International Journal of Social and Development Concerns

ISSN 2524-1478 (Online)

Vol. 22 | Post COVID-19 Recovery and Sustainable development
Vol. 22 Article 11 | October 2024

Literary Detachment for Politeness and Effective Communication in Healthcare Services

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Cite as: *Kiura, M. K. (2024). Literary Detachment for Politeness and Effective Communication in Healthcare Services. International Journal of Social and Development Concerns, 22(11), 162–181.*
https://doi.org/10.5281/zenodo.14000136

Abstract: *This paper interrogates the role of literature in facilitating effectiveness of communication in the healthcare sector. In this very crucial sector where performance in a matter of life and death, any constructive effort towards its improvement in service delivery is highly encouraged. The paper contributes by presenting a literary perspective of how effectiveness in healthcare communication is achieved. The paper introduces literary detachment as a product of cultural aesthetics which interlocutors in the healthcare services use to achieve politeness which enhances effectiveness of communication. This qualitative study finds a knowledge gap because the available literature on politeness and effective communication is from linguistics, anthropology, and even health sciences but with a limited horizon into how politeness is achieved for effectiveness in healthcare communication. Qualitative data is collected from five healthcare facilities in Nyamagana Municipality in Mwanza Region, Tanzania through non participant observation as well as documentary review. Furthermore, a conceptual framework which includes principles of socio-stylistics as well as politeness theories is employed to guide the process. Findings show that detachment is the main strategy for achieving politeness and it operates through sub strategies which include the inclusive 'we', in-group identity markers, give or ask reasons, as well as the cooperative. As a cultural product, detachment transforms healthcare facilities to effective stages where culture is performed, and healthcare providers as well as the patients transform to a powerful cast with various roles to perform in the grand cultural drama of transacting healthcare services. Illustrations of the effectiveness of detachment are provided using examples from data collected of cultural performances which facilitate cultural politeness such as the ritualised formulaic greetings from the Swahili culture. In the end, the paper restates the importance of cultural aesthetics in all sectors of our society. The paper recommends a paradigm shift in all academic disciplines, including medicine and healthcare, to embrace cross/multi-disciplinary approaches to their research work in order to broader and enrich their knowledge base which informs development and implementation of respective policies. More studies should also be focused on the significance of the various aspects of intangible heritage of cultural aesthetics to tap the wealth of collective cultural wisdom.*

Keywords: *detachment, politeness, effective communication, healthcare, cultural aesthetics*

1.1 Introduction

This paper presents a unique contribution to the ongoing cross/inter/multi-disciplinary synergy from the variegated spaces of knowledge as a requirement for realisation of broader, deeper, clearer, and, thus, better understanding of ourselves and our worlds. In this effort, the discourse herein offers a literary prism for critical observation of communication within the very important healthcare sector. It also presents a (re)statement of the central role of African oral literature in the process of collective (re)negotiation and (re)generation of cultural knowledge, skills and attitudes which prop and propel society through the dynamics of existence. Detachment is specifically addressed as a key literary product by which politeness is realised and is deployed to enhance efficiency and effectiveness of communication in our healthcare sector. One reason for success of detachment in this task is in the fact that majority of stakeholders in the healthcare sector especially in Tanzania, including most of the citizens, are sufficiently cultural and literary even where levels of numeracy and literacy are significantly low.

1.2 Study Background and Motivation

Literature has been defined as the art that uses language creatively in addressing reality and human experiences (Kiura 2017) and part of such address is in providing to the people unique appropriate aesthetic means of what Chesaina (1997) calls propping and propelling the society in its dynamic existence. Within this view, scholars posit that African oral literature continues to occupy what Rethabile (2013) calls a revered place in people's lives largely owing to its uniqueness (alluded to above) as it is comprised of culturally specific interactive activities, be they visual or verbal, which constitute a continuum where people's thoughts and actions can be shared (Ajibade 2005).

The centrality of oral literature is emphasized by Shitemi (2009) who argues that oral literature is fused and integrated in people's daily interaction through communication, language use and other modes of transmitting knowledge like norms and social ethics. These, as well as other literary scholars are in agreement that celebrations, cultural festivals, rituals, ceremonies, meetings, as well as other notable events and occurrences such as deaths, disasters and calamities, including public health, disease outbreaks and pandemics like Covid 19 in 2019 and the ongoing Mpox in 2024, etc., related activities in searches for godly intervention and many other situations where members of specific communities converge individually and collectively serve as mediums, platforms and spaces presided over by oral literature or where its functional features are manifest.

This paper draws motivation partly from the conviction of the power and effectiveness of literature in addressing every aspect of reality and human experience as highlighted above. It is further motivated by the desire to utilize the cross/inter/multidisciplinary approach to search and discourse on knowledge. As Lemke (1995) argues, intellectual discourse should not be conducted selfishly, exclusively or in adversarial manner. He explains that such limiting notions belong to those who wish to impose their views on others and force the view of their opinion as the only one and as the only right one. We agree with Lemke that such notion is harmful to the community. As such, a literary view of the situation in our healthcare sector is a welcome addition to the several existing views which include those from linguistics, anthropology and medicine.

Uniqueness of requirement of high degree of precision and correctness in both the theoretical and practical aspects of healthcare sector compared to other sectors of society necessitates deployment of multiple intellectual battlefronts to enable the sector generate adequate reserves of appropriate

knowledge, skills and attitudes to help it address the obviously monumental healthcare demands in line with international and local healthcare standards and agenda. The world has a better regard for the centrality of cultural knowledge in development and positive transformation of society including through participating in midwifing strategies for sustainable development of our healthcare sector.

1.3 The Problem, Aims and Objectives

Tanzania, which hosts about 150 linguistic communities within more than 120 tribes is one of the most culturally vibrant countries in Africa (Mlama 2008). The country displays a highly prolific production and performance of various art forms from across these communities and an improving (albeit minimally and slowly) proactive support and facilitation towards growth of the creative arts sector by the state). Mlama also observes that despite the long period of obvious minimal regard for the immense power and potential of the oral literature to enhance development by the colonial leadership as well as the postcolonial powers, the creative art has continued to impact life in many positive ways. In fact, Mlama further indicates that oral literature has been active in the healthcare sector and that ‘There is, however, still a large proportion of oral art outside official art, which portrays Tanzanian life from a non-official point of view. For example, referring to the 'Health for All' campaign, the following dance song was composed about a corrupt doctor in Namionga village in Mtwara region:

Jamani ee
Nilitembea huko na huko
Nikaenda kijiji cha Namionga
hadi zahanati
Nikawakuta watu wengi
wamekaa wanazungumza
Nikawauliza jamani kuna nini hapa
Wakajibu
Ewe mganga naomba dawa
kichwa chauma
Mganga akasema
'Nyoosha mkono upewe
Kwani madawa kweli ni adimu.' (Kiswahili)

Hear
I went to many parts
I went up to Namionga village
to the dispensary
I found many people seated and talking
I asked them what was happening
And they answered
'Doctor I would like some medicine
I have a headache
'The doctor said
'Stretch your arm [pay] and you will get some
You know that medicines are scarce’.

Mlama further observes that this type of oral art, though, remains marginal and localized, and that indeed, it is often dismissed as 'local' and 'ethnic-based' and thus having no role or place in national cultural identity.

With this kind of institutionalized marginalisation, many scholars including those of communication among populations, as well as those of healthcare (Aisha 2021, Bello 2017, Bremmer 2012), approach their studies almost exclusively from either a linguistic perspective or other non-literary disciplines. There seems to be little attention to what Funiss and Gunner (2008) view as the place of oral literatures in the local processes of negotiating meaning by contributing the agency of artistic creativity (such as detachment) and its relation to enhancement of communication within the healthcare sector for success in the intended social action.

In their attempt to foreground the indispensability of attention to orality if we hope to attain a comprehensive interrogation of communication, Funiss and Gunner(2008) posit that in the field of folklore studies, particularly in America, the shift away from a focus upon 'reified persistent cultural items' to 'folklore as a mode of communicative action' was marked by an expansion of the concept 'performance' (such as healthcare staff/patient interaction)such that it no longer simply meant gesture, voice quality, etc., in the moment of performance but came to encompass a focus on the artful use of language in the conduct of social life - in kinship, politics, economics, religion - opening the way to an understanding of performance as socially constitutive and efficacious . . . these critical reorientations relied centrally on the ethnographic and analytical investigation of form-function-meaning interrelationships within situational contexts of language use (Bauman and Briggs 1990). Based on the foregoing, there appears to be a perspective on effective communication in healthcare that has not received adequate scholarly attention in Tanzania as well as the rest of Africa and denying the healthcare sector useful information with which to improve service delivery. The aim of this paper is to explain the place of oral literature in healthcare services by exemplifying how the literary technique of detachment facilitates politeness which eventually enhances effectiveness of healthcare communication in line with Tanzania vision and national agenda. Improvement in the healthcare sector will help not only Tanzania as a country, but also the regional ministries in charge of health and beyond.

1.4 Literature Review

Rethabile (2013) carried out PhD research which presents subtle arguments on African oral literature. The study supports the assertion by Sunkuli and Miruka (1990) that Africa is currently actively engaged in self-rediscovery and rebirth out of colonial and even neo-colonial destruction. In the process it is bringing forth renascent energy towards the appreciation of age-old oral traditions. This argument has been supported by Salm and Falola (2002:60) who claim that:

> Oral literature still penetrates some facets of daily life in Swaziland and many parts of Africa. It is true that the occasions for its performance are not as frequent as in the past, but some of its genres, especially folksongs, dirges, modern professional music, topical songs and proverbs as well as the annual performance of the reed dance and Incwala ceremonies, are still being used in the moral education of the young.

These scholars, while noting threats to the oral art find its place in many aspects of the society still very important. Their sentiments are reinforced by Haywood (1966) who castigates proponents of the erroneous notion that oral literature constitutes remnants of past creativity and is on its deathbed. He asserts that oral literature is not survival, but rather a living organism, still growing and developing wherever people live, struggle, hope, despair and die.

However, the need for proactive support for growth of a vibrant oral literature, which is what this paper is doing, is still a concern of scholars. Rethabile (2013) refers to this as some forms of cultural

reinforcements which would help to guarantee sustainability of a vibrant folklore. Indeed, Okpewho (1992) believes that in order to ensure the survival of oral literature, modern concert parties should incorporate stories from the oral tradition into repetitions of oral theatre and also into transforming materials from contemporary written fiction into peculiar format of oral dramatic performance.
Salm and Falola (2002) concur with Okpewho and add that oral literature provides an outlet for social criticism and commentary and contributes to social cohesion. Even though Haywood (1966), Salm and Falola (2002) deal with Swazi oral literature, the need for support towards growth and sustainable development of vibrant oral literature prevails in Tanzania as well as the rest of Africa. Recognising and encouraging literary views on human experience, including admission of contribution of literary discourses to understanding and improving communication within the essential services of the healthcare sector.

With regard to literatures guiding studies on politeness in communication and interaction, Mariam (2021) made choices that are relevant to this discourse. She presents literatures exploring social factors influencing politeness in interaction such as Leng (2019) in a study on communication between health care providers and people of low social economic status. The aim of this study was to discover factors that underlie effective communication behaviour of the health care provider in Netherlands. A theoretical model of behaviour was used to find out which factors underlie effective communication behaviour towards people of low social economic group. This study found that the factors underlying effective communication behaviour of health care providers towards people of low social economic status differs much from the factors found in the literature about doctor-patient communication among other groups than low social economic status. It is advised that communication would be more effective towards people of low social economic status when healthcare providers adapt a patient-centred communication style. This study is essential for the current study as it gives explanations on how social factors can influence communication between health care providers and patients which is one of the objectives of the present study. However, the present study focused on the issue of politeness in communication using the theory of politeness as provided by Brown and Levinson (1987) and it went one step ahead focusing on not only health care providers but also patients.

In addition, Mariam guides us in reviewing research work by Madula et al (2018) which focuses on the communication and barriers to effective communication. Madula's study revealed the existence of some communication barriers such as disrespecting and verbally mistreating pregnant women, language limitations by some health care providers and discrimination due to one's status which are affecting maternal service delivery in some health facilities in Malawi. This study was essential for the present study as it explains in detail the effects of status in communication as well as the effects of absence of politeness in communication which are also the objectives of the present study. The present study specifically dealt with studying how status such age and gender can influence the way politeness is used in communication using Brown and Levinson politeness theory for the analysis of the study.

Another important study was done by Kwame and Petrucka (2021) which reveals a challenge similar to what is obtaining in many healthcare jurisdictions in Africa. The study found that nurse-patient communication had been poor, with health care providers dominating the process. Most nurses disregarded patients' needs and concerns and even went ahead to abuse and humiliate them especially in maternal or antenatal and primary healthcare settings in public healthcare facilities where many people were of low socio-economic status.

1.5 The Effects of Politeness in Communication

Adams (2013) examines the influence of politeness strategies on patients' involvement in decision making and the study reveals that the collaborative behaviour of General Practitioners (GPs) positive politeness has convincing effects while their negative strategies give rise to ambiguity which leads to confusion. Patients' negative politeness demonstrates anxiety when presenting hypothetically controversial decisions while their use of positive politeness act as a means of encouraging cooperation. GPs employ positive politeness when supporting patients' decisions, offering reassurance and reducing damage to face. Conversely, disagreement is conveyed by the lack of such strategies and absence of reparative work. This study is essential to the current study as it helps interrogate and explain particularly the effects that politeness has in communication.

In addition, studies have adopted a synthesis of Brown and Levinson's politeness theory and Leech politeness maxims as theoretical framework. These have been able to discover that various politeness elements accomplish a number of communicative functions. An FTA with redress amends unpleasant health practices and FTA without redress tactfully obtains medical data for diagnosis. Knowledge of these elements of politeness and their discourse functions are vital to this paper. Additionally, Khamis and Njau (2014) conducted a study on patients' level of satisfaction with the quality of healthcare at Mwananyamala hospital in Dar es salaam, Tanzania. The findings show an overall dissatisfaction leading to recommendations for drastic redress measures. This is a possibility even for this study and therefore the literature is useful.

1.6 The Conceptual Framework

The study argues that linguistic elements that constitute politeness and communication draw from literary elements. In addition, the success of the literary elements in developing and delivering politeness constructions for effectiveness of communication draw from linguistic elements. Therefore, mutually inclusive linguistics and literary process is at play working towards a common goal of creating politeness which facilitates effectiveness in healthcare communication. For that reason, a combination of theoretical perspectives and principles is the best way of helping us interrogate the language of interest and explain its structuring and functioning within the context of healthcare provision. Emphasis is on the role of the literary elements and the paper pays more attention to the aspects of the conceptual framework that underpin the literary aspects of the study.

Socio-stylistics: Socio-stylistics examines critically the language of social groups in various social contexts. Our task involves the language of communication in healthcare sector, specifically focusing on care givers and patients within health facility settings in Tanzania. The discourse ventures into how detachment, a literary product of culture, plays a significant role in generating and deploying politeness during the interaction of healthcare givers and patients in a way that results in better communication and subsequently better results for healthcare targets. Since the language and literature of the community of the healthcare givers and patients are encapsulated in the socio-linguistic activities at the hospitals and health centres, an analysis the dynamics of communication would not be adequate using either a sociological theory on its own or even stylistics on its own. The combined approach complements to provide adequate analytical tools for the complex inquiry at hand.

It is worth noting that the concept of socio-stylistics is relatively a new area in the broad discipline of Linguistic Stylistics (Ashipu 2010) and also not as widely used within literary studies as several other approaches and theories. Ashipu further observes that Stylistics generally is text-centred and the concern of stylisticians is not simply to describe the formal features of texts for their own sake, but in order to show their functional significance for their interpretation of the text or in order to relate literary effects to linguistic causes where these are felt to be relevant within the context of rendition.

Furthermore, Crystal and Davy (1969) argue that the aim of socio-stylistics is to analyse language habits with the main purpose of identifying from the general mass of linguistic features which are common to language as used on every conceivable occasion, those of social context; to explain, where possible why such features have been used as opposed to other alternatives, and to classify these features into categories based upon a view of their function in the social context.

Basing on to his focal point of criticism, Geoffrey Leech (1983) proposes a politeness principle. This principle is to coexist with Grice's cooperative principle and it is of equal or greater importance. He adds this principle account for the tendency of people to violate the cooperative principle in conversations (Locher, 2004). To Leech, the cooperative principle and the politeness principle are always in conflict with each other. For example, a conflict a speaker might encounter between wanting to ask for a favour straightforwardly and not wanting to impose. In such a case, one of them has to be sacrificed and the politeness principle accounts for the cooperative principle to be violated.

Leech (1983) formulated six maxims as guidelines for communication and interaction in the context of politeness. The first maxim is named the tact maxim in which the guiding requirement is for one to minimize cost to another and maximize benefit to another. The second maxim is generosity maxim which provides for one to minimize benefit to self and maximize cost to self. Approbation is the third maxim which provides for one to minimize dispraise to another and maximize praise to another. The fourth maxim is that of modesty which requires one to minimize praise of self and maximize dispraise of self. The fifth one is called the agreement maxim which requires one to minimize disagreement between self and another and maximize agreement between self and another. Lastly, the sixth maxim named sympathy which requires one to minimize antipathy between self and another and maximize sympathy between self and another.

Realization of effectiveness in communication among healthcare stakeholders requires sufficient character formation and development to enable each individually and all collectively to actualise each maxim as per need through creativity in performing tasks of interaction within the healthcare context. In other words, Leech is prescribing use of literary performances as the best way of realizing the maxims. In such a situation where the entire healthcare ecosystem deploys language (words and actions) creatively to realize politeness leading to effectiveness in communication, then it becomes clear that literature in its various genres and forms becomes the dominant feature at all communication interfaces in the sector. Each and every stakeholder must be a competent literary artist to successfully interact with the healthcare domain. Luckily, most Tanzanians as well as other Africans of speaking age occupy various ranks in literary prowess as producers, consumers and critics of folklore all at once. According to Leech, the health sector will be as successful as the performances of poetry, drama, prose, short forms etc. by the interacting stakeholders. Illustrations in the later sections will confirm prevalence of fruitful efforts in use of creativity initiated by healthcare givers as well as patients.

1.7 Methods

This is a descriptive study which undertakes qualitative analyses of data collected through non participant observation and documentary review mainly from 5 healthcare facilities in Nyamagana District of Mwanza - Tanzania. Purposive and convenient sampling techniques are employed.

1.8 Findings and Discussions

Cultural Aesthetics of Detachment, Politeness and Communication

Academic inquiries and scholarly discourse from all disciplines that find themselves paying attention to production, performance or use of creative works which use language produce better results if they consider such works, performances and use as cultural aesthetics. Proverbs, riddles, puns, narratives, songs, plays, satires, as well as other non-standard uses of words, statements, and gestures are better viewed as products of culture which express culture while regenerating it for the future irrespective of the context where they are being used. Throughout generations, cultures have developed, and continue to develop creativity in language use to address every aspect of human experience. As such, literature is everywhere facilitating and sustaining life. In many instances, it is so spontaneous, almost natural, to employ literature in ordinary life without noticing it.

Based on the argument above, this paper wishes to illustrate how it is literature that plays the greatest role in creating politeness which enhances further performances of communication in the various aspects of provision of healthcare services. Language of politeness and communication in healthcare cannot be adequately discussed exclusive of the cultural aesthetics involved. In fact, a keen observation of the activities and interactions within healthcare facilities will reveal a kind of complex theatre where everyone who enters is an actor, a fictional character, and all actions and utterances are fictional too. The success of the healthcare facility depends on how well each participant uses creativity. In other words, there is little room for the standard human being in hospitals, you have to be sick to be a patient, and you have to be dramatic as a healthcare giver to smile at patients as they die.

Patients and caregivers use detachment to achieve politeness which enhances services. We shall identify some forms of politeness strategies recorded from various healthcare facilities in Nyamagana – Mwanza Tanzania and illustrate how detachment enabled their use and how the medical interaction was indeed performance of culture.

The inclusive "We"

Hospital A: Example 1
Provider*:* *Ni lazima tuwe wavumilivu ili tuweze kupata huduma nzuri*
We must be patient so as to receive good services
Hospital B: Example 2
Provider: *Tusichoke jaman eh, umeme unarudi muda si mrefu*
Let us not despair dears, power supply is returning in no time

Mariam (2021) analyses the above interaction communication from a linguistic perspective and observes that the inclusive "we" was used in the conversation between health care providers and patients as an important strategy of politeness to reduce Face Threatening Acts (Henceforth FTAs). The inclusive "we" was used to mean "you" where the health care provider was insisting that the patients should remain calm so as to receive good services. This communication was prompted by what caregivers noticed as build-up of unrest among the crowd of patients from the seemingly unclear slow pace of attending to them. Instead of the health care provider saying "*you must be patient so as to receive good services*", he employed the inclusive "we" to reduce the imposition on the hearer and therefore, the statement sounded as an advice than a command. There was immediate calm among the patients. Communication was effective.

With regard to the example of the utterance spoken by the health care provider in hospital C when the electricity suddenly went off. Mariam argues that the caregiver used the inclusive "we" to mean "you" so as to redress the FTA of imposition to the hearer (see Example 2). It was used to communicate courage to the patients not to despair for the services would soon resume. The health care provider was commanding the patients to stay calm and wait but to reduce the FTA, she used the inclusive "we" so that the patients would not feel like they are being ordered to be patient. The patients were observably satisfied with the message and they resumed normal conversations among themselves. Communication had succeeded again.

From the two illustrations, Mariam observes that the inclusive "we" is used when the health care providers do not want to use the express power to make orders to the patients. Hence, it helps to create a sense of collective responsibility which effectively redresses the FTAs. The inclusive "we" is one of the sub strategies of positive politeness strategies as suggested by Brown and Levinson (1987) in their theory of politeness. It involves the use of first-person plural pronouns such as *we, us* and *our* to stir up a sense of unity and rapport between interlocutors. Speakers use the inclusive 'we' to call upon cooperative assumption thereby redressing the imposition. Health care providers use the inclusive "we" to enhance cooperation by including themselves and the patients in an activity that requires the responsibility of the patients only. The inclusive "we" helps to mitigate the FTAs on the positive face of the patients.

A look at the successful communication from a cultural aesthetics perspective will help us identify how detachment was employed to enable use of politeness which contributed to effective communication, and to see how the entire process was a cultural performance staged in different community theatres (hospitals) which are open twenty-four hours every day of the year.

In literary presentation, detachment is one of the most prevalent strategies for transacting information in its various forms. Detachment operates on the principle that the exclusive self of the originator of a piece of information, news, wisdom, advice or other message, is not necessarily the most appropriate medium or means of its delivery to the audience. This principle is even more pronounced when the message involved is ensconced in creativity. Such information is best delivered by other safer and more effective media. These media are already in existence and in active service and other new ones are developed by the artist who has a message depending on several considerations. That is how certain information comes to us through song, oral narratives, and proverbs. Detachment, therefore, involves the process of

minimising self from the process of delivering own message and optimizing other(s) to deliver the message because the outcome is better that way.

Detachment is realized in several ways that have been developed with evolution of communication culture among communities. In the process of developing creative means of communication, communities collectively train members in the use of these media so that they can use them to send information or use them to receive information sent by others. When one decides to produce a poem to deliver message, he is minimizing himself from the immediate process and delegating to the persona and the other literary characters whose reception by the audience is more effective. The cultural credibility of the literary medium is an advantage for it holds the inclusive and interactive delivery elements that a mortal individual lacks.

The credibility of the creative medium of delivery of message is given collectively by the community as a tested and proven product of their culture which is cleared for such tasks as cultural service to the community whenever need arises, which is always. Looked at closely, detachment is a process of submitting to the superiority and authority of culture and surrendering your important information to cultural instruments for a culturally interactive delivery to the audience.

Literature is a product of culture. It is the art that uses language creatively in addressing reality and human experiences. In other words, literature is produced by the culture for use in addressing every aspect of existence, including inexistence. It is a custodian and a carrier of people's culture. It is within the milieu of literature that various options for detachment, minimizing self, are availed whenever we need to communicate important information, particularly among members of our cultural communities. Any time we employ an element of literary creativity in our interactions, we have already used detachment for we have delegated our task to a cultural product to facilitate us for success.

The cultural concept of importance, especially with regard to matters that an individual would wish to communicate to other(s), is very unique. It appears that salutations, greetings, regard, etiquette are regarded so highly culturally to the extent that there are cultural systems, standards, and calibrated, almost ritualistic and formulaic procedures addressing them for the benefit of cultural health (wellbeing for all). How an adult and a toddler interact when they come into contact in the morning, for example, is as important to the culture as how two kings interact when they meet in their thrones. These contact procedures are clearly strategic dramatic performances of universal application across the jurisdiction of each culture. A close look at the words and actions of these salutations will reveal their more literary than linguistic weighting in form and content. That probably explains why children are trained with all seriousness to embrace them and abide by their correct application right from birth. The fact that they are never cumulative demand that the ritual is performed each day we wake up and with each person we meet, however difficult this could be some times. Culture demands that we perform the rituals nonetheless; it also demands our pursuit of virtues well aware that they are conditions so perfect that they are unachievable, yet worth striving for.

These cultural demands upon each and every person to carry out salutations faithfully as long as they are alive make us view the ritual as a cultural performance. The procedure is clearly beyond activities within the whims of any individual. Another important aspect of the salutations is that it reveals elements of detachment. That is why once you meet in the morning of a new day; a need arises to inquire and

communicate life status between or among the parties that have met. At this point, each member of the meeting party changes to a character in a cultural drama and assumes a role relative to the characteristics of the rest. It is in this detachment that it becomes clear who should start uttering what, and how the rest of the performance is carried out. In other words, we begin by surrendering to the culture for our utterances to be valid and culturally admissible for the interaction.
A successful completion of the cultural performance at the salutation level is already effective introductory communication which to a great extent informs the success and effectiveness of subsequent communicative interaction. The said subsequent interaction is equally guided by cultural provisions for verbal, non-verbal communication, power relations as well as ethics until you perform the parting culture. This scenario is the norm in most oral cultures and countries where socialistic and communal existence are prevalent. Tanzania is an example of such a community.

Within the healthcare facilities literary detachment is of critical significance. Whereas life out there is a great theatre where culture is performed as people go about their businesses, the healthcare facility creates a second level of detachment for both the caregivers and the patients. Whereas literary and cultural detachment continue throughout the day, the caregivers must undergo a professional detachment in which Juma son of Masanja becomes a doctor, nurse, clinical officer or other designation. A scenario akin to a play within a play emerges where Juma must balance detachment in cultural performance with detachment in professional medical performance.

On the other hand, a person who leaves home to go seek healthcare services at a healthcare facility begins employing detachment for politeness with the people he or she interacts with as cultural performance. However, once at the healthcare facility, he adopts a second role of a patient for which he is expected to apply detachment to realize politeness in the context of outpatient performances. Like the professional healthcare providers, the patient has to balance his cultural performance to safely navigate situations such as where professional health caregivers will require that he performs as a patient. The two sets of interlocutors (performers) will need to submit (detach) significantly and creatively to both the cultural and the professional authorities in order to harmoniously use the provisions of the culture and the profession which offer recognisable and reliable ingredients (including literary language resources) for structuring the politeness needed for effective communication.

From the foregoing, it is evident that politeness is not the result of random individual activity, rather, it is a product of cultural evolution and it is also an embodiment of that culture. Before proceeding to give further illustrations of how detachment enables politeness which enables effective communication in healthcare services, let us outline some discernible characteristics of detachment as well as politeness in order to see the link to cultural aesthetics.

To start with, detachment should be viewed as an economic vessel for simultaneous delivery of broad signification, including politeness which is crucial for effective communication in healthcare for the realization of both professional and cultural goals. Characteristics of detachment as deployed for realization of politeness in the context of communication in specific healthcare environments include the following: Detachment is culturally (re)generated and, therefore, the politeness which it generates is also cultural. Also, detachment (re)generates cultures. The inclusive and participatory aspects of detachment provide spaces for interacting interlocutors in the healthcare sector to (re)negotiate emerging experiences and sometimes new forms may emerge which eventually become part of their cultures.

For example, hearers of certain politeness related words or statements for the first time or those who encounter new politeness related experiences for the first time within the healthcare interactions acquire something new for themselves, if such was already part of their cultural repertoire, and for their cultures if such new phenomena did not already exist in such respective cultures. These new additional ingredients to politeness communication crystalize once they have been negotiated through communication and interaction among those involved. In such cases, caregivers as well as patients become conduits through which their cultures broaden. In addition, detachment (re)subscribes to the cultures in that the provisions of the present culture form the points of reference for detachment. Another characteristic is that detachment (re)subordinates itself to the cultures. In other words, efforts towards upholding the demands of the culture should supersede desire to deviate and deviation (where necessary) should be as within characteristic (iii) above as possible.

In addition, detachment (re)speaks the languages of the cultures. The main languages of the community and their key cultural practices should provide material for interaction while providing for targeted use of those from other languages and cultures on a case-by-case basis. Also, detachment (re)seeks (re)validation and (re)justification from the cultures. We all represent our cultures in assessing the success or failure of efforts towards use of politeness as well as the effectiveness of communication. No individual is singularly an overall examiner of cultural processes. To understand detachment, a look at how McCulloch (2010:189) illustrates the kind of literary/poetic/detachment character created by artists to enable use of detachment for better delivery of message and literary address of human experience will help. According to him, and quoting from Keats, a 'poetical character itself … it is not itself — it has no definition — is everything and nothing' in addition, 'It has no character — it enjoys light and shade; it lives in gusts, be it foul or fair, high or low, rich or poor, mean or elevated'. He adds that a 'Poet is the most unpoetical of anything in existence; because it has no identity — he is continually informing and filling some other Body'.

Nielsen (2004). Argues that whereas there are theoretical debates about the first-person narrator in fiction, the communicative framework that artists create present a picture indicating that there is an existing text with an authority that is independent of the artist. It is our view that this authority is the culture and the text indicated by Nielsen include the cultural provisions on, for example, politeness and etiquette, and which the interlocutors are required to perform as characters representing the detached artist.

While interrogating the question of detachment using the culture of masking, Parkes 1987) observes that Japan is distinguished as a culture in which the use of mask to conceal the true feelings and impulses for the sake of harmonious interaction with fellow human beings is perhaps more highly developed and socially more obligatory than any other. In Japan and also in the West, and in the context of detachment by use of masking, the masked character is viewed in the strict legal sense of the agent responsible for actions and therefore rewarded or punished for them. This was seen in the image of the mask rather than the head or body behind it.

An important observation by Parkes is that the actual mask is first and foremost a surface, mediating between outside and inside. With the mask, the performing detachment character is able to go forth and successfully present himself/herself as such-and-such a figure. He adds another important aspect of the

detachment mask that, as it reveals, the mask also conceals: while a literal mask protects the most vulnerable part of the body (the death mask and surgical mask are special cases), its figurative counterpart conceals that aspect of our exterior which most betrays the inner life of the wearer. The weaknesses of the individual healthcare interlocutor is concealed through masking and we are left observing the authoritative and credible culture as the presenter of the message.
An interrogation of the illustrations of detachment in the following section will help to further clarify the characteristics outlined above and show how they constitute literary performances of culture and of the profession.

In-group Identity Markers

Hospital A: Example 3
Provider: *Njoo rafiki*
Come friend
Dada, utaingia chumba namba tano.
Sister, you will enter room number five.
Hospital B: Example 4
Provider: *Mbona hujaenda famasi mpendwa?*
Why haven't you gone to the pharmacy dear?'
Patient*:* *Uwii nilikua sijui kama natakiwa niende sahivi mami. Asante*
Oooh, I did not know that I was supposed to go there now mummy. Thanks.

A linguistic view of the two examples above realises in-group identity markers as a linguistic strategy which includes the use of generic names. In East African communities there are several such names and in Kiswahili, a common language to most East Africans, it includes honorifics such as *mama* 'mother', *baba* 'father', *dada* 'sister', *ndugu* 'comrade' *rafiki* 'friend', *mpendwa* 'dear' and others. From a perspective of cultural aesthetics, this strategy is a cultural performance which begins with detachment. The Swahili culture has already provided a set of names, as listed above in Kiswahili, for use to minimize the person of the initiator of the interlocution process and to foreground the cultural alternatives which produce better results. Mariam (2021) notes that there were different cases that the health care providers and patients used honorifics in their conversation so as to redress the FTAs.

Data collected show healthcare providers using these terms to reduce the relative power and status difference with the patients (politeness), hence lessen the commands in the imperative sentences by turning them into requests. The constructions in example 3 and 4 above are such performances of culture and of the profession. The healthcare provider vacates the government status through detachment and wears a cultural mask of a *rafiki, dada, mama, baba* of a patient he is probably meeting for the very first time. This performance creates a unique scene (politeness) which enables communication and performance of a professional healthcare service. Mariam further notes that honorific *dada* 'sister' was used by the healthcare provider towards an adult patient who, from observation, seemed to be of the same age with the healthcare provider. The use of honorifics helped to reduce the distance between health care providers and patients by making the imperative sentence sound more like a request rather than a command.

The act of a professional medic addressing a strange female age mate patient as *dada* 'my sister' to the comfort, concurrence, approval and satisfaction of the addressee as well as the secondary target

audiences at the healthcare facility, is not a simple linguistic event. This is a complex cultural performance that is expected of all parties to the interlocution at the healthcare facility. According to most East African cultures, led by the Swahili, every age mate is a sibling. Better still, every member of your community is a member of you family at best and a friend at worst. It is this aspect of culture that detachment uses to create politeness and achieve communication in healthcare services among strangers. Having surrendered and submitted (through detachment) to the authority of the binding culture, the service provider and the patient achieve politeness and succeed in perpetuating the culture. Habwe (2010) posits that honorifics as politeness forms in Kiswahili are used in the context of healthcare services to foster politeness which establishes good social bounding between healthcare providers and patients. In Nyamagana Municipality hospitals, honorifics were used by both health care providers and patients to show that they respect and care for each other. This improved solidarity and reduced distance between them which in turn made their communication effective. In other words, literary detachment was employed successfully, politeness realised and communication enhanced as cultural and professional dramas were performed.

Give or Ask Reasons

Hospital C: Example 5

Provider*:* *Dada umeambiwa ukae usubiri sababu mtandao hauko vizuri. Ukiwa sawa tu ntakuita.*

Sister, you have been told to sit down and wait because the network is not stable. Once it becomes stable, I will call you.

Patient: *Aha, sawa.*

Aha, Okay.

From a linguistic perspective, providing information and answers to overt or covert questions is seen as a strategy for politeness. According to Mariam (2021), using the give or ask reasons strategy, healthcare providers gave information to patients with answers to suspected questions arising from some sudden operational challenges. This helped the patients to understand why health care providers performed an FTA and therefore minimized the threat. For instance, a visibly disturbed patient was seen walking towards the records service window when the front counter staff stopped her and told her to sit and wait. The patient sat without asking a question. Then, the record keeper called her and explained the reasons for her to sit down and wait (example 5 above).

Beyond the linguistic view is the perspective from cultural aesthetics. As indicated earlier, cultural literary detachment is an economic literary tool with which the culture harnesses stylistic and thematic synergy in a way that the desire to realise politeness is approached from multiple strategic fronts simultaneously to guarantee success in creating politeness and eventually realizing effective healthcare communication. In this case, it is noteworthy that the linguistic view of each strategy for politeness as independent and autonomous in operation seems atomistic and inadequate for explaining the success in achieving politeness and subsequent effectiveness in healthcare communication. The cultural provision for inclusivity, collective negotiation, determination and implementation of life, is a guiding provision in the use of detachment. We argue that detachment is the main strategy for realisation of politeness and that what the linguistic view presents as a strategy is indeed a sub strategy under detachment. The inclusive ‘we’, in-group identity markers, give or ask reasons, as well as the cooperative are better

viewed as prongs of detachment. As will be seen, it is difficult for one of them to proceed exclusive of one or more of the other prongs.

Example 5 is presented under the discussion on what linguists isolate as give or ask reason. However, a close scrutiny of the very first word of the very first statement by the healthcare provider reveal the stark presence of foregrounded backup from in-group identity markers. *Dada* 'My sister' signifies the cultural destination of the detached medical staff. She vacates her medical post and adopts a new status as a member of the patient's immediate family, even an age mate. This new cultural detachment statuses of the patient and her doctor sister pave way for the succeeding section of her statement giving it legitimacy, for it ceases belonging to her and begins to be viewed as coming from the culture with legitimacy and authority. As such, the audience has no problem owning the entire statement. It is at this point when seemingly two strategies join hands to address one politeness matter with greater success than in a case where one prong attempted to achieve the same politeness without the other.

Performance of culture is exemplified better using the data on what the linguists classify as cooperative strategy. Examples 6, 7, 8 and 9 present data which constitutes clear contexts of use of literary detachment as cultural performance. We witness a dramatic scene in which a professional healthcare drama is performed within the performance of a higher cultural drama. All members of this unique cast employ detachment in order to be in-character (effective roleplay) for the constantly changing roles and continuously changing scenes in the plays at hand. Study the extracts below and note that it resembles an extract from a script of a play. One would add stage directions and asides to enable easy visualization of the underlying staging of Tanzanian culture with its ritualised activities such as greetings, initiation and conclusion of interaction. The harmony and flow of the performances only cement the argument that all interlocutors arrive at the healthcare facilities with the basic structure of the script fully rehearsed and the various possibilities of new roles to be played practiced at past performances and with an inbuilt capacity for adapting to new circumstances flawlessly without compromising the stylistic as well as the thematic aspects of the performance.

Cooperative Strategy

Hospital D: Example 6
Patient: *Shikamoo mama*
Good morning mother
Provider: *Marahaba. Hujambo?*
Good morning. How are you?'
Patient: *Sijambo.*
I am fine.
Provider: *Karibu.*
Welcome.
Patient: *Asante.*
Thank you.

Hospital D: Example 7
Patient: *Bwana Yesu asifiwe.*
Praise Jesus.
Provider: *Amina, habari ya uzima?*

Amen, how are you?
Patient: *Nzuri, kumbe upo hapa?*
Am fine, so you work here?
Provider: *Ndiyo, karibu.*
Yes, welcome.
Patient: *Asante.*
Thanks.

Hospital B: Example 8
Patient: *Asante.*
Thanks.
Provider: *Asante kushukuru.*
Thanks for the appreciation.
Patient: *Kazi njema.*
Nice work.
Provider: *Asante. Ugua pole.*
Thanks. Get well soon.
Patient*:* *Asante.*
Thanks.

Hospital B: Example 9
Patient: *Habari za sahizi dada?*
How are you now sister?
Provider: *Salama. Karibu.*
Fine. Welcome.
Patient: *Asante. Samahani mi nna shida.*
Thanks. I excuse me please, I have a problem.
Provider: *Ehe.*
Ehe.
Patient: *Nimesahau kadi yangu ya bima nyumbani.*
I forgot my health insurance card at home.
Provider: M*mmhmmh.*
Mmmmmmh.
Patient: *Sa sijui unaweza kunisaidia?*
Now, I don't know, are you able to help me?
Provider: *Ushawahi kutibiwa hapa?*
Have you ever been treated here?
Patient: *Ndiyo.*
Yes.
Provider: *Sawa, haina shida tutatumia taarifa zako za zamani. Subiri tu apo kidogo.*
Okay, no problem, we'll use your previous information. Just wait there a moment.
Patient: *Haya. Asante.*
Okay. Thanks.
Provider: *Asante kushukuru.*
Thanks for appreciating.

From a linguistic perspective, Mariam (2021) explains the cooperative as another positive politeness strategy used by the healthcare providers and patients, and which was observed in active use in Nyamagana Municipality hospitals. These involved elaborate greetings at the point of first contact of patient and healthcare provider, or patient with another patient or care giver with another care giver. Greetings came at the beginning of the process of healthcare interaction between each patient and each of the providers that will serve him or her. It is worth to note that in each healthcare facility the number of performances of greetings can be estimated to be equal to the total number of patients and caregivers multiplied by a modest 10 as the number of individuals involved in interactive contact to elicit performance of greetings. With about 2000 interlocutors in one health facility per day, it is possible for the cultural detachment and performance of 20,000 greetings, 20,000 instances of politeness, and 20,000 instances of effective healthcare communication. The culture also provides for aesthetically significant conclusion of interaction through ritualised performances of farewell. The ritualised greetings and farewell involve the hearer, turn taking and backchannels.

The performance of any type of ritualised Swahili greetings involves culturally predetermined basic structures of initiation, progression, and adjournment of the session (Ali, 2015) with several guiding factors at work. These factors are well known to all those who understand the Swahili culture. There were three common forms of culturally ritualised performances of greeting by the health care providers and patients at first contact when initiating conversation or service-based interaction. The first form is the one initiated by the younger of the two interacting parties towards older party. The Swahili culture creatively adopted a foreign word without Kiswahili grammatical meaning *Shikamoo* but with huge representational potential because its use in that form transcends time and space. It is applicable everywhere every time as long as a younger person has come into contact with an older person. In the morning, it represents 'Good morning', in the afternoon, 'good afternoon', in the evening, 'good evening'. It is a creative metaphor of cultural power relations and the ritualised greetings enact enforcement of the cultural power relations. The response to this form is *Marahaba,* another symbolic utterance borrowed from Asian culture and Arabic. Like the salutation, this response transcends time and space. After this response, the elder takes charge to give direction to the rest of the ritualised greetings in a known backchannel manner.

The second form is *Habari yako* 'How are you', the response to which is *nzuri* 'fine'. This is commonly used by people of the same age. Another form of greeting is associated with Christians' style of greeting *Bwana Yesu asifiwe* 'Praise Lord Jesus' the response to which is *Amina* 'Amen'. This type of greeting was used by the health care providers and patients who shared the same religious background especially the Protestants and Pentecostals. All forms of greetings survive because they have submitted to the cultural authority behind the ritualised greetings. The various forms of greetings are effectively ritualised and are cultural performances with same mission. The essence of these performances of ritualised greetings is such that contravening any aspect of the performance can cause severe impoliteness and ruin or destroy communication.

Cooperative strategy was also revealed through ritualised conclusion of interaction through appreciation and farewell as in observed in examples 8 and 9 as recorded at hospital B. Example 8 presents the conversation between health care provider and patient in Hospital B after the patient had received the medication. The patient thanked the health care provider before leaving the hospital. He did this to show

appreciation for the service that was rendered to him by the health care provider. The health care provider on the other hand thanked the patient for appreciating the services provided. Then, they finished the conversation with a farewell.

Detachment is at play here because cultural authority demands power to rest with age. As such, an older patient vacates junior ranks when faced with a younger professional healthcare provider. The doctor must also vacate his official authority and wear the culturally approved mask of junior level and immediately initiate performance of the ritualised greetings preferably in a combination of detachment prongs in such a statement as *Shikamoo Baba*? 'Good morning Dad?' since this fidelity to culture across spaces in all sectors of society is clearly firm, the culture finds avenues for regeneration, perpetuation and entrenchment. Politeness is cultural and applies everywhere in the society, healthcare facilities are just some among the many spaces where cultural drama takes place daily. Professionals as well as ordinary people know when to employ detachment and engage in literary performance to guarantee realisation of one or more ends for self as well as for culture.

1.9 Conclusion

The aim of this paper was to present an alternative to the linguistic view of the strategies for politeness in realization of effectiveness in communication within the healthcare services. It set out to illustrate how politeness is realised through literary detachment drawn from cultural aesthetics. Using similar data to the one used in the linguistic view, we have managed to illustrate that, indeed, literary detachment is instrumental in achievement of politeness which is required for effective communication within the healthcare service interactions. We have illustrated that detachment is a culturally generated strategy which involves collective synergy for collective benefit. It involves surrendering one's message to the superior and more effective cultural aesthetic constructs for guaranteed success in delivery to the target audience. The paper has illustrated how performance of professional healthcare service activities involves staging of complex drama in which, through detachment, all interlocutors are members of the cast and the healthcare facility is a huge theatre stage where the action takes place. We have demonstrated that the professional healthcare performance occurs within the authoritative higher cultural performance. We have demonstrated that linguistic elements on their own cannot cause politeness until the cultural aesthetics of detachment and performance of culture are involved. Using greetings which are easily assumed to be common phenomena, we have demonstrated how these constitute literary presentation of ritualised performances as an aspect of detachment. They are a key part of cultural performance and play a major role in creating politeness towards effective healthcare communication. Finally, we have made claim that healthcare facilities are creations of the community in which the people's culture is supposed to be collectively performed, (re)negotiated, (re)generated and perpetuated. The linguistic view is correct, but the literary view as presented is broader and deeper and inclusive of the linguistic perspective. Literary detachment is a strategy for achieving politeness for effective communication in healthcare as illustrated.

1.10 Recommendations

The study recommends that cross disciplinary approach to research is emphasized in all fields of study to broaden and enrich discourses that inform policy. We recommend that the healthcare sector embraces cultural aesthetics as part of the training with deliberate follow up of its application in service provision, especially in matters of healthcare communication. Other than detachment, the study recommends

scholars to explore the significance of cultural ritual to medical and healthcare practice with a view to harnessing the value embedded for use in service delivery.

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