

# Cultural linguistic strategies in HIV/AIDS discourse in Shona: A survey of Bindura Hospital.

By

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## Abstract

*This study looked at HIV/AIDS/STI discourse in Shona, a language in which sex is considered a taboo subject. In Shona certain words cannot be said because culture does not allow it. HIV/AIDS being largely a sexual condition, it was hypothesized that health personnel face problems in communicating HIV/AIDS/STI treatment information. The study carried out at Bindura Hospital showed that this was the case but however, health personnel develop linguistic techniques and strategies to pass on and receive information on these touchy subjects. Data were collected, through the use of a questionnaire, from a random sample of 40 health personnel at Bindura Hospital; and established that taboos are catered for through cultural strategies like metaphors, euphemism, allusions and other linguistic options e.g. slang and code switching. This tended to dilute and at times distort messages; which compromised on clarity therefore undermining efforts to curb the spread of the pandemic.*

**Keywords:** HIV/AIDS, language taboos, linguistic techniques, metaphors, code-switching.

## 1. Introduction

This study was carried out against a backdrop where HIV/AIDS has become one of the most pressing medical issues the world over. The bulk of current medical discourse shows that indeed the world is under threat from this pandemic and a lot of focus is trained on how the pandemic can be contained. Compiling statistics on the rate of spread of the disease, Elizabeth Rauh Bethel (1995) came up with some scary figures:

Prior to 1985, slightly more than 13 000 cases had been reported from nations around the globe to the World Health Organisation. That year, the figure more than doubled, to 28 422 cases. Five years later in 1990, the number of people with AIDS had increased thirteen fold to 390 206 reported cases worldwide. Between 1993 and 1995, an estimated 6.9 million women, men, and children had become newly infected with the HIV virus...

As of 1993, the estimated distribution of cumulative HIV infection in Sub-Saharan Africa was 9 Million as compared to 5 175 000 for the rest of the world. Another study dated 2000, states that more than 30 million people were estimated to have HIV-1 infection worldwide and 16 000 new infections, mostly acquired heterosexually, were estimated to occur each day. Significantly, most of the HIV-1-infected people live in less-developed countries, *mainly in sub-Saharan Africa* (my emphasis) and Southeast Asia (Egger and Davey Smith, 2000.)

A UNAIDS and WHO survey of 2001 showed that on average one person out of ten in the 15-49 age group in Sub-Saharan Africa had HIV infection and that average life expectancy had plummeted down to 47 years and was still going lower. *Children on the Brink*, 2002 estimated that 71% or 24.5 million people living with HIV/AIDS in the world live in Sub-Saharan Africa, Later statistics by UNICEF's *Zimbabwe Human Development Report* of 2003 stated that in Zimbabwe, one in every four adults aged between 15 and 49 years was living with HIV. The same source stated that life expectancy was focused to decrease to 35 years or even lower by 2010 (UNICEF, 2003).

More recent figures by *AIDS and HIV Information from Avert.org* show that in Zimbabwe at the end of 2007, 1 300 000 people were living with HIV/AIDS- constituting an adult rate of 15.3%. Of these, 680 000 were women and 120 000 were children. There were 140 000 AIDS deaths, leaving 1 000 000 orphans. The same source states that “an estimated 22.4 million adults and children were living with HIV in sub Saharan Africa at the end of 2008. During that year 1.4 million Africans died from AIDS. Around 14.1 million children have lost one or both parents due to the epidemic. Sadly more than 17 000 children are infected with HIV every year, the majority through mother to child transmission. DFID (2008)

With such statistics there cannot be enough research done on HIV/AIDS. Studies into ways by which the pandemic can be arrested in its rampage are of crucial importance, and this paper makes a modest contribution to that goal. The paper makes no claims of being pioneering work; a lot has already been written in Zimbabwe on the place of language in HIV/AIDS discourse. (See for example Mashiri et al, 2002, Chigidi, 2009). Like the mentioned scholars, this particular researcher sought to add a linguistic dimension to the corpus of knowledge generated on the scourge by showing how matters relating to language may have a part to play in the struggle to curb the spread of HIV/AIDS in Bindura (a mining and farming town 87km north of Harare, Zimbabwe.) It is my considered opinion that language, within a cultural context, has an important part to play in the efficacy or otherwise of disseminating information about, and treatment of, HIV/AIDS in our communities.

### ***AIDS and Culture***

There is a definite inextricable link between AIDS and a people’s culture. Though HIV is a medical condition presenting itself clinically, the condition is culturally constructed, “perceived, understood, and acted upon (or not acted upon) within a framework of culturally derived meanings.” Taylor, (1995) (See also Berger and Luckman, 1967). It is in the context of this cultural dimension characterized by traditions and taboos (a socio-linguistic perspective) that this study sought to examine HIV/AIDS. It attempts to explain whether there is a correlation between language and the spread of the infection, its prevention or treatment. According to Dyk (2002) HIV/AIDS prevention programmes must be contextualised so that they are sensitive to local customs, cultural practices, religious beliefs, values, traditional norms and practices. The way that communication about HIV/AIDS is conducted, information exchanged, attitudes examined and support given determine the health personnel’s impact in preventing and controlling HIV/AIDS. Writing on discourses of HIV/AIDS in South African media, Mark Connely and Catriona Macleod (undated) saw the social dimension of AIDS as pervasive and central. They cite Treichler 1999:18 who says “Until HIV/AIDS’s simultaneous material and linguistic reality is understood we cannot begin to read the story of this illness accurately or formulate intelligent interventions.’

### ***Purpose of the study***

It is usually with a lot of discomfort that African people discuss matters to do with sex and sexuality; even inside homes and between spouses. This is especially so, among the Shona people. Muganda, 2000; Samukange, 2000 cited in Shumba et al, 2003 in their study of sexual maturation among adolescents observed that neither parents nor teachers in the Shona context talk to their children about growing sexual maturation because of cultural taboos. They posited that both parents and teachers generally feel embarrassed and ashamed to discuss matters to do with sexuality. Interviews conducted in Rio de Janeiro with gynaecologists revealed that the doctors often found it difficult to discuss issues related STI and sexuality with female clients. (*Network Family Health International, Vol 21, No.4 2002*). It was hypothesized in the initial stages of the research that our own health personnel have the same difficulty. It was therefore interesting to unravel the methodologies and strategies that medical personnel use to circumvent the problem, save face, while still communicating effectively in therapy. This study therefore focuses on linguistic taboos in the context of health practice because any talk about STI’s and matters relating to HIV/AIDS of necessity includes the use of such tabooed words. It examines the pragmatic cultural strategies that health workers have or use to try and avoid breaking rules relating to taboos.

### ***Research Questions***

The research was guided by the following questions:

Are language taboos an issue in HIV/AIDS treatment discourses?

What strategies do health personnel use to save face in potentially embarrassing situations?

What effect does the face saving have on the import of their communications?

What implications are there in HIV/AIDS therapy and treatment?

### ***Taboo***

Tischler (1983) cited in Chigidi, 2009 posits that “Every society has means of training and of social control that are brought to bear on each person, making it difficult for individuals to act or even think in ways that deviate too far from the group’s values and norms. Deviation would be regarded as taboo and all societies have their rules about taboos. The same point is developed by Meade, 1930 also cited in Chigidi, 2009.

To respect taboo was duty towards society, because whoever broke it caught the taboo contagion and transmitted it to everyone and everything he came into contact with. Thus it behoved the community to enjoin respect for taboo, and even more, it behoved the individual to avoid contact with things taboo, otherwise his infraction of this potentially conventional inhibition recoiled upon him, in particular, with deadly severity. (Meade, 1930:18)

Wadaugh, (1998:234) sees taboo as “the prohibition or avoidance in any society of behaviour believed to be harmful to its members in that it would cause them anxiety, embarrassment, or shame.” Another insightful definition is one according to Tagil, (1995) who posits that “Taboo can be characterized as being concerned with behaviour which is believed to be supernaturally forbidden, or regarded as immoral or improper; it deals with behaviour which is prohibited or inhibited in an apparently irrational manner. In language, taboo is associated with things which are *not* said and in particular with words and expressions which are *not* used.” Those who break taboo rules are rebellious and society labels and punishes them as obscene, vulgar, offensive and blasphemous.

As follow up to Tagil’s, (1995) definition, taboos can thus be divided into two categories; linguistic taboos and non-linguistic taboos. Non-linguistic taboos involve ‘deviant’ behaviours like incest, bestiality, homosexuality, disrespecting parents, eating meat of animals from which people derive their totems, working in the fields on selected sacred days etc. Linguistic taboos forbid the saying of certain things. Such things should not be said, not because they cannot be, but because people do not talk about them. Certain objects can only be referred to in certain circumstances, or only by certain people. Wadaugh, (1998). Both in traditional and modern societies, “compliance with verbal taboos is part of the ethnography of communication; for society sometimes places certain words under strict verbal censorship”. Yankah (1998: 15) cited in Mashiri, et al. (2003). Examples of tabooed subjects are sex, male-female genitalia, semen, excretion, bodily functions, death, religious matters, politics etc.

Much as they may be touchy as regards non-linguistic taboos, the Shona people are more sensitive to the use of taboo words. Even when it is unavoidable to use them, they try in all ways possible to substitute them for others that are more palatable. A competent speaker of Shona is therefore aware of speaking norms that prohibit verbal references to certain words... whose direct verbalisation could unleash forces of instability or stir grief (Mashiri, et al. 2003).

From the foregoing it can be inferred that linguistic taboos are an issue when considering treatment and talk about STI’s, HIV/AIDS. Talk about STI is talk about sex and HIV/AIDS have generally been characterized as sexual conditions. It is therefore important to find out what pragmatic options health personnel employ as they deal with such matters, considering that they are a frequent occurrence in a health practitioner’s average day at work.

### ***Cultural Linguistic Strategies***

In order to deal with the mentioned taboos, pragmatics or cultural linguistic strategies are used by the Shona to minimize embarrassment and save face. Levinson, (1983) defines pragmatics simply as “the study of language usage.” It relates to the way that human beings use language in a social context. In other words it is the study of language from a functional perspective that is, it attempts to explain facets of linguistic structure by reference to non-linguistic pressures and causes.” If one were to link it to Chomskyan linguistic distinctions between competence and performance- or Saussuer’s *langue* and *parole*, pragmatics would be concerned solely with performance/ *parole* principles of language use, or utterance meaning. Dwelling only on the competence plain of language is bound to violate rules governing linguistic taboos and it is necessary to look at performance and how meaning can be best conveyed with as little violation as possible to the sensibilities of people as the health workers discharge their duties.

Some of the cultural strategies used involve the use of euphemism or the dressing up of certain words or subjects in language to make them more palatable or presentable. Euphemistic words and expressions allow us to talk about unpleasant things and disguise or neutralize the unpleasantness... They also allow us to give labels to unpleasant tasks and jobs in an attempt to make them sound almost attractive (Wadaugh, 1998). It is a politeness strategy in which such things are talked about in a very roundabout way or with the aid of euphemisms, metaphors and allusions. At times people develop an elaborate system of substitutions including substitute words with no traceable associations as well as words from other languages (Mncube, 1994). Zeroing in on the Shona people, Mashiri et al. (op.cit.) say in the introduction to their paper, “Naming the Pandemic”, “the Shona people consider matters relating to sex, death, illness or the other’s misfortune as taboo or unspeakable. Thus, (they) create and use numerous euphemisms, metaphors, colloquial expressions and slang for naming HIV/AIDS or referring to its consequences since they perceive the acronym HIV/AIDS as too direct, highly unsettling and face threatening (Lin 1999: 12, Gao and Ting-Toomey 1998:77).

### ***Design***

The design took the form of a descriptive survey with the questionnaire as the chief data collection instrument. The interview was also used with a few of the respondents to get more inside information from the more experienced members of staff at the Hospital.

### ***Sample***

Purposive sampling was used in this research. This method is handy and appropriate when the researcher’s interest lies in each member of the group, rather than merely representativeness. In this sampling, the researcher “purposely selects certain groups or individuals for their relevance to the issue being studied.” (Williamson, et al, 1977:224) Bindura Hospital staff comprises 120 qualified nurses, 104 of whom are females and the rest (16) male. Forty health professionals (30% of the total and roughly representing three main age groups that emerged) participated in this research. The nurses were selected since they were easily accessible; they were the people manning the different departments from which data was collected. The departments represented are as follows: the Children’s, Female, Male, Maternity wards and the OIC (Opportunistic Infections Clinic). Each department is staffed, on average, by 8 nurses during day time, and 3 during the night. (The OIC, however, does not operate at night). The research did not focus on the ancillary or support wing of the personnel at the hospital; although interesting findings could be gleaned from that section. It also left out the patients although the hospital treats on average 80 patients daily, 500 patients weekly and 1800 patients monthly. It was felt that that larger population needed its own separate research.

Of the 40 respondents 6 were male and 34 female representing a percentage of 15 and 85 respectively. The age ranges were twenty two respondents from the 20 to 30 range, nine from the 30 to 40 range, seven from the 40 to 50 and two from the 50 and over ranges. This shows that the majority of the respondents

are in the relatively young group. It is also this group that has the least post training experience and least experience in treating HIV/AIDS related ailments.

### ***Data Collection***

The questionnaire and interview methods were used to collect data. Combining the two was preferred because the methods are complementary. The questionnaire enabled health personnel to give their views without embarrassment because of its anonymity. The open and closed-ended questions that were included in the questionnaire gave the health personnel an opportunity to present objective and subjective information vital for the study.

## **2. Findings**

### ***Are language taboos an issue in HIV/AIDS treatment discourses?***

It emerged from the study that there is a definite issue as regards language taboos when discussing matters related to sex and sexuality. It was also clear that given the unequal ratio of male as compared to female staff, there are no provisions for having same sex therapy sessions where male personnel deals with male clients only, and vice versa. Even if that were the case, the research established that the taboo issue would still come into play. The survey showed that in the main, the health personnel at Bindura hospital do not have marked problems communicating about AIDS/STI. 15 respondents thought that personnel are free to talk about these issues, 12 were comfortable, while 11 indicated their discomfort and 2 said that they were embarrassed by taboo words.

The above shows that the majority (27), representing 67% do not have problems of communication about the sensitive issues in HIV/STIs and 13 respondents, or 33%, feel some discomfort in communicating such matters. 13 seems to be a small number, but given that it represents about a third of the respondents, it becomes quite significant. It was felt that the embarrassment they profess might have important implications in HIV/STI therapy and treatment. It was thus postulated that there may be a correlation between language and HIV/STI prevention or treatment.

It also surfaced from the research that patients have a greater challenge communicating about such matters. Asked whether patients are Free, Comfortable, Uncomfortable or Embarrassed about sexual conditions, responses showed that health personnel perceived patients as having a greater problem with taboo words than health workers. 5 respondents thought patients are free to discuss such issues, 10 thought they were comfortable, while 16 said they were uncomfortable and 9 indicated that they are embarrassed. This gives us a total of 25 respondents, representing 63%, who thought that there was a problem with patients discussing taboo subjects. The survey quoted the following as issues causing the most discomfort:

‘Sexual practices and problems, especially condom use’.  
‘H.I.V/AIDS and other S.T.I’s, especially genital ulcers or genital herpes’. ‘Patients think we as health professionals will publicise their status since we come from the same community’.  
‘Sex and S.T.I’s.’ ‘Male, female genitalia’. ‘Opening up about the particular complaints they have’.  
‘Opening up and showing where it hurts is a problem’. There was the observation that ‘Old people feel embarrassed to discuss their sex life and problems with young health practitioners.’

### ***What strategies do health personnel use to save face in potentially embarrassing situations?***

Most of the respondents (25) said that they use Shona through and through, but employ metaphors, allusions, euphemisms and circumlocution to save face. 11 said that they code switch to English should there be a potentially embarrassing moment. Four said that they sometimes code switch to slang as a face saving measure especially when dealing with younger patients.

Comments raised about the logic of using Shona were that most clients understand or use the language as mother tongue. There was a strong feeling that all that there is to say is better said in this language. An elderly respondent said of the matter, 'In health issues there is no need of change of language when communicating with client/patient. Patient's language is the one which should be used to avoid communication break down or a client/patient is asked which one he/she is free to use.' (sic) The catchment area of Bindura is mostly the rural areas and farms around it, the mining community and the urban dwellings. All the people from these areas understand the language and for the younger generations, it is their mother tongue. The Shona idiom used is however coloured with euphemisms, metaphors and allusions to try and avoid the taboo issue.

Those who opted for English were of the opinion that the use of this language is better 'because some Shona words are not acceptable to some cultures and religions' and that English is a common language accessible to a significant portion of our population. Saying all there is to be said in English does not have the cultural entailment of the taboo curse. The other advantage associated with English is that it is the language of science, and one that has a complete corpus of biological terminology available to transcend the boundaries ascribed by cultural taboos. The same can be said about those opting to switch into slang in embarrassing moments. Their view was that slang is less formal and therefore lightens up the situation. As Lederer (1997: 5), cited in Mashiri et al points out, "slang allows us to break the ice and shift into a more casual and friendly gear". It was found that with the younger aged patients this was a useful alternative.

***What effect does the face saving have on the import of communication and what implications are there for HIV/AIDS therapy and treatment?***

There were opinions that in using euphemisms, metaphors and allusions as ways to circumvent certain words, expressions etc. something is lost in terms of the full meaning of the substituted part. The following are some of the submissions by respondents: 'you will miss the exact point because you will be generalizing,' 'differential diagnosis instead of proper diagnosis maybe derived,' 'Sometimes in avoidance you will be causing more harm as meaning can be disturbed'.

In code-switching to English, a serious supposition is made; that people do understand English presumably because it is the official language of business, governance and wider cross-cultural communication in Zimbabwe, hence responses like 'Using English is effective but it is difficult for those who do not understand the language'. While a significant portion of the urban Zimbabwean population is proficient in the use of English (which is spoken as a second language in the country) the same cannot be entirely true of some of the rural populations.

Thus, a kind of catch 22 situation is engendered, where in an effort to avoid taboo words cultural pragmatics are used ironically to the detriment of meaning, yet switching to English or slang also mars its effective delivery.

### **3. Discussion**

It appears that both probing for information about the patients' conditions and responses to the questions during the diagnostic stages may be hindered by these social taboos. In an effort not to break taboo rules and considerations both the patient and the health practitioner may resort to more round about ways of gathering and conveying information. Thus sexual intercourse is vaguely referred to as 'sleeping with a man' or 'sleeping with a woman' to female and male patients respectively. This is an example of euphemism or circumlocution. In some cases it is called 'bonde', a metaphor translating to 'sleeping mat', or 'kuisa', a slang term equivalent to 'putting' in English. Sexually transmitted diseases are 'diseases of the sleeping mat' and the phallus is called 'nhengo yechirume', translating into 'organ of the male'. Semen is referred to as 'mbeu yababa', or 'father's seed'. The euphemism 'kuzasi kwenyu' or 'your lower regions' or 'nzira yemwana' 'the path of the baby', 'kunobuda neweti' or 'where the urine comes out through' are sometimes used to refer to female genitalia.

Such avoidance as detailed above has been observed as impeding or dulling the full import that might perhaps have obtained had the actual words been spoken. This is suspected to be causal to miscommunication or misinterpretation (although to a small extent) as noted by Dr. Chris Ellis, (1999) who works in the KwaZulu –Natal region of South Africa. He says, “One of the most common causes of misinterpretation in the diagnostic process is that many African languages use metaphors, allusion and euphemisms especially when dealing with illness.” Misinterpretation in diagnosis is frightful. It may lead to wrong medication or prescriptions at times with dire implications to the patient.

There is also the hesitation to mention HIV/AIDS. Often both the health practitioner and the patient will talk about and name the opportunistic infections or conditions that result from a compromised immune system. They will refer to TB, herpes, pneumonia etc, but they will skirt naming the pandemic. They may allude to ‘mukondombera’ (the scourge) or ‘zvirewe zvamazuva ano’ (diseases of today) but not HIV/AIDS. Similar observations were made about the Xhosa in South Africa, “Although it is common to refer indirectly to illnesses, HIV/AIDS has a special status in the hierarchy of diseases. It is the new *threat to harmony* and if one breaks the *hlonipha* (taboo) custom of avoiding this name with its close relation to another taboo, sex, one is invoking chaos and adversity. (Mncube, 1994) It is the same evasion or practice of ‘beating about the bush’ which is seen in this research as leading to ambiguities that may compromise the efficacy of the therapeutic interaction. It was also found out to be contributory to reluctance by some patients to take the necessary HIV tests.

#### **4. Recommendations**

In 1995 the then minister of health in South Africa, Dr. Nkosazana Dhlamini-Zuma was quoted in Connelly and Mcleod op cit. as outlining five key strategies to fight HIV/AIDS in the years ahead. These were school-based life skills programmes, widespread use of media, appropriate treatment of sufferers, increased access to condoms and providing adequate support. These issues are important interventions that may help arrest the pandemic’s rampage. They also tally with the recommendations of this research.

In line with matters relating to the taboo issue, many respondents in this research favoured the first two of Dhlamini-Zuma’s recommendations, that sex education must be government priority and media should harnessed more, to disseminate information. The following comments by respondents were common: ‘health education should continue so that people feel free to discuss sex, STI’s and HIV/AIDS related conditions’, ‘parents and teachers should start teaching children from early ages the subject (sex related issues) to avoid resistance and embarrassment. I feel the proper words should be used in their languages’, ‘the media should be used with celebrities and other well-known personalities like politicians playing lead roles in such campaigns’.

The government of Zimbabwe is making efforts to raise awareness through HIV/AIDS education in schools and even institutions of higher learning. A case in point is Bindura University of Science Education where HIV/AIDS is a compulsory course of study in the programmes offered in all faculties. The research suggests that it is perhaps in the context of such education that people may become increasingly free to discuss sex, STI’s and HIV/AIDS related conditions.

However, these educational endeavours are mostly carried out in English. Trying them in Shona might meet with resistance among participants. Such was the case with the Nepalese educational programme ‘Chatting with my best friend’, a programme on safe sex and HIV/AIDS awareness beamed on radio. Binayak Aryal, one of the producers said, “Initially we got letters complaining about the discussions on use of condoms, sex or sexual organs...” With time and patience the producer saw changes, “Now there is a change. Even parents and school teachers advise young people to listen to the program.” On the same issue Nirmal Rijal, another producer of the same programme, underscores the need to open up, “Without talking, these issues remain a taboo. It is something that needs to be discussed.” IPPF, 2009.

There was an observation that as they avoid taboo and save face, medical personnel are actually coming up with a specialist discourse, a sub-dialect of Shona for medical purposes or some specialist discourse. The medical superintendent of Bindura Hospital was of the opinion that the taboo situation far from inhibiting the medical personnel it actually empowers them by enriching their language and repertoire of lexical items to cater for that which cannot be said. She mentioned all the paraphernalia used to mask embarrassment as a rich cultural resource which makes it possible to get 100% meaning in therapy situations with the least embarrassment among interlocutors. However this sub-dialect could prove to be the closed kind with the entailment that it has to be taught to members of the public who will want to access health services. Recommendations were that popular media figures, politicians and celebrities could be used to disseminate the education.

## 5. Conclusion

This survey made the observation that, to some extent, the taboo norm is an issue in African society. Because of it, medical practitioners have to develop strategies to avoid certain words that are difficult to verbalise. This avoidance was seen to be potentially detrimental to or at least compromising, in terms of the efficacy of therapy in the context of HIV/AIDS and STI's. There seems to be a case for the demystification of the sexual taboo through formal or institutionalised education and informal education in the home environment and social settings. Such education should start at children's early ages so they grow up in a culture less enslaved to taboo. Popular social figures should be used through the media to demystify taboos. The pandemic should be named; sex and sexuality talked about using their proper names, and so perhaps water down the taboo curse. Given the substance that children are exposed to anyway through TV, perhaps Shona society is guilty of unnecessarily deifying the sexual taboo?

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