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Multilingualism, Social Inequalities, and Mental Health: An Anthropological Study in Mauritius

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Declaration

This thesis has been composed entirely by myself, László Lajtai, Ph.D. candidate in Social Anthropology. All work, unless otherwise specified, is entirely my own, and has not been submitted for any other degree or professional qualification.

12th October 2014

Laszló Lajtai

Abstract

This thesis analyses two different features of Mauritian society in relation to multilingualism. The first is how multilingualism appears in everyday Mauritian life. The second is how it influences mental health provision in this country. The sociolinguistics of Mauritius has drawn the attention of many linguists in the past (Baker 1972; Stein 1982; Rajah-Carrim 2004; Biltoo 2004; Atchia-Emmerich 2005; Thomson 2008), but linguists tend to have quite different views on Mauritian languages than many Mauritians themselves.

Language shifts and diverse language games in the Wittgensteinian sense are commonplace in Mauritius, and have been in the focus of linguistic and anthropological interest (Rajah-Carrim 2004 and Eisenlohr 2007), but this is the first research so far about the situation in the clinical arena. Sociolinguistic studies tend to revolve only around a few other domains of language; in particular, there is great attention on proper language use – or the lack of it – in education, which diverts attention away from equally important domains of social life. Little has been published and is known about mental health, the state of psychology and psychiatry in Mauritius and its relationship with language use.

This work demonstrates that mental health can provide a new viewpoint to understand complex social processes in Mauritius. People dealing with mental health problems come across certain, dedicated social institutions that reflect, represent and form an important part of the wider society. This encounter is to a great extent verbal; therefore, the use of language or languages here can serve as an object of observation for the researcher. The agency of the social actors in question – patients, relatives and staff members in selected settings – manifests largely in speaking, including sometimes a choice of available languages and

language variations. This choice is influenced by the pragmatism of the ‘problem’ that brings the patient to those institutions but also simultaneously determined by the dynamic complexity of sociohistorical and economic circumstances.

It is surprising for many policy makers and theorists that social suffering has not lessened in recent decades in spite of global technological advancements and increased democracy. This thesis demonstrates through ethnographic examples that existing provisions (particularly in biomedicine) that have been created to attend to problems of mental health may operate contrary to the principle of help. In the case of Mauritius, this distress is significantly due to postcolonial inequities and elite rivalries that are in significant measure associated with the use of postcolonial languages. Biomedical institutions and particularly the encounters among social actors in biomedical institutions, which are not isolated or independent from the prevailing social context, can contribute to the reproduction of social suffering.

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Chapter 1. Introduction

This thesis is about the challenges facing people in the context of mental healthcare in a multilingual society, particularly when mental healthcare professionals have their own characteristic place in the hierarchy and diversity of language use and they have been trained in languages other than their patients' primary language of self-expression. The dissertation aims to contribute to the field of applied medical and linguistic anthropology in an interdisciplinary approach. Three different themes will converge in it: mental health, languages and Mauritian society. The specificities of the field, the complexity of the multilingual setting with related sociohistorical, economic and political trends will require an extensive introduction to ethnographic descriptions and the related microanalyses. The fieldwork was multi-sited; the fieldsites will show the functioning and attempt to demonstrate the limits of various different sites of biomedical mental health provision in Mauritius. As the researcher is a medical doctor, the perspective of the research might have had its advantages in accessing institutions of healthcare but also set significant limits as well due to the researcher's particular background and stance. The observations of the research aimed to focus on language related events and aspects of the fieldsites. The anthropological analysis of the health institutions was attempted to be carried out while conceiving these institutions as integrated subsystems of Mauritian society as a whole; therefore, they are intended to be seen as gateways to enter into an observational stance that may offer a perspective beyond the boundaries of the localities. The hypotheses subsequent to the analysis of linguistic examples collected in those fieldsites may help to reach new understandings about the functioning of contemporary societies through highlighting some linguistic processes that play an important role in the

reproduction of social inequalities.

Language and power, language as social capital

Human social life and human language are inseparably intertwined with one another. Languages cannot be studied without the embedded social context and more attention needs to be paid to the pragmatic elements of language use. Ludwig Wittgenstein introduced the term the language game *(Sprachspiel)* (1953). The concept of language game for Wittgenstein does not only include characteristics of particular language usage but social acts in general, acts and concepts about everyday life (Das 1998). Mikhail Bakhtin also argued that utterances carry a set of situational, socially shared rules about how to interpret them, and these rules are extra to the dictionary meanings (1985 [1925], 19-21). He posited that the right understanding is contextual, whereby nonverbal elements of the communication, most importantly the intonation, play a key role in signalling the generated and perceived meaning. Paul Grice coined the term ‘conversational implicature’ that refers to the exchange of extra information, which is implicated in the conversations but beyond the semantic meaning of the words and expressions (1981). In the literature of linguistic anthropology, the term ‘contextualization cue’ (Gumperz 1992) points to the elements in speech when individuals not only converse but also transmit hints as to how the utterance or text are meant to be understood.

As language use is social, it provides a field where social inequalities become real and observable, especially through the ubiquitous diversity of actual languages. Linguistic knowledge and skills can be regarded as kinds of ‘knowledges’ *pace* Michel Foucault (1977 [1975], 27) who suggests that knowledge and power directly imply one another. He argues that power is not homogeneous but consists of various

power techniques connected to one another in a sophisticated, interlinked way. The aim of the techniques of power is not only oppression but also reproduction of certain knowledge to maintain the existing power relations. Foucault concludes his argument stating that certain people rather then others have much more influence defining what can be regarded as knowledge. Social Identity Theory (Tajfel 1982) indicates that human beings are prone to distinguish themselves as members of a group as opposed to others. Social identity is individual and emotional and connected to the notion of Self. In the dichotomised construction of 'in-group' and 'out-group', positive features are attributed to one's 'own group'. Tajfel's concept intends to explain the reasons behind ethnocentrism and racism. This theory suggests that social discrimination could be connected to the pragmatic use of language.

Social groups and their boundaries are at the centre of anthropological research. When social groups share the prominent feature of common language(s) they are denoted either as a linguistic community, which is a group "held together by frequency of social interaction patterns and set off from surrounding areas by weaknesses in the lines of communication" (Gumperz 1968, 463), or as a speech community, which means "participation in a set of shared norms" (Labov 1972, 120). Each speech community comprises dynamically changing and floating language varieties amongst which the boundaries are semipermeable. Speech communities can be monolingual or multilingual. Human beings embrace not only a pre-wired predisposition to acquire the mother tongue but also a capacity and an impetus to discriminate between linguistic variations. For example, language attitude experiments indicate that human beings instinctively associate height to a voice. Not only visual but also acoustic stimuli can be distinguished as 'us' or 'others' and serve for potential xenophobia. Automatic associations to utterances are often not neutral but encompass judgements on the speaker of the voice,

categorising them according to stereotypes. A pioneer study revealed that listeners rated English speakers more intelligent but French speakers more likeable in Montreal although the same person was reading out the recorded text (Lambert et al.1960). Later works on beliefs of 'folk linguists' perceptional dialect maps based on regional stereotypes (Preston 1989) or attitudes towards dialects and accents in complex societies (for example, Coupland 2007) also indicate that the social phenomenon of discrimination of language variations is universal.

The reproduction of knowledge and power structures and the drive to distinguish one's own group from another can form a linguistic shape, as Bourdieu points out (2002 [1980], 47, 221). He finds that the French education system was grounded on elite 'knowledge' to reproduce elite-ness itself whilst aiming at the acquisition of control over the performance of language. Symbolic power is exercised through speaking and language where people with disadvantaged *habitus* are intimidated. As Duranti pointed out summarising Bourdieu's theory about language, "[a] language can only exists as a linguistic habitus, to be understood as recurrent and habitual systems of dispositions and expectations" (Duranti 1997, 45). Bourdieu's Marxist concept of 'linguistic marketplace' (1977) suggests that speech is not only an active behavioural sequence, as the speech act theory holds, but also has an economic value as some speeches, talks and other spoken narratives can be sold or exchanged. It follows that certain manners of speech, high prestige linguistic variations would help their speakers to maximise their social capital. This 'linguistic capital' can be become similar to commodities on the 'marketplace' that have a particular type of social potential (Appadurai 1986) and this capital in the linguistic market was created when the capitalist states were formed with only one language variety bearing the status of standard language (Duranti, 1997, 45).

Language as political power: themes of linguistic anthropology

Dell H. Hymes and John J. Gumperz (1964) questioned the notion of language based on a Saussurian structural linguistics suggested by Bloomfield and Chomsky, and intended to replace it with a model of linguistic diversity (Irvine 1989). Their model turned to Malinowski's suggestion that the researchers should not only master the grammar and vocabulary of a language but also focus on the context of the particular language where those words and sentences are used. The new term 'communicative competence' embraced all systematic and collective knowledge such as place, participants, goals, speech forms, intonation, register, style, genre and communal rules added on to the 'grammatical competence' suggested by Noam Chomsky.

Research carried out by linguistic anthropologists proved that the 'right' or 'correct' language is always connected to underlying political reasons (Gal 2006) that often condemn the other variations or languages as 'only' dialects, or incorrect, broken, rotten forms, or not even a language. In European Medieval times, Latin was The Language while other languages were degraded tongues (Joseph 2006, 30). Max Weinreich's words (in Yiddish in the original), "A language is a dialect with an army and a navy" were later rephrased by Ole Stig Andersen as "A language is a dialect with a missionary" (2005). Both nationalistic ideologies and colonizer powers have often used languages to compete with each other, or made languages compete with one another to establish hegemony of centres over marginalised peripheries (Wardhaugh 1987). Doctrines concerning 'correctness', standardisation, orthographic rules, authenticity, and ideologised 'pure' language variations can be incorporated to the umbrella term 'language ideology' or 'linguistic ideology', which is "sets of beliefs about language articulated by users as

a rationalisation or justification of perceived language structure and use" (Silverstein 1976, 193). Grammar books, dictionaries, guarding academic institutions, educational curricula and media are the tools in the hands of dominant powers. The creation of eloquence is usually related to the institutional process of standardization (Joseph 1987, 108-109) and associated with ideological values to some random and neutral linguistic variations that embody social meanings and social relations within the particular speech community. Minorities are often simultaneously linguistic minorities as well using language in their attempts for resistance (Eriksen 1992).

Benedict Anderson (1991 [1983]) analysed the rise of nationalism as a powerful ideology in the 18th-20th centuries. He pointed out that nationalist ideologies were connected with the promotion of national languages and this was connected to the standardization and modernizations of selected language varieties. 'Linguicism' (coined after the term 'racism') or 'linguistic imperialism' (Phillipson 1992; Skutnab-Kangas 2000) have been suggested to highlight the global spread of the English language as a current lingua franca. Social Anthropology has contributed to the development of these linguistic theories significantly through the findings of anthropological field studies in multilingual societies (for example, Gumperz 1958; Kramer 1986; Moyer 1998; Wilce 2000).

The genesis of francophonie

Historically, the development of nationalism in France in parallel to the history of Mauritius is of paramount importance for the current research. Burke (2004, 163) argues that nationalism before 1789 existed in the form of a proto-nationalism, or 'statism', which refers to the idea that early modern states (France, England, and Spain) rather than nations

were the first basis of linguistic hegemony. Standard French based on the Parisian dialect was first the language of the court of the absolutist monarchy in the 17th century; then, its use penetrated to the aristocracy, administration and literature. The situation changed dramatically during the French revolution. Subsequently, regional French variations, or 'patois' to use a derogatory term, became elements to be eradicated as the central Parisian dialect symbolically represented the central Parisian government as well:

> The […] decree of 2 Thermidor (20 July 1794) instituted what has been called a reign of linguistic terror. Any document not written in French would be illegal, and any servant of the Republic who drew up a document in a language other than French could be imprisoned for six months and deprived of all his goods and rights. (Adamson 2007, 8)

This policy continued during Napoleon's period of French imperialism as well. The proportion of non-standard French-speaking monolinguals in France decreased from 46% to 25% between 1794 and 1863 and practically no such monolingual was left by 1927 (Ager 1996, 37). The figures indicate that the number of speakers spread across geographical and social terms, from central Paris towards the peripheries, from the upper classes and educated elite towards the ordinary people. In Adamson's words:

> The invention of the new word *francophonie* (the act of speaking French) by a French geographer, Onésisme Reclus, in 1880 indicates that there was a growing interest in the speaking of French outside France, and this is confirmed by the creation in 1883 of the *Alliance française* (Adamson 2007, 10).

When the colonial power of France extended in the 19th century the centralised administration and law along with attached rigid linguistic norms had been implied in the colonies too. Ager says in this regard:

> [O]nly those colonial subjects who were prepared to accept this could participate in the political life of their own countries. Nevertheless, once they did accept this, they could become full members of the French community, and the fact that colonies might be situated thousands of miles from metropolitan France was no barrier to their integration into the nation-state. (Ager 1996, 43).

The 'glottophagia' of French in the colonial context meant that the colonial power was exercised as the imposition of the colonial power's language, standard French; whereas the prestige functions of the local or aboriginal languages (called patois) were annihilated (Calvet 1974 cf Phillipson 1992, 39). In 1972, the then French president Pompidou said "there is no place for regional languages in a France which is destined to play a fundamental role in Europe" (cf. Ager 1996, 43). Today half of French speakers live outside France, but in many Francophone countries just a fragment of the population, the local, educated, postcolonial elite is able to acquire the standard linguistic norms. This norm continues to be widely and axiomatically accepted in those countries, whereas many British ex-colonies have developed their own linguistic standards. Again with Adamson:

> Apart from confusion both in France and in other countries about what the francophone movement actually is, this aspect of the language-related policy of the French government is now under attack […]: predictably, some citizens of the former colonies point to the use by France of the international organisation as a neo-colonial agency, dedicated to destroying traditional languages and using the language of the colonial usurper to strengthen French control over lucrative commercial deals. (Adamson 2007, 89)

The codified French language has gained a strong symbolic sense in France and "[l]inguistic change in this symbol is traditionally seen as decadence, as a form of illness and disease, and state organisations strive to repair the 'damage' and maintain linguistic health by resisting certain

types of change in vocabulary" (Ager 1996, 191). The equal rights of citizens have been presumed to be equalled with the commonly shared access to the one and only one linguistic norm. Thus, this assimilation is one of the ways how a citizen could be part of the Nation. Being a symbol and an elemental social pressure, The Language is often an emotional and publicly discussed issue in France. Apart from the French Academy, a number of other official and non-governmental agencies continuously try to defend the language from corruption and to propagate it (Adamson 2007, 19, 21, 50, 61).

Thus, the development of the relation between politics and the French language has gone through three stages (ibid, 82): the time of the absolutist monarchy, the time of the Great Revolution, the time of the Republic and *Francophonie*. From the time of the Revolution, attitudes to language are characterised by the following principles: insistence on a coherent national language policy, identification of the language as an integral part of the nation, and the conviction that political unity could only be achieved by linguistic unity (ibid. 2007, 9).

Conversational language shifts as social capital

Multilingual or multilectal speakers can switch not only within the same language but also among languages, dialects and sociolects. The choice of use of one language over another when several are available may index ethnicity, or political stance (Heller 1992). The speakers can point to another space or time where they or the listener have been or will be whilst choosing one or the other (Duranti 1997, 18). These choices are interactional, creative, and performative, and contextualization cues (Gumperz 1992) give orientation for the participants of the conversation about the implicated metapragmatic meanings. Code-switching takes different forms but also shows strategic coherence, which is characteristic

to sociocultural arenas (Gal 1987). Diglossia (Fergusson 1959) indicates two different levels of possible speech in the same language used by members of the same speech community. The H (High) is the prestige variation, which is usually more standardised, written, stable and associated with high prestige social activities or institutions whereas the L (Low) is the opposite. Not only the fact of two different established variations but also the phenomenon of change over between them can have social value. Numerous other examples were found later in multilingual situations. People do use several language variations and apply meta-pragmatic rules in choosing and mixing available variations to exercise agency and express identity, but also to accommodate to the interlocutor (Giles, Coupland and Coupland 1991).

Bourdieu and Appadurai's models could be applied to what linguists call 'prestige' in defining H and L varieties when they point out that 'prestige' as a value is created in economic exchange. Not only obvious diglossia features but also more subtle linguistic differences, for example accents, can represent prestige and economic value.

Multilingualism is a phenomenon of contact among languages and their speakers. Unlike in some European nation states, multilingualism is a widespread feature in many societies all over the world. Multilingualism can become a weighty symbolic and practical matter in politics and education when decisions are to be made on the medium of education, media, standard orthography, governmental or legal languages. Although multilingualism is a worldwide phenomenon, languages are not equal. The official or prestige status of languages is often restricted (Edwards 1994, 3).

Social suffering and the role of language in mental healthcare

This work has chosen the domain of healthcare, and mental healthcare within that, as a focus of analysis where the social inequalities are reproduced through language related social practice. Healthcare as such is an institutionalised form of alleviating suffering. Some authors suggest that despite the technological developments and the efforts of certain policy makers in recent decades, socioeconomic differences and inequalities that are entwined with feelings of suffering have not significantly diminished in most societies across the world (e.g. Desjairlais et al. 1995; Leon and Walt 2001; Rogers and Pilgrim 2003). The term social suffering refers to not only the feeling of physical discomfort but the lack of full, physical, mental and social wellbeing. Therefore, negotiations and definitions concerning the medical role may fluctuate between extremes of over-rationalised body-engineering and omnipotent world healing. Medics are entitled to alleviate suffering but the concept of social suffering (Benatar 1997; Das and Kleinman 2001, 2) challenges their competence. Social suffering is connected to existing and reproducing social inequalities, which, themselves, are the consequence of habitual reproduction of power relations. The explanation of why language is a possible and valuable area to study the genesis of suffering is based on theories that suggest the social world itself can be conceived as social language use in the broadest sense. As healthcare is about help and, in theory, both patients and clinicians intend to speak as efficiently as possible to achieve the ultimate goal of health, one would not expect linguistically embedded social inequalities at this level. However, I argue that they do exist and may hinder the amelioration of suffering.

It has been highlighted in studies of medical anthropology that doctor-patient encounters are not just about the exchange of practical

information. Patients tell clinicians their narratives, a special selection of complaints, events, feelings and self-interpretations, and the clinicians will interpret them in a rather selective but interactive way (Kleinman 1988, 15). Patients and doctors have been described as having a rather different interpretation of sickness, as the differentiation between disease, the patient's point of view, and illness, the professionals' point of view would suggest (Eisenberg 1977). The patient's inner dialogue goes through several questions, answers and actions prior to the first encounter with a doctor and after the first encounter is over (Helman 1981). As an extension of Kleinman's theory, it can be suggested that the patient's narrative is, in effect, a joint narrative in the moments of encounter among the participants. The explanatory models (Kleinman 1980, 120) of the patient and the healer are negotiated and adjusted to one another to reach 'a common wavelength'. In this process the patient's actual speech often emerges as a hindrance, and the biomedical doctors may think the patient speaks too much, or too little, or with too much irrelevant data, with too many contradictions, or without enough clarity. The patient, on the other hand, may feel unable to express him/herself properly and satisfactorily, tell everything, or at least convey the subjective relevance of the disease.

This work intends to stress that the act of intertextual narration is a linguistic process as well; the communication of the narrative usually happens through speaking and talking to the presumed healer/clinician. Patients use their private language and communicate simultaneously their adherence to the social group(s) they belong to. During their conversations, patients and doctors bring with them their cultural and social backgrounds with their language variations. Medical doctors usually belong to the upper social echelons and the dominant ethnic, racial or caste groups and master language variations that are closer to dominant, standard or elite languages, whereas patients come from all

sections of the society. Using non-elite language, including regional, social, individual variations can cause further discomfort and misunderstanding between the patient's disease narrative and the doctors' rational illness language. Most patients are unable to compensate their patient-ness with eloquent linguistic features. In other words, as communication theory holds, the problem as such is inseparable from the communication about the problem (Watzlawick, Bavelas and Jacksoni 1967). Healthcare in Bourdieu's model (1977 [1972], 187) can be understood as the production of a joint and customised explanatory model constructed by professionals and patients, the construction of the 'right' narrative, through which they produce and reproduce the commonly shared social capital. The relationship between professionals and patients is reciprocal but often asymmetrical. The professionals belong to those social groups that have usually more liberty to dictate the rules of the language that is used in these encounters, either in the form of staying within grammarian norms or going beyond these norms at ease; for example, in the form of using rare expressions or tropes (Bourdieau 1984[1979], 255). Patients and clinicians/healers from similar ethnic, class, caste, professional and social groups can create a smoother, less disruptive common narrative. For other patients the code-switching can cause further anxiety and frustration.[1] New disciplines, like 'Health Communication', subscribe to conceptions that some patients in multilingual, and usually multicultural societies, have regrettable, 'limited' linguistic competence in the expected language variations (for example, Roberts et al. 2005). These variations happen to be the language of the dominant biomedical system. Even when short-term practical solutions, like translators are offered, the core concept – that the patients are expected to accommodate to the language of biomedicine and not vice

[1] See more about code-switching in a later section.

versa – is not questioned.

Thus, the encounter between patient and professional, the use and choice of language have both emphatic practical and political aspects.

Mental health, language and anthropology

Within the domain of healthcare, language use in the sub-domain of mental healthcare will be the focus of this thesis. Therefore, the specificities that make communication special in mental healthcare compared to general healthcare need to be highlighted. After the term and discipline ‘medical anthropology’ appeared (Polgar 1962; Scotch 1963) Foster distinguished it from medical sociology and suggested that “one of the roots of contemporary medical anthropology can be traced to [...] the culture and personality movement of the late 1930s and 1940s, with collaboration between psychiatrists and anthropologists” (Foster 1974), suggesting that psychiatry, or at least something called psychiatry, was a connection and bridge between medicine and anthropology. ‘Psychiatry’ as such is a heterogeneous complex of diverse concepts, ideologies, agencies and localities. It spreads over from the extremes of ‘mind as body’ neuroscience or ‘brain psychiatry’ to some social constructionist psychotherapy models or to ‘antipsychiatry psychiatry’ (Szasz 1961). Several contact points were suggested between anthropology and psychiatry (Kleinman 1987); however, the heterogeneity of psychiatry, or with more general words, the heterogeneity of the biomedical way of dealing with mental suffering should be considered in any anthropological study that deals with this field.

The current state of psychiatry has been summarised by Young:

> Today, hegemonic psychiatry’s most powerful instruments are its biological etiologies, therapeutic interventions (psychopharmacology) and research programs. Through biological

> reductionism, these instruments desocialise and dehumanize distress, naturalize social and economic inequities, silence the voices of suffering and resistance and eliminate the possibility of agency...[But] the biologization of psychiatric problems has lost its former hegemonic menace. Today it is often patients and their advocates who promote biological explanations, in opposition to the ego-centered psychological theories favored by certain psychiatric authorities (Young 2008).

Current influential diagnostic manuals like DSM-5 (American Psychiatric Association: Diagnostic Statistical Manual) and ICD (World Health Organisation: International Statistical Classification of Diseases and Related Health Problems) are based on the epistemological ground both for mental and somatic disorders that malfunctions perceived, reflected and presented by the patient are detectable and translatable by the observer clinicians. Whereas medical encounters tend to reduce the doctor-patient conversation to selective parts of the illness, narrative psychiatry, in contrast, recreates colloquial conversations in order to assess and possibly diagnose mental disorders that may display communication symptoms too. It looks for ‘mistakes’ in the language/communication of the patient. Psychotherapy as a branch of psychiatry and psychoanalysis as a branch of psychotherapy represent further language related particularities. Each discipline has its own ‘jargon’, but only psychoanalysis and a few other psychotherapies reflect on the commonly created narrative. Nevertheless, this reflection is usually restricted to symbolic semantics in language and does not include broader areas of linguistics, for example language variations and multilingualism. Biomedicine often holds that psychotherapeutic practice is a typical example of placebo (Eysenck 1952; Evans 2004, 170). According to this concept ‘talk therapies’, as some psychotherapy methods are called in medical anthropology (Helman 2007, 276 [1984]), and ‘symbolic healing’ (Dow 1986) may represent common underlying processes with a placebo effect in medicine. As language is a necessary medium in medical

practice and it also has an emphatic role in mental health as carrier of certain symptoms and a possible tool of correction those symptoms, medical anthropology and especially transcultural psychiatry can benefit from the concepts of linguistic anthropology and from field studies that focus on linguistic phenomena in clinical localities.

Fieldwork and methodology

In this section I will highlight how language and multilingualism can be important in human societies and particularly in the reproduction of inequities in human societies, and explain that healthcare and mental health will be the focus of analysis. Data were collected for the analysis via fieldwork in a country where multilingualism is paramount.

Fieldwork was carried out in the main island of the Republic of Mauritius between October 2009 and July 2010. It was multi-sited; four Mauritian NGOs – the Century Welfare Association, the Mauritian Mental Health Association, the Friends in Hope and the *Centre de Solidarité* – formed my main four sites. I attended the base(s) of these associations weekly for a few months each. My presence was similar in all four fieldsites. I arrived in the morning, some time after the institution began its daily routine. I stayed there usually until the afternoon and sometimes until the evening. I participated in daily programmes as either a mere observer or more actively conversing with staff or clients. When possible I managed to keep my status as researcher and not as a worker. Sometimes I took notes in the sites but not very often as I felt note taking during field observation distanced me from the other underlying role. I decided to write most of the notes after the visits in the evenings or the following day. In each association, I had one or two introductory interviews and conversations with the managers. Otherwise, most information I collected derived from observations, casual talks and

personal participation in group discussions, rather than from formal interviews. Occasionally, I also participated in the activities of these associations or their staff, like excursions, evening dinners, parties, celebrations, some of them out of the institutions' premises.

In addition to the four main sites, I made occasional visits to other Governmental and Non-Governmental institutions and associations: the Ministry of Health and Quality of Life, the Ministry of Social Security, Brown Sequard Hospital, Sir Seewoosagur Ramgoolam Hospital, the Goumani Centre, the Joint Child Health Project, Krishnanand Seva Ashram Ayurveda Hospital, the Mahatma Gandhi Institute, the *Bureau Education Catholique, Ledikasyon pu Travayer,* the Bhojpuri Speaking Union, and the Mauritian-Hungarian Friendship Association. Regrettably, I encountered difficulties in communicating with representatives of the Ministry of Health. The line of responsibility was unclear, some decision makers were unreachable and I had to wait for a long time for a reply. The internal structural problems and the hampering interference between political appointees and independent officers in the Ministry have been portrayed in detail by previous researchers (Valaydon 2002). To complicate things further, after the May 2010 elections, the personnel of the Ministries changed dramatically, and as a consequence I had to restart networking. I visited a private hospital (*clinique*), a few private single medical practices (*cabinets*) and interviewed private practitioners. I also had access to electronic and written media on a daily basis and I had numerous conversations with Mauritian and non-Mauritian anthropologists, linguists, sociologists, historians, journalists and writers. These observations and the relevant parts of the interviews were recorded simultaneously with the field site notes.

The three different areas where I stayed – a rather touristy neighbourhood in the North, a working-class estate on the outskirts of the capital, and the centre of urban Curepipe – gave me a relatively good

impression of daily life in different type of dwellings, social classes and groups, but unfortunately, the duration of the fieldwork was not enough to move and stay for a significant length of time in rural or coastal villages, or in the seaside bungalows or in top residential quarters of the upper classes (such as Floréal). I participated in festivals, like the famous *Maha Shrivataree* Hindu religious festival at *Ganga Talao* (Ganges lake), cultural events, many friend or family-oriented feasts and festivities, in the life of a sport club and, notably, in many normal, ordinary days and evenings with my Mauritian friends.

Fieldwork and languages

As my fieldwork focused on language use it is worth mentioning that it has been noted that language often serves as a barrier to scientific research, in particular between the lingua franca of contemporary science (English) and the speakers of other languages outside the English-speaking territories (Meneghini and Packer 2007).

Anthropological studies are typically grounded on stationary fieldwork. The researcher stays and subsequently communicates with the people of the fieldsites for a long time and extensively. Some have argued that language is in a central position in many, if not most, anthropological studies and fieldwork. The observations of the researchers and the assertions of the research participants occur in linguistic forms where the language is not a neutral or mechanical tool but has an inseparable simultaneous constitutive role in the development of claims to ethnographic truth (Clifford 1986). The legitimacy of the anthropologist's role often derives from the communication and notes about the data collected during fieldwork, but differences arise in the level of language consciousness and the possible use of technologies (recording, transcriptions, questionnaires, team discussions, etc). Although it is

always present and important, language can become the special focus in some anthropological fieldwork. New sub-disciplines have evolved in this terrain. In the second half of the 20th century, terms such as linguistic anthropology, anthropological linguistics and ethnolinguistics became practically interchangeable, although some (Salzman 1993) suggest that one could separate anthropology using linguistic methods from linguistics using anthropological methods.

In my fieldwork I did not only use these linguistic methods to reach out towards a distinct research focus. I intended to analyse linguistic phenomena not per se but as golden route to understand fundamental processes of social practice. The linguistic method in doing the fieldwork was simultaneously the focus as well.

The emphasis was not only about what the informants were telling me but also how the informants were telling this to me and how other people (not the informants) were telling things to each other. Therefore, there was a more active (speaking), and somewhat more but not exclusively passive (listening) participation of the researcher in the linguistic interactions in the field. Further to speaking and listening, in the overhearer position, the presence of the observer is virtually 'invisible', for example hearing people talk at the bus stop while waiting for the bus. There is no clear-cut boundary between the listener and the overhearer position, rather a changing tendency of being considered more or less as an agent by the other interacting persons. Even without the possible permission to engage in an interactive setting as an active listener, an ordinary bystander's presence can theoretically also influence the speakers, even on an unconscious level. In other words, people may speak to each other differently in an otherwise empty bus stop or at a bus stop where a few strangers also stand. The methodological problems of social desirability bias (de Vaus 2002, 107) or response effect bias (Wassertheil-Smoller 2004, 109) should be reflected carefully in any research that

focuses on language use. People, the possible respondents and informants, do not only alter their direct response to please the interviewer's assumed wish or to show a better social image of themselves in formal interview, but both the observed and the observer behave differently in any situation when they are consciously or unconsciously aware of the other. The intersubjective narrative is being created in any *in situ* social sphere, where participants, for example researcher and informant, or healer and patient, create socially a unique, one-off narrative (Hunt 2000). Each understanding of the meanings during the intersubjective narrative creation influences the next one. Therefore, the understanding that the researcher achieves by analysing pre-recorded texts is not any more 'objective', or 'better' just different from the understandings he or she makes while being within the situation, or recalling those situations. Standing there and overhearing provokes emotional and cognitive reactions simultaneously in the observer, which would lead to an *in situ* and different understanding and meaning recognition than listening to and analysing a tape *a posteriori*. Anthropological methods differ from many quantitative or half-qualitative scientific methods like the analysis of audio recordings in experimental linguistics, as the emphasis is on the kind of possible understanding, which is only accessible by 'being there'. This should not suggest that the analyses of recordings are less valuable, by any means. However, this does suggest that there is a level of understanding, which can only be achievable by an actively present observer in whom the simultaneous overhearing (and listening, or talking) creates an ongoing contextualised understanding. This type of understanding of the hearer (or the researcher) is what differentiates the method from the reactive observer position of a tourist or a journalist. Hearing what people say makes scientific sense if the personal filter of the overhearer/listener is associated with the researcher's context dependant presence in the society. This can only be achievable by living

in the society for a significant length of time and, in addition, through knowledge centred preparatory stage and continuous knowledge (including language) acquisition during fieldwork.

Languages in this fieldwork

Speaking can be the source of particular bias or blind spot for the researcher. Especially in the complex and compartmentalised Mauritian society it is advisable, or at least would be ideal, to access all major 'compartments'. Although this is obviously impossible, one should at least make reasonable efforts if the research topic is centred on social language use in general. In the last fifteen years, anthropologists and social scientists carrying out fieldwork in Mauritius were all accommodated by one or the other major locally constructed 'compartments', Patrick Eisenlohr (2001, 2006) by Indo-Mauritians, Cathrerinie Boudet (2004) and Tijo Salverda (2010) by Franco-Mauritians, Rosabelle Boswell (2006) by Creoles and Laura Jeffery (2011) by Chagos Islanders. At the same time, Mauritian anthropologists working in Mauritius are rare, a notable exception being Pavi Ramhota (1993, 1998), an Indo-Mauritian who has carried out fieldwork mostly in Indo-Mauritian neighbourhoods.

During the first couple of months, my fieldwork started slowly and later accelerated rapidly to finish in the frenzy of a hardly manageable number of site-observations, meetings, formal and informal interviews and conversations. In retrospect, it became clear that the fieldwork was also active during the 'slow' part but in a different way. At the beginning, I concentrated mainly on improving my Mauritian Creole language and speaking with ordinary people. Learning the language was also about learning about the society. Prior to leaving for the field I tried to learn as much as possible from the existing few language books and having

arrived I contacted the only institution that offers Mauritian Creole language courses, *Ledikasyon pu Travayer* (LPT). In the end, the first course started a few weeks after I had already left the island. As usual in the first part of language learning, the people around spoke so fast that the whole speech merged in one amorphous mass, seemingly impossible to entangle. After plenty of effort, support and the resilient help of some friends for a few weeks, I eventually found two young teachers who agreed to teach me Mauritian Creole. Nevertheless, by the time the formal teaching started, I was already about to break the psychological ice and discover meanings within the people's speech. The country is full of advertisements about English and French-teaching courses, but finding Mauritian Creole teachers is a difficult task, as explained in Chapter 3. The infrequent meetings with the two young teachers were discussions more than formal, disciplined classes. Even if they had the capacity and willingness to reflect upon their own language, they often lacked the basic descriptive notions and reflective knowledge about the vernacular language of the country, like for example, grammar and its complexities. Obviously, their native speaking competence was perfect. When I quoted from Baker (1972, 1982) or Pudaruth (1993 [1972]), however, pointing out some structural aspects of the language it seemed that we were teaching each other. About three months after my arrival, I started understanding the vernacular and after about 6 months, I could participate in normal conversations. Parallel to the growing capacity in communicating in the local vernacular, contacts with my fieldsites, institutions and personalities were becoming more frequent and more specific to my research. In spite of the drastic difference between the beginning and the end of the fieldwork and my deliberate intention to use Mauritian Creole as the medium of communication, the use of English did not disappear completely and if the best interest of the research dictated it was retained for some, typically official purposes.

Despite my interest in languages, it is worth mentioning that I was brought up in a monolingual environment, but unlike most of my compatriots in Hungary I have studied numerous languages in both formal training in my home country and living and working abroad. I was 45 when I first arrived in Mauritius. In the previous years, living in the United Kingdom has helped me to improve my English. Latin was a secondary school subject for me, and later I acquired working fluency in Italian and Spanish, moderate fluency in Portuguese and some very basic French. Just like many Italians or Spaniards, I can read French texts and understand the gist of the texts although I cannot tell the exact grammar rules. One of the major revelations about the language use in my fieldwork in Mauritius was the emotional change I went through regarding the practical advantages of French. In the first weeks, when I was unable to understand spoken Mauritian Creole, I wished I was able to speak French. Around the end of the fieldwork, I was grateful that I could not. It became obvious, if I had been able to speak French in the first place, my research would have taken a different direction. I would have been associated by many Mauritians with local or foreign native French speakers, and it would have been difficult to get away from this imposed identity. I probably would not have been able to collect the data I needed for my research. Speaking French in Mauritius often imprisons the speaker in a comfortable but very confined social sphere. Speaking just English is enough to get by in Mauritius, being the official language, but limits the speaker to an even more limited social sphere than French.

In addition to these languages, I had some basic knowledge in Hindi and could read devanaagri texts but did not speak any other current language of Mauritius. Since this thesis is in English, I will leave the verbatim English quotes from the fieldwork unsigned. Texts from other languages will be signed in italics, and their translation will be given in brackets or footnote. Writing in Mauritian Creole, unless it is a different

verbatim quote, the standards of *grafi larmoni* (harmonised orthography) will be applied. There will be one peculiar choice, the name of one of the principal objects of analysis, the ‘Creole Fransize’ language variation. To write this the following options would also be possible: French-like Creole, French-influenced Creole, French-accented Creole, ‘frenchified’ Creole, *kreol fransize, créole fransisé*. Finally, I decided to use the ‘Creole Fransize’ hybrid form. The Mauritian Creole language has an official English name, I kept the English word ‘Creole’ with capital C, but without é, which has an acute accent in French orthography.

Participant observation in Mauritius

It has been shown why long-term fieldwork has been chosen as the method to research language use in a multilingual society. Such fieldwork is regarded as hallmark of anthropology; it embraces participant observation, a combination of social participation in everyday life and simultaneous and linked scientific observation. An important aspect is that the long-term aim of anthropological fieldwork is to identify rare, non-façade or downplayed phenomena. The researcher is aware that he/she is there working for a specific and more or less defined, scientific purpose. On the other hand, the researcher’s presence is temporary, previously designed and reflective (Davies 1999). Hence carrying out fieldwork implies a specific mindset, because the researcher is simultaneously in an interlinked inside-outside position (Hammersley and Atkinson 2007, 238). The live social context of ethnographic research “inevitably entails some degree of resocialisation” (Emerson et al. 1995, 2). The reflective position determines that the researcher’s attention is consciously focused on the events of social life, including ongoing human relationships and the researcher’s own feeling and ideas.

As my fieldwork focused to a significant extent on politically

debated, controversial or confidential areas in both language use and the situation of mental health in Mauritius, the duration of the research had to be divided among informants from various social groups in order to access the different sources of information. I intended to check new pieces of information with other informants, repeatedly coming back to the same topic at different times in diverse situations. During the first six months, I often felt that my research was not going anywhere because I was not able to verify my sources. Apparently, no-one had told me the 'truth' because speaking with new informants I heard completely opposite interpretations or I gathered new, unexpected and radically different details that made me profoundly revise initial working hypotheses. At this point in time, the 'blind spots' (Ecks 2008) of anthropological methodology appeared to be overwhelming. I had to realise that the researcher's position and with it the entire anthropological fieldwork method can be potentially 'scotomatical'. Knowing a little can be reassuring; knowing a little more raises the anxiety of conscious 'not-knowing'. This was not just an uncomfortable feeling but disturbed my daily activity. I could not fully 'believe' what I saw, I could not trust what people told me or the conversations they had with each other because I knew someone else could have said the opposite or something totally different. Being oversensitive to this scotoma, I was acutely aware that there were things in my vision, in front of my nose that I did not see and could not see. I arrived at the point that Sapir (1938, 7) described referring to Dorsay's work about Omaha Indians: "Two Crows a perfectly good and authoritative Indian, should presume to rule of court the very existence of a custom or attitude or belief vouched for by some other Indian, equally good and authoritative". Further down the line, with more and more triangulation, my anxieties lowered.

Using quantitative or semi-qualitative methods, the collected information usually focuses on the targeted area but nothing else. In

anthropological fieldwork, one is able to include relative preconceptions or knowledge of potentially important aspects. Assisting to the birth of the text the observer can also see what could have been potentially there but was not. For example, listening to a conversation in a multilingual society one does not only hear what is said, in its elementary and/or metalinguistic semantics (and in the interpersonal context) but one is also continuously aware about what else and how else it could have been said (but has been not) from all available options. The automatic assessment of these options is a skill that speakers normally acquire while growing up in a society.

On not using research assistants

Regarding the method of daily fieldwork I made an important decision: not to use research assistants. For this decision it is important to see the comparison with the only anthropological research which was similar in aims and methods to mine, namely Eisenlohr's fieldwork in Mauritius in 1997-98. The findings were published in his thesis 'Language Ideology and Imaginations of Indianness in Mauritius' (2001), in his book 'Little India: Diaspora, Time, and Ethnolinguistic Belonging in Hindu Mauritius' (2006) as well as in several articles. Eisenlohr embraced quite wide areas of Mauritian life and published *verbatim* conversations of diverse situations. Many recordings targeted the linguistic phenomenon of code-switching; therefore, his published transcripts are frequently bi- or trilingual (2006, 116-166). Some are interviews and some look like observations, although we do not find many details about how they were recorded. In his book (2006, 135), he points out that his research assistants were deeply involved in the interpretation of the texts. The English of Eisenlohr's work is of a high standard. However, the published Mauritian Creole texts use inconsistent

orthography. Orthography is a most contested and highly politicised issue in recent Mauritian history. Eisenlohr's study aimed at the analysis of the relation between politics, ideology and language use, which necessarily includes Mauritian disputes about the standardization of the spelling of Mauritian Creole. However, the same ideological dilemma crystallised in his work; that is, there was a marked difference between when he was writing about Mauritian languages and when he was writing in Mauritian languages. Eriksen, a Norwegian anthropologist who carries his fieldwork in the late 1980s - early 1990s explained a few years earlier than Eisenlohr why he was using the LPT's phonetic orthography: "[M]ost scholars agree that if Kreol is ever to achieve status as something more than a poor man's French, it should avoid adopting the idiosyncrasies of French spelling" (1998, 21). About the same phenomenon Eisenlohr explained that his assistants were

> [U]niversity of Mauritius students, who were bilingual in both Bhojpuri and Creole, residing in rural communities different from the one I mainly worked in […] Despite the fact that the identities of the speakers in the recorded interactions were unknown to my research assistants, during most transcriptions sessions, they would immediately voice guesses about a particular speaker's ethnic and socio-economic background, as well as their level of education. (2001, 76)

It seems that the university student assistants who made the transcripts not only translated but actively interpreted the audio recordings. Eisenlohr's description of his methodology drove me to the conclusion that it would be better without research assistants. In Mauritius particularly, it would be impossible to find a 'neutral' interpreter. In this way, I could avoid the possible bias included in the perceptive filter of the assistant in interpreting the listened text through their socially determined classification system and in their abilities to pass it on to the researcher. After Eisenlohr, numerous notable sociolinguistic

studies used the technique of the analysis of pre-recorded texts (in Mauritian context for example, Rajah-Carrim 2004a; Atchia-Emerich 2005; Thomson 2008). Considering this technique sufficiently exhausted, I intended to do something different, which also meant the omission of interpreters as well. I was concentrating more on *ad hoc* talks and utterances, and the less conscious or reflected phenomena that has been repeated many times in ordinary situations. Not understanding, making errors, or being in confusing or misunderstanding situations were regarded as potentially precious data as well in my research when this helped to dig out various layers of meanings. I also avoided using tape and video recorders and preferred writing extended field notes straight after each important event. This technique proved to be more and more difficult towards the end of the fieldwork when my days became increasingly busy. Occasionally I did not have time to write field notes on the same day and I had to allocate a specific time, sometimes a whole day, just for writing. In addition to the intention to avoid the bias of assistants and similar interpreters and rely on the struggle of learning the language, a further reason for the described data collection method was that I worked under the conviction that in any setting that may include people with mental health problems the use of recording equipment could alter the presentation of the problems and even if the participants of the situation are acquiescent, they might not be able to give completely conscious consent for me to use recorders or other technology. Therefore, this dissertation is not based entirely on a scientific analysis of objectified texts; it is based on the analysis of the information collected in the notes taken *in situ*.

Doing anthropology as a clinician

Further to the linguistics and Mauritius specific aspects of fieldwork

method in use to achieve the desired aim of analysing the social practice of a multilingual society there was another element in my fieldwork that caused dilemmas. My medical doctor degree and psychiatrist speciality had an inevitable impact on my contacts. First, on the personal level it challenged my double identity to be a doctor and an anthropologist researcher at the same time. It often proved to be difficult not to inhabit a clinician role, in which such structuring terms as symptoms, diagnoses, guidelines, and treatment are taken as axiomatic. My previous training in psychiatry prevented me from taking a neutral approach to the specific Mauritian reality. Second, doing fieldwork in the field of healthcare as a medical doctor highlights the position of doctors in the particular society. Medical doctors in Mauritius enjoy a lot of respect and prestige as it will be explained more in Chapter 4. For example, the first Prime Minister of independent Mauritius, Seewoosagur Ramgoolam obtained a medical degree in Britain and often worked almost free of charge with poor people. His son, the current Prime Minister, Navichandra Ramgoolam also obtained a medical degree in Ireland. Being a doctor meant that I did not have to explain the reasons for my presence on site. However, my researcher role remained intriguing and my dual background evoked false expectations every now and then. Even if I emphasised that I was not working as a medical doctor in Mauritius, once I disclosed my profession, and I often had to, I realised that my relationship with people changed considerably. This included a mix of respectful tone of voice, projections about my unquestionable hidden wealth, and an element of surprise when they found out what I was actually doing in environments in which doctors are usually absent. For example, in a visit to the Ayurveda hospital in Calebasse, my informant realised that I did not have any transportation of my own. In addition, although I was wearing a business shirt and trousers, I carried a backpack instead of a briefcase. One of the managers had to drive me from the outpatient facility to the inpatient

section hosted in a residential complex in a rural area not served by bus lines. Although parts of the main philosophical principles of this Ayurveda enterprise were simplicity and charity, the manager reflected on my appearance that probably lacked any sort of solemn superiority. Joking in the car, he told me his amusement, “Oh, it seems,… we are getting here this kind of new type of doctors.”

The four NGOs I visited during my fieldwork, although working with mental and physically ill people, could not afford to employ doctors. Only the *Centre de Solidarité* had a partial contract with a practitioner and only in relation to the detoxification stage of the treatment, a short stage in the long route. Most certainly, my profession helped me to enjoy a warm welcome by some NGOs that are active in the field of mental health owing to the chronic lack of doctors specialised in mental health. Outside these specific organisations, I had to accept that the willingness of institutions and health professionals varied to a large degree. Some were very forthcoming and happy to express their views to a foreign researcher who was interested in them; some seemed reserved and afraid that I might spill the beans of some presumed secrets, or work for one of the (opposite) sides of the sociopolitical arena in the country.

A foreign anthropologist amidst overpowering ethnicity issues

Not only the medical profession but the Mauritian system of locally conceived ethno-racial- religious categories represents a challenge for researchers while carrying out long-term fieldwork. The origins and significance of the system of categories will be described in detail in Chapter 2. However, it needs to be mentioned here as well in the section about difficulties for anthropologists working in Mauritius. For example, Eisenlohr describes (2001, 28) how he ended up with the position of

being a ‘cultural specialist’ for Hindu heritage. His ability to speak in Hindi was a “sign of commitment to the ‘Hindu cause” whereas his efforts to learn Mauritian Creole never gave rise to such expectations. Boswell (2006, 150), another anthropologist, was born in a Mauritian Creole family living in Malawi and in her writings she tells about her experience of doing an anthropological fieldwork after returning ‘home’. Her project included a great deal of ethnographical studies of diverse segments of Mauritian Creoles but, as an anthropologist, she became a defendant of the ‘Creole cause’, depicting, on occasions, Indo Mauritians in an unfavourable light. Simmons, the American author of the one of the most seminal works on 20th century Mauritian history pointed out the problem of using local secondary sources for her study: “Because of communal biases, few Mauritians have been able to write about their island with objectivity” (Simmons 1982, 230). If a researcher has family ties in Mauritius, this can open up access to family networks, which could be seem helpful and comfortable initially. However, this may also restrict access, both because of the disapproval of the adopting group or by the suspicion of the presumed other groups who see the researcher as the agent of the ‘others’.

Along with my medical degree, my white skin colour also influenced my relationships in Mauritius. Racial phenotype as possible hindering factor for carrying out anthropological fieldwork in Mauritius has been discussed by some anthropologists (Boudet 2004, 11; Salverda 2010, 31), but many other researchers have limited this subject to anecdotal hints or coffee table discussions, or have simply refused to reflect on this sensitive issue. In that environment, it was impossible for me to keep a low profile in daily Mauritian life. When working with the local Franco-Mauritian population, Salverda witnessed when a Franco-Mauritian woman was asked to show her passport to a nineteen-year-old colleague who could not believe she was actually Mauritian (2010, 219).

A Franco-Mauritian priest said to me referring to the modest neighbourhood where I was staying: *"*These people…don't have leadership, Laszlo. You can live here but if I came here [to do social work], they would not really accept me. They wouldn't say it openly but they would think I am patronising, because… I'm white".

A Franco-Mauritian informant told me exactly the same thing that Salverda published as well (2010, 215):

> A […] Franco-Mauritian man explained how a white addressing, for example, a policeman can be difficult. The policeman may consider the Franco-Mauritian arrogant if the latter addresses the former in French, as French is associated with Franco-Mauritians' colonial hegemony. But if the Franco-Mauritian addresses the policeman in Kreol the policeman may interpret that the Franco-Mauritian thinks he does not speak French and that he is, consequently, looking down on him.

The only place where one can see European looking people are some touristic areas, a few popular beach stretches and a small central patch in the capital city of Port Louis. My problem was that I often turned up at locations that white people tend to avoid. I walked in the streets and used public transport; I went to do shopping in local retail shops, and to villages far off the touristic routes. At the same time, as a doctor, I applied a certain dress code, wearing shirts and business trousers. In the second part of the fieldwork, when I achieved a communicative fluency in Mauritian Creole, this was even more surprising for the people with whom I communicated. Most of them could not understand how could I speak Creole and they were surprised by my accent that was difficult to match with my appearance.

One day a friend of mine from one of the organisations I worked for was driving me home. We decided to pay a visit to one of the executive members of the board of the organisation. She lived in a nice upper middle-lass residential area on the Plaine Wilhelm. I did not know this

Tamil lady in person, and I was asked to wait in the car with the driver. A few minutes later, my friend returned accompanied by an elegant woman, and while they were approaching the vehicle I realised that they were speaking in French. I opened the car door and made a step forward and my friend introduced me in French. I had just started to introduce myself in Creole when my friend apologised to the lady for my daring. Even though every Mauritian can speak Mauritian Creole, in this context it could have been a potential insult addressing a respectful lady in Creole, placing her in subordinate social scale from mine. My friend's reaction was more an automatism rather than the prevention of a real danger, and the lady in question did not take it as an insult because of my background as a doctor and 'language expert'. This highly educated lady, who occupied high positions in both formal and charity networks in helping people with mental health problems was aware of her social position. Some workers from the administration departments of the NGOs were less forgiving because they felt less confident of their own social status.

My 'weird' Hungarian nationality also helped me to avoid being put in prefabricated boxes. I was assigned to an ethnic group with not well-defined boundaries in Mauritius. When we clarified that my home country is in Europe, the usual next question was if we spoke French in Hungary. When I said no, many people sighed with some disappointment than added, "so then, you speak English there". It seemed that in the eyes of many ordinary Mauritian the image of Europe is dominated by a huge and mighty France in the middle, a significant England (not Britain, or UK) next to it, and some additional, blurred peripheries.

My attempts to look 'average' were not always successful. On one occasion, when a friend asked me for another loan and I highlighted some conditions, he told me *"To kouma labank, Laslo"* (Your are like the bank, Laszlo). This meant that he assumed that an 'average' foreign doctor should be rich and not behave like the Mauritian banks that set strict

conditions for any loan. On the contrary, to demonstrate my success in gaining the confidence of Mauritians, another friend told me, just a few months after our first meeting: *"Nou kontan to la [aswar]. - Mersi, ma kifer? - Akoz nou kontan twa… akoz to… You are not like…them"* (We like that you are here [tonight]. - Thank you, but why [are you saying this]? - Just because we like you… because you… you are not like…them... [switching the last part of the sentence into English].)

Overview of chapters

The next chapter, Chapter 2 deals with two major historical moments, which gave birth to the current Mauritian multilingual society: the first is the colonial comradeship between the local Francophone elite and the administration of the British Empire. The second is the immigration of Indo-Mauritian labourers to Mauritius and the rise of the Indo-Mauritian elite into power in the 20th century. This chapter details the categories that Mauritians use to describe themselves, which is necessary as the Mauritian taxonomies are of paramount importance in daily life but they cannot be simply taken for granted and used accordingly by any responsible social science researcher.

Chapter 3 outlines the multilingual language setting in Mauritius and summarises the related ideological trends, relying on the studies of socio- and anthropological linguists. In particular, linguistic characteristics of three main Mauritian languages – Mauritian Creole, Mauritian French and Mauritian Bhojpuri – are examined. Internal divisions, socially meaningful variations and multilingual interferences are exemplified and the unresolved key issue of orthographic standards as the crystallisation point of progressive and counter-progressive agencies, promotion, resistance and sabotage are explained.

Chapter 4 presents the Mauritian biomedical healthcare system, the

powerful ‘Hospitals’, which function under the tight control of the powerful Government, and the parallel segregated private institutions of *cliniques* (private hospitals) and *cabinets* (individual private doctors). Through direct observation, the paternalistic way of treatment and the submissive attitude of ordinary patients treated in public healthcare are described with emphasis on some key linguistic characteristics of this domain in Mauritius.

From Chapter 5 onward, the work presents the main sites of my fieldwork: Mauritian non-governmental organisations. Chapter 5 shows the challenges encountered by the Century Welfare Association, part of an Islamic charity centre, where children with severe physical and mental disabilities are looked after during the day. The analysis focuses on the description of how Mauritians cope with such disabilities and on the services that the carers offer the children, including their commitment to their education. To maintain the image of a ‘school’, fragments of mainstream education penetrate this disability centre, which includes the ‘teaching’ of isolated English words to children with severe learning and physical disabilities.

Chapter 6 deals with a similar but much larger centre, another ‘school’, the Mauritius Mental Health Association. It is attended by children and young adults with mental but not physical problems and the range of mental problems is much more diverse. Differential diagnosis and associated developmental plans are often incomplete, but the staff have to respond to the demanding behaviour of children. Addressing the diagnostic diversity is a practice that the workers learn by experience rather than by formal training. There is a level of severity where vital needs to look after the safety of such children lead the participants of the verbal interactions to use the commonly shared native language. In contrast, when the groups of children are regarded as having reached the level of ‘teachability’, the language related social games surface, and the

children are confused. They learn more about those games than about school related tasks like literacy. Their capacity of self-expression and chances of improving self-esteem are affected negatively.

Chapter 7 portrays an ‘animation session’ at the only Mauritian NGO, the Friends in Hope, which is active in the field of rehabilitation of adult psychiatric patients. The task of this session would be to help the health, the education, and the reintegration of such patients, but the delivery of the session ended up in an unexpected failure. Three main slants converge here, the mental states of the clients, influenced by the underlying disorder and side effects of the medications, the general issue of the semi-literacy of many Mauritians due to the inadequacies of school education as explained in Chapter 3, and the hardship caused by the complications of the traditionalist orthographies of the inherited postcolonial languages compounded with the denigration of the attempts to standardise phonetically the shared native language of the participants. Just as ‘teachable’ children’s teaching becomes wasted in the main, so does the chance of rehabilitating psychiatric patients in these moments.

Chapter 8 focuses on another type of fieldsite and sets a kind of counter-example. It testifies that there are spheres when the commonly shared social practice of a social group may nullify the relevance of some typical language games in a multilingual society. The NGO presented, the *Centre de Solidarité*, works in the area of substance misuse and deals in particular with the consequences of one of the newly emerging and popular drugs, Buprenorphine. In this specific centre, the interaction between the substance user (especially the Buprenorphine user) community and staff are characterised by a kind of ‘democratic’ communication genre that includes the confident and widespread use of ordinary Mauritian Creole, and the consequent omission of significant language related issues of power and hierarchical positioning.

The concluding chapter summarises the findings, refers to the

general theoretical concepts as laid down in the two introductory chapters, and explains how this dissertation contributes to social anthropology through the interdisciplinary approach to health and language related examples of the fieldsites.

Chapter 2. Languages and Some Current Affairs in Mauritius

Introduction

In this chapter, I argue that Mauritian postcolonial elite groups cannot be understood without a historical analysis of Franco-Mauritian/*gens de couleur* relations and emerging Indo-Mauritian political power. In this multilingual context, it is paramount to mention the different languages spoken by different social groups, together with an overview of the taxonomies regarding the relationship between language and social status.

Colonial comradeship and the genesis of Franco-Mauritian and gens de couleur *elites*

When discussing the Education Bill in 1957 the future first Prime Minister of the country, Seewoosagur Ramgoolam agreed that "it would be better to be silent (*'passer sous silence'*) on 'certain' aspects of our history because it might traumatise the youth" (Teelock 1994, 17). Teelock followed with the observation that "… historical research is also still the preserve and domain of the privileged few in Mauritius. A strong feeling exists among the 'intellectual' elite that some things are best left 'under cover' (*sous tapis*)".

In Mauritius, anthropologists cannot avoid confronting history.

Belonging to an in-group, in order to feel and say not just ‘we’ but also ‘us’, as opposed to the ‘others’ (Eriksen 1995), is elementary for daily progress. Daily life in Mauritius is full of historic and geographic allusions to the past and various far away territories.

The Mauritius islands had no aboriginal population and were uninhabited before the 16th century. Mauritians are the descendants of those who colonised and peopled the islands in the 18th and 19th centuries, and they ‘only’ have to count a few generations backwards to the arrival of ancestors. In 1810, when the British took the island from the French, Mauritius was dominated by an ‘educated’ and ‘cultured’ French white elite but the majority of the population constituted first-, second- or at most third-generation slaves. At the time the islands were kept by the British, it was not known that the worldwide British-French wars were over. Unlike the Caribbeans and Ireland where the land was owned by absentee landlords, plantation owners in Mauritius lived locally. The local western elite was already established by 1810, there was no mass immigration to the island from Britain, and no new elite groups immigrated here. The Empire was represented only by just enough administrators to ensure political and military supremacy. The treaty and the policy of the new rulers allowed the local elite to keep its wealth (including land ownership) and customs (including language). The first governor Robert Farquhar set the tone of the relationship between the 8,000 upper-class Franco-Mauritian Whites and the tiny layer of British above them. In this respect Teelock writes:

> [H]e carried on his campaign to promote the interests of Franco–Mauritian colonists while in Mauritius, his policies and attitudes had become so imprinted on Mauritian society that colonists expected succeeding Governors to adopt his style and conciliatory attitude towards them. […] despite hostility between British and French camps, there was an underlying common agenda which was worked out and established in the early years of British

rule. (Teelock 1994, 31-32)

After 1810, the economy decided the fate of Mauritius. Under British rule, land lost its strategic importance and any reason for subsidies. The new Crown Colony was expected to support itself through a tax system and the island was transformed into a monocrop sugar cane economy that proved to be viable until the 1970s. This was a kind of economy that could prosper under the protection of the British Empire. This meant that everything other than sugar had to be imported to the island including staple food (rice), industrial products (clothes, machines) and workforce (labourers). Until 1827, this economy was based on a continuing illegal but lively slave trade (Allen 2001; Chenny, St-Amour and Vencatachellum 2003). Between 1811 and 1821 at least 30,000 slaves were illegally brought to Mauritius (Allen 2001). The previous farming economy disappeared to give space to colossal sugar estates where slaves were sold or hired out and redistributed (Teelock 1994, 133). *Paul et Virginie* by Bernardin de Saint-Pierre, first published in 1787, offers an idealised and romantic version of life in times of slavery. In reality, slavery in Mauritius was particularly cruel (Jumeer 1984, 19; Vaughan 2000; Valentine 2000; Teelock 2001, 121). Slaves were brought to Mauritius mainly from East Africa and Madagascar and to a smaller degree from India and West Africa. The mortality was about 25% pre-embarkation (Allen 2001). During the sea voyage the mortality of the slaves varied by distance between 10% and 25% (Allen 2001; Allen 2003). In Mauritius "[m]ost sugar slaves faced a short, hard and stressful life (Teelock 1994, 22)". The owners of these large estates could become incredibly wealthy but sugar was a volatile industry and bankruptcies were common. The oligarchy became an agro-commercial bourgeoisie (ibid, 88).

Unconvincing British efforts to diminish the slave trade and the rise

of the free coloured population were important factors in creating a relatively united and homogeneous white Franco-Mauritian society. The French speaking ruling class was even able to open an office in London and actively lobbied in order to win the support of a few members of the British Parliament (Burroughs 1976; Teelock 1994, 29). Literacy was the privilege of a few in a country where the entire press was in French.

Slaves of the West Indies and Mauritius were freed on 1st August 1834. "On the day of emancipation, there was little joyous celebration. Slaves felt they had been deprived and cheated out of emancipation because they were still forced to work for the same owner for no pay" under the so-called apprenticeship scheme (Teelock 1994, 331). It was not until five years later, on 31st March 1839, the apprenticeship finished. 53,230 apprentices were freed, 46.3 % of the total population of Mauritius at the time. While the ex-apprentices were given nothing, £2 million was given to Mauritian slave owners as compensation in 1835. The British Parliament thereby generously rewarded the estate owners whose slave 'ownership' was largely based upon illegally smuggled slaves during the early British period. They swiftly re-invested the acquired capital to the sugarcane economy, for example buying even more land (Teelock 1994, 331). The small-scale slave owners, including many 'poor' whites, were badly hit.

The events between 1810 and 1839 established a colonial comradeship that persisted throughout the subsequent decades, particularly until 1945, and to some extent until today. The British administration relied upon local, mainly white and to lesser degree mulatto elites, continuing the base of domination in the society that had formed during the French period. The local elite and mostly the local Whites occupied the key posts in the administration (Boudet 2004, 68). Common interests were shared between the British colonial administration and the local, predominantly White Franco-Mauritian

plantocracy. Running the colony depended on the co-operation of British colonial power and the local Franco-Mauritian elite, since the local French plantation owners needed credit from London banks in order to support their business (Storey 1997).

These Franco-Mauritians landowners were different from the ordinary Whites in the French period, because of their enormous economic power. Their wealth became concentrated. The number of sugar mills increased steadily until 1830 to several hundreds, but after that time, decreased considerably (today there are about 10) (Brookfield 1959b; Allen 1988; Rouillard 1990, 34; North-Coombes 2000, 64-69; Teelock 2001, 304). After 1830, peripheral, less profitable lands were sold in two stages; in the 1840s, during the *petit morcellement* and between 1860 and 1890, during the *grand morcellement*. Those lands ended mostly in the hands of Indo-Mauritian small planters.[2]

As a response to the electoral democratisation in the 1950s, a few thousand less well-off Franco-Mauritians left for South Africa, mainly to Natal (Bullier 1981). Being afraid of the 'Indian peril' before the declaration of independence in 1968, many Mauritians, especially *gens de couleur* emigrated as well, mainly to Australia. However, the richer segments of Franco-Mauritians remained, and as their wealth was not nationalised after independence in 1968, they continued to play an important role in the island's economy although they now comprise less than 1% of the population. They still own the majority of the sugar estates and after the diversification of Mauritian economy from the 1970s they successfully invested a part of their capital in the tourist industry. After the end of apartheid in South Africa, many people of Mauritian ancestry returned to Mauritius.

Less well-off whites might have taken the opportunity to marry into

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[2] The arrival of Indo-Mauritian labourers will be discussed in the next section.

the rich(er) *gens de couleur* families. This meant *déchéance*, decline, a loss of white privileges and being outcast from 'white circles' (Arno and Orian 1986, 64). Racially based endogamy has been permanently important in Mauritius to sustain social and economic supremacy, as even very recent ethnographic fieldwork evidences (Salverda 2010). The key to maintaining a 'pure' stock has been based on the control of the sexuality of white females (Arno and Orian 1986, 128). Setting up strict colour boundaries had a pragmatic economic rationale in excluding potential competitors from the uppermost echelons from the society and keeping the size of this layer small. The poorer members of the community, often members of a very large extended family, were helped out financially if they kept the rules of racial endogamy (Boudet 2004, 68). Knowledge of genealogy became extremely important among Franco-Mauritians (Salverda 2010, 167; see the works of Courtaux 1892; Le Juge de Segrais 1914; Lincoln 2000; or the works of *La Société de l'Histoire de l'Ile Maurice*). The custom of cousin marriage has also been accepted practice among Franco-Mauritians (Salverda 2010, 166). During Salverda's fieldwork in 2005-2006, the results of a questionnaire showed that "76.2 percent of the Franco-Mauritians opted for another Franco-Mauritian partner, […] [and] 14.8 percent had a foreign partner – most likely, all white" (2010, 164). South African and Australian Whites could be acceptable marriage partners, although they are English speaking. However, marrying someone from the nearby Reunion island (a French territory) used to be perceived as potentially 'contaminating' as Reunion whites are considered less strict about ethnic boundaries and more lenient towards *metissage* (mixing). During my fieldwork, a Franco-Mauritian disclosed to me the 'secret' that once in the history in his family there was a stain, meaning, one of his many ancestors was 'black'. Consequently, although their family looks white and he had important roles in the management of the Catholic church, they have not been accepted by

many Franco-Mauritian circles. His partner, a ‘pure’ Franco-Mauritian had to put up with this hidden predicament. Although such attitudes continue to prevail, liberal families are increasingly challenging such exclusivist practices.

The term ‘General Population’ was used for census purposes. This excluded Indian and Chinese immigrants (the later Indo- and Sino-Mauritians) but included groups that were distinct and differentiated in Mauritius. Within this category there was a strict colour line between whites and ‘non-whites’, and a fluid boundary between affluent *gens de couleur* and the rest of the Creoles (they could be called Afro-Mauritians but this term is not in common use in Mauritius). The difference between the latter two groups was originally constructed by who was a slave and who was free, which often corresponded to the fact of who had and who had not only Black African ancestors. Subsequently, wealth, education, language use and phenotype (the darkness or lightness of skin colour, and straightness or curliness of hair) became the combination of features that create the difference. Within the General Population group, which has fluid internal boundaries, the mechanism of *blanchiment* became attached to upward social mobility. In particular, the elite second next to the top, the *gens de couleur* tends to use the process of *blanchiment* (becoming White or Whiter) through the careful choice of marriage partner (Arno and Orian 1986, 91; de Gentile 1996, 203; Boudet 2004, 298). From the perspective of *gens de couleur*, the “lighter-skinned individuals are higher up in the pigmentocracy of Mauritius” (Boswell 2006, 56). Marrying a white spouse can be a symbol for upward mobility for a Creole, with the chances that the children’s skin colour might be lighter (Salverda 2010, 216).

Finally, the lines within the small ‘White’ group have been segregated. The parallel rivalry and co-operation between colonial elite groups also resulted in segregated social lives. Up until the end of World

War II, British colonial policy was usually characterised by pragmatism and paternalism but also by blatant racist views according to today's standards. The words of Edward Twining, an influential colonial administrator in Mauritius from 1937 until end of World War II, who occupied several key positions in the Mauritian government and worked for the M16 intelligence service to mobilise Britain's effort during the war years in 1944, can illustrate the circulating imperial attitudes (cf. Jackson 2001, 111):

> At any rate I pity him [the Governor] as it is one of the most difficult Governorships in the Empire. The French, Coloured, Hindo, Mahomaden, and Chinese communities all hate each other. The French try to keep control of all their ill-gotten gains through the exploitation of slave labour. They have deteriorated physically, morally, and mentally. They hate us and are pro-Vichy. The coloured people are accomplished, clever, inconsequential, degenerate, the descendants of ex-slaves. They despise us . . . The Indians are a miserable lot, weak, lazy, Indian. They distrust us. The Chinese are just parasites . . . The English – well they are beyond description and deserve all they get.

The anthropologist Benedict (1961, 36, 47) and the geographer Brookfield (1958; 1959a) in the 1950s indicated that about 10,000 Franco-Mauritians and circa 500-1,000 Britons lived in the island at the time, but the two groups hardly socialised with each other either. [3] Even the Britons were divided in two further groups – traders and administrators – in contrast with each other.

The rise of Indo-Mauritian elite, the evolution of segregation, and the transformation of caste

Due to a labour shortage caused by the presumed 'too high' labour

[3] The overall population was about half a million people at the time.

wages of the emancipated ex-slaves, the British Empire favoured the recruitment of Indian labourers to work on the Mauritian sugar cane plantations (Carter 1995).[4] Mauritius pioneered the indenture system, which was later extended to the Caribbeans, Guyanas, Malaysia, Fiji and elsewhere. Mauritius also absorbed the largest immigration wave of this kind. The import of indentured labourers began in 1839 and forty years later Indo-Mauritians formed nearly 70% of the country's population; this percentage remains the same today. The labourers were recruited from poor, mainland agricultural areas, and from illiterate agricultural working castes. The largest group came from an area in North India, which is today western Bihar and eastern Uttar Pradesh. They spoke the local Bhojpuri language. Although many of them were Sunni Muslims, the majority was Hindu. Tamils and Telugus were also recruited from South East India and Marathi speakers from an area east of Bombay.

The indentured labourers were not slaves but they lived in restricted and brutal circumstances, which were nearly as bad as those under the previous slavery system. At the beginning, only males were recruited. Later, a proportion of women was recruited as well. The treatment on the plantations was so harsh that the Empire suspended recruitment after a few years then instituted a government-regulated system of recruitment and transportation. Only three Indian ports, Calcutta, Madras and Bombay were allowed to be used for the departure of labourers. Upon arrival, the labourers were briefly held at a depot, given an individual number, and then swiftly distributed to employers, principally to the sugar estates. They had to sign unbreakable contracts that bound them to the estates for one year (and later for five years). One third of the labourers returned to India afterwards. An identity pass system was introduced only for the Indian labourers, at their own cost. Indians without passes were labelled

[4] This section is mainly based on the work of Carter (1995).

as ‘vagrants’, captured by the police, and kept in vagrant depots. The passes were subsequently embellished with photographs. By 1873, 129,617 photos were filed in 21 vast albums when the Indian population in Mauritius was about 220,000 people.

In the estates, the labourers lived in camps, and the expression *kan* (camp) became symbolic for a way of life. The camp was usually at a considerable distance from villages; thus, different segments of the population remained largely segregated. In the camps, conditions were poor. The employers – the estate owners – paid low wages but provided accommodation, clothing and food. There were many complaints about the provisions of the latter goods because the employers wanted to minimise expenses. The whole system was chiefly paternalistic and hierarchic. Males worked from dawn till dusk in the sugar fields six days a week. Any day’s absence from work, even for sickness, meant two day’s loss of wages; this was the infamous and hated ‘double cut’ system. Males had to provide a ‘certificate of non-marriage’, in order to get married locally. Unlike the time of slavery, females usually did not work in the fields; when they or the children did, they were paid much less. Females had to “concentrate upon their domestic tasks” (cf. Carter 1995, 242) and legislation was passed to place them under the control of their husbands or other male relatives. Runaway wives were brought back to their husbands with the help of the colonial police. Children rarely had the chance to attend school but they soon became involved in field labour; therefore, many from the young generations grew up illiterate until the end of World War II. The treatment of the workers in the field was often harsh. Physical punishment or abuse by the owners, or more frequently from the entitled overseers was commonplace. The overseers, *sirdars* who occupied intermediary positions, were somewhat better paid and acted as interpreters both in real and figurative senses. It seems that mainly they were able to save enough money after a few years to buy some small

peripheral land.

The estates became small, isolated worlds. The white owners lived in mansions or in urban areas; they socialised only with their peers, or other white inhabitants of the island. The Indian labourers had to live in camps, miles away from villages and the mansions, with very limited opportunities to leave. In between, both socially and spatially, an intermediate class of usually middle and upper-class Creoles lived in or close to the estates. They were excluded from the white circles and they excluded the Indians from their own circles. The ex-slave poor Creoles and their descendants, the Afro-Mauritians, often moved to coastal villages and took up the occupation of fishing, or moved to Port Louis and worked in the docks.

In the late 19th century, Chinese traders and shopkeepers settled in Mauritius from the Kwantung district in South China. They were mainly Hakka speakers from North Kwantung and some Cantonese speakers from South Kwantung (Ly Tio Fane-Pineo 1985, 93). The last major immigration wave was a small group of wealthy traders from Gujarat who formed an Indian Muslim elite. They were divided into two Sunni sections: the Gujarati-speaking Surtees, and the Kutchi-speaking Mehmans (Rajah-Carim 2004; Atchia-Emmerich 2005, 94). Thus, the ethnic composition of Mauritius was set by the beginning of the 20th century and has not changed much since then.

Despite their numerical majority, Indians were excluded from any political power. When after a lengthy debate Mauritius was offered elections in 1886, such limits were set that from the population of 360,000 (including 250,000 Indians) only 4,000 inhabitants (including less than 400 Indians had the right to vote (Buckley 1975). The British governor from 1883 to 1889, Irish-Catholic Pope-Hennessy, asserted: “[Indians] are foreign to our style of politics; they have certain customs and usages of their own, in some respect perhaps more rational than ours;

but, at all events, they are not in our political system" (Pope-Hennessy 1964, 240).

The 20th century brought the rise of Indo-Mauritians, symbolised by Mahatma Gandhi's visit in 1900. During his visit he was still mainly accommodated by his fellow Gujarati compatriots, elite Muslim traders. In the first decades of the century, the increasing consciousness of Indian Nationalism penetrated Mauritius. The Arya-Samaj movement played a very important role in this. The first free elections after World War II resulted in a Hindu Indo-Mauritian dominated government. The expression 'Hindu' requires special attention (see also Appendix 1) as in Mauritius it is colloquially used for those Indo-Mauritians who only have North Indian Hindu ancestry, and it often equates with the term 'Indian'. Thus, the blurred, manipulative and contradictory semiotics of this categorisation often, but not always, or at least not always fully, means that some groups are excluded from being 'Indian'. Indo-Mauritians of South Indian ancestry, even those who follow a branch of Hinduism, are often excluded from being Hindu or even being Indian because they are not of North Indian ancestry. Most Muslims' ancestors came from North India but they can be marginalised because they are not Hindu. Christian Indo-Mauritians can be excluded in the same way. Having deducted all people from the latter three groups, 'Hindu' inhabitants, in this restricted sense, still have a slight numerical majority in Mauritius: there are more Hindus than all the other groups together. The split between Indo-Mauritian groups after 1945 was largely caused by the global effect of South Asian history, especially partition of India and Pakistan. By the 1950s, most political parties within and outside the parliament and the government took 'ethno-religious-racial' dimensions. This system is known in Mauritius as 'communalism'. In effect, all large Mauritian groups are very divided but this is usually only known inside their group, while the other constructed groups often see each other as monolithic.

Because of the established three-member constituency system, small groups stand no chance at the elections on their own; therefore, the history of Mauritian party politics since the 1950s to date is about fluctuating, seemingly unstable coalitions and alliances. It suffers from fractionism and occasional dissidents who join up with a previous 'enemy'. The groups who are smaller in number, for example Muslims, Tamils, Sino- or Franco-Mauritians are attracted by all sides and often change their loyalty. Typically, there has been one governing 'Hindu' party (typically the Mauritian Labour Party, *Parti Travailliste*) and one 'Creole' party (typically the *Parti Mauricien Social-Démocrate*, PMSD) in opposition. The political system complicated since the 1970s with the emergence of two new forces, the *Mouvement Militant Mauricien* (MMM), an originally Marxist party and its breakaway offshoot, the *Mouvement Socialiste Mauricien* (MSM), which in fact is mainly the party of somewhat less affluent, middle caste (but not always middle class) Indo-Mauritians.

'Inter-community' marriages are rare; as Nave pointed out (2000), second generation children of 'mixed' marriages tend to be assimilated in one or other parent's original group. Nave's study in Mauritius in 1996 demonstrated that 70% of university students hoped for an endogamous marriage, and with the consideration of parental consent this rate went up to 84%; meanwhile, class preferences were less dominant. Caste is one of the most significant but also one of the most taboo issues in Mauritius. It determines the life of many Hindu Indo-Mauritians who usually keep it confidential but is almost completely unknown or ignored by ordinary Mauritians of other backgrounds. One of my Creole informants lived with an Indo-Mauritian partner. Both were divorced. After several months and many informal talks, I dared to ask him about his partner's caste belonging. He was surprised but wanted to satisfy my interest. He answered, hesitantly, "*Mo sipoze, li gran nasion"* (I suppose she is of

high caste), then expressed his desire to change the topic. The emphasis here is on the element of surprise and I think he simply did not know. In Mauritius, convivial partners can live together without being aware of the depth of each other's consanguine, clan or caste group's internal details and their relevance. Although the colonial recruitment of labourers targeted agricultural castes, the Indian labourers brought with themselves relative caste diversity. It has been suggested that in many post-indenture Indian Diaspora settings, the caste divisions tended to reduce to a dichotomy (priest versus non priest) pair (Mesthrie 1990). This is certainly not the case in Mauritius. Since indenture, there has been a level of levelling but the fundamental concept and allocated social practice of caste has not disappeared. On the contrary, it has strengthened lately.

The caste of North Indian Hindus was among the personal details recorded by the colonial administration. These ship records, however, are now held in the archives of the Mahatma Gandhi Institute and access is very restricted. Indo-Mauritian citizens, if they know their ancestor's indenture number have the right to request the records. It has been rumoured that the ancestors' caste belonging is not disclosed (it is blacked out in the photocopy) but the assistants can 'whisper' it into the ears of the offspring. A few researchers (Benedict 1961; Carter 1995; Chowdury 2008) had access to the details of the ship records. Benedict described the state of castes in the mid 1950s (Benedict 1961, 20). The upper two varnas (Brahmins called *Maraaz*, and Ksatriyas called *Babooji* in Mauritius) are about 10% of the 'Hindus' and separate themselves from the rest but form alliance with each other. 'Low castes', equivalent to Sudras in India, are divided in two large groups (the *Raviveds* and the *Rajputs*) and form together about one third of the 'Hindus'. The Vaisya middle caste is the only one which is more clearly divided in subsequent jaatis. Most top leaders of the country, the first prime minister (later president), the second prime minister (currently president) and the sons of

both (one of them is currently prime minister, the other is the head of another party in the governing coalition) have come from this group. Political strife in the independent Mauritius often mirrors underlying caste rivalries, for example between the *ahir* and *kurmi* jaatis, one being the jaati of the first prime minister, and the other of the second prime minister. The caste issue as a whole is usually regarded as taboo. It has been known since the availability of Benedict's biography (2000-2001) that the first anthropological work on Mauritius, carried out by himself in the mid 1950s, was commissioned by the Colonial Office in London. However, when Benedict's work appeared in Mauritius it caused mayhem, partly because he had described a ritual of animal sacrifice, associated with the so-called low castes. While doing so he did not just describe the caste system as an ethnographer; he explicitly analysed a custom which is not 'pure' Hindu and the existence of which is denied or glossed over by the elite Indo-Mauritian groups. Finally, he was denoted a *persona non grata* to enter the country in 1974 by the first Prime Minister, Seewoosagur Ramgoolam (ibid, 123-124). In public, it is politically incorrect to ask or to mention people's caste. As a contrast to this tendency, a recent book demonstrated that members of parliament mirrored the caste proportions in their constituencies (Chazan-Gillig and Ramhota 2009, 288-379). This book was banned from sale in bookshops at the time of my fieldwork. Nevertheless, my observation and the comments of my informants coincided with its finding. During the 2010 national elections, at the time of my fieldwork, the candidates of both competing alliances, including the MMM, which gave up many of its original principles and joined the ethos of *Realpolitik*, were designed by the ethno-religious and caste set of the area.

Categories in Mauritius: pragmatics and

controversies

In June 2011, at a conference on Mauritius in Leeds, the participants and speakers formed two groups as usual: Mauritians and foreign experts specialising on Mauritius. At some point, well into the day, some foreign experts began challenging each other about what they meant by using certain categories to describe certain groups of Mauritian people. If someone in the role of an 'expert' says Indian, Indo-Mauritian, Creole, *Kalkattiya*, or Muslim etc., these expressions can be easily put under attack by other experts. The speakers soon became defensive, acknowledging the right of the audience to challenge their intervention, but also calling for a pragmatic attitude as if saying, 'well, we still need to read these papers and continue speaking to each other somehow'. The non-Mauritian participants started mentioning words and expressions like 'odd', 'bizarre', 'perpetuated' concerning the Mauritian categorisation system(s). After some debate the internal solidarity among the researchers won, they agreed that this contradiction could not be resolved but the academic event must continue. The Mauritian participants were listening with interest and tacit smiles, as if silently saying, 'Well guys, this is just the way it is'. It has been mentioned several times in literature on Mauritius (for example, Benedict 1962; Mannick 1979; Lee 1999) that Mauritians abroad call themselves 'Mauritians' and share a sense of commonality in mixing together: they speak Creole, enjoy sega and eat Mauritian specialities together.[5] In contrast, multiple divisions and a plethora of self-identifications prevail in the home country where they tend to call themselves (and others) terms like *malbar*, *laskar*, *madras*. Adele Smith Simmons writing about the history of modern politics in Mauritius summarised the situation like this:

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[5] Sega is a Mauritian dance.

> In a small society where anonymity does not exist, status is ascribed rather than achieved. Some Mauritians try to change community by changing names, but no one can escape his or her family tree. Who one is and who one's relatives are often matters more than individual merit. […] Although it may sound as though everyone knows everyone else on Mauritius, they do not. Paradoxically, the small and 'gossipy' island maintains, still, divisions that obstruct a real understanding among its various communities. Because they do not live together, and because they rarely mix except at official functions, Mauritians generally have had little understanding of class and social differences within communities other than their own. […] [G]enerally each community has a stereotyped and monolithic impression of the other. […] The lack of understanding of another's community, combined with the tendency to view others in derogatory terms, leads to an atmosphere of suspicion and distrust… In this situation, communal loyalties dominate. (Simmons 1982, 14)

Speaking with Mauritian people in Mauritius one would quickly note that people use various sets of categories to refer to their identity and the presumed image of the 'others' is a frequent part of daily life and communication. Most people do use some sort of categorisation system about themselves but despite their obvious overlap, those systems do not match perfectly with each other. Even the same person may use different systems in different moments and occasions and the systems are full of apparent 'contradictions' for an outsider observer.

The fact that categories exist and their use is particularly frequent and important in Mauritius is a *fait accompli*. These categories, however, are not neutral but are associated with stereotypes. The words of Malcolm de Chazal, a famous Mauritian writer is often quoted to illustrate this (2004[1951], 9-10):

> L'île Maurice est un pâté de roches dans l'océan Indien où, sur un fond de colonialisme négrier, vivote une pseudo-civilisation dont chaque communauté de l'île revendique le monopole…Ce pays cultive la canne à sucre et les préjugés. Sept mil blancs, sur une population de quatre cent soixante mille, y ont installé leur hégémonie et leurs idéaux…. Dans cet enfer tropical, personne ne

> rencontre personne – hors des castes, des familles, des croyances, des franc-maçonneries du sang, tout est tabou. Voici une Ligue des Nations où la guerre des préjugés est endémique et atroce, surtout pour ce qui est du préjugé de couleur.
>
> (Mauritius is a pack of rocks in the midst of the Indian Ocean where, based on slave colonisation, a pseudo-civilization is muddling through and each community claims monopoly... What this country is producing is sugarcane and prejudice. Seven thousand Whites in a population of four hundred and sixty thousand have imposed their ideas and hegemony … In this tropical hell, no one knows another person - outside caste, families, faiths and Freemason blood, everything is taboo. This is a League of Nations where the war of prejudice is endemic and atrocious; particularly what concerns the prejudice of colour.)[6]

In Mauritius, the topics of identity and stereotypes have drawn the attention of anthropologists not only from the 1950s (Benedict 1961) to the 1980s (Eriksen 1998) but also continuously including the last two decades. Ari Nave (fieldwork in 1994-95) (Nave 1997; 2000) and Lynn Marie Hempel (fieldwork in 1997 and 2000) (Hempel 2003; 2009) addressed the topics of ethnicity and identification in the Mauritian context with methods of current sociology, sociopsychology and anthropology. They found that ethnic identification is paramount in Mauritius even nowadays. For example, Nave found in a large sample of university students that they preferred marriages based on ethnic-racial-religious-caste endogamy in 91.7% of cases. Consequently, Nave made clear his own political view and actively attacked the best-loser system, which requires candidates to declare their ethnicities in parliamentary elections (Nave 1998). The question remains, however, if one is critical towards the categorisation and the associated practice, what kind of categories could one use instead? Suggestions for reforms can implicitly take the whole system for granted. The Dalit movement in India, for

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[6] My translation.

example, is fighting for better treatment for untouchables. However, achievements for positive discrimination of untouchables in schools, workplaces, and politics would implicitly accept the caste system as a whole. It is different when one addresses the particular labels with their, often distorted, semantics than when one addresses the existence of the system as a whole. Only addressing both can lead to real deconstruction.

The subsequent definition of Mauritian ethnic-racial-religious-caste category could be the following: a dynamic but more or less stable subjective feeling of belongingness to a group, the in-group, excluding certain others who do not belong to this group, and excluding oneself from belonging to other groups. This emotional belongingness typically coincides with the economic interests deriving from the mutual economic aid and preferential support dominant within the group. This would not exclude mutual aid with people from other categories just setting it to a lesser limit, advantage and emotional satisfaction. The belongingness, frequently but not always, is associated with a notion of extended kinship, or potential kinship formation. Kinship groups typically prescribe preferences and rules about marriage (and similar partnership) and the belonging of newborn children in marriages. Finally, the in-group markers are often features of bodily phenotype but can be, in combination, symbolic signs or symbolically interpreted cultural practice too. I would argue that accent or the way of speaking language(s) form part of bodily phenotypes as well, as the sounds are produced by the sound organs. Therefore, the phenotype can be not only visible but audible (and olfactory and tactile) as well.

Eriksen summarised some circulating stereotypes, that is characteristics of one's own ethnic group and characteristics of others (1998, 54, see Appendix 2). To describe these stereotypes he also had to use an arbitrary list of category labels. Eriksen highlighted the interlocking nature of these stereotypes, pointing out that the individual

adult might have some agency to modify or disregard encultured identities he or she had been brought into during childhood, but influencing the stereotypes of others about him or herself is much more difficult. Individual agency is usually weak against the shared stereotypic cognitions of large and dominant groups of people around the possible outstanding individual. Therefore, individuals tend to drift to counter-groups, looking for counterweights to challenge the perceived negative stereotypes. Not surprisingly, individuals bother much less about perceived positive stereotypes in their regard. If an enlightened Mauritian individual adult might reach the point of not taking for granted the (complicated and controversial but lively) system(s) of surrounding typologies and intend to consciously ignore, disregard, deconstruct or challenge his or her own ideas this freedom would be limited. Other individuals, the members of both the in-group and the 'Others' would keep holding the same stereotypes towards the person who intends to 'free his or her mind'. In addition, an ideal free runner must continue to observe the surrounding unchanged social interactions and adapt to its reality.

Bourdieu posited (1991, 223) "[t]he act of categorization, when it manages to achieve recognition or when it is exercised by a recognized authority, exercises by itself a certain power: 'ethic' or 'religious' categories […] institute a reality by using the power of revelation and construction exercised by objectification in discourse". Brubaker and Cooper (2000), based especially on Bourdieu's previous works, suggest a differentiation between 'categories of practice' and 'categories of analysis'. The term 'categories of practice' can be similar to other terms like 'folk', 'native', or 'lay categories'. These categories entail emic terms and expressions that the 'people of the field' tend to use to group phenomena. In contrast, the categories of analysis are the terms the social scientists use, in an etic manner. In Mauritius, at first it seems clear the

local categories of practice are contradictory and illogical but the problem is that most potential ‘categories of analysis’ do not offer a solution to the problem. If ‘official’ and ‘unofficial’ categories exist simultaneously, which the situation is in Mauritius, one could be tempted to believe that the official categories are closer to the ‘scientific’ ones. However, at least in the presented example, it is obvious that the official categories are just as ‘illogical’ as the ‘lay’ ones and are quite close to them in effect. On one hand, the Mauritian categorisation systems seem to be complicated, illogical, contradictory, historically embedded (‘traditional’, or ‘perpetuating’) and abused (for example, by some ‘nasty’ politicians). On the other hand, they are extremely important and in general used (including contested usage) in Mauritian daily life; they are literally inevitable.

In Appendix 1, I present a few official, popular and anthropological categorisation systems. The evidence of their illogical nature has not steered me to find the ‘real’, the ‘right’ system. In the thesis, like many other researchers, I will use local descriptive expressions. However, in the meantime, I will remain critical about the underlying and occasionally abusive ‘metagrammar’, subsystems of systems, to pinpoint some elements in this process that cause suffering in Mauritian society.

Summary

The reasons for the current diverse linguistic picture are grounded in the history of the country during the time of slavery under French and British rule and during the time of the arrival of indentured labourers from the British Empire in the 19th century. The linguistic diversity is based on and accompanied with the structure of an ethnically and religiously diverse society. Even the units of this diversity, the denoted categories of description or analysis can be a matter of an ongoing

dynamic dispute among social actors within Mauritius and the source of practical and ethical dilemma for researchers.

Chapter 3. Languages in Mauritius

Introduction

The strikingly diverse language situation of Mauritius has attracted researchers for a long time. In the theoretical context of the theory of linguistic capital, the present analysis will focus on Mauritian Creole, Mauritian Bhojpuri and Mauritian French and on their interferences and interplay. Special emphasis will be put on the orthographic disputes, literacy and education, and the overarching rivalry and invisible comradeship among postcolonial elite groups interested in preserving a situation that, in combination with other social factors, prevents people from improving their social and mental well being.

Multilingualism in Mauritius

Nearly every Mauritian citizen shares one common language - French based Mauritian Creole, but this language is excluded from many significant and prestigious settings. The official medium of state education is English but primary education is usually trilingual, English-French-Creole. Six to eight 'oriental' languages are also taught in schools (Bunwaree 2001; Sonck 2005). Monolingualism is virtually nonexistent; even bilingualism is rare and appears only in Creole-French form. Creole-French-English trilingualism is frequent; sometimes among Sino-Mauritians and Indo-Mauritians tetra and pentalingaulism (Creole-French-English-one of the Chinese languages, Creole-French-English-Bhojpuri or other combinations) also occur. There are even examples of

hexa- and heptalingualism (Stein 1982). The unique composition of Mauritian multilingualism can only be understood in a historical context.

As there was no indigenous population in the island, subsequently no language can be appointed as representative of a primordial claim for the territory. Mauritius has been continuously inhabited since 1721, in the first decades by white French slave-owners and black slaves. The establishment of diglossia between the colonial, typically Indo-European H(igh) language (acrolect) and the local L(ow) Creole (basilect), lexified by speakers of the dominant colonial language, developed just like many languages in other areas of the world after the 16th century (Bickerton 2002). This diglossia was a French – French based Mauritian Creole diglossia.[7] It is notable that between the strata of ex-slaves and ex-slave-owners there was a mixed social layer made up of Mauritius-born people of mixed African and European progenitors, manumitted ex-slaves and free artisans, and other immigrants mainly from India. The attitude to languages amongst this quite influential middle range and often middle class population, and their intentions and motivations to use either French or Creole, have been important elements in the complex picture of language in Mauritius up until the current day.

From the British conquest in 1810 until 1839, the linguistic situation meant a practical co-existence of the French acrolect, the Mauritian Creole basilect, and the English used by the new British administrators. Yet, this situation changed dramatically in the mid 19th century with the arrival of the indentured labourers and their manifold native languages from the Indian subcontinent. By the late 19th century, the use and role of languages in British colonial Mauritius had stabilised with Mauritian Creole as the overarching lingua franca and French as the prestigious acrolect. English was deployed for law, administration,

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[7] See more details about this diglossia in a later section (page 60, 73).

education and trade, and a wide range of Indian languages, led by Bhojpuri, were used for the domains of private life and religion. By the middle of the 20th century "[the] multiplicity of languages found in Mauritius [was] a factor emphasising and reinforcing the separateness of [ethnic] groups" (Benedict 1961, 33). Speaking Creole in an inappropriate context used to be a severe social blunder (Benedict 1961, 36). "Language [was] symbolic of upward social mobility. A rise in the social and economic scale in Mauritius often [led] to the abandonment of the local Creole patois, or of an Indian language, in favour of French or English" (Benedict 1962).

Today, the constitution of domains in daily language is unique, complex and reflects some, but not all, social divisions (Chaudenson 1979; Atchia-Emmerich 2005, especially 126-189).

Creole is usually used with family members, friends, neighbours, servants and household employees, colleagues, especially subordinate ones in workplaces, people in the street (unless they are strangers), in the market, in most shops, with taxi-drivers and policemen, and in personal conversations. Muslims, Non-Bhojpuri Hindus, Afro-Creoles and Sino-Mauritians speak the most Creole. Despite its widespread use, the official domains of Mauritian Creole are very limited.

French is the preferred language in banks, post-offices, clubs, restaurants, private clinics, with office clerks, government officers, bosses, Catholic priests, and in reading and writing. Despite the diglossic French-Creole situation there is no domain where either French or Creole are absolutely dominant. Usually when one is dominant, the other still has important functions at certain times and for certain people. The mixing of two languages is commonplace, code-switching can be topic or attitude related and it can occur in the same sentence, sometimes even several times.

English is used with tourists, strangers (except Creole strangers),

teachers, and occasionally with friends. It is used in some business settings and it has a relevant role in offices, government institutions and court. Otherwise, it has a secondary or tertiary role after the two main languages. English words, phrases and expressions, however, play an essential part in typical Mauritian conversation, characterised by code-switching, code-mixing, and stylistic hints. Context specific code-switching and code-mixing among the four main languages are usual and widely accepted (Nadal 2002; Eisenlohr 2006, 111-167).

The oriental or ancestral languages in society are only used in specific religious contexts and in other solemn moments in everyday life. In addition to these, Bhojpuri and Hakka Chinese are still spoken in some family homes in the interactions between family members. Despite the infrequent practical usage, oriental languages have a high symbolic, emotional, identity-forming and political importance. The policies of the French and British governments have been rather different (Miles 2000). The local *L'Alliance Française* is the oldest branch outside France; it is much more active than the British Council and controls a far more generous financial budget (Tinker 1977; Eriksen 1998, 88; Atchia-Emmerich 2005, 39). Many scholarships have been offered to Mauritians to study in France for free, which includes courses at the nearby Réunion University. Mauritian authors publish a lot in French but there is very little locally published literature written by Mauritian authors in English (Mahadeo 2004).

In the 21st century, languages in Mauritius have kept their strong symbolic value representing membership to ethnic and other social groups (Atchia-Emmerich 2005).

Estimates based on Census (see Appendix 5) data suggest that 75% of the population speak Mauritian Creole as L1 (first language), 20% speak Bhojpuri as L1, and 4% speak Mauritian French (not the standard French of France) as L1. The huge majority of the people that speak a

language other than Creole as L1, are able to speak this language as L2, a second yet usually still fluently spoken language. In other words, more than 95% of Mauritians speak Mauritian Creole most of the time (Virahsawmy 2003). 80% of nursery age children are mainly exposed to Mauritian Creole during the prime time of first language acquisition (Rajah-Carrim 2003).[8] However, people responded differently in a self-disclosure study carried out by Atchia-Emmerich in 2001. 58-68% of respondents stated that their first language was Creole, 31-35% stated that it was French, and about 15% stated that both Creole and French were their first languages (Atchia-Emmerich 2005, 124-126). The author suggests that some respondents were unable to distinguish precisely between the two languages. Only about 3% of people said that their first language is Bhojpuri and 1.7% said that it is a Chinese language. According to this study, people speak Creole on average 45-55% of the time, except *gens de couleur* (35%) and Franco-Mauritians (15%). Atchia-Emmerich's study can be interpreted as an example for social desirability bias error in social science research. In reality, most Mauritian people speak Mauritian Creole in most of their daily utterances. This is what an objective recorder could detect. However, when the people are asked about their own language usage they distort the fact and claim they speak more French and less Creole because this is what they would desire (Eriksen 1998, 78).

The same study shows that people use Mauritian Creole as a written medium in only around 5% of cases, except for the Bhojpuri-Hindus and Tamils who use Creole in 25% of cases. People write 33-55% in French and about 45% in English except the *gens de couleur* who write less in English. Written Bhojpuri, Hindi, Urdu and Chinese appear very rarely (Atchia-Emmerich 2005, 127-135). During my fieldwork, I could also

8 This does not mean that the language of the nurseries is Mauritian Creole. See the parts of Chapter 2 on education.

observe that reading for pleasure seemed the privilege of the tiny intellectual elite. Most Mauritians read if they have to. On public transport, for example, I could seldom see people read besides a few occasions when student were reading textbooks. I was often asked to read out various texts for friends, for example letters from the Taxation Office. Few bookshops were found in the whole island. Most of them were combined with stationery shops and were almost only selling schoolbooks. The very few bookshops with broader selection typically offered imported non-fiction books in English and novels in French. Books in Creole were very rare even in these rare bookshops. I estimated that they consisted of about 1% of all book titles. I never saw any books for sale in shops in Mauritian Bhojpuri.

The only exception were a few books in Creole and a few in Bhojpuri available in the bookstore of the *Ledikasyon pu Travayer* (LPT, Education for the Worker), a leftist organisation. The political party associated to LPT has only ever attracted a tiny fragment of voters, but as promoters of the cause of Mauritian Creole they have done perhaps more than the Mauritian governments. They have published works of Mauritian writers, translations of major international literature, language books and an excellent Creole-English dictionary (2004 [1985]). Only very recently has a second dictionary of reasonable quality appeared (Carpooran 2009). LPT developed and applied a phonetic alphabet in their works. However, the respectful activity of LPT also represents a trap. Following the principles of their ideology, they have connected the promotion of Mauritian Creole associated with their political, Marxist-Trotskyist cause. Instead of becoming a shared common matter, Mauritian Creole and phonetic writing are linked with the cause of a leftist political party. Opponents of the democratisation of language use can ridicule such efforts, associating them with the LPT. Moreover, the activity of LPT is very “helpful” for many responsible institutions, including several elected

governments, as LPT have been doing the job, the development of linguistic corpus of the main Mauritian language, for the representative, executive power.

Language and ideologies in Mauritius

Eisenlohr (2001; 2007) identified three major contemporary ideological and political trends in Mauritius, particularly regarding the process of identity formation and nation building.

The first puts an emphasis on the French-Creole continuum, stresses that Creole is a near but subordinate (L or Low) variation of French, or uses the term *patois*, a derogatory expression for dialect. It emphasises the Francophone characteristics of the island and its languages, which bring it closer to other similar territories in the world, for example the Caribbean. This view has been the prevalent ideology of Francophone colonial and post-colonial elite groups and is backed by Francophone intellectuals within and outside Mauritius.

The second trend imagines Creole as a separate language from French with no hierarchical relation and emphasises the differences between the two languages. Proponents of this view, for example LPT members, point out that French was a colonial language and its use has been entwined with an unjust social hierarchy. They would promote Creole as the sole national language, "credibly fashioning Mauritian Creole as an autonomous language [that] emerges as a key element in a postcolonial nation-building project" (Eisenlohr 2007, 984). This is based upon the principle that vernacular language has a key role in the formation of a nation, and that the nation has the right to independence and autonomy. Such an approach in Mauritius is represented by political forces on the left that emphasise class rather than ethnicity.

The third ideological-political trend appeared partially as a reaction

to the first two. Some post independence elite groups, particularly Indo-Mauritians, hold that creolisation is a reminder of colonial relations and also a threat to the newly achieved dominance of Indo-Mauritians in the state apparatus and the 'purity' of cultural heritage. This view promotes not only ritual but also educational and media use of ancestral (or 'oriental') languages. It is ideologically close to the Hindu nationalist movements in India, "minimizing the temporal and spatial remove from India" (Eisenlohr ibid, 990), and imagining a cultural and linguistic purity in Mauritius. The position of Mauritian Creole is in the centre of the first two ideologies. The third also encompasses ideologies about Mauritian Bhojpuri, as Eisenlohr shows:

> [H]indu nationalists call Hindi the 'ancestral language' they stake claims for, simply 'our language,' and they sometimes maintain that Hindi is widely spoken among Hindus in Mauritius. This is done by categorising Bhojpuri as Hindi, erasing the important linguistic and socio-linguistic differences between Hindi and Bhojpuri and thereby appropriating a wide set of linguistic practices for the purposes of Hindu militancy" (Eisenlohr 2001, 54).

Subsequently, I will introduce the most important characteristics of Mauritian Creole, Mauritian French and Mauritian Bhojpuri. English and other ancestral languages spoken on the island such as Tamil, Telugu, Marathi, Hakka and Cantonese will not be discussed.

The road to the recognition of Mauritian Creole

Mauritian Creole is one of ninety-three Creole and eleven French based Creole languages (Ethnologue database).[9] Pidgins are the restricted contact languages or forms of communication between people who do not share a common language. This phenomenon was frequent in early modern slave societies. According to Derek Bickerton (1981), in the first

[9] https://www.ethnologue.com/subgroups/creole accessed 17/04/2014.

new generation where the children's first language becomes a pidgin, this language transforms, becomes re-grammaticalised and able to express the wholeness of human mind and soul. These newly born languages are the Creole languages, which share many similar characteristics across the world. These languages often borrow the majority of their vocabulary from one particular 'old' language. Those 'lexifiers' are historically often the languages of the previous slave owners and therefore typically Western-European or Indo-European languages. As mentioned above, eleven independent Creole languages are known today that had been mainly lexified by the French language. Bickerton's main study area was the English lexified Creole of Guyana. English-based Creoles, not only in Guyana but for example in Jamaica as well, have a multitude of intermediate variations between the standard, so-called acrolect English and the most extreme variations, which are unintelligible for average English speakers. This continuous spectrum is called the Creole continuum. In contrast to this, French lexified Creoles (mainly in the Caribbean but also in the Indian Ocean) have been described as representing examples for classic diglossia, with a spoken standard French and a local French lexified Creole without numerous intermediate variations. Some Mauritius related linguistic studies pinpoint the existence of Creole Fransize.

Syntactic characteristics of Mauritian Creole support Bickerton's hypothesis (Adone 1994, 24-37) and it has retained one of the most Creole typological features of all Creole languages (Grant and Baker 2007). One of the most striking features of Mauritian Creole is that it presents more similarities to Haitian Creole than to the Creole of neighbouring Réunion island (Baker and Corne 1982, 24; Baptise 2002). Rodrigues is part of the Republic of Mauritius, whereas the Republic of Seychelles is an independent country. Seychelles Creole is regarded as an independent language for political reasons, but the similar Rodrigues

Creole is regarded as a dialect of Mauritian Creole. The Mauritian Creole accent is distinguishable from both the Réunion Creole and Seychelles Creole accents (Haring 2003). Other Mauritian Creole accents are also distinguishable on regional, ethnic and class bases (Baker 1972; Rajah-Carrim 2004a).

Standard modern descriptions of the language were made by Corne (1970) Moorghen (1972) and Pudaruth (1993 [1972]) and Baker (1972). Baker's book from 1972 has been regarded as the best hallmark in Mauritian Creole linguistics. It is much less known that actually the first up to par linguistic description and analysis was actually made by the largely forgotten Roland Kiamtia in Wales as early as in 1959. In the last forty years, several hundred linguistic articles and studies have analysed scientifically the particularities of the Mauritian Creole language. Consequently, in spite of opposite claims in Mauritius, the fact can be stated without doubt that Mauritian Creole is a language for the world.

Mauritian Creole has been profoundly described by linguists but its linguistic characteristics are hardly known by its speakers. The linguists who have researched Mauritian Creole have usually worked and lived abroad. Mauritian Creole has not been a subject to study or to teach in Mauritius, except a recent vague initiative that will be mentioned in the section on Education. In the University of Mauritius or in the Mahatma Gandhi Institute there is no dedicated department set up for Mauritian Creole. There is no extensive corpus of literature in Creole, but sporadic written records are available since the very beginning, virtually since the birth of Mauritian Creole. The first written record of the Creole words "*moy fini mouri"* (I have died) is from 1734, from the time of the first generation after the re-occupation in 1721. A whole sentence was recorded by Grant, a French planter of Scottish descent in 1749 (Baker and Corne 1982, 247). The first catechism was translated and published in Creole in 1828 and the first descriptive language book (by Charles

Baissac) in 1880. The New Testament was translated into Creole by Samuel H. Anderson in the 1880s. Sixty shorter and longer Creole texts in total have been found from the time before 1930 (Baker, Fon Sing and Hookoomsing 2007).

One of the major obstacles to a wider use of Mauritian Creole is the lack of written or orthographic standards. Linguistic standards never grow 'naturally'; they are made. They are about the making of arbitrary decisions based on different grounds. Despite written records since 1734, an acknowledged standard still had not been put in practice in 2010, the time my fieldwork. A breakthrough seemed imminent in the late 1960s, when a Mauritian writer, Dev Virahshawmy published a series of articles proposing a phonetic orthography based on one of the spelling systems designed for the closely related Haitian Creole. This was the first such attempt. Virahshawmy himself launched at least two further refined suggestions. Another was used by Baker in his seminal book and another was developed by a working group of the LPT. A Mauritian linguist, Vinesh Hookoomsing made a new proposal for a harmonised orthography (*grafi larmoni*), which could be downloaded from the government's website.[10] None of them are perfect and each of them embrace minor inconsistencies, but most newer versions seem to be good enough to arbitrarily choose one of them and close out the never-ending disputes. Until the time of the research none of the proposed writing systems had been accepted in unison by all members of the pro-phonetic side.

The phonetic principle is simple, one letter symbol stands for one and only one sound, and one sound is written for only one letter. The ideal practical solution is when these letters are chosen from those letter

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[10] http://www.gov.mu/portal/site/education/template, accessed on 15/03/2010. This website has been changed to the latest but almost unchanged orthographic suggestion *(Lortograf Kreol Morisien*) compiled by Arnaud Carpooran (http://www.gov.mu/portal/goc/educationsite/file/Lortograf%20Kreol%20Morisien%20upd.pdf . (Accessed on 24/05/2012).

symbols, which are easily available since the global diffusion of modern press. None the less, it is almost impossible to apply this rule for any real language completely; partly because of the ubiquitous internal variations in each language. However, attempting to make orthography relatively close to the above rule is possible. The benefit of this application is tremendous; alphabet writing in this way makes the acquisition of literacy fast and easy for the new generations. In countries where the phonetic orthographies are established, six-year-old children are able to learn to read within a few months. The time of the attempts to use phonetic writing in Mauritian Creole is usually counted since the suggestion of Virahshawmy in 1968. Nonetheless, the best example to prove the feasibility of the phonetic principle is the forgotten dissertation of Roland Kiamtia. His abundant verbatim Mauritian Creole examples, put on paper well before the 'spelling wars' in Mauritius began, were written with a spelling close to IPA symbols. These examples are easily readable in our day by not only Mauritians who are familiar with the phonetic principles but by the majority of the population of the world that uses the Roman alphabet.

Mauritius, like many other places in the world, has to bear a post-colonial heritage, including post-colonial languages, in this case, French and English. The orthographies of a few European languages, which typically happened to be the languages of the modern colonizer powers, were standardised in the 17th century, mainly to support the administration of these early modern states. These early orthographic standards were not comprehensively grounded on the phonetic principle as the authority of Latin was still too strong at the time. Subsequent colonies did not only have to take over the language of the colonizers for diverse economic and prestigious purposes but the attached old-fashioned spelling systems as well. National languages promoted by the nationalist movements in the 19th century mostly used the phonetic principle.

Actually French and English spellings are among the most complicated and idiosyncratic ones. Their acquisition requires much effort for new generations in host native countries. Mauritians are to learn not one but two complicated post-colonial orthographies. One of these, the English language, has subsequently become a global supra central language in the 20th century. Its spelling idiosyncrasies therefore have been further globalised. Even current writing has to use this system dated from the 17th century.

The battleground of writing in Mauritius is crystallised in relations to traditional, etymological French spelling. This is called ‘etymological’ in the sense of reflecting historical features of Latin and Medieval French. Although the etymological writing of French and English are complicated and often illogical, they are existing standards that are acquired through long drills. It is disillusioning for the politically influential promoters of etymological writing that it can hardly become a standard for French lexified Creoles, because its rules, arbitrary and often illogical but standardised for French, cannot be consistently applied to another language than French unless one intends to set up another long list of new idiosyncrasies. Writing Mauritian Creole with French etymological orthography always contains a level of insecurity, of possible pitfall, which discourages the attempt of writing Creole or writing at all. The insecurity of writing Mauritian Creole in an etymological way also confronts the occasional dogmatic and intolerant attitudes in France and the Francophone word regarding any non-standard type of speaking or writing.

Another circulating argument against phonetic standardisation in Mauritius aestheticises the non-standard variations and regards them as iconic for some kind of post-adolescent or merry-go-round creolised way of life. Sometimes the people who voiced such ideology are the same people who are totally intolerant to any kind of non-standard variation in

French or English. These ideas were sometimes combined with anti-aestheticising the opposed, phonetic orthography and label phonetic variations, for example the use of ‘w’ as ugly, or barbarian (for example, *wi* instead of *oui*). These critics would probably regard English writing as very ugly with so many such words like water, wife or winter. A further often voiced argument to reject phonetic writing and Mauritian Creole together was that they could have led to a linguistic ghetto, isolation and devaluation of positions on the world market. This argument disregards the existence of such nation states which happily use their own identified national language(s) for internal domains and retain foreign, supracentral languages for external contacts like trade or migration.

The pro-etymological promoters were evidently from those social groups who had vested interest in possessing the linguistic capital of the knowledge of French language, many *gens de couleur* and Franco-Mauritian persons, the francophone Mauritian press and the Catholic Church. However, I heard examples of this view on the side of the Indo-Mauritian elite as well, not because most of them were pro-francophone but because they were anti-creolist, afraid of the enmeshed contamination of Creole language and Creole people to ‘pure’ Indian ‘cultural’ elements. This crystallised clearly in the rejection of Baker and Hookoomsing’s suggested phonetic system, which could have been used in a standard way for writing both Mauritian Creole and Mauritian Bhojpuri as well. Elite groups of varying sides have been unsympathetic towards phonetic writing because of the background of its promoters, often on the left side of the political arena.

Orthographic issues and practicalities of standardization became key battlefields of the trench war between contesting ideologies in Mauritius. The promotion of phonetic writing became labelled as ‘radical’, and many from the elite groups did everything to sabotage any change, and to ridicule, disdain and discredit the pro-phonetic promoters.

I saw almost no example of a consistent public use of any kind of phonetic spelling. The few places where LPT writing and *grafi larmoni* appeared were publications that reached and interested only a minute layer of intellectuals. The ordinary Mauritian simply never has the chance to let the logic of phonetic spelling click in. The rare existing examples for writing in Creole, for example shop signs or poster advertisements, use mainly inconsistent etymological writing. By the time Mauritians grow up and could as adults realise the underlying contradictions and controversies, it is too late because the patterns of certain written word forms are already engraved in their memory.

Lakampagn *and* Fezer *- Creole Fransize and other Creole variations*

Most research on Mauritian Creole has been carried out abroad, mainly in Britain and France. It relies mostly on the scarce written sources, often disregarding varieties. However, varieties within Mauritian Creole are of importance both generally to understand the life of ordinary Mauritians and specifically to understand the findings of my research.

In a study (Rajah-Carrim 2004a, 200), Mauritians were asked, in which region is the best or purest Mauritian Creole spoken. The majority of the people interviewed in this study did not have a problem answering this question, which suggests they are well aware of existing differences. The majority indicated that the speakers of the Black River area, characterised by Creole fishing villages are the closest to the "best pronounced" variation. This would perhaps suggest that the Mauritian Creole spoken by the rural Indo-Mauritians in the North, markedly different from the Mauritian Creole of Creole fishing villages, is less prestigious.

A young Mauritian linguist Guilhem Florigny told me in an

interview that he is able to distinguish intuitively at least a dozen different Creole variations, including different districts of Port Louis. However, for those who still think Creole is only broken French, or just a *patois*, it would be scandalous to acknowledge this language as an object for scientific research and then accept the findings about existing accents and dialects within Creole.

The description of the main Mauritian Creole variations usually follows the four categories coined by Philip Baker (1972, 39-40):

- Ordinary Creole
- Bhojpuri-influenced Creole
- French-influenced Creole
- 'Refined Creole'

In a simple summary, Ordinary Creole is spoken by most Mauritians, especially by ordinary (ethnically) Creole people. Bhojpuri-influenced Creole is what some but not all Indo-Mauritians of North Indian ancestry speak. The Creole spoken by most Indo-Mauritians in fact falls in the spectrum in-between Ordinary Creole and Bhojpuri-influenced Creole. French-influenced Creole is how Franco-Mauritians speak Mauritian Creole. Virtually all of them have good native competence in spoken Creole but they speak it with a particular accent. This variation could be called a dialect of Mauritian Creole. The 'Refined Creole' in Baker's terminology is what somebody speaks when he/she wants to sound like French-influenced Creole but this effort is incomplete because the speakers lacks proper native French competence. This variation is associated with urban, middle class people with numerous years in academic education and fair but not full competence in spoken French. Baker argues that Refined Creole distinguishes [s] and [ʃ] or [z] and [ʒ] consonants but is unable to distinguish the French [ø], [œ] and [ə] vowels or the [o] and [ø] vowels.

More recently Eisenlohr gave a new description that he called

'Creole fransise' (2006, 135).[11]

		Ordinary Creole	Creole Fransize and French	English
Phonological substitution		[s]	[ʃ]	-
		[z]	[ʒ]	-
		[i]	[y]	-
Lexicon	change	*lakaz*	*maison*	*house*
		labutik	*magasin*	*shop*
		koze	*parler*	*to speak*
		aster	*maintenant*	*now*
		servi	*utiliser*	*to use*
		gete	*voir*	*to see*
	insertions	-	*en fait, au fait*	-
Morphology	plural marker	*bann*	*les*	-
	possesive	-	*de*	*of*
	verb suffixes	-	various (for example –*ons*)	-

These linguistic markers are also associated with ideology, which suggest that the use of Creole Fransize elements make the language 'clearer', 'nicer', more 'refined', less 'careless', and more understandable. The intentions and the practice to pronounce Mauritian Creole in this French imitating way, while the language remains syntactically and lexically Creole, is akin to the Labovian hypercorrection phenomenon.[12] This practice is often considered snobbish and affected, but sometimes labelled as the 'improvement' of Creole. The present research confirms that different levels of Creole Fransize, similar to the Bickertonian mesolects (intermediate variations between the H version

[11] Table is slightly modified.

[12] In Labov's classic experiment, the workers of a Department Store in New York City pronounced the [r] sounds in the expression 'fourth floor' according to the standard prestigious way when the utterance was in a stand alone emphatic position [with an r] or when it was part of a colloquial chat [without an r]. The conclusion is, in the moments of presumed importance, people pronounce words (and use language in general) in a way they think is prestigious (see for example, Meyerhoff 2006: 34).

acrolect and L version basilect) can be identified in Mauritian Creole and there is a notable fluidity in how speakers choose, switch and shift among non-standard mesolect variations.

For example, in this word *'semen'* [semɛ̃] (road), there are several phonetic parts that are subject to variations, the initial consonant, the first vowel and the second, nasal vowel. All variabilities together produce various variations (see Appendix 3). The direction of the shifting from *sime* towards *chemin,* expressed what my conversation partners signalled as *fezer.* This expression can be translated several ways, for example being posh, a show off, self-conceited, lofty, pompous. However, *fezer* has several synonyms as well and the linguistic expression of this social phenomenon should be examined more closely. *Ferblan* (lit. 'cheap iron' but also 'tin' yet here in the meaning of 'made up white') is often a synonym with *demikle* (semi-light coloured) referring to either local Whites who are 'invisibly not real' Whites and local light-coloured *gens de couleur* who intend to seem lighter. *Demikle* as an adjective or noun is often mentioned together with *deklare* (lit. to declare, meaning to declare or pretend to be white, *deklar blan*) that can be a noun and a verb as well. For example, the expression *"Bann demikle deklare."* exemplifies this. Literally, it means 'The semi-light ones declare.' but the proper translation is 'Some segments of Mauritian society, typically upper class Creoles have a tendency to act in a posh way'. On another occasion when I asked someone define the word *snob* (snobbish), they answered "*fer kouma enn blan", "declare"*, ('to act like a White' or 'to act like someone who wants to pretend to be White'). In addition to the mentioned *fezer*, *grandioz* (grandiose), *vantar* (vain), *gran nwar* (lit. 'big black') show further examples for the rich vocabulary to present the subtleties of this type of social conduct. In another example, someone said for the same type of person and kind of behaviour, *Zot pa frekant avek ti dimounn.* (They do not socialise with small/ordinary people), that is, they look for

the company of Whites if they can.

In this way, a connection could be made between a social group, with ethnic and class parameters, a relational behaviour type and a way of speaking and using Mauritian Creole. This connection, however, should not be totalised or homogenised. Not everyone in the marked social group acts like this in every instance and members of other groups can express similar attitudes at times. The chance of playing and adjusting the language is a given option but its use varies by individuals and situations. Widening or closing social distance has a dynamic nature.

In contrast to the *fezer* type accent of Mauritian Creole, the expression *lakampagn* (countryside) came out many times during my fieldwork referring to another linguistic variation. In Baker's categories, this variation can be identified as Bhojpuri-influenced Creole.

Phonetic characteristics of this dialect are the rolled 'r' or the omission of 'r' instead of uvular 'r' but the capacity of pronouncing such consonants as [tʃ] and [dʒ]. In addition to pronunciation, this dialect featured lexical and syntactical differences as well. For example, *otan* (that much, so much) is used instead of *telman*, *depi… depi* (from…to) instead of *depi… ziska*. Mauritian Creole words with '-e' ending can have two forms, with or without 'e' (for example *koz, koze*) depending on numerous rules. In Bhojpuri influenced Creole the word with 'e' ending is often retained when 'standard' speakers would use the short form.

These language variations are associated with the social stereotype of the *lakampagn*, suggesting that the speakers of this variation are uneducated, 'unsophisticated' and typically rural Indo-Mauritian.

Mauritian French – Cet obscure objet du désir

The key to understanding the linguistic situation in general in Mauritius is the understanding of the position and sociohistorical context

of the French language, which may also open a door to comprehend the functioning of this society. It is a far more important European language for Mauritians than English (Eriksen 1998, 17) and Mauritians have been described as having an ambiguous love-hate relationship with the French language (Baggioni and de Robillard 1990; Atchia-Emmerich 2005, 90). On the individual psychological level, this phenomenon is full of ambiguities and uncertainties but as it is a widely shared practice with embedded meanings and references to the social structure, it results in, or goes with dynamic, simultaneous parallel social ambiguities as well. French has been the symbol of economic and political dominance. However, acquiring and mastering French is not just a symbol but also a real instrument to aspire to higher social status or to retain it. A popular guidebook, addressed to would-be expatriates, reassures them that Mauritians feel proud and passionate of being able to speak French and "will take any opportunity to show it off"" (NgCheong-Lum 2006, 223). Many people in the world would be happy to show off skills in other languages but Mauritius is one of the places where this wish also signals, among others, an implicit class discourse. The Mauritian middle class and the aspiring lower classes, the ones who would ever have the chance to be involved in an 'intelligent' conversation with expatriates would be probably happy to 'show off' their linguistic capital that separates them from the non-elites.

In 2001, 90% of people in Atchia-Emmerich's survey claimed to have a good command of French, and 98.2% said that they had at least some command of French (2005, 90). As mentioned in the previous section, Atchia-Emmerich's study presents significant social desirability bias. The question arises in regard to what 'good command' (*bonne connaissance*) might mean in that study. Already after the first census in 1952 when the use of the spoken languages was queried, substantial doubts were voiced by professional analysts (Brookfield 1957)

concerning the reliability of the data. Brookfield argued that the figures indicate those who claim to speak French and not those who actually speak it. Nevertheless, until the last published Census in 2000, the number of people who declared that French is the first language that they 'usually speak at home' had been continuously decreasing since 1952 to 3% in 2000 (see Appendix 5). Therefore, the data given by Atchia-Emmerich is likely to be overestimated. Nevertheless, in the recent decades, including since the Census in 2000, many aspiring Mauritians from all local category backgrounds have acquired good fluency in French.

Since 1721 then there has been a segment of the population in Mauritius whose mother tongue is French. By far the largest proportion of the French immigrants in the French period came from Brittany and Northwest France (de Gentile 1996, 9; Baker 1982, 37, 39). About "2,500 new White settlers who reached Mauritius in the period 1767-1801, of whom two thirds arrived in the decade 1787-97" (Kuczynski 1948, 761). Few of the French settlers appear to have left following the British occupation in 1810 (Baker 1982, 40-41) but almost no-one came from France after that date either. It is therefore to be supposed that the dialects and languages spoken in Northwest France and to a lesser extent those from Southern France had a major impact on spoken Mauritian French. The many immigrants from Brittany were "'likely to have been speakers of Breton although most if not all of them were no doubt also fluent speakers of French" (Baker 1982, 155). Breton words were identified even in Mauritian Creole vocabulary (Baker 1982, 157).

Chaudenson stated in 1979 that few proper studies had been carried out about French spoken in Mauritius. The work of Baker and other studies on Mauritian Creole such as Pudaruth (1993 [1972]) and Moorghen (1972) were substantial sources of information regarding Mauritian French too. Later on, Baggioni and de Robillard (1990)

described the Mauritian French language more in detail; this study was partly based on a sociolinguistic survey in Mauritius and partly on an unpublished paper of de Robillard (1981). Subsequently, de Robillard, who is a Franco-Mauritian, published a 143-page book (1993), a kind of French-French dictionary abut the particularities. Lexical items from dialectal and maritime sources may sound archaic to today's standard French speaker. The 'archaic' words form part of normal Mauritian Creole vocabulary. This suggests that Mauritian French and Mauritian Creole form an overlapping pool in contrast to standard French (Appendix 4). It is notable that these words are not obvious Creole insertions in French speech, which can also occur by conscious intention of Mauritian French speakers.

English has had a major impact on Mauritian French and in Mauritius anglicisms are not only accepted and used by native speakers of Mauritian Creole but also by native speakers of Mauritian French. According to Baggioni and de Robillard (1990, 64, 69, 133) the variations of French in Mauritius can be categorised as follows:

- Mauritian French spoken by Franco-Mauritian French native speakers with other Mauritian French native speakers.
- Mauritian French spoken by Creole (usually *gens de couleur*) French native speakers with other Mauritian French native speakers.
- Mauritian French that is relatively close to standard French spoken by Mauritian French native speakers with other Mauritians in neutral or public situations.
- Mauritian French of young Mauritian native French speakers who apply French slang expressions from France.
- French of the Neo-francophones, that is Indo- or Sino-Mauritians, who learnt French in education. This French is close to standard

French but somewhat artificial and less colloquial, or slang like.

- French of the French living in Mauritius (expatriates).

The Creole (typically *gens de couleur*) French native speakers tend to accuse the Franco-Mauritians of speaking 'bad French', degenerated French (resembling Mauritian Creole) or snobbish French. As opposed to the Franco-Mauritians, they think that they (the Creoles) speak the 'right' French, the 'real French of France' and not the Whites. Baggioni and de Robillard (1990, 133) hypothesise that it is anger, frustration and an inferiority complex on the side of the Creoles that leads to such accusations, compensation and grievance. This group voiced some ideas of language ideology predominant in France regarding the 'corruption' of French, under the influence of English for example. Some of them acknowledged having a local accent and speech variation and reported with some sense of culpability that they might not speak 'good enough' French. The Franco-Mauritian native speaker informants of Baggioni and de Robillard (ibid), in contrast, were surprised when confronted with the idea that they would speak any kind of particular French variation. They think they speak French well, like the French, and if anyone speaks French differently from them is because they do not master the French language well enough. Franco-Mauritians appeared to have no guilty feeling about their French, which is markedly different from standard French.

The Creole respondents tended to be less aggressive in regard to the Neo-francophones although they, 'typically' members of the rising Indo-Mauritian bourgeoisie who have returned from France speaking fluent standard French having completed years of studies there, would challenge the old stereotypes, which used to assert that Indo-Mauritians prefer to use English. Franco-Mauritians were even less concerned about this development (1990, 134).

Whilst the number of Franco-Mauritians has been decreasing in the 20th century due to emigration and other reasons, the popularity of the French language has continued and even increased. French occupies a cardinal position in daily Mauritian life. Whilst some governmental descriptions of the country may emphasise the unifying role of Creole as the lingua franca and English as the official language (for example, Joypaul 2001), they usually downplay the significance and prevalence of French in Mauritian society. The majority of Mauritian literary authors write in French. The country's literary production in Mauritian Creole and English is much less, let alone in Bhojpuri or other ancestral languages. The daily newspapers and the television are overwhelmingly in French (Rajah-Carrim 2004a, 31). The French dubbed version of popular North American films or television shows are shown in Mauritian State Television (MBC, Mauritian Broadcasting Corporation),[13] and English novels are sold in French translation. Radio and television programmes are predominantly in French. However, it is regarded as acceptable in Mauritius to insert Creole and English expressions into French texts. When politicians speak Creole to voters to show they speak the 'language of the people', these inserts remain verbatim Creole in the French language newspapers. Jokes and other funny or slang pieces may be in Creole too. Whereas the orthography and style of the French texts are carefully edited, the Creole insertions are confusing and lack any standard, even within the same article. Politicians are forgiven for speaking 'bad' English but not forgiven for speaking 'bad' French. Therefore, the mistakes in French by politicians are carefully corrected by journalists (Lee 1999, 103-106, 109-113). I also heard people ridiculing the mistakes of Indo-Mauritian politicians speaking French. Politicians have less opportunity to have their speech corrected in visual media.

[13] Whereas you can see English dubbed Venezualan soap dramas in Mauritian television on Saturday mornings.

Criticising their grammar mistakes or ‘funny’ pronunciation is a way of expressing frustration against the political majority, but also serves to reiterate ethnic stereotypes.

On the other side, the Indo- and Sino-Mauritian elite, who were called Neo-francophones by Baggioni and de Robillard, do seem to feel the shame and frustration followed by such critical remarks. The element and amount of shame that Neo-francophones feel correspond to their tendency to accept the privileges attached to it. Another tendency of the new Neo-francophone elite is to speak ‘better’, more standard French than the Franco-Mauritians (and the *gens de couleur*). This is the kind of French that the francophone movement intends to propagate globally. This brings them closer to the common and often francophone ideologies of the Republic of France, to the French teaching, to the French expatriates in Mauritius and French citizens in France to meet and possibly to marry.

Baggioni and de Robillard assert (1990, 88), that Neo-francophone speakers distinguish ‘good westerners’ (the foreigners) from ‘bad westerners’ (the former colonizers) through the difference between Standard French and Mauritian French pronunciation and way of speaking. The Mauritian *Alliance Française* and the French policy of promoting French language have had a great deal of detrimental impact on the democratisation of Mauritius. Subsequently, the aristocratic, segregationist elitism of the Franco-Mauritian group became uncomfortable for the otherwise republican official French politics and with the support of an Indo-Mauritian president, Franco-Mauritians lost control over the local *Alliance Française* after the 1980s (Salverda 2010, 185).

Although the situation and the rules of the game ‘Who speaks the better French?’ are dynamically changing, the compliance with the challenge reciprocates the previously set markers of power and a

recurrent embodiment of previous comradely rivalries.

Mauritian Bhojpuri - Survival among Myths and Depreciation

Even though “Bhojpuri is the only Indian language commonly spoken in Mauritius” (Eisenlohr 2004), its risk of extinction was already observed decades ago (Barz 1988; Biltoo 2004; Hookoomsing 2009). Mauritian Bhojpuri is a unique language to Mauritius that has been poorly studied both inside and outside the island. “If you ever have occasion - and the time - to learn Mauritian Bhojpuri, you will become the rarest of rare people, to Mauritian eyes, not to mention an enlightened soul.” - a Mauritian linguist wrote this to me once in an email. Yet, it has an important role in the daily life of many Mauritians and in Mauritian political games. While talking about Mauritian Bhojpuri rather than talking Mauritian Bhojpuri has been part of political rhetoric, members of the Indo-Mauritian elite group in their private life have vested interest in the acquisition and mastering of French and English, which may help preserve dominant elite positions.

The difference between Mauritian Creole and Mauritian Bhojpuri is that there has been a lot of detailed and high quality linguistic studies carried out about the former while the latter is so far an inadequately described language even by linguists. The first dissertation about it dates only to 1970 (Hookoomsing 2009) and ever since less than a dozen descriptive works have been published. When people claim Mauritian Creole ‘does not have a grammar’, ‘it is only a dialect’, ‘one cannot write in Creole’ they are in simply denying the realities of linguistic knowledge. Knowledge about Mauritian Creole does exist, and it would only require political will to implement it in practice. The knowledge about Mauritian Bhojpuri is at a very different stage. Mauritian Creole is treated unfairly

but is not at risk of extinction. In contrast, Mauritian Bhojpuri is dying and it is an open question if responsible language politics can still save it.

Mauritian Bhojpuri is an independent new dialect of Bhojpuri, distinct from Indian Bhojpuri variations (Baker and Ramnah 1985; 1988). The indentured labourers from North India spoke different dialects, but as this language became a kind of lingua franca among rural Indo-Mauritians in the 19th century, the dialectal differences levelled up, some elements of conjugation and honorifics were simplified (Domingue 1981; 1983; Gambhir 1986), for example numbers. Mauritian Bhojpuri also absorbed many loan words from Mauritian Creole (Domingue 1971; Kriegel, Ludwig and Henri 2008). There have been anecdotal reports that in the villages even many Sino-Mauritians and Indo-Mauritians of South Indian ancestry spoke this language. However, proper records of its use before World War II have not been compiled. A double diglossia developed in Mauritius. Mauritian Bhojpuri is Low variation when paired with Mauritian Creole, which is the High variation in this context; in contrast, Mauritian Creole is the Low variation in its relation to French (Stein 1977; Chaudenson 1984). By contrast, Mauritian Bhojpuri is in the Low diglossic position both with Mauritian Creole on one side, and with standard Hindi on the other side. Even in Mauritian families where the ancestral language is Bhojpuri, 70% of the communication occurs in Creole (Atchia-Emmerich 2005, 136). Feelings of inferiority are attached to Bhojpuri. Its speakers often think that their language is not a language in its own right but merely a ‘Hindi patois’ or ‘corrupted’ Hindi (Barz 1980; Mesthrie 1991, 1; Eisenlohr 2004). This linguistic self-devaluing phenomenon is not unique to Mauritius; it also appears in India and in the Indian Diaspora elsewhere (Mesthrie 1991). It is rarely a written language and spoken mainly by the older generations. Bhojpuri speaking children have been taught Hindi and not Bhojpuri in school. Before the 1980s, even the Census would only enquire about Hindi and not about Bhojpuri

speakers. In this regard, Eislenlohr says that

> Nowadays a 'purist' register of Bhojpuri is used in the media in such a way as to demonstrate the assumption of Mauritian Bhojpuri under the larger category of Hindi. This purist register of Bhojpuri is characterised by avoidance of Creole lexical items, which are very frequent in commonly spoken Mauritian Bhojpuri, and by an increased adoption of sanskritized Hindi vocabulary. To a lesser extent, there are also grammatical constructions and phonological features taken from Standard Hindi (Eislenlohr 2004).

Consequently, three levels of the Hindi-Bhojpuri diglossia can be distinguished in Mauritius: standard Hindi, 'pure' Mauritian Bhojpuri, and colloquial, 'creolised' Mauritian Bhojpuri.

In modern Mauritian language politics, Hindi and 'hindiized' Bhojpuri has become ideologically associated with 'Hindu Indo-Mauritians', the largest ethnic group in the country (Eisenlohr 2004). The time when the indentured labourers came to Mauritius is to differentiate linguistically from our current time as no record is known about the state of Bhojpuri from the time of indenture recruitment to Mauritius. Grierson, a Dublin-born linguist who worked for the British administration in the Bengal presidency from 1873. Between 1883 and 1887 he published a seminal work on the local languages with the title 'Seven grammars of the dialects and subdialects of the Bihárí language: spoken in the province of Bihár, in the eastern portion of the North-western Provinces, and in the northern portion of the Central Provinces'. In part 2 (1884), he described the grammar of Bhojpuri language in detail. Subsequently, Grierson took on a major British colonial project - the 'Linguistic Survey of India' in 1898. Eleven vast volumes were published with the results between 1903 and 1928.[14] The second part of the Volume 5 deals with the Bhojpuri dialect in the Province of Bengal and describes the summary of its

[14] This database is available on http://www.joao-roiz.jp/LSI. Accessed 11/09/2011

grammar on pages 50-53. Since then, various attempts to classify Indo-Aryan languages have been suggested and it seems there is a lack of consent among linguist about a possible agreed classification.[15] Moreover, popular usage, diverse self-designations and politically minded distortions further complicate the matter of what term to use to name a North Indian dialect, language or language group. No state-of-art study has been carried out about the exact internal relations among Indian Bhojpuri dialects, their external relations with neighbouring languages, about caste dialects and other variations, and about current distribution of Bhojpuri-Hindi bilingualism. Grierson estimated 20 million Bhojpuri speakers in Bihar at the beginning of the 20th century; the 2001 Census of India reported 33 million Bhojpuri speakers in India.[16] Real numbers may be much higher. The linguistic area of Indian Bhojpuri dialects is found on both sides of the Uttar Pradesh-Bihar state border. This Bhojpuri speaking area continues to be one of the poorest regions in India. Despite major efforts to develop education, many people are illiterate. Primary education is in standard Hindi. Tertiary education is usually in English. Indian Bhojpuri continues to play a secondary and inferior role in most major language domains, such as education, administration, literature and media.

Indians today do not understand Mauritian Bhojpuri, which is full of Creole loanwords and its syntax has changed. Indo-Mauritians who have acquired decent knowledge of Hindi or Urdu in schools or in religious activities may be able to communicate with foreign Hindi/Urdu speakers. The Bhojpuri speaking area is not a favourite destination for travelling Mauritians. To maintain contact with ancestral land and

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[15] For example, Ethnologue (www.ethnologue.com), a well-known catalogue of languages, counts 12 languages in the 'Bihari' group. Mauritian Bhojpuri is not mentioned; whereas 'Caribbean Hindustani', for example, is.

[16] http://www.censusindia.gov.in/Census_Data_2001/Census_Data_Online/Language/Statement1.htm. Accessed 27/11/2011

families is frequent among Franco and Sino-Mauritians but was formerly less common among Afro- or Indo-Mauritians. An Indo-Mauritian who sought out his 'roots' (Naga 2007) claimed to be able to communicate with distant relatives in Bhojpuri. From the 1930s, Hindu activists made use of the metaphor of 'roughness' to describe Bhojpuri and associate it with rural working life. The stigmatization of Bhojpuri served to prove Bhojpuri "unfit for the representatives of a glorious Hindu civilization overseas, which should therefore rather be replaced by Hindi. For some time, a slogan of local Hindi activists was *Motiya choro, Hindi bolo* — Give up the coarse one (Bhojpuri), speak Hindi. (Eisenlohr 2001, 90)".

Prior to the 2010 parliamentary elections, the introduction of Mauritian Creole as an optional subject at Primary level in the state schools was promised by the Prime Minister. After the elections, a new project, a 'National Forum' was proposed, which, according to some of my informants, had the underlying aim to introduce Mauritian Creole in education in parallel with the introduction of Mauritian Bhojpuri. The latter would be hardly possible without prior proper linguistic examination. This delaying tactic had little to do with Mauritian Bhojpuri itself. On the other hand, a slight revival of Bhojpuri seems to be happening. Some children are taught Bhojpuri during Hindi lessons, and teaching materials have been published for them. In the year of my fieldwork, pioneers could take an exam in Mauritian Bhojpuri for the first time.

The orthography of Mauritian Bhojpuri is an example of chronic unresolved issues. Despite the attempts of Baker, the LPT and others (see Goswami Sewtohul 1990) there is no standard or agreed orthography for Mauritian Bhojpuri. Sometimes both devanaagri and romanised versions are used in newspapers. There were rumours that one of the covert arguments against phonetic spelling for Mauritian Creole, like *grafi larmoni,* was that it could have been made 'too easy' using the same

words in Mauritian Bhojpuri texts due to the high number of Mauritian Creole loanwords in it. This would be against the political agenda of those who want to increase the distance between Mauritian Bhojpuri and Mauritian Creole (see the section on language ideologies). For them the Creole loanwords in Bhojpuri make Bhojpuri ‘corrupted’, ‘impure’, too mixed, ‘too Creole’. Using devanaagri to write Mauritian Bhojpuri one is supposed to write the Mauritian Creole loanwords in Mauritian Bhojpuri with devanaagri as well. This option can be regarded as odd or ‘impure’ for purist activists. On the other hand, they hope using devanaagri would facilitate the replacement of Mauritian Creole loanwords with their Hindi equivalents in Mauritian Bhojpuri; where devanaagri obviously would not be a problem.

Regarding India and the rest of the world, romanised spelling for Hindi is widely used. Even Mauritian television uses romanised Hindi subtitles sometimes and this does not threaten the position and co-existence of the mainstream devanaagri usage for Hindi. However, arguing endlessly over the choice of orthography could put off definite solutions for either Mauritian Bhojpuri or Mauritian Creole, which would be in the interest of resisting elite groups. During the time of the fieldwork, the Bhojpuri Department in the MGI employed only two lecturers. Previously, the Bhojpuri Institute had one member/worker, Sarita Bhoodhoo. The Bhojpuri Speaking Union has only one worker and a tiny office. One of the lecturers of the Bhojpuri Department mentioned to me proudly, however, that recent achievements for Mauritian Bhojpuri had made it the most recognised and ‘officialised’ of all Bhojpuri variations in the world.

Education and language

Although this work focuses primarily on health related issues,

education in Mauritius is also strongly influenced by multilingualism and therefore must be discussed briefly in order to imagine the typical background of the people who will be presented in the following chapters.

The 'perennial' issue of language in education (Kalla 1986) goes back to the time of the British occupation and the conversion of the only significant school on the island, the French speaking *Lycée de l'Isle de France* to the English speaking Royal College. Although the established customs and the French-Creole diglossia were largely retained after the conquest, the new rulers intended to introduce their language in a few key areas, like in this major school. These intentions were met with the fervent resistance of the local French speaking elite. The change of the language used for teaching in the Royal College was very slow. Later the introduction of English scholarship that subsidised two students every year to continue their studies in Britain promoted the working fluency of some French speaking students in English. The matter of public education of the Creole population was largely outsourced to charity and religious associations from the mid- nineteenth century. The number of children in schools and the number of years spent in education grew slowly until World War II. The fact that schools charged fees, and also the dispute about the linguistic medium of the teaching constituted obstacles (Ramdoyal 1977).[17] The Catholic Church, the local aristocracy and many from the Francophone Creole upper echelons objected to English, whereas the colonial administration did not support French. Both agreed, however, that Mauritian Creole, the actual mother tongue of the population was not suitable for education as it was not even regarded as a language. With the arrival of the Indian indentured labourers and their children, the situation became more complicated. The labourers themselves came from linguistically very diverse backgrounds. Many

[17] Several sections of Ramdoyal's work served as important background material for this section.

spoke languages and dialects that had no literary standards even in India. The British administration was divided in its approach to the education of Indian children. On the one hand, it supported the potential use of vernacular Indian languages in schools but had to confront the fact that only Hindustani and (literary) Tamil were possible mediums for educational use, although they were distinct from the spoken North and South Indian dialects of the indentured labourers. These schools became unpopular in the eyes of Indian parents and ended quickly in failure. The landowners were also happier if the children worked in the field or the camps instead of spending time in schools. On the other hand, the British insisted on introducing English language in Indian schools. This met with strong opposition on the part of the Catholic Church and many Francophone members of the society who were afraid of losing influence. The difficulty of learning in a different linguistic environment and the low practical benefit of speaking and using English made it unpopular among Indians as well. Policy makers and committees came and went and in the end almost nothing happened.

Generations grew up without any substantial formal schooling. In 1908, only 7,000 out of 60,000 Indian children of school age attended school. The situation changed gradually in the 20th century, partly due to the rise of Indian nationalism. The new Mauritian Indian elite 'rediscovered' their ancestral languages. On the one hand, this intellectual class, and particularly the *Arya Samaj* in Mauritius, promoted education and largely contributed to the rise of the majority Indian population. On the other hand, supporters of this awakening subscribed to the modern, standard Indian languages, and insisted on their introduction to education. The slowly spreading government schools were struggling amid the bickering between pro-English and pro-French policies and the ignorance of Creole. Education did not open opportunities for ordinary people (Benedict 1958). Standard Hindi, Urdu and Tamil appeared in mainstream

schools from the 1930s; then their teaching (and a few more so-called ‘oriental languages’) became comprehensive from the 1950s.

When the majority Indian population gained political power after the first democratic elections, the establishment of the English language in the entire education system was finalised. The pro-English attitude of the government during the late colonial and early independent governments was partly grounded on the fights with rival, Francophone political groups. Education was made free in 1944 for primary schools, in 1976 for secondary schools, and subsequently for tertiary education. The literacy level is about 85%, one of the best in Africa (Mohadeb 2003, 16; Sobhee 2009). However, the measurement of literacy is debatable as many Mauritian children and adults can be regarded as multilingual semi-literates who can read and write in a limited way in various languages but do not have one language they could use close to their maximum communicative capacity. Subsequent governments have continued to invest large amounts in education. Many people are rightly proud of this. Others, however, told me they would never send their children to the same school they used to attend. Previous ‘good’ schools, or ‘star schools’ in local terminology, had been diluted according to these informants. The richest Francophone families and virtually all Franco-Mauritians moved to the mushrooming private school system where French is the medium of teaching. In old colonial times, there was just one secondary school, the Royal College of Mauritius, which was attended by the children of the elite. Later a number of posh Catholic missionary schools were added to this layer. The *Lycée Labourdonnais* that follows the French and not the Mauritian curriculum was founded in 1953, the *l’Ecole du Nord* in 1973. When the state took control over the Catholic schools after independence, upper segments of the elite, particularly the Franco-Mauritians started deserting Catholic schools (Salverda 2010, 150), and this exodus created the need for other, new private schools. After 1990, five more French-

speaking and two more English-speaking secondary schools were opened. Virtually all Franco-Mauritian children attend these schools now but approximately half of the students there are not Franco-Mauritian but belong to other elite groups. An informant explained to me that in the *Lycée* children who have dual citizenship and a French passport, which is often the case among Franco-Mauritians, benefit from significantly reduced fees, while the parents of non Franco-Mauritian children pay exorbitant fees. Practically all young Franco-Mauritians attend foreign universities and return home afterwards (Salverda ibid, 151). Temporal segregation prevails between the Mauritian private and state schools too, as the private schools follow the European calendar and have school holidays when it is summer in Europe, whereas Mauritian state schools have holidays when it is summer in the southern hemisphere (Salverda ibid, 185).

Mauritius has virtually no native English speaking population and very little daily verbal communication happens in English. Indo- and Sino-Mauritian children are scheduled to learn their ancestral languages at the expense of Mauritian taxpayers. However, there are numerous bizarre complications with this. Mauritian Bhojpuri does not equate linguistically with Modern Standard Hindi but in the political discourse, in Hindi lessons, in Hindu religious activities and sometimes in the mind of the pupils the two are forcibly enmeshed. The children of Muslim Indo-Mauritians are currently detached from the Bhojpuri heritage and ancestry. They are compulsorily enrolled in Urdu classes in mainstream schools. Within the Muslim community (Rajah-Carrim 2010), just like as in India, the difference between Hindi and Urdu are emphasised and presented as if they were two different languages whereas linguistically speaking they are variations of the same language. Actually, the difference between Hindi and Urdu is much smaller than between Bhojpuri and Hindi. Tamil, Telugu and Marathi children are enrolled in

lessons for these languages respectively. The peculiarity with the latter three languages is that they are no longer spoken in Mauritius at all. Therefore, they have minimal practical benefit. Another complication is that the children learn literary Tamil, which is no longer spoken in Tamil Nadu in India. The ancestral language of the majority of Sino-Mauritian would be Hakka, and for a minority, Cantonese. However, Sino-Mauritian children are enrolled in Mandarin classes. At least the potential benefit of Mandarin has been growing lately, given the well-known global changes. The less affluent Creole population that is unable or does not want to subscribe to French elite education has been left without any compensation or alternative to the extra language tuition given to children of Asian descent in mainstream schools.

Since the late 1960s, a small group of pro-Creole activists, who are not necessarily Creole ethnically, have been fighting for the introduction of Mauritian Creole in education. Although forty years have passed, until the time of my fieldwork this still had not occurred. This movement goes parallel with other struggles for the emancipation of Mauritian Creole. Most teachers have a vested interest against this step, which would reduce their socially exchangeable linguistic capital. Indeed, many teachers hinder the further democratisation of education. Despite some democratic trends, like the free, available and relatively good level of education the current state also contributes to the preservation of existing segregating differences. As will be mentioned in Chapter 6, affluent Mauritians have to pay significant sums for private out of hour tuition if they want their children to pass the final exams. Furthermore, the spreading French private schools create a new rift between haves and have-nots. Pupils in mainstream schools have to learn in a basically foreign language, in English, which segregates those who are able to switch between languages from those who are not. The linguistic divisions in the country as a whole are manifest in education and this domain sustains the

divisions to a large extent.

Pre-school education was made compulsory in 2008. It has since been reported that most nursery teachers talk French to the 3 to 5 year old children whose mother tongue is Mauritian Creole. A great deal of nursery school teaching consists of parrot learning drills to memorise English songs and other out-of-context English expressions (Auleear Owodally 2010).

The structure of mainstream education follows the pattern of the former colonial power, Britain. The children start school at the age of five, then study 6 years in primary schools up to age 11, when the pupils have to sit for a crucial exam (called CPE, Certificate of Primary Education). Private tuition serves to prepare the pupils for this exam. The Ministry of Education has tried to ban after school private education of very young children. Approximately 30-40% of children fail the CPE. Many drop out of education after the failure, or remain without hope of socio-economic mobility subsequently. Only those who perform excellently in this exam are admitted to the 'good' state secondary schools. Secondary schools are divided in a 5 years initial then a 2 year optional second stage. Secondary school students have to take two further difficult exams (called SC, School Certificate and HSC, Higher School Certificate) at age 16 and 18. The latter exams are organised by a British university (Cambridge) and some say they expect even higher standards in Mauritius than the expectation is in Britain for British students. A similar fail ratio applies to these exams like as to the CPE. Aspiring students continue with their private tuition until they leave school.

The current Mauritian education system is exam centred and highly competitive. As all lessons but the language classes are taught in English from the first day, aspiring students must acquire a fluency in mastering this 'school English'. Whereas the language of the school grounds is Mauritian Creole, the use of Creole used to be punished during the

classes. A few informants told me stories about when they had been hit by teachers because they dared to say something in Creole. Nowadays, especially in lower primaries the use of Creole is tolerated unofficially. There are reports that teachers often choose French, equally unofficially, to explain concepts to the children until they learn to use the 'classroom English' (Rajah-Carrim 2007). Typically, the teacher explains new subjects in French first, then in case of doubt clarifies details in Creole, and at the end dictates notes in English. The pupils ask questions to teachers in French or English and to the classmates in Creole. They are, however, expected to learn the English notes and take the examinations in English. Carpooran (2007) argued that the psycho-sexual development of students has its linguistic manifestation as well in Mauritius. Pre-adolescent children at the height of self-inhibition and respect for authority like addressing the teachers in French. Adolescence, in contrast, with its obvious dynamic of challenging authorities leads the students to return to speaking more Creole, which is the language of intimate conversations, obscenities, and slang. Recent sociolinguistic studies showed that middle-class teenagers use different linguistic media in electronic communication such as text messages, emails and internet according to the level of formality (Rajah-Carrim 2009). The more informal the communication is the more likely they are to use Creole, the more formal it turns they may mix or swap it for French. The use of ancestral languages by today's teenagers is minimal (Bissoonauth 2011).

At the time of my fieldwork in 2009-2010 in relation to the electoral campaign in 2010, the government launched the idea of introducing Mauritian Creole as an optional subject in primary education. It was not about changing the medium of education to Creole or introducing any serious exam in Creole. No timescale was given and apparently no significant preparatory work had been done to realise the government's plan. Even this timid initiative met with tremendous

upheaval in the press,[18] especially in the form of letters to editors. In 2010, it seemed there were hardly any appropriate textbooks or trained teachers on the horizon to deliver the project. Most teachers have no idea whatsoever about their own native language and many subscribe to the erroneous prejudice that Mauritian Creole 'has no grammar' and is just a 'corrupted French'. Not only ordinary people but also school teachers do not acquire any standard writing system that should be the base of any formal teaching. Teachers – just like journalists and secretaries – are interested in preserving privileges and sabotaging any possible loss of their linguistic capital.

The language issue and fees for private tuition are not the only problems in Mauritian education. In close relation to these, a further major obstacle to the reduction of social distance and raising open minded, confident new generations is the paternalistic, authoritarian style of mainstream education. An Australian researcher who conducted classroom observations in the late 1990s (Griffith 2000) noted that the children were instructed by imperative French sentences like *Tirez vos livres!* (Books out!), or *Rangez vos affaires!* (Put your things away!). The children were typically asked to read French or English texts from the textbooks out loud but not to voice their own thoughts or experience. They have to copy the 'right' sentences from the blackboard. The teaching is teacher centred, their task is to convey facts, whereas the students have to copy the given information in notebooks or repeat in chorus. On questioning, children are expected to give the only 'correct' answer to questions, which may be found on the blackboard or in textbooks. Otherwise, they are expected to remain silent. Griffith summarised like this (ibid):

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[18] All major newspapers are in French.

> […] pupils are not engaged in activities that promote and develop their individuality, their ingenuity, their imagination or their autonomy….What children need to know consists in the repeating and memorising of that knowledge rather than in the creative application and adaptation of a body of knowledge. In doing so, children are taught docility and conformity rather than initiative and creativity. Pupils are expected to conform their answers to that knowledge. They are not engaged in situations where learning from and with peers is encouraged and facilitated. In fact they are taught competition rather than cooperation. Their activities in class rarely build on childhood experiences.

According to the ability of the pupils in conforming to this system, they are streamlined as 'good learners' or 'slow learners'. The latter group is treated as losers and the teachers' attention focus on the achievers. Another similar study confirmed these finding adding "Another profound feature of classrooms observed is that their environment is scholastically oriented and it ignores the social and cultural life outside the school" (Chumun 2002, 169). As a young Mauritian linguist summarised the situation to me, "half of the pupils leave school without having much idea about what have been taught in the classrooms".

Summary

Mauritian multilingualism is very much alive but rather complicated and requires knowing a great number of details about the particular language variations that are actually present in everyday life or in public discourses there. Mauritian multilingualism is not only diverse and complicated but also strongly associated with prestige related social practice and language ideologies of political importance. The perennial issue of language in education has mirrored the stages of the development of multilingualism throughout Mauritian history. Therefore, it is a useful example for comparisons in the later chapters regarding language use in healthcare, which is the sociolinguistic domain that is in the main focus of

this research.

Chapter 4. Healthcare and languages in Mauritius

Introduction

In Chapter 4, I will introduce the public and private healthcare systems in Mauritius; in particular, biomedical services that deal with mental health related problems. In order to analyse some linguistic features, it is paramount to show how the socio linguistic reality of Mauritius, explained in the previous chapters, reflects on the daily treatment of health and mental health conditions. The chapter will begin with a short summary of health indicators in Mauritius. Healthcare has five sectors in Mauritius; the lay sector, public healthcare, private healthcare, traditional healing, and the NGOs. The lay sector will be introduced through an ethnographic example. The diverse forms of traditional healing practice will be mentioned briefly through the findings from Linda Sussmann's fieldwork. Language use in these two sectors did not form part of the current research but these sectors should be briefly mentioned to understand the general layout of healthcare in the country and the possible options people can choose. The Non-Governmental Organisation sector and language related issues there will be introduced in later chapters. The current chapter will mainly focus on language use in the institutions of public and private biomedical healthcare. The current state of Mauritian psychiatry will also be described. Through interviews with practitioners, as well as through direct observation, I will offer a description of private and public clinics arguing that the two adjectives of private and public in healthcare have different semantic values in Mauritius.

A few key health indicators of Mauritius

In Mauritius, the health sector is regarded as a key part of the welfare state (Valaydon 2002). In practical terms, this means healthcare is financed by taxes and is free for the entire population at the point of delivery. The health budget is 5.7 % of the national GDP (World Health Organisation 2009). In the public sector in 1999, there were five regional hospitals, three district hospitals and five specialised hospitals with a total of 2,638 beds. In addition, there were 13 private in-patient facilities with a further 580 beds. Together these represented 3.4 public beds and 3.9 total beds per 1,000 inhabitants. In 1999, the robust primary healthcare system included 13 health offices, 23 area health centres, and 108 community health centres, with an average of more than two clinical visits per inhabitant in every year (Valaydon 2002). There were 585 public and 484 private sector doctors, giving one doctor per 1,113 inhabitants.

Health professionals can study at the University of Mauritius and specialist doctors can travel abroad for further training. Currently, there is no shortage of medical doctors in Mauritius; on the contrary, the country exports medical doctors abroad (Devi 2008). Frequent governmental changes due to coalition break-ups or lost elections have caused a high turnover of health ministers. Nevertheless, continuity in policymaking has been, by and large, maintained (Valaydon 2002). The overall health of the Mauritian people has radically improved since 1945, and now it is comparable to any European country. Life expectancy was 59 years in 1968; now it is 68.7 years for men and 75.6 years for women. Infant mortality was 70 per thousand live births in 1968, but now is 14 per thousand (Devi 2008). The fertility rate experienced the largest drop in the world in the 1960s and 1970s after a strong campaign by the

government to prevent overpopulation. It has been reduced to about two children per woman (Kalla 1995). About 25% of the population is under 15 and about 9% is over 60 (World Health Organisation 2005). The country went through a significant period of epidemiological transition. As a consequence, public health struggles with similar non-contagious and chronic diseases to most western countries. Mauritius has one of the highest rates of cerebro-vascular stroke and diabetes in the world. About 20% of the population over the age of 30 is reported to have diabetes and almost another 20% is pre-diabetic (Devi 2008). Significant current public health concerns are: smoking among males; excessive alcohol use by Creoles and Hindus; and general obesity, but particularly among females (Vos, Gareeboo and Florise Roussety 1998; Oogarah-Pratap 2007). These issues indicate considerable, underlying psychological problems.

An example of the lay perspective on Mauritian healthcare

Although the following story of an illness episode will not focus directly on language related issues this example could help to understand what could happen with an ordinary health concern in a family environment. During my fieldwork, I spent a lot of time with a particular family. The wife often suffered from terrible headaches. Their family life was not easy, but it was not an unusual situation at all. Marriages, divorces, re-marriages, care for the elderly, and the birth and schooling of children caused emotional ups and downs mitigated by close family ties. In this reality, the debt problems increased the burden of an already intense family life. No matter how hard the adults worked, they could never pay off their debts. The husband was self-employed and spent most of his days, including weekends, in his workshop. Earnings, however,

seemed to be unable to cover the old debts, and new loans were constantly needed to pay them off. His wife worked hard as well. Employed in the servicing sector she also worked late hours and the remaining time was just sufficient to keep up with the household tasks and keep an eye on the adolescent children. Family members were flowing to each other's homes. Family life was often light-hearted, full of caring, compassion, and plenty of laughter. Of course, meals represented the central joy and a major topic for everyday conversations. However, underneath all the laughter, the weight of debts was unforgettable.

It took a while until they accustomed to the fact that I was doctor, but not a 'really working' doctor, just doing some obscure thing, *resers* (research) as a *dokter mantal* (lit. mental doctor, a psychiatrist, but can also mean a crazy doctor), paid by no-one knows whom but not by the *Gouverman* (Government); someone who definitely does not look like the doctors they normally see or imagine in Mauritius.

After a few months, I heard that my hostess was suffering from headaches. Headaches and minor ailments did not prevent household members from going to work. At home, however, family members may take over some of the tasks if someone is ill, on a mutual self-help basis. As a doctor, I started to ask her some questions in order to give her some advice. The headache became stronger and constant, despite aspirin and painkillers available over the counter in Mauritius. Once, when the pain became particularly strong, she decided to see a doctor in the Jeetoo Hospital in Port Louis. It happened during the weekend and they had to wait a few hours at the A&E, to have access to a three minute session. That session ended with a prescription of a stronger analgesic given to the wife. The situation did not improve in the following days. She showed me that she had lost some hair on the top of her head where it hurt the most. Her husband intervened in the conversation to say that he also had become half-bald when he had been *strese* (stressed) in a very stressful

period of his life.

I tried to help them by suggesting a neurological examination and I shared my ideas about the option of seeing a *spesialis* (specialist) for a CT scan. I promised I would ask a colleague about this possibility. On this occasion, I found out that there are not many private or public neurologists in Mauritius. Eventually, somebody provided me with the Chinese name and phone number of 'the best' neurologist. I texted the news to the family without taking into consideration that the cost of the doctor in question was around Rs500 to 800 (about £12-17 in 2010), excluding any other additional cost for medical tests. This was an amount of money that this family could not afford. The whole situation became very embarrassing.

Shortly after, the husband suggested a tisane. This was not the first time they had considered this possibility. A few weeks earlier, in the same family a child was treated with a minor injury. A plant treatment was applied on his wounds after a quick and efficient biomedical treatment in the hospital. The bandage and the prescribed antibiotics for the injury were up to par. The post-hospital home treatment with the leaves seemed to alleviate pain and accelerate improvement. The tisane symbolised and embodied family care. As a public GP system in Mauritius does not exist, they should have gone back to Hospital for follow up consultations. Home treatment prevented this. They told me that tisane for headache did not taste good. Besides there were rigid regulations as to how many times one has to consume it and at what part of the day. Yet, the wording and tone of voice of the explanation sounded quite convincing and encouraging. And, between the lines, it implicated a less costly expedient. Sadly, I am not sure if the issue of the headaches could ever be resolved. The example has shown that an ordinary working class family that is aware the possible option of using private biomedical healthcare but usually they cannot afford it. This family uses the public health sector to

some extent normally as they can access and afford it; however, the level of service they can achieve there is rather limited. Therefore, they rely great deal on other available, alternative methods.

Traditional healing

Linda Sussman's research conducted between 1977 and 1980 is the only significant study that deals with traditional or faith healing in Mauritius (Sussman 1981; 1983). She observed 32 households, 189 individuals and 279 episodes of illness, interviewed biomedical practitioners, homeopaths, traditional Chinese doctors, herbalists, folk herbalists, specialised secular healers, religious specialists and sorcerers. The results indicated a complex plural health system, where traditional medicine was mainly, but not strictly, based on ethnic divisions (see Appendix 6). Some of the healing forms and roles described by Sussman were later confirmed by Louwe (1986), Jensen (1986) and Hollup (1993), but similar sociological or anthropological research has not been carried out since.

In my research, I did not analyse this particular phenomenon, but from sporadic and anecdotal sources it seemed evident that this sector remains important in attending and dealing with all sorts of health and social problems in Mauritius, including those which could be categorised biomedically as 'proper' psychiatric disorders. For example, one of the staff members at Friends in Hope told me that the families of virtually all their clients have looked, at some point, for the support of some alternative healing practice. "Even Franco-Mauritians" she added.

The same topic also appeared occasionally in the Mauritian daily press, typically with some horror stories about captured charlatan healers who had charged clients exorbitant sums. Such items, along with rumours about animal sacrifice practices, compromise the image of Mauritius as a

modern, enlightened, religiously ‘pure’ and paradise tourist destination. This uncomfortable reality, especially if connected with analysis of the Mauritian caste system, seems to underlie the ban of Benedict’s (1961) and Chazan-Gillig and Ramhota’s publications (2009) mentioned in Chapter 2.

Public healthcare

In the following the functioning of public healthcare will be shown through the description of a public hospital, a dermatology, and a psychiatry out-patient clinic. The example will demonstrate that these spaces have an impact on what is done to patients. Specifically, the length of the consultation determines how much linguistic translating and understanding can take place between health staff and patients. Some more general, Mauritius specific socio-political connotations of public healthcare realities will be detailed later in the comparison section of this chapter.

Bottleneck and the patient crowd in the ‘Hospital’

‘Hospital’ in Mauritius does not only mean a building or an institutional entity. In the vernacular usage of the word, it means the public, or in other words, non-private healthcare in general. After independence in 1968, the new government led by the Labour Party – influenced by the Fabianist British Labour Party - gradually made healthcare and education free. In other words, a significant proportion (or sector) of healthcare and education came to be financed by taxes. The ‘free’ part of healthcare is what Mauritians call ‘Hospital’. Apart from a few, not very significant and declining dispensaries, ‘free’ or ‘public’ healthcare is practised in large hospitals. Not only in-patient care is

provided here but the Casualty and Out Patient Departments (OPDs) of the hospitals provide the great majority of out-patient care as well. Thus, primary healthcare is spatially adjacent to the institutions of secondary and tertiary healthcare. The Hospitals are relatively easily accessible due to the compact size of the island, good access, and communication. Thousands of people turn up, wait and stay in Hospitals every day. Even in the densely populated country of Mauritius, the monstrous hospital compounds are perhaps the most populated spaces after the markets. The bottleneck of this locality holds up the people, tries to deal with them, and then disperses them in different directions. The temporal span of 'dealing' with the patient is comprised partly of patient waiting by patients (the patient patients) and partly of the quick-to-sort type of biomedical conveyor belt. It is relatively easy to see a specialist, but difficult to obtain the thorough and lengthy attention of a specialist.

For some people the existence of these Hospitals and their 'free' service are major achievements and symbols of pride.[19] Many other Mauritians would never dream of entering a public Hospital.

Hospitals are often mentioned with this English word in Creole conversations too; yet, the French (*l'Hôpital*) or the Creole (*Lopital*) expressions do not sound very different from the English expression. The increased frequency of the usage of an expression in English instead of the other two variations expresses a more 'official', 'serious' or 'government-related' sense. Obviously, the proper and written names of the hospitals are also in English. All 'Hospitals', dispensaries, additional facilities and staff including the doctors in the public healthcare are centrally governed by the Ministry of Health. The contracts are decided centrally and they move doctors as figures on a chessboard. The

[19] I use the name of Hospital with capital H when I refer to the complex Mauritian institution and healthcare sector and not only the building or one of the specific hospitals that provide in-patient treatment.

placements are negotiated individually within the Ministry which is in charge of providing the few doctors available to the different ‘Hospitals’, usually accessible by car. Since most doctors, like the urban elite, live in the central Plaines Wilhelms, from here all hospitals are within about 45 minutes drive. (The distance to Brown-Sequard psychiatric hospital would be even less as it is located in the central uplands). Doctors who are willing to work for a long period of time in secondary hospitals, with a very limited in-patient capacity, like Poudre d’Or in the North or Savanne in the South, might have to move closer to the facilities, since they are far away from any central location.

The system works differently for the junior and/or generalist medical staff. They are often placed and shifted to areas, hospitals and other public healthcare institutions where an actual shortage has arisen. These doctors are often uninterested in the actual, current placement. Their onward-looking intention is to specialise, gain experience, save up to open a private practice, then move to a final or long-term place which is closer to where they live, or offers attractive advantages such as an individual contract. In the interim, they might have to spend a couple of years abroad. Nearly every senior ‘Hospital’ doctor has a private practice too, according to their area of specialisation. This is also true for doctors working in the Ministry of Health, in education, or in the judicial system as well. In other words, doctors are allowed to work privately, as long as they spend a couple of hours a day in the Hospitals. In the ‘Hospitals’ they work for fixed salaries, in private practice their income depends on the market. For this reason it is in the doctors’ interest to save energy and time during the hours spent in the public health system for their private consultations.

Dr S., a specialist Mauritian doctor was in charge of setting up a new service for the increasing number of IV drug addicts, who are often HIV-positive. Previously, he trained in the United States and was

influenced by ideas and principles of bio-psycho-social approach to disorders and patients. Sadly, like many Mauritian doctors, he could not use his training once he returned to his home country, for both practical and social reasons. In Dr S.'s case, he was able to take advantage of his training by working for years as a volunteer in an NGO, and giving up the possibility of a private practice. Instead of the usual one hundred patients per three hours in a generalist's consultation, the number of patients in the newly set up service was reduced to forty for the same period of time. The Ministry of Health provided him with junior and generalist doctors with temporary contracts and who usually disliked working with drug addicts. When they were offered the exceptional condition of having to see not 100 but 'only' 40 patients in three hours, they did not spend more time with them, but they left the consultation earlier to attend to their private clients.

I will present one of the hospitals now. The decision to build a new hospital in the north of the island was made during the late colonial times in 1956, and the plans were drawn up in 1962. Finally the Sir Seewoosagur Ramgoolam National Hospital (SSRNH) was built in 1968-1969 (Ramdowar 1998; Rajkoomar 2000, 21; Babooa 2005, 9) around the time when Mauritius had gained its independence. The opening ceremony was on 20th August 1969, and the hospital was named after the Prime Minister between 1961 and 1985 (with one year gap). Before its opening, there were only two main general hospitals. The foundation of the first goes back to the early French colonial times. Nowadays it is called the Dr A. Gaffor Jeetoo Hospital and is located in the capital, Port Louis. The second hospital was built on the urban central highland of the island, slightly uphill from Quattre Borne in Candos. This is the Victoria Hospital. After the SSRNH two more regional hospitals were opened, the Jawaharlal Nehru Hospital in Rose Belle and the Flacq Hospital.

With the new hospital in the north, the accessibility of healthcare

was greatly improved for a large, rural and often poor population. The Indo-Mauritian dominated government was also able to help its main electoral base, the rural, northern Indo-Mauritians. The SSRN Hospital may be regarded as the benchmark of an era. Some argue that as the hospital is still located too much in the vicinity of the capital, most people still have to travel a long way to reach it; smaller and decentralised units perhaps could have been a more rational but certainly less impressive choice (Parahoo 1985, 179). Babooa (2005) carried out a survey of 130 Hospital staff in 2002-2003. It was found that between 1998 and 2002 the attendance rate of nurses and doctors was about 60%, the attendance rate of managers was 70%. To explain this, 86% of all respondents and 96.7% of the doctors stated that the work was boring (ibid 69-73). Several other major flaws were also suggested, such as high personnel turnover, stress, burnout, somatisations (headaches), sexual harassment, and nepotism. The SSRNH has a large catchment area, serves at least 200,000 people if not more, and the huge premises include approximately 500 beds (Rajkoomar 2000, 23). It is located in countryside and surrounded by woods and agricultural land. A large bus station, a taxi stand, a few shops and food vendors are on one side of the road, the hospital buildings on other side. During the day, the two sides of the road and the hospital premises are crowded with people: patients, family members, hospital staff in white cloaks or in nursing uniforms, and uniformed guards. The staff seem busy and serious; the patients are many and patient. The architecture is the usual concrete cubic; the colours are light, whitish, yellowish, greyish and fading.

The number of people, the size of the building (the rooms, the hallways), the available space in the waiting areas, and the invisibly measured turnover ratio create the perception of an overcrowded place. However, this is an organised system. There are no major signs of panic, disorder or loud voices. It seems as if everyone knows his or her place

and role; they might not be very happy about it but are at least in tacit agreement. On the other hand, a sense of haste and over-stretched resources can be deduced from the facial expressions of both patients and staff. Upon arrival at the OPD building, the patients report to the reception area. The few square meters area in front of the reception looked like a scrummage and seems to be ruled according to invisible rules.

Every patient has a file in the hospital. This file is a classic paper folder, with the name of the patient on it. Sometimes, X-ray radiograms overgrow the size of the original folder. During the consultation the doctor has the chance to see all previous turn ups, illnesses and treatments of the patient. The written records are short, so an expert eye can get a fairly deep understanding about the previous history just reading through it quickly. The thickness of the file, occasional longer prints, radiograms, lab tests may signal by and large what had happened before. It is clear that there is no time to examine all previous documentation in detail, but the format of the file allows the doctors to concentrate on the practical relevance in the short time available to read it through. Writing new notes also takes about 15 seconds out of the 270 that on average a doctor devotes to each patient. The records, notes, tests, virtually all written documents are in English; the handwriting is hardly legible, containing loads of abbreviations and medical shorthand. It requires expertise, experience and skills to know the shorthand, understand the context well, read fast, think fast, and make fast decisions making the best use of this kind of documentation. Every now and then, the nurse steps out from the consultation room to the reception area to collect the files of the patients arriving in the interim time. The collected files are placed then on the bed in order. She calls for the next patient after each consultation sequence. The nurse knows many patients; she can recognise many patients already in the hallway and makes short comments to the doctor if necessary. The

co-operation between doctor and nurse seemed a perfect and smooth routine.

The dermatology out-patient conveyor belt

The dermatology out-patient clinic is known by the English term, ‘Skin OPD (out-patient department)’. During busy clinic hours, the corridors of the OPDs are crowded with people. During the 2-hour dermatology OPD, either morning or afternoon, a doctor sees about 20 to 40 patients on average; occasionally the number can reach 50. In this case, the 2-hour consultation time may be extended to 3 hours or more. At the end of the 1970s the daily patient number in Hospitals was reported to be between 50 and 300 (Sussman 1983, 116); this means that the current ratio may reflect a certain service improvement in the last three decades. There are 17 dermatologists in Mauritius: 7 work in the hospitals (in the public sector) as well as privately, while 10 work only privately. If a doctor falls sick, his/her substitution in the OPDs is not easy. The doctor, who works in the hospital in the morning, usually works in his *cabinet* in the afternoon and might even work at home in the evening. The dermatologists meet on Saturdays to discuss individual cases, to share their experience, and to have some social life. All dermatologists obtained their speciality degree abroad. There is no special dermatology in-patient department. If it is necessary, patients with severe *Pemphigus* or drug allergy, for example, can be admitted to the wards of Internal Medicine.

The hours spent in OPD are not entirely devoted to patients. Doctors may have to communicate with each other or with the management, on the phone or in person. On the day of my visit, the dermatologist received 20 patients in an interval of 1 hour 50 minutes. This meant 3-4 minutes per patient on average. The longest consultation was about 7 minutes. As the doctor explained, in case of new and

complicated cases the assessment time can rise up to 10 minutes. The patients varied by age and gender. There were many returning cases due to the often chronic nature of dermatological conditions. Some of them were referred by dispensaries but most came on their own initiative. It is clear that these patients can access a well-trained and experienced specialist in an out-patient department without any previous appointment. The clinical picture was quite average: for example, 4 patients had *Psoriasis,* one had *Erythrodema*. Other illnesses were *Sebborhea Dermatitis*, a minor pigment deficiency, infected wounds, *Alopecia Areata*, *Mycosis Pedis* (possibly caused by alcohol abuse and diabetes), and *Fibroma labii*. In each case, the diagnosis was fast and accurate; the instructions given to the patients were clear. At the end of each session, everyone was dismissed with a prescription. If the illness or condition like the minor pigment deficiency, for example, was not treatable, the patient was prescribed vitamins. The 3 to 4 minutes per patient included listening to the patient's explanations, examination of the skin, and diagnosis. If a patient wanted to continue with the consultation, it was the task of the nurse, who usually sits behind to patient, to stand up and to dismiss him/her with another file in her hands before calling in the next one.

While I was there, a very young mother brought her little child who had a fibroma on her lips. She was shy, and hardly said a word. From the size of the tumour, it was clear that it might have taken a long while for the family to bring the child to the clinic. Again, the diagnosis was fast. This condition required further interventions. The nurse gave the doctor the surgeon's number. During a phone conversation in Creole that lasted no more than 20 or 30 seconds the illness was explained and agreement was reached. The mother was referred to another OPD in the building; the nurse took up the task, showed the way and accompanied the family.

Another woman from a middle class socio-economic background, judging by her dress and speech, came because of *Alopecia Areata* (hair

loss from a circumscribed area of the scalp). The conversation was in Creole with her too. She was the only one who was asked about some possible stress factors, work, husband. This may have extended the consultation for a minute or two.

About 85% of the patients looked Indo-Mauritian, including a few Muslim Indo-Mauritians. All consultations were entirely in Mauritian Creole. It was obvious that the language of the people in public healthcare is Mauritian Creole. It was also obvious that the language of the Indo-Mauritian Mauritians who attend public healthcare is Mauritian Creole. During my stay everyone was speaking in Ordinary Creole during the consultations. I heard no Creole Fransize. The initial greeting *'Bonzour'* was sometimes but not always voiced; the farewell *'Orevwar'* was said only by a few patients. The Mauritian Creole language was commonly shared by the two parties. The extremely reduced doctor-patient relationship was based on the common understanding that here they have no time to enter into discussions as to what language or language variation to use. To fulfil the basic tasks, to treat a patient properly in 3-4 minutes requires that the doctor and the patient speak the same language. This does not mean that communication problems as such would not arise even within this short time, but it does suggest that without a commonly shared language the communication difficulties would have hindered the completion of basic tasks. The existence and use of Mauritian Creole is common sense in this domain. Despite the restricted time frame, the doctor-patient relationship appeared surprisingly good.

The nurses' style seemed serious, patronising and authoritarian. The pace of the consultation is controlled by the nurses whose style mirrors the communication and interaction between doctor and patient. The nurses' serious tone of voice and brief utterances are accentuated by the appearance of the crisp ironed nurse's uniform and bonnets. Privately, I have heard many horror stories from Mauritians about the rudeness of

nurses to patients in the hospitals. However, no similar stories were recounted about nurses who work in private healthcare institutions. The abruptness of manner is likely to be a role characteristic, specific to the particular healthcare system in Mauritius, where boundaries of hierarchy are maintained in this way. This hierarchical division allows the ‘free’ healthcare system to work at low cost but relative high quality. However, the hierarchical setup is not a random choice; it rather reflects wider relational social systems.

The patients are not really treated as responsible citizens, and time is a major factor in this. The short time makes the service economic, in other word inexpensive. The hurried time creates the sense that the providers and particularly the staff, including the doctors are doing their best. The orchestrated cooperation of the staff, the performance and delivery of professional roles seemed to be rational, practical and super efficient within the available framework.

The psychiatry OPD

The psychiatry OPD was in the same single-storey building. Sometimes 2-3 psychiatrists share and use one consultation room of about 15 square metres. This space embraces not only the doctors and patients but also the nurses and the relatives of patients. During parallel consultations of three psychiatrists, three desks and at least six chairs are in use at the same time. Cupboards, files, telephones and some medical equipment are also in the room and serve a continuous constant flow of patients. The consultation space lacks any privacy. The running of such a clinic requires a great deal of organisational skills. In about 2-3 hours, about 30-50 psychiatric patients attend the hospital, divided among the 2 or 3 psychiatrists who are working on that particular day. Twice a week a psychologist works in the hospital, providing the patients with private

sessions. When the psychologist is not there, the space situation is somewhat better. During my observation time, ten patients were seen in 45 minutes, which indicates an average of 4.5 minutes per patient. An epileptic young man on Valproic Acid treatment reported new fits and fever. A seemingly depressed lady suffered from Parkinson's syndrome. A man aged between 35 and 40 who was on antidepressants asked questions about the 'pension', the small payment psychiatric patients receive from the government if they are unable to work. A woman of the same age complained of *fatige* (fatigue)[20] and *tansion* (tension and/or high blood pressure),[21] was diagnosed with depression, and also asked questions about the 'pension'. A man in his thirties who had anxiety symptoms because of a long court case was prescribed Alprazolam and Paroxetin. A young man with a jugular cannula, accompanied by a policeman, presented withdrawal syndromes, mainly pain, caused by Subutex addiction. He was prescribed Diazepam. A middle-age man complained of epigastric pain. He had had tests and examinations for the pain earlier but with no clear results. Another middle-aged woman also complained about abdominal pain. This pain might have been related to a previous epigastric operation in Europe. She had also been seen by a surgeon and a cardiologist who suggested Carbamazepin. At first, she refused and when the term 'psychosomatic' was mentioned to her, she protested, saying she, indeed, felt the pain. The doctor explained to her that Carbamazepin actually had a calming effect, which seemed to re-assure her. She was planning to visit other doctors and undergo additional tests. An old lady, suffering from dementia and oral automatisms came in with her daughter. After her daughter described her mum's depression, insomnia, and nocturnal agitation, the doctor prescribed her a sedative.

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[20] Literally means tiredness; this Creole expression will be explained later.
[21] Somewhat similar to English, the feeling of 'pressure' and the diagnosis '(high) blood pressure' coincide and are often confused.

The majority of the patients were Indo-Mauritian, the rest Creole. One or two patients seemed to be from the middle class. All conversations, except one, were in Creole. The above-mentioned lady who had an operation in Europe spoke intermittently in English and in French (with a Mauritian accent); the psychiatrist spoke in English, French and Creole Fransize to her. All patients left the room with a prescription. In comparison with the dermatology consultation, the time per patient in the psychiatric OPD appeared to be slightly longer, and this made some difference. The attitude of the psychiatrist was welcoming, he made eye contact and asked some of them *Ki manier?* (How are you?) or similar questions. Sometimes there was even a slight physical, welcoming touch between the psychiatrist and some of the patients. In one particular case, when the psychiatrist asked *Ki problem?* (What is the problem?), the lady seemed to be moved for a couple of seconds. She happily began explaining her problems but both parties soon realised there was no time to really get to the bottom of the problems, and the session lasted the average four and a half minutes. No kindness at all was observable in the behaviour of the nurse; however, she showed professional competence.

This out-patient clinic was part of a regional hospital. The bulk of the psychiatric cases are not attended to here but in the only major psychiatric hospital, the Brown Sequard Hospital (BSH). The last published article about this topic reports that in the 1990s there were 875 beds there including seven wards with 475 acute beds, and 18 wards and 400 beds for patients with chronic problems (Motay and Burhoo 2003).[22] That time, in addition to the medical director, 6 psychiatrists, 6 generalists, and 2 psychologists were working in the BSH, while two psychiatrists and one generalist were working at each of the six regional hospitals, according to the same article. In 2005, a new structure was built

[22] The year of the research in Mauritius is given as 1998, some data included was from 2001 and the article was published in 2003.

in front of the 19th century hospital (Anonymous 2005). The in-patient units of this hospital have circa 700 beds (Bhagmal-Cadervaloo 2010). Today, about 9 psychiatrists and a few generalists and psychologists work in BSH. Apart from BSH, only the Flacq hospital admits a few psychiatric patients today in a ward of circa 20 beds (originally designed for patients who have problems with substance misuse). The out-patient section of the BSH has a tremendous caseload. It was reported that in 2010, 2,964 new patients were seen at the Brown Sequard Hospital each year, and the number of consultations was estimated at 250 per day (Anonymous 2005) and 70,000 per year (Bhagmal-Cadervaloo 2010). Additionally to the consultations at the BSH, in 2001, 32,900 patients were seen by the psychiatric out-patient departments and consulting rooms of the regional hospitals and a few satellite consultation venues (Motay and Burhoo 2003), like the one in the example above.

At the time of my fieldwork in 2009-2010, my informants told me that there were 23 psychiatrists in Mauritius. In addition to the 9 in the BSH, 2-3 worked in each of the five regional hospitals, 1 in the Ministry of Health, 1 in the Ministry of Social Security, and a few only in private practice or retired. The number of psychologists (or similar professionals) can be estimated as between 30 and 40 in the country, but many of them do not work in clinical practice.

Many of the patients are treated in the Hospital as its old wings function as an asylum. Given the lack of tertiary prevention, supported housing or residential care homes for psychiatric patients, most patients with chronic psychiatric problems must rely on family members. In 2009, 187 out of 400 patients no longer needed in-patient treatment but had nowhere to go (Anonymous 2009). A few weeks after my fieldwork finished, and after the general 2010 elections, the new Minister of Health visited the Brown Sequard Hospital and was shocked by the condition of some patients (Bhagmal-Cadervaloo 2010).

As regards psychologists, Foo Kune could only find 32 such mental health specialists in Mauritius and the association of the psychologists had only 11 members (Foo Kune 2005, 25, 28). The association is named *Société des Professionels en Psychologie* (Society of Professionals in Psychology), which was itself controversial:

> [Some] people felt this association was a small 'clique' of people who were mostly educated in France.[…] The members of the association felt that the people who were complaining were those who were not able to join the association because they did not have the proper qualifications and were retaliating. The people outside the association felt that the association consisted of people of a few ethnicities and was not open to all. (Foo Kune 2005, 52)

Only 16 psychologists worked in clinical settings (ibid, 29) and perhaps half of this 16 worked in public health practice. Most of those in private practice see mainly members of their own ethnic/religious group (ibid, 41).

The World Health Organisation published, somewhat inaccurately (2005, 313), that there was one psychiatrist and one psychologist per 10,000 population in Mauritius. As the year 2000 Census estimated the whole population about 1,100,000, it would give 110 psychiatrists and 110 psychologists for the country.[23] These figures are exaggerated in comparison with the findings of my fieldwork.

Private healthcare

The private sector can be divided into three different parts. First, the one and only, brand new huge private hospital in Mauritius will be described. This hospital does not have any psychiatric beds and does not

[23] The WHO publication quotes *La santé mentale en population générale : images et réalités* project, the Government's Annual Health Statistics and a few irrelevant publications from the Child Health Project as sources.

seem to intend to be involved with in-patient treatment of mentally ill patients. My interviews and direct observations will mainly focus on the two other types of private healthcare, the cabinet (the consultation spaces of private practitioners) and the clinique (private clinics, but the expression will be explained later) where I interviewed psychiatrists. It will be shown that the time and attention in these spaces will allow markedly different linguistic interactions between clinicians and patients. The diagnosis and treatment of depression and its connection with the semantics of the locally often used expression fatige (tiredness) will be discussed in a separate subsection. As more time is available to carry out the basic assessments of mental health disorders in private healthcare, private practitioners confront more semantic problems than do clinicians and patients in the state health services.

The Apollo-Bramwell Hospital

The Apollo-Bramwell Hospital is located in Réduit in the central uplands, near to the historic governor's residence, an 18th century colonial mansion, the University of Mauritius, the Mahatma Gandhi Institute, and the new Cybercity, in an area which offers probably the most temperate weather conditions on the island and highly sought-after real estate properties.[24]

The decision to build this 200-bed top class hospital was made in 2005, construction started in 2007, and it was nearly finished and more or less functioning during the time of my fieldwork in 2009-2010. It is part of an international network of private hospitals and is owned by the British-American Investment Corporation. It employs about 40 doctors. There is one psychiatrist among the doctors, who is supported by a psychologist. The hospital was built to attract foreign health tourism,

[24] http://www.apollobramwell.com. Accessed 24/04/2011.

especially from the Gulf States and India, and local wealthy patients who would otherwise travel overseas for operations.[25] The local *cliniques* are not equipped or staffed for certain complicated or expensive medical interventions, like open-heart surgery, brain surgery or for long-term opiate addiction rehabilitation treatment like public hospitals. Mauritian health tourism is also undertaken to obtain certain procedures more quickly. Waiting for a hernia operation in the Mauritian public health system, for example, could be about three months, for a cataract operation about a year. This new private hospital offers the procedure immediately. I heard about quite a few people who had been treated for different diseases in French or UK hospitals, including UK private hospitals, which would have been far too expensive even for an ordinary British citizen. Indo-Mauritians may travel to good quality Indian private hospitals, which are cheaper then their European counterparts.

An out-patient consultation could last on average twenty to thirty minutes in the Apollo-Bramwell, an amount of time comparable to the *clinique*s. In case of query or complications the time of the consultation in the Apollo-Bramwell can be extended. However, despite these results, the Apollo-Bramwell was unable to admit patients with psychiatric disorders during my fieldwork, but was starting to admit patients with somatisations and some psychosomatic disorders.

Dr R.'s *Cabinet*

Individual private medical practitioners work in *Cabinet*s.

[25] My informants told me that a consultation may cost Rs 300-500 with a private generalist and about Rs 500-1000 with a private specialist (excluding the laboratory tests and the price of the medication). In a *clinique* a routine check-up with basic physical examination, lab tests, ECG etc. can cost about Rs 5,000, a routine hernia operation may cost about Rs 25,000-30,000. In comparison to this, a 4-week stay for a routine hernia operation in the Apollo-Bramwell hospital, acommodating two family members as well, could be managed at around Rs 450,000 (£10,000). The latter is the price that a foreign patient, a "health tourist" pays.

Sometimes these are located in their own house, but more often in separately rented locations. *Cabinet* is pronounced as [kabine] in French (and in Creole) and not [kæbinət] as in English. It is usually written in the French form; the Creole written version would be *kabine* (identical with the IPA transcript). Some *cabinets* are rented by different doctors at different times. Some *cabinets* group together in clusters in urban areas, where the specialist doctors are more likely to refer patients to each other. Both generalists and specialists have their *cabinets*. The network of generalists vaguely resemble a primary care network, a bit similar to the British GP system, but with the major difference, that they are private doctors and their *cabinets*' location is determined by the market and not by egalitarian planning. Most *cabinets* are equipped with simple, but necessary equipment according to their specialisation. The doctor's name is usually hung at the entry, often quoting in abbreviated form all the degrees and qualifications he has. Sometimes the plaques mentioned the name of the country or city where the doctor gained the specialisations or qualifications. Some cabinets also have a receptionist, assistant, nursing staff, or guard, sometimes all these being performed by one person.

I met Dr R. in a private psychiatric practice in the evening when most Mauritian buses were no longer in service. Accessing a public institution around this time, about 7.00 pm, would be impossible for those without private means of transport because of the lack of public transport after these hours. The interview covered several topics. He talked about his experience in both private and public facilities, his professional career, and some specific cases.

His *cabinet* is located next to one of the major supermarkets in Mauritius. The cabinet was divided in two tiny rooms each serving for medical consultations. The tiny room was furnished with chairs and an examination bed. Dr R. was very kind and welcoming, one of my most open and sincere interviewees. He was an about 50 years old, a tall, slim,

fair skinned Indo-Mauritian dressed smartly in a striped business shirt. His professional and communication skills seemed excellent and did not treat me 'aristocratically' or with any sense of superiority at all.

The interview was carried out in English but we discussed a few Creole and Bhojpuri expressions. In his private practice in the cabinet, he would see about five patients in two hours, with an average of 20 minutes per patient. During the day, Dr R. works in one of the regional public Hospitals. There he sees approximately 30-50 patients per day in about 3 hours. He tells me that he has about 5 to 10 minutes for a new patient there and 2 to 3 minutes for a follow-up. There, his intention is to do the *first* follow-up after a new or newly diagnosed patient, so that he can devote the previous two to three minutes to the new case. If there are no complications it is the generalists' responsibility to prescribe the medication. However, Dr R. says that he can exercise some further control over the treatment of returning patients in the Hospital as the generalists usually attend the patient in the same consultation room. Dr R. thinks that 23 psychiatrists are still insufficient for the country. They numbered 13 when his specialist career began. In the mentioned public hospital there are two psychiatrists and one part time psychologist twice a week. Child psychiatry is practiced by general psychiatrists as well. Dr R. refers quite a few children and their families to the part-time psychologist who can provide speech therapy as well. In addition to the hospital and this private practice, he also works for a private clinic, the *Nouvelle Clinique Ferrière* in Curepipe[26] and teaches the psychiatry module for the Occupational Therapy students at the University.

I mentioned to Dr R. that he had the reputation of being the only Mauritian psychiatrist with a specialisation in Substance Misuse. He corrected this explaining that this degree was the result of a short course

[26] http://www.nouvellecliniqueferriere.com/eng. Accessed 24/04/2011.

about Alcohol Abuse given in Mauritius by trainers from Bordeaux in France. In Dr R.'s experience, the diagnostic spectrum in the hospital is very diverse, with cases of depression, psychosis, alcohol-related problems, anxiety, and suicide. He said that they do not see many Obsessive-Compulsive Disorders in Mauritius, and that eating disorders are very rare. Even among the eating disorders only bulimia seems present and anorexia is a real rarity. The latter information was confirmed in another interview by Dr F., another Mauritian psychiatrist who received partial specialisation training in Child Psychiatry.

Anxiety disorders dominate Dr R.'s day at the private practice. In his experience, it helps that most modern medicines are available in their generic version in the hospital and in the hospital's pharmacy. These are cheap for the hospital and free for the patients. Dr R. studied in India. The medium of instruction is English in Indian Medical Schools, but his Hindi also improved during that time. He can distinguish well the typical Bollywood Hindi, for example, a Hindustani offspring, from the language of a few other Indian films where the actors speak current standard Hindi. Later, he worked in paediatrics and in the Middle East as a generalist. There English was the first language but Hindi was used in communicating with Indian and Pakistani colleagues, and he picked up some Arabic while speaking with patients. His intention was to obtain a specialist degree in the UK but went to France instead.

Dr R. also speaks Mauritian Bhojpuri. He finds it useful in communicating especially with elderly patients. These patients can perhaps report a symptom or complaint more easily when speaking in Bhojpuri. This may also help to create a bond between clinician and patient who belong to the same 'ethnic' group. Nevertheless, they do not speak Bhojpuri during the entire consultation. The interlocutors use their common language, Mauritian Creole, to describe and talk about some Mauritius specific symptoms. In the Mauritian Bhojpuri version the *(mo)*

latet fatige expression (lit. '(my) head is tired', but meaning 'I feel down' or 'I'm stressed out') appears as *(hamar) kapaar fatige* ('kapaar' is 'head' in MB). The word '*fatige'* is identical in both versions. Therefore, Dr R. notes that the patients tend to speak creolised Bhojpuri. He, having spent many years in Hindi speaking areas speaks a more Hindi-ised Bhojpuri. This confirms Eisenlohr's (2006, 53) description of simultaneously existing Mauritian Bhojpuri entities as described in Chapter 2. Psychiatric consultation can be one further domain where this linguistic setting appears and it seems that competence in Mauritian Bhojpuri can certainly help to treat some patients more successfully.

As far as Dr R.'s private praxis is concerned, the main language of communication is Mauritian Creole; only a few patients speak French. In his practice, even French-speaking patients tend to use key Creole expressions: *fatige* (depression), *vertiz* (dizziness), *latet vid* (empty headed). It is important to stress the fact that French-speaking patients turn to the Creole (or creolised) expressions when they talk about their symptoms, which suggests that those expressions carry the strongest individual affective value.

As in other centres, the records are kept in English and Dr R. quotes the patients verbatim in Creole when writing. This note keeping practice is similar to the habits and rules in the public healthcare system.

Overall, Dr R. presents good linguistic competence in Mauritian Creole, French, English, Mauritian Bhojpuri and Hindi. He is pentalingual. In addition, he has some competence in Arabic. Being pentalingual seems to be not just very useful but quite normal for an Indo-Mauritian psychiatrist. Benefiting from the chances to become multilingual one can collect linguistic capabilities to maximize one's chances of acting as a successful practitioner. All languages have their role and place in the linguistic domain of mental health provision. It is important to remember that these languages are not hermetically

separated entities and that boundaries among them can be blurred, so that the actual conversations, with all the possible meanings, linked relations, and chances for healing effects can penetrate back and forth across these permeable boundaries.

Nouvelle Clinique du Bon Pasteur (The New Clinic of the Good Pastor)

A clinic, or c*linique,* is a private healthcare facility in Mauritius. Mauritian public heath does not have 'clinics'. The pronunciation of English and French (and Creole) versions are very similar; nevertheless, *clinique* is typically spelled in French. These clinics offer both in-patient and out-patient services. Their services are paid for either completely by the patient or by private insurance companies. They are much smaller in size than the 'Hospitals'. Their distribution in the island is uneven; the majority are located in quiet, middle and upper class residential areas of the urban Plaines Wilhelms district of the central plateau of the island. They provide routine treatment but are not resourced for very complicated or expensive interventions, like open heart surgeries, for example, because the affluent segments of the society tend to travel abroad for more complicated treatments. In addition, very recently, well-off patients started to attend the brand new Apollo-Bramwell Hospital.

In Mauritius, private clinics are owned by private investors and doctors are hired by the clinics on individual contracts. Sometimes the clinic offers the doctors consultation in exchange for a shared income. Many doctors work in a clinic for a long time but they can be dismissed as well. An attempt was made on the island to open a psychiatric clinic, but that experiment failed during my stay. There were not enough affluent Mauritian psychiatric patients to service a local private facility.

The *Nouvelle Clinique du Bon Pasteur* can be found in a quiet side

street of central Rose Hill. This clinic opened before 1980, and another eight were founded during the following decade (Ramdowar 1998). Inside, everything is spotless, and fresh white colours dominate. About half a dozen people were waiting on the veranda when I was there. Here I met Dr M., a private specialist psychiatrist. He had studied and worked in France and had been employed in Mauritius for the last twenty years. After a few years experience within both the private and public sector, now Dr M. works exclusively in private healthcare. He told me that after his return from France, it was not easy to get used to the fact that every document had to be prepared in English. For many years, he has been involved in a research project with the Mauritian Institute of Health that studied the verbal representation of the patients' narratives, particularly the difference between the use of Creole and French. He confirmed to me that in the Hospital the language of communication between patients and practitioners is Mauritian Creole. In private practice however, the language of communication is mainly French, and only rarely Creole.

While, as we saw earlier, a psychiatrist in the public sector has to see about 50 patients in the Hospital, in this private clinic a psychiatrist sees about 15 patients per day. This means that here, in the practice of Dr M. at the *Nouvelle Clinique of Bon Pasteur*, approximately 20 minutes are allocated for a follow-up consultation. On average, he is able to see one or two new patients per day. More time, approximately 30 minutes, can be dedicated for new patients, which seems to be enough for the psychiatrist to ask the basic, necessary questions. For example, in case of symptoms of depression he has the time to ask fundamental questions about appetite, sleep, marital life, daily routine activities, and work performance.

Psychiatry often deals with chronic conditions. For example, the medication treatment for depression usually should take at least 6 months according to current guidelines. However, in private praxis, the patients

often pay by consultation and not by treatment. Therefore, the patients' interest is that they only attend the clinic to get their diagnosis properly, know about the associated treatment, and wait until the proper treatment is decided. After that, many patients stop attending the private consultations to save costs, as they do not necessarily have to attend private care, because the Hospital can repeat prescriptions and carry out quick follows-up. This is true, in particular, for cases that are more serious. Many of Dr. M's patients, for example, go to see him about three or four times, but then they continue buying the medication on their own in the pharmacies or they attend Hospitals where they have access to free healthcare and medication. Nevertheless, according to a persistent rumour, people seem to believe that drugs supplied by private pharmacies work better than those from the Hospital's pharmacy do. This is probably due to the fact that the pharmacies located in private clinics often sell branded products from international pharmaceutical companies in attractive packaging, whereas the Hospital's pharmacies provide generic versions packaged locally.[27]

Patients are often prescribed high doses of medication and diverse combinations of several drugs in the hospitals, hopefully with good results. Dr M. told me that in private practice less medication is prescribed because here there is more time to ask patients basic, fundamental questions, and therefore the indication of the medication is more precisely targeted. The patients, whose conditions are complicated or for whom the treatment is difficult or unsuccessful may tend to consult

[27] Nowadays, big pharmaceutical companies, typically located in the United States or in Europe, have approximately 15 years of patent for a newly synthesized molecule after their own genuine research. However, the trial and registration process is lengthy and must be made in various different countries. Therefore, they rush to make the most profit out of it in the fastest possible time using all available and affordable promotional techniques. When the patent is over, many other factories are able to produce the same medicine at half price or cheaper. Their brand name is less promoted and they often try to save up on packaging, format, taste and other secondary attributes.

several psychiatrists if they can afford it. It is a commonly shared opinion that complicated cases typically do not get more time or attention in the hospital.

The 23 Mauritian psychiatrists know each other; they often work or have worked together, and they meet to discuss cases at the Mauritius Psychiatric Association, or at dinners organised by pharmaceutical companies. Dr M. felt it was usually not a major issue to ring a colleague to discuss a patient who tends to turn up at the consultations of several psychiatrists. In private practice, one may have enough time for such phone calls; nonetheless, professionals have different personalities and some of them are easier to approach.

Dr M. works five days a week and does not do on-call service. In case of emergency, patients are expected to attend the Hospital's casualty consultation. The working day starts in the morning with an afternoon break after lunchtime. Consultations start again in the late afternoon until the evening. Dr M. has also worked for another private clinic, the *Fortis Clinique Darné*, in Floréal.[28]

Fatige*: depression*

The example of depression can highlight the linguistic aspects of recognising and dealing with mental problems and the differences in public and private healthcare. In the conveyor belt of public healthcare, even if this word is mentioned, there is not much time and willingness to address its specialities. In private healthcare where there is enough time and attention to reach the basic standards, the clinicians are confronted by the apparent linguistic ambiguity of the expression. They may struggle with how to harmonise the semantic knowledge of being a native speaker,

[28] http://www.cliniquedarne.com. Accessed 14/04/2011.

mainly in Creole but also in French and in the intermediate and crossover variations, and the medically standardised conditions and their names (the symptoms and the diagnoses), which they studied in English and standard French. Just like my host family, I often heard the Mauritian Creole expression *fatige,* which can have the dictionary translation of 'tired'. Mauritian mental health professionals I met, including Dr M., think that *fatige* does not only mean being physically and emotionally exhausted, but is also used instead of being depressed. The English word of French origin 'fatigue' is a word that can be used in the medical diagnosis in English as well, like Chronic Fatigue Syndrome.[29] This diagnosis is based on the symptoms of severe, prolonged disabling fatigue, musculoskeletal pain, with impairment of concentration, memory and sleep but without any other medical and psychiatric cause (Fukuda et al. 1994). The *fatige* seems similar but in fact it is markedly different and more common in Mauritius. The expression is part of the vocabulary of everyday language use; that is, it is to assume that the *fatige* feeling is shared commonly across the Mauritian population. Most people would probably identify with a state of mind he or she has experienced at some point of time in life when this word of their mother tongue was used in an every day conversations. Feeling 'tired' either in French, or in English and probably in many other languages can be used both in the sense of physical tiredness, or in the sense of a more complex physical and psychological exhaustion. The French-origin word 'fatigue' means tiredness in English. Neither the French or English words, however, would give back the exact state of mind, the exact perceived and recalled emotional matrix that the expression *fatige* entails in Mauritian Creole. Because of this extended semantics of the expression in comparison with the French and English equivalent terms when the patient presents his or her condition using this

[29] Attested in English since the mid 17th century according to www.etymonline.com. Accessed 30/04/2011.

word Mauritian psychiatrists tend to diagnose depression.

The expression *fatige* can even take an emphatic position in Mauritian Bhojpuri conversations. The use of it would probably be understood by another Mauritian Bhojpuri speaker. Therefore, the word *fatige* should be regarded as part of the lexicon of the Mauritian Bhojpuri language. Evidently, the word *fatige* is not part of the lexicon of Indian Bhojpuri dialects. As the *'fatige* feeling' is shared across the population of Mauritius, it is shared both amongst Mauritain Creole and Mauritian Bhojpuri speakers.

The French expression *déprimé*, on the other hand, does not really make sense in ordinary Creole since it simply does not belong to the usual lexicon of Mauritian Creole language. An ordinary speaker would probably have some associations while hearing *déprimé,* but would not use the word in his or her vernacular speech. Nevertheless, Mauritian French speakers or Mauritians speaking French may use this word in the context in question. As long as the conversation of a consultation or counselling is in French in Mauritius, as it indeed is in clinic of Dr M., the expression *déprimé* (depression) can be used and is used. However, this usage may mean an in-situ translation of the feeling *fatige* to the medical term *déprimé*. Whereas in public healthcare, where the transmitter of feelings and thought is Mauritian Creole the term *fatige* is used instead when the condition is named. French native speakers probably established a semantically consistent lexical entity regarding this word. However, when the professional speaks French or Creole Fransize but the patient speaks ordinary Mauritian Creole confusion may arise. To identify the small yet important nuances between *fatige, fatigué* and *déprimé* often requires time during the patient – professional encounter, and this kind of time is something of which there is not much in the public healthcare sector. The time spent on discussing the semantic details of the patient subjective experience makes a fundamental difference between the two

sectors. Clients in private clinics can afford to ask for the time necessary to reach a relatively precise diagnosis. From the interview with Dr M. and other Mauritian mental health professionals it became clear that clinicians often act as interpreters and think their job is to explain to the patients what a French medical term like *déprimé* actually means.

Comparing biomedical sectors: remarks on 'public' and 'private' and the linguistic aspect of segregation

The *Gouverman* (Government) with capital a G is a major source of disquiet in Mauritius. The overemphasised preoccupation with the *Gouverman* goes back to colonial times (Benedict 1961, 143). Following his fieldwork, Benedict reported that in the mid 1950's 'government' meant the 'other', a "nebulous concept, impersonal, a straw man on which misfortunes, disappointments and frustrations can be blamed". Forty years later Hollup (1993, 281) talked about Mauritian politics in these terms:

> Public attention is focused around a small number of political personalities and not on the particular party's program or ideology. Everything tends to be politicized, symbolised through the distribution of political (state) patronage from government officials, politicians and ministers… […]. The provision of basic public services and their distribution are in fact considered by [the] people as the personal achievements of a particular minister who was elected in the constituency.

During fieldwork, I have frequently heard the people articulating the word 'Government' with a stifled voice, in a manner suggesting 'other', different, and above and not as something that they elected, own, control, or identify with. This 'other' also represents something mighty,

stable, powerful, and detached from the ordinary citizen. The ‘good government’ here acts like a patronising father, who takes care of infants and not of mature individuals. The ‘good Mauritian citizen’ is simultaneously unquestionably loyal to his or her own ‘identity group’ and works hard at maintaining the harmony of the ‘rainbow nation’. This ‘good citizen’ is, however, in a subject position towards to the Government with a capital G, in the maintained and persisting hierarchical stratification and towards its own elite whose power is largely based on the manpower of subjected fellow-members. In this setting, the *Gouverman* is framed as an institution, which is meant to protect paternalistically and discipline its subjects. The elites of the communities are the carriers of ideology and self-conceive themselves as educated, morally-spiritually orientated, and supplying the in-group subjects with ‘cultural’ practice.[30]

The institution of the ‘Hospital’ with its particular spatial and organisational setting and the lack of individualised primary care reproduces and maintains a specific hierarchical social structure. From the interviews and numerous daily comments it seemed that doctors constitute an elite in Mauritius: privileged and well paid. During colonial times, as in the case of many other prestigious positions, most doctors were white Franco-Mauritians, or at best mixed origin upper class mulattos. Since the free public health service started, very few white Mauritian doctors work in Mauritius. The situation has changed because many middle class Indo-Mauritians can now afford to become doctors, and the government expects young doctors to spend some time at the beginning of their career in the public sector. This profession is demanding in regard to the expenses of study and the effort one has to

[30] Except the Franco-Mauritians who no longer have a major *petit blanc* mass to stand behind them. The Franco-Mauritian elite can appeal for support to some segments of the upper class Creole groups but sometimes it remains its own subject; an elite that can only govern itself.

make to acquire the requisite qualification. It is a well sought after and desired job. Usually only wealthy and educated families can afford medical studies for their child. To become a specialist doctor one has to spend a long time abroad. However, it is well remunerated and the respected social role is gratifying. One of the consequences is that the rift between upper middle class doctors and patients in the 'public' Hospitals is huge. The doctors' role here is to provide expertise during a short time dictated by economic efficiency. It is not a predominant task for the doctors to support the patient in their decision-making about their own health. Patients in public healthcare are considered too 'uneducated' and ignorant to be able to make any decision, and less able to exercise a direct influence on the health system.

Nevertheless, many patients are happy that Mauritius has a 'free' healthcare sector and they can benefit from it. The country is not only among the first in the line of GDP per capita in Africa, but has also seen a huge improvement in health indicators. There is a general satisfaction when they compare their health system with Africa or India. However, just like in many other areas of Mauritian society, this relative wealth and progress is due mainly to its elitist and etatist postcolonial system. The segregated system of healthcare mirrors a similar trend in education. In the same way that some people would never set foot in the 'Hospitals', their children would also never set foot in the State Secondary Schools or even at the University of Mauritius. It seems that two (at least, but possibly more) parallel worlds coexist in Mauritius. The segregation occurs in a cluster of domains. For example, the same people who would never attend a Hospital, and whose children would never attend a state school, would also hardly ever use public transport. They would live in upmarket urban suburbs, for example in Floréal, or in a *kampman* (seaside private residence), in comfortable geographical segregation. These segregations are also present in the particular use of language,

which is more specific to Mauritius.

As well as improvements in its health indicators, the country has achieved tremendous progress in literacy and education since independence, but both sectors still suffer from social divisions and segregation. The difference in Mauritius between healthcare and education is that education draws a lot of attention and its issues are a real public concern, but this is much less the case with the healthcare system. Atchia Emmerich's survey on language use is the only published socio-linguistic piece of work that looks at language as used in biomedical healthcare. One question in this survey asks about language use with doctors (Atchia-Emmerich 2005, 167). The result suggests that Creole and French are the main instruments of communication between patients and medical doctors, and not English or any other language. Apparently, the society is divided into those who predominantly use Creole and others who use French to speak to doctors.

The public sphere, which is in fact associated with the powerful Government, divides the usage between English and Creole. English is for written purposes and for professional terminology, Creole is for verbal interactions. The more 'public' means a clear-cut division between written and oral for Creole and English being two obviously different entities.

In the 'private' sphere, the difference between spoken Creole and French is exacerbated despite the fact that the two languages are related and have numerous variations in common. The usage of French and Creole Fransize is associated with a distancing from the 'Government' and a latent opposition to it.

Both 'private' and 'public' healthcare in Mauritius need translations in their functioning. This is of particular importance in psychiatry where the medical categories are less objective and 'suffer' from the semantics of 'particular' languages and where human communications form the major part of diagnosis making and treatment. Narrowing the analysis to

mental healthcare, where the clinician-patient encounter is evidently about more than just conveying factual information, it seems more obvious that the burden of the translation is on different shoulders in the two localities. In private practice, if the patient prefers speaking in French he or she has to translate his or her mother tongue (and 'mother feelings' and 'mother thoughts') to French. The prestigious and more formal segments of the clinician-patient dialogue is in French to construct and express the prestige of the situation, but some of innermost verbal expressions connected to the personal problems may be voiced in Creole (or even in Bhojpuri). The ongoing dialogue embraces a continuous dynamic back and forth motion between the variations. French is one of the languages where modern psychiatry is exercised, even taught and developed. The clinicians are familiar with French terms in psychiatry, due to their training in French speaking countries or because they belong to the elite. When the patient speaks in French, the psychiatrist may be in a comfortable position as the French words and sentences can be matched against the language of psychiatry. On the contrary, in the 'Hospital' practice, the burden of translation is on the psychiatrist. The dialogue here is carried out in Creole as the setting lacks the attributes of prestige and is designed for the 'people' where the language of the 'people' is supposed to be used. It is the clinician who has to translate what the patient is saying into the language (terminology and thinking system) of psychiatry, which is expected to be conducted in English here. The patient is speaking in one language, the psychiatrist has to think and record simultaneously in another in order to fulfil his or her professional role.

Summary

Public provisions offer a minimal but free benefit under the control of a powerful and paternalistic government. Within the frame of

biomedical approach, private provisions offer sufficient but not luxurious service. Language use in consultations often mirrors the social divisions specific of Mauritian society. In mental healthcare, where verbal communication has a vital role, during the short moments of clinician-patient encounters in public healthcare the clinician has to translate the patients' words in colloquial Creole to medical terms and actions quickly and efficiently. In private mental healthcare, there is a trend that the patients are meant to translate their experience into more prestigious Creole variations or to French where this experience becomes closer to the clinicians' specialist language in French and English.

Chapter 5. The Century

Introduction

In this chapter, I will present one of my fieldsites, a school in charge of mentally and physically disabled children. After describing the setting, the daily life and the difficulties that this NGO has to face, I will analyse a specific episode which occurred during the teaching activities carried out in the institution. The purpose is to illustrate the pervasive influence of unresolved linguistic issues in Mauritius.

The Century in Plaine Verte

The Century Welfare Association is an Islamic Charity Association based in the Capital, Port Louis. The site is located in Plaine Verte, in the 'Muslim' area of the city. This is a lively neighbourhood around a big green square with an important bus stop and a market. Non-Muslims often warned me not to go to Plaine Verte as I was a visitor. These warnings usually refer to alleged drug trafficking in the main square. However, in daylight, the area looked like just any other busy and bustling parts of the city, full of children, the elderly, and crowded retail shops. In this area more men wear beards and/or *taquiya* while women wear shawls to cover their head but are rarely veiled. The square hosts occasional political rallies, such as the one during the election campaign in April 2010. The zone also bears the memories of riots and clashes between Muslim and Creole gangs in late 1967 (Simmons 1982, 186). A Muslim informant proudly drew my attention to the rarely mentioned use of Bhojpuri, nowadays more associated with the Hindu community, in Plaine Verte.

As a consequence of the 1967 Muslim-Creole riots, the less well-off Creoles moved to Roche Bois and Saint Croix in the north or to Cassis south of Port Louis, while at the same time affluent Creoles moved to Beau Bassin and other upland towns (Hollup 1993, 144) or emigrated. Muslims migrating to Port Louis from the countryside replaced the Creoles in Plaine Verte and it became almost entirely a Muslim neighbourhood with two Catholic Churches as a reminder of the past. This movement of population created the perception of a 'Muslim area' surrounded by 'non-Muslim areas'.

The Century Welfare Association is located in the Cité Martial section of Plaine Verte, a few yards away from the main road in a tiny street facing shrub-covered Le Pouce Mountain. The ample building looks onto a small cul-de-sac and projects a welcome shade onto the inner yard and the benches resting next to the wall.

The Islamic foundation traces its history to the late 1960s.[31] The land was donated to it in 1977, and the building was gradually completed and extended from the 1980s to date. The school was opened in the late 1990s. The centre offers a variety of activities and services. Its mission statement as is "To promote and enhance the social welfare of Mauritians by providing voluntary committed services". Among the public services, apart from the school for children with learning disabilities and special needs, they also a have a school for adolescent girls let down by mainstream education, a computer centre to attract young people and help them in their studies and education, a gym, a women's centre and a training kitchen on the first floor. They also run Arabic classes and Islamic religious education courses for young people.

[31] See it also http://www.centuryassociation.org. Accessed 26/03/2014.

NGOs and Disabilities

The overall picture suggested that, in Mauritius, the care of patients with physical and learning disabilities is almost completely outsourced into the NGO sector. The presence of the NGOs fills a gap in the provision of the national health service run with the ambition of resembling European welfare systems, albeit for a socially stratified society.

The government exercises control over the NGO sector. As Mauritius is a small country, people who are involved in this sector are often personal acquaintances of one another and fulfil both governmental and non-governmental roles simultaneously. The Mauritian government offers partial financial support for NGOs dealing with general and burning social problems. It is keen on supporting active NGOs because the organisations have responsibility for their own finances. Furthermore, disabled children are more likely to attract the attention of charities. This is true for local, modest charities, as well as for rich foreign ones, for international grants and charities with transnational, overseas activity. Consequently, quite a few NGOs in Mauritius work with children and with disabilities.

The care offered by NGOs and other organisations with limited and occasional finances makes the care of chronic, pervasive social problems – like disabilities – occasional and somewhat unstable. Distance, location, and transportation play important roles in attendance, enrolment, and daily functioning of this particular centre. There could be children and families, however, who do not have the benefit of a NGO school or care centre like the Century in their neighbourhood, and many families do not have access to transportation. For this reason, and despite the activity of many NGOs, many disabled children fall through the net of a somewhat random social care system. The same happens with other, less popular,

urgent social problems which are without a representative charity.

In conclusion, Mauritian NGOs that are active in social help have an essential role in the general service structure but their job is very demanding and requires plenty of effort and goodwill.

The school at the Century Welfare Association

The school, which could be also as regarded a day-care centre, accommodates children with moderate to severe learning and physical disabilities. It forms an integral part of the larger framework of the association, and it is not isolated from the rest of the sections and activities. Although the safety of the children is looked after, the doors are open and usually there is some flow of people in and out of the schoolrooms. The school until recently was divided into two classes, a bigger one for the more severe cases and a smaller and newer one for children with less severe disabilities. The larger classroom occupies a large, cool and well-maintained room on the ground floor of the building with its own kitchen and toilet facilities. This is the heart of the school and especially during the mornings it is the liveliest part of the whole centre. Fast spinning large fans make the air and the temperature tolerable even in the unbearable heat. The larger classroom is used to host occasional meetings and workshops. During the time of my fieldwork, a small room was created and refurbished in front of the main schoolroom with the purpose of offering a more dedicated place for teaching classes of the smaller group. The management of the school has close connection and daily contact with other sections of the centre.

The on-site school manager has a small desk by the door of the main schoolroom. The children who are able to sit and engage in activities like drawing, painting, and handicrafts sit at a long table on one side of the room. They are usually the older ones. A few, younger children

sit around two or three smaller tables in the middle of the room. The staff, when they are able to sit down, occupy a third table on the far side. Many children, however, move around freely. Some, whose behaviour may become unpredictable or aggressive, are not allowed to leave their chairs and sometimes are tied to them. Two large elevated beds and a few mattresses next to the back end of room, which also gets some light from the backyard, are the dedicated places for children who cannot move due to apparent tetraplegia or similar conditions. Apart from the manager, at least four or five members of the staff are usually around the children; one of them is a teacher, and the others are carers or support workers. All of them are women, typically between 30 and 50 years old; many of them have been working in the centre for many years. Only one teacher takes care of the other, smaller class, but if the children have not arrived or have already left she also joins the staff in the main room. Some female visitors or workers, who are well known by the staff, may pay a visit during the day. All the working females appeared to be Muslims but only a few of them were wearing shawls on the head. Some carers follow the traditional Muslim fashion and are clearly recognisable; however this is not true for all of them.[32] The male site manager of the centre, a respectful, thin middle-aged man, wearing beard, glasses and *taquiya* may turn up if needed at the door showing a great deal of respect towards the women working in the rooms. On one occasion while I was visiting the school, the staff was supported by a few students from the faculty of Occupational Therapy of the University of Mauritius. For a few hours, young men and women were involved in the care of the children.

Despite the traditional role of Urdu and Arabic, and the chronic rivalry between pro-Urdu and pro-Arabic sections of Mauritian Muslims,

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[32] The fashion of female Muslim dress has been changing. Many females started wearing dresses that look ‘more Muslim’ (Jahangeer-Chojoo 2002). Most Muslim females, however, just look like any non-Muslim Indo-Mauritian female, except that they traditionally favour shalwar kameez, over saris.

a great deal of Mauritian Muslim religious activities are delivered in Mauritian Creole (Rajah-Carrim 2004; Donath 2009; Kalla personal communication 2010). It appears that Mauritian Creole is spoken more in mosques than Catholic Churches that are meant to be the strongholds of the (ethnically) Creole cause. Another Muslim informant told me that in the back rows of the devotees during the Friday night prayer in the mosques many people pray to God, that is to Allah, in Mauritian Creole, calling it *Bondie*. While attending the Centre, I realised that all conversations amongst the people were entirely in Mauritian Creole. There was an outer notice board on the wall between the main hall and the classroom of the severely handicapped children. The printed notes, like advice about the courses, times, dates on the notice board were mainly in French and at lesser proportion in English. The website of the association is entirely in English. A few printed copies of another Islamic association's newsletter were found sometimes in the hall. Those were written mainly in Mauritian Creole, with etymological orthography.

Problems with diagnostic clarity

No psychologist, psychiatrist, or other trained mental health professional is attached to the Century school. As mentioned earlier, specialised child psychiatric or child psychological service, let alone juvenile neuropsychiatry, has not yet come into existence in Mauritius. Some children were taking medications prescribed by generalists, paediatricians or psychiatrists. However, as usual and just as in the case of adults, the children seen in the governmental sector do not get more than a few minutes attention from the specialist doctors. As a consequence, even in this area, the biomedical treatment is limited to medication, and does not cover a complex bio-psycho-sociological approach. Sometimes, staff members may accompany the child and the family to the Hospital

consultations. Then, with a prescription in hand, they may feel again the lack of integrated service and comprehensive planning, which, in an ideal world, should meet the complex needs of a particular child with his or her particular illness or disability.

For example, an adolescent Creole girl in the school was having active auditory hallucinations. She was in the group of teachable children, where she was one of the oldest. Her attention was often distracted by her hearing of voices. Her speech stopped every now and then, and she looked rigidly elsewhere, seemingly concentrating on something else, caused probably by a state of *rhexis* (thought stoppage). When this happened, her inability to speak was accompanied with short catatonic periods when the extremities were fixed in an unnatural position. Thus, her behaviour was sometimes bizarre. She also shared with us some delusional thoughts of religious (Christian) content. Yet, in the moments when she was not troubled, one could have normal conversations with her and she even tried to follow the normal school activities. She told us that the voices were telling her to break the table but that she was able to resist the order. Overall, based on a brief impression, she seemed to present an early onset psychosis. She had been seen by psychiatrists in the BSH, as are most people with psychiatric conditions, and had been prescribed medication on a regular basis. Nobody knew the name of the medication, but her behaviour improved after that. For her, as well as for her family, the principal concern was her future. There was no planning or communication among the interested parties, or discussions on the prognosis to address her individual needs. A charitable NGO can offer its goodwill and make, perhaps, some efforts to liaise and comment upon the problems, but even with the best intentions it may be unable to mobilize and strategically co-ordinate the complex care of a complicated or difficult mental health case.

The school embraced a number of children with various

diagnostically and prognostically unclear conditions, some with learning disabilities and many with mixed learning and physical disabilities at very different levels. It was a common understanding that these problems can be called upon by the common term *'andikap'* (handicap). However, the biomedical investigation usually stopped at this point and the very nature of the set of the problems remained undifferentiated due to the aforementioned limitations and underdeveloped co-ordinating circuits. Precise diagnosis was not given and individual needs were not assessed in the context of individual socio-cultural backgrounds, or discussed in prognostic terms. The workers of the centre explained that the doctors of the hospitals were always busy and they had no intention to develop multi-agency cooperation. Families tried to elaborate their needs and suffering in lay terms and used services in a rather *ad hoc* way. NGOs like the Century did have experienced lay staff, but without the necessary training in order to work in an efficient and coordinated manner. At the same time, they struggled to survive financially.

Therefore, in scientific, professional terms, 'handicapped' children were homogenised because of the lack of individual diagnosis. Most of them had chronic conditions; many have been attending the school for many years, seeing the same carers and staff on a daily basis. The carers knew the children well, their likes and dislikes, as well as their family and social conditions. This place was not distant or alienated at all. It was full of life and often full of joy. However, the carers' knowledge of the children was based on practical factors, with many subjective elements. They were grouped according to whom was able to receive a class or not, who was able to sit at a table, who could be left on his/her own, who could eat on his/her own, or not move at all. The group of children affected by tetraplegia, for example, occupied the tall beds and mattresses, and needed to be moved and turned over from time to time to achieve a better blood circulation. Some of those severely disabled

children produced some sounds, which were at times interpreted as if the child might have felt the need to be moved somehow, into a more comfortable posture. This was the way problems were addressed on a down-to-earth, practical level.

A day in the centre

The daily rhythm of the school has many busy moments that require plenty of organisational skills and a lot of experience. The staff explained to me that there was a time when the school could help the families of the children with transportation to the centre but this ceased due to lack of funding. Therefore, families help each other or hire taxi type transportation. Although the bus stops of the main bus lines are only about 200 meters from the school, public transportation in Mauritius would hardly be suitable to transport disabled children. Mauritian public buses are often crowded and wheelchair friendly low ramp doors or lifts are not yet in use.

Because of transportation problems and financial difficulties, not all children can attend the school every day. The families' resilience, commitments, weather conditions, and seasonal fluctuations also affect attendance, and the actual set-up of the school, the number of children, the amount of hard work, and the challenges vary day by day. The morning arrival and the afternoon departure of the children is also challenging. The arrival time may be extended as late as 10.00 am or later. Some children may be already collected by 12.00 noon; others are normally present from the early opening to mid-afternoon when the school closes. It was particularly touching to see parents carrying their children with severe physical learning disabilities, dressed appropriately for a school day, on their backs and lying them down in the zone dedicated to them. Just a few hours later, in the middle of the day, when

other engagements permitted, the same dad turned up again and brought the paralytic kid away in a similar manner. They explained to me that these families are very grateful for the school's existence and for the few hours breathing time they gain when they do not have to closely monitor the child and take constant care of him/her. Otherwise, without the school the family would be left alone in dealing with their children's disability.

Feeding

Meals, and food in general, play a very important role in Mauritian life, in addition to their practical relevance. Sometimes the Centre receives food or drink donations, but providing alimentation is primarily the task of the families. The school does not have the financial means to offer a comprehensive catering service, so the children arrive with their own lunchboxes, tins and bottles of food and drink. Each family prepares lunch for their child according to their traditions and means. Before lunchtime, the lunchboxes are stored in the kitchen area. The mornings are busy with the staggered arrival and allocation of the children to their places. This is followed by a relatively short period of teaching and playing, which I will analyse later. Then comes lunchtime. Feeding these children is not easy, lunchtime requires good organisational skills and it is also tiring physical work. Food needs to be served, each day different, for each different child, just as the families have brought it that day. Children should be supervised as many children are not self-sufficient and cannot eat on their own. Some have a severe learning disability and may not completely apprehend what a 'normal' mealtime constitutes, some may become aggressive while being fed, some cannot move their hands (although they may move other body parts, speak, or interact in some way), and some cannot move at all.

The most popular traditional Mauritian meal is cooked rice with

kari (loosely, curry). *Kari* is an umbrella term for a variety of things, for example vegetables, meat, sauces, and spices. As rice is a staple food, the amount of rice can symbolically reflect the prosperity of the household. Some children are given huge rice portions although they may struggle with swallowing and chewing. The rice needs to be put in the mouth by spoonfuls, piece by piece. This requires a staff member to sit in front of or beside the child, encouraging him, and supplying the rice portions. In the case of a huge plate of rice this may take 10 to 15 minutes, while to be sure whether the child is still hungry could be rather uncertain. The families expect empty boxes back at the end of the day. Apart from the rice-*kari* diet, sandwiches are also frequent and popular in Mauritius. The shape of the bread usually follows the French baguette pattern, but they also have the Anglo-Saxon square type bread. Sandwiches, being more solid, require more chewing abilities. For some children staff members have to tear the sandwiches piece by piece, including the particular filling of the sandwich, into the right size, and place it in the child's mouth, then wait. In the meantime, there is a constant interaction among the staff members, and the children who had finished or are still waiting for their turn and need to be looked after. Older children in better condition may help the staff with simple tasks. This is also the time when the children in the other group are having their lunch, so those children may come to this room, which has kitchen and toilet facilities, before or after the mealtime.

Overall, distributing the meals, feeding the children who cannot eat on their own, clearing up the leftovers and tidying up take a great deal of time. Once the children have completed their meal, the staff can sit down and have their own lunch. Once this has finished, it is usually the time when the family members arrive to pick up their children. Having presented the daily typical life cycle of the school, it is clear that the work in the school is hard both emotionally and physically. Therefore, the following description needs be understood in this context.

Teaching in English to disabled children

The Century Welfare Association runs a school, similar to others of the same kind in Mauritius. The designation ‘school’, however, implies expectations associated with mainstream education. This means that the chronic problems of the Mauritian education system, as discussed in Chapters 2, such as elitism, segregation, postcolonialism, greedy teachers, resistance to mother tongue education, over-competitiveness, exam centeredness, parrot learning, shortage of creativity, and shortage of self-esteem boosting may also appear in special schools. Because special schools are based on charity, both in their financing and in their functioning, they do have a solid emotional base of goodwill that prevents some of the extremes of mainstream education such as the private tuition system. Nonetheless, certain other problems like the unresolved issue of mother tongue education which are present in the mainstream education system do affect special schools as well.

As mentioned earlier, all on-site verbal communication (except when people were initially addressing me) occurred in Mauritian Creole. There was just one exception, the period which was called ‘teaching’. In connection with the varied but often-severe learning and physical disabilities, the speech of the children was also affected. Some of them were not able to communicate verbally at all. Others could communicate a little but with difficulties and at a limited level. Speech and Language Therapy would have been appropriate for many of them. However, some might have had more vital needs than speech therapy. Developmental treatments should have focused on even more basic functions, like the use of the hands, independent movement, and more self-control in toilet training. Two blackboards were on the wall, one with the list of names of the children and reminders advertising upcoming events in English. The

other blackboard was used for teaching. Both blackboards showed the date of the day in English format. Teaching started with listening to or singing the national anthem, watching the national colours in a flag for a few solemn moments, and the children seemed to enjoy the moment. Yet, soon after, when the 'official' part of the teaching started, the language of the conversation changed. Most staff stopped talking, and the staff member who was the teacher (but also contributed quite a lot to the general work the support workers) began speaking in English. As the children had major difficulties even with their mother tongue they were unlikely to understand a foreign language. With repetition, some might have memorised a few words but those could have been words of any language, as those words had no connection to their daily life whatsoever.

For the next 15 to 20 minutes, the teacher recited the days, months and colours to the children in a mix of French and Creole Fransize then tried to pronounce them in English:

Lundi, mardi, mercredi, jeudi, vendredi, samedi, dimanche[33] – Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, Sunday.

Janvier, février, mars, avril, mai, juin, juillet, août, séptembre, octobre, novembre, décembre – January, February, March, April, May, June, July, August, September, October, November, December.

Jaune, bleu, rouge, vert, noir, blanc – Yellow, blue, red, green, black, white.

Then, the teacher drew a picture of a house on the blackboard, wrote under the picture 'I draw my school' (*verbatim* like this, in English). The pronunciation of the individual letters was practised by repetition following the English way of pronouncing the letters. For example, a boy, seemingly having a slight learning disability, had to repeat *'dee'* for 'd', while the teacher was showing the letter 'd' in the

[33] I am using French orthography here to illustrate Creole Fransize pronunciation.

word ‘draw’ written under the picture. The words were said first in Frenchified Mauritian Creole, then in English, with the expectation that the children imitate the teacher and repeat the words exactly. Some could not speak at all, some did not understand the task, some probably were confused by its relevance, and some might have been able to repeat but even for them the isolated words with no context were unlikely to reach any meaningful level. During the day, Creole Fransize pronunciation was rarely heard, especially among the workers. This changed during the time of teaching. The names of the days, months and colours were pre-pronounced in Creole Fransize, which sounded similar to the respective French words, and more or less could have been part of a meaningful French utterance. French orthography how I put the words above reflects that they were pronounced using [ʒ] instead of [z], [ʃ] instead of [s], for example. Those words are the safe words where the enmeshment is easy to execute. Changing from *zanvie* to *janvier* is quite safe; when it is pronounced it requires the alteration of only one sound from [z] to [ʒ]; when in written, it needs the alteration of just two letters, the ‘j’ and the ‘r’; the latter is owing to the silent ‘r’ ending in French. The result is ambivalent enough, could be part of two languages, but reflects the upper-class, educated pronunciation of a word.

Presumably, a teacher would feel uncomfortable if (s)he said “Now I am speaking in Creole” using Ordinary Mauritian Creole pronunciation in the moments of academic teaching. The teacher would feel perplexed as if (s)he were not in the role of a teacher who, as an ‘educated’ person, is supposed to speak in English or in French, or at least using Creole Fransize.

As it is often the case, the difference between Mauritian Creole and French was enmeshed. The use of frenchified pronunciation created a desired ambivalence, an embodied hybridity, where the words could actually be part of two languages, and neither the speaker nor the listener

is expected to be more precise. The ambivalence is associated with former common experience and knowledge where a lot is known but much is not transparent or explicit. Many factors may converge in this realised phenomenon, first these are lists of words with some practical importance (see more about the phenomenon of a 'list' later below), and second, they are safe words. 'Safe' does not mean they are not obscene but that they could be part of any safe Mauritian conversations.

In addition, the reason that the teachers choose these particular words and match them with their English equivalent is that they serve better to hide the difference between Mauritian Creole and French. The teacher did not say "now I am talking in Mauritian Creole and now in English". The teacher did not write, for example, two columns on the blackboard grouping and matching some words in Mauritian Creole on one side and English on the other. The children are not told explicitly what the language is called that they normally use, or whether the form of communication being used among people is actually a language that has a name at all. In effect, which language has just been translated into English was left unsaid.

Writing two columns and making the teaching more visible would also be obstructed by the lack of any standard spelling system. A teacher who is acting in the role of a teacher is meant be accurate in writing, and since for the reason explained previously in this study accurate and standard writing in Mauritian Creole is not plausible, the teacher does not venture into it.

From meaningless English to the meaning of enmeshment

No further attempt was made to use the English words in sentences, in a conversation, or to express any feelings or thoughts in any

meaningful way. In this school, this would have been hardly possible anyway. The French language was not used either. As described in Chapter 2, speaking Mauritian Creole with a more French pronunciation would not suggest that proper French is being spoken. It may serve as self-deception, or signal societal differences among Mauritian social groups who all speak Mauritian Creole but in somewhat different ways.

In this specific example, instead of providing the students with the three lists of words the teacher could have encouraged the students to use the same vocabulary in a real context by telling them a story about some personal experience. In this case, the students might have learnt a few words in a foreign language. If one supposes the children of the Century school have the capacity to learn a few foreign words at all, and one is convinced that this is what should be taught during the 'golden time of academic teaching' in the midst of the otherwise hard and busy day, then this method would seem to be at least plausible if not advisable. However, this method of teaching is something that seems impossible to realise in Mauritius because this method would upset the apple cart of the underlying beliefs and the common but unwritten and unspoken agreements not to be straight and positive about Mauritian Creole.

The lists, for example names of the months, cover up the difference between Mauritian Creole and French but even a simple story from everyday life would reveal it. Although English is the official language of Mauritius, English words are foreign words for these children. The importance lies not in the English but in the relative closeness of French and Mauritian Creole in the case of these particular word lists. The two languages may be related and their vocabularies are similar but they are two languages. This difference would unfold in any meaningful conversation after two or three consecutive sentences. After a few words or one-two sentences, even with the hardest control and consciousness one could not avoid saying something in Creole without making it clear

that those utterances had certainly not be said in French. For example, a number of basic words would clearly mark the boundary between Mauritian Creole and French. A few words for example: *'mo'* (F. *'je'*, E. 'I'), *'li'* (F. *'il/elle'*, E. 'he/she'), *'oule'* (F. *'vouloir'*, E. 'want'), *'gete'* (F. *'voir'*, E. 'see, look'), 'aster' (F. *'maintenent'*, E. 'now'). Another paramount example is that Creole syntax applies compound verb structures with *'pe'*, *'ti'* or *'finn'* whereas the French equivalents are often conjugated and not compound verb structures.

Phonetics and prosody are often telling too. That is, the pronunciation of individual words can be consciously changed at some points, like changing a few [s] for [ʃ] (written in French as 'ch', in English as 'sh'). This change represents an effort. However, as discussed in Chapter 2, these changes can never be perfect. There is always a sense of inaccuracy and subsequent insecurity there. It is easy to swap [s] and [ʃ] but to change an [e] to [ə], to [ø] or to [œ] or to change an [o] to [ɔ] when it is needed, but only when it needed, is difficult. With some practice, it is fairly easy to distinguish even in the case of isolated words whether those have been said in Frenchified Mauritian Creole or in French. As seen in Chapter 2, even the Mauritian French pronunciation is markedly different and distinguishable from Standard French. The intonation of Mauritian Creole (and of Mauritian French) also differs from Standard French, which could be also noticeable after a couple sentences in a row. Yet, it is still easier to hide differences in phonetics and prosody but the differing elements in lexicon and syntax seem to be an impossible obstacle to overcome. Teaching a list of words avoiding any reference to more complicated grammar structures prevents the teacher making any comparison between French and Mauritian Creole and from recognising that their everyday language is a language in its own right.

Summary

The schools for children with physical and learning disabilities are not isolated places in the country and social trends, including the unresolved language related issues do penetrate into them. The fact that the existence of the school of the Century Welfare Association is based a great deal on charity (goodwill, love, compassion) helps to overcome a number of obstacles, but even the best intentions and moral efforts cannot prevent pivotal social issues from manifesting in such a demanding setting.

Chapter 6. The Mauritian Mental Health Association (MMHA) and the Catch of Literacy

Introduction

The purpose of this chapter is to describe the fieldwork I have carried out in one of the chosen sites. First, I will briefly describe the site's structure and functioning and its role dealing with mentally disabled people (mostly children) in Mauritius. Next, the analysis will focus on the feelings of powerlessness amongst staff in attending to children suffering from a set of diverse psychopathological problems combined with professional identity issues. I will present a few examples of how the institution and its workers try to find new strategies to overcome their frustrations as professionals while struggling to maintain the parameters typical of a normal school. In particular, the analysis focuses on language use in the school and on how its activities reflect the fragmented linguistic spectrum of Mauritius, reproducing its class and cultural divisions.

The Mauritian Mental Health Association (MMHA)

The Mauritian Mental Health Association is usually depicted in local vernacular as a school, *enn lekol*.[34] In effect, it is certainly more than

[34] The official name of the school is in English.

a simple school but perhaps something less comprehensive than its name would suggest. The association was founded in 1959 but started functioning only in the 1970s (Brouillet 1992, 144, 148).[35] Its founder and principal promoter was Dr A. Raman, the first Mauritian psychiatrist. The MMHA has become a school and day-care centre for children and young people with learning disabilities and behavioural problems. For the sake of simplicity, unless otherwise mentioned, I will often call the institution a school from this point on.

Like many other institutions I mention in this thesis, the MMHA is also located in Rose Hill at the northern outskirts of the town, in an area called Stanley. This is a lower-middle class residential neighbourhood about 30 minutes' walk from the town centre. The school's ample leafy ground comprises several buildings but also plenty of open spaces including a football pitch and parking for the school buses. The entry building contains a few offices, a small foyer, a kitchen and a vast hall for the day-care centre. Two other buildings have numerous rooms for classes and another building houses a workshop. In addition to the football-pitch sized playing ground, a cultivated garden and a few roofed verandas can be found attached or in between the buildings. The boisterous school life, especially during the breaks, takes place in the middle areas between the buildings where people can avoid the sun during the long summer months. More than 150 children and young people are enrolled in the school but not everybody is present everyday.

A day in the school

Some children are brought here privately but most of them commute in two school buses. One bus collects people from the northern

[35] See also http://www.actogether.mu/sante_details.aspx?id=26. Accessed 27/06/2011.

bus station in Port Louis and goes uphill on the old route to Rose Hill; the other one departs from Curepipe passing the upper urban areas to arrive at the same destination. Although an ordinary bus route goes by the school compound it is rarely used by the attendees, as the school bus is free of charge for all of them. Given the bus routes, the catchment area covers a large but mainly urban area, where perhaps half of the population of the island resides. However, it is important to note that this area is the chief urban area of the country; therefore, the children from rural areas or from the fishing villages are unlikely to attend this school because of the geographic distance. Similar schools and facilities, and a few other NGOs, can be found in those regions as well.

Considering all the distances, it can be estimated that the children leave home at about 8.00 am. They are usually accompanied by family members. The bus picks them up between about 8.30 and 9.00 am. A few parents bring their child to the school on a daily basis. Most staff members take the same school bus to go to work and return home. The children travel with staff members, including those staff whose children also attend the school. Both students and workers arrive at the school between 9.00 and 9.30 am. The institution is not only divided into 'school' and a 'day-care centre', but is further divided into classes according to age, severity of problems and 'teachability'.[36] At about 10.00 am, when everybody has settled down, comes a period that I will call the 'Golden Time'. Preparations for lunch start from as early as 11.30 am and the lunch break period will last until about 1.00 pm. Managerial meetings occur usually during the lunch break. Between 1.00 and 2.00 pm there is another, shorter, golden teaching time. Then, from 2.00 pm to approximately 2.30 pm it is the time for tidying up and preparation for departure. It will take the children another 10 to 40 minutes to get home.

[36] The rationale of this will be explained later.

Most children are collected at the bus stops and stations from where they walk home.

Staffing, structure and functioning

The staff consist of volunteer workers, trained teachers, healthcare professionals, administration staff and caretakers. Many trained teachers were volunteers in the past and the school supported them to attend some form of training and obtain qualifications. Many staff members are not trained to deal specifically with children with mental problems. Volunteers can enjoy free travel to the place and perhaps free meals, in addition to looking after their own children. Doing this, they can gain experience with the possible prospect of subsequent training and becoming employed. It seemed clear that most teachers learn what to do by experience and usually this experience is acquired here at the school. The school has only one full-time psychologist, a Frenchwoman living in Mauritius. The psychologist, one of the secretaries, the director and I were the only foreigners in the school. There is also a part-time Mauritian speech therapist, a part-time autodidact 'music therapist', three managers, and two administrators. One teacher is employed by the Ministry of Education.

The centre embraced the following classes and sections that I mention using their own terminology:

- Section 1: 'Nursery' for children from 6 to 9 years.
- Section 2: 'Special Educational Needs' class run by the Ministry of Education for children from 9 to 14 years
- Green Class: 'Severely challenged students' from 9 to 14 years
- Yellow Class: (A new class, still under formation)
- Section 3A: Young people from 16 to 18 years

- Section 3B: Young people from 14 to 16 years
- Section 3C: ‘Severely challenged’ young people from 14 to 18 years
- Sheltered Workshop: Boys from 18 years and above
- Sheltered Workshop: Girls from 18 years and above
- Day-care Centre: Typically from 20-25 years and above

Despite its long history and success, the centre, like many NGOs in Mauritius and around the world, is continuously challenged by financial difficulties (Anonymous 2011b; Rivet 2011). The Ministry of Education and the Ministry of Health have supported some of the school’s activities. Fundraising events and donations from private companies support the centre as well. Although parents are expected to make some small contribution, circa Rs200 monthly (£4.50 in 2010), the majority of the families do not pay as much or anything at all as most families live in absolute poverty. Ethnically and religiously speaking, and following the Mauritian categorisation system, no Franco-Mauritian and just a few Sino-Mauritians attend the school. The rest of the population, Creoles and Indo-Mauritians, including all subgroups, are represented more or less according to their overall proportion in the population.

Staffing in the context of Mauritian education

The official salary of a primary school teacher in Mauritius at the time of my fieldwork was about Rs12.000 (£265) per month, slightly above the national average wage. Secondary school teachers can earn about Rs20.000 (£440). Headteachers earn somewhat more. Teachers working in special schools or with children with special needs are entitled to a supplement to their salary. Therefore, a primary school teacher working with children that are more difficult can earn close to an ordinary secondary school teacher. However, it is important to emphasise, the

income of teachers who work in normal state schools is much higher than their official salary. This is particularly true for secondary school teachers. The highly competitive Mauritian education system is exam-centred. It is a general perception that without private tuition, a child would not pass or achieve sufficiently good results in the crucial exams mentioned in Chapter 2, and the quality of teaching in the state schools is insufficient. In a class in a normal state school, there are 25 to 40 students on average.[37] Private tuition is offered in small groups of about five students on average and even in some cases individual tuition. The controversy of the system is that often the same teachers provide private lessons in their own houses for the children whom they teach daytime in the state schools funded by taxpayers. A job in a state school is generally regarded as a stable and desirable government job. However, apart from assuring the employment in the school the teachers' interest is to keep their energy for their afternoon and evening private lessons. Often, there is a huge difference in their enthusiasm between the two parts of the day. The better reputation a teacher can gain as a private tutor, the more assured the additional part of the teacher's income becomes. Once the private teacher is able to attract more children to teach, he or she will increase the number of children taken to the group for private classes. The achieved income is multiplied in this way. A teacher with a well-established private teaching praxis can reach a monthly income up to Rs100.000 (£2200). Naturally, they have to work hard and long hours for this, be a good teacher, a good 'politician' daytime, and a good marketing expert in the afternoons. Obviously, poor people cannot pay for private lessons. Lower-

[37] In Mauritius there are two types of private schools. So-called 'private schools' are run by the Catholic Church, in effect work with the least able, more deprived children, and are often located in more remote areas. The other types of private schools are 'French schools', which are part of an informal network of schools around the island (see Chapter 2), and International/British schools, principally attended by the children of elite expatriates, and thus akin to so-called 'independent schools' in the UK.

middle class families might have to make tremendous sacrifices if they have high aspirations regarding their children.

The teachers in the MMHA who obtained their qualifications on special courses after serving as volunteers still earn significantly less than teachers in state primary schools. Private tuition to prepare pupils for the exams is not an option for these people. What would they teach? The only teacher in the MMHA who is paid by the ministry and not by the association is paid significantly more than the teachers paid by the NGO, and receives the supplement in addition (all in all Rs26,000, i.e. £572). However, private tuition is out of question for that teacher too for the same reason. Two teachers (or workers) are usually assigned to each class, but in the class with the centrally managed and paid teacher there was only one teacher working during the time of my fieldwork. The other teacher had left some time before and although the post had been advertised the educational authorities were not able to recruit new staff to fill the vacancy. This is why the senior manager who had also worked elsewhere had to help the teacher here on a regular basis. Although the MMHA staff cannot do private tuition, the management had to face the occasional unfortunate situation that their own teachers and volunteers are inclined to take up part-time jobs in the evenings. For example, they might work in the tourism industry as musicians or hotel-maids, although these private sector jobs are considered less stable. The relatively poorly remunerated daytime work in the association was regarded as more stable and therefore more desirable.

The client groups of the MMHA

It has been briefly mentioned that the MMHA deals with children with learning disabilities and behavioural problems. The nature of difficulties and diagnoses needs to be explained further. First, by the

definition 'Learning Disability' I am following the current British usage of the term. The word *andikape* in Mauritian Creole does not have offensive connotations like 'handicapped' currently has in Britain.[38] Therefore, MMHA is known colloquially as a *lekol pou zanfan andikape*, a school for handicapped children. Another term, *deprivilize* could occasionally be attached to this expression, which is more or less synonymous with the current British usage of the term 'deprived'. Colloquially, MMHA can be called a *lekol pou zanfan andikape ek deprivilize*, a school for handicapped and deprived children. However, when we want to know more about the reasons, problems and medical diagnostic categories potentially applied to the young people who attend this association the situation is rather more unclear.

As described in Chapter 3, the state healthcare system can provide free, reasonable quality but often not profound and comprehensive enough care for its citizens. Those who can afford to seek other care than the state healthcare would hardly turn up at the MMHA. The managers of the school explained that many families who approach the MMHA are not particularly open about the details of the child's problems and do not verbalise their feelings. In general, just like the Century, this place is often perceived as a 'school', and not as a therapeutic institution.

The centre can afford to employ only one psychologist and a part-time speech therapist. The only psychologist is overloaded with work and not able to diagnose all the 160 children of the school. The psychologist partly works directly with some children and families but also provides advice and guidance for the teachers, volunteers and other workers who

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[38] In Britain, the terms that describe this condition have changed a few times over the last few decades. According to the two current major diagnostic taxonomies, the ICD and DSM systems, 'Mental Retardation' is still the received term to denote conditions characterised by low IQ. After the word 'retarded' had become an offence in Britain, the term 'Mental Handicap' was in use. This term had also become politically incorrect and was subsequently changed to 'Learning Disability', which is meant to be one of the various disabilities.

are in the daily frontline; he/she is also involved in management. My contribution was repeatedly asked for but these diagnostic discussions had to be limited. First, I always had to emphasise I was not working in Mauritius as a clinician but as a researcher. Second, the information that I heard about particular clients was usually too limited to tell more than what experienced workers of the association would know anyway.

The management of MMHA is actively involved in the national policymaking process concerning the problems of 'deprived' children both in the NGO sector and in co-operation with the government (which practically means some ministries). Looking after children with so-called 'special needs' is almost completely outsourced to NGOs in Mauritius. On the one hand, this means, in fact, that many problems are met with the enthusiasm and creativity of dedicated people, which may be helpful to sort out difficult problems and reduce the waste of resources through bureaucracy. A recurring topic of the discussions is the stigmatisation attached to this kind of problem in Mauritius. It is presumed that the stigmatisation is one of the reasons why many mental health concerns, including the problems of disabled children, are not attended by any institution. The existing supportive organisations are usually overcrowded but still often on the verge of closure owing to instable funding sources.

The power of stigmas is not only presumed in the number of people who do not seek 'public' help but also in the evident reservation of many families when, after many doubts, they turn up at the institution. Major difficulties emerge in keeping in touch and working together with the families as well. Many families are happy with the fact that their child is in a suitable place during the day but do not want to get involved with any more therapeutic work, such as consultations with the centre's clinicians or institutional work, or parental involvement in managing or controlling the institution. Most children arrive at the centre after having dropped out of mainstream schools. There is some, but often-insufficient

communication among previous schools, the families and the MMHA. Schools and families flounder whilst trying to portray the problems in lay terms and avoiding talking publicly about magical or religious remedies and practices.

Many children and young people had some level of learning disability but major physical disability was supposed to be a contraindication to be admitted to this school. A few children, however, struggled with sitting, walking, eating and other co-ordination problems. A few could not speak and a few did not show any interest in communicating. Social interactions, carrying out simple tasks, or learning was very difficult or even impossible for this last specific group. Diagnostically speaking, the clients might have broadly varied from mild to severe mental retardation. These people, in my estimate, might have formed about two thirds of all clients in the school. I think that about a third of the children and young people did not appear to have any symptoms of intellectual deficit in their ability to communicate. Less was known about the investigations about the aetiology and co-morbidity of this group. The word *andikape* (‘handicapped’) in Creole could, somewhat euphemistically, mean learning disability, but can be used in a more general sense as well to absorb all sorts of ill-defined difficulties. To be precise, one could add *andikape mantal* (mental handicap). These labels are often enough to stop any further investigation. I heard that a few clients might have epileptic seizures as well but the relation of those with the major presented problem, for example mental retardation, was unclear. A few children displayed signs of varying levels of autistic disorder, including perhaps a few with proper autism. Autistic disorder as such is a rather uncharted territory in Mauritius; I hardly heard the term mentioned. The presumed autistic children I saw in the school appeared both with and without a co-morbid status of learning disability. A few children seemed to have ADHD (Attention Deficit Hyperactivity

Disorder), and although this term was brought up a few times in conversations in Mauritius, I did not hear about many who had been diagnosed and specifically treated for this disorder. In fact, even with some experience, it was not easy to detect whether the challenging behaviour of a child is typical of ADHD or not. A few children, in some classes, seemed to be a bit 'naughty' but never at an extreme level. Probably only a few children whose occasional defiant behaviour was a problem appeared to have ADHD. During my stay, I have not seen or heard of major violence or major deliberate self-harm committed by a child or young person.

The teachers, workers and volunteers who were with the groups of children in the individual classes usually perceived their work as hard. Almost everyone seemed to be deeply committed to the work and have a great deal of goodwill. They often did not know much about a particular child's background and underlying problems. As explained above, some of this might have derived from the lack of investigations, limited chance to communicate with other professionals and the families, and problems with internal communication between the small professional-managerial staff and the many children with diverse difficulties. As also mentioned, not all of the staff had received special training. Unfortunately, most training available was not profound and practical enough. Some had a lot of practical skills and experience gained in the centre. Further to the finding that everyone found the work hard, many of them found it particularly exhausting. This exhaustion seemed to be connected to the feeling of powerless in resolving the challenging behaviour of some children. They were sometimes unsure what exactly to do with certain children apart from take care of them for the day.

Insufficient diagnostic process, reserved and stigmatised families, limited funding and few highly qualified staff; all these hampered the establishment of individual development/treatment/care plans for the

clients. I think this could have contributed to the occasional feeling of tiredness and disempowerment among some staff. On the other hand, the day-to-day struggle with daily challenges train the people well with how to deliver the guardian role, that is, how to keep the children safe and relatively happy for a certain number of hours in a day. Surely, this must have been an enormous help for many families. They got some breathing space for the period their child was in the school, that is, away from home. Otherwise, the families are usually left by themselves due to limited overall resources and lack of developed home care schemes. Not all but many families struggle with the feeling of shame within their community and extended families, which leads to further social isolation and subsequent depression, which may affect how the child is treated. Rumours of not infrequent physical restraint and corporal punishments were circulating about some families' attitude to their 'problem child'.

Some key problems in dealing with the particular client group

The provision of a protected environment and hosting children with challenging behaviour in a safe place with no violence is in itself a fantastic achievement for which the MMHA and similar non-governmental charity organisations should be given a lot of credit. It is important to say that there is a zero-tolerance policy in this centre regarding physical punishment towards the children. There had been examples of workers sacked because they breached the rule. It is not intended in this study to diminish the institution by pointing out the problems arising in its daily activity and its efforts to provide a safe and comfortable environment for the children.

Nevertheless, it could be observed that the staff confidence seems to be lowest when the period of Golden Time comes, approximately from

10.00 am to 11.30 am and from 1.00 pm to 2.00 pm. This is the time when the purpose is not about travelling, arriving, settling, relaxing, eating, tidying up, and preparing to leave. The Golden Time is a challenge to every group in the school but may be the least in the Day Centre, in the main hall of the main building, where younger adults are occupied with activities like knitting, drawing, decorating, playing with boxes, and even learning to cook. These activities vary between therapeutic work and creative activity. The expectations in the workshops are not excessive. Some clients, mostly older adolescents do really work; others just mostly talk, pass the time and socialise.

The Golden Time challenges the confidence and identity of the staff in their professional role. At this point, the covert question may emerge, “And now what?”, “What to do?”, “How to fill this timeslot with content?” “How to perform a professional role?” “How to teach (in a school)?” A great deal of insecurity arises on this point, because the staff have no individual developmental plan for any of the children in the group. The structure, the timetable, the spatial division, and the daily routine maintain a ‘school’ in the Mauritian sense. Generally speaking, to some degree, the institution manages to teach children with different levels of learning disabilities. However, detecting and establishing the nature, stage and severity of problems with relative professional expertise in co-operation with professionals, families and maybe even the children, could be of further help. These diagnoses could be broken down to minuscule daily planning regarding each client, each symptom, and each function. This could enable the hopefully trained and skilled staff and make the work less reactive, trying to sort out conflicts by practical experience. Unfortunately, this approach is unrealistic here as well as in other similar institutions in the country.

If the professional tasks were realistic and agreed, broken down to smaller, daily pieces, and the progress re-assessed then the efficiency and

the success could be measured and fed back to further planning. A transparent and meaningful structure would boost the confidence of the workers in their professional identity. Without that, the time dedicated to emblematic functional activities that make a school a school is associated with tiresome frustration in a constant reactive muddling with the unpredictable challenging behaviour of some children. The teachers and carers are left to rely on their goodwill, good heart, their common sense and experience, and this allows them to develop fascinating skills during the work in the centre over the years.

Language in the MMHA

Language use within the MMHA, in general, follows typical Mauritian patterns, but it should be set in the context of the powerlessness and tiredness among the staff. The overwhelming majority of oral communication is carried out in Mauritian Creole. This language is understood by everybody (except the foreign secretary). Some people who aspire to a higher status in the social echelons choose to occasionally converse in Creole Fransize. Discussions at the management meeting are typically in French with some Creole and English insertions. When they required my active presence at the meetings, these insertions were more frequent. Contact with the outside world in the form of receiving phone calls or greeting strangers or visitors (like parents) is either in French or in Creole depending on the status of the call. Presumed ‘lower class’ visitors (for example contractual handymen) who ‘only’ speak Creole are dealt with by the Mauritian secretary. Written formal correspondence, formal documents, including reports, case-notes, and training materials are mainly in English and sometimes in French. The foreign secretary can deal with those well. The notes of the teachers and volunteers, such as the records about the day in class notebook are mainly in French, sometimes

in English and on some occasions in Creole. The latter is an achievement of a few Creole alphabetization courses organised by the *Ledikasyon Pu Travayer* (LPT), attended by a few teachers from the MMHA. MMHA was the only place (apart from my visits to LPT) where I met people who had participated in such a course. Other written materials, the textual environment around the children, like posters or signs on the wall, are all in English or French. They seemed to be imported. Posters about the parts of the body, for example, could equally decorate British or French classrooms. Regarding the books, most of them are picture books for small children, similarly imported stock in English and French, just as in the few bookshops in Mauritius. Mauritian publications for children are very rare. There is only one organisation, a nursery in Curepipe run by a member of the LPT, which published a few bilingual Creole-English books on its own. Apart from the LPT bookshop, the MMHA was the only place where I saw these books during my stay in Mauritius. Strangely enough, these bilingual books were found in the MMHA in the classroom of the severely disabled small children who could not read at all. As they were often agitated and disruptive and their capacity to understand any verbal utterance was limited, there was not much scope to read for or with them. Thus, these bilingual books were not used during the time of my observations. I did not witness any sign of the use of any other (for example, 'ancestral') language in the school and the day centre apart from Creole, French and English.

The use of Mauritian Creole in managing children with limited speaking abilities and challenging behaviour

Below, I will describe an example that shows one of the roles of Mauritian Creole, the native language and mother tongue of most

Mauritians. The importance of this role is handling vital problems and daily challenges of the safety of children who can hardly speak and need basic, simple and unambiguous communication. In this regard, teachers or instructors have to detach from prestige related social language games.

One Monday morning, in a group for mixed moderately and severely impaired children one of the two teachers had to take one of the children to another institution for treatment.[39] As two teachers are necessary to look after between 6 and 8 children aged 10 to 14 years old, another staff member joined the group to help out.[40] One of the children was lying on a mattress. The teachers explained to me the child had been diagnosed with epilepsy and should take Valproate Acid.[41] She had had a seizure earlier that morning. They told me that when she takes the medication she is quieter and more somnolent. In that moment, she looked sleepy; perhaps she was in a post-seizure somnolent state. The staff believed that the seizure happened because the family had failed in giving her the medicine during the weekend. Later on, she woke up and became more and more agitated. She spoke very little and the utterances towards her were limited to simple and usually imperative sentences. Otherwise, she looked more vigorous, active and capable then most other children in the group. We moved outdoors to a shadowy place because of the heat and brought a table with paper and pencils with us. Some children were drawing simple pictures, but most of them were given the task of following lines on pre-printed sheets with a colour pencil. One of the boys of the group, the most impaired mentally, although physically strong, struggled in his task. He was docile and tried to concentrate on the line with pencil in hand, but the task was difficult for him even when

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[39] The stories are slightly changed to prevent the recognition of any particular individual but still retaining the essence of the story.

[40] In well-resourced institutions of affluent countries this ratio is 1:1, or even 3:2 on the favour of workers.

[41] An antiepileptic medicine that also has a mood stabiliser effect

the teacher was holding his hand. Gradually becoming more and more active, the behaviour of the epileptic girl changed at one point. She started to be very hyperactive trying to win the attention of the staff. *"Pa fer sa!"* (Don't do this!), *"No",* they told her with determination but it seemed to no avail. She started to abuse the boy. The staff did not know what to do because they could not interpret the reasons for the sudden change in behaviour. After having tried to engage her unsuccessfully in other activities, they decide to segregate her from the other children. The teacher walked away with her to a distance of about 30 yards and started to play a ball game with her giving verbal instructions in Creole. During this activity, I could observe that her spatial coordination and gross motor movements were clumsy; she was hardly able to catch the ball but she enjoyed the game and the direct attention. The other teacher was left on her own with the other seven impaired children. Slowly the school day ended and they started preparing to leave. No ideal solution had been found that day to manage every child and 'teach' them. Dealing with the problems was reactive but it seemed a usual daily occurrence. The most important aim to keep the children safe was accomplished, but the overall feeling of the grown-ups was frustration. Depending on the degree of their communicative capacity, severely impaired children are difficult to communicate with. In their case, the task and the daily struggle is to regress to the basic elements of a language. The examples evidenced that these base verbal instructions can only be voiced in the mother tongue (L1) of the impaired children. When it is about 'yes', 'no', 'don't do this', 'are you hungry?', 'do you need to pee?' it seemed evident that these sentences were voiced in Creole. In this way, there was some chance that the instruction was followed, the information was passed, or an interim dialogue could be established. However, it also seemed evident that the severely impaired children, who perhaps could have learnt some basic literacy, would never acquire any reading skill because of the lack of

mother tongue literacy and because the attention of the teachers had to be diverted to more vital tasks.

Food actions, food talk and the gateway to diglossia

Tension and frustration are of course not even but vary class by class, day by day and from moment to moment. To sense how palpable they are it is enough to see the switch at about 11.30 am. This time is early for lunch even in Mauritius but the preparations began around this time. Suddenly, the sense of insecurity started oozing away. Finally, everyone shared a common aim. One could see that everyone was becoming happy and well set in a role to reach the state of satisfaction and contentment through getting prepared to eat, eating and relaxing after having eaten. The lunch break would seem a little long for an outsider, but in this context it may be not ‘long’ if it is compared with something else that one would be supposed to do instead. In fact, in a sense, the lunch break did seem to have a certain therapeutic effect; in an interactive matrix among helpers it improved the momentary well-being of the ‘deprived’ disabled children. At lunchtime, everybody knew what to do; the uncertainties were temporarily over. Unlike in The Century, most children do not need to be fed in the MMHA, so the hard work of feeding is significantly less. Nevertheless, there were many practical things to do, to shuffle furniture, draw tables and chairs here and there, find the lunch boxes brought from home, go to the toilet in the yard and back, then eat, tidy up and have a rest. All these activities were often accompanied with chatty communication that helped the staff socialise with each other and the children are also free to chip in. Many children communicated more this way than during the ‘Golden Times’.

Two factors seem to coincide in the temporality of the practice of

the lunch break. One is the general frustration caused by the challenging behaviour of disabled children and the feelings of insecurity in the professional role to sufficiently deal with these challenges. On the other hand, the attitude of people to eating and alimentation in Mauritian society in general is an equally important factor. In the realisation of lunch break in the MMHA, locally emerging distress is resolved by an exterior mechanism, commonly applied in the society. Food, however, is not just something to prepare, eat and talk about but it could be something to teach as well. Being a favourite, neutral and common topic, it is naturally picked up when the task is to teach words, to teach the name of things and to teach the distinctions between things.

The next example took place in the class of the presumably most able children on another day, when the teaching was meant to focus on colours and vegetables. The colours functioned in just the same way as they did in The Century; in the following, I will describe what happened with the names of vegetables.

Vegetables, just like colours, form a list. Separate names of a list of things were asked by the teacher and the children were expected to answer with one word, the name of a vegetable. The answer again is an isolated noun. The children were not expected to use these nouns as part of meaningful sentences. Therefore, verbs, conjunctions, and prepositions (and the lack thereof) were not voiced when the 'right' answer was given. If the task had been to tell a story of the lunch of the family last Saturday, the children would probably have included some vegetable names as well that form part of the *kari*, the part of the meal that accompanies the cooked rice. Meaningful sentences would have composed a conversation. However, speaking in proper sentences as part of formal teaching was not done as those sentences would have been in Creole. Of course, these children were unable to speak in correct meaningful sentences in any other language but in Creole. This particular kind of speaking, answering

with isolated words, mostly nouns, instead of speaking continuously is a genre of speaking that represents the ‘real’ teaching in Mauritian schools. As seen in Chapter 2, this genre is something that emblematically makes a school a school. Thus, if the MMHA intends to keep the image of a school it is supposed to abide by the image of what a ‘school’ entails in Mauritius. The presumed ‘real’ teaching moments are neither the time of warming up/tidying up time sections of a class, nor the informal instructions of the teacher, nor the comments of the children to each other. The ‘real’ teaching comes after a few minutes into the class, when after the initial upheaval and settling the teacher finally asks a question like this, “What vegetables do you know?” In a mainstream school in this very moment, in this ‘real’ teaching, this question would be asked in English. In the MMHA, even in the class of the most ‘teachable’ children it would have been absurd to switch to English. So the question arises what language was spoken during the classes in the MMHA, when the ‘real teaching’ began going on? This language was not explicitly named.

In effect, of course, the children speak Creole, their mother tongue, the only language they know, if they have at least the minimum capacity to express themselves in any language. Yet, when the moment comes to enter in to the ‘real’ teaching, which that day was to respond to the teacher with names of vegetables, the usual language the children know should somewhat be bent. In other words, the expectation was to swap from Ordinary Creole to Creole Fransize. Suddenly, the pronunciation of certain words, the very words of the ‘real’ teaching changed. They become isolated words of the Creole Fransize vocabulary. They formed part of an intermediate variant that had no name, no clear boundaries, and no reflected definition. They were distinguished from Ordinary Creole by their pronunciation, from standard French by the lack of proper French syntax and other minimum requirements to speak meaningfully. Just as in The Century, the example in MMHA showed as well how the boundaries

between Creole and French were enmeshed. Further to the propensity to ‘parrot learning’, when the students are expected to mechanically give back a memorised piece in the exact way the teacher requires and not to explore the world with their own view and vocabulary, the lists, the list of vegetables in this example, gave the chance to list a few nouns, which are more or less similar to the French counterparts. The underlying aspect of using the names of the vegetables, these nouns, was that these words are quite close to each other in Creole and in French. They are close but they are not identical. However, using other elements like a verb would have unequivocally identified Creole and not French. The lack of conjugation of the verbs or the lack of verbs, as Creole often omits verbs where French would use one, could be telling.

With the articulate, emphatic pronunciation of *légume* [légym] instead of *legim* [legim] (both meaning vegetables), the difference is narrowed down to difference between two vowels [y] and [i]. It shows a postcolonial illustration for the Labov paradigm (see for example, Meyerhoff 2006: 34). In Labov’s classic experiment, the workers of a Department Store in New York City pronounced the [r] sounds in the expression ‘fourth floor’ in varying way. They used the standard prestigious way with an [r] when the utterance was in a stand-alone emphatic position but without an [r] when it was part of a colloquial chat. The conclusion is, in the moments of presumed importance, people pronounce words (and use language in general) in a way they think is prestigious. In postcolonial societies, the prestige is defined by the aftermath of colonial times and actively pursued by the postcolonial elites.

Hearing and especially repeating the word *légume* [légym] the children learn a lot; may be not much about botany and cuisine but a lot more about society. They learn about differences and about the aggregated prestige associated with difference-markers. They learn that

vegetables have two ways of being named. One of them for the use among themselves, and in the family, and even with the teacher informally; whereas, the other form is emphatic, formal and meant to be called and recalled as the 'right' way of saying things. They learn that usually they do not say things in the right way but they should learn in the school from respectful authorities how to say them in the 'right' way.

Two elements make the prestige matrix unmistakably postcolonial. One is that the Creole language has no (explicit) name in this process; actually the very language used in teaching is nameless. The spade is not called a spade. The linguistic differences are blurred to make it possible to hide the differences and to disallow the study of the language of the subaltern, the non-elite as something of equal value. The other matter in the postcolonial dynamics is that it is not random which pronunciation or language usage is 'standard', prestigious and obtains the merit to be taught in schools. The 'right' pronunciation has the value of corrective reference towards which the different, not-prestigious, 'non-standard' variants are meant to be corrected. The 'right' pronunciation happens to be the presumed pronunciation of the standard language of a former colonial power. Moreover, in Mauritius, the standard language of a former colonial power continues to be embodied by the holders of the surviving economic power, the Franco-Mauritians, and the French-educated non-whites who care more about standard French pronunciation. The mother tongue of Mauritian French speakers 'naturally' performs the 'right' way of doing (doing while saying) things, such as the right way of pronouncing words. Not only the continuity between pre- and postcolonial elites but also postcolonial global politics reinforces the educationally institutionalised diglossic difference making. The promoters of the francophone movement, that is the 'cultural' policy of the Republic of France, also enhances the relationship between 'being educated' on one hand and speaking a certain language and language variation on the other.

Enabling and disabling the disabled - the catch of literacy

Another group was full of ‘naughty’ boys. At the start of the day, they were loudly and fiercely discussing the ins and outs of the previous night’s Liverpool–Manchester United football match.[42] The atmosphere was animated and it was hard to keep it under control, let alone to begin some kind of ‘proper’ teaching. Some of the boys had some physical disabilities, like gross motor co-ordination problems. Many were largely illiterate, and most seemed part of that section of the attendees of the school who dropped out of mainstream education mainly because of social and behavioural issues as they could not keep up with the accelerated pace of the educational rat race. Possibly, they had not learned much academically in those schools from where they were transferred to the MMHA. During the early morning discussion, they were lively and had difficulties regarding discipline. At half past ten, half of the group and all of the formerly over-boisterous boys, in the age range around 10-14 years, moved to the veranda of the main building for a music lesson, where the group was suddenly transformed into a well organised and quality performing music band. The music teacher, or music therapist, worked part-time in the centre. He also worked in other similar schools and as a professional musician as well. His attitude towards the children and all the clients of the schools was magnificent. He was cool, quiet, and wise, but still listening with empathy. He explained music in a low baritone using a language full of compassion, picturesque images and

[42] Football is the most popular sport to play and English football is the most popular sport to watch in Mauritius. Mauritian football fans are traditionally divided into Liverpool and Manchester United supporters, with their own clubs. Most other English teams, even including Chelsea, have very few Mauritian supporters.

subtle jokes. The boys had no problem concentrating on what he was saying. They became responsive and carefully followed the instructions. They tried hard to do what they had to do to play the music well. They were given different, mostly wooden percussion instruments, and others to shake. Some of them already had quite good skills playing the given instruments after plenty of music lessons; others tried new ones, to see if they were more able on those ones. They played as a band, which required the orchestrated co-operation of about 10 people at the same time. They had to listen to the rhythm, wait for their turn, follow the rhythm and play what was expected. If it was not perfect, the teacher gave some advice and they started again. And then, the harmony and polyphony of music clicked in. 'Real' music was being made, a quality of which even a learned musician could have been proud. Even to listen was a unique moment, but the boys were performing it too, so it must have been a double pleasure. All of this happened without issues of discipline, without difficulties of motor co-ordination, without feelings of inferiority of being 'unable', 'non-standard', or not 'educated'. All in one in a brilliantly co-operating band, whose members had nearly jumped on each other a few minutes before because of a football match played over six thousand miles away. A near hypnotic joy delighted their face. The moment seemed to be cathartic.

After lunch, the same group returned to have a literacy class. The word 'literacy' is quite confusing here. One would interpret its meaning as a lesson for alphabetisation, to learn to read and write. After the music class it was clear that these boys had a real, perhaps in part a latent, capacity to learn, provided they were accorded an appropriate approach. Obviously, the need for literacy was desperate for them. They lagged behind mainstream education and the need for literacy in Mauritian society is hardly questionable. However, when a 'literacy' class comes, the children are provided with a kind of French lesson. As the 'one cannot

read and write in Creole' rule prevails, one feels compelled to teach reading and writing in another language. English is off the table in the MMHA, where the children have really basic needs and just basic previous capacities to learn. It seemed sensible that the children were not forced to learn English in the MMHA, as teaching English would have been extremely difficult and impractical. This left the only option to teach the children to read and write in French. Thus, the 'literacy' class became a French lesson. French letters and characters are familiar to most people; for example, they are often used for shop signs. However, the class was not called a French class and even the word 'French' was never voiced (let alone the word 'Creole'). The teachers make the children believe they teach 'literacy', the literacy of another unnamed language, the literacy of the 'universal' language. However, the problem arose while teaching literacy like this, that a massive rift was created between the spoken language, the only one these deprived children knew, and the written language, a possession of only those who had gone through the trials of mainstream education.

Regarding the written language, the problems happen to be threefold for the children. The first problem is that there is a discrepancy between what we say and what we write, because one is in Creole and the other is in French, a challenge for the mind. Pronunciation, that is phonetics, can be fooled somewhat (not completely) and the difference enmeshed, like between *légume* and *legim*. Yet already in vocabulary, there are fundamental differences, as for example the basic pronouns and verbs are different.[43] In syntax, there are huge differences. For example, one is meant to gather such concepts as grammatical gender, article and declination on one side, in French, and continuity auxiliary, or imminence auxiliary on the other side, in Mauritian Creole. The second problem is

[43] As also seen in the previous Chapter 5.

that writing in French is a hassle. It is even difficult for French children, for people whose mother tongue is French. French orthography is etymologic based on principles from the mid 17th century. French education, just as British education, has to spend much more time on literacy than many other countries, which have an official language with an orthography based on the phonetic identification principle. The third problem is down to the dogmatic nature of the relation of francophone nations with the French language, the low tolerance to non-standard variations, that is, to the perceived 'errors', for example spelling mistakes. To write in French in a simplistic way is much less tolerated than in English.

The boys faced a complicated problem. Their chances to acquire literacy properly went down to near zero. This part of the day in the MMHA was wasted; the feeling of frustration and inferiority was created, and it remained. Theoretically, the MMHA could have chosen a revolutionary route and propagated mother tongue education and literacy, against the common notions of the ruling elite groups. Just like nearly all such institutions, it did not. Perhaps some of the parents would also object to seeing their children taught Creole, believing it enshrines them as second-class citizens. In the way teaching was carried out the image of the school, and the intention to be compliant with the norms was respected. It is to hypothesise further, however, that the reasons are not only down to the adaptation of charitable feelings to Mauritian realities. It is also about the engraved mindset, like Bourdieu's *habitus*, of the staff running the institution. The staff often seemed unable to surpass the psychological obstacle of doing something for the potential benefit of a vulnerable population and doing what the base mission would dictate (in a linguistic sense at least), that is, 'make the disabled more able'. Doing so would be against the rules of social prestige and hierarchy internalised by the human beings who deliver the service.

Summary

In this chapter, it has been demonstrated how postcolonialism works in practice in a particular fieldsite. Not only the disabled children in the MMHA but even their parents may not have any direct experience of colonialism, the imposition of foreign and superior rule, the conscious and mass use of human beings to serve other human beings' wealth. However, in a postcolonial society like this, the speed of the ship is dictated by the postcolonial elites that desperately try to catch up in the race for global capitalism, leaving the marginal groups behind. The parallel trends of charity, commitment and creativity (all found at the MMHA) may offset the gap to some degree, but in crucial moments, when the disabled could become more 'able', when people with impaired communicative abilities could become less impaired in the dynamic scale between the antipodes of able and disable, and when the disadvantages of vulnerable children could reduce, the chances of system failure remain significant.

Chapter 7. "One cannot write in Creole" – Alphabet in the Friends in Hope

Introduction

In this chapter, I will present another of the NGOs where I carried out my fieldwork. This NGO, the Friends in Hope, is the only one that works in the area of adult mental health in Mauritius.[44] I will describe its structure and functioning and highlight those who work or who attended here as patients. Special emphasis will be put on the description of language use through the detailed outline of a particular *'animation'* group session where many Mauritian linguistic complexities crystallised and were added to the mental problems of psychiatric patients. This combination resulted in a fiasco in terms of what the session intended to achieve. The event exemplifies how the linguistic inequalities and unresolved controversies in Mauritius contribute to the reproduction of social disparities, and obstruct the possible success of mental treatments.

The Friends in Hope

The organisation was founded in 1997 by a group of parents and family members who had to look after others in the family who suffered from psychiatric disorders (Anonymous 2011b). Later, the institution

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44 The name of the organisation is in English in original. .http://www.friendsinhope.com. Accessed 21/12/2011.

benefited from the acquisition of a site in Bonne Terre in the urban district of Plaines Wilhelms near to the Victoria Hospital. Professional staff, including Mauritian healthcare professionals returning from the UK and France, were assigned to the management and professional running of the service. Not long before my fieldwork, the association opened its new, second base in the North, in Triolet, not far from the *Kominote* of the *Centre de Solidarité* in Solitude.[45]

The centre in Bonne Terre is hosted in two one-storey residential buildings. The staff consisted of two senior psychiatric nurses, one psychologist, two or three assistants/animators, one manager of the sheltered workshop, two administration staff, and a few volunteers who were involved in specific activities, like managing the weekly music therapy. The patients were divided into two main groups, the *stagaires* (trainees, interns) and the *adherents* (members), according to the severity of their problems and ability to take part independently in the daily activities. If the adherents had attended the centre for a long time and their mental state had been stable they could integrate in the maintenance and catering of the centre.

The Friends in Hope is a day care centre with the primary aim of rehabilitating adult psychiatric patients. Over time, some board members and staff have been involved in nationwide politics of Non-Governmental Institutions and in the management of many aspects of mental healthcare in Mauritius. Their activities also included care pathway development and work on the de-stigmatisation. Therefore, they became involved in prevention as well. Two members of the staff run an information desk twice a week in the foyer of the Brown Sequard Hospital. They also had a second hand bookshop in the back building in Bonne Terre. A major commercial mall on the central highland also allowed the organisation to

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[45] See Chapter 8.

sustain a book selling stand. One of the activities of the sheltered workshop was the production of cards, postcards and paintings.

New patients or the families of new patients were expected to pay a low monthly fee. Individual and corporate sponsors, the Government of Mauritius, and the European Union also contributed to the financial viability of the project. Nevertheless, as is ‘normal’ in the world of NGOs, the uncertainty of finances did cause anxieties.

As the difference between the two kinds of patients suggests, the mental state of the clients varied enormously. Non-violent behaviour and compliance with the daily co-living in the centre were conditions to attend the centre. Having spent many years in the centre, some patients had become nearly equal to the staff. In contrast, one could see patients actively hallucinating, with major problems of communication, influenced heavily by the side effects of medication, or expressing worrying level of anxiety. Transport difficulties made the attendance of some patients erratic.

Initially, the atmosphere of the place seemed informal and lively. After some time, it also became clear that diverse hierarchical relations among people were also prevalent. Overall, the relationship between staff and patients seemed more paternalistic than in a similar institution in Britain. On the other hand, this place was much friendlier and more intimate than the Mauritian Hospitals. Senior staff were quite anxious about the fact that it was difficult to employ trained mental health professionals in Mauritius who would be able to provide ‘modern’ mental healthcare and rehabilitation treatment.

The days at the Friends in Hope

Patients could stay in the centre from about 9 am to 4 pm, but the opening times seemed rather flexible. Not every patient came every day.

On the other hand, occasional outings, fundraising and other external events were organised during weekends. The daily routine began with a warm-up session in the morning, which often included some physical exercise or relaxation. There were two group sessions, one in the morning and one in the afternoon. Between the morning and afternoon block of activities, people had their lunch together. An evaluation session with the *adherents* closed the day for the clients. Staff had meetings after this evaluation session and they discussed emerging matters informally during the lunch break. The lunch break was the typical time for individual consultations with the patients, family members, or other visitors as well.

The group sessions aimed to play a significant role within the service that the organisation provided. The morning group session was typically divided into two sub-groups, one for the more severe patients who needed '*animation'* and another group, which seemed more like group psychotherapy.

Speaking in the Friends in Hope

The linguistic situation in the Friends in Hope was the most diverse of all institutions I visited in Mauritius, including the public, private and non-governmental sectors.

As seen, the name of the organisation is in English. Its website is in bilingual English and French but one can find here the best educational material in Mauritian Creole that summarises the warning signs of psychiatric problems for lay people. The newsletter of the organisation is nearly completely in French. When I was asked to write a short article about the history of psychiatry in this newsletter, I managed to write this text in Mauritian Creole. To my surprise, when I saw the printed version of the paper a couple of weeks later, I realised that one of the senior staff members had translated my Mauritian Creole text into French. When I

queried this, it was explained that the readers would not be able to understand written Creole texts.

The front office was the main contact with the outside world. The phones were often ringing and the typical response was bilingual, '*Alo, Friends in Hope, Bon Jour'.* Then the conversation usually continued in the language that the caller used; either in Creole, or in French, or in mixed Creole-French, or in a few occasions in English.

The patients used Creole with one another but some clients did this in a strong Creole Fransize form. One patient sometimes used English. The difference between the linguistic form that the patients used with each other and the form the patients used (had to use) with the staff seemed like a principal example of the hierarchical differences that divided the two patients and staff in the context of paternalistic mental healthcare. The patients talked to the staff in Creole but they mixed Creole with occasional French insertions to an individually varying extent. These insertions often seemed to signal the intention of certain patients to present a favourable image about themselves to the staff or to claim an outstanding position within the group of clients. The professional staff used a diverse mix of Creole and French towards the patients both in informal situations and during therapeutic sessions. Sometimes it appeared that they would have preferred to speak only in French but 'for the sake of the patients' they mixed it with Creole or changed their French to Creole. 'The leftover', the elements of French that remained in their manner of speaking was revealing.

It was especially noteworthy that the less senior members of staff tended to use more French with the patients than the more senior staff or managers did, giving an example of the Labov paradigm.[46] Verbal

[46] See also Chapter 2 and 6. Conscious emphasis on the prestigious linguistic forms in societies where diglossic situation are commonplace can be analogous with tendencies of hypercorrection in monolingual speech communities. In Labov's view,

communication among staff, including both professional and administration staff, presented a picture of classic diglossia. Lower rank and junior staff consciously tried to address senior staff in French; whereas, senior staff presented a very diverse mix between each other and occasional 'downward' trends. The latter manifested in responding in Creole to people at a lower hierarchical position in the centre who had addressed them in French. The latter trend included an ironic tone sometimes; the senior staff were perfectly trilingual but talking back in Creole to the less senior personnel sometimes meant that they were mocking the intentions of those trying temporarily to climb up the social ladder. Nevertheless, when the staff, and especially the Creole members of the staff, spoke in Creole they used a strong Creole Fransize accent.

'Official' written communication, for example reports to the Hospitals about a patient, or reports to a Government office about the organisation had to be made in English. The committee and planning meetings of the association that were attended by the management and board members were entirely in French. The minutes were taken in French; then, if needed, translated into English. Occasional educational material, for example poster texts to describe a psychological problem in a group sessions were in Creole, using *in situ* invented, non-standard, frenchified orthography. I did not hear anyone, neither clients nor staff, speaking in any Indian or Chinese languages. However, when I said a few words in my basic Hindi, I could note by the surprised laugh of a few people that a section of the clients understood what had been said.

My role in the association was peculiar and hard to categorise by Mauritian stereotypes. The organisation could not afford to employ a psychiatrist. They were quite happy that they were able to afford one full-

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hypercorrections are characteristic to low middle class usage of language. Members of this group intend to distinguish themselves emphatically from social groups at presumed lower social position.

time psychologist. The patients only saw psychiatrists in Hospital consultations for a few minutes. A doctor turning up in the centre and sitting within the circles of clients was strange and somewhat flattering for everyone. It was not easy for the patients to speak naturally with me but our relationship became more relaxed after a few months. I emphasised many times that I was not working as a psychiatrist in Mauritius. Therefore, I did not systematically explore the patients' histories, the current state of their symptoms or treatments from a psychiatric point of view. The situation was new to me as well as I had not worked in the field of adult psychiatric rehabilitation before. I had never spent so much time semi-informally with psychiatric patients before this occasion.

My unusual position was compounded by my unusual language use. First, we talked mainly in English with staff members. This drifted towards Creole gradually over the months. My spoken Creole was a surprise for everyone. It was unusual that a white foreigner spoke in Creole but my Ordinary Creole accent was even more unusual. It was weird for them to hear my *zoli, semen* [semẽ], or *plis* instead of *jolie* [ʒoli], *chemin* [ʃəmẽ] or *plus* [plys]. Referring to my language use, and especially my ordinary Creole, I had to express a couple of times, particularly to some Creole clients and staff, that I did not mean to offend them. Some senior staff members made excuses for me or helped me out on occasions in order to prevent the predicament. Some people could not help addressing me in French, even knowing I would not be able to respond in that way. After a lot of questions like: *"Dr Laslo, Vous allez à la réunion?"* ("Dr Laszlo, are you going to the meeting?") once I could not help to respond jokingly to someone I knew would not be offended: *"Wi Madam, moz'ale."* ("Yes, Madam, I am going.", ironically using French conjugated forms with Creole words where it is not necessary.)

What is 'animation'?

The expression *animation* does not form part of a usual English vocabulary. However, it may turn up in Mauritian English, or at least it occurred frequently in the Friends in Hope. There is an equivalent word in French and Creole (and in many other languages such as Spanish, German, or Hungarian with similar spelling). Etymologically, this word derives from the Latin word *animus* (soul) and refers to the action of 'giving [the] soul (back)' to people. Literarily, 'to animate' means 'to energise' or to make people active who are otherwise uninterested, indifferent or lethargic; in a broad sense, the word may also mean 'to entertain' or 'to help to have fun'. Occasionally, this action has a legitimate role in mental healthcare. It is based on the concept that people are meant to show some 'normal' level of interest and activity in the social world, and these are insufficient in the case of many psychiatric conditions. According to this model, boredom, the opposite of 'being animated', is not just a simple form of unhappiness but something that can aggravate the severity of mental problems. Thus, it seems logical that efforts that aim to give interest and vitality back with the help of therapeutic methods can form part of a biomedical treatment.

Animation sessions like those at the Friends in Hope could be seen ordinarily in the psychiatric institutions of many countries within the realm of biomedical psychiatry.[47] Nonetheless, similar groups are not exclusive to mental health; they could serve for light-hearted play to entertain children in camps or elderly people in care homes too. Often some kind of educational element is also attached to such groups. These groups are characterised by interactions among group members, the sense of (usually temporal) group membership and coherence, and the emphasis

47 For example, such a group could be akin to group sessions that Occupational Therapists organise for people in psychiatric wards or in drop-in centres.

of the leadership of a moderator (often a staff member with expertise and authority) who helps to deliver the main task.

The start of the 'animation' session and the task

One a hot Tuesday morning I was running a little late. When I arrived at the centre, the session of the *animation* group for the *stagaires* had already begun in the main hall in the ground floor. As usual, a stand with a white flipchart was placed next to the front window. One of the *animators*, and a member of the staff, stood beside the board. A few patients sat in a loose circle next to the wall. As not all the chairs were occupied I was able to join in, sitting down quietly on a free chair. Other staff members were also sitting within the circle. The warm-up discussion had already started. Normally, these constituted greetings, small talk, friendly jokes, and comments about the plans for the day. The instructions for the day's session had just been given.

The task seemed simple. I remembered playing the same game in primary school and during the cheerful evenings of summer camps. One could suppose that this game could be fun for typical 12-year-old pupils in many countries. The task was that someone had to say a word and somebody else had to say another word, which started with the last letter of the previous word.

The session was very similar to other such daily routine sessions in the associations in most aspects. Normally, it was reassuring for the patients that these sessions were planned and structured. Also this day, everything looked familiar for patients and staff alike.

Where the problems arose

That day the main task was to continue the chain of words but,

despite the exercise seeming very simple, it ended in total failure.

The instruction as usual was given in Mauritian Creole but the individual words that were used to play with to make a chain of words were either French or English words. Why? To identify the last letter of a word in English and French one has to know the written form of these words. As only those words that have written form could be used in this game one had to use French or English words that day as 'One cannot write in Creole', a sentence that I often heard in Mauritius.[48] 'One cannot write in Creole' can be asserted both in the sense that one is 'unable to write' (that is, correctly, in standard form) in Creole, and equally in the sense that one 'is not used to' or one 'does not want to' write in Creole. However, when isolated words were suggested by the participants of the group this day it became obvious that most participants, many patients and sometimes even the staff, could not write correctly in French or English either. They were incapable of doing so to varying degrees and this incapacity tended to fluctuate dynamically during the further approximately 45-minute session.

Three separate sets of problems seemed to interplay in the failure of the suggested activity and accomplishment of the '*animation'* session's goal.

Communication problems of psychiatric patients

The first problem was connected to specific psychiatric conditions that the patients had. Generally, many psychiatric patients struggle with motivation, communication and concentration difficulties and these symptoms are characteristic of the underlying psychiatric disorders. Depressed people may speak less and slower because of the slowing-

48 This sentence was told to me usually in English but the Creole version *"(nou) pa ka'v ekrir (an) kreol"* was also said occasionally.

down of their thinking process, often caused by the increased amount of worrying thoughts. Apathy and decreased motivation to initiate human contact are characteristics of Chronic Schizophrenia. Acutely psychotic people may communicate less and become more solitary if they are overwhelmed by disturbing thoughts generated intrinsically in the mind. Both acute and chronic psychosis but also conditions such as Asperger's Syndrome or Learning Disabilities can make the speech sound unusual. These communication problems differ from the genuine speech disorders, for example stuttering, where the speech problem is the principal symptom and not a secondary sign of another underlying disease.

The concentration problems of psychiatric patients are often triggered by the adverse effects of medications that are given to treat psychiatric disorders. For example, sedatives (like Diazepam) and certain antipsychotics (like Chlorpromazine) can cause poor concentration and somnolence.

This morning, the group included the following patients:

a) A patient who had suffered from Chronic Schizophrenia for decades. He did not speak at all usually, unless having some very specific request.

b) A talkative patient with slightly under average intelligence. He was often distracted and needed constant reminders to keep his concentration, a problem probably caused by his medications (Chlorpromazine and others).

c) An obese patient who often fell asleep during the session, possibly similarly due to his medication.

d) Another patient who was involved in a major disagreement with his family at home, but in the centre he was active and conformist, usually dominant in group sessions.

e) A patient in the acute stage of psychosis, suffering from

hallucinations and presenting strange behaviour. She rarely talked to anyone but responded to questions with brief, but accurate answers after a long time.

f) Another patient who had been abused, experienced multiple psychotraumas, and suffered from a major anxiety disorder. She was very afraid of speaking.

For these patients, the rationale of *'animation'* may be indeed beneficial. They may really need to get some support to communicate, to improve their mood, and may need external encouragement to deliver certain cognitive tasks.

Problems with literacy

The second problem was related to the mere deficiency in literacy and alphabetization among some patients. Their example demonstrated how average Mauritians struggle with the 'correct' standard spelling of words, supposedly in English or in French. For example, one of the patients in the group, a somewhat reserved person and regular attendee of the centre for a long time, was definitely over the acute stage of his illness. There was not any observable strangeness in his communication with other patients during the day. His intelligence appeared to be normal. However, in this game one could realise that he was almost completely illiterate. Like many Mauritians, he was able to recognise most French and some English words in verbal interactions if those were said separately, even though he was unable to engage in long and particularly diverse conversations in French, let alone in English. However, he had no idea how to write these languages at all. This incapacity was hardly known or noted by either the fellow patients or highlighted by the staff as a key problem. It seemed that one can simply get along like this in the

Mauritian society, where communication is predominantly oral and where the mastering of alphabet(s) appears to be the prerogative of a few.

Other patients and even staff members who were supposed to represent authority and expertise also demonstrated varying levels of uncertainty about 'correct' writing. Eventually, dictionaries had to be used to ensure the spelling of certain words. This created an additional problem because only a few in the group were able to use a dictionary at all. The session was an example of the fact the many Mauritians, despite having spent many years in mandatory education, and being able to read and write to some extent, are still not fully confident in these abilities. That day, a huge contrast emerged between the ease and comfort of the verbal introductory part of the session and the embarrassing failure of the 'animation' during the delivery of the main task of the session.

The burden of the orthographies and getting lost in absurdities

The third contributing aspect was the particular difficulty that stemmed from the complicated and confusing orthographic standards of the French and English languages that are based on traditional etymological principles. Even averagely educated native speakers can struggle a great deal with the correct spelling of words in these languages. In this group, it was possible to observe what happens when these languages are supposed to be used by non-native speakers, here by Mauritian psychiatric patients.

Examining the difficulty with orthographic systems it is clear that the *repertoire* of sounds in the three languages is different to some extent. In addition to this, according to the established standards in French and in English, the pronunciation of the letters are often different as part of the alphabet from how the same alphabet letters appear in words.

In French, in the row *a, b, c, d, e*…. the letter ‘e’ is pronounced as [ə]. So, in French when you read out a, b, c, d, e… you say [a], [be], [se], [de], [ə]… When used in a French word the ‘e’ can be pronounced as [e], like ‘*effacer’,* or [ɜ] in ‘*exciter’,* or [ə] in ‘dedans’. The letter ‘e’ of the alphabet is akin with variations like é, ê, ë, and è, where the ‘é’ is usually [e] and the ‘è’ is usually [ɜ] but there are a lot of exceptions and uncertainties.

In ordinary Mauritian Creole, there is no [ɜ] and [ə] but only [e]. Creole Fransize tend to use both [ɜ] and [ə] at varying extent.

The same ‘e’ letter when pronounced separately in the alphabet in English sounds as [i:]. In an English word it can be pronounced as [i:] like in equal, or [ɪ] equate, or [e] in equity. The letter is ‘e’ is often unpronounced, especially at the end of the words, when it has the function of a marker that sign that the vowel of the word is open vowels and not closed, like fat – fate, pet – Pete, mop – mope, cut – cute. Therefore, the ‘e’ in English is not always a letter of direct acoustic value.

In the group this day, the *animator,* a staff member told the following instructions to a patient:

“Alfed, li bizen dir enn mo ek to bizen dir enn lot mo ki koumanse avek dernie let sa mo la.” (Alfred, he has to say a word, and you have to say another word, which begins with the last letter of that word). The instruction seemed clear.

In order to say a safe word, one can always turn to food and choose a food name. So, one of the patients said *zariko* (bean).

The staff member froze with the felt pen in hand and was embarrassed how to write *zariko* on the flipchart. This word was a Creole word and thus hesitation and an internal dilemma emerged. An educated person who is in the role of moderating an *animation* group in the capacity of authority and expertise may feel that he/she is not supposed to

write down any Creole word. Moreover, it is uncertain how to write *zariko* as this has never been taught in schools because writing in Creole does not take part of the Mauritian school curricula.

A short discussion followed among the present staff members. The tension temporarily decreased after the explanation that this word should be written 'correctly' as *haricot* but when 'you are passing the market' you could say *zariko* there. The problem here is that the words *zariko* [zariko] and *haricot* [ariko] are although obviously related and mutually understandable but they are also markedly different as well to demonstrate evidently that they belong to two different languages. To compare it with an example, it is not difficult to figure it out that the German word 'Mutter' [mutə] and the English word 'mother' [moðə] are similar and related, as the German and English languages are closely related to each other. However, the difference between the two words is marked enough to demonstrate that German and English are two different languages. Here, the Creole word starts with the sound [z] but the French word starts with a sound [a]. However, when writing down *haricot* one must use the notion learned at school, which cannot be figured by the mere logic of phonetics. Namely, when one reads out the word *haricot* the first sound is an [a] and the last sound is an [o], but when one writes the word it must start with a 'h' and end with a 't'. The spoken difference between *zariko* [zariko] and *haricot* [ariko] does not help to figure out the written *haricot* word's initial 'h' and ending 't'. As the French spelling is etymological and therefore idiomatic, the reason to apply a 'h' in the beginning of the word *haricot* and a 't' at the end is particular, scholarly knowledge.

The task this day in the Friends in Hope was to say a word with the last letter of the previous word. *Haricot* quickly divided the group in terms of who had acquired the correct spelling of this particular French word and who had not. As explained above, for some patients even to

write such simple words like *haricot* was a difficult chore. To write *haricot* one has to be aware of the Creole – French diglossia, and know that the same thing (the bean, in this example) has at least two different (but often similar) name variations. The recognition and interpretation of this difference is embedded in the entire social context of the diglossia in Mauritius.

Nearly all discussions, the instructions, the comments, the corrections, the reminders, the praises, the reprimands, so at least 95% of the verbal corpus that was used during the group session of that day was in Creole. Thus the scholastic explanation of the animators, from the position of educating authority, about the indisputable fact that *haricot* must be written with an initial 'h' and ending 't' had to be said in Creole. One of two languages was used to try (and fail) to write (French or English), and another language (Mauritian Creole) was used to explain the complicated spelling peculiarities of the standard orthographies of two other languages. Whereas the first language, the Mauritian Creole, which was used to interact, to express thoughts and feelings, and to 'animate' psychiatric patients was not highlighted or even mentioned by name in the this task that required literacy. The presence of Mauritian Creole was implicated only, like an invisible and unspoken anti-reference, like an invisible ghost in the room that everyone is aware of but no-one can or wants to see.

By saying, 'say a word', one is using words in that very moment. This speech action is an action that intends to achieve that the co-interlocutor do or do not do something. The speech action may refer to its carrier itself, when the verbal instruction is given about the language itself. What happened here was that the word 'word' in the sentence 'say a word' signified a different dimension of the 'word'. The instruction therefore separated two distinctive dimensions. To show this with an example, this could be similar when someone says 'tell me a word' in

English but the answer could only be words like *Wissenshaft* or *pahele* or *marodi* or similar words in a foreign language that is not English; in this case, the respondent is not allowed to say ‘bonny’ or ‘ghost’ or ‘Charlie’ or any other word of English, the language of the instruction. Thereby, the instruction denies, negates and ultimately annihilates the word-ness of the word ‘word’.

Back to the specific exercise, it seemed that a desire arose in the group to use more English words to avoid the upsetting issue of the Creole – French interference. English is often taken as a more democratic choice, as it is widely believed that no-one masters English in Mauritius, therefore everyone struggles with it ‘democratically’. Indeed there is virtually no native English speaking population in the island, and usually the Creole words are more different from English than from French. A few staff members in the Friends in Hope speak very good English as they had worked in the UK. The difference in competence to speak and write English was equally marked among the participants who had very different level of knowledge and competence in English. Yet, it seemed at this point that diverting the play towards English words was a somewhat safer choice.

However, another problem struck with the frequent ‘silent e’ at the end of English words. So, when someone says ‘come’ and finally the group manage to write down the four letters, *c, o, m* and *e* that signify ‘come’ the shape of the word written on the flipchart can already be of difficulty. In the concept of the English alphabet, four letters represents three sounds, which mean one meaning. Fortunately, this is a quite frequent and relatively simply English word. Some people were able to recognise the picture and particular sequence of the four letters of *c, o, m, e* and captured the meaning ‘come’. However, writing an English word one uses the letters of the English alphabet ‘c’, ‘o’, ‘m’, ‘e’. This was tried in the group too. The task is to say a word that begins with a certain

letter. Therefore, that certain letter has to be separately identified. To identify a letter one has to pronounce the letter in the form how it is in the alphabet and not how it is in the word that has this letter as the first or the last position. The letters of the word ‘come’ have to be voiced separately. Thus, the spelling of ‘c’ is [si:], ‘o’ is should have been [əu] or [ou],[49] ‘m’ is [em] and ‘e’ is [i:]. Therefore, one has to call the silent ‘e’ and say [i:] while spelling the word ‘come’. Here the difficulty continued. The instructor turned to the next patients and told him:

“*Alor, Bernard, dir enn mo ki koumans avek let [ə]*.” (So, Bernard, say a word that starts with [ə]).

Perplexed silence. Everyone felt something was not right there. We were referring to the (silent) ‘e’ in the word ‘come’, which a few second ago was just called as [i:] but by now the instructor requests a word that starts with this [ə]. The [i:] sound that otherwise marks silence here had just gone through a metamorphosis and became [ə].

The sound [ə] is not part of the phonetic system of this sentence “*Alor, B, dir enn mo ki koumans avek enn let…*”. This part of the sentence, without the last sound, contains no [ə] as that part of the sentence was said in Ordinary Creole where the [ə] sound does not exist. In the meantime, [ə] is a sound of the French language, it may be a sound of Creole Fransize. Furthermore, it is a sound of the English language but does not appear in the word ‘come’, neither when the word is voiced nor when its letters are voiced separately. With the request for a word that starts with [ə], the instructor evoked a French word instead of an English word although he might have wanted to ask for another English word, as explained above, to have a safer option than asking for a French word. It seemed he was just afraid of saying “Say a word that starts with [i:]” because the participants could have given a wrong answer, saying a word

[49] In this group, [o:] was said like in a foreigner’s speech or in some British dialects.

that starts with the letter ‘i’ (like ‘idiot’) although the last letter of the previous word (‘come’) was an ‘e’. So, the instructor quickly corrected himself, “I wanna say.., say a word with [ə] but not with [ai]”. The [ai] is the English pronunciation of the letter ‘i’ when it stands alone in the alphabet.

Thus, the request was for, at least formally, saying a word that starts with [ə], by which the instructor meant that a word ought to be written with an initial ‘e’. If one is semi-literate and struggles with spelling one may think of words that really start with [ə], that is, with a schwa, an unstressed and toneless neutral vowel. In English particularly, there are quite a lot of words that begin with a schwa (for example, ‘amount’), but are they typically written with an initial ‘a’. But then if one is supposed to say a word that begins with an ‘e’ in French, those words when pronounced would never sound with an initial [ə] but usually with [e] (like effacer) or [ɛ] (like exciter). To complicate this, ‘e’ can represent [ə] both in French and English but never as an initial sound of a word.

The group session went on for a while in similar manner, without much change, and without any apparent solution to the problem. The confusion continued to be significant and the participants looked relieved when the session was over. Instead of becoming ‘animated’ and cheerful, and instead of learning or re-learning something useful, confusion and some sort of reciprocated disheartenment dominated the scene.

Summary

Concerning French and English, speakers are supposed to be aware of the rule that letters may sound differently in the alphabet than in words and to be also aware that letters may signify different acoustic items in the initial position of a word, in-between a word and in the final position of a word, and to be aware of the frequent exceptions to the rules. Moreover,

speakers should be ideally aware of the inherent ambiguities of English and French orthographies, the fact that the relationship in French and in English between signifier and signified is fundamentally ambiguous, and that this ambiguity unfolds when talking and writing come forth together.

In the specific case of Mauritius, speakers need to understand explanations and instructions about the previous rules in a language, Mauritian Creole, which itself does not have such standard rules, and to which it is often inappropriate to refer. Ordinary interlocutors in Mauritius cannot be perfectly aware of all these and have to bear and carry some degree of perpetual uncertainty. Ambiguity and uncertainty polarise the social groups of the interlocutors.

As explained in earlier chapters, all this has profound historical grounds and constant daily reference to something that happened thousand miles away in the rising European colonial powers of France and England in the 17th-18th century. The reference is temporal (17-18th century), temporal-dynamic (to what has and what has not changed ever since), spatial (North-West Europe), economic (early capitalism and colonization that required standard languages and standard orthography), alienated (something with primary relevance in a far-away, different society and exported afterwards), and cultural (referring to the modernity coming of age in the 17th-18th century).

The multiplicity of complexities and the multiple ambiguities all together refer to something particular to Mauritius and to the sensitive equilibrium of its multiple fragmented society. In order for Mauritians to overcome the difficulties exposed in that *animation* session, somebody could propose to write Mauritian Creole using its phonemic principles. It would be rather easy to write ‘e’ to express [e] and not to write ‘e’ to express any other sound. It would be easy to express [e] with one letter only and only with the letter ‘e’. Signifier and signified would be in unambiguous harmony. After the attempts in the last forty or so years,

following the latest version of the orthographic proposals for Mauritian Creole, this harmony would be almost perfectly realised.[50] It would be even possible to write a thesis like this in Mauritius without frequently using spell check and an on-line dictionary. Yet, this easy choice does not occur in contemporary Mauritius as the examples presented in this thesis demonstrate. Mauritius remains a postcolonial country with a special relationship to the ex-colonisers and their languages. The current example in this chapter has intended to portray how extreme and bizarre this setting could become and how it hinders the treatment of mentally ill patients.

[50] With a few exceptions such as the nasal sounds.

Chapter 8. Drug Scenes in Mauritius

Introduction

In this chapter, I will present one of the fieldsites, *Centre de Solidarité,* a Non-Governmental Organisation that deals with drug addiction and similar problems of substance misuse. Language use is central to the process of dealing with and treating such problems. The chapter will highlight the connection between the social practice of using psychoactive substances and conversational strategies through the realization of particular language use.

The Centre de Solidarité *as an NGO*

Picture 8.1 The entrance of the *Centre de Solidarité*[51]

[51] Taken 30/05/2009.

Substance misuse is another typical sector where NGOs are numerous in Mauritius. This field is strongly coupled with the treatment of AIDS as well. The *Centre de Solidarité pour une Nouvelle Vie* (CdS), to give its complete name, is one of the oldest and largest NGOs operating in the area of substance misuse on the island.[52] It was launched in 1988 by an Italian based initiative and in co-operation with the Catholic Church (Sooben 2003). It follows models developed in Italy and the United States. These models are grounded on the idea that biomedicine is unable to meet properly the particular needs of the treatment of substance misuse and substance addiction. Smaller, flexible, more informal units run largely by ex-users have proved to be more efficient in this field.

Since 1996, the *Centre de Solidarité* is no longer connected to the Church having become an independent organisation managed by an executive committee. It has been supported financially by individual members, corporate sponsors, international grants and the Mauritian government. Nevertheless, as in the case of most NGOs, expansion and shrinking of sections and activities have occurred according to available funds. The CdS specialises in treating male clients with drug and alcohol problems. Female substance users can turn to other specific institutions like *Chrysalide* in Bambous or *S.O.S Alcool Femmes Étoile D'Esperance* in Curepipe.

The structure of the Centre de Solidarité

The centre has five sections in three different local bases. The Prevention section is based in Curepipe. It offers courses and educative sessions and works with schools, media, companies and local authorities.

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[52] The Centre of Solidarity for a New Life.

The Therapeutic Community, the '*Kominote'* is based in Solitude, a village on the northern outskirts of Port Louis, near Triolet. The main base is in Rose Hill, located about 500 metres south of the city centre in a small lane next to the main bus route. It is the base for the remaining three sections, management and all other major institutional activities, like accounting, meetings or courses. The three sections in the Rose Hill base are Family Therapy, 'Reception' (*L'Acceuil*, or *Lakey*), and Reinsertion. The admin support of the CdS is also based in the Rose Hill centre.

The functioning of the Centre de Solidarité

Upon the clients' initial self-referral the first contact point is the Family Therapy section, which is based next to the entrance of the main building, and there is always someone here in the daytime to attend to potential drop-in clients. The workers in this section respond to phone calls as well. They start working with the families immediately. Sometimes family therapy remains the primary treatment all the way along. Consequently, in addition to attending to occasional drop-ins and new applicants, the family therapy section has a caseload of long-term treatments with or without the involvement of other sections, both prior to and after any other kind of intervention.

After the initial contact, if the user aims at discontinuing the use of the substance, detoxification could be the next stage, with the approval of the professionals of the CdS. This may be the simple straightforward consequence of the initial contact but sometimes it is reached much later, when the client's motivation has become clear and the views of clients and workers agree about the subsequent plan. Detoxification is not carried out within the premises or under the direct surveillance of the CdS. The clients are directed either to the Brown-Sequard Hospital or to a private practitioner doctor, with whom CdS has a co-operating agreement. A

period of approximately 15 days is calculated for detoxification. After this, the client is admitted to the *L'Acceuil* section, which can accommodate circa 5-15 people in a few rooms at the rear of the main building. This part of the building comprises a kitchen, a dining room, a staff room, a veranda and a yard. The treatment stage in *L'Acceuil* is currently about 3 months. Therefore, there is a constant turnover of clients, who must get involved in the daily routine of the section, like cooking or cleaning. Clients as well as staff, spend their days intensively together. The clients are expected to participate in group meetings and individual sessions with one of the staff members of *L'Acceuil* or with one of the two psychologists of the organisation. In addition, there is plenty of informal talk and interaction among clients, especially in the kitchen and on the veranda. Smoking is allowed in designated areas and it often structures the day and the interactions of people. The veranda was the place where I had the unusual experience of people suddenly engaging me in conversation in Creole. People here have recently become drug-free, some of them after a long time in their life. What they have in common is their past addiction. They live here in close contact/interaction and the substances they have previously abused (drug or alcohol) are the central topic of all conversation. Some clients have spent several periods in *L'Acceuil*. Theoretically, they are free to leave at any time, breaking the virtual contract between them and the organisation. Sometimes in the initial first few weeks, visits home are discouraged, and the visits of family members are controlled by the staff. Other times, the clients travel to *L'Acceuil* on a daily basis and attend it as a day clinic. Meanwhile, the work with the family might continue in the family therapy section.

When the time in *L'Acceuil* is over, the clients are supposed to be drug-free, to have overcome the withdrawal period, and not to be at risk of prompt relapse. At this moment, they are regarded as ready to work psychologically with themselves and family members about the ins and

outs of substance misuse. In cases of severe addictions, when the risk of relapse remains high in the mid and long term, the ex-addict can continue the treatment in the therapeutic community in Solitude. This section will be described in a later section in details.

When all previous therapeutic stages, the initial contact, the prompt family interventions, the detoxification, *L'Acceuil* or *L'Acceuil* plus Therapeutic Community have been completed, the clients end their treatment in the Reinsertion section. This final part of the treatment aims to help the reintegration of the client into society, with more family therapy and family support, and sometimes contact with work places, addressing work and family related concerns after a long time of being out of 'normal life'. The reinsertion work may last up to a year.

In the early years of the CdS, the periods of each intervention stage were somewhat longer, and the rules were stricter. Later, this was reduced and changed partly for financial reasons, partly as a consequence of changes in therapeutic philosophy. A solid core of the CdS's staff, about 6 to 7 people from the total 20, has been working in the association for about 10-20 years. This suggests that those staff members are very experienced in the treatment of substance misuse while the relative low turnover of personnel is a sign of the functional stability and a well-established adjustment between therapeutic aims and operational structure.

Conversations in the Centre de Solidarité

While sitting on the veranda in the centre's *L'Acceuil* area, I was surprised by the ease with which the clients approached me without reservation and talked to me in Creole. At that time, I had been living in Mauritius for a few months and such an impromptu interaction had hardly ever occurred to me before. In previous fieldwork interactions, people had

not only been apprehensive about my being a medical doctor, with a white skin and of 'weird' nationality but I had had to go through the usual language games of the country in deciding with what linguistic medium to start and continue in a conversation and when to switch languages during the conversation. Neither in occasional nor accidental situations, had anybody ever started a conversation with me in ordinary Creole, the language of the everyday, spontaneous and familiar interactions in Mauritius. It seemed that the matter of *ladrog*,[53] through conversational genres and personality features (both pre-misuse and misuse-reactive ones) was overwriting the normative inhibitions of customary language games of this multilingual society. However, just like many other conversations, discussions and comments during my subsequent visits to the *Centre de Solidarité* and the *Goumani Centre*, a great part of the *ad hoc* conversation concentrated on the phenomenon of Subutex. First, I was surprised by the constant mention of this drug in daily conversations. Later, I came to understand the importance of this drug in Mauritius.

On a Sunday afternoon, a singing-dancing-eating party for clients, family members and visitors was organised in the *L'Acceuil*, in the backyard of the CdS. Most people from the centre – clients and workers alike – already knew me, but I was getting curious glances from a few family members. As usual, it was impossible for me to keep a low profile. On the other hand, the etiquette in Mauritius is not pushy or intrusive but rather reserved until people have mutually clarified who is who. As I was hanging around next to the makeshift stage, a former drug user did not have any problem in opening up with me. We engaged in a conversation and he happily talked about his 'hybrid' family with many so-called intercommunity marriages and relations. These kinds of marriages are not uncommon in Mauritius; what is uncommon is that somebody would

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53'Drugs, illicit substance'.

speak about this kind of private details with ease and genuine confidence. 'Pure', locally conceived endogamous families and/or marrying up are prestigious; 'inter-community' relationships, however, are more usually hidden or viewed with some trepidation. This ex-client talked to me freely about how much he had plumbed the depths for many years, with the usual pathway from alcohol to heroin then to Subutex, and finally to all sorts of crime, but in his case, also to recovery and reinsertion to 'normal' life with a family and a job. A human story that happens to many people in the world, simple to listen to maybe but one of the deepest journeys a person can go through. It was a story of real salvation that he told me there next to the stage. After such a battle for survival, one can easily believe, the otherwise usual reservations about 'inter-community' relations do not really seem important.

On another occasion, a *toxikoman* (drug-user in Creole) client in the *L'Acceuil*, in his early thirties, gave me an outline of his life, which I think could be regarded characteristic of present drug use patterns in Mauritius.[54] He started with alcohol and cigarettes at the age of 14. Then it reached the stage of *sirop* (syrup). Some opioids, typically Codeine, are in medical use to treat coughs, suppressing the sensitivity of receptors in the respiratory tract. These medicines can be produced in liquid form and the patients are supposed to take a spoonful as a dose. A spoonful of cough syrup usually contains a very small amount of opioid, especially in combined forms when the syrup contains various anti-cough substances (not only opioids) at the same time that work in different ways to suppress coughs. Some cough syrups marketed in Mauritius are often regarded as problematic in many countries because they contain too large an amount of Codeine or other opioids. After consuming a large amount from a bottle of syrup, for example the whole bottle, the opioid effects can

[54] To keep confidentiality, I often use composite characters.

clearly manifest because the amount of opioid brought into the body is not insignificant. In Mauritius, this type of drug use appears frequent. This is not just due to the fact that syrups with significant Codeine content are freely marketed but it may be connected to the rumour that users can bribe some staff members in pharmacies to provide large amounts of cough syrup bottles. Consequently, the use of Codeine, which is an opioid, is often an introductory phase of a later more profound opioid use. Syrup use was reported to me as more frequent among teenagers and among polytoxicomanic (multiple, near simultaneous use of several drugs by the same person) people. This particular client continued with 'brown' (the English word is used in Creole too), that is, with impure IV Heroin, and finally a few years ago arrived to the end point of IV Buprenorphine. He said that he had felt "*ek Subutex pena traka"* ("There are no worries with Subutex."). The sexual pleasure, especially the orgasm he experienced was hugely enhanced and he became more energetic in his work as well. It is worth mentioning here that in contrast to Buprenorhin most other well-known opioids like opium or Heroin normally reduce the desire for and ability to have sexual pleasure. While already being involved in misusing substances, he got married, had two children, and worked in construction. His wages were about Rs10,000 (£220) per month.[55] After a few years, he purchased Subutex every other day and paid 1,000 rupees (£22). The amount of Subutex for 1,000 rupees was enough for 3-4 injections per day, that is, altogether 6-8 injections for two days. Thus, his monthly expenses on drugs reached Rs15,000. To fill the gap of the deficit in budget he started selling valuable goods from home and the homes of family members. He also started asking for loans from family members and refused to support his own family financially. He lied frequently to his family who believed

[55] The average wages of an worker in the CdS also vary around Rs10-12,000 per month.

him for a long time. Eventually, all such ‘easy’ resources terminated and he had to start stealing. He told me that some drug-users collect waste iron but that this can only bring in an income of Rs200-300 rupees per day. He told me that this was not enough for him and said the dose available for Rs200-300 can only prevent the withdrawal symptoms after a few years daily Buprenorphine use but would not give any further pleasure. He was also quite convinced that the quality of Subutex he purchased had deteriorated, which contributed to the decreasing pleasure and more *traka* (problem, worry). Finally, his family became aware of his situation and after some time, they approached the *Centre de Solidarité*.

I did not see members of elite groups in the CdS among the users of mainstream substances as they do not use local NGOs if they struggle with substance misuse problems.[56] They were not found in the CdS, just as they almost never attend public hospitals, their children never attend state school, and their children are not found in schools for ‘handicapped’ children that have been described in the previous chapters.

The Kominote

8.2. The building and the front garden of the *Kominote*.[57]

[56] From the examples I heard, upper-class drug and alcohol addicts tend to seek treatment in private clinics to some extent but they often leave the country and seek presumably higher-quality help in Reunion Island, South Africa or Europe. This also gives them the chance of getting away from the usual microsocial environment and anonymity, which is virtually impossible for ordinary Mauritians.

[57] Source: http://www.actogether.mu/sante_details.aspx?id=7, accessed 02/04/2014

Therapeutic communities tend to create a virtual space with their own laws to eradicate the deeply engraved habits from the minds of substance addicts. After some, lengthy time ex-users might be able to live outside and not fall back to the old ‘bad’ community. Such therapeutic communities are often compared with military recruitment centres, like marine training, or religious cults, where the aim of training is the brainwashing of the applicant through drills, isolation and verbal aggression, replacing a former set of norms with a new set of norms. Some former drug users relapse after they have left a therapeutic community. Some of these ex-users wish to return here and a few of them never leave the place again. Marie-Gisele Landes-Fuss’s book, A Red Brick Building, Ugly As Hell, in Venice, California (1984 [1982]), the *MONAR* of Marek Kotański (Karpowicz 2004), or the *Leo Amici* (http://www.leoamici.hu) are among the places where the motives for creating spaces such as a therapeutic community are discussed.

The *Kominote* of the CdS in Solitude was strict but far less strict than many such communities in the world, for example in the three mentioned above. Clients voluntarily give up some of their freedoms, their movements are limited, they have to follow the rules of the institution and, most importantly, abstain from using psychoactive

substances. One of the staff members is always on site during the night. During daytime, another 3-4 staff members are present, including a driver and the psychologist who comes to visit the *Kominote* 2 or 3 times a week. The clients are expected to clean, cook, and look after the premises. Workshops (bicycle making), a vegetable garden, an abandoned chicken farm, and a washing shelter are located around the main building. A small gym is functional in one of the rooms; otherwise, the furniture is simple and practical. In the front garden, there are benches for relaxation or to meet visitors. The clients share one dormitory.[58] In between the dormitory and the kitchen, behind the main entrance in the middle of the building, the main hall is the communal place where meals are served at the long table, Television is broadcast in the evenings, and the group sessions are held in the afternoons. Staff meetings are held in the morning to discuss the previous day and night, the progress of individual clients and general matters. Later in the day some clients may have individual sessions. The afternoon period is dedicated to group sessions, which form a key role in the treatment of the clients. The use of group sessions, both as 'proper' group therapy or 'just to share' feelings and ideas about every day matters, is an established treatment form in mental health institutions. On the one hand, it may focus on the fundamental problem, the psychopathology, the key task of the treatment and overall reason the people have come together in the place. On the other hand, it may also function as means of discussing everyday matters of the community (in the sense of community of the *Kominote*), and common concerns arising from living together. There was a great deal of simple daily joy in living here: games, television, and discussions about football, food, and women. The attitude of the staff was often supportive, emotionally available and therapeutic in the sense of classic psychotherapy and not like the

[58] Only male clients live here; one may find females among the staff.

‘therapists’ of some military type therapeutic communities. Importantly, parallel to the expectation from the clients to abide by the regulations of the centre, the therapeutic attitude did not only want to impose only exterior thoughts and norms but, as in ‘normal’ psychological therapy, they also intended to draw on the feelings of the clients and build upon them as well.

As a consequence, social interactions among the clients before and after the therapeutic sessions like the after-lunch group session were quite informal. There were differences of character, generation and there was a marked difference between the two groups, the chronic alcohol addicts and the former IV Subutex users. Whereas members of the former group were carrying a lot of shame, members of the latter group tended to recall the memories of past Buprenorphine use with joy and sparkling eyes even years past the heavy use period.

Some people lived here together for a long time and really got to know each other. Staff and clients bumped into each other in the premises many times a day. Even I – a stranger, a visitor, and a *dokter* – could mingle among the people to some extent and it was not impossible to exchange a few words about life, family, and football matches. The language of the conversations, of course, was Mauritian Creole. This was working well in most situations in the life of the *Kominote*, including staff meetings and discussions except in the therapeutic group sessions where there was expectation to speak Creole *and* use a more sophisticated, psychologised language using the phrasing and terminology of psychotherapy. This seemed to radiate an awkward atmosphere. Some people, both clients and staff made an excuse to leave the group. Other people started fidgeting, sweating profusely, or yawning. Some clients started speaking differently, in a much flatter and more undemonstrative way than before, during the more informal moments of the session. Some staff members changed the style of moderation manners and became more

directive and even paternalistic in response to the awkwardness in the air. However, these group therapy sessions represented just a small amount of time, one hour three times a week, compared to the entire time the clients spent in the *Kominote*.

A genre of talking, a way of being

In the previous three NGOs I have discussed, there were attempts to 'educate' the clients/patients to speak better within the wider realm of propagating socially specific norms. Two of those organisations acted in the aegis of a school, in effect, and an institution with the emblematic legitimacy of a 'school' is supposed to educate the uneducated. In the two care centres for disabled people the perceived and legitimising task of 'school' prescribed the norm, a norm of the particular society, which entails the underlying concept that small people, children, the poor, and the marginalised speak badly, and that it is the task of the institution to 'teach' and correct the flaws in speech to change 'bad speaking' to 'good speaking'. This coincided with the distinct task of teaching speaking to children who have speech difficulties in any language, including their mother tongue. The staff, 'the ones who teach and can speak better' are inherently superior to the clients.

In the third NGO, and in public mental healthcare, patients are also often placed in a childish position with limited agency, promoted by the underlying chronic psychiatric problems, especially Chronic Schizophrenia and long-term depression. The disabling mental disorders and the hierarchical, elitist society collude. In public healthcare, the outcome is the reduction of verbal communication to a minimum and the striking contrast between the spheres where patients are present and the arena for interprofessional discourse. In 'Friends in Hope', the internal hierarchy and the subordinate position of the patients was clear.

Therefore, the organisation worked at its best when focusing on educational and caring tasks. On the other hand, a complicated trilingual (or quadrilingual) linguistic situation was characteristic there, as one of the areas where the complicated but socially embedded and socially specific relations are manifest.

The way and style of communicating in the *Centre de Solidarité* was different not only from the other observed institutions but also from the usual trends of daily verbal interactions among actors of the society in the public sphere. The reason is that the staff at this institute was responding to the communication style of the substance user community they worked with.

"Parmi bann toxikoman pena endien, pena kreol, pena misilman…" a client in the CdS told me. Literally this means "There is no Indian, no Creole, no Muslim among the drug addicts" and suggests that the usual differentiation and hierarchy making among the so-called Mauritian 'communities' and the ethnically/religiously based social networking has largely lost its importance in the sphere of drug users (mainly among Buprenorphine users). As mentioned, inside the walls of a centre that works with drug users, the usage of Mauritian Creole seemed naturally trouble-free. Understanding this is to highlight how a specialist institution responds to a particular genre of talking (and being) of a social group, the substance users.

This centre has a liminal status between private and public, where verbal interactions – including the therapeutic ones, the practical ones about everyday matters, and the ones related to co-living among people staying inside – do have a level of informality, but it is still not entirely like a close family or a close circle of friends or work comrades. In theory, language games could appear in institutions that offer a service and places with open access to the public, like the *Centre de Solidarité*. However, they did not appear here, or they appeared much less frequently.

Only by living in Mauritius and communicating with various people on the daily basis can one tell what is 'missing' here. There was a lesser degree of manoeuvring, of suspicion, of stereotypes, and of guessing games about who is who and who is the other in relation to "who am I?". This familiarity was partly caused by the techniques developed to treat substance users, which are the basis of the centre. This is a kind of 'family', of 'surrogate family' and the clients seemed indeed to be adapting their communications style and joining in the informality. This means that people spoke nearly as spontaneously, nearly as 'normally' in the centre as they would have done at home or with their best friends. This phenomenon could be invisibly usual for many 'lucky' countries but this is a phenomenon of exception in Mauritius.

In the centre, where the priority is dealing with difficult social problems, the use of an 'ancestral' language would have been nonsense. The suffering here overwrites the political games of the upper echelons. The use of the two postcolonial languages was peripheral among staff and minimal among clients. Some reports, correspondence and accounting had to be English or in French as the Centre is an established institution. Record keeping was mixed, using some English and some French but also quite a lot of Creole written with etymological orthography and with even some pioneering attempts to use new standard written Creole. Overall, written communication seemed secondary in the CdS as most of the tasks related to the base functioning are linked to oral communication. Thus, the usual complications and contradictions between written and oral played a smaller and not a central role. A few staff, who might have had claims to belong to higher social echelons, spoke some French to each other but, in the context of CdS this was marginal and limited to private, *sotto voce* conversations in the staff kitchen. For example, they told me apologetically "*Nou gagn tandans koz Franse"* (We have a tendency to speak French). No such comment has ever happened in the *Accueil* area

or during my visits in the *Kominoté* in Triolet. Addressing clients in French or English with the inherent hierarchical connotations and the possibility of interpreting the relationship in an emphatic superior-subordinate scale would have challenged the core of the therapeutic relationship between substance user and specialist staff and would have ruined the desired sense of familiarity. In the context of CdS, it could appear ludicrous to be *fezer* (arrogant) and behave in a *gran nwar* (boastful) manner.[59] I am not saying that there were no examples of this at all within thousands of daily interactions, but their number and importance seemed lower and subordination did certainly not represent the spinal cord of the base task of this type of organisation. The situation in the drug clinic reflected upon and mirrored the usual interactions and communicative genre of the substance user to some extent, as usually occurs within the drug user 'community'.

In stark contrast to the way of working that had evolved in the CdS during the longstanding involvement with a particular client group, one of the workers of CdS told me that in the counsellor training he participated in, the trainers used exclusively French training materials and there was no attempt whatsoever during the course to translate the concepts to Creole and treat Mauritian Creole and French on an equal level. He said this was the only counsellor training that had been organised in Mauritius. The participants – the would-be counsellors – were expected to learn the theoretical concepts and models in French, and then go out into the communities and work in Creole. My informant attributed this attitude and subsequent communicative gap to the fact that the training organisers were *demikle*[60] or *gran kreol*;[61] that is, they were members of the affluent francophone, mulatto upper social echelon and

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[59] See chapter 2 about more details regarding these expressions.
[60] Mulatto (lit. 'half-light').
[61] 'Great Creole', in an ironic sense; referring to other similar expressions like 'gran blan' (Great White) and 'gran nwar' (Great Black).

not from the target population for whom the counselling was about to be offered.

The life of substance users revolves around the substance which determines an experience that the non-users think artificial, but that the users share with each other and which determines their thoughts and actions trapped in the constant and repetitive procurement of the substance and the repetitive cycle of mental states of use and non-use (or after use). Actions may also include speech acts with the directionality to procure future portions of substance. In terms of temporality, the substance organises the present to realise a future. Substance users create a microcosm, a 'community'. In the case of drug users, the illicit nature of the drug requires more co-operation with each other; while people affected by alcoholism may retain more relations with their family and microsocial environment, even if these relations are conflictive and strained, and deflect less toward a new 'community'.[62] This kind of 'egalitarian' conversation within the drug user 'community' ought to be reproduced to some degree in an organisation or by professionals that intend to work with this client group. Some staff members told me stories about difficulties that emerge when foreign speaking volunteers engage in the work of NGOs that deal with client groups. They told me that English only speakers find the communication so restricted that it cannot reach the necessary level that is required for work with clients. The much more frequent French only speaker expatriates often fail to learn Creole. They can communicate with the clients because the majority of the population is able to understand French to a significant degree. However, and here a worker referred to the clinical work of one of the previous managers of the CdS, a French native speaker, it is a fallacious illusion to believe that

[62] I have used the word 'community' between apostrophes here in order to mark a contrast with the so-called official 'communities' in Mauritius attached to the associated disapproving expression 'communalism'.

there is really a working therapeutic relationship, a necessary ‘as if familiarity’ feeling between worker and client while they are not using the same language. The hierarchical relations that are mirrored in a therapeutically intended but French-speaking conversations are exactly the ones many drug users absconded from and created an ‘opioid democracy’ instead with its unpretentious language of Mauritian Creole.

Summary

In conclusion, this chapter has presented that in current day Mauritius the leading concern in the field of substance misuse is Buprenorphin (or Subutext), an opioid drug, but the consumption of alcohol has also remained a frequent problem. Within the multiple, compartmentalised, and often hierarchical stratification of Mauritian society along with its diverse, hierarchical multilingualism substance misuse may create an alternative social being, a kind of ‘opioid democracy’, observable through altered communicative practices. This ‘surrogate egalitarianism’ is not just about a talking/conversational genre but more about relations in general within the drug user community. Substance misuse may have a detrimental effect on health and social life. The drug does not only overwrite the mainstream games about speaking and using languages and language variations; more broadly conceived it overwrites a larger set of social games too. In Mauritius, this appears in the form of challenging, disregarding and dissolving the hierarchical social structure interwoven with sophisticatedly stratified multilingualism and overwriting the pervasive omnipresence of ethno-religious-racial classification and the imposed ‘identity’ system. This phenomenon is more predominant among the Buprenorphin users than among users of alcohol in excess. The communication practice is different not only among substance users but also the conversational style between staff and

clients in an institution that deals with the problem area. The observation of the field site showed that the staffs' way of speaking has come closer to the more 'democratic' style, and not only with clients but among staff members as well. This element was more frequent in the speaking of staff members who directly communicated with clients in the therapeutic interactions than in the auxiliary, administration staff of the organisation.

Conclusions

This study has highlighted that healthcare in general and mental healthcare in particular are domains where language related socio-political trends and issues manifest in a multilingual society like Mauritius.

The multilingual setting, the role and associated value of the particular languages and language variations in Mauritius can be traced back to the history of major political forces in the last three centuries. Colonial heritage, including the inherited ex-colonial languages, did not disappear but is channelled into the management of power by new, postcolonial elite groups. The power of elite groups are partly based on economic capital, such as inherited land ownership, preserved positions in the management of the private economic sector, and better access to executive institutions such as the central Government. Partly, however, this power is based on social capital, within which language related knowledge and skills are paramount in this multilingual society. This study emphasises the difference between two groups of languages in Mauritius. Mauritian Creole, the commonly shared lingua franca, and Mauritian Bhojpuri, the only surviving spoken Indian language, are in the first group. As opposed to these, the postcolonial administrative languages (French and English) and the South Asian literary languages (especially standard Hindi) are in the second group. The thesis has argued that one of the signs and practices of the postcolonial dominance and power relations is the continuation of segregating and compartmental use of colonial languages. Besides the quotidian reference to colonial times by mere speaking, the *diaspora* component of Mauritian life, as it has been demonstrated by Eisenlohr (2001, 2006) in relation to the so-called ‘ancestral languages’, has also contributed to keeping the issue of

languages alive and ideologically important. The historical introduction to the field, the description and the explanation of the exact features of Mauritian multilingualism were necessary to prepare the understanding of the findings in the fieldsites, demonstrate the important details of Mauritian multilingualism, and show how social discrimination is present in the daily use of language.

Characteristics of Creole Fransize variation had been mentioned in the past by linguists and anthropologists (Baker 1972; Atchia-Emmerich 2005; Eisenlohr 2006). This study argues that the exact positioning of the occasional but meaningful use of this variation of Mauritian Creole, or in other words, the shifting around the intermediary variations between the only theoretically pure antipoles of the Creole-French diglossia, is a major terrain where the able members of society convert their knowledge and skills, where social distance is preserved, and where upward social mobility of marginalised or deprived segments of the society is hindered. That is, those who can adapt, and surf upon the waves of ambiguities of linguistic code-switching, are better off.

The middle part of the thesis showed that within the area of healthcare the results of changes after the country reached its independence in 1968 are twofold. On the one hand, the establishment of free and comprehensive public healthcare has contributed to major health related developments and achievements. For example, life expectancy in Mauritius is relatively high and the country has been largely freed of many contagious diseases. These achievements in Mauritius are typically associated with the centralised efforts of a powerful Government. The Fabianistic policies of the independent government have resulted in a number of other positive achievements, for example the opening of free education for large, previously deprived social groups. Institutions like public hospitals could have not been established without the ethos and effort of those policies. However, simultaneously, in the context of

healthcare regarding the entire Mauritian society, as part of the preservation of dominance of old and new elite groups, inequalities have been reproduced as well.

Both public and private health sectors have been described in this thesis. The ‘conveyor belt’ type public healthcare does not cover certain needs; therefore, other segments of the plural healthcare system, such as the market-oriented private healthcare, non-governmental charities, and traditional healing continue to play an important role in attending health problems, including mental health issues. At the time of the fieldwork, healthcare is similarly segregated like many other domains of Mauritian social life. It is not just about the sheer economic advantage where the haves are able to pay for a service and the have-nots are not. The structure of divisions is linked to the usual ethno-religious-racial marking lines in Mauritius, which are connected with the diverse and often contradictory local categorisation systems. The development and reproduction of inequalities in healthcare are similar to divisions in other areas of this society, for example in education.

Accessing the basic but reasonably up to par services in the ‘conveyor belt’ of large and crowded public hospitals occurs in Mauritian Creole, the *de facto* common language of the Mauritians. Official documents are written in English, however, as the standardisation of Mauritian Creole has not been satisfactorily resolved and commonly acknowledged. Accessing more than just basic healthcare and reaching out to the somewhat higher standards of private healthcare necessarily entails in Mauritius a switch of language use towards a more mixed version of Mauritian Creole with French elements, or a local variation of proper French language. This switch is typical in many other areas of Mauritian life as well, but the skills that are required to use these linguistic variations are unequally distributed. When people in need (or their family members) seek help in healthcare, they must choose among

the existing options. As one has to communicate in these settings, it is impossible not to choose a variation. The choice of prestigious language variations when accessing better (or proper) service is a way to have a better chance of alleviating suffering. This social practice, manifesting in any such instant of choice, crystallises a frame of speech actions where the act is the choice itself. In the context of Mauritian multilingualism, any choice occurring in the reality of social players contributes to the preservation of the norms of inequality and divisions. This practice does not only adapt to a norm but actively creates and recreates the norm as well. When ordinary people look for help in public healthcare or when members of elite look for help in exclusive institutions, they may obtain the help they needed while performing health related social practice, but, at the same time, the encounters with all these institutions may also play a part in recreating some patterns that have contributed to the emerging social suffering in the first place. The ethnographic examples in this thesis show that Mauritian healthcare institutions indeed provide shelter for some people in the manifestation of suffering, but simultaneously and often invisibly, guard and police some social norms that may be the source of origin of it.

The ethnographic chapters gave examples of vulnerable social groups affected by different kinds of mental disorders. The fieldsites of this study, for example The Century and the MMHA, show that even though the vital needs of the clients are managed by ordinary variations of speaking, the need to uphold a prestigious institution also embraces the internalised ‘desire’ to act in a professional role with the associated prestigious language variations. This can result in bizarre outcomes, such as the teaching of English to severely impaired children or teaching covert French in the masquerade of literacy to socially deprived children. The French language, the ‘object of desire’, in spite of similarities, is just too different from vernacular Mauritian Creole. It carries the controversial

mental load of colonial reference to the past of slavery and the current reference to the tiny but racially often exclusivist and hardly visible affluent Franco-Mauritians. It is associated with the post-imperial promotions of pro-francophone agency of the Republic of France and with purist, linguistically intolerant one nation-one-language attitude of modern French politics. Consequently, the desire to switch to French is incomplete and frustrating. It results typically in a complicated, contradictory, and semi-reflected use of intermediary forms.

Although health related achievements and successes, as presented in the beginning of Chapter 3, are remarkable in Mauritius, this anthropological fieldwork shows what is behind the statistics. In the local context, these achievements present a much more complex picture. It is possible that owing to more widespread human migration in the globalising world multilingual societies will become more a frequent phenomenon. By analysing the Mauritian case, this study aims to contribute to the knowledge with which humankind may be able to avoid the reproduction of suffering in these new cultural and social realities.

Appendixes

Appendix 1. Categories in Mauritius

1. Categories of fact books and dictionaries

1.1. The Fact Book of the CIA:[63]
Ethnic groups: Indo-Mauritian 68%, Creole 27%, Sino-Mauritian 3%, Franco-Mauritian 2%
Religions: Hindu 48%, Roman Catholic 23.6%, Muslim 16.6%, other Christian 8.6%, other 2.5%, unspecified 0.3%, none 0.4% (2000 Census)
Languages: Creole 80.5%, Bhojpuri 12.1%, French 3.4%, English (official; spoken by less than 1% of the population), other 3.7%, unspecified 0.3% (2000 Census)

1.2. Wikipedia:[64]
Official language: English
Vernacular: Mauritian Creole, French, English, Rodriguan Creole
Hindus make up 52%, Roman Catholic 27.5 %, other Christians 8.6%, Muslims 16.6% and non-religious 0.4% while other religions up to 2.5%, and an additional 0.3% didn't specify their religious beliefs.

1.3. The *Diksioner Morisien* (Dictionary of Mauritian Creole; Carpooran 2009) is the work of Arnaud Carpooran, a native speaker Mauritian linguist. He gives the meanings of Creole words along with monolingual

[63] https://www.cia.gov/library/publications/the-world-factbook/geos/mp.html. Accessed 27/06/2010.
[64] http://en.wikipedia.org/wiki/Mauritius. Accessed 27/06/2010.

explanations and translations in French and English.[65] His English translations are presented in brackets. After the colons, I have also translated Carpooran's Mauritian Creole explanations, which do not necessarily coincide with the author's English translations in brackets.

- *Indien* (Indian): Someone from India.

- *Indo-Morisien* (Indo-Mauritian): A Mauritian who has or claims ancestral ties with India.

- *Indou* (Hindu): Someone who believes and practices Hinduism.

- *Malbar* (Hindu): Slang term for Hindus in Mauritius; can be used in a pejorative sense.

- *Tamoul* or *Tamil* (Tamil): An Indo-Mauritian of Dravidian origin.[66]

- *Madras* (Tamil): Slang term for Tamils in Mauritius; can be used in pejorative sense.[67]

- *Kalin* (dark skinned Tamil): A Tamil who has dark skin.

- *Marati* (Marathi): An ethnic group in Mauritius originating from the western Indian state of Maharashtra.

- *Mizilman*: A Muslim, a person who believes in Islam.

- *Laskar* (Muslim): Slang term for Muslim in Mauritius; can be used in a pejorative sense.

- *Kreol* (1) (Creole): The name of an ethnic group in Mauritius that includes the descendants of slaves and a population of mixed origin that follows the Christian religion.

- *Kreol* (2) (Creole): The inhabitants of an island who have known the reality of the colonization and slavery.

- *Rodrige* (a person living in Rodrigues): A person who was born in Rodrigues.

- *Ilwa* (inhabitants of the smaller dependencies of Mauritius and

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[65] The Mauritian Creole words are quoted in italics and with Carpooran's spelling in *Grafi Larmoni.*

[66] *'Telougou'* entry is not given.

[67] I have not come across this term anywhere else.

situated in the Indian Ocean): Name of the inhabitants of certain Indian Ocean islands.

- *Milat* (mulatto): A person who has mixed European and African physical appearance.

- *Metis* (person of mixed race): A person who has either mixed genetic roots or mixed cultural origin.

- *Neg* (Negro): A term that the Whites once used to describe the Blacks during the time of slavery and colonization.

- *Nwar* (coloured people): A person whose skin is brown.

- *Mazanbik* (African-type Mauritian): A Mauritian who has physical traits similar to an African; can be used in a pejorative sense to denote a person with dark skin, African features and hair.

- *Mazanbik* (2) (fuzzy hair): Fuzzy, African style hair.

- *Zoulou* (1) (Zulu): An African nation/people.

- *Zoulou* (2): Slang, possibly a pejorative term for black skinned people.

- *Nas* (diminuitive for 'nasion' as an ethnonym): Diminutive for nation in the sense of Creole type African.

- *Nasion* (1) (Mauritian of Creole origin or African type): A Mauritian who is part of the Creole group or has African traits.[68]

- *Nasion* (2) (Caste): Various Hindu castes in the Mauritian society, differentiated as 'gran nasion' (caste that is considered higher) and 'ti-nasion' (caste that is considered lower).

- *Gran-Nasion* (Hindu considered as belonging to a high caste): A Hindu, who according to the other Hindus, is considered a member of a high caste.

- *Ti-Nasion* (low caste): The people who are part of a caste that is considered to be inferior within certain Mauritian communities where

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[68] The meaning 'nation' is also given alongside the other two cited meanings.

caste exists.

- *Blan* (a white person, Franco-Mauritian, any white foreigner): Name of the Mauritians who have European ancestral ties. European foreigner who has white skin colour.

- *Franko-Morisien* (Franco-Mauritian): A Mauritian who has or claims narrow ancestral ties with Europe.

- *Sinwa* (1) (Chinese): A person from China.

- *Sinwa* (2) or *Sino-Morisien* (Chinese): Mauritians whose ancestors came from China.

- *Kantone* (Cantonese): A Chinese group who came from Kanton in China and have settled in Mauritius.

- *Aka* (Hakka)[69]

- *Makaw* (Chinese): Slang term for Mauritians who have ancestral ties with China; can be used in a pejorative sense.

2. Official categories of Censuses and the Constitution

2.1. Categories of Censuses since 1810 (Kuczinski 1948, Bowman 1991, Teelock 2001):

1810-1830	White	Free Coloured	Slave				
1835	Free		Slave				
1837	Free		Apprentice	Indian			
1846-1851	General Population		Ex-Apprentice	Indian			
1861-1881	General Population			Indian			
1891	General Population			Indian		Indo-Mauritian	
1901	European and Mixed		African	Indian		Chinese	
1911-	General Population			Indian	Indo-		Chinese

[69] No further explanation is given for Hakka.

1931			Mauritian	
1944-1952	General Population	Indo-Mauritian		Chinese
1962-1972	General Population	Hindu	Muslim	Sino-Mauritian
Since 1982	[no ethnic or religious category is asked]			

2.2. The Constitution of Mauritius prescribes that each electoral candidate in Mauritius must disclose his or her 'ethnicity'. Four categories have been adopted:

1. Indo-Mauritian
2. Muslim
3. Sino-Mauritian
4. General Population

3. Categories of anthropologists

3.1. Burton Benedict I. (fieldwork between 1955 and 1957) (1961,10):

1. Mauritian – anyone of Mauritian nationality.

2. Indian – any Mauritian of Indian birth or descent.

3. Franco-Mauritian – any Mauritian of French descent who is accepted as 'white'.

4. Creole – any Mauritian of mixed African or Indian and European descent.

5. Chinese – any Mauritian of Chinese birth or descent.

6. Hindu – the follower of any sect or branch of Hinduism.

7. Northern Hindu – a Hindu whose forbears came from Bihar, or certain surrounding provinces where Hindi or a dialect of Hindi was spoken.

8. Tamil – a Hindu whose forbears came from the Tamil-speaking areas of South Asia.

9. Telugu – a Hindu whose forbears came from the Telugu-speaking

areas of South Asia. Tamils and Telugus are occasionally referred to together as Southern Hindus.

10. Arya Samaji – a follower of one of the branches of the reformed Hindu sect of Arya Samaj.

11. Sanatani – a follower of orthodox Hindu ritual.

12. Muslim – a follower of Islam.

3.2 Burton Benedict II. (1961, 47-51):

1. Britons
   1a. Government servants
   1b. Commercial group
      1ba. Anglo-Mauritians
      1bb. Expatriates
2. Franco-Mauritians
3. Creoles
   3a. upper stratum
   3b. middle stratum
   3c. lower stratum
4. Chinese
5. Indians
   5a. Gujarati
   5b. (other) Muslims
   5c. Hindus

3.3 Baggioni and de Robillard (fieldwork 1980's) (1990, 38) (my translation in English):

1. General Population
   1a. Franco-Mauritian, White, White Rat, *'Blanc bec'*[70]

[70] Literarily 'white beak' but can mean 'greenhorn' too.

1b. Frontier, *Gens de couleur, 'Faire/fer blanc'*, Mulatto[71]

1c. Creole, Afro-Mauritian

2. Asiatics

2a. Indian

2aa. Hindu, Indian, Indo-Mauritian, Malbar

2aaa. Indian, Indo-Mauritian, Malbar

2aab. Tamil

2aac. Telugu

2ab. Musulman, Lascar

2ac. Baptised Indians

2b. Chinese, Sino-Mauritian, Macao

3.4 Thomas Eriksen (fieldwork 1991-92) (1998, 50):

1. Franco-Mauritians
2. Coloureds
3. Creoles (excluding the Coloureds)
4. Hindus ('Hindi-speaking')
5. Muslims
6. Tamils
7. Sino-Mauritians

3.5 Rosabelle Boswell (fieldwork 1999-2000) (2006, 46-47):[72]

1. Créoles of Mauritius

1a. White Franco-Mauritian Families

1b. *Mulatto gens de coleur*

1c. Black Afro-Mauritian Families

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[71] The English word '*frontier'* is similar to the French word *frontière* used by Baggioni and de Robillard. The French usage in Mauritius refers to a borderline category between White and 'not quite White': the Frontiers may look white but are not accepted by the Whites.

[72] The names are as they appear in Boswell's work, including the inconsistent orthographies.

1ca. *Créole Morisyen*

1caa. *Créole Madras*

1cab. *Créole Sinwa*

1cac. *Créole l'Ascar*

1cb. *Rodriguais*

1cc. *Ilois*

1ca, 1cb and 1cc are sub-categorised by Bowell in three further categories: *Ti Créole*, *Créole Bourzwa*, and *Klas Travailleur*

Appendix 2. Stereotypes according to Eriksen (1998, 54)

Stereotypes of others:

Creoles – Lazy, merry, careless

Hindus – Stingy, dishonest, hard-working

Muslims – Religious fanatics, non-minglers

Sino-Mauritians – Greedy, industrious

Franco-Mauritians – Snobbish, decadent

Coloureds – Clever, conceited, overambitious

Stereotypes of self:

Creoles – Sincere, humane

Hindus – Sensible, care for family

Muslims – Members of a proud, expanding culture

Sino-Mauritians – Clever, industrious

Franco-Mauritians – ‘True Mauritian’, dignified

Coloureds – ‘True Mauritian’, intelligent

Appendix 3. Language use as recorded in Mauritian Censuses from 1944 to 2000

Responses to question 'language usually spoken' in seven Censuses, number of respondents and their percentage in the population (Stein 1982, 225, 1986; Bissoonauth and Offord 2001; Rajah-Carrim 2003):

	1944	**1952**	**1962**	**1972**	**1983**	**1990**	**2000**
Creole	149,380 35.6%	197,706 44.2%	289,112 45.3%	428,434 51.86%	521,950 53.98%	617,630 60.5%	791,465 69.24%
Bhojpuri	-	-	-	-	197,050 20,38%	201,616 19.7%	142,385 12.46%
Hindi	219,093 52.3%	174,474 39.0%	206,978 32.4%	262,198 31.74%	111,134 11,49%	12,845 1.3%	7,245 0.63%
Urdu	-	11,795 2.6%	40,667 6.4%	23,470 2.84%	23,572 2.44%	6,804 0.7%	1,789 0.16%
Arabic	-	-	-	-	1,813 0.19%	208 0.02%	-
Tamil	-	9,481 2.1%	17,970 2.8%	29,094 3.53%	35,646 3.68%	8,002 0.8%	3,622 0.32%
Telugu	-	3,564 0.8%	6,721 1.1%	17,364 2.10%	15,364 1.59%	6,437 0.6%	2,169 0.19%
Marathi	-	1,341 0.3%	7,420 1.2%	12,036 1.46%	12,420 1.28%	7,535 0.7%	1,888 0.17%
Gujarati	-	796 0.18%	734 0.11%	403 0.05%	531 0.05%	290 0.03%	-
Chinese languages	9,931 2.4%	11,262 2.5%	13,621 2.1%	9,417 1.4%	6,156 0.64%	3,650 0.3%	8,736 0.76%
French	35,895 8.6%	36,227 8.1%	53,367 8.3%	39,240 4.75%	36,048 3.73%	34,343 3.4%	39,827 3.44%
English	1,386 0.3%	656 0.2%	1,824 0.3%	2,279 0.28%	2,028 0.21%	2,232 0.2%	3,505 0.31%
Other and not stated (and 'bilingual ' in 1990)	3,500 0.8%	160 0.03%	332 0.05%	2,264 0.27%	3,151 0.33%	121,064 11.5%	140,438 12.29%
Total	419,185	447,462	638,746	826,199	966,863	1,022,656	1,143,069

Responses to question ‘language of forefathers’ (and similar questions) in six Censuses, percentage of respondents in the population (Stein 1982, 225; 1986; Bissoonauth and Offord 2001; Rajah-Carrim 2003):

	1952	**1962**	**1972**	**1983**	**1990**	**2000**
Creole	37.2%	29.2%	32.9%	29.0%	33.8%	37.0%
Bhojpuri	-	-	-	18.7%	33.6%	31.6%
Hindi	40.8%	36.4%	38.9%	21.56%	3.7%	3.1%
Urdu	5.5%	13.5%	8.7%	5.7%	4.4%	2.9%
Arabic	-	-	-	7.0%	0.2%	0.1%
Tamil	4.4%	6.5%	6.9%	6.8%	4.7%	3.9%
Telugu	1.4%	2.4%	2.9%	2.6%	2.0%	1.6%
Marathi	0.4%	1.7%	2.0%	2.1%	1.7%	1.5%
Gujarati	0.3%	0.2%	0.2%	0.3%	0.2%	-
Chinese languages	2.8%	2.9%	2.5%	2.1%	1.7%	2.0%
French	7.1%	6.9%	4.4%	3.4%	2.2%	1.9%
English	0.1%	0.2%	0.3%	0.2%	0.1%	0.1%
‘bilingual’	-	-	-	--	10.9%	-

Appendix 4. Variability of the word **semen** *[semɛ̃] (road)*

A word akin to the French word *'chemin'* [ʃəmɛ̃] ('route', 'path', 'street') can be pronounced in a variety of ways. They are as follows in approximate hierarchical order:

1. *'chemin'* [ʃəmɛ̃] (This is the original French form]

2. [ʃœmɛ̃] (This is the typical Creole Fransize form. It is only possible to write this form with IPA characters but neither with French nor *grafi larmoni* orthographies.)

3. [sœmɛ̃] (It is only possible to write this form with IPA characters but neither with French nor *grafi larmoni* orthographies.)

4. [səmɛ̃] (It is only possible to write this form with IPA characters but neither with French nor *grafi larmoni* orthographies.)

5. *'semen'* [semɛ̃] (This form is given by Carpooran 2009, 869 and LPT 2004 [1985], 212)

6. *'seme'* [seme]

7. *'simen'* [simɛ̃] (This form is given by LPT 2004 [1985]:212)

8. *'sime'* [sime] (This form is given by Baker and Hookoomsing 1987, 295 and by LPT 2004 [1985], 212)

Most people I heard used Variation 5 and I used it as well. Some people used Variation 2 (Creole Fransize) and expected me to use either Variation 1 or 2, which means upper class and/or francophone orientation. A few people who themselves used Variation 5 also expected that I use Variation 2 instead of Variation 5. Most people came to terms with my use of Variation 5 but when I used Variation 8, following two mentioned

dictionaries and some literature of Dev Virhashawmy, I met with perplexed laughs and disapproval. This was because my audience and conversation partners were mainly urban people. ‘*Sime’* is the ‘*lakampagn’* (countryside) variation that is similar to what Baker (1972, 39) described as Bhojpuri Influenced Creole.

Appendix 5. Characteristics of Mauritian French[73]

Archaisms:

Standard French	Mauritian French	Mauritian Creole	English
se dépêcher	*dégager*	*degaze*	to be in hurry
chaussure	*souilier*	*soulie*	pair of shoes
tirer	*hisser, tirer*	*ise, rise, tire*	to pull
voir, regarder	*guetter* (usually imperative)	*gete*	to look, to see
-	-	*vwar*	to pay a visit
parler	*causer*	*koze*	to talk, to speak
cueillir	*casser*	*kase*	to collect
chercher	*roder*	*rode*	to look for
grand	*bel, belles*	*bel*	large, huge
vêtements	*linge*	*lenz*	clothes, dress

English-French semantic interference:

Standard French	Mauritian French	Mauritian Creole	English
diffuser (an email, a description)	*circuler*	*sirkile*	to circulate, to spread
avoir la responsibilité de	*être en charge*	*ansarz*	to be in charge
formulaire	*forme*	*form*	form
correspondence (transportation)	*connection*	*koneksion*	connection
excercer les fonctions de	*agir comme*	*azir kouma*	to act as
demande (a form or an act to apply for something)	*application*	*aplikasion*	application
BUT:*club* [klʌb]	*club* [klyb]	*klib*	club [klʌb]

[73] Based on Baggioni and de Robillard 1990, 86-88, Chaudenson 1979, 577-579, Baker 1972, 40-43, Corne 1999, 174 and Pudaruth 1993 [1972], 18-38.

Examples of English expressions in Mauritian languages:

Standard French	Mauritian French	Mauritian Creole	English
apéritif	*drink*	*ti drink*	drink, aperitif
sens unique	*one way*	*wanvey*	one way
prise electrique	*plug*	*plug*	plug
excuse-moi	*sorry*	*sori*	Sorry
avertissement, cote d'alerte	*warning*	*warning*	warning
sens interdit	*no entry*	*no entry*	no entry
station-service	*filling*	*filing*	petrol station

Prosody:

The Mauritian French intonation is telling for its rising exclamatory intonation, which is similar to Mauritian Creole intonation.

Some phonetic particularities of Mauritian French:

- Standard French open vowels tend to be closed in Mauritian French. Therefore, certain minimal pairs become identical. Differences between *roc/rauque, fait/fée, pâte/patte* disappear. These words sound more like the latter ones, the vowel is more closed.

- The 'r' remains silent after a vowels like 'a', 'o', 'u' but before a consonant or at the end of the word and the vowel is pronounced longer instead. *'Carte'* is pronounced as [ka:t], *'port'* as [po:], *'pour'* as [pu:]. This feature is characteristic to the Franco-Mauritian native French speakers as opposed to Creole (*gens de couleur*) French native (L1) speakers.

- Word ending '-t' is often pronounced unlike in standard French where it is silent. For example: *'bout', 'fouet', 'juillet'*.

- In contrast, some word endings, typically double consonants, are not pronounced: *faible* > [feb], *artist* > [a:tis], *quatre* > [kat], *sucre* > [syk].

Some syntactic particularities of Mauritian French:

- Less subjunctives, more passive structures, adjective duplications, and more ‘avoir’ instead of ‘être’ auxiliaries are used in Mauritian French.

- The pronouns ‘y’ and ‘en’ are seldom used.

- Words and expressions like ‘même’, or demonstrative ‘–là’, prepositions ‘dans’ and ‘avec’ are more frequent, whereas conjunctions ‘à’ and ‘de’ are often omitted or exchanged.

- More double negatives.

- Verbal structures: Current continuous tense with ‘être à’

Standard French	Mauritian French	Mauritian Creole	English
Je suis à faire	*Je fais*	*Mo pe fer*	I am (just) doing

- Perfect tense with ‘avoir fini de’

Standard French	Mauritian French	Mauritian Creole	English
Il a bu une tasse de thé	*Il a fini boir une tasse de thé*	*Li finn bwar enn tas dite*	He has had a cup of tea

- Future tense with ‘aller + inf.’

Standard French	Mauritian French	Mauritian Creole	English
Je mangerai plus tard	*Je vais manger plus tard*	*Mo va manze plitar*	I am going to eat later

- 1st plural imperative with ‘aller’

Standard French	Mauritian French	Mauritian Creole	English
Finissons	*Allons finir*	*Anou fini*	Let’s finish it

- Structures with infinitive

Standard French	Mauritian French	Mauritian Creole	English
-	*Je fais les enfant manger*	*Mo fer bann zanfan travay*	I made the children work
J'ai acheté se livre pour que mon frère lise	*J'ai acheté ce livre pour mon frère lire*	*Mo'nn aste sa liv la pou mo frer lir*	I've bought this book for my brother to read

- Pronouns

Standard French	Mauritian French	Mauritian Creole	English
Je lui telephone	*Je la teléphone*	*Mo telefonn li*	I have phoned him

Appendix 6. Types of healers and illness categories treated by healers in Mauritius (Sussman 1981, 1983)

	Type of healer	**General illness categories treated**	**General illness categories diagnosed**	**Ethnic group of practitioners**	**Specialties**
Secular	Biomedical	Illnesses of God	Illnesses of God	Varied	All
	Homeopathic	Illnesses of God	Illnesses of God	Franco-Mauritian	Chronic
	Chinese	Illnesses of God	Illnesses of God	Sino-Mauritian	Chronic
	Professional Herbalist	Illnesses of God	Illnesses of God	Tamil	Varied - especially chronic and common minor
	Folk Herbalist	Illnesses of God	Illnesses of God	Mostly Creole	Varied - common minor
	Secular Healer	Illnesses of God	Illnesses of God	Mostly Creole	*Tambav*,[74] sprains, rashes, rheumatism kidney ailments
	Sorcerer	Dead souls/fright, illnesses of Evil/ sorcery	All	Varied	All
Religious	Hindu *maraz*	Dead souls/fright, saints, sorcery	All	Indo-Mauritian	All
	Tamil *pousari*	Dead souls/fright, saints, sorcery	All	Indo-Mauritian	All
	Sai Baba temple	All		Indo-Mauritian	All
	Buddhist sisters	Dead souls/fright, sorcery	All	Sino-Mauritian	All

[74] *Tambav* is a term for certain types of temporal skin alterations of children.

	Type of healer	General illness categories treated	General illness categories diagnosed	Ethnic group of practitioners	Specialties
	Christian clergym en, Shrines, Healing Sects	Illnesses of God, dead souls/fright, sorcery		Varied-Mostly France-Mauritian and Creole	All

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