



HEALTHCARE ENVIRONMENT NEEDS ACCESSIBLE LANGUAGE

Framework and
Guidelines



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The project in short

HEAL (Healthcare Environment needs Accessible Language) is an Erasmus+ project rooted in a very practical challenge: healthcare communication is still not fully accessible, and for Deaf people this can mean higher stress, reduced autonomy, and—in some situations—less effective care.

The project therefore aims to strengthen communication skills among healthcare staff and make information and care pathways easier to understand and navigate. To achieve this, HEAL will co-create training materials, an accessible-language glossary, and an interactive mobile app, working closely with stakeholders through interviews, focus groups, and ongoing consultation. These resources will then be developed and piloted in real settings, supported by targeted training and dissemination actions to encourage uptake and long-term sustainability.

Why this framework?

Before HEAL builds training sessions or digital tools, the project does something that feels almost old-fashioned in the best way: it starts by listening—carefully, systematically, and with curiosity. This phase is all about understanding what actually happens when Deaf people and other disabled people enter a healthcare setting. Not the ideal version written in policy documents, but the real experience: information that’s too complex or ambiguous, conversations that move too fast, procedures explained only verbally, consent and instructions that aren’t truly accessible, and environments that assume everyone communicates in the same way. To map this reality, the partnership combines research on existing evidence and good practices with direct input from the field: interviews, focus groups, and questionnaires involving inclusion experts and disabled people themselves. The goal is simple, and ambitious: identify what works, what fails, and what needs to change so that healthcare communication becomes clearer, safer, and more respectful of autonomy.

What comes out of this work is the heart of what you, as a reader, will find in our magazine: a shared framework—a solid, practical reference that brings together data, real voices, and concrete recommendations. It’s designed to help healthcare professionals understand the communication barriers that Deaf people face and to offer a grounded way forward: not “tips and tricks”, but a structured lens for improving everyday practice.

*The Team of
The Heal Project*



THE TOPICS



DESK RESEARCH

We reviewed international research and official guidance on accessible healthcare communication, with particular attention to Deaf communities rights. We mapped existing tools and training approaches already used in healthcare settings, noting what evidence supports them and where gaps remain. We compared policies and good practices across countries to see what can realistically be transferred and adapted, rather than copied.



SURVEYS

We designed surveys to capture how communication is experienced in everyday healthcare encounters, from both service users and professionals. The questions focused on practical moments—appointments, instructions, consent, follow-up—and on what helps or blocks understanding. Responses were collected to spot patterns as well as country-specific issues.



INTERVIEWS

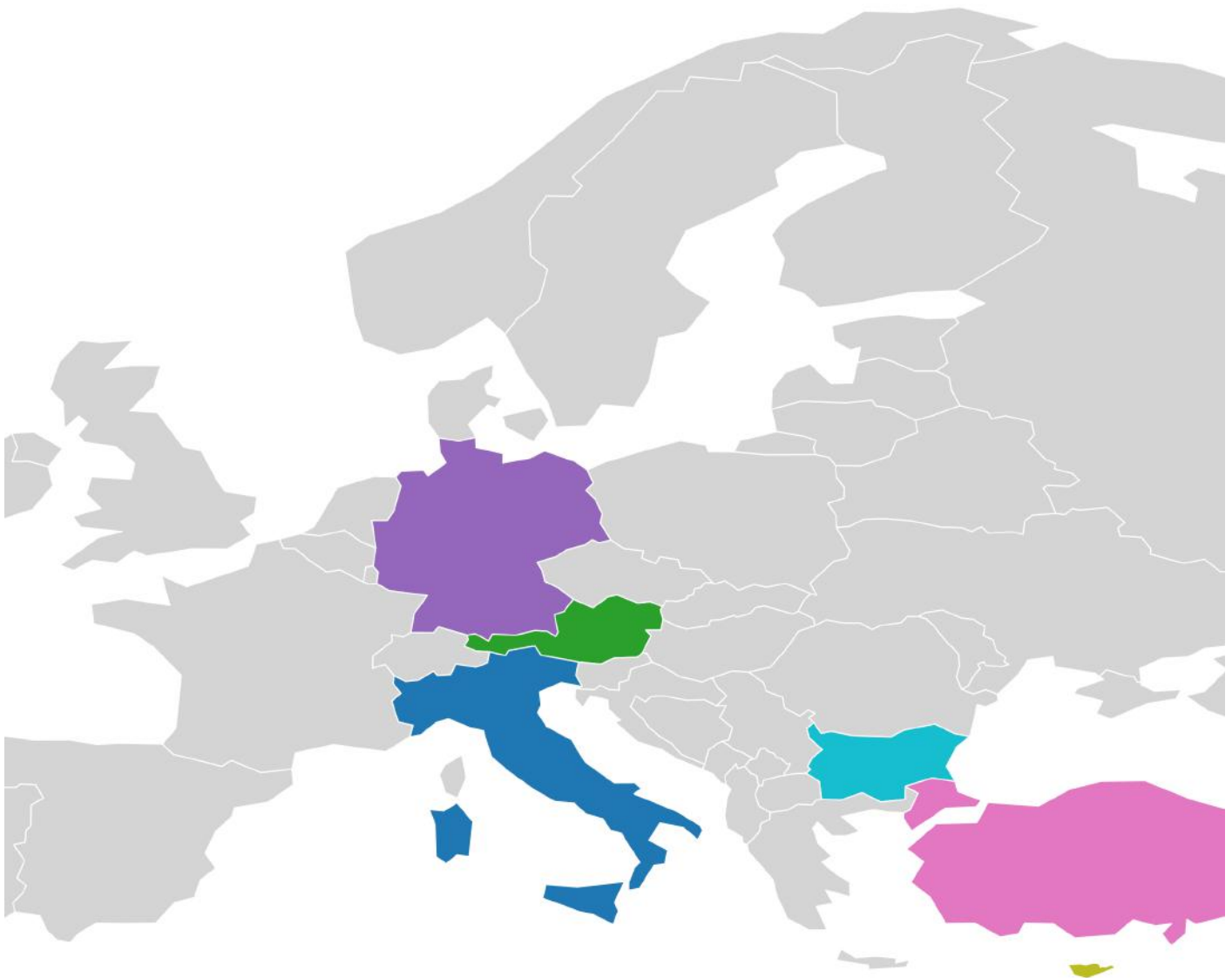
We conducted semi-structured interviews with Deaf people and key professionals to move beyond “general impressions” and capture detailed, real-life situations. Participants were invited to describe specific moments in care. Across conversations, we looked for recurring barriers and the small adjustments that made a big difference, from language choices to interaction routines.



DESK RESEARCH

When healthcare depends on communication

What six countries taught us about access



The Desk research was carried out in the highlighted countries.

SIGN LANGUAGES OVER EUROPE

Across Europe (and just beyond it), healthcare systems are getting better at talking about “access”—but far less consistent at delivering it when a patient needs communication support right now. HEAL’s desk research, carried out across Austria, Bulgaria, Cyprus, Germany, Italy, and Türkiye, starts from a simple reality: access is not only ramps and doors. It’s also language, information, timing, and the ability to understand—and be understood—under stress.

A first shared finding is that the legal language is often strong. Several countries explicitly recognise national sign languages, which matters because it frames sign language as a language right, not a “special favour”. In Germany, federal law states plainly that German Sign Language is recognised as an independent language (Behindertengleichstellungsgesetz [BGG], §6, as presented by the German federal BGG information portal; Schlichtungsstelle BGG, 2022).

Austria embeds the same principle at constitutional level: “Austrian Sign Language is recognised as an independent language.” (Bundes-Verfassungsgesetz, Art. 8(3); RIS, 2026) Bulgaria also moved decisively with its dedicated law on Bulgarian Sign Language, placing recognition into national legislation rather than informal practice. (Ministry of Labour and Social Policy, 2021) Cyprus recognises Cypriot Sign Language through its 2006 recognition law, establishing an “official language” status—though implementation still depends on how policies translate that status into funded service (AccessibleEU, n.d.). Italy, after years of advocacy, anchored promotion and protection of LIS and LIST in national provisions and formally recognised the professional role of LIS/LIST interpreters (Gazzetta Ufficiale, Art. 34 - ter)



Recognized sign languages by law (Report on the status of sign languages, 2003)

THE MAZE TOWARDS ACCESSIBILITY

RECOGNIZED DOES NOT MEAN AUTOMATICALLY ACCESSIBLE



The second shared finding is where the desk research becomes more uncomfortable: rights don't automatically become pathways. Even where sign language is recognised, access can still hinge on local availability, booking rules, and whether frontline staff know what to do. In practice, patients are often navigating a patchwork: some services are designed for planned appointments, others for emergencies, and many depend on region-by-region decisions.

Italy is a clear example of “one country, many systems.” Nationally, the legal direction is moving: the 10 December 2024 decree (published in January 2025) updates the framework around LIS/LIST interpreting professions—important groundwork for quality and accountability.

But day-to-day access still varies widely across regions and even between hospitals. In some places, booking an interpreter is treated like booking any other service—possible, but with advance notice. For instance, ENS Milan describes interpreter requests routed through hospital booking channels with at least 72 hours' notice. In emergencies, other solutions appear: Piemonte launched a model where emergency departments are equipped with a tablet enabling a three-way video connection (patient–clinician–interpreter), paired with staff training and service hours.

Emergency access also shows how digital tools can help—if they’re known and adopted. Italy has multiple channels linked to emergency response systems: “112 Where Are U” is active in a defined set of regions, and specialised services list where it currently operates. Tools like FlagMii describe text-based chat activation to support emergency communication. The desk research points to a key lesson for HEAL: access solutions exist, but patients and professionals need consistent procedures and training so the solution is activated in the moment it matters.

A third shared finding is that data about Deaf/sign language users is still fragile. Disability statistics are improving, but sign-language-user statistics are often missing or estimated rather than systematically counted. For disability prevalence, Eurostat’s comparable indicator shows that in 2024 the share of people reporting activity limitations varies widely—from 12.7% in Bulgaria to 14.5% in Italy, with much higher rates in some other EU countries. For Italy specifically, ISTAT’s disability infographics report 2.9 million people with severe limitations in usual activities (2023)—and also highlight territorial inequalities in municipal social spending on disability-related services.

For hearing loss, European-level reports combine survey sources (including EuroTrak and estimates where surveys don’t exist), underlining both the scale of need and the limits of current measurement. HEAL’s framework therefore has to be honest: evidence-led does not mean pretending the data is perfect—it means naming the gaps and designing tools that still work when prevalence is uncertain.

So, what will readers find in HEAL’s framework (the “why this matters” section)? They’ll find a practical, healthcare-facing way to translate legal commitments into repeatable actions: how to request communication support, how to triage communication needs in emergencies, how to use digital channels safely, and how to reduce regional lottery effects by standardising the minimum access pathway that every provider should know.

**“ABSENCE OF
EVIDENCE IS NOT
EVIDENCE OF
ABSENCE.”**

Carl Sagan -

Definition of the Concept of Inclusion and Inclusion Criteria in the Health Field

Italy

In Italy, the cornerstone legal framework for inclusion is Law 104/1992, which sets the principles for the rights, assistance, and social integration of persons with disabilities. The law frames inclusion as a matter of fundamental rights and calls for measures that prevent marginalisation and social exclusion, across areas such as education, family life, work, and community participation.



Germany

The goal of inclusion is defined as having no healthcare barriers based on disability or communication differences. Solutions involve the use of simplified German Sign Language (DGS) and visual aids.



Austria

Inclusion is defined as equal participation, rather than forcing disabled people to adapt. Criteria include barrier-free communication (sign language, easy language) and no extra costs for people with disabilities.



Definition of the Concept of Inclusion and Inclusion Criteria in the Health Field

Bulgaria

Inclusiveness means equal access to care and participation for everyone. The 2030 Strategy focuses on accessible environments and support for long-term conditions.



Cyprus

Inclusion is defined as involving respect, participation, and support for diverse needs. Criteria include physical access in line with EU standards and cultural competence in delivery.



Turkey

Inclusivity is defined as removing physical, digital, and communication barriers. Main criteria include staff trained in sign language, the presence of interpreters in hospitals, and accessible written/visual materials.



Legal Framework and Status of Accessibility in Healthcare Facilities in Partner Countries

Italy



In Italy, the cornerstone legal framework for inclusion is Law 104/1992, which sets the principles for the rights, assistance, and social integration of persons with disabilities. The law frames inclusion as a matter of fundamental rights and calls for measures that prevent marginalisation and social exclusion, across areas such as education, family life, work, and community participation.

Germany



The legal foundation includes the AGG (General Equal Treatment Act), which prohibits discrimination, and the BGG (Federal Act on Equal Opportunities), which mandates physical and communication accessibility. SGB IX (Social Code Book IX) regulates rights in healthcare and rehabilitation alongside the UN Convention.

Austria



The legal framework is guided by National Action Plans (2012–2020 & 2022–2030) supporting inclusion. Accessibility in healthcare is mandated by Articles 9 & 25 of the UN CRPD, ensuring barrier-free buildings and easy-to-understand medical information.

Legal Framework and Status of Accessibility in Healthcare Facilities in Partner Countries

Bulgaria



Rights are protected under the Disability Law (2019). Public buildings, including hospitals, must be barrier-free, although rural areas still lack proper services. Accessibility mandates include physical access, transport, and communication (sign language, Braille, easy-to-read formats).

Cyprus



The legal framework is based on the Law of 2004 (1(I)/2005), which establishes patients' rights, including access to healthcare, dignity, and non-discrimination. Although Cyprus has ratified the UN Convention on the Rights of Persons with Disabilities, challenges persist regarding physical accessibility and the official recognition of sign language. There is a noted need for modernization of the law to reflect new ethical and technological developments.

Turkey



The right to health is protected by Article 56 of the Constitution and Law No. 5378 on Disabled Persons. The Ministry of Health has launched the "Barrier-Free Healthcare Services" program, where hospitals can earn a "Disabled-Friendly Hospital" certificate by providing sign language interpreters and accessible materials.

Status of Healthcare Professionals and Support for Deaf People

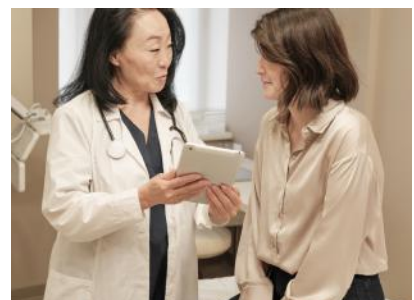
Italy

Italy's framework builds on Law 104/1992. The UN Convention on the Rights of Persons with Disabilities was ratified through Law 18/2009, reinforcing the duty to ensure equal access to healthcare, including communication access for Deaf sign-language users. This has been strengthened by the recognition of Italian Sign Language (LIS) in 2021 and further professional provisions for LIS/LSI interpreters introduced in December 2024—though implementation still often relies on request-based services and uneven availability.



Germany

There is a general lack of sign language training for staff, and patients often have to organize interpreters themselves. Positive examples include the LWL Clinic (specialized psychiatric care) and a dental clinic in Hamburg run by deaf professionals. Platforms like Deafservice.de help list accessible providers.



Austria

There are only 130 sign language interpreters available nationwide. 5 hospitals in Austria have special outpatient clinics for deaf patients. Interpreter costs are often covered by public institutions (e.g., Vienna Social Fund covers up to €10,000/year).



Status of Healthcare Professionals and Support for Deaf People

Bulgaria

Sign language interpreters are trained professionals working in hospitals. Deaf and deaf-blind individuals are entitled to 120 hours/year of free sign language interpreting, with university students receiving an extra 60 hours per semester.



Cyprus

There is a significant training gap regarding effective communication with deaf patients. While the University of Nicosia's Unit for Diversity Competence aims to improve inclusiveness, training specifically focused on hearing impairments is limited.



Turkey

There is no mandatory sign language training for healthcare staff, though some optional courses exist. A mobile app exists to assist with appointments, but real-life use needs improvement. According to 2022 data, 164,594 doctors and 198,465 nurses serve a population that includes 179,867 officially registered hearing-impaired individuals.



Accessibility Is Still Provided "Upon Request"



Italy has strong disability and accessibility laws—including LIS/LISt recognition—but Deaf healthcare access still often depends on patient-led requests, uneven staff training, and limited interpreter availability.

In Italy, accessibility in healthcare is increasingly understood through the lens of reasonable accommodation, aligned with the UN approach: services should adapt so people with disabilities can access care on an equal basis. The key national framework remains Law 104/1992, which protects disability rights and places responsibilities on public services—including healthcare—to provide supports for inclusion, also recognising the role of family caregivers. ([gazzettaufficiale.it](https://www.gazzettaufficiale.it)) Italy strengthened this direction in 2009 by ratifying the UN Convention on the Rights of Persons with Disabilities through Law 18/2009, which affirms the right to the highest attainable standard of health and pushes accessibility beyond "availability" into real usability. ([parlamento.it](https://www.parlamento.it))

In practice, accessibility needs to work across physical spaces, digital tools, and communication. Physical barriers in hospitals and clinics still matter, but so do websites, apps, booking platforms, and digital documents—areas where the "Legge Stanca" (Law 4/2004) is a key reference, promoting accessibility of digital systems used by public bodies and services of public utility, including healthcare. ([normattiva.it](https://www.normattiva.it))

For Deaf sign-language users, the major recent shift was the official recognition of Italian Sign Language (LIS) and Italian Tactile Sign Language (LISt) through Article 34-ter of Decree-Law 41/2021 (converted into Law 69/2021). ([normattiva.it](https://www.normattiva.it)) A further step followed with the Decree of 10 December 2024 (published in 2025), which sets provisions for the professions of LIS and LISt interpreters and supports structured professional training, with attention to teaching delivered by Deaf teachers and expert native LIS users. ([gazzettaufficiale.it](https://www.gazzettaufficiale.it))

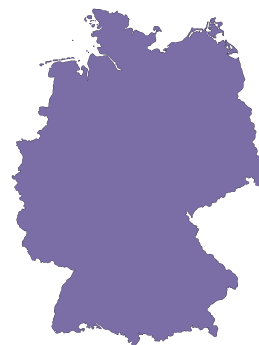
Yet everyday access is often still procedural and patient-led. In many settings, Deaf patients must request interpreting by email or form, provide personal details and the type of appointment, and explicitly ask for a LIS interpreter; the facility then confirms the date, and the interpreter accompanies the patient during the visit.

Even when the service is free, this model makes accessibility depend on planning capacity and administrative navigation—two things healthcare should not require as prerequisites.

Structural gaps persist. Interpreter availability is insufficient for the signing Deaf population, working conditions and pay are often inadequate, and coverage is uneven, with some areas—especially in parts of Southern Italy—poorly served. Interpreter training also rarely includes formal medical specialisation, so competence in healthcare settings is often built through continuing education and field experience rather than a consistent curriculum. Healthcare staff training is another weak point. Deafness, sign language, and communication accessibility are more present in humanities-related university programmes, while many health faculties still teach Deafness mainly through an anatomical-pathological lens, leaving professionals underprepared for accessible communication. This often forces Deaf patients to organise accessibility themselves. There are also encouraging innovations, especially in emergency contexts. In Piemonte, Comunic@ENS_Pro supports communication in emergency departments via a dedicated tablet connecting the Deaf patient, healthcare worker, and a LIS translator through video-call—an approach that has expanded after COVID-19 and is gradually spreading. ([malattierare.gov.it](https://www.malattierare.gov.it)) Emergency access tools differ by region as well, including the "Where Are U" app linked to the 112 system in Lombardy and dedicated Deaf-access solutions such as 112 Sordi supported by FlagMii technology. ([regione.lombardia.it](https://www.regione.lombardia.it)) Overall, Italy has strong legal foundations and meaningful recent progress, but healthcare accessibility—especially communication access—still too often works "by request," shaped by uneven training, limited interpreter capacity, and administrative friction.

GERMANY

Access Isn't a Favour



Germany's desk research shows a clear gap: strong accessibility rights on paper, but Deaf patients still hit communication barriers—especially interpreter access—in everyday care.

In Germany, accessibility in healthcare is established through both legal regulations and international standards. Key legal foundations include:

- **General Act on Equal Treatment (AGG):** This act prohibits discrimination based on disabilities and requires public and private institutions offering healthcare services to provide accessible access. It mandates that these institutions ensure barrier-free access to their facilities and services.
- **United Nations Convention on the Rights of Persons with Disabilities (UNCRPD):** This convention obliges Germany to ensure equal access to all public services, including healthcare. It demands barrier-free communication, physical accessibility of buildings, and adapted services for individuals with disabilities.
- **Federal Act on Equal Opportunities for People with Disabilities (BGG):** This act requires public institutions to ensure accessibility in terms of physical accessibility (e.g., wheelchair ramps, accessible toilets) and communication (e.g., sign language or simple language).
- **Sozialgesetzbuch IX (law):** This regulates the rights of people with disabilities and stipulates that healthcare facilities must create accessible services, particularly in terms of rehabilitation and medical care.

The situation of healthcare professionals in Germany concerning the effective care and support of hearing-impaired individuals is marked by several challenges. A central issue is the lack of training in sign language and the specific communication needs of deaf individuals. Although some universities and training institutions offer seminars on interacting with deaf people—often initiated by dedicated sign language instructors—these opportunities remain exceptions and are typically based on personal initiative rather than structural integration into curricula.

In practice, deaf patients often bear the responsibility for organizing sign language interpreters themselves—even for urgent medical matters. When physicians or nursing staff take the initiative, implementation frequently fails due to the unavailability of interpreters on short notice—a clear indication of the existing shortage of skilled professionals in this area.

At the same time, there are encouraging examples: For instance, the LWL Clinic Lengerich provides a specialized department for hearing-impaired individuals in psychiatry, psychotherapy, and psychosomatics. (<https://www.lwl-klinik-lengerich.de/de/fuer-patienten-angehoerige/die-klinik/medizinischefachabteilungen/#behandlungszentrum-fur-horgeschadigte-27298360>)

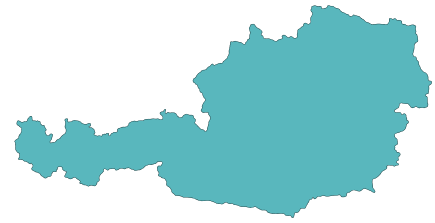
Similarly, there are physicians with sign language competence, such as a dental practice in Hamburg where the dentist and several assistants are themselves deaf—an exemplary model of lived accessibility.

(<https://vonschuleralarcon.de/>)

Additionally, the volunteer-maintained website deafservice.de offers an overview of accessible rehabilitation facilities and physicians with expertise in treating deaf patients. While not comprehensive, this resource serves as an important guide for many affected individuals.

AUSTRIA

From Rights to Reality



Austria has strong accessibility commitments, but Deaf people still face everyday communication barriers—especially inconsistent training and interpreter access—making inclusive care too dependent on individual initiative.

Austria's idea of accessibility in healthcare is often reduced to architecture, but the real test is simpler: can every person—regardless of physical, cognitive, or sensory impairments—use services, understand information, and receive care on an equal basis? In this sense, accessibility is about removing barriers that block access to diagnosis, treatment, and follow-up, so that equitable care becomes routine rather than exceptional. In Austria, this goal is supported by a combination of laws, policy measures, and international commitments. The Federal Disability Equality Act (Bundes-Behindertengleichstellungsgesetz, BGStG) prohibits discrimination against persons with disabilities, including in healthcare, and requires providers to take reasonable steps toward accessibility. Austria's ratification of the UN Convention on the Rights of Persons with Disabilities (UNCRPD) reinforces the obligation to ensure equal access to public services, including barrier-free communication, physical accessibility, and adapted services. The National Disability Action Plan (Nationaler Aktionsplan Behinderung) translates these principles into concrete national measures, while broader health law (Gesundheitsrecht) emphasizes appropriate care for all patients—implicitly requiring adaptations when people's needs demand it.

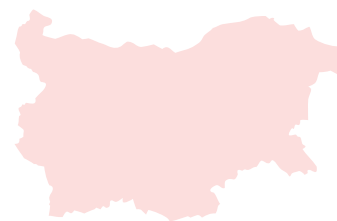
Yet the daily reality for Deaf and hearing-impaired people shows how easily rights on paper can become fragile in practice. Many healthcare professionals still lack consistent training in sign language and in Deaf-specific communication needs. Although workshops and training exist, they are not always embedded in medical curricula, which means accessible communication often depends on personal goodwill or improvised solutions rather than a reliable system. Interpreter access is another pressure point:

Deaf patients may struggle to arrange sign language interpreters for appointments, and availability can fall short—especially at short notice or in emergencies. Costs can also become a barrier, even if public health insurance may cover interpreters in certain cases, because uncertainty and administrative friction can delay support. At the same time, Austria also offers promising examples. There are initiatives that develop easy-to-understand health information in sign language or provide specialized support in specific healthcare contexts. Organizations such as Equalizent gGmbH work on inclusion for Deaf and hearing-impaired people and raise awareness among healthcare professionals through training and educational efforts. Volunteer-maintained resources—including deafservice.de and similar websites—help by listing accessible rehabilitation facilities and physicians with relevant experience.

This mix of progress and gaps highlights the central issue: communication accessibility too often relies on individual initiative instead of stable structures. A truly inclusive healthcare system must combine physical accessibility with dependable communication—interpreters available both in person and remotely, visual supports, and clear written materials—alongside staff training in practical communication strategies and Deaf cultural competence. Strong legal frameworks like the BGStG and UNCRPD already provide the foundation; the next step is making responsibility, standards, and funding consistent enough that Deaf people can access care with clarity, safety, and dignity every time.

BULGARIA

Accessibility Shift: Stronger Rights, Better Interpreting



Bulgaria has strengthened disability and inclusion rules since 2019—expanding accessibility from buildings to information and sign language—yet healthcare access still varies sharply by region, resources, and service availability.

Bulgaria has pushed a major shift in disability policy. After reform steps beginning in 2018, the Disability Act—effective from 1 January 2019—became the key legal reference guaranteeing rights for people with disabilities. What’s striking is how broadly the law defines “accessibility.” It is not limited to ramps or elevators, but stretches across the environment people move through and the information they must be able to understand: reasonable accommodations, accessible communication, and personal mobility sit at the heart of the concept. The aim is equal access not only to healthcare, but to public services and everyday life—urban spaces, transport, information systems and emergency services—and it even explicitly includes access to sea beaches. The logic is simple: barriers are identified, then removed, whether they appear in pedestrian routes, public-service buildings (including hospitals), transport, or communication channels.

This broader definition matters most when it becomes practical for Deaf and deafblind people. According to the Social Assistance Agency, deaf and deafblind people can receive free Bulgarian Sign Language interpreting services up to a 120-hour annual limit, accessed through an application process and an expert decision. Deaf and deafblind higher-education students and doctoral candidates can receive additional interpreting time—up to 60 hours per semester beyond the annual limit—recognising how communication needs grow in academic settings. Bulgaria has also formalised interpreting as a profession through a state educational standard for the “Sign Language Interpreter,” describing the role in detail: accurate two-way interpretation between spoken Bulgarian and Bulgarian Sign Language, with flexibility to use different sign-communication forms, and the option of consecutive or simultaneous interpreting, delivered live or remotely through real-time technology.

The interpreter’s responsibilities extend across many contexts—including hospitals and public institutions—while emphasising confidentiality, accuracy, and familiarity with Deaf culture. Even the physical demands of the work are acknowledged, noting that interpreters may need rotation after about twenty minutes depending on the situation.

All of this sits inside a wider inclusion framework. Bulgaria’s Law on the Integration of People with Disabilities focuses on preventing discrimination and supporting socio-economic participation through allowances and targeted assistance, while also encouraging employment via workplace adaptations and incentives. In healthcare, the Constitution and the Health Act frame access to care as a right, treating health—physical, mental, and social well-being—as a national priority supported by principles like equal access and accessible, high-quality services. The system also foresees integrated health-social services and home-based support for people with chronic conditions, disabilities, and older people needing daily assistance. And yet the gap between rights and reality remains. Bulgaria’s Strategy for Poverty Reduction and Social Inclusion 2030 prioritises equal access to quality healthcare and broad environmental accessibility, but persistent challenges—uneven distribution of doctors and facilities, high costs, limited outpatient rehabilitation and specialised services, especially in rural areas—mean accessibility still feels inconsistent. Bulgaria’s direction is clear and increasingly comprehensive; the next challenge is making it reliable everywhere, so access isn’t a matter of geography or luck.

CYPRUS

Patients' Rights on Paper, Accessibility Still Catching Up



Cyprus has a strong patients' rights foundation and international commitments, but accessibility—especially communication access for Deaf people—still needs clearer standards, recognition, and targeted professional training.

Cyprus's modern conversation on healthcare accessibility starts with a turning point in 2004, when the country introduced a patients' rights law that formally recognised core protections: the right to healthcare and treatment, to dignity, to access health services, and to non-discrimination. That framework also addressed privacy and hospitalisation conditions, signalling an important shift—healthcare was not only about services, but also about how people are treated while receiving them. Two decades later, the same law shows its age. Technology, lifestyles, and ethical standards have evolved quickly, and the call now is for an update that does more than “refresh” wording. The ambition is to modernise the legal principles and, at the same time, confront long-standing misconceptions that have historically contributed to the marginalisation of persons with disabilities. In practice, this means treating accessibility as something pursued fully—not partially—and as a right that must work in real settings, not only on paper.

Cyprus has also anchored its direction in international standards by ratifying the United Nations Convention on the Rights of Persons with Disabilities, aligning national commitments with broader disability-rights expectations. Yet a key tension remains: while built-environment accessibility has been a policy goal, it is still challenging to implement consistently. And communication access is even more fragile. A particularly telling gap is that sign language is still not officially recognised as a form of communication bridging hearing and Deaf communities, with government efforts described as limited and mostly focused on media and public communication rather than everyday service delivery.

The structure of the healthcare system adds another layer. Cyprus operates with both public and private sectors: the public system—administered by the Ministry of Health (Cyprus) and state-funded—aims to ensure access for taxed citizens, while the private system relies on out-of-pocket payments through private clinics and hospitals. In such a mixed landscape, accessibility can become uneven unless standards and responsibilities are crystal clear across both sectors.

When it comes to training and support for Deaf people or people with hearing loss, the picture is mixed and—importantly—hard to verify publicly. Deaf Patients or with hearing loss are generally grouped under “persons with disabilities” in official documents. There are encouraging steps, though: in September 2023, the University of Nicosia established the Unit for Diversity Competence in Healthcare and Healthcare Education, aiming to build a more inclusive health environment through training opportunities for healthcare staff. The initiative is promising, but the gap remains: targeted studies or structured training series specifically focused on hearing loss and Deaf communication are not clearly evidenced here.

Inclusion criteria become the practical lens: who is eligible for services under the General Healthcare System; whether physical and communication accessibility are ensured (including interpreting or assistive technologies); whether cultural competence is supported; and whether medical research and clinical trials follow ethical rules that protect representation. The direction is clear: Cyprus has the foundations. The next step is to turn them into consistent, recognised, communication-accessible care—especially for Deaf people—across the whole system.

TÜRKİYE

"Barrier-Free" Turn: Rights on Paper, Tools in Motion



In Türkiye, accessibility in healthcare is legally recognised and increasingly supported by national "barrier-free" tools, yet Deaf communication access still depends heavily on uneven implementation and optional training.

In Türkiye, the promise of accessible healthcare starts at the top: the right to health is anchored in the Constitution, where the state is tasked with organising health services so people can live in physical and mental well-being. Alongside this, disability legislation such as Law No. 5378 on Disabled Persons frames "accessibility" as more than a building requirement—it extends to transport, information, communication technologies, and the everyday services people need to use independently and safely. That policy direction has been translated into healthcare-specific action through the Ministry of Health (Türkiye), which promotes "Barrier-Free Healthcare Services" standards and a "Disabled-Friendly/Barrier-Free Hospital" approach. In practice, this has meant pushing hospitals toward clearer signage, written and visual information supports, and—crucially for Deaf patients—interpreter-backed communication. Türkiye has also invested in direct, practical access points: for example, the "Engelsiz Sağlık İletişim Merkezi (ESİM)" model was presented as a way for Deaf people to reach emergency support, request interpreting, share location, and navigate appointment systems via video communication with sign-language-competent staff.

At the same time, the system still shows a familiar gap between "available" and "reliably available." The text you provided is blunt about training: there is no single, mandatory pathway that ensures all healthcare professionals can communicate effectively with Deaf people, even if some hospitals and universities run sign-language courses locally. A good sign is that this kind of training does happen in the public system—sometimes through formal protocols and cohort courses for hospital staff—but it remains uneven rather than guaranteed everywhere.

Scale also matters. Türkiye's hospital network has grown and shifted across sectors over time; Ministry-linked statistics show, for example, that by 2015 the total number of hospitals was over 1,500, with large shares in public and private provision. And while national initiatives have produced measurable outputs—one public account notes that 145 hospitals had received an "accessibility certificate" since 2013—the real test is whether a Deaf person can count on communication access on an ordinary Tuesday, not only in best-practice facilities. Finally, even the numbers behind disability and hearing impairment can vary by data source and definition—Türkiye's own disability database reporting and survey-based estimates do not always align—so accessibility planning has to stay honest about uncertainty while still building services that work in real life.

REFERENCES AND RESOURCES



The Heal Framework gives you not only a general overview of the State of Art in the partner countries, but also a list of resources and references that can be useful for your daily work and routine in the healthcare system. Go on our website through the link or QR code and discover which tools are already available in your country.

Filters will help you navigate the resources and references, to make it easy for you to find what you need in no time.

If you have some resources to add, if you know some tools that are not listed here and that would be useful for the accessibility of the healthcare system for the Deaf community, please go on our website and contact us!

THE GUIDEBOOK

RESIST

Research, Interview, and Survey Tables

[https://projectheal.eu/
resist-the-guidebook/](https://projectheal.eu/resist-the-guidebook/)





SURVEYS

The target group gives feedback

**"NOTHING ABOUT US
WITHOUT US."**

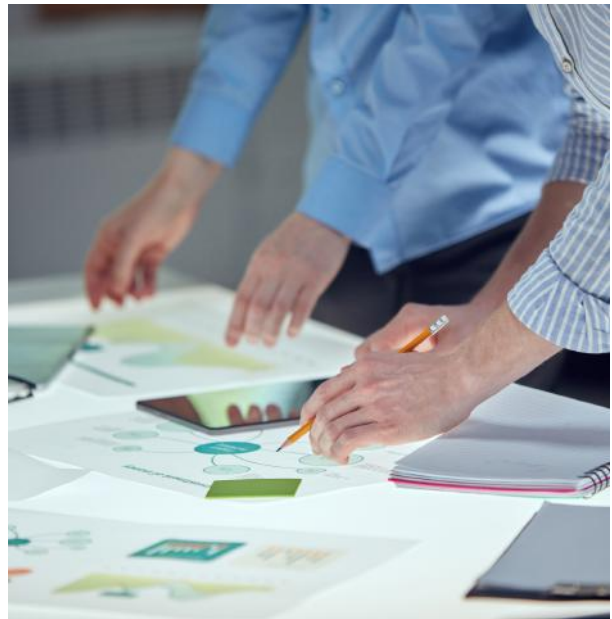
UNITED NATIONS

To understand what "accessible healthcare" looks like in everyday life—not only in laws and policy documents—we ran a coordinated survey across six countries. The goal was practical: to capture real experiences and working conditions around communication access, with a particular focus on Deaf people, sign language access, and the wider idea of accessible language in healthcare settings. This section introduces how the survey was designed and implemented, so readers can interpret the results with the right context.

The Methodology

We followed a shared procedure across all partner countries to keep the data comparable. First, the partnership agreed on a common questionnaire framework: the same core questions were used everywhere, with minor adaptations only where national healthcare structures or terminology required it. The survey was then translated and checked locally to ensure clarity and cultural fit—especially for sensitive wording around disability, Deaf communities, and healthcare experiences. The aim was not just linguistic correctness, but functional accessibility: questions had to be understandable, unambiguous, and respectful.

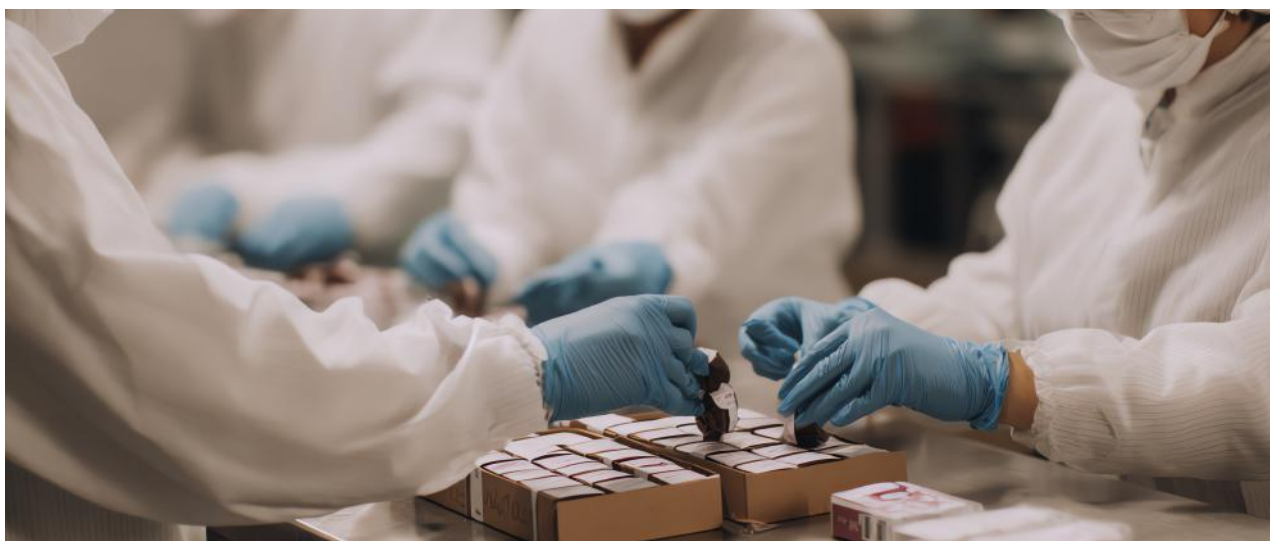
Recruitment was carried out through partner networks connected to healthcare, disability advocacy, and community services. Each country used channels that made sense locally—often a mix of institutional contacts and community-oriented dissemination—so we could reach people with direct knowledge of accessibility barriers and enablers.



Importantly, we treated accessibility not as a single “feature,” but as a bundle of conditions that shape whether care is usable: physical access, communication access, information clarity, and the availability of support (including interpreting and assistive tools).

Because the survey touched on personal experiences and potentially sensitive situations, we used an ethics- and privacy-aware approach. Participation was voluntary, and the survey introduction clarified what data would be collected, why it was being collected, and how it would be used in project reporting. We avoided collecting unnecessary identifying details and focused on patterns rather than individual stories, so the findings could inform recommendations without exposing participants.





Once data collection closed, partners reviewed results locally and then shared them in a common format for cross-country synthesis. This allowed us to look at national differences while still identifying recurring themes across contexts—for example, where policy looks strong but implementation is inconsistent, or where good practices exist but remain dependent on individual initiative rather than embedded systems. In the next articles, each country’s results are presented in its own context, followed by a comparative reading that highlights what seems structural, what seems local, and where change could be most impactful.

**To see the two
reports, go on our
website or scan the
QR code**

**[https://projectheal.eu/
/resist-the-
guidebook/](https://projectheal.eu/resist-the-guidebook/)**



PILLS Professionals



A total of 94 healthcare professionals participated across the six countries.

- Predominantly female participants (Italy 77%, Bulgaria 60%, Cyprus 91% female, Germany 62.5%).
- Age mainly between 31–60 years (Bulgaria strongly 51–60; Italy 51–60; Cyprus 31–40; Austria and Germany younger distribution).
- Educational level generally high (majority Master's and PhD in Bulgaria, Austria, Italy, Cyprus).
- Roles include: nurses, doctors, social/healthcare workers, administration staff, volunteers.
- Vast majority are hearing (100% Bulgaria, Cyprus; 90% Austria), while Austria and Germany include Deaf/HoH professionals.
- Sign Language competence:
 - Very low in Austria, Cyprus, Bulgaria
 - Moderate in TR
 - Very high in Austria and Germany (many fluent signers)

Across countries, most professionals have had at least one experience with Deaf or hard of hearing patients

Common experiences reported:

- Reliance on writing, gestures, lip-reading, and family members
- Difficulty in collecting accurate clinical information
- Positive experiences when interpreters or sign language were available
- Frustration due to inability to communicate directly with the patient

What worked well:

- Eye contact, calm interaction, visual aids, written communication
- Presence of interpreters (live or remote)
- Professionals with sign language knowledge report smooth communication (Austria, Germany)

What did not work:

- Lack of interpreters
- Overreliance on lip-reading
- Time-consuming communication
- Misunderstandings of Deaf patients' needs

PILLS Deaf community



Sample Size & Gender:

- Italy: 20 responses. The majority were female (65%).
- Turkey: 12 responses. All respondents (100%) were male, recruited primarily from a sports club.
- Germany: 32 responses. The majority were male (62.5%)
- Austria: 15 responses. The majority were female (60%).
- Bulgaria: 15 responses.
- Cyprus: 6 responses. The majority were female.

Age:

Participants in Italy and Cyprus predominantly young, mostly aged 20–30

Türkiye: mostly aged 31–40

Austria, Bulgaria, Germany: broader distribution 31–60

Educational background ranges from high school to university degrees:

I

Preferred Communication:

Sign Language (National variations: LIS, TİD, DGS, ÖGS, CSL, BgSL) is the preferred method of communication across all countries.

Written communication and mixed methods (bilingual) serve as secondary preferences

Experiences are largely negative to neutral.

- Italy: 40% negative, 30% neutral.
- Germany: Many reported traumatic experiences, particularly in emergencies or ambulances where staff refused to remove masks or communicate in writing.
- Bulgaria: Participants reported being ignored or doctors speaking to hearing relatives instead of the patient.
- Turkey: Participants noted that staff often claim to know sign language but only know a little, which causes confusion.

Specific Difficulties:

- Common themes include impatience, shouting (as if volume helps), refusal to write notes, and use of complex medical terminology.
- In Austria, specific incidents involved medical procedures (e.g., surgery, examinations) performed without prior explanation, causing shock and distress



INTERVIEWS

The community is our strength

This report serves as the consolidated analysis of the interviews and focus groups conducted across the partner countries (Italy, Austria, Bulgaria, Cyprus, Germany, and Türkiye) for the HEAL project. The primary objective of these activities was to define the specific gaps in the healthcare system regarding deaf accessibility and to identify the basic structures required for the subsequent Work Packages (WPs). The report covers qualitative and quantitative data collected between June 2025 and October 2025 from 6 different countries.

INTERVIEWS AND FOCUS GROUPS

Direct contact with the target group

The objective of this report is to synthesize the main qualitative findings emerging from these activities, identifying shared challenges, unmet needs, and structural gaps related to communication accessibility in healthcare settings for Deaf people. Rather than presenting country-specific findings separately, the report adopts an integrated thematic approach to capture common patterns and cross-cutting issues.

Across all partner contexts, communication barriers were identified as the most critical challenge, affecting access to healthcare at every stage—from appointment booking to consultations, follow-up, and emergency care. Although interpreters and digital tools are available in some settings, their use remains inconsistent, insufficiently institutionalized, and largely dependent on individual initiative rather than systemic provision.

The findings underline the need for structured training of healthcare professionals, clearer institutional protocols, and sustainable accessibility measures. This report provides a qualitative evidence base to inform the development of the HEAL theoretical framework, training modules, and pilot activities.

This consolidated report brings together the qualitative findings from these activities into a single analytical framework. By focusing on shared themes and recurring experiences, the report moves beyond local contexts and contributes to a broader European understanding of accessibility challenges in healthcare.

The integrated analysis presented here directly supports the subsequent work packages of the HEAL project, particularly those dedicated to training development, capacity building, and practical implementation.

The data collection involved focus groups and one-on-one interviews conducted in 6 partner countries. In total, in-depth discussions were held with over 35 key stakeholders.

The study ensured a diverse range of stakeholders. The participant distribution listed in the reports is as follows:

Deaf Individuals: Participants providing lived experiences of communication barriers (e.g., 2 participants in their 60s in Cyprus , 2 participants in Türkiye , 3 patients in Germany, 1 participant in Italy).
Healthcare Professionals: Doctors, nurses, dental assistants, dietitians, and occupational therapists (e.g., 4 healthcare workers in Austria , 1 nurse and 1 dental assistant in Cyprus, 5 professionals in Italy).
Interpreters & Advocates: Sign language interpreters and disability rights advocates.

Profile Category	Number	Percentage
Deaf participants	≥11	≥34%
Healthcare professionals	≥16	≥50%
Interpreters / Accessibility experts	≥5	≥16%





"It's not just about communication tools — we also need the system itself to change."

Country	Participants	Sessions	Method
Germany	5	5	Interviews
Austria	5	5	Interviews
Türkiye	6	1	Focus Group
Cyprus	5	4	Focus Group & Interviews
Bulgaria	≥5	1	Focus Group
Italy	5	5	Interviews

Format: Sessions were held both in-person (hospital meeting rooms, offices) and via online platforms (Zoom, Google Meet, WhatsApp) depending on participant preference, utilizing sign language interpreters to ensure full accessibility. All activities followed the common HEAL Focus Group Guidelines and addressed the thematic areas of communication, tools and support mechanisms, accessibility, and additional needs.

Sessions were conducted either online or in person, depending on local context, and appropriate accessibility measures were ensured.

Interviews and focus groups were conducted with Deaf individuals, healthcare professionals, sign language interpreters, accessibility and disability experts, and representatives of DEAF organisations and advocacy groups.

Theme	Coverage
Communication barriers	100%
Interpreter shortage	80%
Emergency access problems	100%
Lack of staff training	100%
Need for digital tools	100%
Accessibility policy gaps	80%



"From the moment I enter the hospital, everything requires extra effort. What is normal for others is twice as hard for me."

"In emergencies, it's even worse, because everything depends on phone calls, which completely excludes me."



TOPIC 1

Communication

A universal finding across all countries is that communication remains the most significant barrier.

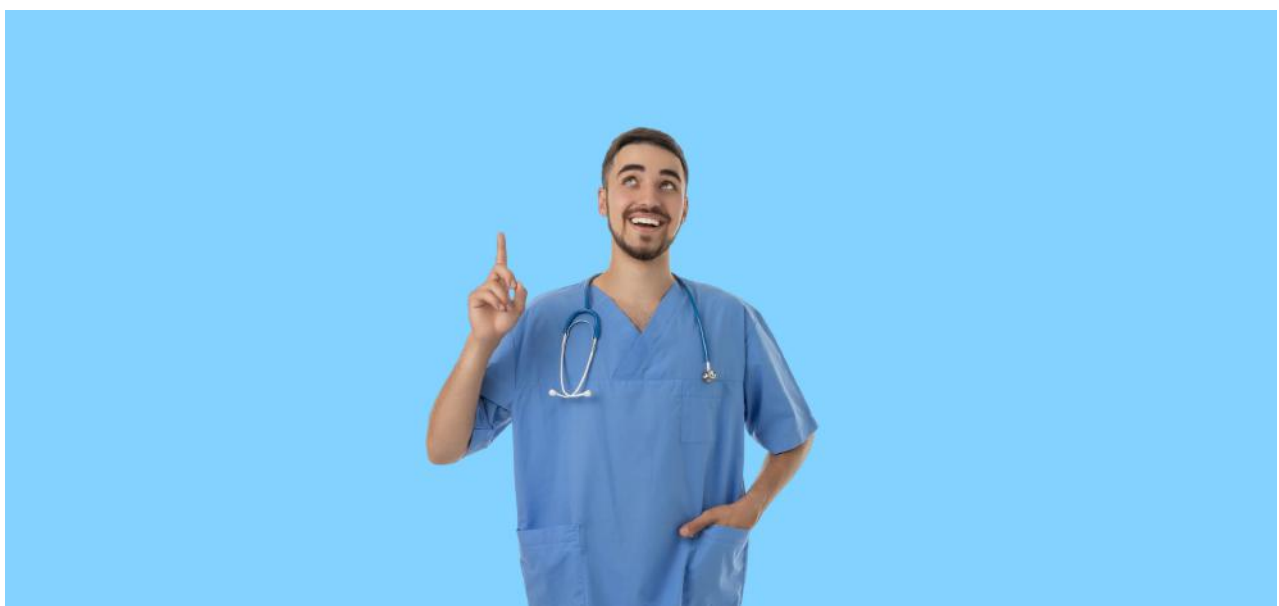
- Time and Speed: Doctors often speak too quickly and allocate insufficient time (highlighted in Türkiye and Germany reports), making it difficult for deaf patients to understand diagnoses.
- Emergencies: Reliance on telephone-based appointment and emergency systems (like 112) excludes deaf individuals. Participants in Bulgaria summarized this by stating, "In emergencies, everything depends on phone calls, which completely excludes me".
- Privacy: The lack of professional interpreters forces patients to rely on family members, compromising patient privacy.

Communication Barriers in Healthcare

Communication emerged as the most central and pervasive challenge across all interviews and focus groups.

- Deaf participants consistently described difficulties throughout the healthcare pathway, including appointment booking, communication during consultations, understanding diagnoses and treatment plans, and accessing follow-up information. Telephone-based systems were identified as a major barrier, particularly in emergency situations.
- Healthcare professionals acknowledged these challenges and reported limited training and confidence in communicating with Deaf patients. Communication often relied on improvised strategies such as written notes, speech-to-text applications, or family members acting as intermediaries.
- Participants frequently reported feelings of inequality and exclusion within healthcare settings, sometimes described as being treated as second-class patients.

"Communication works well when professionals know sign language."



TOPIC 2

Tools

Existing digital tools are insufficient.

Needs: Participants demanded the availability of tablets in doctor's offices connected to Video Remote Interpreting (VRI) services.

Current Status: Apps like Google Live Transcribe are used but have a high error rate with medical terminology. In Austria, the "DEC 112" app is seen as progress but is not yet widespread.

All countries (100%) stressed the urgent need for digital and professional tools (see table below)

Italy, Germany and Austria report progress through video interpretation and digital aids, but insufficient availability remains.

Türkiye, Bulgaria and Cyprus emphasize lack of institutional interpreter services.

Bulgaria: "Every doctor's office should have a tablet connected to a live sign language interpreter."

"One-third reported not using any tools because they didn't know they existed."

"Every doctor's office should have a tablet connected to a live sign language interpreter."

"We used various means: Telesign, interpreters, pictures, written communication."

Tool Need	Countries
Live sign language interpretation	6
Emergency text-based services	6
Medical sign language glossary	6
Staff digital training	6

TOPIC 3

Accessibility

Accessibility is defined not just as physical access, but as a systemic failure.

Legal Gaps: Even in countries where sign language is legally recognized, such as Bulgaria (since 2021) and Austria, practical implementation in hospitals is inconsistent.

Waiting Rooms: Reliance on auditory cues (calling names) causes deaf patients to miss their turn or experience significant stress.

TOPIC 4

Proposed Solutions

Training: Mandatory, short training modules on sign language and deaf awareness must be established for healthcare workers.

Complaints Mechanism: A clear mechanism (e.g., Ombudsman) must be set up to address accessibility violations.

Inclusion: Deaf organizations must be involved in policymaking as decision-makers, not just consultants.

In addition to communication, tools and accessibility, all partner countries emphasized deep systemic problems

- violation of privacy when family members interpret,
- ethical risks of misdiagnosis,
- inequality in access to emergency services.

(see table below)

"Participating in the survey made me wonder what more I could do."

Systemic Issue	Coverage
Lack of institutional policy	80%
Absence of structured staff training	100%
Limited funding for inclusion	80%
Ethical risks (privacy, autonomy)	100%



Conclusions

The consolidated data collected from 6 countries for the HEAL project quantitatively and qualitatively confirms that current healthcare systems do not adequately meet the needs of Deaf patients. 100% of participants indicated a need for professional support (interpreters or digital tools) in communication. Key conclusions for the Theoretical Framework are:

- - Technology alone is insufficient; staff training is essential.
- - Interpreting services must be institutionalized; reliance on family must end.

The HEAL project's goals (glossary, training materials) align perfectly with the urgent needs identified in the field. Persistent communication and accessibility barriers remain. The findings provide a strong qualitative foundation for the next phases of the HEAL project.

This report demonstrates conclusively that the barriers faced by DEAF individuals in healthcare are structural, systemic and persistent across Europe. The consistency of findings across six countries confirms that accessibility challenges are not marginal issues but core deficiencies of current healthcare systems. The HEAL project offers a scientifically grounded, ethically sound and operationally viable response. By combining research, education, digital innovation and policy development, HEAL establishes a transferable European model for inclusive healthcare communication. The findings confirm that barriers faced by deaf individuals in healthcare are systemic, not incidental. The convergence of data across six countries demonstrates that the problems are structural and European-wide.

Key conclusions:

- Communication is the foundation of healthcare equity.
- Digital tools and professional interpretation are no longer optional, but essential.
- Training of healthcare professionals must become mandatory and continuous.
- Accessibility must be institutionalized through policy, funding and monitoring.

"NO ONE IN THE SYSTEM MEANS HARM; THEY JUST DON'T KNOW OUR NEEDS."

"THERE IS A HUGE NEED FOR TRAINING."

HEALTHCARE ENVIRONMENT NEEDS ACCESSIBLE LANGUAGE



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