of repetition in Ahmadou Kourouma's <i>Allah n'est pas obligé</i> . Vol. 8 (2), p. 191–208 4. Ettobi, Mustapha (2015), Translating orality in the postcolonial Arabic novel: A study of two cases of translation into English and French. Vol. 8 (2), p. 226–240			
Total number of articles (2005–2015)	102 articles 2009–2015	626 articles 2005–2015	368 articles 2005–2015	135 articles 2008–2015	180 articles 2005–2015	134 articles 2005–2012	

Figure 2: Subject areas coverage of TS articles on Africa (2005–2015)



APPENDIX 2

Figure 1: Map of Africa showing Zambia and neighbouring countries

Source: Bush Buzz, n.d.



Figure 2: Provinces of Zambia
Source: Embassy of Japan in Zambia

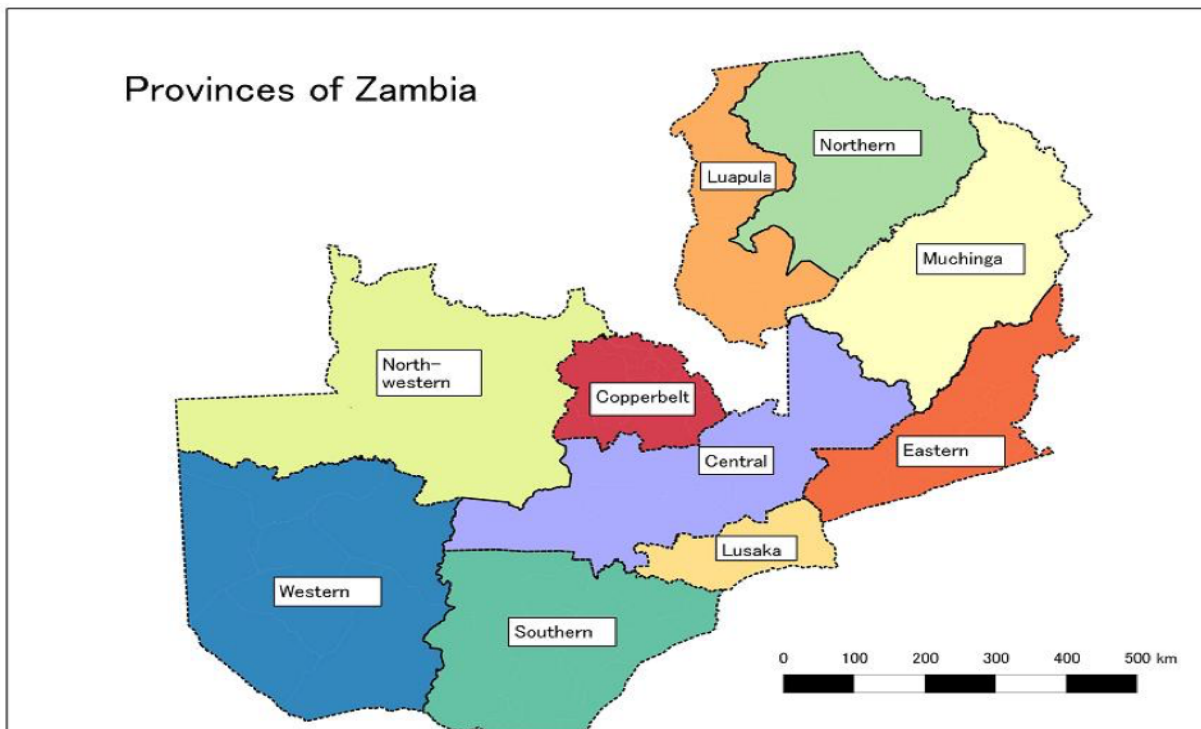


Figure 3: Map of Zambia indicating rail line, towns and neighbouring countries

Source: Nations Online Project (n.d.) © 1998-2017: nationsonline.org



Figure 4: Ethnological map of Northern Rhodesia

Source: WHKMLA Historical Atlas (2005)

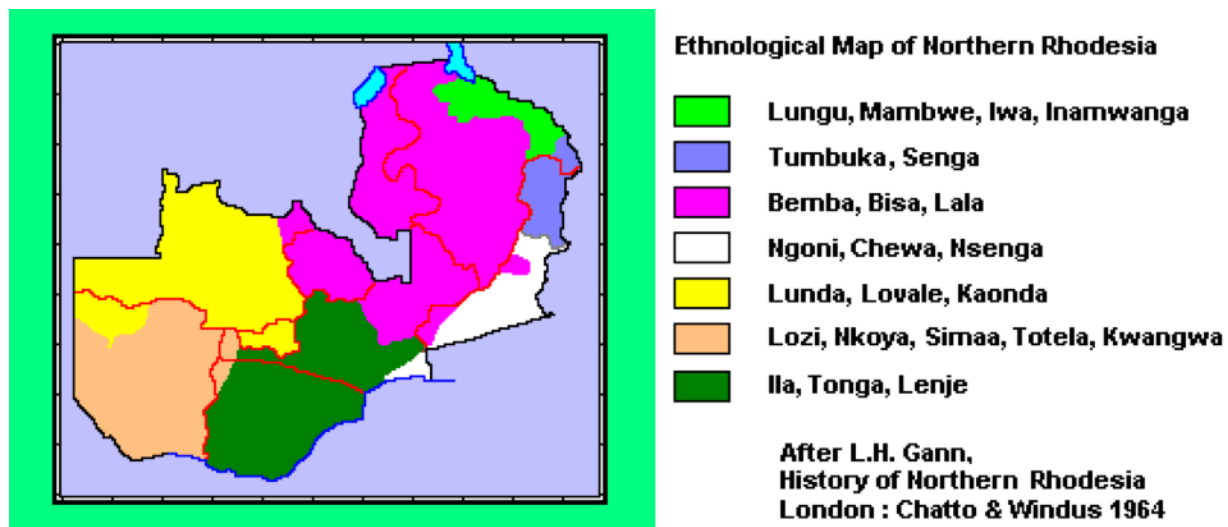


Figure 5: Dominant regional languages in Zambia.

Source: Wikimedia Commons 2016

