Sociolinguistic Research in a 'Foreign' Territory: Challenges and Problems of Fieldwork at a Malawian Hospital

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In the paper, I reflect on a sociolinguistic fieldwork that I conducted at a regional referral hospital in Malawi. I discuss some of the problems and challenges of conducting sociolinguistic research in what I have chosen to call a 'foreign territory'. In my case, the notion of 'foreign territory' referred to two situations. The hospital was a 'foreign territory' to me because I am a sociolinguist, and not a health services professional. Secondly, the research site was culturally, ethnically, and linguistically 'foreign' to me. I reflect critically on some of the challenges and/or problems of conducting sociolinguistic research in an unfamiliar *Community of Practice*.

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1.1 Introduction

This paper is a reflection on fieldwork experiences gained from a sociolinguistic study I conducted at a regional referral hospital Malawi in 2002. The paper highlights some of the problems and/or challenges of conducting research in what I call a 'foreign territory'. In my case, the notion of a 'foreign territory' has two referents. First, 'foreign territory' refers to the hospital where I conducted the study. It was a 'foreign territory' because I am a sociolinguist, and not a health services professional. The hospital was, therefore, not my usual domain of work. Secondly, the research site (the Northern Region of Malawi) was geographically, ethnically and linguistically 'foreign' to me as will become clear later in the current paper. In writing this reflexive account of my fieldwork, I concur with other researchers (see, for example, the various contributions in Shacklock & Smyth, 1998) who argue that apart from presenting research findings, social researchers should tell stories of the struggles, dilemmas, and agonies behind the research process itself. For both the experienced and inexperienced researchers, reflexive accounts of research can be revealing "because they clearly show how the researcher, as an individual, cannot walk away from the difficulties of working relationally with other human beings in a research setting" (Smyth & Shacklock, 1998: 8). A reflexive account serves as "a window on how others have faced up to the challenges and dilemmas that occur as a result of the values and interests inherent in all forms of human inquiry" (Smyth & Shacklock, 1998: 8).

The paper is arranged as follows. In the next section, I define the key terms that will be used in the paper. In the following section, I discuss my fieldwork

in terms of its location, time, objectives and methods of collecting data. The challenges and/or problems of fieldwork that I met are discussed in subsequent section. I conclude the paper in the final section.

1.2 Key Terms

It is important at this stage to define the key terms that will regularly appear in this paper. The first term is *fieldwork*. Fieldwork is an extended period of interaction between the researcher and the researched. The researcher stays in the environment in which his/her informants and/or phenomena are located. Though the origins of fieldwork are closely associated with anthropology, its use has been extended to other disciplines, including sociolinguistics.

The term *health services* refers to the provision of counselling, preventive and curative drugs as well as the provision of health related information. *Health service providers* shall mean a man or woman who provides people with preventive and curative drugs as well as health-related information. Health service providers include doctors, nurses, and hospital support staff. These health service providers serve *clients*. In this paper, the term *clients* shall be used as an umbrella term that covers categories such as out-patients, in-patients and patients' guardians.

1.3 Theoretical Framework

The theoretical construct, *Community of Practice*, will be used significantly in this paper. *Community of Practice* is gradually becoming a generally accepted theoretical and methodological basis of inquiry. This construct is used in a manner that is closely related to the

Speech Community and the *Discourse Community*. The concept of a *Community of Practice* was propounded by Lave and Wenger (1991; see also Wenger, 1998). According to Eckert and McConnell-Ginet, a *Community of Practice* can be defined as:

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

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

According to Wenger (1998), there are three crucial dimensions of a *Community of Practice*. The first dimension is that of mutual engagement. This means that there is regular interaction among members of a

Community of Practice. They meet either formally or informally to discuss matters of mutual interest. At the selected hospital, there was regular interaction amongst the various categories of service providers. This interaction was conducted through face-to-face encounters or written communication as in the case of patients' records. The second dimension of a *Community of Practice* is that there is a joint enterprise. Members of a *Community of Practice* have a shared goal or mission. The mission of a hospital is to cure patients' ailments, thus reducing human suffering and saving lives. The third dimension of a *Community of Practice* is a shared repertoire. Like any other profession, the medical profession boasts of its own register. At the hospital, one easily noticed this register even on notices and signs, for example, terms such as *examination room, dressing room, radiology* and many others. Members of a *Community of Practice* share linguistic resources such as specialised terminology and linguistic routines.

The central feature of the *Community of Practice* is practice. The focus is on what members do. The key question is: What practices or activities indicate that people belong to one special group? The practices or activities of a group include discourse and interaction patterns. In addition, becoming a member of a *Community of Practice* involves gaining control of the discourse appropriate to that group. Within a *Community of Practice*, individual members will differ. Some people will be core members whilst others will be peripheral members. "The basis of this variation lies in how successfully an individual has acquired the shared repertoire, or assimilated the goals(s) of the joint enterprise, or established patterns of engagement with other members" (Holmes & Meyerhoff, 1999: 176).

The misleading picture that has been painted

about the professional *Community of Practice* is that of homogeneity. In the case of my study site, I am aware that complete homogeneity in the characteristics and ways of doing things among health service providers is impractical. Service providers are characterised by diversity in a number of aspects: nationality, race, professional status/experience, sex, mother tongues, and so forth. With these attributes, it is unrealistic to expect all service providers at the hospital, as members of one *Community of Practice*, to act or verbally interact in a uniform manner.

1.4 The Fieldwork: An Overview

The sociolinguistic study was conducted at the Mzuzu Central Hospital in Northern Malawi. Mzuzu is the regional capital of the Northern Region. Taiwan funded the construction of the hospital, and also provided equipment, drugs and some medical personnel. The 300-bed state of the art referral hospital caters for all the districts of the Northern Region. The hospital offers general out-patient treatment, in-patient treatment and specialist treatment.

The hospital is located in a region in which Chitumbuka is the lingua franca. In contrast, the Central Region is predominantly Chichewa-speaking whilst Chichewa and Chiyao are the major languages in Southern Region. Since Malawi's attainment of independence in 1964, the country has had Chichewa as the national language. During the dictatorial era of President Hastings Kamuzu Banda, Chichewa was promoted at the expense of other indigenous languages. Despite this, the Northern Region has resisted the encroachment of Chichewa. The Northern Region itself is linguistically heterogeneous but Chitumbuka emerges as the lingua franca of the region.

The sociolinguistic study was conducted from April to August 2002. The main objective was to establish how Malawi's language policy, and in particular the Mzuzu Central Hospital's language policy and language practices impacted on communication between service providers and clients. I planned to satisfy the following specific research objectives. First, I sought to identify patterns of language use and choice at the hospital. Second, I wanted to identify linguistic and non-linguistic barriers to communication and the strategies used for overcoming such barriers. Third, I wanted to audit the hospital's language facilitation services. I combined qualitative and quantitative methods of collecting data. To this end, data were collected through questionnaires, interviews with key informants, focus group discussions, document analysis and field notes gathered through participant observation.

2 The Fieldwork Experience

2.1 Relevance of the Study

On a number of occasions, I was challenged to spell out clearly the relevance of my study. One of the questions I was constantly confronted with was: What had Sociolinguistics got to do with a hospital? Was this not just a case of overstreching Sociolinguistics? A number of people, both within and outside academia, confessed that they had previously never heard about a hospital-based sociolinguistic study. For example, a senior officer who served on the research committee of the Ministry of Health admitted that it was for the first time that his committee had to grant research clearance to a hospital-based sociolinguistic study.

The crucial question then became: How important is language in the delivery of health services? To those who may not be aware of the critical importance of language in client-health service provider interaction, Ngqakayi has this to say:

> Many people tend to associate health care with only with medical cure or drug therapy. This association functions to obscure the powerful and complementary role of verbal communication in medical procedures such as history taking and the establishment of diagnosis, quality care can be seriously compromised by the inappropriate use of language or by inadequate communication (1994: 22).

Ong et al echo Ngqakayi's sentiment: "While sophisticated techniques may be used for medical diagnosis and treatment, inter-personal communication is the primary tool by which the physician and patient exchange information" (1995: 903).

One of my key informants was particularly unconvinced about the importance of my sociolinguistic study at the referral hospital. His view was that I was engaged in a study whose objectives were trivial. As far as this informant was concerned, Malawi had more pressing health services problems that warranted research. Such pressing and more research-meriting issues included HIV/AIDS, shortage of drugs and hospital equipment, the acute brain drain among health services personnel, and so on. The uphill task for me was to convince such skeptics that the language factor was a serious enough topic in

health services that warranted research.

2.2 Researcher: Outsider or Insider?

I was also confronted with the dilemma as to whether I, a Sociolinguist researching in a hospital, was an insider or an outsider (see also Sarangi, 2002). By conducting a sociolinguistic study in a hospital setting, I had moved into a 'foreign territory' given that my area of specialisation was not health services delivery, but Sociolinguistics. Conducting a sociolinguistic study at a hospital demands that the researcher, who is professionally an outsider (cf. Sarangi, 2002), should come to grips with how the new *Community of Professional Practice* works. To this end, I had to familiarise myself with not only some of the basic medical registers but also some of the norms of the medical culture. This process meant reading about the new *Community of Professional Practice.* Of course the idea was not to specialise in medical issues, but to form a general appreciation of how and why things are done in certain ways in a particular professional context. Doing so would enable me as a researcher to make meaningful interpretations of my data. Prior to the start of the study, I visited the hospital for a week in December 2001 in order to familiarise myself with the research site. As an outsider, I had to learn the hospital's routines.

There was also another way through which I was an outsider. I conducted the study in a predominantly Chitumbuka-speaking region. Chitumbuka is not my mother tongue nor is it one of my frequently used languages. I have partial fluency in the language. Second, I was ethnically and regionally an outsider because I come from the Southern Region of Malawi. My research assistant, on the other hand, was at home geographically,

linguistically and culturally. He came from Karonga, one of the districts in the Northern Region, and he spoke Chitumbuka fluently. He also spoke Chichewa (the national language of Malawi), English (the official language of Malawi) and two of the minority languages of the Northern Region, Chinyiha and Chilambya. The research assistant was very close to the clients in linguistic and cultural terms, a situation which made it easy for him to interact meaningfully with clients. The research assistant administered questionnaires to hospital clients, and these were largely Chitumbuka-speaking individuals.

On my part, I conducted interviews with service providers in either Chichewa or English. Due to my low proficiency in Chitumbuka, I opted out of interviewing clients since the majority of them preferred to be interviewed in Chitumbuka. Some Chitumbuka-speaking clients who were proficient in Chichewa insisted on being interviewed in Chitumbuka. This was meant to demonstrate their allegiance to Chitumbuka. The use of Chitumbuka in this case was a deliberate attempt to mark regional identity. So anyone who did not speak Chitumbuka was "not one of us". My inability to speak Chitumbuka well placed me in the "not one of us" situation. When a researcher is not accepted, it becomes difficult for him/her to achieve his research goals in full.

In addition, one also has to appreciate that since independence, Northerners have always complained of being sidelined in national development. The Banda regime (1964-1994) was accused of marginalizing and persecuting Northerners. After the fall of the Banda dictatorship, Northerners became bitter when Chakufwa Chihana, leader of the Northern-based Alliance for Democracy (AFORD) failed to win the presidency. Bakili Muluzi's two terms of office as president (1994-2004)

were characterised by tensions between Northerners and people from the other two regions. When Bakili Muluzi, a Yao from the Southern Region, won the 1999 presidential elections, some angry Northerners destroyed property of non-Northerners who were living in the Northern Region (see Ott et al 2000). Non-Northerners were threatened with eviction. So when I arrived in the Northern Region in 2002 to conduct my study, there were still some ethnically-oriented political tensions between Northerners and non-Northerners. It was not unusual for a non-Northerner to feel out of place. My own case was no exception.

2.3 Access to the Research Site

The Kampala Declaration on Intellectual Freedom and Social Responsibility, which was adopted by Malawi in 1994 (see Kamwendo, 1995), urges researchers to ensure that there is no compromise on scientific, ethical and professional principles and standards. I followed a number of steps to ensure that my study satisfied the required ethical standards. The first step was to acquire a research clearance from the Ministry of Health. The Ministry of Health has a research committee that is charged with the task of reviewing and clearing all health science research projects in Malawi. As a member of the teaching staff of Chancellor College at the University of Malawi, my application for research clearance had to go through the Research and Publications Committee of the college. The chair of the Chancellor College Research and Publications Committee cleared my proposal for onward submission to the Ministry of Health. The Ministry, thereafter, approved my research proposal without any problem.

The National Health Sciences Research Committee

of the Ministry of Health provided me with a research permit which I delivered to the hospital director. The hospital director and his staff then allowed me to conduct my study. This, however, did not mean that I could conduct my study at any time of the day or in any section of the hospital. I had to go through heads of sections to seek 'local' clearances. For example, I had to speak to the head of the radiology section before I could conduct my study in his section. In some cases, the clearance took some time to come by. The longest waiting time for a clearance was one day. This is understandable given that staff and their heads of sections had to ensure that the presence of a researcher would not negatively impact on their service delivery. In addition, one has to appreciate that the service providers were very busy with the heavy demands presented to them at this busy regional referral hospital. Another challenge or problem was that I had to adhere to the official visiting hours as the only time to conduct research in the hospital wards. Conducting interviews outside the visiting hours could have led to the disruption of the operational routines of the hospital.

Sarangi (2002) notes that negotiations for routine access to different professional sites can be time-consuming and frustrating. In some cases, clearance comes "after exhausting and frustrating negotiations with the relevant bureaucratic bodies" as was the case when Barkhuizen and de Klerk (2002: 164) set out to study the sociolinguistic situation at a South African prison. In my case, accessing some of the service providers was a problem. They had such a heavy workload and busy schedule that arranging interviews with them was difficult and time-consuming. For example, on one occasion I had to wait for slightly over an hour before I could interview a doctor. I had made an appointment for the interview. However, at the agreed

time, the doctor had to attend to an emergency. I had to wait patiently. If I had lost my patience and gone away, I would have lost this key informant's views. In another case, a previously scheduled interview with a doctor had to be shifted to the following day because of unforeseen pressing demands on the part of the doctor.

2.4 The Busy Service Providers

One of the challenges or constraints was the busy schedule of the service providers. My initial plan was to administer the service providers' questionnaires through interactive interviews. But the situation on the ground was such that the service providers were so busy that it would have been impossible to complete the interview within the time allotted for the fieldwork. I therefore decided to change the strategy. The service providers had to complete the questionnaires during their own free time (cf. Saohatse, 1997). By using questionnaires, I was unable to seek extra information or clarifications from the informants.

2.5 Research Ethics

As principal investigator, I had to ensure that ethical fieldwork practices were followed. The hospital was a "sensitive" research site (cf. Renzetti & Lee, 1993). The research assistant and I, therefore, had to observe certain standards. Basically, the ethical research standards were centred around the autonomy of the informants, respect for the informant, veracity (truthfulness), beneficence (to do good to the informant), non-malfeasance (to do no harm to the informant), and the protection of the confidentiality and privacy of the informants. These are the rights of hospital-based informants (i.e. patients) as enshrined in the

Nuremberg Code of 1947 and the Helsinki Declaration of 1957 (see Kendrick, 1995). Upon meeting a prospective informant, the first step was to request him/her to take part in the study. The research assistant and/or I would give a brief overview of the study. The description of the study had to be presented in such a way that neither too much nor too little information was made available to the would-be-informant. What was needed was information that was just enough to make the informant comfortable and knowledgeable (Cameron et al 1997; Wolfram & Fasold, 1997). I feared that giving away too much information would have encouraged social desirability bias in responses. It is for this reason that Cameron et al argue that "it is not considered unethical for the researchers to protect their own interests in various ways. They are permitted, for example, to be less candid about the ultimate purpose of their research. Many research designs require that the investigator conceals their goal" at least in some ways (1997: 147).

On the other hand, not telling the informant about the nature of the study was unethical. The informant has the right to know what the research is about so that he/she can decide whether or not to take part in it. The response rate was high-98%. Whilst the research assistant and I would politely encourage prospective informants to take part, we did not use coercion since it is unethical. We upheld the wishes of the informants totally. For example, one of my key informants, a Malawian citizen of Asian origin, refused to have his interview audio-taped. I, therefore, interviewed him without audio-recording the interaction as per his wishes. As soon as the interview was over, I recalled from memory the informant's main points and then wrote them down in my research diary.

Whilst there was only one case of refusal to

be audio-recorded, there were some cases of clients who refused to respond to the questionnaire that was administered by the research assistant. The non-response rate was about 2%. Some of the outpatients and guardians were elusive. They claimed that they did not have the time for the questionnaire since they were on a queue for clinical examination or treatment. Others said that they had to go home without delay so that they could rest, hence they had no time for the questionnaire. Some guardians said that they were too busy with caring for their patients. Others said that the conditions of their patients were so critical that they could not respond effectively to a questionnaire during those depressing moments. There were a few respondents who openly said that their core business at the hospital was to receive medical treatment or to provide care to their patients, and not to be subjected the unprofitable business of answering a researcher's questions.

Informants provided verbal informed consent. Once an informant had accepted to be interviewed, we assured him/her that all the information provided by him/her would be treated in strict confidence. Informants were also assured that the study's report would not identify them by name but through the use of pseudonyms. To this end, I followed Feagin's use of pseudonyms that preserved informants' ethnicity and other essential traits (Feagin, 2002: 33). Whilst researchers can strive to maintain the anonymity of their informants, the latter may sometimes dislike the practice of being kept anonymous. This, however, was not the case in my study.

The research assistant and I adhered to the principle of non-malfeasance as follows. Before asking for an informant's consent for an interview, the health condition of the informant was thoroughly considered.

Amongst patients, we interviewed only those who were not critically ill and were able to speak fluently. The critically ill and those who were either very young or very old were left out. It was deemed unethical to interview critically ill patients (see also Saohatse, 1997).

2.6 Suspicions

My presence (as well as that of my research assistant) raised some suspicions at the beginning. For example, the research assistant and I were suspected of being journalists who wanted to write stories about the quality of services at the hospital. For those who were uncomfortable with journalists, we were unwelcome visitors. Others thought that we were inspectors from the Ministry of Health headquarters. However, these suspicions waned gradually. One reason could be that the hospital authorities had communicated to the hospital staff about the study. Secondly, my research assistant and I always explained what we were doing at the hospital. We also carried with us and produced to our respondents the research clearance letter all the time.

Whilst the suspicions surrounding me died down quickly at the hospital, the same was not the case outside the research site. At the motel where I stayed for nearly five months, some people suspected me of being a member of the National Intelligence Bureau (NIB). This suspicion was triggered by my behaviour. I carried with me notepads and documents all the time. People would see me taking down notes. They would also find me asking questions informally about language and related issues. Some local residents even wondered how on earth I could afford to pay for motel accommodation and meals for close to five months. These were all signs of a secret agent. To make

matters worse for my case, my arrival in Mzuzu in April 2002 had coincided with the State President's visit to the Northern Region. I was therefore suspected of being part of the President's security and/or intelligence service. So in the end, I wore different labels. To some, I was an academic researcher. To others, I was a government spy.

Another Malawian researcher, Munthali (2001), who conducted medical anthropological fieldwork in his own home area in Rumphi in the same Northern Region, was also suspected of being a member of the Criminal Investigation Department (CID) of the Police. Elsewhere, Sociolinguists' fieldwork behaviour has also attracted suspicions:

> Even if we present our purpose for interviewing in a straightforward manner, we must realise that informants can easily become suspicious of our motives. It is sometimes difficult for informants to believe we are simply interested in speech. We have, on occasion, been suspected of being everything from a tape recorder salesman to FBI agents (Wolfram & Fasold, 1997: 104-105).

3. Conclusion

Walford (2001:1) has observed that many textbooks on research tend to "present research largely as an unproblematic process concerned with sampling, questionnaire design, interview procedures, response rates, observation schedules and so on." The personal side of the research process e.g., fieldwork challenges and/or

social dilemmas, are rarely given a prominent position in research reports. It is important that social scientists should engage in reflective practice. They should reflect on their fieldwork and give written accounts of such reflections. Such reflexive accounts of the research process (e.g. Shacklock & Smyth, 1998) should be produced "in the hope that others will benefit from this sharing of practical experience" (Walford, 2001: 3).

The referral hospital posed some unique challenges and/or problems to me as a sociolinguistic researcher. As a sociolinguist, doing research at a hospital was like making a journey into an unknown territory. I was an outsider in this community of professional practice. Though Malawi is my home, I found myself to be some kind of a stranger in my own country because I, a Southerner, was conducting research in the Northern Region - a region that was ethnically and linguistically different from my home region. The study was indeed an academic journey that exposed me to various challenges and/or problems of conducting research outside one's familiar domain.

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