



Hacettepe University Graduate School of Social Sciences

Department of Translation and Interpretation

English Translation and Interpretation

**EVALUATION OF ADAPTATION TRAINING PROVIDED BY THE
MINISTRY OF HEALTH AND THE WORLD HEALTH
ORGANIZATION: PATIENT GUIDES WITHIN THE CONTEXT OF
HEALTHCARE INTERPRETING TRAINING IN TURKEY**

Sıla Saadet TOKER

Master's Thesis

Ankara, 2019

**EVALUATION OF ADAPTATION TRAINING PROVIDED BY THE MINISTRY OF
HEALTH AND THE WORLD HEALTH ORGANIZATION: PATIENT GUIDES WITHIN
THE CONTEXT OF HEALTHCARE INTERPRETING TRAINING IN TURKEY**

Sıla Saadet TOKER

Hacettepe University Graduate School of Social Sciences

Department of Translation and Interpretation

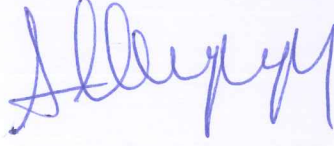
English Translation and Interpretation

Master's Thesis

Ankara, 2019

KABUL VE ONAY

Sıla Saadet TOKER tarafından hazırlanan "Evaluation of Adaptation Training provided by the Ministry of Health and the World Health Organization: Patient Guides within the Context of Healthcare Interpreting Training in Turkey" başlıklı bu çalışma, 21.06.2019 tarihinde yapılan savunma sınavı sonucunda başarılı bulunarak jürimiz tarafından Yüksek Lisans Tezi olarak kabul edilmiştir.



[Doç. Dr. Şirin Okyayuz] (Başkan)



Prof. Dr. Aymil Doğan (Danışman)



Dr Öğretim Üyesi Sinem Bozkurt

Yukarıdaki imzaların adı geçen öğretim üyelerine ait olduğunu onaylarım.

Prof. Dr. Musa Yaşar SAĞLAM

Enstitü Müdürü

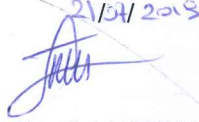
YAYIMLAMA VE FİKRİ MÜLKİYET HAKLARI BEYANI

Enstitü tarafından onaylanan lisansüstü tezimin/raporumun tamamını veya herhangi bir kısmını, basılı (kağıt) ve elektronik formatta arşivleme ve aşağıda verilen koşullarla kullanıma açma iznini Hacettepe Üniversitesine verdiğimi bildiririm. Bu izinle Üniversiteye verilen kullanım hakları dışındaki tüm fikri mülkiyet haklarım bende kalacak, tezimin tamamının ya da bir bölümünün gelecekteki çalışmalarda (makale, kitap, lisans ve patent vb.) kullanım hakları bana ait olacaktır.

Tezin kendi orijinal çalışmam olduğunu, başkalarının haklarını ihlal etmediğimi ve tezimin tek yetkili sahibi olduğumu beyan ve taahhüt ederim. Tezimde yer alan telif hakkı bulunan ve sahiplerinden yazılı izin alınarak kullanılması zorunlu metinlerin yazılı izin alınarak kullandığımı ve istenildiğinde suretlerini Üniversiteye teslim etmeyi taahhüt ederim.

Yükseköğretim Kurulu tarafından yayınlanan **“Lisansüstü Tezlerin Elektronik Ortamda Toplanması, Düzenlenmesi ve Erişime Açılmasına İlişkin Yönerge”** kapsamında tezim aşağıda belirtilen koşullar haricince YÖK Ulusal Tez Merkezi / H.Ü. Kütüphaneleri Açık Erişim Sisteminde erişime açılır.

- Enstitü / Fakülte yönetim kurulu kararı ile tezimin erişime açılması mezuniyet tarihimden itibaren 2 yıl ertelenmiştir. ⁽¹⁾
- Enstitü / Fakülte yönetim kurulunun gerekçeli kararı ile tezimin erişime açılması mezuniyet tarihimden itibaren ... ay ertelenmiştir. ⁽²⁾
- Tezimle ilgili gizlilik kararı verilmiştir. ⁽³⁾

21/04/2018


Sıla Saadet TOKER

¹“Lisansüstü Tezlerin Elektronik Ortamda Toplanması, Düzenlenmesi ve Erişime Açılmasına İlişkin Yönerge”

- (1) Madde 6. 1. Lisansüstü tezle ilgili patent başvurusu yapılması veya patent alma sürecinin devam etmesi durumunda, tez **danışmanının** önerisi ve **enstitü anabilim dalının** uygun görüşü üzerine **enstitü** veya **fakülte yönetim kurulu** iki yıl süre ile tezin erişime açılmasının ertelenmesine karar verebilir.
- (2) Madde 6. 2. Yeni teknik, materyal ve metotların kullanıldığı, henüz makaleye dönüşmemiş veya patent gibi yöntemlerle korunmamış ve internetten paylaşılması durumunda 3. şahıslara veya kurumlara haksız kazanç imkanı oluşturabilecek bilgi ve bulguları içeren tezler hakkında tez **danışmanının** önerisi ve **enstitü anabilim dalının** uygun görüşü üzerine **enstitü** veya **fakülte yönetim kurulunun** gerekçeli kararı ile altı ayı aşmamak üzere tezin erişime açılması engellenebilir.
- (3) Madde 7. 1. Ulusal çıkarları veya güvenliği ilgilendiren, emniyet, istihbarat, savunma ve güvenlik, sağlık vb. konulara ilişkin lisansüstü tezlerle ilgili gizlilik kararı, **tezin yapıldığı kurum** tarafından verilir *. Kurum ve kuruluşlarla yapılan işbirliği protokolü çerçevesinde hazırlanan lisansüstü tezlere ilişkin gizlilik kararı ise, **ilgili kurum ve kuruluşun önerisi** ile **enstitü** veya **fakültenin** uygun görüşü üzerine **üniversite yönetim kurulu** tarafından verilir. Gizlilik kararı verilen tezler Yükseköğretim Kuruluna bildirilir.
Madde 7.2. Gizlilik kararı verilen tezler gizlilik süresince enstitü veya fakülte tarafından gizlilik kuralları çerçevesinde muhafaza edilir, gizlilik kararının kaldırılması halinde Tez Otomasyon Sistemine yüklenir

* Tez **danışmanının** önerisi ve **enstitü anabilim dalının** uygun görüşü üzerine **enstitü** veya **fakülte yönetim kurulu** tarafından karar verilir.

ETİK BEYAN

Bu alıřmadaki bütn bilgi ve belgeleri akademik kurallar erevesinde elde ettiđimi, grsel, iřitsel ve yazılı tm bilgi ve sonuları bilimsel ahlak kurallarına uygun olarak sunduđumu, kullandıđım verilerde herhangi bir tahrifat yapmadıđımı, yararlandıđım kaynaklara bilimsel normlara uygun olarak atıfta bulunduđumu, tezimin kaynak gsterilen durumlar dıřında zgn olduđunu, **Prof. Dr. Aymil DOĐAN** danıřmanlıđında tarafımdan retildiđini ve Hacettepe niversitesi Sosyal Bilimler Enstits Tez Yazım Ynergesine gre yazıldıđını beyan ederim.



Sıla Saadet TOKER

ACKNOWLEDGMENTS

I would like to thank my thesis advisor, dearest Prof. Dr. Aymil Doğan. Completion of this thesis would not be achieved without her enlightening advice and invaluable supervision. My dreams came true thanks to her continuous support. She not only provided academic guidance but also reflected her tremendous life energy to my personal life.

The most special thanks go to my precious ones in my life, my lovely parents and my dear sister for their endless support and backing me up unconditionally for every decision I made in my life.

My deepest gratitude is extended to Prof. Dr. Toker Ergüder for his encouragement at each and every phase of my thesis and remarkable contribution from earlier drafts until the completion of this study. He consistently and fully supports me not only in my working life but also in my academic career.

I am also indebted to my lovely friend Aylin Karayığit for her generosity in making available research materials to me as well as inspiring discussions which turned out to ideas one by one.

I would like to thank the Ministry of Health, Turkey and the World Health Organization to make my study possible with their permission. My special thanks go to Dr. Pavel Ursu, WHO Representative in Turkey and my other colleagues in the World Health Organization Country Office in Turkey for their support.

I am also grateful to Assoc. Prof. Dr. Şirin Okyayuz for her remarkable support with her proofreading in detail and Dr. Sinem Sancaktaroğlu Bozkurt for her supportive ideas and contribution. I also would like to thank all scholars in the Department of Translation and Interpretation at Hacettepe University.

I convey my special thanks to Dr. Özlem Onar for her generous support for my study during the design process and afterward.

I am also grateful to Doç. Dr. Dilek Öztaş, Dr. Asiye Çiğdem Şimşek, Dr. Fatih Aydın, Esin Yılmazaslan, İnci Öztunca for their contribution to this study.

I would like to thank the Migration Policy and Project Department of the Directorate General of Migration Management in the Ministry of Interior, Provincial Directorate of Migration Management of the Governorate of Ankara, Department of Community Health Services and Education of Directorate General of Public Health in the Ministry of Health as well as the Migration Health Unit in the Directorate of Public Health Services in the Ankara Provincial Health Directorate in the Ministry of Health for their approval to administer the questionnaire and conduct this study.

The last but not the least, I would like to thank the patient guides who took part in this study. This research would not have been possible without their dedication and sincerity to this study.



ABSTRACT

TOKER, Sila Saadet. *Evaluation of Adaptation Training Provided by the Ministry of Health and the World Health Organization: Patient Guides within the Context of Healthcare Interpreting Training in Turkey*, Master's Thesis, Ankara, 2019.

Communication barriers and cultural differences are significant problems for people moving to a new society and encountering many challenges in getting access to public services. Especially a displaced population experience difficulties in communicating with the officials and the host society especially in health settings where human health is concerned. Therefore, these people seek the help of healthcare interpreters to mediate and provide communication between the interlocutors for more comprehensive mutual understanding in medical interaction. In this regard, healthcare interpreter training has vital importance in providing quality interpreting services and delivery in interpreter-mediated encounters.

With this framework, this study aims to evaluate the adaptation training provided to patient guides by the Ministry of Health and World Health Organization as a part of the "Adaptation Training to Turkish Health System for Syrians under Temporary Protection" under "Sihhat Project (namely, Improving the Health Status of the Syrian Population under Temporary Protection and Related Services Provided by Turkish Authorities) within the context of healthcare interpreting training. This study investigates the socio-demographic and professional profiles of patient guides who have received the adaptation training, their opinions on receiving healthcare interpreting training as well as the opinions and needs to learn the new interpreting related subjects to be included in the curriculum, also the patient guides' opinions and level of satisfaction on the training they received. A descriptive method was used in this study. The questionnaire was administered to the sample group of the study who are 64 patient guides recruited in health facilities in Ankara to collect their opinions and information which were analyzed for the purpose of the study.

The study results seem to reveal that the socio-demographic and professional profiles of the patient guides and indicate that they are eligible for receiving upper-level healthcare interpreting training. They also revealed that the patient guides have mostly positive opinions and their needs on the inclusion of new minimum crucial interpreting-related subjects in the curriculum. Moreover, the study presents some aspects to be improved through investigation of their opinions presented and level of satisfaction on the training received.

Key Words: Healthcare Interpreting Training, Adaptation Training for Syrians, Patient Guides, Community Interpreting, Public Service Interpreting.

ÖZET

TOKER, Sıla Saadet. *TC Sağlık Bakanlığı ve Dünya Sağlık Örgütü tarafından Sağlanan Adaptasyon Eğitimlerinin Değerlendirilmesi: Türkiye’de Sağlık Çevirmenliği Bağlamında Hasta Rehberleri*, Yüksek Lisans Tezi, Ankara, 2019.

İletişim engelleri ve kültürel farklılıklar, bir topluma yeni gelen ve toplum hizmetlerine erişmekte birçok zorluk yaşayan kişi için önemli bir sorundur. Özellikle, zorla yerinden edilen nüfus, insan sağlığının konu olduğu sağlık kuruluşlarında yetkililerle ve ev sahibi toplulukla iletişim kurarken zorluklar yaşamaktadır. Bu sebeple, bu kişiler tıbbi etkileşim sırasında daha kapsamlı bir karşılıklı anlaşma sağlanması amacıyla iletişimi kolaylaştırmak ve desteklemek için sağlık çevirmenlerine ihtiyaç duyarlar. Bu bağlamda sağlık çevirmenlerinin eğitimi, tercümanın iletişimi sağladığı ortamda kaliteli çeviri hizmeti ve çıktı sağlanması için hayati öneme sahiptir.

Bu çerçevede, bu çalışma “Sihhat Projesi (Geçici Koruma Altındaki Suriyelilerin Sağlık Statüsünün ve Türkiye Cumhuriyeti Tarafından Sunulan İlgili Hizmetlerin Geliştirilmesi)” kapsamında verilen “Geçici Koruma Altındaki Suriyelilere yönelik Türk Sağlık Sistemine Adaptasyon Eğitimleri”nin bir parçası olan TC Sağlık Bakanlığı ve Dünya Sağlık Örgütü tarafından sağlanan hasta rehberlerine yönelik adaptasyon eğitimlerini, sağlık çevirmenliği eğitimleri kapsamında değerlendirmeyi amaçlamaktadır. Çalışmada, bu değerlendirme amacıyla adaptasyon eğitimini almış hasta rehberlerinin sosyodemografik ve mesleki özellikleri, onların sağlık çevirmenliği eğitimi almaya yönelik görüşleri ile beraber alanla ilgili müfredata eklenebilecek yeni konuları öğrenmeye yönelik görüşleri ve ihtiyaçlarının yanı sıra almış oldukları eğitime yönelik görüşleri ve memnuniyet düzeyleri incelenmiştir. Bu çalışmada betimleyici yöntem kullanılmıştır. İlgili bilgi ve görüşleri toplamak ve çalışmanın amacına yönelik analiz yapmak için Ankara’daki sağlık kuruluşlarında istihdam edilen 64 hasta rehberinden oluşan örneklem üzerinde anket uygulanmıştır.

Çalışmanın sonuçları, istihdam edilmiş olan hasta rehberlerinin sosyodemografik ve mesleki özelliklerinin daha üst düzeyde bir sağlık çevirmenliği eğitimini almaya uygun olduğunu göstermiştir. Çalışma, aynı zamanda bu hasta rehberlerinin eğitim müfredatına tercümanlık alanı ile ilgili yeni asgari düzeyde gerekli konuları öğrenmeye ihtiyaç duyduklarını ve eğitim müfredatına eklenmesine yönelik olumlu görüşe sahip olduğunu ortaya koymaktadır. Öte yandan, bu çalışma rehberlerin aldıkları eğitim konusunda görüşlerini ve memnuniyet düzeylerini ele alarak geliştirilebilecek bazı yönlerini ortaya koymaktadır.

Anahtar Sözcükler: Sağlık Çevirmenliği Eğitimi, Suriyelilere yönelik Adaptasyon Eğitimi, Hasta Rehberleri, Toplum Çevirmenliği, Toplum Hizmetleri Çevirmenliği.

TABLE OF CONTENTS

ACCEPTANCE AND APPROVAL.....	iv
YAYIMLAMA VE FİKRİ MÜLKİYET HAKLARI BEYANI	v
ETİK BEYAN.....	vi
ACKNOWLEDGMENTS.....	vii
ABSTRACT	ix
TURKISH ABSTRACT.....	x
TABLE OF CONTENTS.....	xi
LIST OF ABBREVIATIONS	xi
LIST OF TABLES	xv
LIST OF FIGURES	xvi
INTRODUCTION.....	1
CHAPTER 1.....	1
1.1. PROBLEM SITUATION.....	4
1.2. AIM OF THE STUDY.....	6
1.3. IMPORTANCE OF THE STUDY.....	6
1.4. RESEARCH QUESTIONS AND SUB-QUESTIONS.....	7
1.5. DEFINITIONS.....	8
1.6. ASSUMPTIONS.....	10
1.7. LIMITATIONS.....	10
CHAPTER 2: THEORETICAL FRAMEWORK.....	11
2.1. COMMUNITY INTERPRETING	11
2.1.1. General Overview	11
2.1.1.1. Court Interpreting	13
2.1.1.2. Police Interpreting.....	14

2.1.1.3. Emergency and Disaster Interpreting – ARÇ	15
2.1.1.4. Healthcare Interpreting	16
2.1.1.5. Conflict Interpreting	16
2.1.2. Community Interpreting in World	17
2.1.3. Community Interpreting in Turkey	18
2.2. HEALTHCARE INTERPRETING	19
2.2.1. A General Overview.....	19
2.2.2. Healthcare Interpreting in the World.....	20
2.2.2.1. The Migrants in Healthcare Interpreting	22
2.2.3. Healthcare Interpreting in Turkey.....	23
2.2.3.1. Status of Syrian Refugees in Turkey	23
2.3. COMMUNITY AND HEALTHCARE INTERPRETING TRAINING..	25
2.3.1. The Current Status of Healthcare Interpreting Training	26
2.3.1.1 Adaptation Training for Syrians under temporary protection to Turkish Health System	29
2.3.1. 2. Content Analysis of the Materials of the Adaptation Training for Patient Guides	31
2.3.2. Interpreting-related Subjects That May Be Included in the Curriculum	33
2.3.2.1. Standards of Healthcare Interpreting Practice.....	49
2.3.2.2. National Professional Standards for Interpreters Enacted By Professional Qualifications Authority In Turkey	51
2.4. RELEVANT STUDIES ON HEALTHCARE INTERPRETING.....	52
CHAPTER 3: METHODOLOGY.....	56
3.1 DESIGN OF THE STUDY.....	56
3.1.1 Design of the Study.....	56
3.1.2. Content Validity of the Questionnaire	56
3.2 PARTICIPANTS	56
3.3 PROCEDURE	58

3.4 DATA COLLECTION INSTRUMENTS	61
3.5 DATA ANALYSIS	62
CHAPTER 4: FINDINGS AND DISCUSSION	63
4.1. FINDINGS AND DISCUSSION ON SOCIO-DEMOGRAPHIC AND PROFESSIONAL PROFILES OF THE PATIENT GUIDES	63
4.1.1.Socio-demographic Profiles of the Patient Guides	63
4.1.2. Professional Profiles of the Patient Guides	68
4.2. FINDINGS AND DISCUSSION ON PATIENT GUIDES' OPINION ON RECEIVING HEALTHCARE INTERPRETING TRAINING	75
4.2.1. Patient Guides' Opinion on the Inclusion of New Subjects in the Curriculum	75
4.2.2. The Relation between Their Willingness to Learn New Subjects during the Training and Their Level of Education	90
4.3 FINDINGS AND DISCUSSION ON PATIENT GUIDES' OPINION ON ADAPTATION TRAINING THEY RECEIVED	101
CHAPTER 5: CONCLUSION AND RECOMMENDATIONS.....	109
5.1. CONCLUSIONS REGARDING THE RESEARCH QUESTIONS ..	109
5.2. RECOMMENDATIONS FOR FURTHER STUDIES	112
REFERENCES.....	113
APPENDIX 1. English Questionnaire.....	122
APPENDIX 2. Turkish Questionnaire	130
APPENDIX 3. Volunteer Consent Form – Turkish Version	138
APPENDIX 4: Hacettepe University Ethical Commission Clearance Letter.....	140
APPENDIX 5: Approval letter of Migration Policy and Project Department, Directorate General of Migration Management, Ministry of Interior.....	141
APPENDIX 6: Approval Letter of Provincial Directorate of Migration Management, Governorate of Ankara.....	142

APPENDIX 7: Approval letter of Department of Community Health Services and Education, Directorate General of Public Health, Ministry of Health.....	143
APPENDIX 8: Final approval letter of Migration Health Unit, Directorate of Public Health Services, Ankara Provincial Health Directorate, Ministry of Health.....	144
APPENDIX 9: Originality Report	145
Autobiography	146



LIST OF ABBREVIATIONS

WHO	: World Health Organization
MOH	: Ministry of Health, Republic of Turkey
IMIA	: International Medical Interpreters Association
CHIA	: California Healthcare Interpreting Association
NCIHC	: National Council on Interpreting in Healthcare
IFRC	: International Federation of the Red Cross and Red Crescent Societies
TRCS	: Turkish Red Crescent Society



LIST OF TABLES

Table 1: International Examples for Standards for Healthcare Interpreting Practice....	49
Table 2: Number and percent of patient guide interviewed and response rates	57
Table 3: Number and percent of health facilities and response rates	59
Table 4: Distribution of health facility category by type of response	60
Table 5: Sex distribution of the participants	63
Table 6: Age distribution of the participants	63
Table 7: Distribution of educational background of participants.....	64
Table 8: Distribution of educational background of participants	65
Table 9: Distribution of mother tongues of participants	66
Table 10: Distribution of additional languages of participants	67
Table 11: Distribution of time spent in Turkey after migration	68
Table 12: Distribution of previous employment experience of participants.....	69
Table 13: Distribution of previous employment experience as a healthcare interpreter of participants	70
Table 14: Distribution of the number of working days and working hours of the participants	71
Table 15: Distribution of the participants' previous working experience in written translation and interpreting.....	72
Table 16: Distribution of participants' use of types of interpreting	73
Table 17: Distribution of the participants who are willing to learn facilitating techniques	75

Table 18: Distribution of the participants who are willing to learn different types of interpreting	76
Table 19: Distribution of the participants who are willing to learn memory techniques	77
Table 20: Distribution of the participants who are willing to learn note-taking techniques	78
Table 21: Distribution of the participants who are willing to learn manners and attitudes.....	79
Table 22: Distribution of the participants who are willing to learn the medical terminology	80
Table 23: Distribution of the participants who are willing to learn accessing resources.....	82
Table 24: Distribution of the participants who are willing to learn intonation	83
Table 25: Distribution of the participants who are willing to learn discourse analysis techniques	84
Table 26: Distribution of the participants who are willing to learn cultural differences.....	84
Table 27: Distribution of the participants who are willing to learn interpreter needs...86	
Table 28: Distribution of the participants who are willing to learn ethical rules.....87	
Table 29: Distribution of the participants who are willing to make practice during the training and inclusion of an expert interpreter as trainer	88
Table 30: Distribution of the participants who are willing to learn the facilitating techniques in correlation to their level of education	90
Table 31: Distribution of the participants who are willing to learn the different types of interpreting in correlation to their level of education	91

Table 32: Distribution of the participants who are willing to learn memory techniques in correlation to their level of education	92
Table 33: Distribution of the participants who are willing to learn note-taking techniques in correlation to their level of education	93
Table 34: Distribution of the participants who are willing to learn attitudes and manners in correlation to their level of education	93
Table 35: Distribution of the participants who are willing to learn medical terminology in correlation to their level of education	94
Table 36: Distribution of the participants who are willing to learn to access resources in correlation to their level of education.....	95
Table 37: Distribution of participants who are willing to learn about intonation in correlation to their level of education.....	96
Table 38: Distribution of the participants who are willing to learn discourse analysis techniques in correlation to their level of education.....	97
Table 39: Distribution of the participants who are willing to learn cultural differences in correlation to their level of education.....	98
Table 40: Distribution of the participants who are willing to learn interpreter needs in correlation to their level of education.....	99
Table 41: Distribution of the participants who are willing to learn ethical rules in correlation to their level of education.....	99
Table 42: Distribution of the participants who are willing to do practice with an expert interpreter as a trainer in correlation to their level of education.....	100
Table 43: Distribution of the response rate for evaluation of the training.....	101
Table 44: Distribution of the participants' level of satisfaction on the training they received.....	102

Table 45: Distribution of the participants' opinions on the duration of the training	103
Table 46: Distribution of the participants' status of encountering any problem during interpreting.....	103
Table 47: Distribution of the evaluative opinions of the patient guides on the training they received	105



LIST OF FIGURES

Figure 1: Types of Community Interpreting	13
Figure 2: The weekly program of the adaptation training provided for patient guides	32
Figure 3: Classification of Interpreting according to its modalities and subjects	35
Figure 4: Distribution of the assignment year in the health facilities where they are currently employed	71



CHAPTER I

INTRODUCTION

In this chapter, basic information about the study is provided. This chapter is comprised of the motive to study in the field of community and healthcare interpreting, its importance and the aim, research questions with its sub-questions as well as definitions, assumptions and limitations.

Our world is always in a state of influx. Therefore, people are driven to change their country of residence due to a wide spectrum of reasons, sometimes in pursuit of discovering new cultures and places but also mainly with the aim of escaping from war, conflict, bad living conditions, and poverty (Rudvin & Tomassini, 2011, p. 13). A lot of natural disasters and man-made disasters, including wars and armed conflicts, which cause a large population to feel the urge to change their places and to find a suitable country to immigrate. Generally, the main motive for migration is a desire to be able to have better living conditions as well as to survive for many forcibly displaced people.

This movement is experienced densely on the global scale and affects all countries in the globalized world. Especially, countries such as Islamic Republic of Iran, Lebanon, Pakistan, and Turkey, which are located in the nearby geography where conflicts occur embrace most of the migrants (United Nations High Commissioner for Refugees [UNHCR], n.d.). Turkey is one of the countries receiving a high number of refugees fleeing their homes due to armed conflicts in bordering countries, especially Syria. The statistical data from the Directorate General of Migration Management (n.d.), Ministry of Interior shows that Turkey hosts nearly 3.640 million Syrian beneficiaries, a number which increased dramatically since 2011, the year of violence breakout. It is important to note that Turkey considers Syrians as people under temporary protection, not refugees.

The influx of people from Syria was so high that Turkey felt obliged to develop an administrative capacity which would enable her to provide quality services to these people while still protecting the living standards of Turkish citizens. To this end, Turkey has introduced new legislative arrangements (Directorate General of Migration Management, Ministry of Interior, n.d.). As a result of these arrangements, related

departments and directorates were established under the Ministries, such as the Directorate General of Migration Management affiliated with Ministry of Interior and Department of Migration Health affiliated with Ministry of Health, etc.

Governmental authorities, non-governmental organizations (NGOs), international organizations and local governments contribute to the implementation of promising projects designed to address the challenge of integration of migrants (Kirişci, Brandt, & Erdoğan, 2018, para. 2).

One of the projects conducted with the collaboration of the International Federation of the Red Cross and Red Crescent Societies (IFRC) and the Turkish Red Crescent Society (TRCS) enabled the establishment of “Community Centres” so as to provide long-term community support to displaced people in Turkey. The project aims to strengthen protection services, psychosocial services, and health education through the 15 community centers operated by the TRCS and supported by IFRC. Since the launch of these centers in November 2012, the TRCS has supported nearly 1.8 million displaced people in protection camps and urban areas according to data provided by IFRC (International Federation of the Red Cross and Red Crescent Societies [IFRC], 2018).

Another important project entails the efforts in the health sector provided by the Ministry of Health (MOH), Turkey with the support of the World Health Organization (WHO) Regional Office for Europe as “Adaptation Training to Turkish Health System for Syrians under Temporary Protection” under “Sıhhat Project (namely, Improving the Health Status of the Syrian Population under Temporary Protection and Related Services Provided by Turkish Authorities)” after Turkey enacted the “Legislation on Work Permit for Foreign People under temporary Protection” in 2016 (WHO in Turkey, 2017, p. 42). As an international organization, WHO supports the Turkish Government in serving both Syrians and the host community through this training embracing the “leave no one behind” policy (ibid, p.9). The adaptation training was designed and implemented for Syrian doctors, nurses, mental health and psychosocial workers (Ursu, Nitzan & Şener et al., 2018, p. 121) as well as Arabic and Turkish speaking people either from the border cities of Turkey or from Syria, who were given a ‘new status’ called “patient guides”. In this way, their integration into the Turkish health system was maintained when these people were instated in Turkish health facilities.

In this study, the abovementioned adaptation training provided to patient guides is evaluated through ‘the questionnaire on the opinion of patient guides on adaptation training and their needs regarding healthcare interpreting training’ administered to the people employed in this scope. Their opinions on the adaptation training they received and also receiving healthcare interpreting training are analysed as well as their needs for new subjects to be included in the curriculum of healthcare training. The current study also aims to contribute to the standards to be established for higher-quality adaptation training by questioning the points where the patient guides need to improve. Below is an overview of this study:

Chapter 1 of this study focuses on a general overview of the study. It presents brief information on the problem situation, the aim of the study, the importance of the study, research questions as well as sub-questions, assumptions, limitations, and definitions of some important terms.

Chapter 2 is devoted to the theoretical framework of the study. The current situation of community interpreting and healthcare interpreting is presented on both the national and international platform. Community and healthcare interpreting training are addressed in terms of the current situation and the minimum crucial subjects to be included in the content of the Adaptation Training. Lastly, relevant studies on healthcare interpreting are presented.

Chapter 3 presents the methodology used in the study. The design of the study, participants, the procedure of the study, data collection instrument and information on data analysis methods are provided.

Chapter 4 presents the findings and discussion of the results of data collected by the questionnaire through tables and charts. Findings related to each research question and sub-questions are addressed as well as the subject’s remarks on the related issues.

Chapter 5 is devoted to conclusions of the study. Suggestions on healthcare interpreting training are provided.

1.1. PROBLEM SITUATION

The language barrier and cultural differences emerge as significant problems for newcomers – forcibly displaced or voluntary migrants- moving to a new society in a different country from their countries. They encounter many challenges when trying to get access to services in various settings in the host country primarily as they need to communicate with the officials and the host society.

Communication is mediated by interpreters in community interpreting settings, which makes interpreters a crucial link between two interlocutors. In this regard, the need for the high quality efficient training for interpreters is immense (Hale, 2007, p. 26) to have competent interpreters for efficient service. However, Hale (2007, p. 26) states that:

“The demands placed on the community interpreter are high, yet there are no consistent standards for their practice or any formal requirement for adequate training around the world, as the job of the community interpreter continues to be misunderstood and undermined by many.”

Literature shows that bilingual people such as bilingual family members, existing staff in the service settings exert an effort to provide communication between service providers and people with linguistic varieties in community settings of the host communities as an ad-hoc solution around the world as well as Turkey.

The need for the organization of systematic language services has led to the efforts of many institutions in investing in training of permanent staff to provide expertise and qualified service in pursuit of professionalism in the world (Rudvin & Tomassini, 2011, p. 3) which underscores the fact that there is a big room for the development of professionalism and training of community interpreters as well as healthcare interpreters.

Either trained interpreters or bilingual people who may be a family member, a friend or a colleague can provide healthcare interpreting services when there is a lack of any healthcare interpreting settlement in Turkey, like other countries. In the recruitment ads of Turkish public health institutions, different terms are used to describe manpower need such as “a person who can speak a foreign language”, “language assistant”, “patient guide”, “patient guidance staff” rather than “interpreter”. Healthcare

interpreting is a field which is not frequently deemed a branch of the profession of community interpreting; however mediated communication is provided to overcome the language barriers through different ad-hoc solutions.

In the recent years, this field also required investment and improvement especially with the impact of a great number of migrants arriving in Turkey. However, the initiatives are very few especially in the training of the interpreting service providers.

As stated above, adaptation training for the patient guides is provided to Arabic and Turkish speakers to serve Syrian beneficiaries under temporary protection in Turkish health facilities. However, the content of this training is confined to 4 main modules which consist of communication, patient rights and privacy, Turkish Healthcare System and general definitions/medical terminology. Therefore, “the Adaptation Training”, as its name implies, encompasses only the information on their adaptation to the Turkish health system. Yet, what these patient guides actually do is establishing communication and mediation between the healthcare professionals and foreign patients in addition to directing people to the right departments and orienting them from one location to another. The work they perform is not limited to directing people and translating words from one language into another one. Also, they also “interpret” and this necessitates some certain standards of training. The training of a competent interpreter necessitates the inclusion of some interpreting-related subjects. However, this content is not provided in adaptation training. It is noteworthy that the patient guides who are considered to have received the necessary training are not so aware of what their training lacks and think that the training they have received entails the all they need to know about their job. More explicitly, they are not aware that interpreting requires special training in line with certain standards. As a result, their opinion on the training they received and their needs as to the task they perform was taken into account in this study and shaped as to see the current situation of the patient guides.

Adaptation training should be improved for healthcare interpreting training in order to have competent patient guides, namely healthcare interpreters working in Turkish health facilities so that non-native patients in a host society can access equitable and efficient healthcare services.

1.2. AIM OF THE STUDY

This study aims to evaluate the adaptation training provided jointly by the Ministry of Health (MOH) and the World Health Organization (WHO) to patient guides to investigate the following:

- the socio-demographic and professional profiles of patient guides who have received the adaptation training,
- the patient guides' opinions on receiving healthcare interpreting training as well as the opinions and needs to learn the new subjects related to the field to be included into the curriculum of the training as well as opinions on the inclusion of professional interpreters as trainers,
- the patient guides' opinions on the adaptation training they received and their level of satisfaction,

Outcomes of the study would be used to improve the training program and will contribute to the revision and improvement of the content for further training as well as the refreshment training that may be provided in the future.

1.3 IMPORTANCE OF THE STUDY

Taking into consideration that community interpreters serve as a communication mediator to support people in need due to language and culture differences, it is crucial to provide efficient and qualified training for these interpreters for effective communication. Also, effective healthcare interpreting is essential for equal access to healthcare service for non-native end-users.

Research on healthcare interpreting and training of healthcare interpreters is very scarce in Turkey; therefore, this study is important since it will develop of the field in Turkey.

Looking at only the context of adaptation training, while studies aiming at the evaluation of the training for doctors and nurses have been already carried out, unfortunately, a comprehensive study focusing on the part for patient guides does not exist apart from unpublished WHO internal reports which provide general information. Also, another study, published in March 2018 has been conducted to evaluate the

adaptation training covering all trained health professionals using paired t-tests to analyze whether their knowledge level differs between pre- and post-test scores.

Moreover, the patient guides are multitasking while they both interpret and directing the patients to the right place and their performance on the establishment of communication and mediation between patients and health professionals should be taken into consideration. However, the training they received does not include any theoretical or practical dimensions or information interpreting. Moreover, they tend to be ignorant of the fact that interpreting is not only about being bilingual and speaking both languages but also establishing genuine communication and interaction between the parties. Thus, this study is considered to raise awareness in both patient guides and in healthcare professionals about the need for interpreting training.

Also, this study is considered to provide information to health professionals about the opinion of the patient guides on the adaptation training; therefore, this study may contribute the improvement of the current status of healthcare interpreting training in Turkey.

1.4 . RESEARCH QUESTIONS AND SUBQUESTIONS

1. What are the socio-demographic and professional profiles of the patient guides?
 - What are the socio-demographic profiles of patient guides?
 - What are the professional profiles of patient guides?
2. What do patient guides think about receiving healthcare interpreting training?
 - Do the patient guides think that new subjects as to interpreting should be included in the curriculum?
 - Is there a relation between their willingness to learn new subjects during the training and their level of education?

3. How do patient guides evaluate the adaptation training they have received?

- What is the level of satisfaction of patient guides as regards the training they received?
- What do the patient guides think for improving the training they received?
- Do they encounter any problems during the interpreting in the health facility?
- Are the patient guides satisfied with the duration of the training?

1.5 . DEFINITIONS

The definitions presented below were used to designate the framework of concepts adhered to in the study for the purposes of this thesis to avoid confusion.

- (1) **Adaptation Training:** Adaptation training is used to refer the training of Syrian health professionals under temporary protection offered by the Government of Turkey, Ministry of Health and supported by the World Health Organization under SIHHAT Project. However, within the scope of this study, adaptation training is used to refer only to the training provided to patient guides within this context.
- (2) **Syrian health professionals:** Syrian doctors, nurses, medical translators/patient guides, mental health and psychosocial workers employed in the Turkish health settings.
- (3) **Patient Guides:** In this study, Patient Guides refer to the Arabic and Turkish speakers recruited by the Ministry of Health to work in Turkish health facilities in order to provide interpreting services to Arabic speaking patients and support their access to healthcare.

- (4) **Healthcare Interpreters:** In this study, healthcare interpreters refer to people who interpret in the medical settings for the provision of communication between healthcare providers and foreign patients. Even if the delivery is related to health, this does not mean that the interpreter providing communication is a healthcare interpreter, instead, a staff interpreter or conference interpreter may also carry out the interpreting services related to health. More explicitly, the difference between healthcare interpreters and other mentioned-type of interpreters is the interlocutors in the interpreted encounter.
- (5) **Temporary protection:** “An arrangement developed by States to offer protection of a temporary nature to persons arriving en masse (*in mass*) from situations of conflict or generalized violence, without prior individual status determination” (International Organization for Migration [IOM], n.d.).
- (6) **Syrians under temporary protection:** In this study, this term refers to the people fleeing to Turkey due to the current war in Syria. The Government of Turkey grants them temporary protection status. This is an application of a geographical limitation to the 1951 UN Convention on the Status of Refugees (For detailed information, see Chapter II). Regardless of any exception, Syrian participants in this study will be referred to as ‘Syrians under temporary protection’ staying stick to the term used in the SIHHAT project to avoid any political bias.
- (7) **SIHHAT Project:** This acronym means “Improving the health status of the Syrian population under temporary protection and related services provided by Turkish authorities” and “Adaptation Training to Turkish Health System for Syrians under Temporary Protection” are provided in the scope of this Project (For detailed information, see Chapter II).

1.6. ASSUMPTIONS

- (1) All participants are assumed to have attended and have focused on the training provided.
- (2) All participants are assumed to have performed the tasks in the adaptation training to the best of their abilities.
- (3) All participants are assumed to sincerely answer the questions in the questionnaires given for the purpose of this thesis and evaluate their own performances.

1.7. LIMITATIONS

- (1) This study is confined to the evaluation of adaptation training provided jointly by the Ministry of Health (MoH) and the World Health Organization (WHO) under SIHHAT Project for Patient Guides working in the Turkish health facilities affiliated with MoH.
- (2) The population of the study is limited to the trained patient guides employed only in health facilities located in Ankara, one of the cities affected by the migration.
- (3) The needs analysis encompasses only the minimum crucial subjects of healthcare interpreting training.
- (4) Due to practical reasons, the evaluation was carried out only through the opinions of the Patient Guides.

CHAPTER II

THEORETICAL FRAMEWORK

This chapter focuses on the theoretical background of the study. Basic information on community interpreting is presented in the first part while the second part is devoted to healthcare interpreting. The current situation of community and healthcare interpreting training is presented in the last part. The adaptation training and the minimum crucial subjects that may be added in the curriculum of this training are addressed in this chapter. Also, the relevant studies on healthcare interpreting are presented.

2.1. COMMUNITY INTERPRETING

2.1.1. A General Overview

Community interpreting is viewed as an area of expertise in translation studies only within recent years (Taibi & Ozolins, 2016, p. 1). Through population shifts, either peaceful or forced, societies become more complex; besides, linguistic and cultural diversities emerge (ibid). As a result of these shifts, information need becomes enormous and this need necessitates the existence of community interpreters who mediate the communication (Pöchhacker, 2004, p. 29).

Although community interpreting seems the most widely accepted term designating the practice, the terms “public service interpreting” in the UK, “cultural interpreting” in Canada and “ad-hoc interpreting” or “dialog interpreting” are used as other designations (Mikkelsen, 1996, p. 78; Taibi & Ozolins, 2016, p. 1). Pittarello (2009, p. 62) states that the term “community interpreting” was introduced at the First International Conference on Interpreting in Legal, Health and Social Service Settings which was held in 1995.

Community interpreters mediate communication between different interlocutors who have different language communities and cultures providing deeper and more comprehensive mutual understanding in multinational and multicultural societies (Rudvin & Tomassini, p. 24). Thanks to communication-mediated by interpreters, the culturally and linguistically diverse people can meet their needs in community-based settings such as courts, hospitals, notary, etc. when they encounter language barriers.

As for the definition of community interpreting, Gürçağlar and Diriker (2004, p. 74) define community interpreting as following:

“the term used to refer to the mode of interpreting deployed when members of a minority/non-official/foreign language enter into contact with the public sphere which speaks the majority/official language.”

As stated by Angelelli (2004), if speakers communicating with each other do not share the same language and culture, this communication needs to be mediated by interpreters.

According to ISO 13611:2014 Interpreting - Guidelines (2014) on community interpreting standards, community interpreting ensures execution of the right to communicate and access services for people who have linguistic diversity while seeking for delivery service in the community.

Taibi and Ozolins (2016, p. 11) also define community interpreting in a more detailed way:

“...it bridges the communicative gap between public services and those citizens or residents who do not speak the mainstream language, and thereby improves relations and cohabitation between different social groups; facilitates information flow between mainstream/established community members and less powerful, minority or newcomer members; and provides opportunities for the latter to improve their socio-economic position and participate more effectively in their (*new*) community” (ibid).

Community interpreting settings which can be elaborated as the social context of interaction are public sector institutions (Pöchhacker, 2004, p. 15). Generally, community interpreting settings are social services such as school; medical settings such as hospitals, health centers, clinic, legal settings such as police stations and courts (Şener, 2017, p. 18).

Considering both parties of users in community interpreting, it can be said that people with cultural and linguistic varieties in communities, mainly migrants and primary interlocutors providing public services such as doctors, social service providers, legal officers create bilateral communication-mediated by community interpreters.

Interpreting mode is generally consecutive interpreting (this may be consecutive with notes) and also whispered interpreting in which the interpreter is positioned next to

listener/s rendering the message in low volume (Pöchhacker, 2004, p. 19). This mode provides the opportunity for the speaker to speak uninterruptedly without waiting for the interpreting to stop.

Considering the present situation in Turkey, Doğan classifies community interpreting as court interpreting, police interpreting, emergency and disaster interpreting, sports interpreting, healthcare interpreting, conflict interpreting (Doğan, 2017a, pp. 61-67).



Figure 1: Types of Community Interpreting

2.1.1.1. Court Interpreting

The need for people who mediate communication between people with different languages and cultures has emerged as a result of human's seeking their rights and the requirement of the fulfilment of legal obligations. This need dates back to antiquity even though this type of interpreting was not conceptualized at that time (Doğan, 2010). Nowadays, court interpreters allow defendants/litigants and court personnel to communicate despite the language barriers (Mikkelsen, 2016, p.2).

The term “court interpreting” is more widespread while “legal interpreting” and “judicial interpreting” terms are also used (Doğan, 2010).

Regarding the setting of interpreting, court interpreters provide communication in quasi-judicial and administrative hearings (Pöchhacker, 2004, p. 14) as well as in law offices,

law enforcement agencies, jails and prisons and public service institutions related to the judiciary (Mikkelsen, 2016, p.1).

Those accused of a crime have the right to a defence and the right to be informed regarding charges. If the litigants do not speak the language of the court system in the country, an interpreter is assigned to this person to ensure their rights during the hearings (ibid, p.2).

In Turkey, this right has been assured by the Code of Criminal Procedure (Article 202) and it is stated that “If the suspect or the accused and the victim or the person who has been harmed as a result of the crime do not know Turkish or are handicapped, a court interpreter is assigned by court for interpreting of aspects on claims and defence” (Ceza Muhakemesi Kanunu, 2004)

Related associations or entities have not been established in Turkey; yet, there is a list of interpreters in Turkish Foundation of Judicial Development. When necessary the interpreters are assigned from the list (Doğan, 2017a, p. 63).

2.1.1.2 Police Interpreting

Similar in some ways to court interpreting, police interpreting is used during the police proceedings as well as reporting process on crime by crime victims or witnesses (Herráez & Rubio, 2008, p.123).

Police interpreting still needs to be researched and improved around the world. Also, in Turkey, due to the lack of professionalization and institutionalization of police interpreting is not yet established. When tourists, migrants, refugees or people under temporary protection need interpreting service when they are to communicate with law enforcement units, the interpreting service was provided through as hoc solutions. At the present time, there is no distinct type of interpreting called “police interpreting” in Turkey (Doğan, 2017a, p. 63).

2.1.1.3 Emergency and Disaster Interpreting – ARÇ

Communication problems emerging during the search and rescue operations after a variety of disasters necessitate the use of interpreters especially in the countries in which disasters are relatively more frequent and devastating.

In emergencies and crisis, planning and preparedness for response are really important as well as mediation which can be referred to as a key concept in communication (Salama-Carr, M., 2018, p. 217).

Doğan (2016, p.61), who is a member of the Emergency and Disaster Interpreting Organization (ARÇ) in Turkey, describes the role of emergency and disasters interpreters as below:

“In rescue operations, interpreters have to perform a number of roles: from the obvious role of enabling communication by diminishing language barriers, through resolving temporary conflicts emerging in multicultural teams, to complex problem-solving and decision-making, all of which has to be carried out with due attention to and awareness of ethical issues derived from this type of operational context.”

To be able to save lives with effective communication in emergencies and disasters, the need for mediated-communication was met with ad-hoc solutions; however, the need for interpreting services in an emergency situation still needs to be researched and investigated worldwide (Salama-Carr, 2018, p. 217).

In Turkey, people encountered with a language barriers when the foreign during the search and rescue teams arrived in Turkey to provide aid following the 1999 Marmara Earthquakes. Given that no mechanism was available to provide interpreting service, there was an endeavour to enable communication through bilingual people in disaster sites for foreign rescue teams. This experience highlighted the lack of planning and organization. As this need become apparent, the first training was initiated by academics from the Department of Translation and Interpreting of the Faculty of Letters of Istanbul University for people who want to provide voluntary interpreting services during the operations. The initial project was called “Interpreter-in-Aid at Disasters Project” which is ‘ARÇ – Afette Rehber Çevirmenlik’ in Turkish (Bulut & Kurultay, 2001, p. 250). During its foundation. Doğan A. from Hacettepe University was the first teacher of interpreting in this programme. A year later she started to train volunteers at that

university as well but it was not a part of the curriculum; some years later the endeavour became fruitful and the course to help search and rescue teams to communicate with could appear in the curriculum. Other universities followed to training on emergency and disaster interpreting (Doğan, 2016, p. x).

The scope of the organization of ARÇ (Afette Rehber Çevrimenlik Organizasyonu) was improved in time and gained recognition as ARÇ through academic studies and international collaboration. It is also included in the list of service providers in the Strategy Document of Disaster and Emergency Authority in Turkey (ibid, p. 61).

ARÇ has increased the awareness at the public and institutional level and promising developments exist in planning and response to emergencies (Bulut & Kurultay, 2001, p. 254) in terms of overcoming the communication barriers.

2.1.1.4 Healthcare Interpreting

Communication barriers resulting from linguistic variations between healthcare providers and patients pave the way for health disparities and impact the effectiveness of health promotion. In these circumstances, the need for healthcare interpreters is inevitable. Detailed information on healthcare interpreting will be provided in later parts of this chapter.

2.1.1.5 Conflict Interpreting

Conflict interpreting, as a term, came into being when the United Nations provided healthcare services in the areas where there were conflicts between the tribes and national religious and political counterparts. Interpreters were working under United Nations and as member of AIIC accompanied healthcare services for interpreting services. B. Moser-Mercer, who was also head of department in Geneva University, then Ecole de Traduction et D'Interprétation was one of those who joined this team of United Nations to provide interpreting services as she was also an academician, she introduced the type of interpreting provided in such circumstances as “conflict interpreting”. This type of interpreting later became the concern of many researchers all around the world and also was covered within the topic areas of community areas of community interpreting now about to be launched in Turkey.

2.1.2 Community Interpreting in World

In a general overview, community interpreting differs in each country; however, Australia, Canada, Sweden, and the United Kingdom are the leading countries that made a progress in that field. Especially in the 1980s and 1990s, developing countries also started to germinate in the field for the provision of linguistic and cultural mediation such as Spain and Italy as well as the countries receiving migrants (Taibi, 2014, p. 52).

In the context of (im)migration, access to public service lies in the core of communication need. Sweden and Australia took necessary action in the 1960s to meet the demand for interpreting services to help immigrants moved to host society, unlike other countries (Pöchhacker, 2004, pp. 14-15).

In the 1980s and 1990s, when the need for communication-mediated by interpreters has escalated in public institutions, community interpreting gained the necessary visibility (ibid, p. 15). According to Taibi, while promising policies, accreditation systems, and training opportunities blossomed out in the leading countries; professionalization in this field needed to be improved (Taibi, 2014).

Australia, as one of the leading countries in the field, has taken remarkable steps since the 1970s to ensure adequate organization, training, and quality on community interpreting. Establishment of the National Accreditation Authority for Translators and Interpreters (NAATI) as accreditation and standard-setting body is a great example in this regard (ibid). Its mission is developing and sustaining high national standards ensuring the availability of interpreters responding to the changing needs and demography of the Australian community (National Accreditation Authority for Translators and Interpreters [NAATI], n.d., para. 3) while it aims to strengthen the translation and interpreting industry's competitiveness and also make a contribution to community demand for everyone to be able to communicate and interact (ibid).

In Canada, community interpreting started to gain prominence in the 1980s despite the fact that overall it still continues to remain largely unregulated (Sasso, 2015, p. 35). ISO 13611:2014 (2014) – Guidelines for Community Interpreting which is the first standard

published by ISO directly addressing Community Interpreting provides a universal framework in the field for the countries in lack of related legislation such as Canada. This guidance document presents the basic principles and practices necessary to ensure quality community interpreting services for all language communities as well as in all forms of community interpreting. Immigration plays a big role in the emergence of community interpreting in most countries; likewise, the prominence of community interpreting in Canada is accompanied by a change in Canadian immigration in the first half of the twentieth century (ibid).

Spain can be considered as one of the relatively good examples with developments in professionalization in the field. While interpreting services were provided by untrained bilingual people, the need for professionals has emerged in ‘intercultural mediation for non-Spanish speakers’ (Taibi, 2014). The status of community interpreting is developing in Spain; however, the need for community services also necessitate the improvement of training opportunities and professionalization in the field (ibid).

Community interpreting is still gaining visibility as a response to increasing needs in health, education, legal areas to meet the communication requirements of speakers of different languages in the host communities all around the world.

2.1.3 Community Interpreting in Turkey

Community interpreting is mainly needed by immigrants, asylum seekers, refugees and other minority groups as like in other countries. However these have a high impact on Turkey since the country hosts a big community fled Syria after Syrian crisis in Turkey.

Diriker and Gürçağlar state that a general legal framework is available in Turkey regarding the utilization of a community interpreting in public settings despite the fact that there are still lots to be done especially regarding the qualifications. Once this point is taken into consideration, regulations will need to be amended according to the emerging situations and improved professionalization will be required together with the full implementation of the current legislation (Diriker & Tahir-Gürçağlar, 2004, p. 75).

While community interpreting services are provided for patients, health professionals in health settings; disaster victims and S&R teams in disaster areas; defendant/litigants and court personnel as well as tourists, foreign visitors in the host society, this service

mainly focuses on migrants, refugees and asylum seekers in Turkey. The main reason for the increased prominence of community interpreting is the unprecedented immigration flow to Turkey from bordering countries; mainly from Syria where a devastating conflict broke out in 2011.

Currently, Turkey hosts migrants from different countries such as Iraq, Afghanistan, Pakistani, Myanmar and mainly Syria, these include unregulated migration or forced migration (Directorate General of Migration Management, n.d.). The migrants and refugees with language and cultural varieties experience language problems in Turkey which is the hosting country. Thus, the provision of an interpreting service which is responsive to their needs in different public settings is essential. In conclusion, community interpreting is used by people like migrants and refugees to meet their communication needs in public settings.

2.2. HEALTHCARE INTERPRETING

2.2.1. A General Overview

Community interpreting requires the interpreters to be in private spheres of human life and it takes place in different settings such as a notary, lawyer's office, police station, courtroom, hospitals or health facilities (Hale, 2007, p.26).

It is irrefutable that communication mediated by an interpreter in a healthcare setting is so vital that a language barrier may cause serious dangers like misdiagnosis which may affect or even cost a human life. The mediation service for communication is as important for health professionals and service providers as much as patients (Rudvin & Tomassini, 2011, p. 3).

Health interpreting is used for communication between health service providers and patients and it has gained prominence as one of the main branches of community interpreting all around the world. As a profile of community interpreting, healthcare interpreting has also emerged in multinational countries to provide effective communication and access to health services in an equitable manner in any situation and place in the contact of human health which is a fundamental necessity for human existence (Doğan, 2017a, p.66)

Healthcare interpreting can also be referred to as medical interpreting or hospital interpreting (Pöchhacker, 2004, p. 15). Given that these different labels represent to the same concept, Tebble defines medical interpreting as the use of a medical interpreter when patients and their healthcare professionals do not share the same language and there is a need the presence of a third person, a medical interpreter (Tebble, 1999, p. 180).

According to Doğan (2017a, p.66), the healthcare interpreter's workplace is not always the same. This interpreter shall interpret in places wherever doctors or health professionals encounter with patients. These places may primarily be hospitals, health centers, and field hospitals; however, any setting such as the location of an accident or a refugee camp may be a designated workplace for healthcare interpreters.

Dialogue is generally carried out as face-to-face between two participants who do not speak the same language with the support of a third person who may work in all fields of healthcare (Tebble, 1999, p. 180).

2.2.2. Healthcare Interpreting in the World

Healthcare interpreting is present and practised mainly in the US and Canada followed by Australia, in the sense that many hospitals are investing in healthcare interpreting training; therefore, recruiting staff interpreters rather than finding ad-hoc solutions to this vital demand (Phelan, 2001, p. 35).

In the United States of America, significant changes have influenced the delivery of healthcare services to limited English-speaking patients in the last decades of the 20th century and first decades of the 21st (Angelelli, 2004). According to Angelelli's statement, her impact triggered the academic questions and consequently the prominence of services for communication between healthcare professionals and patients with language and cultural differences (ibid).

Interpreting which is provided in the healthcare settings was first researched in the 1970s; however, interpreting as a field of academic study in its own right hardly existed. The first academic research and contributions were made in the other fields rather than interpreting studies. Nursing, social work, linguistics, and psychiatry are examples of

some of these domains. While these continue to contribute to this field, research has been conducted in new branches of health sciences and some of the social sciences (Pöchhacker, 2006).

As a first step taken, Title VI of the Civil Rights Act 1964 protects service recipient practices against discrimination on the basis of race, color or national origin. This Act, therefore; led to the emergence of the need for professional healthcare service provision for communication mediation for patients with limited proficiency in the language of the host society (Angelelli, 2004, p. 1). As a result of these emerging needs and the yielding prominence of healthcare interpreting, the establishment of the related corporations and associations was initiated.

The International Medical Interpreters Association (IMIA) was established in 1986 as a US-based organization at the international level and it works on the development of professional medical interpreters as the best practice to equitable language access to healthcare in over 70 languages; besides, the IMIA is the oldest and largest medical interpreter association in the USA. The association aims to define training requirements and qualification; identify professional standards of practice; promote the establishment of professional interpreting services by medical institutions and related agencies and the profession itself (International Medical Interpreters Association [IMIA], n.d.).

Furthermore, the California Healthcare Interpreting Association was founded in 1996 (formerly called the California Healthcare Interpreter's Association till 2003 when it changed to better reflect its mission of serving the public interest of Limited English Proficient patients) (California Healthcare Interpreting Association [CHIA], n.d.). California Standards for Healthcare Interpreters - Ethical Principles, Protocols, and Guidance on Roles & Interventions - or the CHIA Standards were released in 2002 and recognized at the national level as an essential tool for raising language-service quality and quality of care (ibid).

A further example is the National Council on Interpreting in Healthcare (NCIHC) established in 1994 by enabling multidisciplinary leadership in this emerging field and forming a common voice for equitable and effective language access in healthcare (National Council on Interpreting in Healthcare [NCIHC], n.d.).

In conclusion, there exist standard-setting organizations for the profession of medical interpreters and its advancement. The standards set by these associations will be further elaborated in the sections concerning the standards of interpreting practice, focusing on healthcare interpreting.

2.2.2.1. The Migrants in Healthcare Interpreting

Migrants with limited or no proficiency in the language of the host society experience language barriers during their interactions in public settings. The need for interpreting services inevitably emerges when people migrate to another country especially forcedly such as asylum-seekers, legal or illegal migrants and refugees in their interactions at courts, police stations, hospitals, and health centers, immigration services, border patrols, schools (Diriker & Tahir-Gürçağlar, 2004).

Migration triggered the advancement of professional interpreting in the community setting around the world and also impacted the host society's responses as one of the major historical developments that lead to an increasing movement of multilingual populations (Ozolins, 2015, p. 319). The provision of effective healthcare to these linguistically and culturally diverse migrant populations has emerged as a crucial issue and led to an increase in prominence of healthcare interpreting for provision of communication between healthcare providers in the host society and the migrants.

According to the WHO Health Evidence Network Synthesis Report (2018, p. ii) which sheds light on strategies to address communication barriers for refugees and migrants in healthcare settings in the European Region:

“Policy considerations include the development of national policies and the promotion of intersectoral dialogue to augment the knowledge base and resolve the common issues (*language barriers*) identified, such as the provision of training and confusion regarding the roles of mediators/interpreters, that affect strategy implementation and evaluation.”

While healthcare interpreting for migrants gains considerable prominence all around the world, Turkey which receives a great deal of immigration, especially from Syria has also started to introduce legislation arrangements to ensure migrants access to public services in different areas such as education, municipality, and social services and

health. Also, these arrangements provide them with employment opportunities. Turkey enacted the “Legislation on Work Permit for Foreign People under temporary Protection in 2016. In this framework, healthcare interpreters are trained and employed to enable the communication between healthcare providers and Syrian patients in health settings such as Refugee Health Centres, Migrant Health Units, Community Centres, hospitals, etc. Different projects are in place to provide training programmes and arrange the employment of these people in Turkey carried out by different institutions and organizations such as Ministry of Health, World Health Organization, International Federation of the Red Cross and Red Crescent Societies (IFRC) and the Turkish Red Crescent Society (TRCS).

2.2.3. Healthcare Interpreting in Turkey

In Turkey, institutionalization for the profession of healthcare interpreting has been initiated with the establishment of the Department of Health Tourism and International Patient Support Unit under Directorate General of Health Promotion affiliated with the Ministry of Health, Turkey. This unit provides 7/24 emergency interpreting service from 6 languages which are English, Arabic, Russian, German, Persian, French into Turkish and vice versa (Doğan, 2017a, p. 66).

Healthcare interpreting as a sub-branch of community interpreting has also gained prominence in Turkey given that it attracts many tourists who come to the country for health tourism to facilitate the opportunities such as transplantation, infertility treatment, etc or a vacation. During the interactions, communication mediated by healthcare interpreters necessitates the existence of healthcare interpreters. Moreover, nowadays Turkey hosts a large amount of refugees and migrants, which triggers the need for healthcare interpreting services for their access to equitable and effective healthcare.

2.2.3.1. Status of Syrian Refugees in Turkey

The status of refugees is identified and defined around the world with international regulations and countries adopt these regulations into their national legislative arrangements. The status of refugees is recognized as a result of the adaption of international conventions and agreements.

Turkey is a signatory country to the 1951 Geneva Convention and its 1967 Additional Protocol on the status of refugees. Turkey applies a geographical limitation to the 1951 UN Convention on the Status of Refugees ("Refugee Convention") (Şimşek, 2018, p. 1). In line with this limitation, asylum rights are limited only to European people, while people under temporary protection status shall be given to Syrian people who have fled to Turkey so that they are not considered as “refugees”. Namely only people running away from a conflict or a war in Europe can be accepted in refugee status in Turkey.

Temporary Protection ID documents are given to the Syrian refugees living in Turkey. This ID document allows the Syrian people to officially access to health, education, social services, and municipal services due to the revised legal framework in Turkey. As stated before, “Regulation of Work Permits for People under Temporary Protection” enacted by Turkey in 2016 ensures Syrian people’s access to employment opportunities and participation to the registered work labour market (United Nation High Commissioner for Refugees, 2019, p. 6).

Regional Refugee and Resilience Plan, Turkey (2019, p. 7) states that the need for basic services and increased demands for public services are visible across all sectors, especially in areas with a high volume of Syrians under temporary protection. Syrians under temporary protection need to engage with the host community through consultations in order to express their specific needs and to create a dialogue with host society and authorities. However, the needs of the Syrian people outweigh the ability of institutions to respond to needs. Therefore, public institutions, need additional resources to strengthen their infrastructure and services for a response to the specific needs of Syrian people. Language barriers remain as one of the most problems for Syrians under temporary protection in their ability to access services and integrate them into local communities. This is largely visible in the health and education sectors where Syrians under temporary protection face difficulties in understanding procedures and instructions.

Communication is the heart of the effective dialogue during the service provision and the language barrier problem should be addressed to respond to their needs in all areas, especially in the health sector which is essentially important to human life.

2.3. COMMUNITY AND HEALTHCARE INTERPRETING TRAINING

Healthcare providers, as mentioned in previous sections, often encounter patients who do not have the same language called limited language proficient persons (LLP) due to extensive population mobility (Rosenberg, 2010, p. 147). To be able to create a bridge between these people with different languages, interpreters - professional or nonprofessional (bilingual family members, any acquaintances or colleagues) - provides mediated-communication between the healthcare professionals and patients.

Many healthcare institutions like other public settings in the past usually relied on informal and ad hoc freelance interpreters through relatives, children, friends and bilingual staff considering that only knowing a language is enough to interpret (Rudvin & Tomassini, 2011, p. 3). Throughout history, the communication provided by non-trained people was common practice. Today, communication between people with language varieties still relies on the untrained interpreters and Pöchhacker (2004, p. 22) refers to these untrained bilingual people as “natural interpreters” or “lay interpreters”.

However, as a result of escalating moving population, newcomers had a growing need for professional interpreting services in order to access to efficient, qualified and equitable services provided in public settings. Therefore, despite these typical ad hoc solutions which emerged as an initial response for language differences due to lack of any plan by host societies (Sasso, 2015), a slow realization of risks of using non-qualified and non-trained staff has started to arise in all public service setting (Rudvin, & Tomassini, 2011, p. 3). Pöchhacker (2004) states the following:

“On the whole, it was only when task demands exceeded what ‘ordinary’ bilinguals were expected to manage that the job of interpreter was given to people who had special knowledge (of the culture involved or of the subject matter) and skills (in memorizing and note-taking or simultaneous interpreting) as well as other qualifications, such as moral integrity and reliability.”

As a result of the emergence of gradual awareness on the importance of the need for communication, the need for systematic organization of language services was also acknowledged. This awareness led many institutions to invest in the training of freelance or permanent staff and recruit them as professional interpreter all around the world (Rudvin & Tomassini, 2011).

2.3.1. The Current Status of Healthcare Interpreting Training

Training on healthcare interpreting is developing around the world, and some country-specific examples can be cited; the USA can be considered a pioneer in the development of healthcare interpreting training since the training opportunities for interpreters in healthcare have considerably increased across the United States. In 1994, the National Council on Interpreting in Healthcare (NCIHC, n.d.) first came together and initiated strategies to raise the quality of the profession and the formal preparation of the interpreters serving in healthcare settings. While documents on a national code of ethics and standards of the practice in healthcare published in the early 2000s, national standards for training programs started to be developed in 2007 together with separate efforts to certify healthcare interpreters supported by this council and other organizations.

Developments in the US yield the gradual prominence of training programs in the country such as Massachusetts Medical Interpreter Training which provides training programs as well as educational materials and consulting services to organizations. Massachusetts Medical Interpreter Training, part of UMass Medical School's MassAHEC Network, offers interpreter training throughout Massachusetts and in other states with a focus on the state's health providers and community-based organizations. They state that the main aim of medical interpreters trainings is to achieve medical accuracy and cultural sensitivity as well as the provision of specialized knowledge of medical terminology, ethics, and cultural traditions for interpreters. This prerequisite for the delivery and receipt of effective healthcare.

Another example is the Commission for Medical Interpreter Education founded under The International Medical Interpreters Association- IMIA (formerly Massachusetts Medical Interpreting Association - MMIA) which is a US-based international organization. The Commission's mission is stated as to enhance the quality of medical interpreting education by promoting and facilitating an accreditation process of educational standards. There are 10 accredited programs under this commission. As a first program accredited by IMIA in the US, the University of Memphis Healthcare Interpreter Program is offered to bilingual individuals through the University of

Memphis' School of Public Health. The second example among these 10 programs can be the Medical Communications Ambassadors (MCA) which was created to provide a quality medical interpreting course for students who are bilingual in Spanish and English with a desire to learn how to be a professional interpreter and attain more expertise in the field. The Medical Interpreting and Translating Institute Online also can be presented as an example of an online training course and it provides a self-paced interpreting course for bilinguals fluent in English and another language (International Medical Interpreters Association [IMIA], n.d.).

Canada is another example for development in healthcare interpreters training. Some institutions are working on the development of training and their standards of healthcare interpreters. Healthcare Interpretation Network (HIN), founded in 1990 is a network of individuals and organizations focusing on improvement of access to high-quality healthcare for patients with limited English proficiency. The organization is working on the need for the development of standards on the training of language interpreters in the healthcare sector. It mainly aims to strengthen access to quality healthcare by providing education, to conduct research and exchange information, to raise funds and look for resources with respect to the education and training of qualified language interpreters, to promote common education and professional standards in the field (HIN National Standard Guide for Community Interpreting Services, 2007, p. 3).

In Canada, there are also some other organizations whose activities contribute to the development of healthcare interpreters training such as Association de l'industrie de la langue/Language Industry Association – AILIA, Critical Link Canada and Association of Canadian Corporations in Translation and Interpretation – ACCTI.

In Turkey, there are few examples of community interpreting training. Firstly, programmes were launched in community interpreting, specifically in relief interpreting. Istanbul University has started an interdisciplinary certificate programme which is called as Interpreters-in-Aid at Disasters (namely Afette Rehber Çevirmen/ARÇ). The profession and training of community interpreting were formalized in Turkey thanks to a leading project after a protocol signed between Istanbul University, Turkish Translation Association and the Turkish Directorate

General of Civil Defence. From the beginning, in the scope of the project, a multi-disciplinary certificate program was launched on Interpreting-in-Aid at Disasters (Diriker & Tahir-Gürçağlar, 2004, p.75).

“Training in Community Centers” can be shown and considered as the best example since professional interpreters took an active role as a trainer during the training. Training has been conducted under the collaboration of Translation & Interpreting Association of Turkey and Turkish Red Crescent Society (TRCS) with the financial support of International Federation of the Red Cross and Red Crescent Societies (IFRC) with the aim of professional development of community interpreters who provide interpreting service from Arabic to Turkish and vice versa. This training was carried out in Gaziantep, Ankara and in Istanbul in 2018 (Çeviri Derneği, 2018, para. 7). Before the initiation of the training, academic members from the Association administration board conducted a need analysis test in 13 Community Centers by visiting them. The same members have themselves conducted this training as trainers. According to feedback received from trained Community Interpreters, this kind of training is also necessary for people who serve other fields of community interpreting, the roles of community interpreters, requirements of their working conditions along with their needs (ibid).

Another project shows the efforts in the social sector provided by Ministry of Family, Labour and Social Services, Turkey. It is the “Strengthening of Social Service Centres and Ankara Provincial Directorate providing service for Refugees under Temporary Protection” in collaboration with UN Refugee Agency (UNHCR) (Ministry of Family, Labour and Social Policies, 2017). The project mainly aims to increase the capacity of the existing national social and protection system to provide services to people with specific needs. Alongside outreach work and psychosocial support, training activities for staff on international protection are also supported (United Nation High Commissioner for Refugees [UNHCR], 2018, p. 3). Within this framework, recruitment of trained and employed interpreter and staff to work with social workers and employment of trained staff who know Arabic and Persian to support Social Service Centres are among the aims of the project.

For healthcare interpreting, the scale is narrowing considerably. “Adaptation training for patient guides provided by the Ministry of Health and World Health Organization” can

be shown as an important example in this field. Detailed information for that training will be provided below.

In conclusion, professionally trained interpreters ensure improved and qualified communication in healthcare and facilitate the equitable access to services for non-speakers of society native language. This leads to patient satisfaction and good health outcomes. For that reason, the training for healthcare interpreting is essential for better communication during the provision of healthcare service.

2.3.1.1 Adaptation Training for Syrians under Temporary Protection to Turkish Health System as National Example

Adaptation Training for Syrians under temporary protection is conducted under the “Sihhat Project (namely, Improving the health status of the Syrian population under temporary protection and related services provided by Turkish authorities) after the Government of Turkey enacted the “Legislation on Work Permit for Foreign People under temporary Protection” in 2016. The aim of the 3-year period SIHHAT Project initiated by the Ministry of Health is mainly to develop and strengthen the health services provided for Syrian people under temporary protection (Sihhat project, n.d.). In this scope, while health professionals have the opportunity to carry out their profession by learning the health system in Turkey, the Syrian patients have the opportunity to receive services in their own language and culture.

The Ministry of Health designed and implemented the adaptation training of Syrian doctors, nurses, medical translators, mental health and psychosocial workers to improve Syrian’s access to quality and equitable services as well as linguistically and culturally sensitive services with the support of the World Health Organization.

The training of patient guides has tremendous importance to be able to provide communication mediated by interpreters addressing the language barriers. In this framework, 5-day theoretical training has been designed for the patient guides for their adaptation to the Turkish health system and medical terminology used in health settings.

These individuals were initially referred to as healthcare interpreters at the beginning; however, this changed to the patient guides and patient guidance staff at the end. The

designation ‘interpreter’ changed to ‘patient guides’ due to the fact that they had not completed an undergraduate program in this field. This was for the sake of protecting the prestige of the profession itself. Later this term has changed to “patient guidance staff” due to a wide scope of their terms of reference. Their duty in the health facilities is to accompany the patients upon entry to the facility to exiting the building. This includes registration, consultation, examination, referral, etc. Therefore, the wide scope of their function is reflected in their denomination. But in this study, the term ‘patient guide’ is used to refer to these trained people.

There is an application and admission process. Bilingual people are subjected to a language exam which assesses their language proficiency level in both Arabic and Turkish. The exams are prepared and carried out by academic members of the Department of Translation & Interpreting (Arabic-Turkish) at Yıldırım Beyazıt University. If the candidates obtain a certain score from this exam and prove that they are linguistically-qualified, they become eligible for the recruitment. They are assigned to the health facilities in different provinces in Turkey with the scope of the SIHHAT Project in line with their exam score.

The training is held in different provinces in Turkey, mainly Ankara and Istanbul as well as Gaziantep, Adana, Hatay, İzmir, Mersin, and Şanlıurfa. A total of 1193 patient guides have been recruited by the Ministry of Health since the beginning of the programme (WHO in Turkey, 2019) and they have been assigned to work in different levels of health facilities in 61 different provinces in Turkey. In Ankara, where this study is carried out, 70 patient guides have been recruited (Individual meeting with Sıhhat Project authorities, 22 January 2019).

The patient guides may be already trained before recruitment or they may first be appointed to health facilities and then attend to training according to time availability. Thus, there are still some patients guides recruited but not trained. In the sample of this study, 4 out of 61 participants stated that they did not receive the adaptation training for patient guides.

Moreover, not all the people employed and/or trained with in the scope the project did not migrate from Syria to Turkey. A small number of participants in this study are

originally Turkish bilinguals who can speak both Arabic and Turkish. Also, there are Turkmen patient guides who provide the interpreting service in Arabic- Turkish (For statistical data, see Chapter IV).

The curriculum of the adaptation training for patient guides has been prepared by academic members of Ankara University and its content is as detailed below.

2.3.1. 2. Content Analysis of the Materials of the Adaptation Training for Patient Guides

Materials of the patient guides training constitute a book entitled as “Lecture Notes on Health Literacy Training for Patient Guides” and a booklet “Basic Medical Terminology Dictionary” for provision of some basic medical terminology examples. Also, print-outs of presentations made by trainers are distributed to the trainees. The course book is comprised of 4 main sections which can read as follows:

- 1- Communication
- 2- Patient Right and Privacy
- 3- Turkish Healthcare System
- 4- General Definitions

The first chapter presents brief information on communication in a general framework and explains the importance of communication in healthcare provision, communication process, verbal and non-verbal communication, communication setting, empathy, I and you language, effective listening, communication barriers and communication techniques.

The second chapter presents the historical background of human rights, history, and development of patient rights, patient rights principles, declarations and agreements on patient rights, medical malpractice, legislation, and health professionals’ rights, privacy, and confidentiality.

The third chapter briefly explains the Turkish health system which needs revision in line with the new Government structure. It entails health system organization, Ministry of

Health organizational structure and organigram, definitions of health professionals, health financing, health service provision, general health insurance, private health services, and legislation on access to health services of the refugees under temporary protection.

The last chapter is devoted to general and basic definitions of the medical terms in different medical fields such as anatomy, physiology, pathology and also disease classification is explained. Some suffixes, prefixes, and roots of medical terminology are provided.

The ‘Basic Medical Terminology Dictionary’ is considered as a basic resource and provides Turkish and Arabic translation of certain terms. It also includes some sentence patterns commonly used in healthcare settings with translation from Turkish into Arabic.

The weekly programme of the adaptation training for patient guides is as presented below:

HOURS	1st DAY	2nd DAY	3rd DAY	4th DAY	5th DAY
08.45-09.30	Opening Introducing the training program Meeting	Application Process for Health Services in Turkey- 1	Medical Terminology- Suffix-1	Verbal Non Verbal Communication - 1	History of Patient Rights-2
09.30-09.45	Break	Break	Break	Break	Break
09.45-10.30	Preliminary Test Application	Application Process for Health Services in Turkey - 2	Medical Terminology- Suffixes - 2	Verbal Non Verbal Communication - 2	Privacy and Confidentiality - 1
10.30-10.45	Break	Break	Break	Break	Break
10.45-11.30	Organization of Health Services in Turkey	Introduction to Medical Terminology	Medical Term Analysis- Application - 1	Empathy You*I Language	Privacy and Confidentiality - 2
11.30-11.45	Break	Break	Break	Break	Break
11.45-12.30	Health Human Power	Medical Terminology-Roots - 1	Medical Term Analysis- Application - 2	Effective Listening in Communication - 1	Sample Case Presentation by Drama Method -1
12.30-13.30	Lunch break	Lunch break	Lunch break	Lunch break	Lunch break
13.30-14.15	Health Service Presentation Organization- 1	Medical Terminology- Roots - 2	Medical Terminology Application and Evaluation Medical Term Analysis-Application	Effective Listening in Communication- 2	Sample Case Presentation by Drama Method -2
14.15-14.30	Break	Break	Break	Break	Break
14.30-15.15	Health Service Presentation Organization- 2 and general health insurance	Medical Terminology- Prefixes - 1	Communication Techniques	History of Human Rights	Evaluation of Training
15.15-15.30	Break	Break	Break	Break	Break

Figure 2: The weekly programme of the adaptation training provided for patient guides

2.3.2. Interpreting-related Subjects That May Be Included in the Curriculum

Interpreting is a decision-making process; therefore, it requires the use of knowledge. It is not only a matter of the choice of words but also making a decision on a manner, an attitude, a technique or method, tone of voice, identity in line with the situation as well as knowledge on certain issues. In this section, the curriculum content including facilitating techniques, types of interpreting, note-taking techniques, memory techniques, manners and attitudes, medical terminology, accessing resources, intonation, discourse analysis techniques, cultural differences, interpreter needs, ethical rules and interpreting training by an expert interpreter as trainer.

(1) Facilitating techniques

Interpreting is a complex process due to the interpreter's internal dynamics such as cognitive burden as well as other external difficulties. Therefore, a competent interpreter should have the related knowledge and skills to be able to overcome these problems that may be encountered at any time during the interpreting (Doğan, 2017a, p. 185).

Firstly, the interpreter's cognitive infrastructure must be strengthened so that the interpreter can tackle and prevent the predictable overload and the problems that may be encountered during the process. Strengthening this infrastructure becomes possible through different practices such as shadowing practices, practice on increasing unit content of memory capacity, practice on adjusting the duration between listening and speaking which defined as ear-voice span by Daniel Gile (Doğan, 2017a, p. 187).

There are also lexical and syntactic strategies to deal with the problems when encountered if they are not prevented before and to compensate for any possible losses in the delivery. Some of the strategies and tactics listed by Doğan (2017a, pp. 190-200) are following as postponing, restructuring, ignoring, directing the listeners to another resource of information, generalization, explanation, approximation, transcription, skipping, filtering, dividing, predicting, using some certain words to gain extra time, etc.

Kazancı (2003) has carried out a study to analyze the effect of lexical and syntactic strategies on simultaneous interpreting in her Master Thesis. Focusing on alternative solutions and strategies on reformulation, she presented the results of the students' performance after a training program designed for the control and the experiment group students. Results of the study show that the strategies allow the students to improve themselves in a short time. These results display the importance of the inclusion of strategy training in curriculum and consciousness-raising exercises on the strategies in the scope of interpreter training.

All these strategies and tactics can be detailed and provided in the training so that they may provide a big contribution to an efficient and competent delivery provision in the encounter for an interpreter.

Especially, these strategies may be life-saving facilitators for healthcare interpreter in the health settings where it is much more possible to come across with the urgent need for communication. This type of needs requires effective and quick solutions for successful interaction between foreign patients and healthcare providers.

A study carried out by Al-Khanji et al. (2000, 556) on the compensatory strategies usage in simultaneous interpreting underlies the necessity for:

“...examining the possibilities of teaching interpreting students how to employ some analytic strategies, such as learning the range of solutions and the ways in which these solutions or strategies can be applied effectively. This could be a particularly useful teaching technique for dealing with fast delivered speeches in simultaneous interpreting...”

(2) Types of Delivery in Interpreting

Communication between people with different languages is always needed and this need is addressed in different settings with responses in different ways throughout history. This situation leads to the emergence of different types of interpreting.

Doğan (2017a, pp. 49-68) classifies the types of interpreting in two ways, namely their modalities and their subjects.

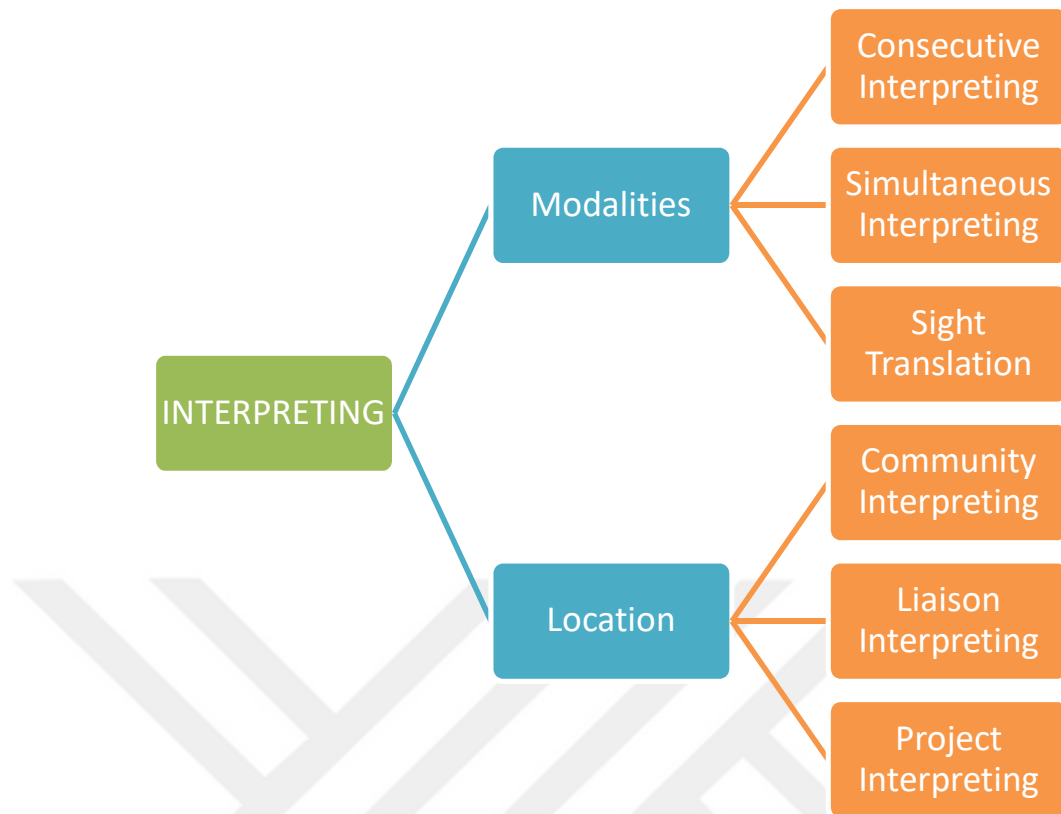


Figure 3: Classification of interpreting according to its modalities and location

As the above chart reveals, there are three different modalities. Consecutive interpreting is reproducing the message given by the speaker after the completion of the speech into target language. The length of the speech differs from 1 minute to 20 minutes, which requires a note-taking process. In consecutive interpreting, the interpreter relies on a combination of notes, memory and general knowledge (Gillies, 2017, p.5) to be able to convey the message in the same message.

Secondly, simultaneous interpreting (SI) is one of the most complex tasks which requires a cognitive perspective. Christoffels and de Groot (2005, p.1) define SI as following:

“...one has to listen to and comprehend the input utterance in one language, keep it in working memory until it has been receded and can be produced in the other language, and produce the translation of an earlier part of the input, all of this at the same time. Thus, language comprehension and production take place simultaneously in different languages.”

In this framework, this demanding task can be performed in the booth in which the required equipment is provided to relay the interpreter's voice to listeners. A submode of simultaneous interpreting is whispering which is provided outside the booth with low voice taking near location to the listener.

Lastly, sight translation is another type of interpreting which can be used as a pedagogical exercise for training purposes. Information from a written text is reexpressed in the target language orally.

Doğan (2017a, pp. 61-68) classifies the interpreting into 3 categories according to their locations. Community interpreting is the overarching term to encompass the locations where it is delivered. It came into being in the multilingual countries to fulfil the communication needs of the people with language barriers when they want to receive services from the public institutions of the country they sought refuge, migrated or visit as a tourist. Emergency and disaster interpreting, sports interpreting, police interpreting, court interpreting, conflict interpreting, healthcare interpreting are the sub-branches under this umbrella term. In addition to that, liaison interpreting is the one delivered by the staff interpreters in public institutions. Finally, interpreters are also recruited in the international or multinational projects. The subject field varies according to the focus of the project. As explained, each type of interpreting necessitates also different skills and knowledge and the interpreter is to be aware of what skills shall be utilized when and at what stage of the encounters that they mediate.

(3) Memory Techniques

Each kind of interpreting requires the skill to use certain memory techniques. Doğan et al. (2009, p. 69) state that "Interpreting is a complex process which challenges the brain by memory-intensive processes, necessitating immediate proper response to unexpected situations, in which a vast number of cognitive, affective and psychomotor skills function almost simultaneously; thus, its training requires peculiar practices..".

Undoubtedly, simultaneous interpreting is so demanding a cognitive activity that consequently affects many cognitive functions. The biggest challenge of this complex process is as many processes have to be carried out concurrently by the interpreter (Morales et. al., 2015, p. 82).

In addition to simultaneity, Doğan (2017a) quoting from Setton (2006) underlines the other two important factors, namely incrementality and immediacy are the other challenges of simultaneous interpreting which require the adoption of multitasking strategies to cope with these challenges during the delivery. In this scope, immediacy calls for preparedness to deal with the unexpected immediate situation on the affective and cognitive bases while incrementality means the situation in which the mind may be overloaded with the received information resulting in the prevention of successful rendition on interpreting process.

Memory needs to be explained to have a better understanding of the cognitive and affective processes in simultaneous interpreting, the memory becomes a good resource to be elaborated. Tzou et. al (2012, p. 214) states that working memory is one of the critical resources.

“...Working memory is a limited capacity component of information processing that is involved in processing and storage of currently active information while other cognitive tasks are being carried out”.

There are different models developed by different researchers on memory. For example, Baddeley has developed an influential model. According to this model, working memory is composed of two temporary stores which are a phonological loop and visual sketchpad (Morales et.al., 2015, p. 83). It provides rehearsal of the stored information and works as a central executive for coordination of active contents. It also supports cognitive activities such as coordinating, planning, updating the information plan and retrieving the contents from long-term memory (ibid).

Moreover, towards the end of the 1970s, Gile observed the cognitive challenges experienced by interpreters in simultaneous interpreting and started to research cognitive psychology literature and developed a set of ‘Effort Models’ of interpreting. His Effort Model consists of four models which are reception effort, production effort, memory effort and coordination effort (Gile, 2018, p. 536). The first one, reception effort, refers to all mental operations for perception and understanding of the source speech together with other environmental input like presentations or any documents on the screen or audience reactions and also any analysis supporting to reach the conclusion about their meaning (ibid). The second one, production effort means all

mental operations related to decisions on ideas/feelings to be expressed to the production of the target speech. It includes the selection of the words and their assembly in the speech (ibid). The memory effort, the third one, is the storing information received in source speech for a short period (up to a few seconds) by awaiting the further process. Then this information is discarded (if not well-understood) or reformulated in the target language for delivery (ibid). Lastly, the coordination effort is the allocation of attention to the other three efforts on the basis of the needs as the source and target speeches emerge (ibid).

As explained by many researchers, memory is important for accurate and efficient delivery in interpreting. Therefore, related practices to improve the memory capacity would be beneficial in the training of the healthcare interpreters.

(4) Note-taking Techniques

As explained above, consecutive interpreting as a modality of interpreting requires conveying the speaker's messages after the speaker gives pause for interpreting. In that frame, the length of the speech may vary as long consecutive and short consecutive (Yamada, 2018, p. 1387). The interpreters use note-taking techniques in a systematic manner for the reformulation of the message in the first one while the decision is left to interpreter whether to take note or not in the latter. Note-taking is important in increasing the quality in interpreting delivery and it is generally preferred by interpreters to provide more security in memory (ibid).

Notes represent the skeleton of the speech which consists of ideas in a certain order. These ideas are related to each other. In the encounter, this structure of the speech should be analyzed by the interpreter even before the note-taking process (Gillies, 2017, p. 9). In this way, the notation would become the visual representation through this analysis of the source speech, with the notes as clear as, even clearer than the analysis in structure. Therefore, the interpreter can easily convey the speaker's message to the audience (ibid).

The first system on note-taking for interpreting was formulated by Jean Francois Rozan in his book published in 1956. After that, other experts have developed other systems by building on his system (Marani & Tabrizi, 2018, p. 504).

Gillies (2017, p. 10) states that good analysis and successful note-taking would result in effective short-term memory operations and quality consecutive interpreting delivery too heavily in his book. However, he also warns the interpreters against too focusing on notation which may lead to hinder effective listening and analysis of source text. That point is really important for interpreting training as well, if an incompetent trainer trains people to such an extent that the notation is like a transcription, trainees may be discouraged during the training. This may lead to misgiving on note-taking and refraining from taking notes in interpreting (Yamada, 2018, p. 1387).

Stating that there is no single exact way to take notes during a speech, Gillies (2017, p. 12) provides a compilation of some ideas created by many interpreter's views and his own experiences as a trainer and an interpreter in his book. This compilation includes some suggestion and solutions inspired by the problems that student interpreters encountered presenting them in a methodical and clear manner. The book gives comprehensive information on strategies related to different topics in notetaking such as the use of margins structure and links, clauses, use of abbreviation, word order, noting numbers, improvising symbols, and so much more.

All related strategies are explained in detail, the one could learn and internalize a skill on "learning by doing" (ibid) rather than listening to how it is done. This skill can only be improved through self-practice.

(5) Manners and Attitudes

Interpreters' role boundaries need to be clarified. Their performance criteria also need to be identified. Otherwise, the quality of interpreting may be uneven and inconsistent which lead to the potential for inaccurate and/or incomplete communication in the interpreted encounter (NCIHC, 2005, p.2).

The interpreter should refrain from any personal involvement in the communication they mediate being aware of the boundaries of their professional roles. In this frame, National Standards of Practice for Interpreters in Healthcare (NCIHC, 2005, p.8) identifies the objective as "to clarify the scope and limits of the interpreting role, in order to avoid conflicts of interest" in the scope of role boundaries.

In addition, situationality need to be taken into account in interpreted encounters. This refers to the factors which make a text relevant to the situation in which the interlocutors are placed (Doğan, 2017b, p. 113). All these elements may affect the communication mediated by interpreters.

Moreover, the interpreters have a responsibility to provide interpreting service in line with style and language use adopted by the interlocutors in the interpreted encounters. The wording and style in a speech may vary from person to person. This is referred to as register; therefore, the interpreter should take the register into consideration while delivering. Detailed information on register and its theory are present in the section on discourse analysis.

(6) Medical Terminology

Comprehensive knowledge on medical terminology allows interpreters an understanding of the source text which leads to higher quality.

Medical terminology has its basis in Latin or Greek. The pronunciation of terminology may vary in different languages (Erten, 2016, p.48). Learning medical terminology is similar to learning a new language and it is generally only clear for doctors, nurses, medical students, and other health professionals. However, there is a certain consistent lexical structure. Medical terms are comprised of roots, prefixes, and suffixes. These make it easier to decode the words and make sense of them (ibid, p. 49). Provision of such examples of medical terminology would be very beneficial for healthcare interpreter training

Moreover, interpreters are required cope with the vast number of terms. The training needs to provide guidance on the resources that should be selected and how interpreters create their own glossaries. Since medicine has many branches, developing their own glossaries of the words they encounter in daily work may be more practical than focusing on the whole terminology provided in the general healthcare interpreting training for healthcare interpreters working in a specialized health setting focusing on only one branch.

(7) Intonation

In interpreting,, intonation has a communicative role in signaling turns in discourse, to emphasize information in an utterance, to unearth the implicatures in the messages, to distinguish the questions from the statements, to render the attitudes such as warning, neutrality, surprise, boredom and other emotions (Seeber, 2001, p. 69).

Both speakers and interpreters comply with these intonational patterns during the interpreting since intonation is a factor affecting both the interpreter's perception of a message to be conveyed and the listeners' reception of the message rendered (Waasaf, 2007, p. 178).

It can be inferred that intonation is an important element in communication in all settings as well as healthcare settings to be able to render the messages in an effective manner; therefore, interpreters are to be trained accordingly. For healthcare settings, correct intonation is a must to avoid any miscommunication which may lead life-threatening even irrevocable results.

(8) Discourse Analysis

Language and discourse are the result of mental constructs of a speech community. Discourse analysis is the analysis of language in use and investigation of what that language is used for (Brown, Gillian & Yule, 1983, p. 1).

Speakers may desire to highlight some aspects in a sentence or utterance by emphasizing certain elements. What the speaker wants to focus on may be arranged by making use of “theme” while “rheme”. Considering this relation between theme and rheme requires the correct use of language (Doğan, 2017b, p. 77), the interpreter should take this into consideration in the communication. An interpreter should be able to differ what the speaker says from what s/he her/himself conveys to the listeners; therefore, this difference should be rendered correctly during the interpreting (Doğan, 2017b, p. 79) In other words, the interpreter should be aware of where and how theme and rheme are to be reflected in the target language (Doğan, 2017b, p. 80). In other words, the interpreter should have discourse competence which is the ability to create a

meaningful whole by connecting sentences in the frame of discourse. These connections may be physical and explicit or implicit (Kaburise, 2011, p.40).

Regarding the relation between Cognitive Science and Interpreting Studies (Doğan, 2017b, p. 124), Brown and Yule (1983, p. 234) mentions two terms which are bottom-up processing and top-down processing. While the first term refers to work puzzling out the meanings of word and sentence structures and then building up a composite sentence meaning, the latter means anticipating the next sentence based on the context as well as composite sentence meaning (ibid). During interpreting, the interpreter's mind makes use of both types of processing which can be referred to as "interactive processing" when dealing with the problems faced due to various reasons such as the usage of uncommon and field-specific terminology, losses resulting from speaker's pronunciation and the limited capacity of memory (Doğan, 2017b, p. 131).

Another important aspect to be taken into consideration in interpreting is register. In interaction between people, language use (wording and style) may variate in line with the level of the sincerity of the communication medium and type of communication (oral or written) (Doğan, 2017b, p. 149). Many studies have been carried out to analyze this difference in language use. Register theory has been used for the first time by Halliday in order to explain the relationship between the functions of language and types of language. In the scope of this theory, language variables are listed as following: field of discourse, the tenor of discourse and mode of discourse (Doğan, 2017b, pp. 150-155). Register theory is to be taken into consideration during the interpreting in mediated-encounters. The interpreters have two main responsibilities which are their own responsibility as one party in the encounter and their interpreting responsibility in line with style and language use adopted by parties in the encounter as messengers (Doğan, 2017b, p. 164). At that point, it is noteworthy to explain different forms of addresses such as the use of direct speech (first person- style) and indirect speech (third-person) address that can be favored by interpreters in interpreted-encounters. Literature mainly shows that interpreters prefer to use the speaker's direct speech to render the messages received from primary interlocutors in face-to-face interpreted encounters, (Dubslaff & Martinsen, 2007, p. 57) which is regarded as a norm by professional interpreters. Meanwhile, untrained interpreters who may be considered as natural

interpreters tend to adopt indirect speech in the encounters where they mediate (ibid). Generally, the addition of “s/he says” and/or a shift into the third person is considered as a lack of professionalism for the interpreter. This issue is still being debated as third person singular can be much more functional in certain situations, especially in community interpreting sessions. For example, the use of a first or third person was on the agenda as a discussion point in 2002 on the NCIHC-list, the online discussion group of the U.S. National Council on Interpreting in Healthcare (Bot, 2007, p. 83). Even though there are no certain rules specified in the related guidelines, interpreters should have related skills to be able to make the correct decision on the preference of style in line with the situation in the encounter.

Interpreters should be aware of the speech acts, presuppositions, implicatures and entailments embedded in an utterance and evaluate what has been said regarding the intentionality, situationality, taking into account the register theory parameters. A part of this issue can be considered in a better way within frame of speech act theory, which was first voiced by J.L Austin in 1962 and developed further by John R. Searle. In this theory, the ways of language use of people is analysed (Pew, 2015, p. 1095). Each utterance itself is called “locution” while every utterance has an illocution which reflects the intent of the speaker with use of verbs suggesting warning, promising, greeting, offering, objecting. The same words may have various illocutionary acts depending on the context in which they are uttered (ibid, p. 2096). In conclusion, an interpreter should be able to identify the function of illocutionary acts, to take the perlocutionary act in the source consideration and to provide accurate interpreting so that the meaning of illocution and perlocution should be interpreted in source and target language (Doğan, 2017b, p. 229). Moreover, the interpreter should consider “seven standards of textuality”, which are cohesion, coherence, intentionality, acceptability, informativity, situationality, intertextuality as they fit in the discourse of the interaction also taking into account the register profiles (Doğan, 2017b, p. 230).

Different meanings can be inferred from the utterances and sentences delivered by people in the speeches. What people said may implicate different meanings.

“Implicature is a special case of situations in which the perceived meaning extends beyond the literal meaning. Conversational implicature is, therefore,

something which is implied in conversation, that is, something which is left implicit in actual language use” (Wang, 2011, p.1162).

These implications may result from the opinions, behaviors, manners, attitudes, and feelings of the speakers or listeners (Doğan, 2017b, p. 234).

Lastly, it is important to provide brief information on world knowledge, general knowledge as well as their importance in an interpreting process. Doğan (2017b, p. 52) defines world knowledge as the fact itself. On the other hand, general knowledge provides the information on the phenomenon. When they have new information in a dialogue, they can benefit from their own general and world knowledge they have to be able to make the newly received information sense for themselves.

As a result, all the above-explained points are important in the interpreting process for better delivery in interpreted encounters.

(9) Cultural Sensitivity and Competency

When people from different countries and societies come together, some challenges that emerge, need to be addressed. In addition to the language barrier, there is also a cultural difference as a challenge to be handled. Addressing the cultural difference can be the heart of well-established communication with the culturally diverse population. As a result of lack of understanding and tackling these differences, cross-cultural encounter (Betancourt, Green & Carillo, 2000, p. 27) may lead to complexity in communication for people with different social and cultural backgrounds. Intercultural communication, which can be defined as the interaction between people with different cultural backgrounds is not only language translation but also rendering messages in line with situated beliefs and practices (Piacentini et al., 2019, p. 258) in these cross-cultural encounters.

When this point is taken into account in the healthcare context, health systems also tackle the diversity in culture in addition to the language. Communication in a health setting and people’s understanding of health are shaped by their cultural background. Especially migrants, coming from different cultural and health systems have different experiences on migration journeys and healthcare utilization (ibid, p. 257). Communication may be influenced by their entitlements to healthcare and their

understandings during the consultations (ibid, p. 258). Therefore, the combination of culture and their migrant status along with other structural and societal dimensions may create difficulties in a healthcare setting such as a lack of trust in healthcare providers and different perceptions in gender roles.

The impact of these differences should be taken into consideration by interpreters during the interpreted healthcare provision. In this sense, intercultural communicative competence necessitates certain skills besides linguistic competence and requires the ability to consider other cultures without being judgemental (ibid, p. 258). As a result, cultural competence and awareness are required for an interpreter who mediates a medical encounter to be able to have more tolerance and acceptance of people with different cultural backgrounds. In this regard, a comprehensive review on challenges of healthcare providers published by Kavukcu and Altıntaş (2019, p. 5) also states that interpreters remove the communication burden to a certain extent by tackling with the linguistic barrier between patient and provider; however, they may not be able to meet the needs of refugee populations, which are a specific group and these go beyond “speaking the same language” which may not be enough to be able to respond to the displaced population’s needs highlighting the essentiality of the training of interpreters to serve a certain group in a culturally sensitive manner.

Cultural awareness on encounters with refugee patients is essential for their access to equitable and efficient healthcare provision; therefore, cultural competency component in a healthcare interpreting training has remarkable importance. An article published by Griswold et. al. addresses the domains to be covered in training in terms of cultural awareness presenting investigation findings from medical students in the context of healthcare provision to refugees. The study suggests that cultural diversity training with a patient-based learning approach would contribute to increasing their cultural sensitivity and competency (Griswold, et al., 2007, p. 55). This approach should be applied to healthcare interpreting training.

(10) Interpreter’s Needs

Interpreting is a complex process which may be considered as a challenge for human memory and requires a higher competence than the average cognitive burden. A well-designed training programme may help the interpreters tackle this challenge. The factors

impacting the interpreting process may vary from time to time, place to place and day by day, for example, fatigue, health problems, etc. (Doğan, 2017a, p. 69). Other than the pressure of the interpreting process, the interpreters try to tackle these unexpected factors. While dealing with them, working conditions must be appropriate for an interpreter for quality service provision (ibid, p. 70).

The problems experienced related to workplace or working hours may impede them in fulfilling their duties and providing efficient delivery. As regards to the workplace, issues about booths and interpreting equipment inevitably adversely affect the interpreter's performance and competence impeding their focus on the delivery (Doğan, 2017a, p. 71). While the workplace-related issues are mainly encountered in simultaneous interpreting, working hours is also important for all types of interpreting and in translation.

There are international standards for working hours for interpreters. During the interpreting process, the interpreter experiences a complicated cognitive process. As explained in detail in the section on memory techniques, the interpreter has three main challenges referred to as immediacy, simultaneously and incrementality which places a high burden on memory during simultaneous interpreting. There is a similar burden during consecutive interpreting, especially in long speeches. Therefore, working conditions shall be well-managed taking these challenges into consideration in line with the interpreter's rights.

(11) Ethical Principles

While rendering the messages during interpreting, interpreters should be comply with some ethical principles which are confidentiality, respect, accuracy and completeness, impartiality, role boundaries, professionalism and integrity, anti-discrimination. It is significant for interpreters to make ethical decisions in all settings, especially healthcare settings.

“Confidentiality” implicates keeping the information gained during the interpreting secret by declining to render any information about the patient to providers and to convey to the patient any personal information about the provider (CHIA, 2002, p. 25).

The interpreter must not disclose any information outside the treating team if the patient does not consent or unless required by law (NCIHC, 2005, p. 6).

“Respect” is an acknowledgment of the dignity of all parties placed in the interpreting setting. According to the National Council on Interpreting in Healthcare (NCIHC, 2005, p.13), the interpreter shows respect professionally and also promotes direct communication among healthcare providers and patients as well as patient autonomy in the encounter.

“Accuracy and completeness” require rendering of the messages accurately and completely and conveying the spirit and content of the original message. The interpreter has the responsibility of reflecting the speaker’s register, style, and tone in the same manner. The flow of communication is to be managed and transparency is to be taken into consideration (NCIHC, 2005, p. 5).

“Impartiality” means avoiding any bias or preferential behaviors that impact the accuracy of the interpreting of the interaction between interlocutors (CHIA, 2002, p. 26). Interpreters should be able to identify any conflict of interest also not allow personal judgments or cultural values that may impede objectivity (NCIHC, 2005, p. 6).

“Role boundaries” refers to limits of the interpreting role. The interpreter is to be aware of the boundaries of his/her professional role and refrain from personal involvement during the assignment. The interpreter should confine his/her professional activity to interpreting within an encounter (NCIHC, 2005, p. 8).

“Professionalism and integrity” mean fulfillment of interpreting assignment in line with professional standards such as being honest and ethical in all business practices (NCIHC, 2005, p. 9). He/she should be well-prepared for the given assignment. Also, he/she should be able to maintain the public’s trust in the interpreting profession (ibid).

“Antidiscrimination” requires to avoiding any use of discriminative remarks or behavior against people in an interpreted encounter. In the healthcare interpreting context, when an interpreter feels discrimination against a patient, he/she may refer this patient to another healthcare provider after understanding of an intention of any kind of discrimination.

The abovementioned principles are to be taken into consideration by interpreters in all settings where communication is mediated by interpreters. However, ethical dilemmas are much common in healthcare settings. Therefore, interpreters should understand their options and analyze their actions while conveying the messages. That's why, healthcare interpreting training should include the content that may help them discuss the ethical dilemmas and explore ethical decision-making process (CHIA, 2002, p. 32).

(12) Interpreting Practices by an Expert Interpreter Trainer

The trained interpreter may take an active role in the training as a trainer and provide practical examples (such as role-playing) for an interactive learning process.

Practice during the training and even after for self-studying is a requirement for successful delivery in the interpreting process. Some people may partially complete the task thanks to their natural talent without any special training (Gile, 2018, p. 546), but it is generally considered that performing good interpreting requires training which includes practice and a good trainer who has comprehensive knowledge and familiarity with the all mental, cognitive and affective processes in the interpreting as well as environmental impacts to this process.

Gile (2018) explains the main four objectives of training as follows:

- “- to teach students the basic techniques of interpreting, generally both consecutive and simultaneous,
- to improve their proficiency in the use of these techniques up to professional level,
- to teach them professional norms,
- to test their level of proficiency at the end of training to provide the market with qualified professionals.”

Also, in the training, specific exercises can be given to students to attain better results and outputs from the training. These are shadowing exercises, paraphrasing exercises, counting backward in the booth while listening to a speech. When this phase is complete, simultaneous skills are acquired through practice, both in the classroom, with the guidance given by the expert instructors and self-study groups (Gile, 2018, p.546). Gile (2018) also states that “Through practice, attention management is fine-tuned and some cognitive components of simultaneous are gradually automated”.

The minimum crucial interpreting-related subjects to be included in the content of the training are as listed above. The rationale behind the inclusion of each subject is elaborated under each heading. After an elaboration on the subjects for inclusion into the curriculum, it is beneficial to present healthcare interpreting practice standards at the international scale.

2.3.2.1. Standards of Healthcare Interpreting Practice

Standards of practice are a set of guidelines defining the tasks and skills which the interpreter should be able to perform during the profession and the rules that they should conform to.

“...For healthcare interpreters, the standards define the acceptable ways by which they can meet the core obligations of their profession – the accurate and complete transmission of messages between a patient and provider who do not speak the same language in order to support the patient-provider therapeutic relationship (NCHIC, 2005, p.1).”

These standards of practice are not the same in all countries.

Association	Standards of Practice	Publication year
International Medical Interpreters Association (IMIA) and the Educational Development Center (EDC)	“The Medical Interpreting Standards of Practice”	2007
The California Healthcare Interpreting Association	The California Healthcare Interpreters Association (CHIA) Standards’	2002
National Council on Interpreting in Healthcare (NCIHC)	“National Standards of Practice for Interpreters in Healthcare” NCHIC	2005

Table 1: International Examples for Standards for Healthcare Interpreting Practice

Efforts on publication of certain standards for interpreting practice have been initiated at the beginning of the 2000s. Table 1 which presents some examples from different countries.

“The Medical Interpreting Standards of Practice’ is the only and oldest standards of practice published specifically for medical interpreters at international level and developed by International Medical Interpreters Association (IMIA) and the Educational Development Center (EDC). They serve as essential evaluation and competency tool for professional interpreters all around the world and identify the main performance standards and competencies required of a ‘competent’ interpreter (IMIA & EDC, 2007, p. 7). Moreover, this first published standards for the profession remained the only standard of practice focusing the practice of medical or healthcare interpreting as a specialization at the international scale, also translated and adopted in some other countries (Ph, 2016, p. 37). During the development of these standards of practice, DACUM (Developing a Curriculum) process is used as a method of occupational analysis for professional and technical jobs. Through this process, experts worked on describing and defining the tasks of their job, identifying the specific knowledge, skills, tools, and attitudes which are needed to carry out their tasks in a correct way (IMIA & EDC, 2007, p. 11). These standards take complexities of interpreting and the clinical interview into consideration underlying that medical encounter is an interactive process. In this process, language is used as a strong tool to understand, evaluate and get a correct diagnosis. Therefore, the interpreter should be aware of how to engage with the service provider and foreign patient in an effective and efficient manner to be able to realize nuances and socio-cultural assumptions in the conversation (IMIA & EDC, 2007, p. 12). Communication may become more complicated when different cultures are embedded. In this framework, a competent interpreter can mediate these barriers by addressing both linguistic and extra-linguistic aspects of communication (ibid, p. 12).

The Medical Interpreting Standards of Practice explains that practice spans three major task areas which are an interpreting, cultural interface, and ethical behavior. A brief explanation of each of these task areas has been detailed in these documents (ibid, p. 12).

“National Standards of Practice for Interpreters in Healthcare” is the second example of standards of practice which was developed and published by the National Council on Interpreting in Healthcare in 2005. These standards of practice were developed as a reference for interpreters. It aims to guide the practice of all interpreters and to acquaint

non-interpreters with the standards recognized in this profession (NCHIC, 2005, p. 1) providing a common base of understanding.

Specifically, these standards for practice are developed for the use and adoption for training, hiring, performance monitoring and discussion on certification of professional competence. It contains 32 standards of practice grouped under nine headings (accuracy, confidentiality, impartiality, respect, cultural awareness, role boundaries, professionalism, professional development, and advocacy) which show how the standards relate to the nine ethical principles of the National Code of Ethics (NCHIC, 2005).

‘The California Healthcare Interpreters Association (CHIA) Standards’ was published in 2002 for medical interpreters in the United States in to a state region. These standards define the fundamental purpose of healthcare interpreters as the facilitation of communication between two parties with different language and culture. Moreover, they describe the roles and strategies available to interpreters to help the parties address communication barriers such as differences in cultural norms (Ph, 2016, p. 39).

Lastly, ‘Canadian Standards, namely The National Standard Guide for Community Interpreting Services (NSGCIS)’ developed by Canada Healthcare Interpretation Network [HIN] in 1996 is a standard which is not focused only practice in healthcare settings but also different fields and specializations to meet the needs of interpreters (ibid, p. 40).

Healthcare-specific standards do not exist in Turkey while a general frame for the interpreters has been drawn through “National Professional Standard for Interpreters”. Below, brief information on these national standard is provided.

2.3.2.2. National Professional Standards for Interpreters Enacted By Professional Qualifications Authority in Turkey

In Turkey, Professional Qualifications Authority is an affiliated authority with Ministry of Family, Labour and Social Services and it defines and identifies professional qualifications as well as establishing National Qualification System with quality assurance at the international level (Professional Qualification Authority, n.d.).

Professional Qualification Authority identifies National Professional Standards which can be defined as minimum norms presenting required knowledge, skill, manners and attitudes of a profession (Professional Qualification Authority, n.d.).

National Professional Standard for Translators & Interpreters were also enacted by this Authority (reference number 12UMS0274-6). Qualification level of this profession was identified as Level 6 from 8 Level Matrix.

This standards-setting document includes a definition of the profession, its rank in the international classification system, related legislation, working place and conditions, and other requirements under the scope of introduction of the profession. It also presents interpreter's roles, procedures, performance index, tools and equipment, knowledge and skills, manners and attitudes under the scope of profession profile (Professional Qualification Authority, 2012). Standards set in Turkish National Professional Standards should be included in the content of healthcare interpreting training in Turkey.

2.4. RELEVANT STUDIES ON HEALTHCARE INTERPRETING

Few studies have been carried out on healthcare interpreting in Turkey since the field has started to gain prominence in very recent years in addition to the research conducted on the international platform.

Firstly, as a national example, Olcay Şener (2017) has written a Master's Thesis on Healthcare Interpreting in Turkey entitled "Healthcare Interpreting in Turkey: Role and Ethics from a Sociological Perspective". This thesis aims to analyse the roles of the healthcare interpreters in relation to ethics in Turkish health settings with a case study via interviews made with healthcare providers and patients as well as audio-recordings presenting the interaction between them during the provision of care. The study implies the scarcity of research in the field and also highlights that no association developed a healthcare interpreting code of ethics and conduct at the time the thesis was drafted.

As another example at the national level, Dilek Turan (2018) has carried out a study on healthcare interpreting addressing physician-patient communication in Turkey. Turan

stresses that there is an “asymmetrical” relationship prevailing between the physician and the patient in this communication due to physician’s use of medical jargon (in the physician-patient-interpreter triangle) and the study examines healthcare interpreter’s role during this communication through examples.

Jan Cambridge (1999) has carried out research in the UK to address information loss during the bilingual healthcare provision mediated by the untrained interpreters. In the research, discourse analysis has been performed for seven extempore simulated consultations between medical practitioners and volunteer patients speaking a foreign language whose communication provided by educated but professionally untrained native speakers of the foreign language.

Sara Pittarelo has written a paper to explore the distinction in Italy between “interpreter” and “mediator” used as different terms for people who provide communication between healthcare providers and foreign patients as well as the reasons behind this separation. Questionnaires were administered to both healthcare personnel and interpreters/mediators and interviews were carried out in order to provide information on interpreter/mediator’s roles and tasks, invisibility versus active participation and the use of personal pronouns and indirect speech. Moreover, 26 mediated interactions were observed in line with prearranged parameters in order to analyse whether perceptions and practice on the mentioned topics are consistent or not.

Sleptsova et.al. (2014) carried out a literature review with keywords (interpreter/translator, communication and role and their combinations) in PubMed, CINAHL, PsycINFO, and PSYNDExPlus with the aim of analysing publications on healthcare interpreting as well as associated roles, expectations, and outcomes together with the references of these publications on condition that all searched articles should present empirical evidence. In total, 1121 research have been analyzed and different results have been concluded such as the transmission of information in a faithful manner, acting as a cultural broker, acting as a clarifier, advocator of patients or mediator roles. In conclusion, the research presents that there is no consensus on the role of healthcare interpreter; besides, the research implies the requirement of the need for clarification of function before medical encounters.

Zendedel et al. (2016) conducted a survey through 54 semi-structured in-depth interviews with general practitioners, migrants and family interpreters with the aim to examine perspective differences between these three interlocutors focusing on interpreter's role, power, and trust in interpreters. The study concludes that family interpreters are trusted more since they act as advocates of patients, on the other hand, GPs do not trust the competence of family interpreters. Given that these opposing opinions of the interlocutors may cause miscommunication, conflict or even mistreatment, the study implies the requirement to train GPs in order to make them aware of family interpreting difficulties and their rights to call professional interpreters when needed during the medical encounters.

A mixed-methods study carried out by Floor van Rosse et. al. (2015) in the Netherlands addresses the patient safety risks resulting from language barriers and the way for detection and reporting of language barriers in Dutch hospital care through screening of 576 patients' medical records together with qualitative analysis of 17 patient admissions with language barriers and 12 in-depth interviews with healthcare providers, patients and/or their relatives. The results show the existence of a high amount of risky situations during the healthcare provisions due to language barriers. The study implies the requirement of bridging the language barriers as well as the identification and reporting of these situations in addition to the need for new solutions for this bridge. It also presents that language barriers must preferably be bridged with professional interpreters.

Another study has been conducted by Hsieh & Kramer (2012) on the healthcare interpreters' roles and functions. This study explores difficulties and dangers when a utilitarian view of the interpreter is imposed in healthcare settings with in-depth interviews and focus groups with 26 medical interpreters from 17 different languages and cultures and 39 providers of five specialties. Collected data is analyzed through grounded theory. The study found that when interpreters are considered and act as passive instruments, a utilitarian approach may compromise the quality of care by silencing patients' and interpreters' voice, objectifying interpreters' emotional work, and exploiting patients' needs. The study implies that consideration of interpreters as

active part instead of passive instruments, both healthcare providers and interpreters can collaborate better and allow the interpreters to maintain control over their expertise.

Intercultural Mediation in Healthcare: From the Professional Medical Perspective written by Izabel E. T. de V. Souza (2016) is a book presenting the interpreter's role as intercultural mediator. It explores the international examples for standards of practice and interpreting culture and review on medical interpreters' cultural work. The book's main objective to study the professional medical interpreters' perspectives about their practice to bridge between the providers and patients in healthcare provision also to redefine the professional role and scope of service based on the interpreters' own set of professional values and beliefs in general.

This chapter provided the theoretical framework on community and healthcare interpreting. The next chapter, the methodology of the study is presented.

CHAPTER III

METHODOLOGY

This chapter entails the methodology that sheds light on the evaluation of adaptation training for patient guides. The chapter consists of information on the design of the study, participants, procedure of the study, data collection instruments and data analysis techniques used to evaluate the outputs of the subjects.

3.1 DESIGN OF THE STUDY

3.1.1 Design of the Study

A descriptive method is used in this study. The data collection tool is formulated in line with the research questions of the study. The results showing the information received by the patient guides are analyzed to find the responses to these questions.

3.1.2. Content Validity of the Questionnaire

The questionnaire was prepared by the researcher student together with the advisor. After the preparation, two field-expert opinions have been solicited, one of whom was an expert on assessment and evaluation and the other, an expert in the Interpreting Department. Upon the receipt of their opinions and suggestions, the questionnaire has been revised and finalized, then the approval process for ethical clearance and administration of the questionnaire have been initiated.

A pilot study was conducted on 5 patient guides working (Adana x 2, Mersin, Gaziantep, Hatay) in the health facilities other than Ankara. The questionnaire has been revised according to the results.

3.2 PARTICIPANTS

The population of the study consists of the patient guides recruited in Turkish health facilities within the scope of SIHHAT Project all around Turkey. The sample of the study consists of only the patient guides recruited to health facilities located in Ankara under this project and the sample size was 70 healthcare interpreters employed in Ankara health settings under this project; however, 6 of them were not eligible to

participate in the study due to various reasons stated below. Therefore, the sample size of the study is 64 people. In this study, only the healthcare interpreters employed in Ankara have been included due to the fact that Ankara is among the most affected cities by the sudden influx of migration.

Selected patient guide		
	N	%
Completed	61	87,1
Incomplete	3	4,3
Non Eligible	6	8,6
Total	70	100

Table 2: Number and percent of patient guide interviewed and response rates

As seen in the table given above, 70 patient guides were recruited in health facilities located in Ankara and they were selected as the sample of the study. However, 6 patient guides were non-eligible to complete the questionnaire; therefore they were excluded from the study and the number of participants was identified as 64 patient guides. 3 patient guides from 64 eligible participants did not respond to the questionnaire even though they had been contacted as seen in the table as incomplete rate.

The reasons for non-eligibility read as follows:

- 1 patient guide has left the office for another assignment in a different province in Turkey.
- 3 patient guides were performing their duties in the emergency services in a training and research hospital located in the very center of the province, therefore the questionnaire couldn't be administered due to their intense workload.
- 1 patient guide was on maternal leave.
- 1 patient guide was on annual leave during the data collection period.

In conclusion, a total of 61 out of 70 patient guides completed the questionnaire and the response rate is 87.1% as shown in the table.

4 out of 61 participants did not receive the adaptation training provided by the Ministry of Health and WHO under the scope of the Sihhat Project. Therefore, they could only respond to the questions in Section I and Section II, and not the questions in Section III.

1 participant started to fill the questionnaire; however, this participant left it uncomplete since s/he had to deal with a patient urgently at the time of the interview, responding to the question number 27.

3.3 PROCEDURE

- (1) Initially, a literature review has been conducted.
- (2) The questionnaire was prepared by the researcher student under the supervision of the advisor. After the preparation, two opinions have been received from the field experts. Upon the receipt of their opinions and suggestions, the questionnaire has been revised and finalized, then the approval process for ethical clearance and administration of the questionnaire has been initiated.
- (3) Ethical Commission Approval has been obtained from Hacettepe University Ethical Commission on 13.12.2018 (See Appendix 5) The study has been conducted with the approval received from the 4 following institutions:
 - Approval was obtained from the Migration Policy and Project Department, Directorate General of Migration Management, Ministry of Interior on 16.01.2019 (See Appendix 6).
 - Approval was obtained from Provincial Directorate of Migration Management, Governorate of Ankara on 01.02.2019 (See Appendix 7).
 - Approval was obtained from Department of Community Health Services and Education, Directorate General of Public Health, Ministry of Health on 12.03.2019 on the condition that the study will be conducted in line with the principles stated in the official letter (See Appendix 8).

- Final approval was obtained from Migration Health Unit, Directorate of Public Health Services, Ankara Provincial Health Directorate, Ministry of Health on 02.04.2019 (See Appendix 9). This official letter ensuring the final approval for field implementation has been distributed to all the health facilities where patient guides are employed.

- (4) A pilot study has been performed through the administration of a questionnaire to 5 trained patient guides working (Adana x 2, Mersin, Gaziantep, Hatay) in the health facilities other than Ankara. According to the results, the questionnaire has been revised.
- (5) The health facilities constituting primary, secondary and tertiary healthcare settings including Migrant Health Centres, Oral and Dental Health Centres, Training and Research Hospitals and Public Hospitals have been identified.
- (6) During the field implementation, all health facilities have been visited by the researcher and individual face-to-face interviews have been carried out with the patient guides. Some of the data has also been collected via e-mail.
- (7) Data collection has been completed within 10 working days from 02.04.2019 to 18.04.2019 (Visits are made between 2-11 April 2019).
- (8) Data collected has been entered into SPSS. This data has been locked on 19.04.2019 and analysis was initiated.

Selected health facilities		
Completed	36	94,8
Incomplete	1	2,6
Non Eligible	1	2,6
Total	38	100

Table 3: Number and percent of health facilities and response rates

- (9) Patient guides are recruited in 38 health facilities located in Ankara. As seen in Table 3, 1 facility is non-eligible and one facility is classified as an incomplete facility where only 2 patient guides are recruited but they did not fill in the questionnaire and are non-responders. As a result, 36 health facilities have been completed as seen in the Table presented above.

Category of Health Facility	No of Health Facility		No of the patient guide		No of Response received by visits		No of Response received via e-mail	
	N	%	N	%	N	%	N	%
Completed								
Refugee Health Centre/Training Centre	2	5,6	4	6,6	4	7,7	0	0,0
Migrant Health Unit	4	11,1	4	6,6	3	5,8	1	11,1
Training and Research Hospital	8	22,2	20	32,8	19	36,5	1	11,1
Eye Health Hospital	1	2,8	1	1,6	1	1,9	0	0
Children Health Hospital	1	2,8	4	6,6	4	7,7	0	0
Women Health Hospital	2	5,6	5	8,2	5	9,6	0	0
State Hospital	8	22,2	10	16,4	4	7,7	6	66,7
Oral and Dental Health Hospital	7	19,4	9	14,8	8	15,4	1	11,1
Oncology Hospital	1	2,8	1	1,6	1	1,9	0	0
Chest Diseases and Thoracic Surgery Hospital	1	2,8	2	3,3	2	3,8	0	0
Occupational and Environmental Health Diseases	1	2,8	1	1,6	1	1,9	0	0
Total	36	100	61	100	52	100	9	100

Table 4: Distribution of Health Facility Category by type of response

- (10) The Table presented above shows the 11 categories of the health facilities included in this study. In total, 52 patient guides have been interviewed face-to-

face by visiting 25 health facilities while 9 patient guides have sent their filled questionnaires via email from 9 different health facilities. Also, this table shows the distribution of the response by the way of contacting with the participants for questionnaire. The reason for online data collection is the far distance of these health facilities to the city center and difficult to reach them.

3.4 DATA COLLECTION INSTRUMENT

Data has been collected by questionnaire on the opinion of patient guides on adaptation training and needs analysis as to healthcare interpreting training (See Appendix I).

The questionnaire is composed of 32 questions in the three sections:

Section 1: Socio-demographic and professional profiles

This section consists of the first 14 questions inquiring about the socio-demographic and professional information of the patient guides. Questions include sex, age, educational background, the duration they lived in Turkey after migrating, previous professional experiences and current working conditions.

Section 2: Opinions on the inclusion of the new subjects in the curriculum

In this section, 13 questions (questions 15 - 27) investigate the opinions of patient guides on receiving healthcare interpreter training by inquiring their opinions on the inclusion of the new subjects in the curriculum. Yes-no questions were used to inquire whether participants would like to learn these subjects in line with their needs during the provision of their professional service.

Section 3: Opinions and level of satisfaction as regards adaptation training

In this section, 5 questions (questions 28 - 32) investigate the patient guides' opinions on the evaluation of the 5-day- theoretical adaptation training that they have received. It aims to gauge their level of satisfaction. A likert scale question was addressed to participants as well as multiple selection questions to make them rate their level of satisfaction. Also, their opinions were solicited to be able to strengthen/improve the training. Lastly, this section seeks to learn any problems that the patient guides encounter.

In general, the questionnaire aims to reveal socio-demographic and professional information of patient guides as well as the opinions and level of satisfaction on the training they received. It also seeks to understand their opinions about receiving healthcare interpreting training as well as their opinions on learning the new interpreting-related subjects.

3.5 DATA ANALYSIS

Statistical Package for Social Sciences (SPSS) has been used to analyze the data collected by the questionnaire. Frequencies of each question have been found. Correlation between the level of education and each question has been analyzed and discussed through crosstabs.

Pearson Chi-square test which is a statistical test applied to sets of categorical data for evaluation how likely it is that any observed difference between the sets arose by chance was performed and the statistical significance level is accepted as $p < 0.05$ for all the participants and the characteristics. All the results can be seen in figures, tables, and graphs in Chapter IV.

This chapter presented the method used in the study to collect data on the evaluation of the adaptation training and analyze the data on patient guides' socio-demographic profiles and their opinions on the inclusion of the new subject in the curriculum of the adaptation training as well as their opinions and level of satisfaction on the training they received. In the next chapter, the results of the above-explained questionnaire responded by the participants are given and discussed in detail.

CHAPTER IV

FINDINGS AND DISCUSSION

In this chapter, findings and discussion concerning the data collected by the questionnaire are presented. The findings related to research questions, participants' comments and the related discussions are given, as well.

4.1. FINDINGS AND DISCUSSION ON SOCIO-DEMOGRAPHIC AND PROFESSIONAL PROFILES OF THE PATIENT GUIDES

This section aims to find an answer to the first research question of this study investigating socio-demographic and professional profiles of patient guides who have received adaptation training.

4.1.1. Socio-demographic profiles of patient guides

Sex	N	%
Men	45	73,8
Women	16	26,2
Total	61	100

Table 5: Sex distribution of the participants

As seen in the Table 5, 73.8% (n=45) of the participants (which is more than half) are men while 26.2% (n=16) of the participant are women. These figures show that patient guides are mainly men.

Year of birth	N	%
1967-1980	9	14,8
1981-1990	28	45,9
1991-2000	24	39,3

Table 6: Age distribution of the participants

As seen in Table 6, the age distribution of participants is classified in three age groups as the year of birth between 1967-1980, 1981-1990 and 1991-2000. Based on this categorization, 14.8 % (n=9) of the participants are grouped in the year of birth 1967-1980, almost half (45.9) of the participants are grouped in the 1981-1990 period while 39.3 % (n=24) in 1991-2000.

Education	N	%
Primary school graduate	0	0
Secondary school graduate	2	2,3
High school graduate	12	19,7
Vocational school	6	9,8
Bachelor's degree	31	50,8
Master programme graduate	10	16,4
Total	61	100

Table 7: Distribution of educational background of participants

Table 7 shows that the educational level of the participants is relatively high. It can be seen that all of them have attended school after primary school degree. While half of them (50.8%) have a bachelor's degree, 16.4% (n=10) of them have a master's degree and 9.8% (n=6) of them have graduated from a vocational school providing 2-year education after high school graduation. The figures demonstrate that 46 participants out of 61 have a university degree. The areas of expertise are presented in Table 8.

The statistical data given above may imply that these people have been recruited on the basis of their language proficiency regardless of their level of education and expertise in order to meet the urgent need for communication between newcomers and the host society, which resulted from a sudden influx.

Educational Backgrounds	N	%
Public management	1	2,2
Teacher	10	22,3
Engineer	8	17,9
Banking	2	4,5
Industrial management	1	2,3
Pharmacy	1	2,2
Fine arts	1	2,2
Statistics	1	2,2
Archelogy	1	2,2
Finance	1	2,2
Language and literature (Arabic)	4	8,9
Language and literature (Turkish)	1	2,2
Language and literature (English)	1	2,2
Information technologies	3	6,7
Biology	1	2,2
Business management	1	2,2
Product management	1	2,2
Health	2	4,4
Translation and interpreting (Arabic and English)	1	2,2
Mathematics	1	2,2
Chemistry	1	2,2
Medical documentation secretary	1	2,2
Total	45	100

Table 8: Distribution of educational background of the participants

As seen in Table 8, participants have an educational background in different areas. Only 8 out of 45 people have an educational background in departments related to language and interpreting. 1 participant has a degree as an English teacher, 6 participants have a degree in language and literature in different languages and only 1 participant has a

degree in Translation and Interpreting Department which is in English-Arabic. Other participants have different expertise area including health.

Mother tongue	N	%
Turkish	5	8,2
Arabic	42	66,9
Turkmen	14	23,0

Table 9: Distribution of mother tongues of participants

Table 9 shows that participants have three different mother tongues. The mother tongue of 42 (66.9%) participants is Arabic, while 14 (23%) participants' mother tongue is Turkmen. Only 5 (8.2%) participants' mother tongue is Turkish.

Since there are many Turkmens living in the border cities in Turkey and in Syria, this provides them with the chance to be exposed to interactions between Turkish and Arabic speakers and thus may be bilingual. The number of Turkmens recruited is relatively high.

Despite the fact that statistical data shows the mother tongue of the largest population is Arabic, the dialect differences in this language may cause trouble in communication between the speakers of even the same language. Chiang et al. (2006, p. 1) states that "The Arabic language is a collection of spoken dialects with important phonological, morphological, lexical, and syntactic differences, along with a standard written language, Modern Standard Arabic (MSA)" (Chiang, et al., 2006, p.1). This difference leads to possible linguistic problems between patients and interpreters. If the interpreter does not fully comprehend what the patient says, successful interpreting is not possible. This may leave the patients desperate, even untreated. One participant's comment on this dialect difference is stated as follows:

"I know Fusha (Modern Standard Arabic) which is the Arabic dialect used as literary in books, newspapers, and news. However, the patients generally are using 'ammiyah' which is generally used by the public. This difference sometimes may create a communication problem with the patients. Even though I ultimately manage to provide

communication and help them, I would be glad to receive information how we can deal with these differences and how we can improve ourselves in terms of language competency through practices during the training.”¹

Additional Language	Response		Beginner		Intermediate		Advanced	
	N	%	N	%	N	%	N	%
Turkish	56	45,2	0	0	3	11,5	53	63,1
Arabic	19	15,3	0	0	0	0	19	22,7
Turkmen	2	1,6	0	0	0	0	2	2,3
English	47	37,9	14	100	23	88,5	10	11,9
Total	124	100	14	100	26	100	84	100

Table 10: Distribution of additional languages of the participants

As seen in the table, 37.9% (n=47) of the participants know English as L2. When Table 10 is taken into consideration, it can be said that all participants know both Arabic and Turkish, which was a requirement identified for application to be a patient guide position.

¹ Note that English translations are done by the author for the purpose of reflecting the content in English as closely as possible, therefore a word-for-word translation style has been adopted.

Date/Year	N	%
2004-2005	2	3,3
2006-2010	5	8,2
2011-2015	45	73,9
2016-2017	6	9,9
Missing	3	4,7
Total	61	100

Table 11: Distribution of time spent in Turkey after migration

As seen in Table 11, the largest proportion of the participants (73.9%) have come to Turkey between 2011-2015. 3 out of 61 participants did not respond to this question since they are originally Turkish citizens and bilingual who can speak both Arabic and Turkish and did not immigrate from any country. It can be inferred that both Turkish citizens and displaced people fleeing any other countries are eligible to apply to patient guide vacancies on the condition that they have a certain level of proficiency in both Turkish and Arabic.

4.1.2. Professional profiles of the patient guides

In this part, the previous employment experiences, duration of the assignment, number of working days and hours and the type of interpreting they used in the interpreted encounter are presented and related statistical data is provided below.

Previous employment experience	N	%
No experience	7	11,5
Translator & Interpreter	25	41,0
Teacher	13	21,3
Worker	3	4,9
Carpenter	1	1,6
Pharmacy technician	1	1,6
Sales clerk	1	1,6
Statistician	1	1,6
Foreign trader	1	1,6
Health technician	1	1,6
Engineer	3	4,9
Computer technician	1	1,6
Anaesthesia technician	1	1,6
Dental technician	1	1,6
Water seller	1	1,6
Total	61	100

Table 12: Distribution of previous employment experience of the participants

Table 12 presents the various forms of employment areas the participants were engaged in previously. 11.5% (n=7) of the participants have no previous work experience in their life. It is noteworthy that 41.0% (n=25) of them have experience in interpreting and translation. 21.3% (n=13) of them have previously worked as a teacher in various fields. It is noteworthy to state that there is also one English teacher among them, which may make it easier for this person to be involved in the interpreting process, 4 participants have experience in the health sector which shows that they have background information and a knowledge of terminology.

Previous employment experience as a healthcare interpreter	N	%
No experience	28	45,9
Private sector	20	32,8
Public sector	3	4,9
Other	10	16,4
Total	61	100

Table 13: Distribution of previous employment experience as a healthcare interpreter of the participants

Table 13 presents the participants' previous employment experience as a healthcare interpreter. While almost half of them have no previous experience as healthcare interpreter, 54.1% (n=33) of the participants have working experience as healthcare interpreter in various capacities, such as freelance, volunteer or staff in health facilities in the public or private sector.

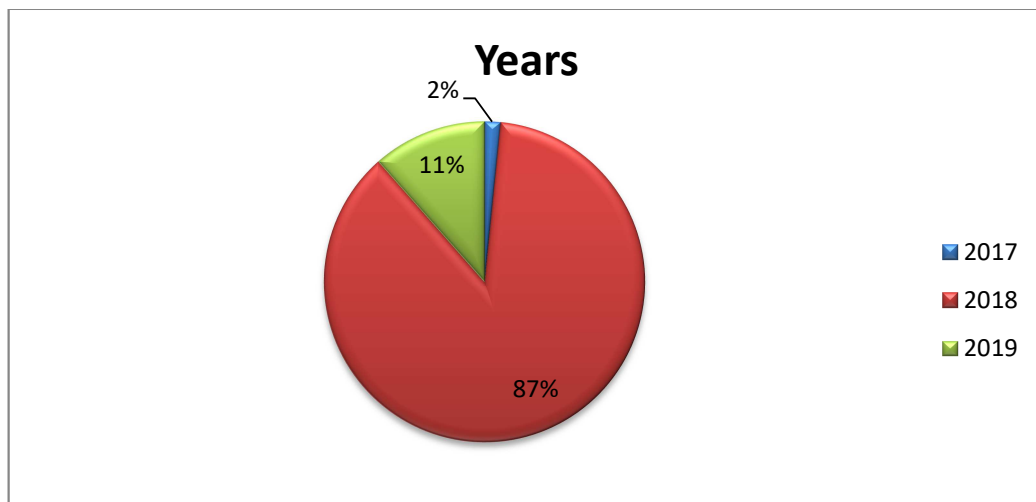


Figure 4: Distribution of the assignment year in the health facilities where they are currently employed

Figure 4 shows that the participants have begun their duties in the health facilities where they are assigned in 3 different years from 2017 to 2019. While the largest percentage

(87%) of the participants have started to work in their health facilities in 2018, 11% (n=7) of them have commenced their work in 2019.

This figure implies that most of the participant has been performing their duties for almost one year or more which is enough to observe the deficiencies in themselves during their performance, the problems that may emerge in interpreted encounters, the aspects to be developed in their profession. Therefore, their opinions on receiving healthcare interpreting training are so valuable that further training should be designed in line with their field experiences and suggestions.

Number of Working days	N	%
5 days	52	85,2
6 days	9	14,8
Total	61	100
Working Hours	N	%
7-8 hours	33	54,1
9-10 hours	28	45,9
Total	61	100

Table 14: Distribution of the number of working days and working hours of the participants

This table summarizes the number of working days and working hours of the participants. While 85.2% (n=52) of the participants work 5 days a week, 14.8% (n=9) of them work 6 days a week. 54.1% (n=33) of the participants work 7-8 working hours per day and 45.9% (n=28) of them work 9-10 working hours per day.

The number of the working days and the working hours are important for an interpreter in the sense that these people carry out work which requires them to be vigilant, active

and quick-minded. If the working conditions are not appropriate, the performance of the interpreter may be affected adversely as mentioned in Chapter II.

Previous working experience in written translation or interpreting	N	%
Yes	44	72,1
No	17	27,9
Total	61	100

Table 15: Distribution of participants' previous working experience in written translation and interpreting

Table 15 shows that the participants previous working experience in written translation and interpreting. More than half of the participants have related experience while only 27.9% (n=17) of them do not have working experience in the field.

Considering the percentage of the population with experience is considerably high, we can infer that even though it was not a requirement for the application to the position of patient guides, general population prefer to apply since they have more or less experience in interpreting field regardless of their expertise.

Type of interpreting	N	%
Simultaneous interpreting	29	19,1
Consecutive interpreting	82	53,9
<i>With taking notes</i>	34	41,7
<i>Without taking notes</i>	48	58,3
Sight translation	15	9,9
Written translation	26	17,1
Total	152	100

Table 16: Distribution of participant' use of types of interpreting

Table 16 presents the distribution of patient guides' utilization types of interpreting in the encounters. In the design of the question, more than one option can be chosen. When we look at the data related to consecutive interpreting, 48 participants did not take any notes during the interpreting and 34 participants performed their job with the help of the notes they had taken. In this regard, it is noteworthy that participants who did not take notes during the consecutive interpreting are expected to be aware of how to relate the knowledge that they have already have with received knowledge during the interpreting. As mentioned in the part where discourse analysis is explained, the interpreter is expected to know how they can fill the meaning gaps in their minds when they received new knowledge in the interpreting process.

Moreover, memory techniques are one of the fundamental requirements for effective interpreting if the interpreter does not take notes in consecutive interpreting. Also, information on note-taking techniques could be provided even though they do not take notes. As a small recommendation, the interpreters should have a small notebook for any need during the interpreting.

As shown in the statistical data, 15 participants stated that they did sight translation. However, they even do not have any information on the types of interpreting and the on requirements of these types of interpreting which they perform in the interpreting. As

explained in the types of interpreting part, this type may be used even during the training of patient guides with the aim of pedagogical exercises.

In general, most of the patient guides stated that they listened to the patients before entering the doctor's room. After receiving all related information such as patient's anamnesis, problem and requests, they enter into the doctor's room together. At that point, interpreters are expected to be aware of the limits of their responsibility and be strict to this frame. For example, when the patient explains his/her health problems, if the interpreter advice this patient without any health professional consultation, this situation may create problems. Role boundaries, explained in the section on ethical rules, should be strictly drawn and the interpreter needs to be well-trained on this issue.

Information received from the participants reveals that even though they do not take notes for the interpreting practice, they take basic notes during the consultation such as the doctors advice, measurements and value of the patients so as to give them to the patient for their perusal afterward.

Some participants stated that they also provide support on the phone especially for arranging an appointment via appointment line used in the Turkish health system.

4.2 FINDINGS AND DISCUSSION ON PATIENT GUIDES' OPINION ON RECEIVING HEALTHCARE INTERPRETING TRAINING

Findings and discussion on data collected on the opinions of patient guides on the inclusion of new subject in to curriculum and correlations between their willingness to learn these subjects and their educational background are presented below.

4.2.1. Patient Guides' Opinions on the Inclusion of New Subjects in the Curriculum

This part presents the responses of the participants who are willing or unwilling to learn various new subjects in the training. 13 different subjects are listed below together with the related statistical data.

Facilitating techniques	N	%
Yes	50	82,0
No	11	18,0
Total	100	100

Table 17: Distribution of the participants who are willing to learn facilitating techniques

As seen in Table 17, 82.0% (n=50) of the participants are willing to learn facilitating techniques while 18.0% (n=11) of them preferred not to learn these techniques.

The interviews showed that some participants asked the one who conducted survey what these techniques refer to. This approach implies that the participants are not even aware of the existence of these techniques consisting of some strategies and tactics that they can facilitate during the interpreting session.

Facilitating techniques might be used for compensation of insufficient meaning by tackling the problem and exerting effort for retrieval of the required linguistic items to be able to find a solution. They can be utilized even to avoid a problem in communication (Al-Khanji and El-Shiyab, 2000, p.550) .

Different types of interpreting	N	%
Yes	53	86,9
No	8	13,1
Total	100	100

Table 18: Distribution of the participants who are willing to learn different types of interpreting

This table shows that 86.9% (53) of the participants responded positively to the question regarding investigating their need to learn different types of interpreting. Only 13.1% (n=8) stated they do not need to learn these types.

As stated in Chapter II, each type of interpreting necessitates different practice and skills to be adopted. Gile (2018, p. 546) states that in many programs consecutive interpreting is practiced before simultaneous interpreting considering the first one is an accelerated version of the latter one. However, “there is comprehension and ‘deverbalization’ of the source speech and then reformulation” in both according to Gile (2018). Teaching consecutive prior to simultaneous provides some advantages. One of them is practising attentive listening. Consecutive interpreters interpret the meaning not the syntax, if it is not necessary to do so for some reason such as items to be kept in the short term memory. It is also noteworthy to underline that memory that keeps the syntax and words is the short term memory which has 7 ± 2 capacity, thus, they fade away (ibid). Gile (2018) also states that “Practising consecutive before simultaneous interpreting also makes consecutive a good diagnostics tool for language comprehension, language production, and analytical skills: if an interpreter’s output in simultaneous interpreting is weak, the problem may lie in poor comprehension of the source language, in poor analytical skills, in poor language”

In addition, the reason for the negative responses may be the unawareness of the different requirements of each type of interpreting. It is probable that the participants who gave negative response think that the inclusion of the interpreting types in the

curriculum will provide only theoretical information to be memorized. However, awareness-raising on the requirements of each type may yield more than it is supposed.

Memory techniques	N	%
Yes	54	88,5
No	7	11,5
Total	100	100

Table 19: Distribution of the participants who are willing to learn memory techniques

Table 19 presents that 88.5% (n=54) of the participants expressed their need to learn memory techniques while 11.5% (n=7) expressed their unwillingness to do so.

One participant stated that “Doctors and patients sometimes make very long speeches and it is not possible to remember each word. In such cases, I generally comprehend the idea and convey the main message rather than translating word by word.” This example may provide an advantage in some cases such as emergency or time-restricted cases. However, generally, some crucial words or information may be lost in this summary process, which may lead misdiagnose and result in even irreversible treats.

Rudvin and Tomassini (2011, p. 3) stressed the importance of adequate communication in the medical sector mentioning the potential threats of misdiagnoses and subsequent legal liability of healthcare providers. Also, they stated that:

“..informed consent and professional liability in cases of misdiagnosis or omitted diagnosis, are very serious indeed, primarily for the patient but also for the health professional and the institution”.

Considering these likely challenges, the use of memory techniques are a requirement for the interpreters for an effective and accurate service provision when long speeches are performed by the interlocutors in encounters in order to avoid any loss of the source message.

Doğan et. al (2009, p.69) also highlight the importance of memory saying that “The success of the interpreting performance depends upon the realization of higher level immediate mental processes in the best way”.

Note-taking techniques	N	%
Yes	49	80,3
No	11	18,0
Missing	1	1,6
Total	100	100

Table 20: Distribution of the participants who are willing to learn note-taking techniques

As it is shown in Table 20, 80.3% (n=49) of the participants would like to learn note-taking techniques while 18.0% (n=11) of them do not want to the inclusion of note-taking techniques into the curriculum. Also, one participant did not respond to the question.

As seen above, most of the participants stated that they generally perform consecutive interpreting without notes. This may be an effective way for the speeches with a short waiting period but the longer the speech is, the higher the risk of losing crucial information is. Therefore, the interpreters may ultimately have to take notes if one of the interlocutors makes a long speech and there is no possibility for a repeat, for example in an emergency situation. This underlines the necessity of learning the note-taking techniques.

Also, it is noteworthy to add that in consecutive interpreting, the biggest cognitive challenge for the interpreter is the management of note taking, note reading, and speech reconstruction after a prolonged waiting period which may vary from some seconds to several minutes (Gile, 2018, p. 546). Information on these processes is necessary to make the interpreters good listeners. If they only focus on the note-taking without understanding the meaning, they may fail to reconstruct the speech in spite of the notes taken.

Manner and attitudes	N	%
Yes	48	78,7
No	13	21,3
Total	100	100

Table 21: Distribution of the participants who are willing to learn manner and attitudes

The statistical data presented above shows that 48 participants want to receive information on the manners and attitudes of an interpreter while 13 of them did not agree on the inclusion of this subject into the curriculum.

One participant has talked about an experience stating that “...For example, one doctor may not accept the patient for examination. In such cases, I refer that patient to some other doctor in the same department without informing by the patient...”

Also, one participant expressed her positive opinion by saying that “...we are learning these by doing, therefore, I am using my own methods that I developed by my own initiative; however, I am quite sure that there are manners and attitudes that we should perform but do not know or think about. That’s why I would like to learn all of them during the training...”

Another participant said that “some participants may sometimes be aggressive. In that type of cases, I am entitled to call the security; however, we are here to provide services to people; that’s why, I do not want them to feel insulted or offended by calling the security. However, I would like to know what exactly I should do in such type of cases.” Similarly, another participant gave another example saying that “Sometimes, a tension may emerge between doctors and patients due to various reasons such as prescription of antibiotics, etc. and we sometimes do not know how we can ease and mediate this tension”.

The above examples show the importance of providing training on manners and attitudes of interpreters during the service provision.

Medical terminology	N	%
Yes	49	80,3
No	11	18,0
Missing	1	1,6
Total	100	100

Table 22: Distribution of the participants who are willing to learn the medical terminology

Medical terminology is already included in the current curriculum of the adaptation training provided to patient guides as one of the four modules. In fact, this question is designed to investigate the participants' opinion on receiving more comprehensive information for a longer duration.

Table 22 shows that 80.3% (n=49) of the participants are eager to receive more comprehensive information on medical terminology while 18.0% (n=11) do not think that they need more information on this subject. Also, one participant did not respond to this question. It is noteworthy that this question is the most welcome question. Most of the respondents responded positively and also emphasized their desire to have more information on medical terminology. They also underlined this opinion with the same statements on question investigating their opinions on improvement/strengthening of the training they had received.

As statistically shown, the largest part of the participants stated they needed more room and time for medical terminology in the training. Also, they stated that a comprehensive medical terminology resource should be provided to them to study on their own even after the training since it is not possible to memorize all terminology during the training.

One participant stated, "I have developed a self-study system for myself. We have received a few lessons on terminology but we are using much more terms in daily life. I write down the commonly used terminology that I often see at work and I study this medical terminology and try to memorize the list. I have created my own dictionary."

Considering that the medical terminology is composed of a very comprehensive information that includes many terms and it is not possible to memorize all of this at once, it is obvious that teaching self-study methods or developing their own dictionaries composed of the commonly used words is a good way in addition to provide the general systematic logic of the medical terminology. This logic refers to the usage of prefixes, suffixes and roots in Latin words.

As mentioned before, there are some different related practices to improve the memory capacity. Some studies were carried out on the effect of different memory practices. For example, Doğan (1997) has conducted an experimental study on the use of mnemonic keyword method in the training of terminology composed of Greek and Latin morphemes, and showed that this method was effective in learning the morphemes in a short period and helped decipher the complicated terms constructed by the combination of 3 or 4 morphemes. The study also showed that interpreting was as successful as remembering the terms in a sentence.

In addition, medicine consists of many different fields, which are to be taken into consideration in the curriculum. Some participants perform their duties in specialized hospitals (e.g. children- women health hospitals, oral-dental health hospitals, and oncology hospitals). Provision of the medical terminology resources in different fields would be beneficial for the participants' use according to their statements so that they can acquire comprehensive terminological knowledge in their fields.

Moreover, as explained previously, Arabic has different dialects. One participant requested detailed information on medical terminology in different dialects since they may experience difficulties with regards to dialect variations.

One participant stated that “We also need to learn what the Latin medical terms refer to. For example doctors say a Latin word to explain the disease of the patient; however, we do not know this term and what disease the patients have therefore we have difficulty in conveying the message in an accurate manner...”. Another participant states similarly that “..we need not only the equivalences of the words in the target language but also the meanings; for example, when we say the Arabic equivalence of “leukemia” to the patient, s/he directly ask them what this disease means...”. Thus, these remarks reveal

the need to provide them the training of mnemonic keyword method as Dogan puts it (1997).

Accessing resources	N	%
Yes	51	83,6
No	10	16,4
Total	100	100

Table 23: Distribution of the participants who are willing to learn accessing resources

Table 23 shows that the number of the participants who are willing and unwilling to learn how they can access related resources that will facilitate their work when they need information on medical terminology and field of medicine. While 83.6% (n=51) of participants stated their willingness to learn how they can access the above-explained resources while 16.4% (n=10) of them disagreed.

One participant stated that if it is needed, s/he is using the Google translate which may not be considered as the most reliable resource for professional interpreting service. Therefore, the provision of information as to how they can access reliable resource is necessary for effective and accurate delivery during the interpreting.

One participant stated that “we try to find our resource on our own; however, I do not think it is enough so the ways to reach reliable resources should be provided in the training”.

If the participants learn how they can access reliable resources, it would prevent the wasting time on useless and unreliable resources and it would yield more information for both health professionals and interpreters.

Intonation	N	%
Yes	40	65,6
No	21	34,4
Total	100	100

Table 24: Distribution of the participants who are willing to learn intonation

This table demonstrates that 65.6% (n=40) of the participants stated their need to receive information on intonation during interpreting while 34.4% (n=21) of them stated otherwise.

One participant highlighted the importance of the body language in addition to intonation. S/he emphasized that these factors affect the quality of communication between people with different language combinations.

Intonation is an important factor which may affect the communication which is even not mediated by an interpreter. Additionally, in an interpreted communication, the interpreter actually becomes the voice of the speaker. Therefore, these interpreters should reflect the same implicatures in a message conveyed by the speaker. Also, as stated in Chapter II, the intonation of the interpreter should be so reflective that the listener should receive the same message (warning, directing, agreeing, etc).

Discourse analysis techniques	N	%
Yes	46	75,4
No	14	23,0
Missing	1	1,6
Total	100	100

Table 25: Distribution of participants who are willing to learn discourse analysis techniques

Table 25 shows that 75.4% (n=46) of the participants are willing to learn discourse analysis techniques as they are aware that real intention and meaning of the speech may be misunderstood thus may affect the interpreting. Meanwhile, 23.0% (n=14) of the participants state that they do not want to receive information on these techniques while one participant did not respond to the question.

Cultural differences	N	%
Yes	47	77,0
No	12	19,7
Missing	2	3,3
Total	100	100

Table 26: Distribution of the participants who are willing to learn cultural differences

As the Table 26 shows, 77.0 % (n=47) of the participants have responded to this question positively. They are aware that cultural differences between individuals in a society may affect communication if these differences are not conveyed or taken into consideration appropriately in the interpreted encounter. While two participants did not express their opinion on this subject, 19.7% (n=12) do not have the desire to be informed on cultural differences and its effects on the interpreting.

One participant has agreed on the necessity for the inclusion of this subject into the curriculum: “It is really important, for example, women patients sometimes visit the gynaecology unit with their husbands. When they ask a question, we may encounter some problems resulting from cultural differences while responding to their questions. Provision of some types of information related to women’s health is considered as shameful in the Arab culture while that’s not the case in this country. In such cases, their husbands react badly and even get angry at us.”

Another participant presents an example related to differences in country health systems S/he stated that “Here, a consent form is always requested from the patients before the operations. This is due to the law in the Turkish health system. Yet; this is not the case in Syria. This makes the patient feel uncomfortable and sometimes they don’t agree to sign this form before operations.” This presents a good example of cultural differences which has roots in the different systems. Another example related to the differences in country health systems is expressed as follows: “Patients sometimes come to a health facility in order to get a prescription with a relative’s ID card or without an ID card. Since the Syrian health system does not require ID card verification for prescription, they do not want to understand or know of this Turkish regulation, therefore; they object. Only when I ask a doctor to explain whether it is possible or not, they finally believe the doctor when s/he stated that it is not acceptable in line with the Turkish health system regulation”

It seems that the interpreters try their best to explain the differences in the health systems to the patients. Thus, these differences may be explained to the interpreters themselves during the training through various scenarios. In this way, brainstorming session may be used to find solutions performed by the people who know their own countries’ health system on how these problems can be worked out more creatively.

From some examples presented, we can also infer that foreign patients mistrust the interpreters to some extent once again probably as a result of cultural differences. It is reported that there are some cases in which the patients do not believe the interpreter and ask their relatives to repeat what the health professional says.

In her book presenting interpreter's role as intercultural mediator, in reference to the patient's trust in the interpreter, Izabel E. T. de V. Souza (2016, p. 126) underlines that if the interpreter provides clarity and peace of mind - lack of stress- to patients, this helps the patient feel respected and included. This also may contribute to improving patient trust levels that can lead to collaboration.

Moreover, one participant stressed that "Syrian people are not very good at waiting for their turn in examinations. When we tell them to wait, they suppose that they are being discriminated against and ill-treated. I always explain that this is the same treatment Turkish citizens receives. However, they always complain about that situation. I always try to mediate this problem and calm them. But I would like to be informed about how exactly I should handle the situation."

Interpreter needs	N	%
Yes	48	78,7
No	11	18,0
Missing	2	3,3
Total	100	100

Table 27: Distribution of the participants who are willing to learn interpreter needs

As shown in Table 27, 78.7% (n=48) of the participants wish to learn about interpreter needs while 18.0% (n=11) do not have the desire information on this subject. Also, two participants did not respond to the question.

Some participants stated that their roles should be clarified and they should not be assigned other duties such as carrying the patients, calling the appointment line on behalf of patients or accompanying them to a pharmacy.

As stated in Chapter II, the working conditions should be formulated for efficient service since interpreting is a challenging act.

Ethical rules	N	%
Yes	41	67,2
No	19	31,1
Missing	1	1,6
Total	100	100

Table 28: Distribution of the participants who are willing to learn ethical rules

Table 28 shows that 67,2% (n=41) of the participants are willing to receive information on ethical issues. 19 participants do not desire to information on ethical issues such as confidentiality, respect, etc. These participants stated that they were knowledgeable about that issue since they were already informed in the training in the patient rights and privacy module. However, the module they refer to covers only info about patients; such as their information shall be kept confidential and should not be shared with third parties. As explained in Chapter II, these rules concerns and principles can be expanded and may then include the issues concerning interpreters and interlocutors. Thus they may avoid any problems resulting from ethical dilemmas.

The California Healthcare Interpreters Association (CHIA) Standards (2002) clearly state that an ethical decision-making process helps the interpreters deal with the common ethical conflicts and dilemmas which may arise when any action in line with one or some ethical principles conflict with the other ethical principle(s).

One participant highlighted the importance of such training, especially for the Psychiatry Department.

Practice and inclusion of expert interpreter as a trainer	N	%
Yes	48	78,7
No	12	19,7
Missing	1	1,6
Total	100	100

Table 29: Distribution of the participants who are willing to make practice during the training and inclusion of an expert interpreter as a trainer

Table 29 indicates that 78.7% (n=48) of the participants are willing to make practice during the training and also they confirm the requirement of inclusion of expert interpreter as a trainer in the training. 19.7% (n=12) of them said that they do not need to practice and to include an expert interpreter while one participant did not respond to this question.

One participant stated that “No theoretical information on interpreting or being an interpreter has been provided to us during the training.” This implies that both receiving information on interpreting and theoretical information on health system related subjects would yield much more for the interpreters.

One participant has stated the following opinion: “There was no one who can provide information on the Arabic language and the importance of language awareness in the interpreting.”

Another participant has highlighted the necessity of practice in the training in another to the question as regards suggestions to improve/strengthen the training they received.

This question can be considered as the core question to understand their perspectives of this profession. Deliberate practice is important in this profession because it refers to practice which is carried out intentionally, goal-directed, systematically and continuously. As previously stated, Setton (1999) talks about three factors which make

interpreting challenging: One is “simultaneity”, interpreting act simultaneously with speech delivery. The second one is “immediacy” which refers to the fact that interpreter has to be prepared in a cognitive and affective manner to tackle the unexpected immediate situations. The last one is “incrementality” and refers to the fact that the mind can be overloaded with information thus hindering the successful rendition of the interpreting. Also, effort models of interpreting developed by Gile (2018) refer to the importance of obtaining a higher performance with less effort as explained in Chapter II. This is only possible with practice in interpreting training. Therefore, a platform should be provided for the interpreters for deliberate practice of interpreting that encompasses all the mentioned factors and models.

Furthermore, an expert educated interpreter may take an active role in the training to help provide practical examples in the interactive learning process. The negative responses may infer that these participants are not aware of its necessity for quality service and do not think about improving.

4.2.2. The Relation Between Their Willingness to Learn New Subjects During the Training and Their Level of Education

In this part, the correlation between the participants' opinion on the new subjects to be included in training and their level of education is discussed. Pearson Chi-square test was performed and the statistical significance level is accepted as $p < 0.05$.

Collected data has been analysed from all those participants with higher education (47 out of 61 participants) who are the majority of participants. Participants with higher education are assumed as people graduated from vocational school and the ones with bachelor's and master's degree (77.05%).

Since the accumulation of higher education brings about expertise both on level of theory and application, individuals who have attended certain institutions and attained expertise in a specific field would be more cognisant of certain ways of thinking associated with further knowledge and training.

Education	Facilitating techniques			
	Yes		No	
	N	%	N	%
Primary school graduate	0	0	0	0
Secondary school graduate	2	100	0	0
High school graduate	10	83,3	2	16,7
Vocational school graduate	5	83,3	1	16,7
Bachelor's degree	27	87,1	4	12,9
Master programme graduate	6	60,0	4	40,0
Total	50	82,0	11	18,0
* <i>Pearson Chi-Square: 0,370</i>				

Table 30: Distribution of the participants who are willing to learn the facilitating techniques in correlation to their level of education

In Table 30, the correlation between the participants who are willing and unwilling to learn the facilitating techniques and their level of education is presented even though the data does not seem statistically significant.

38 out of 47 participants with higher education responded positively stating their willingness to learn this subject while only 9 of them provided negative response. The percentages of participants with higher education who responded positively range from 60.0% to 87.1%.

It is possible to say that the participants responded negatively think that they do not need to improve themselves and consider themselves as competent interpreters supposing that what they perform is what they should perform in the mediated interaction.

Education	Different types of interpreting*			
	Yes		No	
	N	%	N	%
Primary school graduate	0	0	0	0
Secondary school graduate	2	100	0	0
High school graduate	11	91,7	1	8,3
Vocational school graduate	6	100	0	0
Bachelor's degree	28	90,3	3	9,7
Master programme graduate	6	60,0	4	40,0
Total	53	86,9	8	13,1
*Pearson Chi-Square: 0,088				

Table 31: Distribution of the participants who are willing to learn the different types of interpreting in correlation to their level of education

In Table 31, the correlation between the participants' willingness to learn different types of interpreting and their level of education is presented even though the data does not seem statistically significant.

40 out of 47 participants with higher education responded positively stating their willingness to learn this subject while only 7 of them provided negative response. The percentages of participants with higher education who responded positively range from 60.0% to 100%. Probably, all participants with negative responses think that learning the names of the types of interpreting may not yield any contribution to their daily-life service provision quality. However, as mentioned in Chapter II, each type of interpreting has correlating features with different requirements. If the interpreter is aware of the mode to be performed in the encounter, they may be able to meet the

necessary criteria.. It has been observed that some participants are not aware of the type of interpreting they perform.

Education	Memory techniques*			
	Yes		No	
	N	%	N	%
Primary school graduate	0	0	0	0
Secondary school graduate	2	100	0	0
High school graduate	11	91,7	1	8,3
Vocational school	6	100	0	0
Bachelor's degree	27	87,1	4	12,9
Master programme graduate	8	80,0	2	20,0
Total	54	88,5	7	11,5
* Pearson Chi-Square: 0,748				

Table 32: Distribution of the participants who are willing to learn memory techniques in correlation to their level of education

In Table 32, the correlation between the participants' willingness to learn memory techniques and their level of education is presented even though the data does not seem statistically significant.

41 out of 47 participants with higher education responded positively stating their eagerness to learn this subject while only 6 of them provided negative response. The percentages of participants with higher education who responded positively range from 80.0% to 100%. This shows that most of the participants are aware of the necessity for including of memory techniques' in the curriculum regardless of level of their educational background. The patients may keep their encounters long since they do not take the interpreting process into consideration. This situation would be common for people trying to communicate in health facilities. Also, there may be emergencies which require efficient interpreting. In conclusion, larger number of the participants support the inclusion of memory techniques in the curriculum.

Education	Note-taking techniques*			
	Yes		No	
	N	%	N	%
Primary school graduate	0	0	0	0
Secondary school graduate	2	100	0	0
High school graduate	10	83,3	2	16,7
Upper high school	5	83,3	1	16,7
Bachelor's degree	26	86,7	4	12,3
Master programme graduate	6	60,0	4	40,0
Total	49	81,7	11	18,3
*Pearson Chi-Square: 0,390				

Table 33: Distribution of the participants who are willing to learn note-taking techniques in correlation to their level of education

In Table 33, the correlation between the participants' willingness to learn note-taking techniques and their level of education is presented even though the data does not seem statistically significant.

37 out of 46 participants with higher education responded positively stating their eagerness to learn this subject while only 9 of them provided negative response. The percentages of participants with higher education who responded positively range from 60.0% to 86.7%. The interlocutors in a speech may keep their encounters long since they do not take the interpreting process into consideration. Notation is very important to be able to provide effective production in delivery.

Education	Attitudes and manners*			
	Yes		No	
	N	%	N	%
Primary school graduate	0	0	0	0
Secondary school graduate	1	50,0	1	50,0
High school graduate	10	83,3	2	16,7
Upper high school	3	50,0	3	50,0
Bachelor's degree	27	87,1	4	12,9
Master programme graduate	7	70,0	3	30,0
Total	48	78,7	13	21,3
*Pearson Chi-Square: 0,212				

Table 34: Distribution of the participants who are willing to learn attitudes and manners in correlation to their level of education

In Table 34, the correlation between the participants' willingness to learn attitudes and manners and their level of education is presented even though the data does not seem statistically significant.

37 out of 48 participants with higher education responded positively stating their eagerness to learn this subject while only 10 of them provided negative response. The percentages of participants with higher education who responded positively range from 57.0% to 87.1%. Even though the result is not statistically important, one of the participants has highlighted the importance of the manners and attitudes performed in the interpreted encounters. S/he stated that they were experiencing some problems not only because of the interpreting process but also different manners performed by the foreign patients. This statement implies that the patient guides need to learn what manners and attitudes for an effective interpreting rather than focusing only on theoretical information.

Education	Medical terminology*			
	Yes		No	
	N	%	N	%
Primary school graduate	0	0	0	0
Secondary school graduate	1	50,0	1	50,0
High school graduate	9	75,0	3	25,0
Upper high school	5	83,3	1	16,7
Bachelor's degree	29	93,5	2	6,5
Master programme graduate	5	55,6	4	44,4
Total	49	81,7	11	18,3
*Pearson Chi-Square: 0,068				

Table 35: Distribution of the participants who are willing to learn medical terminology in correlation to their level of education

In Table 35, the correlation between the participants' willingness to learn medical terminology and their level of education is presented even though the data does not seem statistically significant.

39 out of 46 participants with higher education responded positively stating their eagerness to learn this subject while only 7 of them provided negative response. The

percentages of participants with higher education who responded positively range from 55.6% to 93.5%.

Additionally, the ones who do not want to receive more information on medical terminology generally tend to prefer self-study. One participant stated that “we learn the main rules and logic for terminologies during the training. After that time, we can study on our own for further terminology if needed”. This shows that some people may opt to self-study after they learn the basic rationale for a certain subject.

Education	Accessing resources*			
	Yes		No	
	N	%	N	%
Primary school graduate	0	0	0	0
Secondary school graduate	2	100	0	0
High school graduate	9	75,0	3	25,0
Upper high school	6	100	0	0
Bachelor's degree	26	83,9	5	16,1
Master programme graduate	8	80,0	2	20,0
Total	51	83,6	10	16,4
*Pearson Chi-Square: 0,678				

Table 36: Distribution of the participants who are willing to learn to access resources in correlation to their level of education

In Table 36, the correlation between the participants' willingness to learn access resources and their level of education is presented even though the data does not seem statistically significant.

40 out of 47 participants with higher education responded positively stating their eagerness to learn this subject while only 7 of them provided negative response. The percentages of participants with higher education who responded positively range from 80.0% to 100.00%.

It is obvious that the majority of the participants have provided a positive response to this question. Considering that these people are aware of the importance of the accessing to reliable resources, it is necessary to include this subject in the curriculum since these patient guides usually need new information during their assignment.

Therefore, it is imperative to learn effective ways to access the reliable information they need.

Education	Intonation*			
	Yes		No	
	N	%	N	%
Primary school graduate	0	0	0	0
Secondary school graduate	0	0	2	100
High school graduate	8	66,7	4	33,3
Upper high school	4	66,7	2	33,3
Bachelor's degree	22	71,0	9	29,0
Master programme graduate	6	60,0	4	40,0
Total	40	65,6	21	34,4
*Pearson Chi-Square: 0,360				

Table 37: Distribution of participants who are willing to learn about intonation in correlation to their level of education

In Table 37, the correlation between the participants' willingness to learn intonation and their level of education is presented even though the data does not seem statistically significant.

32 out of 47 participants with higher education responded positively stating their eagerness to learn this subject while only 15 of them provided negative response. The percentages of participants with higher education who responded positively range from 60.0% to 71.0%.

The ones who responded negatively state that they can comply with the requirements on intonation and body language during the interpreting process. However, further training may help highlight the importance of tonation and overcome unnoted lacks that may impact on communication.

Education	Discourse analyses techniques*			
	Yes✔		No✔	
	N	%	N	%
Primary school graduate	0	0	0	0
Secondary school graduate	2	100	0	0
High school graduate	10	83,3	2	16,7
Vocational school	4	66,7	2	33,3
Bachelor's degree	22	73,3	8	26,7
Master programme graduate	8	80,0	2	20,0
Total	46	76,7	14	23,3
*Pearson Chi-Square: 0,828				
✔ excluding missing				

Table 38: Distribution of the participants who are willing to learn discourse analysis techniques in correlation to their level of education

In Table 38, the correlation between the participants' willingness to learn discourse analysis techniques and their level of education is presented even though the data does not seem statistically significant.³⁴ out of 46 participants with higher education responded positively stating their eagerness to learn this subject while only 12 of them provided negative response. The percentages of participants with higher education who responded positively range from 66.7% to 80.0%.

During the interpreting, real intention and meaning of the speech may not be correctly understood. This situation affects the interpreting. The data shows that most of the participants are aware of this necessity.

Education	Cultural differences*			
	Yes ▴		No ▴	
	N	%	N	%
Primary school graduate	0	0	0	0
Secondary school graduate	2	100	0	0
High school graduate	11	91,7	1	8,3
Vocational school	2	40,0	3	60,0
Bachelor's degree	24	80,0	6	20,0
Master programme graduate	8	80,0	2	20,0
Total	47	79,7	12	20,3
*Pearson Chi-Square: 0,169				
▴ excluding missing				

Table 39: Distribution of the participants who are willing to learn cultural differences in correlation to their level of education

In Table 39, the correlation between the participants' willingness to learn cultural differences and their level of education is presented even though the data does not seem statistically significant.

34 out of 45 participants with higher education responded positively stating their eagerness to learn this subject while only 11 of them provided negative response. The percentages of participants with higher education who responded positively range from 40.0% to 80.0%.

Even though the data is not statistically significant, one statement given by a participant is "...Syria is a country which has no single language and education system. There are large pronunciation and dialect differences from its villages to cities, from east to west, from north to south. It is impossible to explain this difference and the problems to people who are not aware of that situation. Therefore, communicating with the people who are aware of this difference and listening to their opinions and experiences in the workplace would help to overcome these problems by providing better understanding.."

Education	Interpreter needs*			
	Yes✓		No✓	
	N	%	N	%
Primary school graduate	0	0	0	0
Secondary school graduate	1	50,0	1	50,0
High school graduate	12	100	0	0
Upper high school	3	50,0	3	50,0
Bachelor's degree	25	83,3	5	16,7
Master programme graduate	7	77,8	2	22,2
Total	48	81,4	11	18,6
*Pearson Chi-Square: 0,088				
✓ excluding missing				

Table 40: Distribution of the participants who are willing to learn interpreter needs in correlation to their level of education

In Table 40, the correlation between the participants' willingness to learn interpreter needs and their level of education is presented even though the data does not seem statistically significant.

35 out of 45 participants with higher education responded positively stating their eagerness to learn this subject while only 10 of them provided negative response. The percentages of participants with higher education who responded positively range from 50.0% to 83.3%.

Education	Ethical rules*			
	Yes✓		No✓	
	N	%	N	%
Primary school graduate	0	0	0	0
Secondary school graduate	1	50,0	1	50,0
High school graduate	9	75,0	3	25,0
Upper high school	2	33,3	4	66,7
Bachelor's degree	22	73,3	8	26,7
Master programme graduate	7	70,0	3	30,0
Total	41	68,3	19	31,7
*Pearson Chi-Square: 0,365				
✓ excluding missing				

Table 41: Distribution of the participants who are willing to learn ethical rules in correlation to their level of education

In Table 41, the correlation between the participants' willingness to learn ethical rules and their level of education is presented even though the data does not seem statistically significant.

31 out of 46 participants with higher education responded positively stating their eagerness to learn this subject while only 15 of them provided negative response. The percentages of participants with higher education who responded positively range from 33.3% to 73.3%.

Education	Practice*			
	Yes✓		No✓	
	N	%	N	%
Primary school graduate	0	0	0	0
Secondary school graduate	2	100	0	0
High school graduate	11	91,7	1	8,3
Vocational school	4	66,7	2	33,3
Bachelor's degree	24	80,0	6	20,0
Master programme graduate	7	70,0	3	30,0
Total	48	80,0	12	20,0
*Pearson Chi-Square: 0,590				
✓ excluding missing				

Table 42: Distribution of the participants who are willing to do practice with an expert interpreter as a trainer in correlation to their level of education

In Table 42, the correlation between the participants' willingness to do practice and their level of education is presented even though the data does not seem statistically significant.

34 out of 45 participants with higher education responded positively stating their eagerness to learn this subject while only 11 of them provided negative response. The percentages of participants with higher education who responded positively range from 40.0% to 80.0%.

In conclusion, most of the tables presenting the distribution of the willingness of the participants for the inclusion of different subjects into the curriculum in correlation to their level of education are not statistically significant, , However, the rate of the

comments to open-ended questions is higher in the responses provided by the participants with the higher educational background while the other participants preferred only to mark their choices for multiple-choice questions rather than to explain and commend.

The fact that these were found to be insignificant shows merely that the patient guides who participated in this survey are not aware of what interpreting training may supply them with, which would enable them to perform better during their rendition in healthcare interpreting.

4.3 FINDINGS AND DISCUSSION ON PATIENT GUIDES' OPINION ON ADAPTATION TRAINING THEY RECEIVED

In this part, the participants' level of satisfaction and their opinions on the adaptation training they received are presented.

Evaluation of the training	N	%
Response	56	91,8
Non-response	5	8,2
<i>Missing</i>	<i>1</i>	<i>20,0</i>
<i>Non-trained</i>	<i>4</i>	<i>80,0</i>
Total	61	100

Table 43: Distribution of the response rate for evaluation of the training

As shown in Table 43, the question was answered by only 56 participants. This is due to the fact that 4 participants have been recruited but not trained; since the adaptation training was completed and there was no any other training that can be provided. Also, as stated previously, 1 participant had to leave in mid-training due to an urgent need for an interpreter in the health setting where s/he is assigned. This part provides statistical data collected from 56 participants.

Evaluation of the training excluding missing	N	%
Weak	4	7,1
Medium	15	26,8
Good	22	39,2
Very good	14	25,0
Perfect	1	1,8
Total	56	100

Table 44: Distribution of participants' level of satisfaction on the training they received

Table 44 indicates, 39.2% (n=22) of the participants think that the training was good while only 1 participant found it perfect. 7.1% (n=4) of the participants found the training insufficient.

Some participants rated separately the modules. The general tendency was to rate the medical terminology and communication module higher. The participants are not very satisfied with the other modules which include the history of patient/human rights, legislation on health system, which are not directly related to the interpreting.

One participant stated that "... the number of participants was high. Therefore, classes were so crowd, which is not conducive to an effective learning and focusing..."

The reatings are low due to the duration of the training elaborated in Table 45.

	Long		Suitable		Short		Total	
	N	%	N	%	N	%	N	%
Theoretical Training (5 days) excluding missing and non-trained	1	1,8	22	39,2	33	58,9	56	100

Table 45: Distribution of participants' opinions on the duration of the training

As seen in Table 45, most of the participant think that the duration of the training was too short. Many comments were related to the duration of the training.

Many participants found the duration too short and the content dense. Generally, the participants would like longer training divided into short duration with regular intervals and less condensity.

One participant expressed that “very dense content which can be learned in 2-3 months has been provided in only 5 days. When the content is so dense and trainers speak so fast to be able to finish all subjects on time that we can't learn and adopt all. After a while, we lose our concentration...”

Similar statements related to losing concentration due to dense content was made by other participants, as well.

Moreover, one participant remarked that “If the training is provided with regular periods, we can have chance not only to refresh what we had in previous training but also learn new information in order to make up our deficiencies if any.”

Encounter any problem	N	%
Yes	10	16,4
No	46	75,4
Missing	5	8,2
Total	61	100

Table 46: Distribution of participants' status of encountering any problem during interpreting

46 participants stated that they do not encounter any problems during the interpreting process while only 10 participants stated that they experience some problems.

In this question, one participant stated that “I rarely provide interpreting services since I am unfortunately instructed to refer the foreign patients upon entry and sometimes carry the patients, etc.” Another participant said that “We provide interpreting and referral services everywhere such as the police station, pharmacy, courthouse, graveyard, etc. For example, the health care professional identified that the patient’s ID card was a false document. We had to accompany this foreign patient to the police station. Also, when there was a funeral, we had to accompany the relatives of the person that passed away for the burial procedures. One day we even had to go to a guest house to support the social services documentation procedures..” Moreover, similar statements were made by some participants as well. In this study, the role of interpreters was not addressed however, it is important to highlight that the Ministry of Health has legalized the terms of reference of these patient guides in its legal resource. In addition to this legislation, the scope of their working place and field could be clearly specified.

Another problem experienced is: “Doctors generally do not call me/an interpreter when a foreign patient visits them. After a while, I printed out a small card with a note – For foreign patients, please drop a call to the interpreter – Here is my phone number. I am distributing these notes to both doctors and those responsible on duty in the entrance of the health facility.”

As can be seen, patient guides are trying to find their own solutions to overcome problems they have encountered. But this may not be the possible each and every time. Therefore, they should be heard and their problems should be addressed during regular interval training.

Lastly, participants stated that the problems they encountered generally did not result from the interpretation process. Reasons varied from crowdedness preventing them from being able to serve every patient in a timely manner or the manners of the foreign patients.

Evaluation criteria for the training	1 Fully disagree		2 Disagree		3 No opinion		4 Agree		5 Fully agree		Missing	
	N	%	N	%	N	%	N	%	N	%	N	%
The date and timing of the training was suitable	3	4,9	7	11,5	2	3,3	31	50,8	13	21,3	5	8,2
The training is provided in an comprehensible way	1	1,6	2	3,3	8	13,1	23	37,7	20	32,8	7	11,5
The training materials (presentations, book, dictionary) was enough	0	0	7	11,5	5	8,2	21	34,4	21	34,4	7	11,5
Training increased my interest in the interpreting profession	2	3,3	3	4,9	4	6,6	23	37,7	22	36,1	7	11,5
The training contributed to my professional development	0	0	3	4,9	5	8,2	22	36,1	25	41,0	6	9,8
The training contributed to my personal development	0	0	5	8,2	5	8,2	25	41,0	20	32,8	6	9,8
The training increased my motivation in this profession	0	0	3	4,9	10	16,4	24	39,3	17	27,9	7	11,5
It was easy to follow-up content of the training	2	3,3	9	14,8	6	9,8	23	37,7	13	21,1	8	13,1
Content of the training was enough to gain new professional knowledge and skills.	2	3,3	13	21,3	6	9,8	24	39,3	9	14,8	7	11,5

Table 47: Distribution of evaluative opinions of the patient guides on the training they received

As presented in the table given above, certain likert scale questions on adaptation training have been addressed to the trained participants. 31 (50.8%) out of 56 participants agree that the date and timing of the training were suitable while 3 participants totally disagree on this matter.

When the comprehensibility of the training is taken into consideration, 8 out of 54 participants did not express their opinions. The largest proportion of the participants (n=43) think (both agree and fully agree on options) that the training is provided in a comprehensible way while only 3 participants do not think in that way.

The same proportion (34.4%) of the participants both agree and/or fully agree that the materials of the training were enough. Meanwhile, 8.2% (n=5) of the participants do not have any opinion on that matter. One participant stated that s/he has a more comprehensive and informative resource which contributes to professional skills.

37.7% (n=23) of the participants agree and 36.1% (n=22) of them fully agree that this training increased their interest in the profession while 2 participants did not respond to this question on purpose. This leads us to infer that most of the trained participants currently have a higher interest in interpreting.

41.0% (n=25) of the participants fully agree on the contribution of the training to their professional development while 41.0 (n=25) of the participants agree on the contribution to their personal development. No participant marked fully disagree on the contribution of the training to either professional or personal development.

39.3% (n=24) of the participants agree that the training increased their motivation in the interpreting profession while 16.4% (n=10) of them do not have any opinion on the increase in their motivation.

37.7 % (n=23) of the participants agree that it was easy to follow up the content of the training while 6 participants do not have any opinions on that matter.

Last but not the least, more than one fifth (21.3%) of the participants disagree that the content of the training was sufficient for new professional knowledge and skills while 9.8% (n=6) participants did not have an opinion. Also, 39.3% (n=24) of them agree that the training content was efficient.

Also, one participant highlighted that “learning about issues such as medical terminology, how we can keep our distance with the patient, what approach we should adopt during the interpreting and so on were beneficial. For example, I was previously telling the patient to “stop” during interpreting in a rude manner but now we have learned how we should communicate with them in a congenial manner. Now I say “please wait” or I will interpret with your permission”. Thanks to this communication module in the training, we now are able to communicate in a better manner.

Improvement/Strengthening of the Training

The questionnaire also entailed a question about the participants’ opinions to strengthen/improve the training. This provided invaluable suggestions based on their experiences in the healthcare settings. All the suggestions and opinions read as follows:

“...The training should focus more on us interpreting. Of course, other information provided is necessary for us but we need the subject-related information as we perform interpreting itself. In addition, it would be better to make this training continuous as similar as regular in-service training which are provided to our colleagues who are public servants in our workplaces. Also, the system where we are employed is newly structured and everyone of us is learning by doing how it should work. Therefore, the related materials shall be regularly provided to update us and inform us about any changes in the system...” This comment also supports one of the arguments of this study, which is interpreting-related subject should also be focused on as well as health system related subjects.

Another participant stated that “..I would like to improve my language proficiency as well. Yes, we are bilinguals but still, we need to receive training that can improve our language skills, therefore, some content can be included with regards to language skills...”

Moreover, one participant suggested a more interactive training. Opinions of patient guides should be recognized and they should be able to voice their problems during the training. Time should be allocated to listen to their needs and problems; thus, things could be changed for the better. Another participant has supported this opinion stating that “If everything is read from the presentation, this is not an efficient training. That

was the case for the training received. It is not possible to keep everything in our mind. The training should be more interactive”.

One participant has provided one suggestion which is not directly related to the training. But s/he stated that they generally have to call 182 Appointment Line for the foreign patients. If an Arabic interpreter is assigned to provide interpreting services in this line, their workload will be lighter and they can focus on service provision in the health facility itself. Similar statements were made for this appointment line by others saying they spend a big part of their working hours making appointments for foreign patients on this line. The general suggestion is the allocation of a different line for only Syrian patients or the assignment of Arabic interpreter. This could save time from their working hours.

Another participant suggested organizing the training by classifying the medical fields such as gynecology, internal medicine, and oncology, etc. S/he stated that this type of classification may lead to more fruitful training for the patient guides.

One participant also raised an interesting issue “Health professionals who can speak Arabic are also employed in the health facilities such as migrant centers and refugee training centers. However, the case is different in other facilities such as hospitals. The curriculum can be adapted according to these different working conditions of the interpreters. If an interpreter working in the first facilities is assigned to latter ones, s/he probably will face many challenges.

Another participant found this questionnaire to be beneficial in terms of receiving of their opinions and their interactive participation to the training process. Also, s/he thinks that communicating with the foreigners may be beneficial too.

In this chapter, findings and discussion of data collected by the questionnaire administration is presented. Next chapter presents the conclusion as well as the recommendations.

CHAPTER V

CONCLUSION AND RECOMMENDATIONS

This chapter is devoted to conclusions drawn from the data analyses, recommendations for further research. The answers to the research questions of the study, which were listed in 1.4. are presented based on the findings.

5.1 CONCLUSIONS REGARDING THE RESEARCH QUESTIONS

Healthcare interpreting training plays an important role in the provision of communication in medical encounters between healthcare providers and foreign patients, which result in a high quality healthcare service at facilities. The use of trained interpreters in the encounters, especially with the culturally diverse multilingual migrants ensures that communication barriers are overcome in healthcare settings. Therefore it is significant to encompass at least the minimum crucial requirements and subjects related to the interpreting field in the curriculum of the healthcare interpreting training. Raising awareness to 'train' the interpreters would be very significant to use interpreters to the best of their ability and potential (Rudvin & Tomassini 2011, p. 23).

In this frame, this study addresses the adaptation training provided to patient guides by the Ministry of Health and the World Health Organization within the context of healthcare interpreting training. The aim of this study is to investigate the socio-demographic and professional profiles of the patient guides who have received training, their opinions on receiving healthcare interpreting as well as their opinions on inclusion of the new subjects in the curriculum, and also their evaluation of the training they received. A questionnaire was administered to gauge the opinions of patient guides on adaptation training and their needs regarding healthcare interpreting training to 64 patient guides recruited in health settings and filled the questionnaires. Data collected by means of this questionnaire has been analyzed and findings and discussion are presented with tables to provide a more comprehensive understanding of the results.

This chapter is devoted to conclusions drawn from the data analyses and recommendations for healthcare interpreting training. The answers to the research

questions of the study as well as their sub-questions are presented in line with the findings.

Conclusions drawn from the results of the analyses for the research questions of the study are presented as follows:

Firstly, the socio-demographic and professional profiles of the patient guides have been identified and explained. The distribution of their sex, educational background, mother tongue, additional languages together with their level of proficiency, time spent in Turkey after migration, their previous employment experiences have been explained as well as the types of interpreting they practiced. The data shows that the socio-demographic and professional profiles of the patient guides are appropriate for receiving upper-level healthcare interpreting training.

Secondly, the patient guides' willingness to learn new subjects to be included in the curriculum has been investigated as well as the correlation between their willingness to learn a new subject and their educational background. The subjects are facilitating techniques, types of interpreting, memory techniques, note-taking techniques, manners and attitudes, medical terminology, accessing the resources, intonation, discourse analysis techniques, cultural differences, interpreter needs, ethical rules and interpreting practice by expert interpreter trainer. Even though results show that a large amount of the patient guides express their eagerness to learn these subjects in line with their needs, there were those who stated they are already known or there is no need to learn since these were not used by these patient guides during the interpreting. These findings imply that the reason for negative responses for the inclusion of new subjects in the curriculum may be attributed to the fact that these participants do not feel the urge to learn new knowledge and skills and are not aware of what they need. Moreover, they do not feel this is a necessity for quality service provision as a result of new acquirements in the field as they are already recruited. Therefore, they do not need to improve themselves to perform much better. Also, their opinions as regards the inclusion of an expert interpreter were solicited and we concluded it would be helpful for a professional interpreter to train these people by a trainer who can convey the interpreting-related content in a better and comprehensive way with the inspiration of her/his field and

market experience. Considering patient guides perform a duty requiring field-specific expertise such information could be provided in the training for these people.

Lastly, the evaluation of the adaptation training through the opinions and level of satisfaction of patient guides revealed the following: Their opinions on the level of training comprehensibility, the sufficiency of the materials, effect on the increase in professional development and motivation as well as personal development. Collected data shows that average level of satisfaction is rated as medium level due to the fact that patient guides think that some aspects of the training should be improved. Also, the general tendency was to comment on the modules separately. In line with this separation, the largest group expressed their satisfaction with the medical terminology and communication module while there was a large group which is not happy with the other two modules especially some subjects such as the historical background of human and patient background and Turkish health system which is recently restructured. Rather than that type of theoretical information, the practice may be included in the curriculum according to the general consensus.

Regarding the improvement of the training, they stated that more time should be allocated to medical terminology. Provision of field-specific medical terminology information is requested by the participants. Moreover, different Arabic dialects should be taken into consideration while designing related terminology resources. Many of the patient guides stated that the duration of the training was too short but the days of the training content was so dense that they started to lose their concentration. More frequent but shorter training content was generally suggested for more productive training and more update on information related to the field. In addition, many patient guides stated that training has increased their professional motivation and development as well as positively contributing to their personal development.

In the end, this study comes to a conclusion that adaptation training may be adapted to the patient guides' needs in line with their opinions. Thus, the inclusion of interpreting field-related subjects into the curriculum is a must. For the design of the refresher training curriculum or further adaptation training, their field experiences should be taken into consideration with a more interactive exchange of views. The duration and content of the training should be improved in line with their preferences. The focus

should be on better and higher quality service provision to tackle language barriers and cultural differences in the encounters occurred in the health settings.

5.2 RECOMMENDATIONS FOR FURTHER STUDIES

Recommendations for future research can be listed as follows:

- The same questionnaire can be administered to a larger sample group with the inclusion of all recruited patient guides around the country so that the data gathered from the study can be generalized.
- This study investigated the inclusion of only minimum crucial subjects in the curriculum. The scope of the interpreting-related subjects can be widened and a similar study investigating the inclusion of all required subjects can be carried out.
- A similar study can be carried out another group which was trained and recruited to provide interpreting services in healthcare settings under another project mentioned previously. Therefore, the existing situation of healthcare interpreting can be addressed more comprehensively.

REFERENCES

- Al-Khanji, R., El-Shiyab, S., & Hussein, R. (2000). On the use of compensatory strategies in simultaneous interpretation. *Meta: Journal des traducteurs/Meta: Translators' Journal*, 45(3), 548-557.
- Angelelli, C. V. (2004). *Medical Interpreting and Cross-cultural Communication*. New York: Cambridge University Press.
- Betancourt, J., Green, A., & Carillo, J. E. (2000). The challenges of cross-cultural healthcare-diversity, ethics, and the medical encounter. *Bioethics Forum*, 16, 27-32.
- Bot, H. (2007). Dialogue interpreting as a specific case of reported speech. *Healthcare Interpreting*, 77-99.
- Brown, G., Gillian, B., & Yule, G. (1983). *Discourse analysis*. Cambridge: Cambridge University Press.
- Bulut, A. & Kurultay, T. (2001) Interpreters-in-Aid at Disasters, *The Translator*, 7:2, 249-263)
- California Healthcare Interpreters Association. (2002). *California Standards for Healthcare Interpreters*. California: California Healthcare Interpreters Association.
- California Healthcare Interpreting Association. (n.d.). Access: 11 March 2019, <http://www.chiaonline.org/History>
- Cambridge J. (1999). Information Loss in Bilingual Medical Interviews through an Untrained Interpreter. *The Translator*, 5(2), 201-219.
- Çeviri Derneği. (2018). Access: 08 April 2019, <http://www.ceviridernegi.org/haberler.html>
- Ceza Muhakemesi Kanunu. (2004). Access: 17 February 2019, <http://www.mevzuat.gov.tr/MevzuatMetin/1.5.5271.pdf>

- Chiang, D., Diab, M., Habash, N., Rambow, O., & Shareef, S. (2006). Parsing Arabic dialects. In *11th Conference of the European Chapter of the Association for Computational Linguistics*, 369-376.
- Christoffels, I. K. & de Groot, A. M. B. (2005). Simultaneous Interpreting: A Cognitive Perspective. Kroll, J. F. & de Groot, A. M. B. (Eds.). *Handbook of bilingualism: Psycholinguistic approaches* (454-479). New York, NY, US: Oxford University Press.
- Directorate General of Migration Management, Ministry of Interior. (n.d.). Access: 10 February 2019, http://www.goc.gov.tr/icerik6/temporary-protection_915_1024_4748_icerik
- Directorate General of Migration Management, Ministry of Interior. (n.d.). Access: 10 February 2019, http://www.goc.gov.tr/icerik6/migration-strategy-document_913_991_998_icerik
- Directorate General of Migration Management, Ministry of Interior. (n.d.). Access: 10 February 2019, http://www.goc.gov.tr/icerik3/duzensiz-goc_363_378_4710
- Diriker, E., & Tahir-Gürçağlar, Ş. (2004). Community interpreting in Turkey. *Çeviribilim ve Uygulamaları*, 14, 73-92.
- Doğan, A. (1997). “Simultane Tıp Çevirisi Eğitiminde Bellek Destekleyici Anahtar Sözcük Yönteminin Etkililik Derecesi (Effect of Mnemonic Keyword Method in the Training of Simultaneous Medical Interpreting)”. Doktora Tez Özeti. *Hacettepe Eğitim Fakültesi Dergisi*, 13, 165-170.
- Doğan, A. (2010). Court Interpreting Developmental Stages in the World and the Existing Situation in Turkey. *Journal of Translation Studies*, 20, 27-51.
- Doğan, A. (2016). Anybody Down There? Emergency and Disaster Interpreting in Turkey. *Mediating Emergencies and Conflicts* (59-83). London: Palgrave Macmillan.
- Doğan, A. (2017a). *Sözlü çeviri Çalışmaları ve Uygulamaları*. Ankara: Siyasal Kitabevi.

- Doğan, A. (2017b). *Sözlü ve Yazılı Çeviri Odaklı Söylem Çözümlemesi*. Ankara: Siyasal Kitabevi.
- Doğan, A., Ribas, M. A. & Mora-Rubio, B. (2009). Metacognitive tools in interpreting training: A pilot study. *Hacettepe Üniversitesi Edebiyat Fakültesi Dergisi*, 26(1), 69-84.
- Dubslaff, F., & Martinsen, B. (2005). Exploring untrained interpreters' use of direct versus indirect speech. *Health Interpreting: Discourse and Interaction*, 53-76.
- Erten, A. (2016). *Tıp terminolojisi ve Tıp Metinleri Çevirisi*. Ankara: Seçkin Yayıncılık.
- Gile, Daniel. (2018). Simultaneous interpreting. Chan, S. (ed). *An Encyclopedia of Practical Translation and Interpreting* (531-561). Hong Kong: The Chinese University Press.
- Gillies, A. (2017). *Note-taking for consecutive interpreting: A short course*. New York: Routledge.
- Griswold, K., Zayas, L. E., Kernan, J. B., & Wagner, C. M. (2007). Cultural awareness through medical student and refugee patient encounters. *Journal of Immigrant and Minority Health*, 9(1), 55-60.
- Hale, S. (2007). *Community Interpreting*. New York: Springer.
- Herráez, J. M. O & Rubio, A. I. F. (2008). [Interpreting in police settings in Spain: Service providers' and interpreters' perspectives](#). Valero-Garcés, C. & Martin, A. (Eds.). *Crossing Borders in Community Interpreting: Definitions and Dilemmas* (123-146). [Philadelphia](#): John Benjamins Publishing.
- HIN National Standard Guide for Community Interpreting Services. (2007). Access: 02 April 2019, [http://www.saludycultura.uji.es/archivos/HIN_National_Standard_Guide_for_CI_\(Canada\).pdf](http://www.saludycultura.uji.es/archivos/HIN_National_Standard_Guide_for_CI_(Canada).pdf)

- Hommes, R. E., Borash, A. I., Hartwig, K. & DeGracia, D. (2018). American Sign Language Interpreters Perceptions of Barriers to Healthcare Communication in Deaf and Hard of Hearing Patients. *Journal of Community Health*, 43, 956-961.
- Hsieh, E., & Kramer, E. M. (2012). Medical interpreters as tools: Dangers and challenges in the utilitarian approach to interpreters' roles and functions. *Patient Education and Counseling*, 89(1), 158-162.
- International Federation of the Red Cross and Red Crescent Societies. (2018). *International Appeal Revision* (Revision No: 6). Geneva: International Federation of the Red Cross and Red Crescent Societies.
- International Medical Interpreters Association and Education Development Center, Inc. (2007). *Medical Interpreting Standards of Practice*. United States of America: International Medical Interpreters Association and Education Development Center.
- International Medical Interpreters Association. (n.d.). Access: 02 April 2019, <https://www.imiaweb.org/education/accreditationhistory.asp>
- International Medical Interpreters Association. (n.d.). Access: 10 March 2019, <https://www.imiaweb.org/basic/default.asp>
- International Organization for Migration. (n.d.). Access: 26 February 2019, https://publications.iom.int/system/files/pdf/iml25_1.pdf
- International Organization for Standardization. (2014). Access: 04 March 2019, <https://www.iso.org/obp/ui/#iso:std:iso:13611:ed-1:v1:en>
- Kaburise, P. (2011). *Speech Act Theory and Communication: A Univen Study*. Newcastle: Cambridge Scholars Publishing
- Kavukcu, N., & Altıntaş, K. H. (2019). The challenges of the healthcare providers in refugee settings: a systematic review. *Prehospital and Disaster Medicine*, 34(2), 188-196.

- Kazancı, H. (2003). *Effect of Lexical and Syntactic Strategies on Simultaneous Interpreting*, Unpublished Master's Thesis, Hacettepe University, Ankara
- Kirişci, K., Brandt, J. & Erdogan, M. M. (2018). *Syrian refugees in Turkey: beyond the numbers*. Access: 10 February 2019, The Brookings Institution website: <https://www.brookings.edu/blog/order-from-chaos/2018/06/19/syrian-refugees-in-turkey-beyond-the-numbers>.
- Marani, R., & Tabrizi, H. H. (2018). Note-taking in Persian-English Consecutive Interpreting: Considering Iranian Translation Teachers' and Students' Opinions. *Journal of Language Teaching and Research*, 9(3), 504-509.
- Mikkelsen, H. (1996). The Professionalization of Community Interpreting. *Global vision: Proceedings of the 37th annual conference of the American Translators Association*, pp. 77-89, Virginia: American Translators Association.
- Mikkelsen, H. (2016). *Introduction to Court Interpreting*. New York: Routledge
- Ministry of Family, Labour and Social Policies. (2017). Access: 10 April 2019, <https://ankara.ailevecalisma.gov.tr/projeler/gecici-koruma-statusundeki-siginmacilara-hizmet-vermekte-olan-ankara-il-mudurlugunun-ve-sosyal-hizmet-merkezlerininshm-kapasitelerinin-guclendirilmesi>
- Morales, J., Padilla, F., Gómez-Ariza, C. J., & Bajo, M. T. (2015). Simultaneous interpretation selectively influences working memory and attentional networks. *Acta Psychologica*, 155, 82-91.
- National Accreditation Authority for Translators and Interpreters (NAATI). (n.d.). Access: 04 March 2019), <https://www.naati.com.au/about/who-we-are/>
- National Council on Interpreting in Health Care. (2005). *National Standards of Practice for Interpreters in Health Care*. Washington: National Council on Interpreting in Health Care.
- National Council on Interpreting in Health Care. (n.d.). Access: 12 March 2019, <https://www.ncihc.org/history>

- National Council on Interpreting in Health Care. (n.d.). Access: 02 April 2019, https://www.ncihc.org/assets/documents/publications/National_Standards_5-09-11.pdf
- Ozolins, U. (2015). Ethics and the role of the interpreter. H. Mikkelsen & R. Jourdenais (Eds.), *The Routledge Handbook of Interpreting*, 319-336.
- Pew, B. J. (2015). How to Incite Crime with Words: Clarifying Brandenburg's Incitement Test with Speech Act Theory. *Brigham Young University Law Review*, 2015(4), 1086-1115.
- Ph, I. E. D. V. S. (2016). *Intercultural Mediation in Healthcare: From the Professional Medical Interpreters' Perspective*. Osaka: Xlibris Corporation.
- Phelan, M. (2001). *The Interpreter's Resource*. Clevedon: Multilingual Matters.
- Piacentini, T., O'Donnell, C., Phipps, A., Jackson, I., & Stack, N. (2019). Moving beyond the 'language problem': developing an understanding of the intersections of health, language and immigration status in interpreter-mediated health encounters. *Language and Intercultural Communication*, 19(3), 256-271.
- Pittarello, S. (2009). Interpreter Mediated Medical Encounters in North Italy: Expectations, Perceptions and Practice, *The Interpreters' Newsletter*, 14/2009, pp. 59-90.
- Pöchhacker, F. (2004). *Introducing Interpreting Studies*. London: Routledge.
- Pöchhacker, F. (2006). Research and methodology in healthcare interpreting. *Linguistica Antverpiensia, New Series—Themes in Translation Studies*, 5, 135-159.
- Rosenberg, E. (2010). Health care across a language divide, *Patient education and counseling*, 81(2), 147.
- Rudvin, M., & Tomassini, E. (2011). *Interpreting in the Community and Workplace*. Nueva York: Palgrave Macmillan

- Salama-Carr, M. (2018). Mediating emergencies and conflicts: Frontline translating and interpreting, *Translation Studies*, 11:2, 217-219.
- Sasso, A. (September 2015). Titles, community interpreting, and health care settings. *MultiLingual*, 34-38.
- Seeber, K. G. (2001). Intonation and Anticipation in Simultaneous Interpreting. *Cahiers de linguistique française*, 23, 61-97.
- Setton, R. 1999. *Simultaneous Interpretation: A Cognitive Pragmatic Analysis*. John Benjamins. Amsterdam, NY, Philadelphia.
- Sıhhat Project. (n.d.). Access: 19 April 2019, http://www.sihhatproject.org/proje-faaliyetleri_0-657.
- Şener, O. (2017). *Healthcare Interpreting in Turkey: Role and Ethics in a Sociological Perspective*. Master's Thesis, Dokuz Eylül University, İzmir.
- Şimşek, D. (2018). Integration Processes of Syrian Refugees in Turkey: Class-based Integration, *Journal of Refugee Studies*, 0, 1-18.
- Sleptsova M., Hofer G., Morina N., & Langewitz W. (2014). The Role of the Health Care Interpreter in a Clinical Setting—A Narrative Review. *Journal of Community Health Nursing*, 31(3), 167-184.
- Taibi, M. (2014). Community interpreting and translation in the Arab world: Status quo and strategies for change. *Babel*, 60(1), 52-69.
- Taibi, M., & Ozolins, U. (2016). *Community Translation*. London: Bloomsbury Publishing.
- Tebble, H. (1999). The Tenor of Consultant Physicians. *The Translator*, 5:2, 179-200.
- Turan, D. (2018). Sağlık Çevirmenliği: Hekim-Hasta İletişimi ve Hekimin İktidar Pozisyonunun Değerlendirilmesi Üzerine Bir Çalışma. *Electronic Turkish Studies*, 13(20), 751-777.

- Tzou, Y. Z., Eslami, Z. R., Chen, H. C., & Vaid, J. (2012). Effect of language proficiency and degree of formal training in simultaneous interpreting on working memory and interpreting performance: Evidence from Mandarin–English speakers. *International Journal of Bilingualism*, 16(2), 213-227.
- United Nation High Commissioner for Refugees. (2018). Access: 10 April 2019, <https://www.unhcr.org/tr/wp-content/uploads/sites/14/2018/11/01.-UNHCR-Turkey-Fact-Sheet-September-2018.pdf>
- United Nation High Commissioner for Refugees. (2019). *3RP Regional and Resilience Plan - Turkey 2019-2020* (Unpublished). United Nation High Commissioner for Refugees.
- United Nation High Commissioner for Refugees. (n.d). Access: 10 February 2019, <https://www.unhcr.org/afr/figures-at-a-glance.html>
- United Nation High Commissioner for Refugees. (n.d). Access: 10 February 2019, <https://www.unhcr.org/afr/figures-at-a-glance.html>
- Ursu, P., Nitzan, D., Şener, S., Sucaklı, B., Şimşek, M., Beqiri, M. et al. (2018). Protracted Emergency in Turkey – Supporting Provision of Essential Health Services to Syrians under Temporary Protection. *Public Health Panorama*, 4(1), 120-125.
- van Rosse, F., de Bruijne, M., Suurmond, J., Essink-Bot, M. L., & Wagner, C. (2016). Language barriers and patient safety risks in hospital care. Mixed methods study. *International Journal of Nursing Studies*, 54, 45-53.
- Vocational Qualification Authority. (2012). National Professional Standards for Translators & Interpreters (Reference code: 12UMS0274-6). Ankara: Vocational Qualification Authority.
- Vocational Qualification Authority. (n.d.). Access: 15 April 2019, <https://www.myk.gov.tr/index.php/tr/kurumsal/misyon-vizyon>

- Waasaf, M. L. N. (2007). Intonation and the structural organization of texts in simultaneous interpreting. *Interpreting*, 9(2), 177-198.
- Wang, H. (2011). Conversational implicature in English listening comprehension. *Journal of Language Teaching and Research*, 2(5), 1162-1167.
- WHO in Turkey. (2018). Annual Report 2017 on Health Emergency Response to the Crisis in the Syrian Arab Republic (Report No: 2017). Denmark: World Health Organization Regional Office for Europe.
- WHO in Turkey. (2019). Annual Report 2018 on Health Emergency Response to the Crisis in the Syrian Arab Republic (Report No: 2018). Denmark: World Health Organization Regional Office for Europe.
- WHO Regional Office for Europe. (2018). *WHO Health Evidence Network Synthesis Report* (Synthesis Report 62). Denmark: WHO Regional Office for Europe.
- Yamada, H. (2018). The Validity of Note-taking for New Consecutive Interpreting Learners: An Empirical Study of University Interpretation Courses. *Theory and Practice in Language Studies*, 8(11), 1387-1396.
- Zendedel, R., Schouten, B. C., van Weert, J. C., & van den Putte, B. (2016). Informal interpreting in general practice: Comparing the perspectives of general practitioners, migrant patients, and family interpreters. *Patient education and counseling*, 99(6), 981-987.

APPENDIX 1

QUESTIONNAIRE ON THE OPINION OF PATIENT GUIDES ON ADAPTATION TRAINING AND THEIR NEEDS REGARDING HEALTHCARE INTERPRETING TRAINING

This questionnaire was prepared to in order to evaluate the patient guides' opinion the Adaptation Training they received which was provided within the cooperation of World Health Organization and Ministry of Health as well as their opinion on receiving healthcare interpreting training. The data to be obtained from the questionnaire will be utilized for evaluation of the healthcare interpreting training needs of patient guides working in Turkish health institutions and for Master Thesis which will contribute to the improvement of working setting in terms of Patient Guides who make the communication possible.

The questionnaire consists of three following sections:

- Socio-demographic and professional profiles
- Opinions on the inclusion of the new subjects in the curriculum
- Opinions and level of satisfaction on the received adaptation training

You are not expected to write your name on the questionnaire. The care and sincerity you take while filling out the form is extremely important in terms of achieving the purpose of the study.

Thank you for your participation and contribution.

QUESTION FORM

SECTION 1: SOCIO-DEMOGRAPHIC AND PROFESSIONAL PROFILES

1. Your Sex: Women ☐ Men ☐
2. Your date of birth: (Specify as a year)
3. Please indicate your level of education?
 - a) Primary school graduate
 - b) Secondary school graduate
 - c) High school graduate
 - d) Vocational high school
 - e) Bachelor's degree
 - f) Master programme graduate
4. On what field and which year did you complete your education?

5. What is your mother tongue?

6. What languages do you know and what are their levels?

Language	Beginner	Intermediate	Advanced

7. What is the name of your workplace?:
8. From which date do you live in Turkey (*specify as a year*):

9. What was your profession before you started to work in this workplace?
- a) I worked as
 - b) I did not work anywhere
10. Have you ever worked as a healthcare interpreter before you were assigned as a patient guide?
- a) I do not have any experience
 - b) I worked as a healthcare interpreter in private sector
 - c)) I worked as a healthcare interpreter in the public sector
 - d) Other:
11. On what date did you start to work as a patient guide in the health facility that you are working now?
- / 20...
12. How many days and working hours in a day do you work in the health facility that you are working now?
- A number of days in a week:
- Hours in a day:
- Would you like to write a comment?
-
13. Do you have previous experience in written translation and interpreting?
- a) Yes::.....
 - b) No
14. What type of interpreting do you use during the patient/doctor dialogues in the health facility that you are working now?
- a) I am interpreting simultaneously while the speaker is speaking
 - b) I am interpreting after taking notes
 - c) I am doing sight translation
 - d) I am doing written translation
 - e) I am interpreting without taking notes
- Your comments:
-

SECTION 2: OPINIONS ON THE INCLUSION OF THE NEW SUBJECT IN
THE CURRICULUM

15. During interpreting, facilitating techniques for the problems that you encounter can be used, would you like to learn these techniques?

a) Yes

b) No

Your comments:

.....

16. There are different types of interpreting in terms of their subjects and way of presentation, would you like to learn these types?

a) Yes

b) No

Your comments:

.....

17. There are memory techniques that can be used for long speeches during the interpreting, would you like to learn these techniques?

a) Yes

b) No

Your comments:

.....

18. There are interpreting-specific and simple note-taking techniques that facilitate the interpreting process, would you like to learn these techniques?

a) Yes

b) No

Your comments:

.....

19. Interpreters may have to present different manners and attitudes according to the situation at the time of interpreting, would you like to learn them?

a) Yes

b) No

Your comments:

.....

20. Would you like to receive further information on medical terminology?

a) Yes

b) No

Your comments:

.....

21. Would you like to learn how you can access resources that will facilitate your work when you need information on medical terminology and field of medicine?

a) Yes

b) No

Your comments:

.....

22. Intonation is important during the interpreting, would like to receive information on this issue?

a) Yes

b) No

Your comments:

.....

23. During the interpreting, real intention and meaning of the speech may not be correctly understood. This situation affects the interpreting. Would you like to learn the discourse analysis techniques that will facilitate your work during the interpreting?

a) Yes

b) No

Your comments:

.....

24. Cultural differences are important during the interpreting. Would like to receive information on this issue?

a) Yes

b) No

Your comments:

.....

25. There are interpreter needs which are required to be met for a good quality of service provision during the interpreting?

a) Yes

b) No

Your comments:

.....

26. There are ethical rules such as confidentiality, privacy, impartiality, and respect and these rules are important for both interlocutors. Would you like to receive information on these rules?

a) Yes

b) No

Your comments:

.....

27. Would you like to practice the above-mentioned subjects with professional interpreter's trainers?

a) Yes

b) No

Your comments:

.....

SECTION 3: OPINIONS AND LEVEL OF SATISFACTION ON THE RECEIVED ADAPTATION TRAINING

28. How do you evaluate the training that you received?

- a) Weak
- b) Medium
- c) Good
- d) Very good
- e) Perfect

Your comment:

.....

29. How do you evaluate the duration of the training that you received?

	Long	Suitable	Short
Theoretical Training (5 days)			

What would you recommend for the duration and frequency of the training?

- a) More than 5 days
- b) Short but more often
- c) Other recommendation:

30. What would you recommend to strengthen/improve the training?

.....

.....

31. Do you encounter any problem during the interpreting in the health facility that you are working?

- a) Yes
- b) No

Your comments:.....

32. Please respond the below questions by choosing the suitable option for yourself.

	1 Fully disagree	2 Disagree	3 No opinion	4 Agree	5 Fully agree
The date and timing of the training was suitable					
The training is provided in a comprehensive way					
The training materials (presentations, book, dictionary) was enough					
Training increased my interest in the interpreting profession					
The training contributed to my professional development					
The training contributed to my personal development					
The training increased my motivation in this profession					
It was easy to follow-up content of the training					
Content of the training was enough to gain new professional knowledge and skills.					

THANK YOU FOR YOUR PARTICIPATION AND OPINIONS

APPENDIX 2

HASTA REHBERLERİNİN ADAPTASYON EĞİTİMLERİNE YÖNELİK GÖRÜŞ VE SAĞLIK ÇEVİRMENLİĞİ EĞİTİMİNE İLİŞKİN İHTİYAÇLARINA YÖNELİK ANKET

Bu anket, Dünya Sağlık Örgütü ve T.C. Sağlık Bakanlığı işbirliği ile Geçici Koruma altındaki Suriyelilere verilen sağlık hizmeti sırasında görev alan Hasta Yönlendirme Personeline yönelik Adaptasyon Eğitimi sonrasında bu kişilerin katıldıkları eğitime ve bir sağlık çevirmenliği eğitimi almaya yönelik görüşlerini değerlendirmek amacıyla hazırlanmıştır. Anketten elde edilecek veriler, sağlık hizmet kuruluşlarında çalışan Hasta Yönlendirme Personelinin sağlık çevirmenliği eğitimi ihtiyacının değerlendirilmesi ve çalışma ortamının bu ortamda iletişimi mümkün kılan bu personel açısından da geliştirilmesine katkı sağlayacak olan Yüksek Lisans tezinde kullanılacaktır.

Anket, 3 bölümden oluşmaktadır:

- Sosyo-demografik ve mesleki bilgiler
- Eğitim içeriğine yeni konuların eklenmesine yönelik görüşler
- Adaptasyon eğitimine yönelik görüşler ve memnuniyet düzeyi

Ankete isminizi yazmanız beklenmemektedir. Formu doldururken göstereceğiniz özen ve samimiyet, çalışmanın amacına ulaşması açısından son derece önemlidir.

Katılım ve katkılarınız için teşekkür ederiz.

SORU FORMU

BÖLÜM 1: SOSYO-DEMOGRAFİK VE MESLEKİ BİLGİLER

1. Cinsiyetiniz: ☐ Kadın ☐ Erkek

2. Doğum tarihiniz: (Yıl olarak belirtiniz)

3. Eğitim düzeyiniz nedir?

a) İlkokul mezunu

b) Ortaokul mezunu

c) Lise Mezunu

d) Yüksekokul mezunu

e) Üniversite mezunu

f) Lisansüstü

4. Mesleki eğitimi hangi alanda aldınız ve hangi yıl tamamladınız?

.....

5. Anadiliniz nedir?

.....

6. Hangi dilleri hangi düzeyde biliyorsunuz?

DİL	BAŞLANGIÇ DÜZEY	ORTA DÜZEY	İLERİ DÜZEY

7. Çalıştığınız kurum adı:

8. Hangi yıldan itibaren Türkiye’de yaşıyorsunuz :.....

9. Şu anki sağlık hizmeti kuruluşunda çalışmaya başlamadan önce yaptığınız meslek nedir?

a) olarak çalıştım

b) Başka yerde çalışmadım

10. Hasta Yönlendirme Personeli olarak atanmadan önce başka bir sağlık kuruluşunda tıbbi tercüman olarak çalıştınız mı?

a) Hiç tecrübem olmadı

b) Evet daha önce özel sektörde tıbbi tercüman olarak çalıştım

c) Evet daha önce kamu sektöründe tıbbi tercüman olarak çalıştım

e) Diğer:

11. Hangi tarihte şu an hizmet verdiğiniz sağlık kuruluşunda hasta yönlendirme personeli olarak çalışmaya başladınız? (ay ve yıl olarak belirtiniz)

..... / 20....

12. Şu an çalıştığınız kurumda haftada kaç gün ve günde kaç saat çalışıyorsunuz?

Haftada kaç gün:

Günde kaç saat:

Açıklama yazmak ister misiniz?

13. Daha önceden sözlü veya yazılı tercüme deneyiminiz var mı?

a) Evet

b) Hayır

14. Çalıştığınız kurumda doktor/hasta görüşmeleri sırasında aşağıdaki hangi tercüme türlerini kullanıyorsunuz? (Birden fazla seçenek işaretleyebilirsiniz)

a) Konuşmacı konuşurken aynı anda çeviriyorum

b) Konuşmacının söylediklerini not aldıktan sonra çeviriyorum

c) Yazılı metinden sözlü olarak çeviriyorum

d) Yazılı metin çevirisi yapıyorum

e) Konuşmacının söylediklerini not almadan çeviriyorum

Bu konuyla ilgili yazmak istedikleriniz :

BÖLÜM 2: EĞİTİM İÇERİĞİNE YENİ KONULARIN EKLENMESİNE YÖNELİK GÖRÜŞLER

15. Tercüme yaparken karşılaştığınız sorunları gidermeyi kolaylaştıran teknikler kullanılabilir. bu teknikleri öğrenmek ister misiniz?

a) Evet

b) Hayır

Bu konuyla ilgili yazmak istedikleriniz:.....

16. Sözlü çevirinin konularına ve yapılaş biçimlerine göre farklı türleri vardır. bunları öğrenmek ister misiniz?

a) Evet

b) Hayır

Bu konuyla ilgili yazmak istedikleriniz:.....

17. Tercüme yaparken uzun konuşmaları akılda tutma teknikleri vardır. bu teknikleri öğrenmek ister misiniz?

a) Evet

b) Hayır

Bu konuyla ilgili yazmak istedikleriniz:.....

18. Tercüme sırasında akılda tutmayı kolaylaştırıcı. tercüme için özel ve basit not alma teknikleri vardır. bu teknikleri öğrenmek ister misiniz?

a) Evet

b) Hayır

Bu konuyla ilgili yazmak istedikleriniz:.....

19. Tercüme sırasında tercümanın duruma göre farklı davranış biçimleri ve tavırlar göstermesi gerekebilir. bunları öğrenmek ister misiniz?

a) Evet

b) Hayır

Bu konuyla ilgili yazmak istedikleriniz:.....

20. Tıbbi terminoloji konusunda daha fazla bilgi almak ister misiniz?

a) Evet

b) Hayır

Bu konuyla ilgili yazmak istedikleriniz:.....

21. Tıbbi terminoloji ve konu alanına dair bilgi almak istediğinizde işinizi kolaylaştıracak başvuru kaynaklarına nasıl ulaşabileceğinizi öğrenmek ister misiniz?

a) Evet

b) Hayır

Bu konuyla ilgili yazmak istedikleriniz:.....

22. Tercüme sırasında ses kullanımı ve ses tonlaması önemlidir. bu konuda bilgi almak ister misiniz?

a) Evet

b) Hayır

Bu konuyla ilgili yazmak istedikleriniz:.....

23. Tercüme sırasında, söylenenin gerçek niyeti ve anlamı her zaman anlaşılamayabilir. Bu da tercümeyi etkiler. Bu konuda tercümeyi kolaylaştırıp size yardımcı olacak söylem çözümlemesi tekniklerini öğrenmek ister misiniz?

a) Evet

b) Hayır

Bu konuyla ilgili yazmak istedikleriniz:.....

24. Tercümede kültür farklılıkları önemlidir. Bu konuda bilgi almak ister misiniz?

a)Evet

b) Hayır

Bu konuyla ilgili yazmak istedikleriniz:.....

25. Tercümanın iyi hizmet verebilmesi için karşılanması gereken gereksinimleri vardır. bu konuda bilgi almak ister misiniz?

a) Evet

b) Hayır

Bu konuyla ilgili yazmak istedikleriniz:.....

26. Tercümanlık mesleğinde gizlilik, mahremiyet, tarafsızlık, saygı gibi etik kurallar vardır ve hem tercüman hem de tercümeden yararlanan taraflar için önemlidir. Bu kurallar hakkında bilgi almak ister misiniz?

a) Evet

b) Hayır

Bu konuyla ilgili yazmak istedikleriniz:.....

27. Yukarıdaki konuları uzman tercüman eğitmenlerle eğitim sırasında uygulamak ister misiniz?

a) Evet

b) Hayır

Bu konuyla ilgili yazmak istedikleriniz:.....

**BÖLÜM 3: ADAPTASYON EĞİTİMİNE YÖNELİK GÖRÜŞLER VE
MEMNUNİYET DÜZEYİ**

28. Aldığınız eğitim hakkında ne düşünüyorsunuz?

1. Zayıf
2. Orta
3. İyi
4. Çok iyi
5. Mükemmel

Açıklama yazmak ister misiniz?:

.....
.....

29. Katıldığınız eğitimin süresi hakkında ne düşünüyorsunuz?

	Uzun	Uygun	Kısa
Teorik eğitim (5 gün)			

Eğitimin hangi süre veya hangi zaman aralıkları ile verilmesini önerirsiniz?

- a) 5 günden daha fazla
- b) Kısa ve sık aralıklar ile
- c) Önerim:

30. Eğitiminin güçlendirilmesi/geliştirilmesi için neler önerirsiniz?

.....
.....

31. Şu anda hizmet verdiğiniz kurumda çeviri sırasında bir sorun yaşıyor musunuz?

- a) Evet
- b) Hayır

Bu konuyla ilgili yazmak istedikleriniz:.....

32. Lütfen aşağıdaki soruları kendinize uygun seçeneği işaretleyerek yanıtlayınız.

	1 Hiç katılmıyorum	2 Katılmıyorum	3 Fikrim Yok	4 Katılıyorum	5 Kesinlikle katılıyorum
Eğitimin düzenlendiği tarih/zamanlama uygundu					
Eğitim anlaşılabilir biçimde verildi					
Eğitim materyalleri (sunum. kitap. sözlük) yeterliydi					
Eğitim çevirmenlik mesleğine olan ilgimi artırdı					
Eğitim mesleki gelişimime olumlu katkı sağladı					
Eğitim kişisel gelişimime olumlu katkı sağladı					
Eğitim meslekteki motivasyonumu artırdı					
Eğitimin içeriğini takip etmek kolaydı					
Eğitimin içeriği yeni mesleki bilgi ve beceriler kazandırmak için yeterliydi					

KATILIMINIZ, FİKİR VE DÜŞÜNCELERİNİZ İÇİN TEŞEKKÜRLER

APPENDIX 3

ARAŞTIRMA GÖNÜLLÜ KATILIM FORMU

Bu çalışma. “DSÖ ve Sağlık Bakanlığı ortak projesi kapsamında geçici koruma altındaki Suriyelilere verilen Sağlık hizmeti sırasında görev alan tercümanlara yönelik eğitimin değerlendirilmesi” başlıklı bir araştırma çalışması olup **Dünya Sağlık Örgütü. Türkiye Cumhuriyeti Sağlık Bakanlığı ile işbirliği içerisinde Suriyeliler için Türk Sağlık Sistemine Adaptasyon Eğitimleri kapsamında verilen “Hasta Yönlendirme Personeline yönelik Sağlık Okuryazarlığı Eğitimi”nin etkinliğini değerlendirme ve çevirmenlik mesleği açısından ihtiyaçları belirleme** amacını taşımaktadır. Çalışma. Sıla Saadet TOKER tarafından. Prof Dr. Aymil Doğan danışmanlığında yürütülmekte ve sonuçları ile **Suriyeliler için Türk Sağlık Sistemine Adaptasyon Eğitimleri kapsamında verilen Hasta Yönlendirme Personeli Sağlık Okuryazarlığı Eğitiminin etkin olup olmadığını ve çevirmenlik mesleği açısından ihtiyaçlarının ne olduğu bilimsel yöntemle** ortaya konulacak. böylelikle bu eğitimlerin gelişimine ışık tutulacaktır. Araştırmanın yapılması için Hacettepe Üniversitesi Etik Komisyon onayı alınmıştır.

- Bu çalışmaya katılımınız gönüllülük esasına dayanmaktadır.
- Çalışmanın amacı doğrultusunda. Suriyeli Hasta Yönlendirme Personeline yönelik eğitimin etkinliği ve hizmet sunumuna ilişkin görüş ve yeterlik algısını ölçme anketi yapılarak sizden veriler toplanacaktır.
- İsmınızı yazmak ya da kimliğinizi açığa çıkaracak bir bilgi vermek zorunda değilsiniz/araştırmada katılımcıların isimleri gizli tutulacaktır. Aynı şekilde kendi ifadelerinizi belirtmek isterseniz isminizi yazabilirsiniz.
- Araştırma kapsamında toplanan veriler. sadece bilimsel amaçlar doğrultusunda kullanılacak. araştırmanın amacı dışında ya da bir başka araştırmada kullanılmayacak ve gerekmesi halinde. sizin (yazılı) izniniz olmadan başkalarıyla paylaşılmayacaktır.
- İstemeniz halinde sizden toplanan verileri inceleme hakkınız bulunmaktadır.
- Sizden toplanan veriler korunacak ve araştırma bitiminde imha edilecektir.
- Veri toplama sürecinde size rahatsızlık verebilecek herhangi bir soru/talep olmayacaktır. Yine de katılımınız sırasında herhangi bir sebepten dolayı rahatsızlık hissederseniz çalışmadan istediğiniz zamanda ayrılabilirsiniz ve rahatsızlığın giderilmesi için gerekli yardım sağlanacaktır. Çalışmadan ayrılmanız durumunda tarafınıza hiçbir sorumluluk getirmeyecektir ve sizden toplanan veriler çalışmadan çıkarılacak ve imha edilecektir.
- Veri toplama sürecinde sormak istediğiniz herhangi bir soru olursa çekinmeden araştırmacıya sorularınızı yöneltebilirsiniz.

Gönüllü katılım formunu okumak ve değerlendirmek üzere ayırdığınız zaman için teşekkür ederim. Çalışma hakkındaki sorularınızı Hacettepe Üniversitesi İngilizce Mütercim Tercümanlık Bölümü Öğretim Üyesi Prof. Dr. Aymil Doğan'a (mail/tel) yöneltebilirsiniz.

Araştırmacı Adı : Prof Dr Aymil Doğan
Adres : Hacettepe

Üniversitesi

Beytepe Kampüsü Edebiyat Fakültesi
Posta kodu: 6800 Beytepe/Ankara
İş Tel : (0312) 297 83 75

Bu çalışmaya tamamen kendi rızamla. istediğim takdirde çalışmadan ayrılabilceğimi bilerek verdiğim bilgilerin bilimsel amaçlarla kullanılmasını kabul ediyorum.

(Lütfen bu formu doldurup imzaladıktan sonra veri toplayan kişiye veriniz.)

Tarih:

Katılımcı Ad ve Soyadı:

Adres:

E-posta adresi:

Telefon:

İmza:

APPENDIX 4

HACETTEPE UNIVERSITY ETHICAL COMMISSION CLEARANCE LETTER



T.C.
HACETTEPE ÜNİVERSİTESİ
Rektörlük



Sayı : 35853172-100
Konu : Sıla Saadet TOKER Hk.

SOSYAL BİLİMLER ENSTİTÜSÜ MÜDÜRLÜĞÜNE

Enstitümüz Mütercim Tercümanlık (İngilizce Mütercim Tercümanlık) Anabilim Dalı Öğretim Üyesi Prof. Dr. Aymil DOĞAN'ın Sıla Saadet TOKER yardımcılığında yürüttüğü "Hasta Rehberlerinin Yetiştirilmesine Yönelik Sağlık Bakanlığı ve Dünya Sağlık Örgütü Tarafından Verilen Eğitimlere Yönelik İçerik Analizi:Geçici Koruma Altındaki Suriyelilere Yönelik Türk Sağlık Sistemine Adaptasyon Eğitimleri" başlıklı tez çalışması, Üniversitemiz Senatosu Etik Komisyonunun 4 Aralık 2018 tarihinde yapılmış olduğu toplantıda incelenmiş olup, etik açıdan uygun bulunmuştur.

Bilgilerinizi ve gereğini saygılarımla rica ederim.

e-imza
Prof. Dr. Rahime Meral NOHUTCU
Rektör Yardımcısı

Enstitümüz etik kurul kararları <http://belgegitisleri.hacettepe.edu.tr/odunluklar/30214495-6647-4962-9b17-3a204268897c> linki ile görüntülenebilir.
Başlangıç: 2019 sayılı Etik Kurul Kararı'na atıfta bulunarak Gırtlak-Ektrozis İhtisi ile izlenmektedir.

Hacettepe Üniversitesi Rektörlük 06100 Sıhhiye Caddesi
Telefon: (312) 345 3001-3002 Faks: (312) 311 9882 E-posta: yeniyasli@hacettepe.edu.tr İnternet:
Adres: www.hacettepe.edu.tr

Ünvan: Doçent II/194



APPENDIX 5

**APPROVAL LETTER OF MIGRATION POLICY AND PROJECT
DEPARTMENT, DIRECTORATE GENERAL OF MIGRATION
MANAGEMENT, MINISTRY OF INTERIOR**



Konu : Anket İzni

T.C.
İÇİŞLERİ BAKANLIĞI
Göç İdaresi Genel Müdürlüğü
Göç Politika ve Projeleri Dairesi Başkanlığı
149-604.02.02-E.3514

16/01/2019

DAĞITIM YERLERİNE

İlgi : 03.01.2019 tarihli dilekçe

Sıla Saadet TOKER sunmuş olduğu dilekçe ile yaptığı müracaatında; tez çalışmasına esas olmak üzere "Türk Sağlık Personeli ve Suriyeli Göçmen Hastalar Arasında Tercüme Hizmeti Sağlanmak Amacıyla İstihdam Edilen Tıbbi Tercümanlara Yönelik Verilen Eğitimin Değerlendirilmesi" konulu tezi kapsamında Ankara ilinde ikamet eden ve "Tıbbi Tercüman ve Hasta Rehberi Eğitimini" tamamlamış ve Sağlık Bakanlığı tarafından sağlık hizmeti veren devlet kurumlarında istihdam edilen tercümanlara verilen eğitimin görüş ve yeterlik almasına ilişkin ekte belirtilen anket doğrultusunda mülakat yapmak istediğini belirtmektedir.

< SPAN >

< SPAN >

Söz konusu çalışma, 6458 sayılı Yabancılar ve Uluslararası Koruma Kanunu 94 üncü maddesi ile 2014/6883 karar sayılı Geçici Koruma Yönetmeliği 51 inci maddesinde belirtilen gizlilik ilkelerine gerekli hassasiyetin gösterilmesi; çalışmaya konu kişilerden ve/veya aile üyelerinden yapılacak araştırmanın hiçbir aşamasında ad, soyad, telefon, e-posta adresi, ikametgâh adresi ile uyruk, din, mezhep, etnik gruba mensubiyet gibi hassas bilgilerin istenmemesi ve çalışmalar esnasında ses/video kaydı alınmaması kaydı ile anket soruları olumlu değerlendirilmiş olup Ankara İl Göç İdaresi Müdürlüğü ve Sağlık Bakanlığı ilgili birimleri tarafından da uygun görülmesi halinde çalışmanın yapılabilceği değerlendirilmektedir.

Gereğini rica ederim.

Mehmet Sinan YILDIZ

*Bu belge elektronik imzalıdır. İmza şartının aynısı görmek için <https://www.e-imzalar.gov.tr/EvrakDuyurulmasi> adresine girilerek (qT4V7mx-+xcGMD-w4L7LL-9GmKU-e0PaeGWEo) kodunu yazınız.

İletişim Çarşısı Mahallesi 12246 No: 6, 06370 Yenimahalle/ Ankara
Telefon No: (312)422 01 00 Faks No: (312)422 09 00
E-Posta: gocegidaresi@icisleri.gov.tr İnternet Adresi: <https://www.goc.gov.tr>

İlgi için: Mehmet Tolga SAMANCI
UZMAN YARDIMCI
Telefon No:

APPENDIX 6

APPROVAL LETTER OF PROVINCIAL DIRECTORATE OF MIGRATION MANAGEMENT, GOVERNORATE OF ANKARA



Sayı : 41384883-000-E.7690
Konu : Sn.sıla Saadet TOKER

T.C.
ANKARA VALİLİĞİ
İl Göç İdaresi Müdürlüğü



01/02/2019

Sn. Sıla Saadet TOKER

İlgi : 24.01.2019 tarihli ve BİLA sayılı yazı.

İlgide kayıtlı dilekçenizde, "Türk Sağlık Personeli ve Suriyeli Göçmen Hastalar Arasında Tercüme Hizmeti Sağlamak Amacıyla İstihdam Edilen Tıbbi Tercümanlara Yönelik Verilen Eğitimin Değerlendirilmesi" konulu teziniz kapsamında Ankara ilinde ikamet eden ve "Tıbbi Tercüman ve Hasta Rehberi Eğitimi" tamamlamış ve Sağlık Bakanlığı tarafından sağlık hizmeti veren devlet kurumlarında istihdam edilen tercümanlara verilen eğitimin görüş ve yeterlik algısına ilişkin anket doğrultusunda mülakat yapmak istediğiniz belirtilmektedir.

Bahse konu çalışma 6458 sayılı Yabancılar ve Uluslararası Koruma Kanunu 94 üncü maddesi ile 2014/6883 karar sayılı Geçici Koruma Yönetmeliği 51 inci maddesinde belirtilen gizlilik ilkelerine gerekli hassasiyetin gösterilmesi; çalışmaya konu kişilerden ve/veya aile üyelerinden ad, soyad, telefon, adres ile din, mezhep, etnik gruba mensubiyet gibi hassas bilgilerin istenmemesi; çalışmalar esnasında ses/video kaydı alınmaması, çalışma tamamlandıktan sonra çalışma çıktılarının araştırma dışında kullanılmaması kaydı ile olumlu değerlendirilmiş olup, bir örneğinin müdürlüğümüzle paylaşılması rica olunur.

Ayrıca dilekçenizde talep ettiğiniz "Eğitimi tamamlamış ve Ankara'da istihdam edilmiş tıbbi tercümanların isimleri ve iletişim bilgileri ile çalıştıkları kurumlara ilişkin bilgiler, müdürlüğümüzde mevcut olmadığından tarafınızla paylaşamamaktadır.

İlgilerinizle sunarım.

Bayram YALINSU
Vali a.

*Bu belge elektronik imzalıdır. İmzalı suretinin salını görmek için <https://www.e-imzaları.gov.tr/firma/degisim> adresine girerek (kTqLyk-Elc6am-3LWGG/-KkaUC1-4Tx6HCO7) kodunu yazınız.

Barbaros Mah. Birinci Sok. No:3 Çankaya
Telefon No: (312)439 40 40 Faks No: (312)439 40 66
e-Posta: ankara@gic.gov.tr İnternet Adresi: <http://www.gic.gov.tr/>

Bilgi İçin: Osman DÖRKAC
İl. GÖÇ YÖNETMELİ
Telefon No:

APPENDIX 8

FINAL APPROVAL LETTER OF MIGRATION HEALTH UNIT, DIRECTORATE OF PUBLIC HEALTH SERVICES, ANKARA PROVINCIAL HEALTH DIRECTORATE, MINISTRY OF HEALTH



T.C.
ANKARA VALİLİĞİ
İL SAĞLIK MÜDÜRLÜĞÜ



Sayı : 51381736-604.02
Konu : Araştırma İzni

DAĞITIM YERLERİNE

İlgi : 28/03/2019 tarihli ve 62693856-604.02-204 sayılı yazı.

Hacettepe Üniversitesi Edebiyat Fakültesi İngilizce Mütercim Tercümanlık Bölümünü Öğretim Üyesi Prof.Dr. Aymül DOĞAN sorumluluğunda Yüksek Lisans Öğrencisi Sıla Saadet TÖKER tarafından yapılmak istenen "Hasta Rehberlerinin Yetiştirilmesine Yönelik Sağlık Bakanlığı ve Dünya Sağlık Örgütü Tarafından Verilen Eğitimlere Yönelik İçerik Analizi: Geçici Koruma Altındaki Suriyelilere Yönelik Türk Sağlık Sistemine Adaptasyon Eğitimleri" başlıklı araştırma izin talebi, ekte yer alan Halk Sağlığı Genel Müdürlüğü'nün 12.03.2019 tarih ve 89217678 barkod numaralı yazısı ile belirtilen ilkelere bağlı kalınması koşulları ile uygun bulunmuştur.

"Onay alınmasından itibaren 10 gün içinde" yapılacağı belirtilen araştırma hakkında, hasta rehberi/tıbbi tercüman eğitimlerini tamamlamış ve Sıhhat Projesi kapsamında kurumunuzda veya bağlı kuruluşlarda hasta yönlendirme personeli olarak istihdam edilmiş kişilere bilgi verilmesi ve tebliğ-tebelhük belgesinin tarafınıza gönderilmesi hususunda;

Bilgilerinizi ve gereğini arz/rica ederim.

e-imzalıdır.

Uzm.Dr. Ayşe ÇUHADAR BULUT
Başkan a.
Başkan Yardımcısı

Ek:
Araştırma İzin Talebi (Prof. Dr. Aymül DOĞAN)

Halk Sağlığı Hizmetleri Başkanlığı Çiğ Sağlığı Hizmetleri
Rıdvanlı Cad. İbrahim Müteferrika Sok. No:9 Ulus Altındağ/ANKARA

Telefon: Faks No:

e-Posta: irem.yildirimli@sağlik.gov.tr İnternet Adresi:

Evrakın elektronik imzalı suretine <http://e-belge.saglik.gov.tr> adresinden 8878255-066d-40be-8c58-ec2h33529d14 kodu ile erişebilirsiniz.

Bu belge 5070 sayılı elektronik imza kanuna göre güvenli elektronik imza ile imzalanmıştır.

Bilgi için: İrem YILDIRIM

SOSYAL ÇALIŞMACI

Telefon No: 0312 3025367

APPENDIX 9

ORIGINALITY REPORT



**HACETTEPE UNIVERSITY
GRADUATE SCHOOL OF SOCIAL SCIENCES
MASTER'S THESIS ORIGINALITY REPORT**

**HACETTEPE UNIVERSITY
GRADUATE SCHOOL OF SOCIAL SCIENCES
TRANSLATION AND INTERPRETING DEPARTMENT**

Date: 14/07/2019

Thesis Title : EVALUATION OF ADAPTATION TRAINING PROVIDED BY THE MINISTRY OF HEALTH AND THE WORLD HEALTH ORGANIZATION: PATIENT GUIDES WITHIN THE CONTEXT OF HEALTHCARE INTERPRETING TRAINING IN TURKEY

According to the originality report obtained by myself/my thesis advisor by using the Turnitin plagiarism detection software and by applying the filtering options checked below on 14/07/2019 for the total of 166 pages including the a) Title Page, b) Introduction, c) Main Chapters, and d) Conclusion sections of my thesis entitled as above, the similarity index of my thesis is 9 %.

Filtering options applied:

1. ☒ Approval and Declaration sections excluded
2. ☒ Bibliography/Works Cited excluded
3. ☒ Quotes excluded
4. ☐ Quotes included
5. ☒ Match size up to 5 words excluded

I declare that I have carefully read Hacettepe University Graduate School of Social Sciences Guidelines for Obtaining and Using Thesis Originality Reports; that according to the maximum similarity index values specified in the Guidelines, my thesis does not include any form of plagiarism; that in any future detection of possible infringement of the regulations I accept all legal responsibility; and that all the information I have provided is correct to the best of my knowledge.

I respectfully submit this for approval.

14/07/2019

Date and Signature

Name Surname: Sila Saadet TOKER

Student No: N15223042

Department: English Translation and Interpretation

Program: Master Programme – with thesis

ADVISOR APPROVAL

APPROVED.

Prof. Dr. Aynıl Döğen
(Title, Name Surname, Signature)

AUTOBIOGRAPHY

Personal Information

Name Surname : Sila Saadet TOKER
Date of Birth and Place : 19.09.1994 / Van

Education

Bachelor Degree : Hacettepe University - English Translation and Interpretation (2012-2016)
Political Science and Public Administration (Minor Degree)
Anadolu University (2017- ...) - Health Management Department
Master : Hacettepe University - English Translation and Interpretation
Foreign Language : English, German

Job Experiences

Apprenticeship : EDF Conference Interpretation and Translation Company (06.03.2015 - 31.05.2016)
Better Languages.com Ltd (Erasmus Internship Programme) (Nottingham in the UK)(15.06.2015 - 15.09.2015)
Republic of Turkey Ministry of Energy and Natural Resources- General Directorate of European Union and Foreign Affairs (09.06.2014 -22.06.2014)

Institutions : Freelance Interpreter as part time employee / EDF Conference Interpretation and Translation Company (06.03.2015 - 31.05.2016)
Freelance Translator (June 2016-January 2017)
Translator/Interpreter & Programme Assistant (January 2017 – ...) /World Health Organization Country Office in Turkey

Date: 21.06.2019
