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PERSPECTIVE

Health Care Justice: Improving Emergency Response to Sexual Violence Against Deaf Women

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People with disabilities often face discrimination and barriers when seeking medical treatment.[1] They may experience violations of their basic rights in health care settings, including denial of care, lack of informed consent, or inadequate accommodations, resulting in disparities in the quality of care received compared to individuals without disabilities.[2] Sexual violence represents a widespread societal issue with severe immediate and long-term physical and mental health consequences.[3] While growing evidence indicates that men and boys also experience sexual violence, global prevalence data remain limited.[4] Sexual violence is recognized as a human rights violation and a global public health crisis by the World Health Organization.[5] Emergency rooms (ERs) represent critical points of access to both health care and justice for survivors. Previous research has documented significant communication challenges for deaf patients in ERs, which becomes even more critical in cases of sexual violence, where clear communication is essential for both medical care and legal documentation.[6] However, for deaf women, who face heightened vulnerability to sexual violence, fundamental barriers to ER care constitute violations of their rights to health, dignity, and equal access to emergency services as guaranteed under the Convention on the Rights of Persons with Disabilities.[7]

The World Health Organization estimates that one in three women worldwide experiences sexual violence during their lifetime, while UNICEF reports that more than 370 million women and girls globally have been subjected to rape or sexual assault during childhood, underscoring the magnitude of this human rights violation.[8] People with disabilities are disproportionately affected by violent crime generally, with women with disabilities being twice as likely to experience sexual violence compared to those without disabilities.[9] Additionally, women with disabilities face higher rates of physical force during sexual violence and are more likely to experience violence over extended periods.[10] Contributing factors include greater

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social isolation, exposure to diverse perpetrators, dependency related to disability, difficulty identifying disability-related abuse, and cultural or societal barriers.[11]

This elevated risk is particularly pronounced during childhood, with children with disabilities being 3.14 times more likely to be sexually abused than their peers without disabilities [x^2 *(1, N = 40,211) = 330.92, p < .001*].[12] This pattern extends across disability types: Danish population data reveal significantly higher sexual victimization risks for children with attention-deficit/hyperactivity disorder, speech impairments, and intellectual disabilities, with comorbid conditions further increasing vulnerability.[13] Notably, meta-analytic findings across multiple countries, including in North America, Western Europe, Africa, Asia, Australia, and Israel, show that people with sensory disabilities, such as deaf women, carry the highest risk *(OR = 7.57, p < .001, k = 12)* compared to those with intellectual deficits *(OR = 1.81, p < .011, k = 24)*, physical disability *(OR = 1.71, p = .007, k = 16)*, or mixed types of disability *(OR = 1.76, p < .001, k = 28)*.[14] Despite these high rates, only approximately 15% of assault survivors seek emergency care, with rates even lower among those with disabilities due to accessibility barriers.[15]

Recent research documents how barriers related to gender, disability, language, and cultural factors can further increase vulnerability and impede access to support services after assault.[16] Deaf women and girls face overlapping challenges that significantly increase their risk of sexual violence.[17] This elevated risk is documented across diverse settings. Among the general adult population, deaf women are approximately 1.5 times more likely to experience sexual violence than hearing women.[18] In terms of childhood experiences, nearly 50% of deaf girls report experiencing sexual abuse before adulthood.[19] Among clinical populations, 56% of deaf women accessing outpatient mental health treatment report lifetime physical abuse.[20] Among the higher-education population, 69% of deaf female undergraduates disclose experiencing at least one sexual assault, with 56% encountering multiple forms of assault—rates that far exceed the 25% sexual assault prevalence found among hearing women.[21]

Deaf violence survivors face unique forms of communication abuse, including perpetrators damaging hearing aids, confiscating communication devices, refusing to repeat information, and deliberately misrepresenting situations when serving as informal interpreters with service providers.[22] Research further reveals the severity of underreporting among deaf survivors specifically, with 49% never reporting their abuse at all and 11% attempting to report but not being believed.[23]

Studies examining relationship dynamics have found that deaf women in relationships with hearing partners experience reduced ability to negotiate during conflicts due to hearing privilege imbalances.[24] While deaf-deaf relationships show more equal power dynamics and better negotiation, they still report concerning rates of sexual coercion, potentially due to limited awareness about intimate partner violence within the Deaf community.[25] However, the close-knit nature of Deaf communities can create additional barriers to help-seeking. Survivors report concerns about confidentiality and fear that disclosing abuse will damage their standing in the community, particularly if the perpetrator is well regarded.[26] Furthermore, many deaf women depend on family members or caregivers, who may be the perpetrators, for communication assistance.[27] Economic vulnerability significantly compounds safety barriers for deaf women experiencing intimate partner violence. Deaf women face disproportionate unemployment and underemployment, with one study documenting rates exceeding 80% among survivors of intimate partner violence. The same study found that systemic barriers to vocational training and higher education exacerbate this marginalization, with approximately three-quarters of deaf survivors reporting educational attainment at or below the high school level.[28]

This heightened vulnerability is compounded by structural factors: deaf children often lack access to comprehensive sex education in sign language, limiting their understanding of consent and personal boundaries.[29] During an interview,

a deaf woman participant expressed how tactile communication, fundamental to Deaf culture, can create vulnerability: "Being deaf means we're always touching to communicate. We touch someone to get their attention—it's just normal for us. When we're kids, we don't know which touches are okay and which aren't."[30] This observation illuminates how the necessity of touch-based communication in Deaf culture may inadvertently complicate children's ability to recognize and report inappropriate touching. Sometimes, educational institutions themselves can be sites of risk, with approximately 51% of deaf abuse survivors reporting abuse in connection with school settings.[31]

Despite nearly five decades of civil rights legislation in the United States intended to ensure equitable health care access, people with disabilities continue to experience significant disparities in health service delivery, highlighting the persistent gap between legal protections and practical implementation.[32] For deaf women seeking emergency care, this gap manifests through multiple systemic failures: insufficient qualified interpreters, inadequate Deaf cultural competency training, and absent accessible reporting mechanisms. Consequently, deaf women encounter significant communication challenges with providers and limited access to qualified sign language interpreters during medical encounters, directly compromising their ability to receive appropriate emergency care.[33] These barriers result in measurable delays; patients who utilize American Sign Language experience prolonged emergency department stays, a 9% increase—equivalent to 30 additional minutes—compared to English-speaking patients.[34] Such delays fundamentally compromise time-critical sexual assault care protocols, potentially jeopardizing forensic evidence collection and prophylactic interventions.

Current health care approaches perpetuate these problems by emphasizing targeted interventions rather than addressing fundamental structural inequities. Health care providers often resort to inadequate communication methods such as handwritten notes, lip-reading attempts, or vocal modifications rather than implementing appropriate communication accommodations.[35] This medicalized framework positions deaf women as passive recipients instead of active participants in their health care decisions, contradicting core principles of disability rights and patient autonomy.[36]

Global evidence-based prevention and response programs for deaf survivors remain critically scarce. Recent research in developed nations reveals significant gaps between recognizing deaf individuals' vulnerability to sexual violence and implementing culturally appropriate intervention protocols, particularly in time-sensitive emergency settings.[37]

Evolving emergency care standards for sexual assault survivors provide important context for addressing deaf women's specific needs. Shifting societal attitudes toward sexual assault have transformed emergency department protocols, increasing utilization rates and establishing trauma-informed care standards.[38] Emergency departments now offer survivors comprehensive services addressing both physical and mental health needs, including crisis counseling, treatment for sexually transmitted infections, emergency contraception, and care for HIV exposure prevention and forensic examinations.[39] Many emergency departments now utilize sexual assault nurse examiners (SANE)—nurses specialized in supporting sexual violence survivors. SANE programs are instrumental in supporting psychological recovery, delivering comprehensive care, gathering forensic evidence, and improving legal outcomes and community responses.[40] However, these advances in standard emergency care protocols often fail to address the unique communication and cultural needs of deaf survivors, highlighting the critical importance of specialized interventions.

Addressing these gaps requires evidence-based interventions to enhance emergency care for deaf survivors. Essential reforms include establishing standardized visual communication protocols featuring anatomical diagrams, procedural explanations, and validated emotional assessment scales.[41] Cost-effective environmental modifications—optimized lighting for lip-reading and sign language communication, alongside unobstructed sight lines in examination rooms—provide high-impact

improvements.[42] Additional structural improvements include enhanced documentation protocols prioritizing patients' communication preferences during triage and implementing interpreter-specific confidentiality guidelines.[43] While emergency departments can utilize video remote interpreting as an interim solution, developing partnerships with local deaf advocacy organizations remains vital for establishing on-call support networks and mental health referral pathways.[44] Robust privacy safeguards are essential, particularly in smaller communities where health care providers may have personal connections to survivors.[45] Health care facilities must also designate staff for specialized sign language and Deaf cultural competency training through digital platforms.[46] Integration with local deaf organizations should establish comprehensive services encompassing training for health care workers, interpreters, law enforcement, and support providers.[47] Such comprehensive services should align with European policy frameworks that require systematic staff training and standardized communication protocols.[48]

Sexual violence against deaf women constitutes a critical intersection of human rights and health care justice, demanding urgent global intervention. Deaf survivors face significant barriers to emergency care that fundamentally violate their rights to health equity and dignified treatment.[49] While basic health care accessibility exists through disability legislation, comprehensive, culturally competent protocols remain essential, including mandatory interpreter services and specialized provider training.[50] Pilot interventions' successes demonstrate the feasibility of systematic emergency care delivery, making health care transformation a fundamental human rights imperative requiring immediate action.[51] Future research should systematically assess health care systems' fulfillment of human rights obligations, evaluating emergency provider training requirements and institutional support mechanisms for ensuring equitable, accessible emergency care.

References

1. L. I. Iezzoni, M. M. McKee, M. A. Meade, et al., "Have Almost Fifty Years of Disability Civil Rights Laws Achieved Equitable Care?," *Health Affairs* 41/10 (2022).
2. C. Bowley, A. Mason Furmage, K. Marcus, and S. D. Short, "Case Study: Degree of Integration of Disability Rights into Allied Health Professional Education," *Health and Human Rights* 20/1 (2018).
3. L. Berger, B. Tuschy, S. Stefanovic, et al., "Forensic Medical Examination After Sexual Violence: Implications Based on Victims' Perceptions," *In Vivo* 37/2 (2023); D. Stockman, L. Haney, K. Uzieblo, et al., "An Ecological Approach to Understanding the Impact of Sexual Violence: A Systematic Meta-Review," *Frontiers in Psychology* 14 (2023).
4. S. K. Chynoweth, D. Buscher, S. Martin, et al., "Characteristics and Impacts of Sexual Violence Against Men and Boys in Conflict and Displacement: A Multicountry Exploratory Study," *Journal of Interpersonal Violence* 37/9–10 (2022).
5. World Health Organization, "Violence Against Women" (March 25, 2024), https://www.who.int/news-room/fact-sheets/detail/violence-against-women.
6. C. Tannenbaum-Baruchi, P. Feder-Bubis, and L. Aharonson-Daniel, "Communication Barriers to Optimal Access to Emergency Rooms According to Deaf and Hard-of-Hearing Patients and Health Care Workers: A Mixed-Methods Study," *Academic Emergency Medicine* 32/3 (2025).
7. Convention on the Rights of Persons with Disabilities, G.A. Res. 61/106 (2006), art. 25; European Union of the Deaf, *Combatting Gender-Based Violence and Discrimination Against Deaf Women and Girls in the EU* (2024).
8. World Health Organization (see note 5); UNICEF, "Over 370 Million Girls and Women Globally Subjected to Rape or Sexual Assault as Children – UNICEF," (October 10, 2024), https://www.unicef.org/turkiye/en/press-releases/over-370-million-girls-and-women-globally-subjected-rape-or-sexual-assault-children.
9. E. Harrell, "Crime Against Persons with Disabilities, 2009–2019 – Statistical Tables," Bureau of Justice Statistics, NCJ 301367, https://bjs.ojp.gov/library/publications/crime-against-persons-disabilities-2009-2019-statistical-tables; E. Ledingham, G. W. Wright, and M. Mitra, "Sexual Violence Against Women With Disabilities: Experiences with Force and Lifetime Risk," *American Journal of Preventive Medicine* 62/6 (2022).
10. G. Gault, A. Wetmur, S. Plummer, and P. A. Findley, "Violence Against People with Disabilities: Implications for Practice," in E. Slayter and L. Johnson (eds), *Social Work Practice and Disability Communities: An Intersectional Anti-Oppressive Approach* (Rotel Project, 2023).

11. S.-B. Plummer and P. A. Findley, "Women with Disabilities' Experience with Physical and Sexual Abuse: Review of the Literature and Implications for the Field," *Trauma, Violence, and Abuse* 13/1 (2012).

12. P. M. Sullivan and J. F. Knutson, "Maltreatment and Disabilities: A Population-Based Epidemiological Study," *Child Abuse and Neglect* 24/10 (2000).

13. A. Elklit, M. Pettersson, A. Salbøg Petersen, and T. Nielsen, "Is There Consensus on Child Violence Exposure Measures? A Study of Six Recommended Instruments," *European Journal of Psychotraumatology* 15/1 (2024).

14. A. Mailhot Amborski, E. Line Bussières, M. P. Vaillancourt-Morel, and C. C. Joyal, "Sexual Violence Against Persons with Disabilities: A Meta-Analysis," *Trauma, Violence, and Abuse* (2022).

15. E. Harrell, "Crime Against Persons with Disabilities, 2009–2015 – Statistical Tables," Bureau of Justice Statistics, NCJ 250632 (July 2017), https://bjs.ojp.gov/library/publications/crime-against-persons-disabilities-2009-2015-statistical-tables.

16. J. Garcia, *A Deaf Latina's Experience with Sexual Assault/Harassment*, master's thesis (Lamar University-Beaumont, 2023).

17. J. M. Mastrocinque, C. Cerulli, D. Thew, et al., "Understanding Intimate Partner Violence Perpetration Involving the Deaf Population." *Journal of Interpersonal Violence* 37/1–2 (2022).

18. M. L. Anderson, I. W. Leigh, and V. J. Samar, "Intimate Partner Violence Against Deaf Women: A Review," *Aggression and Violent Behavior* 16/3 (2011).

19. S. Schild and C. J. Dalenberg, "Consequences of Child and Adult Sexual and Physical Trauma Among Deaf Adults," *Journal of Aggression, Maltreatment and Trauma* 24/3 (2015).

20. P. Johnston-McCabe, M. Levi-Minzi, V. B. van Hasselt, and A. Vanderbeek, "Domestic Violence and Social Support in a Clinical Sample of Deaf and Hard of Hearing Women," *Journal of Family Violence* 26/1 (2011).

21. R. A. E. Smith and L. H. Pick, "Sexual Assault Experienced by Deaf Female Undergraduates: Prevalence and Characteristics," *Violence and Victims* 30/6 (2015); B. Fisher, F. Cullen, and M. Turner, *The Sexual Victimization of College Women* (US Department of Justice, National Institute of Justice, 2000).

22. Mastrocinque et al. (see note 17).

23. E. Wakeland, S. Austen, and J. Rose, "What Is the Prevalence of Abuse in the Deaf/Hard of Hearing Population?," *Journal of Forensic Psychiatry and Psychology* 29/3 (2018); M. H. Kvam, "Sexual Abuse of Deaf Children: A Retrospective Analysis of the Prevalence and Characteristics of Childhood Sexual Abuse Among Deaf Adults in Norway," *Child Abuse and Neglect* 28/3 (2004).

24. M. L. Anderson and I. W. Leigh, "Intimate Partner Violence Against Deaf Female College Students," *Violence Against Women* 17/7 (2011).

25. M. L. Anderson and C. M. Kobek Pezzarossi, "Violence Against Deaf Women: Effect of Partner Hearing Status," *Journal of Deaf Studies and Deaf Education* 19/3 (2014).

26. Mastrocinque et al. (see note 17).

27. C. Tannenbaum-Baruchi, P. Feder-Bubis, B. Adini-Weisel, and L. Aharonson-Daniel, "How Deaf People Cope in Routine and Emergency Situations: Suggested Paths for Thought and Action," *Harefuah* 153/9 (2014).

28. M. S. Ballan, M. Burke Freyer, L. Powledge, and C. Nathan Marti, "Intimate Partner Violence Among Help-Seeking Deaf Women: An Empirical Study," *Violence Against Women* 23/13 (2017).

29. C. Jones, K. Stalker, A. Franklin, et al., "Enablers of Help-Seeking for Deaf and Disabled Children Following Abuse and Barriers to Protection: A Qualitative Study," *Child and Family Social Work* 22/2 (2017).

30. C. Tannenbaum-Baruchi, *A Mixed-Methods Study of Resources, Barriers, and Self-Efficacy Perceptions of Persons with Hearing Disabilities During Routine and Emergency Situations*, doctoral dissertation (Ben-Gurion University of the Negev, 2020), p. 72.

31. E. Wakeland, S. Austen, and J. Rose, "What Is the Prevalence of Abuse in the Deaf/Hard of Hearing Population?," *Journal of Forensic Psychiatry and Psychology* 29/3 (2018).

32. Iezzoni at al. (see note 1).

33. Mastrocinque (see note 17); Sullivan and Knutson (see note 12).

34. C. Heitz, K. Challen, and W. K. Milne, "Hot Off the Press: SGEM#383: Tommy Can You Hear Me—Deaf and Hard-of-Hearing Patients in the ED," *Academic Emergency Medicine* 30/3 (2023).

35. Iezzoni et al. (see note 1).

36. G. P. Meehan, *Flourishing at the Margins: An Exploration of Deaf and Hard-of-Hearing Women's Stories of Their Intimate Lives in Ireland*, PhD dissertation (University of Maynooth, 2019).

37. K. Urbann, P. Bienstein, and T. Kaul, "The Evidence-Based Sexual Abuse Prevention Program: Strong with Sam," *Journal of Deaf Studies and Deaf Education* 25/4 (2020).

38. K. Chalmers, M. Hollender, L. Spurr, et al., "Emergency Department Preparedness to Care for Sexual Assault Survivors: A Nationwide Study," *Western Journal of Emergency Medicine* 24/3 (2023).

39. Ibid.

40. A. Fernández-Collantes, C. Martín-Vázquez, and M. C. Martínez-Fernández, "Patient and Healthcare Provider Satisfaction with Sexual Assault Nurse Examiners (SANEs): A Systematic Review," *Healthcare* 12/23 (2024).

41. C. Tannenbaum-Baruchi, "Enhancing Nursing Students' Communication Skills with Deaf Patients: Workshop

Impact on Nursing Education Programs," *Nursing Outlook* 72 (2024); J. Kritzinger, *Exploring the Barriers and Facilitators to Health Care Services and Health Care Information for Deaf People in Worcester*, PhD dissertation (Stellenbosch University, 2011).

42. Tannenbaum-Baruchi et al. (2024, see note 6).

43. T. G. James, K. A. Coady, J. M. R. Stacciarini, et al., "'They're Not Willing to Accommodate Deaf Patients': Communication Experiences of Deaf American Sign Language Users in the Emergency Department," *Qualitative Health Research* 32/1 (2022).

44. T. G. James, J. R. Varnes, M. K. Sullivan, et al., "Conceptual Model of Emergency Department Utilization Among Deaf and Hard-of-Hearing Patients: A Critical Review," *International Journal of Environmental Research and Public Health* 18/24 (2021); J. Terry and C. Robins-Talbot, "Mental Health First Aid™ for Deaf Communities: Responses to a Lack of National Deaf Mental Health Service Provision," *Journal of Public Mental Health* 23/2 (2024).

45. K. Aguillard, R. Hughes, G. L. Gemeinhardt, et al., "'They Didn't Ask.' Rural Women with Disabilities and Experiences of Violence Describe Interactions with the Healthcare System," *Qualitative Health Research* 32/4 (2022).

46. J. M. Rotoli, S. Hancock, C. Park, et al., "Emergency Medical Services Communication Barriers and the Deaf American Sign Language User," *Prehospital Emergency Care* 26/3 (2022).

47. J. Napier, L. Clark, L. Leeson, and L. Quigley, "'I Faced So Many Barriers': Access to Support for Deaf Female Survivors of Domestic Violence in the UK," *Journal of Language Rights and Minorities* 3/1 (2024).

48. European Union of the Deaf (see note 7).

49. Napier et al. (see note 47).

50. Terry and Robins-Talbot (see note 44).

51. James et al. (2021, see note 44).