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Chapter 3
Improving HIV/AIDS consultations in Malawi. How interactional sociolinguistics can contribute

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1. Introduction

This chapter illustrates and discusses some of the ways in which applied linguistic research can make valuable contributions to ongoing endeavours to improve the delivery and format of HIV/AIDS consultations in Malawi. Malawi is a developing country with a population of just over 13,000,000, and like in many of its neighbouring countries, HIV/AIDS is the most common disease (Bowie & Mwase, 2011). In spite of various HIV/AIDS programmes initiated and funded by the government and several non-governmental agencies, public health services are suffering from inadequate patient compliance and adherence to the programmes' recommendations (Ministry of Health, 2012). In this chapter, we argue that a better understanding of the ways in which healthcare professionals and clients communicate with each other during consultation sessions can help improve this situation. However, while we focus on HIV/AIDS consultations in the context of Malawi, the linguistic approach we demonstrate – namely, interactional sociolinguistics – is also applicable to studies in other healthcare contexts.

Our particular focus is antenatal counselling sessions which are routinely attended by pregnant women during the first trimester of their pregnancy. These counselling sessions are

part of antenatal appointments and are typically delivered by an HIV counsellor, a nurse, or a hospital attendant, and cover topics around family planning and HIV/AIDS, maternal health, and care for the newborn baby. We identify and discuss several discourse strategies which healthcare providers use to get their message across and to achieve the aims of these antenatal HIV/AIDS consultations, namely to enhance an understanding of HIV/AIDS, to share the benefits of HIV testing, and to facilitate informed decisions for the mothers and children. Our findings indicate that regularly drawing on these strategies, including asking particular kinds of questions directed at the clients, telling anecdotes and frequently making reference to local knowledge and customs facilitate the women's contribution in these consultations, which may ultimately result in their increased participation, compliance and adherence to the programmes' recommendations.

1.1 Background: HIV/AIDS consultations in Malawi

HIV/AIDS is currently one of the most challenging health issues that Malawi faces (Bowie & Mwase, 2011), with an estimated 900,000 people infected with the virus. The HIV prevalence rate among adults per year is over 10%, and women are more affected than men (National Statistics Office, 2016). In an attempt to deal with these growing numbers, Malawi has adopted an integrated family care model, which means that general primary care, including sexually transmitted infections, family planning, antenatal, tuberculosis and HIV/AIDS clinics are now all located in the same health centre – thus facilitating people's access to care and knowledge (PEPFAR, 2013). However, in spite of these changes, HIV/AIDS programmes face additional challenges, including funding shortages and a shortage of human resources, which have negative implications for the quality of the services provided (Ministry of Health, 2011;

McCoy et al, 2004; Bowie & Mwase, 2011; Keehn & Karfakis, 2014). Moreover, patients often struggle to overcome long travel distances to health centres (especially in rural areas), and religious, cultural, and often economic factors – though healthcare is free in Malawi – which prevent them from either seeking advice or adhering to prevention and treatment programmes.

As part of a nation-wide HIV/AIDS programme, all health centres in Malawi offer voluntary HIV counselling and testing centres, antiretroviral therapy (ART) clinics for people infected with HIV/AIDS, and a voluntary testing programme specifically for pregnant women and mothers operated in antenatal clinics. The data that we discuss in this chapter was collected from the latter, namely an antenatal clinic that is part of the prevention of mother to child transmission (PMTCT) programme. In this programme, all pregnant women are given an option to have an HIV test so that if they test positive, measures can be taken to prevent transmission of the virus to the unborn child.

One of the central issues in this PMTCT programme is a relatively low patient adherence to the recommendations and a high drop-out rate. Several recent studies conducted in different hospitals across Malawi indicate that about 30% of women drop out, and that of those staying on the programme, only a third adhere to the full recommendations made by the health practitioners at every visit (Haas et al., 2016; Keehn & Karfakis, 2014). Another study showed that some health facilities had as high as 58% of women and infants listed as 'loss to follow up' (Tenthani et al., 2014:589), and a study conducted in the Zomba district, where our data was collected, pointed out that the situation is even worse in this area with less than 20% of qualifying mothers (sample n=387) adhering to the full recommendations of the programme in this region (van Lettow et al., 2011). This is particularly

true for postpartum treatment, which has even lower adherence rates (e.g. Haas et al., 2016; Keehn & Karfakis, 2014).

Reasons for not fully adhering to the recommended treatment are often linked to limited information about ART, and patients' inadequate knowledge about PMTCT (Keehn & Karfakis, 2014). Some patients even claimed they were healthy and thus saw no need for treatment (Kim et al., 2016), while others feared the side effects of the therapy (Zhou, 2016). The perceived 'uncaring attitude' of healthcare providers towards the patients was mentioned as another reason for the low adherence of PMTCT programmes in particular (Chinkonde, Sundby and Martinson, 2009). Moreover, due to largely patriarchal family structures, some women tend to rely on their husbands or village/clan elders and custodians for decision making, and often follow the advice of traditional birth attendants and healers, as well as traditional beliefs that discourage people from taking medication (Ministry of Health, 2009; Mbweza, Norr and McElmurry, 2008; Jonasi, 2007; Chasi & de Wet, 2006).

These issues are well-known to the relevant governmental agencies and NGOs, which strongly advocate an improvement in the provision of current services with a particular emphasis on ensuring that individuals have sufficient access to information about HIV/AIDS, and are able to utilise and act upon this knowledge. Thus, access to relevant information and patient involvement in the care plan are crucial aspects in the fight against HIV/AIDS in Malawi (see also National AIDS Commission, 2010). However, studies on patients' non-adherence to HIV treatment have shown that it is not necessarily a lack of information that leads to these issues, but that numerous contextual factors also contribute, such as economic and psycho-social difficulties which are often ignored in patient-health provider interactions (Chasi & de Wet, 2006; Penn, Watermeyer and Evans, 2011; Watermeyer & Penn, 2012). These issues are

particularly relevant in the context of HIV/AIDS consultations in Malawi with its relatively low patient adherence rates of PMTCT. Therefore, communication that considers the patients' lifeworld, as well as their views and lived experiences is encouraged in healthcare interaction (after Mishler, 1984).

Taking an interactional sociolinguistic approach – as we illustrate below – can help shed new light on and address these issues, while providing useful insights into how meaning (and hence knowledge) is conjointly constructed and negotiated among interlocutors. Such an approach thus acknowledges the agency of clients and rejects models that view healthcare communication as unidirectional encounters where the healthcare providers pass on information to their clients who merely absorb it.

In contrast to the overall rather gloomy picture of patient adherence in Malawi in general, the statistics that we gained from the hospital where we collected data are rather encouraging. In this particular health clinic the drop-out rate is just above 10% and thus considerably below regional and country-wide averages. In line with previous research that has established that patients are more likely to comply with a proposed treatment plan and adhere to their prescriptions if they are satisfied with the communication with the healthcare providers and the resulting therapeutic relationship (e.g. Davis & Fallowfield, 1991), we assume that one of the reasons that the drop-out rate in the hospital where we collected data is comparatively low, may be related to the ways in which the counselling sessions are conducted. In this chapter we thus focus on illustrating some of the interactional practices that the healthcare providers routinely engage in in these comparatively successful consultations. We focus, in particular, on illustrating some of the ways in which client involvement is achieved.

In what follows, we first describe the methodology that we used to collect data, including some of the ethical considerations involved in these processes. We then discuss three examples of authentic interaction between a healthcare provider and a group of pregnant women that we recorded at a rural hospital in Malawi. In our analyses we illustrate some of the discursive strategies that the healthcare providers use to facilitate the delivery of information, ensure the women's understanding and increase their participation in the counselling session, which may then, in turn, translate into an increase in treatment adherence.

2. Introduction to the methodology

The data that we analyse and discuss in this chapter was collected at an antenatal clinic at a rural hospital in Malawi. During these antenatal clinics, group counselling sessions are offered to pregnant women at their first visit as part of their regular antenatal programme. As part of the PMTCT programme, expectant mothers are also given the option of undergoing an HIV test (which usually takes place after the group counselling sessions). We observed 26 of these (and other) counselling sessions, audio-recorded more than 20 hours of interactional data, and conducted interviews with clients and healthcare providers. The data analysed in this chapter is drawn from the audio recordings of interactions, observations and interviews with the clients and health providers. All data was originally in Chichewa (the national language of Malawi) and has been translated into English for the purposes of this research. The audio-recorded data from the counselling sessions were transcribed using adapted transcription conventions typically used in conversation analysis (Kroger & Wood, 2000: 193-4; Cameron, 2001: 36-40; and Silverman, 1997:232-3), which are presented at the end of this chapter.

We use interactional sociolinguistics to analyse our data with the aim of gaining a better understanding of the healthcare interactions within the socio-cultural context of Malawi. Interactional sociolinguistics is a linguistic approach that is particularly suited to analyse interactional data as it considers both, the micro details of an interaction as well as contextual background in which the encounter takes place (see also Zayts & Lazzaro-Salazar, this volume). This approach has thus been described as building bridges between micro level analyses, as typically done in conversational analysis, and macro levels of analyses, which often tend to focus on *what* participants say (e.g. in thematic analysis) rather than *how* they say things to negotiate meaning (Sarangi & Roberts, 1991). Interactional sociolinguistics has been used extensively in research of medical interactions (e.g. Heath, 1992; Maynard, 1992; Candlin, 2006; Sarangi & Brookes-Howell, 2006; Strunck & Lassen, 2011; Zayts, Yelei and Schnurr, 2012; Zayts & Schnurr, 2014), and it is considered to be particularly beneficial for this type of study because of its emphasis on meaning making as a collaborative process that takes place throughout an interaction (Gumperz, 1999).

Taking an interactional sociolinguistic approach in this study thus enables us to identify and analyse specific discursive practices used by the healthcare providers and their clients in their encounters, while at the same time taking into consideration the wider context in which these discursive practices occur. More specifically, such a micro-analysis of the talk in the form of interactional sociolinguistics provides insights into how meaning and relationships are constructed (Sarangi & Roberts, 1991; Rampton, 2010), while at the same time linking observations to macro-level categories, such as culture and customs that may be of relevance to the interpretation and understanding of the micro level observations (Gumperz, 1982, 1999; Drew & Heritage, 1992). This link between the micro and the macro is particularly beneficial for investigations of healthcare interactions as it generates a more complex picture

– in particular by combining analyses of different data sources – which enables us to understand local practices in the specific and the wider context in which they appear (Heath, 1992; Maynard, 1992; Candlin, 2006; Sarangi & Brookes-Howell, 2006; Zayts, Yelei and Schnurr, 2012; Zayts & Schnurr, 2014; Strunck & Lassen, 2011).

2.1 Ethical considerations

Ethical approval to collect the data for this study was obtained from the University of Warwick (as part of the PhD project of the first author), the National Committee on Research in the Social Science and Humanities (NCRSSH) under the Malawi National Commission for Science and Technology (NCST), the Malawi Ministry of Health through the District Health Officer (DHO), and also the District HIV/AIDS Coordinator of Zomba, which is the district where the health centre is located.

Moreover, consent was obtained from all participating individuals. We agreed with the participating hospital on the practicalities of gaining participants' consent to take part in the study. This was an important step as it turned out that some of the ethical practices that are standard in many Western contexts (such as asking participants to express their consent by signing a consent form), were inappropriate in this particular context (Upval & Hanswani, 2001; Shaibu, 2007; Henderson et al., 2007; de Vries et al., 2015). Due to the relatively high illiteracy rate among the clients of the participating hospital and due to a general resistance among some of the participants to sign anything on paper because of potential legal implications and the significance attached to appendage of signatures (Upval & Hanswani, 2001) it was decided to record participants' oral consent after the study (and all relevant information, including their rights to withdraw at any point) had been introduced to them,

and they had been given ample opportunity to ask questions. This procedure was considered appropriate by the participants and was approved by the relevant ethics committees.

3. Analysis of antenatal HIV/AIDS counselling in Malawi

We have chosen three extended excerpts that are representative of our data to illustrate some of the discursive strategies frequently used by the healthcare providers to achieve the aims of these antenatal HIV/AIDS consultations, namely to enhance understanding of HIV/AIDS, share the benefits of HIV testing, and facilitate informed decisions for the mothers and children. Our particular focus here is on the uses and functions of specific types of questions, anecdotes, and reference to local knowledge and customs. Regularly drawing on these strategies, we argue, contributes considerably to facilitating the clients' contribution in these consultations, which may ultimately result in their increased participation, compliance and adherence to the programmes' recommendations (e.g. Gilroy et al., 2004; de Kok, Laurier and Widdicombe, 2012; Watermeyer & Penn, 2012; Penn, Watermeyer and Evans, 2011), and result in the very low drop-out rates of this clinic.

3.1 Asking questions

In line with what seems to have become standard practice in many medical interactions that take an interview format (Gleeson, 2009), the healthcare providers in our antenatal HIV/AIDS consultations frequently pose questions to the attending women. Excerpt 1 illustrates some of the ways in which the counsellors typically ask questions and the effects and responses this generates from the women. In the transcripts below we first provide the original (Chichewa)

followed by the English translation, and we have highlighted the most relevant lines in bold for ease of reading.

EXCERPT 1

Context: HP1, a female counsellor, at the beginning of her talk to a group of 14 pregnant women. This talk is held prior to conducting an HIV test, and at this point in the interaction the counsellor is outlining the agenda of the talk. W refers to several women speaking at the same time, W1, W2, etc. refer to individual women.

1	***HP1***	***mmm chabwino, inuyo ngati amayi woyembekezera***
		mmh alright, as pregnant women,
2		***Mukuwona kuti ndikofunikira kuti inuyo muyezetse magazi? (1)***
		do you think it is important for you to have a blood test?
3	*W (ena):*	*[Eee]*
	W (some):	[Yes.]
4	*W (ena):*	*[Mmm] ndikofunika*
	W (some):	[Mmh] it is important
5	***HP1***	***Kufunika kwake ndikotani?***
		What is its importance?

6	*W1:*	*Udziwe mmene muliri mthupi mwako*	
		So that you should know how your body is.	
7	***HP1:***	***Mudziwe mmene muliri mthupi mwanu, eti?***	
		You should know how your body is, right?	
8	*W:*	*Mmm*	
		Mmh	
9	***HP1***	***Ndeno mukadziwa?***	
		And when you know?	
10	*W2:*	*Kutetezera mwana amene tikumuyembekezerayo*	
		To protect the baby we are expecting.	
11	***HP1:***	***Kumutetezera mwana amene tikumuyembekezerayo, eti?***	
		To protect the baby you are expecting, right?	
12		***Makamaka ngati mwapezeka kuti muli ndi HIV, tili limodzi?***	
		Especially if you are diagnosed with HIV, are we together?	
13	*W:*	*Eee*	
		Yes.	
14	***HP1***	***Ngati mulibe kachilombo? (2.5)***	
		If you do not have the virus? (2.5)	

15 *W2:* *Kudzisamala*

To take care of yourself.

16 HP1: ***Kudzisamala?***

To take care of yourself?

17 *W2:* *Eee*

Yes.

18 HP1: ***Mudzikadzisamala bwanji?***

How will you protect yourselves?

19 *W3:* *Mmene ungadzisamaliremo*

Whatever you can do to take care of yourself.

20 *HP1:* *Awa akuti 'mmene ungadzisamalirire'*

This one says 'whatever you can do to take care of yourself'

21 ***Ena? (.) tikuganiza kuti tidzikadzisamala bwanji?***

Others? (.) How will we take care of ourselves?

22 ***Tidzikadzisamala bwanji tikapezeka kuti tilibe kachilombo?(.)***

How will we take care of ourselves if we are found free of the virus?

23 *W4:* *Pokapewa kuti tisatenge*

By preventing it, so that we do not contract it.

24 *HP1:* *Pokapewa kuti musatenge.*

By preventing it so that you do not contract it.

25 *Mudzikapewa bwanji? Mayankho onsewo mukuperekawo ndi olondora,*

How will you prevent it? All those answers you are giving are correct,

26 *koma simukumasu:la. Tamasulani bwinobwino (.)*

but you are not elaborati:ng. Please elaborate well (.)

27 ***Mudzikapewa bwanji kuti <u>inuyo</u> musatenge kachilombo?***

How will you prevent it, so that <u>you</u> do not contract the virus?

28 W4: *Kuchepetsa anthu ogonana nawo, komanso kumakhala ukumayezetsa*

By reducing the number of sexual partners, and also to get tested

29 *pafupipafupi, komanso kumadziwa kuti munthu*

frequently, and to know the person you

30 *>amene ukugona nayeyo<* (.) *ngati <u>ali</u> okhulupirika*

are >having sex with< (.) if he <u>is</u> trustworthy.

31 **HP1:** ***Amayi anzathu akuti kuchepe::tsa anthu ogonana nawo***

Our friend here says by redu::cing sexual partners,

32 ***komanso kuyezetsa magazi, >komanso amene ukugonana naye::yo<***

and having a blood test, >and the one you are having sex wi::th <,

33		***akhale wokhulupirika (.) e:ti?***
		should be trustworthy (.) righ:t?
34	W:	Eee

In this excerpt, the healthcare professional utters a series of questions which all, arguably, facilitate the women's engagement in and ultimately contribution to the counselling. After initial greetings the healthcare professional opens her talk with the questions rather than delivering information in a monologue style which, like in another study on provider initiated counselling in Africa (Ndirangu, 2016), arguably reinforces the communication dominance by health providers. The health professional starts with a closed yes-no question in lines 1 and 2 asking the women about whether it is necessary to have a blood test. This generates affirmative responses from several women (lines 3 and 4), and so, despite the relatively closed nature of the question encourages the attendees to participate and engage in the counselling. This question and answer sequence is then immediately followed by another, this time more open-ended, question in which the healthcare provider enquires about the reasons for the women's previous response (e.g. 'What is its importance?' line 5). The women respond to this with more elaborate answers, including making concrete suggestions (e.g. W1, 'So that you should know how your body is' line 6). After repeating the woman's (W1) answer in the form of a checking question ('You should know how your body is (.) right?'; line 7), the healthcare professional poses another question, which receives a brief acknowledgement and minimal feedback from some of the women (line 8). This repetition not only affirms the correctness of the women's answers but also encourages the women to participate in the interaction, and

for the healthcare professional it provides a welcome opportunity to check the women's knowledge and understanding of HIV/AIDS.

Throughout the remainder of the excerpt, the healthcare provider asks successive questions, which are all derived from the women's responses. Some of her questions encourage the women to talk about measures of HIV/AIDS prevention, which directly addresses one of the crucial aims of these sessions. This successive use of questions thus leads to an elicitation of the women's knowledge, which results in a more active participation, sharing and negotiation of knowledge compared to scenarios in which the healthcare provider delivers the information in the form of a monologue or lecture. This style is further reinforced by the relatively informal format of the questions ('And when you know?' line 8 and 'If you do not have the virus?' line 14**)** which marks the informality of the interaction. This informality is in contrast to the use of closed ended questions which may indicate the institutional alignment on the part of the health professional thereby reinforcing the formality of the discourse (e.g. Candlin, 2006). As can be seen from some of the women's answers, this strategy is successful as it involves the women in the interaction and gets them to participate by showing that they have the relevant and appropriate knowledge (e.g. 'To protect the baby we are expecting,' line 10, and 'By preventing it, so that we do not contract it,' line 26). This participation also enhances shared ownership of knowledge by ensuring that relevant information is not only provided by the healthcare provider but is conjointly produced among all participants (Candlin, 2006). Patient participation is highlighted as important in positive treatment outcomes in acute paediatric medical encounters where treatment is negotiated between parents and medical practitioners in interaction (e.g. Stivers, 2006). Similarly, engaging with patient's expertise in managing chronic conditions such as rheumatoid arthritis can contribute to positive health outcomes (Sanderson & Angouri, 2013). It may also have

positive effects on the women's behaviours after the counselling session in terms of increasing their adherence to the advice discussed during the session (Penn, Watermeyer and Evans, 2011).

Most of the questions posed by the healthcare professionals took the form of knowledge checking or so-called display questions, whereby the counsellors check if the women have paid attention and know the answer (Athanasiadou, 1991; Mehan, 1979). Other types of questions asked included those that request information that the questioner does not know (which occurred only rarely); rhetorical questions which are intended to provide information and may not require answers; and evaluative questions that require the women's opinions. In most cases in our data, the linguistic formulations of the questions were open-ended and started with various wh-forms, such as 'what', 'why' or 'when', This style of questioning was significant in that it not only facilitated a collaboration between the women and the health professionals in the interaction but also engaged the women in information sharing.

As we can see from the transcript, the women's answers become more elaborate, and the healthcare provider follows up with further questions until she is satisfied with the provided information. Through the use of successive questions the women are encouraged to participate, thus taking an active role in these counselling sessions and actively contributing to shaping the direction of the interaction. The women therefore take centre-stage in (re)producing and displaying their (collective) knowledge about HIV/AIDS, while constructing the role of healthcare professional as a facilitator whose main aim is to make explicit the already existing knowledge of the women (Levinson, 1992). This close association of the women with knowledge is further reflected when the healthcare professional explicitly

attributes some information to the women (rather than to herself or another abstract institution), whom she thereby constructs as the expert – such as in line 31 (‘our friend here says…’).

This question and answer format has several advantages. For example, clients are explicitly allocated a turn which ensures that their voice is heard and they are given the opportunity to ‘express their own concerns and fears about the future’ (Silverman, 1997: 215). Even though question and answers in medical interaction are said to reinforce power asymmetries since the questioner assumes control over the answerer (Ribeiro,1996), and through questioning the experts exhibit power (van Dijk, 1993), their use in HIV counselling has been considered helpful in aligning the client and counsellor in the information delivery process (Peräkylä & Silverman, 1991; Silverman, 1997). Like in classroom interaction, in the counselling interactions, which combine the interview format with the delivery of information (Peräkylä & Silverman, 1991), the frequent use of open ended questions contributes to involving the women and increasing their participation. Due to the healthcare providers’ frequent questions, the atmosphere and structure of these counselling sessions resembles the typical classroom interaction structure of initiate, respond, feedback (IRF) (Walsh, 2011; after Sinclair & Coulthard, 1975). Although other scholars have argued against reducing teaching discourse to this sequence and acknowledging the benefits of other structures (Cazden, 2001; Seedhouse, 1996) – such as student initiatives in the form of questions to the teacher (Waring, 2009) – IRF frequently occurs in our data and seems to be an effective strategy in the context. One of the women, in interviews, referred to the counselling sessions as a dialogue ‘it is a chance to remind one another and discussing in order to help each other. You say this, she also says that, that way knowledge is advanced, learning is on-going’. This attests that

questions are more engaging for the clients than the didactic style of communication used in health promotion messages.

Another strategy frequently used by the healthcare providers in these counselling sessions is making reference to local knowledge and traditional customs, which we discuss next.

3.2 Reference to local knowledge

In our data there are several instances where the health professionals make references to shared knowledge between themselves and the women by using specific metaphors and referring to local knowledge and customs to facilitate an understanding – often of complicated technical terms and processes. They also often used metaphors as euphemisms for sexual organs, sexual practices and sexually transmitted illnesses. Excerpt 2 below illustrates how references to local and shared knowledge facilitate the generation of shared meaning and ultimately understanding.

EXCERPT 2

Context: This transcript is taken from another talk by HP1. This female counsellor and a group of 15 pregnant women are talking about HIV transmission from mother to unborn baby.

1	W6:	*Mwanena kuti mmene tililimu tikhoza kumpatsira mwana amene*
		You have said that in this state we can infect the baby we are
2		*tikuyembekezerayo (.) chikhaliremo mwana amakhala ndi thumba lake (.)*

expecting (.) yet the baby is in his or her own sac (.)

3 *zingatheke bwanji?*

how is this possible?

((several lines omitted in which HP1 addressed this question to the other women, but after not receiving a response, she provides the following answer))

4 HP1: *Munamva kuti °"mayi woyembekezera chitetezo chake*

Have you ever heard that ° "a pregnant woman has

5 *chimakhala chotsika?" °*

low immunity?" °

6 W: *mmm*

Mmh

7 HP1: *Tikakhala kumudzi timati °"chifukwa choti akugawana*

In the villages we say, "It is because she is sharing

8 *ndi mwana magazi akugawana ndi mwana" °(.)*

her blood with the baby they are sharing" (.)

9 *Timatero eti?*

That is what we say, right?

10 W: *Mmm*

Mmh

11 *HP1:* *Chitetezo cha mayi woyembekezera chimakhala chotsika nthawi zambiri*

The immunity of a pregnant woman is usually low

((omitted 35 lines, during which she explains what happens in the body and the attention given to a pregnant woman at various visits of antenatal to protect her from illnesses))

12 **HP1:** ***Chomwe chimachitika ndi chonena kuti (.)***

What happens is that (.)

13 ***mwana inde amakhaladi mthumba mwake (.)***

the baby is indeed in his or her own sac (.)

14 ***koma tonse timadziwa kuti mayi amakhala ndi timati cha?***

but we all know that the mother has what we call

15 ***nsengwa eti?***

a winnower ((cervical membrane)), right?

16 W: *Mmm*

Mmh

17 **HP1:** ***Nsengwa (.) nsengwa ija imagwira ntchito ngati sefa (.)***

Winnower (.) the winnower functions as a sieve (.)

18 ***imasefa zoyi:pa kuti zisapite kwa mwana.***

it sifts the ba:d things so that they do not pass to the child.

19 W: *Mmm*

Mmh

20 HP1 ***Zipite zabwino zokhazokha (.)***

Only the good things should pass (.)

21 ***Sefa ikabooka chimene chimachitika ndi chani?***

What happens when a sieve is worn out?

22 W (one): ***Imatulutsa ndi zoipa [zomwe***

It releases the bad bits [as well].

23 HP1: **[*Imatulutsa ndi zoyipa zomwe***

[It releases] the bad bits as well.

24 W: *Mmm*

Mmh

25 HP1: *Nde mayi ali ndi HIV, kuyembekezerako kukumutsitsa chitetezo,*

So the mother has HIV, the pregnancy is reducing her immunity

26 *HIV ikumutsitsa chitetezo,* ***ndiye abwere kaya ndi malungo,***

HIV is reducing her immunity, **so if she suffers from malaria,**

27 ***amutsitsanso chitetezo (.) ndiye kuti nsengwa ija imayambano***

that will also reduce her immunity, it means that the winnower starts

28 ***kugwira ntchito ngati sefa yobooka (.)***

to function as a worn out sieve,

29 ***imakhala kuti panthawi imene mukudwala ija***

it happens that as you are ill

30 *imakhala ilibe mphamvu [yoteteza kuti-]*

it no longer has the strength [to protect the-]

31 W10: [(∧∧∧∧∧)]

32 HP1: *Mwati bwa?*

What did you say?

33 W10: *Imayipitsa (∧∧∧∧) (.) kunkhani ya sefa ija*

It spoils a lot (∧∧∧∧) (.) on the issue of the sieve.

34 HP1: ***Eee, imakhala kuti nsengwa ija ikugwira ntchito ngati***

Yes, it happens that the winnower is functioning as

35 ***sefa yobooka (.) eti?***

a torn sieve (.) right?

36 W: *Mmm*

Mmh

37 HP1: *Nde kuti inunso chitetezo choti mumuteteze mwana uja*

And it means your bodily immunity that should protect the child

38 *kuti musampatsire HIV panthawi imene ija chimakhala kuti palibe,*

from HIV at that time is lost

39 *nde HIV ikhoza kudutsa kupita kwa ndani?*

so HIV can pass and go to who?

40 W (some): *kwa mwana*

to the baby

41 HP1 *Kwa mwana mosavuta (.) Tili limodzi?*

To the baby easily (.) Are we together?

42 W: *Eee*

Yes

In this excerpt, the healthcare professional provides further clarification about mother to child transmission, which directly addresses a question asked by one of the attending mothers (lines 1-3). The woman's question is prefaced by her repetition of what the healthcare professional has previously said, which signals the woman's involvement and participation as she has apparently not only followed the talk but is also critically engaging with it.

The healthcare professional begins her explanations with a question directed at the women (lines 4 and 5), before she addresses the question more directly by referring to local

knowledge and practices (lines 7 and 8). Her response is relatively long and elaborate, and makes frequent reference to shared knowledge and local practices. For example, she begins her explanations by relating the concept of lowered immunity to knowledge that the women already possess (e.g. 'in the villages we say' line 7). Here, the practitioner not only establishes shared knowledge (van Dijk, 2003) but also transfers the locus of knowledge generation from some abstract medical domain to the realm of the women's concrete everyday experience (i.e. the village). After gaining some minimal feedback from the women (line 10) in response to her previous utterance-final tag question (e.g. 'right?' line 9), which the healthcare professional seems to understand as agreement, she continues with her explanations by using the metaphor of *nsengwa* (winnower) for the cervical membrane and *sefa* (sieve) as an extended metaphor to explain how the membrane functions. These metaphors are frequently used by all the health professionals who participated in this study, and they thus seem to be standardised metaphors in this particular local community.

'Winnower' and 'sieve' are both kitchen utensils that the women can easily relate to because they are an essential part for the preparation of *nsima* (a corn meal) – one of the typical meals in Malawi. It is thus very likely that all women own these kitchen utensils and regularly use them to prepare the corn flour for *nsima* by winnowing the corn to remove husks. After this milling process, before the flour can be used, sieving is essential because the flour may have a lot of lumps and some unwanted bits. There are thus some clear parallels between the preparation of this meal, a practice that the women regularly engage in in their everyday life, and the possible transmission of diseases from mother to child in the womb. By bringing these two domains of household practice and medical/bodily processes together, the healthcare provider effectively explains a relatively complex process and makes sure that the women understand the potential dangers and implications for their unborn child.

The metaphors of 'winnower' and 'sieve' are then further elaborated when the healthcare provider asks the women about the dangers and negative consequences of a worn-out sieve (line 21), which, as can be seen by the immediate response of one of the women (line 22), increases their understanding. This is then picked up and further elaborated by the healthcare professional who provides a concrete example (of a mother with Malaria). The women's involvement (and thus perhaps also their understanding) increases considerably after this explanation (as signalled, for example, by their more frequent utterances, overlaps with the healthcare provider, and minimal feedback), suggesting that the healthcare provider's strategy of referring to local practices and knowledge has indeed facilitated the women's understanding and participation (lines 22, 33, 40). This is particularly evident towards the end of the excerpt when the healthcare professional's statement uttered with rising intonation (lines 37-39) is immediately completed and responded to by the women (line 40), which is then repeated and thus legitimised as the correct answer by the healthcare professional (line 41). The women's strong affirmative reactions (line 42) to the healthcare provider's question 'are we together?' (line 41) further reinforce this impression of the women's understanding and active engagement with the counselling talk.

The benefits of using metaphors in interactions between medical experts and non-experts have also been attested by Gülich (2003). Moreover, Candlin (2006) argues that using language associated with the life world rather than medical terminology enables the healthcare provider to enter into the world of the patient/lay person and emphasise common ground and build rapport. The metaphors used in this talk, such as 'sieve' and 'winnower, ' can be described as so-called 'within-group metaphors' (Rolf, 2009:164) that derive their meaning from the specific local group. Drawing on the underlying shared cultural knowledge, these within-group metaphors and frequent references to local knowledge in the medical

discourse are useful for providing an 'interpretive frame' (Hilligoss, 2014: 120) which helps to make less familiar concepts more tangible and concrete by giving them a form that can be more readily understood by the women.

3.3 Storytelling

Storytelling is another strategy that the health providers in this clinic frequently utilised to explain medical concepts and procedures to their clients. In studies of healthcare communication, the benefits of storytelling are long acknowledged – especially in the form of narratives in which patients present their experiences to physicians, and which help the latter make sense of the patients' conditions (Heritage and Robinson, 2006; Hunter, 1991; see also Thurnherr et al., this volume). In this study, we explore some of the communicative functions of the stories with a particular focus on how they facilitate the clients' understanding of relatively complex information.

EXCERPT 3

Context: A male counsellor (HP4) is talking to a group of 16 pregnant women about voluntary male circumcision as an HIV prevention strategy

1	*HP4:*	*Komanso mdulidwe paokha (.) umatha kuteteza kufala*
		Also, circumcision alone can reduce the spread of
2		*kwa HIV ndi 60 percent*
		HIV by 60 percent.

3 *Tingotenga ujeni mm uyu*

Let's take this er er this

4 ***>akhale gule ameneyu wa kwa Joni<***

>let's refer to this as a dance by John<

5 ***nanga sitimati kwa Joni ee kubala ndiye kwa Joni eti?***

don't we say John, yea John's seed yea? Right?

6 W: Eee

Yes

7 ***HP4:*** ***Hule uja ali ndi kachilombo ka HIV***

This prostitute has HIV

8 °***nde tiyerekeze panopa ma gu- anyamata ten***°

°**suppose there are ten gu- boys here** °

9 ***mwina tatopa tinali kundende (.)***

may be we are tired because we were in prison (.)

10 *W:* *Mmm*

Mmh

11 **HP4** ***tonse osadulidwa (.)***

We are all uncircumcised.

12 ***Nde tikufuna kugona naye amene ujayo eti? (.)***

So we want to have sex with this one, right? (.)

13 W: Mmm

Mmh

14 HP4: ***Zitha kutheka kuti mwa anthu ten akugona naye amene uja (.)***

It is may be that among the ten people who will sleep with her (.)

15 ***anthu tonse tikhoza kutenga kachilombo ka HIV***

all of us can contract HIV

16 ***kupaturapo munthu mmodzi eti?***

except one, right?

17 W: Mmm

Mmh

18 HP4: ***<u>Sichoncho</u> eti? Nde zitha kutheka kuti apapa tilipo anthu (.)***

***Not so*? So it is also possible that there are (.)**

19 ***okwanira angati? (.) Okwanira ten eti? (.)***

how many of us? (.) Ten of us, right? (.)

20 ***oti tinadulidwadulidwa***

all circumcised

21 ***>monga mmene aliri akulu amene tawatsekera mkatimo<***

>just like the gentleman in the drawer over there <

((referring to a model of a penis))

22 W (ena): *Ee*

W (some): Yes

23 HP4 *>kaya mbokosi kaya muchani?<*

>is it a box or what?<

24 ***Nde:: kugonana kwa amene aja kupezeka kuti***

So the <u>ten</u> people's sexual activity

25 ***kupezeka kuti pa anthu <u>ten</u> aja***

it will be found that the <u>ten</u> people

26 ***apeze::ka anthu <u>siki:si</u> oti satenga kachilombo ka HIV***

may resu::lt in <u>six</u> not contracting HIV

27 ***°pamene anthu folo akhoza kutenga kachilombo° eti?***

°while 4 people may contract HIV° right?

28 ***Mwaona pamenepo tachepatu eti?***

You see that we have been reduced right?

29 W: *Eee*

W: Yes

In this excerpt, the healthcare provider tells the women a little story in order to help them understand the benefits of male circumcision – more specifically, the numerical odds of getting infected with and without circumcision. He explains that male circumcision reduces the chances of getting infected with HIV by 60% for the men and their sexual partners. Telling the women what seems to be a spontaneously invented story about a hypothetical scenario around a male protagonist, John, helps him get this message across to the attending women.

The anecdote opens with a metaphor for sexual activity which he refers to as 'a dance by John' (line 4), which he constructs as culturally familiar by checking with the women, 'don't we say John, John's seed? Right?' (line 5) to which the women strongly agree (line 6). The healthcare provider thereby starts his story by establishing shared understanding (van Dijk, 2003) between participants. The story is located in what may be a familiar situation for these women, namely the male protagonist returning from prison and visiting a prostitute (lines 7-9). This choice of characters and scene places HIV/AIDS discourse in the familiar context where same-sex intercourse among prisoners and intercourse with prostitutes are known to contribute to the spread of HIV. This choice thus reflects typical elements of HIV/AIDS discourse in Malawi (Breitinger, 2011). The healthcare provider skilfully makes reference here to this discourse and thereby enters into the client's lay world to facilitate meaning (Candlin, 2006) and shared understanding. Through this anecdote, the (medical) world of the healthcare professional and the (life) world of his clients are brought together (Bleakley, 2005) which facilitates the women's understanding.

The story evolves around ten imagined circumcised men who sleep with an HIV infected prostitute, resulting in four men getting infected with the virus and six men remaining uninfected. This way of breaking down and simplifying the complexities of statistics speaks directly to the women's relatively low literacy and numeracy knowledge (of the 37 women interviewed, only five had attained education up to junior secondary school, two did not go to school at all, six only completed primary school, and the rest dropped out during junior primary school). Thus, by telling this story the healthcare provider translates abstract percentages into more concrete and palatable numbers (e.g. Tannen & Wallat, 2006). He is empathetic towards the women as he takes time to explain the significance of male circumcision to the reduction of HIV infections using this story (Bleakley, 2005). This is further reflected in his use of the inclusive first person plural pronoun 'we' when referring to the men (e.g. lines 9, 11, 12, 28), thereby making the story more concrete and adding to its real-life touch. Although portraying himself as one of the ex-prisoners may potentially downgrade his expert position and standing in the context of the counselling (Bleakley, 2005), considering the rather questionable moral nature of the characters in the context of HIV/AIDS discourse (Seidel, 1993; Drescher, 2010; Breitinger, 2011), this inclusion seems to catch the women's attention as their heightened involvement and frequent minimal responses show (e.g. lines, 10, 13, 17, 22). These positive effects are further evidenced by the responses the healthcare provider's final question generates. His checking that the women have understood the numerical implications ('you see that, we have been reduced, right?' (line 28)) is responded to positively with several women uttering a convinced 'yes' (line 29).

The positive effects of stories in HIV programmes – especially with regards to information retention – are outlined by Vaughan et al. (2000) and Bleakley (2005), who argued that stories contribute to creating a more relaxed atmosphere which brings the worlds of

healthcare professionals and patients' closer. Moreover, stories may facilitate an understanding of complex information (e.g. Clark & van Der Wege, 2015; Dahlstrom, 2014). These positive effects of the story on the women's understanding and imagination (Clark & van Der Wege, 2015) were also confirmed in some of the interviews we conducted with the women after the counselling sessions. For example, one of the women specifically commented that although she already knew a lot of what had been discussed before attending the counselling, she also learned something new – including 'how male circumcision reduces HIV infections, that I did not know'. Testimonies like this provide further evidence of the positive effects of using anecdotes to translate abstract knowledge into more concrete and relatable experiences.

4. Implications for healthcare practitioners

Applied linguistic research, like the one presented here and in the other chapters in this volume, provides important insights into our understanding of the actual practices in which participants engage in healthcare encounters. By identifying and critically discussing actual practice, this kind of research constitutes a central element of improving patient-centred medicine – particularly in illustrating how a set of linguistic resources can be used to enhance meaning (Sarangi, 2004) and increase client participation. Taking an interactional sociolinguistic approach enables researchers to identify and describe the specific discursive strategies that are found to be effective in a particular context, and to show evidence of this to healthcare practitioners – for example by providing and discussing transcripts of authentic interactions, as in this chapter.

Findings from such studies are of interest not only to those practitioners who work in similar socio-cultural and medical contexts but also more generally to anyone practising medicine involving regular interactions with clients. Gaining a better understanding of the

communicative practices that characterise this professional domain is important and has wide-ranging implications. It could even be argued that just like there is a need for evidence-based medicine for medical practice, there is also a clear need for evidence-based communication in healthcare settings (Brown, Crawford and Carter, 2006).

Our study, although it has focused on examples of good practice recorded in just one hospital in Malawi, provides such evidence by identifying and discussing some of the discursive strategies which assist the healthcare providers in achieving the aims of HIV/AIDS counselling sessions. The comparatively low drop-out rates at the hospital where we collected data seem to suggest that the healthcare providers' interactional behaviours indeed constitute good practice, and could thus be used as evidence to support ongoing endeavours to improve the delivery and format of HIV/AIDS consultations in Malawi and other socio-cultural contexts. After all, involving clients in knowledge (re)production and sharing (e.g. via questions) (Tannen & Wallat, 2006) and making complex information more understandable and memorable for them (e.g. via drawing on context-specific metaphors and stories) are beneficial in healthcare encounters more generally (Gülich,2003; Vaughan et al, 2000).

This study and its approach are thus relevant to practitioners' training and practice in HIV/AIDS consultations and other healthcare specialities elsewhere. As Silverman (1997) argues, the analysis of transcripts of authentic interactions between counsellors and their clients, such as the ones used here, can make important contributions to professional training as they provide evidence of what is actually going on during these interactions, and how for example knowledge is shared and advice is collaboratively constructed in actual practice (see also Chimbwete-Phiri, forthcoming). The kind of evidence provided here – actual transcripts, as opposed to simulations, for example – is often more useful for practitioners than a simple presentation of theoretical normative standards of good practice (Silverman, 1997). Such

linguistic analyses – especially when supported by interactional sociolinguistics – are useful resources for a critical 'reflection' of current practice (Sarangi, 2004:8); valuable for trainee practitioners in highlighting successful clinical encounters. Moreover, they raise awareness of linguistic choices for practitioners; and provide a basis for assessing professional practice (Sarangi, 2010) and its impact on client understanding and compliance in counselling. We hope that more applied linguistic research will continue such work – in particular by directing future research endeavours more towards largely overlooked geographical areas and discursive practices in languages other than English, as was done in this study.

5. Conclusion

The aim of this chapter was to discuss some of the ways in which applied linguistic research, specifically interactional sociolinguistics, can make valuable contributions to ongoing endeavours to improve the delivery and format of HIV/AIDS consultations in Malawi. We have argued that by improving the communication between healthcare professionals and clients during HIV/AIDS consultations, clients' participation may be facilitated and their understanding can be enhanced, which in turn may positively affect their compliance and adherence to the programme's recommendations. Our analyses of HIV/AIDS consultations for pregnant women in a local hospital in Malawi have focused on three specific discursive strategies regularly displayed by the healthcare providers, namely asking questions, referring to local knowledge and customs, and telling stories. These constitute good practice in terms of encouraging client participation in the consultations of our context and have been described as beneficial for medical interactions in previous research, in particular for counselling and other interview-format type interactions (e.g. Peräkylä & Silverman 1992; Silvermann 1997; Tannen & Wallat, 2006; Candlin, 2006). Like in these previous studies, in the

specific context of HIV/AIDS counselling for pregnant women in Malawi, these strategies facilitated the women's contribution in these consultations – as reflected in their heightened involvement, active participation, and sharing their previous knowledge of HIV/AIDs. They thus directly address the aims of the counselling sessions, namely to enhance the pregnant women's understanding of HIV/AIDS, share the benefits of HIV testing, and facilitate informed decision making. Such a focus on good practice and using an interactional sociolinguistic approach – as we have done in this chapter – is thus an important part of general attempts to better understand and improve current practices in healthcare contexts.

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Appendix: 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

(^^^^^) inaudible talk

? Rising intonation for a question

↑ Rising intonation

↓ Falling intonation

. Stopping intonation

, Flat or continuing intonation

'….' Speaker's quoted talk

[Beginning of overlapping talk

[End of overlapping talk

°word° Sounds that are softly uttered than the surrounding talk

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

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

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

- Cut-off or unfinished words

= Latching talk

_____ Emphasis

… Omission of talk in the segment

Heh/ hah Laughter

hh Outbreath during speech denotes laughter

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