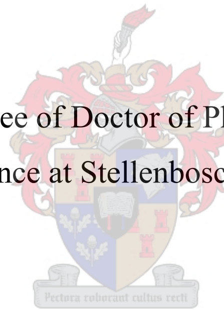
# Communicating taboo topics in gynaecological consultations in Malawi:

# A Sociolinguistic study on effective strategies used in a conservative culture

by

Marion Chirwa Kajombo

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April 2022

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# Declaration

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# Dedication

I dedicate this study to my brother Dennis Dornasio Panji Chirwa who was murdered while pursuing of an academic qualification in a foreign country.

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# Acknowledgements

I would like to express my sincere gratitude to individuals and institutions in South Africa and Malawi for the different roles they played, which have allowed me to conduct this study successfully. My supervisors, Lauren Mongie and Frenette Southwood, for their insights, constructive criticism, dedication and for providing me with opportunities to showcase my study at an international seminar and through a chapter publication. They both believed in my dream of becoming the 1st PhD holder in my clan and they cared about my welfare and that of my kids.

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# Abstract

The clinical gaze, which is the combination of doctor expertise and information obtained from and on the patient, is the basis of diagnosis and prognosis (Foucault 1975). As such, open doctor-patient communication becomes a prerequisite for successful medical consultations. However, in a generally conservative Malawian cultural context, gynaecological topics are considered taboo, especially when discussed across genders. Despite the conflict between biomedical requirements of openness and sociocultural requirements of silence about gynaecology-related topics, consultations with male gynaecologists, who outnumber female gynaecologists in Malawi, are conducted. However, the nature of communication in these consultations was not known. This study therefore investigated the nature of gender-discordant communication about topics related to sex, women's bodies, reproduction, and infertility in Malawian gynaecological consultations.

This qualitative study is embedded in a sociolinguistic theoretical framework, making use of Situated Discourse Analysis (Gee 2011), Interactional Sociolinguistics (Gumperz 1982, 2015), and X-phemism Theory (Allan & Burridge 2006) to study Chichewa-dominant interactions between male gynaecologists and their patients in a public hospital in Blantyre. The study hospital is a district and referral hospital treating emergency cases referred by other, smaller healthcare facilities.

There were two participant groups (all Chichewa-speaking Malawians), namely four gynaecologists practicing at the study hospital, and 12 women who had consulted a gynaecologist at least once in the 12 months prior to data collection. Individual interviews were conducted with the patient participants. They were asked questions about their communication experiences in gynaecological consultations (such as, which terms they found appropriate, whether and, if so, how culture influenced their communication, what discourse strategies they have experienced gynaecologists using), using an audio-recording they had listened to at the beginning of the interview as prompt. This scripted audio-recording was of a simulated gynaecological consultation in Chichewa. The gynaecologists were also interviewed individually, amongst others on discourse strategies used and the influence of culture on Malawian gynaecological practice. Eight simulated gynaecological consultations also took place, with eight patient participants each consulted one participating gynaecologist on a medical condition of her choice. (Each gynaecologist was therefore involved in two simulated consultations.) The interviews and simulated consultations were audio-recorded, transcribed

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and analysed thematically; by means of Interactional Sociolinguistic methods (Gumperz 1982, 2015) and Situated Discourse Analysis (Gee 2011). Further, taboo referring expressions were analysed using the X-phemism Theory (Allan & Burridge 2006).

From the perspectives of former patients and practicing gynaecologists drawn from the interviews and simulated consultations, it was found that: (i) communicating about culturally taboo topics was indeed a challenge, which (ii) could be overcome by establishing relationship boundaries and identities of interlocutors and by using negative politeness strategies; (iii) sociocultural principles were involved in acceptability judgements on Chichewa terms used to refer to sex-related matters; and (iv) the current practice in gynaecological consultations was deemed successful but could improve. In short, this study found that despite cultural restrictions on discussing topics such as sexual health and reproduction, sociolinguistic strategies are used to achieve the goals of gynaecological consultations in the culturally conservative Malawian context.

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# Opsomming

Die kliniese blik, wat die kombinasie is van doktersdeskundigheid en inligting wat vanaf en op die pasiënt verkry is, vorm die basis van diagnose en prognose (Foucault 1975). Daarom is oop dokter-pasiënt-kommunikasie 'n voorvereiste vir suksesvolle mediese konsultasies. In die meestal konserwatiewe Malawiese kultuur word ginekologiese onderwerpe egter as taboe beskou, veral as dit met persone van die teenoorgestelde geslag bespreek word. Ondanks die botsing tussen biomediese vereistes van openheid en sosio-kulturele vereistes van stilte oor ginekologieverwante onderwerpe, vind daar inderdaad in Malawi konsultasies met manlike ginekoloë, waarvan daar meer as vroulike ginekoloë in Malawi is, plaas. Die aard van kommunikasie in hierdie konsultasies was egter nie bekend nie. Hierdie studie ondersoek die aard van geslagsdiskordante kommunikasie oor onderwerpe wat verband hou met seks, vroueliggame, voortplanting en onvrugbaarheid in Malawiese ginekologiese konsultasies.

Hierdie kwalitatiewe studie is ingebed in 'n sosiolinguistiese teoretiese raamwerk, en maak gebruik van Interaksionele Sosiolinguistiek (Gumperz 1982, 2015), Gesitueerde Diskoeranalise (Gee 2011) en X-femisme-teorie (Allan & Burridge 2006) om Chichewa-dominante interaksies tussen manlike ginekoloë en hul pasiënte in 'n openbare hospitaal in Blantyre te bestudeer. Die studiehospitaal is 'n distriks- en verwysingshospitaal wat noodgevalle behandel wat daarheen deur ander, kleiner gesondheidsorgfasiliteite verwys word.

Daar was twee deelnemersgroepe (almal Chichewa-sprekende Malawiërs): vier ginekoloë wat in die studiehospitaal praktiseer, en 12 vroue wat minstens een keer in die 12 maande vóór data-insameling 'n ginekoloog geraadpleeg het. Individuele onderhoude is met die pasiëntdeelnemers gevoer waartydens vrae gevra oor hulle ervarings met kommunikasie in ginekologiese kontekste (bv. watter terme hulle gepas vind; of en, indien wel, hoe kultuur hul kommunikasie beïnvloed; watter diskoersstrategieë hulle ginekoloë gebruik het), aan die hand van ‘n oudio-opname waarna hulle aan die begin van die onderhoud geluister het. Hierdie oudio-opname was van 'n gesimuleerde ginekoloog konsultasie in Chichewa. Die ginekoloë is ook individueel ondervra, onder meer oor die gebruik van diskoersstrategieë en die invloed van kultuur op die Malawiese ginekologiese praktyk. Agt gesimuleerde ginekologiese konsultasies het ook plaasgevind: Agt pasiëntdeelnemers het elk een ginekoloogdeelnemer geraadpleeg oor 'n mediese toestand van haar keuse. (Elke ginekoloog was dus by twee gesimuleerde konsultasies betrokke.) Die onderhoude en gesimuleerde konsultasies is opgeneem (met slegs klank) en getranskribeer en is tematies ontleed; deur middel van Interaksionele

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Sosiolinguistiese metodes (Gumperz 1982, 2015) en Gesitueerde Diskoersanalise (Gee 2011). Taboe verwysende uitdrukkings is geanaliseer deur van X-femisme-teorie (Allan & Burridge 2006) gebruik te maak.

Uit die perspektiewe van voormalige pasiënte en praktiserende ginekoloë in die onderhoude en gesimuleerde konsultasies is gevind dat: (i) kommunikasie oor kultureeltaboe-onderwerpe inderdaad 'n uitdaging is, wat (ii) oorkom kan word deur die daarstelling van verhoudingsgrense en identiteite van gespreksgenote asook deur negatiewebeleefdheidstrategieë te gebruik; (iii) sosiokulturele beginsels betrokke is by aanvaarbaarheidsoordele oor Chichewa terme vir seksverwante sake; en (iv) die huidige praktyk in ginekologiese konsultasies as suksesvol beskou word, maar kan verbeter. Kortom het hierdie studie bevind dat ondanks kulturele beperkings op die bespreking van onderwerpe soos seksuele gesondheid en geslagsvoortplanting, sosiolinguistiese strategieë suksesvol gebruik word om die doelwitte van ginekologiese konsultasies in kultureel konserwatiewe Malawi te bereik.

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# Chapter 1 : Introduction

## 1.1 General introduction

This is a sociolinguistic study that investigates how communication about culturally taboo topics takes place between patients and male gynaecologists in medical consultations in a Malawian public health setting. Given the general conservatism of Malawians (see Section 1.7.2), a gynaecological consultation may create the juxtaposition of taboo and secrecy with medical consultation requirements of openness and clarity. This results in a situation that Iedema, Rhodes and Scheeres (2005:331) call "interaction volatility", which requires interlocutors' competence to appropriately navigate taboo topics while achieving the intended consultation goals. The possible occurrence of interaction volatility necessitated the study of situated discourse strategies and semantic resources that are used to discuss taboo topics in gynaecological consultations in a hospital in Blantyre where Chichewa is the main language of communication.

## 1.2 Rationale for the study

It is widely acknowledged that effective communication is necessary for successful medical care (Berry, 2007: 3; Blasi, Harkness, Ernst, Georgiou & Kleijnen, 2001; Macdonald, 2004b: 1). However, several aspects of the situational context of medical consultations can jeopardise open and clear communication, including the power imbalances (Pilnick & Dingwall 2011); the cultural silence that surrounds certain medical conditions (Ussher, Perz, Metusela, Hawkey, Morrow, Narchal & Estoesta 2017:1907ff); and stigmatised and stigmatising health conditions such as mental illnesses and sexually transmitted diseases (STD) (Leigh & Reiser 1980:18). Furthermore, in most cultures, women's sexual embodiment is socially constructed as shameful, which leads to secrecy and silence about it (Ussher *et al.* 2017:1908). Allan and Burridge (2006:7) argue that although mentioning genitals is taboo in many societies, it is typically regarded as more taboo to mention female genitals than male genitals (see discussion in 2.7.1.1). Since some topics of gynaecological consultations relate directly to women's sexual embodiment, it can be argued that discussing them may be construed as taboo on three fronts: they may be about stigmatised ailments, they may involve genitals, and they may portray the woman as a sexual being.

According to Chinyanganya (2013:1072), African people generally discuss sex and sexuality with a lot of discomfort and embarrassment and may use of euphemism among other strategies in order to mitigate this discomfort. Euphemistic expressions for sexual topics is also common

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in Malawian initiation ceremonies (Banda & Kunkeyani 2015:3). However, employing euphemism in medical settings has been found to have a negative effect on communication in HIV/AIDS-related medical consultations in South Africa (Anthonissen & Meyer 2008:31) and in Zimbabwe (Chinyanganya 2013; also see 2.7). Thus, effective communication in Chichewa-language gynaecological consultations would require incorporation of sociocultural strategies. Such strategies are neither necessarily obvious nor constituents of formal gynecologist training in Malawi.

## 1.3 Problem statement

In Malawi, matters concerning women's health and sexuality are associated with shame and secrecy, hence their discussion is taboo (see discussion in 1.6.2). In a gynaecological consultation, discussing cultural taboo topics such as sex, genitals and reproduction are unavoidable. In Malawian referral hospitals, gynaecological consultations are likely to be with a male gynaecologist[1] (see discussion in 1.6.3), which may make it more culturally constraining to discuss these taboo topics. These conditions cause a gynaecological consultation to be interactionally volatile, requiring strategic negotiation between open communication as per medical consultation requirements and the restrictions of cultural taboo on matters concerning women's health and sexuality. Since such strategies in language use would incorporate social-contextual aspects, they become a topic of sociolinguistic study. However, a review of the available literature shows that very little is known about the sociolinguistic nature of the consultations with male gynaecologists and the strategies with which taboo topics are navigated in the Malawian setting.

## 1.4 Purpose of the study

The research study was conducted with the aim of finding out how male gynaecologists and patients interact in gynaecological consultations in Malawi, where the topics of discussion are taboo, especially across genders. To achieve this aim, the study's main research question is the following: What are the sociolinguistic strategies used in interactions between male gynaecologists and their female patients in a medical consultation in Malawi when the topics of discussion are taboo in cross-gender interactions? The following subquestions contribute to answering the main question:

i. How do Malawian gynaecologists and their patients articulate their communication experiences in gynaecological consultations?

[1] In this study, gynaecologists and/or obstetricians are referred to as "gynaecologists".

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ii. Which linguistic strategies are used by male gynaecologists and their patients to navigate taboo topics during consultation?

iii. How do male gynaecologists and patients account for their choice of sociolinguistic strategies?

iv. According to gynaecologists and patients, to what extent does the current social practice meet their communicative needs during consultation?

## 1.5 Possible contribution of the study

This study contributes to the body of sociolinguistic knowledge on strategies used in interactionally volatile settings, by exploring how taboo topics are discussed in a setting where they cannot be avoided. It will also add to the medical and health humanities literature on the process of rendering effective medical care by revealing current linguistic practices in gynaecological consultations and their perceived effectiveness. Thus, the findings can inform communication training for medical personnel and can be used for orienting foreign medical personnel (or those unfamiliar with local culture) in Malawi and in similar settings elsewhere. In brief, the study was conducted to create sociolinguistic knowledge which would make a positive contribution towards maternal and infant healthcare in Malawi.

## 1.6 Background information on language, culture, and health in Malawi

### 1.6.1 Linguistic setting

Like most African countries, Malawi is linguistically heterogenous, with a former colonial language, English, as the official language.[2] English is spoken by the educated elite mainly living in urban areas, viz. 0.3% of the population (Lora-Kayambazinthu 2003:147). Malawi has fifteen distinct languages, each with its own varieties (Lora-Kayambazinthu 2003:148). These languages are the mother tongues[3] of Malawians. In 1968, four years after Malawi gained independence from Britain, Chichewa became the national language,[4] and alongside English, an official language (Downing & Mtenje 2017:1). Chichewa is a variety of Chinyanja, which is spoken in Malawi's neighbouring countries Zambia and Mozambique, but Chichewa developed distinctively from the other varieties of Chinyanja because of deliberate language planning introduced after independence, which entailed, amongst others, the establishment of

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[2] The formal language for government administration, legislature, education and media (see Lora-Kayambazinthu 2003:148).

[3] For the purposes of this dissertation, a mother tongue is seen as a language that coincides with one's ethnic group.

[4] In this context, a national language is an indigenous lingua franca used for mass dissemination of information.

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the Chichewa Board, the introduction of Chichewa as a subject and a language of teaching from primary to secondary school, and the establishment of a degree in Chichewa at the then only university in the country, the University of Malawi. In addition, Chichewa lessons were aired on what was then the country's only radio station, in a program called *Tiphunzitsane Chichewa* 'Let's teach each other Chichewa'. The choice of Chichewa as a national language was politically motivated as the first president was Chewa by tribe. However, it has also been argued that more Malawians at that time spoke Chichewa than any other language (Downing & Mtenje 2017:1).

The policy of having Chichewa as the only national language was in use for 26 years, until 1994 when a democratic government was established, but the impact of the one-national-language policy is still evident as there is a generation consisting of mostly urban Malawians whose home language[5] is Chichewa (Lora-Kayambazinthu 2003:149, 150), despite their mother tongues not necessarily being Chichewa. The 1998 census showed that 57% of the population spoke Chichewa at household level. Although Chiyao and Chitumbuka are currently also designated national languages (Downing & Mtenje 2017:1), Chichewa is a national lingua franca as a result of its history, whereas Chiyao and Chitumbuka can be considered as "regional lingua francas". In fact, Lora-Kayambazinthu (2003:148) classifies Chiyao and Chitumbuka as minority languages, just like the other 12 remaining languages.

This this study was conducted in area in which the main spoken language is Chichewa

### 1.6.2 Cultural setting

#### 1.6.2.1 Defining "Malawian culture"

Malawi is an ethnically diverse society, with cultural groups being either matrilineal or patrilineal. Although the urban population constitutes people with different cultural and/or ethnic backgrounds, the shared spaces, experiences, and laws have enabled Malawians to develop a culture that can be described beyond existing ethnic groupings. In this dissertation, the term "Malawian culture" refers to a way of "doing life" in a manner that is unique to and common amongst Malawians – not only in terms of dress, food, and rituals (such as funerals and weddings) but also in terms of communication, attitudes, beliefs, and expectations. Furthermore, this dissertation refers to the group of Malawians practicing this culture as the "Malawian society". I acknowledge, however, that sharing a culture or ethnicity does not mean

[5] "Home language" here refers to the language for communicating with family and friends, especially in informal settings.

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individuals act alike, as individual and/or socialisation traits also may play a role in communication processes (see Berry 2007:61). Thus, the Malawian culture described in this dissertation is a generalised and common form of culture of people living in Malawi, rather than specific ethnic or individualised traits and practices acquired through personal experiences.

In the Malawian context, gender is binary and it coincides with one's sex. This is the definition of gender that is used in this dissertation, because it reflects the Malawian understanding of gender and gender relations (see power relations in Blantyre Malawi in Riley & Dodson, 2015). Malawian society can be described as conservative. Sometimes this is attributed to the 31 years of dictatorship (Mtenje 2018:216–219), but Munthali (2017) argues that in rural areas, the disciplinarian culture under the guardianship of chiefs has made Malawians fear the unknown. Both urban and rural populations in Malawi were exposed to what Tamale (2011:16) describes as one of the two worst dictatorial laws on dress codes in Africa, calling it "a new script, steeped in the Victorian moralistic, anti-sexual, body-shame edicts [on women's bodies]" (see Lwanda's (2003:114) for a description of Banda's moralistic speeches). The observance of the law because of fear also applies to cultural norms regarding public discussions of bodies, reproductive health, and HIV/AIDS. The conservative approach to public discourse was formalised in 1968, four years after independence, by establishing a Censorship Board under the Department of Culture, enacted through the Censorship and Control of Entertainment Act, Chapter 21. An example of the control that this board exercises over public reference to women's bodies is the 2017 arrest of a Malawian woman, who was incarcerated for carrying a placard that read, "*Kubadwa ndi nyini sitchimo* - My pussy, my pride!!" 'It is not a sin to be born with a vagina - My pussy, my pride!!' in a march against gender-based violence Mzungu (2017). A similar incident occurred when the Chishango company released a new type of condom and used a picture on its packaging and on billboards showing a woman with a bare tummy and a bare upper thigh (see Swanson, 2002). Religious and women's rights groups protested against the picture used, to a point that the product was re-branded and the photo of the woman was replaced by a shield. (*Shield* translates as *"chishango"*, the company name, in Chichewa). Although the Chichewa term *kondomu* is used to refer to a condom, any brand of condom is also called *chishango*, making *chishango Chishango* synonymous with *kondomu*.

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#### 1.6.2.2 Discussing taboo topics in the Malawian context

In this conservative cultural context, it is considered taboo to discuss women's health issues in public. Random samples of text from exclusive women's secret groups on Facebook[6] also show that women do not refer to sex and related matters explicitly, even when they post anonymously through the all-female group's administrators. It is even more taboo to discuss women's sexual health in the presence of men. In fact, in most hospitals, it is unheard of for a man to be present in the delivery room to witness the birth of his child (Arnio, Chipeta & Kulmala 2013; Kululanga, Sundby, Chirwa, Malata 2012). Indeed, the layout of delivery rooms in public hospitals prohibits the presence of men (apart from the medical personnel): Delivery rooms accommodate more than one patient at a time, meaning that fathers would not be welcome as there would be no privacy for the other patients. This physical arrangement reflects a culture that prohibits men from participating in women's health issues.

The following sections explain my experiences as a Malawian woman who was born into and raised in the culture. The discussions draw from my own knowledge and experience, and those of my friends and family members, of matters that relate to gynaecology. I acknowledge that my interpretation of aspects of Malawian culture may be subjective, but I rely on my knowledge and experience and on those of family and friends because publications on these topics are hardly available; where there has been a publication on the topic, it is cited. The discussion starts with referring expression for private parts and sex, which is followed by pregnancy and infertility, menstruation and cultural rites for children, as points of entry into understanding Malawian culture.

Growing up in Malawi, one rarely hears orthophemistic and dysphemistic terms (defined in 3.4) for body parts and some bodily functions related to sexual health, as verbalising them is taboo. The only exception would be when someone is swearing in a verbal fight or for fun (for instance, intoxicated people or students riding in university buses and/or cheering on their sports teams, where they can hide within the crowd). This made it hard for me to do a spontaneous translation from English to Chichewa as my knowledge of the orthophemistic or dysphemistic terms in Chichewa is limited. Hence an English-Chichewa dictionary was consulted regularly. Translating the Chichewa to English was interesting as I had often not encountered euphemistic expressions such as the following before: *kumaso* 'the face' or *uku*

[6] I was a member of some of these groups before initiating this study, but others I joined during the course of the study. In all instances, I obtained permission from the administrators to include in my dissertation terms related to sex, reproduction and women's health used on the Facebook page.

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'there' for genitals, *mbuyo* 'the behind' for the buttocks, *kugwa mdothi* 'falling into the soil' for menarchy, *kukhala kumwezi* 'staying at the moon' *or kusamba* 'bathing' for menstruating, *mphamvu ya abambo* 'a man's power' for sperm, *umuna* 'manly' for semen, *chikazi* '(that) of females' for vaginal discharge, and, on social media, *ndata*[7] and *gadafi*[8] for female and male genitals,[9] respectively; and, more recently, *kukazinga tchipisi* 'frying chips'[10] for sexual intercourse.

As a result of talking about sexuality in explicit ways being taboo in Malawian society, it is also taboo for parents to provide details about reproduction to their children. Children are often told either that babies are purchased from the hospital, or that they are a gift from God.[11] Children of all ages are expected not to discuss someone's pregnancy. This is related to the fact that not all pregnancies end in delivery; miscarriages and still-births occur frequently. Indeed, among Malawians, there is often a fear that one can mysteriously lose a pregnancy, which is understandable given the high infant and maternal mortality rates in the country (see 1.7.3) and in Africa in general. Because of this fear, superstitious belief is rampant, hence a pregnant woman is not expected to announce her pregnancy or the gestation age; have a baby shower before the baby is born; buy too many baby items such as clothes before the baby arrives; let other people touch her pregnant belly (with the exception of her husband); or name the baby before it is born.

[7] *Ndata* is the name of the name of the place where a mausoleum was built for the former first lady by her husband; they were both laid to rest in it. The former president called it the *Mpumulo wa bata* 'a place for resting in peace'. It is possibly for this reason that the vagina is called *ndata*, to insinuate that it is a resting place for a man.
[8] A penis is called *gadafi* because a penis can be "found hiding in a tunnel" (i.e., in the vagina) the same way the former Libyan leader, Gadhafi, was found hiding in a tunnel when he was captured.
[9] There could be other explanations, but these are the ones I have come across.
[10] *Kukazinga chips* 'frying chips' appear to be a random reference, one of which the origin could not be traced.
[11] I grew up being told and believing the "bought from the hospital" version until I was about 9 years old and heard from my friends that babies were made by parents, which I thought was disgusting and embarrassing. I have told my oldest daughter a version of the "gift from God" story, namely that God takes parts from mommy and adds them to parts from the daddy to build a baby in the mommy's' tummy. Her query on how the baby comes out of the mommy's tummy caught me off guard; and I told her I did not know because the doctor had put me under anaesthetics when she and her siblings were born. It is only now that she is 9 years old that I have told her about caesarean sections and showed her the incision marks for her younger sibling's births. She still does not know that I gave birth to her naturally. I have opted for a somewhat expanded "gift from God" version so that people do not lie to her and so that she does not feel disgusted when she hears that it requires parts of both men and women to make a baby. I am an educated woman, the daughter of a female HIV/AIDS counsellor who, for a Malawian woman, is uncharacteristically candid about sex, reproduction and sexual health, yet I am influenced by cultural norms and expectations and feel inept when discussing sex and reproduction with my children. This appears to be a common experience amongst Malawian woman.

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In addition to the taboo topics discussed above, the topic of puberty and the bodily changes that occur during puberty (including menstruation) [12] are rarely discussed before a child reaches puberty. In fact, it is a taboo for parents to discuss sex and sexual matters with their children (Chirwa 2009). Therefore, parents often leave the responsibility of advising their children on such matters to others. In most settings, especially in the central and southern parts of Malawi, initiation ceremonies are common when reaching puberty and again when getting married. In urban areas, religious congregations now take responsibility for these initiation ceremonies, replacing traditions such as *fisi* 'hyena'. "Hyenas" are elderly men organised by the village chief to have sex with initiates (young girls who have or are about to reach puberty) or widows as both these groups of women are considered unclean and in need of cleansing. This state of being unclean is also reflected in the Chichewa euphemistic term for menarche, *kusamba* 'to take a bath'. Until recently, there were no subjects in formal education addressing these taboo topics. However, Life Skills was introduced in 2002 as a primary school subject in an attempt to curb the rapid spread of HIV in Malawi (Chirwa 2009). According to Chirwa (2009), problems with the teaching of this subject in Zomba (Chirwa's study district) included the cultural prohibition of talking to children about sensitive topics. Malawians generally believe that by not talking explicitly about sex and sexual health to their children,[13] they protect their children. They fear that exposure to such topics will make children want to experiment with sex. This section gave background information on how Malawians may understand and (not) discuss taboo topics related to sex and reproduction. In the following section, the Malawian medical setting is discussed.

### 1.6.3 The medical setting in Malawi

The Ministry of Health and Population is the overseer of health care in Malawi. There are three types of health care service providers, namely: public, private for-profit, and private not-for-profit (Makwero 2018:1). Services offered at private clinics/hospitals vary from primary to

[12] Growing up, I did not understand what menstruation was. The first time I heard about it was when I eavesdropped on my mother's discussion with her friends about one of their daughter's menarche, but I was confused, thinking that one only menstruates when one gets a boyfriend (like the friend's daughter) and has sex. By this time, I had learnt from friends where babies come from but not the details thereof. And the women had talked about boyfriends too, so my eavesdropping lead me to arrive at this conclusion: boys plus sex equal menarche. The women called it *kukula* 'to grow up' (=menarche), while *kusamba* 'to take a bath' means "to menstruate". My friends were no better informed than I was.

[13] My mother, who has been an HIV/AIDS counsellor for many years, freely talks about sex and sexuality, STDs and other matters pertaining to reproduction to her adult children now, but she only started doing so when we were in our 20s. I am not sure whether her frankness is because of our ages or because she has now been working in this field for a long time, but I suspect the latter.

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specialised care depending on their financial and infrastructure capacity of the facility. The public health sector has three tiers: In the primary tier, there are health centres with constituent and village clinics, as well as dispensaries (Makwero 2018:2). Health centres offer out-patient and maternity services within an area of a district, and in urban areas they may serve a population of 237,000 (Makwero 2018:2). Despite district hospitals (in the second tier) being referral hospitals within districts, poor gatekeeping at primary level leads to congested district hospitals (Makwero 2018:2). There are 26 district hospitals in Malawi, whose staff members at every hospital include either one or two doctors as well as 10 to 20 clinical officers[14] and medical assistants, who are all assisted by nurses, serving a population of 140 000 to 1 400 000 per hospital (Makwero 2018:2). The tertiary tier has four central hospitals across the country, and they are referral hospitals for the district hospitals found in their respective regions. Central hospitals provide specialised health services, and they also act as district hospitals within the districts in which they are situated. Specialised care, like gynaecology, are offered in central hospitals and private clinics. The hospital where this study was conducted is a central hospital which does not only operate as district hospital but also as referral hospital for the surrounding districts.

#### 1.6.3.1 Gynaecology

Formal maternal health services in Malawi are provided by midwives, clinical officers, general practitioners, and gynaecologists (Thorsen, Meguid, Sundby & Malata 2014:2) depending on the tier the hospital falls into. In 2006, Malawi's fertility rate was 6.3 children per woman while the infant mortality rate was 69 per 1000 live births (NSO 2006). Malawi has had a high maternal death rate at 1:7 (Arnio *et al.*, 2013), and its maternal mortality rate of 574 death per 100 000 maternity cases is among the highest in the world (USAID 2019). These high rates may be attributed to poor management of maternal healthcare (Combs Thorsen *et al.* 2014; Combs Thorsen, Sundby & Malata 2012).

With the help of nurses, midwives provide gynaecological services at primary health centres, whereas these services may be provided by nurses, midwives, clinicians, and doctors at district hospitals. Complicated cases are referred to gynaecologists at central hospitals. It is also possible for women to pay for specialised care, for non-complicated medical conditions, at central hospitals. When seeking specialised medical care in central hospitals or private clinics,

[14] Clinical officers have fewer years of medical training than doctors and are meant to work alongside doctors, assisting them. However, in most cases, clinical officers would "run" a hospital as a doctor, due to the scarcity of doctors. Clinical officers can make diagnoses and prescribe medication.

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women are likely to find themselves in a male gynaecologist's consultation room: From 1992 to 2002, 80% of graduates from the College of Medicine, the only doctor training institution in Malawi, were male (Muula, Nyasulu & Msiska 2004:637).

#### 1.6.3.2 HIV/AIDS, sex campaigns and contraception

My earliest memory of hearing about HIV/AIDS is the following jingle on one radio station: *Amayi mukhale panyumba, abambo mukhale panyumba, kwabwera matenda owopsa EDZI. EDZI, matenda alibe mankhwala EDZI, EDZI* 'Women stay at home, men stay at home. There is a dangerous disease, AIDS. AIDS is a disease without a cure, AIDS, AIDS'. Later, some radio advertisements carried the message that using a condom can prevent the contraction of HIV. Condoms were referred to as *mpira wa abambo* 'men's ball', probably suggesting it is what a man can 'play with' (=use) for protective sex. Eventually, the ABC's (Abstain, Be faithful, Condomize) were discussed on youth programs of the radio station and in *Edzi Toto* (Anti-AIDS) clubs in secondary schools, and the word *kondomu* 'condom' was mentioned often. At the Anti-AIDS clubs, they would demonstrate how condoms protect against STDs, but never distributed them, while university anti-AIDS clubs distributed condoms and still do. The term *mpira wa abambo* 'men's ball' is now rarely used. More often, people use the name of one brand of condoms, *Chishango* 'shield' referred to above, for any brand of condom. Apart from condoms, other contraceptive methods are also available in family planning clinics and public and private hospitals. Over-the-counter methods in pharmacies are limited to condoms, contraceptive pills, and the morning-after pill. The male condom, however, is the most publicised method of contraception.[15]

## 1.7 Chapter layout of the dissertation

This dissertation has nine chapters, organised as follows:

Chapter 1 introduced the study by contextualising the research problem and questions, and the aim of the study, and provided contextualising information on Malawian culture.

Chapter 2 discusses relevant literature on which this study is based. In this chapter, the gap in the field of sociolinguistics (and in medical training in communication skills) that the study aims to fill is identified.

[15] I only learnt about most of the alternative methods through internet searches and during gynaecological consultations, when I had to choose a family planning method, six weeks after the birth of my first child. I was married and 29 years old at the time.

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Chapter 3 presents the theoretical framework that informed methods of data collection, analysis and interpretation. The two approaches to Discourse Analysis as well as the X-phemism theory are outlined and selecting them as theoretical framework is justified.

Chapter 4 presents the methodology by discussing how the research participants (both the women patients and the male gynaecologists) were approached and selected, the two data collection instruments used, the how data was analysed and interpreted, and the ethical considerations involved in the study.

Chapters 5 to 8 present and analyse the data and discuss the findings of this study thematically:

Chapter 5 discusses participants' narratives on what is considered taboo topics in Malawi in general and in gynaecological settings in particular, and why these topics are considered taboo. In addition, it discusses participants' explanations of the circumstances that heighten the need to observe taboo-related restrictions. The chapter closes with a discussion on how participants thought taboo topics are successfully communicated in gynaecological settings. This chapter pertains to the research question "How do Malawian gynaecologists and their patients articulate their communication experiences in gynaecological consultations?"

Chapter 6 discusses and explains the choice of referential terms by participants in interviews and simulated gynaecological consultations, in an attempt to answer research questions "Which linguistic strategies are used by male gynaecologists and their patients to navigate taboo topics during consultation?" and "How do male gynaecologists and patients account for their choice of sociolinguistic strategies?".

Chapter 7 discusses discourse strategies employed to introduce, present and sustain taboo talk in simulated gynaecological consultations, again to answer research questions "Which linguistic strategies are used by male gynaecologists and their patients to navigate taboo topics during consultation?" and "How do male gynaecologists and patients account for their choice of sociolinguistic strategies?"

Chapter 8 presents participants' evaluation of the way taboo topics are discussed in gynaecological settings, to answer research question "According to gynaecologists and patients, to which extent do the current social practice meets their communicative needs during consultation?"

Chapter 9 draws conclusions on how taboo is communicated, and its efficiency in meeting communication requirements. It also makes recommendations for the communication training of medical professionals and for further research.

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Having introduced the study and the study setting in this chapter, Chapter 2 presents literature on communication, culture and taboo studied in different societies around the world with close attention to medical settings in conservative cultures.

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# Chapter 2 : Literature review

## 2.1 Introduction

This chapter reviews literature that forms the basis of this study on discussing the communication of taboo topics in gynaecological consultations in a Malawian hospital. It shows the importance of effective communication and the complexity of navigating taboo topics in medical consultations. It also discusses the role that sociolinguistics can play in understanding the discursive dynamics of culturally sensitive medical consultations. The discussion of findings from selected studies aims to indicate the gap in our understanding of the communication of taboo topics in gynaecological settings in a culturally conservative society. The topics discussed are the term “health communication” (2.2); intercultural communication and its presence in medical settings (2.3); the analysis of communication in medical consultations (2.4); the relationship of communication theory to sociolinguistics (2.5); sociolinguistic research in medical consultations (2.6); and sociocultural dynamics and their effect on communication in medical consultation (2.7).

The studies cited in this chapter were conducted in three African countries (South Africa, Zimbabwe and Malawi), Jamaica, The Netherlands, Turkey, and the United States of America (specifically the rural Mid-West). Some of these research contexts (such as those in Zimbabwe, Jamaica, and Turkey) could be said to be similar to those in Malawi in the sense of being relatively conservative. Others are however more liberal and are in developed countries, such as the Netherlands and the United States of America. South Africa could be viewed as intermediate in that some parts of its society might be conservative but South Africa could be said to have more advanced medical care than the other conservative countries selected. However, the common element with the selected settings is that they all contain useful findings regarding communication in healthcare settings, including findings about the experiences of patients and medical personnel, especially gynaecologists. In these studies, data was collected either first-hand through observations and audio and/or video recording of real or simulated medical consultations, or second-hand through self-reports. The discussion begins with describing the role of communication in healthcare settings.

## 2.2 Health communication

According to Griffin (2012:6), communication is “the relational process of creating and interpreting messages that elicit a response”. Communication is central to all aspects of all human relationships, including those formed in healthcare settings (Berry 2007:2-3). The study

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of communication in healthcare settings was established as a subdiscipline in 1975 (Harrington 2015:4). Health communication studies messages that create meaning in relation to a person's physical, mental, and social well-being in varying contexts for a variety of purposes (Harrington, 2015: 9–10). The first publication of case studies in health communication, in the early 1990s, became useful instructional tool for medical trainers, because the case studies allowed students to enhance their theoretical understanding of communication in healthcare settings (Ray 2005:xi). There are as many approaches to studying health communication as there are un-unified theories to communication (see Babrow & Mattson in Thompson, Dorsey, Miller & Parrot 2003). However, these approaches are unified by their emphasis on the usefulness of communication as a tool in medical consultations to help health practitioners to achieve their goals of providing information to the patient, giving them instructions and/or re-assurance, and/or influencing their opinions, attitudes and behaviour (Berry 2007:39).

Effective health communication is also important when communicating about sensitive topics like terminal illnesses, as a patient's understanding helps reduce anxiety even when a solution is not attainable (Simpson, Buckman, Stewart, Maguire, Lipkin, Novack & Till 1991:1385). For instance Audette and Waterman's (2010:360) study found that open communication reduced instances of depression in patients with cancer-related side effects pertaining to their sexual health (specifically gynaecological malignancy).[16] Further, doctors sometimes assume that they have communicated effectively when this was not the case; this can be remedied with proper training in how to use effective communication techniques without compromising the quality of a consultation (Simpson *et al.* 1991:1385). Cordella (2004:1) argues that effective communication occurs when the information is intelligible, and the people involved have a shared understanding of what the most appropriate exchange of information entails. Health communication occurs in various forms, for example through mass information campaigns, on leaflets distributed to patients, on billboards, at clinics during face-to-face consultation or in electronically mediated medical consultations. The following section will show that culture-specific beliefs and attitudes are present in the listed forms of health communication, as culture is inseparable from communication.

## 2.3 Culture in health and communication

As mentioned above, culture is an ever-present component of communication in medical consultations. According to Berry (2007:58), one's health belief system is culturally

[16] Abnormal cell division in the genital tract, which may lead to the development of cancer.

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constructed since culture may influence but not dictate the basis of one's understanding of and reaction towards illness (see 2.7 and for culture and mental health see Kirmayer & Swartz (2014)). For instance, the Western belief system is based on the biomedical model, in which germs are said to cause illnesses, while some Chinese people believe in pain being a result of destiny, and some Africans hold spiritual and magical beliefs about the causes of different health conditions (Berry 2007:58-9). This means that the culture of the patient and doctor may operate alongside the biomedical culture in a consultation. In some cases (for instance in the case of migrant doctors and/or migrant patients), there may be three cultures involved: two from the interlocutors and one from biomedicine. In the Malawian setting under study, there are basically two cultures. The first is that of the interlocutors, which has been loosely defined as "Malawian culture" (see 1.6.2.1), and the other is the biomedical referred to as medical science. In addition to shaping one's beliefs about and the understanding of illness, culture finds its way into a medical consultation through communicative styles and verbal language (Berry 2007:60).

Martin and Nakayama (2010:84-6) argue that the numerous definitions of "culture" can be grouped into three points of view namely: social scientific, interpretive, and critical views. All of these points of view all acknowledge that culture affects communication, but they differ in their explanation of how culture and communication relate to each other. These differences are as follows: For social scientific definitions, culture comprises perceptions that influence communication, while the interpretive point of view is that perceptions influence communication in order to reinforce the original perceptions. The critical point of view combines elements of the initial two approaches and adds another perspective to them, asserting that culture is a group of perceptions that influence communication by either reinforcing or changing the established perception. Although they differ in explaining the relationship between culture and communication, all three show that communication cannot be separated from culture (Martin & Nakayama 2010:84-86). These points of view can be related to the sociocultural tradition approach to communication studies developed by Sapir and Whorf, which looks at communication as a cultural tool which is guided by "the premise that as people talk, they produce and reproduce culture" (Griffin 2012:43), because culture manifests itself in communicative styles and verbal language (Berry 2007:60).

An example of culture determining how one talks in a medical consultation is found in Chinyanganya's (2013) study: Because of the cultural taboos surrounding the topic of sex, Shona-speaking health personnel reported that they either used culture-based strategies

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(including metaphors, euphemism and allusions) or linguistic strategies (such as code switching and slang) when structuring HIV/AIDS messages. Other studies have also shown that cultural knowledge on the part of the doctor is important, especially in a multicultural setting, not only as way of fulfilling the patient's right to healthcare but also because patients feel respected when a doctor show knowledge of their culture (Deumert 2010; Bogataj in Ličen, Karnjuš & Prosen 2019:107-16). One of the reasons that studies on language use in health settings have been become useful when training doctors is because of this interface between language and culture and the important role both play in medical consultations.

Studying intercultural communication through conversational analytical methods recently became useful for structured communication training of medical personnel (see Paternotte, Van Dulmen, Van der Lee, Scherpbier & Scheele 2015). However, Epner and Baile (2012:34) caution that cultural knowledge must not be assumed to apply to all patients as it may result in stereotypes, and hence become counter-productive. This sentiment is echoed in Weijts, Houtkoop and Mullen's (1993) study findings which show that the extent to which patients uphold culture varies from patient to patient. Epner and Baile (2012) and Weijts, Houtkoop *et al.* (1993) therefore argue that the approach to successful intercultural consultations is that the doctor uses patient-centred intercultural communication approaches which respect the beliefs and needs of the particular patients. In this regard, Epner and Baile (2012:35-6) proposed eight principles of patient-centred intercultural communication which would assist in understanding verbal and non-verbal cues from patients. These include the inherent need to be heard and cared for, the acknowledgement that words and touch can heal and harm, the inclusion of the patient's family, the power of non-verbal cues, and the importance of spirituality. It can be argued that patient-centredness may also diffuse the effects of the power asymmetry that typically characterises communication in healthcare settings. Since power is skewed towards the doctor (see 2.7.3), the use of the patient-centred model of interaction can diffuse this power asymmetry because the doctor acts as a facilitator of the process which allows the patient to speak openly and ask questions (Stewart 1984:167).

The responsibility for having a successful consultation rests more on the doctor than the patient (see 2.7). In addition, apart from training, proper application of intercultural communication skills also requires experience on the part of the doctor (Gibson & Zhong 2005:630) in ways of accommodating the patient when conducting consultations. Such experience would have to include general cultural knowledge and knowledge of a variety of possible patient personalities since the flow of information is a negotiated effort of both the patient and the doctor for

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progress to be achieved (Epner & Baile 2012:38). For instance, Gibson and Zhong (2005:629) found that in health settings, successful intercultural communication was mainly a result of doctor's empathy. Ulrey and Amason (2001:454–455) operationalised "cultural sensitivity" as the use of the patient's native language and the demonstration of knowledge and recognition of the patient's cultural values when assessing and treating the patient. In addition, they found that effective intercultural communication in consultations relate positively with the doctor's cultural sensitivity and negatively with the doctor's anxiety levels (Ulrey & Amason 2001:458): The more cultural sensitivity is observed in the doctor, the more effective is the communication. In contrast, the more anxious the doctor was, the less effective the cultural communication was. Thus, a further finding was that doctors' cultural sensitivity correlated negatively with their levels of anxiety. These results indicate that intercultural communication skills in consultations are required if the doctor is to effectively communicate medical matters to the patient. Following the discussion in this section, it can be argued that patient-centred intercultural communication is about cultural appropriateness as defined by the patient. The next section discusses communication in one-on-one encounters with patients.

## 2.4 Communication in medical consultations

### 2.4.1 The significance of communication in medical consultations

Since the French Revolution in the 18th Century, what is called "the clinical gaze" has been the basis of diagnosis in medical consultations (Foucault 1975). Before the Revolution, a doctor obtained information on a patient's condition by listening to the information presented, voluntarily and/or upon request, by the patient. With the Revolution came a new tradition, that of seeking evidence in/on the body of the patient, in addition to listening to the patient. The information from these two sources of enquiry is synthesised using the doctor's knowledge and experience before making a diagnosis. Thus, the consultation process starts with the information gathered from the patient and proceeds with what Lange and Lu (2014) describe as "the doctor's sensations, perceptions and experiences", which make effective communication a necessity.

According to Stewart (1984), the goals of a medical consultation include patient compliance and satisfaction because these have a direct bearing on patient health. A medical consultation involves (a) doctor(s) and a patient navigating the medical condition of a patient. (Davis & Fallowfield, 1994: 41) explain that communication may be negatively affected when the doctor fails to do the following: introduce themselves, ask for clarification from patients, allow or

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encourage patients to ask questions, ask about patients' feelings, and provide information in a form that patients can use. This implies that the doctor needs to establish rapport and guide the direction and content of the communication during consultation in order to obtain the required information from the patient.

Effective communication may facilitate patient disclosure, which contributes to high-quality information gathering, diagnosis and treatment. For instance, effective communication from the doctor may make patients feel at ease, in control and valued (The Royal College of Nursing 2015), thereby reducing work-related stress on the part of the doctor and reducing hospital expenses as patients follow treatment regimens (Kee, Khoo, Lim & Koh 2017:98).

The open and effective communication described above is possible because of the relationships developed during consultations. Camanho (2013:469) explains that the doctor-patient relationship is consistently complex since it is at the same time close (deals with intimate details), technical (explains the ordinary using medical perspectives), and professional (having to offer the best options which form the basis for patients' decisions). According to Berry (2007:40), these relationships are developed through gradual self-revelation, and their quality is improved through the proper use of social and perceptual skills, namely empathy and trust, which are important skills because patients often feel helpless and vulnerable (Berry 2007:40).

### 2.4.2 Sources of miscommunication

The importance of effective communication is also acknowledged by patients to the point that miscommunication results in complaints. In fact, patients generally do not complain about the medical practitioners' medical competence but about communication with medical practitioners (Simpson *et al.* 1991:1385). It can be argued, however, that the low numbers of complaints about medical competence does not necessarily imply that all practitioners are competent. Rather, one needs to consider that most patients may not have the knowledge and expertise on which an assessment of a doctor's medical competence could reliably be based, but that patients are equipped to assess the communicative competences of their doctors.

Miscommunication caused by doctors may include failure to elicit relevant talk and to make psychosocial and psychiatric diagnoses, interrupting patients while the patients are describing their ailments, and assuming that they have successfully communicated to the patient when they have not (see Simpson *et al.* 1991:1385). Patients may also contribute to miscommunication. For instance, Weijts, Widdershoven, Kok and Tomlow (1993) found that patients' information-seeking strategies affected the type of response given by the doctors:

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Patients' use of indirect requests yielded positive responses, while directly seeking new information resulted in negative responses (Weijts, Widdershoven *et al*. 1993:416-422). In other words, when using what the doctor considered to be "undesirable" types of questions, patients did not get the expected responses from doctors. In addition, Differences between the doctor and the patient, whether in language, religious beliefs or culture, can also lead to miscommunication during consultation (Durieux-Paillard 2011). These factors are discussed in the following paragraphs.

The transactional nature of a medical consultation implies that doctors and their patients affect and get affected by each other's contribution to the communication process (Berry 2007:9). One non-verbal contribution is the doctor's emotional state during consultations. The doctor's negative emotional state negatively influences their verbal and non-verbal communication patterns and general attitude towards patient Kee *et al.* (2017:103). In contrast, positive perceptions related to the patient and condition of the patient displayed through doctor's affective skills are essential in some consultations. In this regard, Van Dulmen, Nübling and Langewitz (2003) argue that since some gynaecological issues are coincidentally emotional and marital issues, patients require emotional support from gynaecologists. In addition, a study in the United States showed the importance of affective skills, where patient satisfaction and adherence to doctors' recommendations correlated with the friendliness of the doctor towards the patient and the patient's opportunity to provide information and discuss non-medical issues (like personal matters) freely (Freemon, Negrete, Davis & Korsch 1971:307). Thus, failure in affection may negatively influence communication in consultations.

Another inherent factor which can be a source of misinformation is the nature of medical science, from which three possible factors emanate. The first is universal and pertains to the complexity of medical information. The other two are contextual as they depend on the linguistic and cultural context in which medicine is practiced. All of three factors may be present in settings that have under-developed scientific language and discordant cultures. The following paragraphs outline how these three aspects of medicine may affect communication.

The initial inherent source of miscommunication in medicine is described by Berry (2007:66) as being complex by nature of medical information. This complexity is attributed to the fact it is human-generated, hence it may be ambiguous, uncertain, and dynamic, and it may appear contradictory as new discoveries are made and new knowledge replaces existing knowledge Berry (2007:66). Thus, doctors may be uncertain and contradict themselves, to the dismay of their patients, who believe that the doctor should know better. There is little the doctor can do

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about the changing state of medical knowledge other than present the complexities of medicine, which may lead to dissatisfaction on the part of the patient.

Secondly, miscommunication also may occur when non-medical terms are not available in a local language. In such cases, doctors find it easier to communicate in the language they were trained in, as was the case at Malawi's Mzuzu Central Hospital in Kamwendo's (2008:320) study. Doctors in this study explained that, unlike the local languages, English has the ability to convey scientific information (Kamwendo 2008:320). In Kamwendo's (2008) study, English was also the default language for Malawian Chichewa-speaking doctors who did not understand Chitumbuka, the regional lingua franca, as well as for Taiwanese-speaking medical personnel who could communicate either directly or through an interpreter (Kamwendo 2008:321). English was used with patients and their guardians who had Chitumbuka (in 88% of the cases) and Chichewa (11.7%) as home language (Kamwendo 2008:324). Kamwendo (2004:1) argues that misunderstandings that occur in multilingual and language discordant situations as the one described here, can eventually lead to misdiagnosis, inappropriate medical treatment and even loss of life.

Lastly, miscommunication may arise when cultural understanding of illness is in conflict with the biomedical understanding thereof. An instance where the biomedical culture presented by the doctor clashed with the culture of the patient is found in (Keller 1999) rural American study, where urinary incontinence was rarely presented as a medical condition because most women believed that it was an inevitable symptom of aging. In addition to normalising illnesses, culture can affect communication in clinical settings when it dictates how interactions are structured. Weijts, Houtkoop *et al.* (1993:292) argue that some discursive practices used in clinical settings may reinforce cultural stereotypes and prevent the discussion of required communication concerning sensitive topics of sexuality and reproduction. For instance, Weijts, Houtkoop *et al.*'s (1993) study found that in order not to embarrass the patient, the discussion of certain topics that was intentionally delayed until rapport was established in subsequent visits was forgotten and never discussed (see 2.8.1.1). Thus, culture's influence over what is presented and how may affect communication in medical consultations.

## 2.5 Relating communication study approaches to sociolinguistics

This section connects general approaches to the study of communication to the field of sociolinguistics, and in the process justifies why this study followed a sociolinguistic approach. On the one hand, it can be argued that researchers' interest in finding out how effective communication takes place in these rather difficult circumstances may have motivated studies

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on medical communication. On the other hand, the motivation could be the need to improve the situation, given that most patient complaints are about communication with medical practitioners rather than about their diagnostic abilities (Simpson *et al.* 1991:1385).

According to Burton and Dimbleby (1995:235-249), there are three main approaches to communication studies, namely the process approach, the semiotic system approach, and the cultural studies approach. As a process, communication involves recognising, understanding, and evaluating others while adjusting one's approach based on the feedback obtained in order achieve the desired conversational goal (Berry 2007:27). Furthermore, studying communication as a process entails studying how meanings and relationships are negotiated using social skills to control the meaning of verbal and non-verbal signs (Berry 2007:27). In sociolinguistics, such meaning and relationship negotiations are discussed at syntactic, semantic, and pragmatic levels (at the latter level, also in terms of face management) (see Chapters 5 to 8), which makes the semiotic approach to communication theory relevant to this study.

In the semiotic system approach to studying communication, language is regarded as a system of signs and their meanings, whereby its underlying structures and patterns are demonstrated in use (Burton & Dimbleby 1995:239). The components of the semiotic system constitute what is referred to as "syntax" and "semantics" in linguistics (Berry 2007:27). In an interaction, the use of syntax and semantics is guided by underlying social conventions which speaker-hearer who are competent users of the language in question subconsciously adhere to for them to interact in an appropriate manner in a given situation.

The cultural studies approach relates the semiotic signs and meaning to social groupings within a given society (Berry 2007:28). In sociolinguistics, human communication is defined as "a process through which signs are used within cultures in order to give meanings to the world around us and to the world within us" (Burton & Dimbleby 1995:234). "The world around us" refers to the physical world, whereas "the world within us" refers to the social world that an individual has been exposed to. Sociolinguistics is related to both linguistic and communicative competences. Canale and Swain (2014:40) define "linguistic competence" as the knowledge of grammatical rules of a language, while "communicative competence" refers to the knowledge of how to use language appropriately in different contexts. Since contexts are socially constructed, Canale and Swain (2014:40) describe this contextual linguistic competence, i.e., sociolinguistic competence, as "the knowledge of rules of language use". In this study, these rules are understood to be in use during an interpersonal communication process, specifically

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during interaction between a gynaecologist and a patient. In an interaction, the meanings and relationships provided by the semiotic and cultural systems are negotiated by interlocutors and may be accessed through verbal and non-verbal the behaviour of interactants. Hence, this sociolinguistic study on a product of culture, namely taboo language, uses all three approaches to communication theory. This is in line with Berry's (2007:27) argument that although each approach is distinct, the three are intertwined, hence they are mostly presented together or in pairs.

Although communication is the activity that is of concern in this study, the main object of study is language. Therefore, this study can be described in general terms as a linguistic endeavour. The specifics described in the paragraphs above contextualise this endeavour as a study of the linguistic and sociocultural knowledge used by patients and doctors in gynaecological consultations to overcome linguistic taboo. The study falls within sociolinguistics since it studies the use of language by specific groups of individuals, in a given physical setting and specified culture. Furthermore, because it studies how words are used in an interaction to "do cultural things" which facilitate effective communication, the object of study becomes the discourse. The following section discusses studies on language use in medical consultation and the sociolinguistic competence entailed therein.

### 2.6 Sociolinguistic studies of medical consultations

Although the field of medicine is largely viewed as situated in the so-called hard sciences, studies situated in humanities offer important insights into the requirements for satisfactory medical care. The extreme line of argument in favour of situating the study of medicine with the realm of humanities would be that medicine is not a science but an art and a humane endeavour as it aims to achieve good things for the well-being of human beings, which entails adhering to ethics and moral guidelines (Thomasma & Pellegrino 1981:6-7). However, a moderate argument by Van Leeuwen and Kimsma (1997:100) is that medicine is both a science (as it does not restrict itself to laws and ethics) and an art. Van Leeuwen and Kimsma's (1997:101-2) justification for viewing medicine as an art is the inevitable uncertainty in medicine since doctors do not directly apply knowledge to situations like other scientists do but combine their understanding of a situation with their knowledge of medicine and their experience in resolving situations, just like lawyers and theologists do (see clinical gaze in 2.4.1). Medicine is seen as a discursive practice that varies because of the social and historic setting in which it operates (Van Leeuwen & Kimsma 1997:104). This understanding of medicine as a discursive practice has led to discourse analytical studies that aim to reveal

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existing traits in given contexts. Kamwendo (2004:85-86) explains that since all communication is structured, Discourse Analysis (DA) can be used to study any form of communication, hence as DA is an approach often used when studying communication in medical consultations.

### 2.6.1 Discourse studies

Since DA studies the relationship between discourse and action. In the medical practice it involves studying how interactions are transformed into useful medical texts, such as medical records and diagnoses, which then lead to actions such as treatments (Jones in Tannen, Hamilton & Schiffrin 2015:841). The role of the discourse analyst is to unravel the often complex, indirect connection between interaction and action through available text, which was traditionally regarded as straightforward by health educators and medical personnel but is now acknowledged to be complex (Jones in Tannen *et al.* 2015:842). In medical settings, the objects of study in DA have been narratives of illness in and outside the clinic, written texts and lately also computer-mediated texts (Jones in Tannen *et al.* 2015:843). Clinical encounters have been by far the most common study area for discourse analysts (Jones in Tannen *et al.* 2015:843-7), and the focus has been on the interaction between the doctor and the patient who bring in their own distinct knowledge, expertise and expectations.

Initial studies of discourse in clinical settings looked at the structuring of conversations between the doctor and the patient, which resulted in the characterisation of consultation conversation like Ten Have's (1991:139) six phases. These phases are opening, complaint, examination or test, diagnosis, treatment or advice, and closing (Ten Have 1991:139). Jones cited in Tannen *et al.* (2015:846–847) explains that from the 1990s, studies in clinical communication began including ethnography in order to enrich "the perceived narrowness of conversion analytical approaches to doctor–patient communication" with socially embedded and "ecologically valid" accounts, that is, accounts that are validated by competent users. Data was collected through methods that embraced the non-linear nature of human activities, such as in-depth interviews and participant observations. These methods capture what Sarangi and Roberts (1999:2) call the "thickly textured" and "densely packed" nature of human activity. Multidimensional approaches were justified because of interactive volatility. The latter situation, Iedema *et al.* (2006) argue that participants negotiate organisational needs and their own needs when communicating.

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From the combination of methodologies, it can be seen that the study of discourse embraced interactive volatility. Kamwendo (2004:168ff) analysed discourse using Conversation Analysis (CA) but interprets interaction data that was deemed to be embarrassing using the sociolinguistic approach of Grice's face-threatening act (FTA) theory (Kamwendo 2004:168ff). In recent years, the discourse analytical approach to studying medical communication has been influenced by (i) medical anthropology, which studies the varying explanatory models of illness and danger across cultures; (ii) medical sociology, which studies how the communication of health and risk are part and parcel of social structures; and (iii) culture studies, which look at the nature of biomedical communication. All three (i-iii) show that there is a relationship between social-culture and medical practice (Jones in Tannen *et al.* 2015:841). The next section further explores this relationship.

### 2.6.2 Communication studies in Africa

In some African contexts, effects of multilingualism (the cause of which is explained in 1.6.1) manifest in the medical consultation. Whereas doctors often speak two or more local languages, they are typically formally trained in one or more of their country's official languages and may use these official languages in consultations. The social history of and multilingualism in Southern Africa has led to the study of the following aspects of doctor-patient communication: (i) power relations in the clinic during the colonial and/or apartheid eras in South Africa (e.g., Butchart 1997); (ii) the effects of language policies, language choice and language barriers on patient rights and service delivery (e.g., Deumert 2010 in South Africa; Sobane 2013 in Lesotho; Banda & Kunkeyani 2015, Kamwendo 2004, 2008, and Kunkeyani 2013 in Malawi); (iii) language use in medical consultation (e.g., Anthonissen & Meyer 2008 in South Africa); and (iv) the effects of culture in gynaecological consultations (e.g., Chinyanganya 2013 in Zimbabwe).

Based on the findings of their study on question-answer sequences used in consulting HIV/AIDS patients in South Africa, Anthonissen and Meyer (2008) argue that cultural taboos are a barrier to communication. This concurs with the findings of Chinyanganya (2013) among Shona speakers in Zimbabwe on STD, HIV and AIDS, where sex, death, and illness are taboo topics. In Chinyanganya's (2013:1075) study, 63% of the medical personnel reported that patients were uncomfortable with discussing sexual practices and problems, especially condom use. At the same time, about 33% of the medical personnel indicated that they had problems communicating about sex and sexuality. While most medical personnel reported that their

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general impression was that medical personnel had no issues with communicating about taboo topics, Chinyanganya (2013) argues that 33% cannot be ignored and that there were indeed communication challenges for the medical practitioners. Medical personnel also indicated that using linguistic strategies such as euphemism and code-switching (see 2.8.1.2) to avoid taboo expressions sometimes led to miscommunication and thus affected the outcome of consultations negatively (Chinyanganya 2013).[17]

## 2.7 The sociocultural dynamics in medical settings

It is widely acknowledged that one's health belief system or one's understanding of illness emanates from one's culture, hence culture determines the way people react to illness (Berry 2007:58), which may be recognised from how one generally communicates bout illness (see 2.3). However, this does not mean that people who share a culture or ethnicity act uniformly in terms of how they communicate about health, since differences in personality traits and social groupings (amongst other factors) also play a role in communication (Berry 2007:61). Several aspects of the socio-situational context of medical consultations can jeopardise effective communication, including factors pertaining to gender (Roter & Hall 2006:95), age (Chinyanganya 2013:1075) and power relations (Cordella 2004:59). It can be argued that the degree to which gender, and age interface with culture and manifest themselves during consultations may depend on personality; however, the generalisations may act as a guideline

[17] On a methodological note: Chinyanganya's (2013) study, using interviewing to collect inside information, provides an overview of how cultural taboos and restrictions are present in one African medical setting, namely a healthcare facility in Zimbabwe. Findings from this study can however not be used to draw parallels with this current study. Firstly, the Chinyanganya sample consisted of nurses, whose manner of communicating with patients may differ from that of gynaecologists' given that the lengths of their training and apprenticeship periods differ. In Malawi, for instance, four weeks of doctor training is dedicated to living in rural communities where the doctors in training gain cultural and/or linguistic knowledge from the people they live with (Makwero, Lutala & McDonald 2017:314). This is important as Cordella (2004:35) argues that successful doctor–patient communication may in part depend on the doctor's ability "to identify the patient's own sociocultural framework for illness and negotiate appropriate treatment without provoking a schema conflict". In addition, since Chinyanganya's (2013) study was not just on STDs but also on HIV/AIDS, data was collected in a range of departments, including the hospital's children's ward (Chinyanganya 2013:1074) where issues that might concern adult patients only (such as those pertaining to sex and reproduction, the discussion of which is culturally taboo) might not have arisen. For example, STDs and certain gynaecological conditions like menopause and infertility are not commonly discussed outside of gynaecology. It is hence to be expected that the majority of the participants in the Chinyanganya (2013) study reported that communication about those taboo topics is not an issue for them. Chinyanganya (2013:1075) explained that the motivation for using a questionnaire with which to collect data was to encourage truthful responses given that anonymity was possible. However, the use of a questionnaire to collect data might have affected the results negatively. This is because cultural or linguistic competences are mostly subconscious, hence it is difficult to self-report on them. Thus, the questionnaire data could have represented well thought-out responses which might be present the ideal (instead of actual) situation during consultations. This was the case in Kamwendo's (2004) study in Malawi, where participants reported in interviews that they explicitly mention taboo expressions but they were found not to do so in real conversations . The use of data collection methods other than interviewing in Kamwendo's study may have assisted in understanding how sensitive topics were communicated.

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and a starting point for understanding general communication behaviour. Factoring sociocultural characteristics into communication contexts brings forth the dimension of appropriateness, discussed in 2.3. Under such circumstances, effective communication can be defined as "the intelligible exchange of information and mutual recognition of the most appropriate way to participate in the exchange" (Cordella 2004:1).

When one considers appropriate ways of using language for communication, one also needs to consider that the topic of discussion and the relationship between the interlocutors create the context. Sociocultural relationships between interlocutors are based on societal views of what is acceptable in given contexts. What is not acceptable may culturally be classified as taboo, yet in some cases it could be that very thing that has to be discussed in medical consultations. In these cases of conflicting reqirements of communication, meanings and the relationship between the interlocutors have to be redefined (see Berry 2007:27). Such redefinition is achieved through the creation of a new interpretative schema that is mutually negotiated by interlocutors (see Epner & Baile 2012:38) using non-static means via language. It can be argued that, in addition to negotiating mutual meaning and relationship (Berry 2007:27) (see 2.7.1), interlocutors avoid schema-conflict. The formation of an acceptable schema as argued by Gumperz (1982:206), and an area of sociolinguistic interest as sociocultural contexts are the backbone of Gee's (2011)situated meanings and the relationship construction activities being done through language. The interpretive schema that is based on social cultural concepts is known as -onomic knowledge (sic) (Silverstein, 2004: 621).

### 2.7.1. The subsections that follow discuss linguistic taboo as a cultural construction that may heighten the need to refer to culture when interlocutors negotiate meaning and relationship during medical consultations. Also discussed are other sociocultural aspects – gender, power and age – which may have a bearing on communicating about taboo topics. The way communication in consultations is influenced by socially constructed notions of power, age, gender and linguistic taboo is discussed together with "approapriate" communication in medical consultations. Taboo language and communication in medical settings

#### 2.7.1.1 Historical brief on taboo and the human body and disease

Wardaugh (1998:234) defines "taboo" as "the prohibition or avoidance in any society of behaviour believed to be harmful to its members in that it would cause them anxiety,

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embarrassment, or shame”. Diseases and illnesses have been taboo topics because of their associations with fear, sin, and evil (Allan & Burridge 2006:203-209). At a time when causes of diseases and how they spread were not known, diseases were associated with witchcraft and were sometimes understood to have been caused by women or foreigners. Women were either accused of lacking proper hygiene when menstruating, or of witchcraft- linked both with their abilities to procreate and with their menstruation cycle coinciding with the lunar cycle (Allan & Burridge 2006:163-169). In modern-day Malawi, traces of beliefs in witchcraft are still found, with some believing that HIV and AIDS are caused by witchcraft (Lwanda 2005:256–265).

The human body is generally believed to be sacred, and therefore taboo, but in many societies female genitals is typically regarded as a more taboo topic of discussion than male genitals (Allan & Burridge 2006:7). In many cultures, women’s sexual embodiment is socially constructed as shameful, and that leads to secrecy and silence (Ussher *et al.* 2017:1908). The topics discussed and examined in gynaecological consultations relate directly to women’s sexual embodiment and are hence construed as taboo – traditionally because they pertain to ailments, may involve genitals, and concern women’s bodies. According to Allan and Burridge (2006:1), the use of a word can be forbidden because it causes discomfort or harm. Of course, the language used in gynaecological settings is constrained because unrestrained use of language may cause discomfort more than causing harm.

#### 2.7.1.2 The linguistic taboo continuum in health settings

The restrictions on discussing gynaecological topics may vary according to culture. For instance, in Western societies (e.g., The Netherlands), the sociocultural movements of sexual liberation and feminism have led women to be more aware of sexual health issues (Weijts, Widdershoven *et al.* 1993:295; Frenken & Van Tol 1987:144). This has not been the case in most non-Western societies (see Chinyanganya 2013; Kamwendo 2004; Kırımlıoğlu & Saylıgil 2016). For instance, in a Jamaican study by Bourne, Charles, Francis, South-Bourne and Peters (2010), in which attitudes towards cervical cancer screening were studied by analysing the 2002 Reproductive Health Survey data collected amongst 7,168 women, it was found that 36% of the women had never considered having a Pap smear done, whereas 11% thought that they did not need one. This is an example of insufficient knowledge about sexual health. At the same time, some cultures’ restrictions on the matter affect sexual health communication in consultations. Such instances were reported in a study on question-answer sequences used in consulting HIV and AIDS patients in South Africa, where Anthonissen and Meyer (2008:31)

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argue that cultural taboos in the consultation are a barrier to communication about the sexual aspects of HIV.

Despite sexual liberalisation, some forms of prohibitions still exist in Western cultures, with the topic of sex being either referred to as sensitive, delicate, embarrassing (Weijts, Houtkoop *et al.* 1993:310) and/or causing discomfort (Faithfull & White 2008:231). In contrast, in non-Western cultures, the topic is referred to as taboo. Kırımlıoğlu and Saylıgil (2016:29) explain that in Turkey, matters pertaining to gynaecology and obstetrics are considered private and personal, and messages about these matters are either confidential or forbidden. These sentiments in Turkey reflect the sentiments expressed in studies done in Zimbabwe (Chinyanganya 2013), South African (Anthonissen & Meyer 2008), and Malawi (Kamwendo 2004). Although Western and non-Western cultures regard gynaecological topics differently, the existence of some form of restriction – whether mere embarrassment, or embarrassment and cultural constraints – has an impact on linguistic behaviour and attitudes towards gynaecology-related topics. Hence, the present study treats taboo as a continuum and not a static construct. On this continuum, taboo includes everything that is private, sensitive, embarrassing, or socially forbidden to be stated in public or in the presence of non-intimate members of the society. Thus, some societies may regard a specific topic as somewhat taboo, whereas others will regard it as highly taboo or even as not taboo at all.

**2.7.1.3 Discussing sex-related topics in health settings**

When communicating about topics regarded as taboo, like any other forms of communication prescribed by culture, register or the choice of content, delivery, and audience may be influenced by culture: Thus, hat one says, how one says it, and the relationship between the interlocutors are reflected in the type of language used. The studies discussed below show that it is challenging for both medical practitioners and patients to discuss matters that are culturally considered taboo.

As stated in 2.6.2, 63% of medical personnel in Chinyanganya's (2013:1075) study on STD, HIV and AIDS amongst Shona speakers in Zimbabwe reported that patients were uncomfortable discussing sexual problems and practices; and about 33% of the medical personnel indicated that they had challenges in communicating to patients about sex and sexuality. Weijts, Houtkoop *et al.*'s (1993) had similar findings in actual gynaecological consultations in The Netherlands, where it was reported that difficulty in discussing sensitive topics was marked by a number of strategies in the consultations, for instance delaying raising the topic (300-304) and avoiding stating sexual terms altogether (304-308). In the first instance,

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the topic was introduced towards the end of the consultation or in the follow-up consultation. On the one hand, Weijts, Houtkoop *et al.*'s (1993) explanation of the use of delaying strategy is in line with one gynaecologist's explanation about the reason he pushed a patient's talk on sexuality to a follow-up consultation, was the need to first establish with the patient a relationship of trust and confidence. On the other hand, once the rapport was established, linguistic strategies such as avoidance, de-personalisation and tuning were used. (These are outlined with examples in 2.8.) The use of such strategies is necessitated by the difficult-to-mention sex-related topics which have to be mentioned in gynaecological consultations.

### 2.7.2. Gender

Roter and Hall (2006:95) argue that gender is the social characteristic of a doctor that most significantly impacts communication in medical consultations. Gender may not only influence the way language is used but may also form the basis of doctor choice and patient satisfaction, as will be shown below. The discussion begins with Roter and Hall's (2006) review of the meta-data from a range of published studies.

Roter and Hall's (2006:103) analysis of the findings of seven studies shows that female doctors do exceptionally better than their male counterparts in patient care and in all four communication functions of a medical consultation presented in 2.4.1: In other words, female doctors ask more questions, actively build a relationship with their patients better than male doctors, and are more explicitly emotionally responsive (Roter & Hall 2006:100). Furthermore, although there were no difference in the nature of the biomedical patient education delivered by male and by female doctors, female doctors did more psychosocial patient education than males (Roter & Hall 2006:100). This correlates with Uskul and Ahmad's (2003) findings in conservative, non-Western Turkey that male gynaecologists were rated lower in terms of communication styles, content, patience, and the perception of patient's character and ability than their female counterparts.

Despite evidence that female doctors are better communicators and thus achieve the goals of a medical consultation better than male doctors, Roter and Hall's (2006) metadata shows that both male and female patients generally preferred male over female doctors for non-intimate medical matters (Roter & Hall 2006:103, 104): For both male and female patients, gender preferences do not correlate with patient satisfaction in non-intimate consultations. Roter and Hall (2006:104-5) argue that these mixed results were obtained for two possible reasons. Firstly, patient satisfaction could be influenced by personal values and/or prejudices about

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gender. Secondly, in some instances, unfulfilled high expectations placed on female doctors disadvantage them, especially the young ones.

Studies discussed in this paragraph show that the same female patients who had preferred male over female doctors for non-intimate consultations, preferred female doctors for intimate consultations, some of which could lead to physical examination. This was evident in Phillips and Brooks's (1998) study in the United Kingdom, which found that whereas 14% of the female patients preferred female gynaecologists for advice about diet and feeling overweight respectively, at least 74% and 70% preferred a female doctor for Pap smear tests and breast examinations, respectively (Phillips & Brooks 1998:545), i.e., when the reason for consulting a gynaecologist is intimate and may require physical examination. Roter and Hall (2006:103) explain that such a preference could be based on the fact that female patients expect more understanding, and experience less embarrassment associated with physical exposure, in gender-concordant gynaecological consultations than in gender-discordant ones. These percentages might be even higher in conservative societies, as Uskul and Ahmad (2003:206, 213) argue, in a culturally conservative society, female patients would be more constrained about their medical conditions with male than with female doctors, hence asserting that proper diagnosis and treatment in gynaecology are best achieved in female dyads in conservative settings like Turkey.

According to Hall and Roter (2002:221), other studies show that trust shared within gender-concordant consultations is a key reason for preference for female gynaecologists. They argue that positive assessments of male gynaecologists were attributed to their awareness of the natural discomfort of gender-discordant consultations, thus as compensation for this shortfall, many male gynaecologists created an environment in which their patients could easily interact with them. They did this by positive talk and partnership building, among other strategies. Similarly, Kirimlıoğlu and Sayligil (2016:34) argue that male gynaecologists who make a deliberate effort to build their patients' trust are rated more positively by their patients than those who do not.

The studies in the paragraph above connect the gender of the doctor to communication, patient satisfaction, and to the attainment of consultation goals. It shows that in intimate consultations, female doctors are preferred by female patients and that female patient disclosure is heightened in gender-concordant consultations, which results in successful consultations, without negatively affecting the personal dignity of the patient. The findings from Phillips and Brooks's (1998) study are dependable because they collected data from primary sources, who were

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gynaecological patients. Thus, the finding that female patients prefer female doctors for intimate consultations is more dependable than Chinyanganya's (2013) study findings on the same topic. This would imply that there is more preference for female than male gynaecologists, especially in conservative societies.

The number of female gynaecologists is however not sufficient to always meet the need for intimate consultations. Roter and Hall (2006:96) argue that few females specialise in gynaecology and paediatrics as these specialisations are lifestyle-burdening in the sense that they require longer and less convenient working hours compared to specialisations in primary care, and thus the latter are preferred by female doctors (Roter & Hall 2006:96). Recall that in Hall and Roter's (2002:221) study, positive assessments of male gynaecologists were attributed to the male gynaecologists being aware of the fact that their patients would prefer female-to-female consultations and compensating by creating an environment for their patients in which to interact more easily. Van Hall (1982:89) suggests the use of androgyny during gynaecologist-patient interaction, which would entail that male gynaecologists take on the "female" characteristics of listening well to their patients; this will enable the doctors to be empathetic and understanding, thereby allowing their patients to communicate better with them. This concurs with findings in Christen, Alder and Bitzer's (2008) study, namely that it is not the gender itself that matters but gendered communicative styles, hence the recommendation that male doctors use patient-centred approaches to communication (Christen *et al.* 2008:1480). Whereas an enabling environment is one of the bases for a successful gynaecological consultation, it does not remove all cultural constraints, which will be discussed further below.

### 2.7.3. Power asymmetry

In a medical consultation, the power is skewed: The doctor has more power than the patient because of the context, which includes the institution, the latter being the doctor's place of work but a facility to which the patient is merely a visitor. Like an interviewer derives power from the ability to make decisions and to control the direction of the interview (Young & Weiyun He 1998:119), the doctor as the interviewer during medical consultation might derive power from the doctor-patient interaction during consultation. According to Weijts, Houtkoop *et al*. (1993), doctors have and are given the power to, among other things, determine the vocabulary that will be used. It has been argued, however, that friendships and admiration that develop between doctors and patients tend to diffuse inherent power imbalances, the evidence

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of which is former patients recommending their doctor to others (Camanho 2013:469). Therefore, it is expected that doctors who hold the power described above are also responsible for solving the interaction volatility of medical consultations on sensitive matters. They could do this by using their position of power to create a good relationship with their patient by steering talk in an appropriate and acceptable direction and using appropriate and acceptable vocabulary. The studies that follow discuss findings on how doctors enact this power in sensitive consultations.

In order to explore how talk about sexuality is organised during gynaecological consultations, Weijts, Houtkoop *et al.* (1993) conducted a study in The Netherlands with the premise that "some discursive practices in clinical discourse may reinforce cultural stereotypes regarding female sexuality and may impede a sound conversation about sexuality and reproduction", thereby negatively affecting the quality of medical care provided (Weijts, Houtkoop *et al.* 1993:292). It was argued that by postponing talk about sex and using implicit talk, doctors in this study were re-enforcing cultural stereotyping. Thus Weijts, Houtkoop *et al.* (1993:311-12) propose that doctors use their power to raise sexual issues earlier, that is during history taking, and to talk explicitly so as not to constitute a discursive practice that reinforces stereotyping, because such stereotyping disadvantages patients.

Faithfull and White (2008) is an example of a study that shows the negative effects of doctors not initiating sensitive talk about sexual health when they conduct patient education about pelvic radiotherapy. According to Faithfull and White (2008), pelvic radiotherapy could cause abnormal narrowing of the vagina, which could be prevented with vaginal dilator therapy during and after the radiotherapy. Faithfull and White (2008) established that medical staff did not discuss this possible side-effect with patients when preparing them for pelvic radiotherapy, and only 61% of the doctors enquired about sexual difficulties post-procedure (Faithfull & White 2008:231). There was a general expectation amongst doctors that a nurse or the radiographer would discuss the radiotherapy' effect on sexual health with the patient, but 63% of the patients reported not ever receiving information on this topic (Faithfull & White 2008:232). Faithfull and White (2008:232) argue that doctors (those who hold the power in this setting) need to initiate talk about vaginal dilation therapy and other sexual health topics if the women are to talk about these topics.

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### 2.7.4. Age

In addition to gender, the age of a patient in relation to that of the doctor can have an impact on communicating sensitive topics. In this regard, Chinyanganya (2013:1075) found that age correlated with language style shift in the youth and was a barrier to communication for older patients: Doctors would use slang with young patients as a way of maintaining the dignity of the patient when discussing sensitive information. In the same study, it was found that older patients were more uncomfortable than younger patients when discussing sexually related conditions with younger health personnel. In many African cultures, it is taboo for older people to discuss sex and sexual health matters with the younger generation (see, e.g., Lwanda 2005; Munthali 2017 ), and only designated older relations or non-relations are tasked to do so at designated life stages of the young person, such as at the onset of adolescence or during marriage initiation ceremonies in the case of the Yao in Malawi (Kunkeyani 2013:30). It can be argued that the situation at the clinic in Chinyanganya's (2013)study was not only embarrassing for older patients because of age difference, but they were also in a less powerful and more vulnerable position compared to the young health worker, which is not normally the case in their everyday lives.

## 2.8 Linguistic strategies for communicating taboo

The interactive volatility of consultations where taboo topics are discussed presents an opportunity for new schema to be formed by both the patient and the doctor. According to Silverman (1994: 427), in medical consultations, taboo topics are discussed with "expressive caution" , so as to save the faces of both interlocutors while meeting the biomedical requirements of openness. This section presents strategies that were (i) used in real (i.e., non-simulated) gynaecological consultations in Weijts, Houtkoop *et al.*'s (1993) study in The Netherlands and (ii) reported in questionnaire data collected by Chinyanganya (2013) in Zimbabwe.[18]

### 2.8.1. Delaying

This strategy was employed in two ways: either talking about sex as a topic or using delicate terms was delayed. In the first instance, the talk about sex and related topics was pushed to the end of the consultation, in some cases after there has already been an indication that the

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[18] Zimbabwe is comparable to Malawi physically and the two countries have close historical ties as they were both in the British Federation of Rhodesia and Nyasaland. Past contact between people of these two countries may have influenced the development of cultures that are similar.

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conversation is almost finished, or such topics were only raised in follow-up consultations. This may however result the topic under discussion not receiving the required attention or never being discussed in subsequent consultations. In the second instance, patients delayed using delicate terms by using pauses or fillers when disagreeing with the doctor (Weijts, Houtkoop *et al.* 1993:300-304).

### 2.8.2. Codeswitching

During medical consultations, codeswitching may be of two kinds: either the register changes from formal to informal, or the speaker switches to another language. These two types of code switching were both reported in Chinyanganya's (2013) study, where medical personnel explained that they would either switch from Shona to English or use slang, especially with young patients, to avoid the embarrassment caused by using Shona taboo expressions (Chinyanganya 2013:1075). Codeswitching from Shona to English was reported helpful as the English terms do not have the same taboo, “curse” effect as their Shona equivalents (Chinyanganya 2013:1076). Furthermore, English is seen as the language of science and as such allows for clear communication about medical matters. However, the limitation on the use of English in Chinyanganya’s study was that not everyone speaks and understands this language.

As stated above, it was reported that slang was used with younger patients to “lighten the situation” as slang is less formal and makes embarrassing situations less embarrassing (Chinyanganya 2013:1076). However, the disadvantage of using slang is that not all situations need to be “made light”, and not every patient may like their situation to be seen as being taken lightly. Some slang expressions are meant only for casual settings and, if used by a doctor, would be dysphemistic (see 3.4) – and comparable to mentioning death using a euphemistic dysphemism, which would be “inappropriate, insensitive, unprofessional and tabooed” (Allan & Burridge 2006:40) – since medical settings require a level of formality. Thus, lightening the situation needs to be done with caution. As there were no patient respondents in Chinyanganya's (2013) study, it is not possible to establish how the patients responded to medical personnel’s “lightening ” of a potentially embarrassing situation.

### 2.8.3. Avoidance

According to Weijts, Widdershoven *et al.* (1993:304), avoidance involves using vague terms, omitting delicate terms and using pronouns instead of nouns. The use of vague terms is also

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referred to as "circumlocution" by Chinyanganya (2013:1075), and includes euphemism – for instance, *go to grass* a literal translation from Dutch used in Weijts, Houtkoop *et al.* (1993:304) to refer to a period of trying to fall pregnant after several infertility tests. Similarly in Malawi, because HIV and AIDS are associated with sex or sexual practices, it is common to avoid direct mention that a person died of AIDS; instead the euphemistic expression *kumwalira atadwala nthawi yayitali* 'die after a long illness' is used, which inevitably implies "died due to HIV and AIDS-related illnesses" (Kamwendo 2004:174). In Chinyanganya's (2013:1075) study, more than two-thirds of the medical personnel interviewed said that they use metaphors, allusions, euphemism, and circumlocution during consultations. "Euphemistic expressions neutralise the unpleasantness … making the expression more palatable or presentable" (Chinyanganya 2013:1074).

Simple but strategic word omission occurred up to 5 times in 5 lines of a turn in Weijts, Widdershoven *et al.*'s (1993:305) study. The interlocutors are able to infer the omitted parts from previous conversation and understand what has been omitted, like in pro-drop languages. The data was however collected in Dutch, which is not a pro-drop language. Patients in this study avoided mentioning the term *vagina* when they had to refer to their genitals; only doctors used the term (Weijts, Widdershoven *et al.* 1993:309). This is in line with the argument that doctors are given agency in the choice of vocabulary.

Weijts, Widdershoven *et al*. (1993) describe the peculiar use of pronouns and adverbs as a way to avoid mentioning the taboo noun. Firstly, there was the consistent use of demonstrative pronouns like *this* and adverbs as a way of replacing terms referring to sexual-related matters (Weijts, Widdershoven *et al.* 1993:305). Once the topic was introduced, the follow-up discourse contained pronouns and adverbs that did not conform to standard anaphoric rules of referring expressions. In fact, some pronouns did not have a clear referent (Weijts, Widdershoven *et al.* 1993:307-308). Secondly, the patient and the doctor used the adverbs *afterwards* to refer to 'after sexual activity' where sexual activity was mentioned earlier by the doctor.

Avoidant speech styles, which are typically used to maintain peace in potentially volatile relationships (Allan & Burridge 2006:9), are used here to maintain face in gynaecological settings. It has been argued, however, that the use of avoidant speech styles can negatively affect their intended purpose. In this regard, Chinyanganya (2013:1077) argues strongly against their use as he claims that it allows for some meaning to be lost, which can eventually lead to a misdiagnosis. In addition, Weijts, Houtkoop *et al.* (1993:304–305) show that

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miscommunication is possible when a vague term is not within the other interlocutor's frame of reference. In an example provided by Weijts, Houtkoop *et al.* (1993:305), the doctor used *down there* to refer to sexual abuse. The patient was not familiar with this use of *down there* and, as such, the doctor was only understood after several utterances made in an attempt to communicate about sexual abuse with the patient. According to Allan and Burridge (2006), avoidance can lead to attrition of terms when a whole generation does not acquire the dysphemic expression.

### 2.8.4. Depersonalisation

According to Weijts, Houtkoop *et al.* (1993:308–309), the strategy of depersonalisation severs the connection between the person and their most private actions and bodily aspects through nominalisation and the use of definite articles. For instance, instead of including the actor, nominalisation was used in the following sensitive questions: "Any problems with defaecation?" or "You never have problems during making love?" (as opposed to "Any problems when you defecate?" or "You never have problems when you make love?". Similary, nouns like *vagina* and *breasts* were not accompanied by possessive adjectives like *your* (as in *your vagina* or *your breasts*); instead, the definite article was used to render *the vagina* and *the breasts* (Weijts, Houtkoop *et al.* 1993:308-309); possessive adjectives *your* (by the doctors) and *my* (by the patients) were used only when referring to non-sensitive body organs like legs or arms (Weijts, Houtkoop *et al.* 1993:308–309). According to Weijts, Houtkoop *et al.* (1993:311), strategies which do not result in explicit mentioning of terms referring to female sexuality and body parts (like de-personalisation) reinforce stereotypes.

### 2.8.5. Tuning

Tuning occurs when one group of interlocutors consistently adopts the other group's use of terminology use and communicative style. In Weijts, Houtkoop *et al.*'s (1993:309) study, a doctor adopted the patient's respectful distance style and use of omissions. None of the patients, however, tuned in to their doctor's communication styles (Weijts, Houtkoop *et al.* 1993:309-310); patients instead used pronouns to replace the dysphemistic or/ orthophemistic expressions that the doctor had used. For instance, the term *vagina* was never used by patients although doctors used it (Weijts, Houtkoop *et al.* 1993:309-310).

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Table 2.1 summarises the strategies used when communicating about taboo topics (Weijts, Houtkoop *et al.* 1993). Patients and doctors collectively used a total of five strategies with doctors using all five and patients using only three.

Table 2:1 Strategies for communicating linguistic taboo

| **Major strategy** | **Device** | **Performer(s)** |
|---|---|---|
| **Delay** | delaying sex-as-a-topic | Patient & Doctor |
| | refraining from answering questions | Patient |
| | producing perturbations in the context of delicate terms | Doctor & Patient |
| **Codeswitching** | slang | Doctor |
| | using a "scientific language" like English | Doctor |
| **Avoidance** | using vague terms | Doctor |
| | omitting delicate terms | Doctor & Patient |
| | using pronouns | Doctor & Patient |
| **De-personalisation** | nominalising | Doctor |
| | using definite articles instead of possessive pronouns | Doctor |
| **Tuning** | adopting patients' use of pronouns and their omission of delicate terms | Doctor |
| | repeating patients' terms | Doctor |
| | omitting doctor's references | Patient |

Adapted from Weijts, Houtkoop *et al.* (1993:310)

Chinyanganya's (2013:1077) overall argument is that the strategies used by medical personnel impede rather than assist in consultations as communication becomes vague and obscure. Table 2.1 shows the prominence of gynaecologists in using different strategies for communicating about taboo topics. This prominence can be a result of the fact that doctors would mention the terms while patients would follow with a pronouns (Weijts, Houtkoop *et al.* 1993:309-310). There is also the general understanding that gynaecologists need to initiate talk as the topic is embarrassing for women to initiate, and that by listening without prejudice doctors will create a safe environment that will sustain the talk (Audette & Waterman 2010:360).

## 2.9 Chapter summary

This chapter provided an overview of existing literature related to the topic of this study. The literature has shown that culture may dictate the communication dynamics during a medical consultation, and that communication is central in medical consultations. The interface of culture and health communication is twofold: (i) It constitutes the patient's understanding of

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health and illness and how to talk about these topics, and (ii) effective communication is a product of culture. Effective communication encompasses cultural prescriptions, including the prescription of what is and what is not appropriate in terms of topic and manner of talking about the topic. This has resulted in interactional sociolinguistic studies (see Chapter 3) being conducted to examine how social constructions such as taboo, gender, and power interface with communication in consultations. Sociocultural dynamics in consultations are considered to determine appropriate communication behaviour: For instance, it has been argued in this chapter that taboo topics are one such cultural prescription in the consultation that affects communication, and that social attributes such as gender and power that affect communication may also specifically affect how taboo topics are discussed. Existing studies do not describe what happens in Malawian gynaecological settings: Either they either were conducted in a more liberal context (i.e., not in a conservative society), or the made use of secondary data, or their findings did not show how safe environments are created by using language.

It has been shown that (i) the existence of communication requirements in a conservative setting concerning taboo topics about female sexuality and reproduction discussed in cross-gender medical consultations and (ii) the requirements of openness in medical consultations would present heightened interactive volatility. To establish what strategies are used to effectively communicate in such an environment, the relationship between interlocutors and the way meaning is constructed could be studied using Discourse Analytical methods and sociolinguistic approaches. The next chapter discusses theories that would help in understanding the linguistic processes involved in achieving effective communication while simultaneously fulfilling medical consultation requirements.

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# Chapter 3 : Theoretical Framework

## 3.1. Introduction

Sociocultural restrictions on taboo language do not necessarily impede successful communication, because sociocultural tools can offer alternatives to using taboo language (as discussed in Chapter 2). The application of such sociocultural tools in medical consultations is guided by the requirements of the clinical gaze (see 2.8.1–2.8.3). The communication that occurs in gynaecological consultations needs to negotiate two sources of discourse (the social and the biomedical cultures-see 2.3) and can therefore be referred to as "hybrid communication" (see Seale, Butler, Hutchby, Kinnersley & Rollnick 2007). A theoretical framework that would assist in identifying the tools used has to consider the negotiations involved in successful hybrid communication. This chapter discusses the theories that have informed the methodology used to collect, analyse, and interpret the data in this study. One of these theories, Discourse Analysis (DA), fall within the framework of Social Constructivism, in which language and culture are viewed as existing in a dialectical relationship (see Boas 1940; Mead 1949; Everette 2012), and in which discourse simultaneously reflects and (re)produces or challenges cultural norms, including norms for how language may be used in specific settings (Fairclough 2011:215). This study uses Social Constructivism as framework given that the central topic under investigation, linguistic taboo, is a cultural construction. In particular, this study draws on aspects of the following as its theoretical framework: DA (3.2), as stated above, specifically Gee's Situated Discourse Analysis (SDA) and Interactional Sociolinguistics (IS); and X-phemism of taboo expressions (3.3). Section 3.4 discusses the implications of the theories on the study while, the chapter summary (3.4) shows how these theories worked together in studying communicating taboo topics in gynaecological settings.

## 3.2. Discourse Analytical theories and methods

DA is both a theory and a method for studying language use (Gee & Handford 2012:1). Within the field of linguistics, DA can be approached from anthropological, descriptive or functional linguistics; sociolinguistics, or systemic linguistics (Kaplan & Grabe 2002:196), and the realisation that changes in language use are linked to social change has however resulted in the use of discourse analysis as a method of studying social change in a number of disciplines other than linguistics (Fairclough 1992:1), including anthropology, education, history, political science, psychiatry, and sociology (Gee & Handford 2012:5). Jorgensen and Phillips (2002:1) argue that the unifying element among the different approaches to DA is the understanding that

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in every social situation, a particular linguistic pattern acts as a blueprint for the language structure used. However, due to discourse being studied by many disciplines, "discourse" is hard to define (Fairclough 1992:3; Jorgensen & Phillips 2002:2); one is likely to come across non-specific definitions such as "(discourse is) a particular way of talking about and understanding the world (or an aspect of the world)" (Jorgensen & Phillips 2002:1). Discourse would best be defined and its function and the analytical method best be described within the parameters of the approach to DA being used in a given study. The following paragraph describes the terms "discourse" and "DA" as used for the purposes of this study.

This study approaches DA from within Sociolinguistics, which focuses on the interactive nature of language. It is concerned with the motivations behind the use of particular language structures in given contexts, not merely with the information being conveyed. Through a sociolinguistic lens, discourse is "an integration of words, values, beliefs, attitudes and social identities at production and interpretation levels" (Gee 1996:127). Because of the incorporation of social aspects, DA in Sociolinguistics typically does not use sophisticated linguistic terminology, allowing non-linguists (such as medical practitioners and their trainers, who are the target users of this study's findings) to easily access study findings (Wooffitt 2005:80-2). The two specific discourse analytical theories and methods used in this study are discussed in 3.2.1 and 3.2.2.

### 3.2.1. Interactional Sociolinguistics

Interactional Sociolinguistics (IS) is an approach to DA that developed from the need for scientific, qualitative, analytical methods for studying people's ability to interpret the intended meaning conveyed within a community of practice (Gumperz 2015:309). This followed the realisation that people do not necessarily speak explicitly, but use extra-communicative knowledge to relate what is said to the situation at hand to understand speaker's intended message (Jaspers 2012:135).

According to the founding theorist of IS, Gumperz (2015:309-13), IS is built on the assumption that discourse carries within it contextual tools that (i) point towards the relevant sociocultural background knowledge required for meaning making and (ii) contribute to the achievement of communication goals in a given interaction. According to Gumperz (2015:310), IS builds on Garfinkel's (1967) argument that, despite the use of indirect and non-explicit expressions, interactants understand each other, because the missing information is found in the shared sociocultural background knowledge, also referred to as a "deeply internalised social order".

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Apart from Garfinkel, IS uses Grice's (1975) notion of implicature to make connections between what is said and the internalised social order (Gumperz 2015:310-1). Grice's "implicature" can be defined as the intended meaning that can be understood using previous knowledge of what is meant by particular expressions in given contexts (Grice 1989:37). Speech events are thus studied because societal beliefs and values (the internalised social order) come to the surface in speech events (Gumperz 2015:309). The connection between what is said and the social order can be made by using explicit signalling devices (for example, by expressions like "just kidding") or implicit signalling devices (through co-occurring contextualising cues such as codeswitching and prosody). IS studies the latter type of devices (Jaspers 2012:136-7). Thus, in IS, the speech event provides an opportunity to see how which signalling devices are used to point out presuppositions required for interpretation (Gumperz 2015:309). IS argues that macro-rules, such as norms of a speech community, are accessible in micro-settings or in speech events (Gumperz 2015:309). It follows that to study how linguistic phenomena like taboo topics are navigated in particular communication situations or micro-settings is to tap into the sociocultural knowledge shared within a community of practice (Al-Khatib 1995:445).

IS is an eclectic field of study, shaped by Gumperz with the aim of understanding and interpreting the relationships between culture, society and language (Cordella 2004:7). It studies language as a cultural behaviour (like ethnography does), and draws on the constructs of Speech Act Theory and on Conversation Analysis procedures without necessarily "reconstruct(ing) conversation strategies employed to formulate specific actions" (Gumperz 2015:317). Rather, IS studies situated interpretations of intent by establishing what the most likely interpretations are, what assumptions and inferential processes are used, and what their relationship is to what is literally said (Gumperz 2015:317). Although IS has mainly been used for studying (mis)communication in Western workplaces (Jaspers 2012:138), the current study uses it for studying communication and possible causes of miscommunication in the gynaecological consultation because of the implicit communication associated with communicating taboo in a setting where explicit communication would be expected. The subsections below discuss situated interpretation using frames and framing (3.2.1.1), and conversation inferences (3.2.1.3), followed by a discussion of Goffman's face strategies (3.2.1.2) which are implicatures related to embarrassment.

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#### 3.2.1.1. Frames and framing

IS postulates that meaning is understood by the recipient through possible scenarios or envisions which are called "activity types" or just "activities" (Gumperz 2015:316). Gumperz (2015:316) likens an activity type to Goffman's schema or frames, which Gumperz claims actors strategically manipulate to achieve intended communicative goals in real life. Goffman's Frame theory proposes that although every utterance has multiple meanings, interlocutors are able to understand each other by using frames or schema. These frames or schema are constructed from within the activity in which the utterance occurs (Gumperz 1982:130). The term "interpretive frame" refers to the summation of the interlocutors' previous experience of similar situations and their knowledge of grammar and lexicon. The interpretive frame is used to identify permissible interpretive options in conversations (Gumperz 1982:21–2). These interpretive options include (i) themes, (ii) differing levels of importance in points raised, and (iii) items distinguishing key points from minor ones (Gumperz 1982:21-2), derived from already socially constructed parameters of frames, identities and relationships (Jaspers 2012:140) which constitute the social order. Hence, successful communication requires the existence of a common frame. In this regard, the objective of IS is to study "how language is employed", which includes a description of how language is used in a particular setting by particular people (Gumperz 1982:154-5).

Frames are analysed using Gumperz's (1982) contextualisation as it is used in discourse (Gordon in Tannen, Hamilton & Schiffrin 2015:327). As the contextualisation process is a subconscious process for interlocutors (i.e., participants are unaware of what they are doing), it can only be brought to the fore through analytical studies (Gumperz 1982:131). Formulaic utterances (Gumperz 1982:133-4), conversational codeswitching (Gumperz 1982:62ff), prosody, and other non-verbal cues (Gumperz 1982:140ff) may function as contextualisation cues (see 3.2.1.1). That contextualisation cues are subconsciously produced and interpreted is seen in the functional codeswitches that language users engage in but cannot explain (see Gumperz's 1982 study).

An interpretive frame is made up of the interlocutors' previous experience from similar situations, their knowledge of grammar and their knowledge of the lexicon which, when used together, determine permissible interpretive options in conversations (Gumperz 1982:21–2). As stated above, successful communication requires the existence of a common frame.

Frame analysis is the process of identifying (i) the parameters which interlocutors use in a given context to make inferences that help to arrive at applicable presuppositions and background

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knowledge and (ii) whether there is a shared frame or not (Goffman 1986). The notion of inference is related to Grice's (1975) theory of implicature which explains the multi-level processes involved in meaning-making using associations that are mostly sociocultural (Gumperz 2015:310). It can be argued, based on Gumperz (1982:31), that gynaecological consultations, like any other any activity type, may help one to make particular inferences using knowledge obtained from previous encounters. Goffman (1986:496–7), argues that as long as the speaker has used efficiently framed their massage in a given context, miscommunication is a result of cultural incompetence.

Frame analysis also identifies potential sources of miscommunication between different sociocultural groups (Holmes 2013:381-2). When the knowledge schema on which a frame is constructed is presumed to differ between interlocutors, frame shifts (movement from one wrong frame to the intended one) may be initiated to avoid miscommunication (Jones 2012:199). In a conversation, multiple frames may be deployed simultaneously or alternatively by changing register or by changing footing (Jones 2012:197-8). Footing involves the assignment of the role being played through the use of specific linguistic and paralinguistic resources that project on the relationship being established between the speaker and the listener (Goffman 1981:128). This projected self is called alignment (Goffman 1981:128). The next section describes the notion of face and face strategies which could be regarded as alignment activities used in conversations.

#### 3.2.1.2. Conversation inferences

As stated above, a variety of frames can operate in a given context. This necessitates the use of conversational inferences, which are "the situated or context bound process(es) through which intent is understood after which responses are formulated" (Gumperz 1982:153). This section discusses how conversation inferencing is used to connect that which is said to the right frame. Conversation inferencing is the process of making meaning through the use of contextualisation cues (Gumperz 2015:315). Contextualisation cues are verbal signs which construct contextual grounds for situated interpretation when they co-occur and are processed together with other cues (Gumperz 2015:315) A contextualisation cue signals contextual presuppositions about the activity, meanings and connections within the text (Gumperz 1982:131). These cues may be categorised as verbal or non-verbal signs. Non-verbal signs include tone, pitch, laughter, pauses, gestures, and eye contact, while verbal signs are either symbolic signs or indexical signs that get their meaning by directly connecting the sign with the context (Gumperz 2015:315), as discussed below.

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Symbolic signs include lexical and grammatical rules while indexical signs are contextual in that their refering items can only be deduced from the context, for instance deictic expressions *here* and *there* (Gumperz 2015:315). Grammatical contextualising cues may include foregrounding, subordinating, or linking various semantic elements together (Gumperz 1982:208). Thus, using these cues, language would be used to highlight important items, to trivialise others, or to connect things that are not normally connected. Codeswitching may also be classified as a verbal sign, because it initiates a shift in presuppositions which affects interpretation, like other discursive juxtapositionings within a stretch of talk (Gumperz 2015:315). In other words, the choice of using a language other than the one initially used is purposeful, and it communicates the sociocultural elements just like any other signalling device does. Codeswitching is thus regarded as functional (Millar 2002:33) since it can be used as a communicative strategy by the speaker to achieve particular interpretations (Gumperz in Tannen *et al.* 2015:315). It has, however, been argued that presuppositions are dynamic in that they may vary from person to person and may shift in the course of an interaction (Gumperz 2015:313). Over time, however, particular presuppositions are associated with particular speech events in given cultures, which form a link between the lexical and the social, making inferencing possible (Gumperz 2015:310) .

The IS approach can be summarised as an approach which studies communicative competence as the ability to use both linguistic and functional competences when communicating (Awang & Ibrahim 2010:2), by developing an interpretive schema (Cordella 2007:7) or frame and footing (Goffman 1974, 1981, respectively), from the shared point of reference developed within a society or a societal knowledge schema, which Gumperz (1971:101-2) refers to as a code. The argument in IS is that this code, which is common knowledge in the macro-setting, guides the interlocutors when negotiating linguistic strategies in micro-settings, which are specific interactional contexts.

#### 3.2.1.3. Face and face work

According to Goffman (1955:213) , an interlocutor evaluates the other participant, just as much as they evaluate themselves, to decide how they will present themselves. Their decision forms a "line" which is a pattern of verbal and non-verbal actions that are consistent with the evaluation of the situation formed during an interaction, and which guides their behaviour (Goffman 1955:213). A positive social value claimed by an interlocutor from the line others assume the interlocutor has taken is called a face (Goffman 1955:213) . When there is consistency (as judged by self and others) between the line that one takes and the expectations

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other interlocutor(s) have, it is said that one "has face", is "in face" or is "maintaining face" (Goffman 1955:213-4). One can lose face either when one's line is not acknowledged by others or when they do not know which line to take (Goffman 1955:215). The former is also known as "being in the wrong face", while the latter is also referred to as "being out of face". When one is out of face, one can be given face by the other interlocutor, who can provide a line to take. Meanwhile, an interlocutor is expected to have self-respect by choosing to say non-embarrassing things in addition to being considerate of others by ensuring that they are not "defaced" (Goffman 1955:215). During medical consultations, these face activities are crucial for both doctors and their patients as they may assist in effectively communicating illness, which may be considered defacing for the patient.

Once a face has been established, interlocutors make the effort to manage it throughout the conversation. The management strategies take into account the individual's need to be autonomous and respected (negative face) and the need to be like by others (positive face) (Jones 2012:25-6). However, there are times when some actions threaten the established face, that is, they are insulting or embarrassing to communicate. These FTAs can be incidental, accidental, or deliberate (Jones 2012:14). During medical consultations, FTAs are typically incidental – not intended to spite, insult or embarrass. For instance, during gynaecological consultations, insults or embarrassment can sometimes occur due to the naming of genitals and sexual activities, even though the intention was to communicate effectively and not to insult or embarrass. In the following paragraphs, Goffman's view on strategies people take in an event of a FTA are outlined.

In an interaction, the constituents of an individual's line are expected to be "coherently unified and appropriate" (Goffman 1956:268). An absence of such a line may lead to embarrassment of self and inevitably of others, since an interaction is a joint venture (Goffman 1956:268). The summation of deliberate actions that one takes to ensure that one's actions are consistent with one's face is known as "face work" (Goffman 1955:216). An example of face work is poise, which is used to control oneself when embarrassed and which avoids the embarrassment of others which could result from one's own embarrassment (Goffman 1955:215). According to (Goffman 1955) , the first poise one may take is avoidance. One can avoid either physically, by using a go-between, or by changing the topic and waiting until one is sure of the kind of line that will assumedly be supported. When the FTA has to be performed, it may be hedged, some parts may be left out, or circumlocutions, deceptions and ambiguous responses may be used. However, once the threat has been committed, interlocutors use tacts to circumvent it.

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The first tact is to pretend that a FTA has not been committed (Goffman 1955:217-8): The one who loses face can distract the others by changing lines, while s/he recovers from face loss; and/or other interactants can avoid acknowledging the loss of face of an interlocutor to give them a chance to recover their face. A second tact is the corrective process of repairing lost face, which occurs when a FTA is acknowledged, as outlined below.

The corrective process begins when a FTA is acknowledged (as stated above) by the person whose face is threatened. Several moves can be made to ratify the loss of face. According to Goffman (1955:220-1) the following 4 steps occur: (i) raising alarm that a FTA has been committed (challenging); (ii) giving the offender a chance to correct or justify the FTA (offering); (iii) the offender can accept the offer as satisfactory (acceptance) and; (iv) the offender can compensate the other or punish themselves, depending on who was offended (thanks). These moves are followed by acceptance and gratitude. However, variations to the ritual code of the corrective process may also be applied (Goffman 1955:221), or the offender may even argue against the challenge, causing the offender to salvage their face by maintaining the challenge and/or withdrawing angrily (Goffman 1955:221-2).

Embarrassment is caused by unfulfilled expectations, including the expectation of being uncomfortable by others (Goffman 1956:268). It can be argued that in the Malawian context, women would expect to be embarrassed if they were to consult a male gynaecologist and would even be more embarrassed if they end up not being embarrassed. Goffman (1956:265) presents a continuum of embarrassment, discomfiture and uneasiness, on which embarrassment is at the high end and uneasiness is at the lower end. At the same time, Goffman (1956:265)acknowledges that a consistently uncomfortable and uneasy encounter becomes an embarrassing incident. Thus, embarrassment can be in the matters being discussed or as a result of consistent uneasiness, which Roberts et al. (2005) call “trouble in interaction”. Goffman (1956:266) argues that, socially, an embarrassed individual tries as much as possible not to be agitated by employing actions which are culturally understood, like laughter and scratching one’s head, because showing agitation may be construed as a weakness or defeat and/or other negative attributes and may abruptly stop the communication. Finally, Goffman (1955:231) argues that although face work is a universal phenomenon, every culture has a number of tacts to deal with FTAs that constitute the repertoire of a given language and that these tacts operate within a particular framework shared among the people of the same culture (Goffman 1955:231). It is important therefore to discuss how the taboo topics are communicated in gynaecological consultations using sociocultural knowledge on communication in

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gynaecological consultations. The options that are known by a competent language user when faced with linguistic taboo are discussed in the section that follows.

### 3.2.2. Gee's Situated Discourse Analysis (SDA)

#### 3.2.2.1. Introduction

This study uses Gee's (2011a, 2014) approach to DA, called "Situated Discourse Analysis" (SDA), which is based on the three tenets: The first tenet is that language is used for more than just conveying messages. According to Gee (2011a, 2014), language is used simultaneously for communicating information, constituting an identity, and performing activities. In SDA, communicating information is referred to as "saying" (Gee 2011a:3), and the terms "identity" and "activities" are used in a special ways: In a given language exchange, "identity" means a summation of what one portrays oneself to be, hence it is referred to as "being" (Gee 2011a). Conversely, "activities" are the things that are done using language, through structures and meanings, hence acting is also referred to as "doing things" (Gee 2011a:2). From this perspective, verbal communication thus includes saying, being, and doing things. Gee (2011a:2) further argues that interactants may only fully understand the information being said when they also understand who the other person is being and the action the other person is performing when they say the things they say. Thus, in summary, SDA views language as a tool for communicating meaning which is derived from three sources simultaneously: what has been said; who the speaker is being; and what is being done through what has been said. In SDA, the meaning of what is being said, who one is being, and what activities are being done are products of more than just form and function – they are also a product of context. Thus discourse, which is the object of study in SDA, includes context. This type of discourse is referred to as the big 'D' Discourse (Gee 2011a:30). That the meaning of an utterance is derived from context is the second tenet of SDA.

Whereas discourse analysists may study utterance meaning (Gee & Handford 2012:1-4), which is also referred to as "general meaning" (Gee 2011a:63-4), the study of big 'D' Discourse includes context (Gee 2011a:6-8) and is classified as the study of utterance-token meaning or situated meaning (Gee 2011:63-5). Situated meanings are meanings in which form-function correlations of language are tied to specific situations and specific contexts of use (Gee 2011a:63-6). According to Gee and Handford (2012:4), "any aspect of context can affect meaning". The open-ended use of context, which may include posture, physical, cultural and/or historical setting, affects the validity of SDA; however, context must be used as widely as

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possible, to the point that the analyst is satisfied that no other inclusion of context will change the meaning arrived at (Gee 2011a:67-8). Context is also referred to as the "non-language items of discourse", which include thoughts, emotions, objects and places (Gee 2011a:44). Indeed, Gee (2011a:28) describes Discourses as ways of combining language and non-language items that help one to form identities and practices.

The third tenet is that utterances obtain meaning within a situated practice where norms help to point out what one is "being" and what one is "doing" Gee (2011a :5 , 9). According to Gee (2011:5), the adherence and non-adherence to the conventions and norms regarding what is appropriate and normal language use in a given practice, impacts on the success of communicating information. Therefore, in a verbal exchange, people may simply follow norms and conventions to be appropriate; however, tactical communication also entails the intentional use of conventions to one's advantage, such as to gain things that are wanted and valued by society like respect and kindness, which Gee (2011a:5) refers to as "social goods". Social goods are setting-based, hence they can be at community level, institutional level or as specific as in a gynaecological consultation, for instance. The way language is used to obtain, distribute or withhold social goods is referred to as "politics" (Gee 2011a:69). Politics is one of the activities performed through language; these activities are called "building tasks", discussed below.

#### 3.2.2.2. Building tasks

Gee (2011a:16-20) argues that when people use language, they perform one or more of seven building tasks. These tasks, which build various aspects of social reality, are significance, practices, identities, relationships, politics, connections, and sign systems and knowledge (Gee 2011:16-20). Each task uses words and grammatical rules as tools for building and designing structures and meaning (Gee 2011b:48) in given contexts (Gee 2011b:72). Building tasks are important in this study as they are a point of entry into the understanding the identities (being) and activities (doing) constructed in the gynaecological consultation when talking about (saying) taboo topics. By describing the activities and the identities, the study will describe the Malawian gynaecological consultation as a practice. The following paragraphs describe each of Gee's seven building tasks and also explain how they relate to this study.

Firstly, the Significance building task refers to the ways in which one's use of language may classify a topic as important or trivial (Gee 2014:94). Gee explains that significance is built through either the syntactic order of presentation or through subordination: Topics appearing last and those in subordinate clauses imply facts that are common knowledge or trivial. In contrast, facts that are important are placed in the sentence-initial position and/or in the main

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clause. Apart from using sentence structure to point out what information is more important, paralinguistic features like stress and intonation are also used, as well as lexical items whose semantic meaning point to the significance or insignificance of what is being discussed. Studying this building task allowed for the identification of what is deemed significant during gynaecological consultations.

The second building task is the building of Practices. Practices or activities are undertakings that are socially recognised and institutionally or culturally supported, like interviewing patients and giving them medical advice (Gee 2014:94). Activities are routinised and are governed by standards and norms in the institutional, social or cultural setting; therefore, when studying this building task, one simultaneously studies the systems that enforce the status quo and the values normalised in the given setting (Gee 2014:104). It involves looking at the structure and pattern and stating whether it is routinised or varies (Gee 2014:105). In this study, a gynaecological consultation is classified as a practice, and I investigated whether there were institutionalised standards and norms surrounding linguistic taboo and its use in such consultations.

Identity is the third building task described by Gee (2011:18a; 2014:95, 112-20). This task involves using language in a way that (i) defines the role one is playing 'here and now"(Gee 2011a:89) and (ii) assigns a role to the other interlocutor. In other words, it shows who one is "being" through one's linguistic choice in a given setting. Two of the questions that arose with regard to this building task was whether or not the doctor-patient and male-female identities were maintained simultaneously, and why this was (not) the case. It was also important to establish which other identities participants portrayed in their use of language as Gee argues that one can portray a number of identities in one exchange, simultaneously or alternately. Particularly the identities of respectable gynaecologist and talking patient were at issue in this study as the former leads to patient satisfaction, while the later would affect the achievement of the medical goals of the consultation.

Related to identity is the fourth building task, Relationship building. Identities define the boundaries of the relationship between the interlocutors (Gee 2014:120-1). For relationship building, language is used to create and/or sustain relationships as guided by the identity that each participant assumes or is given. Parameters set by one's identity on the relationship may be mitigated or even invalidated if one does not follow the set parameters in a given context. In this study, the relationship between the doctor and the patient is studied in relation to the identities they portray and the impact it has on how they communicate taboo topics.

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The fifth building task is the Politics building task, which deals with the discursive strategies used in obtaining social goods. Gee (2014:124-5) explains that social goods, such as respect and privacy, are setting-based. According to Gee (2014:126), larger and greater categories of social goods are described by the positive and negative face needs (see 3.2.1.2 above), as participants in every interaction try to mitigate their own face needs and those of the other participant. The term "politics" is used because the way social goods are claimed and distributed may give or withdraw power and status to/from the people involved (Gee 2011:96). The interlocutor's motives, responsibilities, rights and wrongs are demonstrated under this task. This study investigated the way social goods are distributed in the light of linguistic taboo, where there is a potential threat to the social good of respect and privacy: In a gynaecological consultation, physical examination invades one's privacy, and the discussion of genitals may threaten one's self-respect, which may have to be protected or regained through a variety of discursive strategies.

The sixth building task is the Connections task in which language is used to show existing or new connectedness or relevance between entities (Gee 2011a:96-7). Words and grammar draw relevance between explicitly connected things (Gee 2014:132-3), whereas the fill-in tool (see 3.2.2.3) may be used in the case of non-explicitly stated connections. Strategies for communicating linguistic taboo include the use of vague or euphemistic expressions; for one to understand such expressions, associations interlocutors make within and outside of the text need to be identify.

The final building task, the Sign Systems and Knowledge task, describes privileging or denigrating a sign system or source of knowledge. One sign system or source of knowledge can be constructed as relevant and more prestigious than another by choosing it to communicate in. This is the case as one's choice of language or dialect may be linked to one's identity and beliefs that some knowledge and feelings are better expressed in one language or dialect than in another.

Gee (2011:9) describes his approach as a form of Critical Discourse Analysis as it does not analyse language use as an end in itself but as a means to point out and even intervene in social-political issues, problems and controversies intricated in the very nature of language. This fits very well with the reasons for conducting this particular study, one of which is to impact the training in and promotion of effective communication skills in Malawian gynaecological consultations.

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#### 3.2.2.3. Tools of enquiry to use for identifying the building task

According to Gee (2011a:121-2), the following question can be applied to analyse each of the building tasks: *How are situated meanings, social languages, figured worlds, intertextuality, Discourses, and Conversations being used to build and sustain (or change or destroy) … [a particular building task]?* Each of the listed items are tools of enquiry. This section outlines the six tools of enquiry that are used to identify the tasks being built within the text. Also included are questions that guide the analyst when using each analytical tool.

Firstly, when part of the interpreting process is analysing meaning using context, the analyst uses the situated meaning tool (Gee 2011a:151-5). The guiding question is here is *What specific meanings do listeners have to attribute to these words and phrases, given the context and how the context is construed?* (Gee 2011a:153) Secondly, the analyst uses the social languages tool (Gee 2011a:157-65). The following is the guiding question: *How are words and grammatical structures (types of phrases, clauses, and sentences) used to signal and enact a given social language?* (Gee 2011a:161). Thirdly, the analysis of textuality is achieved by finding out whether, in the text under study, references are made to other texts through content, idea or style (Gee 2011a:165-8). The guiding questions are *How are words and grammatical structures (e.g., direct or indirect quotation) used to quote, refer to, or allude to other ''texts'' (that is, what others have said or written) or other styles of language (social languages)?* and *Does intertextuality go so far as to be an example of mixing or switching between voices or styles of language (social languages)?* (Gee 2011a:166). The fourth tool, figured worlds, involves finding expressions that are labelled as either normal or not in a given situation because of the associations they have – in other words, distinguishing acceptable from unacceptable expressions in a given communication situation (Gee 2011a:168-76). In analysing figured worlds, the following questions are asked: *What typical stories or figured worlds are the words and phrases of the communication assuming and inviting listeners to assume?* and *What participants, activities, ways of interacting, forms of language, people, objects, environments, and institutions, as well as values, are in these figured worlds?* (Gee 2011a:171). Finally, the analysis of big 'D' Discourses involves recognising identities being enacted through the use of language (Gee 2011a:176-84). The questions to ask to identify the identity being communicated are as follows: *How is the person using language, as well as ways of acting, interacting, believing, valuing, dressing, and using various objects, tools, and technologies in certain sorts of environments to enact a specific socially recognizable identity and engage in one or more socially recognizable activities?*; *What Discourse is this language part of, that is,*

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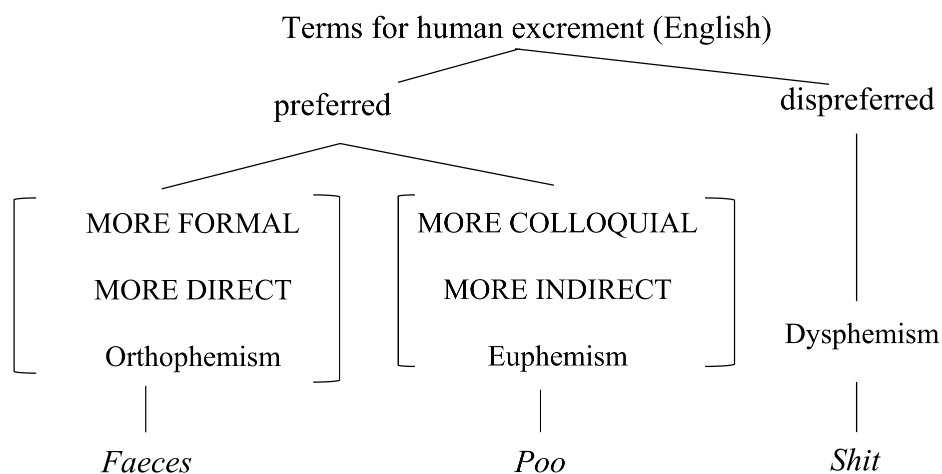
*what kind of person (what identity) is this speaker or writer seeking to enact or be recognised as?* and *What sorts of actions, interactions, values, beliefs, and objects, tools, technologies, and environments are associated with this sort of language within a particular Discourse?* (Gee 2011a:181).

All these tools of enquiry are used for each building task. While acknowledging that SDA may be rendering mere opinions of the researcher, Gee (2011a:185-6) also states that the validity of an analysis depends on (i) how each of the six tools of enquiry validate the claim(s) being made from the analysis (Gee 2011a:185) and (ii) whether there is detailed linguistic evidence of the claims made (Gee 2011a:186). SDA is an approach to DA which pertains to the structuring of situated meaning identities and activities. Below I discuss a complementary approach to DA, which focuses on the interpretation of situated discourse.

### 3.2.3. X-phemisms and taboo expressions

This section describes a theory about linguistic taboo options which relates them to the sociocultural options at macro-level (discussed in the IS theory above). Allan and Burridge (2006:15) argue that X-phemism describes the three options that competent language users have when faced with a situation where a taboo expression is eminent. These options are orthophemism (a direct and formal expression), euphemisms (a more colloquial and indirect expression) or dysphemism (a potentially harsh or offensive expression), as illustrated in Figure 3.1 below.




Adapted from Allan and Burridge (2006:34)

Figure 3:2 The X-phemism of solid excreta (English)

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As seen in Figure 3.1, an English language user has three options when referring to human excreta, which are either preferred or dispreferred – the latter, known as a "dysphemism", being "not preferred, not desired and not appropriate" (Allan & Burridge 2006:33). The preferred is further split into (i) the formal and direct orthophemism, and (ii) the informal and indirect euphemism. It is expected that competent speakers of a language would conform to the cultural restrictions of when to use which option, but this is not always the case. For instance, although the dysphemism is typically dispreferred and often taboo, it is allowed in particular contexts (Saville-Stroke 2002:211; Allan & Burridge 2006:32), such as when said as a joke. The dysphemistic expressions "denote a taboo topic" hence they are also referred to as taboo terms (Allan & Burridge 2006:238)

Transferring the discussion to options with which to refer to human excretion to Chichewa, there would be at least three terms in the standard variety, namely *manyi, chimbudzi* and *bibi* (as shown in Figure 3.2). Competent users of Chichewa can easily identify the dyphemistic expression amongst these three, namely *manyi*. However, taking into consideration that the English term *poo* is used with and by children just like *bibi* in Chichewa, whereas *chimbuzi* is a term that would be used by adults and in a setting like the hospital or advertisements, *chimbuzi* would be the orthophemistic expression. However, *bibi* is more direct that *chimbuzi.* The term *chimbuzi* also refers to and can be translated as 'toilet', depending on the context, which means that despite being formal like orthophemistics expressions, *chimbuzi* is indirect like euphemistic expressions.

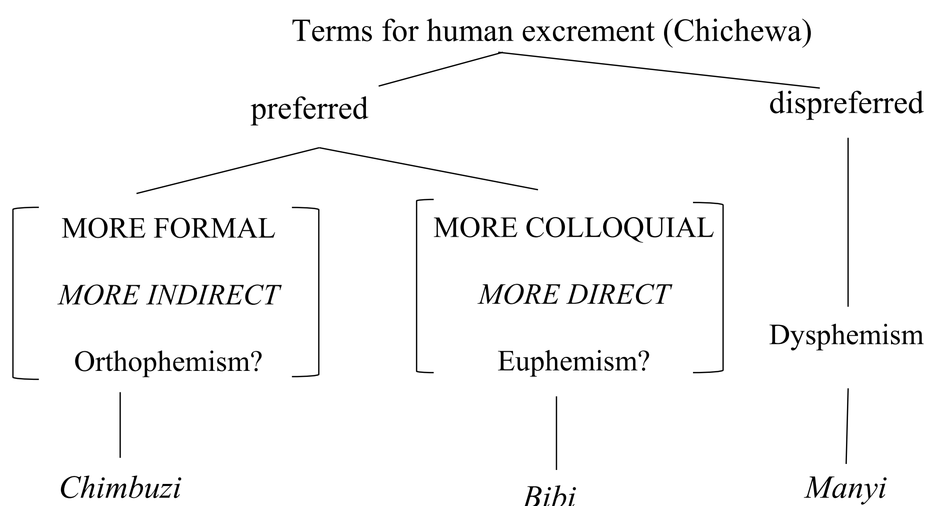


Figure 3:3 The X-phemism of solid excreta (Chichewa)

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Figure 3.2 shows that it difficult to classify the above Chichewa expressions, unlike what was the case for their English equivalents in Figure 3.1. In Chapter 6, possible reasons for the challenges of this classification system in Chichewa are discussed in more detail in 6.2. Since X-phemism only applies to linguistic expressions, it is not used as the major theory in studying the communication of linguistic taboo in this current study.

### 3.3. Implications for the study

Due to the sociocultural aspects entailed in the discussion of taboo topics, two approaches to DA, namely IS (3.2.1) and SDA (3.2.2), were selected for use in this study, as they allow one to access specific and generalised ways of language use, respectively. In other words, Gee's (2011, 2014) SDA allows for a discussion of specific linguistic and non-linguistic tenets of Discourse, which may reflect social tenets, whereas IS focuses on finding the language system that may be attributed to the general linguistic traits of the society under study. As this study is a seminal undertaking in the Malawian context, it was deemed necessary to use both SDA and DA. SDA provided a description of language use and possible variations in the situation by individuals as far as linguistics taboo is concerned, while IS was used for wider cultural interpretations in this study setting. Such an approach is based on the understanding that a user’s sociolinguistic ability is a product of communicative competence.

According to Canale and Swain’s (2014) theory, such competence includes grammatical, sociolinguistic and strategic competence. It can be argued that to effectively communicate what culture defines as linguistic taboo, one is guided by sociolinguistic and strategic competences in a given situation. Sociolinguistic competence includes sociocultural rules of use and discourse (Canale & Swain 2014:30), while strategic rules are those that are employed when there is communication breakdown (Canale & Swain 2014:31). Furthermore, sociolinguistic competence covers the appropriateness of topics, role, setting and interaction norms and the appropriateness in attitude and register (Canale & Swain 2014:30) in a given situation. Since language provides a variety of linguistic choices for achieving different language functions, interlocutors negotiate their roles or identities and actions with each other in any communication event. However, it can be argued that in hybrid communication or an interactionally volatile situation, such as one in which requirements of medicine and culture are juxtaposed, such negotiations would be eminent.

In a similar fashion, the social understanding of conversation strategies that display sociolinguistic and strategic competences have been studied by navigating contextualisation cues in the IS approach to DA. Given that taboo talk may evoke feelings of embarrassment, it

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was expected that face and frame strategies would be used to negotiate identities and meaning in conversations. In addition, there is a high possibility that face strategies may influence linguistic constructions used and literal meaning. This necessitated the inclusion of Gumperz's notions of conversation inference and presuppositions (3.2.1.2) and Goffman's notions of frames and framing (3.2.1.1) to thoroughly investigate linguistic constructions used and the situated meanings thereof. In addition, since linguistic taboo may evoke feelings of embarrassment, Goffman's notions of face and face work are included (3.2.1.3), to discuss the possible communication strategies people employ in embarrassing situations.

In studying Discourse within the framework of IS, I describe competences which may be commonly shared between Chichewa users in Malawi. IS argues for the existence of several options which are in operation at the same time despite cultural restrictions, hence this chapter discusses the available options related to linguistic taboo using Allan and Burridge's (2006) description of X-phemisms, the lexical options available to mitigate (or not) a linguistic taboo expression. Moreover, Wooffitt (2005:80) argues that DA is mainly concerned with the concept of repertoires, and in particular, how things like linguistic structures (e.g., figures of speech and metaphors) are used in particular contexts. The X-phemisms of linguistic taboo provides for the study of such lexical choices for taboo expressions.

## 3.4. Chapter summary

This chapter gave an exposition of theories drawn upon in this study. These theories explain interaction, including interaction in an interactive volatile situation. The basic assumption is that there is an underlying and commonly shared system that informs the construction of meaningful and purposeful discourse. As a theory, DA relates the form and function of an utterance to its situated meanings. Two approaches to DA that have been used to describe the relationship of form and function to situated meaning are SDA and IS. On the one handIS posits that an interaction contains contextualising tools which assist interlocutors to make connections between what is said and what is meant, with reference to sociocultural knowledge commonly shared between the interlocutors. It is this common knowledge that helps in producing contextualisation cues and negotiating frames when making inferences and managing face (as discussed in 3.2.1.2 and 3.2.1.1 respectively). On the other hand, SDA explains that (i) four tools are used to situate meaning, (ii) what people say builds interlocutors' roles, and (iii) relationships help people to perform certain tasks (see 3.2.2). These tools are socially constructed to build identities and practices. Finally, the types of lexical items used when mentioning taboo items are set out by X-phemism theory. Although Allan and Burridge's

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(2006) X-phemism theory might not apply as is to Chichewa, more data is discussed in Chapter 9 to indicate possible patterns that occur in Chichewa. The four theories have been shown to complement each other, and therefore they are used to study taboo as communicated in gynaecological settings. The theories informed the methodology, as shown in the next chapter; together they indicate the need for data consisting of real conversations in real situations. Furthermore, when discussing the findings in Chapters 5 to 8, I draw on the theories discussed in this chapter.

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# Chapter 4 : Methodology

## 4.1 Introduction

This chapter outlines the methodology employed in this study during data collection and analysis. The discussion contains a description of the overall research design (4.2), participants (4.3), data collection methods (4.4), and data analysis procedures (4.5). I also discuss ethical considerations (4.6) and the methodological limitations of the study (4.7).

## 4.2 Research design

This is a qualitative and interpretive study of situated meaning related to communication about taboo topics in gynaecological consultations. Interpretivism posits that social reality is "subjective and co-constructed by the researcher" in his/her quest to make sense of reality formed by language and linguistic devices (Chandra & Shang 2019:11). The aim thereof is to discover and build theory on themes (see 4.5.1) that emerge from the data collected (Chandra & Shang 2019:11). Subjectivity of the findings is reduced by triangulation of data sources (in the case of this study, literature, interviews, and simulated consultations; see below); personal interviews; the use of multiple informants; and the presentation of evidence and extracts from the data that explain the conclusions reached (see 4.2) (Chandra & Shang 2019:12).

Qualitative research by nature aims to find "the hows and whys" of a particular phenomenon (Chandra & Shang 2019:3), whereas the objectives of quantitative research are to find "the how much and to what extent" (Chandra & Shang 2019:3), which would have been unattainable in the case of this study. The qualitative approach is preferred in this study as the study investigates Chichewa speaker's knowledge of "the hows and whys" of language use when communicating taboo in medical consultations. This abstract knowledge is called "communicative competence" (Hymes 1968), which entails that knowledge that enables a language user to successfully communicate with others in a variety of speech events within a speech community (Saville-Troike 2003:2). Communicative competence used in an interaction is also known as "interactional competence" and entails the knowledge of linguistic and communication conventions that one requires to create and sustain a conversation during a speech event (Gumperz 1982:209). According to (Nguyen 2011:1), interactional competence includes knowledge on sequencing of actions, topic management, formulation of referents, conversational turn-taking, and participation frameworks. This study considers a gynaecological consultation to be an example of a speech event, therefore it focuses on

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discovering the interactive competences that coincide with the use of linguistic taboo in gynaecological consultations.

This study has the following attributes of qualitative research: Firstly, it uses theory for general understanding of a social phenomenon but allows patterns to emerge from the data. Also, the process followed during data collection, analysis and discussion is nonlinear in that there is constant checking and re-checking between data and theory (see 4.4 and 4.5). Secondly, its aim is to discover new concepts or ideas (pertaining to communicating taboo topics), and to challenge the X-phemism theory as it was described in 3.4 above. Thirdly, data sources are triangulated. Data were collected from two sets of participants who are Malawian interlocutors in a medical consultation, namely male gynaecologists and patients. In addition, data was collected in two manners, namely via simulated consultations and discursive interviews (see 4.3.1.1 and 4.3.1.2 below, respectively). Finally, context is central in this study as the findings and the data analysis and interpretation reflect the particular linguistic and cultural setting (Chandra & Shang 2019:3-6).

Below, the following will be expounded on: Data was collected from 16 participants via individual interviews. In addition, individual simulated gynaecological consultations took place between eight patient participants and the four gynaecologists (two consultations per gynaecologist). The data was analysed making use of thematic analysis, SDA, IS methods, and X-phemism.

## 4.3 Participants

The participants consisted of four male gynaecologists working within one of the main cities in Malawi, and 12 women who had visited at least one Malawian gynaecologist in private and/or public hospitals no more than one year prior to the commencement of data collection. All participants had to be Malawian by birth, had to have grown up in Malawi and had to self-identify as Malawian.

The four gynaecologists were recruited from one public referral hospital (see 1.6.3 for Malawian referral hospitals). It is a non-fee-paying hospital, so doctors see patients from different socioeconomic backgrounds (some gynaecologist participants were however also in private practice at fee-paying institutions). Gynaecologist participants’ characteristics can be found in Table 4.1, alongside the medical condition for which they were consulted in the simulated consultations.

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Table 4:1 Gynaecologist particulars and consultation topic

| Participant | Description of age[19] | 1st language | Experience in gynaecology | Simulated consultation conditions |
|---|---|---|---|---|
| Dr AS | Above 55 | Chichewa | 17 years | Pregnancy & Menopause |
| Dr OB | Above 55 | Chichewa | 17 years | Infertility & Menorrhagia |
| Dr DW | Above 35 | Chichewa | 6th & final year of training | Menorrhagia & Infertility |
| Dr KG | Above 35 | Chichewa | 6th and final year of training | Cervical Cancer & Period pain |

The sample of patients consisted of 12 women residing in the same city as the gynaecologists. Women of various ages and marital statuses were included to ensure greater representation of the Malawian population seeking gynaecological care. Table 4.2 below shows the characteristics of the patient participants and, for the eight who had a simulated consultation, the medical condition they selected for this consultation. As can be seen in Table 4.2, all patient participants were adults, half being younger than 30. Included were 4 divorcees, 1 widow and 7 married women.

Table 4:2 Patient particulars and consultation topic

| Simulated consultation condition | Age ranges and marital status | | | | | |
|---|---|---|---|---|---|---|
| | 18-29 | Status | 30-39yrs | Status | 40+ | Status |
| Menstruation pain | Patient 2 | divorced | | | | |
| Menorrhagia | Patient 5 | married | Patient 6 | married | | |
| Cervical cancer | | | Patient 9 | divorced | | |
| Pregnancy | Patient 12 | married | | | | |
| Infertility | Patient 3 | married | Patient 1 | married | | |
| Menopause | | | | | Patient 8 | widowed |
| N/A | Patient 4 | married | | | | |
| N/A | Patient 7 | divorced | | | | |
| N/A | | | | | Patient 11 | married |
| N/A | | | Patient 10 | divorced | | |

[19] It would have been culturally inappropriate for me to directly ask the qynaecologists for their age, so their ages were estimated based on the information about schooling, training and years of practice provided in the individual interviews.

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## 4.4 Data collection

### 4.4.1 Data collection methods

Data was collected by means of simulations (see 4.3.1.1) and interviews (see 4.3.1.2). The former allowed for the identifying unconscious sociocultural linguistic tools displayed as language speakers speak, while the latter collected narratives about past experiences and opinions on communicating about taboo topics in (non-simulated) gynaecological consultations. The reasons for using these two methods are discussed below.

#### 4.4.1.1. Simulated consultations

Discourse analytical studies require the use of naturalistic data (Brown & Yule 1983; Gee 2011; Gee & Handford 2012; Gumperz 1982), hence recording real gynaecological consultations would have been the most ideal source of naturalistic data. However, preliminary enquiries about recording real, live doctor-patient consultations were not met with positive responses by administrators and doctors, for several reasons: Firstly, I am neither an insider in the medical field, nor conducting research on a topic that was directly related to the main agenda of the hospital, which is medical procedures.[20] Secondly, the content of doctor-patient consultations are often sensitive and meant to be confidential, so an outsider's presence during these private consultations would have created ethical difficulties. Furthermore, recording real consultations would have been considered an unnecessary breach of doctor-patient confidentiality. Therefore, I resolved to collecting data from simulated consultations.

Simulated dialogues are used in doctor training worldwide so as not to cause harm to patients while the trainee doctors practice their clinical interview skills (Nestel, Debra & Bearman 2015:2). Although the authenticity of simulated dialogues has been questioned (Seale *et al.* 2007:177), they have contributed greatly to the understanding of medical dynamics (Roter & Hall 2006:45-6). In fact, Seale *et al.* (2007:178) recommend the use of simulations for studying hybrid communication where strategies like frame shifting and negotiations as well as sensitivity to contextualising cues are required. Therefore, this study used simulated dialogue data, with reference to existing literature to put in place measures that enhance authenticity, as explained below.

[20] Although this study fits into the new field of medical humanities, which is concerned with the inclusion of the arts in medical education (see Kirklin & Richardson 2001; McManus 1995), improved communication in health settings is not part of the main agenda of the hospital.

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The type of simulated patients used depends on the contribution they are expected to make to the simulated encounter (see Nestel *et al*. 2015:1). For instance, actors were used in Kruijver, Kerkstra, Bensing and Van De Wiel's (2001) study because they (and not the nurses whose language skills were being studied) were required to control the direction of the conversation. The current study, however, aimed at studying uncontrolled language skills of both patients and gynaecologists, thus trained patients were used in simulated consultations. A trained patient is a former patient who uses their own discretion to employ previous knowledge and skills during simulated consultations (Nestel *et al*. 2015:1). They are not professional actors, hence they do not adhere to scripts but tend to personalise what they have been prepped to do. In this current study they were asked to explain the choice medical condition they had chosen for their simulated consultations, as will be explained in the paragraph that follows.

Authenticity of the simulated consultations was increased, firstly, by having real gynaecologists with no less than 5 years of experience of working in a Malawian hospital participating in the consultations. Secondly, both gynaecologists and patients described themselves as competent speakers of Chichewa and as Malawians. Thirdly, the social categories of those who took part in the simulated consultations coincided with their real social categories in terms of age, gender and marital status. Fourthly, this study used authentic physical contexts for simulations, given that Seale *et al*. (2007:180) showed that authentic physical contexts (that is, authentic physical surroundings) contribute to the authenticity of simulated dialogues. All simulated consultations were conducted within the hospital premises: half of the eight in real consultation rooms, and other half in two gynaecologists' private offices within the hospital. Finally, the simulated patients could choose with which medical condition they would present in their simulated consultation (see Table 4.2) as long as it was a condition they were at least partly familiar with. The patients' knowledge of the condition was confirmed during pre-consultation briefing. During this briefing, some patients indicated that they would use the simulated consultation as an opportunity to get a second opinion on a condition they had previously had, while others regarded these consultations as a chance to get more knowledge on a particular condition, which they had no personal experience of.

At the time arranged with the gynaecologist and patient participant for their simulated interview, I met the patient participant at the hospital, introduced the two participants to each other and set up the recording devices before leaving the office or consultation room, only to return once the participants existed and announced that the simulated consultation had ended.

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#### 4.4.1.2.Discursive interviews

Cruickshank (2012:42) argues that in discursive interviews, intentions, feelings, purposes and comprehension of the interviewee are revealed. Since cultural norms are not always consciously adhered to by language users, I had to build an enabling environment for the interviewee to think about what they do when they communicate within a given situation. I, therefore, selected participants carefully, conducted interviews in a comfortable setting, and framed follow-up questions that elicited thoughts about what interlocutors do subconsciously (see Appendices A and B for interview schedules for gynaecologists and patients, respectively).

The interviews were semi-structured with open-ended questions, allowing the participants to talk more than me. As a result, gynaecologists gave narrative accounts about their work including how they communicate within the Malawian setting and a possible simulation of what they can and would say to a patient in various contexts. To the patient participants, I initially asked preliminary questions to establish rapport before asking them to listen with me to a pre-recorded audio of a (fictional) scripted gynaecological consultation with a male gynaecologist (see Appendix C). This use of a pre-recorded fictional script is an adaptation of Chafe (1980) and Tannen (1981), who showed films to their participants to comment on. This is in contrast with Boromisza-Habashi (2012) who used real-life (unscripted) audio-recording for discussion. I opted for an audio-recording of a scripted because scripted consultations allowed the researcher to include all three X-phemism options of approaching taboo topics (see Allan & Burridge 2006; Saville-Troike 2003; also see 3.4), and to ensure that a variety of taboo topics are covered. Where the participant had not encountered specific taboo topics before, they were asked to imagine how they would perceive and produce talk about particular linguistic taboo topics during gynaecological consultations.

After listening to the pre-recorded audio, the semi-structured interview followed. The interview questions elicited narrative accounts from the participants on their linguistic choices and strategies, who reflected on their own production and consumption of discourse about taboo topics during gynaecological consultations.

### 4.4.2 Data collection equipment

Apart from the interview schedule and the pre-recorded scripted consultation, data collection equipment included two rechargeable MP3 recorders (always used simultaneously), to record all interviews (with the participants' permission). This type of recorder allowed for audio data to be instantly uploaded onto a computer and on OneDrive. Notebooks were used for recording

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the following information: details of participants, the date of the data collection, any matters that required follow-up, and other fieldnotes, including notes on any discourse that was peculiar as a reminder to pay careful attention to these when analysing data.

### 4.4.3 Data collection procedure

The interview schedules written in English and submitted for ethical clearance in South Africa. After which they were translated into Chichewa and both language versions were submitted for ethical clearance in Malawi and South African. The interviews were conducted in pre-arranged places deemed safe by the participants, i.e., spaces free from intrusion which could add to participant discomfort about discussing taboo topics. Eight patient participants chose to go to the hospital for their interview. It was not possible, however, to secure private rooms in the hospital in which to conduct the interviews, because part of the gynaecology wing was undergoing renovations at the time of data collection. As such, most interviews were conducted in my car parked away from pedestrians within the vicinity of the hospital. One interview was conducted in my car in the parking lot of a hotel where the participant had been working on the day of the interview. And lastly, two interviews were conducted in the board rooms at the workplaces of the participants. All simulated consultations and all interviews with gynaecologists were conducted at the hospital, either in gynaecologists' private offices or in consultation rooms. The following section describes procedure I followed to be allowed into the hospital for data collection purposes.

#### 4.4.3.1. Entering the institution

I applied to the Hospital Administrator to conduct the study at the hospital. The application included a copy of the approved research proposal, the ethical clearance letter from the Malawian National Commission of Science and Technology, proof of registration from Stellenbosch University, an introductory letter from the Malawian University of Science and Technology (where I work), and my business card for easy reference when giving feedback.

My application coincided with an unscheduled two-week Christmas holiday for government institutions;[21] offices were closed from 21 December 2018 to 6 January 2019. On 21 January 2019, I enquired in person about the progress of my application from the secretary of the Hospital Administrator and was informed that permission had been granted. Thereafter, I approached the Head of the Department of Gynaecology and Maternity and requested

[21] This holiday occurred a few months before national elections and was perceived by Malawians as a way in which the governing party was attempting to secure more votes in the upcoming elections.

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permission to interview his staff members. He requested a copy of the research proposal, which I supplied (excluding the interview schedules). He asked for time to study the proposal before informing his colleagues about my planned research. After two days, I made a follow-up appointment with him, during which he asked for a short introductory note and letters of consent as he said he first had to approach the gynaecologists himself before I could do so. Less than a week thereafter, he gave me permission to contact his staff directly. I then arranged meetings for interviews and simulated consultation either by phoning the gynaecologists or by visiting them in person in their respective offices, as explained below.

#### 4.4.3.2. Approaching the gynaecologists

Even though the gynaecologists were in principle willing to taking part in the study, it was hard to find 45 continuous minutes during normal working hours to collect data from them:[22] Their schedules were busy and erratic, because the hospital is both a referral and a teaching hospital, so they attended to emergency cases; did ward rounds, teaching, and tutoring; took part in other medical projects; and also worked in private hospitals where their services are sought after. I initially decided to strategically sit in the hospital corridor leading to their offices in the College of Medicine building from 08:30 to 16:30 daily, which is when the offices closed. During this time, I would approach any available male gynaecologist to introduce myself and attempt to schedule interview and simulated consultation times. The two guards with whom I was acquainted by the end of my first week in the hospital assisted me in identifying gynaecologists, because they moved around the hospital without visible identification (e.g., name badges) on them and their offices were not name-labelled. Scheduling appointments in this manner was however unsuccessful as the gynaecologists would invariably only appear when they were on a short break before going back to attending to either students, an emergency or normal ward rounds.[23]

I finally requested the gynaecologists' mobile numbers from the Head of Department, who gave these to me with the permission of the gynaecologists. I called each gynaecologist to schedule an appointment, but I would still sit in the corridors just in case a time slot became available sooner.

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[22] After a period of failing to manage to interview the gynaecologists (either because scheduling the interview proved difficult or because they had to cancel the interview appointment several times), my supervisors suggested that I break the interviews into 10-minute slots to achieve my objectives without imposing myself on the gynaecologists' work schedules. In the end, this was however not necessary.

[23] I also learnt that, due to the renovations that were in progress, not all gynaecologists' offices were housed in the hospital. The other office block was not far from the hospital, so I could move on foot between the two sites in under five minutes. I visited both sets of offices in an attempt to recruit gynaecologist participants.

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#### 4.4.3.3. Approaching the female (patient) participants

Women who participated in study were approached by means of a call for participants posted on two Facebook secret groups of which I am a member: One is for Malawian mothers, pregnant women and those trying to fall pregnant, and the main topics discussed in this group are pregnancy and baby care. The other constitutes women of all ages and marital statuses that discussed any topic of interest to women. The selection criteria for patient participants were that they had to be Malawian, had to be able to speak Chichewa and had to have had sought medical attention in the past year for one or more conditions pertaining to sexual or reproductive health.

A preliminary enquiry was made through the administrators of three Facebook groups about whether I would be allowed to source participants and to take screenshots of some of the posts on the sites, which I would anonymise. I first sent the administrators a short self-introduction, explaining what I am studying and why, and included my request to source members and sample some posts related to the work I was doing. I also explained the measures I would take to anonymise the data so as to not reveal the true identity of the women or the name of the Facebook group I recruited them from. I concluded by inviting questions from the administrators. Of the three groups which I approached, two accepted my request. The administrators of the third group did not want to allow any researcher into what is meant to be an exclusive, secret group as their members would feel exposed.[24] All discussion with the administrators occurred on WhatsApp, where they had added me to their private WhatsApp group to discuss my request.

I had to change the privacy settings of my personal Facebook page from private to public so that the administrators and potential participants could authenticate my identity. I decided to use a "study friendly" Facebook profile picture, one showing me with my children so that administrators and potential participants could see that I was a mother. Before posting the poster requesting voluntary participation, the administrators were informed that and when the post would be made so that they could immediately freeze the comment box. This was done to bar group thought on the decision to participate or not, because if the group decided to participate, those who did not want to participate might be coerced into doing so; and if the group decided not to participate, those who would decide to participate would be opening

[24] As a Malawian researcher, I understood the fears of the administrators who refused my request. This group was frozen a few months later, because the administrators had reason to believe that some men had been added to the group under false names. Another, similar group was opened shortly thereafter.

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themselves up for criticism by the group. Interested participants were then requested to contact me using Facebook messenger where they were given my mobile number and theirs was requested for further arrangements. Although only two participants were recruited from the secret sites, Facebook assisted me greatly as people who were not based in Blantyre but knew me personally (and were Facebook friends with me) invited their friends and acquaintances in Blantyre to participate. Some participants also invited their friends to participate. Although this chain referral was not planned, it enabled me to recruit 12 patient participants.

Once interest was shown, the potential participant was given a written brief on what the research was about and what would be required of her should she consent to participation. She was given a day to think about her choice to participate before being requested to confirm or deny her interest. If she confirmed, and after the informed consent form was signed, she was given a list of possible ailments or conditions from which she had to choose any two which she would be comfortable to discuss with a gynaecologist in a simulated consultation. From this, I chose two people of different ages, for each ailment/condition. Dates for simulated consultations were arranged first with the gynaecologist, after which I enquired about the availability of individual patient participants. In cases where the consultation date coincided with the date of their individual interview with me, the female participants stayed at the hospital the whole day.

## 4.5 Data analysis

The overall analytical method used is thematic analysis (see 4.5.1). Themes were developed from content that appeared repeatedly. DA was also done, as was an analysis of lexical expressions using X-phemism theory. All data was processed through Computer-Assisted Qualitative Data Analysis (CAQDAS) using Atlas.ti, which allows one to analyse data inductively, and made it easier to identify themes after coding the data. The identified themes are presented and discussed in Chapters 5 to 9.

Once recorded, interviews and simulated consultations were transcribed by me using Potplayer, a free download application that allows one to type and control the player without changing windows, because it can be minimised and pinned on top of any window. In addition, it has functions that allows the transcriber to select a portion of a recording they want to transcribe and to repeat only the selected portion until the transcriber is satisfied with the transcription. After all data transcription had been completed, the data was analysed in the source language, which was predominantly Chichewa (with some codeswitching to English). This ensured that cultural nuances found in the source language were maintained. When findings are presented

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in Chapters 5 to 9, discourse fragments are first presented in Chichewa before the English translation thereof is provided. Whenever a linguistic strategy could only be shown in literal translation, the expression was first translated verbatim from Chichewa to English before presenting the idiomatic English meaning.[25] Although I have extensive experience in translating between the two languages, translations were checked by two of my colleagues from the Language and Communication Studies Department of the Malawi University of Science and Technology, a department that has extensince experience in translating English and Chichewa texts. After translation, the data was uploaded into files on the Atlas.ti in order to be analysed using a particular analytical methods where themes emerged. The sections that follow discusses the analytical methods used, starting with thematic analysis.

### 4.5.1 Thematic analysis

Thematic analysis (TA) is the identification, analysis and reporting of patterns or themes from a data corpus (Braun & Clarke 2006:79). It is a flexible analytical tool that works well with many different types of theories (Braun & Clarke 2006:78)), including DA. Data was analysed by combining inductive and deductive methods of analysis on the following data items: 16 discursive interviews (12 with the participating women and four with participating gynaecologists) with a combined length of 7 hours and 38 minutes, and eight simulated consultations with a combined length of 1 hours and 58 minutes. Data that answered the research questions was marked with a descriptive code and eventually all data with the same codes were easily retrievable and grouped using Atlas.ti's prompts after which the organised data were exported Excel for easier reference.

TA can be employed to analyse data at micro, macro, and meso-level (Braun & Clarke 2006:81). This study engages TA at meso-level where it is used as a contextualistic method which acknowledges experiences, meaning and realities of participants and the effects of discourses at societal level (Braun & Clarke 2006:81). Sections 4.5.2, 4.5.3 and 4.5.4 explains how IS (see 3.2.1), Gee's SDA (see 3.2.2), and X-phemisms (see 3.3) were incorporated.

#### 4.5.1.1. Analytical procedure

Braun and Clarke's (2006:87-93) non-linear six phase TA guideline outlined in the paragraphs that follow was used. During the first phase, one familiarises oneself with the data by reading

[25] In such cases, verbatim translations are presented in single inverted commas, while the idiomatic English meanings appear in single brackets and are preceded by the symbol =. In certain extracts, bold is used for ease of reference during the discussion of the extract.

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and re-reading through the whole data corpus while searching for and taking down notes on meanings and patterns (Braun & Clarke 2006:87-8). According to Braun & Clarke (2006:87), it is advisable to participate in the data collection and to do one's own transcriptions as this allows one to encounter the data several times, so I collected and transcribed all the data myself. While transcribing, reading and re-reading, I highlighted taboo expressions and started to notice that some topics were regarded as more taboo than others. I also noticed that English was used in interviews and consultations despite explaining to participants on several occasions prior to data collection that Chichewa would be used in the interviews and simulated consultations.

The second phase entails generating initial codes (Braun & Clarke 2006:88-9) from the list produced while taking down notes during Phase 1, which organises data into meaningful groups. A code identifies a feature of the data which presents either interesting assumptions or semantic information that relate to the phenomenon under study (Braun & Clarke 2006:88). When using Atlas.ti to identify linguistic features related to communicating about taboo, Phase 2 and phase 3 can be done together since Phase 3 is about relating codes to each other, as explained in the next paragraph.

In Phase 3, one searches for themes (Braun & Clarke 2006:89-91) by bringing together codes into groups of related codes. It is advisable to produce a mental map connecting related codes which can then be candidate themes. To this effect, a thematic map was generated using Atlas.ti, showing potential themes and sub-themes extracted from the data as coding progressed.[26]

Phase 4 is a review of the themes (Braun & Clarke 2006:91-2), where themes are refined by ensuring that there is coherence between data on each theme, that every candidate theme has the appropriate number of sub-themes, and that there are themes at theme level as well as at data set level. At this stage, thematic maps were reviewed to ensure that they were in line with the theoretical approaches used. When all requirements are met, one proceeds to search the data sets for any possible themes that could have been overlooked. Once this is done to one's satisfaction, and the thematic maps work, one proceeds to the fifth phase.

In Phase 5, one defines and names the themes. At this stage, one ensures that themes do enough but not too much work. One also determines the aspect of data each theme presents and

[26] In Atlas.ti, thematic maps showing relationships between code groups are generated automatically from the relationships generated.

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develops an explanation and a story in relation to each theme. Hereafter, stories that relate themes to other themes are developed. When the themes are clearly defined, they must be assigned a precise name that communicate what is happening in the data.

In Phase 6, a report on the themes is written. The report presents analytical write-ups that develop an argument based on the developed themes. Logical, interesting, and non-repetitive write-ups that present an argument in a valid manner are required, as are arguments that are supported by extracts from the data which clearly exemplify the themes under discussion.

In this study, the main themes were developed, bearing in mind the research questions, from language experiences in gynaecological settings, linguistic strategies used by gynaecologists and patients in simulated consultations, and topic management associated with linguistic taboo in medical settings. After code generation, relationships between codes were identified and developed into sub-themes. Then the sub-themes were aligned to the theories set out in this study and discussed using IS analytical methods, Gee's Discourse Analytical tools and X-phemisms to discover how IS issues manifest themselves in gender-discordant gynaecological settings in a public hospital. As stated by Jorgensen and Phillips (2002:4), despite every approach to DA being a complete package of theory and method, it is possible to combine approaches within the Discourse Analytical theory with other theories, as was the case in this study where the two DA approaches were complemented by X-phemism. The following section discusses how the SDA procedure was used.

### 4.5.2 The Interactional Sociolinguistics analytical approach

The overall objective of using IS was to establish how conversations about linguistic taboo were framed and negotiated in a Malawian gynaecological consultation. According to Gumperz (2015:174), an IS analysis should suggest the most likely interpretations, the assumptions and inferential processes involved, and the relationship between what is literally said and what is meant.

This analytical approach can be likened to the approach known as theme-oriented discourse analysis outlined by Roberts and Sarangi (2005) where ethnology, sociology and DA complement each other when studying interaction. This analytical method was also used by Seale *et al.* (2007:179) in their study of ambiguity frames. The difference, however, is that with the IS analysis employed here, themes are arrived at inductively while in theme-oriented DA themes are analysed deductively. This study opted for inductive thematic analysis to allow for

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the discovery of the many possibilities that may be available since, to my knowledge, the study pioneers IS research on the discussion of taboo topics in health settings in Chichewa.

#### 4.5.2.1. Analytical procedure

There are two phases involved in undertaking IS: the ethnographic phase and the thematic analysis phase (Gumperz 2015:317). The first phase involves data collection, which has a bearing on the analysis, hence it is presented in this section. The initial requirement is that the researcher familiarises themselves with the ecology of the local community which is useful for identifying and decoding the background knowledge that subtly accompanies verbal communication (Jaspers 2012:141). This also includes identifying relevant encounters and key people to collect data from (Gumperz 2015:317). Thus this usually entails long-term ethnographic fieldwork (Jaspers 2012:141). However, in this study, this was waived because of the reasons explained below.

This study was conducted in a society I am very familiar with and in a district where I have visited gynaecologists for a number of reasons, including antenatal visits for my three children. I am a 40-year-old Malawian woman who was born and raised in Malawi and had lived in Blantyre for almost 10 years before embarking on this study. The longest I had left Malawi was for 2 years (at 26) when I studied in South Africa. My stint as research assistant on a team conducting a gender-based violence baseline survey across Malawi taught me how to separate me being a Malawian from me studying Malawian people. Furthermore, as part of my secondary school requirements, I have read the books on Chichewa culture, which include *Maliro ndi Miyambo ya a Chewa* ‘Chewa Funerals and Culture’and *Kukula ndi Mwambo* ‘Growing up cultured’, where nuances of the culture on how women are socialised, women’s health, and reproduction are discussed. Thus, my familiarity with the setting influenced the choice of the language Chichewa, the setting, and participants for the study.

The second phase, which is regarded as the actual analysis, has two steps, namely identification of presupposition evoking signals, and explaining the presuppositions in the encounter (Gumperz in Tannen, Hamilton & Schiffrin 2015:313). Hence in this study, the following steps were performed in line with TA. The initial step involved reading and listening to transcribed data to isolate data extract that depict linguistic taboo using Atlas.ti. Initially, all sections containing linguistic taboo communication was identified. From these sections, linguistic taboo content and both linguistic and paralinguistic taboo contextualisation features were isolated.

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Thereafter, both verbal and non-verbal[27] contextualising signals were identified and coded. These were coded and developed into themes as outlined in TA procedure above. The data extracts were then discussed in relation to possible sociocultural schema at macro level. This analytical procedure is in line with the IS procedure used by Awang and Ibrahim (2010), the only difference being that in the Awang and Ibrahim (2010) study, non-verbal data was not included. In summary, as is the case with all IS analytical procedures, this study also "(applied) conversational analysis procedures … on inferencing to describe the meaning making processes involved" (Gumperz 2015:312) in articulating linguistic taboo in gynaecological settings.

### 4.5.3 Gee's situated discourse analytical procedure

Gee (2011:16-20) argues that language simultaneously passes on messages and communicates other intentions through the messages. The aim of analysing the data using Gee's SDA approach was to find the intentions when communicating taboo in gynaecological consultations which allows for effective communication. In order to identify these intentions, 10 tools from Gee's (2014b) toolkit were used (some for more than one purpose), selected for the following specific purposes: to show how meaning is arrived at; to describe the experiences of participants; to show how the gynaecological consultation is constituted as a practice; to explain how connections are made; and to identify how language constitutes the roles and relationships of the interlocutors.

The Situated Meanings tool (Gee 2014b:157-161) identifies patterns behind the meanings expressed in Malawian gynaecological consultations, especially those patterns related to linguistic taboo es. The question adopted for the study of this topic was: *What specific meanings do people have for the expressions that are linguistically taboo?* (see Gee 2014b:159).

Related to situated meaning is the matter of context because context is where meaning is situated. It follows then that tools that analyse aspects of context as described by Gee would include interlocutors and social and medical factors. Firstly, the roles the interlocutors portray and how they portray and sustain them were analysed using the Identity Building, Relationship Building and the Politics Building tools, respectively. The Identity Building tool (Gee

[27] As data from the simulated consultations was audio-recorded in my absence, the non-verbals that were accessible were the paralinguistic features of tone, pitch, laughter, pauses, volume, speech rate, modulation fluency and accent.

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2014b:112-20) was used to establish how gynaecologists and their patients build their respective identities, how they maintain them and, if they do not maintain them, which identities are used concurrently or replace the main identities. These were followed by a discussion on reasons related to the identities they assume or why they change them. In pursuit of this, the study had to answer questions guiding this tool as suggested by Gee (2014b:116), including: *What socially recognised identity or identities are being enacted and how other interactor's identities being received?* and *What identities are assigned to others and what identities are being offered to others?*

The Relationships Building tool (Gee 2014b:120-4) was used to establish the nature of the relationship between gynaecologists and their patients, whether boundaries are set by the identities they assume, and how boundaries are maintained, negotiated, or lost. The question is *How are words and grammatical items being used to create or sustain relationships with others in relation to cultural setting?* (Gee 2014b:121). Related to the Relationship Building tool is the Politics Building tool (Gee 2014b:124-31), which helps discover the social goods that are at stake in gynaecological consultations and how gynaecologists and patients gain, lose and/or retain them. The questions for this tool include *What counts as a social good?*, *How is it distributed or withheld?* and *How should social good be distributed in the wider society through words and grammar?* (Gee 2014b:126).

Context also includes culture or the expectations about how things ought to be done and how they work. In this regard, the study looked at the appropriateness of language used for communicating taboo using the Activity Building tool, Sign Systems and Knowledge Building tool, Connections Building tool, and the Context is Reflexive tool. Questions considered here included *What culture is established for consultations through the Activity Building tool?, How is viable and unviable knowledge established?* and *How are connections made?*

The Activity Building tool (Gee 2014b:102-12) was used to establish what makes a Malawian gynaecological consultation a distinct practice, by responding to Gee's question *What activity is being established (…) and which societal group, institutional norms or cultures support (it)?* (Gee 2014b:104). In addition, the Sign Systems and Knowledge Building tool (Gee 2014b:141-7) was used to look at the place of Chichewa in gynaecological consultations in contrast with the (unexpected) use of English in said consultations, as well as cultural beliefs and knowledge systems. It also established the social knowledge that affects the use of linguistic taboo expressions from the narratives about what is regarded as normal in the setting under study.

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The guiding question was *How does the use of language and grammar privilege or de-privilege particular language and knowledge systems?* (Gee 2014b:142).

Furthermore, the Connections Building tool (Gee 2014b:132-141) was used to find out how coherence is achieved when communicating taboo topics and how things were made relevant through connections and/or disconnections established by words and grammar. Another tool related to meaning that was used is the Context is Reflective tool (see Gee 2014b:90-4). This tool was used to analyse how context as a reference point is constituted, whether it is created, reproduced or changed using words or grammar. In addition, it helped establish whether the constitution of context is done consciously or not. Finally, once connections and context for framing meaning were identified throughout the data, the Frame Problem tool was employed to re-check any matters that make context relevant and useful in the understanding of how linguistic taboo is used in Malawian gynaecological consultations. This was either explained by the participants themselves or related to my own cultural knowledge and experiences.

Finally, the place of taboo in the Malawian context and the importance of communicating it in particular were analysed using the Significance Building tool (Gee 2014b:8-102). The question that is used as a guide is *How are words and grammatical devices being used to build up or lessen significance (importance, relevance) for certain things and not others?* (Gee 2014b:98).

### 4.5.4 X-phemism analysis

All taboo expressions produced spontaneously by participants, but not those elicited by me, constituted the sample for X-phemism analysis. These were collected from the interviews and simulated consultations. Initially, the three X-phemism categories of orthophemism (acceptable and formal expressions), dysphemism (unacceptable) and euphemism (acceptable and informal) outlined in 3.3 above were used to categorise the expressions. This was done to establish whether or not the Chichewa expressions would fit into the theorised frame developed by Allan and Burridge (2006) based on the English language.[28]

## 4.6 Ethical considerations

The research conforms to ethical guidelines of Stellenbosch University and the Republics of South Africa and Malawi. Stellenbosch University classified my research as medium risk, thus it had to be cleared by both the General Linguistics Departmental Ethics Screening Committee and the Research Ethics Committee: Humanities. In Malawi, ethical clearance was obtained

[28] As taboo is a cultural construction, it was expected that the categorisation would be culturally based and not universal. As will be shown in Chapter 7, the categorisation of X-phemism do not capture the Malawian understanding of linguistic taboo and how to communicate it. This led to an attempt to define new categories.

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from the National Health Science Committee of the National Commission of Science and Technology, and gatekeeper (i.e., institutional) permission was obtained from the study hospital's administrator and the Head of the Gynaecology Department.

As stated above, I also obtained permission from two secret Facebook groups' administrators. The administrators assisted in ensuring that possible participants remained anonymous through the processes outlined in 4.3. Before participants confirmed their participation, a consent form (see Appendix D) with a brief introduction of the research was given to them. The participant and I read through the consent form together, to allow for queries and clarifications, after which both parties appended their signature to the form. The participant kept the part that has information on what has been consented to, while I kept the signed part (see Appendix E). Data was only collected from persons who consented by signing the informed consent form. Furthermore, only adults participated in this study. In all written and public discourses, participant identities, Facebook group names, and the hospital's name were anonymised. Participants are referred to as either Dr or Patient followed by a number to distinguish them from other participants.

Another ethical consideration was the collection of data via simulated consultations instead of real consultations in order to circumvent the potential of a breach of doctor-patient confidentiality. All participants were informed that the consultations are not real. Participants were at liberty to choose any private, comfortable venue for their interviews.

During interviews, respondents were allowed to skip answering any question. They also had the right to withdraw from the study altogether if they were uncomfortable (or for any other reason). The researcher ensured that the respondents understood that they would not deliberately be exposed to any physical and psychological harm during data collection and discussion and presentation of data. Psychological and physical safety was ensured in the following ways:

(i) Data was collected on weekdays between 09:00-11:00 and between 14:00-16:30. This allowed participants to travel to the hospital during daytime (when public transport is readily available and safe), and to have lunch at their usual lunch time. I also paid transport costs for all participants.

(ii) The audio-recorder was carried in a secure bag and recordings were stored on the researcher's laptop and backed up on OneDrive. Both the storage places and actual files were password protected. They were only accessible to me and my two supervisors.

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(iii) To build trust in the participants, I ensured to portray trustworthiness in dressing like a traditional Malawian woman, in full length dresses or skirts, and using Chichewa, a common Malawian language.

(iv) Furthermore, each participant was given my business card from my workplace (at the university) in Malawi. Since the university is in the outskirts of Blantyre, the participating women were also informed that they could contact the police instead to find me.

(v) All participants were provided with procedures they could use to access the electronic version of the thesis once it is published online, while a summarised version of the thesis was sent to each female participant on WhatsApp as most would not have reliable internet access. This was done to assure the participants that they were not misrepresented and that conditions set in the consent agreement were adhered to.

The data that was collected is accessible through a password my computer and OneDrive. The raw data can only be accessed by me and my supervisors, who are accustomed to practicing research ethics. The recordings have been anonymised by cutting off the preliminary, information-giving sections before storing the recording. Full anonymization was however not possible, as explained below.

## 4.7 Methodological limitations

One methodological limitation of this study was that fully anonymising the gynaecologists for the Malawian audience was not possible as nationally there are only four major public hospitals where such specialists practice and only one referral hospital in the district, I collected data. Since there are not many gynaecologists at this hospital, the gynaecologist participants might be recognisable to Malawian readers. This was discussed with the gynaecologist participants in the preliminaries, and they understood and agreed to participate despite the possibility of them being identifiable by the Malawian audience.

Another limitation is that translating expressions that carry sociocultural meaning is often not perfect. This necessitated the use of explanations in some cases. In this regard, it helped to have research supervisors who do not share the culture under study, because they pointed out where explanations were unclear explanations or areas were overlooked in my argumentation.

I aimed for including six gynaecologists and having 12 simulated consultations, but this was not possible, due to gynaecologists' work schedules. All gynaecologists at the referral hospital consulted with at least 40 patients per day, they were involved in training other doctors, and their work schedules were not fixed since most cases referred to the hospital were emergency

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cases. In addition, they also practice in private hospitals, hence they treasure their free time. However, the four participating gynaecologists provided sufficient data for this study in the four interviews and eight consultations. Coincidentally, they also represented two extreme ends of experience levels. This allowed me to collect data on experience, as experience is a factor in hybrid communication research findings.

## 4.8 Chapter summary

Qualitative methods were used to study communication about taboo topics in gynaecological consultations. Data in this study consists of simulated consultation interactions and interview discussions. The former provided the near-naturalistic data required to analyse discourse in gynaecological consultations, whereas the latter provided experiences and cultural perspectives related to taboo communication. To make the simulated consultations more reliable, doctors were asked to treat them as a real consultation and patients were to suppose that they are a woman of their own age and sociocultural and socioeconomic background with the selected ailment. In addition, the consultations took place in the hospital with real gynaecologists and with women who consulted gynaecologists on medical conditions they had previously had. The only thing that was not real was that the women were not sick (meaning that they were not patients at the time, and doctor-patient confidentiality would therefore not be violated by recording and analysing the consultations). The collected data was analysed making use of Thematic Analysis, IS analysis, SDA and X-phemism.

All research ethics requirements from the Republics of South Africa and Malawi were met. In Malawi, where the study was conducted, every point in the medical hierarchy had its own clearance requirements, and these were met.

Although there were methodological challenges, this qualitative study still managed to achieve the set goals by using alternatives that were possible and permissible. Chapters 5 to 8 present and discuss the study findings as follows: Chapters 5 present an overview of participant experiences; and Chapter 6 discusses the nature of the expressions used, Chapter 7 the discourse strategies, and Chapter 8 participants' evaluation of Malawian gynaecological consultations as a practice.

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# Chapter 5 : Communication in Malawian gynaecological consultations: Participant perspectives

## 5.1. Introduction

This chapter thematically presents and discusses findings that relate to participants' (both gynaecologists and patients) experiences and sociocultural knowledge of linguistic taboo in Malawi. The chapter first provides an overview of linguistic taboo in both the general Malawian context and the gynaecological contexts (Section 5.2). This is followed by the contextual elements that perpetrate participants' levels of embarrassment, shame and anxiety when talking about culturally taboo topics during gynaecological consultations (5.3); as well as the effects of linguistic taboo on gynaecological consultations as a practice in Malawi (5.4). The data discussed in this chapter makes it clear that respect for self and others is one of the main considerations that underlie the approaches that Malawian patients and their gynaecologists have to discussing taboo topics in gynaecological consultations.

## 5.2. Defining taboo communication

Wardaugh (2010:249) defines "taboo" (see 2.7.1.1) as "the prohibition or avoidance in any society of behaviour believed to be harmful to its members in that it would cause them anxiety, embarrassment, or shame". This conceptualisation of the word is certainly reflected in the study participants' descriptions of (i) Malawian society in general, in which taboo topics are prohibited in the sense that talking about sex, and anything related to it is forbidden, and (ii) gynaecological consultations, where the avoidance of taboo topics is said to be prevalent. One example of such descriptions is in the following extract from my interview with Dr KG, who explained that it is forbidden to discuss sexual organs in Malawian society:

Extract 5A:

Dr KG: *Takula* in a society where *kungotchula ziwalo*, like private parts, is not the usual thing, then *umachita manyazi.*

We have been raised in a society where the mere mention of body organs, like private parts, is not the usual thing, then you start feeling embarrassed.

In this extract, Dr KG indicates that "the mere mention" of sexual organs is taboo and causes embarrassment. Note that Dr KG does not use the taboo Chichewa expression *maliseche*, which is a close equivalent to *private parts* (which he does use, but in English), but generalises to *ziwalo* 'organs' (see discussion in 5.2.1). This indicates that he avoided naming sexual organs

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outside of the consultation room. This avoidance is echoed by Dr AS, who described gynaecological issues as "secret things" in the following extract.

Extract 5B:

Dr AS: *(...) mukamakamba za a* gynae *ndi oyembekezera kuli zambiri za ngati chani, ngati za chinsinsi, zinthu zoti anthu ambiri safuna kutani, kufotokozafotokoza (...)*
(…) when you are talking about gynaecological and obstetric cases, there are a lot of things that are like what, like secret things, things that most people do not want to talk about (…)

Dr AS in 5B emphasises the fact that gynaecological consultations are unique in the sense that typical topics of discussion in gynaecological consultations are things that are considered culturally taboo and are thus kept as secrets in Malawian society. However, topics such as women's sexual embodiment, effluvia and reproduction are the very topics that patients have to discuss with their gynaecologists. Thus, it can be argued that in 5B Dr AS posits the "secret" nature of the things discussed in gynaecological consultations to be one of the most significant characteristics of the communication in such consultations.

Further, the gynaecologists' characterisation of gynaecological issues as "embarrassing things" (5A) and "things that most people do not want to talk about" (5B) implies that conversations between gynaecologists and their patients are more face-threatening than typical doctor-patient consultations since taboo topics are unavoidable in gynaecological consultations, and that social goods such as dignity and respect are therefore a more prominent feature of such consultations. Given that topics such as those referred to above feature prominently in gynaecological consultations, patients and gynaecologists report that their linguistic behaviour is aimed at mentioning taboo topics in a face-saving way rather than to avoid the topics completely, as is done in other contexts in Malawi.

Subsections 5.2.1 to 5.2.3 provide an overview of three distinct topics that were reported by the study's participants to cause discomfort or shame, as well as particular words and expressions related to the three topics that are considered taboo in gynaecological settings.

### 5.2.1. It is taboo to refer to sex directly

As is the case in many societies around the world (cf. Eldridge & Giraldi 2017); Griffin 2012:92; Al-Khatib 1995:447ff), sex is viewed as a private matter in Malawian culture, and discussing one's sexuality and/or genitals with a non-intimate person is viewed as an invasion of the privacy of the one being discussed (Mkandawire 2012:59). In Malawi, the taboo nature of displaying and talking about anything related to sexuality were strengthened by the strict conservative rules that were imposed by dictator President Hastings Banda in the first 30 years

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of Malawi's independence (Mtenje 2018:218). Now, over 20 years after Banda was forced out of power, the restrictions are still present, including legislation against discussing female genitals in particular settings (see 1.7.2.2 concerning institutionalised control). These laws, rules, and norms reinforce the belief that talking about sex and displaying certain parts of a woman's body (discussed in 5.2.3) are highly taboo and should be avoided at all costs.

Dr AS explained that patients are often uncomfortable discussing anything relating to sex, genitals, and sexual experiences: "So, typically women for example will not say about their sexual issues" [originally said in English]. This extract reveals that Malawian gynaecologists expect their patients to avoid discussing sexual issues, which echoes the argument that talking about sexual embodiment is taboo when the setting necessitates it (as discussed in 5.2). The extracts below, one from an interview with a gynaecologist and the other with a patient, expound on this notion by showing that patients' experience different degrees of discomfort based on the extent to which gynaecologists make use of explicit terms such as "sex". In Extract 5C, Dr KG describes a reaction that patients often have when asked a question about having sex.

Extract 5C:

Dr KG: (…) *kumfunsa kuti* ok, "Are you sexually active?" *mtsikana. And mwina she is 19, 20.* She will start laughing and look at you weird.
(…) asking that, okay, "Are you sexually active?", a girl. And maybe she is 19, 20. She will start laughing and looking at you weird.

Dr KG explains that he may get laughter in response to his question about the patient's sexual history. In such a situation, the non-verbal reaction of laughing can be interpreted as a sign of embarrassment and/or discomfort, especially when it is accompanied by a strange gaze as mentioned above. Such an interpretation echoes Kunkeyani (2013:250)'s finding that responding with laughter is a sign of embarrassment, and Kirimlıoğlu and Sayligil's (2016:29) finding that patients in Turkey (another conservative society) were embarrassed when asked questions about sex as such matters are considered private and personal and are therefore confidential and forbidden topics.

Based on the Malawi's sociocultural context, it can be argued that there are two reasons why direct talk about sex causes embarrassment. The first reason is that sex is classified as a private matter as it is considered an intimate matter that should only be discussed in intimate relationships. Thus, by discussing sex, familiarity and/or intimacy are suggested between interlocutors, and this makes the patient uncomfortable since the nature of gynaecologist-patient relationship is neither familiar nor intimate. According to Gee (2014:125), when

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distance is expected, expressions of familiarity are construed as being too personal and signify a misunderstanding of relationship boundaries. Thus, the explicit discussion of the intimate topic of sex may be construed as a sign that the gynaecologist has misunderstood or wants to change the relationship boundaries, which would result in patient discomfort.

The second source of embarrassment is the undesirable ways in which patients assume that they would be judged by their gynaecologist. For instance, patients assume that what the gynaecologist would know about their sexual experiences will make the gynaecologist characterise them as not being a respectable person, as explained by Dr AS:

Extract 5D:

Dr AS: So, typically women for example will not say about their sexual issues. But sometimes for me to figure out what that issue is I need that information. Ok. *Koma chifukwa choti,* one, they don't want me *kuti ndidziwe za zimenezozo,'*cause *amaganiza kuti mwinamwake ndiwapanga* judge *ndizina zotero…*

…So, typically women for example will not say what their sexual issues are. But sometimes for me to figure out what the issue is I need that information. Right. But the reason that, one they don't want me to know about such things, because they think that maybe I may judge them or things like that….

In 5D, Dr AS uses the English adverb *typically* to imply that it is normal for patients not to want to talk about their sexual issues with him, and that he believes that this is a result of the fact that his patients might believe the information would make him judge them about their sex lives. As such a judgement would pose a threat to their dignity, it can be argued that for some patients, withholding information is a strategy aimed at attaining or maintaining dignity and respect (see 5.4.1). In other words, dignity and respect are social goods that are useful in establishing a preferred identity and relationship in gynaecological consultations in which sex and sexual organs are mentioned.

### 5.2.2 It is uncomfortable to suggest and/or confirm infertility

This section discusses infertility as another face-threatening topic. The issue of patients withholding information about infertility was raised by the gynaecologists both directly and indirectly. Extract 5E below is Dr DW's response to the question, "What things do your patients find hard to explain during consultation?"

Extract 5E:

Dr DW: *Nthawi zambiri anthu amene ali ndi vuto lakusabereka, mwina amatha kupezeka kuti abwera, ndikumangonena "aah ine ndikumva kupweteka mmimba" basi. Abwera tsiku lina, "a ine ndikumva kupweteka mmimba" koma sakufotokoza vuto lawo lenileni. Matenda ena onse, anthu amakhala omasuka kufotokoza. Azimayi amatha kunena bwinobwino kuti vuto langa lili*

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*pakuti, chiwalo chakuti, kufotokoza bwinobwino. Ngati anawuzidwapo kuti vuto ndi lakuti amafotokoza. Ngati akumva ululu ochokera penapake, nthawi zambiri amafotokoza. Sindimapeza mavuto ena aliwonse pamenepo.*

Most of the times, people who have infertility issues can come, and just keep saying things like, "Uhm I feel pain in my abdomen". And end there. They come again another day, (and say,) "Uhm I feel pain in my abdomen" but they don't explain what their real problem is. When it comes to all other ailments, people are able to explain freely. Women can mention that they have a problem in such and such a place, with this particular organ… explaining properly. And if they were previously told of their problem, and when they feel pain from particular places, they explain, with these I do not have any problems.

In Extract 5E, the gynaecologist describes the general tendency of patients to circumvent the discussion of infertility more than they do with other medical conditions, even during follow-up consultations. Although Weijts, Houtkoop *et al.* (1993:299-300) argue that discussing sensitive topics becomes easier once rapport is established (e.g., during follow-up visits), the data from this study seems to indicate that discussing infertility may require more than merely establishing rapport. Similar sentiments on the difficulties of discussing infertility were expressed by another gynaecologist, Dr KG, who cited instances in which it appeared that a patient would rather have him "guess" what her medical condition is than explicitly state that she suspects she is infertile.

Extract 5F:

Dr KG: *(Amayembekezera kuti a dokotala) … anene kuti mukudwala chakuti. Iweyo usanatchule kuti ndikudwala chakuti. Chifukwa ngati ena amangonena kuti mmimba mmandivuta, munayamba kale kale panopa mwina 3yrs mukundivuta. Uwafunsa mafunso ena aliwonse kumwa mankhwala chani, ayi. Ukamatengabe* story *ija, kumapita kumapeto then umazazindikira kuti mwina munthu uja ali ndi vuto lobereka. Komano sananene zimenezija* upfront *and ndichomwe wabwerera.* Soo. *Amawona ngati kuti mwina mukamawayeza muja, kaya chani, kenako mungolipeza vuto lija kuti owoo, chikupangitsa kuti asabereke ndi ichi. Olo mwina mukamapanga treat vuto lomwe lammimba zomwe atchulazo, mukusakasaka mupezeka kuti mwapangaso treat chani…*

(They expect that the gynaecologist) …will say that you are suffering from such and such a disease, even before you mention what you are suffering from. Because some just say that "I have stomach problems. It started a long time ago; it could now be three years of suffering". You ask them every possible question, the medication they take, anything. Nothing. So when you continue with history-taking, towards the end, then you realise that the person could have infertility issues. But she didn't say that upfront. So, they think that when you examine them, they think you will discover the problem saying, "This is what is behind your infertility". Or maybe that while treating the issue of abdominal pain they had mentioned and you are looking at its causes, you will also by chance treat the what …?

MCK: *Zosaberekazo.*

The infertility issues.

Dr KG: *Vuto losaberekalo. So pali* that group *lokuti amayembekezera kuti* we will figure out *chomwe akudwala.*

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Infertility issues. So there is that group (of women) that believe that you will figure out what they are suffering from.

In 5F, Dr KG explains that Malawian patients are not usually upfront about infertility, and that they seem to expect that the gynaecologist would initiate discussion of infertility or can guess what the reason for the consultation is. It can be argued that patients refrain from directly stating that infertility is the reason they are consulting the gynaecologist, becauseinfertility is a socially ostracised condition in Malawi, as Dr OB explains:

Extract 5G:

Dr OB: *Nkhaninso imakhala yozungulira malingana ndi chikhalidwe. Nanga si anthu osabereka mchikhalidwe chathu amakhala ngati onyozedwa.*
The story is also cyclical because of culture. Since those who 'cannot bear children' (=are infertile) in our culture are condemned.

Extract 5G shows that some gynaecologists do understand why patients would not explicitly say that they are infertile. Gynaecologists in Extracts 5F and 5G differ in terms of length of practice and thus in terms of clinical experience: The former was in his final year of gynaecological studies whereas the latter had been practicing for over 20 years. Thus, unlike the less experienced gyneacologist who attributes patients' communication behaviour to their lack of understanding of consultation requirements, the more experienced gynaecologist explains that patients often avoid talking about infertility as a way of protecting their dignity and respect which they consider to be important during consultation. The cultural condemnation mentioned in Extract 5G is discussed further below.

In Extracts 5H and 5I below, the patient participants mostly associate infertility with multiple abortions, which Malawians generally view to be related to a previously reckless sexual lifestyle and promiscuity at a young age, which explains why patients feel embarrassed when their infertility is discussed and/or diagnosed. The fact that infertility may be due to natural causes rather than being related to the women's lifestyle or other choices is down-played, as is evident from the extract below which contains a patient participant's answer to "What causes infertility?":

Extract 5H:

P10: *Nthawi zambiri chimachititsa mwina ndikutaya mimba. Mmene unali tsikana umakonda kumwa makhwala kuchotsa mimba. Ndiye ukakhala kuti nthawi imeneyo wapezano mamunano kuti ufuna ukwatire umapezekano kuti mwana sakupezeka mnyumba. Ena chimakhala kuti chilengedwe mmene analengedwerera pathupi lawo, mmapezeka kuti mphatso nyumba sikutani, siyikupezeka, nde mavuto ambiri amene ndimaona amakhla ngati amenewowo.*
Most of the times, it could be abortions. When you were young, you often used to take some medicine to abort. So, when you find a man to marry you, then it becomes hard for you to get

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pregnant. Others are naturally infertile. They just find that they cannot have children. So that is what I know about such problems.

Patient 10 attributes infertility to either previous abortions or nature. Her association of infertility with previous abortions is probably a result of the fact that abortion is illegal in Malawi and is therefore often carried out without following best practices, which could lead to infertility. However, by saying, "most of the times, it could be abortions" and "others are naturally infertile", Patient 10 makes the connection between infertility and abortions strong and factual, while suggesting a weaker connection between infertility and nature. In addition, her mentioning abortions before natural causes places significance on the former and not on the latter. Here it is important to note that the embarrassment associated with abortion seems to emanate from that which is implied by abortion, namely both promiscuity and pre-marital sex. Other diverse causes of infertility are listed in Extract 5I by Patient 9 who is more educated (she has a Masters degree) than Patient 10 in 5H (who has a Junior Secondary School Certificate), lists a diverse range of causes of infertility, including abortion. She also specifically indicates that the woman is mostly thought to be at fault when a couple is not able to have children.

Extract 5I:

P9: *Zomwe zimapangitsa munthu kukhala osabereka, pali zifukwa zambirimbiri zimene ndinamva kuti zimapangitsa munthu kukhala osabereka. Ena amati.., eeh* of course *kwathu kuno, kaya ndinene kuti kwina kuli konse tikawona kuti munthu sakubereka timangowona kuti ndimzimayi amene ali ndi chani? Ali ndi vuto chifukwa choti ndimzimayi amene amatani, amanyamula mwana eti. Koma nnamva kuti abambo pena amatha kukhala kuti umuna wawo ndiwofowoka. Pena amatha kukhala kuti mzimayiyo mwina chiberekero chake sichili bwino. Pena mwina ena amanena kuti mwina mzimayiyo mwina ali mtsikana machotsachotsa mimba kapena nde zinawononga chiberekero, ndimamva nkhani ngati zimenezo. Ena amatha kunena kuti ndizakumtundu ndinamvaponso masiku anowa kunena kuti munthunso ukakhalanso wonenepa kwambiri zimathanso kupanganso* affect fertility *yake. Ndiye* I think *pali zinthu zosiyanasiyana. Pena amatha kunena kuti ma* hormones *kaya azimayi ena basi amangokhala basi samapanga* period*, olo* period *yawo imangopanga yosalongosoka mwina mwezi uno apanga, mwezi wamawa satani? Sapanga nde zimene zijazo zimapezeka kuti zikuwasokoneza* fertility *yawo. Kupezeka kuti munthu akulephera kutani, akulephera kubereka.*

What makes a person to be infertile, there are several reasons that I have heard that are behind infertility. Some people say…, of course here in Malawi, maybe I should say everywhere, when we see that a couple cannot have children, we always assume it is the woman who has a problem. This is the case as she is the one that carries the pregnancy. But I have heard that sometimes men can have weak sperm. Other instances, it can be that the woman's uterus is not alright. Yet sometimes some people say that when the woman was young, she used to terminate pregnancies frequently and so maybe she destroyed her uterus, I hear such stories. Some people say it is hereditary. I have also heard that gaining a lot of weight may also negatively affect one's fertility. So, I think there are a lot of things. Sometimes they say it is

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> hormones, some women do not menstruate or have irregular menstruations as such their fertility is affected and they fail to bear children.

In addition to asserting that infertility is thought to be due to promiscuity on the part of the woman (which lead to abortions), in Extract 5H, Patient 9 also claims that it is universally assumed that the woman is the responsible party when a couple is infertile when she says, "in Malawi, maybe I should say everywhere, (…) we always assume it is the woman who has a problem". This implies that even if the woman did not have an abortion, she will still feel guilty and ashamed of her infertility as she is the one deemed responsible for the success of the pregnancy as "she is the one that carries the pregnancy". Further, in Extract 5H, there are seven direct referents to women (*woman/women/she*) while men are only mentioned once as a possible cause for infertility. Such attributes to women often result in patients presenting their infertility problems in an indirect manner during a gynaecological consultation so as to avoid shame and social stigmatisation. The social stigma can be compared to that described by Macdonald & Murphy (2004: 38) where patients experienced the fear of being ostracised after a positive diagnosis of venereal diseases and HIV/AIDS.

In addition to shameful association of infertility, infertility is negatively perceived regardless of the cause. A male Malawian research participant in De Kok's (2008) study is reported to have said that in the Malawian culture, infertility is "unfortunate, very unfortunate". The data from the current study revealed that one unfortunate consequence of being diagnosed with infertility is the possibility of divorce. However, according to De Kok (2008), apart from divorce, there are other negative social consequences of infertility for Malawian women, including social exclusion, emotional and physical abuse, and their spouses engaging in extramarital affairs (with the purpose of impregnating another woman) and/or polygamy as possible solutions to being childless (see also Saur, Semu & Ndau 2005). These negative social consequences can be a result of women's lack of social standing in Malawi, where gender imbalances in marriages are deep-rooted and connected to the economic powerlessness of females (Hayes 2016:95-105). It can therefore be argued that by avoiding infertility talk, the patient may be avoiding receiving a diagnosis that would withhold a lot more social goods from her beyond the consultation room.

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### 5.2.3. Unjustified requests or suggestions of physical examination cause discomfort

The third topic that both groups of participants reported to cause a lot of discomfort or shame in gynaecological consultations is that of physical examination without sufficient, prior explanation of the need thereof and the procedures to be followed. All 12 patient participants indicated that being naked in front of another person was generally perceived as embarrassing. However, there are varying degrees of embarrassment, which are determined by the interplay between factors such as: the nature of the medical problem; the medical procedures required; and the gender of the gynaecologist, with some situations being perceived as more embarrassing than others. This subsection discusses findings that show that when it comes to physical examination, the social goods at stake vary in intensity depending on the situation. Patient 2, for instance, explains below that the request to undress before having a routine Pap smear is embarrassing:

Extract 5J:

P2: *Eeeh, ndinali nditamva kuti kumenekuku ukapita amatere, umavula zonse, amatere amatere. Ndebe manyazibe sangalephere sinanga munthu oti uli bwinobwino, ukuvula, manyazibe sangalephere.*
Yes, I had already heard that when you go there [to the hospital for a Pap smear], this is what they do. You take off your clothes, and so on and so forth. So even though it is like that, one still feels embarrassed, without a doubt. For a person who is alright (=healthy), you are taking off your clothes, you have to feel embarrassed.

MCK: *Zoona.*
It's true.

P2: *Ndithutu, zimasiyana ndikuti ukamva kupweteka penapake.*
Definitely, it is different when you are feeling pain somewhere.

In 5J, Patient 2 explains that being naked when one is not sick makes the Pap smear an embarrassing procedure. Her explanation can be interpreted as follows: One's dignity is more compromised when one has to undress to undergo physical examinations without any signs of illness, than when one has an illness. However, Patient 9, who was ill and pregnant at the time she visited the hospital, was reluctant to have a physical examination until she was convinced that it was indeed necessary. In Extract 5K, she brings another dimension to the need for patients have to preserve their dignity in the gynaecological consultation. She narrates her experience as follows:

Extract 5K:

P9: (…) *Koma atandiwuza kuti zimene mukufotokozazo zikhoza kukhala kuti khomo lachiberekero ndilimene lili ndichani, lili ndi vuto. Chifukwa kuwawa kumene mukunenako zikhoza kukhala*

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> *kuti amati* cervix *ikutani, ikutseguka. Nde atanenano zimenezo mpamene ndinawona kuti aah ndilibe kuchitira mwina, koma adokotala angondiwona. Komano munthu uli lungalunga wabwinobwino basi uvule zovala kusegula miyendo adokotala akuwone adokotala aamuna. Zimakhala zinazake zochititsa manyazi. Mwina zasiyana ndikuti wadwalika zenizeni ulibenso manyazi ena aliwonso ungofuna chithandizo, zimakhala zosiyana.*
> (...) But when he told me, “What you are explaining could mean that it is the cervix that has what, that has a problem. The pain you are describing could be that the cervix is opening up”; so, when he said that, that’s when I realised that I had no option but to have the gynaecologist to just examine me. But when you are alright, all fine, then you take off your clothes and open your legs, the gynaecologist looks at you, a male gynaecologist, it is something that is very embarrassing. It is maybe different when you are truly sick, you are not even shy at all, you just want to be helped. It is different then.

Patient 9 said in the interview (prior to the extract presented in 5K) that she refused to be examined before the doctor had explained the need to do so. She added that a physical examination of the cervix is not an ordinary matter, especially when the doctor is male. Thus, in Extract 5K she explains that one condition had to be met first, namely that she needed to be convinced about the necessity of the examination. From Extract 5K, it can be argued that when interacting with this patient, who did not expect to a have physical examination during the reported consultation, the gynaecologist took the responsibility of justifying the need for an examination, and that his justification of the procedure was an attempt to mitigate the shame that the patient would otherwise have experienced. The fact that the gynaecologist provides a justification for the procedure is also indicative of their relationship in the sense that he constructs his professional identity in relation to that of the patient, thereby steering away from the ordinary male/female roles, since such roles would make the request to undress inappropriate and therefore very uncomfortable.

The discussions in 5.2 make it clear that references that are forbidden, or avoided because they trigger complex emotions of shame, embarrassment, and pity, are typically considered taboo, and thus avoided. This finding is in line with Abrantes’s (2005:87) description of linguistic taboo as something that results from the embarrassment that arises when discussing topics of a sexual nature. Further, the data discussed in this section makes it clear that patients are put in a difficult position in gynaecological consultations due to their society’ understanding of what a respectable woman does and does not do. The next section discusses contextual factors that make the talk about taboo even more embarrassing.

## 5.3. Contextual factors intensify linguistic taboo

The levels of discomfort and anxiety that result from the discussion of private and intimate topics in gynaecological consultations in Malawi are also affected by other sociocultural issues,

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including the gender of the gynaecologist (5.3.1) and the cultural innuendos of the Chichewa language (5.3.2) as discussed below.

### 5.3.1. Gender discordance result in communicative constraints

As discussed in Chapters 1 and 2, there is a high probability of gender discordance in Malawian gynaecological consultations as most of the gynaecologists in the country are men. This is problematic in conservative cultures like those found in Malawi because, according to Uskul and Ahmad (2003:206) in such cultures female patients often find it hard to discuss their sexual health with male physicians. This section presents an overview of the reasons why patients find consulting male gynaecologists challenging. One such reason was provided by Patient 9, who explains that the importance of the social goods of privacy and respect are heightened in situations where men and women interact. In Extract 5L below, Patient 9 discusses her discomfort in mentioning genitals to a male gynaecologist.

Extract 5L:

P9: *Nnawuza a* nurse[29] *ndikulowa, nditazindikira kuti dokotala ndiwammuna nnawuza a* nurse*, kuti ineyo a* nurse *ndabwera ndikungopanga* period *siyindikusiya, za* period*zo siyinali nkhani komano kuti ndifotokoze kuti ukuku kungonditani kungondipweteke nde mpamene chani, panali nkhani. Komano a* nurse *ananena kuti koma adokotala mukuyenekera muwatani? Muwafotokozere.*

I told the nurse when entering the consultation room after realising that the gynaecologist was male, I said, "I am here because I have been menstruating for a long time. My period is not stopping." Talking about menstruation was not an issue but the issue was then explaining that I was feeling pain there. But the nurse told me that I will still have to do what, to say it to the gynaecologist.

MCK: *Nde munakawafotokozerano kapena a nursewo ndi amene anakafotokoza?*

So did you tell him or is the nurse the one who told him?

P9: *Ndinakafotokoza, koma ndimangoti kuti ukuku a dokotala kukunditani, kukundipweteka? Nde adokotala anandifunsa kuti kutiko? Nde nnawawuza kuti njira yachiberekero. Nde anakhala ngati adokotala anditani, andimva. Chifukwa kwathu kuno, ukuku sungangokutchula dzina mwachisawawa iyayi. Olo mwadokotalamo mwina.*

I told him, but I just kept saying, "Doctor, this place here is what, here there is pain". So the doctor asked me, "Where?" so I told him, "The passage/canal of the uterus". So then the doctor seemed to have understood me. Since in our societies here we just don't mention the name of this here anyhow. Maybe [not] even at the doctor's.

It can be argued that in Extract 5L, Patient 9 describes an attempt to maintain her dignity and build a respectable identity for herself as a Malawian woman by being vague about the reason for the consultation even when prompted by the gynaecologist to explain. This vagueness is

[29] The nurse being referred to is female, otherwise an equivalent of the term for male nurse (*a* nurse *a amuna*) would have been used.

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visible in the use of the deictic expression "here", which does not have a specific referent. In Extract 5L, it is apparent that the patient did not feel comfortable explaining her ailment to a male doctor, nor using the Chichewa term for *vagina*, as she first attempted to use the vague descriptor "here", and then the euphemistic terms "the passage/canal of the uterus". The patient's vagueness could have been regarded by the gynaecologist as a case of withholding information, which prompted him to ask what she was referring to. The subsections below discuss similar experiences that were reported by other participants, which show how and why gender discordance makes patients to adhere to cultural linguistic taboo restrictions in gynaecological consultations. Before discussing how (i) the age gap (or lack thereof) between gynaecologist and patient and (ii) the cultural indiscreetness of certain Chichewa terms affect communication about taboo topics, I will discuss – for the purpose of additional contextualisation – the widely held Malawian belief that it is shameful for a man to be a gynaecologist.

#### 5.3.1.1. There is discrimination against male gynaecologists

This section explores the Malawian belief that it is disrespectful and undignified for a man to practice gynaecology. One gynaecologist discusses his sister's objections to his career in Extract 5N below upon being asked how his relatives receive the news that he wanted to specialise in gynaecology. This is followed by Extract 5O, in which a female participant expresses how she would feel if her son would want to be a gynaecologist.

Extract 5M:

Dr OB: *Aa amodzi okha, ena onse anachilandira bwino. Mmafuna kukhala dokotala anasangalala, kenako ndati ndufuna ndikhale oyang'anira za azimayi, chemwali anga okha, ena ake ndi a* nurse*, anaza/sanakhale osangalala. Nde kuwafunsa akuti aaah madokotala onse oyangánira azimayi amangokhala obalalika mitu yawo, kukonda azimayi kwambiri. Nde ndinati ineyo ndupita uku chifukwa choti ndimakonda ma* operation *ndimakondanso ana. Nde Kumalo komwe ndingapange zonse nthawi imodzi ndikuti, ndikumeneku nde nchifukwa chake nnapanga zimenezo. Sindikupanganso* regret *zimene ndimapanga, chifukwa zimandisangalatsa.* I enjoy what I do. *Aah nde panopo ndinganene kuti* I don't know *kuti* experience *imene anali nayo koma* I don't think it's true. *Ndimagwira ntchito ndi anzanga ambirimbiri* I don't think it's true *umangokhala mtima wa munthu. Zimene amanenazo. Chifukwa even amene asali madokotala, kaya ma* lawyer*, kaya ndani, ndi mtima wa munthu, eeh koma sikuti ndi ntchito imene ingakupangitseyi kuteno.*

Uhm only one, everyone else received the news well. When I wanted to be a doctor, they were happy. Then I said I want to be a gynaecologist, only my sister, the one who is a nurse, she was, she wasn't happy. So, when I asked her, she said all gynaecologists have screwed up minds; they love women too much. So, I explained to her that I was taking that direction because I love operations and I love children. So that was the only place I could always do both. And I don't regret what I do because it makes me happy. I enjoy what I do. Uhm so right now what I can say is that I don't know the experience she had, but I don't think it is true. I

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work with quite a number of colleagues; it's just one's personality to be saying what she was saying. Because even those who are not doctors, for instance lawyers or whoever, it is one's personality. Yah. But it is not your profession that makes you to be like that.

MCK: *Nde masiku ano amati bwanji achemwali anuwo, amakhala ndi maganizo omwewa?*
So what does your sister say now? Does she still hold the same view?

Dr OB: *Ife ndi olemekezeka pano, timatchedwa ababa, mlerankhungwa ndi zina Zotero. Nanga mtundu onse sitikuyangánira ndife tsopano.*
We (=I) are well respected. We (=I) are called father, the patriarch and so on. Since we are now looking after everyone.

In Extract 5M, Dr OB emphasises the significance of his sister's disapproval by pointing out that she was a nurse, which implies that she had personal insight into gynaecologists being promiscuous, having worked at the hospital. In this extract, it is clear that the sister believed there to be a connection between male gynaecologists and promiscuity, and that she viewed male gynaecologists unfavourably. In contrast, the gynaecologist himself constructs a positive identity for male gynaecologists and doctors by describing them as people who "look after everyone" towards the end of Extract M. The supposed connection between gynaecology and promiscuity was also discussed by Patient 9 in Extract 5N below, where she argues that she would never support her son if he were to decide to be a gynaecologist, due to the profession's supposed association with promiscuity.

Extract 5N:

P9: *Chifukwa choti ndikuwona ngati moyo wake ukhoza kukhala pa chiwopsezo kwambiri kuti* daily *azikhalira kuwona maliseche a azimayi.* Daily *azikhalira kuwona maliseche a azimayi zikhoza kumamuyika mmayesero. Mwina akhoza kupezeka kuti Wayamba khalidwe lolowerera. Nanga* daily *azikhalira kuwona maliseche a azimayi? Nde a zipezeka kuti mwina, akachoka mmene muja mwina mzimayi akamatuluka basi iyenso Wayamba kusilira mwina atagona ndi munthu. Ndizija pena mwina timamva a dokotala agwiririra munthu, ujeni* patient*. Nde ine sindingamulimbikitse, bola atapanga* specialise *mwina za ana. Kaya za khansa, zinazake koma osati zauchembere wazimayi. Ine ndikhoza kulimbikitsa ana a akazi azipanga* specialise *zimenezozo koma osati ana aamunayi.*
Because I feel like his life will be in great danger for him to keep seeing women's genitals daily. Seeing women's genitals daily would put him in temptation. He may develop immoral behaviour. It is not on to be seeing women's genitals daily! It may happen that after seeing these women, on his way out he might develop some feelings and start wishing he slept with someone. This is how we may have heard that a doctor has raped someone, I mean a patient. So, I wouldn't encourage him. It would be better if he specialises maybe in paediatrics, or maybe cancer, anything but gynaecology and obstetrics. I can encourage girls (=daughters) to specialise in these things, not boys (=sons).

MCK: *Mmm.*

P9: *Komasonso mwinanso ulemu wakenso pa ineyo ukhoza kutha. Ndipa azichemwali ake omwe. Chifukwa nde achita kutidziwa mmene/akawona mzimayi uja aziwonanso kuti amayi anganso ndekuti ali chonchi, azichemwali anganso ali chonchi.*

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And even his respect towards me may degenerate. Even towards his sisters. Because he will actually know us the way, when he sees a woman, he will also realise that my mom is also like this, my sisters are also like this.

MCK: *Koma siamakwatiranso mwanayo ndekuti amakhala kuti wadziwabe.*
But doesn't the child also marry? So it means he will still know.

P9: *Eeh kukwatira kuli apopo inde. Nde ndipezeke kuti ndadwala matenda ofunika dokotala wa azimayi kuti andiwone, nde azandiwone iyeyo? Ayi, ameneyo azapange zinthu zina.*
Yes, although marriage happens indeed. So if I get sick and need to see a gynaecologist, then he will have to see me? No, this one will have to do other things.

MCK: *Mmm.*

P9: *Koma makamaka chiwopsezo kwambiri/mantha anga ali pa…* exposure *ku azimayi. Kuti* daily *akuwona maliseche aa…/maliseche ndi maliseche. Munthu wammuna ndi wankazi/munthu wammuna* the moment *wawona maliseche amunthu wankazi, maganizo,* what will come into his mind is sex. *Nde*, what happens after that?
But the danger is mostly, my fear is on (=about) the exposure to women. That he should daily be seeing genitals of… genitals are genitals. A man is different from a woman. The moment a man sees a woman's genitals, thoughts, what will come to his mind is sex. Then, what happens after that?

In Extract 5N, Patient 9 repeats the adverb *daily* (said in English) to emphasise her assertion that men who practice gynaecology are promiscuous and that they do not respect women, which is based on her reported belief that gynaecologists see female genitals too often (daily) not to be affected by it. Such unfounded beliefs clearly construct an undesirable identity for male gynaecologists that can negatively affect communication during consultations.

Despite the sociocultural beliefs that men should not be gynaecologists, not all patients prefer female gynaecologists in all instances as gender preferences seem to be based on the reason for the visit to the gynaecologist (gender preferences are discussed further in 8.2). For instance, in responding to a hypothetical question[30] concerning gender preference, Patient 3 responds:

Extract 5O:

P3: *Chifukwa utha kumasuka naye bwinobwino.* For example*, ngati kuyeza khansa yakhomo la chiberekero ya cha amayi eti.*
Because I would be free with her. For example, for things like having a Pap smear, right.

MCK: *Mmm.*

P3: *Umatha kudziwa kuti andiwuza kuti ndivule andiwone. Nde umadziwa kuti ndi mzimayi mzanga, sindingachite manyazi. Pamene akakhala amuna umayamba kuganiza kaye kawiri katatu. [giggles] Kuti kodi ndufuna ndigwire? Kapena bwanji?*
You actually know that they will tell you to undress. So you know that this is my fellow woman, you are not ashamed. But when it is a male gynaecologist, you think twice or thrice [giggles] that does he want to touch me or what.

[30] The question was hypothetical because there are very few female gynaecologists in Malawi (see 1.6.3.1), and patients visiting non-fee-charging hospitals do not have a choice as to which gynaecologist they will consult.

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In 5O Patient 3 her choice of a female gynaecologist is based on the level of embarrassment associated with undressing and the subsquent invasive medical examination. This supports the argument that for some patients, the preference of female over male gynaecologists may be the result of the lowered levels of discomfort experienced during a consultation with a female gynaecologist.

#### 5.3.1.2. The ages of and age difference between interlocutors can influence communication

In addition to gender and age (including the age of the patient in relation to that of the male gynaecologist) are social characteristics that may determine the linguistic strategies required to maintain face during the consultation. In Extract 5P, Dr KG, who is 35 years old, reports that some young patients are uncomfortable and shy for personal reasons. The extract below is his response to the question: "Do you think that the Malawian culture affects how you work, especially how you communicate with your patients?"

Extract 5P:

Dr KG: [Sighs] Surprisingly *olo utapeza azigogo okuti akuchokera kumudzi olo kuti...,* the moment *abwera kuchipatala and akudziwa kuti akuzamukana ndi* gynaecologist*, amakhala* very open and very comfortable *kunena zinthu, kulongosola vuto lawo lonse ndikuwayezanso, sipamakhala vuto lina lililonse lomwe ukuwona kuti mwina nchikhalidwe nchomwe chikuwapangisa kuti munthuyu asalongosole bwinobwino. Anthu amene mwina ndinawonapo kuti amakhala ndi ngati kamanyazi kapena ngati kavuto amakhala* actually much younger girls *chifukwa mwina amatha kukuwonano* a young doctor *ngati kuti mwina* you are a potential *kaya, kamamuna kawo* or something like that. So *ndi mmene amawoneka ngati akuchita manyazi, koma anthu akuluakulu samachita manyazi, amalongosola bwino kwambiri.*

[Sighs] Surprisingly, even grannies who come from the village, even…, the moment they come to the hospital, and they know they will be meeting with a gynaecologist, they are very open and very comfortable in saying things, in explaining their issue in full. Physically examining them, there is no problem whatsoever, which you may connect with cultural constraints in their speech. The people I have sometimes found to have shyness as bit of a problem are much younger girls, maybe because they see you as a young doctor, maybe like you are a potential like, their man or something like that. So, they then start looking like they are shy. But older people are not shy; they explain everything very well.

In 5P, Dr KG claims that older patients' contributions in gynaecological consultations are more constrained by traditional Malawian culture than their younger counterparts when he refers to elderly rural women who were open and comfortable with him even though he expected the opposite. At the same time, he states that younger patients are more reticent than older patients, which he attributes to the possibility that younger patients may consider him as a potential partner rather than seeing him as a professional doctor. This finding is in keeping with Macdonald's (2004b: 101) claim that young people are generally uncomfortable with

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undressing in public, which could help explain why younger women cannot discuss private matters without being uncomfortable. Thus, although possible causes of discomfort in young patients may differ, Dr KG claims that younger patients are the more likely than older patients to be uncomfortable when discussing cultural taboo topics. Apart from age, another factor that was regarded as a hindrance to communication was the indiscreetness of some Chichewa terms, as discussed below.

### 5.3.2. Some Chichewa terms are cultural indiscreetness

The interview data showed that some Chichewa terms cause discomfort, yet participants reported that Chichewa was to be used in consultations because patients typically prefer to have their gynaecological consultations in the language that they are most competent in. Patient 1, for instance, who has attended private, English-medium schools and could confidently hold a conversation in English, explains that her language of choice in gynaecological consultation is still Chichewa, because *Ndimafuna kuti timvane bwinobwino* (I want us to understand each other very well). This reason mirrors that of the gynaecologists who participated in this study, and reflects broader linguistic trends in Malawi (see Lora-Kayambazinthu 2003). However, although using Chichewa may aid understanding for patients, it does not suffice as a medical language. Two factors in gynaecological consultations hinder the use of Chichewa, which would otherwise be the most convenient and effective medium of communication. These factors relate to the comfort and adequacy of using Chichewa during medical consultations, as discussed below.

Participants presented their views on the discomfort caused by some Chichewa expressions by either reflecting on their personal language choices in previous gynaecological consultations, or by commenting on the use of language in the audio-recording[31] they had listened to (refer to Appendix C). In Extract 5Q below, Patient 12 explains why she would normally codeswitch between Chichewa and English when consulting Malawian gynaecologists, and why she says the speakers in the audio-recording were Malawian:

Extract 5Q:

P12: *Kubisa mawu. Samangofika, samayankhula zimene aku*-ok *amalankhula zining'a pofuna kutanthauza chinthu cha* simple *ngati* let's say 'sex'- *kugonana. Amafuna alankhule kaya, "Mwakhala pamodzi ndi ujeni" Munthu oti sakudziwa zilankhulo zachonchozo, atha kuwona*

[31] The audio-recording was used to establish rapport and elicit information from patients in the individual interviews.

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*ngati kuti wangofuna/kukhala pansi naye, as in pampando umodzi* or something like that*, osati* necessarily *kuti* having sex or…
Hiding some words. They don't just start with, they don't just say, okay they speak in undertones when they want to refer to things that are simple like, let's say 'sex'- 'sleeping with'. They want to say things like, "Have you sat together with so and so?" If one doesn't understand this type of language, one might think that like you just want, to sit with the other person, as in on the same seat or something like that, not necessarily having sex or…

MCK: *Ok. Kodi ziwalo zamunthu munthu ungazitchule bwanji mchichewa kuti uwoneke kuti iweyo ndiwe mMalawi, umayenera kutchula motani?*
Okay. How can one mention human bodily organs in Chichewa in order to show that you are a Malawian? How are you supposed to mention such?

P12: *Eeh mhmm!* I think *timangonena kuti ziwalo pofuna kulemekeza komano mawu ena amene alipowo amawoneka ngati kuti ndi wotukwana, ndipo munthu ukatchula mawu amenewo umawoneka kuti ndiwe opanda nkhalidwe, kuti uwatchule mawu amenewo.*
Eish! I think we just say that bodily organs when you want to respect but the other way words that are there seem to be obscene and so if you mention them, you look like you are uncouth because you have mentioned those words.

MCK: *Moti kupita kwa adokotala simungathe kufotokoza kuti chiwalo chakuti, ndikumva kupweteka pa chiwalo chakuti? Mungafotokoze bwanji kukhala kuti malo obisika pakupweteka?*
So does it mean that when you go to the doctors, gynaecologist, you are not able to name the particular organ, saying such and such an organ is painful? How can you explain when such an organ is in a hidden place?

P12: *Kunoko zimavutadi kutchula bwinobwino,* I think *zimaphweka ukakhala kuti ukulankhula mu Chizungu osati mu Chichewayi. Mu Chichewa kuti unene kuti iyayi üjeni yanga" aah! Sizimawoneka-sizimamveka bwinobwinoyi. Nde* that's why *timangoti timangolankhulapo* English, which make-*ndi imene imakhala ngati ikuphweketsako zinthu.*
Here [in Malawi] it is quite difficult to mention such just like that. I think it's easier when you are using English and not Chichewa. In Chichewa, for you to say "my such and such". No! It doesn't seem, it doesn't sound well. So that's why we just speak English which makes, it is the one (=the language) that seems to makes things easier.

Patient 12 describes the speakers in the recording as Malawian because of the language they use whilst discussing the taboo topics of sex and sexual organs. She further explains that although it is Malawian culture not to be explicit about matters pertaining to sex and genitals, using English to discuss taboo topics is acceptable. Thus, it can be argued that switching to English to avoid the use of offensive Chichewa expressions (i) allows the patient to communicate without compromising the dignity and self-respect that would result from adhering to cultural norms, and (ii) may assist in maintaining a good relationship between the gynaecologist and the patient, which makes English (whether through borrowing or codeswitching) a relationship building tool. The belief that discussing taboo topics in English is more acceptable than in Chichewa is reiterated by Patient 3 in the extract below, where she explains that the naming of sexual organs in Chichewa that may cause discomfort.

Extract 5R:

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P3: *Zinthu ngati zotchula ziwalo zamthupi zimakhala bwino kuyankhula mchizingu, chifukwa zimakhalako ndi kaulemu ulemu eeh koma mu Chichewa zimamveka mwinamwina mosiyana eti.*
Things like names of body parts[32] sound better when you use English. Because it brings with it some form of respect, while in Chichewa it sounds very awkward and very different, yeah?
MCK: *Mmm.*
P3: *Nde umakhala kuti sukudziwa kuti aah ndinene, nditchule kuti bwanji.*
So, you don't know how to mention them.

Another participant, Patient 9, explains that the switch to English makes the information less disrespectful, and that English terms are used by both the gynaecologists and patients:

Extract 6S:
P9: *Chichewa ndi chitumbuka chimakhala* challenge *kuti adokotala achigwiritse ntchito akamatifotokozera zinthu zina. Chimasiyana ndi chizungu. Olo iweyo ukakhala* patient *kuti ufotokoze, zina zimakhala bwino, ndanena kuti ku (dzina la chipatala) eti, zina zimakhala bwino kuzifotokoza mchizungu. Komano chizungunso* being our second language*, zimapezeka kuti* you are leaving out information *yina yoti unakatha kutani, unakatha kunena.*
Chichewa and Chitumbuka become a challenge for gynaecologists when they explain some things. It is different from English. Even for you as a patient to explain, some things are better, I have said at [name of the hospital], right, some things are better when you say them in English.
MCK: *Mmm.*
P9: *Monga kunena kuti* ***kumaliseche*** *ndi* vagina*. Bola ukanena kuti* vagina *sizimawoneka* awkward*-yi. Nde umapezeka kuti uku/chizungu chimapepukira. Kusiyana ndi chilankhulo chathu chinachi ngati Chichewa olo chitumbuka.*
Like saying "the genitals" [indirect Chichewa term used by Patient 9]. It is vagina; it is better to say "vagina". It doesn't look awkward. So you find that there, English is 'lighter' (not much taboo] compared to our local languages like Chichewa and Chitumbuka.

Patient 9 asserts that gynaecologists and patients benefit equally from the use of English, which is respectful, and she refers to 'vagina' to explain her perception of the difference between the two languages. Note that by refererring to the vagina using a general term *kumaliseche* 'genitals' in Chichewa*,* Patient 9 avoided the explicit Chichewa word for a vagina, *nyini*. This could either be because she did not feel comfortable using the Chichewa word, as discussed in this current section, or because she did not know the Chichewa word for 'vagina', as discussed in the next section.

## 5.4. Implications of cultural taboos for gynaecological consultations

The discussion in 5.3 shows the influence of culture on linguistic choices. This section however discusses the effect of culture on communication vis-a-vis the attainment of consultation goals.

[32] In the context of discussing women's health in Chichewa, "body part" is often used to refer to female sexual organs.

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### 5.4.1. Culture influences effective communication

Participants indicated that mutual respect, which is communicated both verbally and non-verbally, helps create a safe environment for interlocutors to discuss embarrassing and sensitive topics. Consider Extract 5T in this regard (commenting on the language used by the gynaecologist in the audio-recording):

Extract 5T:

P9: *Kaya ndinene kuti ndi mawu olemekeza,* culturally *kwathu kunoko kuyankhula nkhani ngati zogonana zimakhala zovuta kuti munthu angobwera* straight *kuti wagona ndi mwamuna kapena munapanga chiwerewere. Zimakhala ngati…, ngati..., zolawula. Ndiye kuchilemekeza chinthu chija kuti chisaoneke cholaula, adokotala nchake akugwiritsa ntchito mawu ngati amenewowo. Kunena kuti..., komanso kuti* patient *asakhale* offended*. Chifukwa pena kuti dokotala akagwiritsa ma* strong words *umatha kuchita manyazi komanso zimakhala ngati zikukuchotsera ulemu.*

I may say that they are something like respectful expressions. Culturally here in our home country, talking about things like those to do with sleeping together, it becomes difficult for someone to just come straight like, "You slept with a man" or "You were fornicating". It seems like, like offensive/taboo. So, in order to respect that thing, so that it does not feel like offensive/taboo, that's why the gynaecologist is using words like those. Saying that…, so that the patient is not offended. Because sometimes when the gynaecologist uses strong words, you become embarrassed, and it makes you feel disrespected.

The emphasis on culture in the explanation in Extract 5T indicates that cultural norms and constraints play a significant role in deciding what to say during a gynaecological consultation and how to say it. It should also be noted that the participant did not use the explicit word for sex in her explanation; instead, she used *chiwerewere* which translates as "fornication". The role that culture plays in word choices in gynaecological consultations and the embarrassment that arises when one does not observe cultural norms is also explained by Patient 2: (also with reference to the langauge used by the gynaecologist in the audio-recording)

Extract 5U:

P2: *Pachikhalidwe chathu, ndikona akugwiritsa ntchito mau onena okuti kukhalira limodzi. Chifukwa anakati anene kuti mumanyengana, akananena kuti mwina mwake akundiyalutsa kapena kuti adokotala aganiza bwanji.*

It is our culture, that is why he is using words like "sitting together". Because if he had said that you were having sex, she would have said that she has been embarrassed or wonder what the gynaecologist was thinking.

The reference to cultural norms, embarrassment resulting from a violation of such norms, and the responsibility of the gynaecologist to establish a respectful relationship with the patient, emphasises the need for the use of culturally appropriate words during consultations. The

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participants also gave particular examples of Chichewa expressions that would be appropriate to use during gynaecological consultations. Consider in this regard the extract below:

Extract 5V:

P11: *Aah tingoyelekeza ziwalo za ife ngati azimayi. akhonza kunena kuti aah tifuna tikuyezeni kumunsiko. kusonyeza kuti mwina akufuna ayeze njila ya nzimayi. ayeze chiwalo chimene zimayi amagwiritsa tchito pobeleka, sanganene kuti tifuna tikuyezeni, mwina kuchitchula chiwalocho akhonza kunena kuti mwina tikuyezeni kumusiko, aah chabwino chiwalo chanu chobisikacho sichili bwino potengela motengela ndi part'yo mmene ilili tingoyelekeza pachizungu mmene ilili* vagina *ija ankhonza kunena kuti chiwalo chanu chobisika, ndi mau'be ophiphilitsa amenewowo, kusiyana ndikungolankhula mmene chilili chiwalocho.*

P11: Uhm, let me give an example of our female body organs. They can say, uhm, "We would like to examine you down there". Which means that they want to examine the woman's passage. To examine the organ that the woman uses to bear a child. They can't say, "We want to examine…", maybe mentioning the organ. But they can maybe say, "Let us examine you down there", uhm "Okay, your hidden organ is not alright", considering the way the organ is, maybe for instance in English the way the vagina is, they can say "your hidden body organ", which is a cryptic expression, instead of just talking about the organ the way it is.

Patient 11 illustrates the indirect way in which gynaecologists refer to the female anatomy when speaking to their patients in Chichewa. According to her, the phrase *down there* is an example of the way in which a gynaecologist would refer to the vagina in an attempt to avoid making the patient uncomfortable. This is similar to the use of *kumaso* 'the face' by Dr KG in Extract 5W below. Note that, like Patient 11, Dr KG uses the English term *vagina*, and plural *we* (discussed below):

Extract 5W:

Dr KG: *So, pali njira zina zomwe umatchulira, sipa Chichewa pali njira zina zomwe umatchulirira. Like kumuwuza munthu kuti ufuna uwone,* you want to look at the vagina *umatha kumuwuza munthu kuti chotsani kabudula tiwone nawo kumaso…* so there are those words that you use depending on *amene ukuyankhula naye…*

So, there are particular ways of mentioning things, Chichewa does have particular ways of mentioning such. Like, telling the person that you want to see, you want to look at the vagina, you can say, "Remove your shorts (=underwear) so we are able to look at the face (=your genitals)". So there are those words that you use depending on who you are talking with.

In Extract 5W, the gynaecologist refers to himself in the first-person plural (*we*) instead of in the first person singular (*I*). This use of the plural could (i) be an honorific expression and (ii) be used to represent the gynaecologist and the hospital during the consultation. Either way, it can be interpreted as an attempt to justify the need for an intrusive examination, since it indicates that an authority, either the gynaecologist or the hospital, has seen the need to have the examination performed (refer to 5.2.3, which discusses the need to justify invasive

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examinations). In the extract above, Dr KG uses the euphemistic term *kumaso* 'the face'[33] to refer to the vagina in order to avoid the culturally offensive Chichewa equivalent. Note that Dr KG himself used the English and not the Chichewa word for "vagina" during the interview. In addition to using associated meaning to preserve the dignity of his patient, Dr KG's also uses the verb *remove* and the pronoun *we* in the extract above, as other possible terms, like *undress* or *strip* for the former and *I* for the latter, may be associated with intimacy between interlocutors and hence may be seen as disrespectful to the patient. The impact of using indirect Chichewa terms is summarised as follows by Dr AS:

Extract 5X:

Dr AS: Whether *amamvetsetsa bwino olo* not I can't say, *koma amakhala* comfortable, you know they are quite comfortable *kuti adzikamba bwinobwino* without feeling embarrassed. *Mukamagwiritsa ntchito mawu ngati amenewo.*
Whether they fully understand or not, I can't say. But they get comfortable, you know, they are so comfortable that they properly explain very well without feeling embarrassed, when you use expressions like those.

Dr AS emphasises that the level of comfort the patient experiences is more important than mutual comprehension as he argues that the former helps in ensuring that the patient gives the information required, since it enables the patient to share more than they would have had they been uncomfortable. Firstly, Dr AS emphasises the importance of comfort by stating the benefits of overcoming embarrassment instead of insisting on the patient's understanding of the gynaecologist's jargon, and secondly, by repeating the adjective *comfortable* to stress the positive effect and importance of using respectful language.

### 5.4.2. Some strategies impede the attainment of consultation goals

As discussed in Section 5.2, respect and dignity are essential components of gynaecological consultations as they assure the patient that the consultation is a safe space. Further, the data shows that there are instances where interlocutors may refrain from discussing face-threatening topics as a way of claiming and/or distributing the social goods of respect and dignity. For example, one gynaecologist explains that as a novice gynaecologist, he avoided requesting physical examination from older patients in order to avoid making them uncomfortable, while

[33] *Kumaso* 'the face' is a commonly used Chichewa term for genitals, possibly because of the following connection between the face and genitals: In Malawian culture, a person is initially named according to their sex (their genitals). Only once the child is born, is the child named, and a factor determining the name given to the child is the child's sex (as evidenced by the child's genitals). Afterwards, the person is known to others by his/her face – when they see a person's the face, they know who it is. The term for face is thus now also associated with the genitals.

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patients and gynaecologists alike report that patients withhold information for the same reason, which negatively impacts the attainment of consultation goals.

Avoidance was presented as a strategy that a gynaecologist reported using before he had acquired the necessary sociolinguistic skills that could help him mitigate face threats while discussing taboo topics. He explains the challenges he had as follows:

Extract 5Y:

Dr KG: *Koyambirirako* it was very difficult. (…) Soo... *zinali zovuta. Makamakano kufika nthawi yokutino uwayeze. Ndeee with* gynaecology *inalino zovuta. Nthawi yina okutii..,* I remember a couple of times *ndimakhala kuti mwina osamaliza kumuyeza munthu uja. Ngati kuti kupangaaa* like vaginal examination *osapanga. Aphunzitsi akafunsa ndimangoti aah sinnapange ndimawona ngati zosafunikira, sizifunikira olo mwina kunena kuti aah* ***a*** patient *sanali* comfortable, *pamene sinnali* comfortable *ndi ineyo kuti ndiafunse kuti ndiayeze.*

*(…)*

*Koyambirira zimavuta chifukwa kuti umachita manyazi* and *chifukwa chokuti ndizinthu zoti sunapangepo and takula* in a society where *kungotchula ziwalo,* like private parts is not the usual thing, then *umachita manyazi.*

In the early stages, it was very difficult. (…) So with gynaecology, it was hard. One time when.., I remember a couple of times, I would not even finish examining the patient, like doing the vaginal examination, I wouldn't. When my lecturer/supervisor *(sic.)*, I would just say something like, "The [honorific] patient was not comfortable", when in actual fact I was the one who wasn't comfortable to ask her to examine her.

(…)

In the beginning, it is hard because it is embarrassing and since they are things that you have never done before and we have been raised in a society where merely mentioning of body organs like private parts is not the usual thing, then you start feeling embarrassed.

In Extract 5Y, Dr KG explains how his lack of face-saving discursive strategies resulted in the avoidance of performing a FTA during his internship at the expense of the well-being of the patient. The use of honorific *a* in '*a* patient' when referring to the patient indicates the respect he had towards the patient. This then re-enforces Dr KG's assertion that it was hard for him to request an older woman to examine her physically. In the Malawian culture, the older the person and the wider the gap between the interlocutors' ages, the more respect the older person requires; in other words, there was a great need to distribute the social goods of respect and dignity to the patient – to the extent that only avoidance sufficed for Dr KG at the time.

In Extract 5Z, Patient 5 explains that one of the reactions that patients have when gynaecologists use culturally taboo expressions is to withhold information, and in Extract 5AA, Dr AS explains the effect of such withholding of information. Patient 5's explanation below came from her response to the question about how the patient in the audio-recording would have felt had the gynaecologist explicitly mentioned sex and menstruation:

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Extract 5Z:

P5: *Odwalayo akanatha mwina kuchilandira potengera kuti mmene mwini wake wachilandirira eti. Koma kumbali ngati ya ineyo zikanandivutabe kuti ndimasuke ndifotokoze kuti vuto ndi chani.*

Maybe the patient could have received it well, depending on her own conviction. But if it were me, I would have had problems to freely interact with the gynaecologist in telling him about my issue.

Patient 5 states that she would not have been able to talk freely about her medical issue had the gynaecologist used explicit words for sex and menstruation with her, and that she would have withheld some information (possibly as a way to avoid further embarrassment). When a patient withholds information during consultation, the information gathering process is affected, as Dr AS explains:

Extract 5AA (partial repetition of Extract 5D)

Dr AS: So, typically women for example will not say about their sexual issues. But sometimes for me to figure out what that issue is I need that information. Ok. *Koma chifukwa choti,* one they don't want me *kuti ndidziwe za zimenezozo,* 'cause *amaganiza kuti mwinamwake ndiwapanga* judge *ndizina zotero,* you know, they will keep that information from me. Same information *ndiyofunika kwambiri* to figure out *zomwe zikuwachitikira iwowo.*

So, typically women for example will not say about their sexual issues. But sometimes for me to figure out what the issue is I need that information. Right. But the reason that, one they don't want me to know about such things, because they think that maybe I may judge them or things like that, you know, they will keep that information from me. (The) same information is important for me to figure out what is happening to them.

Dr AS argues that his clinical gaze is hampered by the absence of information about the patient's condition, and that, in his experience, hiding embarrassing information concerning sex at the expense of one's wellbeing is common in the Malawian setting. This is echoed by Mkandawire's (2012:87-8) findings from a study conducted in a rural area of Malawi's Southern Region, which revealed that abuse would not stop because women could not present domestic violence issues related to sex to the Group Village Headman, despite him being the only mediator who could assist them, because it was taboo to discuss sexual matters with people whom one does not have an intimate relationship.

### 5.4.3. Adhering to cultural norms lengthens consultation time

Given that gynaecologists cannot avoid discussing sex and sex-related matters with their patients, they often make use of circumlocutions when doing so in order to remain culturally appropriate. This means that long explanations are given as a way of showing respect to the patient, as Dr OB explains:

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Extract 5BB:

Dr OB: *Kumufotokozera motalikirapo kusiyana kungolunjika kuti, mwakuti! Nde umakhala ngati kuti ukutanthauzira bwinobwino koma motalikira. Nkhani yake ili yomweyo yomwe. Chifukwa choti ungonena mawu... liwu limodzi lokhudzana ndi chinthu chimene ukufuna kunenacho, zimakhala ngati zolowula. Malinga ndichikhalidwe chathu.*

Giving a longer explanation instead of a short and direct one, like boom! So it is like you are translating in a longer version. Although the topic is the same, because just saying words… one word referring to the same thing you are saying, it becomes offensive or a taboo according to our culture.

Here (in 5BB), the gynaecologist is referring to the use of circumlocutions where direct, non-offensive expressions are not available. Although long explanations effectively mitigate the face threat that is caused by the use of taboo words, it can be argued that such explanations take up more time than direct expressions. Considering that the participating gynaecologists have an average of 40 consultations per day at the public hospital, and more on the days on which they also work at private institutions, the use of circumlocutions to avoid taboo can negatively impact the quality of patient care given that gynaecologists' already have a short period of time for each consultation. The effect of culture on consultations is discussed in chapter 8.

### 5.5. Chapter summary

This chapter has shown that the discussion of taboo topics is forbidden in general Malawian public discourses, but it is acceptable, due to necessity, in gynaecological consultations – with particular linguistic restrictions. According to the participants of this study, FTAs that regularly form part of gynaecological consultations include directly referring to sex, sexual organs, and related matters; acknowledging infertility; and making unjustified requests for physical examination. It has been shown that the taboo nature of these speech acts emanates from cultural norms that associate them with a loss of privacy, respect, and dignity, and that they cause embarrassment, discomfort, and anxiety in patients as well as in some novice gynaecologists. Further, the data discussed in this chapter has shown that the default Malawian approach to avoiding such discomfort is to avoid linguistic taboos altogether, and that this is problematic in gynaecological consultation, as such avoidance may compromise the consultation and therefore the patient's health.

Furthermore, this chapter has shown that in some cases, the communication of intimate matters in gynaecological consultations could raise uncertainty over the type of identity and relationship that is constructed for the interlocutors: There is a need for the interlocutors to

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establish professional gynaecologist-patient identities and relationships in line with the goals of medical consultations. Doing so however require openness, which would require the interlocutors to act against Malawian cultural norms for non-intimate relationships between men and women. Finally, this chapter has shown that one can also use culturally appropriate replacements to mitigate linguistic taboo and to attempt to ensure that the patient's face is not threatened. Some of the strategies, however, could sabotage the achievement of gynaecological consultation goals, while others make the consultations longer than usual.

The data that was discussed in this chapter further seems to indicate that the study's participants believe that the responsibility of ensuring that gynaecological consultations are successful despite the cultural norms that constrain them rests more on the gynaecologists because they are the professionals, and the ones offering assistance. This means that they are in a more powerful position than the patients and have the responsibility of ensuring that appropriate doctor-patient identities and relationships are established in the consultation room. At the same time, gynaecologists are the ones responsible for ensuring that their interaction with their patients do not lead the patient to (i) viewing the gynaecologists as potential partners or (ii) thinking that the gynaecologists are judgemental and view their patients as promiscuous. Altogether, this chapter revealed that participants believed that successful communication is indeed achievable in Malawian gynaecological consultations despite the cultural constraints surrounding them, and that the discursive construction of desirable identities and relationships are important contributing factors for positive outcomes of such consultations.

The strategies used in simulated consultations reported in the next two chapters confirm the position of power that the gynaecologists have and the role they have in ensuring that identities and relationships are of a professional nature and that patients are respected.

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# Chapter 6 : Sociocultural communication strategies: Referring expressions

## 6.1 Introduction

As indicated in Chapter 5, the relationship between a gynaecologist and the patient is expected to be formal, distant, and non-intimate, and that the language style used in such consultations, including the choice of vocabulary and politeness strategies, should reflect this (Bell 1997:243-8). Linguisitc choices of the study participants reflect the formal and distant stance.[34] As discussed in section 3.2.3, Allan & Burridge's (2006:33) theory suggests that orthophemistic (formal and direct) or euphemistic (colloquial and indirect) terms would be used to achieve such formality and distance in every setting. However, the findings of this study show that, like dysphemistic expressions, some orthophemistic expressions were considered taboo in these settings, which – although contrary to the predictions made by Allan and Burridge's (2006) X-phemism theory – is understandable in light of the fact that linguistic taboos are not universal constructions, but reflect the sociocultural setting in which they operate.

This chapter explores the reasons why some orthophemistic expressions were considered taboo in Malawian gynaecological consultations even though X-phemism theory predicts that this is not likely to be the case (6.2); and discusses the face-saving strategies[35] used to avoid (6.3) and mitigate (6.4) linguistic taboo. The chapter also provides an overview of the vocabulary that participants used when discussing taboo topics in the individual interviews and during simulated consultations, in an attempt to establish which linguistic strategies are used to convey culturally sensitive information in a face-saving manner. Whereas expressions used in simulated consultations were collected for analysis, the expressions sampled from the interviews all originated from participants only (that is, I omitted those expressions that were initially stated by me, i.e., that I used before the participant used them). Thus, the interview data include expressions used spontaneously by the participants when discussing their personal experiences, as well as those used during metalinguistic discussions on replacements for taboo terms.[36] This chapter thematically presents and discusses findings from the perspective of the participants, who are Chichewa language users. In the discussion of the findings, I also draw

[34] A position reflected by one's choice of one particular expression over another (Jaffe, 2009).
[35] The focus of this chapter is linguistic expressions; however, some reference to face work was inevitable. Face is however dealt with in detail in chapter 7.
[36] Expressions that appeared more than once during the interviews were treated as one expression, since the aim was to identify terms and not to determine their frequency of occurrence.

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interpretations from my own experiences as a first language speaker of Chichewa born and raised in Malawi. It must be stated however that some perspectives of Chichewa speakers used for analysis and interpretation could be viewed as sexist, politically incorrect or vulgar. However, I chose to present these sociocultural interpretations descriptively as they are understood "on the ground in Malawi", while refraining from revealing my own biases on the subject matter.

## 6.2 Orthophemistic expressions are missing

As mentioned above, Allan & Burridge's (2006:33) theory of X-phemism posits that the preferred option for discussing taboo topics is using either orthophemistic (formal and direct) or euphemistic (colloquial and indirect) expressions. Although Allan & Burridge (2006:29) assert that orthophemistic expressions are formal while euphemistic expressions are informal in every language, the findings from this study contradict this to an extent in the sense that findings from both simulated consultations and the interviews show that participants neither used nor expected the use of formal and direct expressions when talking about taboo topics during gynaecological consultations. The following subsections discuss why participants avoided the use of formal and direct expressions.

Even when English-Chichewa dictionaries showed that Chichewa has terms for every part of the human anatomy and for female biological processes like menstruation and other culturally sensitive topics related to reproduction, sex and sexuality, these expressions were neither used nor recommended for use by the participants in this study. The data from the interviews and simulated consultations seems to show two reasons for Chichewa participants not using what in English would be orthophemistic expressions to refer to taboo topics when speaking Chichewa: (i) because they did not know them in Chichewa; and (ii) because they regard them as taboo expressions (as explained in 5.2.1). The former is discussed in 6.2.1 and the latter in 6.2.2.

### 6.2.1 There is a lack (or attrition) of knowledge of orthophemistic expressions

During interviews, some patients who were asked directly if they could name all parts of the female genitals indicated that they could not, stating that they did not know the terms for all the parts. Extract[37] 6A below presents the response of Patient 12:

Interview Extract 6A:

[37] In this chapter, some extracts are from interviews and others from simulated consultations. Extract headings are labeled accordingly, but the numbering runs sequentially, regardless of the type of extract.

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P12: *Ayi, sindikudziwaponso kuti. ayi ndithu, sindikudziwapo china chilichonse. Ndimangodziwa kuti mawu ofotokoza chiwalo chachikazi ndi awa. Osati ma* parts *a pachiwalo chachikazi kuti mchichewa ndingatchule, ayi sindingatchule.*
No, I do not know anything. Not at all, I do not know anything. I only know the general term for the female genitals. But I certainly cannot mention the specific parts of the female genitals.

There is a possibility that participants were too embarrassed to name the female body parts for me; however, this is unlikely to be the case with Patient 12 in Extract 6A, who states that she would not be able to label the parts even if she were provided with a diagram. Since this question only required a yes/no answer and not the actual naming of the parts, it can be concluded that Patient 12 genuinely did not know the terms. Similarly, Patient 3 was not sure if what she knew were the correct terms for the genitals:

Interview Extract 6B:
MCK: *Kodi mutha kutchula chiwalo china chilichonse mChichewa?*
Are you able to name every human organ in Chichewa?
P3: *Mmm.* [laughs]
MCK: *Kuti ichi ndi chiwalo chakuti, ichi ndi chiwalo chakuti?*
Like this is called this, this is called that?
P3: [laughs] *Ayi.*
[laughs] No.
MCK: *Chifukwa chani?*
Why not?
P3: *Aaahm, pali ziwalo zina zokuti zinapatsidwa mayina, komano sumadziwa kutidzina limenelolo ndilenileni, ndilakedi lenileni? Komanso umati mwina ukatchula eti, anthu ena amaziwona ngati ndizo..., offensive. Kodi tinganene kuti chani?*
Umm, there are some things that were named, but you do not know whether those are their authentic names. But then even when you mention them, some people feel like they are offensive. What can I call them?
MCK: *Zotukwana ngati?*
They are profane, maybe?
P3: *Eeh anthu akhonza kumawona ngati ukulawula, ukutukwana.*
Yes, people may feel like you are saying taboo things; you are swearing.

In the extract above, by saying “you don’t know whether those are their authentic names”, Patient 3 explains that she is uncertain about the expressions she knew for *ziwalo* ‘body parts’ (=genitals), but also that she was concerned that using them would cause offense. This shows that orthophemistic expressions could have been missing in the data not only because of lack of vocabulary, but also due to their perceived inappropriateness. Thus, Extracts 6A and 6B respectively show orthophemistic expressions were either unknown or regarded as a form of linguistic taboo in gynaecological settings, as discussed further below.

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### 6.2.2 Orthophemism is considered a linguistic taboo

This section explains why most participants seem to regard orthophemistic expressions as face-threatening. Consider Extract 6C, which pertains to the audio-recording listened to as part of the individual interview:

Interview Extract 6C:

P12: I think *chifukwa chachikhalidwe chathu ku Malawi kuno. Sitimanena* explicitly *zinthu timayankhula mozemba, sitimanena chilungamo chake zinthu zikakhala kuti zikukhudzana kugonana, yah kugonana kapena ziwalo zathu zachikazi kapena zachimuna.*
I think it is because of our culture here in Malawi. We do not explicitly say things; we mince some words. We don't give the true version when it concerns things that are related to sex, yah sex or about female or male body organs.

MCK: *Kodi a dokotalawa anakangonena mwachindunji zomwe amatanthauza odwalayu anakamva bwanji?*
What would have happened if he had just said directly what he meant? How would the patient have felt?

P12: *Koyamba ndikuwona ngati anakapanga manyazi, kapenanso zinakamufilitsa uncomfortable.*
Firstly, I think she would have felt embarrassed, or she could have felt uncomfortable.

In Extract 6C, Patient 12 explains that using "the true version", which could be seen as orthophemistic terms, may cause embarrassment or discomfort in the patient. The effect of using direct terms for sensitive referents in the gynaecological consultation is thus undesirable because an uncomfortable patient may not provide all the information necessary for accurate diagnosis and effective treatment and may even avoid follow-up consultations. The next extract presents a discussion on the perceived inappropriateness of using a direct referent for genitals.

Interview Extract 6D:

P9: *Dzina lake limavutabe kutchula, ngakhalebe tikakutchula mwina timangoti kumaliseche eti.*
The name is still so hard to mention, although when we do mention it, maybe we just say 'the genital area' (=the genitals), right.

MCK: *Mmm.*

P9: *Eeh mwina kungoti kumaliseche. Koma nde ulowe mwa adokotala nde uziti "Adokotala kumaliseche kukundipweteka" zimakhala ngati zinazake.*
Yeah, maybe just saying "the genital area" (=the genitals). But then you enter the gynaecologist's room and then you say "Doctor 'the genital area' (=my genitals) is painful", it sounds like something else.

In Extract 6D, Patient 9 refers to the genitals by using the term *maliseche*. *Maliseche* 'genitals' is a direct, general, and formal term – in other words, an orthophemistic expression. However, Patient 9 says she would not necessarily use it in a medical consultation as it would not sound right, and elsewhere in the interview (see Extract 5K in 5.3.1), she explained that she once used the vague expression *ukuku* 'this (place) here' to refer to her vagina when consulting a gynaecologist. Thus, although *maliseche* is formal, it is not used often because the directness

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therein makes it unacceptable for some participants. This is contrary to Allan & Burridge's (2006:29) prediction that orthophemistic expressions are preferred when taboo topics are discussed.

According to the participants, the directness of the given orthophemistic expressions causes face threats helps to explain why they are seldom found in the data that was collected for this study. While Dr AS acknowledged the face-threatening nature of Chichewa orthophemistic expressions for sexual organs, he emphasised that these expressions do exist, although most people do not use them:

Interview Extract 6E:

Dr AS: *Timazitchula zinthuzo, zili ndi mayina osati amene anthu amagwiritsa ntchitowo… Chichewa chake chilipo ndichosavutanso ambiri amamva bwinobwino*

We mention them; they have names. Not the names people use… There are Chichewa terms which are not even hard; many understand them.

Given that there are Chichewa words for sexual organs, interlocutors have two options when faced with possible taboo: (i) not to use the taboo expression, as required in the Malawian sociocultural context, or (ii) to mitigate the taboo. The findings from data collected in the simulated consultations align with Brown & Levinson's (1987:68) assertion that when an impending FTA has the potential of threatening the faces of both interlocutors, avoidance or mitigation are the inevitable choices. Thus, face work contributes to the achievement of successful communication in gynaecological consultations in the Malawian setting, as discussed in 6.3 and 6.4.

Since direct expressions are considered to be taboo, expressions that are would be both formal and direct (i.e., orthophemistic) are not acceptable in Chichewa. Contrary, the expressions that are acceptable for use in formal Chichewa conversations are indirect. As such, in this dissertation the indirect expressions that are used in formal settings like the gynaecological consultation, are referred to as “formal expressions” because of the context in which they are used. These formal expressions in Chichewa are not the same as the English orthophemistic expressions, because they are indirect, and not as explicit/direct as their English counterparts.

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## 6.3 Avoiding the FTA

### 6.3.1 Omitting phrases and nouns can be a face-saving strategy

This section discusses two ways in which interlocutors referred to something that was regarded as taboo without directly mentioning it. The first strategy used was omission, and the second was using pronouns and/or prefixes whose referents are context-bound. Consider Extract 6F, for example, in which the gynaecologist omits mentioning what is done with the cotton swab between preparing it and waiting for it to change colour when conducting a Pap smear.

Consultation Extract 6F:

Dr KG: *Tebulolo lili ndi miyendo yoyimikira. Mukayimika miyendo ija, amakulowetsani* speculum. Speculum *ndichongotsekulira aahm njira yodutsa mwanayo kuti tiwone bwinobwino khomo ya chiberekeroyo.*
The table has places for hanging legs. When you hang your legs, they insert a speculum. A speculum is an instrument for opening uuhm the passage of the baby (=the vagina) so that we can properly see the cervix.

P9: *Ok.*
Okay.

Dr KG: *Tikatero timagwiritsa ntchito* cotton *ndichogwirira, nde* cotton *uja timamunyika mu* vinegar. Vinegar *wathu yemweyo timaphikirayu. Nde kenako timadikira 1minute kuti mtundu usinthe. Kutengera ndimmene mtundu utasinthiremo eti, timawona kuti munthu ali ndi vuto kapena alibe vuto.*
After which we use cotton on a handle, then we dip it in vinegar. The same vinegar we use for cooking. Then we wait for 1 minute for the colour to change. Depending on the colour it changes to, we can tell whether the person has a problem or not.

In 6F, the gynaecologist does not name the body part for which the cotton swab will be used. From his explanation, an uninformed patient could incorrectly understand that while the speculum is in the vagina, the doctor dips a cotton swab in vinegar and waits for the reaction. Another instance in which there is a missing referent is in Extract 6G, in which the gynaecologist asks an objectless question:

Consultation Extract 6G:

Dr DW: *Simmamva kupweteka kwambiri?*
Don't you feel a lot of pain?

P3: *Ayi, sindimamva kupwetekanso chilichonse.*
No, I don't any feel pain anywhere.

Dr DW: *Ok. Mmasintha kangati pasiku?*
Okay. How many times do you change in a day?

P3: *Kawiri.*
Twice.

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The gynaecologist uses the verb *change* intransitively. Although *change* is ergative, the environment in which it has been used in 6G required it to take an object, because the literal meaning of the doctor's question is "How many times a day do you change your clothes?" The missing object in this question is *pads* or *nyanda* 'a piece of cloth'.

Mentioning sanitary pads may be regarded as taboo as they are intimate feminine hygiene items closely associated with menstruation, the latter being a taboo topic in the Malawian sociocultural context (see 1.6.2.2). Therefore it may be uncomfortable for some to directly refer to pads in a cross-gender discussion. 6F and 6G exemplify the use of Null NP as a way avoiding a taboo expression. Even when an NP was missing, locatives were used. In Chichewa, the lexicalised locative *ku-* is used with nouns (see Msaka 2019:340). However, in this study, it was found that this locative was used without a noun, which in English translations below were replaced by locatives [place reference missing]:

> *Ukuku* (this [place reference missing] here) = *-ku-* (locative) and *-ku* 'here' (adverb)
> *Kumeneku* (this where [place reference missing] here) = *ku-* (locative) + *-mene-* 'where' + *-ku* 'here'

In the two expressions above, the missing noun would make the referring expressions vague (see 6.4.6), because omitting the noun results in the referent not being made explicit. However, the unmentioned place was understood to be a body part that could not be mentioned because doing so was taboo, thus by implication it is a sexual organ. Thus, the speaker is able to communicate effectively despite the omitted noun.

Data shows that in some instances when the strategy of omitting the NP was used, pronoun affixes were used instead. An instance where pronoun affixes were used to refer to an entity that was not mentioned immediately before or after the pronoun affixes occurred can be seen in Extract 6H below. Instead of repeating *bambo* 'the man' (husband), the gynaecologist uses the pronoun affixes *a-* ('he' + a projection of a positive action on the affixed verb) and *sa-* ('he' + a projection of negative action on the affixed verb).

Consultation Extract 6H:

Dr OB: *Ok, tibwerera ku nkhani imeneyiyi yomwe mwabwerera leroyi. Tineneee kumbali ya bamboo. Bambowa anakhalapo ndi akazi ena m'mbuyomu?*
Okay, we will get back to this issue that you have come for later. Now let's talk about your husband. Has your husband ever had other wives before?

P1: *Aah ayi.*
Uhm, no.

Dr OB: *Ayi, simunamve kuti ali ndi mwana kwina kwake?*
No. You have never heard that he has children elsewhere?

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P1: *Ayi.*
No.
Dr OB: *Chabwino. Kukhalira limodzi, mukamakhala limodzi pamakhala vuto lina lililonse ngati?*
Alright. Being together (=during sex), is there any problem when you are together (=have sex)?
P1: *Ayi.* [whispering]
No. [whispering]
Dr OB: *Tingamanene kuti pasabata mmakhala limodzi kangati?*
How many times can we say that you are together (=have sex) in a week?
P1: *Kawiri.*
Twice.
Dr OB: *Ooh chabwino.* ***A****makhala ndivuto loti mwina mwakeee kuti mwina atulutse mphamvu yawo kuti mwina zimawavuta?*
Alright. Does he have a problem, which may be that for him to release his power (ejaculate), may be it is difficult?
P1: *Ayi.*
No.
Dr OB: *Ayi ndithu?*
None?
P1: *Eeh.*
[affirmative] (=No)
Dr OB: *Ayi chabwino. Tathokoza. Sadwala matenda ena aliwonseyi?*
Alright. Thank you. He does not suffer from any (chronic) diseases?
P1: *Ayi.*
No.

As an agglutinating language, Chichewa allows for the use of a pronoun as a prefix to the verb. However, in Extract 6I above, the referrent of the third-person pronoun prefix *a-* could be ambigous for the following reasons. Firstly, they are used several lines after the antecedant (8 and 12 lines, respectively), which has only been mentioned once. Secondly, other nouns like *sabata* ‘week’ and *vuto* ‘problem’ were used between the pronoun prefixes and *bambo* ‘husband’, and these two other nouns in their prural form allow the same affixed pronoun as *bambo,* the antecedent. Thirdly, the pronoun is gender neutral, so it can refer to any third person, previously referred to in the discourse or not. Despite various possible referents, the patient understood what the gynaecologist meant since the gynaecologist indicated at the beginning that they will talk about her husband. It can be argued that by not repeating the antecedant, the gynaecologist distances the husband from the culturally uncomfortable discussion of possible impotence or delayed ejaculation, thereby making the discussion less offensive than it would otherwise have been.

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### 6.3.2 Codeswitching to English reduces the threat to face

The Chichewa-speaking participants reported that they codeswitch to English to avoid the discomfort caused by some Chichewa expressions. In the extract below, Patient 12 explains both why she would normally codeswitch between Chichewa and English when consulting Malawian gynaecologists, and why she says the speakers in the audio-recording were Malawians:

Interview Extract 6I:

P12: *Kunoko zimavutadi kutchula bwinobwino,* I think *zimaphweka ukakhala kuti ukulankhula mu Chizungu osati mu Chichewayi. Mu Chichewa kuti unene kuti iyayi üjeni yanga, aah! Sizimawoneka-sizimamveka bwinobwinoyi. Nde* that's why *timangoti timangolankhulapo* English, which make-*ndi imene imakhala ngati ikuphweketsako zinthu.*
Here in our home country (=Malawi), it is quite difficult to mention such just like that. I think it's easier when you are using English and not Chichewa. In Chichewa, for you to say, "My such and such" – no! It doesn't seem, it doesn't sound well. So that's why we just speak English which makes, it is the one that seems to make things easier.

Patient 12 identifies the speakers in the audio-recordings as Malawian because of the language they use whilst discussing the taboo topics of sex and sexual organs which, as mentioned in 5.2.1, are considered sensitive topics. She explains that although Malawian culture does not allow explicit referring expressions for sex and genitals, using English to discuss these taboo topics is acceptable. Thus, it can be argued that switching to English in such instances allows the patient to communicate without compromising the social goods of dignity and self-respect. Furthermore, switching to English to avoid the use of potentially offensive Chichewa expressions may assist in the maintenance of a good relationship between the gynaecologist and the patient. Thus, switching to English, whether through borrowing or codeswitching, is also a relationship building tool (also see the discussion of codeswitching in 5.3.2).

There were two types of instances when English terms were used in Chichewa gynaecological consultations. The first is when there were no suitable Chichewa terms, and the second is when the speaker wanted to save face. According to Gumperz (1982:66,75), the former is a case of borrowing while the latter is codeswitching. In the extract below, the word *period* is borrowed from English.

Consultation Extract 6J:

Dr OB: *Nde tikakamba za **period**-yi, nde munayamba **kusamba** muli ndi zaka zinga?*
So when we talk about this period, so how old were you when you started bathing (=menstruating)?

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In 6J, the gynaecologist uses two words to refer to the patient's period: the English word "period", and the euphemistic Chichewa expression *kusamba* 'bathing' (=menstruating)', where the English expression *period* contextualises the Chichewa expression whose surface meaning is "bathing". The gynaecologist also uses this English word to soften the discussion about a topic (menstruating) which would have been even more face-threatening to the patient had it been discussed entirely in Chichewa. Although *kusamba* 'bathing' (=menstruating) may be regarded as euphemistic, the absence of its orthophemistic expression in Chichewa makes its use to be a FTA. This is in line with Kajombo's (2021:223) argument that euphemistic expressions can eventually become dysphemistic in the absence of dysphemistic expressions (see also 6.4.2.2 which discusses on how *kusamba* is regarded as a taboo expression).

The use of English also helped another patient at the onset of a consultation to explain her reason for visiting a gynaecologist. Her response to the question from the doctor about what her medical issue was as follows:

Consultation Extract 6K:

P12: *Ndimafuna ndingodziwa ziwiri zitatu zokhudzana ndi* ***pregnancy***.
I wanted to know one or two things about pregnancy.

In 6K, Patient 12 knew the Chichewa word for pregnancy as she had used the term *mimba* in her subsequent references to pregnancy. It can be argued that the patient uses the English word *pregnancy* in the above extract because she had not yet established rapport with the gynaecologist. Similar instances of the use of English are presented from the same data by (Kajombo 2021), where the patient uses the English term *process* to generalise the Pap smear procedure which she reports to be an embarrassing procedure for her given that it involves taking off one's clothes to be examined by a doctor when one is not sick. Apart from avoidance, mitigation was also employed to soften the face threats that are caused by disussing taboo topics, as discussed in 6.4.

## 6.4 Indirect expressions can mitigate linguistic taboo

This section provides an overview of indirect expressions that are used instead of explicit linguistic taboo expressions in gynaecological settings. The topics under discussion include sex, reproductive organs, pregnancy and infertility, menstruation, and physical examination. The analysis of the indirect expressions has led to the classification of six approaches[38] to the

[38] Note that some expressions may entail more than one approach.

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use of Chichewa terms in gynaecological consultations, given that explicit expressions are not socioculturally acceptable.

### 6.4.1 Euphemism

In this study, a euphemistic expression refers to an indirect word whose connection with its referent is somewhat opaque. Two Chichewa examples that emerged from the data are the euphemistic expressions *gonana* and *nyengana* (both meaning "have sexual intercourse"). The former was acceptable while the later was only acceptable for some participants. Firstly, the term *kugonana* was used and regarded as acceptable by some patients, possibly because the word is derived from the verb *kugona* whose surface meaning is "to sleep with each other willingly", which may be regarded as non-sensitive. However, other patient participants said they would not be comfortable if the term *kugonana* was used in gynaecological consultations, because it was not a respectful word, as argued in the extract below:

Interview Extract 6L:

P11: *"Ndiye kuti inuyo ndiamuna anu* ***munagonana*** *masiku amenewa" kapena "****munachindana*** *masiku amenewa", sichimamveka bwino nkamwamu kapena okumva. Monga ndanena pachikhalidwe chanthu, zikanaoneka ngati dokotalayo ndiwamwano opanda ulemu.*
"So you and your husband had sex in the past few days" or "You had sex (derogative) these past few days", neither sound well when you say them nor to the listener. As I have said, in our culture, it might have been understood as if the gynaecologist is rude and disrespectful.

In 6L, *kugonana* (or *munagonana*) was compared to another socially unacceptable expression: *kuchindana* (or *munachindana*). Both expressions may also be compared to another expression found in the data: *kunyengana* 'to deceive each other'. Despite the use of the morpheme *-na* 'with each other / together / willingly' in each of the expressions above, patients found *kuchindana* and *kunyengana* unacceptable. It can therefore be argued that it is not the suggested consent in *kugonana* that made the expression acceptable (at least to some participants), as *kuchindana* and *kunyengana* are not acceptable (despite the use of the "consent morpheme" –*na*) because their root verbs were considered vulgar and disrespectful. Of these two words, it is only *kuchindana* whose free morpheme has the denotative meaning of "having sex", while the free morphemes *nyenga* 'decieve' and *gonana* 'sleep with' relate to sex euphemistically. In the data, *kuchindana* only appeared in interviews, and where it did appear, it was presented as unacceptable by all, whereas *kunyengana* was accepted and used by some participants. Given that *kunyengana* was acceptable for some participants, those participants could be said to view it as a non-explicit word. This could be a result of the fact that replacements of taboo expressions may gradually become taboo themselves, and that some speakers may regard an

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expression as taboo while others do not during the transitional phase from acceptable to taboo. *Gonana* could therefore be transitioning towards becoming a taboo word, while *nyengana* may already be a taboo word. In brief, *kuchindana* was consistently regarded as a caconym,[39] while the acceptability of *kugonana* and *kunyengana* depended on personal interpretation.

### 6.4.2 Connotation

In addition to using euphemism, another way in which indirect expressions were used to refer to taboo topics was to use the associated or "deeper" meaning of words.

#### 6.4.2.1 Connotative expressions for sexual intercourse and related matters

The following verbs have more than one meaning and were used connotatively in the data to refer to sex: *kumukhuza mkazi* 'to slightly touch', *kugona limodzi* 'to sleep together', *kukhala ndi* 'to sit/be with', *kumanako ndi* 'to ever meet with', and *kukhalira malo amodzi* 'to be in the same place with'. The comprehension of all five expressions would require knowledge of the way the Chichewa language is used within the Malawian context. The following expressions whose connotative meaning is related to sex and sexual organs also appeared in the data: *chikazi* 'femininity / of female' (= vaginal discharge), *chimuna/umuna* 'masculinity' (= semen), *mphamvu ya mzibambo* 'a man's power' (= sperm), and *kukakhala ndichilakolako cha amuna,* 'to have the desire for men' (= to become sexually aroused).

The expressions above have non-sexual denotations, which children and non-proficient foreign language speakers of Chichewa would understand. However, their connotative meanings would not be understood by the same group of speakers. These expressions were (or were reportedly) used during gynaecological consultations, and there their usage cannot be said to be for the purpose of exclusion, since the speakers' aim in interview and simulated consultations was to be understood. Rather, such expressions were used to make the conversation less embarrassing for both the gynaecologist and the patient.

#### 6.4.2.2 Connotative expressions for menstruation and related matters

As mentioned in 1.6.2.2, menstruation is a taboo topic in the Malawian context, as in many other societies. This section presents and discusses findings on menstruation, menarche and illnesses related to menstruation as referred to in the data.

Extracts 6M and 6N shows two expressions referring to menstruation which have the denotative meanings "the moon/month" and "bathing", respectively:

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[39] An undesirable expression.

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Interview Extract 6M:

Dr OB: *Eee ena amanena kuti sinnauone mwezi, ena amanena kuti mwezi uno wandidutsa.*
Yes, some say "I didn't see the moon" (=I did not menstruate); others say, "This moon has passed me" (=I did not menstruate).

Interview Extract 6N:

P4: *... ukhonza kungonena kuti ii adokotala ine mwezi uno sinnasambe*
… you can just say, "Doctor, this month, I didn't bath (=I did not menstruate) this month".

In 6M and 6N, the expressions *mwezi* 'moon' and *kusamba* 'to bath' were used above to refer to menstruation. The use of the expression *kukhala kumwezi* 'to stay at the moon' to refer to menstruation may have developed because the menstrual cycle and the lunar cycle are both 28 days in length. It can however also be argued that *kukhala kumwezi* means "to be in the month", because *mwezi* also means "month" in Chichewa. It follows then that the monthly and/or the lunar cycles are referred to by the term *kukhala kumwezi*; however, the lunar cycle could be said to be the more precise interpretation since the monthly cycle is originally based on the moon.

The use of *kusamba* 'to bath' to refer to menstruation may be the result of the fact that many cultures associate menstrual blood with uncleanliness and see menstruation as the removal of unclean things. Patients regarded *kusamba* as a sensitive term but one which was acceptable for use when consulting a gynaecologist. Patient 4 had indicated that when one needs help, one does not beat about the bush; one just "say it as it is", with reference to the term *kusamba* (see Extract 6O below). Interestingly, this patient participant regards using a euphemism as "saying it as it is".

Interview Extract 6O:

MCK: *Chomwe mmangotchula ndingati chani?*
Which things do you just mention?

P4: *Monga ngati kusamba ukhonza kungonena kuti iih adokotala ine mwezi uno sinnasambe chani.*
Like bathing (= menstruating), you can just say that "Eish, doctor, this month I didn't bath (= menstruate)" etc.

By saying *kungonena kuti iih* 'just say that eish', Patient 4 suggests that it is hard to discuss menstruation, but one just has to do so by using terms such as *kusamba* 'bathing' in consultations. This implies that *kusamba* 'to bath' is as embarrassing as direct and formal expression would be. Similarly, in her discussion of indirect terms, another participant, Patient 10, presents *kusamba* 'bathing' as if its denotation is "menstruating":

Interview Extract 6P:

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P10: *Eyaa, okhaokha okuluwikawo, eyetu ndekuti wamkulu amadziwa zokuti munthu akati ndilikumwezi ndekutino akusamba, pamene mwana sangadziwe zokuti kumwezi ndi chani.*
Yes, only the discreet ones, jah, so an adult knows that when someone says, "I am at the moon", it means she is bathing (=menstruating), while a child cannot know what "at the moon" means.

MCK: *Olo kusamba kumene mwana sangadziwanso.*
Even the word "bathing" itself, they might also not know (its meaning).

P10: *Sadziwa kumene mwina azingoti kusamba mnthupi.*
Of course, they don't know it, maybe they might just think it is bathing the body.

From the extract above, it can be argued that the participant considered the denotative meaning of the word *kusamba* to be "to menstruate". It can be argued therefore that, since there were no other words with suitable denotative meanings available to use, the word with the connotative meaning was used denotatively. This would make *kusamba* a homonym whose meanings are "to bath" and "to menstruate". It can be argued that this normalised use of *kusamba* may have resulted in it being also used as referent of menarchy and menopause, as discussed in the next paragraph.

The case history taking on menorrhagia required discussions on both menarche, menopause, and regular periods. However, Dr OB used *kusamba* 'to bath' for all three (see Extracts 6Q and 6R).

Consultation Extract 6Q:

Dr OB: *Nde tikakamba za* period-*yi nde munayamba kusamba muli ndi zaka zinga?*
So, when we talk about the period, so how old were you when you started bathing (=when menarche occurred)?

In the above extract, *kusamba* 'to bath' was used although it is an expression that refers to menstruation in a connotative manner. It can be argued, therefore, that the gynaecologist is attempting to mitigate a face threat by being obscure in his reference to menarche. Another instance where *kusamba* 'bathing' was used is when discussing menopause:[40]

Interview Extract 6R:

Dr OB: *Menopause mu Chichewa tikhonza kunena kuti ndi pamene mzimayi wasiya kusamba, oti sapitanso kumwezi.*
Menopause in Chichewa, we can say that it is when a patient 'has stopped 'bathing' (=menstruating)'; 'she does not go to the moon (=menstruate) anymore'.

[40] The data showed that some women participants did not know what menopause was, while others knew what it was but did not have a term for it.

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The circumlocutions referred to in the above extract are in line with what Dr OB indicated in his interview, namely that it was better for the gynaecologist to "go round" a sensitive topic than to make shorter and direct references (see 5BB in 5.4.3).

#### 6.4.2.3 Connotative expressions for pregnancy and related matters

Connotation is discussed in this section using formal Chichewa terms for the word *pregancy* as an example. These formal expressions[41] have an indirect connection with the referent in two ways: either their connotation is implied or the expression has a general meaning. The first formal expression is presented in Extract 6S below, where the gynaecologist uses the expression *mimba* 'stomach' for pregnancy.

Consulation Extract 6S:

Dr OB: *Kulibe mimba yomwe inachoka? Sindikunena ya ana awiri mwanena aja, omwalira. koma kuti mimba miyezi siyinakwane kuchoka yokha?*

> Was there no stomach (=pregnancy) that was miscarried? I am not talking about the two children you have talked about, the ones that passed on, but the stomach (=pregnancy) that came off by itself (=miscarried) before it was full term?

The extract above follows a patient's description of pregnancy as *kuyembekezera* 'to be waiting' (=to be expectant). It can be argued that the gynaecologist adjusts his language to that of his patient, given that both *mimba* 'stomach' and *kuyembekezera* 'to be waiting' (=to be expectant) are indirect expressions. However, *mimba* may have been prefered by Dr OB because it does not carry direct associations with a baby (the one being waited for) and the mother (the one doing the waiting) as *kuyembekezera* does. The denotative or surface meaning of the term *mimba* is 'stomach', which in biomedicine is not related to pregnancy, so it is the connotative meaning of *mimba* that has been used in the extract above. Other terms that reportedly could be used to refer to pregnancy include *kuyima* 'to stop', *kudwala* 'to be sick', and *pakati* 'in the middle', which do not refer directly to the body and which were respectful, could be ambiguous, especially for young and novice speakers of Chichewa (see the ambiguity discussion in 6.4.2.1). Since the meaning of connotative expressions is ambiguous to others, it can be argued that outside the consultation room, connotations may be used by the in-group to exclude others.

[41] Recall that these formal expressions are not orthophemistic as they are indirect, whereas orpthophemistic terms are both formal and direct. In Chapter 9, I present a structure that classifies the Chichewa terms differently from X-phemism.

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### 6.4.3 Generalisation

In the data, there were instances where participants tended to use an expression with a general meaning when a specific sexual organ was to be mentioned. One such instance is where Dr KG explained how gynaecologists talk about sensitive matters in consultations:

Interview Extract 6T:

Dr KG: *Like kumuwuza munthu kuti ufuna uwone,* you want to look at the vagina *umatha kumuwuza munthu kuti "chotsani kabudula tiwone nawo kumaso…*
Like telling someone that you want to see, you want to look at the vagina, you can tell the person "remove the panties, so we can see 'the face' (= the genital area)"…

The gynaecologist used the term *kumaso* 'the face' which connotatively means "genital area" instead of *nyini* 'vagina'. Similarly, in her interview, Patient 11 referred to the vagina as "the genital area" when she was requested to provide the Chichewa translation of *vagina* she would use in gynaecological consultations:

Interview Extract 6U:

P11: *Tingoyelekeza pachizungu mmene ilili* vagina *ija akhonza kunena kuti chiwalo chanu chobisika, ndi mau'be ophiphilitsa amenewowo, kusiyana ndikungolankhula mmene chilili chiwalocho.*
For instance, the way it is in English, the vagina, they (=we) can say "your hidden organ". These are still discreet words rather than just mentioning the organ as it is.

In 6U, Patient 11 referred to the vagina as a "hidden organ", which is a general term. Thus, general terms were used by gynaecologists and patients, despite there being a Chichewa term for *vagina*, namely *nyini*. Other general terms used to refer to genitals included *maliseche amunthu wankazi* 'female genitals', *kuthako* 'buttock area' (see 6V, a response to the question how the participant would refer to female reproductive organs when consulting a gynaecologist) and *ziwalo* 'organs' (see 6W), which do not denotatively refer to female sexual organs.

Interview Extract 6V:

P8: *Umamuyankha kuti aah "Ineyo kuthako kwangaku kukhala ngati kuti kwatuluka chotupa"*
You respond, "Uhm, there could be a boil in my buttock area (=genitals)".

Interview Extract 6W:

P11: *…Koma ngati akupita kuseli kwa katani ndekutino akumulemekeza munthu wa mayi kuti mwina* ***ziwalo*** *zake zisaonedwe ndi wina aliyese…*
…But if she is going behind the curtain, it means that the woman is being respected so that her body organs (=genitals) must not be seen by all and sundry…

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Although Patients 8 and 11 in the extracts above use different semantic processes in changing original word meanings, they both achieve generalisation by not specifying their referent, which is genitals. Thus, generalisation was used to avoid specifically mentioning taboo terms.

### 6.4.4 Referential naming

This section discusses how some reproductive organs were named by referring to the organ's attributes, the organ's other normalised function, or the organ's location. The first attribute is that genitals are not displayed in public, hence the following expressions are used to refer to them: *chiwalo chobisika* 'the hidden organ' and *malo obisika* 'the hidden place'. The word *obisika* 'hidden' may prompt one to loosely translate the above expressions as "private parts"; however, in Chichewa, the hidden organs being referred to do not include breasts and buttocks as private parts do in English.

In this study, the normalised function of the vagina was used to refer to the vagina as *kumene kumadutsila abambo* 'where the man passes', *njira ya abambo* 'a man's passage', *njira youdutsira mwana* 'where the baby passes' or just *njira* 'the passage'. Thus, the vagina was named either by its heterosexual or its reproductive function. The two functions when put together could be contracted to just *njira* 'the passage'. The nomenclature for vagina thus reflects the functions thereof since the implied meaning of the verb *kudutsa* is "to pass".

The cervix was referred to as *khomo lachibelekero* 'the door of the the birther' by both gynaecologists and patients. The cervix is thus named after its ability to widen and narrow the opening between the vagina and the uterus, like a door would. Similarly, the uterus was referred to as *chiberekero* 'the birther', that is, it is named after its function (viz. the organ that gives birth). The noun *chiberekero* is from the connotative meaning of the verb *kubereka* 'to give birth'. The denotative meaning of *kubereka* is "to put someone on one's back". Its connection with giving birth appears to be a reference to the fact that babies and toddlers are often carried on someone's back, so *kubereka* 'to have someone put on your back' is equated to having a baby as both expressions entail carrying something.[42]

Other expressions to refer to genitals related to the location of the organs. Although the reproductive organs are not located in the lowest position of the body (like the feet are), the expression *kumunsi* 'the down' is frequently used to refer to genitals.

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[42] These functions are a depiction of normalised culture of heterosexuality and reproduction.

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In all instances discussed in this section, a vague attribute,[43] function or location of the reproductive organ(s) was used to refer to reproductive organs instead of tabooed orthophemistic expressions. This is contrary to the Malawian Ministry of Health's recommendation that medical personnel must use direct references when conducting group family planning sessions (Ministry of Health, n.d.). In the subsection that follows, more indirect expressions that have no natural connection with reproductive organs are discussed.

### 6.4.5 Circumlocution

Where a culturally less embarrassing or a less offensive expression is not available, gynaecologist at times made use of circumlocutions. One instance in which such circumlocution was used is discussed below:

Consultation Extract 6X:

Dr AS: *Panopa chilakolako chofuna kukhala ndi amuna palibe?*
Is the need to be with a man not there? (=Don't you have libido?)

P8: *Aah sichimandipezanso.*
(A negative precursor which implies impossibility), it does not get me (=I don't have it).

The direct Chichewa word for libido is *nyere*. However, in 6X the gynaecologist, to save face, used a Chichewa expression that translates as "the need to be with a man" instead of *nyere*. In casual situations, like when friends are chatting, the word *nyerere* 'ant' is used instead of *nyere*. Acquaintances understand each other when "ant" is used to refer to libido, because of the phonological overlap between *nyere* and *nyerere* and the context in which *nyerere* has been used. However, the gynaecologist used a circumlocution to save the face of both himself and his patient. Thus, in addition to other forms of indirect expressions, doctors and patients use circumlocution to discuss taboo topics that cannot be avoided during gynaecological consultations in order to adhere to the cultural requirements of conventionalised politeness.

### 6.4.6 Vague expressions

This section discusses another way of presenting the topic of pregnancy in addition to connotation discussed in 6.4.2.3. In discussing pregnancy, participants used expressions that were vague but present shared experiences surrounding pregnancy and infertility in Malawian society.

[43] Such vague reference also occurs in the case of male genitals. A penis is for instance often referred to as *chinthu cha abambo* 'a man's thing'.

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Pregnancy and pregnant women were described as follows: *ndiwoyembekezera* 'she is [someone who is] expecting' (= the expectant one); *mwayima* 'she has stopped'; *mimba* 'stomach' or *ali ndi mimba* 'she has a stomach', and *ali ndi pakati* 'she has the middle'. However not all of these expressions were acceptable for use in gynaecological consultations. Those that were deemed appropriate by the participants contained the transitive verbs 'to expect' and 'to stop', as shown in Extracts 6Y and 6Z below. In these extracts, the transitive verb either did not have an object (i.e., was used intransitively) or was nominalised to avoid mentioning a taboo object (also see avoidance in 6.3.1).

Interview Extract 6Y:

P1: *Amagwiritsa ntchito mawu okuti ngati mwayima, osangonena kuti muli ndi mimbayi.*
They use expressions like you have stopped, instead of just saying you have a stomach.

Interview Extract 6Z:

P7: *Komanso nthawi imene ndinali woyembekezera anandiuza zokuti ...*
And also the time I was expectant, I was told that…

The expression *mwayima* 'you have stopped' is a clipping of *mwayima kusamba* 'you have stopped having your period', while *woyembekezera* 'someone who is expecting' could be *woyembekezera kubereka* 'someone who is expecting to give birth' in full. In both cases, although the expressions used would ordinarily require an object, they were understood and are regarded as respectful because they do not contain the direct Chichewa translation of *pregnancy* (*mimba*). In the extract below, Patient 8 explains that mentioning the word *pregnancy* (*mimba*) was disrespectful:

Interview Extract 9AA:

P8: *Ukanena kuti ali ndi* ***mimba*** *ndengatinso kachichewanso kena konyonzetsa.*
When you say, "she is pregnant", it is somehow a derogative expression.

MCK: *Mmm.*

P8: *Ee komano mwaulemu wake koma* ***kuyembekezera****.*
Yeah, but respectfully it is being expectant.

Patient 8 expressed her preference for *kuyembekezera* over *mimba.* Later on in the interview, Patient 8 also shows a preference for *pakati* 'the middle':

Interview Extract 9BB:

MCK: *Mm nanga mawu onena kuti pakati munthu alindi pakati amenewa ndiaulemu ndiokwanira kapena akupelewera?*
Mm. How about the word 'in the middle', 'someone has the middle'? Is it sufficient or not?

P8: *Monga ngati ifeyo aujeni, amalawi.*
But for us as Malawians,

MCK: *Mmm.*

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P8: *Chichewa chimene timayankhula ifeyo, munthu kuti mzimayi ndioyembekezera timatchula Chichewa chonena kuti munthuyu alindi pakati.*
The Chichewa that we use, when referring to an expectant person is, “this person has the middle”.

MCK: *Mh ndichaulemu bwino bwino? adokotala munkhonza kuwafotokozela kuti alindipakati osamuchotsela ulemu?*
Is that respectful enough? Can a gynaecologist tell a patient that she has the middle without disrespecting her?

P8: *Ayi kuyembekezera ndipakati ndikuona kuti chichewacho ndichofanana.*
No. “Being expectant” and “having the in-between” are similar expressions.

The difference between *mimba* and *pakati* is that the connotative meaning of *mimba* (for “pregnancy”) is closely related to the denotative meaning (“stomach”) – given that one’s “stomach enlarges during pregnancy – while *pakati* ‘in-between (life and death)’ makes reference to the high maternal mortality rate in Malawi, implying that the woman is in a state between life and possible death (during pregnancy or childbirth). Three other expressions for *pregnancy* in the data connote this high maternal mortality rate, discussed below.

The first is *wodwala* to refer to someone who is pregnant, with its complementing expression *wachira* for when they deliver. As mentioned above, it is not uncommon for pregnancy to be seen as a threat to the woman’s life. Thus, it can be argued that pregnancy is equated to an illness in the expression *wodwala* ‘someone who has an illness’ (=a patient). *Wodwala* is a noun and can be distinguished from *akudwala* ‘she/he is ill’ as *wodwala* denotes not only an attribute that is part of the person but also that the illness they have is a chronic one. It follows then that participants referred to delivery of a baby as *kuchira* ‘healing’. *Wodwala* and *kuchira* are indirect but formal ways of referring to pregnancy. In brief, for the topic of pregnancy, it was shown that the expressions that were considered appropriate were vague either because of an omitted object or because their connection to pregnancy was provided within the expression’s connotative meaning. The formal expressions which were said to be used in gynaecological consultations (i.e., between non-acquaintances) were indirect, unlike the orthophemisic expressions, which are direct and formal, that one would expect in these settings based on Allan and Burridge (2006:33).

### 6.4.7 Implicature management

#### 6.4.7.1 Avoiding negative connotation

This section discusses terms that were used by gynaecologists when giving instructions to their patients. A common attribute of the expressions is the avoidance of terms that connote sex or other bodily functions. The language used during natural childbirth, as presented by Patient 8,

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suggests that male gynaecologists continue communicating respectfully regardless of the state the patient is in. In the following extract, she explains how male gynaecologists' good work ethics are communicated through their use of language:

Interview Extract 6CC:

P8: *Amakuwuzani kuti mayi dikilani kaye pang'ono nthawi yanu sinakwane, ikakwana nditani ndikuuzani. Nthawi ija ikakwana wamamuna uja amakuuzani kuti chani mayi gwirani ntchito.*
He tells you, "Mom, hold on a little bit, your time has not yet come. When it is time, I will do what, I will tell you". When it is time now, the male (doctor) tells you what, "Mom [honorific], work".

MCK: *Mmm.*

P8: *Kupezeka kuti munthu akugwira bwino bwino ntchito mwana akutani akubadwa bwinobwino opanda vuto linalililonse.*
Then you find yourself working quite well. The baby is born properly without any issues.

Honorifics and *mayi* 'mom/mother/lady' in the above excerpt were used to convey the respect which creates an enabling environment that would result in effective gynaecologist-patient communication. Furthermore, Patient 8 says the male gynaecologist would use the general instruction *gwirani ntchito* 'work' which is more respectful than the direct *tchimani* (=push), which is associated with passing of stools-another embarrassing topic.

#### 6.4.7.2 Formalising the relationship

There were instances in the course of the consultations where the interlocutors expressed FTAs bold on record without negative effect. This section argues that, when the bold-on-record expression is deemed culturally formal, its impact is diffused as the linguistic formalness defines the gynaecologist-patient relationship as formal (and not casual), thus respecting the social distance between the interlocutors. Social distance is an implicit requirement that confirms the existence of relationship boundaries (see 5.2.1 and 8.3.3) This was the case in Patient 3's simulated consultation where she uses a sensitive term at the onset of the consultation, as shown below.

Consultation Extract 6DD:

Dr DW: *Mwabwera kuno chifukwa chani?*
What is the issue that has brought here today?

P3: *Ndili ndi vuto la kusabereka*
I have a problem of not being able to bear children (=infertility).

The patient was consulting the doctor about infertility. Recall that according to the reported experiences of gynaecologists in 5.2.2, infertility is one of the issues that patients find hard to present directly. However, in Extract 6DD, Patient 3 is bold and on record about her condition, using *kusabereka* 'not being able to have children' (=infertility). Her FTA is consolidated by

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the fact that she distances herself from the condition; she uses a direct expression, *ndili ndi vuto lakusabereka* 'I have a fertility problem', rather than an alternative like *ndine osabereka* 'I am not fertile', which would be acknowledging the shameful associations of infertility, or *ndabwera ndi vuto la kusabereka* 'I have come with the problem of infertility'. The second expression attributes infertility to the patient, while the the first and the third distance the patient from it. However, the term *kusabereka* is a normalised formal expression and more acceptable than other, derogatory terms that are often used in casual settings to mock and discriminate against men with infertility issues, such *gocho* 'an infertile man' and the proverbial expression *kukhomera ku Dowa* 'to pay tax in Dowa' (=[of man] to be infertile). This is echoed in the sentiments of a young gynaecologist discussed in the next paragraph.

In 5.3.1.2, a gynaecologist claimed that when a young male gynaecologist is being chatty and friendly, young patients think that the gynaecologist is expressing a personal interest in them, and that the gynaecologist would often "ask direct questions" to avoid this (see Extract 5Q). This indicates that being direct is one way of building a formal relationship and an identity that will make the consultation a professional endeavour instead of a personal one; hence the argument that being "formal" is a form of taboo mitigation. However, this directness does not necessarily mean being explicit, as that would be taboo (see 6.2.2 above on what constitutes a formal expression in Chichewa). Thus, although infertility is culturally an uncomfortable topic to discuss, the use of a "formal" expression helps the patient to build a formal relationship with the gynaecologist. This relationship, in turn, mitigates the effect of the FTA because the relationship has already distanced the interlocutors. Other formal expressions in the data had other face-saving attributes because of their associated meanings, as argued below.

#### 6.4.7.3 Avoiding affirming sociocultural blame

In Chapter 5, participants, especially gynaecologists, argued that infertility was a hard topic to discuss due to societal expectations that all married couples will have children. Infertility was referred to as *mwana/mphatso sa(siyi)kupezeka* by gynaecologists. This expression is a combination of the noun *mwana* 'child' or *mphatso* 'gift' and the verb *kusapezeka* 'not being found'. By making the child the subject of the expression, infertility is not attributed to a shortcoming in the couple in question. It can be argued that blame proportioning would be a reason for the following proverbial expressions not being acceptable: *kubedi/kumphasa sapita* 'does not go to the bed / the sleeping mat' (=unwilling to have sex) and *anagwa mpapaya* 'he fell off a pawpaw tree', the latter implying that the man has "damaged" / ill-functioning private parts. Although these two expressions have connotative meaning which would have allowed

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discreetness, they have an accusatory tone towards one of the members of the childless couple in question.

## 6.5 Chapter summary

This chapter has shown that Allan and Burridge's (2006:33) X-phemism Theory does not account for the whole range of linguistic expressions that are used to discuss taboo topics in Malawian gynaecological consultations, since these expressions are indirect, vague, general and/or have connotative meanings. The reclassified Chichewa terms used to refer to taboo topics is either the preferred (inexplicit and formalised) or the dispreferred (direct/explicit). The data shows that indirectness when referring to taboo topics is preferred over directness. The general approach taken by participants to mitigate face threats was to provide syntactic and semantic clues when indirect expressions were used, which assisted in decoding the intended meanings. Finally, this chapter has also shown that acceptability judgements are fluid in that they may vary from person to person,[44] which could be a sign that some non-taboo expressions are transitioning into taboo expressions. Having discussed the sociocultural strategies used at the level of linguistic expression, the next chapter discusses discourse strategies used in simulated consultation.

[44] By this I am not referring to some Malawians having a tendency to swear and others not. I am referring to the fact that participants in the study did not always agree if an expression is profane / a swear word / insensitive enough to cause embarrassment in gynaecological consultation.

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# Chapter 7 : Discursive strategies: Avoiding, mitigating and correcting FTAs

## 7.1 Introduction

This chapter is a continuation of the thematic analysis and discussion of Chapter 6 since it continues to discuss discursive strategies that are used in Malawian gynaecological consultations. The focus of this chapter is on how different sociolinguistic strategies were used to establish a less face-threatening context for the initiation, sustainment and conclusion of discussions of taboo topics in simulated consultations. In other words, it discusses how taboo conversation are managed. The chapter provides an overview of the following discursive strategies used: preparators used prior to FTAs (7.2); mitigation of threats to face when introducing and discussing taboo topics (7.3); and how face threats were challenged and corrected (7.4).

## 7.2 Precautionary strategies are used prior to FTAs

This section argues that the onset of all simulated consultations, and the pretend physical examination within some simulated consultations, were handled with caution by the gynaecologists because of the impending face-threatening topics that would need to be addressed and the face-threatening examination procedures that would follow. Although not all consultations are as sensitive as the physical examinations are intrusive, it can be argued that gynaecologists in this study treated every consultation as sensitive for two reasons. Firstly, they know that there is a high probability that taboo topics will have to be discussed (see 5.2). Secondly, the impending taboo topics and invasive physical examinations make it inevitable that relationship boundaries and the role of each participant should be established at the onset of the consultation, given the effects of gender discordance in consultations with male gynaecologists (see 5.2.3). Thus, it was imperative that a professional doctor-patient relationship as well as a safe environment for the patient be established even before knowing the reason for the consultation.

The following subsections discuss how greetings and preliminary discussions simultaneously established rapport and developed a professional relationship between the gynaecologist and the patient. The greetings and preliminary discussions in turn allowed for the discussion of taboo topics and conducting pretend invasive physical examinations. This discussion includes how distancing was achieved through social talk (7.2.1), which is followed by the discussion of requests for the patient's name and for permission to conduct physical examinations (7.2.2).

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### 7.2.1 Social distance is maintained through social talk

According to Roter and Larson (2002:243-4), the verbal behaviour of a doctor during consultation is classified as functional and affective. The former is learnt formally and concentrates on fulfilling the medical function of the consultation, whereas the later consists of socio-emotional content. It has been argued that social talk[45] establishes rapport and helps the gynaecologist to respond to patients' emotions, which is one of the functions of a medical consultation (Cordella 2004:25). In this study, gynaecologists set a respectful tone at the onset of the simulated consultations through social talk. This is shown in the extracts below[46] where the gynaecologists welcomed and/or greeted the patient before asking for the patient's name. Extract 7A exemplifies how welcoming remarks were typically made and introductions were typically done.

Extract 7A:

Dr KG: *Khalani pansi.*
Sit [honorific] down.
P9: *Tathokoza adokotala.*
Thank you, doctor [honorific].
Dr KG: *Zikomo. Ndine Dr KG* [mentions surname]*, kaya dzina ndindani?*
Thank you. I am Dr KG.[47] 'I don't know, what is the name?'
P9: [Mentions name and surname]
Dr KG: [repeats name]. *Zikomo.*
[repeats name]. Thank you.

In 7A, honorifics were used in order to establishing rapport through social talk. The gynaecologist used honorific 'you' *-ni* in *khalani* 'sit' when addressing the patient, whereas the patient uses honorific 'we' *ta-* in *tathokoza* 'thank you'. Thus, the gynaecologist establishes a respectful relationship with the patient, and in turn, by referring to herself with an honorific affix, the patient reinforces her own respectable identity in the interaction.

Greetings are another kind of social talk used by gynaecologists in the simulated consultations to signify respect. This is also true in the black South African context (Deumert 2010:57). Usually, when greeting someone, the question "How are you?" seeks to find out about the other

[45] Greetings, personal remarks, jokes, and compliments belong to the affective cluster called "social talk" (Van Dulmen & Van Weert 2001:487) in The Roter Interaction System Analysis (RIAS; Roter & Larson 2002), the latter being a tool for analysing communication dynamics and their effects in medical dialogues (Thompson, Dorsey, Miller & Parrot 2003:126).
[46] Extracts under discussion in this chapter are from the simulated consultation; only one interview extract are used as a tool for discussion. Consultation Extracts are labelled 'Extract' while the only interview extract is labelled "interview extract". Just like in Chapter 5, the extract numbering continues regardless of extract type.
[47] Real surnames are replaced by random initials throughout.

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interlocutor's wellbeing. As it can be assumed that people consult doctors when they are not well, such a question may be regarded as asking for obvious information. In other words, it is possible for a consultation to progress without it, as seen in Extract 7A. In spite of this, other gynaecologists did enquire about their patients' wellbeing through greetings. This could be because of the rapport-building function that such an enquiry performs. Further, this study argues in following paragraphs that the grammatical composition of greetings enhanced the social function of establishing (i) a relationship of respect and (ii) the roles of the interlocutors. In this regard, consider Extract 7B:

Extract 7B:

Dr OB: *Takulandirani mayi. Muli bwanji?*
We [honorific] welcome mum (=madam). How are you [honorific]?

P1: *Tili bwino, kainu?*
We [honorific] are fine. How are you [honorific]?

Dr OB: *Tili bwino.*
We [honorific] are fine.

P1: *Zikomo kwambiri.*
Thank you very much.

Dr OB: *Ine ndine Dr OB, kuno ku Y* [name]. *Tikudziweni, inu dzina nda?*
I am Dr OB. This is [clinic's name]. May we know you [honorific], what is your [honorific] name?

P1: *Ine ndi* [name and surname].
I am [name and surname].

In 7B, the gynaecologist uses respectful language when referring to the patient in order to construct a professional relationship between them. The first instance is in the welcoming statement, where the gynaecologist uses the honorific 'you' *-ni* in *Takulandirani* 'we welcome you [honorific]' and a respectful form of address for the patient *mayi* 'mum'.[48] Furthermore, the patient was addressed using the honorific prefix *mu-* in *Muli bwanji?* 'How are you [honorific[49]]?' In this context, the bound morpheme *mu-* is an honorific second-person referent. *Mu-* was used instead of *u-*, which would have been grammatically correct in this situation as the patient was at least 20 years younger than the gynaecologist. Ordinarily, *u-* is the singular form that refers to a young person, but *u-* may also be used between acquaintances regardless of age. Taking into consideration that *u-* also signifies acquaintanceship, it can be argued that using *mu-* instead of *u-* allows the interlocutor to cater to the needs of the patient's negative face.

[48] As stated in 6.4.7.1, *mayi* 'mom' is the respectful term of address for an older female in general.
[49] Prefix *u-* is non-honorific ('you') and the greeting would be *uli bwanji*?

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In Extract 7B, distancing was also achieved through the marked use of honorifics. It is unusual for one to refer to oneself using honorifics; indeed, showing respect to oneself by using honorifics in this manner may be construed as bossiness. Hence it is expected that first-person singular referents would be used when an interlocutor refers to him/herself. In Extract 7B, Dr OB uses the non-honorific pronoun *ine* 'I' when introducing himself, while maintaining the honorific referent *inu* 'you' for the patient when asking for her name. However, both interlocutors referred to themselves using honorific *ta-* in *takulandirani* 'we welcome you' and *ti-* in *tili* 'we are' and *tikudziweni* 'may we know you'. Although the referent of *ta-* in the welcoming phrase is ambiguous as it could also refer to the hospital, the use of *ti-* in *tili bwino* 'we are fine' in the gynaecologist's next turn shows that he was referring to himself. It can therefore be argued that using honorific equivalents of 'we' distances the speaker by portraying himself as a representative. Using honorifics to create distance between interlocutors in situations where sensitive issues are under discussion is an example of a negative politeness strategy (Brown & Levinson 1987:72). The next section looks at another activity that occurs at the onset of the consultations but has the potential of affecting social distance: asking for the patient's first name.

### 7.2.2 Some gynaecologists asked for the patient's name, in a respectful manner

One is required to give one's first and last name at Malawian hospitals, whereas in the general Malawian context, only children are called by their first names; adults' first names are rarely used in non-intimate settings as it is not respectful to do so. In most urban and/or formal settings, the respectful way is to refer to women is by their surnames, for instance *Mayi Phiri* 'Mum (=Mrs) Phiri'. In contrast, in rural and/or informal settings, one may either be called by one's clan name, for example *NaTembo / NyaTembo /Abiti Joji*, or with reference to one's child name, as in *Mayi a Jane* 'Jane's mother'. The gynaecologists in this study often identified their patients by first name and surname, which may be problematic for patients that feel embarrassed to be asked to give their first name. It can be argued that gynaecologists kept this in mind and made the request in ways that mitigated the face threat to the patient. This subsection provides an overview of the different strategies employed by three gynaecologists at the onset of the record-taking stage of the consultation to obtain their patients' first names.

The four excerpts below exemplify three questioning strategies. In each case in which the gynaecologist wanted to obtain the patient's first name, he started by introducing himself

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and/or giving the name of the clinic before asking for the patient's name before asking the patient for her name, as seen in Extract 7C. All gynaecologists introduced themselves by their medical title (*Dr*) and surname, which establishes the identity of the gynaecologist as an authority figure in a formal setting. Thus, by introducing themselves first, the gynaecologists tried to "break the ice" and demystified their official role within the hospital for their patient. In addition, knowing their doctor's surname would allow their patient to identify the gynaecologist from many others working in the same hospital and thus build the trust needed for the sharing of personal information.

Extract 7C: Strategy 1 (used by Dr DW in both of his simulated consultations)
Dr DW: *Ine ndi Dr DW. Dzina ndani?*
I am Dr DW. Name who? (=What's the name?)
P3: [name and surname]

Strategy 1 is the most direct approach used in the simulated consultations, where the gynaecologists simply asked "what's the name?" Dr DW shortens what could have been *Dzina lanu ndi ndani*? 'What is your name?' to *Dzina nda*? 'Name who?'. The gynaecologist does not use the equivalent of *your* in his question, possibly because *your* was implied given that the patient was the only other person in the room. In Chichewa, the pronoun *your* has honorific and non-honorific versions, both of which were avoided in Strategy 1. It could be that the use of *lanu*, which is a honorific second-person possessive adjective equivalent to *your*, was avoided as it may have suggested that the gynaecologist was looking for a "respectful name" such as the clan name or only the surname, and not for a first name – surname combination; while using non-honorific *your* (*lako*) may have been perceived as offensive and disrespectful. By shortening the question and preceding it with his self-introduction, the gynaecologist shows respect towards himself and the patient. Thus, this question style is respectful in that it maintains social distance, thus catering to the patient's negative face needs.

Strategy 2 is the direct but hedged questioning format, exemplified in Extract 7D and 7E below:

Extract 7D: Strategy 2
Dr OB: *Dzina lija paja nda?*
What is that name?
P6: [name and surname]

Extract 7E: Strategy 2
Dr KG: *Zikomo. Ndine Dr KG,* ***kaya*** *dzina ndi ndani?*
Thank you. I'm Dr KG. I don't know, name is who? (=Thank you. I'm Dr KG. I don't know, what is your name?)
P9: [name and surname]

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Dr KG used expressions that create the impression that the interlocutors were familiar with each other: *lija* 'that' and *paja* 'again' in *Dzina lija paja ndi ndani?* 'What is that name again?' suggests that the interlocutors were already acquainted when, in fact, they were strangers. His use of *dzina* 'name' is mitigated by the implication of familiarity. This helped Dr OB to create a familiar relationship with the patient who might otherwise have felt uneasy about being asked to state her first name.

In contrast, Dr KG used an expression suggesting a lack of familiarity to justify his request for a first name. (Dr KG's use of *kaya* 'I do not know' in *kaya dzina ndindani* 'I do not know, name is who?' (together with falling intonation on *kaya*, that suggest lack of familiarity) reduced the face threat that is caused by asking for a first name. In other words, he uses the Chichewa equivalent of *I don't know* to create distance between the interlocutors in order to show respect and establish a professional relationship with the patient. It can be argued that that, being young, Dr KG used this strategy to distance himself from a young patient to make the patient comfortable, as explained by him in his interview:

Interview Extract 7F:

Dr KG: *Pomwe funso lomwelo kwa munthu nzimayi wankulu kaya* 30 years, 40 years *amayankha* more comfortably without having any thoughts *kuti a dokotala andifunsa funso limenelili* which sounds like a personal question *chifukwa chani?*
But asking the same question to someone older, like 30 years, 40 years, they respond more comfortably without having any thoughts like "The doctor asked me this question that sounds like a personal question. Why?"

From 7F, it can be argued that pretending to be familiar with the patient could have caused discomfort in the (young) Dr KG's case as it might have suggested that he had a personal interest in the young patient, P3 (see discussion on relative age in 5.3.1.2). In contrast, the older gynaecologist "gets away" with suggesting familiarity, because the age difference between him and his patient already creates distance between them.

Unlike Strategies 1 and 2, Strategy 3 does not entail direct questioning, as exemplified in Extract 7G:

Extract 7G: Strategy 3

Dr OB: *Ine ndine Dr OB, kuno ku* [clinic's name]. ***Tikudziweni****, inu dzina nda?*
I am Dr OB. This is [clinic's name]. May we know you [honorific], what is your [honorific] name?

P1: *Ine ndi* [name and surname].
I am [name and surname].

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Strategy 3 employed by Dr OB abandoned direct questioning altogether for the use of *tikudziweni* ‘may we know you’. This question shows respect by being indirect and by employing the use of honorific affixes *ti-* ‘we’ and *-ni* ‘you’. By using *tikudziweni*, the gynaecologist additionally positions himself as a polite person, which could make the patient feel comfortable.

This subsection has shown that gynaecologists requested their patients to state their first names with their surnames by using direct, short questions that suggested (un)familiarity, depending on the situation, as well as by being indirect. The common element in these three strategies was that respect was shown towards the patient while obtaining her first name, thereby reducing the threat to the patient’s negative face. The next subsection discusses sociolinguistics strategies used by gynaecologists to make patients comfortable when introducing and discussing a sensitive and face-threatening topic.

## 7.3 Sociolinguistic strategies are used to mitigate taboo talk

After the patient had presented her ailment or condition to the gynaecologist in their simulated consultation, discussions concerning the ailment followed, which meant that more linguistic taboo was imminent. The interlocutors used a number of strategies to sustain such discussions. The strategies outlined below can be categorised as different forms of negative politeness since they are strategies that acknowledge and respect the face needs of the other (see Brown & Levinson 1987:70), but only partially address these needs, for different reasons. Negative politeness that occurred in the data include delay (7.3.1) and distancing (7.3.2).

### 7.3.1 The delaying strategy

This section pertains to the order in which topics and questions were presented when gathering information about sensitive (face-threatening) but relevant topics in simulated consultations. The delaying of taboo topics occurred in the current study as it did in that of Weijts, Houtkoop *et al.*'s (1993:300-4) (discussed in 2.7.3 and 2.8.1). However, the current study elaborates on three ways in which the delays were achieved: Firstly, with regards to the ordering of topics and subtopics, this study found that the simulated consultation started with less sensitive topics and progressed towards more sensitive topics in a cumulative manner (7.3.1). Secondly, once sensitive topics were introduced, they were first exhausted before moving on to the next topic, even when the patient showed signs of discomfort (7.3.2). Thirdly, less sensitive or non-sensitive topics were used as transitions between two sets of sensitive topics (7.3.1 and 7.3.3).

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These patterns were also evident in the order in which questions were asked about sensitive topics.

#### 7.3.1.1 Delaying stating explicit information about a given topic

Based on the data collected during the simulated consultations, there were instances when interlocutors delayed introducing sensitive topics as a face-saving strategy. This was done in two ways. The first entailed presenting less embarrassing information before more embarrassing information. The second, also a type of delay, entailed giving the implicit version before the explicit version. These delays are shown in the two extracts below, where both delaying strategies were used by the patient (in Extract 7H on menstruation, a sensitive and possibly secret topic; see 2.7.1) and one was used by the gynaecologist (in Extract 7I on examinations in the case of patient-reported infertility, a highly sensitive topic).

Extract 7H:

Dr DW: *Mwabwera ndi vuto lanji?*
What problem have you brought?

P2: *Inetu vuto limene ndabwera nalo ndi pansi pamimbapa ndikumamva kuwawa kwambiri, pakumandipweteka. Komanso…*
As for me, the problem I have come here with is that there is a lot pain below my tummy, it is paining me. And…

Dr DW: *Panayamba liti?*
When did it start?

P2: *Mwina miyezi iwiri yapitayo*
Maybe about two months ago.

Dr DW: *Mmati komanso, cha?*
You were saying “And”. What?

P2: *Komanso ndikumasamba mwachilendo*
I am bathing (=menstruating) in a strange way.

Dr DW: *Mukutanthauza chani*
What do you mean?

P2: *Ngati kusamba mwina kutaya magazi kwambiri.* Period*, ngati matenda achizimayiwa eti.*
Like bathing, maybe wasting a lot of blood. Period, like these feminine illnesses, right.

Dr DW: *Mm. Zayamba liti?*
When did those start?

P2: *Zimenezono mwina* two weeks-*no yathano ndikupanga zimenezo.*
Those, maybe now it has been two weeks I am doing those things.

In Extract 7H, the patient reports the pain (‘there is a lot pain below my tummy’) before reporting the heavy periods. Talking about her heavy periods is further delayed by first providing the implicit version (‘I am bathing (=menstruating) in a strange way’) before the more explicit version (‘wasting a lot of blood. Period …’). The implicit version given by the patient caused the gynaecologist to ask for an explanation, which the patient gives by

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explaining both the heaviness of the bleeding and the meaning of the term *kusamba* 'bathing' she had used to refer to menstruation. It seems the patient was not sure whether it was *mwachilendo* ('in a strange way'), the implicit term *kusamba* 'bathing' or both that the gynaecologist did not understand. She directly explains the former but fails to find a better Chichewa word for the latter, and therefore clarifies her earlier statement by codeswitching to English (using the explicit English term *period*) and adding *ngati matenda achizimayiwa, eti* ('like these feminine illnesses, right?').

Delaying was also used in a consultation on infertility, where the gynaecologist presented implicit information first by initially using a general term, thus delaying the mention of specific body parts to be examined:

Extract 7I:

Dr OB: *Nde mukhala pa bedipo kuti tikuyezeni kuchokera kumtunda mpakana kumunsi*
So you will be on that bed for us to examine you from top to bottom.

P6: *Chabwino.*
Alright.

Dr OB: *Tikamaliza pamenepo tiyezanso za khansa ya khomo lachiberekero. tiyezanso za mawere, za mmimba, zonse tipanga.*
When we finish that, we will also examine cancer of the cervix. We will examine the breasts, and check for pregnancy. We will do it all.

In 7I, 'examine you from top to bottom' is used although the patient will not undergo a full physical examination (as the gynaecologist will not examine the brain, the toes and "everything in between"). With 'examine you from top to bottom', the gynaecologist implies a thorough examination of specific organs, which he lists afterwards. Thus, like Dr DW in Extract 7H above, Dr OB uses delay by implication and by order. Thus, delaying is a strategy of avoiding a FTA, because when the potential FTA occurs, the patient's discomfort would have been mitigated through the order in which the topics were introduced.

#### 7.3.1.2 Delaying the introduction of sensitive topics

This subsection provides an overview of the sequential order of topics introduced in simulated consultations from the time the patient mentioned their reason for visiting the gynaecologist. Presented in Table 7.1 is the chronological sequence of topics. These included the very sensitive topics of sex and sexual effluvia which were discussed in a simulated consultation on menorrhagia. Non-sensitive topics are in green, somewhat sensitive topics in yellow, and very sensitive topics in red.

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Table 7:1 The chronological presentation order of sensitive topics

| Set No. | Topics |
|---|---|
| 1 | Nausea<br>Dizziness<br>Abdominal pain |
| 2 | Family planning<br>Cervical cancer<br>Pap smear<br>Family planning |
| 3 | Sex<br>Effluvia |
| 4 | Pregnancy |
| 5 | Raising children<br>Family medical history<br>Personal medical history<br>Home life and economic status |
| 6 | HIV status of patient then spouse |
| 7 | Physical examination |
| 8 | Hysterectomy |

Table 7.1 shows that very sensitive topics (sets 3 and 7) were surrounded by less sensitive topics (sets 2 and 4, and 6 and 8, respectively). It can be argued that the gynaecologist initially used the non-sensitive topics to establish rapport with the patient. Once he was certain that the patient was comfortable, he initiated discussion of more sensitive topics. This prepared the patient for the discussion of very sensitive topics that would follow. After reaching the highest levels of topic sensitivity, the gynaecologist addressed less sensitive topics before ending the discussion. It can thus be argued that by ordering the topics by levels of sensitivity, the gynaecologist established a good relationship with his patient by being respectful towards her discomfort in discussing sensitive topics. Such ordering could reduce the discomfort a patient would have experienced had the more sensitive topics been addressed first, whereas the de-escalation in sensitivity towards the end of the consultation could allow the patient to leave the consultation room less embarrassed than what might have been the case had a highly sensitive topic been the last topic of discussion.

### 7.3.2. The distancing strategy

Distancing is a negative politeness strategy that is aimed at increasing the social distance between interlocutors in time or space (Brown & Levinson 1987:70, 204). The data in this

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study revealed that distancing was achieved by using honorific affixes and was implied by non-relenting information-seeking tactics, as discussed below.

#### 7.3.2.1 Distancing by using honorific affixes

It was established in 5.2.3.4 that intrusive physical examinations caused psychological discomfort to the extent that some patients withheld information to avoid being examined by a male gynaecologist. This section discusses findings that show that one of the negative politeness strategies that cause impersonalisation through distancing (Brown & Levinson 1987:198) was the gynaecologists' use of grammar (specifically plural or honorific referring affixes) to dissociate themselves from the impending intrusive procedure. To this effect, the gynaecologists used honorific second- or third-person plural affixes (which translate as pronouns in English) when referring to themselves when explaining the Pap smear procedure. Consider Extracts 7J (in which *ti-* 'we' is used) and 7K (in which *ti-* 'we' and *a-* 'they' are used) for two of several examples thereof:

Extract 7J:

Dr AS: *Nde tikayeza timawona kuti kodi pamenepanso tipange bwanji.*
So when we test, we come up with what to do.

Extract 7I:

Dr KG: Mmene timapangira, ndekuti mulowa koyezetsako, kenako mukachotsa kabudula wankati **a**makugonekani pa tebulo. Tebulolo lili ndi moyimikira miyendo. Mukayimika miyendo ija, **a**makulowetsani speculum.
*The way we do it, you will go to the examination area, then when you remove your underwear, they make you lie on the table. That table has places to hang your legs. When you hang your legs, they insert into you a speculum.*

The use of *ti-* 'we' and *a-* 'we' distances the gynaecologists from the actions that they would personally perform by normalising these as actions that all gynaecologists would routinely perform during the course of the required medical procedure.

#### 7.3.2.2 Distancing through non-relenting questioning tactics

Questions about how frequently one has sex are face-threatening because sex is a taboo topic in the Malawian context (see 5.2.1). For this reason, questions about one's sexual activities may evoke fear of being judged (see Extracts 5V of Patient 9's interview and 5CC of Dr AS's). The extract below shows how Dr DW asked a question in a simulated consultation on infertility on the frequency with which Patient 3 and her husband had sex. This information is important as it has a direct impact on conception, which the gynaecologist explains later on in the simulated consultation. It is a sensitive question to which providing an answer is face-

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threatening, but the gynaecologist does not relent in his questioning while also not forcing the patient to provide a direct answer:

Consultation Extract 7L:

Dr DW: *Mmakhala limodzi pa* week *masiku angati?*
How many times a week are you together (=intimate)?

P3: *Iwo amayendayenda eti, nde amapezeka kuti nthawi zina mwina kulibe, nde tilibe masiku enieni.*
He travels quite a lot, ja! So it happens that sometimes he is not there, so we don't have a particular number of times per se.

Dr DW: *Ok. Muchaka chapitachi akhala kunyumba kwa miyezi ingati?*
Okay. In the past year, for how many months was he home?

P3: *Amakhala ku Lilongwe amagwira ntchito yaku shop kumenekoko.*
He stays in Lilongwe. He works in a shop there.

Dr DW: *Oho. Nde tiyerekeze kuti chaka chapitachi mwakhala limodzi kwa miyezi ingati? Osati kukhala limodzi kogonana koma koti iwowo kukhala mnyumba imodzi ndi inuyo kwa miyezi ingati?*
Ooh! So can we say for how many months have you stayed together in the past year? Not the being together of sleeping together but staying in one house with you, for how many months?

P3: *Nthawi yina yake anadzabwera ku holiday anadzakhalako kwa miyezi itatu.*
The other time he came for holidays and he stayed for three months.

Dr DW: *Kwa miyezi itatu?*
For three months?

P3: *Mmm.*
(Affirmative)

Dr DW: Ndiyomwe mungapange consider kuti yokhazikika kwambiri?
Is that the time you can consider to be the one he stayed the longest?

P3: *Mmm.*
(Affirmative)

Dr DW: *Ok nde mwati inuyo ku Lilongweko mmapita kapena basi mumangokhala konkuno?*
Okay, so did you say you go to Lilongwe or you just stay here?

P3: *Ndimapita nthayi zina.*
I go sometimes.

Dr DW: *Mmapita kangati?*
How many times do you go?

P3: *Ndimapita ndimmene ndapezera ineyo mpata.*
I go whenever I am free to go.

In 7L, the patient avoids responding to the face-threatening question on the number of times per week she has sex with her husband by saying they do not live in the same town. However, the gynaecologist pursues an answer by asking about the previous year but only establishes that the longest time they resided together was for three months. By asking about experiences of the previous year, the gynaecologist also distances the sexual encounters from the patient's present experiences. As discussed in 6.4.7.2, such distancing allows the patient to talk about past events without being embarrassed as they are non-existent in the current situation.

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Below is an extract from a simulated consultation on infertility where the gynaecologist asked six questions. Questions 3 to 5 are very sensitive in nature and were asked in succession to sustain taboo talk.

Consultation Extract 7M:

Dr OB: *Tinene kumbali ya bamboo. Bambowa anakhalapo ndi akazi ena m'mbuyomu?* **[Question 1]**
Let us talk about the side of your husband. Has your husband ever been married before?

P1: *Aah ayi.*
Mmm, no.

Dr OB: *Ayi. Simunamve kuti ali ndi mwana kwina kwake?* **[Question 2]**
No. Have you ever heard that he has a child somewhere?

P1: *Ayi.*
No.

Dr OB: *Chabwino. kukhalira limodzi, mukamakhala limodzi pamakhala vuto lina lililonse ngati?* **[Question 3]**
Alright. Being together (=intimate). When you are together (intimate), are there any problems?

P1: *Ayi* [whispers].
No [whispers].

Dr OB: *Tingamanene kuti pasabata mmakhala limodzi kangati?* **[Question 4]**
How many times a week can we say that you are together (=have sex)?

P1: *Kawiri.*
Twice.

Dr OB: *Ooh chabwino. Amakhala ndivuto loti mwina mwakeee kuti mwina atulutse mphamvu yawo kuti mwina zimawavuta?* **[Question 5]**
Oh, alright. Does he have a problem that perhaps when he wants to release his power (=wants to ejaculate) that maybe he has problems?

P1: *Ayi.*
No.

Dr OB: *Ayi ndithu?*
No at all?

P1: *Eeh.*
Yes (=No).

Question 1 sets the stage for discussing the sexual health issues of the patient's husband. Question 2 is related to Question 1 and was used to complement the initial question. This then cumulatively leads to a more sensitive question about the patient's sex life but in a generalised format in Question 3. Although the steady increment in threat to face[50] was meant to mitigate the FTAs, the patient's whispered response to Question 3 indicates possible loss of face. After noticing this, the gynaecologist temporarily withdrew from discussing the details about the sexual act. Question 4 is also about sex, but it asks about frequency of having sex instead of

[50] See 2.2 for reference to the female body being more taboo than the male's, and 2.7.2 which argues for the existence of a taboo continuum.

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possible ejaculation problems. Hereafter, the gynaecologist asked Question 5, which is a follow up on the FTA in Question 3. Withdrawing from a particular line of questioning when the topic is a sensitive one could result in the gynaecologist appearing uncomfortable and, as stated by Dr KG, discomfort on the part of the gynaecologist is not a positive professional trait as "*ngati dokotala ukuwoneka kuti uli* uncomfortable*,* patient *wako amakhalanso* very uncomfortable" 'if you, the gynaecologist, seems to be uncomfortable, your patient is also very uncomfortable'.

#### 7.3.2.3 Distancing by means of depersonalisation

As stated in 2.8.4, Weijts, Houtkoop *et al.* (1993:308–309) describe depersonalisation as a way of disconnecting the person from their most private actions and bodily aspects through nominalisation and the use of definite articles. Extract 7N below, Dr OB uses the locative *ku-* for this purpose:

Extract 7N:

Dr OB: *Ok, tathokoza. kuyabwa* ***kumaliseche****?*
*Alright, thank you. Is it itchy around the genitals?*

In Extract 7N, the term *kumaliseche* combines the locative *ku-* + *maliseche* 'genitals', which is a general term (see generalisation in 6.4.3). The use of locative *ku-* distances the patient from their genitals because it is used instead of the possessive pronoun "your". Thus depersonalisation (see 2.8.4) was used as a way of sustaining the discussion of a taboo topic. The discussion on depersonalisation concludes Section 7.3 on main mitigation strategies used in simulated consultations. Section 7.4 discussed how FTAs were challenged.

## 7.4 FTAs were challenged and corrected using several strategies

During the simulated consultations, there were instances in which it was clear that interlocutors had lost face. According to Goffman (2017:6-9), failure to maintain face occurs when expectations of one interlocutor are not consistent with the line taken by the other interlocutor. The following subsection provides an overview of instances in which these inconsistencies which were challenged by patients indirectly (7.4.1) or corrected by gynaecologists, whether or not the loss was challenged (7.4.2).

### 7.4.1 Indirect FTA challenging strategies

During simulated consultations, both patients and gynaecologists were recipients of FTAs. These were challenged indirectly by reactions of laughter (7.4.1.1), ambiguous statements (7.4.1.2), lowering of the voice (7.4.1.3), and dysfluency (7.4.1.4). The subsections below

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discuss instances which show a gynaecologist using laughter and patients using both laughter and ambiguous statements when challenging FTAs.

#### 7.4.1.1 Laughter

Laughter would not be expected in a medical consultation, given that matters discussed are usually of a serious (not humorous) nature, and that the relationship between the doctor and the patient would mostly be formal and distant. However, there were two instances in the simulated consultation data where the patient and another instance where the gynaecologist laughed: When Patient 9 was asked to explain her fears concerning the Pap smear procedure, which she called "the process", she responded as follows:

Extract 7O:

P9: *Koma mwina* I have been reluctant [laughs] *kubwera kudzayezetsa chifukwa chaa* like the process *eti.*
But maybe I have been reluctant [laughs] to come for a test because of uhm like the process, right?

Dr KG: *Mmudandaula chani inuyo za* process*?*
What concerns do you have about the process?

P9: Just that thought of *kuvula, kuyesedwa* [laughing]. So I was like, is there no other better way or any other way of…
Just that thought of the taking off of clothes, being examined [laughing]. So I was like, is there no other better way or any other way of…

In 7O, Patient 9 was asked by the gynaecologist to give details about the Pap smear procedure, which she initially generalised to avoid losing face. She starts by explaining the first, embarrassing step of the process, which is undressing. Hereafter, she did not give details of the other steps involved; she just refers to "being examined". It is however not being examined, but rather what constitute the examination, that Patient 9 finds difficult to describe in detail to the gynaecologist. Patient 9 however discussed her fears about the procedure with me during the interview, where her explanation still contained laughter, showing her discomfort.[51] Her

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[51] P9: *Ndipo mukhoza kuseka, chifukwa chake ndichozizira kwambasi [laughing]. Komano kwa ineyo ndichifukwa chokwanira kusayezetsa. Chifukwa khansa ya khomo lachiberekero, ngakhale sinnayezetsepo, koma nnamva kuti koyesa kwake ndi kumaliseche eti, nde ndimaganizira basi ndingonyamuka, kupita kuchipatala, ndabwera kuzayezetsa khansa yakhomo lachiberekero. Nde akandiwuze vulani panti, nde ndikagone pabedi, nde ndikatsegule miyendo, basi azikandiwunika. Nde mwina nzachitika tsoka ndukapezako a dokotala a amuna. Nde basi azikandiwona ineyo maliseche anga ayi aaah!*
You will even laugh; the reason is a lame one [laughing]. But for me it is a sufficient reason for not being examined. Because cancer of the cervix, even though I have never been tested before, but I hear that where they examine is your genitals, right, so I think that I just start off going to the hospital, "I have come for cancer of the cervix". Then they will tell me that, "Take off your panty", then I will lay on a bed, then I will open my legs, and then they will look closely. And perhaps I will be unfortunate and find a male gynaecologist, and then he will be looking at my genitals – no way!

Here it is clear that what Patient 9 meant by "be examined" is "lay on a bed, … open my legs, …they will look closely … at my genitals".

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failure to utter the steps in the procedure in the simulated consultation is immediately followed by laughter and codeswitching to English. In Extract 7O, the second instance of laughter signifies embarrassment or discomfort and simultaneously a challenge to the FTA in the gynaecologist's question. Her switch to English could be a confirmation of her discomfort (see 6.3.2 for code switching).

In a similar way, a gynaecologist loses face when a patient asked him an ambiguous question of which the interpretation made him feel embarrassed. In the following extract, a patient was consulting about pregnancy and how one can prepare for it.

Extract 7P:

P12: *Ndingapange bwanji kuti, ngati ndikufuna kukhala ndi mwana chofunika kupanga ndichani pokonzekera kuti ndikhale ndi mwana? Kapena kuti ndikhale ndi mimba?*
What can I do so that, when I want to have a baby, what does one need to do when they are preparing to have a baby? Or maybe so that I can get pregnant.

Dr AS: *Mukutanthauza chani? Inu pokwatiwa anakuwuzani chani?* [laughs]
What do you mean? When you were getting married, what did they tell you? [laughs]

P12: *Nndufuna ndidziwe kuti ngati pali dongosolo linalilonse kupatula kugonana njira ina yake yomwe ndingapange kuti ndikhale kuti ndili ndi mimba.*
I would like to know if there are any procedures apart from sleeping together, any other things that I can do for me to be pregnant.

Dr AS: *Aaah!*
Oooh!

In Extract 7P, Dr AS seems to have been surprised by a question which he had understood to mean "How does a woman fall pregnant?" He asks questions instead of answering the question and ends his second question with laughter. The patient realises that the gynaecologist misunderstood her, and so rephrases her question, indicating that she knows one falls pregnant by having sex. Thus, the face threat experienced by the gynaecologist, when he thought that answering the patient's question would require him to explain how one has sex, is negated. He indicates loss of face not only verbally but also with laughter, just like Patient 9 in Extract 7O above. These were instances where loss of face of was challenged, but there were also instances in which loss of face was never challenged, which are discussed below.

#### 7.4.1.2 Vague responses

In the extract below, a gynaecologist asked for information about menstruation which made a patient lose face, and the patient provided an ambiguous response as a challenge to discussing such a face-threatening topic:

Extract 7Q:

Dr OB: *Mmadumphitsa?*

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Do you skip?
P1: *Eeh ndikumadumphitsadumphitsa.*
Yes, I am often skipping.
Dr OB: *Mumadumphitsa?*
Do you skip?
P1: *Eeh.*
Yes.
Dr OB: *Zinayamba liti zodumphitsadumphitsa?*
When did this start?
P1: *Zinayambika pakanthawi.*
It started a while back.
Dr OB: *Chabwino*
Alright.

It can be argued that the gynaecologist wanted to know if it was normal for the patient to have erratic periods. However, the patient gives ambiguous or vague responses. The ambiguous response follows the gynaecologist's initial question as to whether erratic periods were the norm. He uses simple present tense in the question, 'Do you skip?' The patient responds by partially affirming with 'Yes' but also by indicating that it is not the norm for her to miss periods. She does this by using present continuous tense in 'I am often skipping' which indicates present time only, and that skipping periods was a current (or very recent) development. It can be argued that the ambiguity in the response prompted the gynaecologist to repeat the question, to which Patient 1's response was an affirmative 'Yes' without an expansion. Because of her initial response, which had also suggested it was not the norm, the gynaecologist follow up his second question with a different one to obtain more clarity. Thus, Dr OB asks if for the exact time the patient started skipping periods. The patient's response does not provide specific dates ('It started a while back') although the question needed a specific period of time as answer (e.g., "Eleven months ago"). The gynaecologist then does not pursue the question further, perhaps because he has at least established that skipping periods is the norm in the case of this patient. The indirect challenge in Extract 7Q is explained in the paragraph below.

It can be argued that the patient lost face the moment the gynaecologist wanted to know details about her menstrual cycle. The gynaecologist's awareness of the possible FTA that the topic entails is first shown in his attempt to mitigate the FTA by using a Null NP ('skip' instead of 'skip periods'; see discussion on Null NPs in 6.3.1). However, when the patient still challenges the FTA by providing an ambiguous answer, the gynaecologist repeats the question and only relents once he has enough information to work with. As stated in 7.3.2.2, one reason for gynaecologists not relenting once they engage their patient on a sensitive topic that is face-

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threatening, is that such relenting could be seen as a sign of discomfort on the part of the gynaecologists, and a display of discomfort by gynaecologists has negative repercussions for the consultation as a whole, as argued in 7.3.2.3.

#### 7.4.1.3 Lowered voices

As stated in 4.3.1.1, the simulated consultations discussed in this chapter took place either in the gynaecologist's private offices or in hospital consultation rooms. In both cases, only the gynaecologist and the patient were present. In such an environment, whispering to exclude people does not apply, as it could have in a public setting. This section discusses the whispering that occurred on two occasions. The first is the whispered *Ayi* 'No' in answer to Question 3 in Extract 7N above (*Kukhalira limodzi, mukamakhala limodzi pamakhala vuto lina lililonse ngati?* 'Being together (=intimate), is there any problem when you are together (=have sex)?') The second occurred in Extract 7R:

Extract 7R:

Dr AS: *Kumbuyoko, mukakhala ndi bamboo mmapanga bleed ngati, mmataya magazi? Mukagona ndi bamboo?*
In those times, when you were together with (=sleeping with) your husband, were you bleeding, were you losing blood[52] (=bleeding)?

P8: Ayi [whispered] tikakhala ndi bamboo ndimakhala nawo bwinobwino popanda vuto lina lililonse.
No [whispered], when I was with my husband then, I would sleep with him quite alright without any issues.

In these two instances, the topic under discussion was sex. The patients were responding to questions that required them to comment on what happens when they have sex with their husbands. In the former case, the husband was alive, while Patient 8's husband had passed away some years before the interview. In both cases, it can be argued that the lowering of voice is an indication of a loss of face and an indirect challenge to a FTA.

#### 7.4.1.4 Dysfluency

In some instances when face-threatening topics were discussed, the speaker would start stammering. Unlike the other challenges to FTAs discussed in this section, dysfluency cannot be deemed a strategy as it is typically unintentional. Nonetheless, this section presents such dysfluencies where they occurred directly following a FTA as the dysfluencies were perceived to be signs of discomfort. Consider Extract 7S:

[52] Alternative translations would be 'wasting blood' or 'throwing away blood'.

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Extract 7S:

Dr AS: *Panopa chilakolako chofuna kukhala ndi amuna palibe?*
Do you now still have the urge to be with a man (=libido)?

P8: *Aah, sichi sichimandipezanso*
No, it does not get to me (=no, I do not have libido) anymore.

In 7S, the patient responds to the gynaecologist's question with sudden dysfluency (the repetition of *sichi*), while in the extract below, a doctor, who had less than two years' experience as a practicing gynaecologist, became dysfluent when asking a 27-year-old patient about vaginal discharge.

Extract 7T:

Dr DW: *Chikuma chi, chi, chinakhalako chikazi chafungo nthawi yina iliyonse?*
Does it, have, have, you ever had smelly 'of female' (=vaginal discharge) at any point?

Both libido (in 7S) and vaginal discharge (in 7T) were referred to indirectly, using their associated meanings, *chilakolako* 'the urge' (=libido) and with *chikazi* 'of female' (=vaginal discharge), respectively. However, despite the FTAs being mitigated in this manner, dysfluency occurred.

Similary, at the onset of another consultation, the 24-year-old Patient 3 became dysfluent when she was about to explain to Dr DW that she had an infertility problem:

Extra 7U:

Dr.SM: *Mwabwera kuno chifukwa chani?*
Why have you come?

P3: *Ndi, ndili ndivuto la… kusabereka.*
I, I have fertility problems.

It can be argued that Patient 3's dysfluency in 7U was not only caused by two matters in addition to the taboo topic of infertility which she was about to present: Firstly, the question came before rapport was established, immediately after patient details were taken. Secondly, the directness in the question by Dr DW can be construed as a face threat.[53] Compare Dr DW's question with the following:

Extract 7V:

Dr OB: *Nde tikuwopeni, kwagwanji?*
'So, we are to be afraid of you, what has happened?' (=So, what brings you here?)

Unlike Dr DW in 7U, Dr OB in 7V uses an acceptable way for a host to enquire about the reason behind a visit. Therefore, the stammering as P3 presents infertility as her reason for

[53] In the Malawian culture, asking a guest/visitor to give a reason for their visit is culturally taboo, hence the indirect version would be more appropriate than a direct one.

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visiting signifies her discomfort and challenges the FTA in Dr DW's question. The dysfluencies in 7S, 7T and 7U signify the uneasiness that resulted from the anticipation of discussion of sensitive topics.

### 7.4.2 Correcting face

#### 7.4.2.1 Empathy towards patient's emotional state

It can be argued that gynaecologists in this study understood that infertility is an emotionally charged topic for patients because Malawian society attributes a couple's childlessness to unacceptable practices on the part of only the woman, which may negatively affect the woman's well-being, her marital status, and ultimately her status in society (see 5.2.2). Thus, recognising the shame and guilt that the patient could be carrying may lead the gynaecologist to create a safe space for her in which to communicate about infertility. This is exemplified in Extract 7W:

Extract 7W:

Dr OB: *Koma sindikudziwa kuti mbali ya inuyo anthu akuti ndichani. Akuti vuto limeneli labwera ndi chani? Kapena nokha panokha mmaganiza kuti mwinatu izi zichitika chifukwa chakuti chakuti?*
But I do not know what people are saying about the condition on your side. What are the saying about the causes of this problem? Or maybe on your own, do you ever think these things may be happening because of such and such a thing?

P1: *Ineyo ndimaganiza kuti chifukwa cha ma, ma-kusamba kumene ndimadumphisako mwina pali vuto.*
I personally think that because of my erratic periods, perhaps there is a problem.

Dr OB: *Mmm, nde mukuganiza kuti mwina vuto lake lingakhale chani? Kwa inu nokha, nanga simmidzimu zokhulupirira nzambiri.*
Uhm, so what do you think the problem is? On your own, since society believes a lot of things.

T1: *Zoona.*
True.

Dr OB: *Alipo ena akamba zinandizina kapena?*
There are some people who perhaps say a lot of things?

P1: *Basi anthu amangokamba, amangowona kuti munthuwe ndiwe osabereka basi. Anthu amayankhula zinthu zambirimbiri*
Just that people often say, they just think that you are just infertile. People say a lot of things.

Dr OB: *Chitonzo, ndi zina zotero?*
Extreme ridicule and other similar things?

P1: *Chitonzooo! Eya zowona.*
Extreme ridicule! Yes, it is true.

Dr OB: *And zimenezo zimakupangitsani kukhumudwa kwambiri?*
And such things make you feel stressed?

P1: *Eya.*
Yes.

Dr OB: *Ok. Munakamba za ntchito, mukugwira ntchito?*

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Okay. You said that you are working?
P1: *Eya ndimagwira ntchito.*
Yes, I work.
Dr OB: *Mmagwira ntchito yanji?*
What do you do?

In Extract 7W, Dr OB constructs a relationship with the patient by asking her about her experiences with society regarding the fertility problems for which she is consulting him, thereby showing that he regards the patient's personal experience as important. He reinforces the compassionate relationship he is developing by elucidating the general information that the patient gives when she says *anthu amakamba zambirimbiri* 'people say a lot of things'. His response qualifies the types of things that are said as *chitonzo* 'extreme ridicule', which the patient agrees with. He continues by enquiring whether what society says about infertility causes her stress. Thus, he showed compassion for the patient in two ways. Firstly, he supplied more information when she presented the generalised version. Secondly, he immediately changed the topic to a non-sensitive one towards the end of the extract, which could have helped the patient to save face.

#### 7.4.2.2 Clarifying intentions

According to the gynaecologists in this study, most women will come to the consultation alone if the couple is experiencing fertility problems. Bearing in mind that Malawian society attributes infertility to the woman's undesirable sexual past, gynaecologists volunteered their intentions for the requesting the husband's presence during consultations and explained fertility from the medical point of view in an attempt to persuade the patient to bring her husband for a medical examination. The following extracts show how knowledge is imparted in a way that emphasises the superiority of medical examinations over mere speculation and societal belief that the woman is (solely) responsible for a couple's childlessness.

Consultation Extract 7X:
Dr DW: *Ndiye pakakhala vuto limeneli, zimakhala bwino kuti nonse mukhalepo. Eer chifukwa choti kuyezako timafunika tiyeze inuyo ngati mayi komanso iwowo bamboo, eti.*
So when there is this problem, it is good to for both of you to be present. Eehm because when it comes to examination, we need to examine you as the wife and him, the husband, right.
P3: *Mmm mmm!*
(Affirmative)
Dr DW: *Monga mudziwa kuti nkhani yamwana simunthu mmodzi amene amapanga mwana koma nonse awiri. Eya.*
As you know that baby issues, it is not one person who makes the baby but both of you, right.

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The gynaecologist firstly shows respect to the patient by using shared knowledge to justify the need for the presence of a spouse in subsequent consultations, namely that, since it takes two persons to "make a baby", it is necessary to examine both parties. Under other circumstances, the question "Why is your spouse not here?" could have been used. However, the gynaecologist refrains from asking this question due to his cultural knowledge that the patient could have reservations about bringing the spouse for consultation, given that infertility is a taboo topic not discussed in non-intimate relationships and that the consequences of infertility for the woman could include divorce.

Later in the same simulated consultation, the gynaecologist answers the question about the causes of infertility by educating the patient about the physiological factors in both women and men. Below is an extract of the explanation of factors pertaining to the male that could prevent pregnancy from occurring.

Consultation Extract 7Y:

Dr DW: *Mbali ya bamboo pamatha kukhala vuto loti mbewu yawo ndiyochepa olo mphamvu yawo ndiyochepa. Pali zinthu zambirimbiri zomwe zimapangitsa zimenezizi kumbali ya bambowo, kusuta fodya ndi kumwa mowa ndizomwe zimapangitsa kuti zimenezozo zichitike, mphamvu ya bamboo ichepe. Komanso matenda aja amakhala ndi aa maliseche awo amakhala otupa, zimapangitsanso kuti mphamvu yawo itani, ichepe.*
On the part of the man, there can be a problem that he does not have sufficient seed or he has low power (= a low sperm count). There are so many factors that may cause these things on the part of the man. Smoking and drinking are causes of such things, that the man's power may weaken. But also that disease that makes his genitals to be swollen may also cause the reduction of his power.

By detailing possible causes of infertility in men, the gynaecologist imparts knowledge to the patient. By doing so, he clarifies his intent in asking her to bring her partner along to the next consultation, thereby allowing for the correcting of lost face after a FTA.

#### 7.4.2.1 Re-alignment was used to correct presumed discomfort

Another instance where the gynaecologist realised that the patient had lost face and began to correct it without being challenged is in the consultation on infertility in Extract 7Q, which was in part presented above (in 7.4.1.2) where it was used to discuss ambiguity as an indirect to a challenge FTA. It is used in this section to show how the gynaecologist handled the discomfort of the patient.

Extract 7Z (a partial repeat of Extract 7Q)

Dr OB: *Mmadumphitsa?*
Do you skip?

P1: *Eeh ndikumadumphitsadumphitsa*

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Yes, I am skipping.
Dr OB: *Mumadumphitsa?*
Do you skip?
P1: *Eeh.*
*Yes.*
Dr OB: *Zinayamba liti zodumphitsadumphitsa?*
When did this start?
P1: *Zinayambika pakanthawi*
It started a while back.
Dr OB: *Chabwino*
Alright.
P1: *Yah!*
Ja!
Dr OB: *Nde tikakamba za period-yi nde munayamba kusamba muli ndi zaka zinga?*
So when we talk about these periods, so how old were you when you started bathing (=having a period / menarche occurred)?
*(...)*
Dr OB: *Mmasamba masiku angati?*
You bath (=menstruate) for how many days?
P1: *Mmasamba masiku 7.*
I bath (=menstruate) for 7 days.
*(...)*
Dr OB: *Eeh. Mutayamba kusamba muli ndi zaka 15 mmasamba mwezi uliwonse?*
Uuuhm, when you started your period at age 15, were you having it every month?
P1: *Ayi, ndimapezeka kuti mwina miyezi yosatizana kaya iwiri ndipanga bwinobwino koma kenako ndidumphitsa osapanga*
No, I would find that maybe two consecutive months I would have my period as normal, but then I would skip and not have any.
Dr OB: *Chabwino*
Alright.

In 7Z, although the gynaecologist was indirectly called out for loss of face, he understood his patient and realigned his statements after receiving an ambiguous response. As argued in 7.4.1.2, ambiguous responses often shows that the question being asked is face-threatening and requires giving an uncomfortable response. For the patient, indicating the time when she started menstruating erratically would be an admission of having the culturally ridiculed condition of infertility that is assumed to be linked to promiscuity and/or multiple abortions (see 5.2.2 for the victimisation of the female member of a childless couple). Thus, the gynaecologist does not pursue the issue further using the same line; instead he asks less embarrassing questions concerning menarche (still a taboo topic but less sensitive than infertility). It is through this line of questioning that he establishes that "a long time ago" meant "always". This information is obtained from the response "(since menarchy) … it would happen that may be in two consecutive months I would do it properly, but afterwards I would skip and not do it". This

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information was obtained through realignment rather than by asking directly as he initially did. Thus, the FTA is mitigated by realignment and the patient is able to provide the required information.

## 7.5 Chapter summary

This chapter has outlined three general discourse strategies that were used to manage face-threatening conversations in gynaecological consultation. The first include measures taken before introducing taboo topics that helped define the relationship between the gynaecologist and the patient. This allowed for initiating discussions of taboo topics. Once the interlocutors were comfortable enough to initiate the discussions, mitigation strategies were employed to allow for the continuation of the discussions with bearable levels of discomfort. However, whenever the discomfort levels became unbearable, the third set of strategies – challenging FTAs and correcting lost face – were used. The challenges against FTAs were done indirectly, while corrections did not always follow challenges. This chapter shows that at every stage of the management of conversations pertaining to taboo, sociolinguistic knowledge and resources were used by both interlocutors. The next chapter discusses participants' evaluation of whether communication in the Chichewa gynaecological consultations allows them to satisfactorily meet the medical requirements of these consultations.

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# Chapter 8 : Participants' evaluation of the existing communication practices in Malawian gynaecological consultations

## 8.1. Introduction

Given that effective communication cannot take place when information is presented in the wrong form (Davis & Fallowfield, 1994: 41), this chapter provides an overview of participants' evaluations of the gynaecological consultation in Malawi as a practice. It does this by discussing the extent to which the participants believed that the discourse strategies used in gynaecological consultations contribute to the achievement of both direct and indirect consultation goals despite the face-threatening nature of gynaecological consultations in Malawi.

The direct goals of prognosis, diagnosis and treatment require the skills of probing, giving instructions and reassurance, and influencing attitudes, opinions and behaviours, and the achievement of these goals depends on effective information-gathering and patient education activities (see discussion in 2.2). The indirect goals of establishing an appropriate relationship and emotional responsiveness between the gynaecologist and the patient facilitate the achievement of the direct goals. A thematic analysis of the data revealed that participants' perceptions of the achievement of the interactive goals of the consultations was affected by (i) the gender of the gynaecologist (8.2), (ii) the language(s) used in the consultation (8.3), and (iii) sociocultural dynamics (8.4). Several subthemes that emerged from the data are discussed under these three main themes.

## 8.2. Gender dynamics and communication

This section discusses participants' opinion on and reported experiences of how gender affects communication in the information gathering phase of gender-discordant consultations. The data from this study shows (i) that the face threats caused by gender-discordant consultations are mitigated by the professionalism and empathy that patients reported experiencing in past consultations involving the discussion of taboo topics, and (ii) that urgent medical situations override patients' adherence to sociocultural restrictions on discussing taboo topics.

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### 8.2.1. Communication with female practitioners is preferred

Some patients reported that they preferred female gynaecologists because discussing taboo topics with them was deemed less face-threatening than doing so with a male gynaecologist. Recall Patient 3, who stated that consulting a female gynaecologist would allow her to be open and comfortable during an intrusive procedure like a Pap smear (see Extract 5P): "You actually know that they will tell you to undress ... you are not ashamed. But when it is a male gynaecologist, you think twice or thrice … does he want to touch me or what?" (original in Chichewa). An illustration of this preference is Patient 9 (Extract 5L), who wanted to talk to a female nurse instead of the male specialist when she visited the hospital with vaginal pain while pregnant. When informed that she could not see the female nurse and had to consult with a male gynaecologist, she initially had difficulties performing the face-threatening task of discussing her genitals ("I just kept saying that 'Doctor, this place here is what, here there is pain.'").

According to Dr AS, some patients are not comfortable providing any information to a male gynaecologist. For instance, "they [some patients] will keep that information from me" when referring to the information he needed to make an accurate diagnosis (see Extract 5CC). From Dr AS's statement, one can conclude that some of his patients would jeopardise the outcome of the gynaecological consultation for the sake of observing the broader sociocultural requirement of not discussing taboo topics across genders in non-intimate relationships.

### 8.2.2. Some female gynaecologists have negative attributes

In contrast to those who reported being more comfortable with female gynaecologists, other patient participants in this study assigned more positive attributes to male than to female gynaecologists, many of which could aid communication. Some examples of this are that male gynaecologists were deemed more caring, accessible and accommodating than their female counterparts; for instance, Patient 5 said, "Males care a lot more than females." (original in Chichewa). Patient 5 thus suggested that there is a connection between having a caring character and being a male gynaecologist, and by citing being caring as the basis for her choice, she emphasised the significance of this attribute. When I asked her whether this would have been her choice had her husband been present, she replied in the affirmative.

This positive attribute of being caring is in sharp contrast with how some female participants characterised female gynaecologists. Consider, for instance, Patient 1 who said that female gynaecologists favour some patients, thereby implying that male gynaecologists are impartial

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or fair. Another example of a female participant reporting undesirable traits of female gynaecologists is that of Patient 5 in Extract 8A:

Extract 8A:

P5: *Adokotala achizimayi chimavuta ndimalankhulidwe. Chifukwa nthawi zambiri azimayi ndife anthu osayankhula bwino. Ndekuti athe kumumvetsetsa munthu kapena mwina kumumvetsetsa munthu kapena mwina achitenge chimene munthu, patient akufotokoza kuti amuthandize munjira imene angathe kumuthandiza mwina akusiya kuchimva mmene munthu uja akufotokozera, amayamba kumulalatira kumuyankhula zosakhala bwino.*
The problem with female doctors is the way they talk. Because most of the times, we women don't talk well. So for them to understand what someone, a patient says so that they can assist her the best way they can. They may stop paying attention to what the patient is explaining to them, instead start shouting at them and saying bad things.

Patient 5 constructed the identity of a female gynaecologist as unaccommodating, and therefore unprofessional, and indicated that they communicate with their patients in ways which she found unacceptable.

### 8.2.3. No gender preferences, as long as the gynaecologist is Malawian

Some of the participating women reported that all Malawians, regardless of their gender, acted respectfully, thereby associating Malawian gynaecologists with a level of professionalism that mitigates the face-threatening nature of gynaecological consultations in which taboo topics are discussed. For instance, when responding to the question based on the audio-recording, "Apart from the fact that they are using Chichewa, would you say that this gynaecologist is a Malawian?", Patient 1 said, "I think he is Malawian, because Malawians are respectful, they are never disrespectful (abusive in speaking). So, the way he is asking questions, his words and the way he is talking show that he is a real Malawian." (original in Chichewa). Here it is clear that Patient 1 constructs the identity of the Malawian gynaecologist as respectful because of his/her use of culturally appropriate language. As discussed in 5.1-5.5, being respectful is seen as a prerequisite for being regarded a good gynaecologist, given the significant need for the gynaecologist to build a safe environment in order to ensure the success of the consultation.

### 8.2.4. Urgent medical care may neutralise gender preference

The reported gender preferences discussed above seem to fall away in some cases where female participants present with severe gynaecological problems and view receiving medical care as urgent (including in the case of going into labour). One of several extracts illustrating this is Extract 8B:

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Extract 8B:

P12: *Ayi nnalibe chikayiko (popita kuchipatala) chifukwa choti omwe anadwalapo matenda a* UTI *atha kudziwa kuti sizoti unganene kuti aaah ndikupanga manyazi kuti ndikanena kuti chakuti chakuti, umangopita kuti akakuthandize mwansanga ndithu.*
No, I had no doubts (when going to the hospital) because anyone who has ever had a UTI may know that you do not have the liberty of saying this like, it is embarrassing to say this and that. You certainly just go to seek instant help.

Patient 12 explains that the urgency of the medical problem may cause a woman to communicate more clearly with a male gynaecologist than what would have been the case had the consultation been for a voluntary, routine Pap smear, for instance.

## 8.3. Languages in the consultation

This section presents participants' views on the languages (Chichewa and English) used in gynaecological consultations in as far as communicating about taboo topics is concerned.

### 8.3.1 Chichewa lacks medical terminology (or patients don't know the "right Chichewa words")

Because the language in which Malawian gynaecologists are trained (English) is not the language in which they will practice (Chichewa, Chitumbuka, Chiyao and others), the sociocultural differences regarding taboo between many English-speaking societies and Malawian society (see section 5.3.2) means that clear yet respectful communication during consultations is often challenging. Illustrative of this is Extract 8B from the interview with Dr AS, who after more than 17 years of practising as a gynaecologist still found the problem of clear gynaecologist-patient communication with Chichewa monolinguals unsurmountable.

Extract 8C:

Dr AS: *Zonse, zonse zimene unganene mayina amatenda, ma* description *a mavuto amene anthu akufotoza,* if you look at *ma* body systems, *Chichewa,* I mean, *palibe amene amadziwa kuti mukukamba chani iyayi. Tikamakamba zinthu kaya ma* systems *kuti mthupi mmayenda motere, zinthu zimakhala motere. Si,* there are no equivalent words that you can tell people have no ideas *kuti ukukamba chani.*
Everything that you can say, names of ailments, description of issues, if you look at body systems, Chichewa, I mean, no one knows what you are talking about. When we are talking about systems, that this is how things work, since there are no equivalent words, you can tell that people have no idea what you are talking about.

MCK: *Monga mongoyerekeza?*
Can you give an example?

Dr AS: For example, *ndiye ndikamafotokoza* say *alindivuto la olo akufuna muzapange za* family planning, *za kulera. Tikamafotokoza zamankhwala amene timagwiritsa kuchipatala. Ukamafotokoza kuti mankhwala amagwira ntchito bwanji. ukamafotokoza zimene mthupi zimachitika zimasystems amene amapanga control zakulera,* no equivalent Chichewa words.

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> *Umakhala ngati ukulankhula zinazake zoti munthu sakudziwa kuti kodi a dokotala akukamba chani.*
> For example, when I am explaining, say, the patient has issues with, or maybe she wants to do family planning. When we are explaining how the medicines work, when you explain what happens in the systems that control conception, no equivalent Chichewa words. It is as if you are saying things that the patient does not comprehend what the gynaecologist is saying.

Dr AS emphasises the difficulty of communicating in Chichewa by using the expression "everything" before listing and exemplifying what he means by "everything". In addition, he denigrates Chichewa as a sign system since he argues that it hinders women from having meaningful consultations. This renders Chichewa unsuitable or inadequate in a gynaecological consultation, since "everything" may seem incomprehensible to Chichewa monolinguals who do not understand human anatomy and physiology.

Furthermore, there are instances when Chichewa terms are indeed available (and known to the doctor as well as to the patient), but where the Chichewa term is not fully equivalent to the English medical term. Dr DW provides an example:

Extract 8D:

Dr DW: *Aahm… nthawi zambiri anthu ambiri amavetsetsa, tikayesetsa kuti timufotokozere munthu mchichewa, anthu ambiri amamvetsetsa. Koma pamakhala nthawi zina poti munthuyo mwina sakumvetsetsa. Tiyerekeze: muchiyankhulo cha Chichewa tikangonena kuti chotupa, wina aliyense amachitanthauzira mwakemwake. Wina chotupa aahm kwa iye akutanthauzira kuti ndi khansa. Wina chotupa akuwona ngati nchotupa basi. Nde chotupa chimenecho chikakhala kuti chili malo obisika tiyerekeze chili muchiberekero, aliyense sikuti amawona chiberekero, nde tikumuwuza kuti chotupachi, chili muchiberekero, zizindikiro zimene iyeyo akumva ndikutaya magazi. Nde tikamuwuza kuti ndichotupa, mwina munthu aziganizira kuti ndi khansa, pomwe mwina sikhansa, ndichotupa choti sikhansa iyayi. Nde zimatengera munthuyu zizindikiro zomwe akumva zomwe zikumuchitikira mthupi. Mkuyesera kufotokoza, timafotokoza kuti munthuyo amvetsetse kuti chinthucho sikhansa iyayi. Komanso kuti* treatment *yomwe tikupereka ilingane ndi mamvetsetsedwe ake. Chifukwa pali zotupa zina, tiyerekeze chitha kukhala chotupa koma sichikufunika* operation*. Kwa munthu wina aliyense akangomva chotupa, chifukwa cha zizindikiro zomwe akumva mwina zimakhala kuti aah ngati chili chotupa chikundipangitsa kuti ndizimva kupweteka daily, chikungoyenera kuti, ineyo mmaganizo mwanga chingochotsedwa. Abwera kwa ine ndimuwuza kuti mulidi ndi chotupa koma sichikufunika* operation*, tingokupatsani mankhwala awa mutani, muzipita kunyumba tizakuwonaninso ku* clinic*. (...)* So *zinthu zambiri zima aaah kutanthauzira kwambiri kwa mawu ena amakhala ndi mavuto ngati amenewowo. Osati chifukwa choti zinthuzo nzovuta kumvetsetsa, koma mmene munthuyo akumvera ndi chinthu mmene tamuwuzira, and palibenso mawu ena abwino oposera chotupa. Ayi. mChizungu titha kufotokozera mwambirimbiri pamene mChichewa tingozipanga m'*group *imodzi basi. Chotupa basi.*

> Uhm… most of the time people understand, when we try to explain in Chichewa, most people understand. But there are instances when the person maybe does not understand. For instance, in Chichewa when we say "a swelling". Several people may interpret it in their own way. For one, a swelling may mean cancer. For another, it is nothing more than just a swelling. So when

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such a swelling is in a hidden place like in the uterus, not everyone can see it, so when you say, "The swelling is in the uterus", the symptoms she has is heavy bleeding, so when you tell her that there is a swelling, the person may think it is cancer, when it is not even cancer, it is just a swelling (=non-malignant mass). So it depends on what the patient feels happening in her body. In trying to explain, we explain in such a way that the person understands that it is not cancer, so that the treatment we give must be in line with her comprehension. Since there are some swellings, like it can be a swelling that does not require an operation. When an ordinary person hears a swelling, because of the signs and symptoms they have, maybe it is like, "Uhm if it is a swelling that is causing me to feel pain daily, it must be removed; on my part, I think it should be removed". She comes to me; I tell her, "You have a swelling, but it does not require an operation. We will just give you medicine and then you can do what, you can go home. We will see you again at the clinic". Most people may still uuhm or if they still do not understand what the swelling is, why it is causing pain, or causing another thing, we see them returning. (...) So mostly the interpretation of words faces such problems. Not because the things are hard to understand but because of the way the patient feels, and how we have explained it to her, and there are no better words than "a swelling". In English, we can describe them in several ways. But in Chichewa, we just group them all together: It is nothing more than a swelling.

In Extract 8D, Dr DW demonstrates the limitations of Chichewa medical terminology by explaining how a single expression, *chotupa* 'swelling', may cause miscommunication in gynaecological consultations and cause patient dissatisfaction with the treatment she received, in this case receiving medication instead of an operation and further treatment for "her cancer".

Due to cultural constraints on the use of certain Chichewa words, patients may also find themselves at a loss for "the right Chichewa terminology". Consider in this regard Patient 12's statement that she does not know the Chichewa terminology for the various parts of the female reproductive system: (also see Extract 6A)

Extract 8E:

P12: *So kwambiri sitimawona anthu akuluakulu akulankhula zachiwalo zachimuna kaya zachikazi* explicitly like that*. Amakhala kuti angolankhula machining'a kuti a ang'ono ang'ono asamve.*
So, mostly we never saw older people talking explicitly about male or even female organs. They speak in undertones so that children do not understand,

MCK: *Ndekuti panopa mutha kufotokoza kuti munthu wankazi ziwalo zake ndizakutizakuti muChichewa bwinobwino momveka?*
So, does it means that now you can explain in proper Chichewa that the female sexual organs are as follows*?*

P12: [3 sec silence]

*MCK: Ntakupatsani chithunzi kuti tandifotokozereni kuti ziwalo izi ndi chani?*
If I could give you a picture and say, "Can you name the following parts?"

P12: *Ayi, sindikudziwaponso kuti, ayi ndithu, (...)*
No, I don't know that, not at all (…)

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In Extract 8E, Patient 12 states that she simply does not know the terms for specific parts of the female reproductive system, because adults did not use them in children's presence. The implication is that she did not learn them as a child and now does not know them as an adult. Further, Patients 8 and 11 understand English in addition to Chichewa, and in their respective interviews explained that their gynaecologists fail to explain matters in Chichewa. Whereas these two patients could understand some of the English terminology used by their gynaecologists, monolingual speakers of Chichewa would not be able to do so:

Extract 8F:

P11: *(...) pena akamafotokoza vutolo amatha kufotokoza muchingelezi. Chifukwa pamapezeka kuti palibe mawu oyenela kuti akambe muchichewa. Olo kuti akhonza kubwelekela mau ena kutino tikhonza kumvetsa amawasowa nde, amatha kufotokoza muchingelezi nde ndimatha kumva ngati kuti munthu oti ndinapitako ku* school.

(…) sometimes when they're explaining an issue, they may explain in English. Because there aren't any suitable words that they can use in Chichewa. Or that they may borrow some words, so we may get each other, may not be available, so they may explain in English, then I am able to understand like a person who has been to school (=is educated).

In 8F, Patient 11 emphasises the significance of her knowledge of English by stating that it is key to understanding what gynaecologists are saying when words are borrowed from English or when they switch to English, given the lack of suitable Chichewa terms. It can be argued however, that there is a high possibility that the gynaecologists she had consulted before used English because they knew that she would understand, because she said they just switch without telling her that they have difficulties using Chichewa. Further, gynaecologists had indicated that they use a language that their patient would understand (8.3.3). The lack of extensive medical vocabulary in Chichewa was a recurring theme in the interviews with both gynaecologists and patients.

### 8.3.2 English has a complementary role in gynaecological consultations

As explained in Chapter 6, using English is one of the solutions to the lack of (suitable) Chichewa terminology, and using English can circumvent linguistic taboo (also see 6.3.1 and 6.3.2, respectively). According to the interview data from participants who are Chichewa-English bilinguals, English is not only used during consultations by gynaecologists and patients as a resource which provides terminology, but also as a tool for showing respect. Consider in this regard for instance Dr OB's answer to the question about the language in which he is comfortable to conduct consultations:

Extract 8G:

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Dr OB: *Chimakhala Chingerezi. Makamaka ntchito yathu ya za azimayi yalekana ndi munthu woti ukugwira ntchito kwa ana ukoko. Akati malungo, malungo. Mutu, mutu.* Meningitis, Meningitis. *Pamene kwathu kunoko ziwalo zimene timayang'anira ifeyo zimakhala ngati zobisika. Ndekuti uzitchule mChichewa chimakhala chinthu chovuta kwambiri. Koma Mchigerezi zomwezo tikamaphunzitsa sizimakhala zinthu zovuta kutchula.*
It is English. Especially for our job which concerns women is different from those that work with children there. When they have malaria, it is malaria; headache is headache; meningitis meningitis. Whereas in our field, the organs that we are concerned about, are those that are like hidden ones. So for you to mention them in Chichewa, it becomes very difficult. But in English when we teach the same things, it is not hard to mention.

Dr OB explains that it is easier (and more respectful) to use English than Chichewa to talk about women's reproductive systems. This is despite English being spoken by only 0.3% of the Malawian population[54] (Lora-Kayambazinthu 2003:147) and therefore notbeing an option for the vast majority of Malawians. In Extract 8H, Dr KG explains that English is preferred because it is more direct (exlicit), while using Chichewa makes the gynaecologist uncomfortable:

Extract 8H:
Dr KG: *(...) kumuwuza munthu kuti ufuna uwone,* you want to look at the vagina *umatha kumuwuza munthu kuti chotsani kabudula tiwone nawo kumaso. Pali anthu ena oti mwina* you know *kuti munthu wakulira mtauni* if you speak such *Chichewa saamva,* then you have to be open. *Ena amakhala kuti mwina amalankhula English bwinobwino.* Then you speak in English which actually for *mwina ma* doctors *ambiri zimakhala ngati* it is much easier to say. *Chifukwa nanga si*-learning *yonse imakhala kuti* you are learning in English, so *mmangowona ngati mukutchula zinthu za nkalasi. Pomwe* when you are translating it becomes more uncomfortable for *anthu ena kuti atchule.*
(…) telling the person that you want, you want to look at the vagina, you can tell the person "remove your 'shorts' (=panties) for us to see 'the face' (=the genitals). There are some people that might, you know, that they have grown up in urban areas, if you speak such Chichewa, they won't understand, then you have to be open. Others are those that speak English fluently, then you speak English, which actually for most doctors may seem to be much easier to say. Because, since all the learning is such that you are learning in English. So you just feel like you mentioning things from class. But when you are translating, it becomes more uncomfortable for some people to mention them.

In Extract 8H, it is argued that the use of indirect Chichewa expressions (for the purpose of being respectful) may lead to miscommunication for some patients, and that it is easier to use English this those patients who do speak English.

[54] Recall that Chichewa is the home language for most Malawians, including most Malawians living in urban areas (see 1.6.1). Although most of Malawians who can speak English live in urban areas, not many use English every day.

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### 8.3.3 When it comes to language preference, it is not "one size fits all"

Although English is the language of preference in consultations for many gynaecologists and patients for the above-mentioned reasons, Chichewa is still the language of preference for establishing rapport at the outset of the consultation. One of the main ways in which rapport is established in a consultation, and typically the first step in building a relationship between the doctor and the patient, is through greetings. As discussed above (in section 7.2.1), the greetings in the simulated consultations in this study were mainly done in Chichewa. Interestingly, the findings of this study show that in addition to building relationships, greetings were also used as a tool with which the gynaecologists could indirectly establish their patient's language preference. Consider, for example Dr KG's explanation:

Interview Extract 8I:

Dr KG: *So...* patient *aliyense timampatsa moni, nde timawona kuti wayankha muchilankhulo chanji. Nde default timamfunsa muChichewa. And akayankha mchichewa tikamufunsa kuti afotokoze vuto lake, akayambano kufotokoza mchizungu then mmatha kuwona kuti ok munthuyu mwina ali* comfortable *mchizungu* and then you continue *ndi chizungu.*

So… we greet every patient, then we look at the language they respond in. The default is we ask in Chichewa. And when she responds in Chichewa, and we ask her to explain her issue. If she then starts explaining in English, then you begin to realise that maybe this person is comfortable in English, and then you continue in English.

This indirect enquiry about language preference between the gynaecologist and the patient is respectful, because a gynaecologist asking a patient directly about her language choice would imply that (i) the gynaecologist thinks the patient is an outsider (non-Malawian) who cannot speak Chichewa, or (ii) the gynaecologist is indirectly asking the patient whether she was educated or not, given that English is a language of the educated elite (Lora-Kayambazinthu 2003:149, 148) (see 1.6.1). Furthermore, using Chichewa, and not English, when greeting the patient may construct the gynaecologist's identity as approachable and friendly. In contrast, using English – the language of the elite – may emphasise the position of power that the gynaecologist has in the consultation room.

Interview data from female participants, however, indicate that they are of the opinion that gynaecologists impose their own language preferences on the patient. Some participants stated that they had never been asked about their language preferences during a consultation, and that the obvious choice should be the national language, Chichewa. For instance, Patient 5, who can speak English, stated in Chichewa that "the language that is common and well understood by everyone is Chichewa. So they [gynaecologists] are supposed to use a language that can be understood by everyone". Other participants reported that the language used depended on the

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perceived socioeconomic status of the hospital's clientele: Private, fee-charging hospitals are associated with educated people and the use of English, while public, no-fee hospitals are associated with patients who use Chichewa (as explained in 7.3.1.2). Consider Patient 9's explanation:

Interview Extract 8J:

P9: *Ndikamakakumana ndi dokotala, malingana ndi aahm zipatala zimene ndimapita, ngati ndikapita ku* [name of private hospital], *a dokotala nthawi zambiri amapezeka kuti mwina tikuyankhulana mchizungu.* Not *Chizungu* completely*, komano zinthu zambiri, zimalankhulidwa mchizungu.*
When meeting with a gynaecologist, depending on the type of hospitals I go to, if I am going to [name of private hospital], it happens that the gynaecologist mostly may use English. Not English only, but most of the things are said in English.

MCK: *Chifukwa chani mmayankhula chizungucho?*
Why do you speak English?

P9: *Aaah ndikuwona ngati* [name of private hospital], *ndikhoza kuchiyika ngati chipatala* cha high class *nde mwina adokotala amangopanga assume kuti munthu ngati ukupita kumenekoko, umakhala winawake onena kuti mwina chizungucho umatha kutani? Umatha kuyankhula. Nde kawirikawiri amapezeka kuti ma* conversation *ake akuchitika mChizungu.*
Uuhm, I think a hospital like [name of private hospital] can be described as high class, so maybe gynaecologists just assume that if you go there, you are the type of person, that perhaps English is a language that you can do what, you can speak. So often you find that the conversations are in English.

Patient 9 emphasises that she sees the use of English in private hospitals is an indication of the gynaecologist's judgement of her social class as she believes that being addressed in English signifies that one has been recognised as a member of the higher social class. In other words, a gynaecologist who would use English at the private hospital would be showing respect, while speaking Chichewa would be disrespectful.

## 8.4. Sociocultural dynamics and communication

This section discusses how the sociocultural knowledge of patients may enhance or hinder the success of information gathering and patient education in gynaecological consultations. The following themes emerged from participants' views on how communicating about taboo is impacted by other sociocultural dynamics.

### 8.4.1 The observance of culture establishes good relationships

Culture-specific understandings of an illness that are not in line with the Western biomedical model may influence the way in which a patient presents information regarding the illness, which may, in turn, affect the outcome of the consultation. One such culture-specific health

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belief in Malawi is the belief asserted by Lwanda (2005:256–265) that witchcraft causes illness. Consider for example, the extract below from the interview with Dr M:

Extract 8J:

MCK: *Tinganenenso kuti mwina chikhalidwe mwina chimalowererapo mmagwiridwe anu antchito? Mukamafotokoza zinthu kuti mwina ichi chayambitsa ndi chakuti anthu amalephera kukumvetsani chifukwa chachikhalidwe?*
Can we also say that culture also has its stakes in the way you work? When you explain that this has caused that, are there people who fail to understand because of culture?

Dr AS: *Ooh yeah kwambiri, yeah kwambiri, izo nde… unfortunately kaya ndi fortunately, ineyo munthu ndikamamufotokozera nde ndikawona kuti zimene ndikukambazo ndizachikhalidwe chawo sizikugwirizana. Ndimafotokoza kuti, I know kuti kumvetsa ndikosiyana, chifukwa, I have come across anthu oti abwera ayamba kukamba nkhani, afotokoza ine kwathu, eeh agogo athu eeh kwachitika zotere kuti anawaloza akuti. Nde ndimawafotokozera kuti aah komatu ine nkhani zolodzanazo sikwenikweni kuti ndimazikhulupirira iyayi. And kuti ndizikhala kumafotokoza zimenezozo ndikhoza kukupatsani explanation yanga yokhuzana ndi zimene mukutani mukumveramo. Koma pali anthu oti amabwera ndithu kumafotokoza kuti akuganiza kuti mwina kwawo awapanga ujeni kuti chani, aalodza*
Ooh yeah, quite a lot, yeah, quite a lot. This is, unfortunately with me when I explain to the patient and I see that what I am telling them is in conflict with her culture. I tell them that, I know that we understand things differently, because I have come across people who start telling their story like, "Our grandparents, this is what has happened", that they were bewitched. So I explain to them that, unfortunately, I do not necessarily believe stories about witchcraft. And for me to explain about these things, I would explain it in my own way concerning how you feel. But there are people who come with the belief that they have been bewitched.

The gynaecologist presents two sources of knowledge that may be in conflict with each other about the cause of an illness, namely scientific medicine and cultural beliefs. His explanation shows that he avoids displaying his disapproval of culture-specific beliefs by saying, "I know that we understand things differently (…). So, I explain to them that unfortunately, I do not necessarily believe stories about witchcraft". By first acknowledging the existence of the patient's belief and then discrediting it in an indirect manner, the patient may still feel respected and could, as a result, be willing to listen to the views of the gynaecologist. The gynaecologist, therefore, privileges scientific knowledge systems over cultural knowledge in such a way that it does not threaten the face of the patient.

### 8.4.2 Patients lack understanding of the aim of medical consultations

According to the gynaecologists interviewed for this study, another factor that may influence the outcome of a gynaecological consultation is the fact that patients think that some of the questions the gynaecologists ask are irrelevant and are only asked out of personal interest. As discussed in 5.3.1.2, young patients might believe that doctors are making advances at them by

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asking questions about where they live and about their sexual histories. Furthermore, there are instances where patients feel that they are being judged by the gynaecologist during a consultation whilst either discussing aspects of their sex lives or having conversations about the physical examination of their private parts (see 5.2.1). Gynaecologists construe these reactions as a lack of understanding of the process required to develop a diagnosis and a prognosis. In Extract 8K below, for example, Dr KG explains that patients' sociocultural knowledge of how *asing'anga* or sangomas diagnose ailments conflicts with the requirements of the clinical gaze:

Extract 8K:

Dr KG: *Ena ambiri akabwera kudzakumana ndi gynaecologist amafuna kuti tipange figure out chomwe akudwala. Amatha osatiwuza chomwe tikudwala (sic.) I don't know whether it is a culture yoti mwina kaya chifukwa cha asing'anga kuti amafuna kuti…*
Most of them when they come to meet a gynaecologist, they want us to figure out what their problem is. They may not tell us what we (sic) are suffering from. I don't know whether it is a culture of maybe because of the traditional healers (=sangomas) that they want…

MCK: *Mulosere?*
To predict?

Dr KG: *Eya… anene kuti mukudwala chakuti. Iweyo usanatchule kuti ndikudwala chakuti.*
Yes… they [the doctor] should say that you are suffering from such and such. When you have not said what you are suffering from.

Dr KG illustrates that most of his patients assume that the gynaecologist, as an authority in medicine, should know things even before being told. In other words, patients expect gynaecologists to fill-in the missing information during consultations. Hence the patient gives what little information they deem necessary, especially when dealing with culturally sensitive topics like infertility. An alternative explanation would be that the patient is waiting for the gynaecologist to lead the discussion, for example by asking yes/no questions so that the patient does not have to elaborate on taboo topics.

### 8.4.3 The conflicting knowledge bases about bodies and diseases

Given that it is essential for interlocutors to have a shared paradigm on which their knowledge and understanding about illness in order for communication to be successful in a medical consultation (Paternotte *et al*. 2015:425), since a lack of such shared knowledge can make mutual understanding difficult to achieve. Consider, as an example, Dr AS's explanation:

Extract 8L:

*Dr AS: Ena amaganiza kuti ukalowetsa zala kumeneko zikafika ku mtima. Enanso/* that's how bad they understand their own bodies.

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> Some patients think that when you insert fingers there [in the vagina], they will go up to the heart. Others/ that's how badly they understand their own bodies.

Dr AS in 8L emphasises the lack of medical knowledge that some patients have by providing an example of an assumption made by patients which does not fall within the scope of medical science. Later, he mentions other assumptions that some patients have about illnesses that affect the outcome of consultations as well as patient satisfaction:

Extract 8M:

Dr KG: *Nde palino another approach yomwe nthawi zambiri anthu amatenga, komano imangokhala ndi kumasuka kufotokoza chili chonse, ganizira iwowo, makamaka ukakhala ndi patient woti anapangidwako operation. Vuto lina lililonse lomwe angakhale nalo after that, amalongosola kuti nnapangidwapo operation, nditapangidwa operation nnayamba kumva chakuti mpaka pano. Zimatha kukhala kuti completely unrelated koma nkhani nthawi zonse iziyamba yoti chani, nnapangidwa operation. Olo nthawi zina kaya anapezedwa ndi cyst kaya chani amayamba ndikuti aah anandipeza ndi chovupa nde panopa ndikupanga chakuti. Chimatha kukhala kuti chili completely unrelated. Nde ngati doctor umayenerabe, tikamafunsa mafunso timakhala ngati tikupanga investigate. So umayenera kufunsabe mafunso mpaka upeze kuti story-yi ikutha bwanji.*

And then there is another approach that people often take, but it just emanates from how they are thinking, especially when you have a patient who has had an operation before. Every problem they might have after that, they explain that they had an operation, "After that operation, then I started feeling this until now". They may even be completely unrelated matters, but every issue will start with, "I was operated on". Even those times when they have been found to have a cyst or anything, they start with what… "Uuhm I was found with a cyst, so now this is what is happening". It might even be something which is completely unrelated. So as a doctor, you still have to, when we ask questions, we act like we are investigating. So, you have to ask questions in order to arrive at the conclusion of the story.

This extract makes it clear that the patient's lack of understanding of medicine creates a situation in which it is the gynaecologist's duty to authenticate the patient's narrative. Thus, the relationship between the gynaecologist and the patient is that of an authority and a novice.

Through analysis of the interview extracts, it was established that the medical condition called menopause may not be familiar to patients, and that they tend to rely on cultural knowledge to describe what their symptoms mean when going through menopause. This is exemplified in the following extract, which is in answer to how the gynaecologist explains menopause in Chichewa. (In the question I had used the English term because I did not want to provide the gynaecologist with my own Chichewa terminology; the gynaecologist however still uses the English term *menopause*.)

Extract 8N:

Dr KG: *Kuti* menopause *tingayifotokoze bwanji?* That's a difficult one, cause uuhm! it's not something *chomwe sitimapanga* every day. *Chifukwa chakuti ku Malawi anthu ambiri samabwera*

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*ndimavuta ngati a* menopause. *Komano* mostly *timanena kuti kusiya kusamba. Tsono kusiya kusamba is when munthu wasiya kupanga* menstruate. *Tsono tikanena kuti ooh mwakula mwasiya kusamba ndekuti munthu uja wafika* menopause
You are saying how can I explain menopause? That's a difficult one, cause, uhm, it's not something we do every day. Because not many people here in Malawi come with issues like menopause. But mostly we refer to it as 'stopping menstruation'. Now, menopause is when one has stopped menstruating. So when we say you are now old, you have stopped menstruating, then it means that the person has reached menopause.

While a few educated patients may know the term 'menopause' and may understand what it refers to, most patients are reportedly unfamiliar with the fact that a condition such as menopause exists. Consider Dr AS's explanation:

Extract 8O:

Dr AS: *Ambiri amabwera ndi, samadziwa dzina la, ambiri ndiwoti samazindikira kuti zimene zikuchitikazo kuti ndi* menopause. *Uuumm... koma akayamba kufotokoza iiih iweyo monga dokotala umadziwa kuti iyi ndi* menopause. So I've come across *uuum makamaka anthu oti ku sukulu sanapite, za* menopause *kuti afotokoze kuti ndifuna kuzapanga zakuti zakuti zakuti, amalephera koma ukawafotokozera amamva zimene wawafotokozerazo. Koma iwowo kaya amazikhulupirira kaya* I doubt *eti, chifukwa ali ndi zikhulupiriro zawo. Amabwera ndizinthu, akaamafotokozanso even nkhaniyo "chikuchokera apa, chikudzera uku" ndikumva chonchi eeh chakuti, nthawi zina akambeko zaufiti wakwawo, you know,* so complicated. The educated ones *amatha kungobwera uuh kuti* "ineyo I think...," *chifukwa choti akhala akuwerenganso ndi zina zotero, amatha kumanena kuti ine ndayamba kumva ma* problems *or ma* symptoms *okhudzana ndi* menopause. *Ndikumva mwakuti mwakuti mwakuti.* So those are very easy to deal with*, koma enawa okuti sakuzimvetsa zimenezi amakhala* very confused *kwambiri* and sometimes they believe *kuti ndithudi akudwala pali china chake chimene sichili bwino.* And I, you know, *kufotokoza kuti chikuchitika ndi chani,* I doubt *kuti zimene akufotokozazo azipanga* picture *bwinobwino kuti ukufotokoza chani.*
Most of them who come do not know the name, most are those that do not know that whatever is happening to them is called menopause. But when they start explaining, you know that this is menopause, so I have come across uhm, especially people who have never been to school fail to explain what the problem is, but when you explain it to them, they understand. But I am not sure if they believe it or doubt it because they have their own beliefs. They come with such things as, when they give you the story, they say, "A (big) thing moves from here, passes through this side", "I feel this or that", sometimes they may bring in witchcraft from their places of origin, you know, so complicated. The educated ones can just come and say, "I think I…". Because they have been reading etc., they are able to say, "I started feeling these issues and symptoms related to menopause. I feel like this and I feel like that". So those are very easy to deal with. But these others that do not understand are very confused and sometimes they believe that they are definitely sick and that something is not right. And you know, explaining that this is what is happening, they will not have a mental picture of what exactly is happening.

Extract 8O provides another example of the conflict between the scientific and cultural knowledge systems. It appears that the gynaecologist is not concerned with making one system significant over the other, but instead allows the patient's belief system to exist alongside

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medical knowledge. This could be ascribed to the fact that there would be little time to dismantle the patient's belief system during a consultation, and that the gynaecologists therefore attempt to get the patient to understand his thought processes and solutions, rather than to alter the patient's belief systems.

### 8.4.4 Cultural practices clash with medical urgency

Gynaecologists reported that cultural-specific communication practices at times hinder the provision of timeous medical treatment. This is exemplified in Extract 8P.

Extract 8P:

Dr DW: *Vuto limenelo timalipeza kwambiri mmagulu awiri a ma* patient*. Oyamba ndi azimayi amene akuyembekezera. Tiyerekeze, wina aliyense timadziwa kuti ali ndi ufulu* and *munthu amene wabwera kunoko ndi patient ndi iyeyo. Chiganizo chinachilichonse chinakhala, zomwe ife tingapange zimakhala kuti tamuwuza iyeyo apange chiganizo, tipemphe chilorezo kwa* patient *nde timapezeka kuti mwina pali, pakufunikira* operation *ya* emergency*. Nde* patient *akutino, ok, komano tisanapange operationyi, ndiyimbire kaye agogo anga. Kapena ndifuna ankolo anga amvenso za nkhaniyi. Pamenepo ndipamene ndimawona ngati chikhalidwe chimalowerera. Ok. Nkhani yachiwiri imakhala imeneyo ndiyovutirapo, ndimamvetsetsa kuti* it's not *nkhani yopepusa, komano ifenso timakhala kuti tili ndi munthu amene wadwalika kuti chiganizo chikhale cha changu kuti mwina pasakhale ma* complication*, kapena zinthu zisafike poti zayipiratu kuti sitingathe kupanga kena kalikonse. Ok pamakhala nthawi zina matenda akavuta kwambiri pamayenera kuti munthuyo ngati anali oyembekezera, mimbayo ichotsedwe. Chifukwa choti mimbayo ikuwopseza moyowake. Tiyerekeze kuti munthu woti banja lake ndilanyuwani, mimba yoyamba, anali ndi chiyembekezo chachikulu kuti aah mwana, mimba ikhala bwinobwino, mwana ndidzakhala naye chanichani. Nde tikumuwuza kuti mmene zililimu sitingapitirize. Yah, ndekuti pamayenera kuti anthu ambiri akhale involved. Amuna awo, makolo nthawi zina ambiri zonse, ankhoswe, pamakhala zinthu zambiri.* So in terms of*, kuti* even *ifeyo kumvetsetsa, ndizomvetsetsekadi kuti zikuyenera kutero, sikuti ndichitnhu chokuti cholemera chosafunika munthu mmodzi. Koma pakakhala anthu ambiri pamakhalano kuti iye ujanso akawafotokozera anthu ena chimakhala kuti chisoni, chani zimakhala zikumuchokera. Komano nthenda ija sitimakhala kuti tayiyimitsa ayi imakhala ikutani, ikupitirira. Zinthu ngati zimenezozo, nzomwe zimakhala ngati kuti zikutani, zovutirapo. Komano, sikuti ndi vuto la* patient *kapena vuto la chani chani ayi ndinkhani zovuta ndithu ndipo timamvetsetsa.*

The challenge that I often meet is with two different types of patients. The first is that of expectant mothers. Let's say that everyone has freedom and the person who comes here is the one who is the patient. Every decision is, or the things we can do are those that we have told them to decide, we ask for permission from the patient. So we find that maybe there is a need to carry out an emergency operation. Then the patient says, "Okay, before we do the operation, I should call my grandparent". Or, "I want my uncle to hear this as well". This is where I see culture interfering. Okay. The second instance is more difficult and I understand that it is not an issue to be taken lightly, but we also are having (=have here) a person who is very ill and requires prompt decision-making, so that there are no complications, or it shouldn't get so bad that we can't do anything. Okay, there are some instances in which the illness reaches a point when someone who is pregnant has to have the pregnancy terminated, because the pregnancy

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> is threatening her life. Suppose the lady is newly married; this is her first pregnancy. She had expectations that the baby, the pregnancy will be okay, "I will have a baby" and so on. And then you tell her that the way things are, we can't carry on with this. Alright. It requires the involvement of several people. The husband, the parents, sometimes from both sides, the marriage advisors; there are a lot of things. So in terms of, for us to understand, we just have to understand that she is required to consult other people, we understand, and it is understandable that it should be like that because it is a hard thing that requires more than one person. But when several people are involved, it reduces any sadness in the process. But all the while, it is not like the illness has been stopped from progressing – no, it is still progressing. So things, as things are things are somehow challenging. But it is not like it is the patient's problem (=fault) or anything like that – no, these are difficult issues and we understand.

In the extract above, Dr DW explains that it would be taboo for a woman to agree to the termination of her pregnancy or another emergency procedure (such as the removal of her uterus) without consent from relatives, as such procedures would have further cultural implications. This need to consult family even when the medical matter is understood to be urgent disrupts the provision of timeous medical care, which might directly affect the wellbeing of the patient. This can be the result of the patient's lack of understanding the urgency of the required medical care. Alternatively, it could also be that patients adhere to cultural belief systems (even though it will delay treatment) despite understanding the gravity of their condition. In such instances, the doctor in effect has more than just the patient consulting him, and cultural belief systems overtake biomedicine as the most important source of knowledge in the consultation. It can be argued that by accommodating the patient's culture, the gynaecologist establishes a good relationship with her.

### 8.4.5. The fulfillment of levels of respect towards the patient is subjective

In the patients' interviews, there were conflicting views of the level of respect with which the gynaecologist in one and the same recorded consultation communicated with the patient. Some were of the opinion that the Malawian gynaecologist in the recordings violated the dignity of their patients through their choice of words and did not attempt to mitigate the impending loss of face when the patient had to undress to undergo a physical examination. Consider in this regard Patient 12, for instance, who compares the manner in which Malawian-based and United Kingdom-based gynaecologists make face-threatening requests:

Extract 8Q:

P12: *Madokotala ambiri akamalankhula ku Malawi kunoko ndi choncho. Koma malo ngati ku, mmene nnapita ku school-mu, ayi ndithu nnawona kuti ndikosiyana. Amalankhula mosiyana ndi mmene amalankhulira ma dokotala aku Malawi kuno. Chifukwa ngati mmene amawawuza kuti "vulani zovala", kungowawuza upfront kuti vulani zovala, kunja ameyenera kukufunsa*

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> *kuti "is it ok kuti munthu wina alowe nanu tipange nanu chakutichakuti" osati kungowawuza kuti vulani zovala ndikuwoneni.*
> Most doctors when they speak in Malawi, they speak like that. But in other places, like the time I went to school (=university) [in the United Kingdom], I really noticed that they speak differently from the way they do here in Malawi. For instance, when he was telling her, "Remove your clothes", just telling her upfront to remove her clothes. Abroad they are expected to ask that "Is it okay for someone to go in with you so that we can do this and that", not just saying, "Take off your clothes so I can examine you."

Patient 12 in 8Q interprets *mukachotse zovala* 'remove your clothes' in the audio-recording as a disrespectful command instead of as a polite request and argues that the gynaecologist should ask for permission like gynaecologists in the United Kingdom do. Another participant, Patient 2, had a contrasting opinion on how the gynaecologist speaks to the patient in the same recording, as she said that she would be glad (*kwambiri* 'very much so') to consult this gynaecologist, "because he speaks in a way that is respectful to the patient" (original in Chichewa). These differences in patient views may be due to different levels of proficiency in Chichewa (even amongst Malawians) due to differences in linguistic background (see section 1.6.1) since the nuances of implicature require linguistic and cultural experiences, which not all participants might have had a sufficient amount of. In addition, personal preferences may be another reason. This indicated that even where both interlocutors are Malawian and the gynaecologist is attempting to reduce the face threat, not all patients will consider his attempts at doing so equally.

## 8.5. Chapter summary

The discussion in this chapter shows that the

evaluation of the gynaecological consultation in Malawi as a practice in general is that it is a challenge that is manageable. This has been exemplified in discussions relating to the themes of gender, language use and sociocultural dynamics. The first challenge discussed in this chapter emanates from previous negative attributes assigned to gynaecologists of either gender; a second challenge was the fact that interlocutors find medical terminology either inappropriate or inadequate; and the final challenge pertained to conflicts arising from requirements of two opposing knowledge sources, namely Western biomedicine and Malawian culture.

The discussions in this chapter (i) illustrate the myriads of issues that gynaecologists need to be aware of, and (ii) show that they need to develop a range of skills in order to achieve the direct and indirect goals of gynaecological consultations in which taboo topics are discussed. The fact that the skills that are needed to discuss taboo topics in gynaecological consultations are generally acquired as a result of knowledge gained through experience is one of the themes

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that are carried on as I draw conclusions in the next chapter on the issues discussed in this dissertation.

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# Chapter 9 : Summary and conclusions

## 9.1. Introduction

This chapter concludes the study on communicating about taboo topics in Malawian gynaecological consultations in a hospital in which predominantly Chichewa was used. It begins with a summary of the findings and insights drawn from participants' reported experiences and the simulated consultations regarding the terminology and discourse strategies used (9.2) in an attempt to answer the overarching research question, which was:

*What are the sociolinguistic strategies used in interactions between male gynaecologists and their female patients in a medical consultation in Malawi when the topics of discussion are taboo in cross-gender interactions?*

Section 9.2 is followed by practice recommendations that are based on the study's findings (9.3). Thereafter, areas for further research are highlighted (9.4) and the strengths and weaknesses of the study are discussed (9.5). Finally, a reflection on the social practice portrayed in this study closes the chapter (9.6).

## 9.2. Communicating about taboo topics

This section explains the sociolinguistic aspects of discussing taboo topics in Chichewa-dominant gynaecological consultations in culturally conservative Malawi. Firstly, it discusses findings related to the reasons for communicating about taboo topics in gynaecological consultation being a challenge for both gynaecologists and patients (9.2.1). Next, it provides a brief overview of findings related to the way taboo topics are communicated in the gynaecological consultation. Finally, it summarises findings related to participants' evaluation of the practice (9.2.3).

### 9.2.1. The challenge involved in communicating linguistic taboo

In answer to the first subquestion (*How do Malawian gynaecologists and their patients articulate their communication experiences in gynaecological consultations?*): The findings of this study show that both gynaecologists and patients are of the opinion that communication in gynaecological consultations is challenging as it evokes feelings of discomfort, shame, and embarrassment. This is especially the case for patients when a male gynaecologist is involved. The study shows that these feelings were attributed to (i) the sociocultural association of promiscuity with the person talking about sex and reproduction, especially if the conversation takes place across genders and/or between people who are not in an intimate relationship and

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(ii) the sociocultural unacceptability of exposed female bodies. Thus, when gynaecologists and patients discuss taboo topics, they undertake (FTAs to fulfil the direct goals of consultations, namely accurate diagnosis, determining the prognosis and setting up the best possible treatment plan. In order to adhere to cultural norms so as to obtain the indirect goals of the consultation, namely facilitating patient disclosure, participants in such discussions typically use a range of linguistic strategies that aim at mitigating face loss emanating from discussing taboo topics. These important but opposing tasks, namely discussing taboo topics while saving face, have to be done simultaneously, which makes communication in gynaecological consultations challenging in a conservative society like that of Malawi.

In order to effectively communicate about embarrassing topics, deliberate efforts are made by gynaecologists to build a safe environment in which taboo topics can be discussed. These efforts typically entail using discourse strategies that establish professionalism and allows for discussion of taboo topics with minimised levels of discomfort, shame, and embarrassment. Below negative politeness strategies are discussed as the main discourse strategies used when discussing taboo topics in predominantly Chichewa gynaecological consultations.

### 9.2.2. Politeness strategies used

The aim of this section is to discuss the negative politeness strategies that are used to communicate about taboo topics in gynaecological consultations, with a focus on one result of using these strategies, namely achieving distance between interlocutors. This is done in an attempt to answer the second and third subquestions, *Which linguistic strategies are used by male gynaecologists and their patients to navigate taboo topics during consultation?* and *How do male gynaecologists and patients account for their choice of sociolinguistic strategies?* Negative politeness not only allows for the discussion of topics as per biomedical requirements, but also fulfils the cultural requirement of appropriateness. A gynaecological consultation can thus be considered successful when the biomedical requirements are achieved through participants discussing the necessary topics and when the cultural requirements are achieved through the mitigation of FTAs.

#### 9.2.2.1.Negative politeness

Brown and Levinson (1987:129–211) describe negative politeness as discursive strategies that aim to mitigate FTAs through formality and indirectness.

that is performed through the use of conventionalised indirect expressions and hedging, among other strategies. They argue that negative politeness is a way of showing respect despite causing

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a FTA, especially in cases where FTAs are incidental, as was the case in the gynaecological consultations under study here. This type of politeness entails the use of conventional indirectness (like *Tikuwopeni*, 'Should we be afraid of you?' (=Why are you here?) and hedging (as in the way names are asked: *Paja dzina lija ndi nda?* 'What is that name again?') (see 8.2.2).

In this study, acceptable relationships between gynaecologists and patients were formed using negative politeness strategies[55] to create distancing (discussed below). Negative politeness strategies included circumlocution and circumvention, referred to in the data as *kuyankhula mozungulira* 'talking in circles' (see 5.2.2 and 6.5.1). Circumlocution and circumvention also entail the use of indirect expressions (discussed below) that aim to minimise the face-threatening nature of taboo expressions.

In Allan and Burridge's (2006) X-phemism Theory, orthophemisms (more formal, more direct expressions) and euphemisms (more colloquial, less direct expressions) are the preferred expressions, whereas dysphemisms are dispreferred. However, the Chichewa data from this study indicated that interlocutors judged expressions as preferred, dispreferred or forbidden (and not only as either preferred or dispreferred). Forbidden expression were explicit ones, while both the preferred and dispreferred were indirect expressions. Figure 9.1 below uses the terms for menstruation to illustrate the general judgements guiding the use of taboo words and phrases based on the findings of this study, indicating the reasoning behind the classifications.

[55] However, not all instances of negative politeness in this study conformed to those described by Brown and Levinson (1987): According to Brown and Levinson (1987:211ff) use of indirect expressions, such as metaphors and vague expressions, would classify as doing a FTA off the record. However, in the Chichewa context, when communicating about taboo topics, connotations like *mimba* 'stomach' (=pregnancy) and vague expressions like the generalised *ziwalo* 'body organs' (=sexual organs), may be classified as negative politeness, for the following reason: The absence of dysphemistic expressions in Chichewa (see below) causes connotations and vague expressions to be classified as conventionally indirect expressions, and being conventionally indirect is a negative politeness strategy and not a FTA performed off the record (Brown & Levinson 1987).

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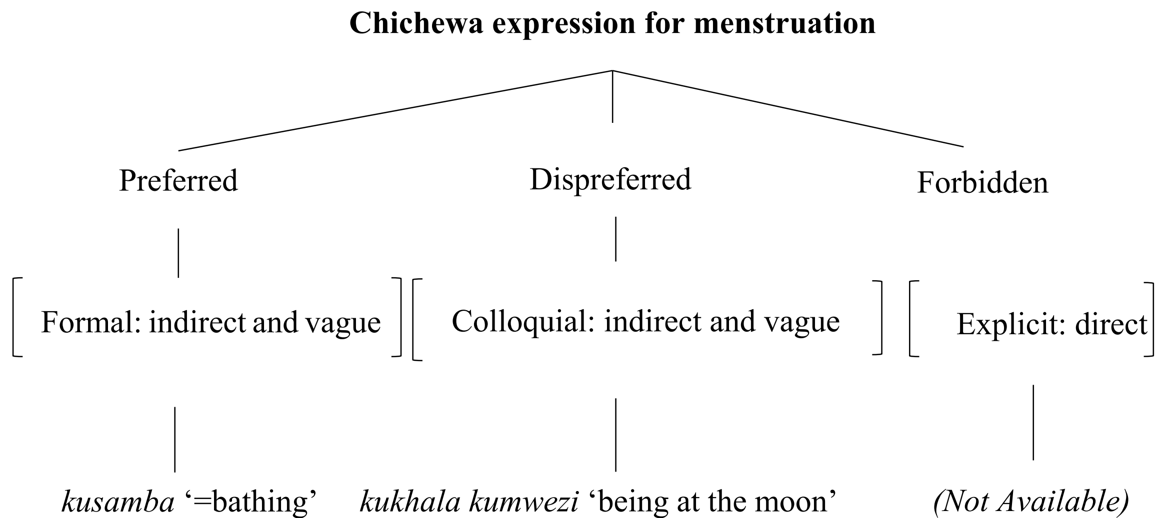


Figure 9:1 The sociocultural classification of Chichewa taboo expressions

As illustrated in Figure 9.1, when referring to menstruation in gynaecological consultations, direct expressions are considered taboo, while only some indirect ones are deemed acceptable, specifically those that are formal and vague in addition to being indirect. Colloquial expressions were deemed acceptable by only some of the participants, which is why the former group is called preferred while the latter is the dispreferred. The formal expression for menstruation in Figure 9.1 has a connotative meaning (as does the dispreferred expression), while an explicit expression for menstruation does not exist in Chichewa. Strategies like use of connotation mitigate the FTA but note that it is culture determines which indirect expressions with connotative meanings are deemed formal (and thus acceptable) or colloquial (making them unacceptable for use during gynaecological consultations). In gynaecological settings, where taboo topics cannot be avoided, the definition of linguistic taboo becomes "lexical items that explicitly refer to a taboo topic such as sex, sexual organs, pregnancy, or infertility".

The extent to which a given expression remains acceptable over time depends on its nature. An example of this is the word *kugonana* 'to (willingly) sleep with each other' (=have (consensual) sex), which was seen as a taboo expression by some participants while others deemed it appropriate. It can be argued that such indirect expressions that are currently regarded as euphemistic may eventually be seen as taboo expressions since they may end up being the sole expression with which to refer to a taboo item, should the forbidden expression no longer be acquired by speakers of Chichewa.

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#### 9.2.2.2.Distancing as a result of using negative politeness strategies

The significance of culture in the communication processes that take place during gynaecological consultations is seen in the way interlocutors achieve distancing as a result of using negative politeness strategies. Distancing strategies are an important part of face work in such consultations, because the perceived social distance between two interlocuters is one of the factors that determine the weightiness of a given FTA, and thus the level of politeness required in the interaction (Brown & Levinson 1987:15-7). In this study, it was found that gynaecologists and patients used linguistic strategies that established distance between them in order to build appropriate relationships with each other and to create acceptable identities for them as a way of establishing a safe environment for taboo talk to take place.

For instance, precautionary face-work strategies were used before discussing taboo topics even started. These included the use of respectful forms of address (like *mayi* ‘mom/mamdam/lady’) as part of the welcoming remarks. Gynaecologists also acknowledged the social distance between themselves and their patients through the use of honorifics that show respect towards the patient, and those that assert the authority of the gynaecologist. Furthermore, bilingual speakers of English and Chichewa reported using (some) English in the Chichewa consultations to distance taboo topics from the conservative sociocultural associations. This distance unburdened speakers from taboo associations, hence the expression that culturally taboo matters *chimapepukira* ‘become lighter’ (=less taboo) when they are referred to in English.

Apart from creating social distance, temporal distance was also created in this study (7.3.2.2 when discussing the number of times the patient has sex per week and 7.4.1.2 erratic periods to establish possible infertility issues). In both cases distancing was achieved by asking about the past to obtain information about the presence (e.g., asking about the frequency with which a patient had sex with her husband in the past in order to gauge whether current the frequency would be sufficient to allow for easy conception). distancing was not only done to separate the gynaecologist from the patient, but also to separate either the gynaecologist or the patient from an intrusive ailment or procedure. For instance, the use of Null NPs allowed gynaecologists to talk about, amongst others, intrusive procedures (like a Pap smear) without indicating one of more of the following: the agent, patient, or instrument, as in *We insert the speculum* instead of *I will insert this instrument into your vagina*.

The avoidance of the discussion of taboo topics until such a time that the interlocutors were certain that clear boundaries have been established and accepted signifies the importance of

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defining relationships and identities when discussing taboo topics. In the consultations, participants used avoidance as a strategy in two ways: They either changed the topic to avoid sensitive topics, or they postponed the discussion (as in the Weijts, Houtkoop *et al.* (1993) study) when an interlocutor, especially the gynaecologist, believed that it was going to evoke embarrassment since a safe environment had not yet been established.

Distancing was done either to define patient-gynaecologist relationship, or to mitigate FTAs suggested by invasive procedures. This resulted in the formation of non-intimate relationships and professionalism which in turn established a safe environment for the discussion of taboo topics, where intimate talk can be interpreted in a non-intimate way. This is in line with Gee's (2014:125) claim that any familiarity in a situation where distance is expected redefines relationship boundaries and resultantly cause discomfort, as argued in 5.2.1. Once a safe enough environment was established and accepted, linguistic taboo was discussed using negative politeness as discussed above. This section argued that respectful relationships are established between gynaecologists and their patients through negative politeness strategies in order to establish an enabling environment that sustains the discussion of taboo topics.

**9.2.2.3.Participants' Evaluation**

Turning to the fourth subquestion: *According to gynaecologists and patients, to which extent do the current social practice meets their communicative needs during consultation?*: As mentioned above, this study found that there was a general consensus that discussing taboo topics in Malawian gynaecological consultations conducted in Chichewa is challenging. In part, this can be attributed to the fact that most gynaecologists in Malawi are men, and concerns about the intentions of the gynaecologist seem to affect the communication that takes place in gynaecological consultations negatively. Further, the study showed that male gynaecologists are aware of such concerns and understand the role they need to play in ensuring that consultation goals are reached. However, not all patient participants had reservations about male gynaecologists, and some rated the performance of male gynaecologists positively, indicating that the current practice is sufficient to make patients feel respected while simultaneously feeling vulnerable and exposed.

Having discussed the strategies used and how they were evaluated by the research participants, the next section presents recommendations emanating from the study.

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### 9.3. Recommendations for practice

From the findings presented in 9.2, a number of recommendations can be made to practicing gynaecologists, patients, and training institutions as a way of advancing women's health services. Firstly, when discussing taboo topics, practicing gynaecologists need to understand that effective relationship building is a requirement for meeting the medical requirements of the consultation. Furthermore, there is need to be respectful by being indirect and avoiding familiar undertones during consultations where taboo topics are discussed. Practicing gynaecologists should be encouraged to involve the patient in making decisions on, for example, which language to use during the consultation and if they would prefer the presence of a third party. Further, the gynaecologist needs to be flexible and adjust their communication strategies to suit the characteristics of the patient in order to successfully meet consultation goals.

Patients, who play an equally important role in gynaecological consultations, also need to take an active role by ensuring that they provide information that is requested or which they deem important. Furthermore, patients that do not feel comfortable should make requests that will help them to be comfortable (such as asking for the reason for a particular medical procedure being performed or a particular intervention, for example, an operation, not being provided or even asking for the presence of a female nurse or guardian). This would be better than the current practice reported by some of the patient participants: Where a patient is not comfortable, she may pretend that the medical matter has been solved, only to move on to another practitioner for assistance.

Further, since this study shows that the importance of teaching the communication skills needed in gynaecological consultations must not be underestimated, the current practice where interns are trained based on personal convictions and experiences of their mentors needs to be replaced by formally structured training sessions. Such training could involve the use of trained patients from whom real-time feedback could obtained, which could mimic the natural acquisition of interactional competency recommended by Gumperz (1982 209). Such training should aim at developing the following interactional strategies: building acceptable relationship and identities from the beginning of the consultation; using linguistic means (grammar and vocabulary) by which gynaecologists distance themselves from their patients, including honorifics, indirectness, connotations and codeswitching to English, when applicable; understanding non-verbal indications of discomfort, like laughter; and recognising the levels of sensitivity related to taboo topics like sex and infertility in a given culture. Such

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training would be useful for Malawian and non-Malawian interns as well as for those gynaecologists who are already practicing.

## 9.4. Directions for further research

Other areas of research that would be equally important in the field of medical humanities (specifically communication and health studies) include gender discordant communication between male patients and female medical practitioners in various medical fields (such as oncology and family practice, fields which have been shown to attract a lot of female doctors); exploring in more detail the effect of culture on the communication between younger patients and gynaecologists of all ages; and investigating gaps in the on-the-job training of different medical practitioner in terms of communication skills.

## 9.5. Strengths and limitations

This study was limited by the inability to record real qynaecological consultations because of ethical reasons. Furthermore, the confinement to an urban setting (due to the unavailability of gynaecologists in rural areas of Malawi) did not allow for access to uncompromised cultural practices that could affect communication, which could or could not have affected the results of this study. It would have also been interesting to involve female gynaecologist for their own perspectives on communicating taboo in similar settings within Malawi.

Despite these limitations, the study contributes to the body of knowledge on an understudied phenomenon in Sociolinguistics and medical humanities. Its findings are authentic as they are based on dependable data collected by means of simulated consultations and individual interviews, which provided data in a restricted situation. In addition, my own experiences and cultural insights as a Malawian helped to unveil connections and explanations that would have been hidden to an outsider. So far a chapter in a book on health communication in Africa and a conference paper at a medical humanities conference have been produced from this study, thereby making a contribution to our knowledge of communicating about cultural taboos.

## 9.6. Closing

This study investigated the strategies used to engage in unavoidable communication about taboo topics by studying how Malawian gynaecologists and their patients navigate them.

This study has shown that the intimate nature of the topics discussed in gynaecological consultations trigger shame, discomfort, and anxiety (mostly for the patients, but there were instances in which gynaecologists showed signs of discomfort). Given the taboo nature of such unavoidable discussions, the gynaecologist and patient attempt to mitigate FTAs through

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various linguistic and sociolinguistic strategies, thereby sustaining the talk. Data indicate that negative politeness strategies were often used, some resulting in distancing in the sense that gynaecologists distanced themselves from the patients and distanced the patients from the medical procedures. Further, in terms of sources of knowledge, the participants of this study reported that gynaecologists need to (i) acknowledge the belief system of the patients (i.e., sociocultural knowledge) and (ii) present the medical information in a respectful manner so as to allows patients to disconnect medical conditions from culture; this will allow biomedical and scientific knowledge to exist alongside cultural knowledge, ensuring that cultural interpretations were not dominant in gynaecological consultations.It can be argued that the mere act of visiting a medical facility is an indication that patients are willing to violate cultural norms and forgo the comfort that stems from the cultural silence associated with taboo topics.

Given that the gynaecologist is typically the interlocuter that is knowledgeable of the conflicting needs of adhering to cultural norms and achieving mutual understanding in a medical consultation, they tend to be the ones that are considered responsible for finding an acceptable middle ground and making sure that the required information is obtained. The task of ensuring that conservative patients open up not only requires skills like probing or explaining why particular information was required, but also requires that the gynaecologist appears comfortable when discussing taboo topics. These skills that enable the gynaecologist to fulfil both cultural and medical requirements when communicating in gynaecological consultations take time and experience to develop, and direct training thereof may be indicated.

Although the current practice allows for the achievement of the goals of gynaecological consultation, the use of alternative referring expressions and discourse strategies may work against the intentions of the participants in more than one way. Firstly, the differences in acceptability judgements by patients makes it difficult to become prescriptive about what the best referring expressions and discourse strategies would be. Further, in some cases, interlocutors may use novel preferred expressions, which may result in miscommunication, in an attempt to avoid expressions of which they doubt the acceptability.

In conclusion, this study has shown that successful communication between male gynaecologists and female patients in Chichewa-dominant gynaecological consultations in Malawi is possible due to various sociolinguistic strategies used by both parties when discussing taboo topics. This study was the first of its kind, using interviews and simulated consultation data, to study communication about gynaecological matters in culturally conservative Malawi. Despite its somewhat narrow scope, it provided insight into doctor-

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patient communication about taboo topics and provided implications for practice that could improve the healthcare provided to women in Malawi.

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# Appendices

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## Appendix A: Semi-structured interview questions for patients

### Preliminary Information

Home

District:……………………………………………………………………………………

Age Group: 18-29 ☐ 30-29 ☐ 40 & above ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Widow ☐

Highest Education Level: None ☐ Primary ☐ O'Level. ☐ Grad. ☐ Postgrad ☐

Occupation: ………………………………………………………………………………

Household composition: Alone ☐ Couple ☐ Extend Family ☐

Single with kids ☐ Nuclear Fam. ☐ Family + Extended ☐

Other ☐ Specify……………………………………………

Languages: Chichewa ☐ English ☐ Other ☐ Specify: ……………………..

1. Can you tell me how long you have lived in this area of Blantyre?
2. Where did you live before?
3. Which hospitals can one go to when they fall sick?
4. Which hospitals do you go to and why?
5. Can you tell me about your last visit to the hospital stated above. How were you assisted?
6. Can you tell me about your experiences at the hospital when you visit a gynaecologist.

*introduce the audio, explain what the participant should listen to in order to answer questions later*

General expectations on language use

7. What does the doctor think the patient is suffering from? Why do you think so?
8. Why is the doctor using the following terms?
    a. Bath
    b. Sleep with a man

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9. What would the patient feel if the doctor did not use euphemism?
10. If you were this patient, would you be comfortable to communicate your issue with the doctor? Why?
11. What other euphemistic expressions are used in consulting the doctor on the same subject matter?
12. Apart from their use of Chichewa, what do you think makes the doctor and the patient Malawians?

**Personal Experiences**

13. How similar/different was the recording from what normally happens when you visit a gynaecologist?
14. Which languages are used in consultation, who decides that and how decision on language made?
15. Describe how an ideal woman talks about women's health issues
16. Describe how does your gynaecologist talk about women's health issues.
17. If you have ever been initiated or counselled regarding feminine health issues, explain how they said a real woman must talk about them. Do you follow them? And why? Do you advise your own children the way you were advised? Why? How do you feel about what you are doing?
18. How do you feel about the language choices you or your gynaecologist makes?
19. Do you remember the first time you visited the gynaecologist? What were your expectations and reservations?
20. For monolingual respondents: Are you comfortable mentioning taboo words in a gynaecological consultation? Please explain.
21. For multilingual respondents: Which language(s) do you use in the consultation? And Why?
22. If you had a choice to choose male or female gynaecologist, which one would you chose and why?
23. Can you tell me about the proceedings of any gynaecological consultation you remember? How were taboo topics discussed? Why did you communicate that way? Find out if they have ever been in a situation where, because of culture, it was hard to communicate their ailment to a gynaecologist. Did they overcome it or not? What did they do to overcome it or if they didn't overcome it, what

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would they do next time to overcome it? (*If they have never been, ask them to imagine such a situation and what situation would it be*?)

**NB:** If the patient is being interviewed after a consultation, ask them issues picked out from the interviews concerning interactional strategies and positioning.

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## Appendix B: Semi-structured interview questions for Gynaecologists/Obstetricians

1. What women health issues are brought to your office?
2. What is the process for one to see a gynaecologist at this hospital?
3. How long are the normal consultation sessions?
4. On average, how many patients do you see in a week for consultations?
5. What were the initial reactions from your family when they first learnt you were going to be or that you are a gynaecologist?
6. What topics are sensitive to talk to Malawian patients?
7. How do you discuss what you perceive to be sensitive issues with your patients? (probe how body parts are named)
8. Why do you discuss those issues in that way?
9. What effect do you think your way of talking about these issues has on your patients?
10. If I was your patient, how would you explain to me the following in Chichewa:

    a) Pap smear procedures?
    b) Infertility?
    c) STI?

11. How do you think culture affects the way you and your patients communicate with other?

    **NB:** If the gynae is being interviewed after a consultation, ask them issues picked out from the interviews concerning interactional strategies and positioning.

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## Appendix C: Transcript for the audio-recording

***Possible Antenatal Case***

Doctor: Come in, have a seat.

Patient: Thank you.

Doctor: Name please.

Patient: Mercy Bokosi

Doctor: How are you today?

Patient: I am not very well.

Doctor: What is the problem?

Patient: I have stomach pain, nausea and general body pains.

Doctor: When was you last menses

Patient: 5 weeks ago

Doctor: Are you just nauseas, or you are also vomiting?

Patient: Just nauseas, I can’t stand the smell of onions.

Doctor: Have you been sexually active in recent weeks?

Patient: Yes

Doctor: I would like to examine your tummy, where you are feeling the pain you are feeling, please go behind the curtain and put this gown on. When done let me know.

Patient: Alright.

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# Appendix D: Consent Form

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**CONSENT TO PARTICIPATE IN RESEARCH**

You are invited to take part in a study conducted by Marion Chirwa Kajombo, from the General Linguistics Department at Stellenbosch University. You were approached as a possible participant because:

(tick appropriate)

☐ you are a practicing gynaecologist and/or obstetrician based in Blantyre.

☐ you are a Malawian woman above 18 years who has consulted a gynaecologist and/or an obstetrician within the past 6 months.

## 1. PURPOSE OF THE STUDY

The aim of this study is to analyse the communication patterns and language used in gynaecological consultations within the Malawian context, in order to gain insights that can be used to train medical practitioners in future.

## 2. WHAT WILL BE ASKED OF YOU?

If you agree to take part in this study, you will be asked to participate in an interview where you will give an account of your communication experiences during gynaecological consultation, as well as in a mock consultation pretending to discuss various hypothetical gynaecological concerns.

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### 3. POSSIBLE RISKS AND DISCOMFORTS

The interview and mock consultation will be recorded. However, any report or publication will anonymise your identity. This means that neither your name not your surname will be provided in the report or publication, and you will be described in such a manner that you will not be identifiable based on the description. The mock consultations will take place within the hospital setting. For interviews, you are at liberty to choose the hospital venue, your home or any private and safe place. However, if there are any problems, inconveniencies, or discomforts, you may contact Ms M. Kajombo (+265 881 770 106 or 22454144@sun.ac.za), Dr L.D. Mongie (laurenm@sun.ac.za) or Dr F. Southwood (fs@sun.ac.za). You can also utilise the Queen Elizabeth Central Hospital's counselling services.

### 4. POSSIBLE BENEFITS TO PARTICIPANTS AND/OR TO THE SOCIETY

The study provides an opportunity for you to reflect on how you communicate during consultation in order to highlight best practices and improve on areas that are overlooked. Findings of this study can inform the training of novice medical personnel and foreign gynaecology experts who practice in Malawian hospitals. The overall goal is to build confidence in patients and to equip medical personnel with communication skills that are useful within the Malawian cultural settings.

### 5. PAYMENT FOR PARTICIPATION

Transport to and from the hospital will be reimbursed for the interview day as well as the day on which you will participant in the pretend consultations. If you are engaged the whole day, you will be given a lunch allowance of K1, 500. Transport and lunch allowances will be given at the end of the interview and/or consultation.

### 6. PROTECTION OF YOUR INFORMATION, CONFIDENTIALITY AND IDENTITY

Any information you share that could possibly lead to your identification will be protected. This will be done by using a pseudonym instead of a name when referring to you in the study, and not mentioning the Facebook Group name (where applicable) from which you were recruited, nor the district and hospital names where this study is taking place. All raw data will be stored in a password protected personal computer drive and backed up in password protected flash drive and password protected personal email account. These will only be accessible to the researcher, Ms. Marion Chirwa Kajombo.

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Transcribers, who are all women above the age of 18 years, will be trained on research ethics and will sign a confidentiality agreement. They will only have access to already anonymised data. If you would rather have the researcher transcribe your recordings than any other persons, tick in this box: ☐

Once the data is transcribed and interpreted, you will be allowed to review and present your own perspectives.

*The final report and publications of the data will never identify you as a participant.*

## 7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you agree to take part in this study, you may withdraw at any time without any consequence. You may also pass answering any questions you are not comfortable to respond to and still remain in the study. The researcher may withdraw you from this study, also with no consequence to you, if you do not provide any information as required in the interview or consultation

## 8. RESEARCHERS' CONTACT INFORMATION

If you have any questions or concerns about this study, please feel free to contact Ms. Marion Chirwa Kajombo at Malawi University of Science and Technology, P.O. Box 5196, Limbe, Malawi and/or the supervisor Dr L.D. Mongie at laurenm@sun.ac.za, and/or Dr F. Southwood at fs@sun.ac.za

## 9. RIGHTS OF RESEARCH PARTICIPANTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research participant, contact Ms Maléne Fouché [mfouche@sun.ac.za; +27 21 808 4622] at the Division for Research Development.

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## DECLARATION OF CONSENT BY THE PARTICIPANT

As the participant I confirm that:

- I have read the above information and it is written in a language that I am comfortable with.
- I have had a chance to ask questions and all my questions have been answered.
- All issues related to privacy, and the confidentiality and use of the information I provide, have been explained.

By signing below, I ______________________________ *(name of participant)* agree to take part in this research study, as conducted by Marion Chirwa Kajombo

_______________________________________ ______________________

**Signature of Participant** **Date**

## DECLARATION BY THE PRINCIPAL INVESTIGATOR

As the **principal investigator,** I hereby declare that the information contained in this document has been thoroughly explained to the participant. I also declare that the participant has been encouraged (and has been given ample time) to ask any questions. In addition I would like to select the following option:

| | |
|---|---|
| | The conversation with the participant was conducted in a language in which the participant is fluent. |
| | The conversation with the participant was conducted with the assistance of a translator (who has signed a non-disclosure agreement), and this "Consent Form" is available to the participant in a language in which the participant is fluent. |

________________________________________ ______________________

**Signature of Principal Investigator** **Date**

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## Appendix E: Pre-Qualification Form

Home Area:……………………………………………………………………………….

Age Group: 18-29 ☐ 30-39 ☐ 40 & above ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Hypothetical medical condition(s) you would be willing to have mock consultation on

- Menstruation ☐
- S T I ☐
- Pap Smear ☐
- Pregnancy ☐
- Infertility ☐
- Menopause ☐

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## Appendix F: Non-Disclosure Form

### NON-DISCLOSURE AGREEMENT

As a transcriber, I confirm that:

- I will transcribe all information as accurately as possible, and that I will indicate any uncertainty about the accuracy of my transcriptions
- I will not disclose any information that I am privy to in my role as transcriber, and that
- I will be withdrawn from my role as transcriber if I fail to do the abovementioned.

By signing below, I ________________________________ *(name of transcriber)* agree to adhere to the commitments stated above.

__________________________________________ ______________________

**Signature of Transcriber** **Date**

**DECLARATION BY THE PRINCIPAL INVESTIGATOR**

As the **principal investigator,** I hereby declare that the transcriber has been trained to perform their basic duties, and that information contained in this document has been thoroughly explained to the transcriber. I also declare that the transcriber has been encouraged (and has been given ample time) to ask any questions, and that the conversation with the transcriber was conducted in a language in which the transcriber is fluent.

__________________________________________ ______________________

**Signature of Principal Investigator** **Date**

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