# Communication in selected Eastern Cape Public Healthcare Facilities offering Termination of Pregnancy services: Inter/Intra-cultural Implications

By

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# DECLARATION

I, Snethemba Fikile Mavuso hereby declare that this thesis is my own work. All citations, references and borrowed ideas have been properly acknowledged. This work has not been submitted previously in its entirety, or in any part, at any other higher education institution for degree purposes. It is being submitted for the degree of Master of Arts in the Faculty of Humanities, Rhodes University, South Africa.

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Snethemba Fikile Mavuso Date

# DEDICATION

This thesis is dedicated to my late Uncle Jerryle Dixie 'Mkhandris' Msomi. Thank you for your teachings and unconditional love. You are gone but never forgotten. With love, Di'shemza.

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# ABSTRACT

This study examines pre-termination of pregnancy (PTOP) counselling, focussing on issues of language and access, and sociocultural influences. This research examines linguistic and cultural aspects of communication between healthcare providers and clients in PTOP contexts.

The overarching aim of this research was to identify patterns that indicate miscommunication and to propose ways to bridge any linguistic and cultural gaps. This research examine how social norms related to turn taking guide healthcare providers - clients interaction and how the clients respond to advice offered during the counselling sessions. The study provides an in-depth understanding of linguistic and cultural barriers in public healthcare, and further emphasizes the need for implementation of support systems for cross-cultural and effective patient-centred communication in healthcare.

The findings in this study are thatpresent that miscommunication occurs within intercultural and intra-cultural medical encounters. Excessive use of medical terminology causes communication difficulties. Clients often provide a positive response to indicate that they understand what the healthcare provider is communicating. Clients sometimes respond positively out of politeness. This practice is common in some cultures; it often occurs when the recipient is interacting with a figure of authority or someone of higher positioning. It is found that healthcare provider's value systems sometimes have an impact on their professional conduct, influencing the type of PTOP counselling provided to clients. Sometimes the language and communication barriers have a negative impact on the quality of care/PTOP counselling.

This study argues that healthcare provider's communication styles and value systems influence PTOP counselling. Healthcare providers have the power to control the medical discourse; their turns at talk influence those of clients. The manner in which the nurses and counsellors address the clients elicits a certain response. This study thus suggests that healthcare providers need to improve their communicative skills, be mindful of their position as power holders and adopt a patient-centred approach, which is crucial for clinical and cultural competence.

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# WORD LIST

| | |
|---|---|
| Implanon | Implanon is a birth control implant that is inserted in the arm and lasts up to 3 years. |
| Loop | The Loop is an intrauterine device (IUD). The Loop is small contraceptive device inserted into uterus and lasts up to 10 years. |
| Nur | Nur is short for Nur-Isterate. The Nur-Isterate is a two-month contraceptive injection. |
| Depo | Depo is short for Depo-Provera. Depo-Provera is a three-month contraceptive injection. |
| Neh | "Neh is an interrogative statement meaning isn't that so", (Urban Dictionary) |
| Eh-eh/ Eh | IsiXhosa speakers commonly use eh-eh as an agreement statement, it means yes |
| Mos | Mos is an Afrikaans term that is commonly used by South Africans. Mos means at least, indeed. |
| Ja | Ja is an Afrikaans term; commonly used by South Africans. Ja means yes when translated into English. |
| Sjoe | "Sjoe is a South African an exclamation, expressive of surprise, admiration, exhaustion etc" (Collins English Dictionary). The term originates from the Afrikaans language. |
| Finish and Klaar | Klaar is an Afrikaans term, when translated into English it means clear. Finish and Klaar therefore means Finish and Clear. |
| Yhu | Yhu is an isiXhosa expression, expressing shock, excitement. |
| Qhub | Qhub is a sound made by a blood clot when it lands into water. |

# ACRONYMS

| | |
|---|---|
| CTOP ACT | Choice on Termination of Pregnancy Act (No. 92 of 1996) |
| PTOP Counselling | Pre-termination of Pregnancy Counselling |
| TOP | Termination of Pregnancy |
| PAS | Post-abortion Syndrome |
| CLS | Critical Language Studies |
| CA | Conversational Analysis |
| CDA | Critical Discourse Analysis |

# CHAPTER 1: INTRODUCTION

## 1.1 Introduction

Under the apartheid government, the South Africa's healthcare system was guided by a discriminatory and exclusionary policy. The policies during the apartheid regime were exclusionary in the sense that it was the minority white population that had access to the best healthcare services, and there was disproportionate resource allocation (Coovadia, Jewkes, Barron, & Sanders, 2009). The apartheid government obtained control over population groups that did not belong to the white population group. The rest of population groups were denied access to quality healthcare services based on the colour of their skin. This was clearly a violation of their human right. Apartheid laws were unjust and created great inequalities in the South African health sector, which persist until this day. Due to these unjust laws, the majority of the population was marginalised and this inevitably had a negative impact on their lives especially black South African population (Coovadia, et al., 2009).

Obtained control used oppressive legislative controls to suppress the rights of people of race groups other than white. Legislative controls determined the positions that people of colour could occupy in the economic sector, determining their income, their livelihood and their standards of living. These structural injustices created social inequalities, and there is still a strong correlation between race and socioeconomic status in South Africa (Myburgh, Solanki, Smith, & Lalloo 2005). In South Africa, there is a very high level of income inequality that determines one's health status and profile (Ataguba, Day, McIntyre 2015). The South Africa Overwiew (2016) indictates that South Africa has an "income Gini that ranges between 0.66 to 0.70, the top decile of the population accounts for 58% of the country's income, while the bottom decile accounts for 0.5% and the bottom half less than 8%". A large black population either earns low wages or is unemployed, and hence they cannot afford medical aid schemes. Black people are the population group that mostly relies on public healthcare facilities (Deumert, 2010). The 2007 October Household Survey showed that, "over two-thirds of white South Africans have access to private health care, compared to only 7% of black South Africans, 19% of coloured South Africans, and 31% of Indian South Africans" (Deumert, 2010:53). A large South African population that cannot afford medical aid schemes and they are is reliant on public healthcare (Cummins, 2002). Clients who belong to lower socio-

economic classes, are relatively powerless and they are mostly affected by these inequalities and poor health services (Deumert, 2010). South Africans who have medical aid schemes have better experiences of the medical encounter and most of the time they have positive health outcomes.

There are still great inequalities in health. This study focuses on issues on language and access, as contributing factors to health inequalities. Despite the fact that there are language policies that advocate for multilingualism, the South African healthcare sector is still faced with major communication challenges caused by language barriers, and cultural diversity of healthcare providers and clients. Communication challenges in healthcare have been a barrier to quality care for decades, hence research in health communication can be traced back to 1973 (West & Frankel, 1991). In the TOP context, linguistic and cultural differences of healthcare providers and clients sometimes has a negative impact on quality of service. Language difference causes miscommunication and the healthcare provider's values systems influences their professional conduct.

In this chapter, I introduce the research study and the research goals. This chapter discusses the historical roots of public health in South Africa, provides a contextual background to TOP and an outline of the chapters. The section that follows, presents the research problem and research goals of this study.

## 1.2 Research problem

In TOP, trained professional nurses and midwives perform first trimester abortions in South Africa (Harries, Stinson, & Orner, 2009). When the pregnancy is beyond 12 weeks, a doctor performs the abortion (Harries, et al, 2009). Often the doctors do not share the client's first language. The nurses usually share a common language with the clients. In the Eastern Cape, there are three principle languages these being English, IsiXhosa and Afrikaans. 78.8% of the population has isiXhosa as their first language (Census, 2011). Doctors usually have one of these languages as their mother tongue, and they are sometimes fluent in more than one of these language. There are cases where the doctor is not fluent in any of these languages. The reason being that there is a growing number of foreign doctors working at South African public hospitals, and English is usually their second language and sometimes a third language. It is

therefore common to find doctors who are not linguistically equipped to care for their clients, causing communication difficulty (Crawford, 1999). Communication difficulty is most likely to result in miscommunication and misinterpretation, often leading to misdiagnosis and poor medication adherence. In some cases, miscommunication between healthcare providers and clients, may cause health complications that could lead to serious physical damage or even loss of life. It is therefore concerning that the clients may sometimes not understand what is communicated to them during PTOP counselling. This means that the clients may give consent to a have a TOP procedure performed on them without being fully aware of its implications, such as risks and side effects both physical and psychological, and most importantly what to do during an emergency. Another challenge within TOP is that healthcare provider's culture, their personal values and beliefs sometimes influences their styles of communication and the type of counselling provided. CTOP literature asserts that negative attitudes of the healthcare providers serves as a barrier to women accessing safe abortion (Sigcau, 2009). Healthcare providers sometimes address the clients using a harsh tone and speak negatively about TOP procedure, allowing their personal value systems to negatively influence the counselling. The healthcare provider's value systems determine the type of counselling they provide. It is negative in the sense that it no longer becomes patient-centred and the information provided is not to help the client, but rather to reinforce these value systems and influence the client's decision.

This study addresses the following questions:

- How social norms relate to turn taking, conversation repair, and providing information that guides healthcare providers and patient interaction?
- How patients respond to advice offered during the counselling sessions?
- Are there any patterns that indicate miscommunication?
- Is there an association between certain styles of communication and outcomes such as patient satisfaction?

In summary, this research is focused on intercultural and cross-linguistic communication in the PTOP healthcare context; cultural voids; asynchrony; critical language awareness; and conversation analysis. I analyse the communicative process by examining and exploring

cultural implications and relations of power between healthcare providers and clients. At the same time, I examine how these features influence communication.

### 1.3 Research goal

This research examines linguistic and cultural aspects of communication between healthcare providers and patients in a PTOP context.

In particular, this research examines the following:

- How language and culture influence communication between the healthcare providers and patients in the PTOP context.
- I assess the way in which healthcare providers and patients deal with cultural euphemism, metaphors and cross-cultural communication.
- I establish a corpus of isiXhosa lexical items (related to euphemisms and metaphors) that is used in this context.

### 1.4 Contextual background

In the following sections of this chapter, I discuss the historical roots of public healthcare in South Africa and its transition from a discriminatory apartheid period to the present democratic post-apartheid period. Historical determinants of health are discussed to enhance the understanding of the current challenges faced by the South African health system; and I discuss how health inequalities are a barrier to positive health outcomes. Communication challenges within the health sector are also discussed, and how they negatively affect the quality of service provided. This study seeks to examine linguistic and cultural aspects of PTOP counselling. For this reason, I then provide a contextual background to TOP and TOP law reform.

#### 1.4.1 Transition of the South African health system

Apartheid laws were unjust and policies were reviewed after the election of South Africa's first democratic government. The new government "inherited huge inequalities in health status and healthcare provision across racial, socioeconomic, and urban/rural boundaries" (Myburgh, et al., 2005:474). By the time apartheid was abolished in South Africa, the healthcare system was

facing massive challenges. South Africa has been a democratic country for over two decades and the government is still grappling with massive health inequalities (Coovadia, et al., 2009). The previous health policies of the South African apartheid government have contributed to the state of the current health policy, services and disparities (Myburgh, et al., 2005). The new government developed policies that aimed to address some of the inequalities and improve public health services (Myburgh, et al., 2005:474). The post-apartheid government has implemented and promoted inclusive policies that focus on equity and they seek to redress previous apartheid discriminatory policies (South African Health Review, 2016).

### 1.4.2 Healthcare policy reform

The new health policies are aimed at transforming South Africa's healthcare system structures, to improve healthcare services and to ensure that the population in general has access to quality health services (Myburgh, et al., 2005:). These new health policies placed a strong emphasis on the development of primary health care because it was the only way to transform South Africa's healthcare system and to ensure that everyone had access to healthcare (Myburgh, et al., 2005). Apartheid's unjust laws and policies discriminated against people based on race and gender (Coovadia, et al., 2009). The policies aim to redress these inequalities in health, to improve population health, and ensure that all South Africans have access to quality healthcare services irrespective of race, income, culture or language (Deumert, 2010). The new health policies were revolutionary because of their inclusivity, focus on equity and improving the quality of life for the previously marginalized population (South African Health Review, 2016).

The Patients' Rights Charter (2008) and the National Health Act (2003) advocates for multilingualism and multiculturalism in the South African health system. The National Patients' Rights Charter (2008) also provides that patients have a right to "health information that includes the availability of health services and how best to use such services and such information shall be in the language understood by the patient. The Patients' Rights Charter (2002) and the National Health Act (2003) explicitly state that patients have a right to be assisted in a language they understand, because it is important for patients to be well informed about their health status and treatment options (Deumert, 2010). Patients successfully participate in decision-making concerning their health and treatment options when they are addressed in a language they understand and are proficient in (Deumert, 2010). The current health policies are aligned with the South African constitution, which binds the state to work

towards the progressive realisation of the right to health (Coovadia, et al., 2009). South Africa Section 6 of the South African Constitution (1996) also promotes multilingualism and multiculturalism in all sectors, including health. The health policies show positive initiatives, but the current government has failed to address some of these challenges in the health system due to lack of policy implementation (Coovadia, et al., 2009).

Lack of policy implementation has further slowed the process or attempts to redress these health inequalities in South Africa (Deumert, 2010). Lack of policy implementation is one of the reasons the South African health system has not been successfully transformed, because the new government inherited a very unequal health systems and the government has been faced with the difficulty in addressing these issues (Deumert, 2010). The new government had to deal with disparities in health and across all sectors (Coovadia, et al., 2009). The new government was suddenly responsible for the development of new policies and policy implementation, and inevitably, there were different perspectives on what the greatest priorities were (Harrison, 2009). This has had negative consequences for mostly patients of lower social class and health professionals in the public health sector (South African Health Review, 2016). Reports on the progress in South Africa from the time when apartheid became abolished up to the present has indicated that it is failures in leadership, stewardship, and management that have undermined the good policies and constitution (Coovadia, et al., 2009). Poor decision making by the current government is the reason for inadequate implementation and for the public health system remaining untransformed (Coovadia, et al., 2009). It is also important to highlight that just because some of these challenges still persist it does not mean that there has been no progress (South African Health Review, 2016).

### 1.5 Health inequalities and social determinants of health

The Primary Healthcare sector remains in crisis. I say this because there is lack of resources, there is a shortage of medical staff, some of the health professionals do not undergo necessary training, issues of language barriers persist, and the result is that a large part of the South African population does not have access to quality care (Coovadia, et al., 2009). This is discussed further in chapter 5, the data analysis of this thesis. According to Deumert (2010), during year 2006 the South African private healthcare sector spent six times more than public healthcare, taking in an unequal numbers of doctors and nurses. Patient's health and their health outcomes are affected by the structure and function of the health system or access to health

services (Ataguba, et al., 2015). There are also other determinants that are potential barriers to quality healthcare and these cannot be ignored when trying to address communication challenges in the health sector (Ataguba, et al., 2015). According to Ataguba, et al., (2015:1), these potential barriers result from "multidimensional and complex factors linked to the social determinants of health, which include a range of social, political, economic, environmental, and cultural factors, including human rights and gender equality". This then means that the only way our government can successfully tackle health inequalities is by acknowledging and beginning to understand that social determinants of health influence population health and they need to develop a holistic approach (Ataguba, et al., 2015). To reduce health inequalities South Africa would have to develop and implement policies that seek to address these social determinants in health (Ataguba, et al., 2015). Successful policy implementation would improve the quality of healthcare services and the quality of life for all South Africans (Ataguba, et al., 2015).

In summary, despite the law and policy reform, a large number of the population still does not have access to quality healthcare. Although healthcare has become more accessible to everyone, the levels of access to health services still varies significantly according to population group ('race') and socio-economic status (Deumert, 2010). South Africa's past injustices still have a negative impact on a large population (Deumert, 2010). Patients socio-economic status is a determinant of the kind of health service patients receive (Coovadia, et al., 2009).

### 1.6 Disparities in public and private healthcare system

The apartheid government invested mostly in health facilities in the urban space, creating huge health inequalities (Coovadia, et al., 2009). Healthcare inequalities remain between the public and private health sectors, between rural and urban centres (Coovadia, et al., 2009). There has always been a division between the public health sector and the public and private sectors (Coovadia, et al., 2009:825). There are substantial inequities in healthcare, not just in private and public health but also amongst provinces and within provinces (Coovadia, et al., 2009).

The 2003 National Health Act shifted the responsibilities of both the district health system and primary healthcare from national level to provincial level (Coovadia, et al., 2009). Developing

provincial health policy is now a local government and provincial responsibility, guided by the framework of national policy and public health service delivery (Coovadia, et al., 2009). The act centralised power within the provinces and resulted in some of the local authorities neglecting their responsibilities (Coovadia, et al., 2009). According to Coovadia, et al., (2009), local authorities abandoned some of their preventive health policies and this resulted in further disparities and marginalisation. Health and development studies have revealed that there are great health service delivery disparities amongst the provinces, and the nine provinces do not have the same health infrastructure (Harrison, 2009). The 2003 National Health Act has worsened the situation in some provinces (Harrison, 2009). The new government set about trying to transform the health system, and to provid substantial capital funding to the worst-off provinces in 1995/6 and 1996/7 (Harrison, 2009). This resulted in rapid and significant improvement of the health system but since then the progress has slowed down (Harrison, 2009:16). This is due to the many factors mentioned earlier, primarily due to lack of political will, poor leadership and poor fiscal management (Harrison, 2009).

This study is located in the Eastern Cape and was conducted in three different public hospitals. Data collected was at two sites located in a township and the third one was located in a suburb. To maintain the privacy and anonymity of this study, the names of the townships and the suburb which the sites were located at will not be mentioned. The Eastern Cape health system is in crisis, staff shortages and poor primary healthcare are the two most persistent problems (Health Systems Trust, 2016). The Health Systems Trust (2016) report indicated that there are high levels of patient dissatisfaction in some of the Eastern Cape health facilities; the patients were not satisfied with the public health services being provided to them. One of the patients that was interviewed complained about nursing staff taking long lunch breaks and refusing to assist the patients during a time that was supposedly during their work hour (Health Systems Trust, 2016). The Health Systems Trust (2016) states that "the Eastern Cape spends R91 per capita on primary health, the second lowest in the country after Limpopo and way below the national average of R158". The least resourced provinces are mostly affected, both the health professionals and patients are disgruntled (Health Systems Trust, 2016). The research in this thesis also attests to this.

Healthcare providers across the spectrum are affected by these challenges in the healthcare system (South African Health Review, 2016). Healthcare providers that work in public health

have it worse than healthcare providers do in the private sector (South African Health Review, 2016). Healthcare providers working in the public sector, work under harsher conditions and often they do not get support from management (South African Health Review, 2016). According to the South African Health Review (2016), these challenges make it difficult for these healthcare providers to uphold their professional code of ethics and provide good quality care. The public health sector has a huge staff shortage, as well as drug and equipment shortages and that can have severe consequences (Deumert, 2010). The public health sector provides services to the uninsured majority of South Africans (Deumert, 2010). In some public clinics and hospitals, the health services have a number of set patients they see daily, and once they have reached that number they refuse to assist any more patients (Deumert, 2010). When patients are turned away, they have an option to either return early the following day, pay for a private doctor or seek assistance at a neighboring hospital (Deumert, 2010). Most of the time the patients are desperate to access the services and do not challenge the healthcare providers. The patients are aware that they have no negotiation power and there is little they can do when the healthcare provider denies them service.

In summary, it is the role of the local authorities to improve basic working conditions for health care providers. The South African health system has several challenges of healthcare disparities that still need to be addressed at local and national level. I have taken into account how the social determinants of health and historical past have contributed to the current healthcare crisis.

### 1.7 Language and access in healthcare

In South Africa, there is a large body of knowledge focused on doctor-patient interaction, which addresses language issues in the healthcare sector. Existing research in health communication have mostly focused on general medical consultation between the healthcare provider and client, or have been conducted in HIV or TB clinics. This study examines communication within a TOP context, exploring the linguistic and cultural implications. There is a lack of research that speaks to the communicative challenges within pre-termination of pregnancy (PTOP) contexts. This research will be the first study in South Africa that focuses on communicative process in TOP, as well as linguistic and cultural aspects of communication

between health service providers and patients in a PTOP context. It is the first time that there is actually data that captures what goes on in PTOP counselling.

According to West and Frankel, (1991) back in 1973 interest in healthcare communication was encouraged by the growing realization that communication challenges in health were resulting in poor health outcomes and poor medication adherence. Studies in doctor-patient interaction have also addressed issues of patient's levels of communicative involvement during the medical encounter (Robinson, 2003). These studies have indicated that patients are communicatively passive, and hardly ask for medical information about their health (Robinson, 2003:28). Studies have suggested that patients' lack of involvement in the medical encounter may have negative health outcomes and result in poor adherence (Robinson, 2003). Patient participation is often encouraged because it is associated with patients' satisfaction and positive outcomes (Robinson, 2003). South Africa's health policy also emphasised the importance of patient satisfaction and empowerment: and the Patients' Rights Charter (2002) outlines the rights and responsibilities of patients in public health facilities (Deumert, 2010), further suggesting that patients should be involved in healthcare decision-making and treatment.

Robinson (2003) mentions a few factors that contribute to low levels of patient participation. Robinson (2003) suggests that patients may sometime prefer to taken on a passive patient role, because they are avoiding decision-making responsibility and may avoid asking questions because they do not want to seem like they are questioning the doctor's capabilities. The second explanation Robinson (2003) provides is that patients may choose not to seek information about their health because they fear the outcome or fear that the information may result in more uncertainty about the diagnosis (Robinson, 2003). Patients trust their physicians because they have this impression that they possess all the medical knowledge because of their medical profession (Robinson, 2003). Patients tend to be intimidated by the medical terminology used by healthcare providers and they may sometimes fear that asking questions would make the diagnosis more complex to understand (Robinson, 2003). Most of the time clients will politely nod and not indicate to their physicians that they do not understand what is being communicated to them (Robinson, 2003). Patient participation is associated with positive health outcomes (Robinson, 2003). Research in health communication has indicated that highly educated patients tend to have high levels of participation and tend to ask more questions (Robinson, 2003). The quality of interaction between healthcare provider and patient can

determine how much information the patient chooses to disclose (Drew, Chatwin & Collins, 2011).

When examining doctor-patient communication, it is often found that there is unequal distribution of authority or power in the medical encounter (Robinson, 2003). The healthcare provider controls the medical discourse and discourse types (Robinson, 2003). Unequal encounters often occur when the healthcare provider and patients belong to different linguistic and cultural backgrounds (Robinson, 2003). In this study, I am interested in exploring how healthcare providers and clients are positioned in relation to each other in the conventions of the discourse type, because discourse types and orders of discourse vary across cultures (Fairclough, 1989). When speaking of culture I refer to culture in a broad sense, "whatever it is one has to know or believe in order to operate in a manner acceptable" to members of that particular group (Psathas, 1968:500). Culture models people's perception, and their interpretation (Psathas, 1968).

The doctors are the most powerful medical staff in the health institution, normally they exercise power over other medical staff such as a nurse, and the patient, and the nurse exercises this power over their patients (Fairclough, 1989). Doctors have an impact on their patients wellbeing, their verbal behaviour impacts patient's adherence to medication, shaping patients' beliefs and understanding about their illness and treatments (Drew, et al., 2011). Analysis of the recorded PTOP counselling sessions helps to determine whether the positioning affects the power of healthcare providers, creating an imbalance of power amongst the health professionals, and patients (Fairclough, 1989). This study is interested in the communicative practices in healthcare and aims to improve health communication; create language awareness; further emphasise the importance of language policies and implementation; and ways to bridge linguistic and cultural gaps in the South African health system (Drew, et al., 2011). As mentioned earlier, language can be a barrier to positive health outcomes, because it sometimes leads to miscommunication and interaction between the healthcare provider and patient becomes 'unproductive' (Deumert, 2010). Language is powerful in the sense that it is through our ability to use language that we are able to interpret, and attach meaning to the world around us (Torabi, 2010:156).

## 1.8 TOP services in South African public healthcare

As mentioned above, this research took place at selected Eastern Cape healthcare centres that offer PTOP counselling.

South Africa's Choice of Termination Act (Act 92 of 1996) replaced the Abortion and Sterilization Act (1975). The Abortion and Sterilization Act (1975) was adopted during the apartheid era, providing termination of pregnancy services under strict conditions (Guttmacher, Kapadia, & Naude, 1998). Under the 1975 Abortion and Sterilization Act, women could legally terminate pregnancy only when the pregnancy was a threat to the woman's life, the life of the foetus, if the woman was raped or became pregnant through other unlawful intercourse such as incest and or sexual intercourse with a 'mentally defective' female" (Guttmacher, et al., 1998). The apartheid government passed the Abortion and Sterilization Act (1975) to control the black and coloured population growth (Guttmacher, et al., 1998). The implementation of this Act was to promote reproductive rights of women, but because it was restrictive, it failed to decrease the number of illegal abortions and to increase access to safe abortion services (Guttmacher, et al., 1998).

The transition from apartheid to democracy increased emphasis on human rights, racial and gender issues. The new government supported revision of abortion legislation and the new health policies were more progressive (Macleod & Feltham-King, 2012). Law and policy reforms wanted to ensure that TOP services were accessible to all South African women. The new government introduced the Choice on Termination of Pregnancy Act of 1996 to promote women's reproductive rights and to prevent deaths that result from unsafe abortion (Harrison, 2009). The African National Congress (ANC's) Reconstruction and Development Programme outlined new national goals stating, "Every woman must have the right to choose whether or not to have an early termination of pregnancy according to her own beliefs" (Guttmacher, et al., 1998:3). South Africa's Choice on Termination of Pregnancy Act No. 92 of 1996 (CTOP Act) promotes woman's reproductive rights; the act enables women to have access to safe and legal abortion services (Harries, et al., 2009). There is support of abortion access as a means for creating greater gender equality as well as furthering women's rights (Guttmacher, et al., 1998). The CTOP Act allows women to have first trimester abortions up to 12 weeks (conducted by trained nurses and midwives) and from 13-20 weeks' onward terminations are

available under specified conditions, conducted mainly by doctors (Harries, Stinson, & Orner, 2009). There are still some challenges and barriers to women assessing safe and quality TOP services. In chapter 2, I discuss these barriers and the impact they have on women seeking TOP services. Chapter 2 contains a theoretical literature review that supports this thesis.

### 1.9 Outline of chapters

Chapter One: The context chapter provides an introduction to the study and the research goal. In this chapter, I provide background to the South African healthcare system. I discuss health inequalities and disparities in public and private health. I outline the Patients' Rights Charter (2002) and the National Health Act (2003) on multilingualism and multiculturalism. Background context to TOP Services in South African Public Health Facilities is presented**.** The chapter also provides an outline of chapters.

Chapter Two: Chapter two is the theoretical framework and literature review chapter. In this chapter, I outline the theory that relates to this research. The chapter begins by discussing some of the existing research in health communication. Highlighting some of factors contributing towards miscommunication in health. The chapter discusses TOP literature and barriers to women accessing safe and legal TOP.

Chapter Three: The methodology chapter discusses qualitative research approaches and qualitative methods used in the study being observation, counselling sessions and in-depth interviews. The chapter discusses the advantages and disadvantages of selected methods for analysis. The chapter concludes by providing a detailed discussion of how data was collected.

Chapter Four: In chapter four I present the data, extracts taken from PTOP counselling sessions, post-counselling interviews with clients and interviews with healthcare providers based on their experience of providing PTOP counselling. The data is presented thematically. I present a demographic profile of participants in table figures. I also provide a description of each site. With each section, I provide a short summary of the data presented.

Chapter Five: This chapter entails the data analysis and discussion. In this chapter, I present the data and I provide an interpretation of data presented. In the interpretation and summary, I engage with the literature presented in chapter two.

Chapter Six: In this chapter, I discuss the research findings, limitations of this study and present conclusions and recommendations.

## 1.10 Summary

This chapter provides a contextual background to the South African health system, and its policy reforms. This chapter highlights some of the communication challenges in the healthcare sector, and the risks in a TOP context. This chapter then goes on to explain what the research entails, stating the research problem and the overarching aim of this research. I then provide some of the social determinants to health that contribute to healthcare inequalities. The new "inclusive" health policies are outlined, and the chapter discusses how health inequalities remain unaddressed due to lack of policy implementation. The chapter indicates that new language policies and patient charters state that everyone has a right to quality healthcare and patients have a right to be assisted in their mother tongue. It is argued that language plays a pivotal role in doctor-patient communication as it can determine the effectiveness or ineffectiveness of the communication. The chapter provides a contextual background to TOP and TOP law reforms. The last section of this chapter, provides an outline of all the chapters presented in this thesis.

In the next chapter, I discuss and outline the literature review and indicate how it is related to this study.

# CHAPTER 2: THEORETICAL FRAMEWORK AND LITERATURE REVIEW

## 2.1 Introduction

This chapter begins by discussing some of the existing research in health communication. It also discusses barriers to women accessing safe and legal TOP services. Intercultural communication and sociolinguistic theory is discussed, and the way in which language and culture may influence communication between the healthcare providers (nurses/counsellors) and clients in PTOP counselling sessions. This chapter discusses literature and theory relevant to this study. The literature and theory presented in this chapter is applied to this study in the data analysis, to explore the linguistic and cultural implications of PTOP counselling; and relations of power between healthcare providers and clients. The literature and theory helps us understand how social norms guide our communication actions, and how the same social norms are resources for shared socio-cultural understanding (Silverman, 2001). The focus in this chapter is on communication as a social phenomenon realized through interaction.

In South Africa, there is a large body of research focused on issues of language and access in public domains (Anthonissen, 2010; Penn, Watermeyer & Evans, 2011; Levin, 2007; Crawford, 1999). Studies in health communication focused on communication challenges have indicated that language barriers have a negative impact on the quality of care. These studies have been conducted in different public healthcare settings, examining whether language and cultural differences between healthcare providers and patients hinders communication (Levin, 2007). In the following section of this chapter, I discuss some of the existing research in health communication conducted by eminent scholars Claire Penn, Christine Anthonissen, Michael Levin and Athalie Crawford.

## 2.2 Present research in health communication

### Research Study 1: Managing linguistic diversity in a South African HIV/AIDS day clinic.

Anthonissen has produced a large body of research which examines the role of language and culture in doctor/pharmacist and patient interaction. Anthonissen (2010) conducted research in

public HIV care facilities in the Western Cape. The clinics were multilingual, with English, Afrikaans and IsiXhosa as the dominant languages (Anthonissen, 2010).

In this context, miscommunication occurred even when doctors and patients were speakers of the same language. Most of the doctors and clients in her study belonged to different linguistic groups. In some cases, the doctor and client would both be proficient in English, but not have similar levels of proficiency, which then still caused communication problems (Anthonissen, 2010). Anthonissen (2010) explains that English was the lingua franca at clinics, but Afrikaans would often be a more preferred language by both doctors and patients because it is a strong regional language in the Western Cape and patient's proficiency in the language was stronger than English. Doctors consult in either English or Afrikaans (Anthonissen, 2010). Most of the patients had English as a second language and some as a third language (Anthonissen, 2010). The patients had either Afrikaans or isiXhosa as their first language (Anthonissen, 2010). Some clients had other South African indigenous languages as their first language, but acquired isiXhosa because of their place of location (Anthonissen, 2010). The clients had acquired isiXhosa through interacting with isiXhosa speakers in their communities (Anthonissen, 2010).

In this study, the doctors had high levels of proficiency in both English and Afrikaans, and consultations would be conducted in the patient's language of choice (Anthonissen, 2010). Interpreting services were offered to patients who did not have high levels of proficiency in English and Afrikaans (Anthonissen, 2010). Some of the patients declined the interpreting services offered to them (Anthonissen, 2010). According to Anthonissen, (2010), patients at the HIV care facilities were reluctant to have the interpreters present during the consultation, as they found the presence of a third person intrusive (Anthonissen, 2010). The patients used their basic understanding of English and Afrikaans, "negotiating meaning with whatever linguistic resources are available to them" (Anthonissen, 2010:120)

In similar research done by Anthonissen (2010), English was widely used as a lingua franca and sometimes the regional language as an additional language (Sobane & Anthonissen, 2013). The HIV care facilities were multilingual, with a variety of linguistic repertoires and cultural backgrounds (Sobane & Anthonissen, 2013). Some of the patients knew no or very little English which then often lead to miscommunication and negative health outcomes (Sobane & Anthonissen, 2013). Watermeyer & Penn (2009) note that "the nature and wide distribution of

HIV-infection and the complications associated with non-adherence, make it imperative that patients understand their condition and the treatment" (Sobane & Anthonissen, 2013:271). It is therefore important for the healthcare provider, including the pharmacists who disperse the medication, to check that the patient understands the information being communicated to them (Sobane & Anthonissen, 2013). The findings in these studies have illustrated (through analysis of talk) that lack of understanding is minimised where the doctors and pharmacists do not simply ask a yes/no-question as to whether the patient has understood but rather have patients demonstrate understanding of the information provided to them (Sobane & Anthonissen, 2013).

**Research Study 2: Why don't patients take their drugs? The role of communication, context and culture in patient adherence and the work of the pharmacist in HIV/AIDS.**

The following study was conducted at four South African antiretroviral therapy (ART) clinic sites, examining the medical encounter between the pharmacist and the patients, addressing the communicative challenges, trying to understand what leads to poor adherence (Penn, Watermeyer & Evans, 2011).

In the findings of this study, it was reported that the patient's failure to correctly take ARV treatment was because of miscommunication between them and the pharmacist. Sometimes the clients were unclear as to the instruction provided by the pharmacists, and end up taking incorrect dosages (Penn, et al., 2011). ARV treatment does not work if not taken correctly and incorrect dosages may even lead to health complications and in the long-term loss of human life. Effective communication between pharmacist and patient is important, achieving concordance and positive health outcomes (Penn, et al., 2011). The pharmacists give the patients instructions on how to take treatment; they would sometimes use pauses, which acted as 'understanding checks' (Watermeyer & Penn, 2009*).* The pause would usually be followed by a nod, which was a way in which the patients indicated that they understood the instruction (Watermeyer & Penn, 2009). This technique is not always helpful, and may not always "provide the pharmacist with a true reflection of patients' understanding of instructions" (Watermeyer & Penn, 2009:2063). As stated by Watermeyer and Penn (2009:2062), that "in cross-cultural interactions and institutional interactions in general, patients may respond positively out of politeness or deference to the authority of the health professional".

Communicative and contextual factors play a role in the poor adherence to ARV treatment (Penn, et al., 2011). Contextual factors (including language and culture barriers) often impinge on the primary task of the pharmacist and demand an expanded role which extends to counselling and advice giving (Penn, et al., 2011). According to Penn, et al., (2011:312), "the pharmacist requires a set of skills which extends beyond merely knowledge of ART to issues of communication, culture, context and life world". It is important for the patient to understand the dosage instruction given to them by the pharmacist (Watermeyer & Penn, 2009).

Some of the theoretical and empirical findings of these research studies are relevant and support the data analysis presented in chapter 5 of this thesis. This is true of research study 3 below as well, which was conducted by Levin (2006).

**Research Study 3: Use of asthma terminology by Xhosa-speaking patients in South Africa – how it affects asthma-control questionnaires and questionnaire-based epidemiological studies.**

The aim of this study was to examine whether differences in the definitions of common respiratory medical terminology by patients and doctors cause miscommunication in medical settings and to explore culture-specific models used by parents in their definitions (Levin, 2006). Data was collected through in-depth, semi-structured interviews were with English-speaking doctors, and Xhosa-speaking parents from a short-stay ward and an allergy clinic (Levin, 2006).

The finding of this study, reported that most of the Xhosa words such as 'isifuba' were not part of the doctors' vocabulary, and some common English words such as "wheezing" were not part of the parents' vocabulary (Levin, 2007). In instances where the words were part of the English-speaking doctor's and isiXhosa-speaking parent's vocabulary, there were significant differences in the definitions, "with many clinically significant discordances being apparent" (Levin, 2007:74). It was established that parents do not use the word asthma exclusively for a medical diagnosis of asthma (Levin, 2007). Some parents were unable to define asthma in terms of a medical diagnosis, to them 'isifuba' is equivalent to 'esma' (Levin, 2006). Parent also poorly understood words for asthma symptoms, and this may lead to communicative challenges and misdiagnosis (Levin, 2007).

The study reported that 83% of parents from the short-stay ward, in addition to 64% of parents from the allergy clinic were unable to give a definition. The doctors must be mindful of the fact that English respiratory medical terminology may not be part of the patient's vocabulary, and even if they are, they may be understood differently. Levin (2007:77) suggests that, "the word isifuba should be avoided as a disease name for parents as it does not comprise adequate explanation or counselling". If Xhosa-speaking patients use the word asthma/i-esma, "the doctor should explore further to determine whether it refers to any generic chest disease or symptoms, or to a specific chest disease" as a way of avoiding miscommunication (Levin, 2007:77). Clearly what this study shoes is a lack of equivalence when using medical terminology i.e. between English mother tongue speakers and isiXhosa mother tongue speakers. This is supported further by Research Study 4 below.

**Research Study 4: 'We can't all understand the white's language': an analysis of monolingual health services in a multilingual society.**

Crawford conducted a study in three township hospitals based in Cape Town. In her study, Crawford focused on investigating the interpretation services of these hospitals. Most of the doctors in the study were not fluent in the language spoken by the majority of the clients they provided care for. The doctor would ask the nurses who shared a common language with the client to assist with the interpretation. From this study, Crawford (1999) proposed a communication hierarchy model. The model may have some limitations when applied to current communication studies in health. However, the communication hierarchy model remains useful in trying to help us understand the language challenges and power relations in healthcare.

The communication hierarchy model proposes that there are power relations that encompass relationships between doctors and patients, doctors and nurses, nurses and patients (Crawford, 1999). Patients occupy a minimally powerful position in relation to the doctor's power and knowledge, and they are placed at the bottom of the communication hierarchy (Crawford, 1999). Healthcare professionals use medical terminology to communicate illnesses to their patients. Studies have shown that even though both English speaking patients and patients speaking indigenous African languages struggle with the medical terminology and are unable to effectively communicate their illness to doctors, patients speaking indigenous African

languages are worse off than a middle-class white, English-speaking patient (Crawford, 1999). Therefore, although both patients struggle to understand the medical terminology, the English speaker remains higher in the communication hierarchy. Patients speaking indigenous African languages on the other hand, may struggle not only with the medical terminology but they may also struggle to communicate in English. Studies have shown that a large number of healthcare professions lack the information and skills to effectively bridge potential linguistic and cultural gaps (Kagawa-Singer & Kassim-Lakha, 2003). Crawford's study further finds that there is no equivalence between terminology, and that euphemisms such as a *Ugawulayo* 'the one who chops down' are used in isiXhosa, for example to refer to HIV-Aids.

In Crawford's (1991) communication hierarchy, healthcare providers and clients are positioned according to their professional status and their English proficiency. Healthcare providers develop their own lens to view reality (Kagawa-Singer & Kassim-Lakha, 2003). The healthcare provider's lens is influenced by their natal culture and by the institutional culture (Kagawa-Singer & Kassim-Lakha, 2003). According to Kagawa-Singer & Kassim-Lakha (2003:581), the healthcare provider's "sets of beliefs and values intersect to varying degrees to form the clinician's blended worldview". Miscommunication is mostly likely to occur when the healthcare provider uses a Eurocentric approach in diagnosing and treating patients of diverse linguistic and cultural backgrounds (Kagawa-Singer & Kassim-Lakha, 2003). The use of a one-sided Eurocentric perspective by the healthcare provider may lead to miscommunication and health complications (Kagawa-Singer & Kassim-Lakha, 2003).

Comparing the studies

As stated in chapter 1, South African public healthcare facilities attend mostly to patients of low socio-economic status (Levin, 2007). The studies discussed above indicate that language issues are "closely followed by socio-economic issues as major access barriers" to quality healthcare for patients who are speakers of South African indigenous languages (Levin, 2007:75). According to Anthonissen (2010) miscommunication often occurs when the patients either have had limited formal schooling and when they are unfamiliar with the medical terminology used by doctors. These four studies advocate for an intervention that raises linguistic and cultural awareness amongst healthcare providers; and the need to improve the effectiveness of communication and quality of care (Sobane & Anthonissen, 2013). These

studies are insightful when it comes to PTOP interviews as similar issues are raised between healthcare providers and clients.

The purpose of the research is to propose effective communicative strategies that bridge these potential linguistic and cultural gaps in PTOP counselling.

### 2.3 Barriers to women accessing safe and legal TOP services

Despite the implementation of the CTOP Act, there continues to be barriers that prevent women from accessing safe and legal abortion (Sigcau, 2009). These barriers include lack of trained healthcare providers to perform abortion, lack of knowledge about the woman's rights to a safe and legal abortion, and social stigma associated with abortion (Sigcau, 2009). Studies on TOP have indicated that because of these barriers, women continue to use illegal abortion services and 13 per cent die due to complications from unsafe abortions as reported (D'Souza, 2014). Some women continue to use illegal abortion services because they are not aware of the CTOP Act and their right to accessing safe abortions (Sigau, 2009). Sometimes the women go to TOP clinics and hospitals to have an abortion and they are turned away because there is a shortage of healthcare providers who are willing or trained to perform abortions (Harries, et al., 2009). A pro-life healthcare provider may refuse to perform an abortion; however, they are obliged to inform a woman of her reproductive rights to choose an abortion according to the Act, and to refer the client to another provider or health facility (Harries, et al., 2009). Studies have shown that some healthcare providers do not want to provide TOP service because of the social stigma attached to abortion (Sigcau, 2009). Healthcare providers mostly fear being judged by other community members for providing the services and being isolated by their colleagues in the work environment (Sigcau, 2009). Even though abortion has been legalized, the public still has a negative attitude towards abortion (Sigcau, 2009). Legalization of abortion has not transformed negative reactions to abortion. Furthermore, religion and culture often influence the attitudes of the wider society and their opinion towards abortion (Sigcau, 2009). This is further explicated in chapters 4 and 5 of this thesis.

TOP research has examined religious variables and influence on abortion attitudes (Sigcau, 2009). Language barriers can have a negative effect on PTOP counselling in the same way that the above research studies have indicated. The health-service provider's personal values

can also sometimes become a barrier to women accessing safe abortions (Sigcau, 2009; Vincent, 2011). This is because language reflects cultural values and norms of a particular society that speaks the language (Jiang, 2000). Culture therefore plays a significant role in conversation, it can determine whether the conversation succeeds or fails. "Culture is often described as that which includes knowledge, beliefs, morals, laws, customs and any other attributes acquired by a person as a member of society" (Burnard & Naiyapatana, 2004:755). Patterns of interaction form the basis for individuals' communication styles and vary across cultures and within cultures (Gudykunst et al., 1996). Healthcare providers thus have a "double impact" because they are figures of authority as health professionals, and at the same time, they are "carriers of culture" (Crawford, 1999:28); which means that their cultural beliefs affect their identities as healthcare providers, and may influence the way in which they communicate with patients, thereby negatively affecting the PTOP counselling (Altmayer & Wolff, 2013).

Abortion is still arguably viewed by a large portion of the population as being morally wrong and as an act against God's will (D'Souza, 2014:1). The nurse's attitudes towards abortion are influenced by the community's view (Sigcau, 2009:18). TOP literature asserts that negative attitudes of the healthcare providers serve as a barrier to access safe abortion (Sigcau, 2009; Vincent, 2011). The healthcare provider's personal beliefs and value system affects their professional conduct and this is evident in the quality of care they provide to women seeking TOP (Sigcau, 2009:11). The negative attitudes of the healthcare providers do not only affect the quality of care but also become a major barrier to women accessing safe TOP services. (Sigcau, 2009:11).

Varga (2000) in (Sigcau, 2009) conducted a study on abortion amongst South African adolescents and participants in the study shared their encounters with nurses, indicating that nurses are rude towards them and this makes them fear going to TOP clinics. The nurse's negative attitude and the way in which they communicate with their clients is the reason some women continue to have unsafe illegal abortions (Sigcau, 2009). In Varga's (2000) finding it was reported that many of the participants were traumatized by the negative experiences with healthcare providers and it made them not want to return back to the TOP clinic (Sigcau, 2009).

### 2.3.1 How healthcare provider's value systems influence PTOP counselling

Historically, abortion debates in South Africa have been politicized (D'Souza, 2014). The state decides on whether women should be denied or given access to TOP services. The state has the decision making power over women's reproductive rights (D'Souza, 2014). The apartheid state passed the 1975 Abortion and Sterilization Act and introduced the use of contraception to control the growth of black and coloured people population. South African black people still have negative views towards abortion because of the 1975 Abortion and Sterilization Act (Guttmacher, et al., 1998). The Abortion and Sterilization Act is one of the reasons many black people are against abortion, their attitudes towards abortion are also influenced by their cultural beliefs (Guttmacher, et al., 1998).

The religious and cultural beliefs of the African people encourage respect for the sacredness of human life, which for them begins at conception (Sigcau, 2009). African people largely believe that abortion is a sinful act and any person that partakes in this act is morally corrupt (Sigcau, 2009). As will be shown later in this thesis, women who terminate unwanted pregnancies are stigmatized and labelled as murderers by members of society. Women have been granted access to abortion services but because of the stigma attached to abortion they get to exercise reproductive rights with consequences to face afterwards (D'Souza, 2014). According to Sigcau (2009:240), "the juxtaposition of abortion as killing and culture as the preserver of life implies that resistance to abortion is essential to the maintenance of cultural values and the nation". Abortion is only considered socially acceptable when the pregnancy is a threat to the women's life, that of the foetus, or in cases of rape. Sigcau in D'Souza (2014) terms this as the "conditional acceptance" of abortion, which changes the meaning of abortion; and in these cases, abortion becomes acceptable and it is viewed as saving a life rather than as ending one.

As mentioned previously, healthcare providers are not willing to work in TOP clinics because of the fear of being stigmatized by their communities for providing TOP services (Harries, et al., 2009). Healthcare providers form part of a wider community guided by its value systems that influence their attitudes towards abortion (Varkey, 2000). Organizational culture in healthcare influences the way in which healthcare providers conduct themselves in the workplace, but it cannot ensure that their personal values and beliefs do not affect their professional conduct (Gudykunst, 1991). As alluded to earlier, there is a lack of healthcare

providers to provide TOP services and few are trained to provide the service. Studies have indicated that the few available healthcare providers that work at TOP clinics have considered moving to different wards because of the number of women who come to terminate pregnancy (Harries, et al., 2009). Due to being short-staffed, it becomes difficult for the healthcare providers to provide the service to every woman seeking TOP services. Sometimes the healthcare providers do not receive support from hospital management, and they feel burn out. Harries, et al., (2009) reported that some of the healthcare providers want to be moved to different wards in the hospital not because they feel over worked, but because of the poor treatment they receive from their colleagues who are anti-abortion.

Rights and duties are assigned to individuals in changing patterns as they occupy new positions; it is to ensure they fulfil their responsibilities (Harries, et al., 2009). Harries, et al., (2009:5) states that, "these patterns are themselves the product of higher-order acts of positioning through which rights and duties to ascribe or resist positioning are distributed." TOP policy reform resulted in a shifting role of the mid-level provider or nurses, who now had to provide TOP services, which had been previously left to the doctors (Harries, et al., 2009). There were mixed reactions to the policy and varying degrees of willingness of staff to providing the services (Harries, et al., 2009). Some of the nurses and mid-wives had positive attitudes about the policy reform and the newly assigned role and they found it to be empowering (Harries, et al., 2009). These nurses and mid-wives had a positive outlook because they saw this as an opportunity to broaden their skills base whilst providing a service to women with unplanned pregnancy (Harries, et al., 2009). Despite the positive attitudes of some of the nurses, they were struggling to adjust to their new environment (Harries, et al., 2009). The nurses providing the TOP services often felt stigmatized and ostracized by their fellow colleagues (Harries, et al., 2009). TOP policy reform has not been successful in transforming the attitudes of many South African's on abortion and effective provision of TOP services seems to depend on the willingness of healthcare providers (Harries, et al., 2009).

Nurses who provide abortion services are sometimes pro-life and choose to work in TOP wards because they believe it is their professional duty. These nurses often take on the saviour role, and feel it is there duty to save the women from making indecent decisions that may have a negative impact of their lives. As a result, women end up feeling guilt after PTOP counselling and some are said to not return on the day of the procedure. In Varkey's (2000) study the

women indicated that the nurses' do not provide them with support and the nurse's approach is what makes them seek illegal abortion services. There are however some healthcare providers who are pro-choice, providing TOP service and this does not allow their personal views to affect their professional conduct (Harries, Stinson, and Orner, 2009).

## 2.4 Communication challenges in healthcare

### 2.4.1 Imbalanced use of languages

Language is not merely words that are strung together to form sentences. Language is a social construct and it influences the way in which we interpret the world around us. Language is a powerful tool that is sometimes used as a way of dominating the 'other'. The South Africa language policy during the apartheid area is an example of how language can be used to exercise power. During the apartheid era, English and Afrikaans were the only recognized languages. English and Afrikaans were the dominant languages and were deemed superior. The indigenous languages were seen as social languages, languages with a low status (Kaschula & Ralarala, 2005). Linguistically this is incorrect because all languages are seen as equal. It is because of colonization that English has its status and power. The colonizers pushed for the use and dominance of their language. English and Afrikaans became developed at the expense of the indigenous languages. During this period, there was an imbalance in use of languages. This practice has been continued in a democratic South Africa. In South Africa, we have a triglossic structure of language use (Kaschula & Ralarala, 2005). All languages are within a pyramid, with English on top of the pyramid, followed by the Afrikaans language and then placed at the bottom is the rest of the African languages (Kaschula & Ralarala, 2005). South Africa continues to be largely linguistically homogenous in terms of professional language practice i.e. in the case of healthcare this triglossic situation also prevails.

In the following sections of this chapter, I discuss linguistic and cultural barriers to communication in healthcare. This theory will again support the data analysis in chapter 5.

### 2.4.2 Intercultural communication in healthcare

"Intercultural communication is a scientific field whose object of interest is the interaction between individuals and groups from different cultures, and which examines the influence of culture on who people are, how they act, feel, think and, evidently, speak and listen" (Aneas & Sandin, 2009:4). Intercultural communication occurs when speakers are from different cultural groups and it has become part of our everyday interaction (Kaschula, 2009). In intercultural communication, the speakers possess different worldviews that influences the way in which they speak (Kaschula, 2009). "World-view refers to our larger philosophical outlook or ways of perceiving the world and how this outlook, in turn, affects our thinking and reasoning patterns" (Ting-Toomey & Chung, 2012:119). When such an interaction takes place, miscommunication is most likely to occur with the intercultural disparities possibly impinging on effective communication (Varonis & Gass, 1985). In a PTOP context, miscommunication is mostly likely to take place when the healthcare provider has difficulty understanding and making sense of culturally embedded issues and concepts in the language of the patient (Kashula, 2013). The intercultural dynamic relates to monolingual English speaking healthcare providers and their isiXhosa-speaking clients. Intra-cultural communication is communication that takes place between speakers of the same culture i.e. isiXhosa speaking nurses and their patients. In this study both intercultural and intra-cultural communication exist.

The South African health sector conducted a language survey, which showed that fewer than 5% of the doctors at the institutions studied were able to speak their patient's first language (Penn & Evans, 2009). The doctors mainly speak English whilst patients may understand English; some are not fluent in the language. This usually causes ineffective communication between the doctor and the patient, sometimes leading to misdiagnosis (Penn & Evans, 2009). In cases where there is communication failure between doctors and patients from different linguistic backgrounds, the patients often have to mime their sickness (Crawford, 1999). In some instances, a mother-tongue speaking nurse is called to assist the doctor with the interpretation process (Crawford, 1999). In the South African context, it is very common to find doctors that are not linguistically equipped to care for their clients; but the nurses often speak the same language as the patient (Penn & Evans, 2009; Crawford, 1999). The Kouga Patient Satisfaction Survey Report (2010) that was conducted in clinics around the Eastern Cape shows that 91.9% of the nurses speak in a language the patient understands. Miscommunication may still occur even when the nurses and patients speak the same language

because of the medical terminology that is used by the nurse during consultation and which sometimes cannot be translated into isiXhosa (Crawford, 1999).

## 2.5 Linguistic and cultural barriers

Language barriers impede effective communication, decreasing the quality of the services received by the patient and sometimes leading to misdiagnoses (Hussey, 2012). Effective communication is achieved when there is an understanding between healthcare providers and the clients (Arnold, Coran, Hagen, 2012). For communication to be effective their needs to be an understanding between the health-service provider and patient and for an understanding to be reached does not mean that there has to be an agreement (McLauren, 1998). Arnold et al., (2012:399) explains that "effective physician–patient communication requires both parties to be actively involved in the medical encounter and engage in competent, skills-based communication". According to Arnold et al., (2012) communication is most likely to be effective when healthcare provides adopt a patient-centred approach and this results in positive health outcomes.

Hussey (2012) did a study, interviewing doctors about their experience of medical practice and the relationship they have with their patients. According to Hussey (2012:191), doctors that participated in this study "felt that a form of "paternalistic medicine" was practiced at the hospital because of the language barrier". The doctors suggested that the patients did not seem to have any problem with this practice. The doctors who were interviewed reported that the patients were mostly silent and rarely asked questions about their illness. The doctors in this study interpreted lack of participation from the patients as a form of acceptance of the methods that were used during the consultation (Hussey, 2012). To some extant this interpretation may be true. In some cases, the patients may be silent because of language barriers and because of their value system (Hussey, 2012). In some cultures, it is considered disrespectful to question a person of authority (Hussey, 2012). The patient may see the doctor as a health professional who possesses medical knowledge and whose job is to treat the ill (Fairclough, 1989). A patient may nod to what the doctor is saying because culturally that is how they are expected to respond meaning that the patients silence is not always a positive response to the service they are receiving.

Non-verbal cues can sometimes cause misunderstanding more than verbal language if they mean something different to sender and receiver (McLauren, 1998). An example would be of how some isiXhosa patients may avoid making eye contact when speaking to a doctor. If the doctor and patient are from different cultural groups, the avoidance of eye contact may be interpreted differently. The patient may be avoiding eye contact as a sign of respect and the doctor may misinterpret it as an act of avoidance. The doctor may think the patient is ashamed that they have been taking their medication incorrectly or are not being truthful. In the western culture when someone avoids making eye contact it is usually interpreted as someone hiding their face so that the other person is not able to read a lie off their face. In Xhosa culture, you show respect when you speak to an elder or someone is of higher social ranking and avoiding making eye contact usually signals respect. In this case, a patient who belongs to a Xhosa cultural group may avoid making eye contact with the doctor because of their high ranking in terms of social class and their profession. Non-verbal cues will cause misunderstanding if the doctor and patient interpret them using their symbolic system.

The success of patient-centred communication does not solely rely on the doctor's approach; the patient should have communication skills such as listening and negotiating (Arnold, et al., 2012). Patients are hesitant to ask questions related to their health because of lack of understanding (Arnold, et al., 2012). The consultation becomes unidirectional resulting in decreased quality of care and patient dissatisfaction. (Arnold, et al, 2012). Patient's linguistic inability leaves them feeling powerless and they blame themselves for miscommunication (Hussey, 2012). Patients are not aware of their right to accessing quality healthcare services in a language they understand (Watermeyer & Penn, 2009). Language barriers make the patients feel anxious and their anger is sometimes directed to isiXhosa-speaking nurses (Crawford, 1991). The mother tongue nurses are often used as unpaid interpreters and they are not happy about having to interpret for the doctors, stating that it is not their job description (Crawford, 1999:30). According to Crawford, (1991) the nurses equally direct the anger towards the patients and not towards the doctors.

### 2.5.1 Health literacy

In trying to improve intercultural communication, it is also important to address the issue of medical terminology and the difficulty that patients are faced with when presented with printed

materials (Penn & Evans, 2009:). The IndexMundi (2015) measures literacy of people above the age of 15 who can read and write. It was reported that 93% of the South African population is literate (IndexMundi. 2015). The challenge with this report is that it measures the population's reading and writing ability without a breakdown of the percentages into the different language proficiency. The index shows that a large South African population is literate but if a survey was done specifically measuring the population's English proficiency the percentage would probably greatly decrease. The reality is that there is a population of people of colour, who have never been formally taught English and as a result they are unable to read and write in the English language. This group of people would consist of mostly your lower class black citizens who do not have the means to access the language.

Patients in Sobane & Anthonissen's (2013) study which examines communicative challenges in HIV/AIDS clinics in Lesotho, reported that health service providers have never asked them questions that were based on the information given in the printed materials (Sobane & Anthonissen, 2013). The patients also reported that printed materials are handed out to them without the healthcare provider asking whether they are literate, or understand the language (most of the time being English) which the medical information is written in (Sobane & Anthonissen, 2013). This therefore goes to show that often high levels of patient literacy are assumed by the healthcare provider and this is a flawed assumption. Some patients who were proficient in English also struggle reading the printed materials because they were not familiar with the medical terminology (Sobane & Anthonissen, 2013). Some of the patients reported difficulty reading the medical terms, they stated that they only look at the illustrations and read the parts written in their home language (Sobane & Anthonissen, 2013).

Illiteracy is therefore a problem because it affects the quality of service received by patients. The medical terminology used in printed materials is difficult for patients to understand. Patients should be provided with information regarding their medical condition in a language they understand. Saville-Troike (2003:268) defines literacy as "a source of power, which enhances the potential for increase of access to knowledge". Literacy is the ability for reading, writing, and processing the information, and then "health literacy implies skills which enable a person, not only to read and write, but also to read and interpret health information" (Mokwena, 2015:197). WHO defines health literacy as "representing the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand

and use the information in ways which promote and maintain good health" (Nutbeam, 2000:259). Health literacy is important because it empowers the patients, helping them make informed decisions about their health (Mokwena, 2015).

### 2.6 Linguistic and cultural competence

Different worldviews between the healthcare provider and patient can affect the quality of care (Hussey, 2012). Cultural competence is important for healthcare providers and it is a means to effective doctor–patient relationships (Kagawa-Singer & Kassim-Lakha, 2003). Cultural based communication allows for the consultation to bi-directional and gives the patient negotiation power (Kagawa-Singer & Kassim-Lakha, 2003). Both the healthcare provider become active during the consultation, it may also build trust between the two parties. The mother tongue speaking nurses and interpreters may serve as cultural mediators but effective communication between the doctor and patient would improve confidentiality and quality care (Hussey, 2012).

As alluded to earlier, our cultural norms and values influence our speech. "Culture influences our worldview and the way in which we interact with other people." (Aneas & Sandin, 2009:4). Aneas & Sandin (2009:5) explains that "culture is not something which we "possess"; rather cultures form an inherent part of the person, and it is culture which bestows individual and collective identity: a complex identity which is articulated across multiple social belongings". An individual's culture forms part of their identity and plays a significant role in conversation, it can determine whether the conversation succeeds or fails. Individuals learn various patterns of interaction and these vary across cultures.

#### 2.6.1 Effective communication

The manner in which healthcare providers communicate whether it is within intercultural or intra-cultural communication can lead to negative health outcomes. The manner in which health professionals communicate with their client has significant impact on the outcomes of the medical encounter. Effective communication is associated with positive health outcomes (Arnold, et al., 2012). According to Ting-Toomey (1999:5), "effective communication across cultures demands a level of 'mindfulness' and a critical perspective about identity and relational meanings in an intercultural setting". Ting-Toomey's (1999) theory of "mindful"

intercultural communication can be a tool to bridge potential linguistic and cultural gaps. Langer isolates three qualities of mindfulness: (1) creation of new categories, (2) openness to new information, (3) awareness of more than one perspective (Gudykunst, 1991). The reason "mindful" intercultural communication is important is because it leads to trust and trust in the doctor–patient relationship is very important, because when the patient feels they are being understood by the healthcare provider they are not reluctant to ask questions related to their medical condition (Arnold, et.al, 2012). Effective doctor–patient communication requires both parties to be actively involved in the medical encounter and to engage in competent, skills-based communication (Arnold, et.al, 2012). Ting-Toomey's theory of intercultural communication can be extended to intra-cultural communication, as it requires the speaker and receiver to be open to new knowledge and being "mindful" of the other person's background (Arnold, et al., 2012).

Effective communication occurs when the speaker and recipient, are able to interpret the message with similar meaning, minimizing misunderstanding (Gundykunst, 1991). Ineffective communication occurs when the speaker and recipient base their interpretation on our symbolic systems (Gudykunst, 1991). "Cognitive therapists stress that we must become aware of our communication behaviour in order to correct our tendency to misinterpret others' behaviour and communicate more effectively" (Gudykunst, 1991:33). According to Langer (Gudkunst, 1991), people become mindful of others' behaviour once they focus on the process of communication which can help determine how our interpretations of messages differ from others interpretation of these messages (Gudkunst, 1991).

In the following section, I will discuss ethnomethodology as an approach to be used in the data analysis of this thesis in chapter 5.

### 2.7 Sociolinguistic approach

This study adopts a critical language study (CLS) approach. CLS approach is useful for this study because it aims to reveal, "Connections which may be hidden from people such as the connections between language, power and ideology" (Fairclough, 1989:5). A CLS approach analyses social interaction, focusing on linguistic components of the interaction (Fairclough, 1989). In this study, the CLS approach seeks to reveal hidden determinants in the system of

social relationships and health, and the impact they have on PTOP counselling (Fairclough, 1989:5). To investigate how healthcare providers' communicative choices, affect the quality of interaction and of patient participation in a PTOP context.

Holmes (1992) in (Wardhaugh, 2006: 11) states "the sociolinguist's aim is to move towards a theory which provides a motivated account of the way language is used in a community, and of the choices people make when they use language". To effectively investigate the linguistic and cultural interaction between healthcare providers and clients, this study uses interactional sociolinguistics, which is concerned with "how speakers signal and interpret meaning in social interaction" (Bailey, 2008).

Language is a 'communal possession', and speakers of the same language share knowledge, and norms and rules of talk (Wardhaugh, 2006). Language is influenced by the social norms and cultural patterns of a group of people (Wardhaugh, 2006). A speaker's background influences their speech, and communication styles; and the speaker's positions most likely affect the interaction. Which is why then miscommunication often occurs when speakers do not share a common language, because speakers possess different worldviews and in cross-linguistic and intercultural communication, meaning can be easily misinterpreted. Language and society are intertwined, language is not external from society and therefore cannot be separated (Wardhaugh). People acquire language and rules of language through society. These rules and norms of talk serve as a guide in our interactions, and help people organize their social relationship within a particular speech community (Torabi). Language and the ability to use language, demonstrates our possession of consciousness and ability to interpret our social world (Torabi, 2010). Language allows us to have the ability to interpret and bring meaning to our surroundings (Torabi, 2010).

Language is said to be humankind's greatest gift because it binds us together and enables us to create and maintain order together (Torabi, 2010). In order for human social life to work, speakers must want achieve the same outcome through talk otherwise; what will occur is a breakdown in communication (Torabi, 2010). The speakers are able to communicate/receive information, interpret the information and respond based on common-sense knowledge (Torabi, 2010). People make sense of their everyday life, relate to each other using shared knowledge, developing an understanding of each other and social situations (Silverman, 2001).

Social order depends upon shared meanings because it is through shared knowledge system that members of society maintain social order and make sense of their social worlds (Torabi, 2010). Common-sense knowledge is acquired through socialization and forms part of their sociolinguistic identity; it may then vary from person to person (Torabi, 2010). Common-sense knowledge is embodied in one's language and is used in different social settings in order to negotiate meanings (Torabi, 2010).

Research that takes on a sociolinguistic approach, is concerned with the relationship of language to society (Wardhaugh, 2006). I will examine how cultural knowledge and rules from the social contexts impact communication in healthcare settings. In this thesis I investigate how order in a health setting is achieved and maintained (or not) through language.

### 2.7.1 Language, culture and identity

Individuals learn various patterns of interaction that are based on the norms, rules, and values of their culture (Gudykunst, Matsumoto, Ting-Toomey, Nishida, Kim, Heyman, 1996). It is through culture that individuals learn how to behave and respond to others (McLauren, 1998). Culture influences the way individuals are socialized in terms of individualistic and collectivistic tendencies (Gudykunst, et al. 1996). Keesing (1974) in (Gudykunst, et. al 1996:512) states, "Culture provides its members with an implicit theory about how to behave in different situations and how to interpret others' behaviour in these situations". We are not born with culture; we learn theories of culture through socialization (Gudykunst, et al. 1996). These patterns of interaction influence the individuals' style of communication, which varies across cultures and within cultures (Gudykunst, et al. 1996).

People from an individualistic culture have different communication styles from those of a collectivistic culture (Fitzgerald, 2010). Communication styles differ across cultures, verbally or nonverbally signals of respect are also interpreted differently by people of individualistic and collectivistic cultures (Fitzgerald, 2010). "Cultural individualism-collectivism has a direct effect on communication because it affects the norms and rules that guide behaviour in individualistic and collectivistic cultures" (Gudykunst, et al. 1996:511). Fitzgerald, (2010) describes individualistic and collectivistic cultures as "ways members perceive self, goals, and duty". Members of collectivistic cultures view themselves as part of a group,

whereas members of individualistic cultures are self-orientated (Fitzgerald, 2010). "Individualism is a social pattern that consists of loosely linked individuals who view themselves as independent of collectives and who give priority to their personal goals over the goals of others" (Triandis, 1995 in Oetzeli & Ting-Toomey, 2003:602). Whereas "collectivism is a social pattern consisting of closely linked individuals who see themselves as part of one or more collectives (family, co-workers, tribe, nation) and are willing to give priority to the goals of these collectives over their own personal goals" (Triandis, 1995 in Oetzeli & Ting-Toomey, 2003:602).

People do not always ascribe to the values, norms and beliefs of their cultural groups. Healthcare providers may sometimes ascribe to norms and believes of their cultural grouping, but not necessarily agree to every single one of them. Which is why then people are differing on their degree of collectivism and individualism (Ting-Toomey & Kurogi, 190 in Fitzgerald, 2010). Ting-Toomey uses the terms independent and interdependent self to refer to "the degree to which people conceive themselves as relatively autonomous from, or connected to, others" (Toomey and Kurogi, 190 in Fitzgerald, 2010:2). Individuals are guided by the norms and values of their cultural groups, which helps mould their identity but it does not mean that all individuals of that group will ascribe to these values and lead the same life (McLauren, 1998). Individuals may vary and may not follow the exact orientation of their collectivistic or individualistic cultures (Fitzgerald, 2010). An individual can reject some of their groups' cultural norms and values they may feel they do not identify with. According to McLauren (1998:20), "individualism includes the belief that each person should have the right to develop him or herself according to personal choice, whether or not that suits the society". Healthcare providers who do not allow the negative attitudes of the wider community and of their cultural groups in regards to abortion would be exercising their own personal rights. McLauren (1998) further explains that "intercultural specialists who has done research on individualist and collectivist tendencies have put forward the idea that individualism and collectivism co-exist and interact and should not be seen as opposite". Healthcare providers who are highly individualistic can as well have collectivist attributes (McLauren, 1998).

In the following section, I discuss CA, which is closely related to sociolinguistics theory.

## 2.8 Conversational analysis

CA is a tool used to analysis both social and institutional talk (Goodwin & Heritage, 1990). As stated previously, intercultural communication theory suggests that language cannot be isolated from culture, because culture determines the content of information and how it is delivered (Gudykunst et al., 1996). CA supports intercultural communication theory, its theory also suggests that individuals learn certain behaviours through socialization, including linguistic norms and values in which then influences the way in which we communicate and interpret the world around us (Goodwin & Heritage, 1990). In line with this sentiment, CA is used in this study to examine and explore cultural implications and relations of power between healthcare providers and women seeking PTOP services. CA analyses the communicative process, seeking to explore what is said in a verbal and non-verbal interaction (Antaki, 2011). The focus is on communication as a social phenomenon realized through interaction. CA will help me to effectively investigate the linguistic and cultural interaction between patients and healthcare practitioners, which is concerned with "how speakers signal and interpret meaning in social interaction" (Bailey, 2008). CA supports intercultural theory as explicated above in that it looks at how social norms guide our communication actions, but also the same social norms are also resources for shared socio-cultural understanding. CA has been a useful method to draw from because it demonstrates the norms and rules of interaction and how use of these norm and rules or lack of affect communication (Robinson, 2003). CA in this study is used to investigate how a range of cultural phenomena, are produced by actors through talk and how the organization of talk helps maintain and recreate order (Goodwin & Heritage, 1990).

Through CA, one is able to identify recurring patterns in a communication event, and how these patterns are used to realize a social phenomenon in interaction, e.g. the sequence of advice giving, of news-delivery, etc. CA is used to analyse the overall structure of PTOP counselling; identify if there are any patterns, whether in terms of turn-taking, conversation repair, and participation of interlocutors that indicate miscommunication, how healthcare provider and patients repair misunderstandings. CA is a useful approach because it is based on an attempt to describe people's methods for producing social interaction (Silverman, 2001). Through CA one can discern whether there are patterns in the interaction between the healthcare providers and clients that show methods of maintaining shared understanding of what is going on, and how or whether institutional roles are being maintained. CA is useful in identifying the kinds of choices doctors make in their turns at talk, in terms of how they design their turns, and

identify how institutional identity and institutional context may influence communication during the PTOP counselling session (Goodwin & Heritage, 1990). CA is focused with how turns and sequences are designed are tied to larger social and interactive processes (Goodwin & Heritage, 1990:295).

### 2.8.1 CA features:

As stated by Maynard and Heritage (2005:428), "features of conversation analytic theory and method imply a systematic approach to the organisation in interaction". In this section, I will be discussing CA features that will be applied to this study in analysing PTOP counselling in chapter 5. These micro-pevel conversational features such as turn-taking, conversation repair, sequence organization, and selection of lexical items will be examined.

#### 2.8.1.1Turn-taking

As stated by Wilkinson & Kitzinger (2011:29) "the organization of turn-taking is fundamental to talk in interaction analysis: understanding how turn-taking works is an important prerequisite for CA research". Turn-taking is a feature of CA, which is sometimes thought of as a technical phenomenon (Wilkinson & Kitzinger, 2011). The use of turn-taking to analyse doctor-patient interaction, can reveal significant details of interactional implications such as displays of power or (non-) cooperation (Wilkinson & Kitzinger, 2011). I use turn-taking system in this study to examine how turns are taken up, whether participants have equal turns of talk, what occurs when turns are interrupted, and to examine whether both the healthcare provider's and patient's linguistic background and their rules of talk have any influence on how turns are taken up during the PTOP counselling.

#### 2.8.1.2 Repair

The second CA feature is repair, this feature is a 'repair mechanism' used "when turn-taking errors and violations occur' (Silverman, 2011). Repair in talk occurs when a speaker says something that they immediately regret or find inappropriate, and then not continue with what they were saying to fix the problem (Wilkinson & Kitzinger, 2011). Another repair practice insertion repair that is used when the speaker "cannot be possibly complete in order to go back and add something (the word probably) into his turn-in-progress – technically" (Wilkinson &

Kitzinger, 2011:27). Talk can also be repaired by using a replacement word "(replacing one word or phrase with another), deletion (removing a word from a turn-in-progress), and reformatting" (Wilkinson & Kitzinger, 2011:27). "Recipients of a turn can also initiate repair on it if they find it problematic in some way (e.g. pardon? or huh? may be used to claim a problem of hearing" (Wilkinson & Kitzinger, 2011:27).

#### 2.8.1.3 Sequence organization

Sequence organization is "ways conversationalists link turns to each other as a coherent series of interrelated communicative actions is" (Mazeland, 2006:156) A sequence is basically an 'ordered series of turns' used by participants during talk to accomplish and coordinate an interactional activity (Mazeland, 2006). An example of sequence is when a speaker asks a question and the recipient responds with an answer (Mazeland, 2006).

#### 2.8.1.4 Word Selection (Lexical choice)

Part of this study is to look into the participant's lexical choices. Turns at talk are composed of lexical items selected from amongst alternatives, and part of this study is exploring to why speakers prefer some lexical items to others and to whether they are suitable within TOP context. I also explore whether the cultural beliefs of the participants being both the healthcare provider and patient have any influence on their lexical choice. For example, some nurses may refer to procedure as "terminate a pregnancy" and whereas others may refer to it as to "abort a child".

#### 2.8.1.5 Overall Structural Organization

This study draws on analysis of overall structural with the use of CA as analytical tool. PTOP counselling between healthcare providers and patients is organized into phases. PTOP counselling is usually structured: and I use CA to analyse how the healthcare provider and patient orient to and negotiate the boundaries of each phase of the interaction (Wilkinson & Kitzinger, 2011:27).

## 2.9 Strengths and Weakness of CA

When compared to other analytical approaches, CA takes a much detailed approach. CA does not use summarized or coded representations, instead it analyses detailed recordings of interactional activities and detailed transcripts. CA identifies various facets and subtleties in an interaction that would otherwise not be recognized by other analytical approaches (Drew, et al., 2011). CA as a discourse and narrative analytic methodology focuses on micro-level conversation, providing detailed data, and transcripts can be re-analysed (Drew, et al., and 2011). One of the disadvantages of adopting a CA approach within any study is that it is time consuming since it takes on a detailed approach. CA also uses a large body of data, which can be difficult to analyse. CA transcription is a subjective process, it based on researchers understanding of the text that may sometimes lead to inaccuracy (Have, 1990). Issues such as stereotyping and over generalisation may arise, but at the same time, the availability of the text means that it can be re-analysed and reviewed (Have, 1990). CA has been criticised by many scholars for being "resistant to making connections between such 'micro' structures of conversation and the 'macro' structures of social institutions and societies" (Fairclough, 1989:12). According to Fairclough (1989:12), CA then "gives a rather implausible image of conversation as a skilled social practice existing in a social vacuum, as if talk were generally engaged in just for its own sake". Which is when then Ethnomethodology is proposed in the chapter two as a complimentary approach to CA.

CA reveals some of the language and cultural barriers that impedes effective communication. The following section discusses Critical Discourse Analysis approach as an analytic tool which supports CA.

## 2.10 Critical discourse analysis approach

Mesthrie (2000:323) in (Saville-Troike, 2003:255) defines discourse as "different ways of structuring areas of knowledge and social practices or systems of rules implicated in specific kinds of power relations". CDA is primarily a qualitative method used to analyse texts of social and institutional talk that explores the relations between language, communication, knowledge, power and social practices (Cameron, 2001). CDA's aim and function is to explore how a discourse can be controlled through talk and overt or hidden acts of communication in context.

Discourse Analysis (DA), like CA is a qualitative research method for investigating social phenomena and is interested in social and institutional interaction (Cameron, 2001). DA explores how interlocutors draw on shared meaning to communicate with each other. DA will be used to investigate relations of language, culture, communication, power and social practices (Cameron, 2001).

Discursive actions are accomplished through talk in interaction which is why talk and action are viewed as "intertwined in a constitutive manner to provide meaning and shared understanding (i.e. inter-subjectivity) as well as to pursue certain agendas and activities with others in talk" (Schegloff, et al., 2002:5). CDA research has shown that people's understanding of the world is not merely expressed in their discourse, but that it is actually shaped by the ways of using language which people have available to them. How Cameron (2001:15) explains is it is that "reality is discursively constructed", meaning that speakers make and remake reality through their interaction about things using the 'discourses' they have access to. Communication studies have analysed spoken discourse, using CDA method to make explicit what usually gets taken for granted and also to show what talk in interaction accomplishes in people's lives and in society at large (Cameron, 2001). CDA analyses talk in interaction, interprets it and reflects on its meaning and to some extent it reveals other aspects of speaker's lives. CDA theory suggests that people speak about certain matters or topics and what they said in these discussions is drawn from their community's repertoire (Cameron, 2001).

CDA is used to investigate how power functions in society and how social relations influence communication in a TOP context. This study is to focus on language, and how language is used by healthcare providers and patient communication in PTOP counselling and to understand how language enables us to understand issues of social concern (Fairclough, 1989). CDA as qualitative method will useful for this study in examining how ways in which healthcare providers communicate are constrained by the structures and forces of those social institutions within which we live and function (Fairclough, 1989). To also show how health professionals, have to adapt to healthcare organizational culture and particular language use (Fairclough, 1989). Using CDA method, I will be able to examine whether the patients are disadvantaged in consequence of the inequalities of communication (Fairclough, 1989).

### 2.10.1 CA and CDA comparison

CA and partly CDA focus on everyday use of language in mundane or institutional interaction. Harvey Sacks, one of the co-founders of CA always emphasised that "there is no hearable level of detail that may not be significant, or treated as significant by conversational participants" (Silverman, 2001:188). CDA does not focus on the finer details of talk. Existing studies of talk which have applied CDA does not focus on particles like 'mm' and 'uh huh' as would by CA researchers and it is apparently because these particles do not contribute "to the substance of what discourse ends up saying" (Silverman, 2001:188). CDA studies have been concerned with social control, issues of dominance, power and positioning in talk (Silverman, 2001). CDA presumes a particular social theory to explain the participant's communicative behaviour (Saville-Troike, 2003). CA and CDA tend to overlap with each, and these two approaches will provide a holistic understanding of the experiences of patients in the PTOP context.

## 2.11 Position theory

### 2.11.1 Language and power

Whorf (1962:246) in McLauren (1998:99) defines language as "vast patterned-system distinct from others, in which are culturally ordained the forms and categories by which the personality not only communicates, but also analyses nature, notices or neglects types of relationships and phenomena, channels his reasoning and builds the house of his consciousness". Linguistic exchanges can express relations of power (Bourdieu, 1991). Language is sometimes used by dominant groups to exercise power over less dominant groups. Thompson, in Prinsloo, (2009:82) explains domination as "circumstances where established relations of power are 'systematically asymmetrical' or 'when particular agents or groups are endowed with power in a durable way which excludes, and to some significant degree remains inaccessible to, other agents or groups of agents, irrespective of the basis upon which such exclusion is carried out'". As alluded to earlier, language is linked to culture, influencing our worldview and our perceptions of others. It can be institutional culture, in a medical encounter the healthcare providers are power holders, control the medical discourse, and discourse types. Power within the health setting can be maintained and reinforced through use of language, for example through use of medical jargon which exclusive to those within the profession.

According to Fairclough (1989:2), "the exercise of power, in modern society, is increasingly achieved through ideology and more particularly through the ideological workings of language". The way in which people are positioned in social and work environments will most likely influence their language use. Language use reflects different positions in the social hierarchy (Bourdieu, 1991). According to Bourdieu (1991:1), "individuals speak with differing degrees of authority, words are loaded with unequal weights, depending on who utters them and how they are said, such that some words uttered in certain circumstances have a force and a conviction that they would not have elsewhere". Language is part of their social life; people use language to negotiate their way through life (Bourdieu, 1991). When someone fails to acknowledge or neglects forms of power during an interaction, it could be interpreted as being disrespectful and it may have a negative impact on the communicative process (Saville-Troike, 2003).

### 2.11.2 Positioning Theory in Talk

McLauren (1998:8) defines communication as "a dynamic process, always changing, each participants affecting and being affected by others". Individuals learn communication from others and by communication with other (McLauren, 2998). Interacting with speakers of different linguistic and cultural groups, exposes one to different styles of communication and may cause a shift in our worldview and our positions in talk. Positioning and identity is always in relation to other people. Davies & Harré (2007) define positioning as "our interpretation of a role and how we play out the practices and beliefs of that role in which the context makes sense". We are always tied to our identities and this may be the reason why some healthcare providers have difficulty separating their personal believes from their professional conduct.

Positioning theory was developed in social psychology as a tool for research on the dynamic inter-personal relations in which selves were given content (Hollway). Positioning theory has been extended to intra-personal and inter-group levels of analysis (Harré, et al., 2009). Positioning theory seeks to create a type of empirical analysis, which articulates micro and macro-processes in a single explanatory whole (Tirado & Gálvez, 2007). According to Tirado & Gálvez (2007:233) positioning theory "analyses, far from considering the interaction participants as clean slates who easily change subject position and when the situation alters, it considers them to be active agents in the construction of the interactions, and pays special

attention to the aspect of continuity which can link different episodes of the interaction". Positioning refers to the "actions in which people find themselves in and are bound by their interaction within a system of rights and responsibilities" (Tirado & Gálvez, 2007:232). Our socialisation determines the way people interact. Our individualistic and collectivistic identities and learnt styles of communication reveal themselves through our interaction with others. Positioning theory is interested in how speakers place themselves and others in talk and how these positions are negotiated (Tirado & Gálvez, 2007:232; Gudykunst, 1983).

Communication is the transferring of messages from one speaker to another and part of the communication process includes participants taking up different roles and positions (Tirado & Gálvez, 2007). Speakers take up positioning in the course interaction; as such, it is a discursive process (Harré, et al., 2009). According to Harré, et al., (2009:10) "people undertake positioning acts, and as such they are or claim to be positioned in certain ways, which endows them with the right and/or the duty to assign or ascribe positions". There are high and low order positioning, and speakers are positioned according to their social status, which determines their positioning in the communication hierarchy (Harré, et al. 2009). Harré, et al., (2009) explains that when there is internal conflict in a position where the speaker may feel that the other speaker does not have a right to give them that positioning or right to take up that position. According to Harré, et al. (2009) this is when the phase of second-order positioning. Sometimes cultural differences may emerge between rights and duties causing speakers to reject their positioning and re-position themselves (Harré, et al., 2009).

The use of language can create shift in positioning, whether it is sustaining or rejecting the positions during the interaction. According to (Tirado & Gálvez, 2007:231), "the sense of positioning's extremely dynamic and changes easily depending on the narratives, metaphors and images through which they are constructed". Positions are negotiable; in the sense that if a person believes that they are positioned lower than they should be, they can reject that position and take up another positioning (Tirado & Gálvez, 2007). For example, in one of the research sites, we addressed one of the nurses as "sister" and before we could continue to introduce ourselves and discussing the purpose of the research project, she stopped us and corrected us and said she is "Dr X". To her maybe title and the power it had attached to it was important and she then felt the need to be addressed with the correct title. Sometimes speakers unintentionally place each other in lower positioning and sometimes that can determine the

turn the interaction will take. Some speakers will question the positioning and may reject it and in some cases the speaker may submit to the assigned positioning (Tirado & Gálvez, 2007).

Within TOP contexts, the clients are positioned as passive and powerless agents, who need comply with healthcare provider. The women also place themselves in a powerless positioning and are careful of their language use because they desperately need to access TOP services and they avoid any sort of communication conflict. The women are well aware of abortion stigma and it is deemed to be immoral, and that the nurse's attitudes may be influenced by those of the wider community. Women seeking TOP services do not become active agents in talk, and will use an avoidance approach because they fear offending the healthcare provider and the quality of service they receive. This is aligned with what ethnography of communication proposes that people learn norms of communication that guide them in their interaction, and constantly help them negotiate their way through life (Hymes, 1989). The clients know that a certain response maybe interpreted as being disrespectful, hence they will respond in a way that may not seem ideal but at that moment it does to them as it avoids conflict that may negative affect the quality of care they receive. In this study, I will be using positioning theory to explain how healthcare providers take up their position and from where the patient's powerlessness is derived (Davies & Harré, 2007).

The healthcare providers are aware of their power they over their clients as health professional and exercised power through talk. As mentioned previously, health-service providers use a shouting tone of voice when they counsel women seeking TOP services. The participants in Varky's (2010) study have reported that nurses speak down at them and use language and tone they normally would not use when speaking to patients seeking different services. The clients position themselves in powerless positions in talk because of lived experience and experiences of others who have received unpleasant treatment when seeking TOP services. According to Davies & Harré (2007:13), we learned how to take up a particular role through observation of others in that role. The women may then see it better for them to position themselves in a way that does not seem to question the healthcare providers, because they are the carriers of medical knowledge. In some instance, the clients do not exercise their agency at all.

## 2.12 Summary

This chapter presents some health communication theory in South Africa. The chapter also discusses the barriers to women accessing safe and legal TOP services. Arguing that healthcare providers have a double impact as health professionals and carriers of culture, hence their personal values and beliefs influence their professional conduct. This chapter also states that TOP law reforms have not changed the attitudes of wider society; abortion stigma and healthcare provider's negative attitudes negatively influence PTOP counselling. Sociolinguistics is summarised, focussing on linguistic behaviour and cultural norms, investigating how they influence talk. CA and CDA are discussed as analytical tools used in the analysis and interpretation in chapter 5. This chapter highlights that culture has an impact on one's language use and styles of communication, therefore influencing the type of counselling provided. Intercultural communication theory is discussed in relation to some of the communication challenges that face the health sector. In discussing communication, hierarchy and positioning theory are highlighted to explain how healthcare providers and clients position themselves in relation to each other, and how linguistic power determines ones positioning.

The chapter that follows outlines the research methodology followed in this thesis.

# CHAPTER 3: METHODOLOGY

## 3.1 Introduction

This research takes on a qualitative research approach which will help answer the questions in the study. Qualitative research is a method of investigation that provides a deeper understanding of social phenomenon (Silverman, 2001). Qualitative research has been used to examine doctor-patient interviews, providing detailed interpretations of medical encounters. Qualitative sociolinguistic research is important because it helps us determine what factors enable and prevent effective communication between healthcare providers and patients (Watermeyer & Penn, 2009:2054). Later on in this chapter, I discuss the qualitative research approach and its strengths. In this study I used purposive sampling, and in this chapter I discuss why this sampling technique was the most appropriate in recruiting the participants. This study thus draws on qualitative research methods. This chapter provides a discussion on the combined qualitative research methods used to collect data and explains how each research method was used. The methods used to collect data are observations, audio recorded PTOP counselling sessions and in-depth interviews. These methods collected data which is used to examine and identify patterns of behaviour in healthcare providers and client interaction in the PTOP context, the linguistic and cultural implications and how they may affect communication and health outcomes.

The following section of this chapter discusses the sampling used for selection of participants.

## 3.2 Sampling

The participants in this study were recruited using purposive sampling. This strategy of sampling uses a non-probability sampling technique, which is non-random. Purposive sampling technique is a tool used to select participants appropriate for the study (Tongco, 2007). With purposive sampling, the researcher selects participants of a specific population group based on their knowledge or experience related to phenomenon of interest (Tongco, 2007). By adopt this sampling technique; the research selects participants most appropriate to the study. Purposive sampling was used to select participants for this study. Purposive sampling

method is appropriate because this study needed specific participants that data could be obtained from. Participants in the study were required to have undergone PTOP counselling. In purposive sampling, interpretation of results is limited to the population under study (Tongco, 2007). The group of participants represents the population group that the study is based on, hence a large number of participants was suitable for this study. The interviews also need interviewees who had undergone the counselling and could speak on their experience of the PTOP counselling. The interview schedule for the healthcare provider's interviews contained questions based on the healthcare provider's experience of providing PTOP counselling hence healthcare providers who were recruited for the study provided the counselling service. The study requires specific participants who had the knowledge and experience related to the research question.

The data for the study was collected at three research sites. Different sites were approached for this study so that there was a diversified group of participants. With the data I am able to cross-check if the identified patterns are consistent across the different healthcare facilities, or if they apply to that particular context. In qualitative research, validation is important and collection of data provides a broader understanding of the communicative processes. Interpretation and analysis is based on findings across all three research sites. Diversification of data helped me gain a better insight as to why speakers may have provided certain speech acts at give moments. The shared experiences of clients varied in terms of the emotions felt by the clients at particular moment/stages of counselling. Their narratives varied in this sense, but there were common threads when in what was shared concerning the quality service provided.

### 3.2.1 Participation of healthcare providers and clients

Once the selected research sites had approved our request to collect data, my co-researchers and I then visited the sites. The day visits took place before the actual data collection process. The visits were initially to help us build relations with the healthcare providers, to inform them about the study and its purpose. I visited two out of the three sites prior to the data collection. It was important to check the sites out before the data collection period, to discuss with the healthcare providers how the study will be carried out, and discuss other measures such as how to approach the clients. The visit helped significantly because I had the opportunity to meet the healthcare providers, and together we were able to discuss the best ways for which data would

be collected. The visit was good in a sense that we were to share ideas with each other and come up with joint solutions. The manner in which we approached the healthcare providers was important, and for our presence to not feel like an imposition. It was also important to build good relations with the healthcare providers, to be respectful of their work environment, especially since my co-researchers and I were going to work closely with them. A week was spent at each site, which was an advantage for this study, because it gave me enough time to become familiar with the environment and as days went by the work relations with the healthcare providers grew stronger.

At all the sites, I arrived early in the morning because TOP wards start operating as early as 6h00 and some a bit later. Arriving early at the site gave me enough time to settle down. Upon my arrival at each site, I would greet the healthcare providers and have a few chats before they too settled in. At Site 1 the nurse would first meet with the clients, explain to the client that we are conducting a study, and looking for clients to partake in the study. At Site 1 and Site 2, the nurse and counsellor would ask the clients if they were interested in participating in the study. In instances where the answer was yes the nurse would call either my co-researchers or I to explain what the study would entail. The clients at Site 1 and Site 2 were approached individually, which was what the nurse and counsellor suggested. At Site 3, my co-researchers and I would go to the waiting room accompanied by the nurse, and the nurse would introduce us to the clients. We would then briefly introduce ourselves and explain to the women that we were conducting TOP research, explaining the study and that it was voluntary and confidential. When the clients at Site 3 went in for PTOP, they would confirm with the nurse as to whether they were interested to participate in the study. My co-researchers and I explained the study to the women in both English and isiXhosa. We explained that we were conducting research that seeks to understand women's and healthcare providers' experiences of PTOP counselling.

Due to ethical reasons and the sensitivity of the study, my co-researchers and I were not present during the counselling. All the counselling sessions were audio recorded. Relevant information about the study was provided to the participants prior to the counselling. At the beginning of every counselling session, the healthcare providers would ask the clients if they were interested in participating in the study. In cases where the woman gave her consent the health service provider would call either myself or my co-searchers into the counselling room to give the client informed consent form to sign and set up the audio recorder. It was demonstrated to both

the healthcare provider and client how to operate the audio recorder, as either party may want to end the recording if they choose to do so. There was only one case where the client, a teenage girl who was accompanied by her mother was overwhelmed with emotions and my co-researcher asked her if she is okay and reassured her that it is okay if she wants to stop the interview and discontinue from the study. The client agreed to have the recording stopped and the recording was erased at that immediate moment.

Participants in this study were nurses, counsellors and women seeking TOP services. Consent had to be obtained from all parties involved in the counselling session (See Appendix 2). There was one counselling session, which included a third party, whereby the mother of the client was asked to join the counselling session because the client was a minor and the nurse wanted the mother to be part of the decision making in selecting a family planning method. Consent had to be also obtained from the healthcare providers for both the counselling and interview. Some of the healthcare providers had recently started on the job and declined to do the interview. They felt they did not have enough experience to speak on whilst others explained that they provided the service because they are required to and did not want to have to think about it beyond that, stating that an interview would require them to think of the services they provide to be more than part of their job. They stated that they were not ready to deal with the emotions of TOP itself.

In the following section, I further discuss qualitative research and data collection methods.

### 3.3 Research methodology

This study uses qualitative research methods, in investigating cultural behaviours and the influences they have on the communicative process between healthcare provider and clients within PTOP context. "The purpose of qualitative research is to describe and understand social phenomena in terms of the meaning people bring to them" (Boeije, 2010). A qualitative approach was used to gather data of the interaction between healthcare providers and women seeking TOP services in the context of occurrence. Methods used in this study include a detailed examination of audio recordings and transcriptions made from the recordings.

### 3.3.1 Strengths of qualitative methods

The value of qualitative methods lies in their ability to help the researcher "make things out" in the context of their occurrence and it helps with understanding behaviour and cultural communication that are imbedded in the context of everyday life (Gray, 1999). Qualitative methods of inquiry seem to provide richer and more detailed information about adherence behaviours and allow researchers to gain a greater understanding of the 'why' factor (Penn, et al, 2011). The value of qualitative methods in understanding barriers to adherence and the potential value of the cultural broker in intercultural settings is discussed. "Qualitative research is characterised by its aims, which relate to understanding some aspect of social life, and its methods which (in general) generate words, as data for analysis" (Patton & Cochran, 2002:2). Qualitative methods are used in this study to understand the participants' social reality and how they make sense of their social world through language (Patton & Cochran, 200). Qualitative methods were most suitable for this study because its methods that aim to answer questions about the 'what', 'how' or 'why' of a phenomenon (Patton & Cochran, 2002). Qualitative methodologies can help address some of the communicative challenges in healthcare. A qualitative approach is appropriate when the researcher wants to understand perceptions of the participants and explore the meaning they give to phenomena (Patton & Cochran, 2002).

This study uses combined qualitative methods to collect data. The research methods used were observation, PTOP counselling sessions and in-depth interviews, which are audio recorded and transcribed into text. An independent translator, trained in translation studies, translated the recorded of isiXhosa counselling sessions, into English verbatim and English conceptual translation. All data is transcribed according to the Jefferson system of transcription notation (See Appendix 5). Data is audio recorded and transcribed by professional transcribers into conceptual transcription.

In the following section of this chapter, I discuss the combined research techniques and how data was collected.

### 3.3.2 Observations

According to Silverman (2001) observational studies, whether it is field notes or extended transcripts, these are not often available because research becomes too consumed by the study and there is barely any time to take notes. Silverman (2001) indicates that these notes are significantly helpful to the research because they allow the reader to formulate their own ideas about the perceptions of the participants. Silverman's (2001) strong emphasis on field notes is based on the argument that a researcher cannot be solely reliant on data, even when the communicative processeses are audio or video recorded and transcribed. An independent translator, trained in translation studies, translated the recorded isiXhosa counselling sessions, into English verbatim and there is English conceptual translation. All data is transcribed according to the Jefferson system of transcription notation (See Appendix 5). Data is audio recorded and transcribed by professional transcribers into conceptual transcription. Selected transcripts are presented in Appendix 6, 7 and 8.

According to Silverman (2001:28) "reliability of the interpretation of transcripts may be seriously weekend by the failure to note apparently unimportant, but often crucial pauses, overlaps or body movements". Which is precisely why I took notes of occurring events whenever the chance presented itself. This study adopts a CA approach as indicated in chapter 2, which is interested in the finer details of talk, but solely relying on CA for the interpretative process, I may not be able to provide the reader with a clear context. Observation is also important in trying to understand the complexities of power relations within healthcare, which I aim to address in the study (Patton & Cochran, 2002).

Descriptive data captures the acts or events during the time of occurrence, presenting a clear picture to the reader. In this study, I was sometimes unable to not everything that was occurring at that particular moment which is something commonly experienced by researchers. Patton and Cochran (2002) suggests that the researcher may not be able to take note of every occurring event but the daily observation will still be of great assistance in the writing up stage of the research. As stated by Patton and Cochran (2002:20), "observational data is also very useful in overcoming discrepancies between what people say and what they actually do and this might help you uncover behaviour of which the participants themselves may not be aware". Silverman (2001) states that an observational study is important because it allows the

researcher "to gather first-hand information about social processes in a naturally occurring context". This proved to be truthful in this research, in the interview with the clients I would ask follow-up questions based on their responses and my own observations. Sometimes the clients could not remember some of the events that had occurred earlier in the day and when I shared my obersations, some of the clients were able to make recollections of the events. My field notes during observation have also helped because when we interviewed the women they sometimes could not recall events of the early morning. Some of the question would be based on what was observed and I would have them engage or provide more information about a particular event, to understand what they made of the event and not for me to merely base that on my own assumption.

I was an overt observer; the clients were informed of the research. Observations started from the time I would step into the TOP ward. Office space was provided to us to conduct the interviews. At Site 1 and Site 3, one walked straight into the women seated, waiting for counselling. At site 2, the clients were seated in a different room and only came to our side when they came for counselling. Site 2 was the only site where the counselling was optional and often I did not have any encounter with the clients. At Site 3, the office provided was a glass door and I could observe movement, the nurse communicating with the clients, and the interactions the clients would have amongst themselves. With this research being centred on PTOP counselling, there is some sensitivity and ethical concerns.

As alluded to earlier, there is a stigma attached to TOP and it is something that is usually kept to oneself almost as a secret because women fear judgment and being ostracized by their communities. I was aware that my presence might cause some discomfort to the clients, which is why my co-researchers and I had to be sensitive in how we approach them. I then left the waiting room and moved to the office space provided to us. It was important to give the women time to take in the information and decide as to whether or not they were interested in partaking in the study. We had to be mindful of our use of language and our body language. The only time I interacted with the clients outside the interview room was when my co-researchers and I were informing them about the study. It was also important to not be in the women's space (waiting room) for too long because I was aware that my presence might make some of the women uncomfortable.

### 3.3.3 Recorded counselling

The purpose of recording these PTOP interactions is to have data that captures what takes place in the counselling session, to capture what is said by the speaker, how it was said and to provide an interpretation and analysis on what influences these communicative processes. The study adopts a CA approach, which focuses on the finest details of talk, and the recordings are transcribed in detail. The transcriptions are detailed and in the analysis, I focus on patterns of talk related to the research objectives. This approach is useful because it is a naturally occurring talk and what is said by the speakers is influenced by the context.

### 3.3.4 In-depth interviews

This study is interest in both the experiences of the healthcare provider and patient within the PTOP context. It is important to have both narratives when trying to tackle such critical health communication challenges, which often lead to poor quality service and negative health outcomes. The advantage with in-depth interviews and open-ended questions is that the interviewee's responses are detailed (Boyce & Neale, 2006). In-depth interviews are a qualitative method used in the study to gain more insight to the client's experience of PTOP counselling and healthcare providers experience on providing TOP service. The questions enquired in the interview were related to the bigger research project, which investigates how first trimester pre-termination of pregnancy (PTOP) consultations are conducted within the public health sector in the Eastern Cape, South Africa, and in the United Kingdom. Some of the responses were relevant to this study. In-depth interviews are an appropriate approach to gain more insight to the context of the recording, in addition to my observations.

In addition to the recordings of the counselling sessions, I conducted individual interviews with the patients and the healthcare providers. In the post-counselling interviews, the clients were asked questions based on the counselling they had just received. The clients had a choice to either have the counselling session recorded or to do a post-counselling interview audio recorded; or have both the counselling session and interview recorded (See Appendix 3). A few women gave consent to only having the counselling session recorded and did not want to do the interview. The study was voluntary and the clients and healthcare providers were not asked to provide reasons for not wanting to participate in the study. But some women who had

given consent to the counselling session being recorded explained to either myself or my co-researcher why they could not do the interview when they came to give back the signed consent form. Some of the women said that they had to rush home before their children got back from school, for some it was before the parents got home and did not want to be asking about their whereabouts. Some would say they are not comfortable discussing the counselling session, and others were overwhelmed with emotions after the counselling session and wanted to leave the PTOP ward straight after the session.

The interview schedule for the clients consisted of questions based on the client's experience of the counselling. The duration of the recordings varied, some were longer than others because some interviewees engaged more. There was one interview, which my co-researchers and I were present in, and we did the rest of the interviews separately. Usually the women waited long hours before they were assisted which sometimes meant that they were tired by the time they went for counselling and hence we could not keep them waiting for the interview. It was important to get as many interviewees as possible, and if they had been made to wait they may even change their minds about partaking in the study. Sometimes the interviewees would indicate before the interview that they were in a rush and that they were hoping the interview would not take too much time. The clients were asked whether they prefer to be interviewed in English or isiXhosa. The questions in the interview schedule were provided in both languages. Often the women would select English. It was explained to the interviewees to feel free to stop the interviewer when the question was not clear to them. There were cases when the questions were not clear, and the question would be rephrased or re-asked in isiXhosa.

In the interviews with the healthcare providers, the questions were based on their experience of PTOP counselling. There were two sets of interviews with the healthcare providers. Most of the questions were about the healthcare provider's experience of providing PTOP services. The interviews took place two days apart, the second interview was a reflection, where the nurse or counsellor shared cases that stood out for them.

The interview questions were open ended. Silverman (2001:13) states, "Open-ended questions are the most effective route towards the end". Open-ended questions provide rich qualitative data. Open-ended questions are great because the interviewee is not limited into giving one answer as they would with closed questions. In the interviews, the responses were spontaneous,

and not influenced by me or by the questions. The interviewees provided answers based on their individual experiences. As a result, the responses were diversified, and rich in data. Closed ended question may sometimes be more preferable to interviewees because the answers are straightforward and do not require them to give their own opinion and to think about the answer (Boyce & Neale, 2006:3). The advantage about open-ended questions is that I was also able to ask follow up questions, and gain more insights of the experiences of healthcare providers and clients.

Silverman (2001:55) states that researchers require communicative skills and training on how to conduct interviews to maximise validity and reliability. I worked closely with Rhodes Critical Studies in Sexualities and Reproduction (CSSR) team, and together we had a number of practice runs to help prepare us for data collection and guide us on how to conduct the interviews. One of the Professors who was part of the research project guided us. The practice runs were helpful because this PTOP research is her area of research and secondly she is located within the Psychology department and is therefore sensitive to these particular research topics. During the practice run, we went through the questions to check if there were better ways of rephrasing them and how to avoid having the interviews seeming like a checklist. My co-researchers and I had to be relaxed, and familiarising ourselves with the interview schedule gave natural flow to when we conducted the interview. As a result, we had a numerous numbers of practice runs, we knew the questions and did not have to keep referring back to the interview schedule during the interview. Most of the interviews had a natural flow that relaxed the interviewees. With the necessary communicative skills, the researcher is able to ask appropriate questions that would draw out the information related to the phenomenon of interest.

Summary

The use of combined qualitative methods is useful because it provides a holistic understanding of the research problem. Combined methods provide more insight and context to the study. The advantage of using the three combined qualitative methods to collect data for the study means that the interpretation in not solely based on my interpretation, providing more insight and increasing the reliability of the research claim. The disadvantage with using mixed methods to collect data is that it may be time consuming and a large body of data has to be analysed.

### 3.4 Ethics

There were certain steps to be taken prior to this study and the data collection process. The first step was having the CSSR research project cleared by the Rhodes University Ethics Committee for ethical approval. The application for ethical approval provided detailed information of the bigger research project, outlining the research problem, research objectives and how the study would be conducted. Full ethical clearance for the research project was obtained from the Rhodes University Ethics Committee. From there the Eastern Cape Department of Health was approached for permission to conduct research in the Eastern Cape public healthcare facilities. Once Eastern Cape Department of Health granted permission, selected hospitals were approached with a request to conduct the study. A similar process was followed. When permission to collect data at selected hospitals was granted, we had to get the healthcare officials to participate in the study. Healthcare providers played a crucial part in this study, without their consent, it would have been impossible to collect data.

Research ethics provide the researcher with guidelines on how to collect data accordingly. The researcher can be held accountable for not following the proper channels in conducting their research. Ethical guidelines are important and protect the participants involved in the study.

### 3.5 Anonymity of the study

This study was anonymous and voluntary. It was explained to the research subjects that the project is voluntary and that they can withdraw from the study at any given point. I also explained to the clients that the recordings of those who choose to withdraw from the study would be deleted immediately. Consent was obtained from the healthcare providers and clients. Participants had to sign consents that were written in English and isiXhosa, explaining the kind of research we were conducting, the purposes of the research and what the research entailed. I read the consent form in whichever language was preferred by the healthcare provider and patient. It was important to also reassure the participants that the study is highly confidential, voluntarily and that if they were uncomfortable at any point they could discontinue from the study. Trust has to be built with the research subjects and they need assurance that data will not be traced back to them individually.

Names of the research subjects are not used in the research. When the research subjects signed the consent forms it was indicated to them that they do not need to provide their given name and should use a pseudonym if they wish to do so. The only information that had to be correct was their age, and occupation. The names of the selected healthcare facilities that we collected data from are also not provided.

In the informed consent forms it was also indicated that people who will have access to the data are those involved in the research project. There were two people who assisted with the translation and transcribing. People within my department were used, the sensitivity of this research was explained to them, and confidentiality was emphasized. The data is securely kept in locked storage so that no one besides those involved have access to the data.

### 3.6 Reliability of qualitative research

Researchers cannot completely claim that they fully understand the experiences of their subjects. A researcher spends a great amount of time analysing data, making sense of communication processes through their own interpretation. Researcher's interpretations can be subjective, and with qualitative research, validity of claims is always in question. With qualitative research, validity of claims is sometimes questioned because it is presumed that the researcher cannot completely be objective (Saville-Troike, 2003:255). Saville-Troike (2003:4) states that "complete escape from subjectivity is never possible because of our very nature as cultural animals; however, the constraints and guidelines of the methodology are intended to minimize our perceptual and analytical biases". One of the challenges with qualitative research is that sometimes the researcher subjectivity may affect objectivity. CA and CDA approaches are criticised for being too subjective in their interpretation. Describing and analysing the negotiation of meaning within texts, relies on the researcher's interpretation influenced by their worldview and potential problems may then arise (Saville-Troike, 2003).

### 3.7 Summary

This chapter begins by discussing the qualitative research approach, and why this study takes on this approach in relation to the aims of the study. Purposive sampling is discussed as a sampling technique used to recruit research subjects. I provide a discussion of how participants

were recruited at each of the three research sites. A qualitative research approach is later discussed, its strengths are highlighted and I discussas to why the qualitative research approach is appropriate for this study. This chapter provides an outline of the three research techniques used in the study to collect data being observations, recorded counselling sessions and in-depth interviews. This chapter addressed the importance of ethics in research, and how ethics ensures that the participants involved into are protected. This study was anonymous, and above I explain as to how I ensure the research subjects remains anonymous. The researcher's subjectivity in qualitative research is also discussed, indicating how it may sometimes lead to the researcher being biased and providing an inaccurate interpretation of data.

In the chapter that follows, I present the data and describing the research sites.

# CHAPTAER 4: DATA PRESENTATION

## 4.1 Introduction

In this chapter, I present data from the three research sites. The data was audio recorded and transcribed using the CA and Jefferson transcription notations as indicated in chapter 3. Data presented in this chapter consists of PTOP counselling, in-depth interviews with the healthcare providers on their experience of providing PTOP and post-counselling interviews with the clients regarding their experience of the counselling. This methodology has been fully explicated in chapter 3 of this thesis. PTOP counselling sessions were recorded to help understand the communication behaviour of healthcare providers and clients. The interviews were collected as part of the CSSR research project. This study made use of interviews related to the research question, focusing on the linguistic and cultural aspects of communication. As alluded to earlier, this study examined patterns of communication behaviour between healthcare provider and clients during PTOP counselling, focussing on the linguistic and cultural aspects of the interaction. In using CA and CDA as analytical tools, I examine how healthcare providers and clients use language in their relationships with one another and how institutional roles are maintained in that use of language is in essence at the heart of the data presentation.

The following themes presented below are based on information I obtained from the PTOP counselling sessions, interviews with health service provider and clients. The themes are as follows:

- Communication Barriers
- Language and Power
- Extralinguistic Features
- Participant Observation

These themes assist with presenting the data later in this chapter.

### 4.2 Demographic profile of participants

All the participants in this study were women. Consent was obtained from 52 participants. The participants in this study were between the ages of 15 and 41. 4 of the participants were below the age of 20, 40 of the participants were between the age of 20 and 34, with 6 participants of age 35 onwards. The participants in this study were mostly black isiXhosa mother speakers, with a few coloured women also involved. In certain instances, male partners were present but they were not part of the PTOP counselling. This will be elaborated upon under the theme of participant observation.

36 participants were single, 2 were married, and the other 14 women did not provide their marital status because they were not asked during the counselling. 12 participants were employed, 13 unemployed, and 27 were currently studying. Some of the participants had low levels of English proficiency.

4 healthcare providers participated in this study. These healthcare providers provided the PTOP counselling. There was 1 black isiXhosa speaking nurse from site 1, 2 white English speaking counsellors from site 2, and 1 coloured English and Afrikaans speaking nurse from site 3.

**Table 1: Participants' demographics**

| **Age** | below the age of 20 | 20-34 | 35+ |
|---|---|---|---|
| | 4 | 40 | 6 |
| | | | |
| **Marital Status** | Married | Single | Marital status not asked |
| | 2 | 35 | 17 |
| | | | |
| **Occupation** | Employed | Unemployed | Studying |
| | 13 | 13 | 25 |

This data consists of 28 counselling sessions, 4 interviews with the healthcare providers and 10 post counselling interviews with the clients. 20 of the counselling sessions are individual counselling sessions and 8 are group counselling sessions. There are 8 counselling sessions conducted in isiXhosa and 20 in English.

The counselling sessions was made up of four main stages which were:

1. Reason for Terminating Pregnancy
2. Pregnancy Options
3. TOP Procedure and Risks
4. Decision-Making
5. Family Planning

The stages within these counselling sessions will allow for further data analysis in chapter 5 of this thesis.

### 4.3 Research sites

This research was located in the Eastern Cape, where 78.8% of the population is isiXhosa mother tongue speaking, followed by Afrikaans at 10.6% and English at 6.5% (SouthAfricaninfo, 2015). The Eastern Cape is one of the most disadvantaged provinces in South Africa as indicated in chapter 1 of this thesis. It is the second largest province and has a population of 6.6 million people (Stats SA, 2016).

Data was collected at three public hospitals offering TOP services. Two hospitals were situated in a township and one in a suburb. I collected data for a week at each research site. All the hospitals where I collected data provided both individual and group counselling. Counselling was mandatory at two of the hospitals, and it was optional at one.

**Table 2: Research Sites Demographics**

| | **Research Site 1** | **Research Site 2** | **Research Site 3** |
|---|---|---|---|
| **Language used in the counselling** | IsiXhosa (7) | English (7) and IsiXhosa (1) | English (13) |
| **Location** | Township | Suburb | Township |
| **Counselling** | Mandatory | Optional | Mandatory |
| **Type of counselling** | Individual and Group counselling | Individual and Group counselling | Individual and Group counselling |
| **Number of consultations** | 7 | 8 | 13 |
| **Number of participants** | 12 | 17 | 21 |

Research Site 1

Site 1 is a large hospital situated in a township, in the Eastern Cape. I collected data from this hospital on the 24th to the 28th of August 2015. The hospital provides healthcare services to mostly a black population.

Data was collected twice at this research site. During the first round of data collection, I collected 4 individual PTOP counselling sessions, 1 interview with the nurse providing the PTOP counselling and 3 post TOP counselling interviews with the clients. In the second round of data collection, 1 individual PTOP counselling session, and 2 groups counselling sessions were collected. The first group counselling had 4 clients and the second one with 3 clients being counselled. 7 counselling sessions were collected at this research site, with a total of 12 participants. The participants were between the ages of 15 and 33.

**Table 3: Demographics for Research Site 1**

| Type of counselling | Age | Language used in the counselling | Occupation | Marital Status | Number of children |
|---|---|---|---|---|---|
| Individual | 15 | IsiXhosa | Studying | Single | 0 |
| | 28 | IsiXhosa | Unemployed | Single | 1 |
| | 22 | IsiXhosa | Studying | Single | 0 |
| | 21 | IsiXhosa | Studying | Single | 0 |
| Group 1 | | | | | |
| | 24 | IsiXhosa | Studying | Single | (not specified) |
| | 33 | IsiXhosa | Employed | Single | (not specified) |
| | 20 | IsiXhosa | Studying | Single | (not specified) |
| | 22 | IsiXhosa | Unemployed | Single | (not specified) |
| Individual | | | | | |
| | 20 | IsiXhosa | Studying | Single | 1 |
| Group 2 | | | | | |
| | 26 | IsiXhosa | Studying | Single | (not specified) |
| | 29 | IsiXhosa | Employed | Single | (not specified) |

| | | | | | |
|---|---|---|---|---|---|
| | 24 | IsiXhosa | Studying | Single | (not specified) |

There were three nurses working at the TOP ward. The ward provided PTOP and TOP services and family planning services. The nurse that worked at this ward were all black isiXhosa-speaking nurses. All the counselling sessions are in isiXhosa. During the counselling, the nurse used a few English terms. All the clients were fluent speakers of isiXhosa and able to communicate in the language spoken by the nurses. There were doctors who assisted the nurses with the pregnancy scanner and to perform the TOP surgical procedure. The doctors were usually, white, Indian or foreign doctors. This was when the clients would encounter doctors of different linguistic and cultural backgrounds to them.

The nurses shared the work amongst themselves, each with different responsibilities. The one nurse was responsibile for taking down the client's history, while the second nurse provided the PTOP counselling, and the third nurse was an assistant nurse. The nurse providing counselling was sometimes assisted by her co-worker. The nurses had not undergone TOP training and had to learn on the job.

PTOP counselling at this site was mandatory. The nurse provided individual and group counselling depending on the number of clients. The nurse would resort to group counselling when there were a large number of clients. The information provided in the group counselling in comparison to the individual counselling was slightly different. For example, in group counselling there were no personal questions during history taking and the information was general information and not directed to one particular individual. The only time the nurse would direct something at individual clients was when they had to give reasons as to why they wanted to terminate the pregnancy. The counselling focused mostly on providing information on the TOP procedure and family planning options.

Language was not a barrier to women receiving safe and reliable TOP services, but instead it was the lack of trained nurses that provided the counselling that was the issue. The nurses had not undergone training; they used the information on the informed consent to guide them. There were some issues around communication, such as the type of information provided. The

counselling was not always patient centred and the nurse would tell clients that they do not promote TOP but rather family planning. Skilful communication is very important in medical practice; it has an impact of quality of care and health outcomes.

Research Site 2

The second research site is situated in a suburb, which is 21.8 kilometres away from site 1. I collected data at this site from the 19th to the 23rd of October 2015. The hospital mostly caters for the black and coloured population.

Data was also collected twice at this site. 18 clients and 2 counsellors participated in the study. The clients participating in the study were between the age of 17 and 41. During the first round of data collection, I collected 2 PTOP individual counselling session and 2 interviews with both the counsellors. There is an additional 5 counselling session from the second round of data collection. The data from Site 2 consists of 8 PTOP counselling sessions, with 4 individual and 4 group counselling sessions. 7 counselling sessions are in English and 1 is in isiXhosa.

**Table 4: Demographics for Research Site 2**

| **Type of counselling** | **Age** | **Language used in the counselling** | **Occupation** | **Marital Status** | **Number of Children** |
|---|---|---|---|---|---|
| Individual | | | | | |
| | 31 | English | Unemployed | Single | 1 |
| | 23 | English | Unemployed | Single | 0 |
| Group 1 | | | | | |
| | | IsiXhosa | Employed | Single | 1+ |
| | | IsiXhosa | Studying | Single | 1 |
| Group 2 | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | 28 | English | Studying | Single | 1 |
| | 25 | English | Unemployed | Single | 0 |
| | 25 | English | Studying | Single | 0 |
| | 24 | English | Employed | Single | 0 |
| | 30 | English | Unemployed | Single | 1 |
| Individual | | | | | |
| | 19 | English | Studying | Single | 0 |
| | 29 | English | Studying | Single | 1 |
| Group 3 | | | | | |
| | 25 | English | Unemployed | (not specified) | (not specified) |
| | 37 | English | Employed | (not specified) | (not specified) |
| | 27 | English | Unemployed | (not specified) | (not specified) |
| | 21 | English | Studying | (not specified) | (not specified) |
| Group 4 | | | | | |
| | 17 | English | Studying | Single | 0 |
| | 30 | English | Studying | Single | 1 |
| | 41 | English | Unemployed | Single | 1 |

At Site 2, there were four nurses and two counsellors working at the TOP section of the ward. The TOP section was part of the maternity ward. At Site 2 there were two black nurses who spoke isiXhosa and English to the clients. There were also two coloured nurses, and one nurse spoke in English and Afrikaans and the second coloured nurse spoke isiXhosa, English and

Afrikaans. During the first round of data collection, there were two English-speaking counsellors from a Christian organisation providing the PTOP counselling. In the second round of data collection a third counsellor from the same organisation joined the team and provided the counselling in isiXhosa and English.

The counsellors were trained in Christian counselling. One of the nurses had recently joined the TOP ward and assisted the other nurses whilst she was undergoing training. The other nurses had all undergone TOP training. The nurses were responsible for recording down the patient's medical history, they briefly provided the clients with information about the TOP procedure and they performed pregnancy ultrasound scans. During the PTOP counselling, the counsellors provided a detailed information about the TOP procedure, discussing some of the risks and pregnancy options such as adoption.

Site 2 had a large number of clients coming in daily and they saw up to 10 clients a day. Site 2 was the only site were PTOP counselling was optional to the clients, and as a result, the number of participants was low. At this research site, TOP services were provided until late morning. The site provided individual and group counselling depending on the number of clients present that day. The counselling at this site was focused mostly on pregnancy options, with a great emphasis on adoption. The counsellor did not provide a detailed discussion on the TOP procedure and how it is performed. The counselling focused on psychological and physical damages of TOP.

Counsellors had to turn away clients who did not speak or understand English. During the first round of the data collection, I was present when one client was turned away as they could not have counselling provided to her due to the language barrier. The counsellor took down the client's number and said she would get an isiXhosa speaking nurse.

**Extract 1**

*C:* *I will get a Xhosa counsellor to phone her =*

*R:* *Mhmm.*

*C:* *= just to try have one last (.) re-assurance*

*R:* *Yeah.*

*C:* *= so that she doesn't feel you know someone with a pink face who didn't get her because I don't think that's good enough.*

(Counselling Session)

The counsellor shared that she does not often encounter clients that are not proficient in the English language or understand the language. The counsellor stated that most of her clients English were *"okayish"*.

Research Site 3

Site 3 is situated in a township, in the Eastern Cape. This research site is situated in a different city from the first two research sites. The hospital caters for a black population.

I collected data at this research site twice. I collected data at Site 3 from 16th to 20th of November, 2015. During the first visit, I collected 6 individual PTOP counselling sessions and 1 interview with the nurse providing PTOP counselling, and 5 interview with the clients. I returned to this site to collect more data from the 4th to the 8th of April 2017. During the second round of data collection, I collected 5 individual and 2 group PTOP counselling sessions. The first group counselling had 6 participants and the second group had 4. At this site I collected 13 counselling sessions, with a total of 21 participants. The participants were between the ages of 17 and 33.

The numbers of women seeking TOP services at this site were high and hence I had an increased number compared to the other two sites. In my view the nurses were also better equipped to provide counselling and do the scans and this made things easier compared to the other two sites.

**Table 5: Demographics for Research Site 3**

| **Type of counselling** | **Age** | **Language used in the counselling** | **Occupation** | **Marital Status** | **Number of Children** |
|---|---|---|---|---|---|
| Individual | | | | | |
| | 29 | English | Employed | Married | 3 |
| | 28 | English | Employed | Single | 0 |
| | 27 | English | Unemployed | Single | 1 |
| | 27 | English | Unemployed | Single | 2 |
| | 27 | English | Studying | Single | 1 |
| | 17 | English | Studying | Single | 0 |
| Group 1 | | | | | |
| | 33 | English | Studying | (not specified) | (not specified) |
| | 28 | English | Studying | (not specified) | (not specified) |
| | 20 | English | Studying | (not specified) | (not specified) |
| | 22 | English | Studying | (not specified) | (not specified) |
| | 31 | English | Employed | (not specified) | (not specified) |
| | 23 | English | Employed | (not specified) | (not specified) |

| | | | | | |
|---|---|---|---|---|---|
| Individual | | | | | |
| | 35 | English | Unemployed | Single | 1 |
| | 25 | English | Employed | Single | 0 |
| | 25 | English | Unemployed | Single | 1 |
| | 38 | English | Employed | Single | 4 |
| Individual | | | | | |
| | 26 | English | Employed | Single | 2 |
| Group 2 | | | | | |
| | 34 | English | Unemployed | (not specified) | (not specified) |
| | 21 | English | Studying | (not specified) | (not specified) |
| | 39 | English | Employed | (not specified) | (not specified) |
| | 20 | English | Studying | (not specified) | (not specified) |

At Site 3, three nurses worked at the women's clinic. The women's clinic offered TOP services and it was located separately from the maternity ward. There were two black, isiXhosa-speaking nurses, the nurses mostly spoke isiXhosa to the clients and used a few English terms. These two nurses worked on the pregnancy ultrasound scan. The nurse providing PTOP counselling was coloured and she spoke English to the clients. The nurse was fluent in English and Afrikaans, during the counselling sessions she used a few isiXhosa terms such as *"thatha"* which means take. All the counselling sessions were in English.

Site 3 had a larger number of women using these facilities. Out of 51 participants in the study, 21 of the participants were from this research site. The nurses had underwent training and they were able to provide the TOP service themselves without needing assistance from the doctors.

The nurses provided the counselling, and performed the pregnancy ultrasound scan as well as the TOP procedure. The nurses shared the work amongst themselves and were able to provide a full TOP service. Shared responsibility and their capability to provide TOP service contributed to the service efficiency and number of clients assisted daily. Site 3 was the only site that provided TOP services throughout the day. The other two sites would not take new clients after a certain time of day, which was usually around late morning.

PTOP counselling was also mandatory at Site 3. Individual and group counselling was offered. When there was a large number of clients, the nurse would ask the clients if they prefer individual or group counselling and then group the clients accordingly. The nurse provided the clients with TOP information, information about the procedure, some of TOP risks and side effects, and family planning methods.

The nurse providing the PTOP counselling used neutral language, she stuck to medical facts, and refrained from using emotive language. The nurse provided information on procedure, some of the risks and side effects without problematizing TOP. The nurse would explain TOP as a miscarriage to the clients. *"It's a miscarriage that you're going to have"*. Whereas in the other two research sites the counsellor would explain the procedure as *"a termination is the termination of the life of your baby (0.4) that is what we are doing here"* and the foetus was referred to as a baby.

**Extract 2**

In an interview with the nurse at Site 3, the nurse said:

> *"Hhh. It's all the same (0.1) it's uhm (.) we talk ↑we talk about anything. Even if someone sitting there, ↓we talk as if you're not coming to an abortion clinic, as if you're coming to the hospital for anything"* (Interview, Healthcare Provider)

The clients at this site could speak and understand English but they had low levels of English proficiency. The use of medical terminology also made it difficult for clients to understand some of the information provided during the counselling. Most of the clients were able to respond to the nurse, but some struggled with the medical terminology related to TOP

procedure and family planning. The nurse would ask the clients to report the information back to her, as a way to checking if the clients understood the information provided during the counselling. Most of the time the information reported by the clients was incorrect.

### 4.4 Presentation of data

Collecting data at three different sites meant that there were differences in the way in which the counselling was conducted even though the research techniques were the same. At all the research sites, the healthcare provider said they choose to do this job not because they are pro-abortion but because they felt they if they do not provide the services someone else would. They felt it is their duty as health professionals to provide the service to women seeking it. The healthcare providers gave the same reason for wanting to work within TOP wards being, higher number of deaths as a result of illegal abortion, other healthcare workers were anti-abortion and there was no one to provide the service, and they felt if they do not provide the service no one will and this results in more deaths of women who seek illegal abortions. The health care providers explained their role in PTOP counselling as providing, information, and guidance and helping the clients to make informed decisions.

#### 4.4.1 Communication barriers

In the interview with the nurse, it was mentioned that it is a challenge having to counsellor as someone who is a speaker of a different language as to herself. There were two nurses who were isiXhosa-speaking, but had they were mostly occupied with their own duties such as performing the ultrasound pregnancy scan. During the second round of data collection, the week I spent there the nurse worked alone with the other two nurses away. The present nurse who usually provided the counselling had to perform all duties herself, duties that were often shares amongst three. In some cases, with the isiXhosa-speaking nurses away, there was no one to help and assist when there is a communication difficulty. The use of English as medium language was not the only barrier at this site, the nurse providing counselling used many intricate medical terms.

The symbols that are used below follow the Jefferson Transcription System as outlined in chapter 3. (See Appendix 5 for Jefferson transcription notations.)

**Extract 3**

*C:* *You know sometimes there is no one and I have to try when someone doesn't speak English, ↑purely Xhosa↑ and believe me (.) and ↑I also have a little bit of (.) words neh =*

*R:* *Mhmm.*

*C:* *= ↑but at the end of that counselling↑ she understands =*

*R:* *Mhmm.*

*C:* *= ↑everything↑ =*

*R:* *Mhmm.*

*C:* *= but I'm trying because my broken Xhosa .hhh (.) we all mos speak broken. We speak broken English, we speak broken Afrikaans, we speak Xhosa =*

*R:* *Exactly.*

*C:* *= and yes something has to come.*

*R:* *Yeah. Yeah.*

*C:* *And at the end of the day I'm actually counselling a, someone who's speaking ↑a language↑ which I'm not speaking.*

*P:* *Mh::mm.*

*C:* *.Hhh this has is challenges.*

(Counselling Session)

Before the nurse would explain the TOP procedure, she would ask the client to listen carefully to the information she provided because they are required to give or present it back to the nurse. Healthcare providers commonly use this method as a way to ensure that the clients understood

what is communicated during the PTOP counselling. This text was transcribed at different stages of the same group counselling session.

**Extract 4**

*C:* *It's very important .hh (.) that you know what is happening to your body. We can't give you information and you don't know what's happening.*

*Ps:* *Yeah.*

*C:* *Some people (.) they take blood pressure tablets and they don't even know the name of it. Am I ↑right↑?*

*P:* *YES.*

*C:* *It's a pink, and a blue and a whatnot.*

*Ps:* *(h).*

*C:* *Yes, neh. Which is not right it's your body.*

(Counselling Session)

**Extract 5**

In this extract, the client was referring to the Depo Provera injection, which is commonly referred to as Depo. The client's response to the nurse's question was i-depo, with the "i" which in isiXhosa means "the", the client in her response was saying she will be using the Depo for family planning. (See Appendix 8 for full transcript).

*42.* *C:* *((Clears throat)). Can I do your blood pressure please?*

*( ) What are you doing to use for family planning?*

*(.)*

*43.* *P:* *I-Depo.*

*44.* *C:* *Hm?*

*45.* *P:* *I-Depo.*

*46.* *C:* *What is that?*

*47.* *P:* *Depo.*

*48.* *C:* *Depo?*

*49.* *P:* *Mhmm.*

(Counselling Session)

This above extract clearly indicates that the language barrier and use of medical jargon can contribute to ineffective communication.

Value System

Another barrier to effective PTOP counselling was the healthcare providers' value systems. The purpose of PTOP counselling is to prepare the clients for TOP procedure and to discuss other pregnancy options. However, the nurse and counsellor from Site 1 and Site 2 would tell the clients that they do not promote TOP. Statements such this may have led to the clients feeling conflicted and dissatisfied with the counselling provided. The clients did not contest what the healthcare providers said because they are power holders and have the power to control discourse medical discourse.

Site 1

**Extract 6**

One participant that did a post-counselling interview from Site 1 said:

*P:* *Mhmm okay (.) the counselling heh (03) actually neh =*

*R:* *Mhmm.*

*P:* *= was not promoting (.) us to do the (.), the aborti- like the termination*

*R:* *Mhmm.*

*P:* *= and a::h (0.3) they're giving us like the (0.2) I, I'd call it like i-terms and conditions of doing it.*

(Counselling Session)

Site 2

**Extract 7**

*C:* *My value system is from the bible. I'm a Christian (.) I'm not saying you have to run your life like that but it's worked for m::e. (0.2) and we take our values from the bible and we believe God gives life and that precious gifts and he knows ↑you when you were formed. (.) So there's that option and there's of course termination which is risky. It's your bod::y. You can see in the consent form (.) it says you can die".*

*P:* *Yeah.*

*C:* *But it's not on::ly that, it's e::motional damage too. I've counselled s::o many girls of every culture. My own culture. It's trou::ble wit-, after terminations. Because when God puts that baby in your stomach he sorts of ↓puts it in your heart.*

(Counselling Session)

**Extract 8**

In one of the group counselling session, the counsellor said to the clients:

*"It is your choice; you get to decide on whether you want to have this baby or not. ↑But just because↑ it is your right (.) does not mean it is the right thing to have an abortion. (0.1) You have to listen to your inner voice. You have to listen to your inner voice, you have to listen to your morals and your ethics as a human being and you have to decide whether what you have here is as same as what you have*

*here so that you're able to make a decision that is to affect you positively in your life."*

(Counselling Session, Healthcare Provider)

The above extracts indicate the healthcare providers' personal values and beliefs and these may sometimes negatively influence PTOP counselling. This becomes even clearer when the data is analysed in chapter 5.

### 4.4.2 Extralinguistic features of talk

Eatralinguistic features of talk are useful when analysing talk as they provide the clarity on what it is that the speakers were trying to achieve in talk.

Tone of voice

Site 1

The nurse at site 1 used an authoritative voice when speaking to the clients. When it came to the clients deciding on the family planning method, the clients would mostly choose a 2-month or 3-month injection. The nurse would deny the clients that option. The nurse would tell the client matter-of-factly that the only family planning options available to them are the 3-year implanon and the 10-year loop because the clients are not responsible for the injection and required dosage that is more frequent.

**Extract 9**

*"You are showing that you are not reliable when it comes to needles"* (Counselling Session, Healthcare Provider).

**Extract 10**

*"So I am going to speak to you about two methods of family planning, which are a 3-year implant and a 10-year loop"* (Counselling Session, Healthcare Provider).

Site 2

The nurse at site 2 often used emotive language and a negative tone in discussing TOP.

**Extract 11**

> *"You must also remember that (.) if you have termination, you're exposing yourself (.) to the ↑possibility of not having another baby again (0.2) and you're also exposing yourself to the possibility of developing <breast cancer> as you get older. .hhh So these are very real sides effects"* (Counselling Session, Healthcare Provider).

**Extract 12**

> *And so when you decide to take the life of your (0.1) babies away the impact (.)is >incredible<. (0.1) The impact on you as women (.) is ↑remar::kable↑. (0.2) And the thing that is even wor::se is the fact you kno::w (.) that you're in a ma::rriage, ↓that this baby actually deserves, the baby has got a right to be born* (Counselling Session).

**Extract 13**

> *↓Your baby come out in pieces. (.) First the little legs will come out (.) and then the tiny (.) the arms and the brain. (0.1) ↑So that child is psychically ↓pulled apart by suction* (Counselling Session, Healthcare Provider).

**Extract 14**

> *"Your first option is to keep your baby. Okay. (0.3) To become the mother God has planned for your life"* (Counselling Session, Healthcare Provider).

Site 3

The nurse from site 3 mostly uses neutral language and spoke in a monotone when discussing TOP but was more factual in their approach.

**Extract 15**

*C:* *That tablet is going to open the mouth of the womb. For that second thing to come out.*

*P:* *Okay.*

*C:* *That is miscarrying.*

(Counselling Session)

The above extracts indicate that the nurses' attitudes towards TOP will influence the type of counselling they provide

Emphasis and speed

Site 1 provided TOP services but the emphasis and what was understood by the nurses to be the purpose of the counselling was to provide family planning and not TOP.

Site 2 counselling mostly focused on the psychological and physical damages that may be experienced by the clients after TOP. The counselling focused mostly on pregnancy options, mostly encouraging adoption since the organisation had a place of safety. These stages of counselling were provided at a slow pace and with elongated speech.

Site 3 counselling had a detailed discussion on the TOP procedure. The counselling was clinical and a lot of medical facts of the TOP procedure and some of the outcome were discussed. The last stage of the counselling focused on family planning.

The emphasis of the session and time spent on the objectives of the counselling session therefore varied from one site to another.

Time and pauses

At Site 1, most of the time the pauses or gaps often followed when the clients had to take up their turn at talk, usually having to respond to a question asked by the nurse. The nurse would ask the clients if they understood the information provided. In addition, when the clients were

asked if they understood their *"mistake"*, the question was often followed with a soft *"yes"*, sometimes a gap of silence.

**Extract 16**

*C:* *I will look up a date for you. We use this book. I will search a date for you. It will tell us which date we can fit you into. So today you are? You went for family planning when you were already pregnant.*

*You do see this thing of yours, right?*

*P:* *(0.2)*

*C:* *Or you do not understand what I am saying, you do not get it?*

*P:* *(0.1)*

(Counselling Session)

Site 2

When the counsellor reached the stage of counselling, where TOP procedure and its risks were discussed, as alluded to in the time and emphasis section, the counselling was provided at a slow pace, with long pauses and with a softer tone compared to the other stages of counselling.

**Extract 17**

*Remember that a termination (.) is the termi::nation of the <life of your baby> (0.5) that is what we are doing here. (0.4) And as ↑result↑ those consequences will be with you for life. (.) You don't have a termination and weeks go by and months go bye and you say "whew I'm so pleased that done. I got over it and now I can move on with life". (0.2) It might, it may happen with ↑animals↑ but with human (.) we've got a brain, we've got a heart, we've got spirit and there's a connection. There is an emo::tional connection with our offspring. (0.5) So be ↑aware↑ of what is ahead of you (.) if you ch::oose (0.2) to having termination* (Counselling Session, Healthcare Provider).

Site 3

The clients had to give back the information on the TOP procedure to the nurse and they often struggled. There were long pauses before the client's response and sometimes the client would not answer the question even after the pause.

The clients would often respond which a *yes*, *mhmm* or an *okay*, the response indicates agreement, or that the clients understood the information communicated. Before the nurse asked for the clients to report the information back she would ask them if they have any questions and if the information was clear. Often the clients would confidently say they understood everything, but the information the clients gave back to the nurse was usually incorrect.

**Extract 18**

(See Appendix 8)

*198.* *C:* *If you have a slight smear on the panty (.) and if you vomit in the first 30 minutes.*

*199.* *P:* *Okay.*

*200.* *C:* *You understand that one?*

*201.* *P:* *Yes, I understand.*

*202.* *C:* *Now when = why must you come back Monday?*

*203.* *P:* *Maybe there's be something happen. If I = if I vomit (.) within the 30 minutes.*

*204.* *C:* *= and?*

*205.* *P:* *(.)*

*206.* *C:* *= and?*

*207.* *P:* *Smelling of blood in my panty.*

*208.* *C:* *S:: =*

*209.* *P:* *Smelling.*

*210.* *C:* *Smear neh.*

(Counselling Session)

Overlaps

There was overlap of talk during the consultation. The overlaps mostly happened when the client was responding to what was being said by the healthcare provider. Overlap of talk usually occurred when the clients were responding to what was being said through the counselling with a *"yes"*, *"mhmm"* or *"okay"* to indicate they followed the talk

The above extralinguistic features show that there is no component of talk that can be considered insignificant and that attitudes are as important as actual speech utterances.

### 4.4.3 Language, power and persuasive talk

In the below extracts, I present data across all three sites to demonstrates the way in which healthcare providers used persuasive language during consulataions.

Site 1

The nurse at site 1 speaks in a way in which she gives orders to the clients with an authoritative tone. The nurse asks the clients which family planning method they will use. If the client selects a family planning method that is not long term the nurse denies the client this method.

**Extract 19**

*"There are two choices of family planning that we are talking about at this moment. We are not talking about Pathogen and what not because ↓the reason you are all here in the first place is because you had these Pathogen, Nari, condoms and these what knots. ↑We are not talking about those things because we can see that they do not work. So the two family planning methods that we talk about here now are an implanon of 3 years (.) and a loop of 10 years. (0.3) We understand each other, right?"* (Counselling Session, Healthcare Provider)

Site 2

The counsellor at Site 2 used emotive language during the counselling.

**Extract 20**

*"And the consequences of having a termination (.) are going to live with ↑you forever. Uhm two out of three ladies who have terminations develop what is called <post abortion syndrome>. They become very sad. (.) They become very depressed. (.) They're guilty, they feel guilty. (.) They have remorse. They have feelings of (.) umh rejection from ↑society because they feel as if they have done something horrible. (.) And uhm (.) it is so uhm (.) it is such a nasty condition that even the psychological terms, they've named it the post uhm abortion syndrome and people go for counselling. Severe counselling in order to deal with emotions"* (Counselling Session, Healthcare Provider).

**Extract 21**

*"All of you are under 9 weeks (0.1) but you're already pregnant with a baby. Your baby is already growing (.) your baby has got heartbeats that are faster than your heartbeats. (0.3) Underst::and (0.1) that they are going to be psychological (.), emotional (.) and spiri::tual consequences. Not to mention the physical (0.2) when you have the termination"* (Counselling Session, Healthcare Provider)

Site 3

The nurse at this site used neutral language in providing the TOP information, in a monotone manner but factually correct. However, when it came to the stage of discussing family planning in counselling the nurse changed her tone and style of communication. The nurse often suggested the loop which is a long term family planning method.

**Extract 22**

*P:* *I don't want the pills cause I'm here because of the pills (laughs)*

*C:* *Then what do you prefer?*

*P:* *I prefer the two-month and then after the two-month then I can do the three year*

*C:* *Because we've got the lo::op. Do you [know about]*

*P:* *[you've got] the ↑loop?↑*

*C:* *↑Yes we d::o↑. This is the loop. Now (0.2) I'm going to suction mos all the contents.*

(Counselling Session)

**Extract 23**

*C:* *Yeah it can't be longer than 10 years. It can't be for longer than 10 years. It must be taken out,*

*P:* *Yeah that's a good one (h).*

*C:* *You want this one?*

*P:* *That's a good one.*

*C:* *This is the one for you neh.*

*P:* *That's a good one.*

(Counselling Session)

**Extract 24**

*C:* *Ja neh. Check what is right for you. Understand? So you'd like the loop?*

*P:* *I'd like the loop.*

*C:* *O::h, excellent. I like people that is making good, positive =*

*P:* *(h)*

*C:* *= decisions but I said I don't want to (.) =*

*P:* *Mhmm.*

*C:* *= influence you neh.*

*P:* *(h) mhmm.*

*C:* *So you're are 100% sure?*

*P:* *I'm making these decisions on my own.*

*C:* *Mhmm. Beauti::ful.*

(Counselling Session)

### 4.4.4 Participant observation

As I mentioned in chapter 3, I was an overt observer. There are two types of observations; there is an overt and covert observation (Anson, 2012). Overt observation refers to a process whereby the researcher informs the people at the research site about the intention of the research and how observation will be undertaken (Anson, 2012). This approach is usually preferred for ethical reasons. There have been some concerns that once people are aware that they are being observed they start to act differently, and what is then observed is an inability to capture the true reality of setting (Anson, 2012). The second observation method is covert observations. With covert observation, the researcher does not disclose the intention of the research. People

are not aware of the ongoing observations (Anson, 2012). There are ethical concerns with this type of observation method due to lack of consent. The one advantage of this approach is that the researcher is able to observe and capture the observations in their truest form. People do not feel a need to put on a performative act because they are not aware that they are being observed.

Although observation in this study was overt, I had to be cautious of my presence so that it did not become invasive. As alluded to earlier, there is already an abortion stigma, which is usually the reason why the clients may not want to be seen in fear of other people knowing they have undergone TOP procedure. I then had to be cautious of my movements and not cause any discomfort. From the observations most of the clients across all research sites were isiXhosa mother tongue speaking. The clients spoke isiXhosa when they interacted amongst themselves. The only time English was used was when they encountered non-isiXhosa speaking healthcare providers.

Prior to the counselling, there was minimal interaction between the healthcare providers and clients. At Site 1 whenever the nurse addressed the clients in the waiting room she was always shouting at the clients, in one of the instances a client was shouted at for playing music on their phone and most of the times the nurse shouted at the clients for the noise level.

In one of the instances the nurse shouted at the clients and said;

*"You must stop making TOP like a casual thing, you need to take it seriously"*

The healthcare providers at the other two research sites did not shout at the clients but would speak with a disapproving tone when they were dissatisfied with the client's response. There was a clear imbalance of power in the way in which the healthcare provider and client interacted.

#### 4.4.4.1 Forms of address (IsiXhosa Politeness)

In my observations, I realised that the clients addressed the nurse as *ma'am, sister* and *mama*. *Ma'am* and *sister* are an informal way of addressing the nurse. Mama means mother in isiXhosa. The term *mama* is commonly used when addressing an older female figure, who

could possibly be your mother as a way of showing respect in isiXhosa. The clients only used *mama* when they addressed the isiXhosa mother tongue speaking nurse. All these terms used by clients are used to show respect, whether it is *ma'am, sister* or *mama*. When analysing the data, I realised that some of clients used *ma'am* and *mama* interchangeabley, and what I realised was that it was during certain stages of the counselling. For example, the client would address the nurse as *ma'am* when the talk was clinical, which was at stages when the nurse discussed the TOP procedure, often using many medical terms. When the counselling reached the stage where the nurse discussed family planning methods, interestingly enough the clients would sometimes switch back to using *mama*.

The isiXhosa mother tongue nurses would often address the clients as *sisi* and *nontombi* when addressing the clients, and sometimes *mntase khaya*. *Sisi* when translated to English it means sister, *nontombi* is young *lady*, and *mntase khaya* when loosely transalted means child of home. The Nurses may have used these terms to show affection, and it is usually how people address each other in isiXhosa and it applies in other African languages. The person these terms are used to address does not have to be related to the speaker. These forms of address are commonly used by speakers of African languages and in African culture there is the notion that Africans are one, very communal and live a collective culture.

#### 4.4.4.2 Observed participant interaction

In the mornings when I would arrive at the research sites, I walked in to the TOP ward with women already waiting to be assisted. The clients had to arrive early at the hospital for a file, which is usually a long process because other clients seeking services from different wards are also awaiting the same line. When I got to the research site I usually walked into the room where the clients waited, some by themselves, others accompanied by the family, friends and partners. At Site 1 and Site 3, I was able to observe the movements of clients and the interaction they had amongst each other. The clients spoke in isiXhosa, referring to each other as *sisi* and *mntase*. *Mntase* being short form of *mntase khaya*. The clients would have on-going conversations, and some kept to themselves. In the post-counselling interviews with the clients there was a question asked regarding the waiting room experience and interactions. I would ask questions about the waiting room and also refer to my own observations.

### 4.4.5 Interpretation

From the above extracts, it is evident that there is an imbalance of power in the medical encounters between the healthcare provider and client. The above extracts also reveal that some features of talk that may be usually taken for granted may surprisingly provide greater insight to the context of the recording. As repeatedly mentioned in this thesis, healthcare providers control the medical discourse and discourse types. Paternalistic approaches to medical care may be considered by parties involved in the medical encounter as a norm, without being aware on how this approach is a contributing factor to ineffective communication between health care providers and clients, and poor health outcomes. The healthcare providers also have the power to influence the client's decision-making in PTOP, and this is achieved through language.

## 4.5 Summary

All the research sites provided TOP services to women who qualified for the procedure, but the healthcare provider's value systems and attitude towards TOP in the PTOP do have an influence in the way in which information is provided during counselling. The type of PTOP and TOP counselling provided differed from one site to the next. Sometimes the counselling was clinical, emotive, factual, and sometimes persuasive. Medical encounters are unequal encounters especially when the client has different cultural and linguistic background from the healthcare provider. The way in which healthcare providers and clients are positioned can be seen as an outcome of the power of those who dominate medical institutions (Fairclough, 1989:59). In the next chapter, I will provide a detailed analysis and interpretation of the interaction between healthcare providers and clients, and the role of language in PTOP counselling will be further highlighted. An interpretation of how the healthcare provider's different communication styles may influence PTOP counselling, and the processes that may underlie the quality and effectiveness of medical interaction and communication are discussed in the chapter that follows.

# CHAPTER 5: ANALYSIS AND DISCUSSIONS

## 5.1 Introduction

This chapter provides an analysis and discussion based on the data presented in Chapter 4, as well as further data presented in this chapter. In the chapter, I discuss the data in line with the theory presented in Chapter 2. Intercultural communication and sociolinguistic theory, together with CA and CDA theory provide insight as to how social organization and other important aspects of culture, and socio-cultural phenomena might relate to patterns of communication in PTOP counselling (Saville-Troike, 2003). As indicated in chapter 3, CA is an analytical tool, which identifies recurring events, recognizing their significant components, and discovering the relationship among components (Saville-Troike, 2003). Identifying patterns of communication in PTOP counselling sessions assists in understanding the processes, which may underlie the quality and effectiveness of counselling (Drew, et al., 2011). CDA is a qualitative approach, which states that discourse is a social construct and I adopt this approach to explore the connections between language, communication, knowledge, power and social practices (Fairclough, 1989; Wodak, 1997). In this chapter I provide analysis and discussion of the role of language within PTOP counselling, and I examine the communication processes between healthcare providers and clients.

## 5.2 Use of medical terminology as a communication barrier

As part of the counselling, the clients from Site 1 and Site 3 had to give and present the information back to the nurses. Clients at both sites were given informed consent forms to read. The informed consent forms informed the clients about the TOP procedure, some of its risks and side effects of the medical abortion. The nurses at Site 1 asked the clients to summarize in their own words what they had read in the informed consent form. The difference with information given in Site 3 is that the nurse asked the clients questions based on TOP information provided in the counselling. For example, the nurse would ask clients who qualified for the medical abortion questions about the intake of medical abortion pills. The methods used at Site 1 and Site 3, served a common purpose which was to check how and if the clients understood what was communicated and how the information was understand.

The following extract is taken from a Site 3 counselling session. The nurse asks the client questions based on the information she had provided on TOP procedure.

**Extract 1**

Site 3

(See Appendix 8)

*108.* *C:* *Now how does it happen? I need to explain how to you. When you're pregnant (.) there is a water sack that starts before the baby starts neh. This tablet is going to loosen that water sack right (.) meaning it will stop the pregnancy. ↓You understand? What do you understand?↓*

*109.* *P:* *That it's going to stop uh the pregnancy*

*110.* *C:* *How? How?*

*111.* *P:* *(0.2) Uh hhh (.) maybe uh.*

*112.* *C:* *What is this? That I have showed you now?*

*113.* *P:* *↓The womb.↓*

*114.* *C:* *No. ↑Huh? It's loosening the [water sack]↑*

*115.* *P:* *[water circle] okay.*

*116.* *C:* *↑What's it doing? ↑*

*117.* *P:* *(0.1)*

*118.* *C:* *↑What is this? ↑*

*119.* *P:* *(0.1) It's the loosening.*

*120.* *C:* *↑Loosening what? ↑*

*121.* *P:* *Of water.*

*122.* *C:* *↑ The water sack. ↑*

*123.* *P:* *Water circle.*

*124.* *C:* *↑Say it again.↑*

*125.* *P:* *The water circle.*

*126.* *C:* *↑What's it doing? ↑*

*127.* *P:* *(.)*

*128.* *C:* *↑ Loosening.↑*

*129.* *P:* *Loo- = loosening.*

*130.* *C:* *↑ What? ↑*

*131.* *P:* *The water circle. The water circle.*

*132.* *C:* *What's it ↑ doing? ↑*

*133.* *P:* *(.)*

*134.* *C:* *↑ Loosening ↑*

*135.* *P:* *Loosening.*

*136.* *C:* *↑The what? ↑*

*137.* *P:* *The water circle.*

(Counselling Session)

### 5.2.1 Summing up and Interpretation

At Site 3, clients were given the informed consent forms to read in the waiting room. During the counselling, the nurse also read the informed consent forms to the client. In addition to the informed consent forms, the nurse provided information on TOP, and explained to the clients how the procedure was to be performed. As mentioned above, the clients were required to give the information back to the nurse as a way of checking if they had a clear understanding of the information provided to them. This part of counselling is very important, especially for clients

who qualified for the medical abortion. Clients who qualified for a medical abortion were give medical abortion pills that they had to take in order for TOP to be successful. The medical abortion takes place at their home, where there is no healthcare provider to provide assistance in case there are any complications. It was important for the clients to understand the information provided to them by the nurse. For TOP to be a success, the clients had to take the medical abortions pills correctly.

When the clients had to give the information back to the nurses, the clients often struggled with the medical terminology. The clients from Site 1 did not struggle as much as clients from Site 3. The reason why clients from Site 1 did not have too much difficulty in explaining the information taken from the informed consent forms could have been because the counselling was provided in isiXhosa, and it being the client's first language. It was then easier for the clients to explain in their own words what they read in the informed consent forms. In addition to the informed consent forms, the nurse would also discuss what was stated in the informed consent forms, therefore making it easier for the clients to grasp. In contrast to Site 3, the counselling was in English and the nurse used medical terminology in explaining the TOP procedure.

From the above extract at line 110, the client is asked by the nurse to explain what happen when the medication expels the pregnancy. At line 111 it is the clients turn at talk, there is a 0.2 pause followed by exhalation as the client attempts to answer the nurses question. In line 111 it seems there was a bit of uncertainty on the client's side, it could have been that the client was trying to articulate the answer in her head before saying it aloud, or the client was not aware of the answer. In line 113, the clients give a response with no pause but *"womb"* is said with a soft tone. In line 117, again, there is a long silence/gap, and this time the client does not take up their turn at talk. In line 118, the nurse asks another answer and in line 119, there is a 0.1 second pause with an answer that does not exactly answer the nurse's question. The client struggles in explaining to the nurse how the medical abortion pill stops the pregnancy. The nurse starts asking questions to elicit answers from the clients. The nurse starts to sound frustrated by the client's incorrect responses and lack of answers. From line 114, the nurse raised her tone of voice and this happens after the clients answered incorrectly the first three times and maintains this tone during this phase of counselling.

There are two reasons as to why the client struggled in giving back the information to the nurse. Either it was because the client was unfamiliar with the medical terminology used by the nurse and therefore does not make sense of the information provided; or it was not that the client did not understand what the nurse communicated, but instead they were not able to explain it in English. In the extract, the client keeps referring to the water sack and the *"water circle"* and most of the time the words were mispronounced. The language used in the counselling and the medical jargon is a contributing factor as to why the client in the above extract struggled in giving the information back to the nurse. The four research studies presented in chapter two, have all reported that language and an extensive use of medical terminology can be a hindrance to effective communication (Anthonissen, 2010; Levin, 2006; Penn, et al., 2011, Crawford, 1991). Something to also consider is that the clients come to the TOP clinic already feeling, *"scared"* or *"nervous"* and the information provided may be too plentiful for the clients to process and the language barrier also then makes the client feel more anxious (Crawford, 1991:39). This means that clients who receive PTOP counselling from Site 2 and Site 3 and who are not fluent in the English language are more likely to experience more anxiousness than clients at Site 1 are where the nurse and client speak a common language.

The nurses' style of counselling, and making the client repeat the information is one of the common strategies used by healthcare providers to confirm how much the clients understand. Healthcare providers use this method to ensure effective communication and bridge the communication gap. According to Sobane and Anthonissen (2013), it is important for healthcare gives to ensure that the clients understand what is communicated to them during the medical encounter. This method alone would not be successful as it needs to be accompanied by other methods which I will speak about later on in this chapter.

In the extract presented above, the nurse keeps correcting the client's misuse of words, which I believe, is not a sufficient way of ensuring that the client understands the meaning of these terms. What is also important to highlight is that by the clients responding with a *"yes"* or a *"mhmm"* which is usually an indication of understanding, does not always mean that the client is following (Sobane & Anthonissen, 2013). In the counselling, the nurse often asked the clients if they understood everything and the clients would respond with a yes and say everything is clear. This was not a truthful response; most of clients gave incorrect answers. It is possible that the clients were afraid to admit that they did not understand the information provided to

them, because they do not want to offend the healthcare provider (Watermeyer & Penn, 2009). In Xhosa culture, and other African languages, it is polite for the speaker to just agree and nod when speaking to someone of authority, and that could be why the clients often provide a positive response (Watermeyer & Penn, 2009).

#### 5.2.1.1 Patient involvement in medical encounters

Foucault (1973) introduced the notion of the clinical gaze. That is, "the doctor's ability to penetrate the body's secrets" and illness; their professional skill to identify and interpret a wide range of bodily signs through visual examination. The clinical gaze forms a central part of examination, yet alone it is not sufficient for diagnosis. The clinical gaze needs to be followed by an interview, with patient participation, thus intimately connecting examination and language (Deumert, 2010). According to Deumert (2010:57), if doctors cannot communicate with patients the "clinical gaze fails to penetrate the depth and range of symptoms, they can only uncover those aspects of a patient's illness which have measurable physical manifestations". Lack of patient participation in the consultation means there is no shared decision making and the clinical gaze holds absolute power. When the patient is not involved in decision concerning their health they become an object of examination (Deumert, 2010). This kind of interaction between healthcare providers and clients is often discouraged because it may lead to misdiagnosis, poor medication adherence and in some instances loss of life. As mentioned earlier in chapter 2, effective communication that includes the client's involvement in all stages of the consultation could prevent these negative health outcomes. In chapter two, Robinson (2003) and research studies have indicated that patient participation is associated with positive health outcomes and patient satisfaction. Clients in this study should be able to engage in discussions relating to their health, determining what happens to their bodies. There should be shared decision making between the healthcare provider and the client. Such an approach ensures mutual understanding and can be beneficial to both the healthcare provider and the patient, and high quality care.

## 5.3 Impact of language use and choice of lexical items

Speakers use language to transfer information and to achieve certain outcomes with the interaction. Sometimes speakers are subtle in their language use and their intentions may not be always clear. Studying interaction in its finest detail allows the researcher to strip the text

apart; patterns of talk that may have been overlooked tend to emerge when the researcher is working with detailed transcription. Speaker's intentions became comprehensible, whether it is through speaker's selection of lexical items or tone of voice, or other extralinguistic features.

What follows are extracts which show the intention of the healthcare provider in the sense that they wish to impart a subliminal or sometimes evert communicative message to the client.

Site 1

The nurse uses the term "*umntwana*", which means child.

**Extract 2**

*C:* *Since she is going to terminate a late pregnancy there (.), she will give birth to a person (.) that is not alive. That is this tiny thing (.) dear. Do you hear me?*

*P:* *Mhmm.*

*C:* *↑Yes↑, because a child will come out of you, here out of you. Being that tiny thing. Blood will not come out (.) children will come out. Do we understand each other?*

(Counselling Session)

Site 2

The following extracts are taken from Site 2:

**Extract 3**

*"Mhmm. I'm sure you're feeling vulnerable. You're also feeling (.) at this stage a little bit confused to how it is going to affect your relationship. You don't know what's ahead of you"* (Counselling Session, Healthcare Provider).

**Extract 4**

*"All of you are under 9 weeks (0.2) but you are all pregnant with a baby. Your baby is already growing. Your baby has got heartbeats that are faster than your heartbeats"* (Counselling, Healthcare provider).

**Extract 5**

*"And what they do with manual abstraction is that they go into the ↑vagina with a metal tube (.) and they suck the baby out. (0.1) Your baby comes out in bits and pieces"* (Counselling, Healthcare provider).

**Extract 6**

(See Appendix 7)

*127. C: How do you think you're going to make sense of that in your own mind?*

*128. P: Hhh.*

*129. C: Once you've had a termination because you wanted this baby? This baby has been a part of your life a few months now because you've actually wanted it before now.*

*130. P: .Hhh.*

*(0.4)*

*131. C: How are you going to let it go?*

*(0.6)*

*132. P: I can't. I can't let go. (0.5) Mh.*

*133. C: But you see when you have a termination (.) you're going to have to let the baby go. Because it won't be (.) physically inside you any longer. But then that's only part of it you see because the other part is emotional. How will you let your baby go emotionally in*

*order for you to move on?*

*134. P: (0.7)*

(Counselling Session)

**Extract 7**

*"Remember that a termination is the <termination of the life of your baby> (0.5) that is what we are doing here. (0.5) And as ↑result↑ those ↓consequences↓ will be with you for life. ↑You↑ don't have a termination ↓and↓ weeks go by and months go bye and you say "whew I'm so pleased that done. I've now got over it and now I can move on with life". (0.3) It might, it may happen with ↑animals↑ (.) but with human. (0.1) we've got a brain (.) we've got a heart (.) we've got spirit and there's a ↓connection↓. There's an emo::tional connection with our offspring. (0.5) so be aware of what is ahead of you if you choose (0.2) to having termination"* (Counselling, Healthcare provider)

**Extract 8**

In this extract, the counsellor was asking the client how she felt about the pregnancy. The client told the counsellor she is fine with her decision

*C: So it is not (.) sensible to remove emo::tion =*

*P: Mhmm.*

*C: = from a highly emotive (.) uhm behaviour and circumstance that is occurring in your life right now. .hh you must understand that <having a termination is not a quick fix solution> =*

*P: Mhmm.*

*C: = to your problem.*

*P: Yes.*

C: *When you're coming to the hospital (.) you were pregnant. You have a ba::by that is growing inside of you .hhh ad you now making a decision (.) on what to do about the life of this baby. There are going to be ↑huge↑ psychological, spiritual and emo::tional consequences (.) as a result (.) of your decision for yourself.*

(Counselling Session)

Site 3

The following extracts are taken from Site 3:

**Extract 9**

C: *If perhaps, you find that you can't speak to them (.) that time neh.*

P: *Mhmm.*

C: *You can always go to your nearest clinic there's a psychologist there .hhh =*

P: *Mhmm.*

C: *= then they do assist if you want to just talk. Because sometimes it is just good to talk you know =*

P: *Yes.*

C: *= just verbalise your feelings. (0.2) Saying how you feel and how (.) it affects you because uh some people get depressed after a while (.) neh =*

P: *Mhmm.*

C: *= and the family doesn't know. But well if you are also having someone that you can talk to it also helps because sometimes we need a support system.*

(Counselling Session)

**Extract 10**

*C:* *You know and she, she made it so easy.*

*R:* *Mh::mm.*

*C:* *Made it so easy.*

*R:* *How so? (.) How did she make it easy.*

*C:* *I guess uhm (0.1) I guess it's the language that she used there.*

*R:* *Mh::mm.*

*C:* *Because (laugh) you know (0.1) Xhosa yo::oh it can be so (0.1) I don't know man how to put it but the way she, she spoke.*

(Interview, with Client)

### 5.3.1 Summing up and Interpretation

In extract 2, the nurse from Site 1 uses the term *"child"*. In extract 3 to 8 the counsellor from Site 2 uses *"baby"*. Sigcau (2009) states in chapter two that in African culture and Christianity it is believed that life starts at conception. This could then be the reason why some healthcare providers who are pro-life may use the term baby instead of foetus. In contrast to the other two sites, the nurse from Site 3 uses the term *foetus* which in medical/scientific and is defined as "an unborn offspring, from the embryo stage (the end of the eighth week after conception, when the major structures have formed) until birth" (MedicineNet). In Goodman & Flaxman (2012), it is suggested that clinicians use pregnancy or foetus as alternative words to avoid being offensive and to not to insinuate that TOP is an end to human life.

The counsellors from Site 2 often used emotive and persuasive language in the counselling. The counsellor would suggest the reason the clients want to terminate their pregnancies was based on their current emotions. The counsellor often described these emotions as a feeling of *sadness, neglect, being abandoned* and *alone*. As presented in extract 3, the counsellor shares with the client how she thinks the client feels using words like "*vulnerable*" and "*confused*".

Most of the time it would evoke emotions. In extract 8, the counsellor tells the client that it is not *"sensible"* to remove emotions from TOP. It is presumed that every woman seeking TOP services are in distress or at least they should be. This is indicated by what is presented in extract 8 and the quote provided earlier in Chapter 4 when the nurse at Site 1 was shouting at clients for speaking freely in a loud tone and listening to music, suggesting that they take TOP lightly and that it is something to be taken serious.

The counsellor had a negative tone when discussing TOP and she explained the procedure in a gruesome manner. As presented in extract 5, the counsellor explains to the clients that, I quote *"they suck the baby out"* and *"your baby comes out in bit and pieces"*. There tends to be an emphasis on *"your baby"*. TOP has some physical and psychological side effects that may be experienced by the clients. As part of the counselling, the healthcare providers have to inform the clients about these possible risks and side effects. In extract 7, the counsellor is informing the client about some of the possible risks. The counsellor explains TOP procedure as *"termination of the life of your baby"* in slowed speech. The counsellor informs the client on how she may experience post-abortion syndrome (PAS) because with human beings *"there's an emo::tional connection with our offspring"*. The counsellor says *"emotional"* in elongate speech, giving it a more of an effect.

In this section, I will focus on extract 6. The counselling started with the clients being very expressive. At the beginning of the counselling, the counsellor could barely get a word in because the client would interrupt her. Extract 6 is taken from a stage of the counselling when the client is overwhelmed with emotions. At line, 128 the client exhales breath without a response. The counsellor continues with her turn adding more to her previous question. The client at line 130 inhales breath, and there is silence/gap of 0.4 second and no response from the client. The counsellor persists in asking the client how she would let go of her *"baby"*. Eventually in line 132 the counsellor responses after 0.6 silence/gap and there is suddenly a drop in her tone of voice, the client in a low tone says *"I can't"* followed by a 0.5 second pause. The client says, *"I can't let go"* with a shake in her voice. At this point it sounded as if the client was about to cry. In line 134 there is a 0.7 seconds of silence with no response from the client. As alluded to in Chapter 3, language is produced with intention, the speaker's response is shaped by the previous turn, and the positions that speakers take up (Langford, 1994:69).

It is not unusual for a client to become emotional during a counselling session. The reason I present extracts 3- 8 is because these extracts go on to show that there is a pattern within these counselling sessions, the counsellor makes use of emotive language in all her counselling. Healthcare providers use emotive language as a form of persuasion, to elicit emotion, and they do this why using certain lexical item and tone of voice. The counsellor's choice of lexical terms elicits emotional responses from the clients. In extract 8, the counsellor is telling the client to not remove emotions. It may be that the counsellor purposefully uses emotive language in the counselling, as some form of persuasion. The counsellors are from a Christian organization and share with clients that their value systems are from the bible. In chapter two, sociolinguistic theory does suggest that a speaker's socio-linguistic/cultural identity will influence their communication choices. Language and culture are intertwined, individual's belief system forms part of their sociolinguistic identity, and most of the time it influences their communication. It is therefore expected that the counsellors who are pro-life and advocates for other pregnancy options such as adoption and parent rather TOP would react in the way that they do.

At Site 3, in discussing TOP and the side effects of the medical abortion pills the nurse would offer her number in case of emergencies. The nurse at this research site did put a strong emphasis on the importance of a support system. In contrast to the other two sites, the nurse at Site 3 would discuss what the clients may experience as a result of Post-Abortion Syndrome (PAS) and suggested places which the client could seek help. The nurse would ask the clients if they had someone trustworthy whom they would felt comfortable to speak with if they are ever to experience PAS. The nurse would tell clients it is important to take care of their mental and physical health. In extract 9, the nurse is advising the client to visit a clinic close to her for counselling if they experience PAS. The nurse adopts a patient-centred approach in her counselling, where the well-being of her client comes first. In one of the post-counselling interviews a client from Site 3 shares that she was *"scared"* when she arrived at the TOP clinic but she felt *"better"* after the counselling. In extract 10, the client shares how the nurse made her experience of PTOP counselling *"easy"*. The client stated that the nurse was able to achieve this through her language use. What the client in extract 10 shares is an indication that healthcare provider's styles of communication are important factors in determining whether the counselling succeeds or fails.

Sigcau (2009: 11) in chapter two, states that there are healthcare providers who are anti-abortion and the attitudes on TOP negatively affect the service they provide. Also in some instance there are nurses who do not allow their personal beliefs to affect their professional conduct. This may be the case with the nurse in Site 2, in her counselling the nurse comes across as pro-choice. In contrast to the other two research sites, the nurse at research site 3 does not indicate whether she is pro or anti-abortion. Instead the nurse provides a service which the clients report to be satisfactory, and she uses a lot of neutral language and medical terms such as 'foetus' in her counselling.

As mentioned earlier in this chapter, the clients usually arrive at the TOP clinic already feeling anxious or feeling other negative emotions. The language used by the healthcare providers in the counselling can either make the patients more anxious or help the clients to be relaxed. The clients are able to process the information provided to them and make more sound decisions. Clinical and linguistic competence stresses the importance of ensuring that the healthcare providers have basic communicative skills (Goodman & Flaxman 2012). Effective communication between healthcare providers and patients goes beyond the use of a shared language. The healthcare provider's style of communication and the way in which the information is provided to the clients is also important.

### 5.4 How healthcare provider's attitudes influence their use of language

Patients have expectations when they come to a hospital: they expect healthcare providers to give them a diagnosis, provide treatment, and explain the illness. According to Deumert (2010), in the lack of such communication, patients feel metaphorically 'robbed'. Lack of such communication leads to ineffective communication, and often the patients are not able to participate in medical encounter and in any decision-making concerning their own bodies (Deumert, 2010).

One of the questions for the post-counselling interviews asked the clients if they had any expectation when the clients came to the TOP and how their expectation compared to their experience. The clients that had expectations, reported negative expectations. As presented in the below extracts, the clients expected the healthcare providers to be *"rude"* and

*"judgmental"*, and expected a poor quality service. The clients expected the nurse to have a negative attitude, and address them in an unpleasant way.

Site 1

**Extract 11**

*C:* *Actually, nurses are not the kindest people =*

*R:* *Mhmm.*

*C:* *= and the nurses (.) they, they are always (.) on a (0.1) shouting attitude*

*R:* *Mhmm.*

(Interview, with client)

**Extract 12**

Site 2

*"At first I was scared thinking maybe she will judge me because of the decision I have taken or she will shout at me all of that because it usually said that nurse are not friendly people. So thought they be swearing at me since I am here to terminate a pregnancy, things like that whereas it is a mistake"* (Interview, Client).

**Extract 13**

Site 3

When the client was asked about how she felt when the nurse discussed advantages and disadvantages of TOP, she said the nurse was nice, gentle and polite.

*R:* *What were, what were you expecting coming here?*

*P:* *Yoh. (h) Most of the time (h) ↑yoh↑ most of the time they can be like, what we expect from nurses, they are rude so I wasn't that at all. I was expecting someone who is going to be harsh =*

*R:* *(h) mhmm*

*P:* *= bad attitude but she is the exact opposite. I don't wanna lie.*

(Interview, with Client)

### 5.4.1 Summing up and Interpretation

The general assumption is that public health facilities provide poor healthcare services and that the nurses are hostile and have a bad attitude. Clients who access public health facilities usually have expected a negative response. The clients in this study also had these expectations, especially since TOP is stigmatized.

Studies on TOP have reported that nurse's negative attitudes towards TOP is one of the barriers to clients accessing safe and reliable TOP services (Sigcau, 2009; Vincent, 2011). Some of the nurses that work at TOP clinics are pro-life while others are pro-choice, and more often than not the healthcare provider's value system determines the kind of service provided to women seeking TOP. Some of the clients, from the extracts presented above, had a negative experience of PTOP counselling and their experiences confirmed this assumption about public health facilities and nurses. Some of the clients received high quality care; in these cases, the client's experience exceeded the client's expectations. This goes to show that sometimes our expectations may lead to false assumptions (Morgan, 2015). The client's expectation meant they had already assumed that their encounter with the nurses was going to be unpleasant, and because they had already made this assumption, the healthcare provider says whatever is said, the clients could have easily misinterpreted it. As stated by Coupland, Gile & Wieman (1991:104), when speakers "intentions have not been read accurately by another participant, and that future actions or opinions of the participant will be predicted on inaccurate reading" this can lead to miscommunication.

Clients come to the hospital already with negative attitudes. The clients reported that they were expecting an unpleasant experience. Clients tend to use a conflict avoidance approach when the nurse speaks to them in a negative tone, sometimes shouting at them. In such cases this creates communication difficulty. As stated above, the clients sometimes misinterprete what is said because of this assumption they have of the nurses. Therefore, what the clients make of the communication may sometimes not be an accurate reflection of what is going on. It then becomes difficult to build trust between the healthcare provider and client. Some of the clients have the pre-conceived idea of the nurse and some of the healthcare providers also assume that every client seeking TOP services is irresponsible. Building trust between the healthcare provider and client becomes more challenging, and may negatively influence the counselling. In chapter two, Arnold, et al., (2012) states that healthcare providers should adopt a 'mindful' intercultural communication approach as it leads to trust between the healthcare providers and the clients. Trust between healthcare providers and clients in crucial any medical encounter, it helps minimize any factors that contribute to communication challenges. In any medical encounter, the healthcare provider and client should be able to interact, negotiate talk and collaborate.

Part of clinical competency is for the healthcare providers to ensure "patient safety, patient comfort and rapport, speed, procedural, completeness, and the ability to detect and manage problems" that may arise during the medical encounter (Goodman & Flaxman, 2012:112). It is important that the clients have a positive experience of the TOP counselling and any other medical encounter, as it creates a free space and the clients tend to open up more to the healthcare providers. Both the healthcare provider and client benefit from this approach because the healthcare provider gains full knowledge of the client's symptoms and therefore can provide them with best quality care. Often such an approach leads to patient satisfaction and positive health outcomes.

### 5.5 Client's reception of language used in PTOP counselling

Most of the clients were not aware that counselling would be provided to them before the TOP procedure. In the post-counselling interviews, the clients stated that the information provided in the PTOP counselling was informative. The majority of the women did not have any knowledge of how the TOP procedure would be performed. The clients stated that they found

counselling *"useful"* as it informed them about TOP procedure, TOP risks, other pregnancy options and family planning.

The following extracts are taken from the post-counselling sharing the experience of the PTOP counselling and information provided.

Site 1

**Extract 14**

*R:* *And you mentioned the terms and conditions (.) that's how it felt like.*

*P:* *I think that is how (.) <It felt to me> =*

*R:* *Ja.*

*P:* *= because (0.2) because by explaining the = the paper they gave me to read*

*R:* *Mhmm.*

*P:* *<To me it was like terms and conditions>, that's how I look at it.*

(Interview, with Client)

Site 2

**Extract 15**

*P:* *The counselling went well inside but (.) uh there were things that our counsellor spoke about uhm (.) some give you chills because (.) you find yourself hurting now that you have arrived here =*

*R:* *Mhmm.*

*P:* *= you find that you're doubting =*

*R:* *Mhmm.*

*P:* *= you want to change your decision; you don't want to change your decision*

(Interview, with Client)

**Extract 16**

*"Uhm okay I found (.) counselling very useful in terms of that (.) they told us that risks of the things we have done that, what would happen and we were told about the (0.1) contraceptives like an advice of which ones should we use and that we should use them, we know that, we know that, the, the abortion is not right and what not. Yeah"* (Interview, Client).

Site 3

**Extract 17**

*P:* *Well (h) when I came here =*

*R:* *Mhmm.*

*P:* *= (0.3) how can I put it? Hh. I was feeling heavy neh =*

*R:* *Mhmm.*

*P:* *= but after the (.) session =*

*R:* *Mhmm.*

*P:* *= in the consultation room I was feeling light. Uhm I'm sure of what I want to do and (.) and yeah (.) that's how good (.) it was*

(Interview, with Client)

### 5.5.1 Summing up and interpretation

In the post-counselling interviews, some of the clients stated that the counselling evoked emotions such as guilt and uncertainty. Some of the women shared that they began to reconsider their decision to terminate the pregnancy.

Healthcare provider's use of language in the PTOP counselling can determine how the clients receive the information, whether it is received in a positive or negative manner. In addition, when the counsellors from Site 2 use emotive language, it evokes emotions and the clients end up providing an emotional response. Also in instances where the counsellor provides the clients the information by reading through the consent forms such as in Site 1, the counselling would have not been a success, and the clients may feel like the nurse is doing a checklist. The nurse from Site 1 often uses the informed consent form and the other TOP printed material as a guide during counselling, and as much as the information was being provided to the clients, it is not surprising that one of the clients felt like the nurse was proving *"terms and conditions"* as stated by the client in extract 14. This goes back to what I mentioned earlier in this chapter, that the healthcare provider and patient speaking a common language does not ensure effective communication, how the information is provided is also important.

The nurse from Site 3 speaks to TOP medical facts and she provides the counselling in a monotone and does not problematize TOP. The clients from site 3 had positive feedback and reported that the nurse exceeded their expectation as stated in extract 17. Language is an important factor and it has an impact on the effectiveness of PTOP counselling. It is not important for clients to understand the language in which the counselling is provided in but also the communicative styles of healthcare providers. As illustrated in chapter 4, extralinguistic factors such as tone of voice and choice of lexical items also contribute greatly to the interaction, and these factors of talk contribute to the effectiveness or ineffectiveness of the counselling.

## 5.6 How moral/value conflict influences PTOP counselling

Moral value is concomitant with TOP theory as outlined in the literature review chapter of this thesis. The nurse from Site 1 and counsellor from Site 2 were not pro-abortion. The healthcare

providers at these two sites provided clients with the TOP services. The nurse and counsellor were clear about their stance on TOP, and during the counselling TOP was discussed in a negative tone. In the post-counselling interviews, the clients indicated that the healthcare providers did not support their decision to terminate the pregnancy and instead were in support of the other two-pregnancy option, which were parenting, and adoption. The nurse from site 3 appears to have a more neutral stance.

Site 1

**Extract 18**

> *"We are not here to promote abortion rather than we are promoting family planning .hhh but then since you are here for it, it is necessary that we give you the service. Do you hear that young lady? .hhh So what we truly, truly, truly emphasise is that we sort out one's family planning to avoid seeing them here again"* (Interview, Healthcare Provider).

**Extract 19**

> *"People do not go for family planning; instead they come to and repeat abortion again and again. You see that dear? It traumatizes us (0.1) as much as it may seem as if it does not traumatize you guys"* (Interview, Healthcare Provider).

**Extract 20**

This extract, is from a post-counselling interview which was based on the client experience of the counselling and pregnancy options that may have been discussed in the counselling by the nurse.

> *R:* *.hhh okay just to speak about (.) uhm the options, if there were options given to you. (.) What was the (.) how did you experience that? (.) That part of the conversation [part of the counselling].*
>
> *P:* *[that part of the] options.*
>
> *R:* *Ja.*

*P:* *It was uh mh::mm (0.5) mhmm (.) it was like uh (0.1) hhh (0.2) they don't want; they don't want me to do the termination.*

*R:* *Okay.*

*P:* *Ja it was like she doesn't want me to do it =*

*R:* *Mhmm.*

*P:* *= and I have no reason for me to do it.*

(Counselling Session)

**Extract 21**

Site 2

*C:* *So X how are you feeling about this pregnancy?*

*P:* *Well mh (0.1) speaking the honest truth I don't know how I feel because (0.1) uh at first I was shocked but (.) I just told myself I need to be strong because I have to finish my studies and all of that. And since I'm doing law it has changed the way I'm thinking because they said you must not confuse the morals and law.*

*C:* *↑Yes.↑*

*P:* *So since they say pregnancy is (.) legal and there is nothing wrong about it if you have valid reasons then (.) it's fine.*

*C:* *Mhmm.*

*P:* *Yeah. ( ) with emotions.*

*C:* *Mhmm.*

*P:* *So I'm fine with it and my friends they support me with it.*

*C:* *[Mhmm] you know X uhm I accept the fact that you… it is your right. It is according to the rules of this country =*

*P:* ↓ *[Okay.]* ↓

*C:* = *it is your right (.) to have a termination* =

*P:* ↓*Yes.*↓

*C:* = *but what one of the things now you need to understand as a human being is, just because something (.) you have a right to do something* =

*P:* *Mhmm.*

*C:* = *doesn't meant it's* =

*P:* *Mhmm.*

*C:* = *the right thing to do.*

(Counselling Session, Healthcare Provider).

**Extract 22**

The client being counselled in this extracted was a married woman:

> *"So when you decide to take your (0.1) baby's life away the impact is >incredible<. (0.1) the impact on you as women is ↑remarkable↑ (0.1) .hh and (.) the thing that is even wor::se is the fact you kno::w you're in a ma::rriage (.) that this bay actually deserves, this baby <has a right to be born>"* (Counselling Session, Healthcare Provider).

**Extract 23**

Site 3

*C:* *We don't (.) treat them with a stigma* =

*R:* *I see.*

*C:* = *of (0.1) this is the clinic and we are, and you are coming here. ↓N::o you are coming for a service* =

*R:* *Yeah.*

*C:* *= just like anyone coming to the hospital.*

(Interview, Healthcare provider).

Some of the clients shared their views on TOP. The interview schedule did not include questions based on the healthcare providers or clients value systems. What was shared by the clients was voluntarily shared by the clients during the post-counselling interview. Some of the clients shared that TOP is *"not good"* but that circumstances have brought them to this decision.

**Extract 24**

Site 1

*R:* *You said you don't condone it? What, what don't you condone? I did not =*

*P:* *Termination.*

*R:* *Termination of pregnancy?*

*P:* *Mhmm.*

(Interview, Client).

Site 2

**Extract 25**

*"Doing abortion is not a (.) good thing at all"* (Interview, Client).

**Extract 26**

Site 3

*P:* *I was scared at the same time I also felt emotional =*

*R:* *Mhmm.*

*P:* *= because it's the very first time I've done this.*

*R:* *Mhmm.*

*P:* *You know and uh it's not something I thought I do in my life.*

*R:* *Mhmm.*

*P:* *I'm catholic, so (.) it's beyond my religion.*

(Interview, with Client)

**Extract 27**

*"No it's (0.1) fine. It's good. Although it's not a good thing what we are doing here (.) but it's a good service"* (Interview, Client).

**Extract 28**

In this extract, the nurse had asked the client about how she felt about abortion. The client's choice of words was *"nervous"* and *"bad"*.

*C:* *How do you feel about abortion?*

*P:* *(0.1) Nervous.*

*C:* *Nervous?*

*P:* *Mhmm a::nd a bit (.) bad.*

*C:* *Bad? (0.2) Am I right when I say that you're uncomfortable?*

*P:* *(0.1) Mh n::o.*

*C:* *You are comfortable but you feel nervous and [bad].*

*P:* *[And bad].*

*C:* *Okay so how do you feel, just tell me what do you mean by bad?*

*P:* *What I mean by bad I mean hhh The conscious (0.1) knowing that I'm doing something that's (0.1) wrong according to (.) my religion but (0.1) yet on the other hand it's a must I do it because of my situation at the moment.*

(Counselling Session)

### 5.6.1 Summing up and Interpretation

Some of the extracts presented are in line with what is discussed in chapter two, supporting the notion that an individual's value system influences their communication and their worldview (Gudykunst, et al. 1996). As alluded to in chapter 1 of this thesis, counselling, "is professional guidance to help a person cope with emotional and other personal problems in that the counsellor uses techniques such as advice, discussion, administration and interpretation" (Dondashe, 2001:3).

In extract 18, the nurse from Site 1 says to the client *"we do not promote abortion but rather family planning"*. The nurse does not state why she does not promote abortion but the mere fact that she made that statement implied that abortion is not a good act which she can support. In the following line the nurse acknowledges "it's necessary" that she providers the client with the service. There may be conflicting identities within the nurse's value system and her professional role, where she is anti-abortion but she is expected to provide PTOP service as a health professional. The nurse's personal values influence her counselling, and her attitudes towards TOP can form a barrier to effective, patient-centred approaches to the counselling.

In extract 21, the counsellor asks the client how the client feels about the pregnancy. The client answers the counsellor's question, stating that she is fine and her legal studies have taught her to not confuse law and morals. In response to what was shared by the client, the counsellor responds stating to the client that having a right to TOP does not mean it is a right thing to do. This statement alludes to what is discussed in chapter 2, that abortion law reforms have not changed the wider society's view on abortion (Sigacu, 2009).

The client in extract 22 is a married woman. The counsellor has a difficulty understanding as to why the client wants to terminate even after the client has provided her reason. The counsellor is explaining to the client that she may later on be regretful and suffer from PAS. The counsellor says that the client will be more remorseful since she is married, the *wor::se, kno::ow* and *ma::rriage* elongated speech/stretched sound, giving it more emphasis. The counsellor's speech is slowed down when says to the client that the *"baby"* <*has a right to be born*> giving the statement more emphasis and with every word made clear.

In the post-counselling, the clients were asked about their experience of the PTOP counselling. The client often expressed that they felt negative emotions. When a follow up question was asked as to why the client felt these negative emotions, the clients would share that TOP goes against their value system. As much as the clients had a right to accessing TOP, there seemed to be a moral/value conflict. Scheper-Hughes & Lock in D'Souza (2014:6) state that, "cultural constructions of and about the body are useful in sustaining particular views of society and social relations". Symbolic-interaction also proposes that people create reality every day through social interaction (Torabi, 2010). D'Souza (2014:9) states that "abortion is not just a simple biomedical procedure, nor is it just a discourse; it incorporates both these elements and actively influences experiencing individuals and their surroundings". According to D'Souza (2014), South African women conform to a conflicting political and social order regarding TOP decision-making; on the one hand a political order that is pro-choice and on the other a cultural order that silences women and their concerns regarding unwanted pregnancies and stigmatizes TOP and women who partake in the act. This goes on to explain as to why the clients in extracts above may have felt conflicted, also because these primarily religious and moral values are strongly instilled in them. Given this, one has to question the process of PTOP against the backdrop of the CTOP Act, which espouses the values and objectives that allow for abortion in South Africa.

## 5.7 The role/use of language in different stages of the counselling

### 5.7.1 Reason for Terminating Pregnancy

As part of the counselling, the clients had to provide reasons for deciding to terminate the pregnancy. As mentioned in chapter 1 of this thesis, the CTOP Act allows women to have first

trimester abortions up to 12 weeks and from 13-20 weeks' onward terminations are available under restricted conditions (Harries, et al., 2009). The CTOP Act states that women have a right to access TOP services "in cases of socio-economic hardship, rape, incest and for reasons related to the health of the pregnant woman or foetus" (Harries, et al., 2002). It is not up to the healthcare provider to determine whether the reason provided by the client is satisfactory. Clients who qualify for TOP cannot be denied access to TOP services.

In the following extracts, the clients provide their reason for terminating the pregnancy.

**Extract 29**

Site 1

*C:* *Why do you want to terminate the pregnancy dear?*

*P:* *They said I should terminate it at home, because I'm still young.*

*C:* *You saying they said that. What do you say?*

*P:* *I also want to terminate the pregnancy because I am still young and I will not be able to manage a baby.*

*C:* *But then a person who is young who gets into relationship things goes for family planning dear (0.2) You do see that you are failing yourself?*

*P:* *(.)*

*C:* *Eh?*

*P:* *(.)*

(Counselling Session)

**Extract 30**

Site 3

*C:* *.Hhh may I ask why did you decide to have an abortion?*

*P:* *(0.1) Uh considering my circumstance ma'am, I thought that I can have, I thought that I can't afford to have another baby. I still have a (.) twenty-month toddler.*

*C:* *Mhmm.*

*P:* *Yes, I am working but it's going to be more difficult (.) and uh she's still young. She still needs my attention.*

*C:* *Okay.*

*P:* *Yeah.*

*C:* *I understand.*

(Counselling Session)

#### 5.7.1.1 Summing up and interpretation

As mentioned in chapter 4, the clients provided five different reasons for wanting to terminate the pregnancy. The clients were either too young, still studying, unemployed, had an unstable partner, or they already had a child/children and could not afford to have an additional one. Sometimes the healthcare providers did not seem satisfied with the client's reasons, and they often gave disapproving responses. Even if the client provided a dispreffered response, the nurse does not have a right to deny the client the TOP service because they are guided by the CTOP Act. The healthcare providers measure the client's reason against their own value systems. In chapter two, Sigcau (2009), explains that abortion is viewed as killing in Christianity and African culture. Abortion is only considered socially acceptable under certain conditions, when the pregnancy is a threat to the women's life, that of the foetus, and in cases of rape and incest (Sigcau, 2009).

In extract 29, the nurse asks the client if she sees that she is failing herself because the nurse believes the unwanted pregnancy could have been prevented. When it is the clients turn at talk, she does not take it up. The nurses asked a question that was to be followed by an answer, instead there is a gap of silence. The nurse then adds a *"eh"* and still no response from the client. As stated in Wilkinson & Kitzinger (2011:29), "a gap of silence between one turn and

the next can be used to foreshadow a 'dispreferred' response". The clients' silence can be interpreted in many ways; it could be either that the client who is a teenage girl does not feel comfortable discussing matters regarding couitus with a nurse old enough to be her mother. Secondly, it could be that the client disagrees with what is said by the nurse and avoids providing a 'dispreffered' response, or the client may just have a response to the question and chooses not to take up her turn at talk. Cultural beliefs about the functions of talk and silence can be a major source of communication difficulties (Coupland, et al., 1991). Often in African culture, when a young person is believed to be at fault, usually when they are being scolded or being called to order, they do not try to reason with an elderly person, usually remaining silent out of respect and not taking a turn. In African culture, a young person is not to question an older person, even when they are not at fault.

As stated in Chapter 2, in positioning theory speakers can either reject or take on the positions given to them in talk. The clients are often positioned as irresponsible subjects, who require guidance. The clients often take up these positions, which often strengthens the position being decided (Goodwin & Heritage, 1990). When the clients reject these positions, usually the nurse insists that it is important for the client to realise their "mistake" with every turn at talk. (Goodwin & Heritage, 1990) explains that when the recipient rejects their position at talk, the speaker may add new material to the utterance, therefore providing further grounds for assessments. Usually when the nurse asks the client questions or makes a statement and the client does not give a response indicating as to whether they agree or disagree with what is being said, often the nurse does adding new material to the utterance. Often the clients would respond with *"mhmm"* which indicates an agreement or acknowledgement of the utterance. Sometimes the clients provide this response out of politeness and not because they agree with the nurse. The positioning between the healthcare provider and client makes it difficult for the client to oppose what is said by the healthcare providers because of the position they occupy as an authority figure, as indicated in the literature discussed in chapter 2. Often the client will provide a positive response, which is not usually a true refection of how they feel.

Sociolinguistics indicates that, people use shared knowledge to understand and interpret meaning; it allows them the ability to read the context and determine what may hinder the interaction (Torabi, 2010). CA theory explains that individuals are guided by rules and structures that help them make sense of their social world and navigate it in certain settings

whether social or institutional (Peräkylä, 2004). Clients are able to determine this in TOP and avoid any forms of interaction that may cause conflict, thereby saving face. Speakers negotiate and share meanings, because they have common-sense knowledge about the world, and have universal practical reasoning (Torabi, 2010). The assumption is that fundamentally through interaction that context is built, invoked, and managed, and that it is through interaction that institutional imperatives originating from outside the interaction are evidenced and made real and enforceable for participants (Heritage, 2005). This image is reinforced by the privileged status assigned to casual conversation between equals, where the determinative effect of institutional and societal structures is perhaps least evident, though however real (Fairclough, 1989).

In contrast to Site 3, the nurse at this site is neutral in her counselling and is pro-choice. In extract 30, the nurse responded by saying "I understand" when the client gives her reason. The nurse advises the clients to go on family planning to prevent unwanted pregnancy. The nurse at Site 3 provides the same information as the nurse from Site 1 but without using a scolding and disapproving tone. The client in extract 11 stated that nurses “are always on a shouting attitude". The client in extract 11 had been counselled by the same nurse in extract 29 and in the extract the client was referring to her own experience of the counselling. As mentioned in chapter 2, in the discussion about barriers to women receiving safe TOP services, the nurses’ attitudes and scolding manner is one of the barriers to women accessing safe TOP service and clients resort to back street abortion (Sigcau, 2009). Healthcare providers could adopt approaches and styles of communication, making use of euphemisms that could make what is communicated less offensive and transmitting it effectively. How the healthcare providers speak to the clients is important, healthcare providers are holder of power in healthcare but it is does not mean it is necessary for them to speak with an authoritative tone to the clients. This approach may hinder communication, as presented in extract 29, the client may become fearful and not open up to the healthcare provider, when it is their turn at talk there are gaps of silences. This does not aid communication, it become unidirectional and unproductive, and so much can be missed in such instances.

### 5.7.2 Pregnancy Options

There are three pregnancy options discussed as part of the PTOP counselling being, parenting, adoption and termination of the pregnancy. Parenting and adoption are the most preferred options by healthcare providers at Site 1 and Site 2.

The extracts below are taken from the counselling sessions, when healthcare providers were discussing pregnancy options.

**Extract 31**

Site 1

The nurse does not discuss the adoption option in detail. She only discusses parenting and abortion because the social workers discuss adoption with the clients.

> *"Whether you do the abortion while you are a few months (.) whether you do abortion when you are many months pregnant, still the complications will be there because I might happen to hit and burst your womb while I am cleaning you at the theatre. Even I can do that. Or you may find out that some things did not come out when I was cleaning you and then you stay at home and your womb rots. (.) Some refuse to be cleaned. Abortion is painful (.) and you find that some people are unable to cope with that pain and they end up saying; "No, leave me alone" and do not want to be touched. That happens (.) I will make you sign something that says that you said I must not touch you; I must not clean you of which if I do not clean you, those things will rot inside you. And then you will end up coming back to have your womb taken out. (.) How are you going to give birth again without a womb? (0.2) I am not scaring you, people. These are the things that you need to know"* (Counselling Session, Healthcare Provider).

**Extract 32**

> *"There by the rural areas we see those women where you find that they are not bearing any children (.) at all. We do not know the reason. The person is beautiful*

*but not bearing any children. Maybe the person had done this thing"* (Counselling Session, Healthcare Provider).

Site 2

The organisation has a place of safety, which is why the counsellors often advise or encourage the clients to carry the pregnancy to term and place the baby up for adoption.

**Extract 33**

*Options:*

*"You can choose to parent (0.1) and that can be challenging (.) but it's rewarding. Because you gaining life, you getting to ↑build in these precious lives"* (Counselling Session, Healthcare Provider)

**Extract 34**

*"So that-, those are your three options (.) All have consequences. Just some carry more joy as a consequence. I know it might be challenging but think of the joy. (0.1) And even if you feel you can't parent (.) giving it to someone else"* (Counselling Session, Healthcare Provider).

**Extract 35**

*"So there is a family that ↑God's↑ also (0.1) if you're not going to do it you know he's also got someone that will love the babies. But I want to show you. We've got these models my girl. It just helps you understand... and I'm going to give you a model ( ). You see it's already perfectly formed (.) and this is 20 so you're between there somewhere, are your two babas"* (Counselling Session, Healthcare Provider).

**Extract 36**

*"I've given you that booklet read through it. It can be hopeful when you see all the babies ( ). And just see the consequences of the other choices (.) They're not from*

*me. It's just those (.) consequences. Every choice has a consequence"* (Counselling Session, Healthcare Provider).

Site 3

**Extract 37**

*Options:*

*C:* *Is there no, nothing I can say .hhh, is there anything that I can say .hhh <that will change your mind>. Say for instance .hhh that there is a (.) adoption options now neh. That (.) if you carry the baby you can give the baby to someone (.) who despe::rately wants one.*

*P:* *(0.2) But it won't be easy*

*C:* *How?*

*P:* *For me to carry the baby for nine months and then give it away. Ah-ah it won't be easy for me to give the baby away that time.*

*C:* *I can, I can understand that one neh.*

(Counselling Session)

### 5.7.2.1 Summary and Interpretation

In extracts from Site 1 and Site 2, the healthcare providers explain to the clients what will happen to the "*baby"* and how the client may regret their decision. The preferred option is for the clients to parent, and the second option is for the clients to place the baby up for adoption.

Research into the nature of discourse processing, has shown situational context to be a more significant determinant of interpretation than it had been thought to be (Fairclough, 1989). Fairclough (1989) states that having power may indicate that one is able to determine presuppositions. Applying this notion to TOP, it would then mean that healthcare providers can determine presuppositions and their propositions concerning PTOP counselling may not

be made obvious. This would then make it difficult for clients to identify these propositions and determine whether to reject them (Fairclough, 1989). Within PTOP counselling it may be difficult for clients to determine whether the healthcare providers are genuinely providing options or trying to persuade the clients to not opt for abortion. Healthcare providers are aware that they possess the power as carriers of medical knowledge and that clients laregly value their advice. The healthcare providers have the ability to influence the client's decision-making process, without seeming as if they are imposing their value systems on to the clients but merely making suggestions/providing advice.

### 5.7.3 TOP procedure

In this stage the healthcare provider, discusses on how the TOP procedure is performed. The purpose of this stage of counselling is to provide the clients with the necessary TOP information so that the clients are able to give informed consent. The healthcare provider provides information on the medical or surgical procedure depending on the procedure the client qualifies for. Women between 1 to 9 weeks qualify for the medical abortion, and are given medical pills to terminate the pregnancy (Harries, et al., 2002). Women between 10 to 20 weeks qualify the surgical abortion (Harries, et al., 2002). With the surgical abortion, the clients are admitted to hospital and instruments are used in the procedure. It is therefore important for the clients to know what will happen to them and to their bodies. It is important for clients such as clients from site 3 who qualify for the medical procedure, because everything takes place at home without a healthcare provider to assist them.

Healthcare providers discuss TOP risks, the physical and psychological. This stage of counselling prepares the clients for what could possibly happen in the future if they choose to continue with the TOP procedure. The way in which these risks are discussed can be terrifying for the clients. Clients may reconsider their decision after being made aware of TOP physical and psychological risks. In other instances, the information may be informative and clients' have the knowledge of which steps to take if they ever experience any of these risks and side effects from the medical abortion pill. However, the clients' reaction to the information is to some extent influenced by the way in which this information was provided by the healthcare providers.

Site 1

**Extract 38**

*C: At first, you will be given two pills that will terminate the pregnancy. Do you understand, young lady?*

*P: Yes, mama.*

*C: You will not drink the first two pills that you will be given with water. You will put them under the tongue and suck them until they are finished. .hh (0.1) You count 4 hours once they are finished, once you have sucked them until they are have dissolved. Hear me well, young lady. You count 4 hours and once it has ended, you go to the nurse not to the doctor. The doctors will not be there. Doctors arrive at certain times. The nurses are always there. You go to the nurse and tap them and say, "4 hours is over now. Can I please have some pills?" You will drink those pills un::til your pregnancy gets terminated. The termination of your pregnancy depends .hhh (0.2) the termination of your pregnancy depends on those pills. Do not get there and rest on the bed, and cover yourself with a blanket when you get and think that magic will happen. Mh-mh (no) your pregnancy will be terminated by those pills. .hh Do you hear me, my sister?*

*P: Yes, mama.*

*C: After 4 hours you go call (.) you go to the nurse and she gives you the pills. If the pregnancy has not been terminated, you count another 4 hours (.) and ask the nurse to give your some more pills. If then the 4 hours is not up (.). The pregnancy will be terminated. How will the pregnancy be terminated? You will give birth, young lady. That process of giving birth will happen to you. You will, you will have labour pains (0.2) and the baby will come out. The womb, the womb will open and a baby will come out. It is just that this baby will come out having done what? It will not be alive. (.) In the end you must be prepared that you will see it.*

(Counselling Session)

**Extract 39**

*Risks:*

> *"It does not mean that it since you do it here (.) .hhh it does not have problems. It does have complications; it does have risks. .hhh (0.1) the reason why you do it here at the hospital is so that you can be close to help should anything happen to you. You do understand what I am saying, right"* (Counselling Session, Healthcare Provider).

Site 2

**Extract 40**

> *"What happens (.) is that they take a tablet, they take a tablet insert, uhm they uhm dissolve it under your tongue. What it does is that it softens the outside of the cervix (0.1) and then they hhh. Once the cervix softened they go into the uterus (.) with a metal tube (0.1) that is about that long and literally stick it into your uterus and they su::ck your baby out. "Your baby come out in pieces. First the little legs will come out and then the tiny (.) the arms and the brain. So that chi::ld is <physically pulled apart by suction>"* (Counselling Session, Healthcare Provider).

**Extract 41**

*Risks:*

> *"So there's still going to be a loss (.) It's going to be a grieving process anyway (.) besides the physical damage. And some girls (.) of all cultures are opting more and more for arbo-, adoption"* (Counselling Session, Healthcare Provider).

**Extract 42**

> *"There are many, many dangers. Not only to your body (.) to your heart and that's what we worry about (.) Because ultimately we want strong women (.) who can run their families, get good jobs (0.1) be valuable members of your community. You're*

*the future South Africa not me. Broken hearts are some::times hard to fix"* (Counselling Session, Healthcare Provider).

Site 3

**Extract 43**

The nurse uses instruments to demonstrate to the clients how the surgical abortion will be done. Focuses on the procedure whether medical or surgical.

*C:* *.Hhh when (.) I give you the tablets (0.1) it's going to work hhh (0.1) within a certain period of time =*

*P:* *Mhmm.*

*C:* *= to go through the system, to do what it is supposed to do.*

*P:* *Alright.*

*C:* *.Hhh and what the tablet is supposed to do is to open the mouth of the womb for us to use the instrument so that we don't force because if we force we can cause other problems.*

*P:* *Yeah.*

*C:* *So (0.2) when we are (.) when it's, we talking about contracting when it's opening the mouth of the womb. It's mos the muscle =*

*P:* *Yes.*

*C:* *= also it opposite, it makes like this neh.*

*P:* *Yeah.*

*C:* *Meaning that it can cause contractions.*

*P:* *Okay.*

(Counselling Session)

**Extract 44**

*C:* *We are going to give you a tablet here.*

*P:* *Okay.*

*C:* *Of which that tablet it's (.) when you are pregnant (0.2) there's this water sack that forms neh =*

*P:* *Mhmm.*

*C:* *= before the baby even starts. Then (.) what this tablet does it just loosens that sack a bit neh =*

*P:* *Okay.*

*C:* *= so (0.2) it can stop the pregnancy.*

*P:* *Okay.*

*C:* *= Understand? .Hhh then with that (.) you will experience slight cramps or bleeding. Sometimes people don't experience anything. .hhh but that is the pill you will be taking here.*

*P:* *Okay.*

*C:* *Then we give you four tablets that you will take exactly at the same time at your house tomo::rrow.*

*P:* *Okay.*

*C:* *That tablet (.) is going to open the mouth of the womb. For that (.) second thing to come out =*

*P:* *Okay.*

*C:* *= that is mis::carrying.*

(Counselling Session, Healthcare Provide)

**Extract 45**

*Risks:*

*C:* *Ja, so uhm abortion has got hh. (0.1) you know mos it can work on your mind, right. ↓It's got its own complications right .hhh ↑with abortions (0.2) you can also have the possibility that you won't fall pregnant aga::in.*

*P:* *Mhmm.*

*C:* *And do you know wh::y?*

*P:* *Why?*

*C:* *It's because uhm (0.1) if you are (0.3) ovulating every month (.) there's mos this egg coming down neh =*

*P:* *Mhmm.*

*C:* *= and you don't know whether that was your last egg that is coming now.*

(Counselling Session)

The client also mentioned in the interview that when she read the consent forms in isiXhosa she became *"scared"* and when she read the consent form in English *"it was more easier"*. (See consent forms in the Appendices.)

**Extract 46**

*"Have you noticed that when something is said in isiXhosa, you find that yoh (.) it is as if it is scary or harsh"* (Interview, Client).

#### 5.7.3.1 Summing up and interpretation

As mentioned earlier in this chapter, the nurse from Site 1 does not use medical jargon in the counselling and the counselling is provided in the client's first language. There is no language barrier, since the nurse and clients speak a common language. In extract 38, the nurse tells the

client to be prepared to see the *"baby"* which *"will not be alive"*. The nurse could have provided the information in extract 38 in a more palatable manner. The nurse refers to the TOP process as *"giving birth"*. The nurse at Site 3 refers to the process as *"miscarriage"*. The nurse at Site 1 has shared that she does not promote abortion; her lexical choice is probably influenc by her attitude towards TOP.

In extract 40, the counsellor explains the procedure in what could be considered a gruesome manner. The counsellors are very descriptive and the use of language could result in the client changing their mind about continuing with the procedure. For example, taken from the above extract *"your baby will come out in pieces"*, *"physically pulled apart by suction"*. *"Su::ck"* and *"Chi::ld"* is in elongated speech, and speech is slowed down when the counsellor *<physically pulled apart by suction>"* which gives emphasis to what is being said.

The nurse at site 3 uses a lot of medical terminology that the clients may not understand. In extract 44, the nurse refers to the procedure as *"miscarrying"*. In the counselling, the nurse uses terms like *"foetus"* and "pregnancy" instead of *"baby"* which is used at Site 1 and Site 2. The healthcare provider's value system could influence their style of communication and their choice of lexical items they use during the counselling.

Printed materials are not user-friendly. Often the nurses assume that the clients are literate, when there is large illiterate population in South Africa (Sobane & Anthonissen, 2013). The informed consent forms at site 1 were in English and were given to the clients at the beginning of the counselling. The clients at site 1 had to give the information they read from the informed consent forms as part of the counselling. At Site 2, informed consent forms were not provided during the counselling. The counsellor at site 2 did not request information from clients as done by the nurses at site 1 and site 2. The nurse at site 3 gave the clients the informed consent forms to read whilst they were still in the waiting room. The nurse would then go through the consent forms during the counselling. The consent forms in site 3 are provided in English and Afrikaans, the clients select the preferred language between these two. There issue with the consent forms and other medical printed materials is the medical terminology used is difficult for the clients to understand. In cases where the consent forms are provided in isiXhosa there are some inconsistencies with the information provided. Sobane & Anthonissen (2013) study indicates that patients who were proficient in English had difficult reading the printed material

because of the use of medical terminology. In addressing challenges of language and access in healthcare, one cannot overlook the issue of printed material (Penn & Evans, 2009). In Chapter 6, I will provide some recommendations as to how the issue of printed materials could be addressed to ensure successful and efficient communication.

### 5.7.4 Decision-making

This stage of counselling usually follows after the healthcare provider has discussed the TOP procedure, the risks and pregnancy options. At this stage of counselling, the client is able to make an informed decision about their pregnancy.

**Extract 47**

Site 1

> *"There is a reason why we book (.) young lady. There are two reasons, okay? (0.1) And these two reasons are affected by those things which I said you must read and tell me about there. .hhh sometimes a person comes here on the first day undecided, okay. Once we have sat down and discussed this thing dear, because for instance there is another side from adoption social workers that we work with but they are not here today, okay. They are usually here (.) because sometimes a person comes here, right, having told themselves that they will do an abortion and once we have sat down as we are sitting to advise you, you find out that another person changes their mind, okay? And say, "No, I would like to step down from this decision." Eve`n after you have heard about these things (.) we give you a chance to go home and decide whether you really want to continue with this procedure, after you have heard about a::ll its complications and risks, okay"* (Counselling Session, Healthcare Provider).

Site 2

**Extract 48**

*C:* *What you have to remember as well is that (.) this baby is your baby as well. And I fully understand (0.1) uhm why you're feeling the way that you are and why you are feeling abandoned and be::trayed. And I'm sure that you also feel very angry about fact that he's put you in this situation because now you have to deal with this baby. But remember that this baby is your baby as well =*

*P:* *Yeah.*

*C:* *= and (.) you cannot only make a decision (0.1) for your partner. You've got to make a decision for you =*

*P:* *↓Yeah.↓*

*C:* *= and how are yo::u going to live (.) with the knowledge (.) of having the abortion as well because although this baby is your partners baby, it is also your baby. And the consequences of having a termination are going to live with yo::u forever.*

(Counselling Session)

**Extract 49**

*"It is your choice; you get to decide (.) on whether you want to have this baby or not. (0.1) ↑But just because it is your right (0.1) does not mean it is the right thing to have an abortion. You have to listen to your inner voice (.) you have to listen to your morals (.) and your ethics as a human being"* (Counselling Session, Healthcare Provider).

Site 3

Here the healthcare provider provides information and asks afterwards if the woman still want to continue with the procedure.

**Extract 50**

*C:* *You still want to do it?*

*P:* *(h) Yes, I still.*

*C:* *Good. [You're 100%]*

*P:* *[Yes, I still].*

*C:* *Because when you come here you must be absolutely sure =*

*P:* *Mhmm.*

*C:* *= this is what you want. .hhh and uhm (0.1) if there's anything that you need to ask me you can stop me anytime =*

*P:* *Okay.*

*C;* *= neh and ask me (.) I can answer you. Right?*

*P:* *Okay.*

*C:* *.Hhh and I don't want to (0.2) affect (0.1) your decision in any way*

*P:* *Mhmm.*

*C:* *I'm not going (0.1) to try change your mind because I've tried that.*

(Counselling Session)

### 5.7.4.1 Summing up and interpretation

Site 1 did not provide the TOP services on the same day. At this research site, the nurses used a booking system. The clients would receive PTOP counselling and a day to return on.

According to the nurse, the reason for using the booking system is so that the clients have time to process the information and decide whether they want to go ahead with the TOP procedure. In extract 47, the nurse explains to the client that the booking is used because some clients change their decisions once having received the counselling. The nurse is aware that information shared in the counselling may influence the client's decision. The nurse can decide to be graphic in her explanation of the TOP procedure and risks to scare the clients from continuing with it. They way in which the counselling is provided may be the reason as to why clients do not return on their date. The nurse uses words like *"failure"* and she tells the clients that she does not promote TOP. The nurse uses a negative tone, and sometimes scolds the clients instead of providing the clients with advice that will assist them make better choices.

The counsellors at Site 2 are guided by the Christian values and tend to use a lot of emotive and persuasive language in the counselling. In extract 49, the counsellor tells the clients that just because they have a right to access TOP services; it does not mean it is the right thing to do. TOP literature in chapter two has indicated that there is a TOP law reform but this has not transformed the attitudes of wider society (Sigcau, 2009). According to Christian values, TOP is viewed as immoral, and it is suggested that a foetus has a right to life from the time of conception. In the counselling sessions the counsellors may not directly say that they are anti-abortion but the type of counselling provided suggests that abortion is not a moral act. In extract 50 there is a rise of voice tone with *"but"* which is followed by how client's right to TOP does not mean is a right thing to do. The counsellor goes on to tell the client that in making their decision, the client needs to listen to their *"inner voice"*, *"moral"* and *"ethics"*.

After providing the TOP counselling, the nurse at site 3 often asks the clients if they are sure if about their decision or if there is anything she can say that can make them change their decision. In this case, the client qualified for medical abortion and the clients are given the medical abortion pills during the counselling. The TOP service is provided on the same day, and clients need to be sure about their decision and the nurse needs to be clear on consent. Counselling is supposed to provide guidance to the clients and help them make a more informed decision. The healthcare providers should not influence the client's decision; the final decision should solely be left to the client. The counsellor says she will not try influencing the client's decision because she has already done that, which is after discussing TOP risks. In extract 47

and extract 50 the nurses at Site 1 and Site 3 acknowledge that information provided in the counselling can lead to the client changing their decision.

Consultation between doctors and patients embody 'common-sense' assumptions which treat authority and hierarchy as the doctor knows about medicine and the patient doesn't; the doctor is in a position to determine how a health problem (Fairclough, 1989). The doctor makes the decisions and controls the medical discourse, and that the patient cooperate (Fairclough, 1989). To find assumptions of this sort embedded in the forms of language that are used, such assumptions are ideologies (Fairclough, 1989). Ideologies are closely linked to language, because using language is the commonest form of social behaviour, and the form of social behaviour where we rely most on 'common-sense' assumptions (Fairclough, 1989). Healthcare providers are likely to impose the discourse type upon clients, in the sense of putting pressure on them in various ways to occupy the constrained subject position (Fairclough, 1989).

### 5.7.5 Family planning

Family planning is discussed in the counselling as a method of preventing unwanted pregnancy. The nurses from Site 1 and Site 3 discuss the different types of family planning, both short and long-term methods. The counsellors at Site 2 suggest that the clients go on family planning if they are not ready to parent but does not discuss the different types of family planning.

Site 1

**Extract 51**

*C: It traumatizes us as much as it may seem as if it does not traumatize you guys. So to avoid such situations of having you coming back here, because we know the consequences of what you come to do here. And we will not sit here as if we are not concerned about your lives. Do you understand what I am saying?*

*P:Yes, ma'am.*

*C: So that means that we will either give you a 3-years planning method or a 10-years one. And we will give a chance to choose between the two. We will not choose*

*for you. It is either you choose the 3-years one called an implanon or you choose the 10-years one called the loop.*

(Counselling Session)

**Extract 52**

*C:* *What are you going to do then after the abortion?*

*P:* *I will go do family planning.*

*C:* *Which family planning method are you going to use?*

*P:* *I will go back to using Pathogen because =*

*C:* *Let us stop right there. Do you understand?*

(Counselling Session)

Site 2

The clients were advised by the counsellor to take necessary precautions to prevent unwanted pregnancy in future.

**Extract 53**

*C:* *= but don't use contraception, don't use abortion [as a contraception] =*

*P:* *[As a contraception].*

*C:* *= because that's not fair on life. It's not fair on your baby. You are pregnant now okay. You're not going to become pregnant. You are carrying your baby, your second baby. So you need to make sure that if you do not want to have another baby (0.2) don't allow your husband to impregnate you. It's not fair on life and it's not fair on your husband either.*

(Counselling Session, Healthcare Provider)

**Extract 54**

> *So now we do not promote pathogen, the needle and the pills after abortion because they are the ones that she will not comply with once she gets out of here* (Healthcare Provider, Counselling).

Site 3

Family planning was suggested to the clients. The nurse would often suggest the loop to clients as against the other family planning methods.

**Extract 55**

*C:* *.Hhh If I can make a suggestion (.) why don't you want to go for the loop in the future (.) have you heard anything about the loop for family planning?*

*P:* *(0.1)*

*C:* *The loop is the device that we can put (0.1) anyway if you're sure you don't want children.*

(Counselling Session, Healthcare Provider)

**Extract 56**

(See Appendix 8)

38 *C:* *Do you think about it? (0.2) Do you realize the consequences?*

*39* *P:* *Yes.*

*40* *C:* *↑You do? (0. 6) My worry is neh, (0.3) you must be able to kn::ow when you have (.) made a mistake. I mean (0.2) not (0.2)*

*like a mistake in a fact that (.) you don't know neh, what to do or (0.2) the fact that you must know that (.) it is your ↓responsibility not to fall pregnant. Do you understand?*

41. *P:* ↓*Yes*↓

42. *C:* ↓*Do you understand that though?*↓

43. *P:* ↓*Yes, I understand.*↓

(Counselling Session)

#### 5.7.5.1 Summing up and interpretation

The clients are advised by the healthcare providers to make "wise decisions" and taking necessary measures to prevent unwanted pregnancies. The last stage of the counselling discussed family planning/contraceptive methods. The clients at Site 1 and Site 3 are asked to select a method. The clients often select depo-provera or nuri-strate, which are the short-term family planning methods. The nurses suggested a long-term method instead, being the implanon, which is the three-year option, and the loop, which is the ten-year option. The clients often change to the long-term options selected by the nurses.

The nurse at Site 1 informs the clients that by the time the clients leave the hospital they have to be on some form of contraceptive. The nurse at Site 1 allows the clients to only select between the two long terms. The nurse would tell the clients that they are failing themselves by not using family planning. In extract 51, the nurse shares that seeing clients having repeated abortions traumatizes them. The nurse suggests to the clients two long-term family planning method options to select. In the same extract, the nurse says she will not choose for the client yet the nurse had already decided that long-term methods is the suitable option for the client. Sometimes the clients would select the two or three-month option, and they would tell the clients that option is not for them. In extract 52, the nurse stops the clients because she selected a different method to the one the nurse suggests to clients. In all the consultations, the nurse would tell the clients that they would be put on long-term family planning methods, which is the implanon, which is a three-year option or the loop, which is a ten-year option. According to the nurse once the clients have come to a PTOP clinic it goes to show that you they cannot be trusted with the injection and the pill. The nurse tells the women that she is there to help

them correct their mistake, and that they are not there to promote TOP but family planning but rather to promote effective family planning.

In extract 53, the counsellor from Site 2 suggested the client use family planning to prevent unwanted pregnancy and not use abortion as a contraceptive. The counsellor adds that TOP is *"not fair on life. It's not fair on your baby"*. As mentioned earlier, in Christianity, life is considered to be sacred and according to the belief system, life begins at conception. TOP goes against the counsellor's belief system and the counsellor discourages the clients from resorting to an act that puts an end to life of the client's *"baby"*.

As mentioned in chapter 4, the nurse at Site 3 suggests long-term family planning methods to the clients. At Site 3 the nurse suggests the long term family planning method is not imposed on clients. The clients have an option to select preferred family planning method, whether it is long term or short term. The nurse often suggests the loop, which is a 10 year contraeceptive. The nurse often provides the counselling in monotone, using medical terms. In this stage of counselling, the nurse becomes more persuasive in talk, with a rise in tone. The clients become more open to the loop once it has been suggested to them. Healthcare providers have an influence on the client's decision making because clients value the opinions of healthcare providers. As indicated in chapter two, the clients value the opinions of healthcare providers, they trust them because it is believed that healthcare providers possess all the medical knowledge.

### 5.8 Language, power and discourse

Linguists and social scientists have indicated that language has become the main medium of social control and power (Fairclough, 1989). This study investigated power in, 'cross-cultural' discourse where patient and doctor belong to different cultural, socio-economic and linguist groups, and the 'hidden power' of the discourse (Fairclough, 1989).

Power is exercised and enacted in discourse (Fairclough, 1989). Fairclough (1989) draws a distinction between 'power in discourse' and 'power behind discourse'. Fairclough (1989) explains that with 'power in discourse', discourse is power struggle where speakers are constantly negotiating power through discourse. In terms of 'power behind discourse', it is the

stake in power struggles for control over orders of discourse that is a powerful mechanism for sustaining power, those who pose power use discourse to re-enforce that power (Fairclough, 1989). In the context of this study, it is the healthcare providers who have the power to control discourse types that are then imposed upon clients. In the healthcare there are power holders who occupy position high up in the hierarchy such as top management and doctors, who exercise power over healthcare providers of lower positioning such as nurses, who then exert their power though discourse onto clients. The power behind the conventions of a discourse type belongs not to the health institution but to the healthcare providers who are power-holders in the institution (Fairclough, 1989). There is institutional culture that the health professionals are guided by; determining the healthcare provider's professional conduct, including the way in which they interact with clients. Healthcare providers take on conventions of a discourse type as a way of maintaining institutional roles. In PTOP counselling, the nurses and counsellors are the power-holders, who control the discourse and enforce patients' passivity with conventions. (Fairclough, 1989).

As stated by Fairclough, (1989:40) "orders of discourse embody ideological assumptions, and these sustain and legitimize existing relations of power". With the data presented in this chapter, there is an unequal encounter, the nurses and counsellors control the discourse and there is an imbalance of power. Healthcare provides are powerful participants and because of their institutional role they have the right to determine which discourse types may be drawn upon (Fairclough, 1989). Discourse types and orders of discourse vary across cultures meaning that when the healthcare provider and client belong to different cultural and linguistic backgrounds the communication disparities become greater; especially when the healthcare giver is a speaker of a highly esteemed English language.

### 5.9 Summary

This chapter presented analysis and interpretation of data. In the interpretation what is highlighted is that communication challenges often occurred between healthcare provider and client when they do not share a common language. Language is sometimes a barrier to effective communication in PTOP counselling. There were communication barriers in both intercultural and intra-cultural communication. The barriers of communication included use of medical jargon, which were unfamiliar to the clients. Culture was another barrier, as the healthcare

provider value system influences the counselling. Healthcare providers who are anti-abortion on religious and cultural grounds influence the way in which the TOP information is provided during the PTOP counselling. Norms of social interaction also vary in different cultures, and may be misinterpreted in cross-cultural communication, because of norms that are imbedded in the speaker's culture. Speakers are guided by rules and structures that help them make sense of their social world and allow them to navigate in certain settings, whether social or institutional. Language use is influenced by wider society especially power structures. Language is a part of society, and not somehow external to it, language is a social process and language is socially conditioned. Power is exercised and maintained through discourse; language can be used as means of domination. All of these theoretically imbedded aspects are clearly discernible from the data analysis presented in this chapter.

Chapter 6 presents the findings, recommendations and conclusion of this thesis.

# CHAPTER 6: FINDINGS, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

## 6.1 Introduction

This chapter provides the findings of this study, the limitations and the recommendations. The findings to be discussed are based on the data presented in chapter 4 and analysed in chapter 5 of this thesis. In this chapter, an overall summary of the findings is provided. Limitations to the study are provided so researchers interested in a similar research topic may know what to expect and be aware of the impact some of the limitations may have on future study.

## 6.2 Findings

### 6.2.1 Intercultural and Intra-cultural miscommunication

Miscommunication occurs within intercultural and intra-cultural medical encounters. Even if the healthcare provider and client share a common language this does not guarantee effective communication. Communication challenges still occur in intra-cultural medical encounters; sometimes the language used in the counselling is not causing a communication barrier, but rather the excessive use of medical terminology. There are also instances where an individual's social culture such as religion may influence the way they undertake councelling sessions.

There are also issues of power relations between healthcare proferssionals and clients which can influence communication. Positioning theory has been used in this thesis to indicate how such power relations can influence communication in a negative way.

In some cases, the miscommunication was unrelated to cultural differences. Considering requirements of effective communication between healthcare providers and patients, South Africa continues to largely be linguistically homogenous in terms of professional language practice. In Site 2 and Site 3 English was the language that was mainly used by the nurses and counsellors in the counselling. There were cases were the patients had difficulty understanding what was being communicated. It often became clear when the clients had to give the

information back to the healthcare provider, they struggled with repeating the information and providing an explanation in their own words. It became apparent that the use of English is exclusive and accentuates the divide of those who have access to it and those who do not. Such a practice is not accommodative to cross-linguistic and intercultural communication.

It is also important for healthcare providers to be aware of the fact that the clients may provide a positive response out of politeness, which may not also be a true reflection of what is going on. As alluded to earlier, communication styles vary across cultures, and in some cultures including Xhosa culture, often a recipient will provide a positive response out of politeness when one speaks to an authority figure. A yes or no answer from the client is not sufficient to determine whether communication is clear. In Site 1 and Site 3 at some stage of the counselling, the clients had to provide an explanation of the TOP procedure, its risks and what to do when suffering from the side effects. In this activity, the healthcare providers used scaffolding, which is a discourse strategy, whereby healthcare providers repeat the information to clients or request an explanation from clients, and ask follow up questions that encourage patients to expand their explanation (Watermeyer & Penn, 2009). This approach is one of the approaches used by health professionals to ensure effective communication and is a strategy to bridge communication gaps.

### 6.2.2 Healthcare provider's styles of communication

Nurse's attitudes and poor health service is a barrier to safe legal abortion. Studies on TOP have reported that women continue to access illegal abortion because they fear being scolded by the nurses (Sigcau, 2009). The nurses in Site 1 often spoke to the clients in a harsh tone of voice, and there were a few instances where I observed this happening at the other two research sites. Nurses and counsellors providing PTOP need to be cautious of the way in which they communicate with clients. These styles of communication can be a barrier to women accessing safe and reliable TOP services, and can negatively affect the health outcomes. Healthcare providers scare off clients by using a harsh and authoritative tone in addressing them. Despite the CTOP Act, there are still negative attitudes toward abortion and the abortion stigma is still a barrier. Some of the healthcare providers and clients in the study share the same sentiments as those of wider society, where abortion is viewed as a sinful act. These views of abortion were often a refection of a value system, and often influence the type of counselling.

### 6.2.3 Power in discourse

Healthcare providers spend years acquiring medical knowledge and skills (Fairclough, 1989:65). The discourses in the medical profession, including use of medical terminology seem exclusionary to people who are not in the profession or who do not have a vast knowledge in the field. Patients occupy a lower position in the medical encounter and the healthcare providers are the holders of power (Fairclough, 1989). The discourses reassert that power, and roles and power dynamics are maintained (Fairclough, 1989). Often the healthcare providers use a paternalistic approach to medical care, and it causes an imbalance of power between the healthcare provider and client. This approach to healthcare can negatively affect communication because the communication becomes unidirectional and clients become passive receivers of care. Lack of client involvement in the medical encounter does not provide a holistic medical experience and may negatively affect the communication.

In relation to this study, there was an imbalance of power, which I address in chapters 4 and 5 of this thesis. Often the healthcare provider would indicate to the client which method they will use for family planning, instead of suggesting it. Family planning methods can have side effects, the clients should get to decide what happens to their bodies and not have the decision made for them.

## 6.3 Limitations of study

This section discusses the limitations of this study.

This study was part of a larger research project and some of the questions on the interview schedule were not directly related to the research question. The questions on the interview schedule may have not been particularly relevant for this study but because the questions were open-ended some of the answers provided by healthcare providers and clients related to issues of language and access. For future research purposes, more direct questions on the linguistic and cultural aspects of communication in PTOP counselling will greatly contribute to growing this type of research, where the research is not only based on my interpretation but also shared narratives of the participants.

### 6.3.1 Reliability of qualitative research

CA and CDA have been critiqued as being subjective approaches. CA transcription is considered a subjective process, and validation of claims is sometimes questioned. With every qualitative research, interpretations can be subjective. The researcher cannot completely be objective, the researcher applies their own understanding to what is being studiesd, which can affect their objectivity.

### 6.3.2 Number of participants

With the research being centred on communication in PTOP counselling, there were some ethical concerns. As alluded to earlier, there is a stigma attached to TOP and abortion is something that is kept to oneself almost as a secret; it is because women fear judgment and being ostracized by their communities. I was aware that my presence would bring some discomfort, which is why my co-researchers and I had to be sensitive as to how we approach the participants. We had to be mindful of our language use and body language. I observed with certain restrictions, as I was mindful that my presence may have somehow been intrusive and I had to be respectful of clients and their space. I could not therefore provide detailed descriptions of every occurring event. It was important to also reassure the participants that the study is highly confidential, voluntary and that if they felt uncomfortable at any point they could discontinue from the study.

## 6.4 Recommendations

This section provides recommendations based on the findings presented above.

### 6.4.1 Effective communication approach

In order to communicate effectively healthcare providers should adopt a 'mindful' approach, and be mindful of the communication process during PTOP counselling. Healthcare providers who provide PTOP counselling should be mindful of linguistic processes, how turns are taken up, how much they control the medical discourse, and avoid being overly dominant. Healthcare providers have the power to control the medical discourse and discourse types often leading to

an imbalance of power. It is advisable that healthcare providers adopt approaches that make the counselling more interactive than merely being unidirectional. Clients need to be active agents of talk and be involved in the communicative processes and that would allow for a more holistic approach to TOP. Healthcare providers need to be mindful of the way in which they interact with the clients as power holders, in that they influence discourse types, turns at talk, because an imbalance of power can hinder communication. Cultural, linguistics and clinical competence practice is required by healthcare providers in order for them to adopt a mindful approach.

All healthcare providers should adopt a scaffolding approach; this approach helps identify any miscommunication during the communication process. The approach allows for healthcare providers and clients to negotiate a way around talk and it helps to bridge the communication gap ensuring communication that is more effective. Nurses who share a common language with the clients can also assist, in cases where language is a barrier. The hospital can offer a course or language/communication classes where healthcare providers learn their patient's language. In this case, the healthcare providers will learn isiXhosa or Afrikaans within a medical context. Communication classes could be offered once a week depending on how flexible the work hours are. The class should focus on communicative skills ensuring clinical and cultural competence in a health setting. Clients should not be turned away from accessing PTOP counselling due to language barriers. TOP is sensitive and clients may not be comfortable having interpreters present during the counselling. In addition, miscommunication also occurs even when the interpreter is present, be it because the interpreter may also struggle with the medical terminology and be unable to translate some terms.

### 6.4.2 TOP training

Sometimes the healthcare providers have difficulty separating their personal value system from their professional conduct. The healthcare provider's value system influences the type of counselling provided. It is important that healthcare providers who provide TOP services undergo training, so that the nurse are able to address these conflicting values which may negatively affect their professional conduct and communication. Training of the healthcare provider is crucial, as it will assist in guiding them, how to not let their personal values and beliefs determine the type of service provided to clients. Training may help healthcare

providers with their styles of communication; affect their language use when using medical terms like *"foetus"* rather than *"baby"*. Healthcare providers need to adopt a patient-centred approach, whereby the information provided is not a reflection of their value system. There should be on-going training. The training will equip the healthcare provider with the communicative skills. Linguistic and cultural competency is important as it can help bridge communicational gaps within TOP. Healthcare providers should avoid the use of persuasive language that try to influence and change the mind of the clients rather than being informative, providing guidance to help clients make a more informed decision.

### 6.4.3 Patient-centred approach

With some of the counselling sessions, there is a clear imbalance of power between healthcare providers and clients. When the healthcare provider adopts a practitioner-centred approach, it accentuates the imbalance of power. With a practitioner-centred approach, the medical encounter is mostly biomedical, where the healthcare giver provides the information and tells the client which steps to take for preventative measures, without involving the client in the decision-making. The clients become a passive recipient of information regarding her sexual reproduction and health. In this sense, the practitioner-centred approach is therefore a paternalistic practice. Research studies on health communication have suggested that healthcare professionals take on a patient-centred rather that a practitioner-centred approach. I share the same sentiments, because a patient-centred approach goes beyond the clinical gaze or biomedical problem-solving approach, clients are actually active participants in the medical encounter. In terms of this study, the clients get to decide what is best for them when it comes to the pregnancy and which family planning method is suitable for them whether long-term of short-term. As alluded to earlier, a patient-centred approach involves patient participation and is associated with positive health outcomes and quality healthcare. Healthcare providers must adopt a patient-centred approach and be mindful of client's cultural differences. A patient-centred approach involves healthcare providers relinquishing some of their power and control of the medical discourse, thus creating a power balance. User-friendly printed materials

Information in printed materials should be accessible to clients and so when they sign informed consent forms they are aware of what they have committed themselves to. There is also non-consistence when it comes to consent forms. The isiXhosa consent forms provide a list of some of the possible physical and psychological effects of TOP by listing them, which is not the case

in the English consent forms. The risks and side effects are not provided in detail in the English consent form. The information provider in the consent form tends to differ in terms of language whereas in the English consent form the term *"foetus"* is used and in the isiXhosa consent the term *"umntwana"* which means baby when translated into English. This goes back to what one of the participants said that it sounds *"scary or harsh"* in isiXhosa. This could be for various reasons, possibly because alternative terms were not there in isiXhosa. There English can be more user-friendly if the procedure was explained in terms that a layperson might understand, clients may not know the meaning of terms such as *"sepsis"* or what *"D & C"* abbreviation means.

Medical terminology used in printed materials such as consent forms needs to written in language that is accessible to the patient. Printed materials can be in English and another principle language that is widely spoken by people of that particular community. There will be challenges when translating the information from English to the other language, for reasons like lack of terminology causing inaccuracy. Even if that is the case, there should be some consistency in terms of the information provided. Improving intercultural communication health involves addressing the issue of medical terminology used in printed materials. Sometimes there are terms that are created and used within communities and terminologists may not be aware of their existence. When translating these printed materials, it would be important that speech communities be consulted. There is no point in terminologists creating new terms when they already exist and are being used as part of speech. Some of the terms may not be suitable for use in an institutional context and not all terms will be documented. This process will take time because translation is costly and requires many resources that the government may not see as an urgent need. Health inequalities

There are disparities in the private and public health sector that have a significant impact on the health inequalities. Middle class citizens receive quality service, and are most likely to be fluent in the English language and are not as affected by English as the language used during the medical encounter. Some of the health inequalities were inherited from the apartheid period as indicated in chapter 1, and government has not been successful in addressing these inequalities. Government should focus on implementation of policy to promote a culturally sensitive approach within a multilingual context and reduce health inequalities. Effective communication is one of the barriers to quality care, amongst many others such as untrained medical staff. Some of the nurses at the research sites we collected data from had not underwent

TOP training, and have had to learn on the job. The healthcare provider also mentioned that they do not receive support from management and that it does not make their job any easier. The healthcare providers working in TOP are not only facing challenges of having to work in public health facilities, some of their colleagues are anti-abortion and ostracize them. These challenges affect the quality of care provided and nurses are not able to work at their optimum level because they are not equipped with skills they need to be able to provide effective counselling. The nurse's experience evolves with time, but there is still a need for basic training. Healthcare providers working conditions affects the quality of care. They often feel frustrated and this frustration is sometimes taken out on the clients.

### 6.4.4 Policy implementation

What is taking place in the healthcare clinics is not a reflection of the current language policy that allows for service delivery in a language of one's choice (National Health Act, 2003). Linguistic imbalances that were a result of previous apartheid policies of linguistic and cultural isolation are still in practice (Crawford, 1999). English is not accessible to, or understood by everyone (National Health Act, 2003). In TOP contexts, the use of English is exclusive and accentuates the divide of those who have access to it and those who do not. South African language policy promotes multilingualism; everyone has a right to be assisted in his or her mother tongue. Sometimes language rights are vague to a sense that it is not stated which steps to follow in making this right achievable or also what is to be done when one's language right is not met. There are many loopholes in the policies, and it is difficult to hold anyone accountable even when there clearly is no effort that is made to meet the language rights of patients. The government needs to implement support systems for cross-cultural communication in healthcare. There needs to be political will and clear policy that multilingualism and multiculturalism at institutional level across all sectors is not only justifiable, but desirable.

## 6.5 Summary

Effective intercultural communication requires that the health professionals incorporate multiple cultures in their practice: their natal culture and that of the patient, and the health care institution's culture (Kagawa-Singer & Kassim-Lakha, 2003:578). Effective intercultural

communication can be achieved through linguistic awareness and cultural competency. Clinical and cultural competence requires the healthcare providers to have the communication skills and know how to apply these skills in a clinical encounter. To achieve effective intercultural communication, the healthcare provider must understand the patient's language and that the client's language influences their worldview, which is applied to norms of talk. Effective intercultural interaction between healthcare provider and client is important because it helps establish a better relationship with clients. This is borne out by the data analysis presented in the interviews in chapter 5 of this thesis. The thesis furthermore highlights the need for effective language planning and policy implementation in the medical sphere in South Africa, particularly when it comes to sensitive medical issues related to termination of pregnancy.

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# APPENDICES

## APPENDIX 1: Ethics Clearance


Rhodes University Ethical Standards Committee, Rhodes University, P O Box 94, Grahamstown, 6140

Tel: +27 46 603 7366 . Fax: +27 46 603 8934 . Email: ethics-committee@ru.ac.za

25-Mar-2015

Dear Prof Catriona Macleod

**Ethics Clearance:** Investigating how Pre-Termination of Pregnancy (PTOP) consultations are conducted within the public health sector in the Eastern Cape, South Africa.

**Principal Investigator:** Prof Catriona Macleod

This letter confirms that a research proposal with tracking number: RU-HSD -14-12-0004 and title: **Investigating how Pre-Termination of Pregnancy (PTOP) consultations are conducted within the public health sector in the Eastern Cape, South Africa.** was given ethics clearance by the Rhodes University Ethical Standards Committee.

Please ensure that the ethical standards committee is notified should any substantive change(s) be made, for whatever reason, during the research process. This includes changes in investigators. Please also ensure that a brief report is submitted to the ethics committee on completion of the research. The purpose of this report is to indicate whether or not the research was conducted successfully, if any aspects could not be completed, or if any problems arose that the ethical standards committee should be aware of. If a thesis or dissertation arising from this research is submitted to the library's electronic theses and dissertations (ETD) repository, please notify the committee of the date of submission and/or any reference or cataloguing number allocated.

Yours Sincerely,

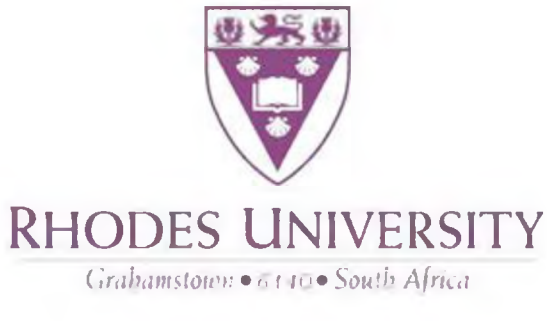
Professor M. Goebel: Chairperson RUESC.

**Note:**

- This clearance is valid from the date on this letter to the time of completion of data collection.
- The ethics committee cannot grant retrospective ethics clearance.
- Progress reports should be submitted annually unless otherwise specified

**APPENDIX 2: Informed consent for service user**

One of my co-researcher's was Jabulile Mavuso whose name appears on the informed consent forms. My name does not appear on the informed consent, but researchers involved in the Critical Studies in Sexualities and Reproduction research programme used the form collectively.




**CRITICAL STUDIES IN SEXUALITIES AND REPRODUCTION RESEARCH PROGRAMME Tel: (046) 603 7329 e-mail: cssradmin@ru.ac.za**

November 2015

Dear service user/ *Msebenzisi wenkonzo obekekileyo*

I am Jabulile Mavuso from Rhodes University. I form part of a research team interested in exploring how pre-termination of pregnancy consultations are conducted in Termination of Pregnancy clinics in South Africa. This study is important in terms of helping us understand these sessions better and in terms of improving these services. Permission to conduct this research has been obtained from the Eastern Cape Department of Health and Dora Nginza Hospital.

*Ndingu Jabulile Mavuso osuka e-Rhodes University. Ndingomnye wabantu abanomdla wokuphanda ngendlela i-counselling yenziwa ngayo phambi kokuba umntu akhuphe isisu kwiklinikhi apha eMzantsi Afrika. Oluphando lubalulekile ngoba lusinceda sazi ngcono nge-counselling kwaye sifumane iindlela zokunyusa izinga lwenkonzo yempilo. Igunya lokwenza oluphando silufumene kwisebe Lwezempilo lase-Mpuma Koloni Dora Nginza Hospital.*

I invite you to participate in this study. If you agree to participate in the study your participation would involve the following:

- Allowing us to audio or video record the consultation session; and/or
- Speaking to us about your experience of the consultation session.

If you prefer to participate in only **one** of these, this is fine.

*Ndiyakumema ukuba uthathe inxaxheba kolu phando. Ukuba uthe wavuma ukuthatha inxaxheba kulophando, inxaxheba yakho izawuquka oku kulandelayo, ukuba:*

- *Imvume yokuba sishicilele] i-counselling sisebenzisa iteyipi rekhodi okanye i-video rekhodi; kwaye*

- *Usixelele ngamava akho nge-counselling. Ukuba ukhetha ukwenze into ibenye, kulungile.*

This is how the research will work:

- The pre-termination of pregnancy consultation that you will have with the health service provider will either be audio or video (including audio) recorded. The researcher will switch on the recording device(s) and will exit the room. She will not be present when you have your consultation with the health service provider. Once the researcher has exited the room, the consultation session will begin. After the consultation is completed, the researcher will come in and switch the recording device off. The researcher will show you where the off switch is for the recording equipment.

  If at any stage of the consultation you wish to withdraw from the study you can simply press the off button on the recording devices. In such an instance all previous recordings will be deleted by the researcher after the consultation.

- The interview you will have with the researcher after the consultation with the health service provider will be audio-recorded. The health service provider will not be present during this interview. You will have a chance in this session to speak about your experience of the consultation. You will not be asked to speak about the reasons for your decision or any other aspect of your life, unless you specifically want to speak about these issues.

*Oluphando luzohamba ngoluhlobo:*

- *I-counselling ozakuyifumana kumongikazi izakushicelelwa kwi-teyipi rekhodi okanye i-video rekhodi. Umphandi uzolayita iteyipi okanye i-video rekhodi alandele ngokuphuma kwigumbi. Umphandi akazobakho xa ufumana i-counselling kumongikazi. I-counselling izoqala xa umphandi ephumile kwigumbi. Xa ugqibile ukuthetha nomongikazi, umphandi uzokungena kwigumbi acime –ivideo okanye iteyipi rekhodi. Umphandi uzokubonisa icinywaphi iteyipi okanye i-video rekhodi ukuze ukwazi ukuyicima xa uziva ukuba awusafuni ungenela oluphando. Kwimeko enjalo umphandi uzocima lonke ushicelelo kwiteyipi okanye i-video rekhodi.*

- *Emva kokuthetha nomongikazi kwi-counselling uzobanodliwano ndlebe nomphandi kwaye kuzosetyenziswa iteyipi rekhodi. Umongikazi akazubakho koludliwano ndlebe. Uzawufumana ithuba lokuthetha ngamava akho nge-counselling. Akuzobuzwa ngezizathu ezibangele ukuba uthathe esigqibo sokuza ekliniki okanye ngobomi bakho ngaphandle kokuba wena uyafuna ukuthetha ngayo.*

Please understand that your participation in this study is completely voluntary and you are not being forced to take part. Although we would really value your participation, the choice of whether to participate is yours alone.

*Sicela uyazi ukuba ukuthatha inxaxheba kolu phando kuxhomekeke kuwe kwaye akekho umntu ozakunyanzela. Nangona singayivuyela inxaxheba yakho kolu phando, sonke isigqibo sesakho kuphela.*

If you choose to, or choose not to, participate in this study, the services you receive will not be affected in any way whatsoever. If you agree to participate, you may stop at any time and discontinue your participation. If you withdraw at any stage, this will not affect the services you receive at the Termination of Pregnancy clinic.

*Isigqibo sokuthatha okanye ukungathathi nxaxheba kolu phando, asizo chaphazela uncedo ozalifumana. Ukuba uyavuma ukuthatha inxaxheba kolu phando, uvumelekile ukuba uyeke nanini na. Ukuyeka kwakho akuzuchaphazela inkonzo ozifumanayo apha eklinikhi.*

In order to protect you, we will not be recording your name for the purposes of this research. Instead, we ask that you make up a name, called a pseudonym. You can sign the consent form with this name, if you wish.

*Ukuze sikhusele wena, igama lakho lokwenyani alizokusetyenziswa kule-research. Kodwa sizokusebenzisa igama ozithiyilelo kolu phando. Ungatyikitya ifomu yemvume ngeligama ukuba uqwenela ukwenza njalo.*

We will, however, ask that you please provide your age. Only the researchers working on this study will have access to this information.

*Kodwa sizakucela usixelele iminyaka yakho. Ngabaphandi kuphela abazokubona ezinkcukacha.*

The recordings of the consultation sessions and of the interview with the researcher will be kept in a safe place and will only be accessed by researchers on the project. The video recordings will not be used in any publications or presentations. This is to protect you so that nobody but the researchers is able to identify you. The purpose of the video recordings is to give the researchers a better picture of the consultation.

*Iteyipi rekhoda okanye i-video rekhoda ezishicilele icounselling kunye nodliwano ndlebe zizogcinwa kwindawo ekhuselekileyo apho ingabaphandi bale-research kuphela abafikelelayo. I-video rekhodi ezishicilelweyo azizopapashwa. Injonga kukhuselela igama lakho. Injongo ze-video rekhodi kukunika umphandabaphandi] umfanekiso ocacileyo nge-counselling.*

The health service providers will not have access to your interview material and will not be told what you specifically said about the session.

*Oomongikazi abazokuboniswa okanye baxelelwe ngodliwano ndlebe nokuthethileyo malunga ne-session ye-counselling.*

If, at any time in the process you feel upset, you may end your participation. For example, you can turn off the recording during the consultation and you can ask for the interview to stop. In

addition, the researcher will provide details of a counsellor should you feel that you would like to make use of these services.

*Ukuba awuziva kakuhle unalo ilungelo lokuyeka ukuthatha inxaxheba kolu phando nanini na. Umzekelo ungacima iteyipi rekhodii okanye i-video rekhodi xa ufumana i-counselling okanye ucele udliwano ndlebe ukuba maluphelisiwe. Kwaye umphandi uzokunika inkcukacha ze-counsellor ukuba uziva ufuna uthetha nayo.*

If you have a person with you (for example, partner, parent, friend, relative) who will participate with you in the consultation session, they must also give their consent to participating in the research. If this person does not want to participate, but you do want to, then we will simply delete the section of the recordings where she or he is speaking.

*Ukuba uhamba nomntu (iqabane, umzali, sihlobo, isizalwane) ozawube ekhona kunye nawe kwi-counselling kufuneka naye lo mntu asinike imvume yokuthatha inxaxheba kolu phando. Ukuba lo mntu uhamba naye akafuni ukungenela uphando kodwa wena uyafuna, sizokucima kwi-teyipi rekhodi indawo ebethethe kuzo ngela xesha le-counselling.*

In addition to the above, one of our researchers will be observing the interactions that take place between service providers and women in the waiting room. Notices about these observations have been put up in the waiting room area. Please communicate with the researcher if you would like her to not include any of the interactions you have with the health service providers in her observations. If you have any questions about this study, please feel free to ask me. In addition, if there are questions that you feel I have not answered, or if you have concerns about the research, you may contact Prof Catriona Macleod, the principal researcher, at Rhodes University by calling her on 046-603-7329.

*Kwaye, omnye wabaphandi uzojonga isimo okanye iindibano nokwenzekayo phakathi koomongikazi namanenekazi kwigumbi lokulinda. Izaziso ngoluphando zibekiwe kwigumbi lokulinda. Ndicela uthethe nomphandi ukuba awufuni ayibandakanye kolu phando inthetho nendibano yakho nomongikazi. Ukuba unemibuzo ngoluphando, ndicela undibuze khululekileyo. Kwaye ukuba awanelisekanga okanye unengxaki ngoluphando, ungaqhagamshela u-Prof Catriona Macleod, okhokela uphando e-Rhodes University, kule nombolo* 046-603-7329.

If you have a complaint about any aspect of this study, you may also contact the Rhodes University Ethical Standards Committee by calling 046-603-8055 or e-mailing ethics-committee@ru.ac.za

Ukuba unengxaki okanye unesikhalazo malunga nayiphi na indawo kolu phando *ungaqhagamshela* ***i-Rhodes University Ethical Standards Komiti*** *(ikomiti ejongene nemigaqo ye-ethics eRhodes University) kule nombolo* 046-603-8055 *okanye kule meyile* ethics-committee@ru.ac.za

(THE ABOVE SECTION IS TO BE KEPT BY THE PARITICPANT) (*Ezi zigaba zibhalwe ngasentla zigcinwa ngumntu othatha inxaxheba kolu phando*)

**TERMINATION OF PREGNANCY CONSULTATION RESEARCH PROJECT/**

***UPHANDO NGE-COUNSELLING XA UMNTU EZOKUKHUPHA ISISU***

**WOMAN PARTICIPANT CONSENT FORM/** ***IFOMU YEMVUME YAMANENEKAZI ATHATHA INXAXHEBA KOLU PHANDO:***

I hereby agree to participate in this research project that seeks to explore how pre-termination of pregnancy consultations are conducted in Termination of Pregnancy clinics in South Africa. Please tick to indicate your response in the below box.

*Ndiyavuma ukuthatha inxaxheba kuphando malunga nokuxhotyiswa efumaneka phambi kokukhupha isisu kwiiklinikhi ezincedisa ngokhupha isisu apha eMzantsi Afrika. Ndicela utikishe ibhokisi ebonisa impendulo yakho apha ngezantsi.*

| I agree to the following:/ *Ndiyavuma koku landelayo* | Yes/ *Ewe* | No/ *Hayi* |
|---|---|---|
| 1.1.The pre-termination of pregnancy consultation session that I will have with the health service provider being recorded. 1.1 *Ukuxhotyiswa endikufumanayo kumongikazi phambi kokukhupha isisu kuza kushicilelwa kwirekhodi* | | |
| 1.2.If you answered yes to the above question, please indicate with a tick how you would prefer the consultation to be recorded 1.2. *Ukuba impendulo yakho ithe ewe kulo mbuzo ungasentla, sicela utikishe ibhokisi ukhethe indlela ushicelelo ufuna ukuba lwenziwe ngayo* | | |
| Video recorded/ *Ushicilelo lwevidiyo* | | |
| Audio recorded/ *Iteyipi rekhodi* | | |
| *Rekhodi* | | |
| An interview with the researcher after the pre-termination of pregnancy consultation session. *Udliwanondlebe nomphandi emva kweseshoni yokuxhotyiswa ngaphambi kokukhupha isisu.* | | |

*kokukhupha isisu.*

The audio recording of the above-mentioned interview.

*Kushicilelo ngeteyipi rekhoda kolu dliwano ndlebe lungasentla.*

I understand that I am participating freely and without being forced in any way to do so. I understand that at any point if I wish not to continue I can withdraw from participating in the study without any negative consequences.

*Ndiyaqonda ukuba ndizingenele ngomoya okhululekileyo kolu phando kwaye kange ndiyanzelwe. Ndiyaqonda ukuba nanini na ndingayeka kolu phando xa ndifuna kwaye akukho sohlwayo okanye iziphumo ezibi xa ndithe ndayeka.*

The purpose of this study has been explained to me, and I understand what is expected of my participation. I have kept a copy of the written explanation given to me

Injongo yoluphando ndiyicaciselwe kwaye ndiyayazi indima ekufuneka ndiyidlalile *kolu phando. Ndizingcinele ikopi yenkcukacha zoluphando endithe ndayifumana.*

I have received the telephone number of a person to contact should I need to speak about any issues that may arise due to participating in this study.

*Ndiyinikiwe inombolo yefowuni yomntu endinokuthetha naye xa kukho ingxaki ngenxa yokuthatha kwam inxaxheba kolu phando.*

I understand that this consent form will not be linked to any recording, and that the conversation recorded will remain anonymous and video recording confidential.

*Ndiyaqonda ifomu yemvume ayidibenanga ne-vidiyo rekhodii okanye iteyipu rekhodi. Kwaye incoko ezishicelelweyo zizohlala ziyimfihlo.*

I understand that no personally identifying information will be released in any form. I understand that these recordings will be kept securely in a locked environment.

*Ndiyaqonda ukuba igama lam kunye nelendawo alizokusetyenziswa. Kwaye ndiyaqonda irekhodii ezishicelelweyo ziza wugcinwa kwindawo efihlakeleyo nekhuselekileyo.*

I understand that if I do not want any of the conversations I have with health service providers in the waiting to form part of the research I will communicate this to the researcher.

*Ndiyaqonda ukuba andifuni indibano yam nomongikazi kwigumbi lokulinda ifakwe kolu phando ndizokuxelela umphandi.*

My pseudonym is:/ *Igama endizithiyileyo ngu:* _____

I am _____ years old/ *Ndinemiyaka e-*

I am currently (please tick where appropriate) /*Ndenza ntoni ngoku (khetha i-box)*

Employed/ ☐

*Ndiyaphangela*

Unemployed/

*Andiphangeli*

Still in school/ ☐

*Ndiyafunda*

_____ _____

Signature of participant/ Date/ *Umhla*

*Utyikityo lo thatha inxaxheba kolu phando*

_____ _____

Signature of the researcher/ Date/ *Umhla*

*Utyikiyo lowenza uphando*

**Where relevant, third party consent (partner, parent, friend, relative, acquaintance or any other person accompanying the woman)/**

***Xa kukho umntu wesithathu (iqabane, abazali, isihlobo, isizalwane, umntu ohamba ne nenekazi)***

The information shared with the person I am accompanying has also been shared with me. I understand the purpose of this study, and I understand what is expected in terms of data collection.

*Ndixelelwa inkcukacha zophando njenge nenekazi endihamba nalo. Injongo yoluphando ndiyicaciselwe kwaye ndiyayazi indima ekufuneka ndiyidlalile kolu phando.*

| I agree to the following: /*Ndiyavuma kokulandelayo* | Yes/ *Ewe* | No/ *Hayi* |
|---|---|---|
| 1. The sections of the recording of the pre-termination of pregnancy consultation where I speak may be used for the study.<br>1. *Into endiyithethileyo kwi-counselling eshicelelweyo kwirekhodi inosetyenziswa kolu phando.* | | |
| 2. The sections of the interview with the researcher after the pre-termination of pregnancy consultation session where I speak may be used for the study.<br>2. *Into endiyithethileyo kudliwano ndlebe nomphandi emva kwe-counselling inosetyenziswa kolu phando.* | | |

I am the _____ (state your relationship with the participant).

*Ndigu/Ndisi* *(xelela ukuba nihlobene njani)*

_____ _____

Signature of third party/ Date/ *Umhla*

*Utyikityo lo mntu wesithathu*

_____ _____

Signature of researcher/ Date/ *Umhla*

*Utyikityo lomphandi*

ADDITIONAL AGREEMENT BETWEEN WOMAN YOUNGER THAN 18 AND RESEARCHERS CONCERNING PARENTAL OR GUARDIAN CONSENT: TO BE OBTAINED AFTER THE CONSULTATION BUT BEFORE INTERVIEW

*ISIVUMELWANO NE NENEKAZI ELINGAPHANTSI KWEMIYAKA ELISHUMI ENESIBHOZO (18) NABAPHANDI MALUNGA NEMVUME YOMZALI: IMVUME IFUNYANWA EMVA KWE-COUNSELLING KODWA PHAMBI KODLIWANO NDLEBE.*

In addition to the agreement signed above, I confirm that I have spoken to the health service provider about the possibility of consulting with my parent or guardian about my decision to terminate my pregnancy.

*Ngaphezu kwesivumelwano esityikitywe ngasentla, ndiyavuma ukuba ndithethile nomongikazi malunga nokuthetha nomzali wam ngesigqibo sam sokukhupha isisu.*

| I confirm that/ *Ndiyavuma ukuba*: | Tick only one option/ *Tikisha ibenye qa* |
|---|---|
| 1. I have chosen not to consult my parent/guardian about my decision and that I would like to continue in my participation in the research<br>*1. Ndikhethe ukungamxeleli umzali wam ngesigqibo sam kwaye ndiyafuna ukuqubekha ngophando.* | |
| 2. I have decided to consult my parent/guardian about my decision and feel that I would like their consent to participate in the research<br>*2. Ndikhethe ukumxelela umzali wam ngesigqibo sam kwaye ndifuna ukucela ivume kumzali ungenela oluphando.* | |
| 3. My parent/guardian has accompanied me to the clinic and gives his/her consent for me to participate in the research.<br>*3. Ndikhatshwe ngumzali wam ukuza apha ekliniki kwaye undinike imvume yokuthatha inxaxheba kolu phando.* | |
| 4. My parent/guardian has accompanied me to the clinic and does not give his/her consent for me to participate in the research.<br>4. *Ndikhatshwe ngumzali ukuza apha ekliniki kwaye akavumi ukuba ndithathe inxaxheba kolu phando.* | |

If you have chosen to No. 2 above, please let us know how we can contact your parent/guardian. If they do not provide their consent, we will delete the recordings of your consultation session and interview.

*Ukuba ukhethe inombolo yesibini (2) ngasentla, ndicela usixelele ukuba singamfumana njani umzali wakho. Ukuba umzali wakho akafuni uthathe inxaxheba kolu phando sizokucima ushicelelo le-counselling nodliwano ndlebe kwirhekodi. lo mphandi*

_____ _____

Signature of participant/ *Utyikityo* Date/ *Umhla*

*lothatha inxanxheba*

_____ _____

Signature of researcher/ *Utyikityo* Date/ *Umhla*

If you have chosen No. 4 above, your parent/guardian should sign the following/ *Ukuba ukhethe inombolo yesine (4) ngasentla, umzali/omele umzali kufuneka atyikike okulandelayo*:

I have read and agree to all the conditions of participation contained in the letter of information and consent form provided to my daughter/custodian, and hereby consent that she may participate in the research.

Ndizifundile inkcukacha kwaye njengomzali/omele umzali ndiyavumelana nemigaqo ebekiweyo kwileta enekcukacha nefomu enikwe intombi yam malunga nokuthatha inxaxheba. Ndiyavuma ukuba angathatha inxaxheba kolu phando.

_____ _____

Signature of parent/guardian/ Date/ *Umhla*

*Utyikityo lo mzali/omele umzali*

**APPENDIX 3: Informed consent for service provider**


**CRITICAL STUDIES IN SEXUALITIES AND REPRODUCTION RESEARCH PROGRAMME □□Tel: (046) 603 7329 □ e-mail: cssradmin@ru.ac.za**

November 2015

Dear service provider/ *Mongikazi/Mongi obekekileyo*

I am Jabulile Mavuso from Rhodes University. I form part of a research team interested in exploring how pre-termination of pregnancy consultations are conducted in Termination of Pregnancy clinics in South Africa. This study forms part of a larger study in which we hope to compare, in the future, how pre-termination of pregnancy consultations are conducted in Britain with those conducted in South Africa. As you may know, in Britain abortion may only be performed if it is recommended by health service providers, while, of course, in South Africa a woman may request an abortion up to 12 weeks of gestation. In addition, the social acceptability of abortion and length of time in which abortion has been legal is very different in the two countries. We believe that these differences will have implications in terms of how the pre-termination of pregnancy consultations are conducted. With your assistance, we hope to be able to understand best practices around pre-termination of pregnancy counselling in the two countries and to assist in developing ideas on how to improve this aspect of care. Permission to conduct this research has been obtained from the Eastern Cape Department of Health and Dora Nginza Hospital

*Ndingu Jabulile Mavuso osuka eRhodes University. Ndingomnye wabantu abanomdla wokuphanda ngendlela i-counselling eyenziwa ngayo phambi kokuba umntu akhuphe isisu kwiklinikhi yokukhupha isisu apha eMzantsi Afrika. Oluphando luyinxalenye yophando olubanzi esinqwenela ukulithelekisa kwixa elizayo nophando olwenziwa eBritane kunye nolwenziwa eMzantsi Afrika malunga nendlela i-counselling eyenziwa ngayo phambi kokuba umntu akhuphe isisu. Xa ujonga eBritane ngumongikazi/ngumongi onegunya sokuthatha isigqibo ukuba umntu angakhupha isisu. eMzantsi Afrika iyohluka ngoba inenekazi liyakwazi ukukhupha isisu nanini na phambi kweeveki eziyi-12 (ezingamashumi amabini) enzima. Kwaye xa uthelekisa la mazwe mabini, kwezomthetho ayohluka amaxesha apho umthetho wokukhupha isisu wathi wavumeleka. Kwaye ukwamkeleka kokhupha isisu ekuhlaleni kohlukile kula mazwe mabini. Siyakholelwa ukuba ezizinto zohlukanisa la mazwe mabini xa kuthethwa ngokukhupha isisu zinegalelo kwindlela i-counselling eyenziwa ngayo phambi kokuba umntu akhuphe isisu. Ngoncedo lwakho siyathemba ukuba sizawukwazi ukufumana ulwazi ngendlela ezisemgangathweni ezinosetyenziswa kwi-counselling kula mazwe mabini. Sinenjongo*

*yokuncedisa ukufumana amacebo anoyusa izinga lokunikezelo lonyango. Ingunya lokwenze oluphando silifumane kwiSebe LezeMpilo apha eMpuma Koloni kunye Dora Nginza Hospital.*

We invite you to assist us in the following way/ *Sicela usincede ngokulandelayo*:

- By allowing us to record the pre-termination of pregnancy consultation sessions that you conduct during the day.

- *Ngosivumela sishicelele indibano ne-counselling oyenzayo imini yonke.*

- By speaking to us in an interview conducted at the end of the day about your experience of the various consultation sessions. In this session the researcher will ask you about what aspects of the consultation sessions you felt went well and what challenges you encountered with specific women or specific situations.

- *Ngokuthetha nathi kudliwano ndleba, ekupheleni kwemini, ngamava akho okwenza lo msebenzi we-session ezahlukeneyo ze-counselling. Kolu phando, umphandi uzakubuza nge-zinto ozibona ukuba zihambe kakuhle kwii-session ze-counselling kunye nezinto ezibe ngumceli-mngeni kuwe xa ubu-counsellisha inenekazi/amanenekazi athile okanye ngenxa yemeko yalo/yawo.*

Data for this study will be collected in the following ways/ *Ulwazi kolu phando uzawuqokelelwa] ngezindlela zilandelayo:*

- The pre-termination of pregnancy consultations that you provide will be either audio or video (including audio) recorded. The researcher will switch on the recording device(s) and will exit the room. She will not be present during the consultation. Once the researcher has exited the room, the consultation session will begin. After the consultation is completed, the researcher will come in and switch the recording device(s) off.

- *Sizoshicelela ngeteyipi rekhoda okanye sisebenzise i-video rekhoda xa usenza i-counselling yaphambi kokukhupha isisu. Umphandi uzoyilayita iteyipi rekhoda okanye i-video rekhoda alandele ngokuphuma kwi-gumbi le-counselling phambi kokuba iqale i-session. Xa ugqibile ukwenza i-counselling umphandi uzakungena acime iteyipi rekhoda okanye i-video rekhoda.*

- The interview you will have with the researcher at the end of the day about the consultation sessions will be audio-recorded.

- *Udliwano ndlebe ozawuthi ubenalo nomphandi ekupheleni kwemini malunga ne-sessions oye wanazo emini luzawushicilelwa kusentyenziswa iiteyiphi rekhoda.*

- Interviews with individual women about their experiences of the consultation.

3. *Udliwano ndlebe nenenekazi ngalinye ngezimvo zalo malunga ne-counselling*

4. Observations of interactions in the waiting room.

4. *Sijonge nesimo okanye indibano phakathi koomongikazi namanenekazi kwi-gumbi lokulinda.*

Please understand that your participation in this study is completely voluntary. If you agree to participate, you may stop at any time and discontinue your participation.

*Sicela uyazi ukuba awunyanzelekanga ukuba uthathe inxaxheba kolu phando. Ukuba uyavuma ukuthatha inxaxheba kolu phando, uyakwazi ukuyeka nanini na.*

In order to protect you, we will not be recording your name for the purposes of this research. In addition, the research is being conducted at a number of sites. While a general description of the sites will appear in the research (e.g. located in a town or city, offering first trimester only or also second trimester abortions), the names of the actual sites or the town/city in which they are located will not be revealed. We ask that you make up a name, called a pseudonym. You can sign the consent form with this name, if you wish.

*Sinenjongo yokukhusela, asizokusebenzisa igama lakho kolu phando. Kwaye oluphando lwenziwa kwindawo ezahlukileyo (umzekelo – idolophu ethile enikezela ngenkonzo zokukhupha isisu ukusuka kwinyanga ezinthathu zokuqala okanye ezintandathu). Xa sithetha ngendawo enikuyo igama le ndawo okanye idolophu ekuyo alizokusetyenziwa xa sipapasha uphando. Sicela uzithiye igama esinolisebenzisa kolu phando. Ungatyikitya ngeligama kwifomu yemvume eyazisiweyo xa uqwenela ukwenza njalo.*

The recordings of the consultation sessions and of the interview with the researcher will be kept in a safe place and will only be accessed by researchers on the project. The video recordings will not be used in any publications or presentations. This is to protect you so that nobody but the researchers are able to identify you. The purpose of the video recordings is to give the researchers a better picture of the consultation.

*Iteyipi rekhoda okanye video rekhoda ezishicelelweyo ze-counselling kuye nodliwano ndlebe zizobekhwa kwindawo ekhuselekileyo apho ingabaphandi kuphela abazawufikelela. I-video rekhodii ezishicelelweyo azizopapashwa okanye zisetyenziswe xa kunikwa intetho. Injongo kukhusela igama lakho ukuze kungabikho nabani na ozawukwazi ukuba wabelane ngeziphi na wena izimvo. Injongo ze-video rekhodii kunika umphandi umfanekiso acacileyo nge-counselling.*

Please note that this research is NOT an evaluation of your performance (good or bad) as a health service provider. No feedback on how you, specifically, conducted the sessions will be provided to the management of the facility. When feedback is provided, it will be in form that makes it impossible for management or any other parties to identify specific individual health service providers.

*Sicela uyazi ukuba oluphando asizojonga umgangatho womsebenzi wakho ukuba mhle okanye awumhlanga njengomongikazi. Asizonikezela nkcazelo kumphathi wakho ngendlela owenza ngayo i-counselling. Ukuba sinikezela inkcazelo kumphathi, igama lo msebenzi alizovela*

*kwaye sizawuqinisekisa ukuba umphathi akanandlela yokwazi ukuba zeziphi na izimvo zakho kanye kanye.*

Please also note that, for similar reasons of confidentiality, we will not be able to share what individual women said about their specific consultation. You will, however, have access to the over-arching findings of the research.

Sicela wazi ukuba, ngezizathu ezidibene nelungelo le mfihlo, asizokwazi [ukwabelana nawe malunga nezimvo zenenekazi ngalinye malunga nendibano kunye ne-counselling ethile eliyifumeneyo. Kodwa sizokuxelela ngeziphumo zophando ngokubanzi.

I am attaching the information sheet that will be given to potential woman participants for your perusal.

*Ndidibanise iphepha elinenkcazelo ezakunikezelwa kumanenekazi abonakalisa umdla wokuthatha inxaxheba kolu phando ukuze uzijongele.*

If you have any questions about this study, please feel free to ask me. In addition, if there are questions that you feel I have not answered, or if you have concerns about the research, you may contact Prof Catriona Macleod, the principal researcher, at Rhodes University by calling her on 046-603-7329.

*Ukuba unemibuzo ngoluphando ndicela uzive ukhululekile ukundibuza nantoni na. Kodwa ukuba awanelisekanga ndicela uqhagamshalene no Prof Catriona Macleod, okhokhela oluphando eRhodes University kulenombolo* 046 683 7329.

If you have a complaint about any aspect of this study, you may also contact the Rhodes University Ethical Standards Committee by calling 046-603-8055 or e-mailing ethics-committee@ru.ac.za

*Ukuba unengxaki okanye isikhalazo malunga noluphando ungaqhagamshela i-Rhodes University Ethical Standards Committee (ikomiti ejongene nemigaqo ye-ethics eRhodes University) kule nombolo* 046 603 8055 *kwaye uthumele imeyile kwi-*ethicscommitte@ru.ac.za

(THE ABOVE SECTION IS TO BE KEPT BY THE PARITICPANT)

(*EZI ZIGABA ZIBHALWE NGASENTLA ZIGCINWA NGUMNTU OTHATHA INXAXHEBA KOLU PHANDO*)

**PRE-TERMINATION OF PREGNANCY CONSULTATION RESEARCH PROJECT/**

***UPHANDO NGE-COUNSELLING XA UMNTU EZOKUKHUPHA ISISU***

**HEALTH SERVICE PROVIDER CONSENT FORM/**

***IFOMU YEMVUME EYAZISIWEYO KAMONGIKAZI/MONGI:***

I hereby agree to participate in this research project that seeks to explore how pre-termination of pregnancy consultations are conducted in Termination of Pregnancy clinics in South Africa. Please tick to indicate your response in the below box.

*Ndiyavuma ukuthatha inxaxheba kuphando malunga ne-counselling efumaneka phambi kokukhupha isisu kwiklinikhi ezincedisa ngokukhupha isisu eMzantsi Afrika. Sicela utikishe i-box yempendulo yakho*

| I agree to the following/ *Ndiyavuma kokulandelayo:* | Yes *Ewe* | No *Hayi* |
|---|---|---|
| 1.1 The recording of the pre-termination of pregnancy consultation session that I will conduct with various women. | | |
| 1.1 *Ushicelelo lwe-counselling endiyenzayo namanenekazi phambi kokhupha isisu.* | | |
| 1.2 If you answered yes to the above question, please indicate with a tick how you would prefer the consultation to be recorded. | | |
| 1.2 *Ukuba impendulo yakho ithi ewe kulo mbuzo ungasentla, sicela tikishe i-box ukhethe indlela ushicelelo ofuna lwenziwe ngayo.* | | |

| Video recorded/ *I-video* | Audio recorded/ |
|---|---|
| *Rekhodii* | *Iteyipi rekhodii* |

An interview with the researcher about these sessions at the end of the day.

*Kudliwano ndlebe nomphandi nge-counselling ekupheleni kwemini.*

The audio recording of the above-mentioned interview.

*Ushicilelo ngeteyipu rekhoda lodliwanondlebe olukhankanywe ngesentla.*

I understand that no personally identifying information will be released in any form. I understand that these recordings will be kept securely in a locked environment.

*Ndiyaqonda ukuba igama kunye nelendawo, elinothi lenze kube lula ukwazi ukuba kwaziwe ukuba izimvo zezam, alizukusetyenziswa. Kwaye ndiyaqonda irekhodii ezishicelelweyo zizogcinwa kwindawo efihlakeleyo nekhuselekileyo.*

I understand that I am participating freely and without being forced in any way to do so. I understand that at any point if I wish not to continue I can withdraw from participating in the study without any negative consequences.

*Ndiyaqonda ukuba ndizingenele ngomoya okhululekileyo kolu phando kwaye kange ndiyanzelwe. Ndiyaqonda ukuba nanini na ndingayeka kolu phando xa ndifuna*

The purpose of this study has been explained to me, and I understand what is expected of my participation. I have kept a copy of the written explanation given to me.

*Injongo yoluphando ndiyicaciselwe kwaye ndiyayazi indima ekufuneka ndiyidlalile kolu phando. Ndizingcinele ikopi endithe ndayifumana yeenkcukacha zolu phando.*

I have received the telephone number of a person to contact should I need to speak about any issues that may arise due to participating in this study.

*Ndiyinikiwe inombolo yefowuni yomntu endinokuthetha naye xa kukho ingxaki ngenxa yokuthatha kwam inxaxheba kolu phando.*

I understand that this consent form will not be linked to any audio or video recording, and that the conversation recorded will remain anonymous.

Ndiyaqonda ifomu yemvume ayizukusetyenziswa ukujonga ukuba izimvo ezishicilelwe kwi-video rekhodii okanye iteyipi rekhodii zezikabani na. Kwaye incoko ezishicelelweyo zizo kuhlala ziyimfihlo.

My pseudonym is/ *Igama endizithiye lona ngu*:

For how many years have you been providing termination of pregnancy services/

*Sekulithuba elingakanani na unikezela ngenkonzo zokukhupha isisu*: ____

Signature of participant/ Date/ *Umhla*

*Utyikityo lothatha inxaxheba kolu phando*

Date/ *Umhla*

Signature of researcher/

*Utyikityo lowenza uphando*

**Where relevant, third party consent (partner, parent, friend, relative, acquaintance or any other person accompanying the woman)**

The information shared with the person I am accompanying has also been shared with me. I understand the purpose of this study, and I understand what is expected in terms of data collection.

| I agree to the following: | Yes | No |
|---|---|---|
| • The sections of the recording of the pre-termination of pregnancy consultation where I speak may be used for the study. | | |
| • The sections of the interview with the researcher after the pre-termination of pregnancy consultation session where I speak may be used for the study. | | |

I am the _____ (state your relationship with the participant).

_____ _____

Signature of third party Date

_____ _____

Signature of researcher Date

ADDITIONAL AGREEMENT BETWEEN WOMAN YOUNGER THAN 18 AND RESEARCHERS CONCERNING PARENTAL OR GUARDIAN CONSENT: TO BE OBTAINED AFTER THE CONSULTATION BUT BEFORE INTERVIEW

In addition to the agreement signed above, I confirm that I have spoken to the health service provider about the possibility of consulting with my parent or guardian about my decision to terminate my pregnancy.

| I confirm that: | Tick only one option |
|---|---|
| • I have chosen not to consult my parent/guardian about my decision and that I would like to continue in my participation in the research | |
| • I have decided to consult my parent/guardian about my decision and feel that I would like their consent to participate in the research | |
| • My parent/guardian has accompanied me to the clinic and gives his/her consent for me to participate in the research | |
| • My parent/guardian has accompanied me to the clinic and does not give his/her consent for me to participate in the research | |

If you have chosen to No. 2 above, please let us know how we can contact your parent/guardian. If they do not provide their consent, we will delete the recordings of your consultation session and interview.

_____ _____

Signature of participant Date

_____ _____

Signature of researcher Date

If you have chosen No. 4 above, your parent/guardian should sign the following:

I have read and agree to all the conditions of participation contained in the letter of information and consent form provided to my daughter/custodian, and hereby consent that she may participate in the research.

_____ _____

Signature of parent/guardian Date

**APPENDIX 4: Informed consent form for Site 3**

# TERMINATION OF PREGNANCY

You have requested a termination of your pregnancy.
Are you 100% sure
Let me tell you about termination - we give you five tablets - you take two orally and repeat one every four hours. You may experience bleeding with pain and you may pass the foetus yourself. If, however, you do not abort we will do that for you.

We will give you an injection which will make you sleepy and then we will place your legs up in stirrups. We will then clean the vulva and vagina and with suction remove the products of conception.
You may bleed and you may on rare occasions have to have a D&C.

Now let me tell you about termination - its complications both mentally and physically.

Termination carries a risk of mental trauma - you may regret having had a Termination of Pregnancy. This may effect your sexual relations in the future. Physically, I have mentioned bleeding and probably a D&C - your chances of falling pregnant are dimished slightly - your chances of having a miscarriage whilst carrying a baby you want may be increased.

Then there is a always the chance of sepsis. Although Termination of Pregnancy is done under strict aseptic conditions there is always a possiblity of conditions going wrong.

---

SUCCESS IS OUR MOTTO

If you have weighed up all these possible complications then we will do the Termination of Pregnancy. You will have to be counselled and you must and I repeat must practise birth control. We will advise you on the best method to suit you.

# OMAWUKWAZI NGOKMUPHO - ZISU

Ufuna ukukhupha isisu?
Ngaba uqinisekile na ngesigqibo sakho?

Ukhupho sisu lunobungozi bokuba lunga wuhlupha umphefumlo wakhosele kukudala wasikhupha isisu esi - uzisole sele kukudala.

Loo nto ingakwenza ungaphinde ufune ukuphinda ulale nendoda okanye utshate ngenxa yesazela.

Amathuba akho okuphinda umithe emveni kokhupho sisu ayancipha ngakumbi xa uthe wopha kakhulu emva kokhupho sisu kwaze kwafuneka uye kucocwa isibeleko ukunganda ukopha.

amathuba ezisu eziphuncukayo sele umfuna umntwana ayanda emveni kokhupho sisu.

unganakho ukuba nokungcola kwesibeleko emveni kokhupho nangona sizakuzama kangangoku ukunganda oko.

Ukuba ke uqonda ukuba nakanjani uyafuna ukukhupha isisu nasemveni kokuba uzivile ezizinto; singaku - khupha ke isisu

**OKWENZIWAYO**

Udityaniswa no - nontlalontle aqiniseke ukuba uyafuna ngenene ukukhupha isisu.

Unikwa iipilisi ezimbini usele emveni koko ubenye emveni kweyure ezine qho.

Ungeva ubuhlungu nokopha ngelilixa.

Isisu singaphuma emveni kweepilisi ezi.

Ukuba ke iipilisi azikuncedanga, uzakuhlatywa inaliti wozele, imilenze izakungxongxiswa kuzanywe ukufunxwa umntwana nezizanva ngesifunxi.

Maxawambi kungade kufuneke ezinye izizamva ziyekukhutshwa kumzi woxhelo – udonyiwe.

KHOMBULA ukhuselo lungcono kunokhupho sisu

Yiya kwikliniki yakho yocwangcwiso – ntsapho' fumane

ukucetyiswa ungeka hlelwa lumitho.

**APPENDIX 5: Jefferson transcription notation symbols**

(.) A full stop inside brackets denotes a micro pause, a notable pause but of no significant length.

(0.2) A number inside brackets denotes a timed pause. This is a pause long enough to time and subsequently show in transcription.

[ Square brackets denote a point where overlapping speech occurs.

> < Arrows surrounding talk like these show that the pace of the speech has quickened

< > Arrows in this direction show that the pace of the speech has slowed down

( ) Where there is space between brackets denotes that the words spoken here were too unclear to transcribe

(( )) Where double brackets appear with a description inserted denotes some contextual information where no symbol of representation was available.

Under When a word or part of a word is underlines it denotes a raise in volume or emphasis

↑ When an upward arrow appears it means there is a rise in intonation

↓ When a downward arrow appears it means there is a drop in intonation

→ An arrow like this denotes a particular sentence of interest to the analyst

Hum(h)our When a bracketed 'h' appears it means that there was laughter within the talk

= The equal sign represents latched speech, a continuation of talk

:: Colons appear to represent elongated speech, a stretched sound

(hhh) Audible exhalation

(.hhh) High Dot Audible inhalation

# Selected PTOP Counselling Sessions

## APPENDIX 6

Research Site 1

| | | |
|---|---|---|
| 1. | C: | What do you understand from that thing? It is important that you read it with understanding, okay (neh)? |
| 2. | P: | Okay. |
| 3. | C: | Mhmm. Sit properly and relax. We are still going to chat here. Sit properly, sister. (0.4) do not sit as if you are passing through. (0.2) How old are you? |
| 4. | P: | I am 28. |
| 5. | C: | (0.1) which method of family planning were you using? |
| 6. | P: | I was using pathogen. |
| 7. | C: | And then what happened? |
| 8. | P: | Mh::mm. I became sick for a long time so I could not visit the clinic on date I was supposed to because I was in pain. So then I ended up not going and then (.) that's what happened. |
| 9. | C: | When was your last period, young lady? |
| 10. | P: | Uh. M::y periods came back in (0.1) February but it wasn't not the usual flow. I got them in February I think for (01) 3 days. I do not know. |
| 11. | C: | Normally it's for how long? |
| 12. | P: | They normally lasts for 3 days. |
| 13. | C: | So in February they lasted for 3 days? |
| 14. | P: | Mhmm. They lasted for 3 days = |
| 15. | C: | Why did [you not]. |
| 16. | P: | = [But] my pads were not full. I'd checked. |
| 17. | C: | Either way, they lasted for 3 days. |
| 18. | P: | Eh-eh (Yes). |
| 19. | C: | So we will then say the last time you got your period was in February. |
| 20. | P: | Mhmm. |
| 21. | C: | (0.2) Do you have a child? |
| 22. | P: | Yes ma'am I have one. |

23. C: When was s/he born?
24. P: S/he was born in 2010.
25. C: Were you pregnant for nine full months?
26. P: Yes ma'am.
27. C: Is s/he alive?
28. P: Yes s/he is alive.
29. C: Is s/he the only child?
30. P: Yes.
31. C: Do you have any sickness?
(0.2)
32. P: A sickness?
33. C: Mhmm.
34. P: Yes, I am HIV positive .hhh.
35. C: Hhh so why do you want to terminate the pregnancy, sister?
36. P: E::h. I will not be able to watch my child because I am not working and as I am not working, I have recently been accepted to school and even the person who impregnated me (0.3) does not want a child.
37. C: Something like this is the reason why need to prevent, sister.
38. P: Yes, I also realized late that I was not getting my period. So (.) I did not think that
(0.1) =
39. C: But you were having sexual intercourse with a man right. Let us talk about this explicitly.
40. P: Yes.
41. C: So you see that there is no such thing (.) you failed yourself, finish and klaar. When you do not prevent then that means you should not be engaging in sexual intercourse with a man. What do you expect when (.) you had sexual intercourse with a man while you were not using any family planning method? How can you not get pregnant? Mhhh? Because in the end you get pregnant. You have a child, right? What did you think you were doing now? (0.1) Mhhh?
42. P: We were using a condom all the time.
43. C: Was it ever said that a condom is for family planning, my sister?
44. P: No.
45. C: What is a condom used for?

46. P: It is used for protection against diseases.
47. C: Okay (.) you see, I like you. We here, we want a person to realize their mistake, neh?
48. P: Yes ma'am.
49. C: Then what is your mistake?
50. P: It is not going to the clinic to (0.1) do family planning. For not coming to do family planning =
51. C: Mhmm.
52. P: = to prevent what I have come to do today.
53. C: Mhmm. exactly, my sister. It is a very small thing that brings you here, it's small, small, small. (0.3) and people fail a lo::t. You fail to do family planning, my sister.

    What are you going to do then after the abortion?
54. P: I will go do family planning.
55. C: Which family planning method are you going to use?
56. P: (.) I will go back to using Pathogen because
57. C: Let us stop right there. (.) Do you understand?
58. P: Yes.
59. C: In order for things to work between us, we need to fix this thing once and for all, okay?
60. P: Yes.
61. C: And we will fix it well without fighting.
62. P: Mhmm.
63. C: Do we understand each other, sister?
64. P: Yes.
65. C: As much as we will give you the service, okay (neh)?
66. P: Yes, my sister.
67. C: At the same time, we need to fix this so that you may not ev::er experience it again. We see that you have experienced it now, right? Because you were using the Pathogen (.) and decided to stop using it as time went by, due to reasons known only by you which we do not know. What that then says to us is that there is no excuse though but then we assume that perhaps did not have know::ledge that there were other family planning methods besides Pathogen and Nur. There are other once off methods (.) for someone like you who is not

prepared to have a baby. You do it once and have a piece of mind. (.) You won't need to frequently visit the clinic. You use that family planning method and stop using it when you are ready to have a child. What I am talking about is a 3-year implant and a loop (.) that is for 10 years. We understand each other mos, sister?

68. P: Yes, ma'am.

69. C: And in your case, you must consider (.) your health already, are you on treatment?

70. P: I have not yet started using it.

71. C: What is your CD4 count?

73. P: I do not know yet. I recently found out (.) in (0.1) Mar::ch.

74. C: You can't not know it. Which clinic do you go to?

75. P: After getting tested (.) I did not go to the clinic.

76. C: Where? Where did you get tested?

77. P: I got tested at (0.3) there were people who were going door to (.), like they were not going door to door =

78. C: Mhmm

79. P: = they ha::d (.) what do you call them? Those things that look like tents?

80. C: You are failing yourself dear, plenty, plenty, plenty of times. And that means that you must wake up (0.1) if you still want to live life, okay (neh)? You cannot blame these people and you cannot rely on them. Where do you live?

81. P: Mh, I stay at Mthatha but then =

82. C: What is the name of the clinic that is closest to you there?

83. P: It is John Du::be Clinic.

84. C: Okay, so what did the people who tested you, who were going door to door, say to you?

85. P: Mm::mh. They expla::ined to me. They told me that there are pla::ces but during that time I was not ready to listen. I told myself that I would find out, I think there are some groups available.

86. C: I am not, I am not talking about groups. (.) Groups are the last thing which will help you to deal with, with this thing. And you will see that when you get there and experience, people who have it, who live with this thing, you will also see that this is no big deal. That is not what I am talking about now. Supposedly, you should have gone for a CD4 count check-up as soon as you were tested positive for HIV. Do we understand each other dear?

87. P: Mhmm, okay.

88. C: Why? Because we depend on it to determine when you need to begin with your treatment and other tests that you need to do apart from the CD4 count tests. Do you understand my sister? Why? So that you can get help early. If you need to start using treatment, you should go ahead and start. Do you hear me?

89. P: Yes.

90. C: So that you can stay healthy as you are, without waiting until you get sick. And the thing with HIV is that, you do not have to wait until you have accepted it. While you are still waiting for yourself to accept it, your body will be getting weaker and weaker. What are you accepting? Because HIV is just like any other sickness. It is not a big deal, my sister. What we preach here is that one should accept it early and go to get help. Do you understand what I am saying?

91. P: Mhmm.

92. C: Because now you are saying that you got tested by two people. You should have taken yourself to the clinic and said, "No, I got tested for HIV and it was discovered that I am HIV positive. I'm here to ask to do CD4 count tests." And you should do that very soon because you can never know with HIV. It is full of surprises. It does things to you, things that you not aware of. We can never know what it may do to you, for instance you just became like this and you can never know where that came from. So that means that you should take very good care of your health, young lady. You can live for 50 years and longer. There is nothing in HIV (.) ore than the fact that you need to accept your status and change your lifestyle and do things the right way. You have a child that was born in 2010, right? That child still needs a mother. S/he still needs to be raised by you. Do you hear what I am saying?

93. P: Mh-mm, I hear you.

94. C: Which means that when you get out of here, you should visit the nearest clinic because we do not specialize in such things here. Do you hear what I am saying?

95. P: Mhmm.

96. C: You should go to the nearest clinic even if it is a public clinic. Even if it is closer to your home. Those people are not there to mind your statuses. If you feel that maybe you are not comfortable with going to the one that is closer to your home, then go to another one. What is important and what I push for is that one must get help early because now you are delaying yourself. You will end up getting

seriously ill. With something that is easily manageable. There is no longer an HIV positive person that gets sick.

97. P: Mhmm.

98. C: None at all. Because people stand up early and use treatment so that one can stay as themselves. The treatment is meant to maintain your normal self/weight. You are the only one who knows that you have this thing. Another person can never know because even now, I cannot see it. I am only hearing it from you since I asked, during our chat and it is possible for you to stay as you are. Do you hear me, girl?

99. P: Mhmm, I hear you nurse.

100. C: Mhmm, which is important. So you are failing yourself. You are failing yourself in so many ways and that is not okay. Do you see this thing of yours makes it easier for me too?

101. P: Mhmm.

102. C: Because the second thing we were going to discuss is family planning neh?

103. P: Yes nurse.

104. C: So there are family planning for people such as yourself.

105. P: Mhmm.

106. C: Because you show that you are not reliable when it comes to needles (0.1) neh. And with us once you come for this abortion thing, we have this thing that you came the first time, it is an honest mistake. But then when we see you do it for the second time it is a no then. It must show that you met with nurses who sat down and spoke with you, and they made you realize your mistake. Because this thing dear, it is worse with you because you no alright already and you do not know what this thing will do to you. It has risk and complications which you will read about and you will tell me what it is you will do. You must know it is not something that we advise. We are not here to promote abortion rather than we are promoting family planning. But then since you are here for it, it is necessary that we give you the service. So we really do emphasize this thing that we fix one's family planning to avoid seeing you here again. So I was going to speak to you about two methods of family planning, which are an implant for 3-years and a loop for 10-years. So I am taking out the implant (.) because for someone like you, I am sure that you will eventually use treatment, right (neh)?

107. P: Yes, nurse.

108. C: So it does not go together with treatment. So I do not even want to you to start it.

109. P: Mhmm.

110. C: So I would advise you to take the10-year loop.

111. P: Mhmm.

112. C: Do you understand, sister?

113. P: Yes, ma'am.

114. C: There are two choices of family planning that we are talking about at the moment. We are not talking about Pathogen and what not because the reason you are all here in the first place is because you had these Pathogen, Nur, condoms and these whatnots. We are not talking about those things because we can see that they do not work. So the two family planning methods that we talk about here now are a 3-year implanon and 10-year loop. You understand, right?

115. P: Mhmm, I hear you.

116. C: These things, young lady if you are ready to have a child, and you have already planned everything and saw that you are working and ready to have a child, like the 10-years one you can come forward (0.1) and say "Please remove it from me. I am now ready to have a child." It does not mean you will finish a 10-year period with the loop inside you ↑but↑ at the same time I am not expecting that you will come back in the next 3 years and already wanting a child because your womb needs to heal, young lady. Abortion is not a child's play.

117. P: Okay.

118. C: Eh (yes). And it has these complications and we are not saying that if you wait for these 3 years, there will not be complications that you tell me about. But you should give the womb a chance to heal. Do you understand, young lady?

119. P: Yes, I hear you nurse.

120. C: Mh. So the method of family planning that you will fall under is the 10-year loop, neh? And a loop is not medicine, which is why it is good for you. It is just a device. Here is a loop, here is an implant. So a loop is the one that is inserted into the womb neh. This one. It will be inserted in you on that day. It will stay there and you won't even feel it when you come out of here. What happens, because you will be admitted here on the 9th, you come back so that you can be admitted. You will arrive here before 8 o'clock and the doctors will arrive here and admit you on the 9th.

121. P: Yes ma'am.

122. C: What happens is, you wake up at your house and bath, put your toiletries, night dress and lunch box in a bag because you will get hungry here. We do not know when the doctors will arrive. Then you will be admitted here from there you go to 27. At 27 that is where your pregnancy will be terminated.

123. P: Mhmm-Mhmm.

124. C: Do we understand each other?

125. P: Mhmm.

126. C: What happens at 27, how is this termination of pregnancy done? You will be given a pill there, okay (neh)? You will be given two pills at first.

127. P: Mhmm.

128. C: You will be given these pills. After being given those pills you count 4 hours, okay? After 4 hours you will get up from the bed and go to the nurse: "Nurse the 4 hours is over now. Can I please get some more pills? My pregnancy has not yet been terminated." Do you hear me? As nice, as I am saying.

129. P: Yes.

130. C: You do that. And repeat that 4 hours and be given some more pills. If the 4 hours is not over yet, you go and ask for more. You will go asking for pills until you see your fetus. Your fetus will come out and you will see it. You will give birth to the child the same way you gave birth to that one. It is just that you will be giving birth to this one before time. S/he will be that thing that I do not know (s/he will be deformed). (.) Do you understand, sister?

131. P: Yes.

132. C: Then you stop. You call the nurse, "Nurse please help me. It seems the fetus has come out. Please come check me."

133. P: Okay.

134. C: The reason, dear is because that is a ward and it is big. There are also people who have sicknesses related to the female reproductive system. So most of the time, the nurses focus on sick people rather than you all, okay? So you all have to cooperate with the nurses. One should not just struggle alone on the bed and sleep there covering themselves with a blanket. Because then the fetus won't come out, young lady.

135. P: Mhmm.

136. C: You will do this thing for two days and go home and end up staying for 5 days.

You hear me, right?

137. P: Mhmm.

138. C: How fast your abortion will be, depends on you and how well you will cooperate with that nurse. After the abortion, you go to the theatre. What happens in the theatre? You get cleaned to ensure that everything has come out. Being cleaned will hurt, sister.

139. P: Okay.

140. C: You will cooperate. You will be given something for pain but what remains is that, it will hurt. It might happen that you bleed there. Do you understand?

141. P: Mhmm.

142. C: Others, I will hear from you. Even the things that I have just told you, they should have been told to me by you. I will mostly hear the other stuff from you. So once all that has been done to you, you are the one who is going to tell the doctor neh when you go to the theatre, okay?

143. P: Mhmm.

144. C: "Doctor, I chose a family planning method here called the loop or eh could you please insert me and not forget about me". Do not make the mistake of leave here without going for family planning because seeing you here again will be a problem. We also won't be happy because that will be failing us, okay?

145. P: Mhmm.

146. C: Yes, my sister. .hhh (0.1) So I think I am done with you. What is important in all this conversation of ours is that date, okay (neh)?

147. P: Yes.

150. C: The 9th of September, the time is 8. Do we understand each other young lady?

151. P: Mhmm.

152. C: Mhmm. Then what you can also do for me is to tell me what this thing says.

153. P: No. Okay. I had not yet read it.

154. C: Read it, sister. You are not rushing to anywhere. It is necessary that you know all of that thing.

You do not need to know it word for word. You will summarize the part that you understand, okay (neh)? Even on that day when the doctor is here, you will go through it again as we are doing right now. The doctor will also sit down with you. Do you understand?

155. P: Yes nurse.

156. C: Mhmm. Then you will sign that thing on that day in front of the doctor. The reason why we book here neh is because sometimes you could come here thinking that this i::s your last option. Sometimes people change their minds after having this conversation with me. Do we understand each other, young lady?

157. P: Yes, ma'am.

158. C: You not arriving here on that day will be an indication for us that you have changed your mind. Normally, there is a department that we work with here, the social workers. They talk about adoption.

159. P: Mhmm.

160. C: Do we understand each other, then?

161. P: Yes, ma'am.

162. C: Mhmm. You should also be getting that informa::tion but they are not here today. Do you understand, young lady?

163. P: Mhmm.

164. C: Because as much as a person comes here wanting to do an abortion. Once we have put you together on that side and one hears what is being said there, you find one person saying that no they have decided to keep their pregnancy and give the baby for adoption, after having thought about all the information that they receive here. Do you understand, then?

165. P: Yes nurse.

166. C: Mhmm but I do not want to dwell much on that side because us, we (.) do not talk about it much.

167. P: Mhmm.

168. C: But that exists. Do you understand?

169. P: Mhmm.

170. C: That is also up to you. You decide what you want. We do not change anyone's mind here, more that the fact that we give you options. You should know that abortion is not the only thing that you can do. There is also adoption. Some people are desperate for children.

171. P: Yes.

172. C: As you are not prepared. But then (.) we say go decide neh at home? Then if you still want to continue, the 9 th is your date and nothing else. At 8 o'clock in the morning. You saw in the morning right?

Take that book so that I can call. Lihle Gomba, Zimkhitha Ma what? Martin?

173. P: Yes, Martin.

174. C: Eh (yes). That is me and that book on that 9th. I want you all here in the centre. Do you understand, young lady?

175. P: Yes, Ma'am.

176. C: Can you summarize that thing for me? So that I can hear that you read it.

177. P: Mhmm-mhmm. I have read it. I (0.3) I think these are its terms and conditions in a way

178. C: Which say what?

179. P: Okay (h).

180. C: I want to hear the essence of it.

181. P: You are told that the risks (.) You are told about its risks.

182. C: Mhhm.

183. P: At the same time, you are told that there can be like things that can happen after, like physical damages.

184. C: Mhmm-mhmm.

185. P: Which you will need to get treated =

186. C: Mhmm.

187. P: = until they are healed.

188. C: Mhmm-mhmm. Until they healed.

189. P: Yes, until they healed.

190. C: Mhmm-mhmm.

191. P: And it is said that the pregnancy might not happen but then if it does happen they will do the procedure repeatedly. I think it is what you were saying.

192. C: Pregnancy?

193. P: Yes, if (.) It is said that if (.) the termination of pregnancy fails, if the pregnancy continues.

194. C: Mhmm

195. P: It is said that the procedure may need to be repeated.

196. C: Mhmm-mhh but what remains is that you won't have the pregnancy when you come out of here on that day.

197. P: Eh (yes).

198. C: No matter when it will be. By all means.

199. P: [It will be continued]

200. C: [What you came to do] will be done to you, no matter how. Even if it is done to you at the theatre, you will be taken to the theatre. You understand, right?
201. P: Yes, I hear you.
202. C: What else is being said?
203. P: Mh::mm, and then it is said (.) that I should also know that I will be given medication for the womb =
204. C: Mhmm.
205. P: = to expel the pregnancy.
206. C: Mhmm-hm.
207. P: And th::en I should agree to the risks and complications that will be related to (.) that medication or the procedure that will be happening.
208. C: Okay. Can you come here again and explain for me?
209. P: Mhmm::mhmm. ↑Here↑ it talks about the physical damages.
210. C: Mhmm-hm.
211. P: =That might happen.
212. C: Mhmm-hm.
213. P: And these ones that it is not necessary for them to…The ones you were saying I must undergo treatment for =
214. C: Mhmm-hm.
215. P: = Until the pregnancy is eventually through.
216. C: Mhmm.
217. P: It seems as if this is what they mean here.
218. C: And what else?
219. P: Uhm
220. C: You might not be able to have children even when you want them, young lady, okay (neh)? Or even if you do get pregnant, you might have miscarriages.
221. P: Miscarriages. Yes.
222. C: Do you understand?
223. P: Yes, I am listening to you.
224. C: You might also have womb related problems. Your womb might give you problems, neh?
225. P: Mhmm.
226. C: Even psychological, and trauma. You might get mentally disturbed neh. And we might see you being a little maniac here because of this.

227. P: Mhmm.

228. C: Yes. So one needs to be prepared. One must be prepared and tell themselves that "I will do this. [In the end, it will be gone]".

229. P: [No matter what comes].

230. C: And these things, okay? Okay then, young lady. So you will sign this on that day with the doctor, okay?

231. P: Okay.

232. C: Is there anything that you would like to ask?

233. P: Mh::m, no.

234. C: There is nothing. Everything is clear, right?

235. P: Yes, Ma'am.

236. C: So please take this thing. I will introduce you to these doctors, okay? I am done with you. Please wait here. I will call these doctors.

**APPENDIX 7**

Research Site 2

| | | |
|---|---|---|
| 1. | C: | Okay. I just need to take down your name, ah (.) X? Is it right? |
| 2. | P: | Yes. |
| 3. | C: | Okay. X just to uhm (.) fill you in for the recorder. My name is X and I'm with an organization called X (.) and what we do is that we counsellor the ladies before they go in for the termination. .hhh so that they understand th::e various procedures, they understand the consequences and they understand uhm (.) what the (.) uhm (.) the whole options are as far uh as termination is concerned. I'm just going to take down your details and we'll go from there. |
| 4. | P: | Okay. |
| 5. | C: | Uhm (.) you name is X. (0.6) Okay. X how old are you? |
| 6. | P: | I'm 31. |
| 7. | C: | You're 31 years old. Are you single or are you married? |
| 8. | P: | I'm single. |
| 9. | C: | You're single. Are you working? Are you studying? |
| 10. | P: | No I'm not working. |
| 11. | C: | You're not working. .Hhh uhm X before you found out that you're pregnant were you using any prevention? |
| 12. | P: | No I wasn't using anything. |
| 13. | C: | Okay. .hhh do you have any children? |
| 14. | P: | Yes, only one. |
| 15. | C: | How old is your child? |
| 16. | P: | 7. |
| 17. | C: | 7 years old. And how far pregnant are you now? |
| 18. | P: | I think I'm 7 weeks. |
| 19. | C: | You're 7 weeks. You haven't had a scan yet, is that right? |
| 20. | P: | I went to the doctor |
| 21. | C. | Okay to = |
| 22. | P: | Last week Friday. |
| 23. | C: | Okay. Did you have a scan? |
| 24. | P: | I don't have a scan with me. He just told me I'm 7 weeks. |

25. C: Okay.
26. P: I didn't ask for a print out.
27. C: Okay. What will happen today is that you go for a scan today just =
28. P: Okay.
29. C: = to make sure.
30. P: Okay.
31. C: Can I just ask you to sign there for me .hhh?
32. P: Okay.
33. C: Okay hhh. X what I've noticed to start off is that uh you are not using any prevention.
34. P: Yes, I stopped.
35. C: Is there any reason for that?
36. P: No uh (0.1) I think tw::o years ago I was bleeding non-stop; I think about twelve months bleeding every day.
37. C: Mhmm.
38. P: Then I went X and at X they said no I must stop maybe it's what I was using to prevent, anything they think maybe I have cancer or (.) = then I said I stop using that thing, prevention.
39. C: Okay.
40. P: Then I was using, I was using just the normal pills. Then I think after I use the treatment they give me at X I stopped then it went back to normal and then I was afraid to start contraception again.
41. C: Yes.
42. P: Because I don't know what was wrong with me. I even do a pap smear twice.
43. C: Okay.
44. P: My last test of Pap smear was last year.
45. C: Okay.
46. P: Then after that I stopped =
47. C: Okay.
48. P: = Using prevention.
49. C: Okay. So you were then having unprotected sex or you were using uhm condoms? O::r
50. P: I was using condom. I stopped using condom (.) this year because my boyfriend asked for a child.

51. C: Mhmm.
52. P: Then we were going up and down looking for help.
53. C: ↓Okay.↓
54. P: Ja. Then yeah Ja I found out on, I found out that uh I missed my periods.
55. C: Mhmm.
56. P: Then I was like "ah oh hayi" worse my parents knew that we were (0.1) planning to have a baby. We were tr- = getting help =
57. C: ↑Yes.↑
58. P: = just for us to have, to get a baby. We went to the doctors, even the traditional healers then they gave me something neh.
59. C: Yes.
60. P: Then after that hhh (0.1) I missed my periods. I do home pregnancy test then it came positive. Then I went to the clinic then it went positive. Then I see a doctor last week (.) for a scan and then the doctor said I'm (.) 7 weeks pregnant.
61. C: Mhmm.
62. P: Ja.
63. C: Now you've said to me you were trying to have a baby.
64. P: Ye::s. I was trying. It was ou::r plan.
65. C: ↓Oka::y.↓
66. P: But (0.1) I noticed the treatment ((clears throat)) after he knew that (.) I'm pregnant. Then he changed completely (0.1) after he knew I'm pregnant. Then I told him "now I am pregnant. I thought you'd say congratulation=
67. C: Mhmm.
68. P: = Because it is what you wanted. It's what you, you've been looking for, wanting to have =
69. C: Yes.
70. P: = But now you suddenly change =
71. C: Yes.
72. P: = What went wrong? Are you cheating or are you seeing, I don't know what is going on? And to me you are just killing me =
73. C: Mhmm.
74. P: = Because it is not easy. Right now I need a support =
75. C: Yes.

76. P: = Not to be funny. Talk funny things or just bringing back the past =
77. C: Mhmm.
78. P: = Whatever happened in the past, it happened there .hhh then it ends there. Then you ask for a baby to me. Then I was being honest with you that, okay if you really love me and I also love you too because I have one son =
79. C: Yes.
80. P: = So we can try (.) a second baby".
81. C: Mhmm.
82. P: But he changed completely. We don't talk (.) even I cannot ask him where is he coming from or where is he (.) I cannot do, I cannot do anything. I cannot communicate with him.
83. C: Mhmm.
84. P: So there is no::thing at home =
85. C: Mhmm.
86. P: = I'm just myself stressing. Every time
87. C: So X you sound as if (.) you feel betrayed by him.
88. P: Too much.
89. C: Because you made this decision together to fall pregnant =
90. P: Yes.
91. C: = and now that you've fallen pregnant uhm (.) you don't have his support, and you feel abandoned.
92. P: Ja, (.) that's how I feel.
93. C: That's a very difficult place to be in.
94. P: That how I feel (.) then I wake up today (.) I think around about 5 'o clock and I decided just to (.) wipe my face and come for termination because I don't have a choice.
95. C: You feel alone.
96. P: ↓Mhmm.↓
97. C: It's a dreadful, dreadful feeling that. Especially now that you set your (.) heart uhm to have a baby hhh and now that you feel as if that your part of the bargain (.) he has just changed =
98. P: Ja.
99. C: = and he's not meeting your needs now (.) the way you want him to.

(0.3)

X what you need to remember as well is that (.) this baby is your baby as well. And I fully understand uhm why you're feeling the way that you are and why you are feeling abandoned and betrayed. And I'm sure that you also feel very angry about fact that he's put you in this situation because now ↑you↑ have to deal with this baby. (.) But remember that this baby is your baby as well =

100. P: Ja.

101. C: = and (.) you cannot only make a decision (0.3) for your partner. You've got to make a decision for yo::u and how yo::u are going to leave with the know::ledge of having the abortion as well (.) because although this baby is your partner's baby, it is also your baby. And the consequences of having a termination are going to live with yo::u forever.

102. P: Mhmm.

103. C: Uh two out of three ladies who have terminations develop what is called post abortion syndrome. They become very sad. They become very depressed. They're guilty, they feel guilty. They have remorse. (.) They have feelings of uhm (.) rejection from society because they feel as if they have done something horrible. And uhm (.) it is so um (.) it is such a nasty condition that even the psychological terms, they've named it the post (.) uhm abortion syndrome and people go for counselling. Se::vere counselling in order to deal with emotions.

.Hhh you must also remember that if you have termination, you're expo::sing yourself to the possi::bility of not having another baby again. And you also exposing yourself to the possibility of developing breast cancer as you get older. .hhh So these are very real uhm =

104. P: Mhmm.

105. C: = side effects that (.) I under::stand at the moment you may not feel are important to your life because you just want to get rid of this pa::in that you're feeling towards your partner. But I feel it's necessary that you con::sider those things so that you don't make the wrong choice (.) in anger. You don't make the ri- = the wrong choice of fear. And you don't make the wrong choice simply because you want to get your partner back (0.1) because at the end of the day you will have to live with this decision forever. Your partner doesn't, (.) doesn't get to live with the feeling =

106. P: Mhmm.

107. C: = that you're going to be dealing with. So it's a very, very important decision for you to make. (0.1) what will happen uhm (.) we don't know exactly (.) ((cough)) we think you're about 7 weeks =

108. P: Ja,

109. C: = you haven't had a scan yet. We need to give you a scan and you will go for a scan today. But at seven weeks what happens is that you will be given a tab::let and the tablet cuts off the blood supply between you and your baby.

What happens is that your uhm the tablet brings about a very heavy, heavy blood, uh bleed. Um that baby will get washed out of your womb with a blood flow. You leave the hospital and you come back after a we::ek and they give you a scan to see whether you are still pregnant. If you ↑are↑ still pregnant, they'll have to do the se::cond procedure on you. And that's when they go in::to the vagina <with a metal tube>.

Remember your cervix is closed. They put a tablet on the tip of the cervix to soften it and then they enter your vagina with a metal tube and they ↓<suck the baby out>↓. Both of those procedures are very violating procedures (.) because they take ↓the life of your baby away↓.

At six weeks your baby is already this size. This is a little model. (.) Just to show you exactly the size of your baby. Your baby has already got the formation of legs. It's got little ↓arms↓. It's already got a head that's forming.

110. P: Mh.

111. C: So it's rightly important to know that (.) what comes out not (.) just as cells that look like blood clots. There are in fact (.) the baby that you already have conceived. So if you're exposed to ↑that↑, you se::e that. Remember that's going to stay with you (.) forever.

The other thing to remember is that uhm (.) termination is you first choi::ce that is why you're here. You second choice might be to become a mom (.) even tho::ugh your partner is not ready or even tho::ugh your partner is rejecting you. Even tho::ugh your partner is not supporting you the way ↑you↑ want him to support you. That is an option that is available to you. (.) And the third option is to have your baby adopted (.) and uh adoption is the process were by you give birth to your baby (.) when your baby is born, your baby comes into a place of

safety such as ours. It stays with us for a period of two months, while you and your partner sign consent (.) to have your baby adopted.

And then once those 60 days are up your baby then becomes uhm adoptable. And that's when a family who are desperate to have a baby but who ↑can't↑ have a baby (.) they will then take uhm control. They will have that baby uhm as their own and uhm (.) you will no longer be financially or psychologically or emotion::ally uhm attached to that baby. It going to be adopted by some other family member.

(0.4)

How do you think you're going to manage=

112. P: HHH.
113. C: = after you've had a termination if that's your final choice?
114. P: ((clears throat)) uh maybe first thing I think the relationship will end.
115. C: ↓Okay↓
116. P: Secondly I will not be fi::ne =
117. C: ↓Mhmm↓
118. P: = because it's what I wanted. =
119. C: Yes
120. P: = But now (.) I don't get what I want. I didn't get the support.
121. C: Mhmm.

(0.7)

122. P: So <I don't know>.
123. C: So [if]
124. P: [it was] not a mistake. (0.1) I wanted it
125. C: Mhmm.

(0.3)

126. P: I don't know.

(0.3)

127. C: How do you think you're going to make sense of that in your own mind?
128. P: Hhh
129. C: Once you've had a termination because you wanted this baby? This baby has been a part of your life a few months now because you've actually wanted it before now.

130. P: .Hhh.

(0.3)

131. C: How are you going to let it go?

(0.5)

132. P: I can't. I can't let go. (0.6) Mh.

133. C: But you see when you have a termination (.) you're going to have to let the baby go. Because it won't be (.) physically inside you any longer. But then that's only part of it you see because the other part is emotional. How will you let your baby go emotionally in order for you to move on?

134. P: (0.6)

135. C: Because you've expressed that this baby was a very much wanted baby.

136. P: Ja, because my first child was (.) an unplanned baby but (.) hhh I managed.

137. C: Mhmm.

138. P: = because his father left me while I was 7 weeks. Then I carried the baby throughout. Nine months. Now he's 7 years =

139. C: Mhmm.

140. P: = without a father.

141. C: Mhmm.

(0.3)

142. C: So you were hoping=

143. P: What made me to be afraid is that I've passed through this 2007

144. C: Mhmm

145. P: = now (.) it's repeating itself again. (0.1) I don't know whether it's torture or, = ↑no↑. (0.3) = because part of me is willing to keep the baby (.) and raise it =

146. C: Mhmm

147. P: = but I don't know hhh but its fine what I can d::o. Just to give .hhh just to ( ) my family because I don't have parents

148. C: Ja.

(0.4)

149. P: but if I take the decision that ((clears throat)) that I don't do termination again. I have to (.) accept that (.) I'm on my own =

150. C: Mhmm

151. P: = and carry

152. C: Mhmm.

153. P: (0.4) .hhh there will be insults (0.1) and I doubt that there will be a relationship if I terminate but it's not (.) the matter. Now it's about me

154. C: Mhmm. (0.3) So your focus is not on the relationship at the moment because you feel as if he has let you down in a way =

155. P: Yeah.

156. C: = and you feel betrayed and hurt =

157. P: Ja.

158. C: = by him. You feel as if it's not your top priority at the moment. You're in survival mode. You're trying to survive this yourself =

159. P: >Ja<

160. C: You're trying to see how you can cope and how you going to be able to man::age to get through this in order to carry on your life with your child whose 7.

Is your child uhm (.) is this man the same father as your 7-year-old? No? No?

161. P: Sjoe it is not easy =

162. C: Ja.

163. P: = it is not easy at all.

(.)

164. C: It sounds as if it is a very difficult decision for you to make.

165. P: Ja.

(0.5)

166. C: It is your decision to make. You got to make it =

167. P: = But it is a decision I have to (0.1) think but then because I don't care about the relationship any more =

168. C: Mhmm.

169. P: = for me the relationship is dead

170. C: Mhmm.

171. P: = but (0.1) the child

(0.2)

172. C: You see the one =

173. P: = to take an innocent child for whatever I did wrong in the past is not going to help.

(0.1)

174. C: You see it's a difficult choice because (.) you know that you have been able to do it in the past.

175. P: Ja.

176. C: You know that you are perfectly capable =

177. P: Ja

178. C: = of raising a child on your own. =

179. P: Mhmm.

180. C: = You've done it. You've been very brave. You have a beautiful 7-year-old .hhh and (.) uh I can almost be very certain that <your joy> and happiness, and purpose in life come from that 7-year- old.

181. P: Ja. That's true.

182. C: and [so] =

183. P: [Every] time he tells me every day that "mommy I love you" and then will kiss me here every day.

184. C: (h) your eyes light up

185. P: Even me, this morning I decided to not take him to school =

186. C: Yes.

187. P: = I left him in bed and come here and maybe he will wake up "uh where is mommy?"

188. C: Mhmm.

189. P: but then

190. C: Ja. Uhm I know that, I can see that you're a mommy by heart. And uh, that's wh::y this decision is such a big decision .hhh and uhm it is important not to allow your feel::ings for your (.) partner who's hurt you to inter::fere with your feelings as to what you want (.) ↓with this baby↓. Because there are two different entities (.) and you can re::direct your anger (.) and your frustrations (.) and your concern. They can re::direct to your baby (.) through what you actually feel for your partner.

190. P: Mhmm.

191. C: So you need to be very certain when you make a decision (.) that there are separate. That you know your feelings for your baby and you kno::w your feelings for your partner. And you make a decision (.) as to whether you want a termination, ↑not↑ on feeling for your partner. Because he may leave you tomorrow, you may leave him tomorrow (.) but you will still need to deal =

deal with your feelings as to what made you do the termination and how = and whether that was the right decision for you.

Remember in a years' time. Two years' time, five years' time you will look back on your life

192. P: Mhmm

193. C: and you will ask yourself the question "<was it the right thing> for me to do?" If you be::lieve in a year or twos time you will look back and say "↑yes↑ it was the right decision" then I think you can honestly say to yourself "go ahead and do it". ↑But if you think↑ it may not be the right decision, you've got to question your (.) yourself now and you've got to look at your motive and you've got to look at a::ll the possibilities (.) because perhaps there's a way out. Perhaps there is another decision that you could make, that will make your life so much more pleasant. Because having a termination is not a quick fix solution. (.) I can promise you, you will not walk out of that hospital and say "sjoe I'm so pleased I did what I did, at least now I can go on with my life". (.) You may feel like that in a years' or twos time but immediately, initially you not going to feel like that (.) because there is too much emotion. There's too much sadness. There's too much ↑trauma↑ that you having to deal with. So those are the things you've got to think about. It is your choice. You::'ve got to make this yourself because you've got to live with the consequences yourself.

What will happen now is that you will go to nurse. They will direct you to the scanning department. You'll have a scan. Once you have a scan you will go back to the nurses. At any stage after your scan you can change your mind if you wish to. You take your form, you hand it in, you walk away from the hospital. <It is your choice>. If you wish to continue you will then be directed to whichever department (,) they need you to go in, in order to have the termination. You're 7 weeks. You do not have to make a decision today. You can go for the scan. You can leave the hospital. If you still feel you need to come back, you can come back in a day or two. So that is very important thing to know. You do not have to make your decision today. (.) Alright.

194. P: Mhmm.

195. C: Do you have any questions?

(0.4)

197. P: No.

198. C: ↓Okay.↓

199. P: I guess I have to think again.

200. C: ↓Yes. Okay.↓ You're going to go now and have a scan and then from there we can work onwards.

201. P: Okay.

**APPENDIX 8**

Research Site 3

| | | |
|---|---|---|
| 1. | C: | How old are you? |
| 2. | P: | 26. |
| 3. | C: | 26 ((clears throat)). Listen the method that you are going to have neh is the one that is do- = done at your house. .hhh that means I will be giving you medication. One here = one for here, and then you're going to have four pills that you take at your hou::se. That means everything is happening <at your house>. Do you understand that? |
| 4. | P: | ↓Yes.↓ |
| 5. | C: | There won't be any nurse there, neh. |
| 6. | P: | ↓Mhmm.↓ |
| 7. | C: | Any nurse ↑neh↑. So what I expect from you is too listen .hhh and listen very carefully because I am going to gi::ve you information, then I am going to ask it back from you. So that I can know that you understand (.) what is happening and that you will not be panicking. Do you understand? |
| 8. | P: | [Yes.] |
| 9. | C: | When things are happening. Okay but before that I need to take down some, a lit bit history neh. |
| 10. | P: | ↓Okay.↓ |
| 11. | C: | Uh when was your last period? |
| 12. | P: | Last month, first week |
| 13. | C: | Which month is that? |
| 14. | P: | ↓March.↓ |
| 15. | C: | Hm? |
| 16. | P: | March. |
| 17. | C: | March. Any high blood sugar? Any illness? |
| 18. | P: | No. |
| 19. | C: | Any operations? |
| 20. | P: | No. |
| 21. | C: | How many times pregnant? |
| 22. | P: | Two. Two, Three. |

23. C: How = how many children do you have?
24. P: Two.
25. C: So this is your third pregnancy neh?
26. P: ↓Mhmm.↓
27. C: Are you allergic to anything?
28. P: No.
29. C: Do you know your HIV status?
30. P: ↓No.↓
31. C: Hm?
32. P: No. I didn't do this year.
(0.1)
33. C: You must check there at you nearest clinic neh.
34. P: ↓Mhmm.↓
35. C: Because counselling takes a long time right.
39. P: Okay.
40. C: Do you know which blood group you belong to?
41. P: ↓No.↓
42. C: ((Clears throat)). Can I do your blood pressure please?
( ) What are you doing to use for family planning?
(.)
43. P: I-Depo.
44. C: Hm?
45. P: I-Depo.
46. C: What is that?
47. P: Depo.
48. C: Depo?
49. P: Mhmm.
50. C: You are 26 years old neh?
51. P: Mhmm.
52. C: And it's your third pregnancy? What you been = you've been using for family planning?
53. P: (0.2)
54. C: Hm? (.) Have you been using anything?
55. P: I was using (.) a pregnancy test but I didn't go for my next date.

56. C: Why not?
(0.1)
57. P: I was out. I was in KZN. Now I forget my things.
58. C: ↑You forgot your things? ↑
59. P: Mhmm
60. C: HUH?
61. P: ↓Yes.↓
62. C: ↑You forgot your things here? .hhh and you go to KZN? ↑ And knowing you must get the = you are due for the injection? Hm?
63. P: (0.4)
64. C: What does it say to me mos?
65. P: (0.1)
66. C: Hmm? (0.2) Hmm?
67. P: (0.3)
68. C: What's it saying to me? (0.2) Huh?
69. P: That I don't care
70. C: That means. No don't say you don't care (.) but do you think you were responsible?
71. P: (.)
72. C: No neh. You don't look (0.2) = how can I say? You look as if uh (0.1) = do you think about this? About the fact that you have (0.1) just left the card here?
73. P: (.)
74. C: Did you think about it? (0.1) Do you realize the consequences?
75. P: ↓Yes.↓
76. C: ↑You do? ↑ (0.2) My worry is neh (.) you must be able to know when you (,) have made a mistake. I mean (0.1) not like a (.) mistake in a fact that (.) you don't know neh, what to do or = the fact that (.) you must know it is ↓your responsibility not to fall pregnant↓. Do you understand? Hm?
77. P: ↓Yes.↓
78. C: ↓Do you understand that though? ↓
79. P: ↓Yes, I understand.↓
80. C: And now you going to go to KZN again mos neh.
81. P: ↓Mhmm.↓
82. C: And then?

(0.2)

83. P: I'm going ↓to carry my stuff. ↓

84. C: ↑Are you sure? ↑

85. P: Yes, I am sure

86. C: ↑how sure are yo::u? ↑

87. P: 100

88. C: ↑100, 110? ↑

89. P: (h)

90. C: ↑Huh? ↑

91. P: Yes, 110

(0.3)

92. C: Okay. (0.3) 110? You must be sure, sure, sure because it's not an easy thing, this thing neh.

93. P: Mhmm.

94. C: It can't be easy ( ).
This, this is the tablet I'm going to give you now neh.

95. P: Yes.

96. C: And then you will be taking these four at your house tomorrow, right?

97. P: Yes.

98. C: You must listen carefu::lly. You must listen because I want the information back from you right.

99. P: Yes.

100. C: No::w hhh (0.4) when you are taking this tablet, like any other tablet you take there is side effects. Understand?

101. P: ↓Yes.↓

102. C: Even if you can take a Pando you going to feel nauseous right. Now same with these tablets. You can, you may have nausea, you may have vomiting, you may have diarrhea. Even a headache. Understand? And a back ache. Anything. You can even have dizziness. Do you understand?

103. P: Yes.

104. C: Those are side effects (.) nor::mal side effects, right. Now (0.1) you did eat mos this morning?

105. P: Yes.

106. C: We always ask if you if you = because you can't take these tablets on an

empty stomach. .hhh when you are (.) taking these (.) you are actually miscarrying. Do you know about the miscarriage neh.

107. P: Yes.

108. C: Now how does it happen? I need to explain how to you. When you're pregnant (.) there is a water sack that starts before the baby starts neh. This tablet is going to loosen that water sack right (.) meaning it will stop the pregnancy. ↓You understand? What do you understand?↓

109. P: That it's going to stop uh the pregnancy

110. C: How? How?

111. P: Uh hhh (.) maybe uh.

112. C: What is this? That I have showed you now?

113. P: The womb.

114. C: No. ↑Huh? It's loosening the [water sack]↑

115. P: [water circle] okay.

116. C: ↑What's it doing? ↑

117. P: (0.1)

118. C: ↑What is this? ↑

119. P: It's the loosening.

120. C: ↑Loosening what? ↑

121. P: Of water.

122. C: ↑ The water sack. ↑

123. P: Water circle.

124. C: ↑Say it again.↑

125. P: The water circle.

126. C: ↑What's it doing? ↑

127. P: (.)

128. C: ↑ Loosening.↑

129. P: loo- = loosening

130. C: ↑ What? ↑

131. P: The water circle. The water circle.

132. C: What's it ↑ doing? ↑

133. P: (.)

134. C: ↑ Loosening ↑

135. P: Loosening.

136. C: ↑The what? ↑

137. P: The water circle.

138. C: ↑ Sack.↑

139. P: Water sack.

140. C: What is it doing? (.) Say it. I need to hear what you're saying.

141. P: (.)

142. C: Loosening.

143. P: Loosening.

144. C: The what?

145. P: Water sack.

146. C: Yes. Meaning that it stops the pregnancy right. Now you're taking this one (.) today. You must check the time (.) right?

147. P: ↓Yes. ↓

148. C: Because tomorrow you will be taking these (.) exactly the same time at your house neh =

149. P: Yes

150. C: = because it is loosening (.) what do we say? It's loosening the?

151. P: The water circle.

152. C: Ja. Not the water circle.

153. P: Sack.

154. C: Sack.

155. P: When uh (.) you = it loosens the waters there's some (.) people they experience cramping and bleeding. Not everyone. You understand? It's not everyone that has it right?

156. P: Yes.

157. C: But it does sometimes happen (.) s:: = cramping (.) and bleeding right.

158. P: Yes.

159. C: Let's take this now with water neh. The important (.) check the time neh. What did you say you were going to use for family planning?

160. P: I-Depo.

161. C: Hm?

162. P: I-Depo.

163 C: Depo. Okay. Take this one tablet, take it with water please neh. As soon as you get home please put on a pad right. Why?

164. P: May I will get bleeding.

165. C: Ye:es. Tomorrow morning please (.) you must eat neh. You must eat right. Then you take these four tablets. Listen very carefully because I'm going to ask you neh.

167. P: Mhmm

168. C: You take these four tablets. (0.1) All four. ↓Put them under your tongue all at the same time. You put them under your tongue at what time? ↓

169. P: 12h22

170. C: 12h22. Put them under your tongue. Leave them there, they must melt. Once they have melted (.) then you swallow them. Right, neh? You put all four under your tongue right.

171. P: Yes.

172. C: Once they have melted (.) you swallow them, then you don't eat for one hour please neh. Reason why (.) these tablets take 30 minutes (.) to go through the system. So you're not going to eat for one hour. It takes 30 minutes to go through the system. <We want you> not to vomit in the first 30 minutes of swallowing the tablet. Do you understand? .hhh because if you vomit within that first 30 minutes of swallowing them (.) there is a possibility that it can fail. Do you understand?

173. P: ( )

174. C: Now why is it going to fail? ↑ We said↑ the white tablet loosens the water sack neh. These four tablets <open the mouth of the womb> for it to come out. Do you understand?

175. P: Yes, ↓I understand.↓

176. C: So (.) with these four tablets must bleed. (knock at the door). Absolutely (Interruption)
Now (.) where was I now? Where was I?

177. P: (h) it open the eh, the womb

178. C: ↑ Yes. ↑ It opens the mouth of the womb neh. And ↑ then↑ ?

179. P: So that it =

180. C: You can bleed neh?

181. P: Bleed

182. C: Neh. So ja. We don't want this to fail neh. When you bleed, you are going to bleed heavily because of this, see it opens the mouth of the womb neh. You're

going to bleed heavy right. You are going to experience = you said this is your third pregnancy neh?

183. P: Yes.

184. C: Have you had pains with your other pregnancies?

185. P: Yes.

186. C: Do you remember them?

187. P: Yes, I remember them.

188. C: Yes, then you will know which pains I am talking about neh. You will have cramps and you will have (.) blood clots right. You know blood clots (qub)

189. P: Mhmm

190. C: They're falling out neh. Those are these you will experience right. Hhh now (.) We don't want this mos to fail neh.

191. P: Yes.

192. C: How will we know that it has failed? I will tell you. I said mos (.) you must not vomit within the first (.) 30 [minutes] neh.

193. P: [30 minutes.]

194. C: = of swallowing because there can be a possibility that it will fail. Also you must have a heavy bleed neh. Not just a smear on the panty or the pad =

195. P: Mhmm.

196. C: = that is not a heavy bleed right. If that happens, <you must come> back Monday morning half pass seven.

197. P: If it happens?

198. C: If you have a slight smear on the panty (.) and if you vomit in the first 30 minutes

199. P: Okay.

200. C: You understand that one?

201. P: Yes, I understand.

202. C: Now when = why must you come back Monday?

203. P: Maybe there's be something happen. If I = if I vomit (.) within the 30 minutes.

204. C: = and?

205. P: (.)

206. C: = and?

207. P: smelling of blood in my panty

208. C: S:: =

209. P: Smelling

210. C: Smear neh

211. P: Smear. Oh.

212. C: Okay. Go::od. Now we are giving you pain tablets for the pains and the cramps neh. The pain tablets (0.1) you must take please (.) two, three times a day. That's for the pain and the cramps. <Two tablets> three times a day. <That's two in the morning, two in the afternoon, two in the evening>. That's for the pain and the cramps right.

Can you see we are here at causality? (.) ↓Causality is there for an emergency. Now emergency can happen if you are reacting to these tablets (.) mean::ing that the side effects that I mentioned when we started. Remember the nausea, the vomiting and the headache, and the =↓

213. P: Mhmm

214. C: Those are the side effects. Some people get them very severe. Do you understand? Like if you vomit, then you just vomit and you can't keep the food neh (.) that is severe. It's not supposed to make you ill. Do you understand?

215. P: ↓Yes.↓

216. C: Same with diarrhea. Same with headaches and dizziness. .hhh it's not supposed to be so severe. Ja. Do you understand? .hhh if it happens then you come to causality so they can help you (.) give you medication to stop this that is making you sick. Do you understand?

217. P: Yes, I understand

218. C: Now tell me about causality. (Phone rings)
Tell me about causality

219. P: If I'm (0.1) I'm dizzy (.) bad dizzy (.) if I come here, I must come straight to the causality so they can help me.

220. C: Ja, any side effects that is making you absolutely sick neh.

221. P: Okay.

222. C: Now (.) hhh you know how to take these ones?

223. P: Yes, under my tongue.

224. C: You know what this is for?

225. P: Pains.

226. C: Pains neh. This is (.) the date for your nearest clinic for your next injection on

the 1st of July. Then can I give you (.) the injection?

227. P: Yes.

228. C: You want .hh the three month mos neh.

229. P: Yes.

230. C: Then can you give me your small blue card please.
Your check-up date will be on the 22nd of this month. That's a Friday neh.

231. P: Mhmm.

232. C: That is a check-up. Meaning that you will come and we'll aa- = ask you how did you take the tablets (.) and you're going to say mos neh.

233. P: Mhmm

234. C: Then we're going to ask you (.) did you bleed neh. You're going to say right.
(Phone rings and counsellor answer)
We do give out our telephone number. Our cell number (.) in case you are = you have enquiries about anything.

235. P: ↓Okay.↓

236. C: Understand? And you phone me? ( ) you can phone me if there's anything that you = that you're unsure (.) of right.

237. P: ↓Yes.↓

238. C: .Hhh can I give you the injection plea::se. Oh ja, on the check-up neh we = we just ask what you have experienced. The pregnancy hormone neh

239. P: ↓ Mhmm. ↓

240. C: = stays in your system for quite a long time (.) so we don't do pregnancy test
(.) because it takes time for the pregnancy hormone to leave your blood stream.
Do you understand?

241. P: ↓Yes. ↓

242. C: We just ask what you have experienced. Hhh. press there please. (0.6)
((cough))
Check-up I said on the 22nd of this month, half pass seven in the morning neh.
Just with your blue card neh.

243. P: Okay.

244. C: Thank you, lady. There you are. Tablets, tablets. Any questions?

245. P: I don't have any questions.

246. C: Do you want to my cell number?

247. P: Yes.

248. C: Here you are

249. P: Thanks.

250. C: Thank you.

251. P: Thank you nurse

252. C: Okay. Bye-bye.