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What if she hears nothing at all? Women's health and deafness as a site of exclusion: an integrative review

E se ela não ouvir nada? Saúde feminina e surdez como lugar d e exclusão: uma revisão integrativa

¿Y si ella no puede oir nada? Salud femenina y sordera como lugar de exclusión: una revisión integrativa

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Abstract

Introduction: The health of Deaf women is shaped by intersecting vulnerabilities that hinder equitable access to healthcare services, particularly in the reproductive cycle. **Objective:** Examine the Deaf women health focusing on the barriers faced by in accessing healthcare. **Methods:** An integrative literature review. Database with the descriptors *"deaf woman"* and *"sign language"* (no language or date restrictions). Studies addressing the health of Deaf women sign language users and

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discussing communication barriers or accessibility were included. 11 articles met eligibility criteria out of 30 retrieved ones. **Results:** They were organized into three categories: (1) Communication barrier vulnerability – lack of healthcare providers fluent in sign language, absence of interpreters, limited consultation time and reliance on untrained intermediaries; (2) Informational and educational vulnerability – abscense of accessible health campaigns, low health literacy and disparities in knowledge about contraceptives, preventive screenings, and chronic diseases; (3) Reproductive and systemic vulnerability – delayed prenatal care initiation, unprepared medical staff, unawareness regarding family planning, and persistent oralism in healthcare settings. **Conclusion:** Deaf women face accessibility barriers in healthcare services. It is mandatory to implement and monitor policies that guarantee sign language interpreters in healthcare settings, continuous training in Libras for health providers and accessible health education materials. These measures are fundamental to guaranteeing person-centered healthcare delivery and aligned with linguistic rights and health equity standards for this population.
Keywords: Women's Health; Sign Language; Deafness; Health Services Accessibility.

Resumo

Introdução: A saúde de mulheres surdas é marcada por múltiplas vulnerabilidades que comprometem seu acesso equitativo aos serviços, especialmente no ciclo reprodutivo. **Objetivo:** Analisar a saúde da mulher surda, identificando as barreiras enfrentadas no acesso aos serviços de saúde. **Metodologia:** Revisão integrativa da literatura utilizando os descritores *deaf woman and sign language*, sem restrição de idioma ou período. Foram incluídos estudos que abordassem saúde de mulheres surdas usuárias de língua de sinais e discutissem barreiras comunicacionais e acessibilidade. Dos 30 artigos recuperados, 11 atenderam aos critérios de elegibilidade. **Resultados:** Foram organizadas em três categorias: (1) Vulnerabilidade comunicacional – ausência de profissionais fluentes em língua de sinais, falta de intérpretes, limitação de tempo de consulta e uso de intermediários leigos; (2) Vulnerabilidade informacional e educacional – ausência de campanhas acessíveis, baixo letramento em saúde e desigualdade no conhecimento sobre métodos contraceptivos, exames preventivos e doenças crônicas; (3) Vulnerabilidade reprodutiva e sistêmica – início tardio do pré-natal, despreparo das equipes, desconhecimento sobre planejamento familiar e persistência do oralismo. **Conclusão:** Mulheres surdas enfrentam barreiras de acessibilidade aos serviços de saúde. É fundamental implementar e fiscalizar políticas que garantam intérpretes de língua de sinais, formação continuada em Libras para profissionais da saúde e materiais informativos acessíveis. Essas medidas são essenciais para assegurar um atendimento humanizado e alinhado aos direitos linguísticos e de saúde dessa população.

Palavras-chave: Saúde da Mulher; Língua de Sinais; Surdez; Acessibilidade aos Serviços de Saúde.

Resumen

Introducción: La salud de las mujeres sordas se caracteriza por múltiples vulnerabilidades que comprometen su acceso equitativo a los servicios, especialmente durante el ciclo reproductivo. **Objetivo:** Analizar la salud de las mujeres sordas, identificando las barreras que enfrentan para acceder a los servicios de salud. **Metodología:** Revisión bibliográfica integradora. Utilizando los descriptores "mujer sorda" y "lengua de signos", sin restricciones de idioma ni de período. Se incluyeron estudios que abordaron la salud de las mujeres sordas que utilizan la lengua de signos y que abordaron las barreras de comunicación y la accesibilidad. De los 30 artículos recuperados, 11 cumplieron los criterios de elegibilidad. **Resultados:** Se organizaron en tres categorías: (1) Vulnerabilidad comunicativa: falta de profesionales con dominio de la lengua de signos, falta de intérpretes, tiempo limitado de consulta y uso de intermediarios no profesionales; (2) Vulnerabilidad informativa y educativa: falta de campañas accesibles, baja alfabetización en salud y conocimiento desigual sobre métodos anticonceptivos, exámenes preventivos y enfermedades crónicas; (3) Vulnerabilidad reproductiva y sistémica: inicio tardío de la atención prenatal, equipos de salud sin preparación, desconocimiento de la planificación familiar y oralismo persistente. **Conclusión:** Las mujeres sordas enfrentan barreras para acceder a los servicios de salud. Es fundamental implementar y monitorear políticas que garanticen la disponibilidad de intérpretes de lengua de signos, la capacitación continua en

Libras para profesionales de la salud y materiales informativos accesibles. Estas medidas son esenciales para garantizar una atención humana acorde con los derechos lingüisticos y de salud de esta problacion.

Palabras clave: Salud de la mujer; Lengua de signos; Sordera; Accesibilidad a los servicios de salud.

Introduction

Caring for the health of individuals and communities in situations of vulnerability demands an in-depth understanding of the conditions that produce such vulnerability and of how health systems can adequately respond to these needs[1]. In this study, the term "deaf women" refers to those who use Brazilian Sign Language (Libras) as their primary means of communication and who identify with Deaf Culture. Within this framework, the health of deaf women is examined as the object of analysis, with the aim of understanding their specific vulnerabilities and proposing improvements targeted at this population.

Deaf women face additional barriers within the healthcare system, including the lack of professionals trained in Brazilian Sign Language (Libras), the scarcity of accessible informational materials, and the continued predominance of oralism in medical communication[2]. These obstacles result in difficulties obtaining appropriate care, understanding medical guidance, and accessing essential services—particularly during pregnancy and the postpartum period[3].

In Brazil, the 2019 National Health Survey (Pesquisa Nacional de Saúde – PNS) revealed that 2.3 million Brazilians have hearing impairment, of whom 90,100 are women. However, among individuals with hearing impairment aged 5–40 years, only 22.4% reported knowing how to use Libras, highlighting the insufficient efforts to promote the language and, consequently, the inclusion of this population in healthcare services[4].

Although Brazilian legislation—through Law 10.436/2002—recognizes Libras as a legal means of communication for deaf people and mandates communicative accessibility in health services, the effective implementation of these provisions remains limited[5]. The absence of interpreters during appointments, the shortage of trained professionals, and the lack of specific guidelines for monitoring deaf women during prenatal care and childbirth are clear indicators of this group's marginalization within the healthcare system[6].

Against this backdrop, the guiding research question is: "What are the main themes addressed in the literature on deaf women's health, and what barriers does this population face when seeking care in healthcare services?" With this question, the present study critically analyzes the scientific production on deaf women's health, identifying the principal barriers to accessing healthcare services and the strategies proposed to promote more equitable and accessible care. By systematizing and analyzing the available evidence, this review seeks not only to highlight gaps in the academic literature but also to contribute to the development of strategies that ensure greater equity and quality in healthcare for this population.

Methods

This study is an integrative literature review, a methodology that enables the analysis of existing research on a specific topic, thereby synthesizing knowledge on the investigated subject. To ensure rigor, the following steps were performed: (1) identification of the topic and formulation of the research question; (2) establishment of inclusion and exclusion criteria; (3) identification of studies; (4) pre-selection based on titles; (5) selection based on titles and abstracts; (6) categorization of selected studies; (7) analysis and interpretation of results; and (8) presentation of the review and synthesis of knowledge[7].

Inclusion criteria comprised: studies addressing the health of sign-language-using deaf women; publications discussing communication barriers and accessibility in healthcare services for deaf women; full-text studies indexed in scientific databases; and articles published in any language with no restriction on publication date. Exclusion criteria were: studies addressing deafness and health without specific focus on deaf female populations; research involving deaf individuals who do not use sign language (e.g., oralized deaf persons); duplicate articles or those unavailable in full text.

The search was independently conducted by two researchers in the Virtual Health Library (Bib-

lioteca Virtual em Saúde – BVS) via the CAPES Journal Portal (Periódicos CAPES). The search strategy was built from the research question and used the broad terms "deaf woman AND sign language" to capture studies describing specific strategies related to deaf women's health. The number of articles retrieved, the selection process, and the main lines of research were organized into tables to facilitate evaluation and discussion.

Results

Initially, 30 articles were retrieved from the Virtual Health Library (BVS). After removal of duplicates and screening by title and abstract, 11 studies met the eligibility criteria and were analyzed in full. The selection process and the number of studies included are illustrated in the flowchart (Figure 1).

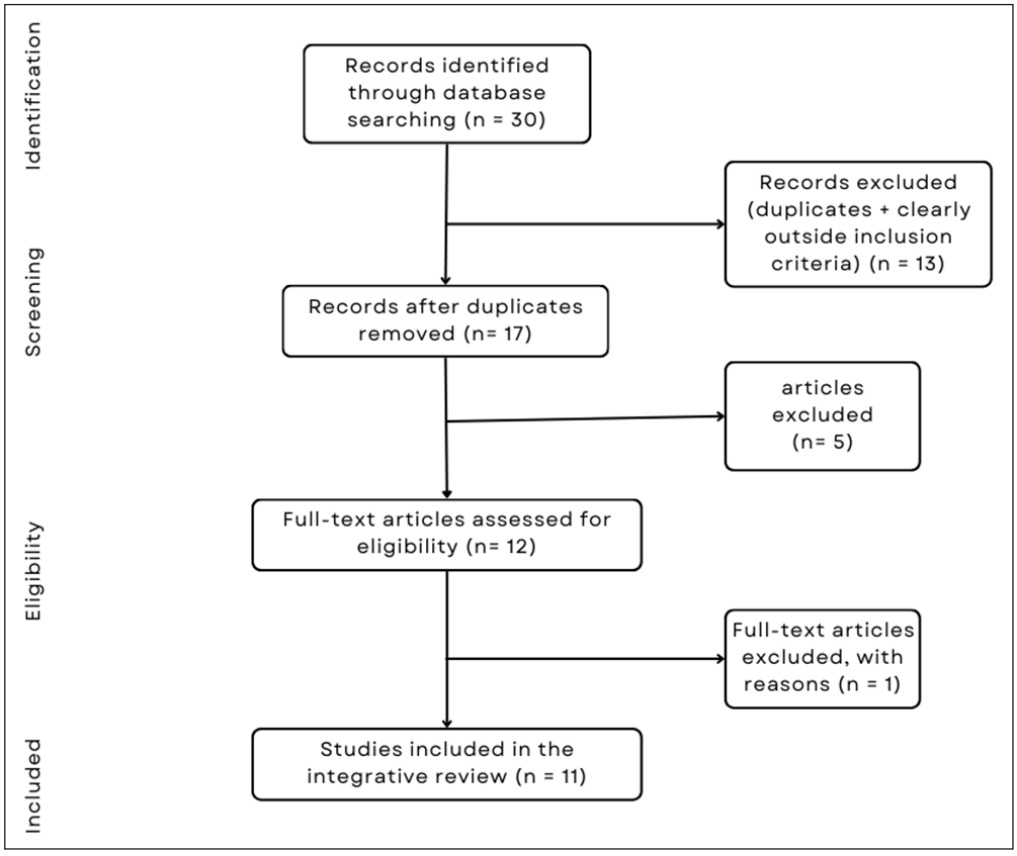

Figure 1. Strategy for article selection

Regarding the characteristics of the selected studies, qualitative designs predominated (n=8), followed by diagnostic/evaluative studies (n=4), clinical practice guidelines (n=2), screening studies (n=2), one evaluation study, one observational study, and one risk-factor study.

Three studies were in English, three in Portuguese, three in French, and one in Spanish; all were conducted in countries where these are official languages, except for one English-language study carried out in non-English-speaking countries. During full-text reading, additional checks were performed to exclude remaining duplicates or articles that ultimately fell outside the scope of this review (Chart 1).

Chart 1. Articles about deaf women and health

Title, Authors, Country, Year	Objective	Study Design	Main Findings
Knowledge of contraceptive methods among deaf women: a qualitative study. Barbosa et al. Brasil, 2024	To examine deaf women's understanding of contraceptive methods.	Qualitative descriptive study .	Communication barriers were the main factor associated with low knowledge of contraceptive methods.
A Bespoke Social Network for Deaf Women in Ecuador to Access Information on Sexual and Reproductive Health. Robles-Bykbaev et al. Equador, 2019.	To evaluate the quality, content, methodological coherence, efficacy, and recommendations of a mobile application developed for deaf women.	Qualitative ethnographic study	The app proved capable of informing future policy, practice, and research initiatives for creating sexual and reproductive health content for deaf women on social media platforms.
Aotearoa New Zealand Deaf women's perspectives on breast and cervical cancer screening. Payne et al. Nova Zelandia, 2023.	To investigate the experiences of women with physical/sensory disabilities when accessing breast and/or cervical cancer screening services in Aotearoa New Zealand and to identify barriers encountered.	Interpretive descriptive qualitative study	Breast and cervical cancer screening experiences for deaf women can be significantly improved through staff awareness of Deaf culture and the use of New Zealand Sign Language (NZSL) interpreters.
Awake Craniotomy for a Left Pan-Hippocampal Diffuse Low-Grade Glioma in a Deaf and Mute Patient Using Sign Language. Po-An Chen et al. Taiwan, 2020	To report the case of an awake craniotomy in a native deaf patient diagnosed with a left pan-hippocampal tumor, using sign language for intraoperative communication.	Case report	The use of sign language for intraoperative monitoring proved feasible and effective in a deaf patient.
Acolher e escutar o silêncio: o cuidado de enfermagem sob a ótica da mulher surda durante a gestação, parto e puerpério Costa et al. Brasil, 2018	To identify deaf women's perceptions of nursing care during pregnancy, childbirth, and the postpartum period.	Qualitative descriptive-exploratory study	Deaf women face significant difficulties in perinatal nursing care due to professionals' lack of sign-language skills, absence of interpreters, excessively rapid speech, and mask-wearing that prevents lip-reading.
Sign language aphasia from a neurodegenerative disease. Falchook et al. Estados Unidos da América, 2013.	To describe and analyze the first reported case of Alzheimer's disease affecting language in deaf individuals who communicate through sign language.	Case report	Assessing degenerative dementia in a deaf patient was challenging; diagnosis confirmed impairment of both episodic and semantic memory.
Évaluation des actions favorisant l'accessibilité aux soins des patientes enceintes sourdes. Equy et al. França, 2012.	To assess the management of pregnant deaf women who use French Sign Language and to propose potential improvements.	Descriptive retrospective study	Significant adaptations occur in scheduled appointments and inpatient care, whereas adaptation remains poor in emergency situations.
Reproductive Justice for the Deaf Community. Panko et al. Estados Unidos da América, 2022	To highlight, based on the literature, the disparities faced by deaf women compared with hearing women and to advocate for the link between unintended pregnancy, its adverse outcomes, and reproductive injustice for deaf women.	Case report – autoethnography	Deaf women are more likely to rely on condoms for contraception. Health resources and physician communication are frequently inaccessible (resources are often spoken or written English; physician encounters lack sign-language interpreters).

Title, Authors, Country, Year	Objective	Study Design	Main Findings
Accessibility of deaf women to the public health system of the Basque Country (Spain) Luengo-Rubalcaba et al. Espanha, 2019	To explore the perceptions and experiences of deaf women regarding accessibility within the Basque Public Health System (Osakidetza).	Qualitative study with an exploratory-descriptive design	Multiple barriers hinder deaf women's access to the health system, constituting a form of health injustice that violates their fundamental rights.
'They Forget I'm Deaf': Exploring the Experience and Perception of Deaf Pregnant Women Attending Antenatal Clinics/Care. Adigun e Mngomezulu. Nigeria, 2020	To explore the experiences and satisfaction of pregnant deaf women with prenatal care in Nigeria.	Qualitative descriptive study	The main reasons for delayed prenatal care were communication barriers during visits, distance/location of clinics, lack of knowledge about available services, and financial issues.
Deaf Women's Health: Adherence to Breast and Cervical Cancer Screening Recommendations Kushalnagar, et al. Estados Unidos da América, 2019	To determine whether disparities in cancer-screening adherence persist for deaf women compared with the general population and whether racial/ethnic disparities exist among deaf women.	Retrospective descriptive epidemiological study	Hearing women showed significantly higher adherence to Pap smears and breast-cancer screening than deaf women. After adjustment, disparities persisted for cervical-cancer screening but not for breast-cancer screening. Race/ethnicity was not associated with screening adherence.

Discussion

The *Convention on the Rights of Persons with Disabilities* (ONU, 2006) states that communication includes languages, display of text, Braille, tactile communication, large print, accessible multimedia, as well as written, audio, plain-language, and augmentative and alternative modes, means and formats of communication — including spoken and signed languages[8]. Discrimination on the basis of disability is defined as any distinction, exclusion or restriction that has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise of human rights and fundamental freedoms, including the denial of reasonable accommodation — understood as necessary and appropriate modification and adjustments that ensure accessibility without imposing a disproportionate or undue burden.

International conventions establish commitments and rules that signatory states are obliged to follow. In this regard, the present review highlights, based on the scientific literature, the health vulnerabilities experienced by deaf women and once again underscores the urgent need for healthcare teams to be able to communicate in sign language and for the systematic presence of qualified Brazilian Sign Language (Libras) interpreters in healthcare settings. The analyzed studies revealed three recurring problem areas, organized into the following thematic categories: communicative vulnerability; informational and educational vulnerability; and reproductive and systemic vulnerability.

Communicative Vulnerability: Linguistic Barriers and Exclusion in Interactions with Healthcare Services

This category addresses the absence of linguistic accessibility as a central mechanism of exclusion for deaf women, affecting both access to and continuity of care in healthcare services. Key issues include the lack of professionals fluent in Brazilian Sign Language (Libras), the purely theoretical (and often elective) teaching of Libras in most Brazilian health-related undergraduate programs—with the notable exception of Speech-Language Pathology—the unavailability of interpreters in emergency settings, and the widespread use of untrained intermediaries (family members or friends). These practices effectively deny deaf women their right to effective communication. Far from being isolated incidents, such barriers are structural and accom-

pany the deaf woman throughout every stage of care, from triage to clinical procedures.

A recurring theme across the reviewed studies was the communication barrier itself[9–14], which manifests in every healthcare setting sought by deaf women, from the moment they enter the facility.

Costa et al.[3] reported that the deaf women interviewed experienced significant communication difficulties during healthcare encounters, primarily due to professionals' lack of Libras skills and the team's inability to manage emotional stress in pregnant deaf women or those in labor[3]. Participants described nurses who could not understand sign language and who displayed impatience. One woman recounted a nurse becoming irritated during delivery because of the "noise" the patient made, while another described being unable to understand breastfeeding instructions provided at a health post[3].

Research highlights multiple obstacles to effective Libras instruction (treated as an L2) in both health sciences and teacher-training programs, including insufficient contact hours and the elective status of the subject[15–16]. A national survey of Libras training among health professionals in Brazil revealed a substantial deficit: of 5,317 programs identified, only 2,293 (43.1%) offered a Libras course, of which just 16.7% were mandatory and 83.3% elective. Course duration ranged from 20 to 80 hours, with the 80-hour load present in only 0.5% of programs[17]. Although the inclusion of Libras in curricula—even as an elective—represents an important achievement, it has not translated into genuine inclusion. Health professionals continue to struggle to understand Deaf identity and specific characteristics, as well as to establish effective communication in Libras[9].

Another major challenge is the strict time limitation of appointments[9]. When communication occurs in Libras, explanations often require greater detail because of the language's own grammatical and discursive structure. In the absence of a qualified interpreter, consultations become exhausting for both patient and provider[12]. This problem is exacerbated in emergencies, where the primary channels for requesting help—SAMU (emergency medical service), fire department, hospitals, or Urgent Care Units (UPAs)—remain telephone-based, effectively blocking rapid access to information and services.

Research conducted by Gallaudet University[18] shows that communicative vulnerability in deaf women often intersects with other axes of inequality, such as ethnicity and socioeconomic status, producing compounded exclusion and low treatment adherence. The same study demonstrates that higher levels of health education are associated with self-care behaviors and improved well-being[19]. Thus, lower educational attainment, communicative barriers, and differences in social class and ethnicity amplify inequities and cause greater harm within the deaf female population.

Healthcare professionals have an ethical and legal duty to convey diagnostic and treatment information clearly, as this is a patient right[20]. However, the linguistic mismatch between Libras and Portuguese can render diagnoses or treatments ineffective, with neither party fully understanding the other. For example, a provider may offer guidance that does not address the patient's actual complaint because of mutual incomprehension. This dynamic contributes to a common experience among deaf individuals: feeling marginalized by society and by public policies that remain indifferent to their communication and accessibility needs[20].

Equy et al.[21] emphasized that, during interviews, deaf women reported being able to secure sign-language interpreters for scheduled appointments when requested in advance. In emergency situations, however, access was severely limited because 24-hour on-call interpreter services are still unavailable in most hospitals.

The shortage of qualified interpreters is frequently "filled" by family members or friends who assume interpreting roles. Silva and Menezes[22] note that these individuals lack the necessary training, leading to communication errors that compromise care quality and can even jeopardize medical procedures. Although offered voluntarily, such informal mediation often causes discomfort, interruptions, and serious clinical consequences[22].

It is worth highlighting that since 2010, Law 12.319 (updated by Law 14.704/2023) has regulated the profession of Brazilian Sign Language translator-interpreter. The legislation aims to ensure more accessible and dignified care for the deaf population, yet effective implementation continues to face obstacles—particularly regarding professional training, adequate service provision in health facilities, and societal awareness of the interpreter's role[23].

Informational and Educational Vulnerability: The Invisibilization of Deaf Women's Health Needs

This category highlights how hearing loss, combined with low health literacy and a history of educational exclusion, severely limits deaf women's knowledge of their own bodies, contraceptive methods, sexual and reproductive health, and disease prevention. The absence of accessible public-health campaigns, materials in sign language, and inclusive educational initiatives perpetuates misinformation and widens the gap between deaf and hearing women—especially on sensitive topics such as family planning, preventive screenings, and chronic disease management.

Accordingly, this category examines women's health broadly[18],[14–13] while centering the specific needs of deaf women. Studies by Kushalnagar et al., Panko, and Falchook et al. emphasize that deafness is a critical factor influencing multiple dimensions of women's health, including access to preventive screenings, treatment adherence, and mental health[18],[14–13]. Kushalnagar et al.[18] demonstrate that communication barriers and the lack of appropriate informational materials reduce the uptake of preventive examinations, thereby compromising overall health outcomes. Panko[14] further notes that many deaf women are at higher risk of unintended pregnancy due to inadequate knowledge of effective contraceptive methods—an issue directly linked to the absence of accessible prevention campaigns targeted at this population.

These findings underscore the urgent need for inclusive, deafness-adapted health policies and practices. One notable example[19] showed a significant increase in breast-cancer awareness among deaf women after the release of campaigns delivered in American Sign Language (ASL).

Kushalnagar et al. and Robles-Bykbaev[18],[11] observed that deaf women possess markedly lower levels of sexual and reproductive health knowledge compared with their hearing peers, reflecting diminished health literacy on these topics. Robles-Bykbaev[11] developed a customized social-network platform to provide deaf women with sexual and reproductive health information. During the translation and adaptation process, the deaf consultants involved revealed substantial knowledge gaps, further illustrating the informational inequity between deaf and hearing women.

Payne's[12] questionnaire-based study highlights the critical importance of healthcare professionals' ability to communicate in sign language. One participant described a mammography appointment in which the radiologist understood some gestures but not actual sign language. At key moments, the provider could not comprehend the patient, who—because of the physical positioning required for the exam—was unable to report pain she was experiencing. Adequate communication would have prevented this situation.

Deaf men and women face similar communication challenges in healthcare settings. Falchook et al.[13] present the case of a deaf woman diagnosed with aphasia and Alzheimer's disease, illustrating the diagnostic barriers encountered by both physician and patient. Similarly, Chen et al.[24] describe a craniotomy to remove a brain tumor in a deaf woman, emphasizing the team's efforts to establish effective communication through a qualified sign-language interpreter. These cases demonstrate the need to ensure accessible information across all medical specialties. Although research on deaf women's health often focuses on the reproductive period, women's health extends far beyond reproduction and encompasses numerous other conditions that likewise require communicative accessibility.

Taken together, these factors perpetuate the marginalization of deaf women—first by society at large and subsequently by the healthcare system itself. Settings that should offer welcoming, informative, and competent care instead become spaces of embarrassment and misinformation. Responsibility for establishing effective communication is frequently shifted onto deaf women, whereas in reality it is the healthcare team's duty to guarantee clear, assertive, and humanized interaction.

Reproductive and Systemic Vulnerability: Inequities in Gestational and Reproductive Healthcare

This category encompasses the multiple forms of neglect and inequity that affect the reproductive health of deaf women. Lack of welcoming prenatal care, professional unpreparedness to care for deaf pregnant women, delayed initiation of prenatal monitoring, limited knowledge of family planning, and the persistent insistence on exclusively oral communication all reinforce an exclusionary healthcare system. This vulnerability is systemic:

it originates in childhood through a medicalizing perspective that is conveyed by healthcare professionals to families from the moment a deaf girl is born and persists throughout her life.

Health vulnerability is particularly intensified for deaf women during the gestational-reproductive period, affecting not only their physical and mental health but also their social and economic well-being[25].

Studies show that these vulnerabilities can be grouped into several domains, most notably the absence of adequate prenatal and postpartum follow-up, which jeopardizes the safety and well-being of both mother and child. This situation is not exclusive to deaf women but is embedded within a broader context of unequal access to healthcare that frequently translates into inequity[26–27]. Such inequities arise from power relations that distribute health resources, goods, and services unevenly, producing disparities in health status and risk levels across population groups[28–29].

Inequalities are often reflected in clinical conditions, varying risk levels, and unequal access to health-system resources. In prenatal care, the primary goals are to ensure healthy fetal development, a safe delivery for the mother, and the newborn's survival. Prenatal care also encompasses psychosocial aspects and educational/preventive activities that are essential for maternal well-being[28].

However, evidence indicates that deaf women do not receive the same level of prenatal and postpartum care as hearing women. Studies[3,30,6,10] show that communication is one of the most critical factors—especially in a first pregnancy—followed closely by healthcare teams' lack of preparation, which stems directly from insufficient knowledge of Deaf identity and culture.

Since 2005, the Brazilian Ministry of Health has recommended that prenatal care begin early, ideally by 12 weeks of gestation, as a key quality indicator[28]. Yet Adigun and Mngomezulu[6], reporting from Nigeria, found that deaf women frequently initiate prenatal care late owing to accessibility and communication barriers. The same study noted that these women often travel long distances to find sign-language-accessible services, with low socioeconomic status serving as an additional factor delaying care.

Costa et al.[3] further revealed that many deaf women were single mothers, underscoring the absence of tailored family-planning strategies for this population. Although Brazil's Family Planning Policy is universally available, deaf women frequently do not seek these services due to lack of awareness or encounter communication barriers when they do[31,10]. The depth of this problem is illustrated by Barbosa et al.[10]: when attempting family-planning counseling, providers found that most participants did not understand the concept of pregnancy planning or methods to prevent it and were unfamiliar with the term "reproductive planning." When the topic was raised, the women spoke about family dynamics and communication barriers but did not mention contraceptives[10].

These access disparities and the mismatch between available services and deaf women's actual needs highlight the urgent necessity of adjusting public health policies—particularly with regard to communicative accessibility and family planning—so that deaf women can receive comprehensive, appropriate care throughout pregnancy and the postpartum period.

The accounts reviewed make clear that, in most cases, Brazilian healthcare professionals are trained to serve only hearing patients, resulting in care that lacks dignity and safety for both deaf women and their children, since essential information is not conveyed adequately.

It is worth emphasizing that professional unpreparedness often begins in childhood. Cruz and Quadros[32] argue that physicians and speech-language pathologists continue to rely on outdated, ineffective methods for language acquisition, thereby perpetuating oralism—an approach that, as this review demonstrates, still permeates other areas of healthcare.

Conclusion

This integrative review clearly demonstrates that deaf women face significant barriers when accessing healthcare services, primarily related to the lack of accessible communication and appropriate health information. Regardless of geographic location or the specific sign language used, deaf women encounter strikingly similar difficulties across prenatal care, routine consultations, preventive screenings, and emergency services.

The recurrent absence of qualified sign-language interpreters and the inadequacy of informational materials consistently compromise care quality. These problems are further exacerbated

by the impatience and occasional disqualification displayed by some healthcare professionals. Overcoming these barriers requires the effective implementation and enforcement of public policies that promote ongoing training of health professionals in Brazilian Sign Language (Libras), the systematic inclusion of qualified interpreters in healthcare settings, and the production of fully accessible educational resources. Only then will the right to health—guaranteed to deaf women under Law 10.436/2002[5]—be truly upheld, ensuring dignified, high-quality, and continuous care.

Positive initiatives already exist in Brazil. Under the leadership of the Ministry of Human Rights and Citizenship, several regional sign-language interpreter centers have been established. A noteworthy example is the Central de Interpretação de Libras in Goiânia, managed by the Municipal Secretariat of Human Rights and Affirmative Policies (SMDHPA), which provides Portuguese ↔ Libras interpretation for health, justice, and civil-documentation services, thereby supporting linguistic rights and social inclusion[33].

Promising legislative advances are also underway. Bill 1752/2022 authorizes the presence of Libras interpreters in hospitals and clinics to accompany deaf patients requiring medical care[34], while Bill 342/2024 mandates that medium- and large-sized hospitals maintain at least one on-duty or on-call Libras interpreter in emergency and urgent-care departments[35]. Both proposals represent significant progress. As Silva and Menezes[22] and Equy et al.[21] have shown, families frequently shoulder the burden of informal interpretation; transferring this responsibility to healthcare institutions—especially in emergencies—would substantially reduce the financial and logistical burden currently placed on deaf individuals.

Finally, this review noted that most included studies were authored by hearing researchers and, predominantly, by men. The scarcity of research conducted from a deaf and/or female perspective underscores the need to amplify deaf women's own linguistic and cultural experiences in order to deepen understanding of their health realities. Moreover, the limited body of literature addressing the full spectrum of deaf women's health reveals that women's healthcare extends far beyond physiology—it encompasses social, cultural, and identity dimensions that demand greater academic and policy attention.

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