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ORIGINAL ARTICLE

ACCESSIBILITY IN FAMILY HEALTH UNITS ACESSIBILIDADE NAS UNIDADES DE SAÚDE DA FAMÍLIA ACCESIBILIDAD EN LAS UNIDADES DE SALUD DE LA FAMILIA

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ABSTRACT

Objective: to analyze accessibility in the Family Health Units, considering laws and regulations in force. **Method:** quantitative, descriptive study, of which the data collection was with structured form, with physical structure data, pedestrian circulation, accessible routes and horizontal circulation. **Results:** 80% of the units have sidewalks and ramps; 40%, parking for cars; none, tactile warning floor, anti-slip floor and with signaling lanes; 20%, informative signs and areas of restricted use; 60% handrails; 80%, auditorium or meeting room; 100%, internal furniture; 40%, wheelchair. Only the sterilization room and dressing room meet in 100% the dimensions recommended by the Ministry of Health (MH), no unit meets in dimensions with sanitary facilities adapted for handicapped, garbage disposal and purge. **Conclusion:** the physical structure of FHU needs to evolve to achieve what is recommended by MH. **Descriptors:** Access to Health Services; Family Health Strategy; Health System.

RESUMO

Objetivo: analisar a acessibilidade nas Unidades de Saúde da Família, considerando leis e normas vigentes. **Método:** estudo quantitativo, descritivo, cuja coleta de dados foi com formulário estruturado, com dados da estrutura física, circulação de pedestres, rotas acessíveis e circulação horizontal. **Resultados:** 80% das unidades possuem calçadas e rampas; 40%, estacionamento para veículos; nenhuma, piso tátil de alerta, piso antiderrapante e com faixas de sinalização; 20%, sinalização informativa e áreas de uso restrito; 60%, corrimãos; 80%, auditório ou sala de reuniões; 100%, mobiliário interno; 40%, cadeira de rodas. Apenas a sala de esterilização e a sala de curativos atendem, em 100%, as dimensões preconizadas pelo Ministério da Saúde (MS); nenhuma unidade atende em dimensões com sanitários adaptados para deficientes, depósito de lixo e expurgo. **Conclusão:** a estrutura física das USF precisa evoluir para alcançar o que é preconizado pelo MS. **Descritores:** Acesso aos Serviços de Saúde; Estratégia de Saúde da Família; Sistema Único de Saúde.

RESUMEN

Objetivo: analizar la accesibilidad en las Unidades de Salud de la Familia, considerando leyes y normas vigentes. **Método:** estudio cuantitativo, descriptivo, cuya recolección de datos fue con formulario estructurado, con datos de la estructura física, circulación de peatones, rutas accesibles y circulación horizontal. **Resultados:** el 80% de las unidades tienen calzadas y rampas; 40%, estacionamiento para vehículos; ninguna, piso tátil de alerta, piso antideslizante y con franjas de señalización; 20%, señalización informativa y áreas de uso restringido; 60%, pasamanos; 80%, auditorio o sala de reuniones; 100%, mobiliario interno; 40%, silla de ruedas. Sólo la sala de esterilización y la sala de curativos atienden, en 100%, las dimensiones preconizadas por el Ministerio de Salud (MS), ninguna unidad atiende en dimensiones con sanitarios adaptados para deficientes, depósito de basura y purga. **Conclusión:** la estructura física de las USF necesita evolucionar para alcanzar lo que es preconizado por el MS. **Descriptor:** Acceso a Servicios de Salud; Estrategia de Salud para la Familia; Sistema Único de Salud.

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INTRODUCTION

Accessibility is a fundamental condition of the environment, which is responsible for improving the quality of life of the population. Accessibility must be applied in spaces, physical environment, transport, communication, information systems and technologies and must also be in the services and facilities that are open to people, being in the urban and rural areas.¹

In the Brazilian Constitution, accessibility is a right. Every citizen must move with security and autonomy, likewise, it is the right of all Brazilians to have access to the health system. The Brazilian health system faces difficulties to meet all the assistance needs, one of the elements that help to make this happen is the inaccessibility of a large part of the population that needs the services of the Unified Health System (UHS), making assistance to this user.²

The Primary Health Care must have, as an attribute, to be accessible and resolute in face of the health demands of the users. This attribute has a structure (accessibility) component and a performance component (use or access). The accessibility provided by this article makes it possible for people to reach the health service, integrating geographic, financial and organizational aspects, in order to favor the provision of services, as well as the capacity to produce and respond to the needs of the population.³

It is necessary to certify to UHS users the importance of their rights related to social coexistence, as well as to clarify their autonomy for the displacement in search of health care, in order to end social exclusion and include citizens in the society of a beneficent form.

Citizens with some type of limitations, whether permanent or temporary, have physical, sensory or mental restrictions that develop blockages and unrealizable compliments of simple daily activities, among which is access to the various services offered to the population. In this group, disabled, pregnant, obese, elderly, children, and others fit together. In this way, it is necessary to apply equipment that allows improvement in the difficulties of existing barriers to health care.⁴

Health, understood as the right of all, is only acquired if people have chances of accessibility to services. Despite the rights already achieved by means of social movements that culminated in the construction of the UHS, one must continue to

fight for a total and partial improvement of this necessary access to the population.⁵

One of the improvements implemented that enabled access was the Family Health Strategy (FHS), which has a strong connection with accessibility, since, among its guidelines, it seeks to guarantee "universality of access". The purpose of the FHS is to strengthen the link between professionals and the population that uses the services provided in the units. Thus, the needs of the population will be considered.⁶

The Family Health Strategy, as a strategy for the reorganization of Basic Health Care, foresees the creation of multiprofessional teams responsible for a certain territory, acting in a space recognized by its population as the gateway to the Health System⁷, and it is therefore, necessary, to worry with access to its diverse clientele.

Factors such as population aging, prevalence of chronic and degenerative diseases, obesity and the incorporation of new technologies put great pressure on the public and private health systems, and for this reason, it is essential to develop solutions that allow associating quality⁸, as well as accessibility.

Accessibility in the Family Health Units (FHU), besides being little discussed in the literature, is a topic of great value in daily life due to the necessary access to the difficulties presented by people with special needs, elderly, among others, who have physical limitations, that in most cases, generate impossibilities in the performance of usual activities, such as their locomotion.

In this way, this study analyzes the application of equipment that establishes a better conviviality, given the difficulties in the physical environment. To do so, it is necessary to provide knowledge, sensitizing professionals and health managers.

The importance of discussing accessibility in FHUs, in small municipalities is justified, due to the ease of carrying out the activities that this enables. The individual who has a disability or impaired mobility must be interconnected with their social environment so that there is no barrier that restricts their autonomy.

In this context, this study aims to analyze the accessibility in USF in small municipalities, considering the laws and norms that guide accessibility. Evaluating the need to implement improvements in the physical accessibility of these health facilities.

OBJECTIVE

• To analyze the accessibility in the Family Health Units considering laws and regulations in force.

METHOD

Quantitative, descriptive study, where it was verified, analyzed and interpreted through a data collection, translated in numbers the information collected.⁹

The data used in this research were collected in five FHUs, located in the urban and rural areas of two small municipalities, which were selected due to the ease of access and the fact that they belonged to the 13th Regional Directorate of Health (RDH), with headquarters in the municipality of Jequié, Bahia, Brazil. Small municipalities are defined as those with a population of less than 20,000 inhabitants.¹⁰

The data were collected from the application of a structured form of checklist, where the researcher through, direct observation, carried out an analysis of the physical structure of the units, pedestrian

circulation, accessible routes, horizontal circulation and physical structure dimensions.

It was emphasized that because it is a study of the observational type, the same did not process by the Ethics Committee, since it did not work directly involving the human beings. However, the data collection was authorized by the Health Department of the municipalities analyzed.

RESULTS AND DISCUSSION

The data allow a thorough analysis of the physical structure of the FHU, understanding that physical barriers are an important impediment to the population's access to health services.

On the pedestrian circulation and accessible routes, the USF present the following reality:

Analyzed structures	Percentage found
Sidewalks and ramps	80% of the units
Parking for vehicles	40% of the units
Tactile warning floor	0% of the units
Non-slip floor	0% of the units
Floor with signaling lanes	0% of the units

Figure 1. Circulation of pedestrians and accessible routes. Jequié (BA), Brazil, 2017.

According to the table presented, it is possible to identify the presence of sidewalks and ramps in a percentage considered satisfactory, since 80% of the units have them, being important to emphasize that these are small municipalities and that all USF of these were analyzed. We understand that the presence of ramps and sidewalks are indispensable for the population's access to health services, which facilitates the movement of spaces, making service users with adequate mobility, especially those with reduced mobility, permanent or temporary.

We emphasize that the FHU, because they are located within the community and provide services for users with different needs, from newborns to the elderly, must be committed to the specific needs of each public. Thus, according to NBR 9050 and the Statute of the Elderly, special vacancies should be established in those areas for persons who are or who are disabled or have reduced mobility.¹¹⁻² In the units studied, there was a deficiency in a suitable place for the vehicles.

Since only 40% of the units had parking facilities, of which there were no vacancies reserved for people with special needs.

Still on pedestrian circulation and accessible routes, the reality found is totally divergent from what is recommended by the Ministry of Health (2008) and ABNT (2004). According to these, tactile signaling should be installed at the beginning and end of ramps and stairs, being fundamental for the visually impaired, since they need attention and orientation in their locomotion.^{11,13} It is also observed the lack of protection for the users and employees of the units, showing non-slip flooring and without signaling lanes, which makes the environment favorable to possible accidents.

On the horizontal circulation and accesses, USF present the following reality:

Analyzed structures	Percentage found
Lifting	0% of the units
Information Signals	20% of the units
Areas of Restricted Use / Service	20% of the units
Handrails	60% of the units
Auditorium / Meeting room	80% of the units
Interior Furniture	100% of the units
Presence of a wheelchair	40% of the units
Information and signaling (visual, tactile, gestural and sound)	0% of the units

Figure 2. Horizontal circulation. Jequié (BA), Brazil, 2017.

According to the data presented in table 02, it was observed that there is no difference in the units, being a relevant factor, since the unevenness makes the internal circulation risky, especially for the elderly and pregnant. Another important factor that we can verify was the presence of chair wheels, in only 40% of the units, the presence of a wheelchair is essential in the composition of accessibility, since it allows the locomotion of users who need to use this tool for different reasons.

One of the most important aspects of healthcare facilities is the signs that indicate the necessary warnings for the ease of use of the services that are provided. Information should be self-explanatory and legible for the public, including people with special needs¹. This information should be presented in texts, figures, embossed characters, Braille and auditory resources, 11 however, in the units surveyed, it is possible to perceive the incipience in the way of presenting such information, since only 20% of the units offer such a resource and yet incomplete, because in none of the units were high relief figures written in Braille and / or auditory resources.

In addition to the information that is not offered satisfactorily, we highlight the importance of handrails present in the access ramps, which is extremely important for the user's safety and displacement, since it provides confidence, stability and balance. However, the study shows that, of the surveyed units, only 60% had rails on ramps. One can not consider a bad percentage, but in the case of units intended to serve publics that may have special needs, ideally, all units, should be presented.

Failure to comply with the norms established by the Ministry of Health impairs users' access to services, as well as jeopardizing the functioning of the units, making it difficult to work and providing risks related to the maintenance of the units, which can be verified when we analyze the existence of areas of restricted use / service. In 80% of the surveyed units, the professionals did not have access to a suitable place to

perform the activities that are provided in that area, resulting in the use of inappropriate places, which represents an additional risk for users.

In addition to the population's access to services and the risks that the physical structure often offers, it is important to emphasize the need for it to provide an integration of the team with the population. Therefore, one of the relevant factors for this to happen is the presence of a suitable environment, in this case, a meeting room / auditorium. In the units presented, we obtained a result of 80% of the units have meeting room / auditoriums, but they do not present all the media equipment, not satisfying all the desired functions.¹

Another relevant factor for the internal functioning of the services and comfort of both users and professionals who provide assistance is the presence of adequate internal furniture. These need to be well located, so as not to offer risks and facilitate everyday activities. In addition, it is also necessary to presence of materials that support the performance of procedures. On this issue, in all units surveyed, they have furnishings and materials that are necessary for the operation of the service.

We emphasize that it is not only important to have a physical structure with all the necessary compartments if they are not in accordance with the one recommended by the Ministry of Health. On the dimensions of the physical structure in the Units, was found the following reality:

Place	According to the Ministry of Health
Reception	80% of the units
Waiting room	80% of the units
Doctor's office	60% of the units
Odontological office	80% of the units
Procedures room	60% of the units
Vaccine room	40% of the units
Dressing room	100% of the units
Auditorium / Meeting Room	60% of the units
Kitchen pantry	80% of the units
Area of deposit of cleaning materials	80% of the units
Disabled toilets for the public	0% of the units
Bathroom for employees	60% of the units
Sterilization room	100% of the units
Trash deposit	0% of the units
Purge	0% of the units
Minimum total area of the environment: 127.7m ²	80% of the units

Figure 3. Dimensions of the physical structure. Jequié (BA), Brazil, 2017.

The appropriate physical space is an important factor for the accomplishment of a good work by the multiprofessional team. In the units surveyed, a great deficiency / inexistence of spaces that are essential to carry out the work in them was perceived. The dimensions and presence from the reception to the total area of the unit were analyzed, where differences between theory and practice were found.

There are several difficulties encountered for ESF to reach its objectives, among them, the physical structure. This fact has already been reported in other studies, that indicate the dissatisfaction of health workers with the physical structure of these units, mainly, because they present improvisation character, which occurs because the physical structure of the units does not follow the transformation process, even in the identification and recognition of the urgent needs for investment in infrastructure and health unit reform and legal requirements for environmental safety and comfort.¹⁴

In the units surveyed, only 40% of the vaccination rooms are in compliance with the dimensions recommended by the Ministry of Health. However, all rooms that are intended for the administration of immunobiologicals are properly equipped for their proper functioning.¹⁵

Although not predominant, the figures above present an inadequate percentage with the dimensions that the Ministry of Health advocates. Values that result in 0% show a worrying reality. As an example, toilets are not separated by sex and do not offer adaptation for the disabled, as recommended¹.

Another barrier found was the widespread lack of garbage deposits in the units, which

should be ventilated, but with protection against rodents. This non-existence occurs in the inappropriate disposal of garbage, generating a focus of infection and causing future damage to the population, as the spread of diseases through direct or indirect contact.¹⁶

The lack of purging was also emphasized, which is fundamental for the separation of common and biological waste. This problem causes the professionals to use inappropriate places, bringing possible risks to the people who provide and enjoy health services.¹⁷

The literature reveals that these problems are not unique to the Brazilian health system. They are repeated in all the countries that pursue integral health care of their citizens, such as the countries of the European Union¹⁸, highlighting the need for immediate and global intervention to improve global health.

CONCLUSION

The study concedes that the issue of accessibility is still something new, there is a great deal of scarcity, when we talk about a necessary access to public health, especially in the Family Health Units, showing that this difficulty mainly affects, those people who have some kind of limitation, which can be mitigated with an adequate structure of the environment.

The analysis of accessibility in FHUs, in small municipalities, shows that their physical structure still needs to evolve significantly in order to achieve what is recommended by the Ministry of Health, since accessibility deficiency provides a decrease in the use of the units' services , leading to a blockage in social inclusion that is necessary, compromising the level of health of the population assisted by family health.

Therefore, it is necessary to raise the awareness of managers and the general community about the importance of the physical adequacy of family health units, so that they solve the problems they face, providing resources for an improvement in the physical structure. Instead, municipalities receive federal funds for their structuring.

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