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NEURODIVERSITY AND THE RIGHT TO HEALTH: THE DIGNITY OF PEOPLE WITH AUTISM

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ABSTRACT

This article examines the relationship between the right to health and the human dignity of people with Autism Spectrum Disorder (ASD), highlighting how structural and social barriers limit equitable access to adequate health services. Based on a critical literature review, based on human rights and neurodiversity, the study explores vulnerabilities of this population, such as communication difficulties, sensory sensitivity and social exclusion, in addition to the scarcity of trained professionals and the concentration of services in large urban centers. The analysis emphasizes the importance of evidence-based therapeutic interventions, such as Applied Behavior Analysis (ABA) and the Denver Model (ESDM), recognizing their effectiveness in developing social and communicative skills, when applied early. The article also highlights the role of assistive technology, such as Alternative and Augmentative Communication (AAC) systems, in expanding access to interventions. It is concluded that the realization of the right to health for people with ASD requires inclusive public policies, continuous training of health professionals and active support networks. Neurodiversity is central to the analysis, reinforcing autism as part of human diversity. In this way, the study contributes to fairer policies, promoting well-being and full citizenship for this population.

Keywords: Right to Health. Human Dignity. Autism Spectrum Disorder – ASD. Social inclusion. Public Policies.

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INTRODUCTION

The right to health, recognized as a fundamental human right and intrinsically linked to the dignity of the human person, constitutes an essential pillar for individual and collective development, allowing each individual to reach their full potential and live with dignity.

The universal and equal guarantee of this right, which translates into access to actions and services for the promotion, protection and recovery of health, is an ethical imperative and an obligation of States. However, the full realization of the right to health for millions of people around the world, including those with Autism Spectrum Disorder (ASD), still faces significant challenges, especially in contexts marked by unequal health systems and insufficient investment in inclusive public policies.

Autism, a neurological condition that affects communication, social interaction, and behavior patterns, demands greater attention from health systems. With a growing prevalence – estimated at 1 in 54 children in the United States (CDC, 2020) – ASD imposes the urgent need for effective public policies that guarantee full access to health services appropriate to the specific needs of this population.

People with ASD often face difficulties in obtaining early diagnosis, accessing therapies such as Applied Behavior Analysis (ABA), and receiving specialized medical follow-up (APA, 2013). These difficulties have a significant impact on their quality of life, development and social inclusion, restricting their opportunities and dignity.

The complexity of autism requires an individualized and multidisciplinary approach, from diagnosis to ongoing lifelong support. Neurodiversity, a concept that recognizes neurological variation as part of human diversity, challenges the exclusively biomedical view of ASD and reinforces the need for policies that promote inclusion and respect for differences. In this sense, the relationship between the right to health and human dignity has become a central theme in the academic and political debate, especially with regard to the effectiveness of public policies aimed at this population.

This article proposes a critical analysis of how the right to health can promote the dignity of people with ASD, considering the perspective of human rights and the concept of neurodiversity. The research was conducted using a critical literature review approach, with the aim of investigating the relationship between the right to health and the promotion of human dignity for individuals with Autism Spectrum Disorder (ASD).

Data collection was carried out in the SciELO and LILACS databases, complemented by a Google Scholar search to expand the coverage of gray literature. The search strategy was structured using Boolean operators (AND, OR, NOT) to refine the results and optimize the selection of studies. The search terms used included combinations such as "Autism Spectrum Disorder" AND "right to health", "Neurodiversity" AND "human dignity" and "Autism" OR "TEA" AND "public policies", ensuring a broad but specific approach to the proposed theme.

To ensure the quality and adequacy of the included studies, inclusion and exclusion criteria were defined. The inclusion criteria prioritized publications in Portuguese and English focused on public policies and access to health for people with ASD, covering children and adults. On the other hand, articles that focused exclusively on private health plans, duplicate publications, and studies that were irrelevant to the Brazilian context or misaligned with the research theme were excluded.

The data analysis was conducted in a narrative and critical way, considering the intersection between the right to health, human dignity and autism. The article seeks to answer the following question: how does the guarantee of the right to health contribute to the dignity of people with ASD? To this end, it adopts an approach based on human rights, neurodiversity, and the ethics of care, examining the barriers that hinder access to adequate health services.

Intersectionality will be used as an analytical tool to understand that people are not defined by a single characteristic, but by multiple identities, such as gender, race, social class, and neurodiversity. This will allow for a broader analysis of vulnerabilities that may impact access to the right to health.

Thus, this article has the following objectives: (1) to explore the concept of human dignity from different philosophical and legal perspectives, providing a theoretical basis for the analysis; (2) examine the specific vulnerabilities faced by people with ASD in accessing healthcare, such as communication challenges, sensory sensitivity, and discrimination; and (3) discuss the importance of neurodiversity in promoting dignity, emphasizing the need for a paradigm shift in the understanding of autism.

By addressing these issues, the article aims to contribute to a more in-depth reflection on the relationship between the right to health, dignity and autism, with the aim of subsidizing the formulation of fairer and more inclusive public policies, promoting the well-being and full citizenship of people with ASD.

RIGHT TO HEALTH AS AN EXPRESSION OF THE DIGNITY OF THE HUMAN PERSON

Human dignity, a fundamental and guiding principle of human rights, consists in the recognition of the intrinsic and inalienable value of every human being. This conception, which transcends individual characteristics such as race, gender, social condition or intellectual capacity, states that each person is deserving of respect and consideration, simply because they are human.

Human dignity forms the foundation of the philosophy of human rights and manifests itself in the search for protection against all forms of degradation and dehumanization. This understanding, essential for the structuring of the legal system, is supported by philosophical and legal perspectives that intertwine and complement each other.

Immanuel Kant, in his seminal work "Foundations of the Metaphysics of Morals", bases human dignity on the capacity for self-determination and moral autonomy, that is, on the ability of each individual to act according to the dictates of reason and the moral law that he imposes on himself. For Kant (2007), the human being, endowed with reason and moral conscience, constitutes an end in itself, possessing an intrinsic value that prevents him from being treated as a mere instrument for the achievement of objectives alien to his own nature. This Kantian conception, by conferring on the individual an absolute and inalienable value, exerts a profound and lasting influence on the construction of the concept of human dignity in the legal sphere, informing the principles and norms that aim to protect and promote fundamental rights.

Dignity, thus understood, is not reduced to a mere theoretical postulate, but translates into a set of rights and guarantees that ensure each person the respect and consideration due, preventing him or her from being reduced to the condition of an object or means for ends unrelated to his or her own realization.

In the field of Law, human dignity is materialized as a set of fundamental rights, essential guarantees for the protection of the person against degrading and inhuman acts, and for the promotion of minimum existential conditions for a healthy life.

Ingo Wolfgang Sarlet (2006, p. 60), when analyzing the dignity of the human person in his work on fundamental rights, defines it as "an intrinsic and distinctive quality of each human being that makes him or her deserving of the same respect and consideration by the State and the community". This conception by Sarlet (2006), which highlights dignity as the foundation for the recognition and protection of human rights, implies a complex of rights and duties that not only protect the individual against degradation and dehumanization, but also ensure the conditions for a dignified life, including the possibility of active and co-responsible participation in society.

From this perspective, dignity transcends the moral sphere, acquiring normative force and configuring itself as a fundamental legal principle. This normative force of dignity, as Sarmento (2016) defines it, elevates it to a "normative principle of maximum stature", with direct implications for the validity and legitimacy of legal norms. Thus, human dignity, far from being a mere rhetorical proclamation, acts as a "compass in the search for the best solution" (Barroso, 2016, p. 154), guiding the interpretation and application of the Law and serving as a criterion for evaluating the legitimacy of laws and public policies.

From this perspective, by recognizing neurodiversity as part of human diversity, the dignity of all people is promoted, regardless of their differences, building fairer and more inclusive societies, in which everyone feels valued and respected.

Thus, any norm that violates human dignity, whether in the abstract or in its implementation, must be considered null and illegitimate. This conception, which links dignity to the validity of the legal system, is supported by Barroso's theory of human rights (2016, p. 492), which characterizes them as "pre- and supra-state", existing independently of recognition by the State. Sarlet (2018), complementing this view, points out that human rights, affirmed in international law, are inherent to the human condition and become fundamental rights when they are incorporated into the domestic legal system, consolidating themselves as "human rights incorporated into the domestic order" (Barroso, 2016, p. 493). This internalization of human rights, guaranteeing them binding force for all state powers (Legislative, Executive and Judiciary), represents the positivization of the moral rights inherent to the dignity of the person, ensuring their effective protection and promotion.

Among these fundamental rights, essential for the realization of human dignity, the right to health stands out, whose guarantee by the State is of special importance. The right to health, recognized by the Brazilian Constitution as a fundamental right, illustrates this realization of human dignity within the scope of the Brazilian legal system.

The 1988 Constitution, demonstrating the importance of this right, dedicates a specific section to it, composed of articles 196 to 200, which establishes principles and norms for the protection of public health and ensuring universal, free and equal access to health actions and services. Article 196, in particular, defines health as "a right of all and a duty of the State", guaranteeing it through social and economic policies aimed at reducing the risk of diseases and injuries, as well as universal and equal access to actions and services for the promotion, protection and recovery of health.

The right to health belongs to the second generation of fundamental rights, which according to Paulo Bonavides are:

> […] are the social, cultural and economic rights as well as the collective or collective rights, introduced into the constitutionalism of the different forms of social State, after they germinated through the work of the ideology and anti-liberal reflection of this century. They were born embraced by the principle of equality, from which they cannot separate, since to do so would be equivalent to dismembering them from the reason for being that supports and stimulates them" (Bonavides, 2008, p. 517).

For Bonavides, these rights, "born embraced by the principle of equality", are inseparable from the search for social justice and require positive action by the State. In this sense, the protection of health has two aspects: preservation and protection. The first refers to policies to reduce the risk of diseases, with preventive treatment for all citizens. The second is related to the protective demands of each individual's health, identifying the right to health as an individual right to treatment and recovery.

Observed as an individual right, the right to health privileges freedom, allowing citizens to seek physical, mental and social well-being. From another perspective, when observed as a collective right, it privileges equality, establishing limitations to individual human behavior, precisely so that everyone can equally enjoy the advantages of life in society.

Dallari (2004) states that "recognizing and treating someone as a person is respecting their life, but it also requires that the dignity of all human beings be respected". Sarlet (2006, p. 60) defines the dignity of the human person as:

> […] intrinsic and distinctive quality of each human being that makes him or her deserving of the same respect and consideration by the State and the community, implying, in this sense, a complex of fundamental rights and duties that ensure the person against any and all acts of a degrading and inhuman nature, as well as guaranteeing him or her the minimum existential conditions for a healthy life, in addition to providing and promoting their active and co-responsible participation in the destinies of their own existence and life in communion with other human beings.

Dignity involves, therefore, both respect among one's peers and protection by the State for the preservation and inclusion of individuals in society.

Respect for human dignity is the foundation of the entire legal system, and it is through its guarantee that the State will fulfill its objectives[4] of building a free, fair and solidary society, eradicating poverty and marginalization, reducing social and regional inequalities, promoting the good of all and ensuring regional development.

However, human dignity, based on the appreciation of the human being, although it is one of the foundations of[5] the Democratic Rule of Law expressed in the national legal system, has not been enough to guarantee a dignified life to the invisible of society, among this category are people with disabilities.

Lack of access to adequate health care compromises quality of life, limits individual opportunities, and undermines people's ability to reach their full potential. Human dignity requires that everyone has access to decent living conditions , implying public policies that aim to reduce socioeconomic disparities between regions.

Another relevant factor refers to health technology, which according to the World Health Organization – WHO, defines as knowledge or skills, organized and applied in various ways in medicines, vaccines, or even producing a system of procedures with a view to improving quality of life and/or solving a health problem.

Thus, it is perceived that the right to health is deeply linked to the principle of human dignity, which is one of the essential foundations of human rights . Thus, there is a cycle of actions that must be strictly followed for the State to achieve its established objectives: the principle of human dignity guides rulers to seek the well-being of all and the effective realization of fundamental rights, which can only be achieved with effective access to the right to health.

The guarantee of the right to health is, therefore, a vital component for the promotion and protection of human dignity and consequently vital for the achievement of the fundamental objectives of the Federative Republic of Brazil and the foundations of the Democratic Rule of Law.

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[4] The fundamental objectives of the Federative Republic of Brazil are set forth in Article 3 of the Federal Constitution.

[5] The foundations of the Democratic Rule of Law are set out in Article 1 of the Federal Constitution.

AUTISM AND THE SEARCH FOR INCLUSIVE HEALTH

THE NEURODIVERSITY PERSPECTIVE

Coined by Judy Singer (1999), the concept of neurodiversity proposes that neurological variations, such as autism, Attention Deficit Hyperactivity Disorder (ADHD) and dyslexia, be understood not as pathologies to be corrected, but as expressions of human diversity, analogous to cultural or ethnic diversity.

Singer (1999) criticizes the medical model of disability, which defines autism based on deficits and limitations, and argues that neurodiversity should be recognized as a fundamental aspect of the human experience, deserving of respect and accessibility. This perspective, which is opposed to the traditional view that seeks the "normalization" of neurodivergent people, emphasizes the appreciation of their differences and potentialities.

The origin of the term "neuro diversity" is intrinsically linked to the autistic rights movement (Ortega, 2009), which questions the medicalization and pathologization of autism, seeking autonomy and the recognition of their identity as subjects of rights. Thus, neurodiversity is consolidated not only as a concept, but as a social and political movement that fights for inclusion and respect for neurological differences (Singer, 1999).

In this context, instead of framing autism as a "pathology" to be treated or corrected, neurodiversity recognizes it as a natural and legitimate variation of human neurological functioning, integrating it into the plurality of the human condition (Silva, 2021).

This paradigmatic shift, which questions the historically dominant medical-deficient model, has significant repercussions for the rights to health and dignity of autistic people. By breaking with the view of autism as a disability or abnormality, neurodiversity opens space for health policies and inclusion practices that respect the autonomy and singularities of autistic individuals (Ortega, 2009; Armstrong, 2015), promoting an approach centered not on correction but on social adaptation and the recognition of neurological differences as essential components of human diversity.

Valuing the potential and contributions of autistic people to society, neurodiversity is based on fundamental principles that guide its vision and practice. These principles include: (1) the recognition and appreciation of neurological differences as intrinsic components of human diversity; (2) respect for the autonomy and self-determination of neurodivergent people in all spheres of life; (3) the focus on skills, talents and potentialities, instead of focusing on deficits and limitations; and (4) the defense of a more inclusive society adapted to different neurological needs and characteristics, promoting accessibility and the removal of barriers (Silva, 2021).

Authors such as Armstrong (2015) highlight the ethical and practical implications of these principles, arguing that neurodiversity not only legitimizes neurological difference, but also calls on society to transform itself, promoting inclusive policies and practices that guarantee the full exercise of citizenship for neurodivergent people.

This social transformation finds strong resonance in the social model of disability (Oliver, 1990), which, like neurodiversity, shifts the focus from the individual's disability to the social and structural barriers that prevent their full participation in society. Both paradigms recognize that the difficulties faced by neurodivergent people are largely the product of a social environment that is not adapted to their needs and particularities (Silva, 2021).

Disability, therefore, is not seen as intrinsic to the individual, but as a result of the interaction between their characteristics and the barriers imposed by the environment. By incorporating this perspective, neurodiversity reaffirms that it is not autistic people who need to be "corrected" or "cured", but society that needs to adapt, promoting accessibility, inclusion, and respect for difference (Ortega, 2009).

This change in perspective is essential to guarantee the dignity of the autistic person, by breaking with the stigma of pathologization and recognition of the autistic individual as a subject with full rights. In this sense, neurodiversity represents a true revolution in the understanding of autism, updating the reductionist view that frames it as a disorder or disease through an approach that corrects it as a singular way of being in the world. In this new perspective, autism is valued for its own norms, values and modes of communication, constituting a culture rich in subjective experiences and diversity (Ortega, 2009).

By avoiding strategies focused on the "normalization" of autistic behaviors, neurodiversity not only destigmatizes autism, but also values the cultural and social contributions of autistic people, reaffirming their potential and inalienable dignity. In this way, neurodiversity not only recognizes autism as part of human diversity, but also emphasizes the intrinsic value of neurological differences in building a truly inclusive society.

In the context of the right to health, neurodiversity defends an approach that respects the autonomy, individuality and, above all, the dignity of the autistic person. This implies adapting health services to their specific needs, ensuring accessible communication, considering their sensory and cognitive particularities, and ensuring their active participation in decisions about treatments and interventions (Silva, 2021).

Shared and collaborative decision-making, with respect to the preferences of the autistic individual, is essential to ensure ethical and effective care. In addition, neurodiversity promotes the empowerment of autistic people, encouraging their self-determination and the development of their skills and potential. The fight against stigma and discrimination, as Armstrong (2015) points out, is crucial to ensure access to health without prejudice and with respect for dignity, through inclusive health services that value the expertise of autistic people themselves.

Despite its growing influence, neurodiversity also receives criticism. Some authors argue that the movement can minimize the difficulties faced by autistic people with more significant support needs (Silva, 2021) and that the rejection of the term "disorder" can hinder access to important treatments and interventions.

However, these criticisms do not invalidate the importance of the neurodiversity paradigm, as the movement does not deny the existence of challenges or the need for support. On the contrary, by advocating that support be offered in an individualized and respectful way, considering the autonomy and preferences of the autistic person, neurodiversity reinforces the dignity of the individual, ensuring that their needs are met without the imposition of models of "normality".

Ultimately, neurodiversity seeks to transform society and the health system so that they are more inclusive, promoting respect for difference and recognizing the right to health as a fundamental instrument for guaranteeing the human dignity of people with autism.

3.2 UNDERSTANDING AUTISM SPECTRUM DISORDER – ASD

Autism, formally known as Autism Spectrum Disorder – ASD, is a neurodevelopmental disorder characterized by difficulties in communication and social interaction and by repetitive and restricted behavior patterns. Defined as a complex condition, this disorder results from the interaction between genetic and environmental factors, although without a well-established single cause (Sandin et al., 2017). Studies show that genetic factors play a central role in the development of ASD, with heritability estimates ranging between 50% and 80%, while environmental factors, such as prenatal complications and exposure to toxic agents, can also contribute to the emergence of the disorder (Tick et al., 2016; Bai et al., 2019).

At the same time, environmental factors have also been pointed out as relevant influences, especially during the gestational period and the first years of life. Among these factors, prenatal complications, advanced age of parents at the time of conception, maternal infections, exposure to environmental pollutants and endocrine disruptors, as well as perinatal events such as hypoxia and prematurity, which can act as modulators of the risk of developing ASD (Bai et al., 2019; Sandin et al., 2017).

The clinical manifestations of ASD are widely heterogeneous, ranging from individuals with high-functioning abilities, such as language preservation and cognition, to more severe conditions, with marked deficits in communication, cognition, and functional autonomy. This diversity is also reflected in comorbidities often associated with the disorder, such as intellectual disability (ID), epilepsy, attention deficit hyperactivity disorder (ADHD), and gastrointestinal disorders, which contributes to the complexity in diagnosis and clinical management (Sandin et al., 2017; Neumeyer et al., 2019). This diversity of manifestations implies the need for an individualized approach to diagnosis and intervention.

The diagnosis of Autism Spectrum Disorder (ASD) is clinical and, according to the *Diagnostic and Statistical Manual of Mental Disorders* – DSM-5[6], is based on two main clinical domains: (a) persistent deficits in social communication and social interaction in multiple contexts and (b) restricted and repetitive patterns of behavior, interests or activities (APA, 2013). In the first domain, it is necessary for the individual to present deficits in all of the following areas: socio-emotional reciprocity, nonverbal communication behaviors that are used for social interaction, and difficulties in developing, maintaining, and understanding interpersonal relationships. In the second domain, diagnosis requires at least two of the following criteria: stereotyped and repetitive motor movements, use of objects or speech; insistence on inflexible routines or ritualized patterns of behavior; fixed and restricted interests of high intensity; or hyper- or hyporeactivity to sensory stimuli or unusual interest in sensory aspects of the environment (APA, 2013).

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[6] The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is a guide published by the American Psychiatric Association (APA) that provides standardized classification and diagnostic criteria for a wide range of mental disorders and is widely used by mental health professionals, researchers, and policymakers to standardize diagnoses.

For the diagnosis of ASD to be concluded, symptoms must be present from the beginning of child development, even if they do not fully manifest until social demands exceed the individual's capabilities. In addition, these symptoms must cause clinically significant impairment in social, academic, or occupational functioning, and cannot be better explained by isolated intellectual disability or by global developmental delays (APA, 2013).

The diagnosis is typically made through a careful clinical evaluation conducted by a multidisciplinary team, composed of professionals such as psychologists, speech therapists, occupational therapists, psychiatrists, and neuropediatricians. However, the diagnostic report for legal purposes, especially in contexts of access to public policies, is an exclusive medical competence, usually issued by psychiatrists or neuropediatricians with experience in the subject (APA, 2013).

This standardized diagnostic approach allows for a more accurate understanding of the individual's needs, and is crucial for the development of appropriate and personalized interventions. The early identification of ASD and the initiation of specialized interventions are crucial for the overall development of the child, since neural plasticity in the early stages of life can enhance functional gains (Lord et al., 2012). In addition, as established by the DSM-5, the symptoms of ASD must be present from the beginning of the developmental period, although they can become more evident only when social demands exceed the child's capabilities.

Lord *et al.* (2012) highlight the complexity in the diagnosis of Autism Spectrum Disorder (ASD), advocating an evaluation that goes beyond the isolated application of tests. For the authors, direct observation of behavior, interviews with parents or caregivers, and analysis of developmental and mental health history are essential. In this sense, tools such as the *Autism Diagnostic Observation Schedule* (ADOS), the *Autism Diagnostic Interview-Revised* (ADI-R)[7] and the *Childhood Autism Rating Scale* (CARS)[8] are important

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[7] The Autism Diagnostic Interview-Revised (ADI-R) The ADI-R is a structured, standardized interview conducted with the person's parents or caregivers to gather information about the child's development and ASD-related behaviors. The interview covers three main domains: 1) communication and language; 2) reciprocal social interaction; and 3) restricted and repetitive patterns of behavior and their administration takes between 90 (ninety) and 120 (one hundred and twenty) minutes and provides detailed information about the person's developmental history (Lord et al., 2000).

8 CARS is a screening and diagnostic tool for children from 2 years of age with suspected ASD that consists of 15 items that assess different areas of the child's development and behavior, such as social interaction, communication, sensory response, among others. Each item is rated on a scale of 1 to 4, with 1 representing typical development and 4 representing severe impairment. The total score ranges from 15 to 60 points and

instruments for screening and are frequently used as technical support in this multidimensional assessment.

In Brazil, the Brazilian Society of Pediatrics (2019) recommends the use of the M-CHAT scale (Modified Checklist for Autism in Toddlers)[9] to screen for early signs of autism in children between 16 and 30 months of age. The Ministry of Health (2018) also recognizes M-CHAT as an essential tool for early diagnosis and promotes its inclusion in the Children's Card, a document widely distributed in the national territory, used for monitoring and promoting child health. This strategy aims to encourage early identification of signs of ASD and facilitate timely intervention.

In this way, the diagnosis of ASD is not based on a single test or exam, but on a careful evaluation of the entire clinical picture, with the aim of understanding the particularities of each individual and providing an accurate and comprehensive diagnosis. The emphasis is on understanding the individualized clinical picture, and not on the mere isolated application of standardized instruments.

In this vein, it should be mentioned that before the publication of the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), autism spectrum disorders were diagnosed as separate categories in the DSM-IV.[10] Among these categories were Asperger's Syndrome and Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS).

Asperger's Syndrome, first described by Hans Asperger in 1944, was characterized by significant difficulties in social interaction and by restricted and repetitive patterns of behavior, interests, and activities, without significant delays in language development or cognitive development. Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS) was a diagnosis used for individuals who met some, but not all, of the criteria necessary for a diagnosis of autism or Asperger's Syndrome. This diagnosis was applied

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based on the total score, children are classified into three categories: No Autism (score 15 to 29.5), Mild to Moderate Autism (score 30 to 36.5), and Severe Autism (score 37 to 60).

[9] M-CHAT (Modified Checklist for Autism in Toddlers) is a widely used screening tool to identify early signs of autism in children between 16 and 30 months of age. It has been adapted and recommended by the Brazilian Society of Pediatrics for use in routine consultations, as part of the assessment of child development, with the aim of facilitating the early identification of children who may benefit from further evaluation for ASD. M-CHAT-R/F is not a diagnostic instrument. A positive result on the questionnaire indicates the need for further evaluation by specialized ASD professionals, who will conduct comprehensive diagnostic evaluations to confirm or rule out the diagnosis.

[10] The DSM-IV is the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association (APA) in 1994 and revised in 2000.

when there were significant delays in social development and communication, but the full clinical picture did not fit into the specific categories of autism or Asperger's.

However, in order to improve diagnostic accuracy, in 2013, the fifth edition of the DSM-5 consolidated the subcategories of autism under the term "Autism Spectrum Disorder" (ASD) and since then, this term has included the previously separate diagnoses of Autism. This unification, supported by studies that have shown the variability and overlap of symptoms between the subcategories, seeks to provide a clearer and more comprehensive understanding of the autism spectrum, recognizing the diversity of manifestations within the spectrum.

The integration of Asperger's Syndrome and Pervasive Developmental Disorder Not Otherwise Specified in Autism Spectrum Disorder into the DSM-5 reflects a more sophisticated and inclusive understanding of the condition, allowing for more consistent assessment and more effective targeting of resources and interventions, benefiting both diagnosed individuals and clinical practice and scientific research. This approach recognizes the heterogeneity of the disorder and the need for individualized support, considering variations in manifestations and the degree of functional impairment.

The evolution of the diagnosis of ASD in the DSM-5 by consolidating the different presentations under a single category, represents a significant advance in neuroscience and psychiatry, benefiting both affected individuals and the scientific community.

For diagnostic and treatment purposes, autism is also assessed for its level of support, which means that individuals are assessed based on the intensity of support required in three main areas: communication, social interaction, and repetitive or restrictive behaviors.

Support levels in Autism Spectrum Disorder (ASD) are a classification established by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), to identify the severity of deficits in social communication and restrictive and repetitive behaviors, and thus determine the amount of support needed for each individual.

These levels can range from mild to severe, indicating the extent of the challenges each person may face and there is no rigid scale, but clinical assessments and observations help determine the level of support needed.

The DSM-5 defines three levels of support for ASD, which help identify each individual's support needs and personalize interventions and treatments: **Level (Needs**

Support), Level 2 (Needs Substantial Support), and Level 3 (Needs Very Substantial Support).

At **level 1,** individuals have notable difficulties initiating social interactions and clear examples of atypical or unsuccessful responses to social overtures from others, as well as may appear less interested in social interactions. Inflexible behaviors and restricted interests cause significant interference in one or more areas of the individual's life that may have difficulties in changing activities and problems with organization and planning (APA, 2013).

At **level 2,** individuals have marked deficits in verbal and nonverbal communication skills, initiating limited social interactions and exhibiting abnormal responses to social overtures, which in most cases makes communication reduced to simple interactions. The behaviors are severe enough to be obvious to the casual observer, interfere substantially with functioning in various contexts, and the individual shows great difficulty in coping with change or switching between activities (Lord et al., 2012).

At **level 3,** individuals have severe deficits in verbal and nonverbal communication skills, resulting in very limited social interactions and a minimal ability to respond to social overtures. They can be practically non-verbal, have extreme behavioral inflexibility, difficulty in dealing with change, and restrictive/repetitive behaviors markedly interfere with the functioning of all areas, making changes in focus or activities extremely difficult and distressing (Lord et al., 2012).

Assessment by level of support is crucial, as it allows the creation of specific and personalized intervention plans and, therefore, more effective to the individual needs of the patient (Lord et al., 2012), and also provides guidance to families on the amount and type of support needed at home and in the community, helping to manage expectations and care strategies (Gillespie-Lynch et al., 2017).

In addition, the categorization of the level of support contributes to the planning of long-term actions, helping families to establish realistic expectations and more appropriate care strategies, promoting the well-being of both the diagnosed individual and their caregivers.

The increase in the prevalence of Autism Spectrum Disorder (ASD) in recent decades can be attributed to greater awareness in society, the improvement of diagnostic criteria, and possible environmental influences. Data from the *Centers for Disease Control and Prevention* (CDC, 2020) point to an estimated prevalence of 1 in 36 births in the United

States. In Brazil, a pilot study conducted in Atibaia, São Paulo, indicated a prevalence of 1 in 367 children (Paula et al., 2011).

Early detection of ASD and prompt initiation of therapeutic interventions are essential to improve the prognosis in the development of an autistic child. While there is no cure for autism, early stimulation can maximize a child's developmental potential, especially during so-called windows of opportunity in the brain, which are periods when neural plasticity is highest. Early and intensive interventions have the potential to form more robust neural networks, facilitating the acquisition of new skills and promoting greater independence throughout life.

In this way, these numbers reflect not only a mere increase in diagnoses, but also a broadening of the understanding of the autism spectrum, which now encompasses a greater diversity of manifestations.

In this context, therapeutic interventions based on scientific evidence play a crucial role in the treatment of autism, aiming to develop social, behavioral, communicative, and functional skills.

Some of the key approaches include:

Table 01

Approach	Description
Applied Behavior Analysis (ABA)	It uses learning and behavior principles to promote social and communicative skills, as well as reduce problematic behaviors.
Treatment and Education for Autistic and Communication-Related Disabilities (TEACCH)	Program that emphasizes adapting the environment and structuring daily activities to meet the needs of the individual.
Occupational therapy	Focused on developing skills to carry out daily activities independently.
Phonoaudiology	It aims to improve verbal and nonverbal communication skills.
Personalized Educational Interventions	Adjusted to the student's individual needs, based on ongoing assessments and collaboration between educators, therapists, and families.

Family support is an essential aspect in the context of interventions for ASD, as the diagnosis can generate a significant emotional impact for family members, often accompanied by feelings of grief, high levels of stress, depression and anxiety. Studies such as those by Dabrowska and Pisula (2010), Pottie and Ingram (2008) and Hayes and Watson (2013) evidence this overload, reinforcing the need for the importance of continuous psychological and informational support for the family.

In this sense, the Pan American Health Organization (PAHO) highlights the empowerment of caregivers as an essential element in interventions aimed at people with ASD, which means providing them not only with practical information and resources, but also with ongoing emotional and psychological support so that they can deal with day-to-day challenges in a healthier and more resilient way. In addition, the active involvement of the family in the therapeutic process contributes significantly to treatment adherence, favoring better results in the child's global development and providing greater well-being to all involved.

In short, ASD is a condition characterized by a wide range of behavioral and cognitive manifestations and presents a wide range of characteristics and levels of necessary support, requiring an individualized and multidisciplinary evaluation to determine the most effective diagnosis and interventions. (Hayes; Watson, 2013).

Individualized, specialized, intensive, continuous and comprehensive intervention, involving a multidisciplinary team of health and education professionals, becomes a fundamental pillar for the development of their potential and for the construction of a fuller life. The synergy between different areas of knowledge, materialized by the performance of a multidisciplinary team composed of health and education professionals, enhances the results of the interventions, broadening horizons and promoting inclusion in its most diverse aspects.

THE VULNERABILITY AND DIGNITY OF THE PERSON WITH AUTISM

People with Autism Spectrum Disorder (ASD), although they have unique potentialities and characteristics that should be valued from the perspective of neurodiversity, face a complex network of vulnerabilities that directly impact their dignity and access to fundamental rights.

These vulnerabilities, often exacerbated by entrenched societal biases and persistent social barriers, create a vicious circle of exclusion and stigmatization. This cycle limits opportunities for full social participation and restricts the full development of autistic individuals' potential.

Understanding the multifaceted nature and extent of these vulnerabilities is, therefore, a *sine qua non* condition for the construction of effectively inclusive public policies and social practices. Such policies and practices should not only promote the full exercise of citizenship, but, above all, guarantee the dignity of people with autism, recognizing them as subjects with full rights and valuing their unique contributions to the richness and diversity of society.

One of the main vulnerabilities faced by people with ASD lies in difficulties in communication and social interaction, characteristics inherent to the disorder. The interpretation of nonverbal cues, eye contact, prosody, emotional expression, and social reciprocity can manifest in atypical patterns, distinct from those observed in neurotypical individuals.

This often results in misunderstandings, social isolation, and difficulties in forming and maintaining affective bonds (Ortega, 2009). In addition to the impact on interpersonal relationships, this communicative barrier restricts access to basic services, such as health, education and social assistance, especially those that require direct interaction and adapted to the specific communicative needs of autistic people.

In this sense, the dignity of these people is violated when their forms of communication are not understood and respected, when they are treated with suspicion, infantilized or disregarded as subjects of rights and capacities. The lack of adaptation of society and services to their communicative needs perpetuates and aggravates this vulnerability, directly impacting their right to social participation and the construction of a full, autonomous and dignified life.

Another significant vulnerability, which profoundly affects the quality of life and dignity of people with ASD, is sensory hyper- or hyposensitivity. Exacerbated or, on the contrary, diminished reactions to sensory stimuli such as lights, sounds, textures, smells, tastes, temperatures, and pain can cause deep discomfort, anxiety, fear, and intense suffering.

This atypical sensitivity makes it difficult to adapt to public and institutional settings, which are often overstimulating or inadequately adapted to the specific sensory needs of autistic people. The analysis of this vulnerability requires understanding the social model of disability (Oliver, 1990), which, unlike the traditional medical model (which locates "disability" exclusively in the individual), understands it as the result of the interaction between the characteristics of the person and the barriers imposed by the environment. In the case of sensory sensitivity, the difficulty does not lie intrinsically in the way the autistic person processes sensory stimuli, but in the lack of adaptation and sensory accessibility of public and institutional spaces.

An environment with excessive sensory stimulation, for example, can be extremely aversive for an autistic person, while an environment with adequate resources and adaptations, such as calming zones, controlled lighting, visual communication resources, and adapted furniture, would allow their full and comfortable participation. The social model of disability, therefore, places the responsibility on society, challenging it to create more inclusive and sensorially accessible environments that respect differences and promote the dignity and well-being of people with autism.

The failure to make these adaptations, in addition to constituting a violation of dignity, imposes concrete barriers to the full exercise of citizenship. The lack of sensory accessibility restricts the participation of people with autism in various spheres of life – social, educational, professional and recreational – significantly impacting their general well-being, autonomy and, consequently, their dignity. In this sense, initiatives that seek to promote inclusion are necessary, such as: adaptations of spaces and materials; professionals with specific training to deal with the learning and behavioral difficulties of neurodiverse people; flexibility of schedules and tasks; early diagnosis, awareness of society, among others.

In addition to architectural and sensory barriers, prejudice and discrimination act as additional obstacles, further compromising the social inclusion of people with ASD. Historically, autism has been seen from the perspective of "abnormality" and "disability", mistaken notions built from a deficient medical model that defines it as a pathology to be corrected. This stigmatizing view, which reduces autistic people to their condition, not only limits opportunities for inclusion, but also reinforces marginalization and hinders the development of effectively inclusive public policies.

By being treated as "sick", and not as individuals with specific rights, people with autism have their dignity violated and their potential unjustly ignored. Thus, a cultural and social change that recognizes its intrinsic value and contribution to society becomes urgent.

The neurodiversity movement (Ortega, 2009; Silva, 2021), when defending the acceptance of neurological differences and the adaptation of the environment to the sensory and communicative specificities of autistic people, emphasizes the importance of an inclusive approach to guarantee their dignity.

In summary, the right to health plays a fundamental role in promoting the dignity of people with autism. It is not just about ensuring access to medical and therapeutic services, but about ensuring that these services are offered in a respectful, inclusive and tailored way

This implies considering the vulnerabilities resulting from difficulties in communication and social interaction, sensory sensitivity and social stigma, promoting comprehensive and humanized care that values the autistic person in its entirety, recognizing them as subjects of rights and potentialities.

An effectively inclusive and equitable health system is, therefore, an essential condition for ensuring the dignity and well-being of people with ASD, contributing not only to their individual development, but also to the construction of a more just and inclusive society.

THE RIGHT TO HEALTH AS AN INSTRUMENT TO PROMOTE THE DIGNITY OF PEOPLE WITH AUTISM

The right to health, a fundamental pillar of human dignity, acquires even greater relevance when we consider the specificities and challenges faced by people with autism. To fully understand this relevance, it is necessary to expand the biomedical understanding of health, often limited to the simple absence of disease, and to embrace a more holistic view that encompasses physical, mental, social, and cultural aspects.

In the context of autism, health should be understood broadly, as a state of complete physical, mental and social well-being, intrinsically linked to the dignity of the person. This conception, in line with the principles of the World Health Organization (WHO), encompasses physical, mental and social well-being, essential for human dignity and the full exercise of citizenship. This approach goes beyond medical treatment and includes access to specialized therapeutic interventions that favor the overall development and social inclusion of people with ASD.

For these individuals, health promotion is not restricted to the absence of organic pathologies, but is a fundamental means to enhance their capacities, develop their autonomy, favor their active participation in the community and, above all, ensure the full exercise of their rights and citizenship (Dallari, 2004; Sarlet, 2006).

The right to health, therefore, emerges as an essential tool not only to guarantee the dignity and full citizenship of people with ASD, but also as a determining factor for their quality of life, their biopsychosocial well-being and their effective social inclusion.

The capabilities perspective, developed by Amartya Sen (2010) and Martha Nussbaum (2000), offers a robust and innovative theoretical framework for understanding the centrality of health in human development and, consequently, its intrinsic relationship with dignity. This approach shifts the focus of public policy and welfare assessments from the simple quantitative measurement of resources, such as per capita income or Gross Domestic Product (GDP), to the qualitative analysis of individuals' real capabilities.

Capacities, according to Sen, represent the substantive freedom that people have to "be" and "do" what they value, that is, their ability to reach states of being and to perform activities that they consider important for their lives. Nussbaum, for his part, complements this vision by proposing a list of ten core capacities that he considers essential for a truly dignified life: life; body health; bodily integrity; senses, imagination and thought; emotions; practical reason; affiliation; relationships with other species; joke; and control over one's own political and material environment (home, work, property).

These capacities, although distinct, are interdependent and mutually reinforcing, creating a virtuous cycle of human development. From this perspective, health stands out as a fundamental capacity that not only contributes to individual well-being, but also sustains and enhances the development of all other capacities.

In the case of people with ASD, the right to health acquires even greater relevance, as the difficulties inherent to the disorder can create substantial barriers to the development of various capacities. Communication and social interaction challenges, for example, can hinder social affiliation and participation, while sensory sensitivity can restrict access to education, work, and leisure. Cognitive processing difficulties, in turn, can affect the capacity for practical reason and control over one's own environment.

Therefore, guaranteeing the right to health for people with ASD goes beyond responding to specific medical needs, being essential to promote integral development, enabling the expansion of their capacities and the construction of a dignified, autonomous and socially inclusive life.

Access to therapeutic interventions based on scientific evidence is a determining factor for the promotion of dignity and the full exercise of the right to health of people with Autism Spectrum Disorder (ASD). Among the most well-documented approaches, Applied Behavior Analysis (ABA) stands out, which has an extensive body of research validating its effectiveness. The pioneering study by Lovaas (1987) demonstrated that children submitted to an intensive ABA program, with 20 to 40 hours per week of early and personalized intervention, showed significant progress in social, communicative and academic skills, when compared to groups that did not receive intensive behavioral interventions. ABA is based on principles of behavioral science, with a focus on positive reinforcement and the modeling of desired behaviors, contributing directly to the development of adaptive behaviors and the reduction of challenging behaviors, promoting greater autonomy and social inclusion (LOVAAS, 1987).

Speech therapy, in turn, is widely recognized as a fundamental approach, especially in children with ASD who have significant difficulties in speech and functional communication. Studies such as the one by Ganz et al. (2012) have shown the effectiveness of the use of Alternative and Augmentative Communication (AAC), including systems such as the Picture Exchange Communication System (PECS) and electronic communication devices, in expanding functional communication and reducing problematic behaviors related to frustration in nonverbal children. The meta-analysis conducted by the authors demonstrated positive results in terms of increased communicative expression and improved social interaction of children with ASD.

Occupational therapy also plays a central role, especially in cases of sensory sensitivities, motor difficulties, and challenges in performing daily activities. Virués-Ortega (2010) conducted a meta-analysis highlighting that interventions based on the sensory integration approach showed significant benefits in emotional self-regulation and in the reduction of disruptive behaviors, especially in children with ASD who have sensory hyper or hyporeactivity. Techniques such as controlled sensory stimulation and the use of adaptive materials help to improve motor coordination and environmental perception, promoting greater functional independence.

Early intervention models have also demonstrated substantial efficacy. The Early Start Denver Model (ESDM), developed by Dawson et al. (2010), uses a naturalistic and child development-based approach, focusing on social interactions during daily activities. In a randomized study, Dawson et al. (2010) showed that children with ASD undergoing ESDM between 12 and 48 months showed significant improvements in cognitive, language, and social interaction skills, highlighting the importance of early intervention in enhancing child development. In a complementary way, the Treatment and Education of Autistic and Communication Handicapped Children (TEACCH) program uses a structured approach, with visual supports and environmental adaptations, promoting learning and autonomy, especially in school environments (ZWAIGENBAUM et al., 2015).

The importance of early diagnosis and interventions is widely corroborated by the scientific literature. Longitudinal studies, such as that by Zwaigenbaum et al. (2015), indicate that interventions initiated before the age of three result in more significant gains in cognitive and social skills, showing that neural plasticity in this critical period of child development can be optimized with specialized therapeutic approaches.

However, the mere offer of these interventions does not guarantee their full effectiveness. For the benefits to be consistent and long-lasting, it is essential that therapies are implemented in a continuous, intensive, and personalized way, considering the unique profile of each person with ASD. In addition, equitable access to specialized services still faces challenges, especially in contexts of socioeconomic vulnerability and in regions with limited resources. Bai et al. (2019) highlight that disparities in access to quality interventions can significantly compromise the development and quality of life of children with ASD, reinforcing the need for public policies aimed at equity and the universalization of health services.

The active involvement of families in the therapeutic process has been identified as a determining factor for the success of interventions. Studies such as those by Hayes and Watson (2013) and Pottie and Ingram (2008) emphasize that family participation not only improves clinical outcomes, but also significantly reduces parental stress levels and promotes a more harmonious relationship between the caregiver and the child with ASD. Empowering parents to apply therapeutic techniques at home, such as positive reinforcement strategies and stimulating communication, provides continuity to treatment and enhances its long-term effects.

In this way, the right to health for people with ASD is not limited to the absence of diseases, but involves equitable and continuous access to quality therapeutic interventions, which allow the integral development and dignity of these individuals. The perspective of capacities, defended by Sen (2010) and Nussbaum (2000), reinforces this understanding by emphasizing that health is an indispensable means for the promotion of all other human capacities, allowing the individual to live with autonomy, dignity and social participation.

For this right to be implemented in a broad and equal manner, it is essential to invest in structured public policies that ensure early diagnosis, the availability of evidence-based therapies, and the provision of specialized support in a continuous manner and adapted to individual needs. Such policies must go beyond the simple allocation of resources, demanding concrete actions, such as the training and qualification of health professionals, the creation of specialized care centers, and the adaptation of clinical protocols to the sensory, communicative, and cognitive specificities of people with ASD.

The active participation of families and people with ASD themselves in all stages of this process, from the formulation to the evaluation of public policies, is essential to ensure that the interventions implemented meet the real needs of this population. After all, families and individuals themselves are on the front lines of daily challenges and can offer valuable contributions to building a fairer and more effective health system.

In this context, public policies aimed at the health of people with ASD become essential instruments to promote dignity and social inclusion, overcoming barriers such as communication difficulties, sensory sensitivity and discrimination. More than ensuring formal access to services, guaranteeing the right to health implies an ethical and political commitment of the State to the promotion of full citizenship and the integral development of this population.

Therefore, a truly inclusive health system must recognize autism as a form of human diversity, rather than as a condition to be corrected. Ensuring the right to health of people with ASD, with personalized interventions and continuous support, is an ethical responsibility and an essential pillar for building a more equitable and just society for all.

FINAL CONSIDERATIONS

In view of the analysis presented throughout this article, it is evident that the right to health of people with Autism Spectrum Disorder (ASD) constitutes a central pillar for the promotion of human dignity and social inclusion. This perspective goes beyond the absence of disease, encompassing integral well-being and equitable access to quality therapeutic interventions, aligning itself with the theory of capacities of Sen (2010) and Nussbaum (2000), by recognizing health as an essential element for the full exercise of citizenship and human flourishing.

However, structural and social challenges persist that limit the realization of this right. Regional disparities in access to specialized services, with a concentration of centers in large urban centers, deprive populations in peripheral regions of appropriate diagnoses and interventions. This scenario is aggravated by the absence of physical and communicational accessibility, such as the scarcity of Alternative and Augmentative Communication (AAC) resources and by the insufficient training of professionals to deal with the sensory and communicative particularities of autistic people. These barriers compromise autonomy and "control over one's own environment", one of the central elements of dignity in Nussbaum's (2000) approach.

In addition, prejudice and discrimination still present in institutional and social contexts reinforce stigmas and exclusions, negatively impacting equitable access to essential services and violating fundamental principles of equity. This exclusion highlights the need for a health care model that transcends the biomedical approach, prioritizing integral well-being and the development of human capacities.

To overcome these limitations, the implementation of inclusive and equitable public policies becomes essential. Ensuring universal, comprehensive, and continuous access to specialized services requires concrete actions, such as the continuous training and training of health professionals in evidence-based approaches, such as Applied Behavior Analysis (ABA) and the Denver Model of Early Intervention (ESDM). These approaches, when applied early and intensively, have been shown to be effective in developing social and communicative skills (LOVAAS, 1987; DAWSON et al., 2010; ZWAIGENBAUM et al., 2015). However, the success of these interventions is conditional on the personalization of care and continuous supervision, requiring consistent and up-to-date training.

Scientific research plays a central role in the qualification of these services. Longitudinal studies, such as those by Dawson et al. (2010) and Ganz et al. (2012), reinforce the importance of early and personalized therapeutic interventions, especially in critical periods of child neurodevelopment. However, significant gaps remain, especially in developing countries, where scientific production and evaluation of intervention models are still limited. Expanding the funding of robust research, with representative sampling and rigorous methodologies, is essential to support both clinical practice and evidence-based public policymaking.

Technology, in turn, emerges as an essential tool in promoting care for people with ASD, especially in contexts of difficult access. AAC digital tools, such as the Picture Exchange Communication System (PECS) and electronic communication support devices, have been shown to be effective in strengthening communication skills and reducing challenging behaviors (GANZ et al., 2012). Additionally, the use of teleintervention platforms and therapeutic monitoring apps contributes to the decentralization of care, allowing families in remote areas to have access to guidance and specialized support, which can reduce regional disparities.

Another determining factor for the success of interventions is the strengthening of intersectoral support networks that connect families, health professionals, educators, and public managers in a collaborative approach. Studies such as those by Hayes and Watson (2013) and Pottie and Ingram (2008) highlight family involvement as an essential component for the effectiveness of interventions, with positive impacts on treatment adherence, caregivers' emotional well-being, and therapeutic progress. Training parents and caregivers to apply therapeutic strategies in daily life, such as the use of positive reinforcement and stimuli to functional communication, is a measure widely supported by the literature.

Thus, ensuring the right to health of people with ASD requires an integrated and multifaceted approach, which articulates equitable access to quality services, continuous investment in scientific research, and the use of innovative technological resources. These measures, when implemented in a coordinated manner, not only promote the full development of individual capacities, but also contribute to social inclusion and the reduction of inequalities.

It is concluded, therefore, that the realization of this right goes beyond the provision of therapeutic services. It requires the construction of a health system centered on equity, dignity and respect for differences, capable of integrating scientific advances, assistive technology and the active involvement of support networks. The perspective of capacities, as defended by Sen (2010) and Nussbaum (2000), highlights that health is an essential means for the full exercise of citizenship and human flourishing. Only through effective public policies that value neurodiversity and ensure equitable access to care will it be possible to promote a truly inclusive society, in which all people, regardless of their differences, have their rights fully respected and their potential fully developed.

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