3. COMMUNICATION CHALLENGES FACED BY DEAF PATIENTS IN ZIMBABWE'S HEALTH DOMAIN

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ABSTRACT

This article explores the politics of inclusion and exclusion of the Deaf community in Zimbabwe's health sector, focusing on the marginalisation of Sign Language. It examines the use of Sign Language in major referral hospitals such as Parirenyatwa and Sally Mugabe, and the attitudes of nurses and doctors towards its use. The research aims to understand the lack of resources and programmes for the deaf community, as medical practitioners primarily use spoken language for communication. Data for the study were collected through questionnaires directed to the administration, doctors, nurses and Deaf patients at Parirenyatwa and Sally Mugabe Hospitals, and from two bus termini where the deaf are concentrated. Supplementary data were collected through focus group discussions and interviews with the Deaf. Data were presented and analysed using a thematic approach. The findings of the study are that there is no defined use and awareness of Sign Language in hospitals, and where there is awareness; the interventions have been weak, thereby failing to ameliorate communication challenges in healthcare settings. The major recommendation of this study is that Sign Language must be prioritised in all public institutions and service centres, particularly hospitals and clinics because communication barriers curtail the Deaf to practise their sexual and reproductive health rights, among other deprivations.

KEYWORDS: *Sign Language, Deaf, impairment, linguistic rights, marginalisation, language policy*

INTRODUCTION

This research examines the politics of inclusion and exclusion of the Deaf community in the health domain. The study is motivated by the perceived marginalisation of SL in Zimbabwe. The focus of the study is to examine the extent, to which SL is used in health facilities with a specific focus on four departments which are, Opportunistic Infections, Family Planning, Out Patient and Casualty of the two major referral hospitals located in Harare namely Parirenyatwa and Sally Mugabe. The article evaluates the Zimbabwean language framework in a view to surmise the extent to which language provisions relating to the use of SL as an officially recognised language as couched in the Constitution of Zimbabwe Amendment (Number 20 Act of 2013 Chapter 1 Section 6) is being implemented in the health domain.

During the outbreak of the Covid-19 pandemic, public health authorities took action to contain the spread of Covid-19 worldwide. While the outbreak prompted clinical trials of antibodies, vaccines and treatments to fight the scourge, researchers from the social sciences note the paucity of research that adopts a community perspective about the virus (Matende & Svongoro, 2021). Regarding Covid-19, there are still significant gaps and obstacles. The challenges mostly affect disadvantaged groups in society, such as the Deaf and people with little English proficiency, and the gaps are particularly noticeable in settings with few resources. Research indicates that during the past century, there has been a rise in the probability of pandemics due to increasing international travel and integration, urbanisation, altered land use, and increased exploitation of the natural environment. This suggests that communication initiatives must be strengthened as well, particularly those targeted at underrepresented groups (Matende & Svongoro, 2021).

The nexus of this article is motivated by the idea that medical practitioners use spoken language to communicate with their clients in their day-to-day business, yet provisions or resources to cater for the Deaf[1] may be non-existent or limited. However, on the positive side, there is a *Zimbabwean Sexual and Reproductive Health SL Dictionary* which was compiled by the HIV/AIDs Management and Support Organisation in collaboration with the Disability and HIV/AIDs Trust after realising the existence of a knowledge gap on HIV/AIDs, sexual and reproduction health rights among the Deaf communities in Zimbabwe. The dictionary is suitable for use by nurses, doctors and society when dealing with Deaf patients. It is against this background that this study investigates the challenges faced by Deaf people in health settings and the attitudes of health professionals towards the use of SL in the health domain.

In a bid to understand the use of SL in the health domain, this research also intends to answer the following questions:

(a) Are the language provisions relating to the use of SL in Zimbabwe being implemented in the health sector?
(b) Is the health domain in Zimbabwe sensitive to the health and linguistics rights of the Deaf?
(c) What are the communication and mainstream challenges faced by Deaf patients when they visit health facilities for services?
(d) Are there any effective implementation and advocacy programmes designed to promote and advance the use of SL in the health domain?

Justification of the study

1 The differential use of the labels Deaf and deaf is deliberate as it is in line with current trends wherein the former represents the culture and the latter captures the condition

SL is an officially recognised language under the current Constitution of Zimbabwe (Amendment Number 20) Act, Section 6 (4) 2013. It is noted within the constitution that *the state must promote and advance the use of SL, and must create conditions for its development.* This means that SL can be used in whatever sphere where communication is needed. Such official recognition calls for research on the language that would guide language planning activities meant to develop and promote the language. However, not much has been done in terms of research in SL as a follow-up to the constitutional provisions of 2013. Thus, the current research which assesses the nature of communication in the health domain, fills in the gap.

The current study therefore satisfies Hymans' (2003) quest that linguists should encourage the study of minority languages and unempowered languages. In a similar vein, Holmes and Meyerhoff (2003) observe that research should be guided by the needs and interests of the communities of the speakers studied as opposed to producing research simply for the sake of academic appetite. To the Deaf community, this research is of immense significance because it develops and creates awareness of linguistic and health rights useful in the discourse about the promotion and development of SL language. It is envisaged that the discussion and findings of this research provide valuable insights towards the development of SL in the health domain in Zimbabwe and make it possible for people who are deaf to access health services within the health settings.

Statement of the problem

The Disabled People's Organisation (DPO) expressed concern over delays in domesticating the acceptance of SL by Zimbabwe's 2013 Constitution (Mutswanga & Sithole, 2014). The DPO emotionally revealed that:

"[w]e have had Deaf adults, especially women in the maternity wards who have been given the wrong medication, but this goes on unpublished and unnoticed just because the concerned people are a minority".

More so, Mutswanga and Sithole (2014), note that DPO's expressed that people who are Deaf but found to be HIV positive at the clinic are likely to go with their misconceptions and without counselling too because the counsellor or nurse cannot sign. Echoing the same sentiments, Masinike reported in *The Herald* (August 20, 2015) in an article titled 'Teach SL in schools' that communication barriers between a Harare doctor and a patient a few years back led to the tragic death of the patient. This raises the concern that Deaf persons face communication challenges in healthcare facilities. In light of the language and disability rights outlined in Zimbabwe's Constitution, this article examines the

degree to which medical personnel uphold the health and linguistic rights of their Deaf patients.

Definition and applicability of disability and impairment

The main focus of this research is on disability concerns, persons with invisible impairments (hearing impairment), and Deaf people's access to health information. The Deaf community in Zimbabwe has remained "invisible," with a lot of attention being paid to disabilities that are easier to see. Similarly, the Human Rights Bulletin (2015) observes that people with disabilities are either disregarded or "hidden" from the public eye as a result of stigmatisation. Because of their situations, some of them are kept anonymous, not recognised as family members, or are just thought to be missing. They feel unworthy and rejected as a result of their marginalisation, which also threatens their ability to function in society. These data are used in this study to determine the difficulties that the Deaf are likely to face in healthcare facilities.

To begin this debate, it is crucial to define disability and impairment, two concepts that have garnered a lot of attention in the academic community. According to the United Nations on the Rights of Persons with Disability (UNCRPD) (2006), the concept of disability is dynamic and arises from the interaction of people with disabilities, attitudes, and environmental barriers that impede their ability to fully and equally participate in society. According to this concept, social obstacles and disability are synonymous. Impairment, then, is a medical condition that might be physical, sensory, mental, intellectual, deaf, or blind. It is a social creation. The Human Rights Bulletin (2015) further states that in certain cases, persons with disabilities are denied equal chances and a normal life because of society rather than a physical or mental handicap. They experience exclusion, prejudice, and restricted access to healthcare and education).

Returning and demystifying certain concepts about sign language

Johnston and Schembri (2007), Meir and Sandler (2008), Emmorey (2002) and Liddell (2003) mention several myth misconceptions surrounding SL. SL was erroneously viewed as a universal, primitive, iconic, incoherent series of pantomime gestures, invented by the hearing community and having no potential to express abstract concepts (Pribanic, 2006). The common misconception is that SL is a grammarless communication via gestures. According to Mugari, Mabugu and Nyangairi (2015), SL is a language in its own right, much like English, Shona, or Ndebele. According to Pirot and Ali (2021), SLs are not derived from spoken languages. SLs are distinct languages that are not based on speech having their grammar, sentence construction, idiomatic expressions, style, and regional

variations. This supports the claim made by Yule (2010), Fromkin, Rodman, and Hyams (2003) that signing is just as primary as speaking. Mugari et al. (2015) further state that until recently, Zimbabwe's Deaf community language was not recognised as a language by the constitution or society. Schmaling (2000) noted that this is not a surprising stance given that SL is thought to be limited in its ability to communicate abstract and sophisticated concepts, and capable only of communicating tangible objects and fundamental information.

Deaf Zimbabwe Trust (2013) states that SL is a complete language with syntax, norms, and structure that goes beyond simple motions. Musengi, Ndofirepi and Shumba (2012), state that SLs have occasionally been compared to pidgins or creoles (Woodword, 1973; Fischer, 1978). However, there is no proof to support this claim. Studies have demonstrated that, despite their differences from English, SLs are fully formed linguistic systems (Siple, 1982), organised like natural languages (Lidell, 1984). Furthermore, according to Mutswanga and Sithole (2012), SL is one of the main ways that Deaf people in Zimbabwe communicate.

SL is a visual language that conveys a message using hand gestures and a variety of body language. In order to communicate, a coordinated mix of hand forms, arm motions, mouthing, body language, and/or facial expressions are used. Mutswanga and Sithole (2012), claim that those who are truly severely deaf utilise this visual gestured language as their first language. Some use English-aided signs, in which you converse in English or Shona, or signed English, which adheres to the English grammatical structure. People who are deaf emphasise that SL is a language unto itself for the Deaf, based on their observations.

Mutswanga and Mapuranga (2014), also show that hearing individuals view SL as a gesture or a way of conversing with their hands. They believe that learning it is useless unless one wants to work with Deaf people, as they do not view it as a language but rather as signals shared by persons with hearing difficulties. SLs are real languages and are not pantomime and gestures. These evaluated works provide scholars with a taste of the opinions that hearing people hold toward the Deaf and the use of SL in Zimbabwe across a range of sectors, including the health domain.

The language situation in Zimbabwe

Even in cases where they are formally recognised by legislation, Indigenous languages in Africa have generally been unable to hold a position of great prestige (Makanda, 2011). Although they are the majority language, they have continued to be used in casual business settings. Makanda (2011), notes that given Zimbabwe's linguistic circumstances, a comprehensive study on

the application of policies and the advancement of society through the use of indigenous languages is thus not only required but also long overdue. This study, which examines the degree to which the SL Provisions (2013 Constitution Section 6) have been applied in the health system, finds great relevance in Makanda's (2011) comment.

The use of foreign languages to further the development in Africa is bemoaned by Mazrui (1996: 3), who contends that "a country cannot prosper using other people's languages without the dangers of subordinating its citizens." He goes on to ask if any nation can come close to first-class economic growth if its discourse on development and change is mostly written in foreign languages. This study provides insight into the importance of adopting indigenous languages for economic growth, with SL use in the health area being no exception.

According to Mugari and Matende (2020), the Ministry of Education, Sports, and Culture of the Government of Zimbabwe has developed language policies (e.g., in 2002, 2006, 2007 and 2013), however, there are few specifics on how these policies are being implemented with reference to the instruction and learning of Deaf pupils. It is explicitly stated in Section (6) 4 of the 2013 Constitution that *the state must foster the use of SL and establish the circumstances required for its advancement.* Accordingly, SL may be applied anywhere that communication is required (Mugari & Matende, 2020). This has led to an evaluation of SL utilisation in the medical field in this study.

Furthermore, Gora (2013) argues that the implementation of a workable language strategy in education is urgently needed. As Zimbabwean citizens, those who speak their mother tongue must utilise their linguistic rights. They become linguistic captives due to Zimbabwe's language crisis. Confirming these observations, Kadenge and Mugari (2015) note that a comprehensive and well-articulated language policy has long been absent from Zimbabwe's sociolinguistic context. These findings serve as the foundation for the study, which looks at the usage of SL in medical settings and how sensitive medical professionals are to the communication requirements of the Deaf.

Access to health information by the Deaf community in Zimbabwe

Deaf individuals are frequently linguistically excluded in society, which means that no one may be aware of their presence. As a result, even within the healthcare system, accommodations must be made for them, (Musengi, 2019). Even in situations when no one speaks their language professionally, they could nonetheless require medical assistance, just like everyone else.

The COVID-19 pandemic that occurred in late 2019 provided an opportunity for academics like Matende and Svongoro (2021) and Ndlovu (2021) to write about the pandemic and information access issues in Zimbabwe. There is no denying that the nature and substance of the rights to healthcare and information access are influenced by linguistic human rights. Matende and Svongoro (2021), claim that during the COVID-19 pandemic, the Zimbabwe Broadcasting Cooperation Television (ZBCTV) did not provide any information for the hard of hearing or the deaf. This demonstrates that Zimbabwe has disregarded and broken the Zimbabwean Constitution Amendment Number 20 Act's Sections 6 (3) (a) and (b), 6 (4), and 63. Furthermore, it goes against the Deaf and hard of hearing people's rights to healthcare and information access guaranteed by Sections 62 and 76 of the Constitution. It also contravenes Sections 22 (1), (2), 3(c), and 83 (d) and (e), which address disabilities.

While research in Brazil describes a scenario of incommunicability among the various social actors that makes it difficult to exchange information and allow professional treatment for Deaf patients and their healthcare providers, which leads to misunderstanding in diagnostic and therapeutic aspects, Steinberg (2006) asserts that in the United States, it is reported that Deaf patients experience fear, mistrust, and frustration in health care encounters (Scheirer, 2009). Additionally, the global health community has taken notice of the unequal treatment of those with impairments (Tomlinson 2009). The United Nations (UN) states that having the best possible health is one of everyone's fundamental rights.

It is less common for deaf people in the United Kingdom (UK) to receive quality healthcare services, communicate effectively during consultations, and obtain health information (Charity, 2014). Barnett et al. (2011) state that while there is evidence that Deaf individuals have limited access to healthcare, there is a dearth of information about their health in the UK and throughout the world. It has been reported that the prevalence of mental health issues, including depression and anxiety, is higher among Deaf individuals than in the general population (Holzinger, Pollard, & Fellinger, 2012). The topic of access, which encompasses communication, information, education, culture, and health care, is one that the Deaf community talks about a lot. Since Deaf individuals are twice as likely as other groups to have high blood pressure, high cholesterol, cardiovascular disease, diabetes, and poor mental health, com,munication is crucial and seems to be failing Deaf people in the UK.

Accessibility is an issue, according to Choruma (2006), especially for less mobile people, who use wheelchairs or have vision or hearing problems. Further

pointing out that communication issues between patients and healthcare professionals are frequent is Choruma (2006). The terminology used at medical facilities is sometimes unclear to outsiders, and this issue is made worse for those who are disabled. Information in Braille or SL is not very common. This study is particularly informative since it validates the historical occurrence of communication barriers between medical workers and individuals who are Deaf.

According to Chakuchichi, Chitura and Gandari's (2011) study on equality and access to HIV/AIDS information dissemination to individuals with disabilities, the best way to lessen the effects of the HIV/AIDS pandemic is through information dissemination, The results of their investigation showed that media coverage of HIV/AIDS does not align with the information requirements of individuals with disabilities, particularly those who are blind or deaf. People with disabilities are equally exposed to HIV/AIDS, according to Chakuchichi et al. (2011), but they do not obtain the necessary knowledge to lessen or ameliorate the disease's effects. The new study expands on the observation and gains valuable insights by thoroughly examining the obstacles encountered by individuals with hearing impairments in various healthcare settings.

According to Choruma's (2006) observations, individuals with disabilities are not usually perceived as a population that is susceptible to HIV or AIDS since their sexuality is not well understood and frequently goes unnoticed by society and family members. This data is important because it helps the researchers achieve their goals by providing insight into the difficulties Deaf people encounter while interacting with medical professionals in Zimbabwean clinics and hospitals.

The Human Rights Bulletin (2015) states that insufficient legal protections exist for those with disabilities to enable them to fully exercise their rights. In actuality, people with disabilities in Zimbabwe are at risk for social exclusion, information sharing, inadequate care and support, unemployment and a lack of meaningful opportunities, patronage, and limited access to services and support in the areas of health, education, and other fields. Language and mobility accommodations for the disabled are either scarce or non-existent among service providers for health, justice, law enforcement, education, and other fields. These pieces highlight how persons with hearing loss are excluded from several fields. For this reason, the study will concentrate on Deaf individuals who have invisible disabilities and the difficulties they encounter in the field of health.

Furthermore, while HIV/AIDS impacts everyone, Choruma (2006), pointed out that those who are already disadvantaged by one or more disabilities may have been much more severely affected by the pandemic and its destructive repercussions. According to Choruma (2006), persons with disabilities are known

to have an extremely low literacy rate, which makes HIV/AIDS communication difficult. Furthermore, there are not many programmes that teach people about sexism to persons with disabilities, and broader HIV/AIDS awareness efforts typically miss this demographic. Regrettably, Zimbabwe lacks national HIV/AIDS programmes that target individuals with impairments explicitly. The majority of counselling and testing facilities cannot assist individuals with impairments. This study is helpful since it clarifies some of the difficulties associated with Deaf people in the healthcare sector.

Furthermore, the majority of state and non-state institutions are not required to package information and services for the benefit of people with disabilities, including those who are blind, hard of hearing, mentally challenged, or have learning problems (Human Rights Bulletin, 2015). People with impairments are thus excluded from services and information that are widely accepted. As per Groce (2004), the involvement of Persons with Disability (PwDs) is crucial for the effective eradication of the HIV/AIDS epidemic. Therefore, the current study investigates whether such problems recur in other health departments, including those dealing with opportunistic infections, family planning, outpatient care, and casualty in two referral hospitals in Harare, Parirenyatwa and Sally Mugabe.

National Disability Policy Act and health

At all levels (prevention, treatment, care, and support), section. 3.7.1 of the National Disability Policy Act guarantees that people with disabilities have access to gender-responsive healthcare services, health-related rehabilitation, and information in the appropriate formats. Disability policy advocates for access to people with disability in different sectors including the health sector. This goal can only be achievable if the dissemination of information is equal. So the health sectors must operate guided by Disability Policy.

METHODOLOGY

In this ethnographic case study, semi-structured interviews and questionnaires were used as part of a qualitative research approach. The Parirenyatwa and Sally Mugabe Hospitals' management, physicians, and nurses received questionnaires. Medical professionals and hospital executives who have assisted in the diagnosis or treatment of Deaf patients were chosen via the use of purposeful sampling. In qualitative research, sampling refers to the process of choosing particular data sources to gather information to meet the goals of the study (Gentles et al., 2015). The following departments which are Family Planning, Outpatient and Casualty, and Opportunistic Infection were selected as well as five nurses using a snowballing sample technique.

When compared to doctors and hospital managers, nurses make up a larger proportion of the workforce, making this sampling approach the best option available. As a result, the researchers were able to locate and choose nurses who have experience providing medical care, and these nurses in turn helped choose other potential responders. According to Atkinson and Flint (2001), the most basic type of snowball sampling is the identification of respondents who are then used to direct researchers to further respondents.

In keeping with the adage "nothing for us without us," information from those who have hearing loss was also gathered. The Deaf patients at these two referral hospitals were the subjects of semi-structured interviews, and further information was gathered from Deaf merchants in Harare's urban area, which is located near the major commuter bus stops of Copa Cabana and Market Square, where a large concentration of the Deaf people reside. In this case, Deaf volunteers were also chosen by the use of snowballing sampling. Through interviews, the Deaf were able to express their opinions about being included in the medical field and the difficulties they currently have while interacting with medical professionals.

To answer the study questions, the researchers gathered data from conventional sources of the necessary information. Throughout every interaction, both the interviewers and the interviewees utilised SL. With the help of a qualified translator, the researchers were able to get data from Deaf individuals. Direct translation was used to convert the SL interviews into English. The data was analysed using a content analysis methodology. Before the study's completion, each participant provided his or her signed informed consent. They were informed that to safeguard people's identities and personalities, anonymity would be upheld. In addition, the Disability Policy Act and the Zimbabwean Constitution (Amendment No.20) Act 2013 were examined to determine the rights of the Deaf.

DISCUSSION

The ensuing discussion is grounded on the thematic approach as revealed by the study's findings. The main topics that comprise the talking points include attitude obstacles, medical interpreters who are not proficient in SL, insensitivity to the language and health requirements of the Deaf, and communication hurdles.

Communication barriers

Researchers collected data by distributing questionnaires to physicians, nurses, and administrators at Parirenyatwa and Sally Mugabe hospitals. The results

indicate that medical professionals find it challenging to interact with deaf patients due to their lack of proficiency in SL. The HIV/AIDS counsellors at the Opportunistic Infections Unit noted that their knowledge of SL is limited, making it difficult for them to effectively explain health-related matters to individuals with hearing impairments. When speaking with patients who have hearing difficulties, HIV/AIDS counsellors at Parirenyatwa's Opportunistic Infection unit utilise written English as their communication language. Researchers found that the main barrier preventing Deaf individuals from accessing health information is a misunderstanding between the patients and HIV/AIDS counsellors.

Deaf patients can communicate, but sadly, medical professionals and nurses speak a language that is foreign to them. In their dealings with deaf patients, all of the nurses and physicians in the departments of casualty, outpatient, family planning, and opportunistic infection have observed that the biggest obstacle they encounter is communication.

The aforementioned remark is also supported by a newspaper article written by Masinike and published in *The Herald* in August 2015. According to Masinike (2015), a few years ago, a patient with hearing loss passed very tragically as a result of a communication breakdown between the doctor and patient in Harare. The primary cause of the incorrect diagnosis was a communication breakdown between the patient and the doctor; the patient did not comprehend the doctor's English words, and the doctor did not understand SL. Barbra Nyangairi, Executive Director of Deaf Zimbabwe Trust, asserts in the same Masinike newspaper article that there are several instances of deaf individuals dying due to incorrect diagnoses that might have been avoided since the physician and the patient could not understand each other.

Similarly, medical professionals at Sally Mugabe Hospital's Casualty Department disclose that interacting with patients who have hearing loss presents significant difficulties. A nurse expressed that since all patients, including those with hearing problems, go through the casualty unit, they should have priority when it comes to SL instruction. The information gathered from medical professionals, including nurses, shows that although SL is an officially recognised language, there are no formal programmes in place to train medical personnel—like nurses and doctors—in how to communicate with the Deaf. This supports the observations made by Choruma (2006) that communication issues between patients and healthcare professionals are frequent.

A deaf youth who had just been informed that she was HIV positive, according to Pasipanodya's (2015) article published in *The Zimbabwean Voice of the Voiceless* newspaper on 3 March 2017, had gleams of unexplainable delight all over her

face as she left the New Start Centre, which provides HIV testing. Anything that is considered "positive" in the Deaf community must be beneficial. The seventeen-year-old seller, according to Pasipanodya (2015), was unaware that the diagnosis was not at all positive and that lifelong anti-retroviral therapy, a balanced diet, and extensive counselling were all necessary. However, nobody at the centre could communicate with her using SL, so nobody could tell her what she needed to do or what she was facing.

These are the sobering facts that deaf individuals must face when attempting to obtain HIV/AIDS information in the majority of medical facilities. Similarly, deaf patients with HIV/AIDS that the researchers spoke with at Parirenyatwa indicated that the main issue between nurses and deaf patients is communication. The patients lamented that because the majority of them were illiterate and did not complete the Ordinary Level, it was difficult for them to grasp health information printed in English. Therefore, individuals would rather hear information on HIV/AIDS explained in their tongue. According to a study by Ndlovu (2016) in the *Pachikoro Contributor* newspaper on October 3, 2016, the average written English proficiency of a deaf individual is thought to be equivalent to that of a hearing fourth grader globally.

Additionally, the deaf patients mentioned that they were unaware of the Zimbabwe Sexual and Reproductive Health SL Dictionary, which was created to facilitate communication about HIV and sexual and reproductive health rights between the nation's citizens who have a hearing impairment and those without. In addition, the deaf vendors stated in the interviews conducted at the Market Square bus stop and Copa Cabana that they avoided visiting clinics and hospitals due to communication difficulties. One deaf lady reported that she was advised, *"You should not get pregnant when you are deaf,"* by the nurse at Parirenyatwa when she requested an explanation of what was occurring during the delivery of her baby/child.

The aforementioned situation supports Choruma's (2006) finding that stigmatisation and prejudice against individuals with disabilities have been reported, as demonstrated by medical staff's incapacity to see beyond their incapacitating illnesses. Nyakanyanga's story in the *Bhekisisa All Africa Global Media* newspaper (2017) states that the Deaf Zimbabwe Trust's baseline survey from 2015 emphasises how difficult it is for the Deaf population to obtain health information. Upon being questioned about their comprehension of a medical male circumcision campaign intended to shield males from HIV transmission, a few volunteers who were deaf responded, *"I thought that my penis would be chopped."*

Lack of SL medical interpreters in the health domain

The absence of certified SL medical interpreters in hospitals and clinics is a significant obstacle for the Deaf to get health information, according to data gathered from questionnaires given to medical professionals in various healthcare units at Parirenyatwa and Sally Mugabe Hospitals. In actuality, the foundation of diagnosis and therapy is effective communication between the Deaf and medical professionals. A nurse at Sally Mugabe Hospital bemoaned the lack of SL interpreters in hospitals despite the government hiring full-time interpreters for courts.

The physicians who participated in the study urged the government to hire medical interpreters who are proficient in SL and should be available to provide interpretation services to patients who have hearing impairments whenever they visit healthcare facilities. According to data gathered from the Deaf, individuals with hearing loss also want SL interpreters at all levels where they are necessary. Additionally, a few nurses working in the family planning section noted that even those without hearing impairments find it challenging to grasp the medical language used to discuss family planning difficulties.

Furthermore, doctors disclosed that they find it challenging to interact with women in the maternity units if they do not have access to medical interpreters who understand SL. The 2013 Constitution's Section 83 protects the rights of people with disabilities to healthcare, education, and protection from abuse. Nonetheless, because not much is being done to promote or execute the linguistic, health, educational, and legal rights of those with disabilities, the requirements of the Constitution remain unfulfilled.

Insensitivity to the health and linguistic needs of the Deaf

The information gathered from medical professionals at the two Harare referral hospitals via questionnaires makes it abundantly evident that these state-run establishments are indifferent to the medical needs and communication requirements of individuals with hearing loss. Health discussions and awareness campaigns are conducted in Shona, Ndebele, and English, which pushes people who have hearing loss to the side. When interacting with patients who have hearing impairments, nurses and physicians at the Opportunistic Infection unit stated that they are unaware of the existence of Matongo's (2012) *Zimbabwe Sexual and Reproductive Health SL Dictionary.* The Opportunistic Infection section at Parirenyatwa Hospital has several general nurses who observe that their department is sensitive to deaf people's concerns since courses on SL training are being conducted.

Regrettably, Zimbabwe lacks national HIV/AIDS programmes that are expressly designed to reach the disabled population. Although HIV/AIDS affects everyone, those who have one or more disabilities may be particularly vulnerable to the epidemic's devastating impacts (Choruma, 2006). Programmes for educating disabled persons about sexism are uncommon, and broader HIV/AIDS awareness efforts typically overlook this demographic. The majority of testing and counselling facilities are ill-equipped to handle individuals with impairments. The short training period prevented several nurses from the Casualty and Family Planning sections from learning SL, which is why the seminars were ineffective. The nurses further made it clear that they had no idea how to use the SL alphabet correctly.

Sally Mugabe Hospital's Principal Nursing Officer (PNO) bemoans the fact that SL instruction has only been the subject of one workshop. Some general nurses expressed dissatisfaction over the fact that while most department heads and Human Resources (HR) managers attended the session regarding SL concerns, very few nurses showed up—even though nurses interact with patients from all backgrounds regularly. These workshops were therefore ineffective. The casualty unit nurses at Sally Mugabe Hospital contend that computer workshops, which are held regularly at the hospital to educate medical professionals on Information and Computer Technology (ICT) matters, should also be held for SL.

Attitudinal problems

The information gathered from medical professionals through surveys showed that one of the key factors working against the language and health rights of the deaf in the health sector is the unfavourable views held by nurses and physicians. Since learning SL is not their primary responsibility, several general nurses in the Opportunistic Infection and Family Planning unit at Parirenyatwa feel that doing so is a complete waste of time. This explains the low frequency of HIV/AIDS patients who visit the Opportunistic Infection Unit for medical attention. It was also mentioned by a few nurses that learning SL is challenging.

Nurses who participated in the research also stated that whenever deaf patients seek HIV counselling, they would rather speak with a deaf patient's relative or in written Shona or English. According to Choruma (2006), certain medical staff members' unfavourable views might make it difficult, "complicated," or embarrassing for those with impairments to visit the hospital. The staff's lack of education and experience, together with their ensuing uncertainty about how to interact with those with disabilities, maybe the cause of these attitudes. Because of their unfavourable views about people, the researchers found that nurses and physicians made little attempt to teach or educate deaf patients

on health concerns such as HIV/AIDS, family planning issues, cholera, malaria, cancer, and typhoid awareness.

CONCLUSIONS

The results of the study demonstrate that hospitals and clinics do not emphasise SL. SL is one of the sixteen officially recognised languages in the nation, according to the Zimbabwean constitution, hence using it in various contexts is protected by the constitution. Nonetheless, Zimbabwe is not adhering to the linguistic regulations about the use of SL. In actuality, Zimbabwe's health system is insensitive to the linguistic and physical needs of the Deaf community. Owing to several issues with the health system, such as stigmatisation and unfavourable attitudes from medical professionals, communication hurdles, a dearth of SL medical interpreters in the medical field, and stigma, the Deaf population is unable to obtain health information.

The researchers advise the government to provide SL training to at least five nurses and five doctors in each department so that they may especially assist individuals with hearing problems when they visit for checkups. Health information and jargon are extremely complicated and challenging to comprehend and interpret, thus medical SL interpreters—rather than interpreters in general—need to be educated. The government should implement targeted HIV/AIDS, family planning, and awareness campaigns on deadly diseases including cancer, malaria, cholera, and typhoid fever for those with hearing impairments, according to deaf merchants at the Market Square and Copa Cabana bus terminals.

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