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ACCESS TO HEALTH SERVICES FOR PEOPLE WITH DISABILITIES IN BRAZIL: AN INTEGRATIVE REVIEW

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Carla Loureiro Portuense Siqueira[1], Mariangela Braga Pereira Nielsen[2], Lara Bourguignon Lopes[3], Rodrigo Scoassante Tavares[4], Maria Clara Sossai de Almeida[5], Laisa de Souza Souto[6] and Roberta Ribeiro Batista Barbosa[7].

ABSTRACT

Although the National Health Policy for Persons with Disabilities was implemented more than two decades ago, there are still significant barriers to access to health services for this population. Thus, the objective of this article is to describe the barriers to access to health services for people with disabilities. This is an integrative literature review carried out with articles published between 2008 and 2023, through the LILACS and PubMed databases, covering Portuguese and English. Abstracts published in journals or event proceedings, repeated articles, theses/dissertations, reviews, and books were excluded, totaling seven articles included. The selection of studies was first carried out by a single reviewer and the doubts were resolved by the other authors. To characterize the articles, the following information was extracted: author, year, objectives and results/conclusion. The technique of Discursive Textual Analysis was used to present the results. The barriers to access to health services were classified as: products and technologies, attitudinal barriers and services, system and policies. It was evidenced that despite the existence of policies aimed at people with disabilities, most of this population still faces many barriers to ensure a dignified life, which is further aggravated in the presence of intersectionality, especially the poorest population and women. Therefore, it is necessary to review public policies, adequately allocating resources to cover everything from infrastructure adaptations to raising awareness in society and training health professionals.

Keywords: People with Disabilities. Health Services for People with Disabilities. Barriers to Access to Health Care. Human rights.

[1] Physiotherapist, Master's student in Public Policies and Local Development at the School of Sciences of Santa Casa de Misericórdia de Vitória-
EMESCAM.
[2] Physiotherapist, PhD in Kinesiology and Physiatry from the National University of General San Martin.
[3] Physiotherapist, resident in the care of critical patients at the Evangelical Hospital of Cachoeiro de Itapemirim - HECI.
[4] Doctor, master's student in Public Policy and Local Development at the School of Sciences of Santa Casa de Misericórdia de Vitória.
[5] Physiotherapist, Master's student in Public Policy and Local Development at the School of Sciences of Santa Casa de Misericórdia de Vitória.
[6] Physiotherapist from the School of Sciences of Santa Casa de Vitória – EMESCAM
[7] Doctor in Pediatrics and Child Health, professor of the Master's Graduate Program in Public Policies and Local Development at the School of Sciences of Santa Casa de Misericórdia de Vitória.

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INTRODUCTION

The Person with Disabilities (PWD) is understood as one whose complete and effective participation in society is restricted as a result of some long-term physical, mental, intellectual or sensory dysfunction, associated with one or more environmental barriers (Brasil, 2015). The United Nations Convention on the Rights of Persons with Disabilities recognizes that disability is an evolving concept and results from the interaction between PWD and environmental barriers such as attitudes, architectural structures, public policies, among others that prevent the full and effective participation of these people in society on an equal basis with other people (Brazil, 2009).

In Brazil, in 2022, PWD made up a significant portion of the population, totaling about 18 million people. Among individuals aged two years or more, 3.4% had visual impairment, 1.1% hearing, 1.2% mental impairment and 1.8% motor impairment. These data highlight the relevance of this group for public health policies and the need for specific attention to their health conditions (IBGE, 2022). In addition, evidence indicates that PWDs tend to die earlier, have worse health conditions, functionality, and have a higher number of health emergencies compared to people without disabilities. This is due to the inequalities and unfair conditions faced by this population (WHO, 2022a).

In view of these needs, the Brazilian health system suffers a significant impact, both in terms of demand for services and associated costs (Medeiros *et al.*, 2021). Inadequate or insufficient care for people with disabilities not only increases direct and indirect costs for the system, due to the greater use of services, but also significantly affects the quality of life of these individuals, resulting in lower social participation and increased inequalities (Pupo; de Almeida; Trenche, 2021)

One of the ways in which the Brazilian State seeks to guarantee autonomy and improve the conditions and quality of life of people with disabilities is through the formulation of public policies that aim to expand access to quality health. In this context, the implementation of the National Health Policy for Persons with Disabilities (PNSPD) in 2002 aimed to promote inclusion and ensure the rights of this population. The first axis of the PNSPD aims to promote health, quality of life and the prevention of diseases in all life cycles, according to the specific needs of people with disabilities (Brasil, 2002).

However, for many years, health care for PWD was restricted to rehabilitation services offered by Specialized Care (SC), which is still insufficient to meet the specific demands of this population, which end up accumulating every day (Brasil, 2009). Although

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the PNSPD was implemented more than two decades ago, PWD still face significant difficulties and barriers in accessing health services, understanding these barriers is essential so that improvement measures can be taken. Therefore, the objective of this article is to describe the barriers to access to health services for people with disabilities.

METHOD

This is an integrative review, with the objective of gathering and synthesizing the results of scientific publications related to the guarantee of people with disabilities to the right and access to health services. The review was conducted according to the adaptation of the Preferred Reporting Items for Systematic Reviews and MetaAnalyses (PRISMA) recommendations (PAGE *et al*., 2023) and has as its guiding question "What are the barriers to access to health services for people with disabilities?".

ELIGIBILITY CRITERIA

All scientific productions that had, in their content, people with disabilities, defense of people with disabilities and human rights, in English or Portuguese, published between the years 2008 and 2023, in Portuguese or English, with a qualitative or quantitative approach, were considered. The exclusion criteria adopted were abstracts published in journals or event annals, repeated articles in the explored databases, theses/dissertations, reviews and books.

SOURCES OF INFORMATION AND SEARCH STRATEGY

The last search for studies was carried out in July 2024 in the electronic databases of the Latin American and Caribbean Literature on Health Sciences (LILACS) and Medical Literature Analysis and Retrieval System Online (MEDLINE/PubMed).

The search strategy used in the LILACS database used the following descriptors, recognized by the Health Sciences Descriptors (DeCS/MeSH) systems in Portuguese and English: (Pessoas com deficiência / Disabled Persons) AND (Serviços de Saúde para Pessoas com Deficiência / Health Services for Persons with Disabilities) AND (Direitos Humanos/ Human Rights). For the search in MEDLINE/PubMed, the descriptors in the English language, recognized by the Medical Subjects Headings (MeSH), were used: (Disabled Persons) AND (Health Services for Persons with Disabilities) AND (Human Rights).

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SELECTION OF STUDIES

Initially, the identified studies were evaluated through the analysis of the titles, discarding duplicate searches in the databases, in addition to those that had no implication with the objectives of this study. Then, the abstracts were read, selecting those that did not meet the inclusion criteria defined in this research. Finally, through the full reading, the studies that dialogued with the objectives of this study were selected, culminating in the final sample included in this integrative review.

The selection of studies was first carried out by a single reviewer, and the doubts were resolved by the other authors. The entire process of selecting the studies, with reasons and number of exclusion at each stage, was listed in the flowchart presented in Figure 1.

EXTRACTION AND ANALYSIS OF DATA/CONTENT

To characterize the articles included in the review, the following information was extracted: Author; Year; Objectives and results/conclusion. To compile and present the results on access and human rights of PWD, the technique of Discursive Textual Analysis proposed by Moraes and Galiazzi (2006) was used.

RESULTS

A total of 126 publications were found in the databases, 32 of which originated from the LILACS database and 94 from PUBMED. Through the analysis of the titles, excluding those that did not imply the objectives of this dissertation, 47 publications were selected, one article was duplicated in the database, totaling 46 studies for reading the abstracts. 33 articles were excluded after reading the abstracts, as they had no implication with the proposed objectives, thus, 13 studies were selected for reading in full, however, six publications were excluded because they did not fit the theme. Finally, seven articles (Amaral *et al.*, 2012; Elijah; Martin; Chaves, 2008; Martins *et al.*, 2023; Mulumba *et al.*, 2014; Neille; Penn, 2015; Pinto *et al.*, 2021; Trani *et al.*, 2022) were in accordance with the inclusion criteria and had the necessary elements to answer the proposed guiding question.

The entire selection process that resulted in the inclusion of these articles is presented in the following flowchart (Figure 1).

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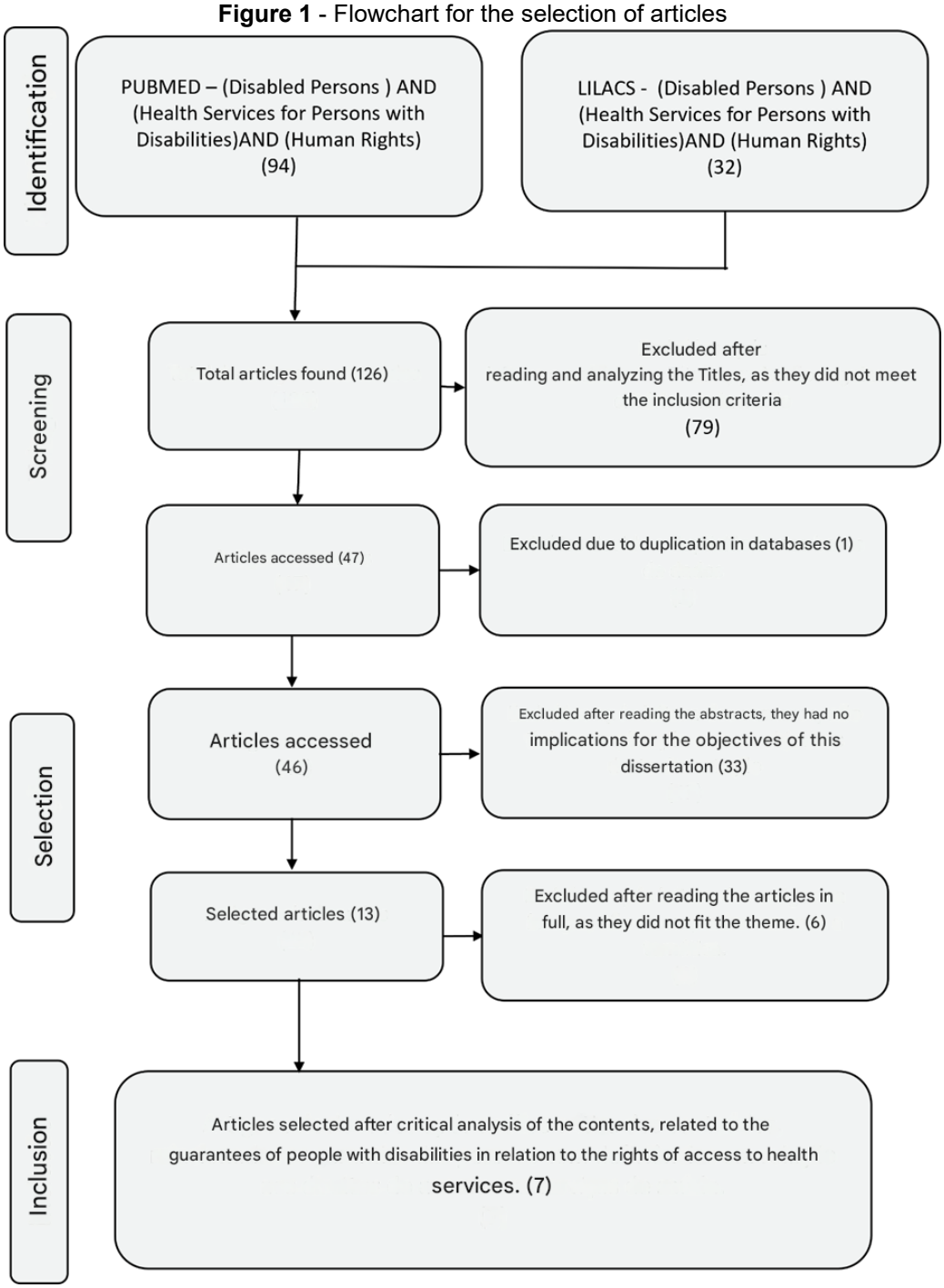
Figure 1 - Flowchart for the selection of articles



Source: Prepared by the author (2025)

The period of research ranged from 2008 to 2023, of the 7 studies, four were carried out at the national level in the states of Recife (Martins *et al.*, 2023), João Pessoa (Amaral *et al.*, 2012), Rio de Janeiro (Elias; Martin; Chaves, 2008), and the entire national territory (Pinto *et al.*, 2021), and 3 international: Afghanistan (Trani *et al.*, 2022), South Africa (Elias; Martin; Chaves, 2008), and Uganda (Mulumba *et al.*, 2014)). Most of the studies had a

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qualitative approach using questionnaires and interviews, with four quantitative studies, three cross-sectional descriptive studies and one quasi-experimental intervention (Chart 1).

Chart 1 – Characterization of the selected studies in terms of authorship, year of publication, place of research, study design, objectives, and quality analysis.

Authorship (Year)	Local	Study design	Objectives
Martins *et al*, (2023)	Recife, Brazil	Qualitative study	To analyze the process of formulation of the Municipal Policy for Integrated Health Care for People with Disabilities in the city of Recife, considering the context, the influence of social actors, the decision-making process and its content.
Trani *et al*, (2022)	Afghanistan	Quasi-experimental interventional study	Investigate the effectiveness of delivering diverse services such as physiotherapy, assistive devices, labor services, educational and advocacy services to participants in a community-based rehabilitation program
Pinto *et al*, (2021)	Brazil, London	Cross-sectional study	To present the national analysis of the accessibility of primary health care establishments for PWD in the first cycle of 2012.
Neille and Penn, (2015)	South Africa	Qualitative study	Explore the lived experiences of people with disabilities in a rural area of South Africa.
Mulumba *et al,* (2014)	Uganda, África	Qualitative study	Understand the perceptions and experiences of older adults and PWD regarding access to health care and related social services.
Amaral *et al, (2012)*	João Pessoa, Brazil	Descriptive cross-sectional study	To evaluate the accessibility of people with disabilities and permanent mobility restriction to the SUS in the city of João Pessoa-PB.

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Elijah; Martin; Chaves, (2008)	Rio de Janeiro	Descriptive Prospective Study	In patients with MMC, to study the real access to obtaining benefits for PWD according to the federal constitution and to identify the facilities and difficulties reported by their guardians.

SUS: Unified Health System; **MMC:** Myelomeningocele; **Source:** Prepared by the author (2024)

Chart 2 presents the main results and the conclusion of each article. The main barriers pointed out regarding access to health services were environmental and social barriers. High levels of sexual abuse, physical and verbal violence, and social exclusion were also observed in individuals with PWD.

Chart 2 – Main results and conclusion described in the seven articles included in the present study.

Authors (year)	Results	Conclusion
Martins *et al.,* (2023)	The municipal policy does not meet the totality of the demand of PWDs. There is a lack of financial resources to be implemented.	The policy of comprehensive health care for people with disabilities in Recife was formulated without the participation of PWD and did not contemplate the broad and complex needs of this population, in addition to having suffered important budget cuts that do not ensure its materialization.
Trani *et al.,* (2022)	PWDs who live in rural areas and have low income suffer even more from discrimination, social exclusion, isolation and barriers to access to services. Being a woman increases the risk of not receiving health care.	The rehabilitation services program can contribute to improving the living conditions of people with disabilities, promoting social participation, and reducing the number of unmet needs.
Pinto *et al.,* (2021)	Regions with smaller territorial and population extensions, and poorer regions of Brazil had worse accessibility. The main physical barriers were floors, access ramp, and handrail. There are almost no international symbols, braille signs, or hearing aids available for people with visual or hearing impairments.	The results showed that it is feasible to reproduce the audit on a large scale and in other sectors of public health. Important gaps in accessibility are highlighted, which increases the risk of violation of the rights of PWDs.
Neille and Penn, (2015)	The main barriers were physical to access to health, access to education, and information (most frequently reported).	The barriers to obtaining services go beyond physical barriers, also including socio-cultural and political barriers. People with PWD in rural South Africa suffer from human rights violations.
Mulumba *et al.,* (2014)	In general, PWDs face physical and social barriers that prevent active participation in political planning. Lack of financial resources to purchase medicines or assistive devices and lack physical rehabilitation or mental health services.	The rights to health and interpersonal relationships in Uganda are not being guaranteed and promoted. In particular, the Ugandan government is failing to fulfil its duty and obligation under international law with respect to the health care of PWDS

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Amaral *et al.,* (2012)	The main barriers pointed out were environmental factors such as ramps, pedestrian signs, uneven sidewalks, lack of handrails on the way from the residence to the health service. Only 16.4% of PWDs underwent some rehabilitation treatment (62.1% physiotherapy and 13.8% psychotherapy).	The study demonstrated a great disadvantage in access to other services of the health system that go beyond primary care, showing that comprehensiveness in health care has not yet materialized.
Elijah; Martin; Chaves (2008)	The main barriers found were inclusion in the school environment (school did not want to accept the child) and obtaining the Continuous Cash Benefit.	Although the three benefits investigated are legally supported, the rate of obtaining them is still unsatisfactory. In addition, obtaining it does not necessarily guarantee access.

Source: Prepared by the author (2024).

DISCUSSION

This integrative review aimed to identify the barriers encountered by people with disabilities in accessing health services. The analysis of the seven empirical articles included in the present study identified barriers in the environmental factors that constitute the physical, social and attitudinal environment in which people with PWD live and lead their lives (WHO, 2004). The most cited environmental factors were described in 3 main categories: barriers: products and technologies; attitudinal barriers and barriers: services, systems and policies.

BARRIERS: PRODUCTS AND TECHNOLOGIES

The barriers of Products and Technologies can be urbanistic such as roads, public and private spaces open to the public; architectural such as the structure of public and private buildings; and in the means of transport (Brasil, 2015). Between August 2007 and December 2008, Amaral *et al* (2012) investigated the accessibility to the SUS by people with disabilities and permanent mobility restriction in the city of João Pessoa-PB, the main barriers pointed out by the participants were related to products and technology. More than half of the interviewees (63.9%) reported facing obstacles such as ramps, pedestrian signs, uneven sidewalks, lack of handrails on the way between the residence and the health service.

Nine years later, Pinto *et al* (2021) presented the analysis of data from the 2012 census of the Brazilian National Program for the Improvement of Access and Quality of Primary Care (PMAQ-AB). In this census, 38,812 basic health units throughout the national territory were analyzed, where the auditors investigated internal and external accessibility of the buildings. The results showed that accessibility was precarious, especially the floors,

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access ramp, and handrail. Only one in three Basic Health Units (UBS) had accessible entrance, 12% had adapted bathrooms, 24% wheelchair-friendly corridors, and 9% adapted drinking fountains. Almost no establishment had international symbols, braille signs or hearing aids available for people with visual or hearing impairments.

Regarding means of transportation, participants with greater mobility limitations need a rented or private car, while mental or hearing people with disabilities usually travel on foot or by public transport. Another interesting point reported was that more than half of the participants used the UBS when they were sick (53.2%) and 31.2% the hospitals. Only 16.4% of PWDs underwent some rehabilitation treatment (62.1% physiotherapy and 13.8% psychotherapy) and a small percentage (5.9%) never sought public health services (Amaral *et al*., 2012).

This reality is not exclusive to Brazil, a study in South Africa investigated accessibility in 12 rural villages with a high rate of people with disabilities and identified that environmental barriers, such as access to buildings and access to information, were the most reported by the participants (Neille; Penn, 2015). In Uganda, the main barriers found were lack of access to medicines and health care, low quality of rehabilitation care and mental health (Mulumba *et al.,* 2014). The World Health Organization reports that despite more than 2.5 billion people needing one or more assistive products (OPM) worldwide, nearly one billion of these people do not have access to these technologies, especially in low- and middle-income countries. Coverage can range from 3% in the poorest countries to 90% in the richest countries (WHOa, 2022)

Thus, although government laws and incentives seek to ensure greater accessibility to this group, it is notorious that their compliance is often neglected under the pretext of meeting other priorities (Santos; Vasconcelos, 2018). The literature shows that environmental factors are more determinant than the dysfunctions and health conditions themselves for the performance of activities and social participation (Hammel *et al.*, 2015). Therefore, changes and/or adaptations in the infrastructure are essential to ensure access, enable socialization and minimize or eliminate these obstacles (Martins *et al.*, 2018).

OCCUPATIONAL BARRIERS

Individual or societal attitudes about the individual's worthiness and worth can generate discriminatory practices, such as stigmatization and neglect, which in turn restrict the social participation of people with disabilities (WHO, 2004). Five of the seven articles

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included reported on discrimination, exclusion and social isolation suffered by PWD (Elias; Martin; Chaves, 2008; Mulumba *et al.*, 2014; Neille; Penn, 2015; Trani *et al.*, 2022; Martins *et al.*, 2023). Unfortunately, this is a very frequent barrier, especially in underdeveloped countries such as Brazil and countries in Africa.

In Uganda, PWD are stigmatized and marginalized by society because of their disability. They are excluded from political planning and do not have an active voice, either due to social exclusion or architectural barriers preventing face-to-face access. It was also reported that, because they do not contribute to their income, they receive less or poorer quality food than other family members, in addition to suffering sexual abuse in exchange for favors or as a source of income (Mulumba *et al*., 2014).

Socioeconomic status is also a major barrier to access to healthcare, as it limits access to assistive technologies. About two-thirds of people with assistive products reported out-of-pocket payments, others reported relying on family and friends to financially support their needs. All these factors predispose this population to worse health conditions, not only biological but also psychosocial, increasing the level of anxiety and stress, leading to a lack of pleasure in activities of daily living and social participation. (WHO, 2022b; Mulumba *et al*., 2014).

Added to this, the difficulty of accessing health services such as rehabilitation and mental health leads to an increase in alcohol abuse as an escape mechanism, further increasing the public health problem. In fact, evidence shows that PWDs die earlier, have worse health conditions, functionality and health emergencies than people without disabilities. This is due to the inequalities and unfair conditions faced by them (WHO, 2022b; Mulumba *et al*., 2014).

In South Africa, great discrimination and social exclusion have also been reported, in which PWD have difficulty developing intimate relationships, exclusion from family activities, loss of friendships, isolation, physical and/or psychological violence. Many participants also reported being sexually abused in exchange for "favors", since they are dependent on self-care (Neille; Penn, 2015). Plummer and Findley (2012) identified that people with disabilities are abused for long periods, are at greater risk of abuse by various types of perpetrators, and experience more abusive tactics. It is also known that women, regardless of age, are more vulnerable to situations of sexual violence, the most aggravating factor is the fact that the perpetrators are often family members or acquaintances, who coerce with threats and intimidation preventing their reporting (Trani *et al*., 2022).

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This elevated risk can be attributed to a number of factors, including reliance on caregivers, lack of privacy, and the societal perception that people with disabilities are less credible or less able to report crimes. The lack of adequate training of health professionals and the police also contributes to the underreporting and minimization of these violations (Guerra *et al.*, 2021).

In addition to sexual abuse, verbal violence is another frequent form of attitudinal barrier that negatively affects PWD, and is often invisible in statistics but has a substantial impact on the emotional and psychological well-being of victims. These discriminatory practices promote a culture of devaluation and dehumanization, where PWD are often seen as less competent or less worthy of respect, perpetuating cycles of social exclusion and isolation (Rodrigues; Bernardino; Moreira, 2022).

Another barrier widely documented in the literature is discrimination, from the denial of employment and education opportunities to inadequate access to services, either due to family overprotection or neglect of their specific needs (Elias; Martin. Chaves, 2008). Social prejudice reinforces the idea that PWD are less capable, excluding them from social, economic, cultural and political spaces (Reis; Araújo; Glat, 2019; Souza *et al.*, 2022). Marginalization perpetuates vulnerability and impedes social mobility, keeping PWDs in conditions of socioeconomic disadvantage. This is often compounded by intersectionality, when people with disabilities also belong to other marginalized groups, such as ethnic minorities, women, and the economically disadvantaged (Elias; Martin; Chaves, 2008).

Finally, a study reported that 71.8% of the difficulties encountered in accessing school were related to the lack of preparation of the education system to receive children with special needs, including prejudice on the part of the educators themselves. It is important to emphasize that for the insertion of children with disabilities in the school environment, it is not enough just to effectively enroll, but also to have a set of actions aimed at their integration. When educators are not trained to meet the needs of students with disabilities, they end up perpetuating discriminatory practices, even if unintentionally (Elias; Martin; Chaves, 2008).

BARRIERS: SERVICES, SYSTEM AND POLICIES

This topic is related to the barriers associated with existing programs and benefits for PWDs; to the administrative and organizational system by municipal, state or federal government authorities; and/or the policies that govern and regulate these systems,

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programs and benefits (WHO, 2004). We know that Public Policies play a very important role in improving the living conditions of this population. Article 23 of Chapter II of the Constitution of the Federative Republic of Brazil of 1988 determines that it is the common competence of the three spheres to take care of health, provide public assistance and protection to people with disabilities (Brasil, 1988).

In Brazil, we have some milestones that involve this theme, highlighting the year 2012 when the Care Network for Persons with Disabilities (RCPD) was established within the scope of the Unified Health System (SUS). The RCPD aims to ensure that the exercise of fundamental rights and freedoms by people with disabilities are promoted, under equal conditions, aiming at their social inclusion and citizenship. In order to expand access, qualify care and offer services based on the needs of PWDs in a systematized and articulated way, including Primary Care (PHC), Specialized Care (SC), Hospital and Urgency and Emergency (Brasil, 2012).

However, even with greater needs and vulnerability, public policies aimed at PWD are recent and still limited. Martins *et al* (2023) analyzed the process of formulating the Municipal Policy for Integrated Health Care for People with Disabilities in the city of Recife, and observed that the municipal policy was developed without the participation of PWD, disregarding their particularities and needs. A lack of financial resources for the implementation of the policy was also reported.

Similarly, Mulumba *et al* (2014) identified that local and national governments do not take measures to incorporate PWD into their participation in any stage of the planning, implementation, and monitoring of public policies. And even when they are informed, the limitation in mobility becomes another obstacle to getting to where the events take place. In Rio de Janeiro, the legal benefit with the lowest number of benefits and the highest degree of difficulty was the Continuous Cash Benefit (BPC), individuals reported the need for several visits to the concession post, lack of knowledge and lack of interest on the part of employees, discredit in the system, and problems with expertise and documents (Elias; Martin; Chaves, 2008).

The BPC is a financial aid of one minimum monthly wage to people with disabilities whose family is unable to provide subsistence or whose per capita income is less than 1/4 of the minimum wage (Brasil, 1982; Brazil, 1995). However, this is a very complex benefit, with rules that are difficult to interpret, which involves both the social security of the National

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Institute of Social Security (INSS) and the Unified Health System (SUS) and there is no institutional communication mechanism between them (Vaitsman; Lobato, 2017).

Neille and Penn (2015) also reported barriers to acquiring disability benefits. They associate the lack of consistency in the method that qualifies PWDs, problems in communicating the process and difficulty in acquiring identity documents. The latter, in turn, also makes it difficult to access education, receive walking aids and work. However, many families depend on this benefit to obtain better access to health such as medicines, health insurance (due to difficulties in accessing the SUS), or even for basic needs such as food, water and electricity because it is the family's only source of income (Neille; Penn, 2015).

PWDs with a high degree of disability need greater care that limits the caregiver from finding a job and helping with the family's income. Mulumba *et al* (2014) demonstrated a similar reality in Uganda in which most PWD do not have the financial resources to buy medicines or assistive devices. On the other hand, the lack of the benefit can generate family exclusion, since the PWD does not contribute to the income, but rather increases costs. On the other hand, those who receive the benefit feel that the interest of family members in them is only because they receive financial benefit (Neille; Penn, 2015).

Trani et al. (2022) analyzed access to health services by PWD in a community in Afghanistan and observed that individuals with post-war disabilities received increased support from physical therapy and walking aids. Being a woman increased the risk of not receiving health care, and having physical disabilities associated with intellectual and/or acquired at birth increased the risk of not having respect from family members and the community element. It was also reported that the wealthiest, with a better level of education, had better access to health services and orthoses, prostheses and mobility aids (OPM), the risk of not having access to health services was higher for poor individuals (Trani *et al.*, 2022). Similarly, affordability measures were better in wealthier regions of Brazil, such as the South and Southeast, and in urban regions. This can be justified by the greater dependence on federal incentives, management of political resources, and technical capacity (Pinto *et al*, 2021).

CONCLUSION

The barriers faced by people with disabilities in accessing health services are multifaceted and range from physical and technological obstacles to attitudinal and institutional barriers. The most commonly encountered situations are: geographical,

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physical and architectural barriers in health units, lack of trained professionals to meet their specific needs, lack of information, prejudice and even cultural inadequacy in treatment and care.

Although there are already public policies aimed at guaranteeing the rights of this population, their actions are not effective for most PWD. The situation worsens in underdeveloped countries and when there is intersectionality, especially the female population. The lack of specific public policies for these groups and the exclusion of PWD in the planning and implementation of these policies reinforce structural inequalities and compromise the full exercise of citizenship. Even in the face of regulatory advances, there are still significant challenges in ensuring universal and equitable access to health, especially in low-income countries.

Thus, it is essential to review public policies aimed at PWD with resources being allocated to remedy the main points mentioned, only then will there be concrete changes, ranging from adaptations in infrastructure to raising awareness in society and training health professionals. The commitment to inclusion and equity should not be restricted to speech, but should be translated into effective actions that promote the autonomy, dignity and well-being of people with disabilities.

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