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# HEALTH POLICIES FOR DISABLED PEOPLE WITH EMPHASIS ON THE DEAF POPULATION: REFLECTING ON INCLUSION IN HEALTH SPACES

**Edine Dias Pimentel Gomes[1]*, Raimundo Augusto Martins Torres[2], Karlla da Conceição Bezerra Brito Veras[3], Leidy Dayane Paiva de Abreu[4], Aretha Feitosa de Araújo[5] and Samuel Ramalho Torres Maia[6]**

[1]Speech therapist, Master in Health Education and Doctoral Student of the Postgraduate Program in Clinical Health Care at the State University of Ceará; [2]Nurse, Specialist in Professional Education in Health, Master in Nursing and Doctor in Education from the Federal University of Ceará; [3]Nurse, Specialist in Obstetrics, Master in Health Education and Doctoral Student of the Graduate Program in Clinical Care in Nursing and Health at the State University of Ceará; [4]Nurse, Master in Clinical Care in Nursing and Health and Doctoral Student of the Graduate Program in Clinical Care in Nursing and Health at the State University of Ceará; [5]Nurse, Specialist in Teaching in Professional Education, Master in Health Education and Doctoral Student in the Graduate Program of Clinical Care in Nursing and Health at the State University of Ceará; [6]Nurse, Specialist in Management, Auditing and Expertise in Health Systems, Master in Clinical Care in Nursing and Health and Doctorate in Clinical Care in Nursing and Health at the State University of Ceará (UECE)

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***Corresponding author:***
***Edine Dias Pimentel Gomes***

**ABSTRACT**

**Objective:** To reflect on the health policy for people with disabilities and its applicability in health spaces. Method: Qualitative and reflective study supported by studies about the inclusion of the deaf population in public spaces. Results: In the present reflection, it was clear that the deaf still find barriers that hinder their rights as citizens to demand health in public spaces. These barriers can be overcome by health professionals through several tools, including Assistive Technologies with health professionals. Conclusion: The reflection demonstrated that public health has the role of ensuring the inclusion of the deaf population using the available resources, in order to ensure the construction of a more inclusive and egalitarian country.

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## INTRODUCTION

Inclusion of vulnerable groups is very often debated in Brazil, especially since enactment of the 1988 Federal Constitution, which aimed at the expansion of democratic rights in Brazil (Brasil, 1988). Vulnerable groups include people with some type of disability who face difficulties in accessing the main health services, such as the deaf. Hearing-impaired people do not always receive care in public spaces from health professionals. This is the case of both deaf people who are not physically able to hear any audible sound, and people with hearing loss. In both cases, health care prepared for this context should be one of the pillars connecting the patient who needs care to health professionals, making it possible that care is provided with quality through efficient communication (Pires and Almeida, 2016; Sanches *et al.,* 2019). However, health professionals are not always qualified to face this type of situation, and this often causes embarrassment to the patient

and an increasing resistance on their part when it comes to seek their rights as citizens (Cunha *et al.,* 2019). This context has existed since long ago, and it is rooted in prejudice and social stigma (Sanca, 2019). To overcome this difficulty, the visual motor language for the deaf was created by Pedro Ponce de Leon, in Spain. In Brazil, the history of visual communication for the deaf community dates back to 1857 with the foundation of the Imperial Institute of the Deaf-Mute in the city of Rio de Janeiro (Jannuzzi, 2005). However, although visual language is a communication mechanism, it is not widely practiced as it should be, especially in the case of health professionals. There is a difficulty for the professional to identify the deficiency. Physical disabilities call attention because of their greater visibility, resulting is faster communication and rapid provision of urgent care. However, mental and especially hearing impairment are not immediately noticed, causing discomfort and stress on both sides (Costa *et al.,* 2018). Thus, deaf people experience difficulties in expressing their needs because traditional communication is carried out orally; so, they resort to use of other mechanisms such as sign language (Cunha *et al.,* 2019). Thus, although deaf people are a minority, the effective respect for their rights has to be advocated, reinforcing the importance of democracy by guaranteeing the inclusion of each and every individual, as well as by training health professionals to face the historical and socio-cultural barriers that arise in this context. Given the above, the present study aims to reflect on the health policy for people with disabilities and its applicability in health spaces.

## METHODOLOGY

This is a qualitative study of the reflection type originated from the course Clinical Care Policies, Practices and Management in Nursing and Health of the Doctoral Program in Clinical Care in Nursing and Health at the State University of Ceará (UECE), held in the second half of 2019. The work was produced through the need to elaborate a reflective text about health policies directed at the deaf population.

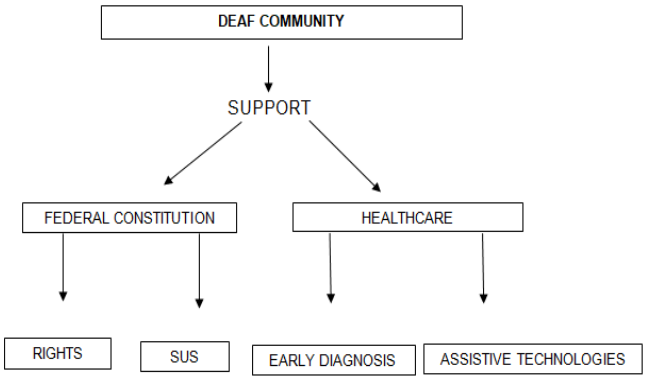
## RESULTS AND DISCUSSION

Public health, as foreseen by the 1988 Constitution, aims to guarantee the exercise of rights for all individuals in the population (Brasil, 1988). Thus, to facilitate the access to this exercise, services are offered in a regional approach, decentralizing laws and rules for each region. In practical terms, this means that each territory must have its own mechanisms to serve the population, obeying a hierarchy from the regional to the federal level. This decentralization has occurred since the 1980s, reinforcing the autonomy of each region through federal regulation and decentralizing decisions, aiming at the optimization of the health sector (Ribeiro *et al.,* 2017). The Brazilian health system has undergone numerous changes over the years according to demand and reality. This was especially so in the late 1980s, with the implementation of a democratic regime that promoted the compliance with democratic rights, although this does not represent an unquestionable truth. The Unified Health System (SUS) was born in this context, articulated with the municipalities by means of the Health Regions, providing greater planning for each territory and healthcare to the population through actions and services, such as primary care, health surveillance and psychosocial care (Brasil, 2011).

Created 31 years ago, SUS still presents a series of flaws regarding thee distribution of resources in the system, hindering the access to health and perpetuating social and historical inequalities in Brazil, hampering equity. Still, despite the flaws, SUS represents an attempt to pratice democracy, for a more egalitarian country (Souza *et al.,* 2017). The main objectives of SUS were established through article 5 of Law 8,080 of 1990, and among them is listed the training of human resources in the health area. The Care Network for Persons with Disabilities was created in this context, based on Ordinance nº 793 of 2012. This network is amed at expanding the services to disabled people and their different terminologies, including the deaf, promoting the qualification of services, disseminating the knowledge for those who are unaware of the subject, and also enabling the exploration of the theme (Brasil, 2012). The agenda regarding the assistance to the deaf population is present in several government documents. However, there is still some resistance from professionals when serving this population, due to lack of technical capacity, lack of experience, or knowledge on how to act in the situation (Sanches *et al.,* 2019). The linguistic condition for the deaf community represents a challenge when accessing health services, because communication is carried out almost exclusively through visual auditory language (Nóbrega *et al.,* 2017). In a search carried out on the PUBMED, SciELO and LILACS databases, the results from studies conducted from 2006 to 2016 showed that 100% of professionals reported not understanding sign language and having difficulty to communicate with deaf people (Souza *et al.,* 2017). This reality calls for the need for the academic community to understand the reasons that lead these professionals to create a barrier in communication. Linked to this, at national level, it is estimated that there are 45 million people with some disability in Brazil. Of these, nine million have some hearing impairment, and two million have a high level of hearing disorder. This latter group includes people who suffer from any hearing problem or who have developed a problem during their lives, such as an accident at work (Instituto Brasileiro de Geografia e Estatística, 2010).

This gap makes it difficult for the deaf to access health services and spaces, but the problem can be overcome through assistive technologies. These assistive technologies, in turn, represent a groups of knowledge sets from different areas; they are artifacts and methods that aim to support people with hearing difficulties, promoting social inclusion (Conte *et al.,* 2017; Bersch, 2017). Such methods help health professionals to offer a more humanitarian service, using these resources in order to create a channel of communication and understanding between the twoparties, becoming a highly useful professional strategy (O'Brolcháin, 2018). Assistive Technologies show results when there is a more efficient training to allow more realistic experiences, creating a desire for learning between these links. They also allow the provision of the service without the need for standardization, respecting individual differences and promoting social inclusion (Baglama *et al.,* 2018). Inclusion should start at school, the place where the deaf have their first experiences with the world, where they realize that there are differences, but which can be overcome. For this, a Sign Language Interpreter (SLI) must be present in the classroom to transmit the information from the teacher's traditional oral language to sign language, so that the transmission of the information is adequate for the student with hearing problems and they can understand it, adapted to their reality. The availability of a Specialized Educational

Service is a very useful tool, because the teacher can elaborate and mix different strategies through different resources, according to the student's needs (Fachinetti and Carneiro, 2017). However, this is not always the reality of basic education in Brazil, which for years has thrived in the lack of investments. Accessibility policies have as a goal to stimulate Sign Language, but they are not put into practice in the majority of the schools in Brazil (Nora, 2017). This reality further increases the barriers of the deaf in the school environment and, as he grows up, in the experience of the difficult habit of demanding the basic right to health in the public space. In addition to forms of motor and visual communication, digital technology is another tool that provides support for health professionals. Mobile computers such as cell phones and tablets are very useful in public spaces, facilitating the service. Computers were until recently the center of activities, but recently they gave way to notebooks and mobile devices such as tablets, which have gained a major role in several spaces (Rodrigues and Coutinho, 2018). These tools are useful in order to streamline the service, bringing a major contribution of technology to democratization. Besides these tools, there is also the hearing aid or prosthesis, known as Personal sound amplification devices (PSAD), that is recommended by speech therapists through a diagnosis. The need for this category for the health area grew significantly in SUS, with an increase of 118% in the period between 2000 and 2010 (Miranda, 2015). After this approach, it is clear that despite the Brazilian Constitution guarantees for deaf people their rights and access to in health spaces, there is a great deficit on the part of professionals. This teamwork brings together a series of professionals who must be able to provide care. Furthermore, Brazilian education is also marked by a lack of investment in education, which is of paramount importance.




Source: Own authorship (2019).

**Figure 1. Health Education Tripod under Assistive Technologies**

Figure 1 shows a tripod that demonstrates the importance of these segments being interconnected, with the objective of guaranteeing the city and narrowing the gap between the disabled and hearing communicators.

## FINAL CONSIDERATIONS

It is evident from this reflection that there is a need to expand thehealth policy aimed at people with disabilities, making it possible to apply it in healthcare spaces. Although the fully guarantee all the rights that the deaf community has is unfeasible, it is possible to rethink what is available to all the elements that are part of this cycle so as to contribute to a more just society. Assistive Technologies appear as a bridge between the health professional, of any category, and the person with hearing loss. Any practice or resource can be sufficient to reduce the difficulties faced by patients, and to promote the effectiveness of democracy from the moment that rights are obtained. For these reasons, it is essential that professionals from different classes be present and that they be trained with resources available in health spaces that create a culture that can meet the different human conditions that the individuals may present. These differences will then be understood from the point of view of adaptability through social inclusion.

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