Negotiating knowledge and creating solidarity: Humour in antenatal counselling sessions at a rural hospital in Malawi

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Abstract

This paper explores the role of humour in the largely under-researched context of HIV/AIDS consultations in Malawi. Drawing on audio-recordings of seven antenatal HIV/AIDS counselling sessions conducted in Chichewa (Malawi's national language) in a rural hospital, we illustrate how the counsellors skilfully utilise the multiple and often contradictory functions of humour (Schnurr and Plester 2017) to engage the pregnant women in the negotiation of knowledge and to ensure they have understood vital information about preventing HIV/AIDS from spreading to their unborn child. The counsellors in these sessions use humour to reinforce solidarity, create a friendly atmosphere, and facilitate the discussion of sensitive or taboo topics, as well as to criticise and rebuke the pregnant women for their lack of knowledge of HIV/AIDS, their lifestyle, and their lack of engagement with the counselling. Due to its capacity to realise these highly ambiguous functions – sometimes simultaneously – humour is an excellent means to assist the counsellors in achieving their objectives.

Key words: humour, teasing, self-denigrating humour, laughter, HIV/AIDS discourse, negotiating knowledge, solidarity

Introduction

Although humour is widely acknowledged to perform multiple beneficial functions in medical settings, most of what has been written about humour in this context comes from medical researchers and practitioners (e.g. Berger et al. 2004; Houston et al. 1998; Granek-Catarivas et al. 2005) and from researchers within psychology (e.g. Sala et al. 2002; Martin 2001) and sociology (e.g. Sanders 2004). Many of these studies have identified and described some of the benefits of humour on well-being and (perceived) health of the patients (e.g. Bennet 2003; Bennet and Lengacher 2006; Boyle and Joss-Reid 2004; Granek-Catarivas et al. 2005).

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For example, humour has been repeatedly found to help patients manage stress and pain, and to increase their pain tolerance (e.g. Stuber et al. 2009). Moreover, "the propensity to laugh may contribute to cardioprotection" (Clark et al. 2001: 87). Further positive effects of using humour towards patients are described in Adams (2002), who advocates the so-called 'clown-therapy', where health care professionals or volunteers dress up as clowns and visit patients – especially in paediatric wards in hospitals (see also Koller and Gryski 2008). However, in a critical review of previous studies, Martin (2001) finds inconclusive empirical evidence for the beneficial effects of humour and laughter, and calls for more research on this topic.

Studies that have focused on the effects of humour on healthcare providers, rather than patients, have also identified a wide range of benefits, such as assisting these professionals in dealing with the stress associated with their job (Bennet 2003; Coser 1960; McCreaddie and Wiggins 2008; Scott 2007), facilitating the management of their own emotions and those of others (Francis et al. 1999), and "subverting or challenging existing professional hierarchies" (Griffiths 1998: 874).

However, in spite of the considerable attention that humour and laughter have received by these scholars and practitioners, discourse analysts have largely overlooked these discursive strategies in their investigations of language use in medical settings. A few exceptions are Pizzini (1991) who analyses the occurrence of humour in obstetrical and gynaecological settings, Du Pré and Beck (1997), who look at the use of self-disparaging humour in consultations with a family physician, and Haakana (2001, 2002), Zayts and Schnurr (2011, 2016) and Rees and Monrouxe (2010) who investigate the use of laughter by nurses and patients. Pizzini (1991) observes that physicians tend to use most humour before and after the critical phases of childbirth thus enabling them to relieve some stress and tension, while Du Pré and Beck (1997) find that patients who claim disproportionate responsibility for actions with potentially negative consequences – sometimes accompanied by humour and/or laughter – often receive emphatic compliments and reassurance from their family doctor, rather than criticism. Haakana (2001, 2002) argues that laughter is often used to mitigate embarrassing, sensitive or painful aspects and to create alignment between participants, and Zayts and Schnurr (2011) show that nurses frequently employ laughter to facilitate their clients' decision making and to assist them in making autonomous choices. In their most recent work, Zayts and Schnurr (2017) describe some of the ways in which laughter is a valuable resource for the healthcare providers and the patients when managing risk talk and negotiating deontic authority. In a study of laughter in bedside teaching encounters, Rees and Monrouxe (2010: 3384) observe that teasing and laughter are used by the medical students, patients and doctors involved in the learning triad as a means to "maintain or subvert existing power asymmetries, to construct identities […] and to construct gender by performing masculinity or femininity." These studies illustrate that humour and laughter in medical contexts may contribute to constructing affiliation between interlocutors (and hence build

rapport), or may result in disaffiliation – especially in those cases where the patients challenge the nurses' institutional authority.

While most of these studies focus on laughter in medical encounters, the discursive strategy of humour remains noticeably under-researched in this context. This paper aims to address this dearth of discourse analytic studies on humour in medical encounters by exploring the role of this multi-facetted discursive strategy in the largely neglected context of HIV/AIDS consultations in Malawi.

HIV/AIDS consultations in Malawi

Malawi is a developing country with a population of 13,066,320 (National Statistical Office 2008). Like in many of its neighbouring countries HIV/AIDS is the most common disease in Malawi (Bowie and Mwase 2011), and the public healthcare system is suffering under funding problems leading to drug shortages and limited health personnel (Ministry of health (MOH), 2011; McCoy e al. 2004; Bowie and Mwase, 2011).

In order to address these issues, Malawi has developed a model which incorporates HIV treatment, prevention of mother to child transmission, and primary care of other health problems in one clinic. This integrated approach includes, among others, a family-care programme model, family planning, and anti-retroviral therapy for all HIV infected patients (PEPFAR 2013). The data that we look at in this paper is taken from antenatal HIV/AIDS counselling and educational talks which are part of the prevention of mother to child transmission programme.

Compliance with these HIV/AIDS programmes is relatively low, with only 40% of qualifying mothers following the full recommendations of the programme (MOH 2012), and many others dropping out – largely due to cultural, religious and educational factors (MOH 2011; MOH 2012). In the Zomba district, where our study was conducted, only 18% of HIV infected mothers adhered to the programme's recommendations (van Lettow et al. 2011). This is particularly noteworthy since the lack of adherence to HIV/AIDS treatment is one of the big issues that public health services in Malawi are struggling with. In this study, we argue that a better understanding of the ways in which healthcare professionals and clients participate in these consultations, and how they negotiate their (sometimes different) knowledge about HIV/AIDS in these encounters, is crucial for improving these services, which can ultimately lead to increased patient participation and enhanced adherence to treatment.

Negotiating knowledge in these HIV/AIDS consultations

In Malawi there are numerous HIV/AIDS campaigns, which compete for people's attention. However, this multitude of campaigns has backfired and resulted in an 'AIDS fatigue' which

has witnessed a general decreasing interest in information about HIV/AIDS (Mitchell and Smith 2003; Mitchell et al. 2010). Healthcare practitioners play a particularly crucial role in the provision of HIV/AIDS services as they are the main source of information for most people (SSDI 2013; Penn et al. 2011; Donalue et al. 2012; Kawale et al. 2014).

Traditionally, healthcare interactions are characterised by asymmetric knowledge distribution with the healthcare professionals having more expert knowledge than their clients. But more recent research acknowledges that the knowledge exchange that takes place during medical consultations is usually not a unidirectional process but involves some kind of collaboration between the healthcare professional and the clients (Tannen and Wallat 2006). The client, who also possesses some kind of knowledge prior to the consultation, is seen as an 'active partner' and co-constructor rather than simply a passive receiver of knowledge (e.g. Candlin 2006).

Several authors make a distinction between different kinds of knowledge. For example, Higgins and Norton (2010) differentiate between local and expert knowledge. They define local knowledge as "ways of knowing that people negotiate in their own terms that are typically outside the boundaries of accepted or authoritative paradigms", and view expert knowledge as that which is authorised and conveyed by medical experts (Higgins and Norton 2010:8). Applied to the context of HIV/AIDS counselling discussed here, it could be argued that one of the challenges of the consultations is to find productive ways of combining and negotiating the healthcare providers' expert knowledge and the clients' local knowledge. This ideal scenario of knowledge sharing is further complicated by the expectation that the production of knowledge related to HIV/AIDS is supposed to involve members of different healthcare institutions ranging from tertiary level institutions to local communities (Chirwa 2011; National AIDS Commission 2011). However, the extent to which this involvement is realised in actual practice is rather questionable (Chirwa 2011).

In our analysis below we illustrate how the counsellors skilfully utilise the multiple and often contradictory functions of humour (Schnurr and Plester 2017) to engage their clients (i.e. pregnant women) in the sharing and negotiation of knowledge in the antenatal counselling sessions with the overall aim to ensure they have understood vital information about preventing HIV/AIDS from spreading to their unborn child.

Methodology, data and theoretical framework

Data were collected at a community hospital in rural Malawi. We conducted participant observations, interviews with healthcare personnel and clients, as well as audio-recorded authentic HIV/AIDS counselling sessions and educational talks delivered by the healthcare professionals to their clients. Overall, we have recorded almost twenty hours of interactions and conducted over 40 interviews. In this paper, however, we draw on a subset of these data

collected for a larger study (Chimbwete-Phiri fc), namely just under five hours of audio-recorded antenatal group counselling sessions and educational talks, supplemented with ethnographic observation. These group counselling sessions were held for pregnant mothers (usually in the first trimester of their pregnancy) who would typically attend them during their regular antenatal visits at the hospital. For these clients, undergoing an HIV test is a routine under the prevention of mother to child HIV transmission programme, which is typically preceded by counselling. This counselling is conducted in a group, rather than on a one-to-one basis in order to save time and resources. On average, these sessions are attended by 15-20 pregnant women and one counsellor. Each session lasts around 20-30 minutes. Educational talks, by contrast, are routinely offered to pregnant women during their regular antenatal visits. These talks are part of the medical routines these women undergo, which also include taking their weight and recording any changes. These educational talks last typically around 20-25 minutes and are given by a hospital attendant or a nurse. They cover topics around family planning and HIV/AIDS, maternal health, and care for the newborn. After these talks some of the women take a specific HIV test.[2]

Although HIV/AIDS is considered to be a significant cause of maternal and infant mortality and some maternal complications can be caused by HIV related immunity deficiencies (McCoy et al. 2004), the HIV/AIDS antenatal programmes in Malawi are experiencing difficulties with regard to client adherence and collaboration (e.g. van Lettow et al. 2011; MOH 2012), and hence are an interesting site for investigation. We use Interactional Sociolinguistics to analyse some of the discursive processes through which knowledge about HIV/AIDS is shared and negotiated among healthcare providers and clients in these antenatal counselling sessions and educational talks in a community hospital in Malawi. Interactional Sociolinguistics is a suitable approach for such an undertaking as it combines an interest in fine-grained discourse analysis of authentic interactions with information about the context in which these interactions take place. It thus builds a bridge between micro- and macro- levels of analysis (Sarangi and Roberts 1999), and is popular in research on medical interactions (e.g. Heath 1992; Maynard 1992; Candlin 2006; Sarangi and Brookes-Howell 2006; Zayts et al. 2012; Zayts and Schnurr 2013; Zayts and Schnurr 2014; Strunck and Lassen 2011). Moreover, Interactional Sociolinguistics postulates that meaning is conjointly negotiated among interlocutors (Gumperz 1982), which makes this approach well suited to address the aims of this study.

In our micro-analysis of selected examples, we will analyse the ways in which the healthcare providers use humour in the HIV/AIDS counselling sessions, and more specifically the role(s) it plays in the sharing and negotiation of expert knowledge by the healthcare professionals and their clients. Considering so-called 'contextualisation cues' (Gumperz 1982) is particularly

[2] Although these educational talks follow a (relatively loose) script and bear some similarities with teaching sessions (see also Chimbwete-Phiri fc), the humour that occurs in these educational talks is as spontaneous as in the group counselling sessions, and there is no evidence in our data of the healthcare professionals repeating a humorous comment or of the humour being rehearsed in any way. Rather, the humour emerges spontaneously and is closely linked to the interactional context in which it occurs.

helpful in identifying humorous instances and interpreting them. In addition, like previous research, we also rely on a wide range of 'paralinguistic, prosodic and discoursal clues' (Holmes 2000: 163), and pay specific attention to the speaker's tone of voice, and the audience's auditory as well as (where possible) gesticulatory responses (Holmes and Marra 2002).

In the next section, we analyse four examples of humour that occurred during the antenatal HIV/AIDS counselling sessions and the educational talks that we recorded at a public hospital in rural Malawi.

Analysis

We identified three main functions that the healthcare providers' humour performs in relation to sharing and negotiating knowledge. The first function is to reinforce solidarity and create support which often contributes to establishing a friendly, open atmosphere, which in turn facilitates the sharing of knowledge and assists the healthcare providers in achieving their institutional aims. The second function of the humour is to facilitate the discussion of sensitive and taboo topics (e.g. sex and male circumcision); and the third function is to criticise and rebuke the clients' lack of engagement with the counselling and their lack of knowledge of HIV/AIDS. We discuss four examples here to illustrate these functions. We have highlighted the humour in bold in all examples to facilitate understanding.

Reinforcing solidarity and creating a friendly atmosphere

Most researchers agree that its ability to reinforce solidarity and create a friendly atmosphere among interlocutors is one of the most basic functions of humour, which is central to all instances (e.g. Holmes 2000). Due to this function, humour has been described as "the glue that bonds" interlocutors (Ross 1992: 2; see also Eisenberg 1986). This function of humour is also one of the most prevalent ones in the antenatal counselling sessions at the Malawi hospital where we collected our data, and it often occurs in conjunction with other functions, as our examples below illustrate.

Example 1

Context: The male healthcare provider (HP2) talks to a group of 31 women (W) who are seeking antenatal services at the clinic. At this point in the session participants are talking about the difference between HIV and AIDS.

1 HP2: Munthu atha kukhala ndi HIV opanda Edzi (.)

A person can have HIV without having AIDS (.)

2 100 percent (.) Kukha:la ndi HIV opanda Edzi

100 PERCENT (.) Having HIV yet without AIDS.

3 W1: Koma zitheka bwanji poti imayambitsa ndi iyoyo?

But how is this possible (.) when it is the one that causes it?

((38 lines are omitted during which the health care provider explains the difference between having HIV and AIDS, including telling an anecdote to explain this))

4 HP2: *Ndizotheka munthu kukhala opanda Edzi (.)*

It is possible for a person to have no AIDS (.)

5 *Ndizotheka munthu kukhala opanda chani?*

It is possible for a person to have no what? =

6 W2: *=Edzi.*

=AIDS.

7 HP2: *Edzi*

-AIDS

8 *Nde ndikamalalikira chonchi (.)*

And when I am preaching like this (.)

9 *ndimalalikira kunena kuti Edzi kulibe (3) Eee (2)*

I preach that there is no AIDS (3) Yes (2)

10 ***Enanu munditukwane***

Some of you may curse me

11 **Several W:** ***He he he [he he***

Heh heh heh [Heh heh

12 **HP2:** ***[mundikanize muntimamo***

[rebuke me in your hearts

13 Several W: *He he he*

Heh heh heh [heh heh heh

14 HP2: [*Koma ndikunena panopa molimba mtima (.)*

[But I am saying now courageously (.)

15 Several W: ((*Phokoso, zoyankhula zosamveka)) heh heh*

((Indistinct chatter)) heh heh

16 HP2: *Panopa sindinganene zabodza (.)*

I cannot tell lies on this forum (.)

17 *ndikuyenera ndikuuzeni zoona zokhazokha (.)*

I have to tell you the truth only (.)

18 *ineyo ndikamalalikira (.) ndimalalikira kunena kuti* HIV*yo iliko*

when I preach (.) I preach that HIV exists

19 *koma Edzi inatha (.)*

but AIDS no longer exists (.)

20 *Amene akufuna Edzi ndi zake zimenezo (.) Chifukwa chani?*

whoever wants AIDS that is their problem (.) Why?

21 *Thandizo la* HIV*lo lilipo lambirimbiri kuchipatala (.)*

Help on HIV is massively available at the hospital

22 *zoyezera ziripo zambiri kuchipatala kuno (.)*

there is a lot of testing equipment at this hospital (.)

23 *kuti munthu ukayezetse ukadziwe (.)*

so that a person should get tested and know (.)

24 *kuti kodi ndili ndi kachilombo kapena ndilibe (2)*

do I have the virus or not ?

25 *ukadziwa (.) uyambe kuwona kuti udzipanga mwanji (.)*

When you know (.) you begin to be aware of what to do (.)

26 *ZAMVEKA ETI?*

IT IS UNDERSTOOD, RIGHT?

27 Several W: *Eee.*

Yes.

The first few lines clearly establish the power asymmetry between the healthcare professional, who is constructed as the more knowledgeable expert, and the clients, who are portrayed as the receivers of information. This asymmetrical relationship with a unidirectional flow of knowledge is, for example, reflected in the lexical choices of the healthcare provider (e.g. 'preach' rather than 'discuss/share with you' in lines 8 and 9), and also the observation that he dominates the floor and talking time, has the interactional right to ask (mostly closed) questions (e.g. line 5) to which the women provide a very short and specific answer (lines 6 and 7), which does not generate new knowledge but rather verbally repeats the healthcare provider's previous claims. However, this relatively static way of interacting is somewhat disrupted in line 10 when the healthcare provider introduces some humour, and portrays himself very differently, namely as the target of the women's curses (rather than an all-knowing expert with important medical information). Through his use of humour at this point in the counselling session, the healthcare provider creates a friendly atmosphere and builds solidarity with his audience. He distances himself – even if only momentarily – from his status as 'preacher' and makes himself more approachable, while still maintaining his more powerful position.

This strategy is very effective as it assists him in tackling the serious, and potentially complex, topic of the difference between HIV and AIDS which he talks about at this point in the interaction. His potentially provocative claim that 'there is no AIDS' (line 9) gains further illocutionary force through the subsequent marked pause (3 seconds) and the agreement marker 'yes', which is followed by another relatively long pause (2 seconds). The fact that at this point there is no audible response from the women indicates that his claim has – at least temporarily – silenced them, perhaps because it is in contrast to their own previous knowledge and beliefs. There is also the strong possibility that this 'news', which questions and challenges the women's previous knowledge, may leave them feeling confused and perhaps even worried as evidenced by the challenging question asked by one of the women in line 3. The healthcare provider's use of humour addresses this possible anxiety and confusion among the women. With his self-denigrating comment 'some of you may curse me, rebuke me in your hearts' (lines 10 and 12), he acknowledges the women's feelings while at the same time preparing the scene for reinforcing his message in the subsequent line (see the utterance initial disagreement marker 'But' in line 14). His utterances are responded to with laughter from the women (lines 11 and 13). The laughter here performs various functions

(Glenn 2003): it makes complicated and presumably dispreferred information more palatable (Sanders 2004), it functions as a valve (Barsoux 1993; Brown and Keegan 1999; Ross 1992) allowing the women to vent some of their anxiety, and it also reinforces solidarity among the women (by laughing together) and also among the women and the healthcare provider (who portrays himself in this humorous way). When repeating his message (lines 14, 16 ff), the healthcare provider exaggerates his own position and humorously describes himself as 'courageously' (line 14), which generates further laughter from the women and some indistinct chatter (line 15).

The humour and laughter also contribute to changing the overall atmosphere of the interaction. While the initial lines of the extract show a strong focus on the healthcare provider as the expert and the one who has all the knowledge (see e.g. his use of the term 'preach' in line 9 to describe this interaction with the women and the overall classroom style of delivery with a question-answer format (Walsh 2011)), after the humour, the power relations seem to be less static and the women make more frequent and meaningful contributions to the rest of the interaction (not shown in the transcript) What was largely a one-way interaction becomes much more of an exchange to which both parties contribute. Discursively this change in atmosphere is reflected, for example, in the more frequent use of minimal feedback by the women (not shown here) and their quick response to his question (e.g. line 27), which both signal higher involvement.

The healthcare provider's use of humour in this example thus realises multiple functions simultaneously, which all contribute to reinforcing solidarity among interlocutors and thus facilitate the creation of a more relaxed atmosphere. The next example further illustrates this, and also shows how humour may assist the healthcare providers in dealing with potentially difficult or taboo topics.

Facilitating the discussion of sensitive and taboo topics

The relationship between humour and taboo topics is a close one: not only are taboo topics often the source of humour (McKeown 2016), but it has also been argued that humour may enable speakers to 'say the unsayable' and to break social taboos while still getting away with it (e.g. Billig 2001). Using humour in this context considerably mitigates the potential threat of talking about a taboo topic, and mitigates the impact of this on speakers and their audience (Freitas 2016). In the context of the antenatal HIV/AIDS counselling sessions, as our examples show, humour is frequently used by the healthcare providers to achieve some of these functions, most notably to 'say the unsayable' and to talk about taboo topics – often related to sexual practices and genitals – without offending or alienating their audience. In this sense, the humour often helps breaking the ice and facilitates the subsequent – more serious – discussion of these important topics. The following two examples illustrate this.

Example 2

Context: During another counselling session between a male healthcare provider (HP4) and a group of 16 pregnant women (W) who attend this session prior to being tested for HIV. At this point in the interaction, participants are talking about the importance of male circumcision to help prevent HIV infections.

1	HP4:	*Kodi mdulidwe ndi chani? (3) Mdulidwe? (.) Mdulidwe wa abambo?* (.)
		What does circumcision mean? (3) Circumcision? (.) Male circumcision? (.)
2		*Tiye:ni, tonse ndiakulu akulu*
		Come o:n, we are all adults.
3	W1:	*Eee*
		Yes
4	HP4:	*Nanga sizokambirana zamuno tanena kuti ndizachinsinsi eti*
		Since we already said that our discussions are confidential, right?
5	W2:	*Sichoncho?*
		Not so?
6	W3:	*Mmm*
		Mmh
7	**HP4:**	***Zili ngati kusimbatu (.) tingofuna tiuzane (.)***
		It is like being at an initiation camp (.) we just want to share (.)
8		***tidziwe tina nditina (.)***
		to know some things (.)
9		***sikuti pali wina amene atakanene pamenepa >kuti mwakutimwakuti<***
		not that one of us will go and tell others >that there was this and that<
10		***ngakhale ineyo nditavula apapa***
		even if I were to take off my clothes here
11		***sikuti kundiona panja mukanene kuti (.)***

when you see me out there don't say

12 **'*amene aja anavula [mwakutimwakuti]*'**

'that one had taken off his clothes [this and that]'

13 **W4:** **[*eh he he he***

[Eh Heh heh heh

14 **HP4:** ***Sinchoncho? Izi zimathera momwe muno eti?***

Not so? These do not go beyond these walls right?

15 **W5:** ***Eee he he he***

Yes heh heh heh

16 HP4: *Mdulidwe wa abambo ndi chani? (2)*

What is male circumcision? (2)

17 W1: *Abambo °amaadula chaji chaocho °*=

The man's °end is cut° =

18 HP4: =*EYA*

=YES

19 W1: °*Kuti chikhale chaukhondo ° he [he he*

°For it to be hygienic° heh [heh heh

20 HP4: EYA [*YA (.) YA*

YES [YEA (.) YEA

21 Several W: [he he he

[heh heh heh

At this point in the interaction participants are discussing the sensitive and taboo topics of sex and genitals associated with male circumcision. Voluntary male circumcision is one of the routine topics included during these HIV counselling sessions, and the Ministry of Health in Malawi rolled out voluntary male circumcision as one HIV/AIDS preventive strategy. Nevertheless, some Malawians have not accepted male circumcision as an HIV prevalence reduction strategy because belonging to an ethnic group, a religious group, and having certain

perceptions of customs influence people's decisions on health matters such as these (Dionne and Poulin 2013). Male circumcision is associated with Islam and the Yao ethnic group, and encouraging male circumcision is regarded negatively by the other groups which make up the majority of Malawi's population (Parkhurst et al. 2015). All these factors contribute to the women's reluctance to freely talk about this topic here. Moreover, they may find it inappropriate to talk about these issues with a male healthcare provider. [3]

Against this background, then, the humour provides a useful strategy to overcome the women's resistance and reluctance, and to create a friendlier atmosphere which facilitates and encourages the sharing of information and the negotiation of knowledge. This is particularly important as it has been noted in the previous literature that the existence of group cohesiveness may facilitate overcoming resistance and may encourage interlocutors to freely contribute their views (Paul 2012). However, as can be seen in the first few lines of the transcript, the healthcare provider engages in a lot of interactional work to involve the women (e.g. his questions, explicit invitation to contribute ('come on') with reference to shared in-group membership ('we're all adults') line 2)). And yet, most of his efforts remain fruitless (e.g. his questions remain unanswered, the women remain very reluctant to participate and make only very short comments), which may of course partly be related to the fact he is a man talking to a group of women, which almost automatically puts him in a precarious position. It seems as if the healthcare provider has reached a deadlock.

However, this is about to change when he introduces some humour into the interaction (line 7ff). By making fun of the situation and comparing it with 'an initiation camp' (line 7) the atmosphere is lightened and the women respond with laughter. Like in the previous example, it is the healthcare provider's use of self-denigrating humour (lines 11 and 12) when he suggests to take off his clothes, and his mimicking of the women for making fun of him for being naked in front of them (line 12), that generate laughter among the women (line 13). He uses this fantasy scenario to remind the women that these counselling sessions are confidential and that nothing 'go[es] beyond these walls' (line 14), which is met with further laughter and explicit agreement among the women. This joint fantasising also performs a range of important interpersonal functions, such as co-constituting a relational connection between interlocutors, and performing interpersonally sensitive acts, such as talking about taboo topics (Stallone and Haugh in press; Hay 2001). Moreover, with his use of self-denigrating humour here, the healthcare provider, like in the previous example, portrays himself as more approachable and minimises the power difference that his audience may have perceived (in which the healthcare provider is the more knowledgeable expert who passes on his (medical) knowledge and teaches the less knowledgeable women). But describing himself as someone who 'had taken off his clothes' (line 12) minimises these effects.

[3] While it would be interesting to explore the role of gender in these counselling sessions, this is not the topic of our investigations here and would go beyond the scope (and word limit) of this paper.

While the humour in this excerpt is multifunctional, its main function is to create a positive environment and to reinforce solidarity among interlocutors which ultimately facilitates the discussion of sensitive topics. As in the previous example, the healthcare provider's use of humour here is successful as the women's increased participation in the subsequent lines indicates. And the woman who eventually answers his question about the meaning of male circumcision (line 17) – albeit tentatively and in a quiet, soft voice – considerably contributes to the collaborative discussion and moves the session forward. This interpretation seems to be shared by the healthcare provider, who enthusiastically responds to the contributions with the agreement marker 'yes' spoken with emphasis and a trace of delight in his voice (lines 18 and 20). The next example provides a further illustration of how humour may facilitate the discussion of taboo topics in this context.

Example 3

Context: This extract occurred during the same talk as Example 1 above. At this point in the interaction the healthcare professional wants to discuss different ways of contracting HIV. In the excerpt below he reacts to a comment by one of the women, who just said that sex is one possible way of contracting HIV.

1	HP2:	*Kodi HIV tingaitenge bwanji?*
		How can we contract HIV? […]
2	W1:	*Pogonana*
		When having sex
3	HP2:	*Akuti kugonana (.) one (.) ena?*
		She says when having sex (.) One (.) Anybody else?
4	Several W:	*((kuyankhula zosanveka))*
	Several W:	((indistinct))
5	HP2:	*Ena? Kugonana* ↑
		Anybody else? When having sex↑
6	W1:	*Kubwerekana malezala*
		Exchanging razor blades

((33 lines have been omitted in which HP2 and the women list different ways of contracting HIV, then HP2 summarises all the ways before dwelling on one woman's earlier response pertaining to sex))

7 HP2: *Tisapangitse kuti kugonana kukhale koipa* (.)

Let us not make sex seem evil (.)

8 Several W: *He he he*

Heh heh heh

9 HP2: *Kungonena kuti 'kugonana' nde mupangitsa kuti kugonana kukhale koipa* ((imitating a woman's voice))

if we just say 'having sex' [it means you are making sex horrible

((imitating a woman's voice))

10 Several W: *[he he he*

[heh heh (laughter)

11 HP2: [*Mukusekerera kapena mukuseka*?

[Are you smiling or you are laughing?

12 Several W: [*he he he*

[heh heh heh

13 Several W: ((*Amayi ena)) tikusekerera he he*

((a few women) we are smiling heh heh

14 HP2: *Eee (.) kugonana ndikwabwino::tu*

YES (.) having sex is very go::od

15 Several W: *he he he [heh heh heh ((kusekabe))*

Heh heh [heh heh heh heh ((more laughter))

16 Some: *[EEE]*

[YES]

17 W1: *EE KWABASI*

YES INDEED

18 HP2: *Kumatipatsa ana* ((cheeky tone of voice))

It gives us children ((cheeky tone of voice))

19 Several W: *Heh heh heh ((kucheza kosamveka))*

heh heh heh ((indistinct chatter))

20 HP2: *Nde musapangitse kuti kugonanako kukhale koipa iyayi*

So do not make sex bad uh uh.

21 Several W: *heh heh heh ((kupitiriza Kuseka)*

heh heh heh ((still laughing))

22 HP2: *Zikumveka?*

Is it clear?

23 Several W: *Mmm*

Mmh

24 HP2: *Kunena kwake tidzinena chonchi (.)*

This is how we should say it (.)

25 *kugonana ndi munthu amene sukumudziwa za mthupi mwake (.)*

having sex with a person whose body status you do not know (.)

26 *mwachidule (.) kugonana ndi munthu amene ali ndi kacholombo ka HIV*

in brief (.) having sex with a person who is HIV positive (.)

27 *mosadziteteza (.) mutenga kachilombo ka HIV …*

without using protection (.) you will contract HIV…

With his humorous comment in line 7 'Let us not make sex seem evil', the healthcare provider teases the women for their attitude towards sex and also criticises one of the women for her choice of words (in line 2). This generates some laughter among the women, and although we do not know whether the woman who was criticised participates in the laughter, the overall atmosphere at this point is very friendly and the laughter seems affiliative as several women join in. The healthcare provider thereby not only reinforces solidarity among interlocutors, but also gets across his (educational) message that sex is not to blame for everything and that 'having sex is very go::od' (line 14). He thereby breaks the taboo of (not) talking about sex,

while also addressing the fact that in the context of HIV/AIDS prevention and treatment in Malawi sex is a common, and possibly over-discussed topic, and, as a consequence, it is one of the topics associated with what Mitchell et al. (2010: 214) describe as "AIDS fatigue" among audiences. Using humour against this background, then, can also be interpreted as a way to not only facilitate the discussions about this taboo topic, but also to spice up (Brown and Keegan 1999) the relatively standardised routine discourse associated with it.

The humour not only emerges from what the healthcare provider says (i.e. teasing the women for the claim given in line 2), but his humorous intentions are also clear from his style of delivery. For example, in line 9 'having sex' ('*kugonana'*) is uttered in a voice imitating the women, which further contributes to the humorous effect and results in more laughter (in line 10). Moreover, by repeating the Chichewa term '*kugonana*' seven times throughout the extract (lines, 3, 5, 7, 9, 14, 20 and 26) – which seems like a strategic exaggeration – the healthcare provider dilutes and considerably weakens the taboo status associated with talking about this topic. This behaviour is in line with one of the prevalent sexuality discourses associated with HIV and AIDS (Seidel 1993; Drescher 2010), according to which HIV seropositive people are associated with promiscuity, and the pandemic is associated with sex. The healthcare provider seems to question and perhaps even make fun of this discourse – for example by teasing the pregnant women in line 18 when he reminds them in a cheeky tone of voice that 'it [sex] gives us children'. Considering that he is talking to a room full of pregnant women, who presumably have engaged in sexual activity in order to reach this status, this comment can be interpreted as having a critical edge to it (Holmes and Marra 2002). This teasing together with his summarising comment in line 20 'So do not make sex bad' is thus to be understood seriously although delivered in a humorous tone. The healthcare provider here successfully questions the common sexuality discourse of HIV that broadly classifies sex as immoral (Breitinger 2011; Drescher 2010). And teasing is an excellent means to achieve this as it enables the speaker to communicate a serious and potentially face-threatening message in an ambiguous manner leaving the audience to resolve this tension (Eisenberg 1986; Alberts 1992). Hence, by talking about sex in an open and perhaps unconventional way in this context, the healthcare provider at the same time offers an alternative discourse of sex (largely based on the medicalisation of the Christian discourse of monogamy (i.e. sex is good with just one (ideally non-infected) partner), which he tries to normalise through the frequent repetitions. The women's responses – first laughter, then signalling agreement (lines 16, 17 and 23) – indicate that these attempts are successful.

It is noteworthy, however, that in contrast to the previous examples, in this exchange the healthcare provider uses the humour to make fun of and tease the women, which is, arguably, more threatening than using humour directed at himself as in the previous examples. Nevertheless, as the women's reactions show, his attempts at humour are successful and contribute to reinforcing solidarity among interlocutors and creating an environment where the women feel secure enough to openly discuss issues around HIV/AIDS. The humour thus contributes to minimising the power differential between the healthcare provider and the

women, making the interactional context more open for the women's contributions. The joint laughter that the humour triggers further contributes to and intensifies these positive effects, which remain present even after a more serious tone is re-introduced into the counselling (from line 24 onwards).

In the next section, we discuss another function that the humour performs in these antenatal HIV/AIDS counselling talks, namely criticising the women for their lack of engagement with the counselling and their lack of knowledge.

Criticising and rebuking clients' lack of engagement with the counselling and their lack of knowledge

Previous research has observed that humour may also assist the speaker in communicating potentially negatively affective speech acts, such a criticism or disagreement, in a more palatable way thereby avoiding unnecessary conflict while still getting the critical message across (Holmes et al. 2001; Schnurr and Chan 2009; Norrick and Spitz 2008; Habib 2008). The healthcare providers in our data also use humour to this effect, in particular when criticising and rebuking the women for their lack of engagement with the counselling and their lack of knowledge. For reasons of space we have chosen only one example here to illustrate how this is achieved in the context of the pre-natal HIV/AIDS counselling talks in this Malawi hospital (but see Chimbwete-Phiri fc for more examples).

Example 4

Context: The excerpt below is from a group counselling talk during which a female healthcare provider (HP1) talks to a group of 14 women who were seeking antenatal services. For most of the women, this is their first antenatal appointment at the clinic. This excerpt occurs towards the end of the talk.

1	HP1**:**	*Chabwino (.) tanena kuti pali njira zitatu zimene*
		Alright (.) We have said that there are three ways that
2		*mayi woyembekezera angathe kumpatsira mwana wake eti?*
		a pregnant woman can transmit it to her child, right?
3		*Komanso takambirana njira zoti: kodi <u>mayiyu</u>*
		We have also discussed: how can the <u>mother</u>

590 *4* *anga- angamteteze bwanji mwana wake kuti asatengere kachilombo*

591 pro- protect her child from contracting HIV

592 *5* *kuchoka kwa ndani (.) kwa iyeyo, eti? (.)*

593 from who? (.) from her, right? (.)

594 *6* *nde pali azimayi ena mumati tikakuyezani magazi lero (.)*

595 So there are some women that when we conduct the blood test on you (.)

596 **7** ***mukapezeka ndikachilombo kukuuzani kuti pitani***

597 **when you are diagnosed with the virus, and we tell you to go**

598 ***8*** ***mukayambe mankhwala <u>mumati</u> °"ndikaafunse kaye abambo"°*** **((in a**
599 **teasing tone of voice and imitating an exaggerated female voice)).**

600 **And receive the medication <u>you say</u> °"let me go and ask my husband first"°**
601 **((in a teasing tone of voice, imitating an exaggerated female voice)).**

602 **9** **W1/2:** ***mmm:↓he***

603 **mmh:↓heh**

604 **((*ena kuchita ngati kuseka)) he he***

605 **((Some women chuckle)) heh heh**

606 **10** **HP1:** ***Mukakafika kunyu:mba:: abambo akukuuzani kuti:*** **((in a teasing tone of**
607 **voice))**

608 **When you get ho:me:: and the husband tells you: ((in a teasing tone of voice))**

609 ***11*** ***>"ine zimenezo pakhomo panga pano ayi"<*** **((in a teasing tone of voice and**
610 **imitating a male voice))**

611 **>"I do <u>not</u> want that in my house"< ((in a teasing tone of voice and**
612 **imitatinga male voice))**

613 ***12*** ***nde inuyo mumasiya mankhwala aja chii↑(.)*** **((in a teasing tone of voice))**

614 **then you drop the medication thump↑ (.) ((in a teasing tone of voice))**

615 *13* *chimene mungadziwe ndi chonena kuti moyo umene*

616 What you should know is that the life that

617 *14* *mukupanga ndi wanu (.) siwaaba:mbo (.)*

you are establishing is <u>yours</u> (.) not the husba:nd's (.)

ndi wanu ndi mwana (.)

it is for you and your baby (.)

inuyo mungasangalare mubereke <mwana oti ali ndi kachilombo::?>

Can you be pleased to bear <a child that has a virus::?>

Tili limodzi? (.) Alipo angasangalare?

Are we together? (.) Is there anyone who can be pleased?

18 W: Ayi

No.

19 HP1: *Kubereka mwana oti ali ndi kachilombo*

Giving birth to a baby that has a virus

20 *chifukwa choti abambo anamukaniza kumwa mankhwala?*

because the husband was stopping her from taking the medication?

21 W: *Ayi*

No.

22 HP1: *Ngati zafika stage imeneyo (.)*

If it reaches that stage (.)

yoti abambo akukukaniza kumwa mankhwala (.)

of the husband stopping you from taking the medication (.)

pezani munthu wina wapadera (.) mukambirane nawo abambowo,

find a third person, an outsider (.) and discuss with the man,

mwachifatse (.) ndi momveka bwino, eti?

calmly (.) and clearly, right?

26 W: *mmm*

mmh

The humour in this example occurs towards the end of the talk where the healthcare provider summarises the main ways through which HIV can be transmitted from mother to child (lines 1-5). Her contribution at this point performs at least three functions: to summarise the information provided earlier, to criticise the women's current practice (for being over-reliant on their husband's opinion), and to give them advice before leaving (which is a crucial element of HIV counselling (Silverman 1997)). The realization of humour starts in line 8 when the healthcare provider tells a short anecdote in which she creates the fantasy scenario of what the women might do when they get home after the talk. Imitating the women's voice and using direct speech (line 8) the healthcare provider makes fun of what she thinks they will do when they return to their husbands, namely asking their husbands (who are largely absent from these antenatal sessions) for advice rather than remembering and putting into action what the healthcare professionals have advised them (i.e. to take the medication). The humour emerges from the healthcare provider's enactment of the imagined situation, her overall teasing tone of voice, ventriloquizing the women's and also their husbands' voices (lines 8 and 11), and also her lexical choice (e.g. the emphasised exclamation 'thump' in line 12).

Although the healthcare provider's humour here is less explicit and is greeted with less laughter than in the previous example, it is nevertheless successful (Liptak et al. 2014). Not only is it responded to by some laughter and other minimal feedback (line 9), but it also facilitates the healthcare provider's attempts to criticise the women for what she perceives to be an over-reliance on their husbands in making decisions about HIV/AIDS treatment, while also preparing the floor for her subsequent more serious reminder of what she thinks the women should do instead (lines 13ff). This criticism addresses the observation that women in Malawi usually rely on their husbands (who are traditionally the head of the family) or other custodians, like grandmothers, to make decisions on their behalf, including those concerning their health (Jonasi 2007; Mbweza et al. 2008; MOH 2011). The move from this relatively subtle humour to more serious, non-humorous advice is smooth, and is achieved via a set of direct questions (lines 16-20) during which the healthcare provider changes the reference point from the hypothetical woman in her amusing anecdote back to the concrete women attending the antenatal counselling.

The women's reactions signal that they have understood the healthcare provider even if they do not agree with her imitation of the situation as the 'mmh:↓ *heh'* with falling intonation indicates (line 9). In Chichewa, 'mmh' uttered with a falling intonation often indicates disagreement (in contrast to 'mmh' with a flat intonation (line 26) which signals agreement). However, this mild expression of disagreement does not necessarily indicate the women's disapproval of the healthcare provider's assessment of the situation but could also be interpreted as (half playful, half serious) going along with the humour. This interpretation is further supported by the subsequent chuckles by some of the women (line 9).

Interestingly, the women do not produce any more laughter as the healthcare provider continues with her criticism and her (humorous) enactment of the imagined interaction between the women and their husbands (lines 10-12). Rather, they seem to have understood the change in tone from the humorous (albeit with a serious edge) to the more serious, and they respond accordingly (e.g. by answering the healthcare provider's questions (lines 18 and 20) and providing minimal feedback (line 26)) – which all signal that they are paying attention. The humour also helps the healthcare provider to reinforce the unequal power relations between herself and her audience, and to remind the women that she is the ultimate expert in medical matters pertaining to HIV/AIDS and her advice should thus be followed. In a way, she thereby also empowers the women, who are constructed as collaborators in this – as is reflected, for example, in her question 'are we together?' (line 17, which reminds the women that they all share the same agenda and that the healthcare provider is 'on their side'). A similar effect is achieved by her construction of an 'us versus them' dichotomy in which she creates an in-group who knows better (consisting of herself and the women) which is put in opposition to the less knowledgeable husbands. So, in this short extract the healthcare provider, on the one hand, exercises her power and maintains and reinforces her powerful position as the more knowledgeable expert, while on the other hand she also empowers the women and assigns agency to them. The humour assists her in achieving these apparently contradictory functions.

Discussion and conclusion

The analysis and discussion of four examples have illustrated that humour is a valuable strategy in the armoury of the healthcare providers who frequently use it throughout the antenatal HIV/AIDS counselling talks that we recorded at a rural hospital in Malawi. They employed humour mainly to reinforce solidarity with the pregnant women who attend these counselling sessions, thereby considerably contributing to creating a positive atmosphere in which the women feel more willing to make contributions and ask questions. This increased their contribution and engagement, as we have shown, and helped the healthcare providers to increase the women's participation in the discussion about HIV/AIDS and the associated sharing and negotiation of knowledge, which are important elements of these encounters. It also facilitated the discussion of taboo topics (largely relating to sexual practices and genitals), which are frequently referred to and which are an integral part of the content that needs to be covered in these counselling sessions. Thus, like in Hakaana's (2001, 2002) studies, participants in our research also used humour (and laughter) to mitigate sensitive and potentially embarrassing aspects. But our analysis has also shown that humour is an ambiguous strategy, and that in addition to minimising asymmetrical power relations and empowering clients (see also Zayts and Schnurr 2017), it may equally well be used to criticise them thereby reinforcing existing asymmetries.

While the humour that performed these functions in our data was often self-directed by the healthcare provider (e.g. in the form of self-denigrating humour as in Examples 1 and 2) or at a larger collective including both women and healthcare provider (Example 3), sometimes the humour was also directed at the women. This was particularly the case in those examples where the healthcare providers mobilised the 'corrective potential' (Weisfeld 1993: 157) of humour to criticise the pregnant women for their current practices and lifestyle (Example 4) or their lack of engagement with the counselling (for more examples, see Chimbwete-Phiri fc). In these instances, the healthcare providers would tease the women or make fun of them (e.g. by creating a fantasy scenario and imitating their voices). Although this is a potentially risky and threatening move, wrapping this criticism in humour proved very useful and turned out to be beneficial for the counselling as it increased the women's engagement and participation. It is precisely this ability of humour to perform multiple, sometimes ambiguous functions – including the creation of solidarity as well as criticising others – that makes it an excellent means to assist the counsellors in achieving their objectives.

Interestingly, unlike Pizzini (1991) we did not observe the humour to occur primarily at particularly tense moments but rather there was humour and laughter throughout the counselling sessions. And unlike previous research on self-denigrating humour in medical contexts, which largely focused on the various functions and effects of this type of humour when used by the patients (e.g. McCreaddie and Wiggins 2008; Du Pré and Beck 1997; Berger et al. 2004), we found that that it was frequently used by the healthcare providers to achieve various positive outcomes. This study has thus provided further evidence that humour is indeed a constitutive discursive strategy in medical contexts, and we hope that by exploring the role of humour in the under-researched context of antenatal HIV/AIDS consultations in Malawi, we contribute to the growing body of discourse analytical research on humour in medical contexts. While the focus of this study was the ways in which those in more powerful positions, i.e. the healthcare providers, used humour, we believe that an important avenue for future research is to explore 'the other side' of medical consultations and look at how patients and clients make use of humour to achieve their objectives, and possibly challenge and subvert the largely asymmetrical power relations and knowledge distribution that still characterise many medical encounters.

Moreover, we believe that a better understanding of the ways in which healthcare professionals and clients participate in these consultations, and how they collaboratively construct knowledge about HIV/AIDS, may contribute to the long needed improvement of the HIV/AIDS counselling services currently offered in Malawi. Identifying and describing some of the discursive strategies that facilitate the aims of these counselling sessions – especially those that successfully contribute to creating an atmosphere where the pregnant women are more likely to actively engage in the exchange and negotiation of knowledge – are thus useful endeavours which will hopefully lead to increasing patient participation and ultimately treatment adherence.

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TRANSCRIPTION CONVENTIONS

(.) A regular pause or gap of less than a second.

(n) Number in parenthesis indicates a pause in speakers' talk of more than a second.

:: Stretched or prolonged sounds, the length of the row of colons represents the prolongation of the sound.

(( )) Descriptions and comments by authors.

? indicates a rising intonation for a question

↑ indicates a rising intonation

↓ indicates a falling intonation

. indicates a stopping intonation

, indicates flat or continuing intonation

'phrase' indicates speaker's quoted talk

[Indicates beginning of overlapping talk

[indicates end of overlapping talk

°word° Indicates sounds that are softly uttered than the surrounding talk

WORD Capitals for words indicate sounds that are louder than the surrounding talk.

>fast< indicates talk that is noticeably faster than the surrounding talk

<slow> indicates talk that is slower than the surrounding talk.

-	indicates words that are cut-off or unfinished
=	indicates latching talk
_____	indicates emphasis by the speaker
…	ellipses indicate omission of talk in the segment
heh or hah	indicate laughter
hh	outbreath during speech denotes laughter

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