“But having small houses spreads HIV”: Problems of Language and Communication in Health Services in Sub-Saharan Africa

Prof. Gregory Kamwendo
University of Botswana

Abstract
Good health is one of the prerequisites for sustainable development. It is therefore not surprising that three of the eight Millennium Development Goals actually focus on health matters. From the three Millennium Development Goals, it is easy to tell that it is only healthy people who can contribute significantly and meaningfully to sustainable development. Governments and other agencies, therefore, have an obligation to offer adequate and quality health services. These health services do not operate in a linguistic vacuum. Language and communication problems sometimes derail the delivery of quality health services. The use of exoglossic languages (such as English, French, and Portuguese) can sometimes be problematic given that these languages are known/used by a minute segment of many a country’s population. On the other hand, the use of local languages has its own problems too. To this end, then, how can local and global languages be meaningfully used in the delivery of health services in Africa? The current paper highlights some of the linguistic dilemmas, contradictions and other challenges that African countries face as they deliver health services. The initial part of the title of this paper is meant to highlight the problems of communicating about one of Africa’s critical health problems i.e. HIV/AIDS. The paper argues that for a long time, enormous language planning efforts in Africa have gone into the education domain, thereby neglecting other domains (e.g. the health domain). In view of the centrality of health to human life and sustainable development, it is important to give a new lease of life to language planning in the health domain in Africa.

1. Introduction
Good health is indispensable to sustainable development. It is well known that poor health undermines sustainable development. The importance of good health for sustainable development is highlighted in a special way by the fact that three of the eight Millennium Development Goals (MDGs) actually address health issues. The three MDGs are: to reduce child mortality; to improve maternal health; and, to combat diseases such as HIV/AIDS, Tuberculosis and malaria. A clear message coming from the MDGs is that
there can be no sustainable development when people do not enjoy good health. For people to enjoy good health, they need to have access to health services such as medical tests, drugs, health education, and others. It is important to stress that health services are provided through some linguistic media. This being the case, there is a need to take a serious consideration of how the language factor impacts on the delivery of health services in multilingual sub-Saharan African countries. For a long time, enormous language planning efforts in Africa have been devoted to the education domain, thereby neglecting other domains (e.g. the health domain). In view of the centrality of health to human life and sustainable development, it is worthwhile to give increased attention to language planning in the health domain in sub-Saharan Africa.

The current paper has been organized as follows. In section 2, I give an overview of the link between language and globalization, with special reference to the linguistically diverse sub-Saharan Africa. In the next section (section 3), I highlight the critical role of language in HIV/AIDS education and clinical settings.

2. Globalization and Linguistic Diversity in Sub-Saharan Africa

Globalization is a widely used and misused concept. It is a concept that cannot be pinned down to one universally accepted definition and/or description. Globalization means and/or implies different things to different people. It is against this background that Held et al. (1999) have remarked that globalization is a concept that comes with multiple, contested definitions and meanings. I will, therefore, not attempt to provide many definitions of globalization. Only two definitions will suffice here. First, globalization can be defined as “the intensification of worldwide social relations which link distant localities in such a way that local happenings are shaped by events occurring many miles away and vice versa” (Giddens 1990: 64). On his part, Mazrui (2004: 1) defines globalization as a “process by which regions of the world become linked, at various levels of society, through an expanding network of exchange of peoples, goods, services, ideas, traditions etc across vast distances”. This interconnectedness of the world cannot be realized to the full without the presence of connecting languages. There is a need, therefore, for languages that enable people of divergent linguistic backgrounds to link up. Today, English is the main language of globalization (see Mazrui 2004). But we need to be critical and ask: to what extent is English a global language? Does everyone have access to English? The answer to the second question is NO. The truth of the matter is that there are inequalities with regard to access to English across the world. Some
people are native speakers of English, whilst others are non-native speakers of English, and there are also some people who do not speak or write English at all.

Sub-Saharan Africa is generally characterized by linguistic diversity. Another common feature is the compartmentalization of Africa on the basis of former colonizers’ languages. To this end, we have the so-called English-speaking African countries (Anglophone countries), the Portuguese-speaking countries (Lusophone countries) and the French-speaking countries (Francophone countries). A critical examination of the so-called English-speaking countries, for example, reveals that in actual fact, such countries are not English-dominant countries. The same situation applies to the so-called Portuguese-speaking and/or French-speaking African countries. In all these countries, the official language is actually a minority language in so far as the numerical strength of its speakers is concerned. The vast majority of the people in sub-Saharan Africa can only communicate through local languages. As lamented elsewhere, the labels Anglophone, Lusophone and Francophone are misleading (Kamwendo & Mooko 2006). This being the case, through which languages, then, can sub-Saharan African countries best deliver their health services? This is one of the key questions that this paper addresses.

Globalization is associated with advances in information technologies, international mobility of labor, increased capital flows across national boundaries and so on. Advances in communications technologies have brought about the time-space compression of the globe. As a result, the advanced information technologies have exponentially increased the ease, economy and rapidity of communication. This, in turn, has given unprecedented access across the world to the global flow of ideas and cultural products (Sklier 1999). Global languages (e.g. English) are the media through which information is able to reach various corners of the world. The major lingua francas of the world (such as English, Spanish, Portuguese, Chinese, Arabic and others) have made national boundaries more fluid and less rigid (Shohamy 2006). This has, in turn, increased the demand for proficiency in the languages of global communication as Shohamy (2006) observes that:

Local languages are no longer useful beyond the specific territory of the nation-states, while other languages are needed. Nations realize this situation and demand that their residents acquire a variety of additional languages that
will be useful for such international and global functions and for economic and academic purposes (Shohamy 2006: 37).

The year 2006 was declared the Year of African Languages. The British Broadcasting Corporation (BBC), on its website, invited contributors to respond to the following question: “As the continent marks the Year of African Languages in 2006 to help promote the use of the mother tongue, does it matter if Africa’s indigenous languages are dying out?” A contributor from Kigali in Rwanda, observed that in addition to one’s mother tongue, “I strongly advise the acquisition of an international language, whether it is English, French or Chinese. The ability to speak an international language provides opportunities for work and life choices”. A Kenyan contributor argued that “as long as nationhood is strengthened, then the more global languages like English and French, will be sufficient. Incidentally, some of my countrymen are taking lessons in Cantonese, in order to take advantage of the Chinese economic emergence”. A Tanzanian contributor cited “the need for the young Africans to keep pace with the rest of the world who speak either English, French or German”. The general feeling throughout the BBC debate is that in this age of globalization, knowledge of languages of international communication is a key asset.

3. Language and Health Services Delivery

In this section of the paper, I highlight the role of language in health service delivery. I adopt the World Health Organization’s definition of health, cited by Evans (2002: 198), as “a state of complete physical, mental and social well-being”. Health services, on the other hand, mean the provision of counseling, preventive and curative drugs as well as the provision of health related information. In this section, I focus on the role of language in HIV/AIDS education (section 3.1) and language use in clinical settings (section 3.2). A summary and conclusion come in section 4.

3.1. Language and HIV/AIDS Education

I begin by making reference to the initial part of the paper’s title which reads: “But having small houses spreads HIV”. It sounds very strange! Since when did small houses begin to spread HIV? Though the quotation sounds strange, it is in fact a real message found on billboards in Botswana. The full text on the billboard read:

“People say small houses strengthen relationships. But having small houses spreads HIV. Having more than one relationship over the same period of time highly increases your risk of HIV infection”.

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When you go for the ordinary and literal meaning, you miss the meaning of the text. Obviously, one does not expect small houses to spread HIV/AIDS. Such a thing has never happened and it will never happen. Since the literal meaning is unacceptable, one then has to search for the context-dependent meaning of the term ‘small houses’. In the context of Botswana English, ‘small house’ is a man’s extra-marital affair (a concubine). The idea of ‘small house’ signifies a woman who is lower in status than the legitimate or senior wife. Though ‘small’ and ‘house’ are ordinary English words, the term ‘small house’ can be misinterpreted by anyone who is not familiar with the Botswana context where the term is widely used. In keeping with the principles of Pragmatics, word meaning is malleable. Words change their meaning(s) depending on the context in which they are used. The billboard I have referred to is an example of the use of language that can bring about unintended meaning despite the fact that the billboard is in English, the main international language. What is special here is that the English language here has been localized or domesticated, and made to carry local flavor. Whilst we may think that through the use of English we are communicating to the entire world, we may not be doing so given that the local English may not be understood by ‘outsiders’. Even for the local audience (i.e. the Botswana audience), English is not the best medium for communicating with it. Setswana, the national language, is the best medium for disseminating HIV/AIDS messages in Botswana.

As mentioned elsewhere (e.g. Kamwendo & Mooko 2006) and earlier in this paper, despite the fact that sub-Saharan African countries are linguistically categorized as French-speaking or Portuguese-speaking or English-speaking, the majority of the people have no competence in these languages. As a result, the said languages are not the best media for HIV/AIDS education in Africa given that they exclude the majority of the people. Therefore, the use of indigenous languages in HIV/AIDS education makes sense. However, the use of indigenous languages in HIV/AIDS comes with a serious setback i.e. the lack of culturally appropriate and acceptable terminologies. For instance, in Uganda, it has been noted that local languages, such as Runyankole, lack the socially appropriate terms for human reproductive organs that health service providers could use in public talks and demonstrations on condom use. What exist in local languages are the crude and socially inappropriate names for reproductive organs (Seidel 1990). Furthermore, HIV/AIDS is closely linked to sexuality – a taboo subject in many African societies (see, for example, Kesby 2000, Mashiri et al. 2002, Mutembei et al. 2002, Lwanda 2003, Horne 2004, Mawadza 2004, Moto 2004, Uys et al. 2005, Batibo & Kopi 2008). HIV/AIDS is a topic that qualifies to be called
face-threatening (see Brown & Levinson 1987 on the face-saving view of linguistic politeness). Therefore, HIV/AIDS education programmes have to seek ways of overcoming these cultural and linguistic hurdles. For every country, there is a need to closely examine the terminologies that are currently in use in HIV/AIDS education in order to determine their effectiveness and social acceptability (e.g. see Moto 2004). This is no easy task in a multilingual and multicultural society.

It has already been noted that every society has its own culturally acceptable and/or unacceptable language use. In view of this situation, it is important that designers of information, education and communication (IEC) programmes on HIV/AIDS be sensitized on the importance of using culturally acceptable terminologies. For example, in Malawi, there have been concerns over the local language terminologies used in HIV/AIDS and reproductive health education. Some people had argued that the terminologies were socially inappropriate. To this end, a joint study between the Centre for Language Studies of the University of Malawi and the Malawi Broadcasting Corporation was conducted to identify culturally appropriate local language terminologies for use in reproductive health education. The study, funded by the United Nations Population Fund (UNFPA), solicited terminologies from selected sections of the Malawi population and health service providers. Among the areas whose terminologies were elicited were: sex terminologies (i.e. terms that express the act of sexual intercourse), terminologies for sexual reproductive organs (i.e. terminologies for male and female organs), terminologies related to pregnancy, terminologies for labour experiences, terminologies for counseling and so forth (Al Mtenje, Director of Centre for Language Studies, personal communication).

With reference to the Southern Africa region, the critical role of local African languages in HIV/AIDS education has been strongly acknowledged by the Open Society Initiative for Southern Africa (OSISA). Based in South Africa, but covering Southern Africa, OSISA is a funding organization that has strong interests in language rights issues. OSISA mainstreams language issues into all its programmes, namely economic justice, education, human rights and democracy building, information and communication technologies, gender, media, and HIV/AIDS. What is particularly relevant to the current paper is OSISA’s interest in the use of African languages in HIV/AIDS education in Southern Africa. OSISA appreciates that it is indigenous African languages that have the capacity to reach the widest possible targets of HIV/AIDS education. It is further recognized that it is important to translate HIV/AIDS materials from exoglossic languages (e.g. English, Portuguese) into local languages, thus promoting the widespread dissemination of
information on HIV/AIDS. Obviously, questions have to be raised about the accuracy of the translations and their culture-specific sensitivity (see Valero-Garces 2001, 2002). Realizing that HIV/AIDS is face-threatening subject, OSISA advocates for the development and promotion of socially and culturally terminology and expressions in indigenous African languages. OSISA’s support for the role of indigenous African languages in HIV/AIDS education is a powerful indication that indigenous African languages have a critical and important role to play in the delivery of health services such as health education.

Linguistic exclusion in HIV/AIDS education can be very critical when it comes to minorities such as the visually impaired, the hearing impaired, indigenous peoples, and refuges or displaced groups of people. The notion of linguistic exclusion refers to a situation whereby a segment of a population is left out of HIV/AIDS education, with language behind the main reason for the exclusion. This may happen due, for example, to the fact that the HIV/AIDS messages are packaged in a language that some of the target audiences for the messages do not understand. One case here is the use of exoglossic languages or the use of national languages as media of HIV/AIDS education on the assumption that every one understands it. For example in countries that have adopted linguistic assimilation policies (e.g. Botswana and its use of Setswana as the national language; Tanzania and its use of Kiswahili as the national language), there is sometimes a tendency to ignore the fact that there are some linguistic minorities that may not understand the national language. There is need to reach the linguistic minorities through their own languages. This is precisely what the Kuru Family of Organizations (KFO), a non-governmental organization working among the San (Basarwa or the so-called Bushmen) in Botswana is doing. Through the KFO’s Community Health Programme, there has been a production of culturally and contextually relevant IEC/behavioural change tools on Tuberculosis and HIV/AIDS. Among the tools produced are health cue cards that allow for interactive sessions in sharing information about HIV/AIDS. Other IEC tools such as banners, shirts and fliers allow people with little or no literacy to pick up health messages (Kuru Family 2007).

Another category of minority language users that is often ignored by health service providers is sign language users. When people refer to minority languages, it is often oral languages that come to mind. The invisibility of sign languages creates the erroneous impression that sign languages are not genuine languages. It is important to stress that sign languages constitute legitimate kinds of human languages (Baker 1999, Skutnabb-Kangas 2000). These are fully developed and authentic languages. Sign languages
allow their users to communicate the same complete messages just as spoken languages do. It is also important to stress that sign language is not the same thing as gesturing. Whilst gesturing is unsystematic and used in an ad hoc manner, signing is an extensive, structurally complex and rule-bound system of communication. Deaf people form a numerical minority. But we can also extend the notion of minority-group status to dimensions of power and status in society. As Baker (1999: 123-124) has noted, “deaf people have much less power and prestige and lower recognition and leverage than majority groups in society”. The majority group here refers to the hearing people. Most ethnolinguistic minorities tend to live in geographically marked areas. This is not the same with deaf people. Deaf people are not born in a deaf community. They are scattered across any country among hearing people. With reference to health services, we need to ask the following questions: do the health services in sub-Saharan Africa provide sign language interpretation? If there is no sign language interpretation, have we seriously considered the implications of the absence of the language service? It is important to bear in mind that all human beings have the right to enjoy various social services (e.g. health services) without being discriminated on linguistic grounds. What is needed for the deaf is special arrangements to have information on HIV/AIDS and other health hazards conveyed to them through sign language. One example that can be cited here is a comic book that is reaching out to the South African deaf community with messages on HIV/AIDS, sexual violence and sexual rights (IRIN 2008). As a politically, linguistically, socially and economically marginalized group, the deaf are usually not the targets of information and education on HIV/AIDS and sexuality.

The issue of illiteracy is also critical in health education. The use of reading materials (e.g. billboards, magazines, pamphlets, posters etc) turns out to be useless when dealing with illiterate people. As such, HIV/AIDS education through audiovisual materials works well (of course assuming that the audio element is a language that the audience understands). Television and videos can also be used, and both carry the advantage that they provide sound and pictures. But televisions and videos are not owned by many people in sub-Saharan Africa. Televisions and videos are luxuries which the majority of the people cannot afford. Televisions and videos are mainly confined to urban areas. Rural areas, with their poverty and lack of electricity, rarely have access to televisions. In such situations, the radio becomes a very important tool for HIV/AIDS education. When it comes to the use of the radio as a health education tool, it is important to stress the importance of having broadcasting policies that are sensitive to linguistic di-
versity in society. Another health education tool is the use of performing artists such as drama groups and musicians.

As we conclude this sub-section, it is important to remind ourselves that combating HIV/AIDS is a top priority globally in line with the Millennium Development Goal number 6. In this era of the HIV/AIDS threat, IEC programmes have become indispensable for empowering people. It is only people who are well informed about HIV/AIDS who can take the necessary and correct preventive measures, and also put in place effective care of those who are HIV positive. HIV/AIDS related IEC programmes take various forms – billboards, banners, leaflets, books, posters, web pages, radio, television, videos, performing arts such as drama and music, and so forth. Artists are taking health messages directly to communities through community languages. This is being done in a number of sub-Saharan African countries. The notion of mother education, as propounded and promoted by UNESCO, is applicable to the health domain. If we are to succeed with health education, then we have to provide it in a language that our target population best understands, and that language is usually the mother tongue.

3.2. Language in Clinical Contexts
Let us now consider language use in clinical environments. Language is very critical during the performance of clinical activities (see, for example, Crawford 1999, Candlin & Candlin 2003, Saohatse 1998, 2000). The importance of language in clinical services can be noted in the following key observation: “While sophisticated techniques have been used for medical diagnosis and treatment, inter-personal communication is the primary tool by which the physician and patient exchange information” (Ong et al 1995: 903). Cameron and Williams (1997) echo the same position:

Although we may think that the primary tools of medicine are technological, the most fundamental tool, upon which all use of technology depends, is that of language. Language allows patients and care providers to make their intentions known, a crucial step in the process of identifying a problem, investigating how long it has existed, exploring what meaning this problem may have, and setting in action a treatment strategy. Thus if problems in linguistic encoding interfere with this process, there may be important consequences (Cameron & Williams 1997: 419).
Ideally, we need clinical encounters (between patients and clinicians) that are language concordant. These are clinical encounters under which the patient and the clinician speak the same language. But in this is not always the case in sub-Saharan African clinical contexts. Sometimes a patient may meet an expatriate doctor who does not speak a local language, or the patient may meet a local doctor with whom she/he does not share a common language. This boils down to having a linguistic discordant clinical interaction. Under such situations, interpretation is required. Interpretation, when performed competently, is an aid to communication in a clinical setting. However, interpretation is not always provided by competent people, thus the quality of the language service may not be satisfactory. In some cases, unwilling and reluctant nurses and/or other hospital personnel provide interpretation (see Crawford 1999, Saohatse 1998, 2000), and sometimes patients may interpret for other patients, or relatives may also interpret for patients. The use of untrained interpreters sometimes comes with inaccuracies that may lead to improper decisions by clinicians. It is therefore important to have well trained interpreters.

To underline the prominent place of language in clinical encounters, I narrate two real life clinical events. One of the events takes place in Europe and the second one in a sub-Saharan African country. Both events stress the centrality of language in the delivery of health services. The first clinical event takes us to Germany. A fifty-six-year old Turkish woman was refused a heart transplant by clinics in Hanover. The reason behind the refusal was linguistic in nature. The patient did not speak German. As such, it was feared that the “patient might not understand the doctor’s orders, might take the wrong medicine and might not be able to get help if there were complications” (Spolsky 2004:1). The decision was that whenever there was no bridging language between a patient and his/her doctor(s), no operation should be carried out. This decision amounts to having a language policy. It is an institution’s language policy.

The second case to highlight the importance of language in clinical contexts comes from Botswana. A colleague from my department at the University of Botswana shared with me her experiences at Princess Marina Hospital in Gaborone in 1982. My colleague, whom I shall call Jennifer, happened to have shared a maternity ward with an Afrikaans-speaking woman from Bokspits. I shall call this Afrikaans-
speaking patient, Mervis. Mervis spoke neither English (the official language of Botswana) nor Setswana (the country's national language). Mervis gave birth, but the newly-born baby had some complications that required that she should be kept under clinical observation before being handed over to her mother. Unfortunately none of the nurses on duty understood Afrikaans. The nurses were, therefore, unable to explain to Mervis why her baby could not be handed over to her. So Mervis was kept in the dark. She grew worried. She wanted to know what was happening. Once approached, Mervis could only say: “Bokspits”, thinking that she was being asked about where she came from. As time went by without any success in communication, Mervis became so desperate that she started to cry. My colleague, Jennifer, became concerned and wanted to assist, but her knowledge of Afrikaans was very minimal. However, Jennifer, using here skeletal Afrikaans, tried to communicate with Mervis. Jennifer struggled to explain to her fellow patient that the baby was unwell, hence she had to be kept under observation. Even though Mervis was using what can be called broken Afrikaans, her colleague eventually understood what the problem was with the baby. Upon realizing that Jennifer could speak some broken Afrikaans, hospital personnel started to use her as a link between them and Mervis. Through her broken Afrikaans, Jennifer was able to serve as a linguistic bridge between Mervis and hospital personnel.

The above described situation is not uncommon in many clinical contexts in sub-Saharan Africa. For example, due to the presence of expatriate health services personnel who speak a global language (and no local language), or even a non-expatriate who does not know a particular local language, some of the patients may not directly communicate with such personnel. So they have to resort to the use of interpreters (see Crawford 1999, Saohatse 1998, 2000 for the case of South Africa). Some expatriate health services personnel may even fail to communicate effectively through English (see Kamwendo [in press] for the case of Taiwanese medical personnel who were working in Malawi).

One area that needs more scrutiny in Africa is the linguistic dimension of the recruitment and licensing of medical personnel (see Kamwendo, in press). Outside Africa, it is the norm that before a medical practitioner can be allowed to practice, he/she must demonstrate fluency in the national or official language of the country. It is against this background, for example, that non-native speakers of English may be required to take English language proficiency tests in English dominant countries. The language proficiency tests certify whether one has sufficient command of a language that would allow him/her to per-
form clinical duties efficiently. But how many sub-Saharan African countries demand that expatriate medical personnel should demonstrate proficiency in a dominant local language before they are licensed to practice? In Malawi, for instance, the Medical Council expects an applicant for a medical practitioner’s license to have adequate knowledge of the English language (Kamwendo, in press). This is an anomaly since English is a minority language in Malawi and the other so-called English-speaking countries (i.e. demographically, English is a minority language). It is through local languages that the majority of the patients are able to interact with hospital staff. The proposal here is that in addition to knowledge of the global language of medicine (English), expatriate medical personnel also need to have knowledge of the local i.e. language and culture of the local people.

In view of the linguistic barriers that exist in African clinical contexts, there is need to have language facilitation for special groups of patients, such as the visually challenged, the speech challenged, those with limited proficiency in English (or any other language) etc. Another issue worth considering is the provision of language courses for health service personnel. These courses should aim at cultivating fluency in a local relevant language that would enable health service workers to carry out clinical tasks without the use of interpreters. Even when an interpreter is used, the assumption should be that the health service worker has some knowledge of the local language that would allow him/her to follow how communication is being interpreted. Supported by such knowledge, service providers would critically follow interpretation, and probably be in a better position to press the interpreter for clarification.

4. Conclusion

In this era of globalization, improved and increased means of travel have meant that no part of the world is unreachable. This is, no doubt, a positive development. The negative angle of this situation is that the increased human mobility around the world has come with an increase in the pace at which human, animal and plant diseases spread. Infections or outbreaks can no longer be confined to certain geographical zones. To this end, we find that health hazards such as HIV/AIDS, bird flu, tuberculosis and others are no longer confined to particular areas of the world. These are no longer national health hazards. These and other health hazards have turned into global health hazards. The world is constantly communicating about the various hazards i.e. their spread and control. This communication about global health hazards takes place through global languages, and English is the main lingua franca of health communication. But not every community in the world speaks English or other languages of global
communication. That is why governments and other health services providers in sub-Saharan African countries need to convert the health messages into local languages which the masses can understand.

It is no exaggeration to say that in Africa, language policy and planning in the education domain has taken the lion’s share of scholars’ efforts and attention. Scholars writing on African education have been preoccupied with questions such as: which language(s) shall serve as media of instruction in schools; and which language(s) shall be offered as subjects of study? The preoccupation with language issues in the education domain is not surprising given the high level of importance attached to education in development discourse. Education is often cited as one of the catalysts for development; and as we all know, no education system operates in a linguistic vacuum. So one cannot fail to appreciate why language policy and planning scholars have shown great interest in the education domain. But the reality is that education is not the only catalyst for development. When one looks at the Millennium Development Goals (MDGs), it can be deduced that good health is one of the catalysts for sustainable development. It is only healthy people that can contribute significantly and meaningfully to national development. In order to achieve the three health-related MDGs, it is important that governments and other health services-providing agencies provide adequate and quality health services. The provision of health services will always be made in some linguistic medium. As such, the language factor should be considered whenever we plan for the provision of healthy services. Since language permeates into all aspects of life, it is important that language scholars explore the role of language in the delivery of health services. We have to ask: Are certain languages acting as barriers or bridges to the effective delivery to health services? If health services delivery experiences some linguistic hurdles, what can, or what should be done in the form of language services?

References


