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# An assessment on the provision of South African Sign Language interpreting services in the healthcare setting during the Covid-19 pandemic

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# An assessment on the provision of South African Sign Language interpreting services in the healthcare setting during the Covid-19 pandemic.

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By

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## Abstract

The Covid-19 pandemic exacerbated the communication challenges experiences by Deaf and hard-of-hearing people in various healthcare settings. The mandatory use of masks did not make communication any easier for such people, challenges related to lipreading and the understanding of non-manual features (facial expressions). Furthermore, owing to the shortage of sign language interpreters in South Africa, Deaf and hard-of-hearing patients had to navigate their way around healthcare settings regardless of the extreme communication difficulties experienced. This research assessed the provision of South African Sign Language (SASL) interpreting services for Deaf and hard-of-hearing people in healthcare settings in the Gauteng province of South Africa during the Covid-19 pandemic. Interviews and an online survey were conducted with Deaf and SASL interpreter respondents to collect data linked to access to healthcare services during the Covid-19 period. Deaf participants expressed the view that the provision of SASL interpreting services in healthcare was inadequate. Deaf participants also indicated that they were unable to book or gain access to an SASL interpreter for medical appointments. This was also the case in emergency situations where a last-minute booking was needed. In addition, a lack of trust in SASL interpreters was manifested by the Deaf participants, owing to the high costs associated with the interpreting services. Moreover, the Deaf participants expressed the view that medical staff tended to have a negative approach to Deaf and hard-of-hearing patients. The recommendations made on the basis of this research are that medical professionals should learn basic sign language and that SASL interpreters should learn medical terminology and the equivalent SASL sign/s to ensure increased accessibility by Deaf and hard-of-hearing people to communication in health care setting.

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# Chapter 1: Background and context

## 1.1. Introduction

The first outbreak took place in China in 2019 and thereafter the deadly quickly spread across the world (World Health Organization, 2023). When the first case of Covid-19 struck South Africa in the early months of 2020, the government announced a hard lockdown to contain the spread of the virus which subsequently claimed many lives.

Covid-19 is a respiratory tract infection that affects the sinus, throat and nose as well as the windpipe and lungs (World Health Organization, 2023). The virus is spread through person-to-person contact and the infection can range from mild to deadly. Globally, people were urged to limit or avoid contact with others so as to ensure that the virus did not spread. In South Africa, people were urged to stay in their homes and avoid physical interactions including social gatherings. Despite the government's efforts, increasing numbers of people in the country started contracting the virus and everyone needed to adhere to strict Covid-19 protocol and seek medical assistance if it were suspected that a person had contracted the virus.

Consequently, communication barriers between the Deaf/hard-of-hearing and healthcare professionals in medical settings heightened during the pandemic. For many, research has shown that healthcare services need to be improved for Deaf and hard-of-hearing communities (Meador & Zazove, 2005). This research primarily examined whether there have been any improvements, and if there was sufficient access to the provision of sign language interpreting services for Deaf[1] and hard-of-hearing [2]people. This research aims to identify the need for and the current provision of SASL interpreters in healthcare settings, as well as to explicate the gaps and challenges linked to the provision of SASL interpreting services in the healthcare setting.

When dealing with a serious illness and in need of a diagnosis, a person would rather be communicated with in a language they fully understand. During national pandemics, it is important that patients receive information in a familiar language as to ensure they understand the diagnosis, follow the prescribed treatment and make a full recovery (Morris, 2020). During

[1] Deaf with a capital "D" refers to those who are culturally Deaf and use sign language as their primary mode of communication.
[2] Hard-of-hearing refers to the group of people who have lost their hearing partially and may still use sign language to communicate.

the Covid-19 pandemic, the need for medical interpreting services increased as Deaf and hard-of-hearing individuals needed to access healthcare.

Interpreting requires a high level of fluency in two or more languages. In addition, the interpreter must act professionally by adhering to ethical conduct. During the pandemic, like the general population, Deaf people had to access healthcare settings for assistance. McKinney, et al (2020) mention that Deaf people in South Africa have struggled for many years to access interpreting services in medical settings and that the national pandemic simply exacerbated this inaccessibility. Under strict lockdown, vital services for disabled people and for Deaf people, were not regarded as "essential services" this despite the fact that an estimated 500 000 to 1.5 million Deaf people in South Africa use sign language to communicate (London, et al., 2020). Statistics have also shown that one out of three Deaf people in South Africa is illiterate which means they cannot communicate or express themselves in a language other than SASL and thus requires an interpreter (Lotriet, 2001). SASL is the primary mode of communication for Deaf people in South Africa hence it is essential to provide SASL interpreting services in healthcare settings to ensure fair and equal access for all. This paper serves to investigate whether SASL interpreting services were provided in healthcare settings, such as clinics, doctors' consulting rooms, hospitals and testing stations. It further seeks to establish whether the number of interpreters was sufficient and whether these interpreters had training in medical settings.

In South Africa, as many Deaf people have mentioned, the vast majority of medical staff, do not know how to sign therefore an SASL interpreter is needed (Huisman, 2020). It has been reported that it is not always possible to book an SASL interpreter owing to a lack of availability and the high costs involved (McKinney, et al., 2020). Zulu and Kritzinger (2014) both explore the need for SASL interpreters[3] in healthcare settings. Zulu (2014) focused on the costs of having SASL interpreters in healthcare settings in the Cape Metropole District and explained the communication challenges Deaf people face in healthcare settings. Some of the challenges faced including the costing of interpreting services. Kritzinger (2011) explored the challenges faced by Deaf people with access to healthcare in the Worcester area. Both studies explained the need to have qualified and trained interpreters in healthcare settings in South Africa so as to ensure to ensure that the communication gaps and language barriers in medical settings are bridged. Medical terminology is an added demand for those interpreters working in the medical and healthcare field (Desrosiers, 2017).

[3] SASL interpreter is someone who facilitates communication between Deaf/ Hard-of-hearing and hearing communities.

During the Covid 19 pandemic, responsibilities fell on local and national deaf communities or language supporting networks to create videos in sign language sharing information on Covid (Napier & Adam, 2022). The videos needed to take into account the cultural and linguistic needs of those signers who are Deaf or hard-of-hearing. Organisations like the Deaf Federation of South Africa (DeafSA), Employ and Empower Deaf (eDEAF) and the Pan South African Language Board (PanSALB) contributed to the various translated resources that were distributed to the Deaf community in South Africa. The South African Sign Language Charter (SASLC) was launched by PanSALB and focuses on three main pledges pertaining to Deaf people. The first is to always ensure access to services and information through sign language, the second is to have a minimum standard of competency in SASL for those working directly with Deaf people, and the third is to ensure that professional sign language interpreting and translation services are readily available (London, et al., 2020). The documents emphasise the need for access to information and communication for Deaf people in various settings. During the Covid-19 pandemic, PanSALB called on the government to make information on Covid-19 and the Covid-19 vaccination, available in languages that people understand – including SASL (South African Government, 2021). Nikiwe Mathebula, the Chief Executive Officer of PanSALB said "Never has the importance of the use of language been more pertinent than it is right now during the pandemic…" (South African Government, 2021) during an interview. PanSALB stressed how important it is for individuals to receive information in their language so that people make informed decisions during this period. During this period, PanSALB translated documents into the official languages in South Africa and into SASL so as to ensure the Deaf and hard-of-hearing communities have access.

The Covid-19 pandemic further exposed the communication challenges experienced by Deaf and hard-of-hearing communities in various healthcare settings. Most individuals in the Deaf and hard-of-hearing communities have "limited access to health literacy and low levels of English comprehension" (Zulu, 2014) and therefore, require information to be relayed in SASL which may be the primary mode of communication for most. The lack of access to information and communication places community at high risk of infection. It is consequently important to have interpreters who understand sign language and have a good command of a spoken language, to bridge the communication gap between the healthcare provider and the Deaf patient. An interpreter would need to "orally convey information from a source language into a target language" (Șimon & Stoian, 2017). Sign language interpreters use a spoken and signed language as their working languages when interpreting. The sign language interpreter will

orally or visually convey the message depending on the target audience. Sign language interpreters mostly use simultaneous interpreting which means the interpreter can interpret at the same time as the Deaf person is signing or as the hearing party is speaking (Desrosiers, 2017). When rendering simultaneous interpreting services, the skills required would be "a high level of accuracy in rendering appropriate translations to the target language, translations quick enough to enable the intended audience to get the speech in real-time, and a high level of preparedness on the part of the simultaneous interpreter prior to the conference" (ATLAS Language Services Inc, 2021).

## 1.2. Aims of the research:

The primary aim of the research is to document the provision of SASL interpreting services in healthcare settings during the Covid-19 pandemic. The secondary aims include investigating the gaps in service provision in healthcare settings identified in Gauteng province and lastly to document the training and qualification levels of the SASL interpreters who rendered interpreting services during the pandemic.

## 1.3. Research questions:

- Primary question

What accessibility issues in health care settings, did Covid-19 pose to the deaf community in Gauteng?

- Secondary questions
  - What were the specific communication barriers experienced by Deaf and hard-of-hearing people in Gauteng during the Covid-19 pandemic?
  - Are interpreters who provide SASL services in medical settings trained and qualified?
  - How can accessibility in healthcare settings be a reality for Deaf and hard-of-hearing communities in South Africa?

## 1.4. Research objectives:

The following objectives were formulated for this research:

- To document the provision of SASL interpreting services in healthcare settings in Gauteng.
- To discuss the patterns and themes identified between interlocutors in medical settings.
- To identify the challenges experienced with the provision of SASL interpreting services during the Covid-19 pandemic.
- To make recommendations regarding the provision of SASL interpreters to rendering services in healthcare settings.

## 1.5. Conclusion

Access to information in healthcare settings is imperative especially during national pandemics. In South Africa, during the Covid-19 pandemic, the Deaf and hard-of-hearing communities also needed to have information translated and interpreted in a language they can fully understand – which for most is SASL. Access is not only important, but it is also a basic human right to have information given in a language people understand so as to ensure no one is marginalized because of the language they communicate in.

# Chapter 2

# Literature

## 2.1 Introduction

There are over 600 000 Deaf people in South Africa who use SASL as their primary mode of communication (Lotriet, 2001). Most hearing people, especially in public service settings such as healthcare, do not know SASL which creates a language barrier. Interpreting has played an important role since the beginning of time as countries and people of different origins were building relationships. Over the many years, interpreters can be seen rendering their services at conferences, in the media, during negotiations and dialogues and various settings including healthcare. The Nuremberg War Crimes Tribunal in the 1940's gave rise to the professional practice of simultaneous interpreting (Șimon & Stoian, 2017). The interpreter's role is to mediate conversations between people who speak different languages and therefore, they are unable or can't understand each other. It is important to look at the modality, the working modes, the social context and the discourse type when analysing perceptions of interpreting.

The SASL interpreter's role is to "remove language barriers between people who are deaf and use Sign Language and people who can hear and speak" (Andriakopoulou, et al., 2007). In a healthcare setting, this role would be to take what the hearing doctor or nurse has said and sign this information to the Deaf person and vice versa. The interpreter would need to make sure that the communication experience for both the Deaf patient and the hearing medical staff member is complete and that the two parties understand each other. The use of sign language interpreters in the healthcare setting not only benefits the Deaf individual but also the medical staff. Access to communication, information, services, education and culture for people with disabilities including Deaf people are points discussed in the Convention on the Rights of Persons with Disabilities (Kuenburg, et al., 2016). Access to healthcare for Deaf people is important as this is a basic human right. Allowing Deaf people to gain access to healthcare services is just one part of this; however, sign language interpreter services also need to be accessible to ensure a more inclusive society. Research has shown that Deaf people are already at risk "of receiving inadequate health care and health-related information" (Ljubičić, et al., 2017) because of the communication barrier between the Deaf person and the medical or healthcare professionals. This then heightens the need for sign language interpreter services in

healthcare settings so that fewer misdiagnoses and more proper healthcare assessments and treatments are made.

There are other useful documents which emphasise the rights of persons with disabilities, including Deaf people, and how they too can enjoy high standards of healthcare provision without discrimination. These documents are the Bad Ischl Declaration in the Austria, Africa Deaf Declaration 2011 in Swaziland, the World report on disability from the World Health Organisation (WHO), the Nairobi Declaration in Kenya and the Position statement On Health Care Access for deaf patients in the United States of America (USA) (Kuenburg, et al., 2016).

As this research focuses on the provision of SASL interpreters in healthcare settings, the language modality would be a signed language or visual language interpreting as the interpreter will be working with a spoken language together with a signed language as the clients would be hearing and Deaf or hard-of-hearing. The working mode for sign language interpreters in healthcare settings is mostly simultaneous even though the interpreter may interpreter may interpret remotely or in person. The healthcare setting which would be the hospitals, doctors' rooms, Covid testing stations and clinics in the community would be the social context and the discourse would be the medical consultations pertaining the Deaf or hard-of-hearing patients' health.

Barriers to the provision of SASL interpreting services include the availability of professional SASL interpreters, uncertainty as to whether the Deaf patient will arrive for the consultation and a lack of funding (Jaeger, et al., 2019). Zulu (2014) found that having interpreter services in healthcare improved and increased healthcare for patients with limited English proficiency. The study indicates that when South SASL interpreter services are provided, Deaf people's access to healthcare and health per se is improved.

For sign language interpreters, the process differs, as the interpreter hears the message spoken and then signs the message to the Deaf audience and vice versa. Simultaneous interpreting requires comprehension and production-related skills (Seeber, 2015). According to Gile (2008) the interpreter uses the following cognitive efforts, listening and analysing, memory, production, and coordination. The interpreter needs to balance the cognitive efforts to ensure the output is of high quality. Interpreters play an important role in "facilitating the communication between two parties speaking a different language" (The Language Doctors, 2020). Accordingly, to bridge the communication gap effectively, the interpreter should be proficient in the languages he or she is facilitating. Furthermore, sign language interpreting

entails receiving a message in one language and delivering the message in another (Access Services Northwest, 2023) – speech to sign and vice versa.

Sign language interpreters have a similar role to that of other interpreters, that is, to facilitate communication between the Deaf or hard-of-hearing communities and those who speak and are able to hear. Sign language interpreters use two languages, one a signed language and the other a spoken language - to facilitate the discussion between two or more parties who are trying to engage. Sign language involves using hand movements, facial expressions and body movements to convey a message (admin_dbcusa, 2020). Through research, scholars have found that sign languages are "fully-fledged, complex, natural languages, with their own grammar, vocabulary, and dialects" (Foltz, 2019). A sign language is also considered "a natural language with its own grammar and structure that is distinct from English" (Access Services Northwest, 2023). Spoken languages evolve and develop over time and develop, and so do sign. Unfortunately, many hearing people in communities, are unable to sign and thus communicate Deaf and hard-of-hearing people.

In the United Kingdom (UK) and Ireland, during the days of the Roman Empire, and later during the medieval times, laws were enforced that rules that Deaf people could "not partake in society as full citizens" ( British Deaf News Team, 2016). This meant that deaf and hard-of-hearing people were unable to participate or contribute to different settings in society such as education, medicine and law. The narrative was the same across many other countries where Deaf and hard-of-hearing people were not included because they were unable to hear. For many years, deaf and hard-of-hearing people in various communities have felt isolated and left out as they were unable to be understood or could not participate in discussions (Samantha, 2022). Through the use of a sign language interpreter, deaf and hard-of-hearing individuals have been able to participate in society and engage in settings they may have not been able to engage in the past. Allowing deaf and hard-of-hearing people, the ability to use language when expressing themselves, removes much of the frustration. However, it should be noted here that sign language interpreting is a specialised skill and just knowing sign language and a spoken language does not just qualify someone to become an interpreter (Access Services Northwest, 2023). It is also important to note that sign languages are not a gestural replica of a spoken language (Tufar, n.d.) as they have their own grammar, lexicon, linguistic structure and nuances. The different form of physical expression between signed languages and spoken languages is called modalities. Spoken languages have speech sounds which are a combination of phonemes created by the tongue placement, lip movement and shape whereas, signed

languages make use of the hands shape, placement, location, and movement (Bergelson Lab, 2022).

Historically, family members or those in the community who could sign or communicate and who had a close relationship with those who were Deaf and hard-of-hearing, would be the sign language interpreter, bridging the gap in communication between the individual who could not hear and the hearing person (The Language Doctors, 2020). Family members were mostly the children of Deaf adults (CODA's), while those in the community who may have learnt sign language would be religious workers, teachers, and social workers (Lotriet, 2001). As the sign language interpreting profession continues to grow and develop, more Deaf and hard-of-hearing people are starting to use professional sign language interpreters across different spaces in society. In countries where sign language is recognised or even accepted as an official language, there is more provision of sign language interpreting services to the Deaf and hard-of-hearing communities in both the public and private sector.

## 2.2. Communication challenges in healthcare settings during national pandemics

### 2.2.1. Challenges faced by linguistic minority groups during the Covid 19 pandemic.

Historically, across the globe, there have been many health disparities for people in linguistic minority groups. These disparities have unfortunately leave many without full access to healthcare which can be detrimental and life-threatening. Research conducted by Meuter et al (2015) and Baru et al (2023) both indicate how language barriers in healthcare settings can have a negative impact on linguistic minorities or second language users.

In Addis Ababa, the capital city of Ethiopia, the working language in healthcare settings is Amharic; however, there are Afaan Oromoo-speaking patients who often go into healthcare settings to request medical assistance. Unfortunately, healthcare providers do not know the language and thus there is a language barrier between the healthcare provider and the Afaan Oromoo-speaking patient (Baru, et al., 2023). The researchers ultimately found that the language barrier affects both the Afaan Oromoo-speaking patients and the healthcare providers negatively. The patients often did not have treatment administered to them, the patients had low health seeking behaviour, increased length of hospital stay, additional treatment costs, they were very ashamed and less confident, were dissatisfied and anxious in healthcare and more.

The healthcare providers were also impacted as they were unable to communicate with the patient about their medical history, they couldn't diagnose and provide treatment and there was unfortunately, increased burden on the healthcare providers' work.

In the United Kingdom and many other countries across the globe, the challenge was not only in the actual healthcare settings but also outside where communication and announcements were made about how citizens can protect themselves from contracting the virus. Communication during this crucial time was a necessity especially for linguistic minorities. Unfortunately, in countries like the United Kingdom, because the information was hard to find and also not easily understood, Deaf people who use sign language had to find alternative ways to get information on Covid 19 (Napier & Adam, 2022). Challenges were not only experienced by those who are Deaf and signed as healthcare professionals in the United Kingdom also felt isolated and frustrated during the Covid 19 pandemic as they were unable to communicate with and accommodate the needs of those who are deaf and use sign language as a primary way of communicating.

2.2.2. Challenges faced by Deaf and had-of-hearing groups in healthcare settings.

Regarding the Ebola outbreak in West Africa, studies have shown that many deaf and hard-of-hearing people were unable to receive information (Samantha, 2022). In the recent COVID-19 pandemic, access to healthcare services for Deaf and hard-of-hearing people was a challenge as well. This challenge was not only seen in South Africa, but also globally. Communication with healthcare professionals during the pandemic was a great challenge the Deaf and hard-of-hearing as everyone had to wear masks which meant that those who could lip-read could no longer do so and there was a lack of sign language interpreters (European Disability Forum, 2021). In addition, use of masks meant that facial expressions and mouth movements could not be identified, and this often led to increased frustrations because of miscommunication. It is therefore essential that medical/healthcare professionals are able to communicate with patients to ensure that they know what their diagnosis and treatments are. Unfortunately, most healthcare professionals do not know sign language and therefore, Deaf and hard-of-hearing patients are at a higher risk of misdiagnosis and miscommunication in healthcare settings. Canadian researchers found that language barriers can greatly affect the quality of care and outcomes Deaf and hard-of-hearing patients experiences (Bowen, 2001). This finding is one among a number of findings on the effects of language barriers on patient access and care. Most

of the findings, emphasise how important communication is with a patient and how this affects the overall experience in healthcare.

In the United Nations Convention on the Rights of People with Disabilities, it is clearly stated that there should be access with no barriers to healthcare for people with disabilities (Kuenburg, et al., 2016). Unfortunately, this is not the reality for most Deaf and hard-of-hearing communities across the world. Deaf communities across the world, as they struggle to access healthcare information and healthcare services (Foltz, 2019). The struggle for access relates mainly to communication barriers. The UN Convention on the Rights of People with Disabilities states that there should be no barriers for people who are disabled, even so, barriers are still present even during pandemics.

The use of face masks during the Covid-19 pandemic created great communication challenges for Deaf and hard-of-hearing people (National Network, 2021) not only in South Africa, but across the world. Consequently, the Deaf struggled to lipread and obtain communication cues like facial expressions. Face masks were used as a preventative measure to decrease the spread of the Covid-19 virus, including in healthcare settings (Mheidly, et al., 2020). Unfortunately, this affected interpersonal communication across society. The fact that healthcare workers and professionals were also all required to wear face masks reduced auditory and visual cues in healthcare settings. This was a great challenge for the Deaf community as it increased the barriers to communication. Deaf people have explained the experience of wearing masks during the Covid-19 pandemic as “extremely anxiety-producing” (Deguara, 2021) as they are never sure what people are saying behind their masks and much important information might be lost.

During the pandemic, Deaf people and those around the Deaf community tried to come up with more creative ways to reduce the communication barrier. One of the ways people tried to do this, was to invent clear masks. Three types of clear masks which were created: face shields, clear plastic with fabric edges, and clear plastic with foam edging ( Universe Contributor, 2020). The face shields and fabric edging masks were not so effective as the former reflects light and creates a glare while the latter lock in moisture tends to fog up. Of the three, the most effective mask was the one with foam edging; however, the problem was that the mask is usually more expensive. For the hard-of-hearing and who have a percentage of their hearing, masks muffle the sounds and have created more of a challenge in trying to hear what people are saying (Holohan, 2020), even though the masks do make it easier to lipread and to see what people are saying.

Other methods of communication are used in healthcare settings such as pen and paper, gestures, lipreading, signage and visual aids like boards and posters. The different ways in which the Deaf participants communicate with medical staff in the study, included the use of, written communication, gestures, lipreading and some visual aids. In the current study, the Deaf participants explained that pen and paper was effective but worked only for basic communication. The use of pen and paper enabled one of the Deaf interviewees to go home and remember what was discussed in the session with the medical professional. However, as mentioned by participants, there are challenges when using pen and paper in these settings including the lack of literacy skills, shortened sentences from the medical staff, delayed responses, and difficulty in reading doctors' handwriting. Unfortunately, written communication has been a challenge for Deaf people for many years, because of the poor quality of education disadvantaged Deaf schools (London, et al., 2020). Written communication is limiting as the Deaf or hard-of-hearing patient may struggle to express what they want to say in written English or any other language. Written communication will also make it difficult to express and understand more complex problems.

### 2.3. Sign language interpreting in healthcare settings globally

Communication barriers in healthcare settings between deaf/hard-of-hearing patients and practitioners have contributed to many health disparities. Unfortunately, there is great misunderstandings before, during and after the process of consultations between the parties. It has therefore become imperative to look for solutions that will create less frustration and will enhance and support the language access rights of those who are Deaf and hard-of-hearing. In the USA, the American Disabilities Act (ADA) stipulates that healthcare providers must provide a sign language interpreter for effective communication when a Deaf or hard-of-hearing person visits any healthcare setting ( Disability Rights NC, 2022). The ADA however, have exceptions where the healthcare provider does not need to provide a sign language interpreter. For example, healthcare providers are not forced to provide a sign language interpreter when the deaf or hard-of-hearing patient is filling out medical forms, scheduling an appointment with the healthcare provider, when admitted in to a hospital and when vitals and blood pressure are checked. However, anytime there is a complicated or lengthy discussion about a patient's health and condition, a sign language interpreter must be provided.

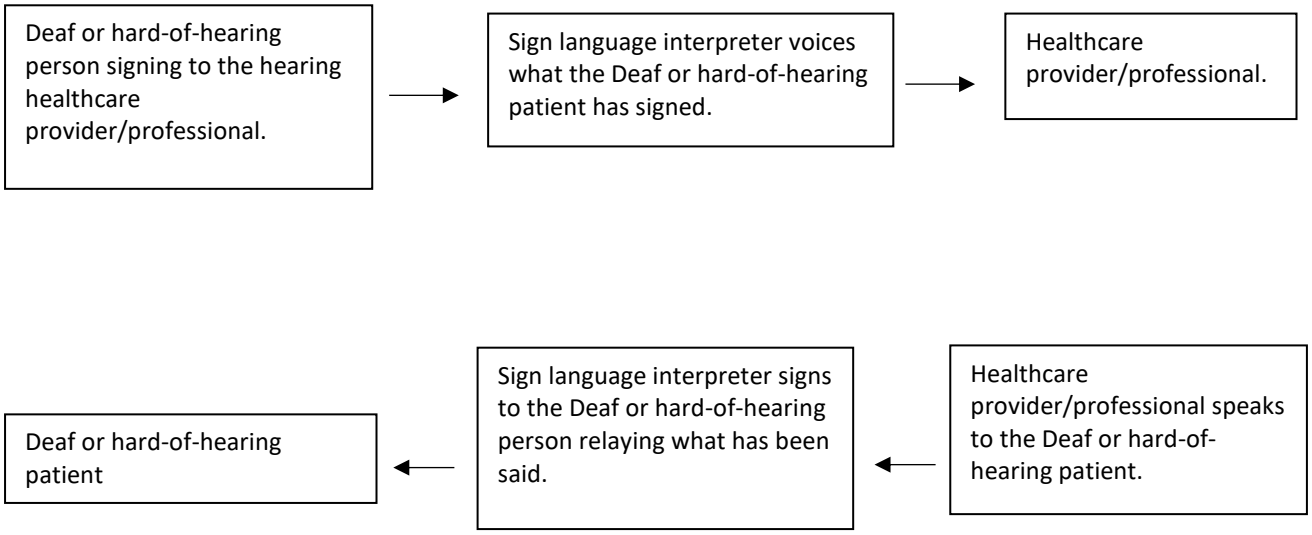



Figure 1: Sign language process in a healthcare setting[4]

As seen in Figure 1, the sign language interpreter is the mediator throughout the interaction between the Deaf and hard-of-hearing patient and the healthcare professional. A professional sign language interpreter should be able to adjust and adapt to the preference of the Deaf and hard-of-hearing patient (Access Services Northwest, 2023), bearing in mind that sign language has its own grammar and structure which is different from and unrelated to English.

Kuenburg (2016) research has shown that, only 41 percent of Deaf people have used and experienced an interpreter in a healthcare setting, while in the Netherlands, Deaf people do not bring an interpreter to consultations. In New Zealand, 39 percent of Deaf people were unable to access interpreting services in healthcare settings (Kuenburg, et al., 2016). The studies done in Germany, Netherlands and New Zealand, show that the provision of professional sign language interpreters in healthcare was an ongoing challenge even before the COVID-19 pandemic. This indicates that the lack of sufficient provision of sign language interpreters and the communication access barriers are not only a challenge experienced in South Africa. In the early 2000's, it was recorded that there were approximately 600 000, or over half a million, South Africans who used SASL (Lotriet, 2001). For decades, these sign language users have had barriers to communication in various healthcare settings as healthcare providers are unable

[4] An adaptation from online source (Deaflink, 2023)

to understand the Deaf and hard-of-hearing patients' language (London, et al., 2020). Advocacy on the part of researchers and the Deaf community resulted in the provincial health department in the Western Cape establishing as interpreting service which included SASL interpreting services. The research carried out by London, et al. has provided insight on how communication access can be improved for marginalised groups, like the Deaf community, and explains the benefits of having improved communication in healthcare.

In Belarus, 25 tablets for translation offices to assist Deaf people to communicate in healthcare settings (World Health Organisation, 2021). These tablets were funded by the European Union's Eastern Partnership Covid-19 Solidarity Programme and were given to healthcare institutions. Using tablets allowed Deaf people to video call the institution and interpreter at the same time to explain their health problems. The interpreters would then interpret virtually without entering the healthcare institution and without putting themselves at risk of being exposed to the Covid-19 virus. Consequently, medical staff were able to clearly understand the health problems of the Deaf patient, diagnose the problems and render treatment effectively. This was one way provision was given to Deaf and hard-of-hearing patients to communicate using a language they understand.

In the USA, existing hospital interpreters, contracted community-based medical interpreters and video remote interpreting (VRI) agencies were used during the Covid-19 pandemic (McKee, et al., 2020). Many of the hospitals in the USA have videoconferencing equipment which is used mainly for hearing people with limited English proficiency. Such systems are easily adapted and could also be used for Deaf people who use sign language to communicate.

Remote interpreters are connected virtually and do not have to be physically present in the healthcare setting. The interpreter can login using their tablet or laptop to render services to the Deaf patient and the medical professional. Other alternative methods have been tested and trialled during the Covid-19 pandemic. Another way to communicate with Deaf and hard-of-hearing patients in healthcare settings, is the speech-to-text app called LiveTranscribe (Hearing Link Services, 2021). Cambridge Hospital in the USA is using this specific app as a means to communicate with Deaf and hard-of-hearing patients as the use of masks during the pandemic was identified as a great barrier.

Desrosiers (2017) explains the ways in which not having a professional interpreter in medical settings can have a negative effect on the health system, those with language barrier and society as a whole. Desrosiers (2017) states that first, if there are language barriers there is low patient satisfaction which results in less use of healthcare facilities and a lack of education on health

behaviours. Second, there is less knowledge and awareness of illness. In one study, for example, it was shown that Deaf communities were behind hearing communities in terms of their knowledge and awareness of AIDS. Third, health disparities exist for Deaf people in the USA using American Sign Language (ASL) as regard to sexual health, cancer, and cardiovascular diseases. Fourth, when language barriers are experienced, patients are unable to express their symptoms which in turn means that the doctors prescribe incorrect dosages of medication. Fifth, patients who are Deaf and have family members come in to speak on their behalf - often have trouble recalling or reporting their own medical history.

Without a professional sign interpreter in a healthcare setting, there is a high risk of incorrect or incomplete information being relayed to the Deaf patient. This may have a negative impact on the healthcare setting and, most importantly, the well-being of the patient, as there could be a misdiagnosis and the wrong treatment may be given. Patients and healthcare settings may then need interpreters to mediate the communication between two or more individuals who use different languages.

In countries like the USA, research has been conducted and developments have been made regarding specialised interpreting by sign language interpreters in healthcare settings.

## 2.4. Legal framework to sign language interpreting

### 2.4.1. Consideration of Disabled people Covid-19

On 26 March 2020, the World Health Organisation (WHO) released a document called the "Considerations of Disabled people during COVID 19" which included ways in which disabled and Deaf people could gain access to healthcare services, public information, water, and sanitation (McKinney, et al., 2020). This document emphasizes the inclusion of people who are disabled including those who are deaf, who for many years, have had communication barriers. The policy ensured deaf people are consulted and given agency when discussing and addressing issues surrounding the linguistic minority group. This policy is a guide to healthcare settings in different countries to ensure equal access us given to healthcare settings despite the communication barrier. Interpreting services can be a tool used to bridge the communication gap between those who are deaf and use sign language and those who are hearing and do not

know how to sign. However, in South Africa during COVID 19, Deaf people continued to struggle to gain access to interpreting services in healthcare settings.

### 2.4.2. The South African Constitution

The South African Constitution, 1996, protects the rights of all those who enter healthcare settings in search of medical assistance. In addition, section 6 of the Constitution allows participants the right to language choice when entering various spheres and sections of society (Van den berg, 2016). Therefore, the importance of language in healthcare is recognised by the Constitution and thus it is important that when Deaf people enter healthcare settings, they have access to SASL interpreters who are proficient in the use of SASL.

### 2.4.3. Worcester Declaration

In South Africa, there is the Worcester Declaration which focuses on the right to health information, healthcare and informed consent for Deaf people. In addition, there are documents that provide guidance for persons working in medical settings and how medical professionals can work with people with disabilities - including not infringing on the rights of Deaf people. However, there is still a long way to go in creating full equality for people with disabilities including Deaf people. The provision of SASL interpreting services in medical settings in the Gauteng region of South Africa, is a challenge. The Covid-19 pandemic highlighted the need for SASL interpreter provision in medical settings.

### 2.4.4. Convention on the Rights of Persons with Disabilities (UNCRPD)

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) has also emphasised that ‘Deaf signers’ or those who are Deaf and use sign language, have the right to access public service and cultural life (United Nations, 2006). This access should be experienced though the national sign language of the Deaf people.

### 2.4.5. The use of official languages act

The use of official languages act was provided to monitor and regulate the use of official languages by national government in South Africa (Government Gazette, 2012). Some of the objectives of the act are to ensure equitable access to services and information is facilitated and to promote language management efficiently. South Africa is multicultural and has twelve official – with South African Sign Language (SASL) approved as an official language by the National Assembly on the 3rd of May 2023 (Parliament of the Republic of South Africa, 2023). Now that SASL is given an official language status, this means that all official settings including healthcare settings, should promote inclusivity and diversity by recognizing the linguistic and cultural diversity of the Deaf community.

### 2.4.6. Batho Phele Principles

Batho Phele are principles rooted in the legislative framework in South Africa, emphasising on putting people first (Walubengo, 2020). This initiative started as a way of completely changing public sector. The eight principles which are focused on are namely, consultation, service standards, redress, access, courtesy, information, openness and transparency and lastly, value for money. These principles enable the public to hold the public sector accountable for quality service in healthcare. Despite the challenges faced by public servants, this initiative encourages creative solutions instead of excuses. In the context of healthcare, the principles would emphasise how healthcare professionals are encouraged to provide equal access to service – regardless of differences in language.

## 2.5. The use of qualified and trained sign language interpreters in healthcare settings

### 2.5.1. Sign Language Interpreter certification

There is a growing need for medical interpreting certification (PGLS, 2023) as this ensures that Deaf and hard-of-hearing communities will receive quality services from professional sign language interpreters. Desrosiers (2017) makes suggestions on the ways in which specialisation certification can be done for interpreters which can also be used in the context of SASL

interpreters. Desrosiers's research also explains why specialised medical training is important. This includes in particular the fact that certain words are derived from Latin and certain concepts are not often used outside the medical setting (Desrosiers, 2017).

Organisations like the Inclusive Communication Services in America, provide professional and affordable interpreting, translation and transcription services for various settings including healthcare. They guarantee that their medical sign language interpreters are fluent in the spoken language and signed language they are using, highly adaptive to environments, culturally aware, know their ethical boundaries, can play a role in advocacy, commit to continuous professional development and most importantly, are trained in medical terminology, diagnosis, medication and procedures (Inclusive Communication Services, 2023).

Newnum (2018) states that interpreting is a highly specialised profession and to become a qualified, professional interpreter requires both practice and training. Interpreter training is important for those interpreters who provide services in the healthcare setting. Being a medical interpreter is a big responsibility as the quality of the medical care and patient depend on the accuracy of the translation. Therefore, training is important, for equipping the interpreter to provide the most accurate translation while rendering their services. Countries like the United States of America (USA) have a certification system for qualified interpreters under the National Interpreter Certification (NIC) (Desrosiers, 2017). In addition, in various other countries like Australia there are institutions that provide certification for interpreters. In South Africa, the South African Translators' Institute has an accreditation system in place where interpreters with proficiency in various spoken languages and SASL can be tested to prove their competence (South African Translators Institute (SATI), 2020).

#### 2.5.1.1. Qualified sign language interpreters

Unqualified interpreters may place themselves in compromising positions as they may not always know how to interpret a concept, or anatomical and physiological terms, or other medical terms in the healthcare setting. Desrosiers (2017) states that while an interpreter does not need to go to medical school to be able to interpret in the medical setting, training is needed. A qualified sign language interpreter is someone who interprets impartially, accurately and effectively (DSDHH, 2022). Currently, South Africa does not have a certification program for specialized sign language interpreters for medical settings. There is a great need though,

however; there is no national test to do such a test for the certification of interpreting in healthcare/medical settings.

There is no standard definition of what a qualified and/or professional sign language interpreter is (Desrosiers, 2017)However, explanations exist of the qualities an interpreter should possess in order for them to be considered qualified and/or professional. Newnum (2018) states that a qualified interpreter should possess five attributes namely, language skills, listening and recalling, ethical behaviour, cultural knowledge, and subject knowledge. Other researchers believe an academic degree is not always mandatory; however, being involved in continuous learning and interpreter training programmes is essential, as this enhances skills including accurately bridging the gap between cultures through accurate communication (Niki's Int'l Ltd, 2016). The consensus is that as a professional, being qualified and/or professional relies heavily on some kind of certification (Desrosiers, 2017).

### 2.5.2. Sign Language interpreter certification and training in a South Africa context

Prior to 1997, no formal training was available for sign language interpreters in South Africa (Lotriet, 2001). Over the past two and a half decades, various training programmes have been established. As the profession continues to grow, interpreters have been encouraged to continue to improve and polish their skills through training and mentorship.

There are currently only three universities in South Africa which provide SASL Interpreter training (WASLI, 2013). These universities include the University of the Witwatersrand (Wits University), the University of the Free State and the North-West University. In the USA, all medical interpreters are required to be certified and trained to interpret in medical settings (McKee, et al., 2020). However, this is not yet a reality yet in South Africa as there are currently no specialised programmes to ensure such training takes place.

South Africa has a shortage of qualified and trained sign language interpreters to render SASL services despite the presence of a Deaf community which needs access to information in legal, medical, corporate, and educational settings. Of the small pool of interpreters, some have undergone formal training through institutions such as the universities just mentioned.

At Wits University, a specialised accredited course is offered called the Diploma in Legal Interpreting (Wits Language School , 2020). Unfortunately, no specialised medical interpreting

courses are offered. There are also no specialised medical interpreting courses offered at the other two universities, the University of the Free State and Northwest University.

Furthermore, no workshops or learning platforms are offered where interpreters can learn more about interpreting and rendering their services in healthcare settings. In the USA, there are various medical courses following which interpreters gain a qualification or obtain a certificate to show that they are competent and capable of working as an interpreter in a healthcare setting. Unfortunately, there is little to no regulation in South Africa on where interpreters can and cannot interpret even if they do not have a certificate or relevant qualification and skill.

Only a few interpreters have received formal training in South Africa through institutions and training providers (Lotriet, 2001). Lotriet (2001) and Zulu (2014) both explored the challenges of interpreter training in South Africa. Training entails learning about the following: language fluency, ethical conduct, cross-cultural understanding, health and medical terminology, real-time interpreting skills, and correct interpretation of instructions.

In South Africa, sign language interpreter training has only been introduced in the last two decades, with training for the first group of sign language interpreters being organised by the Deaf Federation of South Africa (DeafSA) and the Unit for Language Facilitation and Empowerment (ULFE) (Lotriet, 2001). The training focused on liaison or community interpreting with a focus on Deaf culture, history and the linguistic aspect of sign language. The training was both theory based and included practical components. Those who attended the training were able to put what they had learnt into practice. Over the years, access to training has improved as more organisations and higher institutions like universities, are providing interpreter training programmes in which sign language interpreters and those aspiring to become professional sign language interpreters can enrol.

## 2.6. Conclusion

To provide sign language interpreting services to ensure Deaf and hard-of-hearing communities have access to information is not just a need, it is also a right. There are laws that support inclusion through the provision of information in ones own language especially during national pandemics. Countries like America, provide specialised medical sign language interpreters to the Deaf and hard-of-hearing individuals through various service providers. Training is provided to the interpreters so as to ensure they produce the best possible service, and that

information is relayed in the most accurate manner. By providing interpreters in healthcare, most especially during national pandemics and crisis, the health and safety of those who are Deaf and hard-of-hearing is prioritized.

# Chapter 3
# Theoretical Framework and methodology

## 3.1. Theoretical Framework

Simultaneous interpreting studies have mostly followed the descriptive translation studies framework of translation or interpreting processes and results. Translation studies have mostly focused on the role of the translator, the source and target text and the expectancy norms which are the expectations of the result.

David Katans outlines the notion of "Levels of Intervention" which guide the norms and behaviour of interpreters in various different settings (Katan, 2011). Katan explains how it is important for interpreters to introspect and ask various questions when rendering interpreting services. This is then linked to interpreter behaviour and discussions around ethics. Code of Ethics have also been used to mitigate most of the ethical challenges faced in various interpreting settings. These codes of ethics provide guidelines for interpreters on the acceptable norms and behaviours (Kalina, 2015).

The framework which will be used will be that of Sylvia Kalina as she details the expectations of ethics in various settings for interpreters. Kalina (2015) not only discusses quality of interpretation services rendered by interpreters but also the interpreters behaviour and how the interpreter should always act in the interest of the clients (both Deaf and hearing) to ensure "professional dignity" (Kalina, 2015). The expectancy norms which will be discussed together with the findings from the data would be discretion, professional secrecy, interpreting quality, accuracy and continuous professional development. Unpacking some of these norms mentioned in Kalina's work, will allow the researcher to answer the research questions.

## 3.2. Methodology

Descriptive research focuses mainly on the views and attitudes of people towards something (Akhtar, 2016). In this study, the sample population of Deaf and hard-of-hearing people was asked about their views on the provision of SASL interpreters in the healthcare setting during the national pandemic. The research was based on the participants subjective view of the levels

of provision of SASL interpreting services in healthcare settings and how each participant felt about the costing, attitudes and training of SASL interpreters and medical professionals.

### 3.3. Data Collection tools

Surveys and interviews with Deaf and hard-of-hearing participants sharing their observations of and experiences in healthcare settings were used to collect data. Information was gathered and subsequently analysed by the researcher by identifying themes and common statements, and presenting these by means of graphs.

The research and data collection methods deployed attempted to answer the research questions and help achieve the research objectives.

#### 3.3.1. Questionnaires

A written message with the three-minute survey link was sent to various Deaf organisations including the National Institute for the Deaf (NID), Employ and Empower Deaf (eDEAF) and DeafSA. These organisations were asked to spread the message using the summary explaining the research. Those who were Deaf and would like to learn more about the study had to click on the link and answer a few short questions ultimately choosing whether to continue answering the questions or not. The researcher aimed to receive 50 responses from Deaf people across different provinces in South Africa. The survey was conducted online, and the Deaf respondents had two weeks to respond to the survey before it was discontinued.

#### 3.3.2. Interviews

Accordingly, semi-structured interviews were used as a data collection tool. This qualitative approach enabled follow-up questions to be asked where clarity was needed in in regard to the questions posed in line with the interview guide.

The semi-structured interviews were guided by interview questions prepared in line with the interview protocol and guide sheet. The interview process allowed for follow-up and probing

questions that need further clarification in addition to those questions on the interview guide. Interviews were conducted mainly face-to-face, on the phone or on Skype or another virtual platform.

According to Covid 19 research requirements and restrictions, the researcher did not do focus group interviews in the same environment. In consideration of the health and safety of the participants, the focus group interviews were held on a virtual platform to avoid having too many people in the same room. Holding interviews allowed the researcher to answer specific research questions and have smaller samples when doing the research; however, standardising the research was difficult and doing interviews was time consuming.

#### 3.3.2.1. Focus group: Deaf and hard-of-hearing participants

Five Deaf participants located in Gauteng province and representing various demographics (in terms of age, class, gender, race, etc) were chosen to be interviewed regarding their experiences of entering healthcare settings during the national pandemic - to share their unique experiences. The interview process was semi-structured with questions being asked according to a script; however, follow-up questions which were not in the script were also asked depending on what the interviewee has said.

The Deaf interviewees received a Zoom invite to take part in a discussion on their experiences. The sessions were recorded for data collection purposes. The participants were sent consent forms prior to the interviews for them to sign, scan and email back. During the interview session, the researcher asked various questions to which the respondents were encouraged to respond honestly and openly.

#### 3.3.2.2. South African Sign Language interpreter focus group

A message was sent to participants containing an explanation of the research aim and objectives. The researcher's contact detail and information were included in the message so that interested parties could make contact. The researcher waited to receive responses with the aim to have three SATI accredited interpreters.

SASL interpreters were invited to be interviewed for a maximum of 60 minutes, about their experiences in providing services in healthcare settings during the Covid-19 pandemic. The

interpreters had to be located in the Gauteng region and to have at least three years professional interpreting experience. SATI is an association for professional language practitioners in South Africa (SATI, 2021). These interpreters were required to answer questions based on their professional experience and the high quality required by the Institute as it is the only body that currently provides the highest form of accreditation in South Africa.

### 3.4. Sampling

During the sampling process, probability sampling methods were used. A message was sent to the Deaf and hearing sign language interpreter communities and anyone who was interested to participate in the study could respond. Simple random sampling was used as anyone who responded on the invitation for the interview, both Deaf and accredited hearing SASL interpreters, were then able to share their experiences through interview. For the questionnaire, a link was broadcast to various Deaf groups for those who are interested to answer the online questions. All those who responded to the participation request had an equal chance of being selected.

### 3.5. Ethical Consideration

Ethical clearance was obtained. The information and consent forms contained all the information about the research including the ethics clearance number (see Appendices A and B). Participants were invited to take part in the research project voluntarily and were also made aware that they could withdraw from the research at any point even after they had given consent. It is the responsibility of the researcher to ensure that the participants are fully informed as to whether they would like to participate in the research or not, the participants were asked to sign an informed consent form. This form also asked for their permission to being filmed and recorded (audio) (UNITE FOR SIGHT, 2021). Participants were told that their information would be kept confidential, but they would not be anonymous because of the interviews would be videoed. However, the videos would not form part of the research project, so no-one except the interviewer and the supervisor would know who they were. One of the challenges the researcher encountered was, the level of English literacy of some of the Deaf

participants who would be involved in the study. To mitigate this challenge, the researcher ensured that simple English was used in the questionnaire. The researcher also restructured some of the questions to ensure maximum clarity.

### 3.6. Conclusion

Careful consideration needed to be made on how the survey was structured and how the interviews will be conducted. The researcher needed to ensure all participants were involved in the research willingly and gave the most accurate answers to ensure accurate data collection. The groups chosen and the data collection tools which were the questionnaires and interviews, would assist the researcher to obtain data for analysis. The questions in the questionnaire and in the interviews guided the discussions which are presented in the data findings in this paper. Using expectancy norms for interpreters as a framework will also help answer the research questions.

# Chapter 4: Data analysis and discussion of findings

## 4.1. Introduction

The interviews with the Deaf respondents and the SASL interpreters were transcribed manually. The surveys were conducted on an online platform which collated the information. This meant that the researcher was subsequently able to assemble able to gather the information on the system (SurveyMonkey) and use it to create graphs and visual representations which would assist the readers of the paper to understand the findings better. A total of eight interviews were conducted (see Appendices A and B). Six of those interviews were with Deaf respondents who answered questions and shared their personal stories.

## 4.2. Data analysis

### 4.2.1. Interviews with Deaf respondents

The Deaf respondents were given the interview names *Participant A, Participant B, Participant C, Participant D, Participant E* and *Participant F*. All the participants were Gauteng based and had all visited a healthcare setting during the Covid-19 pandemic from March 2020 – October 2021. The themes and highlights of the interviews will be indicated below and will then be discussed and later unpacked in the analysis section. In addition, the online questionnaire was distributed via SurveyMonkey and contained ten multiple-choice questions which were estimated to take Deaf respondents 3-4 minutes to complete. A total of 39 people responded to the online survey and their responses were collated based on the data obtained from the survey are also shared in this section.

| Participant | Deaf/Hard-of-hearing | Race | Age Group | Gender | Region | Visited which healthcare setting? |
|---|---|---|---|---|---|---|
| | | | | | | |
| A | Deaf | Indian | 26 – 35 | Female | Gauteng | Hospital |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | Doctor |
| B | Deaf | Indian | 26 – 35 | Female | Gauteng | Hospital Doctor Clinic Covid-19 Testing Station |
| C | Deaf | African | 18 – 25 | Female | Gauteng | Hospital Doctor Clinic Covid-19 Testing Station |
| D | Deaf | African | 36 – 45 | Male | Gauteng | Hospital Covid-19 Testing Station |
| E | Deaf | Indian | 46 – 55 | Female | Gauteng | Hospital Doctor |
| F | Hard-of-hearing | White | 26 – 35 | Male | Gauteng | Hospital Covid-19 Testing Station |

Figure 2: Demographics of Deaf and hard-of-hearing participants

Among the six Deaf respondents, five identified themselves as Deaf and one was hard-of-hearing. The participants included three Indians, two Africans and one white person. One participant fell into the age group 18 – 25 years, one into the 36 – 45 age group, one into the 46 – 55 age group, while three participants fell into the 26 – 35 age group. Deaf interview participants included four females and one male while one male interviewee was hard-of-hearing. During the Covid-19 pandemic, all six of the participants had visited a hospital, four

had gone to see a doctor (GP), two had been to a clinic and four had been to a Covid-19 testing station.

4.2.2. Interview with SASL interpreter respondents

Three interviews were also conducted with hearing SASL interpreters who were given interview names *Participants 1, 2* and *3*. These sign language interpreters were also based in Gauteng and had rendered their services in various medical settings during the Covid-19 pandemic. The interpreters were asked mainly about their experience when working in the healthcare setting and the observations made.

| Participant | Accredited with the South African Translators Institute (SATI)? | Region | Gender | Race | Years of Interpreting experience? | Years of medical setting interpreting experience? | Qualification |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| 1 | Yes | Gauteng | Female | White | 10 | 5 | Postgraduate qualification at a university (Honours in South African Sign Language and Linguistics) |
| 2 | Yes | Gauteng | Female | African | 9 | 6 | Postgraduate qualification at a university (Honours in Interpreting and Translation) |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3 | Yes | Western Cape | Female | White | 30 | 30 | Postgraduate qualification at a university (Masters in Intercultural Communication with a thesis in Interpreting) |

Figure 3: Demographics and information of the SASL interpreter participants

The sign language interpreters, two white and one African, were all female. They all had postgraduate qualifications from an accredited and recognised university in South Africa. They also had more than five years of general interpreting experience and over three years of interpreting in the medical and healthcare setting and were accredited with SATI.

### 4.3. Questionnaire

4.3.1. Use of SASL interpreters in healthcare settings

Figure 4 below shows where the three sign language interpreter participants, rendered the majority of their services during the Covid-19 pandemic. Participant 1 rendered approximately 80% of her services in hospitals and only 20% was rendered for doctors' visits with Deaf patients. Participant 2 rendered approximately 25% of her services in hospitals, 45% at clinics and 30% at visits to doctors with Deaf patients. Participant 1's time was mainly spent in hospitals whereas Participant 2's time was almost equally divided between the different settings.

Figure 4: Settings where SASL interpreting services were rendered most during the Covid-19 pandemic.

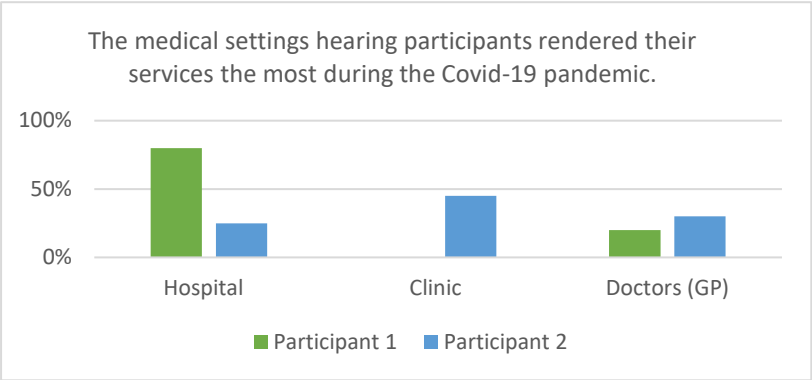
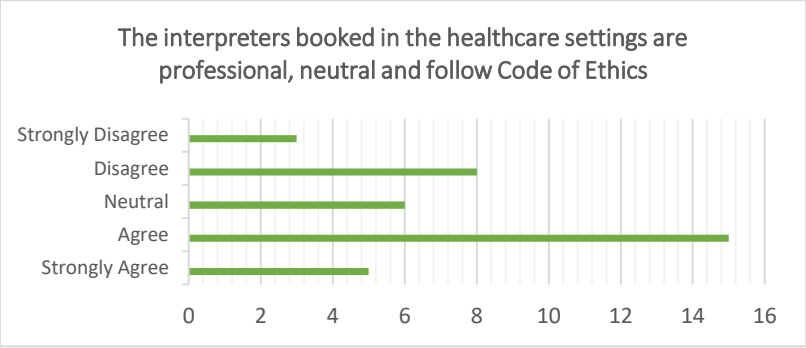



Figure 5 below shows the results of the online questionnaire to which 39 people responded. To the question asking respondents whether "there is a clear booking system for South African Sign Language interpreter in healthcare settings", three people responded they strongly agreed with this, five people said they agree, six people were neutral on the question, 13 people stated they disagreed and eleven stated that they strongly disagreed. More than half of the respondents in the questionnaire thus disagreed that there is an effective SASL interpreter booking system in the healthcare setting context.

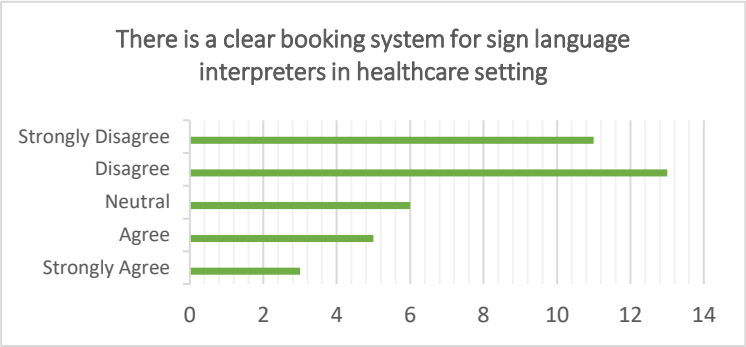
Figure 5: Sign Language interpreter booking system in healthcare settings.




Respondents to the online questionnaire mostly agreed that the interpreters booked in healthcare settings are professional and neutral and follow the code of ethics. Fifteen out of the 39 respondents agreed and five more strongly agreed, while six were neutral. By contrast, of

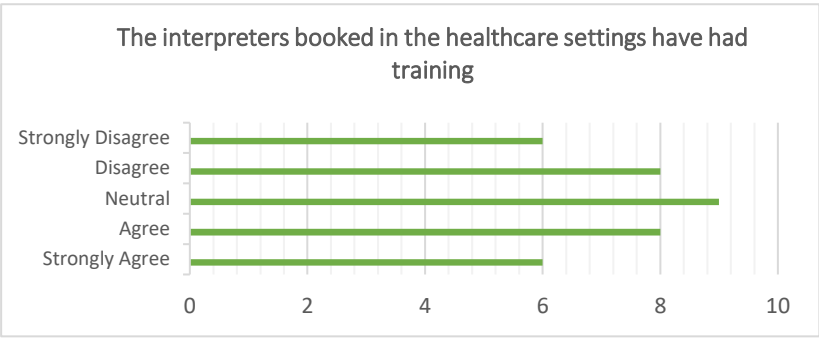
the 39 respondents, eight disagreed with the statement and three strongly disagreed. This shows that just over half of the respondents believe that the interpreters are professional.

Figure 6: Sign Language interpreters booked and Code of Ethics




As Figure 7 below shows, when respondents were asked in the online questionnaire what they thought about SASL interpreters being trained for healthcare settings, 14 respondents agreed that interpreters have had training, with six strongly agreeing. Nine people were neutral while 14 others disagreed with the statement of whom six people strongly disagreed. Accordingly, there is an equal number of people who agreed and disagreed.

Figure 7: Sign Language interpreters booked and training.

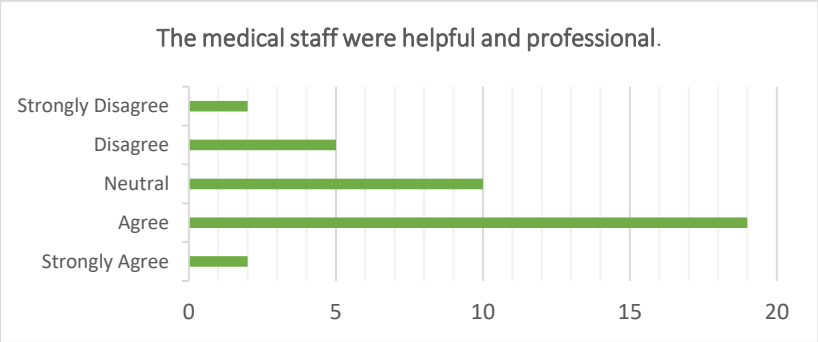



4.3.2. Attitudes in healthcare settings and awareness

As indicated in Figure 8, the Deaf respondents were asked how they felt about the professionalism and helpfulness of medical staff. Only seven of the respondents strongly disagreed or disagreed that the medical staff were professional and helpful. On the other hand,

10 respondents were neutral; however, while 19 agreed and to strongly agreed that medical staff are helpful and professional. Overall, it would appear that more than half of the respondents believed that medical staff are professional and helpful in healthcare settings.

Figure 8: Medical staffs' professionalism and behaviour

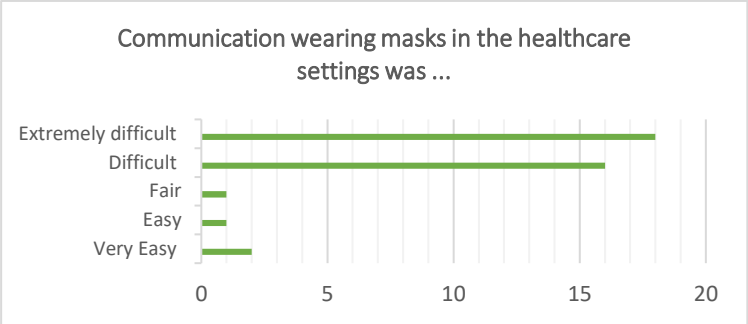



4.3.3. Communication in healthcare

As Figure 9 shows, the respondents were asked how they felt about the communication in the healthcare setting, especially with the use of masks. Only two respondents said communication was very easy, while one said communication was easy and one was neutral on the statement. In contrast, a total of 16 respondents said that communication was difficult, and another 18 said communication was extremely difficult. This meant that overall, 34 people thought communication in the healthcare setting during the Covid-19 pandemic when the wearing of masks was mandatory, was difficult.

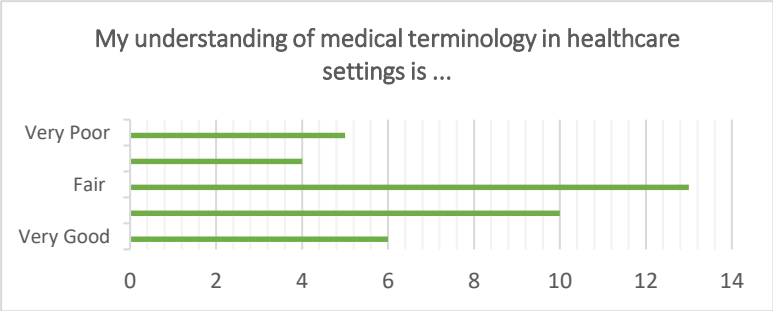
When asked about access for Deaf and hard-of-hearing people to healthcare settings, five people said they strongly agreed that there is accessibility, nine people agreed, six people were neutral on the statement and 10 people disagreed with eight of them strongly disagreed. Overall, 14 people agreed with the statement and 18 people did not agree.

Figure 9: Communication in healthcare settings




4.3.4. Understanding of medical terminology

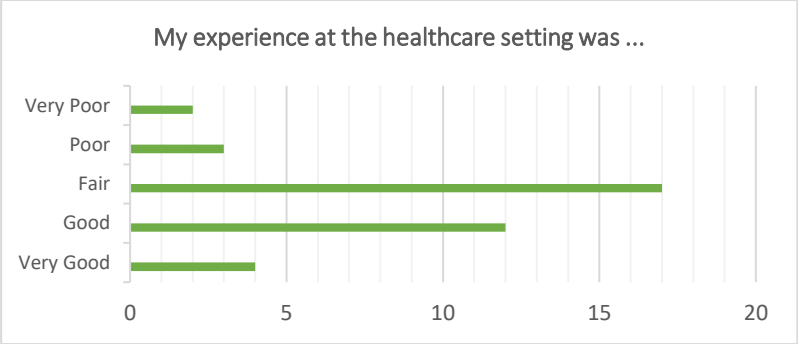
Figure 10: Participants understanding of medical terminology in healthcare settings




The 39 Deaf survey respondents were asked about their understanding of medical terminology when they visit various healthcare settings. As Figure 10 indicates 16 respondents stated that they had a good understanding of medical terminology. Among the 16, six stated that their understanding of medical terminology was very good. Meanwhile, a total of 13 people said that their understanding was fair which means not good or bad - while nine people stated that their understanding was poor and of that nine, five stated that their understanding was very poor. Overall, it would appear that most of the respondents had a good understanding of the medical terminology used in healthcare settings.

4.3.5. Deaf respondents experience in healthcare settings

Figure 11: Experience in healthcare settings




The respondents to the online questionnaire were further asked about their overall experience visiting various healthcare settings during the Covid-19 pandemic. As Figure 11 shows, in total, 16 people said their experience was good with four of the 16 saying their experience was very good. Only five people said that their experience in the healthcare setting was poor, two of whom stated that their experience was very poor. Of the 39 respondents, 17 said that their experience was fair, which meant their experience was neither good nor bad.

## 4.4. Interview responses

### 4.4.1. Use of SASL interpreters in healthcare settings

During the interviews, the participants were asked how they felt about using an SASL interpreter in healthcare settings as well as about the logistics of using an interpreter in these settings. The researcher wanted to know whether it was easy gaining access to an interpreter when making appointments and entering a healthcare setting. In addition, participants were asked whether when emergencies occurred, SASL interpreters were available. Other related questions sort to find out whether the Deaf participant had ever used an SASL interpreter in a healthcare setting, how they booked such an interpreter if they did use one, and whether they felt the booking process was easy. During the interviews the participants gave insights into how they felt and elaborated on why they felt this way.

### 4.4.2. Access to and the provision of SASL Interpreters in healthcare settings

Table 12: Participants responses when asked about access and the provision of SASL interpreters in healthcare settings.

| **Deaf and hard-of-hearing responses** | |
|---|---|
| Participant A | I do not like working with interpreters because of my previous experience…the interpreter did not sign properly… …the information was not accurate … |
| Participant B | If an appointment is short notice, it is extremely difficult to book a sign language interpreter |
| Participant C | I normally go alone; I do not use an interpreter… …because it is difficult to book an interpreter. |
| Participant D | Access to interpreters in medical settings is a big challenge in South Africa. Unfortunately, interpreters are scarce. We have few trained interpreters available to assist the deaf community |
| Participant E | I know how hard it is to book an interpreter… …I am privileged as I have interpreters who I can easily contact for their services |
| Participant F | I have not used an interpreter for many years. My parents, especially my father, has also not used an interpreter in many years as he relies heavily on me |
| **Hearing SASL interpreter responses** | |
| Participant 1 | Deaf people have just approached me directly and asked me for my availability… …for some Deaf people who don't know interpreters on a personal level, it is very difficult for them. |
| Participant 2 | They sent an informal message asking if I was available and asked me if I could go with them to the clinic |
| Participant 3 | The Deaf person will have the contact details of the company. The company has a dedicated WhatsApp line that Deaf people can use to submit their request |

Most of the participants interviewed did not have access to an interpreter at the time they visited a healthcare setting. Participant A did not have an interpreter because she did not like working with them because of her previous experience. The participant stated that "as a Deaf person

getting access… …" is difficult in healthcare setting, especially when consulting a doctor. The participant further explained that because of her previous bad experience with a sign language interpreter, she would rather use pen and paper when communicating in a healthcare setting.

In contrast, participants B, C and D would have preferred to have an interpreter on-site during their visit to a healthcare facility as they are all Deaf not hard-of-hearing. However, this did not happen because as they mentioned, the interpreter was difficult to book. The three participants all had emergency situations where they needed to enter a healthcare setting. Participant B had a last-minute wisdom tooth extraction during the Covid-19 pandemic. She was unable to book an interpreter prior to the extraction because she didn't know it would need to happen so soon. Participant C was involved in a vehicle accident and had to be rushed to hospital where there was no interpreter. Participant D was also rushed to hospital after he had over consumed too much alcohol and eventually found out that his stomach had been burnt from the extensive alcohol consumption. On arrival and during their stay at hospital, none of the three participants, B, C and D, had access to a sign language interpreter even though there were forms and medical information they needed to complete. Participant D mentioned in this regards that in South Africa, there is a shortage of sign language interpreters and that access to communication in healthcare and medical settings is a challenge.

Participant E stated that she was "privileged" to have access to interpreter services whenever they needed to go into a healthcare setting. She shared her story of how in her early twenties she became seriously ill and had to undergo an operation which would have an impact on the rest of her life. At the time, communication was a challenge in the healthcare setting. The participant had problems with her menstrual cycle as she always had a "very heavy flow" and never understood why this happened because she never went to see the doctors with an interpreter. Consequently, she was never fully informed about her illness and diagnosis even though family members or a teacher would at times accompany her to the hospital to try and relay the information to them, but "the information was not fully understood". Subsequently, the participant had the opportunity to use a sign language interpreter in her mid-twenties and has used the same interpreter ever since thus considering herself "privileged" to have access to an interpreter for her doctors' appointments and for any emergency situations that may occur.

Participant 1 is hard-of-hearing and can lipread well. His parents are Deaf and cannot hear at all and cannot lipread. The participants experience in healthcare settings was a little different and he stated that he preferred not to use an interpreter for himself in healthcare settings, preferring to use pen and paper to avoid miscommunication. However, he has taken on the

responsibility to interpret for his parents when they need to consult with medical staff. He generally interprets for his father who is used to him relaying messages. His Deaf father has also rarely used an interpreter when visiting a healthcare setting.

Participant 1 mentioned that it is difficult for Deaf people to book or have access to a sign language interpreter in healthcare settings unless they know one personally. She also mentioned that she did not know of any organisations that offered interpreting services for Deaf people in these settings, but that there are organisations that offer interpreting services in various settings and, if asked, they could perhaps assist in offering interpreting services in healthcare settings.

Participant 2, who is also an interpreter, further explained that the Deaf people who requested her services use WhatsApp as a method of communication as it is "more accessible" than calling or sending an SMS. The Deaf people who requested her services knew her on a personal level. She further explained that she knew of only one organisation that offers SASL interpreting services in healthcare settings. This organisation is based in Braamfontein and assists people who are transgender and want to transition from one sex to another. Participant 2 stated that she was aware of Deaf people who are transgender and had requested the services an interpreter when approaching and get assistance from this organisation.

Participant 3 explained that Deaf people normally contacted a company located in the Western Cape area however, this company does not offer services elsewhere in South Africa. Consequently, Deaf people living in the Gauteng area do not have access to such a company to assist in helping to book an SASL interpreter in various healthcare settings. The Deaf person would need to send through their identity (ID) number including the details of the appointment for the company to organise an interpreter for them. The participant also mentioned in the interview that the Deaf patients never contacted them directly, rather making contact with the service provider which is a private organisation funded by the Department of Health.

### 4.4.3. Interpreter Costs

Table 13: Participants responses when asked about interpreter costs.

| **Deaf and hard-of-hearing responses** |
|---|

| | |
|---|---|
| Participant A | I don't think Deaf people should be paying for interpreting services in healthcare settings… …government should be willing to pay for the interpreting services. |
| Participant B | Deaf people don't understand the process of booking an interpreter… …interpreters should be free to use in medical settings. |
| Participant C | The interpreter was demanding a high fee, we tried to negotiate the price, but they refused. |
| Participant D | I need access to information, but interpreters are not freely available. |
| Participant E | I wish we could have more than a thousand professional sign language interpreters to service the Deaf community. |
| Participant F | I've heard that interpreters are expensive because there is no regulation on the interpreting costs." |
| **Hearing SASL interpreter responses** | |
| Participant 1 | It is not the Deaf persons fault that they cannot hear… …in an ideal world the interpreters' salary would be paid by the government |
| Participant 2 | In an ideal world, interpreting services should be free… …The highest cost should go towards the institutions and the lowest cost should go towards the Deaf person. |
| Participant 3 | It is the government's responsibility as there is a reasonable accommodation act out there. The act stipulates that as a disabled person – this is in the South African Law or British Law, but I read this somewhere – should be given everything you need to match the functioning of peers who are not disabled. |

The interview participants mentioned that interpreters are "expensive". Participant As, B and F mentioned in their interviews that most Deaf people say and believe that interpreting services are expensive. Participant F mentioned that he had heard that SASL interpreters charge high fees which Deaf people cannot afford. He also mentioned that there is no regulation of how much interpreters may charge. Participant 1, an interpreter, supported this, stating that there is "no body to govern the interpreters and the actions of the interpreters". Participant A and B mentioned that Deaf people should not be liable to pay for SASL interpreting services as it is not their fault that they are Deaf and need interpreters for access. Participants A, B and E

believe it is the responsibility of the government to assist with funding for South African Sign Language interpreting services in South Africa. Participant D mentioned that he would like to use an interpreter in the various healthcare settings, but that they were not freely available to him.

Participant 1 (interpreter) agreed that the Deaf community should not pay for SASL interpreting services in the healthcare setting and that government should be responsible for the costs. The participant mentioned that in an "ideal world" this should happen but unfortunately, this is not happening currently. This participant suggested that SASL interpreters should be funded by government to create access; however, if a Deaf person requires a specific interpreter who isn't funded by government, then the Deaf person can then pay the SASL interpreter out of their own pocket. The participant ultimately believed that the "Deaf person should have access to communication without the burden of the costs" in healthcare settings.

Participant 2 also agreed that interpreting services should be provided to Deaf persons at no charge. She did mention that in the world and the country we live in currently, this is not a reality because of the lack of proper systems in place to pay for interpreting services.

Participant 3 felt strongly that it is the government's responsibility to pay for the SASL interpreting costs because of the laws which have been passed that ensure Deaf people have access to healthcare and communication in healthcare. The participant 3 stated that because Deaf people are tax paying citizens in South Africa, they should be accommodated. Participant I also mentioned that a national health programme would not work well in South Africa as there is a "very big divide between private medical aid and public health". She did mention; however, that there is a private organisation currently in the Western Cape that provides interpreter services for Deaf people in the province should they need to go to a medical setting. Deaf individuals send a message on a WhatsApp line requesting the services, giving their ID number as well as the date and time of the appointment together with any requirements; for instance a Deaf person requests an SASL interpreter who uses an Afrikaans dialect.

4.4.4. The role of SASL interpreters in healthcare settings.

Table 14: Participant responses about the role of the SASL interpreters in healthcare settings

| Hearing SASL interpreter responses | |
|---|---|
| Participant 1 | A lot of doctors do not understand why you need to be there as an interpreter and how far you need to go… …if doctors and nurses are aware of what we are there for and know our role, it would make things easier |
| Participant 2 | I have seen Deaf people lose patience as they didn't understand why the doctor didn't understand the role of the interpreter |
| Participant 3 | There is misconception as to what we do as sign language interpreters… …I often find that the medical practitioners do not have respect for what it is that we do. They do not see it as important. Most of them see it as we are threatening their positions. It becomes difficult to manage the flow of information when that medical professional doesn't trust you even though the Deaf person does |

Participants B, D, E and F also mentioned that at times medical staff do not know what the role of the interpreter is. Participant D mentioned in the interview that from his experience, when the interpreter is in the room with the doctor and the Deaf client, the doctors themselves at times gets uncomfortable. He stated that when an interpreter is in the consulting room, they will need to sit or stand near the doctor so that the Deaf patient is able to see the interpreter and still glance at the medical professional when needed. The participant mentioned that if the interpreter is sitting near the Deaf person, the eyes and body language are not visible, and the doctor would not feel as if they were fully engaging with the Deaf patient and vice versa.

Participant 1 further supported this by stating that during the Covid-19 pandemic, many medical staff were "more sceptical of interpreters being around". With experience though, Participant F had realided that "once they know why you are there, they are more okay with it" and become more accommodating.

Participant 2 explained in the interview that there is a lack of awareness on the role of the interpreter in the medical setting. This is not only frustrating for the interpreter, but also for the Deaf client. The participant had witnessed Deaf patients getting frustrated before. She also mentioned that when they voice for the Deaf person who is signing and explaining why they have come for the appointment, the medical staff at times become confused and are not sure who exactly the appointment is for and assume it is the interpreter speaking for themselves.

Participant 3 explained that from her perspective, the medical staff are not fully aware of the role of the interpreter as they at times feel "threatened" by the interpreter. Medical staff often

do not trust the SASL interpreter because they are not familiar with their role. According to this participant, a lack of trust can hinder and affect the flow of information.

4.4.5. Trusting the SASL interpreter

Table 15: Participants responses about trusting the SASL interpreter.

| **Deaf and hard-of-hearing responses** | |
|---|---|
| Participant A | …there was no trust between the interpreter and I… …I don't know if it was actually valuable to have an interpreter who was dropping a lot of information. |
| Participant B | Trusting an interpreter is very important… …there are a few interpreters in South Africa who abide by the Code of Ethics and whom I can trust. |
| Participant C: | I need an interpreter I can trust. I need an interpreter that can abide by strict Code of Ethics. |
| Participant D | Trust is important. You need to have an interpreter whom you can trust. |
| Participant E | I have been using the same interpreter since the age of 24… …I want an interpreter who is professional, and I can trust. |
| **Hearing SASL interpreter responses** | |
| Participant 3 | It comes down to trust and knowing what it is that we do and knowing that we are not there to take away any body's job. We are not doctors after all. They need to trust that we know what we are doing. |

Trust was another theme identified in the interviews. Most participants felt it is difficult to work with an interpreter one cannot trust. Participant A stopped using an interpreter because of her bad experience and now it is difficult for her to trust interpreters again. The common thread among all the participants was that they all wanted to use sign language interpreters they could trust. Participant 1 mentioned that in her view, Deaf people are already "overwhelmed, scared and (their) health is on the line" and to add to all of this the Deaf person feels "vulnerable". Participant 2 agreed that interpreters should always be trusted because "the interpreter should know that they are dealing with people's lives, a community that is already in a minority and vulnerable". Participant 3, on the other hand, spoke of a lack of trust on the

part of from the medical staff. While the Deaf patient may trust the sign language interpreter, the medical staff may not because they might feel "threatened" as Participant 3 mentioned before. Many medical staff are unfortunately, are not aware of the role of the interpreter and what the interpreters' duties are during the visit to the healthcare setting and this creates a lot of uncertainty and mistrust.

4.4.6. Awareness and attitudes in healthcare settings

Table 16: Participants responses when asked about awareness and attitudes in healthcare settings.

| **Deaf and hard-of-hearing responses** | |
|---|---|
| Participant A | Medical staff do not know how to approach Deaf people… …I feel like a burden or that I overwhelm them when the only thing I need is communication. |
| Participant B | Most medical professionals want to fix Deaf people… …it is important that we create awareness. |
| Participant C | They [medical staff] saw that I was Deaf and did not want to attend to me. |
| Participant D | Medical staff are not patient. |
| Participant E | The attitude is horrible. Most medical staff do not care about Deaf staff… …they do not understand what it means when a person is deaf. |
| **Hearing SASL interpreter responses** | |
| Participant 1 | I honestly do not think one can say all medical staff have a good or bad attitude… …some doctors have an amazing bedside manner, and some don't |
| Participant 2 | There are layers upon layers which can only be overcome by creating knowledge, awareness and patience. |
| Participant 3 | If you are going into a private sector like a Mediclinic for example, you are a paying client or paying patient. If you complain about their service, something will actually happen… They are aware of service delivery and having a happy patient whereas in the public sector, they do not really care. |

The response from the interviewed Deaf participants was that many medical staff are not patient or understanding. While some participants, like Participants B, C and D had at least one positive encounter with medical staff, most of the time they felt the majority of the attitudes were negative. Participant B explained that she had come across a doctor and a psychologist who she felt were patient with and understanding of her being Deaf. Both the doctor and the psychologist took time to explain and communicate via text or pen and paper. Participant C had met a gentleman in the hospital she had been rushed there after the vehicle accident. The man who was a medical professional too, was patient and took the time to contact her parents to update them on her progress.

Participant C stated that it was this one man out of all the medical staff who was patient and willing to assist and understand what she was saying by using pen and paper to communicate. Participant D also came across a helpful male medical staff member in the hospital when he was admitted. The person took it upon himself to gesture and explain what was going on and keep the Deaf patient informed.

Participant E mentioned that attitudes in private and public healthcare settings differ. In private healthcare settings like hospitals, the staff are more patient and helpful, whereas, in public hospitals, the staff are not so patient and have a "horrible" attitude. Participant I also mentioned that the attitudes of medical staff in public and private settings are very different. Those in private medical settings are more focused on the patient and "feedback" at the end of the day, and therefore, if there is a complaint, something is done about it. In the public medical settings - this is not the case as the staff in these settings view patients (both Deaf and hearing) as a burden and, therefore, the staff are not as caring.

From an interpreter's perspective, Participant 1 mentioned that one cannot say there is a general attitude among the medical staff. At times she had witnessed "kind, caring and considerate" medical staff and other times they have seen medical staff, while other times she had seen medical staff "forcefully turn the Deaf person's face" so that that the Deaf person would look at them and not the interpreter.

Participant 2 stated that existing attitudes of "embedded fear and stereotypes" can be changed by sharing knowledge, creating awareness and being patient with the medical staff. She mentioned that even if knowledge, awareness and patience are displayed, the Deaf community and interpreters cannot expect an instant change. Participant 2 said that "attitudes take time to change".

4.4.7. Challenges and access issues in healthcare settings during the Covid-19 pandemic

Table 17: Participants responses when asked about challenges and access issues in healthcare settings during the Covid-19 pandemic.

| **Deaf and hard-of-hearing responses** | |
|---|---|
| Participant A | they refuse to lower their mask when communicating with me… …there are a lot of miscommunications. |
| Participant B | I asked if they could lower their mask so that I could try lipread what they were saying as there was no interpreter. |
| Participant C | I struggled to communicate with the nurses and other medical staff. |
| Participant D | Communication was extremely difficult… …they couldn't communicate with me because they didn't know sign language |
| Participant E | people might not want to take off their masks for me to lipread…I get anxious when communicating… …with the masks I cannot see if the person is smiling, angry or facial expressions altogether |
| Participant F | both my parents are Deaf, they cannot lipread properly… …the masks have created a further barrier in the medical setting for us all as we are not sure what people are saying. |
| **Hearing SASL interpreter responses** | |
| Participant 1 | …having to get so much more permission… …being with a Deaf person in the hospital meant I needed to get a Covid test as well…interpreter is not only interpreting but also communicating with the Deaf persons family outside of the hospital. |
| Participant 2 | …struggled to find the place and then the client gave very little detail on the session… …It was very technical |
| Participant 3 | they do not allow the interpreter into operating rooms of any kind. I have had some who refuse and then I sit down and then they come fetch me 5 minutes later because they realize how cut off from the patient they really are. I have also had to go for covid tests myself during covid when I have to interpret, and I have to pay for that because they demand that you have a test done before coming to interpret in an operating room. |

All the participants interviewed mentioned communication as one of the biggest challenges they faced when visiting the healthcare setting. Participants A, B, E and F spoke of the challenges they faced with the masks and how medical staff did not want to lower their masks so that the Deaf patient could lipread and understand what they were trying to say. Participants B, C and E further explained that the use of the masks increased their level of anxiety as they struggled to communicate in these settings. All participants spoke of how they were always unsure of what the medical staff were saying when they had their masks on.

Participant 1 mentioned that the challenges they faced as a SASL interpreters in healthcare settings during the Covid-19 pandemic firstly included the need to get "special permission to be in the wards etc". She also mentioned that whenever she went into a hospital, she had to get a Covid test done. The costs of the Covid test were paid by the SASL interpreter herself; however, because she had medical aid, she was able to claim for the tests done. Participant 1 also explained that because the hospital limited the number of people who were able to visit the setting, the Deaf person's family and partners were not able to be with them in the hospital for support. This meant that the SASL interpreter had an additional role at times because the Deaf person might ask the interpreter to update the family on their condition.

Participant 2 explained her challenges as an SASL interpreter in the various healthcare settings as firstly not being sure where the appointment was to take place and which room or ward, they needed to go to. She said she always needed to do research beforehand on where the session would be taking place. She also struggled to find the meeting areas where she was supposed to meet the Deaf person and the medical professionals. The second challenge encountered was the jargon and terminology which was difficult to understand and interpret. The participant said she struggled to interpret medical terminology and resorted to using shapes and colours to explain what was being said. Fortunately, doctors have posters and visual cues such as skeletons which make it easier to see what the doctor is referring to.

Participant 3 experienced similar challenges to those of Participant 1, as they were both requested to do Covid tests before going into operating theatres. They both had to pay for their own tests as the hospitals would not cover the cost. This was always a challenge for Participant 3 when having to render their services in the medical setting during the Covid-19 pandemic as some areas were stricter with entry requirements. The medical staff would also not let Participant 3 inside certain medical areas because they were unsure of her role as an interpreter. Only after a while, when they realised, they could not communicate with the Deaf individual, would they then allow the interpreter in.

4.4.8. Alternative methods of communication in healthcare settings

Table 18: Participants responses when asked about alternative methods of communication in healthcare settings.

| | |
|---|---|
| **Deaf and hard-of-hearing responses** | |
| Participant A | When I'm alone with the doctors, I use pen and paper… …the information is not enough as we write short sentences… …there is a delay when using pen and paper and the doctors are impatient… …the doctors handwriting is mostly very hard to read. |
| Participant B | Typed text conversation was used with the psychologist on the one day that the interpreter was not available. |
| Participant C | I used pen and paper to communicate with the medical staff… …I also used gestures to indicate to something. |
| Participant D | When using pen and paper, miscommunications can happen because of the lack of literacy skills. |
| Participant E | I at times gesture or use pen and paper to inform them that I am Deaf. |
| **Hearing SASL interpreter responses** | |
| Participant 1 | With written communication, doctors do not know to simplify their language and Deaf people do not have the same English level as their hearing counterparts."<br>Participant 2: "the Deaf client would then have to use gestures or pen and paper, which may leave to complications because what if they get the wrong medication or there is a misdiagnosis. |
| Participant 3 | The doctors will try to write back to the Deaf person but often the written language is also a barrier. Then the doctor just kind go with what they think it might be and send them off and hope another doctor will pick up what is wrong with the Deaf person in a months' time. |

The alternative methods of communication which were used in the various healthcare settings by the Deaf participants were writing and gestures. Pen and paper were used when there was no sign language interpreter present. Participant A mentioned that using pen and paper was a

challenge as there was a delay and the doctors would become impatient. The participant also further explained that reading the doctors handwriting was difficult. Participant C explained that going to see a doctor during the Covid-19 pandemic made her feel “even more nervous” and having to use pen and paper to communicate increased the level of anxiety. When Participant C was asked what was wrong in the doctor’s reception area, they were unable to explain that they needed to see the doctor, the anxiety was too overwhelming, they started writing down that they were “not feeling well” and that they were ill. Participant C also had an encounter at the clinic where they gestured to the security asking where they could take their Covid test.

For Participant D, the gestures were well understood at times as he gestured to the medical staff in the hospital when he was admitted for a burnt stomach after he had consumed too much alcohol. The doctor gestured to the Deaf participant about what he should and shouldn’t do after the operation. The participant said he understood most of what the medical staff were saying because the doctor and the Deaf person themselves used gestures well known in the community. However, Participant D still mentioned that the gestures were not sufficient to pass on full information as he did not understand the directions for taking his medication. He also mentioned that using pen and paper can help but can also cause miscommunication as there may be a lack of literacy skills.

Participant B mentioned that in her experience when going to meet her psychologist on the one day that an interpreter was unavailable, the conversation was done through phone text as the Deaf patient and the psychologist sat next to each other. The participant said that the psychologist was patient and asked many different questions to try and understand her. However, the process was “lengthy” and not as smooth as having an interpreter there. Participant B mentioned that even though she would have preferred to have an interpreter there on the day, by using text communication, she was able to refer back to the messages later when she was at home by herself to recap what had been discussed and what she would need to work on. The text conversation was a reminder of what was discussed in the session. She said normally when she used an interpreter in the session, she needed to focus on what the interpreter was signing, so she could not write down notes and watch the interpreter at the same time. She did suggest that, in therapy sessions, there should be an interpreter and a translation app on a device which would transcribe the speech from the conversation for the Deaf person in order to have something to refer back to later when at home trying to remember what happened in the sessions.

In the interview, Participant 1 explained that written communication is "not always ideal" because Deaf people might misunderstand what is being written down for them to read. She mentioned that doctors are at times unable to simplify their language to make patients understand what they are trying to say. Participant 2 explained that written communication and gestures could also be used in a setting where the interpreter is not present to facilitate the communication; however, there is a big risk of the wrong medication and a misdiagnosis being given. Participant 2 further explained that a sign language interpreter should rather be used in medical settings and should maintain confidentiality and professionalism so that they can be trusted. All the interpreter respondents agreed that using pen and paper, is a challenge in itself as it creates further language barriers.

Table 19: Participants responses when asked about whether medical professionals know how to communicate in SASL.

| **Deaf and hard-of-hearing responses** | |
|---|---|
| Participant A | Medical staff should know basic sign language. |
| Participant B | It would be nice if medical staff learnt basic sign language. |
| Participant D | It depends, in areas where there are a lot of Deaf people living there, the medical staff should learn sign language. |
| Participant E | I wish that medical staff could learn basic sign language… …this would make it easier for them to understand what a Deaf person is trying to communicate… …we need the medical staff to learn sign language for them to better communicate with Deaf people. |
| **Hearing SASL interpreter responses** | |
| Participant 1 | They need to know more than basic sign language to communicate properly with Deaf people. |
| Participant 2 | If you are a front-line worker, you do not know who is going to arrive at your settings asking for help… …We are not expecting them to be fluent in the language, but they should know the basics. |
| Participant 3 | I think when you teach basic sign language to staff at a hospital, they think they can now communicate without an interpreter. They literally chase you out when in fact they only know the basics……They need to know most importantly how to use a sign language interpreter and the role of an |

| | |
|---|---|
| | interpreter. Learning basic sign language is on the side, it is not as important as knowing the importance of an interpreter. |

When asked whether medical staff should learn basic SASL, all the interviewed Deaf participants agreed that it was important in order for them to understand and communicate with Deaf people. Participant E explained that in her view, an increasing number of people were starting to take an interest in learning SASL because many people had seen sign language interpreters on television during media broadcasts when the country was in lockdown. Participant E had realised that more people wanted to learn sign language because more clients were contacting their business to request sign language training. Participant D explained that in his view, not all medical staff should learn basic sign language because in some areas, there are no Deaf people who visit healthcare settings. He did mention, that in areas where many Deaf people reside, staff in various settings should learn basic sign language so that they are able to communicate with the Deaf community.

Participant 1 agreed that medical staff should learn basic SASL and that the training should allow medical staff to communicate more effectively with Deaf people. This participant also mentioned that she was aware that some degrees like audiology and speech therapy studies, include a one-year compulsory SASL course. She said the course is taken in the first year of studies only, but the concern is that at the end of their studies and once they start practicing, the audiologists and speech therapists have already forgotten some of the signs. Participant F's suggestion was that all medical degrees should have one year of SASL. The course should not be taught in the students first year, but rather in their last year of studies just before they finish their degrees.

The participant further explained that the course should only focus on teaching students the practical skill of sign language and not the theoretical aspect which focuses on the study of Deaf culture and history. Participant 2 also agreed and stated that front-line workers should learn basic SASL. She maintained that one cannot force medical staff to learn SASL even though learning sign language would be of great benefit to them. Participant 3 raised the concern, that if medical staff knew basic SASL, they might chase the interpreter out of the room, thinking they could communicate effectively without an interpreter, even though they had only learnt basic communication skills. Participant 3 felt that it would be preferable to rather teach the role and the importance of using an SASL interpreter.

4.4.9. Medical terminology and the development of signs for healthcare settings

Table 20: Participants responses when asked about medical terminology and the development of signs for healthcare settings.

| **Deaf and hard-of-hearing responses** | |
|---|---|
| Participant A | The Deaf community or those Deaf people who often go to medical settings, would need to work with sign language interpreters to help develop signs |
| Participant B | Signs for medical terminology have not been developed yet… …I think in South Africa, we need to establish specialised training for sign language interpreters who work in the medical setting to learn the terminology there. |
| Participant D | Deaf people who know a lot about the medical setting would need to work alongside sign language interpreters. |
| Participant E | Deaf people need to come up with the signs or we can borrow signs from other countries… …interpreters would need to add a little bit of information so that the Deaf patient understands. |
| **Hearing SASL interpreter responses** | |
| Participant 1 | It is a collaboration… …interpreters do not have the power or authority to make up their own signs. It is important that the interpreter agrees with the Deaf person on the signs. |
| Participant 3 | The Deaf linguists need to be involved as well as the hearing sign language linguists. If we can bring these two parties together, we can have an amazing bank of terminology. There can be an equal discussion amongst the table for that because there is a lot of people in the Deaf community who feel a resistance towards hearing people who have knowledge. This is because the Deaf community has been oppressed so much. The knowledge is lost because of the feelings of oppression and the way that other people used to treat them. That kind of collaboration is not there yet because we do not have enough Deaf people who are sign language linguists. |

The Deaf interview participants were asked who should be responsible for establishing and developing signs for medical terminology in South Africa for the Deaf community. Participants A, D and E all said that Deaf people should be the ones to develop and come up with such signs

with the assistance and support of the SASL interpreter community. Most of these participants further explained that the Deaf people who go into medical and healthcare settings regularly and are knowledgeable about these settings should be the ones to assist most with the sign development. They mentioned that a collaborate effort should be made to develop medical specific signs between Deaf people and the interpreters. Participant E also mentioned that if the South African community struggled to find suitable signs, they could borrow medical signs from other countries.

Participants 1 and 3, maintained that the creation of medical signs should be a joint effort of both the Deaf and hearing parties. Participant 3 continued saying that there should be discussions between the two parties on equal footing; however, discussions and collaborations are not taking place currently as South Africa does not have "enough Deaf people who are sign language linguists". All interpreter respondents agreed that the Deaf community needs to lead and be at the forefront of research with the support and advice from the SASL interpreter linguists. The interpreters wanted to have a wide sign-bank of terminology however, but currently there is no sign-bank.

Simply knowing sign language and a spoken language does not qualify someone to be a sign language interpreter (Access Services Northwest, 2023). It is therefore, important that one receives training and continues to hone their skill. This would mean that sign language interpreters who work in specialized areas like healthcare settings, should constantly be learning how to develop signs and collaborating to assist sign language terminology development in the medical and healthcare setting.

Table 21: Participants responses when asked about SASL interpreters understanding of medical terminology.

| **Deaf and hard-of-hearing responses** | |
|---|---|
| Participant A | The interpreters do not understand medical terminology… …sign language interpreters should get trained to learn more medical terminology |
| Participant B | We need to establish a training programme for sign language interpreters for healthcare settings |
| Participant E | There is no interpreter who has training specifically for the medical setting |
| **Hearing SASL interpreter responses** | |

| | |
|---|---|
| Participant 1 | I am not trained specifically for medical settings. I am trained as a general sign language interpreter… …there should be a course dedicated to medical interpreting… …understanding basic medical terminology so that one can interpret for Deaf clients. |
| Participant 2 | We are dealing with real people who want to get back home safely to their families… …Is important to get training. It is beyond the money. It is more about ethics because if you are getting paid, but you feel you are not doing the right job, are not qualified or ready, then do not agree to do the job. |

From the interviews with the Deaf participants, it would seem that they all believe that SASL interpreters should receive training specific to the medical setting so that they are able to understand medical terminology. When the participants were asked if they were aware of a current programme that offered this specialised training, they all stated that they were not aware of such a programme.

The SASL interpreters who were interviewed were also asked if they felt specialised training was needed and whether or not there are interpreters in the field who have had training of this kind for healthcare and medical settings. The participants said they themselves have not had any training specific to the medical setting and were not aware of any other interpreter in South Africa who had. Participant 1 stated that there should be a "course dedicated to medical interpreting" which would help interpreters to learn more terminology and render a satisfactory service in the healthcare setting. Participant 1 further suggested that interpreters should do a formal interpreting qualification in the beginning and then later add a year of specialised medical interpreter training. The participant said that if the interpreter "at least understands the word, then they can explain what it means". Participant 2 also agreed that there should be specialised training; however, interpreters should not just specialise in one category or field. Participant 2 stated that with the way the world is constantly changing, interpreters should specialise in three categories so that they do not become stagnant. Participants 1 and 2 stated that specialisation would help to polish one's skill and render a better service to the Deaf community.

## 4.5. Discussion of results

### 4.5.1. Availability of SASL interpreters in healthcare settings

In the current research, only one out of six Deaf respondents had an SASL interpreter constantly available when entering healthcare and medical settings between 2020 and 2022. The other five Deaf individuals had rarely or never used an interpreter in a medical setting for various reasons. These reasons will be discussed below.

In the research conducted, it was clear that interpreter access and provision were inadequate, as the Deaf participants generally struggled to gain access to an interpreter when entering a healthcare facility for an emergency medical issue or a scheduled check-up or appointment. For many years, Deaf people have had to go to hospital and medical appointments with their family members who would speak on their behalf and relay the information from the medical professional (Zulu, 2014). Deaf people visiting healthcare settings were not sufficiently autonomous and independent to handle appointments and consultations alone. A lack of confidentiality was also not noted, as family members would hear what medical staff were saying and thus be aware of the Deaf individual's medical status first. Over the years, there has been a rise in the number of SASL interpreters available for the Deaf community to use in various settings. However, the increase in numbers has not been sufficient, as there is still a shortage of SASL interpreters in the country to serve the Deaf community.

The Covid-19 pandemic has highlighted the increased need to have more SASL interpreters available to render services for Deaf and hard-of-hearing individuals in healthcare settings. The Deaf participants interviewed in the current research all agreed that there is a need to have access to SASL interpreters in medical settings. There is also no clear booking system to gain access to these few SASL interpreters who are able to render services to the Deaf community. The Deaf interviewee mentioned that most of them would contact an SASL interpreter who they knew personally directly to assist them when going into a healthcare setting. In the online survey, 13 out of the 39 respondents agreed that there is no clear booking system for SASL interpreters. Eleven out of 39 respondents felt strongly that there was no booking system whatsoever for them to use to book an interpreter. This means that over half the participants felt that there was no proper and clear system for booking an SASL interpreter. Eighteen out of the 39 respondents felt that medical and healthcare settings are not accessible, while eight people strongly felt that healthcare settings are extremely inaccessible.

### 4.5.2. Participants' views on the attitude of professionals

Unfortunately, across the world, Deaf communities face the challenge of lack of awareness and training for healthcare professionals on deafness (European Disability Forum, 2021). Most healthcare workers do not have adequate knowledge about the Deaf and hard-of-hearing communities around them and may not know how to ensure that they are better accommodated.

In a study conducted in 2016, was shown that Deaf care competency training for healthcare and medical staff helped to increase skills for caring for people who are Deaf and also helped to improve the attitudes of medical professionals towards Deaf people (Kuenburg, et al., 2016). The hearing interpreters and the Deaf respondents all had a similar view stating that they medical professionals at times delayed treating the Deaf patient, were not patient and did not care about the Deaf person. All the participants interviewed spoke of a negative attitude towards and a lack of awareness of Deaf people in medical settings. However, there were three participants who mentioned that some medical staff who had a more positive attitude towards their job and towards Deaf people. These were the staff that had a more positive "bedside manner". One participant elaborated on this stating that in public healthcare settings the attitude is more negative because nothing gets done when patients complain and bad service is reported. Participant 3 noted that the situation differs in private healthcare settings because the institution sees the patient as a paying client, and this means that if there is a complaint, something will be done about it. Contrary to this, the online questionnaire showed that 19 out of the 39 Deaf respondents felt that medical staff were helpful and professional. This is 49%, which is almost half of the respondents agreeing that the medical staff were helpful and professional.

Nurses who are aware of and emphasised the need to learn and gain more knowledge are the ones who are willing to learn sign language and go through a training course (Ljubičić, et al., 2017). Both the Deaf and the hearing interpreters' participants had a similar view that medical staff should learn basic sign language so that they are able to communicate with Deaf and hard-of-hearing people who use sign language. This would create more awareness and increase knowledge about the Deaf community and therefore potentially improve attitude towards serving Deaf people in healthcare settings. One interviewee mentioned how it is more important that medical and healthcare professionals are taught how to work with sign language interpreters. In response to the online survey, 11 out of the 39 respondents felt that medical staff are not aware of the role of the interpreter and, nine out of the 39 felt strongly that medical

staff have no knowledge at all on the role of the interpreter. Over half of all the survey respondents believed that there is no knowledge of the interpreter's role. Most medical and healthcare professionals are not clear about the role of the interpreter and therefore, explaining the role would improve awareness as well as the relationship between medical staff and sign language interpreters. This would ensure that the healthcare experience for Deaf individual is satisfactory and access to communication is allowed.

Gestures were used by the Deaf participants when visiting healthcare settings and they mentioned that at times such gestures worked well, for instance, if the Deaf person wanted to indicate that they are Deaf or if they needed directions to a specific room. However, gestures also presented a challenge when, for example, the doctor tried to explain how medication should be taken after the medication is prescribed. Some of the participants mentioned that gestures can be effective and useful in healthcare settings; however, they can also be confusing and may be misinterpreted. Most Deaf participants agreed that signage and visual aids are always helpful and effective in healthcare settings as Deaf and hard-of-hearing individuals are able to clearly see a visual representation of what the medical professional is referring to. Sixteen out of the 39 survey respondents stated that their experience in the medical setting was fair. Accordingly, communication experience was not bad but also not great, which means they feel more could be done to improve communication in healthcare settings. Interpreters should also be aware that in asymmetric settings where there are power imbalances like in healthcare, professional ethics need to be adhered to (Kalina, 2015). Asymmetric settings in healthcare, usually mean there is a medical expert and client being in the same environment, yet the one party has more power than the other. The medical professional who may be the doctor or nurse, would hold more power in such settings as they would typically have a higher level of education and know more about medical terminology than the Deaf person would. Kalina (2015) states that it is then important that the interpreter is conscious of the power dynamics. The interpreter needs to have a high degree of intercultural sensitivity and empathy to be able to look through different perspectives, take different interests into account and also to be conscious of the register they would need to use.

### 4.5.3. Costs and funding for SASL interpreting services provision in healthcare

Research in healthcare interpreting over the years have focused mainly on the benefits to the patient, ethical dilemmas, accuracy, impartiality, interpreter roles, advocacy, cultural

brokerage, and interpreter education (Nga Shan Ng & Crezee, 2020). Unfortunately, little research and data have been published on the cost of SASL interpreters in healthcare settings (Zulu, 2014).

The data collected indicated that the participants were of the belief that sign language interpreters are expensive. This was one of the reasons why most of the interviewed participants did not use an interpreter in healthcare settings, there was the stress of having to pay for their own medical bills and adding an interpreter make it even more expensive. Sign language interpreting services could have high hourly costs such services are scarce (Andriakopoulou, et al., 2007). In the current research, the observations made were regardless of whether the interpreter was qualified/ accredited or not; the perception is that interpreting services are expensive. This may be because the Deaf respondents had to pay for the interpreter out of their own pockets. The Deaf respondents explained that it was their responsibility to book directly with the interpreter and pay the interpreter themselves. This goes to show that in the Gauteng region, Deaf individuals were responsible for paying for the interpreter costs before and during the Covid-19 pandemic.

The South African Translators Institute (SATI) states on its website that rates for an accredited sign language interpreter are R550 per hour (South African Translators Institute (SATI), 2020). These rates are a guide for accredited interpreters when rendering services in the market; however, there is no price regulation in the sign language interpreting market, as there is no set standard for how much interpreters should be charging on different levels and in different sectors of the market. Perhaps this lack of standardisation and regulation is why the Deaf participants felt that SASL interpreters always charged high prices. Kalina (2015) emphasises the importance of ethical behaviour and interpreters having to ask themselves more ethical questions which in this instance, the questions would be around whether or not the interpreter should be accepting money from a Deaf or hard-of-hearing patient who really needs the services of an interpreter yet might struggle to afford one.

The participants were asked who they thought should be responsible for paying the interpreter costs and all of the respondents, both the Deaf and the hearing sign language interpreters, were adamant that the government should provide funding for sign language interpreting services in healthcare settings. There is a lack of research on the provision of sign language interpreters in healthcare settings; however, one study that was done in the Western Cape, found that the presence and usage of sign language interpreters in healthcare settings is important for Deaf individuals, allowing them to utilise healthcare in the same way as the hearing population

(Zulu, 2014). This research also explained that sign language interpreting services in healthcare settings are expensive; however, it is the responsibility of the government to invest capital so that Deaf people in society have access to healthcare. Some may argue that it is cheaper and easier to ask a family member or friend of the Deaf patient to interpret for them in a healthcare setting, however Kalina (2015) states it is important to focus on conflict of interest and grounds of disqualification when thinking about professional ethics. Unfortunately, even though some hearing people who know SASL and a spoken language may want to offer their services as interpreters, they may not be aware of codes of ethics which give detail on the importance of quality interpretations, ethical behaviours and boundaries.

### 4.5.4. Challenges with trusting the SASL interpreter

Trust was one of the issues the participants brought to light. Participants spoke of not trusting sign language interpreters. The Deaf participants who were interviewed spoke of the importance of trust and how this plays a role in their use of an interpreter in a sensitive environment such as a healthcare setting. A certified and qualified interpreter always maintains the client's confidentiality and maintains neutrality (acutrans19, 2020). Deaf and hard-of-hearing clients should be able to trust the interpreter they have asked to interpret for them, as information conveyed in a medical consulting is sensitive and private. The interviewed participants stated that they would generally ask an interpreter they trusted to interpret for them in such settings. Unfortunately, some participants also mentioned that there were only a few interpreters that they trusted, while others had lost all trust in interpreters in South Africa and had resorted to making do without an interpreter when visiting a healthcare setting. In contrast, 15 out of the 39 respondents to the online survey felt that sign language interpreters booked in healthcare settings were professional and neutral, and followed the code of ethics. Kalina (2015) states that professional ethics mean that the interpreter needs to uphold professional secrecy. The SASL interpreter will be privy to and receive information in the healthcare settings that is personal and not for them. The information will be about the Deaf or hard-of-hearing patients health and medical history. The information received will make the Deaf or hard-of-hearing patient feel vulnerable and therefore it is crucial that trust is built through secrecy. It is then the responsibility of the SASL interpreter to handle the information with high confidentiality so as to ensure professional ethics are adhered to.

Trusting the interpreter is not only about the interpreter keeping the information discussed with the healthcare provider, confidential. Trusting the interpreter extends further to the sign language interpreter arriving on time, and even arriving at all, for the interpreting appointment. British Deaf people have shared their frustrations with the healthcare system in the country as interpreters are not booked for when they need to consult and there are punctuality issues at times (Foltz, 2019). Trusting the sign language interpreter is of great importance. If the Deaf or hard-of-hearing patient does not trust the interpreter, they may withhold information or may not be fully open to asking relevant questions about their health. Deaf and hard-of-hearing communities may not only have trust issues with only the sign language interpreters, but also with healthcare workers. Deaf communities across the world are very small compared to the number of people who can hear in their countries (Meador & Zazove, 2005). A study done by Meador and Zazove (2005) in the USA, found that Deaf people are reluctant to visit healthcare providers like physicians because they feel inferior to people who can hear. The research has shown that physicians and other healthcare professionals, need to meet the communication needs of the Deaf community to ensure there is more trust. Globally, in Deaf and hard-of-hearing communities, trust is extremely important, and this can also be seen in the above responses gained within a South African context.

### 4.5.5. Tools to support communication in medical encounters

#### 4.5.5.1. Trained SASL interpreters

The research participants explained that in South Africa, the challenges that are present regarding technology and healthcare services, include a lack of resources such as tablets or even virtual remote interpreting systems which other countries like, the USA have. The participants explained that the challenges in South Africa include funding, the network, and the affordability of data. Funding is a challenge because there are not enough funded projects to provide access for Deaf people in healthcare settings. Except for the Western Cape, it is not known whether any money has been allocated to organisations or agencies to provide sign language interpreting services for the Deaf and the hard-of-hearing. Having online or virtual remote interpreting systems would be beneficial for South Africa, as Deaf and hard-of-hearing patients would be able to have immediate access to an interpreter even in emergency situations. Such patients would in turn feel less vulnerable and not have to feel like “burdens”, as was

explained in the interviews – this would be because communication tools would be provided. The interpreters would also not have to put their lives at risk by physically going into the various healthcare settings.

The hearing interpreters who were interviewed, all mentioned how difficult it was to understand and interpret medical terminology. Without understanding the terminology and jargon used in medical settings, the quality of the interpreted message is compromised. Quality is therefore an important aspect of professional ethics (Kalina, 2015). Quality of interpretation is also closely related to the accuracy of the interpretation because if the interpreter is able to effectively understand and convey the message into the target language, the more quality interpretations are rendered. Thirteen out of the 39 respondents to the online survey said their understanding of medical terminology was fair. This shows that there is work to be done on understanding medical terminology and developing a sign bank for healthcare jargon and industry specific terms. All the participants said that the development of signs would need to be a collaborative effort between Deaf linguists and sign language interpreters who render their services frequently in the medical space. One participant suggested holding workshops which would assist the sign development process. Kalina (2015) explains how important it is for interpreters do continuous professional development which has become one of the recent codes of expectancy norms. Professional development, as an interpreter working in various settings and most importantly, in healthcare, requires one to constantly be developing their skill to ensure constant quality services are rendered. Continuous professional development would provide further training as to how quality can be increased and how interpreters should conduct themselves in various settings to ensure professional standards are adhered to.

# Chapter 5

## Conclusion and Recommendations

### 5.1 Research Aim, Objectives and Questions

This research aim was to document the provision of SASL interpreters for Deaf and hard-of-hearing groups in healthcare settings in Gauteng. This aim was achieved as the participants assisted in ascertaining this information. Participants gave insight on how there was little to no provision of SASL interpreters in healthcare, unfortunately. The secondary aim of the research was to investigate the gaps in interpreting service provision in Gauteng and ultimately, document and discuss training and qualification levels of the SASL interpreters who rendered interpreting services during the Covid-19 pandemic. This aim was also achieved as the researcher was able to discuss the reasons why interpreter provision was not sufficient and how South Africa is in shortage not only for trained and qualified SASL interpreters, but the country is also in great need of specialized medical courses for interpreters who aspire to render services in healthcare.

This research objectives were to firstly document the provision of SASL interpreting in healthcare settings in Gauteng. The second objective was to discuss the patterns and themes identified between interlocutors in medical settings. The following objective was to identify the challenges experienced with the provision of SASL interpreting services during the Covid-19 pandemic. The last objective was to make recommendation regarding the provision of SASL interpreters when rendering services in healthcare settings. The objectives mentioned, were all achieved through the research.

The primary research question was what accessibility issues in healthcare settings, did the Covid-19 pandemic pose to the Deaf and hard-of-hearing communities. The paper answered this question by discussing some of the challenges experienced by the Deaf and hard-of-hearing participants. The accessibility issues were identified as costs of interpreting services, understanding of medical terminology, unavailability of booking systems and attitudes of professional medical staff amongst others. Besides the healthcare professionals not knowing SASL and costs being a hinderance to Deaf and hard-of-hearing patience, the challenge was getting access to a wider pool of trained and qualified interpreters who abide by professional ethics.

The secondary research questions was identifying the specific communication barriers experienced by Deaf and hard-of-hearing communities in Gauteng during the Covid-19

pandemic. These communication barriers such as the use of masks, alternative methods of communication not working effectively and no provision of SASL interpreters being the major communication barriers, were discussed in the paper. Participants who had interpreters available to them mentioned how the interpreters struggled with the high level terminology and how accuracy of interpretation would be a challenge at times. The second research question was whether the interpreters who provided SASL services in medical settings were trained and qualified. The question was answered as the research showed most of the interpreters who rendered services in healthcare settings had no specialised training. The third question was on accessibility in healthcare settings can be reality for Deaf and hard-of-hearing communities. This question was answered as the paper discussed legislation and practices which can aid in creating inclusion and equal access to information in the healthcare setting. From answering the research questions, this paper highlighted the importance of establishing different guidelines, procedures and codes of practice and conduct that not only shape the way in which healthcare interpreters work, but also ensure the medical professionals and Deaf and hard-of-hearing patients become aware of the professional standards when working with SASL interpreters.

### 5.2 Limitations of the study

A number of limitations to this research were identified; namely, the interviews were conducted only in the Gauteng region with fewer than ten Deaf people because of time constraints, bearing in mind that interviews are lengthy and time-consuming. In this region there are thousands of Deaf people, therefore, the six Deaf people who were interviewed are not fully representative of the Gauteng region. The six Deaf people interviewed are also insufficient to fully represent all Deaf people in South Africa. In addition, while three SATI accredited interpreters were interviewed, many sign language interpreters are not accredited and they also had experience of interpreting in healthcare settings during the Covid-19 pandemic. Thus, the fact

Language barriers not only affect treatment outcomes, but also have a great impact on the patients view of their care in the healthcare system. In the research, the Deaf and hard-of-hearing patients expressed how most healthcare providers were unable to communicate with them through SASL. Some healthcare providers were patient enough to use pen and paper however, the Deaf and hard-of-hearing patients struggled to read some of the high-level English that was written. The Deaf and hard-of-hearing patients who preferred to have a SASL interpreter facilitate the conversation, most times were unable to access an interpreter because

of the scarcity, no service provider to assist with booking interpreter and lack of full trust in the interpreters. The research shows that patients either want to be able to communicate with the healthcare professional in SASL or use an SASL interpreter who trained, qualified, trusted, and easy to access. Healthcare providers are also advised to have a warmer 'bedside' manner to put the Deaf and hard-of-hearing patient who is already anxious, at ease.

## 5.3 Recommendations

This study makes the following recommendations:

### 5.3.1 Recommendations for healthcare providers

From the findings discussed in Chapter 4, the first recommendation made would be to teach medical staff basic sign language, thus giving them the basics for communicating with patients from Deaf and hard-of-hearing communities. As explained previously in the thesis, if healthcare and medical staff know how to communicate using basic SASL, their attitudes and ways in which they work with Deaf people might change and become more positive. This would also help to decrease the levels of frustration for Deaf and hard-of-hearing patients when visiting healthcare settings because the staff would be able to use basic sign language to communicate when patients are filling out forms.

### 5.3.2. Recommendation for government and policy makers in South Africa

Another recommendation would be the establishment of a board which would regulate and hold sign language interpreters accountable. The board would help to ensure that professional services are rendered and that the cost of interpreting service is regulated, thus ensuring that Deaf and hard-of-hearing individuals who need the services of a sign language interpreter, are not exploited. The third recommendation is to have specialised training for SASL interpreters who render their services regularly in healthcare settings such as hospitals, clinics, Covid-19 testing stations and doctors' consulting rooms. Training should be a strict requirement, with, if possible, certification being awarded to show that an interpreter is qualified to render their services in setting such as healthcare.

Further recommendation would be to access government funds for the provision of accessible language and information for Deaf people across different sectors in South Africa especially healthcare. The funds should be disbursed to well-vetted interpreting agencies that understand the complexities of the Deaf communities around them. These agencies would then be responsible for assisting with booking interpreters and ensuring that Deaf people have an interpreter available to them for healthcare appointments – whether in person or online.

that such interpreters' views were not elicited presents a further limitation to the study.

Policy implementation is essential to ensuring that disparities are decreased in various settings specifically, healthcare. Linguistic minorities and most especially, the Deaf and hard-of-hearing communities will continue to be dissatisfied with healthcare if lack of implementation continues.

### 5.3.3. Recommendations for tertiary institutions in South Africa providing interpreting programmes.

Specialized programs for healthcare interpreting needs to be made available for aspiring SASL interpreters and for those interpreters who continue to render their services in healthcare. A program mapped at ensuring the interpreter is trained to meet expectations not only of the Deaf patients but also of this high-level setting where mistakes and miscommunications can result in misdiagnosis, the wrong treatment being administered and even death.

Further research needs to be done on specialized healthcare interpreting programs globally, to see what the standard is and what is covered. A new program needs to be developed with the needs of Deaf and hard-of-hearing patients, SASL interpreters and healthcare providers in a South African context.

### 5.3.4. Recommendations for service providers in South Africa

Companies or organisations that provide SASL interpreting services for Deaf and hard-of-hearing groups, need to be conscious of the sensitive nature of settings like healthcare. Careful consideration needs to be given when allocating a SASL interpreter to a Deaf person, not only in Gauteng, but in all provinces. Careful consideration needs to be firstly on what the Deaf or hard-of-hearing individual prefers - whether its preference in dialect, gender if the patient is

sensitive to this or even communication preferences of the patient. The second consideration should be about the SASL interpreter. Providers need to do thorough screening on their part to ensure SASL interpreters have some sort of training and have obtained a form of qualification before rendering services in healthcare.

### 5.3.5. Recommendations for the Deaf community in South Africa

It is upon Deaf organisations to create platforms to educate those in the Deaf community about their rights, laws and legislation around topics such as access to equal information and communication barriers in healthcare. Discussions should also be held about the role of the SASL interpreter, expectations and the code of ethics. These discussions will empower Deaf people to identify when they are exploited or treated unfairly by both the SASL interpreter or a medical professional.

### 5.3.6. Recommendations for accreditation bodies in South Africa

Language and interpreting accreditation bodies or third-party organisations in South Africa can develop effective ways in which accreditation and recognition can be done for specialized settings like healthcare. Programs specific to healthcare interpreting should be established in order to provide certification that aims to increase the standard of trained and qualified healthcare SASL interpreters.

### 5.3.6. Recommendation for future research in South Africa

Future research should expand on the study geographically as this research only focused on the Gauteng region. There needs to be further research done in the other eight provinces or a national study which will give a better understanding of this topic across South Africa. By increasing coverage, statistical representation will also increase, and future research will give a better and more accurate understanding of the provision of SASL in healthcare settings across the country. In this research, medical practitioners were not included as participants to give an opinion on the challenges faced and their thoughts on the issue of SASL interpreter provision. Future research should include perspectives of the medical practitioners.

## Conclusion

There is not adequate attention on policy and practice given to eliminate the language barriers experienced by Deaf and hard-of-hearing patients in South African healthcare. The researcher found that the challenges to the provision of SASL interpreters, included barriers to booking interpreters - if the Deaf participant knew a professional SASL interpreter they could contact the interpreter directly, no formal system was available for booking interpreting services in medical settings in the Gauteng province. Another challenge was the costs as Deaf participants generally cannot afford to pay for professional interpreting services when consulting medical professionals about their health and wellbeing. Participants felt there should be subsidisation or funds available for interpreting services for the Deaf and hard-of-hearing from government as healthcare should be available to all regardless of disability.

Overall, the collated data were documented in the form of graphs and statements quoted verbatim from the interview transcripts. The participants shared their thoughts on how the provision of SASL interpreters was lacking during the Covid 19 pandemic in medical settings. The themes identified in relation to the attitudes of medical professionals, trusting SASL interpreters, and the costs and adequate training of interpreters, were documented and discussed. Participants all agreed that it is imperative that medical staff become more aware of and receive information on the Deaf community and how to better attend to Deaf patients' needs in healthcare settings. When working with an SASL interpreter, Deaf participants stated how important it is that they trust the interpreter they use. Trust is built through punctuality, showing up at bookings and, most importantly, not compromising confidentiality in any way.

The researcher recorded some of the frustrations and concerns of the Deaf and hard-of-hearing who visited healthcare settings during the COVID-19 pandemic. If further steps are not taken to provide more sign language interpreters who are trained and qualified in healthcare, these frustrations will continue to increase and the inequality gap will become greater for those who are marginalised, including the Deaf and hard-of-hearing community. It is imperative that more agency and autonomy be given to those who are Deaf and hard-of-hearing by allowing them access to important information about their health and wellbeing.

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