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ORIGINAL ARTICLE

CHALLENGES IN ACCESSIBILITY AND INCLUSION OF PEOPLE WITH DISABILITIES IN HEALTH SERVICES AND SOCIAL ASSISTANCE

Juliana Pedroso Bauab Geraldo*
Sonia Maria Oliveira de Andrade**

ABSTRACT

Objective: To understand the experiences of people with disabilities, their family caregivers and service managers regarding public health policies and social assistance in Campo Grande, state of Mato Grosso do Sul, Brazil, exploring their perceptions about the difficulties of access to these services and care. **Method:** it is a qualitative descriptive research, including people with physical disabilities, between 18 and 65 years, the family caregiver, and health and social care managers of their reference services. Data collection was carried out between 2018 and 2019, through interviews, organized by the Collective Subject Discourse technique, and analyzed and discussed based on scientific literature. **Results and Discussion:** with 32 participants, the results highlight barriers of physical, technological and communicational accessibility, as well as difficulties in public transport and health services infrastructure. Geographical and organizational challenges were also identified, impacting the autonomy and quality of life of these people. **Final considerations:** the study revealed the daily difficulties faced by people with disabilities and their caregivers, highlighting the complexity of barriers and the need for collaborative and comprehensive solutions. An inclusive society requires effective public policies that guarantee equal opportunities for all, with special attention to people with disabilities.

Keywords: People with disabilities. Equity in access. Public policy. Health services. Social assistance.

INTRODUCTION

The history of people with disabilities is marked by a trajectory of discrimination, lack of rights and social inequality, also reflected in the challenges faced by this population for access to health services and social assistance. Over time, different approaches and policies have been developed to deal with these issues, but significant barriers still persist that negatively impact the life and health of these individuals[1].

The barriers experienced by people with disabilities in carrying out their daily activities lead to harmful consequences in the operationalization of their rights. In 2018, the UN published the first Disability and Development Report, which addresses health inequalities faced by people with disabilities and provides evidence-based recommendations to promote equity in health. It also shows that people with disabilities are disadvantaged in most of the Sustainable Development Goals, and indicating that discrimination and lack of accessibility are barriers that put these people at a disadvantage in conditions of inequality in participation and inclusion in society[2].

Thus, the marginalization of people with disabilities affects access to education, work, transport, cultural life, places and public services. It is also known that these people face inequalities in access to health services, while at the same time they are subject to greater risks of illness and poor health conditions[2].

Among the main challenges faced by people with disabilities, the lack of physical accessibility in public spaces and services is highlighted and highlights the importance of adequate structures such as ramps, elevators and accessible toilets, to ensure full and dignified access to the facilities[3]. The lack of accessible technological resources, such as assistive technology equipment and adapted software, also hinders access to information and care. Similarly, the absence of professionals trained in Libras and the lack of informational material in accessible formats, such as braille and audio, limit communication and understanding of these individuals' needs[4].

[1]The research article presents part of the results of the doctoral dissertation conducted within the Graduate Program in Health and Development in the Central-West Region, at the Federal University of Mato Grosso do Sul, School of Medicine, Campo Grande, Brazil.

*Occupational Therapist. PhD in Health and Development in the Central-West Region. Faculty Member at the Federal University of Mato Grosso do Sul. ORCID: https://orcid.org/0000-0003-2741-6113
**Psychologist. PhD in Public Health. Faculty Member at the Federal University of Mato Grosso do Sul. ORCID: https://orcid.org/0000-0002-9897-6081

However, the Convention on the Rights of Persons with Disabilities, with its provisions assumed by the Status of Persons with Disabilities, establishes that full and independent participation must cover all aspects of life, It is crucial to adopt measures that guarantee access and equal opportunities, taking into account the physical environment, transport, information, communication and technologies[5].

It is worth noting that participation occurs when the person is actively involved in carrying out their activities, in which they identify purpose and meaning. However, it is important to consider that body structures and personal and environmental contexts may influence their performance abilities[6]. Therefore, the challenges faced by people with disabilities in accessing services and care are multifaceted, and it is essential that public policies, health programs and professional practices are developed in an inclusive manner and sensitive to the needs of this population. In this context, the following research question arises: "How do people with disabilities, caregivers and managers perceive the effectiveness of public health and social assistance policies, considering the challenges of accessibility and equity?"

This study aims to understand how people with disabilities, their family caregivers and managers of health services and social assistance experience the public policies of health and social assistance available in the city of Campo Grande, State of Mato Grosso do Sul, Brazil. The research also explores their perceptions about access difficulties to these services and care, contributing to a detailed and contextualized analysis of accessibility barriers and highlighting the need for inclusive policies and practices.

METHODOLOGY

This is a descriptive research of qualitative nature that was based on data from the Municipal Census of Persons with Disabilities in the city of Campo Grande, Mato Grosso do Sul, Brazil. Through the data from the Municipal Census of Persons with Disabilities, available on the Intranet platform, a general list of people with disabilities was made available to the researcher by the Municipal Health Department. Subsequently, in Excel spreadsheets, the lists were organized, categorized by urban regions and numbered separately. The selection for the interviews took place in each urban region, randomly, through the free access tool available on the website: https://sorteador.com.br/.

After the draw, the disabled person was located on the Intranet platform, and their census registration data were consulted. After verifying the eligibility of the person with disabilities for inclusion in the study, first through registration data and later by telephone contact, they were invited to participate.

People with physical disabilities aged 18 to 65 years were included, along with their family caregivers when it was considered appropriate, if recognized as an important part of day-to-day life and essential support network. This age group was chosen in order to minimize the impacts of possible comorbidities present at more advanced ages. We also added the managers of health services and social assistance of their reference. People with some involvement that would compromise the understanding and expression of information intended in data collection were excluded.

Primary data collection was performed at home only after approval by the Research Ethics Committee (CAAE: 02624018.0.0000.0021), between December 2018 and March 2019. The interviews that began with a mobilizing initial question of verbal expression addressed to each type of participant: a- "How is it for you, a person with physical disabilities, to be attended by municipal health and social assistance services?" b- As a family caregiver of a person with physical disabilities, what are your main difficulties in accessing services and what are the support strategies offered to you by public health and social assistance services? e c- The guiding question was, as a manager of a municipal service, how do you see the provision and access to services for people with disabilities and their families?. A pilot test was carried out to evaluate the relevance of the main questions, ensuring their alignment with the objectives and methodology of the research. In addition, field notes were made to record and preserve emerging perceptions and interpretations of the experience, enriching subsequent reflections and discussions.

The number of interviews conducted was decided after data saturation, also considering the interference of the COVID-19 pandemic challenges amid data collection. The risks of face-to-face interviews and the difficulty in accessing technology for online interviews were evaluated.

The interviews were transcribed and organized following the technique of the Collective Subject Discourse, which generally consists in extracting parts from similar discourses, so that it is possible to aggregate them without reducing content and quantity, in order to create a collective opinion directly. For this, the following methodological figures were used: key expression, central ideas and discourse of the collective subject[7].

Each participant was coded and numbered in order to associate each type of participant: disabled person (P), family member (F), health manager (HM) and social assistance manager (SAM) and ensure anonymity. Finally, the discourses of the collective subject were analyzed and discussed in light of the literature relevant to the theme.

RESULTS AND DISCUSSION

In total, 250 draws were held, and the difference in the number of draws from each urban region was due to the variation in success in locating, contacting and recruiting participants. Table 1 highlights the occurrence of 70 uncompleted calls, which points out the difficulty of the municipality in contacting people with disabilities registered in the census, with an impact on updating data, situational monitoring and inclusion in public policies that may be necessary.

Table 1. Contacts made to invite participants to participate in the survey by urban region

Information	UR1	UR2	UR3	UR4	UR5	UR6	UR7	Total
Interview Conducted	1	2	1	3	2	2	2	13
Call not completed	4	4	7	28	6	7	14	70
Did not answer the call	3	3	2	3	3	2	1	17
Refusal	1	0	2	3	0	2	0	8
Age above the inclusion age group	15	3	5	22	4	10	14	73
Age below the inclusion age group	8	0	10	8	0	3	5	34
Compromised communication	3	4	2	6	0	3	4	22
Deceased	2	0	0	0	0	0	0	2
Does not live in Campo Grande	1	0	0	1	0	0	0	2
Wrong phone number	0	0	2	0	0	0	1	3
Canceled interview	0	0	1	0	0	1	0	2
Does not have a phone number	0	0	0	1	0	0	0	1
Supposed to return the call	0	0	0	0	0	2	0	2
Institutionalized	0	0	0	0	0	0	1	1
Draws held	38	16	32	75	15	32	42	250

Caption: UR: Urban Region

In the study, 13 people with disabilities, eight family caregivers and 11 managers were interviewed, five from Basic Family Health Units (BHFU) and six from Social Assistance Reference Centers (CRAS).

Before presenting the data analysis, it is important to highlight that the world population is characterized by a comprehensive diversity, which can be analyzed from five different perspectives: dimensional, perceptual, motor, cognitive and demographic. Faced with this, we can understand that each person may have specific difficulties to access certain places[8]. People with disabilities face more challenges due to characteristics that put them at a disadvantage in the context in which they live, and therefore equal opportunities are often only achieved through the use of assistive technology, organizational strategies and adaptations in the environment that help in the performance of their activities and roles in society[9].

Based on this panorama, the central idea presented in this manuscript will address the main barriers of access to services and care

mentioned by the research participants, focusing especially on issues that permeate accessibility.

Mobility and physical accessibility challenges

Accessibility, according to the disabled person, is having "dignity and autonomy to be able to come and go without asking for help". However, in narrating its difficulties for access to services, it reinforces the fact that "lack accessibility in general, from the moment you leave your home," and classifies accessibility as bad, rudimentary and chaotic. Thus questioning

> If you are wheelchair has to have access on the street. Then you have to have access to the bus stop, does not have. [ ]. Arriving there I will have how to go down and up on the sidewalk, to enter inside the post? The post has accessibility? You mean, do you always have to go with a company? You don't have autonomy, you don't have freedom? The privacy of you going alone in such a place? Do you always need help because you have no attitudinal accessibility, no architectural accessibility? We want dignity. Autonomy. Being able to come and go without asking for help. (P2, P3, P6, P7, P13)

The literature demonstrates that the vision of people with disabilities is similar in this respect, understanding that accessibility is the right to be independent for their locomotion and that allows their autonomy to come and go. A right that is sometimes not exercised in the context of the city since in public spaces, the challenges faced to exercise their daily activities persist and exclude them from conviviality and participation[9].

Currently, the concept of urban mobility stems from the condition that allows the movement of people in the city through their social and economic needs. Mobility solutions are means that can be used as bus, subway, cars and other individual and collective transport[10].

Mobility provides people with independence, autonomy and functionality not only to seek care, but for any other activity, such as working, studying, walking, establishing social relations or some occupation of interest or need, and for this it is essential that the transport system is effective[10].

In this sense, the public transport of the city is criticized by the disabled person and the family caregiver, for lack of structure and maintenance of elevators. The lack of monitoring of existing resources and unpreparedness in dealing with equipment have an impact on their use and make it impossible for people with disabilities to access them[9].

> Then you have to have access to the bus stop, no. Then you have to have access to the bus, and often the driver does not stop because he is late. Or sometimes the elevator is broken. (P2, P3, P6, P7, P13)

As a consequence, even though the care service is offered, participants report not being able to use it because they depend on an inaccessible and faulty transportation system. Another problem raised by the health manager refers to the lack of an ambulance adapted to take a person with disabilities and dependent to do an examination, leaving on the patient's responsibility the cost of this transport. In this context, people with disabilities, who are more socially and economically vulnerable, cannot or have more difficulty accessing the available public services[11].

> City hall does not have a social ambulance, an adapted ambulance to take a disabled person from the residence to take a test, to take a consultation, something like that. The family that has to bear with this transport, that the municipality, the state, should be doing its part right. You do not have this possibility. (HM2, HM3, HM4, HM5)

In addition to transportation, the lack of physical accessibility described by all participants includes, in general, urban and architectural barriers that prevent movement on public roads, access to facilities, the circulation and usufruct within the physical space of public services. In general, they are characterized by the survey participants for bumpy and unpaved streets, improper or non-existent ramps on sidewalks and service entrances, inadequate bathrooms and narrow doors.

> Physically we have some difficulties. [...] Our physical space is a ramp, and we do not have some items that accommodate the person with disabilities [...] access is bad [...] If you have a suitable physical space you have even condition to attract this person more, it needs to be within the CRAS, right? (SAM1, SAM2, SAM3, SAM4)

Corroborating this context, the review of qualitative studies found that there is a greater

number of reports of physical barriers to access to health services, present in the path from residence to health units, in the movement between buildings, in the paths of corridors, access to offices and examination rooms, in addition to the presence of inadequate doors and bathrooms[12].

Another impact generated by the lack of physical accessibility of environments is mentioned by the disabled person, directed to the family caregiver:

> Sometimes my mother has to put me over the ledge. I think bad for her, right? We turn as can. (P2, P3, P6, P7, P13)

In daily practice, specifically in health care, the family incorporates into its routine the needs of participation in rehabilitation therapies, treatment and medical follow-up, surgical interventions, search for assistive technology resources, for accessible environments and adapted transport, as well as the search for social benefits, among other searches. They represent, therefore, a set of tasks that use essential tools for care, which are not always adequately arranged or offered by the services and public policies, skillfully and consistent with the imminent need[13].

The responsibility to help with mobility falls on the caregiver, who, due to lack of structure, needs to carry equipment and assist in transfers, requiring effort and physical wear[13]. The greater the dependence, the greater the degree of daily overload that affects the health of the family caregiver[14]. Thus, providing adequate attention and support, with sufficient infrastructure to assist in care tasks are essential for establishing the balance necessary for the preservation of a healthy context of life, both for those who care and for those who are cared for.

Regulations and the implementation of accessibility

The Byelaw of People with Disabilities and the Accessibility Act provide the primary conditions related to accessibility. However, the family caregiver denounces that "the law obliges but does not require" when describing his experience in the spaces frequented[5,15].

As an example, essential services that the disabled person needs to use are mentioned. A Basic Health Unit without access ramp prevented a participant from receiving care. At the Medical Specialty Center, the disabled person and their caregiver report a long sloping ramp at the entrance, which requires a lot of physical effort and has no handrail to ensure safety.

Users' access to care policies depends on whether the environment is able to accommodate it. In this way, the health manager recognizes the failures and is concerned about the surroundings of the service, which has bumpy streets, with stones and without asphalt, configuring itself as a problem for wheelchair users and the user of crutches. The options of the disabled person end up being: give up going, go alone and risk your safety or depend on someone to take it.

> [...] it doesn't make it any easier for someone to get there. There's a really tiny ramp there, and you don't have any support on the ramp. If [...] you don't have crutches, if you don't have them with you, it's more dangerous to fall on the ramp than to climb the asphalt where cars pass [...] it's better to climb the stairs than to walk almost the entire hundred meters on that gigantic ramp (F1, F4, F6).

> You go to a health center, the ramp is extremely steep, there's no parking, the doors are small, there are steps. [...] There's no ramp. [...] [...] you have no idea how many times I have to stop halfway there, just to be able to climb that ramp. (P2, P3, P6, P7, P13)

> The path to get here is very difficult. We find a way to assist them, they, their family, we try to provide referrals. But they need to get here, right? In our unit, because of accessibility, it's really difficult for wheelchair users; a lot of people come with crutches, right? But {wheelchair user}, if he's alone, if he hits a rock there, he ends up falling over and no one's passing by on the street, how are they going to pick him up? [...] So the person ends up not going, because it's a rock, he'll fall into some holes, and it gets really difficult. (HM2, HM3, HM4, SAM5)

Two aspects can be observed about compliance with the legislation that guarantees accessibility. One of them is its non-implementation, narrated by the lack of structures such as the ramp. Another indicates that sometimes the regulations are not applied in the way that the norms establish, exemplified by

the present ramps, but inadequate.

Regarding this, the architectural projects that apply the principles of Universal Design and/or the norms of the Brazilian Association of Technical Standards provide efficiency and comfort to avoid fatigue, as well as strategies to minimize risks and adverse consequences. The standards also establish minimum criteria and necessary parameters for the installation of ramps, railings and handrails, to certify conditions of safety and functionality[16,17].

To remedy the nonconformities, the qualification of civil engineers and architects is indispensable in order to have prior knowledge of current regulations, in order to ensure their application in the preparation of projects and the execution of works. Furthermore, the authors claim that a greater control of these elements by the public authorities is essential[18].

Another example of the wrong use of accessibility regulations is the report of the presence of "more or less adapted bathrooms", according to the social assistance manager. Specifically about this problem, the family caregiver expresses concern to find an accessible toilet in places that accompanies the person with disabilities, because it can be understood as another stressful factor for care.

> We do have some things here, like the entrance and the more or less adapted bathrooms. So it's quite complicated. But they are taken care of. But the right thing to do would be to have a well-suited place for them. (SAM1, SAM2, SAM3, SAM4)

> Because there's the difficulty, for example, of performing CAT (intermittent bladder catheterization), sometimes when you need to pee and the place doesn't have the capacity to do that. (F1, F4, F6)

Often, this and other needs are not met and are accumulated with other demands arising from the responsibility of the caregiver. If the context does not have a structure capable of supporting the family caregiver, the overload on it can lead to damage in their health, loss of quality of life and care provided[19].

In short, the reality described corroborates what the literature finds in the developed studies, in which the person with disability is identified as the individual who has great disadvantage and difficulty of access to spaces and participation, in different dimensions, of the life context[2]. Thus it is possible to understand that with only the provision of basic resources that would act in environmental accessibility, such as paving and pavement in an urban area, the person with disabilities would be encouraged to seek care, with dignity and autonomy mentioned above.

Still in this regard, the family caregiver directs his concern about the impact of exposing the wheelchair to degraded and bumpy circulation surfaces.

> For example, [...] get out of here, go there. The chair almost dismounts, because so much asphalt. There is a law that obliges all houses to have sidewalks in accordance. It obliges, but does not require. (F1, F4, F6)

Regions with poor pavement and rough terrain directly impact the resistance and durability of wheelchairs, in addition to requiring greater physical effort and skill from users to get around. These daily obstacles compromise not only the displacement, but also the preservation of equipment, further burdening those who already face conditions of social and economic vulnerability[20]. The disabled person's speech illustrates this difficulty:

> In the basic unit where I go, which is in the neighborhood, there is no asphalt. There is no ramp. Now you wonder if I have no access ramp, if I do not have a place of access. And all this is my right. (P2, P3, P6, P7, P13)

This report reinforces that the environment where assistive technology is used is crucial for its conservation and user safety, and should be appropriate in order to maximize the efficiency of the resource. When well used, this support instrumentalizes social participation, promotes autonomy and enables inclusion in a more effective way[20].

Technological and communication barriers

Inaccessible furniture with high benches and features such as examination tables without height regulation are highlighted by the disabled person and reinforced by managers, describing the inadequate work environment. This is due to the absence of equipment and other assistive technology resources that directly affect care, such as the elevator for patient transfer,

wheelchair and stretchers/ tables for examinations.

> Most units that will do some specialized examination, something, will not have offices, some equipment, an elevator to be able to carry a patient, chair, gynecological stretcher. If we take the practical part today, we will have difficulty. There is no accessibility in this sense. (HM2, HM3, HM4, HM5)

This reality is also experienced by people with disabilities, who report situations of embarrassment and dependence on others to perform procedures:

> There is no mobile adapted to meet you. The bench, the island of service, is in the heights. How will a woman with disabilities get a preventive exam if the bed is at a normal height? Will she need the person to go with her? (P2, P3, P6, P7, P13)

The technological and structural barriers represented by the lack of resources and accessible equipment reveal that, in many situations, services are not able to meet the specificities of individuals. This problem is recognized by both users and managers, highlighting the need for investment in inclusive infrastructure and assistive technologies that guarantee equity in access and quality of health care.

Concerning access to information, the Brazilian Inclusion Law and the guidelines of the Network for the Care of People with Disabilities provide the commitment to provide all public information in accessible formats and with technologies appropriate for different types of disability[5,21].

Despite this, communication barriers are highlighted by the lack of tactile floor and information material in braille and the absence of interpreters or professionals trained in Libras for service. The aspect discussed here refers to the way information and communication are arranged, and according to the reports of participants, users and providers, social assistance and health services do not satisfactorily contemplate the perceptual diversities of individuals.

> We get by as best we can. It's all very rudimentary. There's no Braille material for blind people, no informational materials. There's no sign language interpreter for a deaf person arriving at a UBSF, or even at SAMU itself. (P2, P3, P6, P7, P13)

> If a hearing-impaired person arrives, it's very rare for people to speak sign language, gesture, or have mastery of sign language. These are rare cases. (SAM1, SAM2, SAM3, SAM4)

> I don't have tactile access at the unit. Besides requesting it, I've already been told a couple of times that I didn't have tactile access. But it's just information. So I think it needs to evolve a lot. To comply with current regulations. (HM2, HM3, HM4, HM5)

Service environments must be designed to be accessible to all people. For this, it is essential to ensure effective communication, with adequate signaling and alternative communication resources, as well as sign language interpreters to support professionals in their work. The lack of communication in different scenarios, involving users, providers and managers, can negatively impact the autonomy and access of people with disabilities to necessary care[22].

Failures in the signaling of service facilities make people dependent on help to locate entrances, exits, rooms and restrooms, as well as making it difficult to express demands, understand guidelines and receive assistance[13,23].

Another important aspect refers to digital technologies, which have transformed the way we access certain services that previously did not depend on online applications or platforms. This expansion of the public digital environment aims to improve services and is crucial for the development of social policies, allowing an efficient management of social programs and facilitating communication[24].

> It's become very difficult for citizens to access INSS public services. The INSS is now practically virtual. It's rare for people to receive physical assistance [...] we help, and often we call from here to help. (SAM1, SAM2, SAM3, SAM4)

The report reflects on barriers to technology acquisition faced by vulnerable groups, such as people with disabilities. According to the social assistance manager, especially for online services, part of the users who use the service end up relying on their infrastructure (telephone, computer and internet) and the help of

professionals to operate them.

Studies show that, despite technological advances, inequalities in internet access and digital skills still persist, especially among different socioeconomic groups. The promotion of accessibility of computer systems is essential to guarantee the exercise of citizenship. Both human diversity and vulnerabilities need to be considered in the implementation of technologies in public services, along with policies aimed at reducing social and digital inequality in the country[25,26].

Geographical and organizational challenges

Another dimension on accessibility is scored by the disabled person and the family caregiver, when reporting the difficulty in accessing a service away from their home.

> [...] do follow-up there in CAPS that is a very long way for me takes, two hours of bus. Very drawn to me. I find it very difficult. [...] I wanted the psychiatrist's consultations even closer here because it is too far away. [...] It is a struggle. The physiotherapy is good, only where it is located? Then the person lives here to go there in CER APAE, the time, public transport that she uses has no conditions. (F1, F4, F6)

> Once they wanted me to do psychological treatment, but they sent me [...] I don't even know where it is, just know that it's far away. They even told me, if you go there we give you a bus pass, but I can't get on the bus. How do I go? (P2, P3, P6, P7, P13)

The geographic, organizational and socioeconomic dimensions are considered related and important factors for the analysis of the use of services, recognized as basic criteria to better delimit the territories in which public services operate[27,28].

However, the entire service network faces challenges in decision-making about location and scope of care, due to the difficulty of overcoming the healthcare model centered on the health logic and the dependence on an insufficient infrastructure. Repeated studies show that the management and planning of care, considering socioeconomic, geographic, cultural and political characteristics, are essential to ensure access to services for the entire population, not only for people with disabilities. This approach can solve problems such as excessive time spent on moving to a service outside the territorial and community context, a situation that is even more detrimental to people with reduced mobility[27,28].

Geographical and organizational barriers pose significant challenges, in which remote or poorly served areas by transport infrastructure can hinder people's movement to health services. In addition, the organization of health services can also create obstacles, such as lack of convenient hours of care, long waiting lines, lack of specialized professionals in certain areas and inadequate physical structures to meet the needs of patients with disabilities or reduced mobility. These barriers, both geographic and organizational, can result in inequalities in access to health care, affecting mainly those who are already more vulnerable due to unfavorable socioeconomic conditions[29,30].

Given the above, ensuring accessibility is not limited to physical adaptations, but requires an integrated approach that takes into account individual needs, assistive technologies and accessible communication to provide an inclusive and dignified experience for all citizens.

The participants of this study, through their speeches, consider that the accessibility of services is not following the principles of equity, for not addressing the different dimensions of human diversity and for presenting physical, technological, information, geographical, organizational and transport. It is possible to conclude that the described impediments make it difficult for people with disabilities in the municipality to access services and have their demands met in the health-social assistance axis in an adequate way.

FINAL THOUGHTS

The study allowed to understand how people with disabilities, their caregivers and managers experience public health policies and social assistance of the city, highlighting their perceptions about difficulties in accessing services and care. It deepened in the accessibility barriers faced by this public, evidencing the direct impact of these limitations on autonomy and quality of life. The research also revealed

that the lack of physical, technological and communicational accessibility are the main obstacles, in addition to problems in public transport and health services infrastructure. These challenges are exacerbated by geographic and organizational barriers that further hinder access to health and social care services.

The results confirm that the implementation of inclusive public policies is essential to promote citizenship and full participation of people with disabilities. The interviews, conducted using the Collective Subject Discourse technique, provided a detailed understanding of the difficulties faced daily by these people and their caregivers, as well as the structural and organizational limitations of the services available.

The participants' reports indicate the need for improvements in urban infrastructure, investment in assistive technology resources and continuing training of professionals who work directly in the care and assistance to people with disabilities and their families.

The reality described by the participants of this study corroborates with the findings of national and international literature, which highlight the disadvantage of people with disabilities in accessing services and participating fully in community life. The barriers described are multifaceted and require comprehensive and collaborative solutions to be effectively overcome.

This study has limitations related to the methodological cut-off and the scope of the field investigated, which restrict the generalization of results. Nevertheless, the findings offer relevant contributions to understand the studied phenomenon and point out paths for future research.

Longitudinal studies should be carried out to investigate the evolution of accessibility conditions and the effectiveness of public policies over time. These studies will allow to monitor the changes in barriers faced by people with disabilities, evaluate the impact of actions implemented and identify areas that still need improvement, providing a continuous view on the effects of these policies on quality of life and social inclusion. In addition, such studies can contribute to adjustments in policies, ensuring that they remain effective in the face of new demands and social contexts.

The search for a truly inclusive society requires a continuous and collaborative effort, involving researchers, managers, professionals and the community itself. This process requires the development and implementation of effective public policies, as well as the promotion of an inclusive culture that goes beyond physical, technological and attitudinal barriers. Only with the active participation of all sectors will it be possible to build an environment that respects differences and promotes equal opportunities for all, especially for people with disabilities.

DESAFIOS NA ACESSIBILIDADE E INCLUSÃO DE PESSOAS COM DEFICIÊNCIA EM SERVIÇOS DE SAÚDE E ASSISTÊNCIA SOCIAL

RESUMO

Objetivo: Compreender as experiências de pessoas com deficiência, seus cuidadores familiares e gestores de serviços quanto às políticas públicas de saúde e assistência social em Campo Grande, estado de Mato Grosso do Sul, Brasil, explorando suas percepções sobre as dificuldades de acesso a esses serviços e cuidados. **Método:** trata-se de uma pesquisa descritiva qualitativa, incluindo pessoas com deficiência física, entre 18 e 65 anos, o cuidador familiar, e gestores de saúde e assistência social de serviços de sua referência. A coleta de dados foi realizada entre 2018 e 2019, por meio de entrevistas, organizadas pela técnica do Discurso do Sujeito Coletivo, e analisados e discutidas com base na literatura científica. **Resultados e Discussão:** com 32 participantes, os resultados destacam barreiras de acessibilidade física, tecnológica e comunicacional, além de dificuldades no transporte público e na infraestrutura dos serviços de saúde. Foram identificados também desafios geográficos e organizacionais, impactando a autonomia e qualidade de vida dessas pessoas. **Considerações finais:** o estudo revelou as dificuldades cotidianas enfrentadas por pessoas com deficiência e seus cuidadores, destacando a complexidade das barreiras e a necessidade de soluções colaborativas e abrangentes. Uma sociedade inclusiva exige políticas públicas eficazes que garantam igualdade de oportunidades para todos, com especial atenção às pessoas com deficiência.

Palavras-chave: Pessoas com deficiência. Equidade no acesso. Política pública. Assistência social.

DESAFÍOS EN LA ACCESIBILIDAD E INCLUSIÓN DE LAS PERSONAS CON DISCAPACIDAD EN LOS SERVICIOS DE SALUD Y ASISTENCIA SOCIAL

RESUMEN

Objetivo: comprender las experiencias de personas con discapacidad, sus cuidadores familiares y gestores de servicios en cuanto a las políticas públicas de salud y asistencia social en Campo Grande, estado de Mato Grosso do Sul, Brasil, explorando sus percepciones sobre las dificultades de acceso a estos servicios y cuidados. **Método**: se trata de una investigación descriptiva cualitativa, incluyendo personas con discapacidad física, entre 18 y 65 años, el cuidador familiar, y gestores de salud y asistencia social de los servicios de su referencia. La recolección de datos fue realizada entre 2018 y 2019, por medio de entrevistas, organizadas por la técnica del Discurso del Sujeto Colectivo, analizadas y discutidas en base a la literatura científica. **Resultados y discusión**: con 32 participantes, los resultados señalan barreras de accesibilidad física, tecnológica y comunicacional, además de dificultades en el transporte público y en la infraestructura de los servicios de salud. También se identificaron desafíos geográficos y organizacionales, que impactan en la autonomía y la calidad de vida de estas personas. **Consideraciones finales**: el estudio reveló las dificultades cotidianas que enfrentan las personas con discapacidad y sus cuidadores, destacando la complejidad de las barreras y la necesidad de soluciones colaborativas e integrales. Una sociedad inclusiva requiere políticas públicas eficaces que garanticen la igualdad de oportunidades para todos, con especial atención a las personas con discapacidad.

Palabras clave: Personas con discapacidad. Equidad en el acceso. Política pública. Asistencia social.

REFERENCES

1. World Health Organization. Global report on health equity for persons with disabilities. Geneva: World Health Organization; 2022. ISBN: 9789240063600. Disponível em: https://www.who.int/publications/i/item/9789240063600
2. United Nations. Disability and development report: realizing the Sustainable Development Goals by, for and with persons with disabilities. Department of Economic and Social Affairs. New York: United Nations; 2018. Disponível em: https://social.un.org/publications/UN-Flagship-Report-Disability-Final.pdf
3. Gréaux M, Moro MF, Kamenov K, et al. Health equity for persons with disabilities: a global scoping review on barriers and interventions in healthcare services. Int J Equity Health. 2023;22(1):236. DOI: https://doi.org/10.1186/s12939-023-02035-w
4. Costa LS, Amorim AC, Gertner SR, Nascimento CA, Ramos BS. Acessibilidade na comunicação para atenção integral à saúde das pessoas com deficiência. Rio de Janeiro: Fundação Oswaldo Cruz; 2022. Disponível em: https://www.arca.fiocruz.br/handle/icict/53796
5. Brasil. Lei nº 13.146, de 6 de julho de 2015. Institui a Lei Brasileira de Inclusão da Pessoa com Deficiência (Estatuto da Pessoa com Deficiência). Diário Oficial da União: Seção 1. Brasília, DF; 7 jul. 2015. p. 2-10. Disponível em: https://www.planalto.gov.br/cCIVIL_03/_Ato2015-2018/2015/Lei/L13146.htm
6. Whalley-Hammell K. Focusing on "what matters": the Occupation, Capability and Wellbeing Framework for Occupational Therapy. Cad Bras Ter Ocup. 2023;31:e3509. DOI: https://doi.org/10.1590/2526-8910.ctoAO269035092
7. Lefèvre F, Lefèvre AMC. O discurso do sujeito coletivo: um novo enfoque em pesquisa qualitativa. 2ª ed. Caxias do Sul: Educs; 2005.
8. Santos SMA. Acessibilidade em museus [dissertação]. Porto: Universidade do Porto; 2009. p. 27-28. Disponível em: https://nomundodosmuseus.hypotheses.org/tag/acessibilidade-em-museus
9. Lee CD, Koontz AM, Cooper R, Sivakanthan S, Chernicoff W, Brunswick A, et al. Understanding travel considerations and barriers for people with disabilities to using current modes of transportation through journey mapping. Transp Res Rec. 2023;2678(5):271-287. DOI: https://doi.org/10.1177/03611981231188730
10. Vasconcelos FM, Wellichan DSP. O trabalhador com deficiência: considerações sobre o cenário nacional e internacional. Braz J Dev. 2022;8(1):6016-6032. DOI: https://doi.org/10.34117/bjdv8n4-594
11. Ribeiro KG, Santos SL, Souza EA, Oliveira BLCA, Oliveira LCM. Determinantes sociais da saúde dentro e fora de casa: estudo em área periférica de capital brasileira. Saude Debate. 2024;48(141):179-194. DOI: https://doi.org/10.1590/2358-289820241408590P
12. Geraldo JPB, Andrade SMO. Pessoas com deficiência e as barreiras aos serviços de saúde: uma metassíntese. Res Soc Dev. 2022;11(6). DOI: http://dx.doi.org/10.33448/rsd-v11i6.29082
13. Moloney M, Taggart L, Hennessy T, Doody O. Exploring implementation of reasonable adjustments in hospitals for people with intellectual disability: using a realist lens. J Adv Nurs. 2024;1-16. Advance online publication. DOI: https://doi.org/10.1111/jan.16566
14. Dadalto EV, Cavalcante FG. O lugar do cuidador familiar de idosos com doença de Alzheimer: uma revisão de literatura no Brasil e Estados Unidos. Cienc Saude Colet. 2021;26(1):147-157. DOI: https://doi.org/10.1590/1413-81232020261.38482020
15. Miranda GMD, Köptcke LS, Albuquerque PCV, Santos MdPR, Carvalho MEL, Reichenberger V, et al. O acesso das pessoas com deficiência aos serviços de saúde: a percepção de profissionais e gestores da atenção primária à saúde. Saude Soc. 2024;33(2):e230582pt. DOI: https://doi.org/10.1590/S0104-12902024230582pt
16. Queiroz LQS. Desenho universal e acessibilidade arquitetônica: conceituações, distinções e aproximações. Geom Graf (UFPE). 2023;15(31):1-14. DOI: https://doi.org/10.51359/2595-0797.2023.260611
17. Albers C, Barth M, Renner JS. "Home, sweet home": do residential projects provide accessibility for people with reduced mobility? Rev Acao Ergon. 2021;15(2):e202101. DOI: https://doi.org/10.4322/rae.v15n2.e202101.en
18. Samenzati RM, Balieiro LT, Pedreiro MRM. Acessibilidade urbana em praças e centros comerciais: foco na aplicação das normas técnicas, especialmente a NBR 9050:2020. Rev Ibero-Am Hum Cienc Educ. 2024;10(12):1409-1421. DOI: https://doi.org/10.51891/rease.v10i12.17486
19. Dias JF, Grossi JB, Costa LA, Furtado SRC, Mancini MC, Sampaio RF. Atenção domiciliar no âmbito da reabilitação e prática centrada na família: aproximando teorias para potencializar resultados. Rev Ter Ocup Univ São Paulo. 2017;28(2):206-213. DOI: http://dx.doi.org/10.11606/issn.2238-6149.v28i2p206-213.

Disponível em: https://core.ac.uk/download/pdf/268318032.pdf

20. Organização Mundial da Saúde. Síntese de evidências para políticas: acesso à tecnologia assistiva. Genebra: OMS; 2020. Disponível em: https://iris.who.int/bitstream/handle/10665/332222/9789240011045-por.pdf

21. Brasil. Ministério da Saúde. Portaria nº 793 de 24 de abril de 2012. Institui a Rede de Cuidados à Pessoa com Deficiência no âmbito do Sistema Único de Saúde. Diário Oficial da União: Seção 1. Brasília, DF; 25 abr. 2012. p. 94-95. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2012/prt0793_24_04_2012.html

22. Clemente KAP, Silva SV, Vieira GI, Bortoli MC, Toma TS, Ramos VD, et al. Barreiras ao acesso das pessoas com deficiência aos serviços de saúde: uma revisão de escopo. Rev Saude Publica. 2022;56:64. DOI: https://doi.org/10.11606/s1518-8787.2022056003893

23. França EG, Pontes MA, Costa GMC, França ISX. Dificuldades de profissionais na atenção à saúde da pessoa com surdez severa. Cienc Enferm. 2016;22(3):107-116. DOI: http://dx.doi.org/10.4067/S0717-95532016000300107

24. Bioni B, Garrote M, Meira M, Paschoalini N. The digitization of the Brazilian national identity system: a descriptive and qualitative analysis of its information architecture. Data Policy. 2022;4:e22. DOI: https://doi.org/10.1017/dap.2022.14

25. Nakayama LF, Moriya HT, Nakamura FS, et al. The digital divide in Brazil and barriers to telehealth and healthcare access during COVID-19. BMC Public Health. 2023;23(1):1234. DOI: https://doi.org/10.2196/42483

26. Gabardo E, Aguilar Viana AC, Castreghini de Freitas OL. The digital divide in Brazil and the accessibility as a fundamental right. Rev Chil Derecho Tecnol. 2022;11(2):1-26. DOI: https://doi.org/10.5354/0719-2584.2022.60730

27. Fonseca BP, Albuquerque PC, Saldanha RF, Zicker F. Geographic accessibility to cancer treatment in Brazil: a network analysis. Lancet Reg Health Am. 2022;5:100153. DOI: https://doi.org/10.1016/j.lana.2021.100153

28. Coube M, Nikoloski Z, Mrejen M, Mossialos E. Persistent inequalities in health care services utilisation in Brazil (1998-2019). Int J Equity Health. 2023;22(1):25. DOI: https://doi.org/10.1186/s12939-023-01828-3

29. World Health Organization. Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies. Geneva: World Health Organization; 2010. Disponível em: https://iris.who.int/bitstream/handle/10665/258734/9789241564052-eng.pdf

30. Da Costa Miranda AL, Paixão ART, Pedroso AO, et al. Demographic, social, and clinical aspects associated with access to COVID-19 health care in Pará province, Brazilian Amazon. Sci Rep. 2024;14(1):8776. DOI: https://doi.org/10.1038/s41598-024-59461-1

Corresponding author: Juliana Pedroso Bauab Geraldo. Avenida Rita Vieira de Andrade, 700, casa 139. Rita Veira. Campo Grande-MS CEP: 79052-420

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