Artha – Journal of Social Sciences
2025, Vol. 24, No. 4, *1-22*
ISSN 0975-329X/https://doi.org/10.12724/ajss.75.1

Linguistic barriers encountered by deaf women in accessing antenatal and postnatal care in Zimbabwe's public hospitals

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Abstract

This article examines the marginalisation of Sign language in Zimbabwe's healthcare sector, particularly in the context of antenatal and postnatal care. It reveals the linguistic challenges faced by Deaf women, who often use spoken language for communication. The study also explores the attitudes of nurses and doctors towards Sign language in the health sector. Data were collected through questionnaires, focus group discussions, and interviews with members of the Deaf community. The research found that communication difficulties were significant barriers for Deaf women seeking care. The lack of sign language interpreters and negative attitudes towards the Deaf by some health professionals further exacerbated these barriers. The absence of a policy framework directing the use and awareness of Sign Language in hospitals further exacerbated these issues. The study recommends prioritising Sign Language in public institutions to ensure Health Rights and a health language policy that guarantees the use of local languages in all public life, including health.

Keywords*:* Sign language, Deaf, Impairment, Linguistic rights, Marginalisation, Language policy

Introduction

This study, employing a qualitative research approach, examines the challenges Deaf women face in accessing antenatal and postnatal care due to language barriers. Zimbabwe's largest referral hospital, Parirenyatwa Group of Hospitals, provides the context for this research effort. The

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purpose of this research is to investigate and gain a deeper understanding of the communication challenges Deaf women face when interacting with healthcare personnel to obtain essential health information during pregnancy and after childbirth. Antenatal and postnatal periods are of critical importance for both the woman and the unborn child, and there is a need for Deaf women to access all the required information to ensure the safety of both the mother and the child. In addition, an understanding of the communication challenges Deaf women encounter during the antenatal and postnatal periods enables researchers to develop targeted interventions, such as strategies and approaches, that can effectively address these issues. This ensures that Deaf women receive the same level of information as hearing women. Section 6 of Zimbabwe's Constitution of 2013 states that, '*The state shall support and enhance the use of all languages in Zimbabwe, including sign language, and must foster the growth of those languages'.*

The above clause demonstrates that Sign language, like the other 15 languages, was granted equal official recognition status. As a result, it is essential to monitor how the policy is being applied in various domains of public life, including health. Section 3.7.1 of Zimbabwe's Disability Policy (2021) emphasises that '*access by persons with disabilities to have access to gender-responsive healthcare services, as well as information on health-related rehabilitation and support at all stages (prevention, treatment, care, and support)*'. This goal can be achieved when the health sector offers translation and interpretation services in various languages to benefit their clients, including pregnant women who are Deaf.

The study investigates access to antenatal and post-natal care explicitly through language at Parirenyatwa Group of Hospitals by selected women who are Deaf. In the survey, "Deaf" with a capital letter 'D' is used to refer to members of the Deaf community or to cultural deafness, while "deaf" with a lowercase 'd' is used to convey a generic view of deafness (DZT, 2016). The World Report on Disability estimates a disability prevalence of 15 per cent of the world population, or more than one billion people (Peta & Moyo, 2020). Current, precise, and reliable data on disability in Zimbabwe are not available. Approximate statistics can, however, be inferred from the standards established by the WHO, World Bank, and UN. It can therefore be estimated that approximately 15 per cent of Zimbabwe's population of 13 million people is disabled (about 2,250.000 people) and more than half of that proportion are women. In a study conducted in Zimbabwe by Eide, Loeb, Nhiwatiwa, and Muderedzi (2001), impairments were found to be uniformly distributed among all age groups, with counts of 45 per cent mobility problems, 34 per cent sensory impairment, and 11 per cent emotional, intellectual, and learning disorders. The prevalence of disabilities like deafness is rising globally, according to the Ministry of Health and Child Care in Zimbabwe, as a result of the rise in chronic health issues.

This necessitates studies that focus on challenges posed by the condition in order to pave the way for interventions. According to statistics, Zimbabwe's female population was estimated to be 7.77 million by the year 2020, and an estimated one in five women was said to have a disability (Peta & Moyo, 2020). Even though there are no specific statistics concerning deaf women, this study assumes that among these disabled women are also the Deaf who get pregnant and need medical help.

Deafness is defined as a degree of impairment that renders a person unable to understand speech, even in the presence of amplification (SANDA, 2008). Deafness, however, is categorised into four levels: mild, moderate, severe, and profound (Cupples, 2018). The study focuses on individuals who are profoundly and severely deaf. Even the loudest noises produced by an audiometer, a device used to measure hearing, may not be heard in cases of profound deafness. The subjects of this research are women with this condition. According to Musengi (2019), Deaf people are often linguistically marginalised in society, with the result that nobody may think of their existence and hence the need to accommodate them even within the healthcare system. Just like everybody else, they may also need medical attention even in cases where no one uses their language professionally (Hwang, 2009). These observations prompted a study of challenges faced in accessing antenatal and postnatal care in Harare.

Antenatal care (ANC) aims to identify high-risk pregnancies and educate women to ensure healthier deliveries and outcomes (USAID, 2013). The care provided to a woman and her newborn child in the hours following birth and for the first six weeks after birth is known as Post-Natal Care (PNC). Women and their partners enter a new stage of family life during this time, and newborns start their lifelong health records. (PNC) is the care given to the mother and her newborn baby immediately after the birth and for the first six weeks of life. This period marks the establishment of a new phase of family life for women and their partners, as well as the beginning of the lifelong health record for newborn babies. It involves a significant amount of learning, especially for mothers who are caregivers to newborn babies. There is a need, therefore, to establish how information is passed on from health care specialists to the deaf mother. This is the case mainly because Zimbabwe has one of the highest maternal mortality rates in the world due to the ineffectiveness of campaigns and education that are given to mothers (WHO, 2015). Medical practitioners or health officers in the study include nurses, doctors and midwives, all of whom are involved in giving information to mothers before and after giving birth.

Women across a spectrum of disabilities face higher rates of adverse outcomes, including pre-term births and low birth weight babies. Few studies have focused on the pregnancy outcomes of Deaf women (Mitra,

Akobirshoev, McKee, & Lezzoni, 2016; Signore, Spong, Krotoski, Shinowara, & Blackwell, 2011). There is limited data about pregnancy outcomes for deaf women. In the USA, a longitudinal study between 1987 and 2013, which included 645 deaf women, found that women were more likely to have a caesarean section, or an increased length of hospital stay following vaginal delivery (Luton, Allan and Kaur, 2022). Additionally, a second American study analysing hospital records between 1998 and 2013, which included 1,385 deaf or hard-of-hearing mothers, found that deaf mothers were more likely to have pregnancy complications such as placental abruption or eclampsia (Mitra et al, 2020). Deaf women were also more likely to have pre-existing hypertension/diabetes. These disparities in health outcomes and access may be linked to the history of oppression faced by deaf communities.

Objectives

The study examines how deaf women are marginalised when accessing antenatal and post-natal care services in Zimbabwe's health sector, with the research explicitly guided by the following objectives:

(a) To identify communication challenges experienced during deaf women's quest to access antenatal and post-natal care at Parirenyatwa Group of Hospitals;

(b) To establish the significance of the challenges; and

(c) To suggest solutions to the challenges of language barriers during interaction between healthcare providers and deaf women.

Deaf mothers and language barriers in Zimbabwe's health sector

Many women who are deaf in Zimbabwe, in general, and in Harare in particular, have given birth and are still giving birth in Zimbabwe's public health facilities. From the perspective of the Ministry of Health and Child Care, every Zimbabwean citizen has the right to health, including prenatal and postnatal care. This important right may not be enjoyed by members of the Deaf community when the majority of medical personnel are not competent in Sign language. Since medical practitioners in Zimbabwe's health institutions have no training in Sign language, there are bound to be language barriers between them and pregnant Deaf women requiring antenatal and postnatal care. The language barriers negatively impact the need for women to access critical antenatal and postnatal care information, and this may lead to detrimental implications for healthcare. It is for this reason that there is a need to investigate the nature of communication between medical practitioners and deaf women, with a view to appreciating its effectiveness, associated challenges, implications, and suggesting possible solutions that guarantee effective communication and beneficial healthcare.

Communication problems faced by the Deaf in antenatal care within African countries.

In 2011, a South African researcher, Kritzinger, observed that numerous communication challenges affect language minorities and Deaf people when they interact with speakers of majority languages. Effective communication is essential, both for the patient who needs to express themselves in terms of symptoms and complaints and for the health providers who must be able to explain treatment protocols, preventative options and make a diagnosis for the purposes of treating any condition that may be affecting the patient's physical, emotional or social well-being (Kritzinger, 2011). To maintain a healthy lifestyle, individuals need access to health promotion and preventive services (Lang, 2009). Collaboration is necessary within primary health care services to develop, deliver, and evaluate health education programs, making them more accessible to individuals with disabilities and addressing their specific needs (Downey & Barr, 2004).

According to Kritzinger et al. (2014), Deaf individuals face unique communication challenges when interacting, which implies that their access to healthcare services differs from the experiences of the general population. In the hearing world, communication challenges for Deaf individuals exist on multiple levels, including individual, interpersonal, and systemic levels, all of which are relevant to healthcare communication. According to Webster (2017), Deaf women in the US are more likely to experience pregnancy complications, and the US is a high-income country that offers interpreters in some of its hospitals. However, there is still a challenge in communication. The situation becomes even worse in middle- and low-income countries, such as Zimbabwe, which has prompted this study.

Effective communication between medical staff and deaf patients is essential (Mweri, 2017). However, medical professionals, such as doctors and nurses, are often unaware of the specific needs of the Deaf community, particularly what is required to facilitate effective communication. Lack of awareness is one of the unfortunate effects of communication barriers in the healthcare system. People who are deaf generally find themselves on the negative end of awareness because they miss out on important health information that is frequently transmitted through television and radio public service announcements. In Nigeria, the child and maternal mortality rates were reported. However, the percentage of the population of vulnerable women in the overall statistics, particularly those who are Deaf, is unclear (Adigun, 2021). However, not all Deaf people lack awareness, as in Zimbabwe, a few television programs are inclusive and educational for deaf people. Therefore, it is essential to ensure inclusivity when disseminating information, particularly health-related information.

Access to health information by the Deaf community in Zimbabwe

The emergence of the COVID-19 global pandemic at the end of 2019 opened the door for researchers, such as Ndlovu (2021), to write about this disease with a particular focus on the issue of information access in Zimbabwe. Unquestionably, linguistic human rights have a profound impact on the nature and scope of the rights to healthcare and access to information. There was no information dissemination targeting people who are hard of hearing or deaf on the only Zimbabwean television channel. This shows that Zimbabwe failed to comply with and violated Sections 6(3) (a) and (b), 6(4), and 63 of the Constitution of Zimbabwe Amendment (No 20) Act 2013. Additionally, it violated Sections 62 and 76 of the Constitution, which guarantee access to information and healthcare for the Deaf and hard of hearing. Information needs should be distributed in accessible formats, such as Zimbabwean Sign Language (ZSL), and these people need to be taken into account when allocating resources and determining priorities (Matende & Svongoro, 2020). However, this literature does not reference access to information on antenatal and postnatal care for deaf people. The researchers argue that even before the COVID-19 pandemic, there was a challenge of access to antenatal and postnatal care information for deaf people, leading to high mortality rates, hence the need for the current research. The population's level of awareness, among other things, is recognised to have a direct impact on knowledge levels about health-related issues and diseases. The population's perceptions of health problems, access to information, understanding of health services, and adherence to therapeutic methods have a significant impact on their overall well-being.

National Disability Policy and Health

At all levels, such as prevention, treatment, care, and support, Section. 3.7.1 of the National Disability Act guarantees that people with disabilities have access to gender-responsive healthcare services, health-related rehabilitation, and information in the appropriate forms. The Disability policy advocates for equal access to social services for people with disabilities across various sectors, including the health sector. This goal can only be achieved if the dissemination of information is equal. Therefore, the health sector must operate in accordance with Disability Policy. Communication is a critical aspect that facilitates access, and language barriers are a serious impediment to achieving this goal. Thus, there is a need to analyse the effectiveness of communication between health personnel and pregnant Deaf people with a view to understanding the impact of language barriers on efforts to access antenatal and postnatal healthcare.

Methodology

This study employed a qualitative research approach because it captures individuals' thoughts, feelings, opinions, and experiences in-depth regarding Deaf women's interactions with health personnel for the purpose of assessing antenatal and postnatal health services. According to Patton and Cochran (2002), qualitative research is distinguished by its purpose, which involves comprehending specific facets of social life, and its methodologies, which generally provide words rather than numerical data as the basis for analysis. To obtain information and insights, qualitative research involves evaluating a small group of participants using non-numerical data (Berg, 2006), as noted by Berg and L. According to Howard (2012), the characteristics of qualitative research include meanings, concepts, definitions, metaphors, symbols, and descriptions of objects. This definition makes it abundantly evident that qualitative research is equipped with all essential tools for stimulating problem-solving (Cochran & Patton, 2002). The study's participants consisted of fifteen Deaf women who had recently given birth, as well as those who were expecting, and ten medical staff members. Only local vendors who visit Parirenyatwa Group of Hospitals for antenatal and postnatal care were selected to participate in this study. Data for this study were collected through a combination of interviews with deaf patients and healthcare workers, focus group discussions, and document analysis of policy and statutory documents to understand the provisions they make regarding deaf persons and access to healthcare, as further explained below.

An interview is a conversation designed to gather information; it is a suitable strategy. First, the researchers conducted face-to-face semi-structured interviews with Deaf women to gather their opinions and experiences regarding access to antenatal and postnatal care at Parirenyatwa Group of Hospitals. These interviews were conducted from the perspective of Easwaramoorthy and Zaripoush (2006), who postulate that when gathering in-depth data on people's opinions, beliefs, experiences, and feelings is necessary, interviews provide an appropriate means to meet that purpose. This method was appropriate and friendly to both the interviewers and interviewees because two members from the research team could communicate using Sign language, the language of the interviewees. Semi-structured interviews were also used to collect data from hospital administrators, midwives, nurses and doctors in the antenatal and postnatal care departments of the hospital.

Views from interviews were complemented by data collected during focus group discussions (FGDs). In the context of Nyumba's understanding of FGDs as a research method that brings together a small group of people to answer questions in a moderated setting (Nyumba, 2018), the research team conducted FGDs with Sign Language professionals and interpreters

to understand the challenges faced by deaf women in maternal and primary health care. The researchers also conducted focus group discussions at Copacabana and Market Square bus termini, where most deaf people, including women, work as vendors. FGDs with deaf vendors were intended to gather their views on the services received from clinics and hospitals in general, as well as the Parirenyatwa Group of Hospitals in particular.

Finally, the researchers also applied document analysis to analyse library and online legal and policy materials, focusing on language, disability and access to healthcare issues. Through document analysis, the researchers aimed to gain an understanding of how policy documents and other researchers view the issues of deafness, communication, and language barriers in healthcare settings, particularly in antenatal and postnatal care settings. For this study, Policy documents such as the Disability Policy and the Constitution of Zimbabwe Amendment (No. 20) Act 2013 were analysed to gain insights into what these critical documents say about the care of the Deaf in terms of language use within the context of government institutions, such as hospitals.

Theoretical Framework

The study employs critical theory, which examines topics related to the development and maintenance of socioeconomic and linguistic disparities. This theory was relevant because the study was dealing with the marginalised group (deaf people) whose language is not used by the majority of people in Zimbabwe. Gartman (2013) noted that Critical Theory develops a theory of culture that explains how ideas create and legitimate class inequalities in modern society. This theory is developed through a critique and comparison of the powerful ideas on culture offered by Pierre Bourdieu and the Frankfurt School Thinkers. Critical Theory focuses on the unity of analysis and critique. This means that, in analysis, the attempt to comprehend what is going on in social life-the attempt, for example, to understand the structure of capitalist social integration and its historical transformations is a critical part of what it means to criticise it (Fraser & Jaeggi, 2018). According to Ndlovu (2021), critical theory encourages and promotes participation or collaboration between beneficiaries of multilingual language policy implementation and policymakers or organisations that drive multilingual language policy and implementation, in order to ensure social justice and inclusivity. The fact that English and Shona are predominantly used in disseminating information on antenatal and postnatal care makes deaf people marginalised and denied access to information. Critical theory is therefore concerned with actions that promote progressive social change, including the enhancement of human freedom and autonomy. It aims to change the way people think and promote equality and progress within communities. Echoing the same sentiments, McNay (2013) argued that critical theorists maintain that paths

to political emancipation emerge from the unmasking and challenging of often unnoticed forms of ideological domination that naturalise exploitative social relations (McNay, 2013).

Ethical Considerations

To ensure the highest possible standards in conducting research, participants' rights were explained to them before they could participate in the research. Hendee (2009: 336) states that it is essential to foster a level of trust and credibility in the development of knowledge. The researchers ensured that the information gathered from the research participants was used solely for research purposes and also ensured that participants' identities were not traceable. The names of the participants were not disclosed. The researchers also ensured that the volunteers would be safe and not suffer any harm or pain. To ensure fair and voluntary recruitment in terms of sampling, the researcher informed the participants that their participation in the survey was entirely voluntary and that they could withdraw at any time. The researchers also guaranteed the participants' privacy.

Data presentation, analysis and Discussion

This section of the study primarily focuses on providing and evaluating data related to the linguistic barriers that Deaf women encounter while seeking prenatal and postnatal care at Parirenyatwa Group of Hospitals. Interviews, focus group discussions, and document analysis were used to gather data for this research. Data analysis was conducted using a thematic approach, in which participants' responses were categorised according to specific emergent themes. The research findings were presented, examined, and interpreted in line with study objectives and research questions.

Communication challenges between the Deaf and medical practitioners and their implications

Data was collected from Deaf women, medical practitioners and professional interpreters. The data analysed for the study revealed the following findings concerning challenges of communication between deaf women and the medical practitioners:

Disclosure of confidential information

One way of communication observed between the Deaf and medical personnel was the use of a patient's helper as an interpreter. This is shown in the following example from a Deaf interviewee:

> *When I visited the clinic I was escorted with a helper who is my sister for interpretation. However, if she is not there I just pick on neighbors whom we often communicate with.*

As indicated above, the patient comes with a relative or neighbour for interpretation during interaction with medical personnel. This is considered inappropriate by some scholars who argue that relatives have an emotional involvement and there is no guarantee of impartiality for professional conduct (Bernnett, 2021). This means the chances of them disclosing all the information relating to their condition are constrained by a desire to protect the image of their relative. One of the interviewed Sign Language interpreters has been quoted as saying that:

> *A friend, child or sister is not a professional and so it is not proper for them to get access to any patient's private information, chances are high that without ethical codes binding them they will gossip about what they hear. I think to solve this challenge they must be many trained interpreters of SL that must be deployed in different hospitals.*

In other words, the argument being raised by the participant is that using a relative as an interpreter breaches the patient's right to confidentiality. A relative or friend may not understand the importance of confidentiality because they are not trained interpreters who follow a code of conduct that guides them in their work. During pregnancy, women go for different tests, including HIV tests, Full Blood Count, Urea and Electrolytes. In Zimbabwe, the status of a person concerning HIV is confidential, and no one must know it unless the person is willing to disclose it to a third party. However, in this situation, the Deaf woman has no choice. The first person to know about her status is the one who is interpreting for her, thus violating the principle of confidentiality. According to Mweri (2018), privacy and confidentiality refer to the state of keeping or maintaining something secret or private. The two are the most important pillars of the medical sector.

A medical practitioner who also participated in the study mentioned the side effects of the use of relatives as stress and depression as a result of the patient's realisation that their privacy has been invaded without any security thereafter. These findings have implications for the welfare, privacy and confidentiality of the Deaf, who are not being taken into consideration when they bring anybody for interpreting in health institutions. Another Deaf participant said:

> *It is better for me to bring someone because the doctors and nurses sometimes actually ask about the person who escorted me to the hospital? This means they expect me to bring someone and I have no option but to bring my relative. I suggest that hospitals use their own Sign Language Medical interpreters.*

The request by medical practitioners for the Deaf to bring an escort to the consultation room is a clear indication of the communication barriers

that exist between medical personnel and deaf clients. By inviting the escorts, doctors are actually infringing on patients' right to confidentiality, yet it is these professionals who are the custodians of medical ethics. The data presented above also indicates a violation of Zimbabwe's Disability Policy. According to section 3.7.4 of the Disability Policy Act 'Persons with disabilities must be provided with the same range, quality and standard of health care as provided to other persons. Chapter 83 of the Constitution of Zimbabwe Amendment (No. 20) Act 2013 also states that it is the right of persons with disabilities to access medical, psychological, and functional treatment. However, it is difficult for women who are deaf during antenatal and postnatal care to get the same quality information as hearing people because there is a barrier in communication.

Information like the importance of routine blood tests, regular blood pressure checks, and antenatal scans in early and late trimester is challenging to access by pregnant Deaf women because of the language barrier. There are several other important activities they need to know about including the taking of prenatal vitamins (folic acids), early booking of the pregnancy at a local clinic and at a leading hospital for mothers with a history of complications in previous pregnancies and signs of pregnancy emergencies to look out for such as features of pre-eclampsia or eclampsia (hypertensive emergencies in pregnancy) and bleeding emergencies in pregnancy (placenta abruption and placenta previa). The medical personnel who are supposed to enlighten Deaf pregnant women on these issues have no training in Sign language, and this makes it difficult for them to share this important information with the patients. This implies that Deaf pregnant women are being excluded from accessing quality health-related information as a result of linguistic barriers.

In one of the interviews, a nurse lamented serious communication challenges faced by deaf women in antenatal and postnatal care in health institutions. She was quoted as saying that:

> *What is disheartening to note is that in the hearing community, lack of information, delays in relaying information and inadequate information about antenatal and post-natal care from medical personnel and poor health seeking behaviour often result in increased child mortality. How much more in the deaf community?*

In the case of communication with the Deaf community, sometimes the information is not encoded and decoded in accessible formats for deaf pregnant women. Medical practitioners are not competent in ZSL, which infringes on the linguistic rights of deaf people in the healthcare domain. Choruma (2006) notes that communication issues between healthcare staff

and patients are prevalent. Many people do not understand the language used in health care units, and these problems are exacerbated for people with disabilities. In fact, the availability of information in Braille or Sign language is rare (Choruma, 2006).

When the researchers further examined the Constitution of Zimbabwe, it was established that Chapter 83 of the Constitution states that people with disabilities must have their individual right to free and informed consent respected within healthcare institutions. Furthermore, decisions in areas including sexual and reproductive healthcare must not be imposed on persons with disabilities, and their individual consent must not be replaced or substituted by a third party. However, it is unavoidable to include third parties when dealing with deaf people, as nurses and doctors may not understand Sign language. It was revealed in focus group discussions that in the absence of relatives or fellow doctors and nurses, other patients could actually be asked to help with interpreting. The issue of consent from the patient's perspective, therefore, is often overlooked.

Patient intimidation

Medical practitioners who were interviewed concerning how they communicate with the Deaf in the absence of the Deaf person's helper revealed that they use ad hoc interpreters. The following example from a doctor interviewee illustrates this:

> *At this hospital no one is proficient in Sign Language. We actually encourage the Deaf to bring their own interpreters or ask among ourselves if someone can try to help the situation. Normally we end up with more than three people trying to communicate with the patient. Health staff, if not all, cannot speak or understand Sign language, this causes a problem of communication between us and Deaf patients. To overcome the issue of miscommunication, nurses and doctors must be trained in SL during their courses, up to and including advanced certification.*

Focus group discussions with deaf people on this method revealed how the Deaf end up feeling intimidated when they have three or four people surrounding them during consultations with doctors and nurses. The patient is also left with doubts regarding whether the medical personnel clearly understood what she was saying, as they will be relying on their rudimentary knowledge of Sign language, which they are not trained to use. According to Dull and Fox (2010), intimidation in healthcare settings can hurt patient safety.

Lack of confidence in the diagnosis and prescription

Interview responses from deaf women revealed that due to the difficulty of communication between patients and medical practitioners, patients often left the hospital without confidence that their situations had been effectively addressed. One of the interviewed deaf women said that,

> *They came to me when my husband had gone out and kept on calling each other because they couldn't understand what I was saying and even up to now l doubt whether they understood what I said. I took the medicine that was prescribed grudgingly.*

As shown by the interviewee's response above, the absence of a professional interpreter in the health facility results in patients being dissatisfied with the treatment they receive. Another pregnant Deaf woman said,

> *My sister interpreted for me but because she is not a medical professional, I doubt if she really understood what was said and whether she communicated my feelings properly. The hospital should have professional interpreters so that we are convinced of the information they give us.*

Trust lays a foundation for a good and beneficial working relationship between medical practitioners and their clients. One of the aspects that feeds into the issue of trust is effective communication, which ensures mutual understanding. When there is no trust between medical personnel and patients, a lack of confidence in both the diagnosis and prescription creeps in. As soon as Deaf patients start to doubt the effectiveness of their communication with nurses and doctors, they will likely have numerous questions about the service they are receiving from the hospital staff. This explains the negative impact of the language barrier between medical personnel and pregnant Deaf women who visit Parirenyatwa Group of Hospitals for antenatal and postnatal healthcare services.

One of the deaf women has been quoted saying *'It was difficult for me to get a card at the reception and pay the consultation fee because of communication challenges because the receptionist was not proficient in Sign language and waited for many hours before l see the casualty officer'*. This clearly shows that communication challenges between pregnant Deaf women and staff at Parirenyatwa Group of Hospitals actually begins before the pregnant women see the doctors. They are first supposed to be attended to by the receptionist for a card stamp. The receptionist at the front desk is not competent in using Sign language. The above response indicates that Deaf individuals face communication challenges at medical institutions, causing anxiety and problems for pregnant women seeking antenatal and postnatal services.

Delayed attendance

Data from interviews and focused group discussions revealed delayed attention as another challenge that derives from the absence of an interpreter during interaction between medical staff at Parirenyatwa Group of Hospitals and pregnant Deaf women. The following response from a midwifery interviewee attests to this:

> *There is a challenge of miscommunication because the staff does not understand Sign language. So it slows down the pace at which they attend to these people because the whole staff will be asking each other if there is anyone who knows Sign language"*

The unavailability of interpreters, therefore, has far-reaching consequences that may not be reported due to a lack of advocates for deaf people regarding these issues. A medical doctor who was interviewed for this research also said:

> *We get help from a primary counsellor who has basic knowledge of Sign language. However, the primary counsellor is not always available for interpreting because she will be busy with her duty of counselling people. As a result, there are often delays.*

The examples above show that women who are Deaf stay longer for visits at the hospital than hearing women. Often, the receptionist will attend to the next hearing patient, while the Deaf person must wait for someone to offer interpreting services. This violates Section 22 of the Constitution of Zimbabwe, subsection 3, which mandates that all institutions and agencies of government at all levels must promote the use and advancement of accessible communication methods. The communication methods used during prenatal and postpartum care are not appropriate for Deaf women. According to Usman et al (2020), patient waiting time is defined as the length of time patients wait before being seen by a clinic's medical staff. It has been recognised as an important indicator for determining the quality of healthcare services offered by health facilities.

According to Kritzinger (2011), effective communication is essential for both patients who need to express themselves in terms of symptoms and complaints and for healthcare providers who must be able to explain treatment protocols, preventive options, and make diagnoses before treating any condition affecting the patient. The primary deaf counsellors cannot explain the diagnosis and symptoms to these two parties because the medical jargon is too deep for someone with basic knowledge of Sign language. This indicates a significant omission of important information when counsellors provide interpreting services between medical personnel and deaf pregnant women requiring antenatal and postnatal care at the hospital.

Failure by healthcare providers to provide professional interpreters to clients constitutes a breach of constitutional rights. There are sixteen official languages in Zimbabwe, as stated in Section 6 of the current constitution. These include Chewa, Chibarwe, English, Kalanga, Koisan, Nambya, Ndau, Ndebele, Shangani, Shona, Sign Language, Sotho, Tonga, Tswana, Venda, and Xhosa. All government agencies and institutions must treat these languages equally (Ndlovu, 2021). According to these pronouncements, all institutions and agencies of government must accommodate all languages.

Parirenyatwa Group of Hospitals, as a state-owned healthcare centre, must ensure the use of Sign language to provide equality between hearing and deaf individuals, as mandated by Section 6.3(b). An official language is a language recognised by law to be the language of public life, which includes medical institutions. Furthermore, every Zimbabwean citizen and legal permanent resident has the right to access any information held by the state or any institution of the government at any level, as per Section 62 of the Constitution Amendment Number 20 Act, Section 2. Article 19 of the Universal Declaration of Human Rights also supports the right to access information (Kubatana, 2021). This right of access is denied to pregnant Deaf women seeking antenatal and postnatal care at health institutions such as Parirenyatwa Group of Hospitals.

Attitudes of Healthcare Staff towards Women Who Are Deaf

The attitudes of the medical staff are a further barrier to accessing healthcare services for Deaf people during pregnancy and after delivery. The inability of health providers to adequately address the unique needs of the Deaf is a significant cause of user dissatisfaction in this scenario. The Deaf may become frustrated with healthcare providers if they behave improperly or miscommunicate (Fellinger, 2011). The following response from a Deaf interviewee attests to this:

> *During labor, I saw that the health professionals were avoiding me because I am Deaf. I think they were scared about how they were going to communicate with me.*

Another Deaf interviewee said:

> *As a deaf woman, being in labour is a difficult experience because there is a time where a woman feels like calling a midwife to come and check the dilatation of the cervix but we are unable to do that because the nurses do not understand our language but the hearing people communicate freely with the nurses. So when l gave birth l was just lying on the bed waiting for their own time regardless of how l felt. During labour, the nurses used Shona, and I did not understand their instructions.*

The responses above clearly show that bad attitudes by hospital staff towards patients often negatively affect the Deaf and make it difficult for them to access health care services. The Deaf community feels frustrated and disappointed by the way health professionals treat them due to communication barriers. During labour, the midwife provides instructions, such as encouraging the patient to lie on their left side, discouraging the patient from pushing before being fully dilated, and instructing the mother to observe fetal movements and inform the midwife if the fetal movements have decreased. All these instructions, among others, are not relayed in accessible formats of Sign Language because the midwives are not competent in Sign Language. This inappropriate form of care during labour leads to increased vulnerability (Hindley, 2006). There is a less positive attitude toward the Deaf compared to hearing people. The communication barrier creates a distance between the Deaf and health professionals. This view is supported by Coryell (1992), who points out that communication methods such as Sign language and lip reading, which are used to understand spoken language, may be valued as disruptive to social interaction and lead to difficulties in building relationships.

The examples above show that the Deaf experience poorer service delivery than their hearing counterparts. This violates Section 56(3) of the Constitution of Zimbabwe (2013), which outlaws discrimination based on language, as per the Equality and Non-discrimination provision. The unavailability of Sign language in the health sector discriminates against the Deaf. There is a need for a complementary dedicated body that enforces the implementation of the language provisions (Ndlovu, 2021).

Deaf individuals are often considered a marginalised group due to their unique communication and accessibility needs that accentuate their differences from the hearing society (Mousley & Chaudir, 2018). Therefore, the incorrect choice of language, such as using Shona instead of Sign language, affects the effectiveness of the message being communicated to the Deaf.

The examples presented above illustrate a significant oversight among health professionals regarding the communication needs of individuals who are Deaf. There appears to be an implicit assumption that all patients possess the ability to understand verbal communication, leading to a reliance on loud speech as a means of conveying information. This behaviour suggests that health professionals mistakenly believe that Deaf individuals are simply choosing to ignore verbal instructions, rather than recognising the fundamental barriers to communication that exist.

Furthermore, the midwives' consistent use of shouting reinforces the assumption that verbal communication is universally accessible, thereby marginalising those who do not communicate through spoken language. This

lack of awareness contributes to a scarcity of accessible health information for Deaf individuals, effectively violating their linguistic rights. Tollefson (1991) emphasises that minority languages and their speakers deserve recognition and respect, as acknowledging linguistic rights is both a moral and ethical imperative.

The communication gap between Deaf pregnant individuals and midwives not only exacerbates health disparities but also fosters feelings of alienation and resentment. This situation highlights the urgent need for healthcare professionals to adopt inclusive communication practices that recognise and accommodate the diverse linguistic needs of all patients, thereby promoting equity in healthcare access and delivery.

As revealed by the example above, they feel disrespected by midwives. Health professionals use only Shona and English as mediums of communication. Deaf people eventually fail to access health facilities during maternity; hence it becomes a cause for concern because what the constitution of Zimbabwe says about language use in government institutions is not being implemented. According to Ndlovu (2020), access to information from disseminating organisations is a serious problem for minority groups. Sign language is not considered when it comes to information dissemination.

The use of the word "encourage" in Section 22(3) undermines the case because it is not binding or forceful, providing institutions with escape routes. Ndlovu (2020) claims that numerous media stories have been published on lobbying and advocacy efforts by the Deaf and Hard of Hearing in conjunction with Community Organisations to integrate Zimbabwe Sign Language in all sectors. However, despite efforts at lobbying and petitioning, little progress has been made in offering Sign language interpretation in the health sector, as observed in this research conducted at Parirenyatwa Group of Hospitals.

Recommendations

To enhance communication in the healthcare sector and achieve more positive health outcomes, the study offers recommendations for both practice and policy. Firstly, to ensure effective communication with the Deaf, nurses, doctors, and other health professionals must have training in Sign language during their courses. Such training can take the form of short courses, refresher courses and periodic workshops. Additionally, all government health institutions must have a comprehensive language policy that accommodates the use of all local languages listed in Section 6 of the Constitution of Zimbabwe. Additionally, government training institutions, such as universities and colleges, should train Sign Language interpreters, which the government can then utilise in public health facilities. For increased awareness regarding issues affecting the Deaf, there is a need for advocacy, which requires all stakeholders, including the government,

non-governmental organisations, and the community, to participate in promoting the use of Sign Language in health domains. Finally, rather than being just a paper document, the Constitution must ensure that there are deliberate efforts to promote and guarantee the use of Sign Language as a linguistic human right, and that access to health information for the Deaf is treated as a linguistic human right. The Constitution must clearly stipulate the consequences of non-compliance with the constitutional provisions regarding the language rights of members of the Deaf community.

Conclusion

The findings from this research show that the absence of Sign Language interpreters in the health sector denies Deaf pregnant women full access to antenatal and postnatal care. There is inequality between Deaf women and hearing women when it comes to getting important healthcare and associated information at Parirenyatwa Group of Hospitals as a result of the language barrier. There appears to be a lack of political will to develop Sign language and provide trained interpreters who can bridge the communication gap between healthcare personnel and the Deaf at facilities like Parirenyatwa Group of Hospitals. Therefore, there is a need for the government to take a proactive approach in ensuring the development and effective use of all officially recognised languages in the country, especially in public institutions such as hospitals. This point aligns with Tollefson's (2001) examination of how language policies in education can marginalise certain groups while privileging others, thereby reinforcing the notion that language planning is inherently tied to power and governance.

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Conflict of Interest Disclosure

All the researchers declare no conflict of interest in this research.