Objective: describing the accessibility of the deaf to public health services. Method: study of a qualitative approach. There were interviewed 11 deaf who communicated in sign language with cognitive condition to interact with the bilingual researcher. The number of subjects was determined based on the criterion of saturation of the talks. The data analyzed followed the thematic content analysis. The research project was approved by the Research Ethics Committee CAAE nº 0448.0.133.000-11. Results: there was a predominance of male participants and SUS-dependent, with an average of 30.6 years old, living with four people and family income up to two minimum wages. From the talks emerged two categories: geographic and organizational accessibility and; sociocultural accessibility. Stand out obstacles to access to health services that are not unique to the deaf, and correspond to organizational problems of accessibility of services. Conclusion: it is stressed that the SUS management should promote the accessibility to public health services for the entire population in an equitable manner. Descriptors: Access to Health Services; Health Care; Hearing loss.

RESUMO
Objetivo: descrever a acessibilidade dos surdos aos serviços públicos de saúde. Método: estudo com abordagem qualitativa. Entrevistaram-se 11 surdos que se comunicavam em língua de sinais, com condição cognitiva para interagir com a pesquisadora bilingue. O número de sujeitos foi determinado com base no critério de saturação das falas. Os dados analisados seguiram a análise de conteúdo temática. O projeto de pesquisa foi aprovado pelo Comitê de Ética em Pesquisa CAAE nº 0448.0.133.000-11. Resultados: houve predominio de participantes do sexo masculino e SUS-dependentes, com média de 30,6 anos, residindo com quatro pessoas e de renda familiar de até dois salários mínimos. Das falas emergiram duas categorias: Acessibilidade geográfica e organizacional e; Acessibilidade Sociocultural. Destacam-se obstáculos de acesso aos serviços de saúde que não são exclusivos para surdos, e correspondem a problemas de acessibilidade organizacional dos serviços. Conclusão: salienta-se que a gestão do SUS deve promover a acessibilidade aos serviços públicos de saúde para toda a população, de forma equânime. Descriptores: Acesso aos Serviços de Saúde; Assistência à Saúde; Perda Auditiva.
The organization of health services in Brazil, of the Unified Health System (SUS), is through a network of health care articulated to promote universal, integral, equitable access, and as close as possible to the users.

Access to health services can be understood as “gateway”, as the place of the user’s host site at the moment of expression of his need and, in a way, the paths taken by him in the system for search for need’s resolution. Universal access as well as being a constitutional guarantee, is flag of struggle of social movements, for which this claim has become a fundamental element of citizenship rights. The exercise of citizenship has great transformative potential, taking into account the real possibilities for change and improvement in meeting health problems of the population.

Accessibility can be understood as the ease to obtain health services, pointing, so, to the degree of difficulty encountered, and is crucial to the health of people with disabilities (PwD). Thinking in accessibility is to ensure the inclusion of all in any environment, activity or use of resource.

As a right guaranteed by law in Brazil, accessibility is also one of eight General Principles (Article 9th) of the Convention on the Rights of Persons with Disabilities, of which Brazil is one of the signatories; where there was established that the government should take appropriate measures to ensure their access, with equality of opportunities with the others to facilities and services open or provided to the public.

Admitting the existence of deaf communication, it was enacted the Brazilian Sign Language Act (Libras), which recognized as legal means of communication and expression the Libras and other expression resources associated with it; regulated by Decree 5626 from 2005, which clarifies the responsibilities of the sectors of Education and Health as the guaranteeing of rights, specifically related to the area of Health, art. 25th established that the SUS must ensure full attention to your health, at different levels of complexity and medical specialties.

For health professionals, enabling accessibility is a key issue to ensure a quality therapeutic action and consequently favor the inclusion of PwDs. Getting access to services is a first step to be overcome by the user when goes in search for satisfaction a health need.

This study started from the following question << How the deaf access public health services? >> To answer it there was drawn the following objective:

- Describing the accessibility of the deaf person to public health services.

### METHODOLOGY

A descriptive study with a qualitative approach, performed at the Foundation Center for Assistance to People with Disabilities (FUNAD), reference service in health, education and human development of the deaf community, located in João Pessoa/PB.

The investigated population consisted of deaf users waiting for attendance in the services of the foundation. Inclusion criteria were deaf people above 18 years old; who communicate by sign language; with cognitive conditions that allowed interaction with one of the bilingual researchers. Number of subjects determined based on the criterion of saturation of information.

Interviews conducted individually, written about the socioeconomic characteristics of the participants and questions about their experiences in public health services. Dialogue established in Libras by the bilingual researcher, in private, protecting confidentiality, comfort and convenience of the subject, the institution and the researcher. Interviews recorded by camera camcorder in video MP4. At the end of each collection, there were transcribed and translated into Portuguese, by the interviewer. Then, videos and transcripts were sent to deaf bilingual judge to identify the full meaning of words and certify the reliability of the translations.

For data analysis, there was followed the thematic content analysis, which constitutes in the dismemberment of the text into units, ie cores of meaning that make up the communication, and subsequent reunification into classes or categories. It continued with the comparison between categories, showing the connections in an attempt to synthesize interpretations and understandings.

Met the prescribed requirements by the National Health Council in Resolution 466/2012; guarded identity of the subject, using code corresponding to each participant, known only by the researcher; authorized by the Ethics Committee for Research of the State University of Paraíba (CEP/UEPB) under number CAAE nº 0448.0.133.000-11.
RESULTS

Figure 1 shows the characterization of the subjects, with a predominance of male participants and SUS-dependent, ie without private health insurances; with an average of 30.6 years old, living with four people and a family income of up to two minimum wages.

<table>
<thead>
<tr>
<th>Rosewood</th>
<th>Barbatimaço</th>
<th>Bugre plant</th>
<th>Capixingui</th>
<th>Monjolo tree</th>
<th>Gurucaia</th>
<th>Bastard cedar</th>
<th>Achiote</th>
<th>Timbo</th>
<th>Marica</th>
<th>Jacaranda</th>
</tr>
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<td>1 to 2</td>
<td>5 or more</td>
<td>1 to 2</td>
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<td>1 to 2</td>
<td>3 to 4</td>
<td>1 to 2</td>
<td>Not informed</td>
</tr>
</tbody>
</table>

Figure 1. Characterization of the subjects of the research *minimum wages.

From the speeches of the subjects two categories emerged: Geographical and Organizational Accessibility and Cultural and Social Accessibility. As subcategories, the category Geographical and Organizational Accessibility was: strategies used in accessibility; Perceived obstacles; and Interpreting service of Libras on health. The Socio-Cultural Accessibility category had as subcategory: Feelings of exclusion/discrimination.

♦ Geographical and Organizational Accessibility

♦ Strategies used in accessibility for deaf people

Today I'm lucky; there is a family health center near my home. The CHA always comes to my house and asks how our health is. He [CHA] always goes there, at home, and when you're with a health problem, he helps us to appoint the consultation. (Marica)

It has a health clinic, where the doctor already knows me, knows I'm deaf. (Rosewood)

I have two deaf friends who helped me to find a health service with an interpreter. They showed me how to get there and now I'm just going. (Timbo)

♦ Obstacles perceived

Long queues, many people, a mess, no accessibility to the deaf. (Monjolo)

He gives the recipe for me to go to another doctor. I get nervous, because it takes a long time. [...] Sometimes appoint for Wednesday, then at Thursday; it's boring, are changing the days, canceling the consultations. There is patience! (Rosewood)

♦ Professional interpreter of Libras at health services

The problem is that it has not, has not, there is no interpreter in health services, there is not. It would be great if it had ... It's very difficult, I wanted it to have a professional interpreter to talk openly, it would be so much easier. (Marica)

In my opinion, the interpreter accompanying the deaf does not work out. The law says that hospitals, PSF or other health services must have an interpreter for the deaf to go there able to communicate. And not an interpreter accompany, as happens. Each service should have its own interpreter, then the deaf go there and so on, solves the problem. So the deaf would not schedule a place and wait for an interpreter accompanies him. That's not right. (Monjolo tree)

In my opinion, have an interpreter woman in doctor's appointment with me does not work, it does not match. It needs to have an interpreter man. Lack very interpreter man; has a lot more woman. I know all the interpreters, missing men interpreters. You need to have equality in the interpreters, men and women. (Bastard cedar)

It is very difficult! Impossible! The services have no interpreter. Communication is poor. If you had an interpreter there I could go there and communicate with him, could explain everything to him. (Bugre plant)

When a deaf go to a health facility, he needs an interpreter who understands and he gets the assistance, but without an interpreter is difficult. I have to go with my wife or mark with an interpreter to be able to explain what I am feeling with my pressure, headache or know what I can, as I need to avoid. I like deaf need an interpreter to go to the doctor and understand what is said. (Capixingui)
Accessibility of the deaf person to public...

I think it’s good because the interpreter speaks the native language of the deaf as deaf I need to understand everything clearly. Communication with an interpreter I understand everything. I think much better treatment in the presence of an interpreter. (Barbatimmao)

If I go to the doctor alone and take the wrong medication and there could give a more serious problem in my body. It would be much worse! So an interpreter following to have a real communication is necessary. I make signs to him and he talks to the doctor, the doctor understands and passes the right medicine and the interpreter can explain everything, as I take the right way medication. Everyone understands. (Bugre plant)

The interpreter must have ethics! For example, a person goes to the doctor, deaf to the gynecologist will do an exam, and the interpreter must have professional ethics. Sometimes if you go with a known interpreter he knows your life, of intimate things, since the interpreter of the own service has ethics, a professional. (Monjolo tree)

♦ Socio-Cultural accessibility

♦ Feeling of exclusion/discrimination

I wish that the deaf could go more to health services, taking care of their own health, be able to talk about what they feel about their health that could have a real communication with the professionals in health services, a real assistance with equality for all. (Jacaranda)

I rate as very negative. All services not give value to the deaf. There’s nothing of accessibility. Terrible! (Monjolo tree)

DISCUSSION

Regarding the health of people with disabilities, the issue of access was identified as a major need for this population, understood quite extended way, including: access to the various opportunities, movement in the city, the available services and resources. Often, the main need is not in physical gravity or the functional impairments, but in extremely complex social processes, which affect social inequalities between citizens.8

Since the creation of SUS, there have been many advances and challenges to overcome. The challenge posed to be overcome as regards access to health services for the entire population, according to the legal provisions. Therefore, some strategies and policies have been formulated and implemented, looking for changes that improve the health conditions of the population, in order to enable the principles governing SUS, such as universal access to health services.9

As the challenge was to expand the coverage of public health services, the structuring of the family health strategy (FHS), among other things, seeks to expand access and improve the efficiency and effectiveness of the actions, serving as a “gateway” to other levels of the health system.10 The FHS follows the ideal of geographical accessibility, which excels by the proximity of the basic health services with the housing of the population taking into account the context of each community and the influence of social determinants of health/disease process. It is in this scenario which interviewees expose how useful is the FHS in order to facilitate access to health services, especially to vulnerable groups, such as the People with disabilities.

Under the SUS, the expansion of coverage of the Family Health Strategy (FHS) reached 95% of the municipalities by 2007, while covering only about 50% of the population, and still faces problems regarding the quality, resolution and securing human resources, particularly the family doctor.10 These data show positive in that it decreases the geographical barrier of accessibility of the population to primary health care, confirming the literature1 findings indicated as a path to SUS consolidation, supported and influenced by WHO and determining the organization of SUS. But also they are very important for the development of the health care practices of deficients, particularly in what regards to movement and social participation, from the perspective of inclusion and the rights of citizenship.8

Regarding knowledge of deafness repercussions for professional conduct in recent decades represented important achievements in the field of social rights, so that deafness is no longer seen as disabilities and the deaf will be recognized as part of a linguistic minority, or that is, belonging to “groups using a language or between group members, whether in public, which clearly differs from that used by the majority, as well as officially adopted by the State”.11

The Declaration about the rights of persons belonging to national or ethnic, religious and linguistic minorities states that “States shall take the necessary measures to ensure that persons belonging to minorities may exercise fully and effectively all their human rights”.12 This form, this change in the way the deaf person is seen is essential to ensure access from his specific, not as deficient but as an individual with a culture and own language.
Accessibility of the deaf person to public health services

A deaf person has access to health system different of hearing people, since he communicates through a visuospatial language and shows his own cultural characteristics. In this sense, his rights are compromised, regarding the diagnostic information of his illness or treatment, by the difficulty of communication. Therefore, communication can be considered as a major factor of accessibility of the deaf person to public health services.

Another strategy aimed refers to the presence of the sign language interpreter in the own professional public health service. Thus, the choice of services that offer interpretation services in Libras, corroborates the literature showing that most sign language users prefer to be served by a health care professional who knows sign language or with an interpreter.

These actions also guarantee the principle of equity of the Unified Health System, to the extent that facilitate increased access of people in situations of inequality in the pursuit of social justice. Nevertheless, the Libras interpretation service in health services is shown still insufficient, considering the need and the number of deaf people who communicate in sign language.

Regarding the organizational structure of services, complaints referred to the queuing and delays in health care, corroborating findings in the literature that show the extended wait for customer service and inadequate physical area of service as difficulties in functional access to health services. Waiting time was also mentioned as an obstacle in the use of health services, presenting itself as a problem for attendances. Even with the formation of queues and disorganization in the health services being identified as difficulties in accessibility, users submit to them for obtaining access to care, often by the fact that the service sought is the most viable alternative, especially in the economic aspect, to seek the resolution of their health needs.

Another problem highlighted concerns the delays in health services, which can disrupt the course of health care. Comparing the literature, there is confirmation of this reality in the search results to assess the Brazilian health system: this has shown that access is still one of the SUS bottlenecks. Access to health services has criticized the waiting time from the point of view of the appointments and fulfillment. The survey also revealed that individuals mentioned have no guarantee continued attention when they need a consultation with a specialist, and that generally do not leave the primary care service with this scheduled consultation.

Brazilian society live today with an advanced legal construction that ensures the well-being of the population through inclusive and universal policies, alongside a still precarious structure that does not guarantee access to or the use of quality services to the extent of the needs of citizenship. It needs to have the implementation of actions that ensure access by subject and completeness in health actions. To do this it is enough vision, political will and a commitment to SUS users. This access should also be ensured through the presence of the interpreter of LIBRAS (ILS) in health institutions, professional able to facilitate communication between Deaf andListeners through the LIBRAS to Portuguese and vice versa; or between other sign language and oral language.

One of the problems referred by the deaf people of this study is the absence of this professional in the health services, confirming results found in other studies. This fact violates Brazilian legislation, Decree 5626 of 2005, governing the right of deaf people to be treated in health services in their language, the Libras. This breach appeared in the speeches of the subjects, demonstrating knowledge of their rights as health services.

It is considered, however, that the professionalization of interpretation in Libras service is relatively new, only because the Libras was only recognized as a language of the deaf in the last decade, and in Brazil, the National Federation of Education and Integration of the Deaf (FENEIS) the main organ responsible. Thus, we consider that the lack of mastery of the subject to be translated by ILS can cause suppression, addition or confusion of information, which makes the deaf, constantly, even enlisting the help of an interpreter does not have access the whole range of information being passed.

The disproportion of women as an interpreter is by historical cultural relationship of women as family and religious works caregiver. When there is a deaf in the family who accompanies is the mother, who, more directly, the child's development and therefore also learn to communicate more effectively. This relationship appears to characterize the subjects when they generally point the mother as the person in the family who knows Libras. With the regulation of ILS profession is expected that this difference in the gender of professionals is minimized with the passage of time.
The speeches evidenced the importance that deaf people print the ILS to have understanding and the transfer of two cultures, the deaf and the listener. Their presence was valued and reported at ease to express themselves openly and freely in their own language - the Libras, and state that only thus would have adequate support, can expose their doubts, what they feel, and understand everything what happens and what is said, and so actively participate in their own health care.

One has to consider as naïve that the presence of the interpreter in health services resolves all the problems of communication between the deaf and the health professional. It's not always so occurs. The presence of the ILS at health services is already provided for in law, though, apparently, it has not been fulfilled. It is important to note that the presence of a third person in the meetings between patients who use sign language and health professionals that they are not familiar, if on the one hand can facilitate communication, can also lead to lack of privacy, and even compromise the autonomy of patients.

Ethical issues related, mainly to the privacy of users who seek health services are frequent concerns for all people. However, deaf users highlight this concern in a more emphatic way, as the presence of a third party to mediate the communication with health professionals is a routine for this segment, as we can notice in their speeches.

The subjects of the research expressed their exception/reservations and fears about the presence of a third person, even a professional of interpretation. They questioned the ethics of this professional who presences moments of intimacy of the users, as represented by speaking above. They also show fear of exposure of their intimacy and privacy loss.

Reported fears are confirmed in other studies showing that among the deaf there are those who refer to the presence of a third person matches between patients who use sign language and health professionals are unaware; on the one hand this can facilitate communication, it can also lead to lack of privacy, and even autonomy by the users.  

Deafness is a serious disabling condition, which can lead to both social and economic burden to individuals, families and society. This fact occurs more often in the poorest classes, because not afford to pay for routine preventive care needed to prevent the auditive loss.  

Accessibility of the deaf person to public...
Hearing loss/deafness is the kind of deficiency harder contact with the rest of society, because hearing is the essential meaning for the acquisition and use of language. Given the invisibility of its limitation, the problem of communication of the deaf individual is not only organic, reflecting mainly the social and cultural aspects. From this perspective, the deaf end up being foreigners in their own country and form a parallel community of listeners.28

Another obstacle mentioned was the devaluation of the deaf subject. However, they have been identified: that deaf and hearing have similar difficulties when seeking health services, although some deaf people can interpret as disregard; lack of patience on the part of professionals; the rush service; revenue from illegible handwriting; little or no explanation of the treatment; and others, such as prejudice against the deaf person.20,17

FINAL REMARKS

From the point of view of geographical accessibility, the subjects interviewed noted the Family Health Strategy next home as an important alternative to facilitate access to health services, as well as the assistance provided. However, also exposed negative factors that influence as obstacles to accessing public health services, which are not exclusive to deaf people, but common to all who seek such services, and that match the accessibility problems of organizational services such as slowness in attendances for formation of lengthy queues and the difficulty to continue stepping through the network of health services in other levels of attention. So that still stands as a great challenge to management of SUS. There were also identified specific barriers for deaf population by problems in the interpretation of Libras, as the lack of gender among professionals in the services, disregarding the legislation, and the disparity of gender among professionals, affecting negatively the accessibility of those people.

Regarding the socio-cultural accessibility, gratuity of public health services has been appointed as the sole means of granting access to health. Considering deaf people, according to the constitutional and legislative, as people with disabilities, so that the gratuity of services is expressed as an effective alternative to minimize the differences between those with physical and social limitations in the general population. Particularly regarding the cultural differences between the deaf community and the listener population, the availability of the ILS for health services was highlighted as essential to the role of deaf individuals for their assistance; however highlighting reservations about the ethics and the loss of privacy as well the bond breakage between health professional and the user.

It is noteworthy that health care for deaf people has been supported by important legislative advances such as the right of deaf people to be served by professional who communicate in sign language, be it the skilled health professionals themselves as the ILS. However, there is non-compliance with this law, and that even so, the professionals use strategies to promote the assistance of deaf people; however unsuccessfully, with regard to the clear understanding of deaf users and their autonomy.

It should be noted, however, that the management of SUS should promote the accessibility to public health services for the whole Brazilian population, equanimous, not only with regard to geographical accessibility and organization, but especially, socio-cultural; this last, essential for the deaf person, since their culture and their language are still little disseminated.

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