Research Article
Artigo de Pesquisa
Artículo de Investigación

DOI: https://doi.org/10.12957/reuerj.2025.88440

# Main communication barriers faced by deaf women during labor

*Principais barreiras comunicacionais enfrentadas pela mulher surda durante o trabalho de parto*

*Principales barreras de comunicación que enfrentan las mujeres sordas durante el trabajo de parto*

*Gabriela Claudio dos Santos*[I]; *Amuzza Aylla Pereira dos Santos*[I]; *Ivanise Gomes de Souza Bittencourt*[I]; *Maria Elisângela Torres de Lima Sanches*[I]; *Alisson Rodrigo Silva de Lima*[I]; *Gessica Vanessa de Oliveira Machado*[I]

[I]*Universidade Federal de Alagoas. Maceió, AL, Brazil*

**ABSTRACT**

**Objective:** to identify the main communication barriers detected by deaf women during childbirth care. **Method: a** qualitative, exploratory and descriptive study was conducted with eight deaf women in two services specialized in the care of people with special needs, located in a city from Alagoas. After due approval by the Research Ethics Committee, semi-structured interviews were conducted between June and September 2024. The data were analyzed through content analysis. **Results:** the deaf women reported difficulties establishing assertive communication with health professionals during childbirth due to them not knowing the Brazilian Sign Language, to absence of an interpreter in the hospital context, to the need for their companion to act as interlocutor in communication, and to mask use. **Conclusion:** communication barriers prevented effective communication between professionals and deaf parturients, which has been shown to affect these women's ability to understand and have autonomy over their role within the birth process.

**Descriptors:** Women's Health; Labor, Obstetric; Nursing Care; Communication Barriers; Deafness.

**RESUMO**

**Objetivo:** identificar as principais barreiras de comunicação detectadas pela mulher surda durante a assistência ao parto. **Método:** estudo qualitativo, exploratório, descritivo, realizado com oito mulheres surdas em dois serviços especializados no atendimento de pessoas com necessidades especiais, localizados em um município alagoano. Realizou-se entrevistas semiestruturadas, entre junho e setembro de 2024, após aprovação do Comitê de Ética em Pesquisa. Os dados foram analisados por meio da análise de conteúdo. **Resultados:** as mulheres surdas relataram dificuldades em estabelecer uma comunicação assertiva com os profissionais de saúde durante o parto devido a falta de conhecimento deles sobre a Língua Brasileira de Sinais, a ausência do intérprete no contexto hospitalar, o acompanhante como interlocutor na comunicação e o uso da máscara. **Conclusão:** as barreiras comunicacionais impediram a comunicação efetiva entre profissional-parturiente surda, que demonstrou afetar a capacidade de compreensão e autonomia dessas mulheres sobre o seu papel dentro do processo de parturição.

**Descritores:** Saúde da Mulher; Trabalho de Parto; Cuidados de Enfermagem; Barreiras de Comunicação; Surdez.

**RESUMEN**

**Objetivo:** identificar las principales barreras de comunicación detectadas por las mujeres sordas durante la atención del parto. **Método:** estudio cualitativo, exploratorio, descriptivo, realizado con ocho mujeres sordas en dos servicios especializados en atención a personas con necesidades especiales, ubicados en un municipio de Alagoas. Las entrevistas semiestructuradas se realizaron entre junio y septiembre de 2024, previa aprobación del Comité de Ética en Investigación. Los datos fueron analizados mediante análisis de contenido. **Resultados:** las mujeres sordas relataron dificultades para establecer una comunicación asertiva con los profesionales de la salud durante el parto debido al desconocimiento de la Lengua de Señas Brasileña, la ausencia de intérprete en el contexto hospitalario, el acompañante como interlocutor en la comunicación y el uso de mascarilla. **Conclusión:** las barreras de comunicación impidieron una comunicación efectiva entre el profesional y la mujer sorda en trabajo de parto, lo que demostró un impacto en la capacidad de estas mujeres para comprender y ser autónomas sobre su papel en el proceso de parto.

**Descriptores:** Salud de la Mujer; Trabajo de Parto; Atención de Enfermería; Barreras de Comunicación; Sordera.

## INTRODUCTION

Communication is a fundamental tool for building human relationships[1], and therefore essential to establish professional-patient relationships. Therefore, from a health perspective, communication is even more important because it is one of the main health professionals' instruments have at their disposal to ensure care directed to the patients' needs[1].

For example, during childbirth (a unique event in every woman's life and surrounded by great vulnerability), communication between health professionals and patients is of fundamental importance so that their wishes and rights

Autora correspondente: Amuzza Aylla Pereira dos Santos. E-mail: amuzza.santos@gmail.com
Editora Chefe: Cristiane Helena Gallasch; Editora Científica: Juliana Amaral Prata

Received: Dec 6th 2024 – Accepted: Apr 11th 2025

Research Article
Artigo de Pesquisa
Artículo de Investigación

DOI: https://doi.org/10.12957/reuerj.2025.88440

are listened to and guaranteed[1]. However, deaf pregnant women experience some deficit in this communication, generating apprehensions that sometimes interfere with success of their pregnancies, which shows certain weakness in the care provided to these women[2].

It is important to note that deafness is characterized by minor or major loss of the normal ability to perceive sounds. It is divided into four different degrees: mild, moderate, severe and profound, which are described according to the amount of decibels that are imperceptible to each person[3]. According to the latest census by the Brazilian Institute of Geography and Statistics (*Instituto Brasileiro de Geografia e Estatística*, IBGE), there are more than 9.7 million deaf people in Brazil, which confirms the need to sharpen our attention to society's communication process with this population group[4].

As well as for all deaf people, access to healthcare for deaf women during their pregnancy and childbirth has been ensured since Law No. 10,436 was approved on April 24th, 2002, proposing the implementation of Brazilian Sign Language in public health institutions in order to guarantee adequate care and treatment for this population segment[2].

Furthermore, as well as the Unified Health System (*Sistema Único de Saúde*, SUS) principles and guidelines in Brazil mentioned above by Law No. 8,080 of September 19th, 1990, Article 196 of the 1988 Federal Constitution establishes that health is a right for all and that access to it must be universal and equal, respecting each person's specificities and guaranteeing the people assisted the right to due information about their health[5,6]. However, even in the face of these achievements, the deaf community still suffers significantly from communication barriers, non-training of professionals and prejudices from society as a whole[3].

Thus, considering the difficulties in communication between health professionals and deaf women in labor, the vulnerability to which these women are exposed during the intrapartum period, as well as the scarcity of scientific evidence discussing the communication process between health teams and deaf women as a determining factor for childbirth, the research has the following guiding question: Which barriers face deaf women in labor when communicating with Nursing teams? The objective is to identify communication barriers between professionals and patients and their impacts on the childbirth experience for these women.

## THEORETICAL FRAMEWORK

The study was based on the Comprehensive care theoretical framework. Comprehensive care arises through the construction of a positive relationship between users, professionals and institutions. When effective, its practice emerges from the clash of many social voices that seek to understand and discuss the health needs that are identified through care provision[7].

In this sense, comprehensiveness acts as a political device capable of criticizing the knowledge and powers responsible for care through an analysis of social arrangements and health institutions. Therefore, by using the theory, the objective is to understand deaf women's health demands, analyzing the practices implemented in health institutions, as well as their effects and repercussions on the life of this community[7].

## METHOD

This is a qualitative, exploratory and descriptive study based on the comprehensive care assumptions[7,8], observing the quality criteria for qualitative research articles (COREQ).

The research was conducted at two public services specialized in assisting people with disabilities and other special needs, located in a capital city from northeastern Brazil. The study participants were deaf women who had given birth in a hospital and met the previously established inclusion criteria. Nine deaf mothers who received services from the aforementioned specialized units were contacted; however, one of them was unable to participate in the study due to health issues. This left eight women in the total sample.

The following inclusion criteria were considered: being a deaf woman; having experienced childbirth in a hospital institution; and being over 18 years old. Deaf women that were not literate in both languages of the study (Portuguese and Brazilian Sign Language) and/or who had some previously diagnosed cognitive-behavioral deficit that prevented them from answering the research form were excluded.

Data collection was conducted from June to September 2024 with one of the researchers applying a semi-structured form, using the interview technique.

DOI: https://doi.org/10.12957/reuerj.2025.88440

So as to test the collection instrument, two interviews were conducted as a pilot test to adjust the form, if necessary. After the interviews and data transcription, it was noticed that some adjustments were required to meet the objective proposed.

The interviews were conducted both in person and online (via video calls on the *WhatsApp* platform) after signing the Free and Informed Consent Form (FICF). The script was divided into two parts: the first one focused on sociodemographic, economic and educational data, and the second one dealt with questions related to obstetric clinical data.

The women were recruited for convenience and were approached in person at the research *loci* and invited to a private location to answer the interview. In addition, telephone contacts were made with the women that were not present at the service *locus* but who were covered by it, inviting them to participate in a timely manner.

The interviews were translated instantly by Libras interpreters and audio-recorded using a cell phone, to be later transcribed. The data collected were analyzed according to Bardin's Content Analysis technique[9], for which three phases were established: Pre-analysis, where the material collected is analyzed through skimming in order to build the research *corpus*; Exploration of the material, with text clippings in categorization and coding units so that they can be recorded; and finally, Treatment of the results obtained and their interpretation, which takes place by organizing the results[10].

Regarding the Pre-analysis, the media files containing the interviews were transcribed in full using Microsoft Excel 2017® and ordered according to the participants and the answers corresponding to each question in the script. Subsequently, the material was skimmed and the text *corpus* was then prepared using Microsoft Word 2017®.

The material was explored through exhaustive reading of the interviews and the text *corpus*, in addition to analyzing and associating text segments from the text *corpus* using the Iramuteq software[11]. After identifying common ideas among the participants' statements, a category was determined: Communication barriers and coping strategies.

Regarding the ethical aspects, the data were collected with due authorization from the management of the research *loci*, as well as with permission and assessment of the Research Ethics Committee belonging to a Public University in the state of Alagoas on May 29th, 2024. In addition, it was also necessary for deaf women to voluntarily agree to participate in the research and, thus, sign the FICF in two identical copies, which contained the appropriate clarifications that guaranteed the participants the right to withdraw from the research without this causing them any harms or penalties. The FICF was translated by Libras interpreters so that any doubts in understanding the information could be clarified.

To ensure confidentiality and anonymity, the participants were coded by the letter P, all followed by an algorithm according to the order of the interviews (P1, P2, P3, P4, P5, P6, P7 and P8).

## RESULTS

Eight deaf women aged between 30 and 44 were interviewed, with only one participant considered oral deaf. The term “oral deaf” refers to deaf people who use oral language as a communication means. Oral deaf people have the ability to both speak and read lips, and their native language is usually their mother tongue[12]. Regarding race/skin color, six women declared themselves brown-skinned and two whit-skinned. As for schooling level, the majority stated not having completed Elementary School.

In terms of occupation, five participants reported being unemployed, two worked as Libras teachers and one was a young apprentice. In relation to family income, three women reported earning up to 1 minimum wage; one, from 1 to 2 minimum wages; another one, from 2 to 5 minimum wages; and three did not know how to answer.

Regarding Brazilian Sign Language, all deaf women were fluent and used it as their first language (Figure 1).

Research Article
Artigo de Pesquisa
Artículo de Investigación

DOI: https://doi.org/10.12957/reuerj.2025.88440

| Participant | Age | Marital status | Schooling level | Main language | Libras literacy *locus* |
|---|---|---|---|---|---|
| 1 | 33 | Single | Incomplete Elementary School | Libras | Educational institution |
| 2 | 44 | Married | Incomplete Elementary School | Libras | No answer |
| 3 | 38 | Married | Incomplete Elementary School | Libras | Educational institution |
| 4 | 36 | Divorced | Complete Higher Education | Libras | Educational institution |
| 5 | 36 | Single | Incomplete Higher Education | Libras | Family environment |
| 6 | 30 | Stable union | Complete High School | Libras | In touch with the deaf community |
| 7 | 39 | Single | Incomplete Elementary School | Libras | In touch with the deaf community |
| 8 | 37 | Married | Incomplete High School | Libras | Educational institution |

**Figure 1:** Characterization of the participants in relation to socioeconomic data, Maceió, AL, Brazil, 2024.

Most of the deaf women stated having no chronic diseases. Among those who reported them, they mentioned hypertension (n=2), followed by diabetes *mellitus* (n=1). Most them also denied having had complications during pregnancy; among those who did, they reported chronic hypertension with complications (n=1) and chronic diabetes with complications (n=1), both during pregnancy.

Regarding prenatal care, all deaf women in the study reported having received follow-up assistance, and two of them stated having been offered it in a high-risk unit. However, all deaf women reported that communication during prenatal care was not effective due to the professionals' non-fluency in Libras. The characterization related to labor is presented in Figure 2.

| Participant | Type of delivery | Childbirth year | Companion's fluency in Libras | Delivery room professionals' fluency in Libras | Presence of a sign language interpreter in delivery room |
|---|---|---|---|---|---|
| 1 | C-section | 2013 | Fluent | Not fluent | No |
| 2 | C-section | 2001 | Not fluent | Not fluent | No |
| 3 | Vaginal | 2010 | Not fluent | Not fluent | No |
| 4 | C-section | 2021 | Not very fluent | One scarcely fluent medical professional | No |
| 5 | Vaginal | 2019 | Not very fluent | Not fluent | No |
| 6 | C-section | 2003<br>2008 | Fluent | Not fluent | No |
| 7 | Vaginal<br>C-section | 2012<br>2014 | Not very fluent | Not fluent | No |
| 8 | C-section | 2018<br>2021 | Not very fluent | Not fluent | No |

**Figure 2:** Characterization of the participants regarding delivery data and fluency in Libras, Maceió, AL, Brazil, 2024.

As for childbirth, C-section was identified as the most prevalent method among the deaf women participating in the study. It is worth noting that the births took place at different chronological times, ranging from 2001 to 2021. Regarding birth place, all reported having experienced it in a public hospital.

Referring to the childbirth conditions, all deaf women reported having a hearing person as a companion, among whom the majority were little or not fluent in Libras. Regarding the professionals in the delivery room, most of the women stated that there were no professionals fluent in Libras during the care provided. Furthermore, all women reported that they did not have an interpreter in the delivery room.

To understand deaf women's perception about the communication process between professionals and patients and the impacts of non-communication during the pregnancy cycle (especially in the intra-partum period), the data were presented in a category: Communication barriers and coping strategies.

**Communication barriers and coping strategies**

This category concerns the communication barriers perceived by deaf women during childbirth and the strategies adopted by the professionals in an attempt to establish communication with the users.

All deaf women reported not having had effective communication with the nurses and physicians that monitored their prenatal care due to non-use of sign language, which was one of the main communication barriers:

Research Article
Artigo de Pesquisa
Artículo de Investigación

DOI: https://doi.org/10.12957/reuerj.2025.88440

> *There was no communication, he spoke, and I didn't understand, he tried to communicate, but he didn't know Libras, so he spoke, and I didn't understand anything. There was a person next to me who helped me, who knew Libras, but there was no communication with the nurse. (P8)*
>
> *I didn't know (Libras). There was no communication, just gestures. I don't like gestures. (P3)*

Regarding childbirth, in addition to highlighting lack of knowledge about the use of Libras among the nurses and physicians present in the delivery room, the deaf women also highlighted the prevalence of communication exclusively aimed at the hearing companion:

> *[...] Most people don't have this communication (in Libras). It's very difficult! (P6)*
>
> *My mother was speaking to the nurses, but I didn't understand anything because it wasn't in Libras, so it was very difficult for me. I just stayed silent, feeling pain, but no one tried to talk to me. (P3)*
>
> *Everything was my mother [...]. My mother talked to the doctor, only my mother talked to the doctor. I didn't interact, people talked there and that was it. My mother spoke to me. (P2)*
>
> *They didn't try to talk to me directly [...] only my mother was helping [...] I waited for them to solve what was happening. (P1)*

Deaf women also pointed out mask use by the professionals as a hindrance to the communication process because it interfered with them seeing the professionals' faces and, consequently, prevented orofacial reading by those who had this ability:

> *[...] I tried to read lips, but it was very difficult, they were usually wearing a mask. (P4)*
>
> *Sometimes I asked them to take off the mask [...] I needed them to take off their mask so they could talk to me [...] I didn't understand any of the explanations they tried to give me. I even got angry too, I always asked them to put the mask down and they put it back on. (P5)*

Another factor mentioned by deaf women in labor was the absence of a Libras interpreter in the hospital context, as this professional could be useful in mediating professional-patient communication:

> *There was no interpreter, so there was no communication [...] in hospitals it's necessary to have this professional [...] to know the explanations for everything that's happening, to be able to understand clearly. This type of monitoring by this professional is very important. (P5)*
>
> *It's very important to have an interpreter to provide information about pain, the medicine in the injection, and what's happening to the baby. People keep saying things verbally, and we get nervous without knowing what's happening, how the child is doing [...]. The nurse didn't know (Libras), so it's necessary to have an interpreter at that moment. (P4)*
>
> *It'd be very important to have a Libras interpreter in the delivery room for a deaf person, for a deaf woman, to know what's happening to this woman at that moment, to have correct monitoring, with accessibility [...] that's what I wanted to change, to have this communication in hospitals, in the various places we go to. It's very important, it's in the law! [...] I always need to have someone with me because there's no communication with the nurses and doctors. (P6)*

The deaf women participating in this study highlighted that lack of effective communication with nurses and physicians during the pregnancy cycle interfered with them understanding the childbirth dynamics and how they could contribute to the birth process:

> *It was very difficult; I had a hard time. [...] They didn't explain anything about the contractions. [...] I didn't know anything, and they didn't know how to explain, they didn't know how to help me at the time. [...] People spoke very quickly, and I couldn't understand anything. I went to another room at the delivery time to try if they could teach me how to do it [...], but they didn't teach me much, they just used gestures. [...] I didn't understand anything, then another doctor came to try to explain and made gestures. The nurse hadn't told me anything, it was the doctor that explained it to me [...]. One of them was able to explain it to me and the other wasn't, so it was very confusing. [...] It was necessary to have an explanation at that moment. I didn't understand anything. (P5)*
>
> *It was very difficult, I couldn't (understand). Lots of people, lots of people talking [...]. (P6)*

Lack of communication during childbirth also triggered negative feelings such as fear, anguish and worry:

> *I was in agony, worried, crying, afraid of dying, I cried a lot. I had no accessibility during my pregnancy [...]. (P8)*
>
> *People were looking: oh! Because she's deaf, she's pregnant! People were looking at me and I didn't understand. I was a little distressed, I thought I was weird. I felt really uncomfortable with those looks, really bad. (P4)*

Research Article
Artigo de Pesquisa
Artículo de Investigación

DOI: https://doi.org/10.12957/reuerj.2025.88440

Furthermore, the deaf women brought up situations in their testimonies that denote obstetric violence, such as restricting the presence of a companion and position and movement constraints:

> *I wanted to have someone with me at that moment because I'm deaf, but sometimes they wouldn't let my companion in. [...] I had some problem and couldn't call anyone to help me [...] and the nurse would leave, then disappear and another one would come back on another shift, it was difficult. (P6)*
>
> *They told me to sit down, open my legs, and lie down so the baby could be born. (P7)*

Regarding the strategies adopted by the professionals to approach the patients, the deaf women reported that nurses and physicians tried to speak, make gestures, mime and write in an attempt to establish communication:

> *[...] just gestures that they kept making, there was no communication at all. (P8)*
>
> *There was no communication, just gestures. I don't like gestures. (P3)*
>
> *They tried to speak orally, but I didn't understand any of the explanations they tried to give me. (P5)*
>
> *Sometimes they try to write [...] it's very difficult, I couldn't (understand). (P6)*
>
> *[...] it was just like some mime, that's all, there was no Libras. (P7)*

However, in the deaf women's testimonies, it can be noticed that using these strategies was not an effective form of communication, given that they were unable to understand the message conveyed.

## DISCUSSION

Based on the deaf women's reports, it was identified that there are communication barriers between them and the professionals involved in their birth process, with a focus on nurses and physicians, who are the professionals on the front line of this care.

The following stood out among the main communication barriers: the professionals not knowing Brazilian Sign Language; absence of a professional interpreter in the hospital context; companions as main interlocutors in communication; and mask use as an impediment to orofacial reading.

Regarding the professionals not knowing Brazilian Sign Language, all deaf women in this study reported not having had effective communication with the professionals in charge of their prenatal care due to not using Libras. Furthermore, 87.5% of the women highlighted that there was no professional fluent in this language during childbirth care.

Regarding the presence of a Libras interpreter, all deaf women participating in the study reported not having had this professional present during childbirth care, which interfered with their ability to establish assertive communication with the professionals for not having due command of the language.

Similar studies[2,13,23] corroborate the results of this research by identifying that deaf users perceive non-use of Libras by health professionals and absence of a Libras interpreter as the main communication barriers faced during health care, showing inefficiency in the care of this population segment, whose basic right to access information about their health is compromised, in addition to highlighting nursing professionals' deficient training of to meet these people's needs.

As established by Decree No. 5,626 of December 22nd, 2005, Libras is only a mandatory academic subject in Higher Education undergraduate courses and in Speech Therapy ones, distancing this topic from other courses in the health area (including Nursing) and creating an educational gap that exerts direct impacts on the training of these professionals[14].

However, it is the duty of the SUS and companies that provide public health care services to support the professionals' training and education in the use of Libras, so as to guarantee comprehensive health care for people who are deaf or have hearing impairments[14].

It is important to emphasize that not knowing sign language does not exempt professionals from their responsibility to ensure deaf people's rights. The Ministry of Human Rights and Citizenship has a program of Interpretation Centers linked to the states, the Federal District and municipalities that provides free services of Libras interpreters with the objective of promoting deaf people's access to communication with individuals or institutions that do not have command of Libras[15]. Thus, in the absence of professionals duly trained to provide services in Libras, these bodies must be contacted by health teams and/or unit managers to enable effective communication with the users.

Research Article
Artigo de Pesquisa
Artículo de Investigación

DOI: https://doi.org/10.12957/reuerj.2025.88440

In Brazil, the Brazilian Sign Language Translator and Interpreter profession is regulated by Law 12,319 of September 1st, 2010[16]. These professionals' main role is to make communication accessible, enabling dialogue between deaf and hearing people by using Libras. In the health area, their presence enables improvements in care quality because it enables better communication between professionals and patients[17].

Communication is one of the main tools used by health professionals to ensure assistance is directed at the patients' needs. In prenatal care, it not only reduces the risk of complications during pregnancy by identifying risk factors, but also contributes to the work of the team that will be in charge of the delivery room by preparing each woman to experience this moment[18].

When it comes to the birth process, in addition to improving it by promoting women's well-being and giving them the confidence they need to experience birth in a positive way, effective communication reduces the need for obstetric interventions[19]. On the other hand, in addition to having been shown to generate negative feelings during birth, lack of effective communication between professionals and patients due to the aforementioned communication barriers has also proved to interfere with deaf women's ability to understand and be autonomous about their role in the birth process.

It is noteworthy that the deaf women in this research experienced childbirth at different chronological times, ranging from 2001 to 2021. However, in this 20-year period, even with the passing of several laws that guarantee comprehensive health care for this community, including Law No. 10,436 of April 24th, 2002, and Decree No. 5,626 of December 22nd, 2005[14,20], as well as the Brazilian Law for the Inclusion of People with Disabilities through Law No. 113,146 of July 6th, 2015[21], no changes were perceived regarding care, given the similar discourse presented by deaf parturients, which shows ineffectiveness in applying the aforementioned laws.

In this study, it was observed that 73% of the pregnancies underwent by deaf women resulted in C-sections, indicating a trend for obstetric interventions in this population group, which may be associated both with the reduction in deaf women's ability to freely decide on the way they wish to give birth and with their non-preparedness to experience and contribute to the natural childbirth process due to the lack of information to which they were subjected throughout the pregnancy cycle, from prenatal care to the delivery room.

Lack of information makes women believe that all the procedures they are being subjected to are routine, favoring expropriation of the female body. In this sense, women in labor become submissive to behaviors they do not understand, but which they accept because they believe it is the best for them and their newborn[22].

In the current study, all deaf women had a hearing person as a companion and, despite having generated more confidence for the parturients and helped in the professional-patient interaction, presence of this person harmed deaf women's autonomy and protagonism, given that the professionals only addressed the companions.

Only 25% of the companions of the deaf women included this study were fluent in Libras; therefore, all the information and procedures were easily discussed between professionals and companions, but transfer of this information and inclusion of the deaf women in this communication process were hindered. Presence of these noises in communication with the deaf women meant that the companions assumed the role of main interlocutor, taking away these women's right to be the protagonists of their own childbirth.

The need for a third person to act as an interlocutor causes deaf people to lose privacy and independence. When the professionals talks directly to the companions instead of to the deaf patients, this prevents or nullifies the latter's participation in their own care[23].

The companions will not always know sign language well enough to act as interlocutor[23] and, even if they do master Libras, they do not play the interpreter role because this requires professional qualifications in order to minimally interfere with the message to be conveyed[17].

In an attempt to understand what was being said, the deaf women participating in the study who had lip reading skills tried to do so, but were unable to due to the professionals using masks.

Surgical masks are Personal Protective Equipment (PPE) aimed at protecting the professionals in the imminence of procedures that may culminate in splashes of blood or other bodily fluids on their ocular, nasal and oral mucosa[24]. However, use of this PPE interferes with seeing their face, preventing adherence to the orofacial reading strategy.

Research Article
Artigo de Pesquisa
Artículo de Investigación

DOI: https://doi.org/10.12957/reuerj.2025.88440

It is important to note that, although lip reading is a strategy used by deaf people, it is not a naturally acquired skill and, therefore, not all members of the community perform it. Furthermore, it does not prove to be a very efficient strategy, as several phonemes have a similar point of articulation that can influence erroneous or incomplete understanding of the information[25].

Regarding the communication strategies adopted by professionals during care, the deaf women participating in this study highlighted the predominant use of gestures/mimes followed by writing in Portuguese. Similar studies also demonstrate predominant use of these strategies by health professionals[13,25,26]. However, these methods have not been shown to guarantee any improvement in communication quality.

In all, 50% of the deaf women participating in this study had Incomplete Elementary School. Linguistic regression shows that the lower the schooling level, the greater the difficulty understanding written Portuguese[13]. In this case, the strategy of using written Portuguese can lead to distorted or incomplete interpretations of the messages, as well as to using gestures/mimes that do not take into account the linguistic system that is specific to sign language.

It is worth highlighting that lack of information, reduction of women's autonomy and absence or restriction of a companion, as well as position and movement constraints, which have all been evidenced in the testimonies of the deaf women in this study, are some of the different forms of obstetric violence.

Obstetric violence is defined as any act that causes harms to the physical and psychological integrity of pregnant women, women in labor or during the post-partum period, and can be perpetrate by hospital personnel, family members or companions[22]. All women are susceptible to experiencing this type of violence, especially during childbirth; however, those with low socioeconomic and schools levels are more predisposed[22].

In the case of deaf women, vulnerability is even more exacerbated due to the communication barriers they experience in their relationships with health professionals. It is to be noted that, when there is no effective professional-patient communication and women are not given adequate guidance, they are more likely to being subjected to this type of violence[27].

Nurses are the professionals who are constantly in contact with women in labor. Communication between women and these professionals is fundamental for recognizing their needs, as well as essential to recognize and minimize violence affecting women's sexuality and reproduction[28]. However, in the case of a deaf woman in labor, without using sign language, nurses will hardly be able to perform their role, offer humanized care and, therefore, free from violence.

In this sense, it is necessary that, nurses ease effective communication throughout the entire birth process by using sign language in order to guarantee humanized, comprehensive and equal care for deaf users, ensuring their right to have access to health information, to understand the procedures to which they will be subjected, to have their doubts clarified and, consequently, to be the protagonists of their own birth, allowing them to consciously choose the way they want to experience labor and the birth of their child.

**Study limitations**

In the scientific field, there are still few studies portraying deaf women's perspective on health care, which indicates the need to expand research in this area to understand the real needs of this population group, not only during pregnancy and childbirth, but throughout all life cycles.

It is worth noting that the study faced some limitations, such as the following: finding deaf women who had experienced childbirth in the aforementioned research *loci*; and the participants' low schooling levels, which may have contributed to a less rigorous assessment of their health care.

## CONCLUSION

The presence of communication barriers between Nursing/Medical professionals and deaf women during childbirth care was evidenced, due to the professionals not knowing Brazilian Sign Language, to absence of a professional interpreter in the hospital context, to the companion acting as main interlocutor in communication and to mask use as an impediment to orofacial reading by deaf women who had this ability.

In an attempt to promote communication with deaf women, the professionals used gestures/mimes, writing in Portuguese and verbalization; however, these strategies did not prove to be efficient in establishing effective communication.

Research Article
Artigo de Pesquisa
Artículo de Investigación

DOI: https://doi.org/10.12957/reuerj.2025.88440

In this sense, it is necessary for managers to ensure training and continued education of the health professionals that provide direct assistance to women in labor so that sign language use and dissemination is made viable, guaranteeing humanized, comprehensive and equal care and, thus, ensuring that deaf women experience labor and birth in a positive way.

Furthermore, it is essential that the Libras academic subject be included in the mandatory curricula of health courses so that all students, especially Nursing ones, are made aware as early as possible of the importance of using sign language to fully meet deaf people's health needs.

## REFERENCES

1. Trindade CD, Cardoso LS, Costa VZ da, Rosa LS, Pozzobon DM, Trindade LR, et al. Nursing Team: communication in pregnant women care. Braz. J. Hea. Rev. 2020 [cited 2024 Dec. 5]; 3(1):551-62. DOI: https://doi.org/10.34119/bjhrv3n1-043.
2. Ferreira DRC, Alves FAP, Silva EMA, Linhares FMP, Araújo GKN. Assistance to deaf manager: communication barriers found by the health team. Saúde em Redes. 2019 [cited 2024 Dec 5]; 5(3):3142. Available from: https://revista.redeunida.org.br/ojs/index.php/rede-unida/article/view/2234.
3. Yonemotu BPR, Vieira CM. Diversidade e comunicação: percepções de surdos sobre atividade de educação em saúde realizada por estudantes de medicina. Rev Eletron Comun Inf Inov Saúde. 2020 [cited 2024 Dec 5]; 14(2):e1827. DOI: https://doi.org/10.29397/reciis.v14i2.1827.
4. Brasil. Instituto Brasileiro de Geografia e Estatística. Censo Demográfico 2010. Brasília: IBGE; 2010 [cited 2024 Dec 12]. Available from: https://www.ibge.gov.br/estatisticas/sociais/populacao.html.
5. Brasil. Constituição (1988). Constituição da República Federativa do Brasil. Brasília: Senado Federal; 1998 [cited 2024 Dec 5]. Available from: https://www.planalto.gov.br/ccivil_03/Constituicao/Constituicao.htm.
6. Brasil. Lei nº 8.080 de 19 de setembro de 1990. Dispõe sobre as condições para promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. Brasília: Senado Federal; 1990 [cited 2024 Dec 5]. Available from: https://www2.camara.leg.br/legin/fed/lei/1990/lei-8080-19-setembro-1990-365093-publicacaooriginal-1-pl.html.
7. Pinheiro R, Mattos RA. Os sentidos da integralidade na atenção e no cuidado à saúde. Rio de Janeiro: UERJ, IMS: ABRASCO; 2006.
8. Pinheiro R, Mattos RA. Cuidado: as fronteiras da integralidade. Rio de Janeiro: UERJ/ABRASCO; 2006.
9. Bardin L. Análise de conteúdo. São Paulo: Edições 70; 2011.
10. Santos FM dos. Análise de conteúdo: a visão de Laurence Bardin. REVEDUC. 2012 [cited 2024 Dec 5]; 6(1):383-7. Available from: https://www.reveduc.ufscar.br/index.php/reveduc/article/view/291.
11. Souza MAR, Wall ML, Thuler ACMC, Lowen IMV, Peres AM. The use of IRAMUTEQ software for data analysis in qualitative research. Rev esc enferm USP. 2018 [cited 2024 Dec 5]; 52:e03353. Available from: https://doi.org/10.1590/S1980-220X2017015003353.
12. Torres EF, Mazzoni AA, Mello AG de. Nem toda pessoa cega lê em Braille nem toda pessoa surda se comunica em língua de sinais. Educ Pesqui. 2007 [cited 2024 Dec 5]; 33(2):369–86. DOI: https://doi.org/10.1590/S1517-97022007000200013.
13. Santos AS, Portes AJF. Perceptions of deaf subjects about communication in Primary Health Care. Rev Latino-Am Enfermagem. 2019 [cited 2024 Dec 5]; 27:e3127. DOI: https://doi.org/10.1590/1518-8345.2612.3127.
14. Brasil. Decreto nº 5.626 de 22 de dezembro de 2005. Regulamenta a Lei nº 10.436, de 24 de abril de 2002, que dispõe sobre a Língua Brasileira de Sinais - Libras, e o art. 18 da Lei nº 10.098, de 19 de dezembro de 2000, 22 de dezembro de 2005. Brasília: Senado Federal; 2005 [cited 2024 Dec 5]. Available from: https://www.planalto.gov.br/ccivil_03/_Ato2004-2006/2005/Decreto/D5626.htm.
15. Brasil. Ministério dos Direitos Humanos e Cidadania. Portaria Nº 434, de 25 de julho de 2023. Dispõe sobre o reconhecimento de Centrais de Interpretação de Libras (CILs) mantidas por Estados, pelo Distrito Federal e por Municípios. Brasil; Diário Oficial da União; 2023 [cited 2024 Dec 5]. Available from: https://www.in.gov.br/en/web/dou/-/portaria-n-434-de-25-de-julho-de-2023-498834124.
16. Brasil. Lei nº 12.319, de 1º de setembro de 2010. Regulamenta a profissão de tradutor, intérprete e guia-intérprete da Língua Brasileira de Sinais (Libras). Brasília: Senado Federal; 2010 [cited 2024 Dec 5]. Available from: https://www.planalto.gov.br/ccivil_03/_ato2007-2010/2010/lei/l12319.htm.
17. Campello ARS, Lira DS, Andrade LC. O tradutor e intérprete de Libras: atuações e considerações. Itapiranga: Schreiben; 2022.
18. Sehnem GD, Saldanha LS, Arboit J, Ribeiro AC, Paula FM. Consulta de pré-natal na atenção primária à saúde: fragilidades e potencialidades da intervenção de enfermeiros brasileiros. Rev. Enf. Ref. 2020 [cited 2024 Dec 12]; serV(1): e19050. DOI: https://doi.org/10.12707/RIV19050.
19. Beserra GL, Oliveira PMP, Pagliuca LMF, Almeida PC, Anjos SJSB, Barbosa AS. Verbal communication of the parturient nurse's dyad in the active phase of labor. Rev Bras Enferm. 2020 [cited 2024 Dec 5]; 73(5):e20190266. DOI: http://dx.doi.org/10.1590/0034-7167-2019-0266.
20. Brasil. Lei nº 10.436 de 24 de abril de 2002. Dispõe sobre a Língua Brasileira de Sinais - Libras e dá outras providências. Brasília: Senado Federal; 2002 [cited 2024 Dec 5]. Available from: https://www.planalto.gov.br/ccivil_03/leis/2002/l10436.htm.
21. Brasil. Lei nº 13.146 de 06 de julho de 2015. Institui a Lei Brasileira de Inclusão da Pessoa com Deficiência (Estatuto da Pessoa com Deficiência). Brasília: Senado Federal; 2015 [cited 2024 Dec 5]. Available from: https://www.planalto.gov.br/ccivil_03/_ato2015-2018/2015/lei/l13146.htm.
22. Souza ACAT, Lucas PHCS, Lana TC, Lindner SR, Amorim T, Felisbino-Mendes MS. Obstetric violence: integrative review. Rev. Enferm. UERJ. 2019 [cited 2024 Dec 5]; 27:e45746. DOI: http://dx.doi.org/10.12957/reuerj.2019.45746.

DOI: https://doi.org/10.12957/reuerj.2025.88440

23. Lopez MH, Griebeler WR, Vergara LGL. Barreiras de acessibilidade enfrentadas por pessoas surdas no setor de serviços: uma revisão integrativa da literatura. Saber Humano. 2020 [cited 2024 Dec 5]; 10(17):165-91. DOI: https://doi.org/10.18815/sh.2020v10n17.456.
24. Galeno JA, Freire FAM, Carvalho GTO, Silva MCG, Mouta AAN, Beltrão RPL, et al. Indispensabilidade do uso de equipamentos de proteção individual. Ensaios e Ciência: Ciências Biológicas, Agrárias e da Saúde. 2021 [cited 2024 Dec 5]; 25(5):541–45. DOI: https://doi.org/10.17921/1415-6938.2021v25n5-esp.p541-545.
25. Rezende RF, Guerra LB, Carvalho SA da S. Satisfaction of deaf patients with the health care. Rev CEFAC. 2020; 22(5):e8119. DOI: https://doi.org/10.1590/1982-0216/20202258119.
26. Pereira AAC, Passarin NP, Nishida FS, Garcez VF. "Meu sonho é ser compreendido": uma análise da interação médico-paciente surdo durante assistência à saúde. Rev bras educ med. 2020 [cited 2024 Dec 5]; 44(4):e121. DOI: https://doi.org/10.1590/1981-5271v44.4-20200028.
27. Silva TM, Sousa KHJF, Oliveira ADS, Amorim FCM, Almeida CAPL. Obstetric violence: theme approach in the training of Certified Nurse-Midwives. Acta Paul Enferm. 2020 [cited 2024 Dec 5]; 33:eAPE20190146. DOI: https://doi.org/10.37689/acta-ape/2020AO01466.
28. Alencar AJC, Silva AA, Gonçalves MM, Silva DMR, Silva MCT. Nursing Care during Humanized Natural Childbirth. Id on Line Rev. Mult.Psic. 2019 [cited 2024 Dec 5]; 13(47) 376-82. DOI: http://dx.doi.org/10.14295/idonline.v13i47.2025.

**Author's contributions**

Conceptualization, G.C.S., A.A.P.S., I.G.S.B., M.E.T.L.S., A.R.L. and G.V.O.M.; methodology, G.C.S.; software, G.C.S..; validation, G.C.S.., A.A.P.S., I.G.S.B., M.E.T.L.S., A.R.L., e G.V.O.M. and A.A.P.S; formal analysis, G.C.S. and A.A.P.S.; investigation, G.C.S.; data curation, G.C.S.; manuscript writing, G.C.S.; review and editing, G.C.S., A.A.P.S., I.G.S.B., M.E.T.L.S., A.R.L. and G.V.O.M.; visualization, G.C.S.; supervision, A.A.P.S.; project administration, A.A.P.S. and G.C.S. All authors read and agreed with the published version of the manuscript.

**Use of artificial intelligence tools**

The authors declare that no artificial intelligence tools were used in the composition of the manuscript "*Main communication barriers faced by deaf women during labor*".