

## Welcoming in the Family Health Strategy: perspectives of people with disabilities in the rural context

Acolhimento na Estratégia Saúde da Família: perspectivas das pessoas com deficiência no contexto rural

Acogimiento en la Estrategia de Salud Familiar: perspectivas de las personas con discapacidad en el contexto rural

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**Abstract: Objective:** to analyze the perceptions of people with physical disabilities living in the rural context about the welcoming provided by the Family Health Strategy teams. **Method:** qualitative study, developed in six cities in Rio Grande do Sul, Brazil, whose participants were 13 people with physical disabilities. The production of information took place from January to May 2019 through semi-structured interviews, analyzed by thematic modality. **Results:** welcoming was related to fondness, affection, relationship of trust, dialogue and closeness with professionals, as well as resolvability of demands or referral to other services. Nevertheless, they listed difficulties regarding the availability of medications, exams, medical care and scheduling of care. **Conclusion:** despite the efforts of the professionals working in the teams to welcome people with physical disabilities living in the rural context and meet their demands, the centralization of care in biological issues and the limitations of accessibility and access to health services are revealed.

**Descriptors:** Disabled persons; Rural areas; Family health strategy; User embracement; Nursing.

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**Resumo: Objetivo:** analisar as percepções das pessoas com deficiência física que residem no contexto rural acerca do acolhimento prestado pelas equipes da Estratégia Saúde da Família. **Método:** estudo qualitativo, desenvolvido em seis municípios do Rio Grande do Sul, Brasil, cujos participantes foram 13 pessoas com deficiência física. A produção das informações ocorreu de janeiro a maio de 2019 por entrevistas semiestruturadas, analisadas pela modalidade temática. **Resultados:** o acolhimento foi relacionado ao carinho, afeto, relação de confiança, diálogo e proximidade com os profissionais, bem como à resolutividade das demandas ou encaminhamento para outros serviços. Contudo, elencaram dificuldades quanto à disponibilidade de medicações, exames, atendimento médico e agendamento do atendimento. **Conclusão:** apesar do esforço dos profissionais das equipes em acolher as pessoas com deficiência física residentes no contexto rural e atender suas demandas, revela-se a centralização do cuidado nas questões biológicas e as limitações de acessibilidade e acesso aos serviços de saúde.

**Descritores:** Pessoas com deficiência; Zona rural; Estratégia saúde da família; Acolhimento; Enfermagem.

**Resumen: Objetivo:** analizar las percepciones de las personas con discapacidad física que viven en el contexto rural sobre la acogida brindada por los equipos de la Estrategia de Salud Familiar. **Método:** estudio cualitativo, desarrollado en seis ayuntamientos de Rio Grande do Sul, Brasil, cuyos participantes fueron 13 personas con discapacidad física. La producción de la información tuvo lugar de enero a mayo de 2019 mediante entrevistas semiestruturadas, analizadas por modalidad temática. **Resultados:** el acogimiento se relacionó con el cariño, el afecto, la relación de confianza, el diálogo y la cercanía con los profesionales, así como la resolución de demandas o la referencia a otros servicios. Sin embargo, enumeraron dificultades con respecto a la disponibilidad de medicamentos, exámenes, atención médica y programación de la atención. **Conclusión:** a pesar del esfuerzo de los profesionales de estos equipos para acoger a las personas con discapacidad física que viven en el contexto rural y atender sus demandas, se revela la centralización de la atención en cuestiones biológicas y las limitaciones de accesibilidad y acceso a los servicios de salud.

**Descriptor:** Personas con Discapacidad; Medio Rural; Estrategia de Salud Familiar; Acogimiento; Enfermería

## Introduction

Throughout history, the concept of disability has obtained varied directions, being influenced by political, ethical and philosophical aspects.<sup>1</sup> Currently, the social model of disability is the most accepted to explain this condition. This model seeks to break the biological and positivist view that the medical model adopts, limiting the understanding of disability to injuries and impairments of the body, as well as the development of public policies that are not directed only to the biological aspects of these people.<sup>2</sup>

Accordingly, people with disabilities (PWDs) are those who have long-term physical, mental, intellectual or sensory impairments, which, when interacting with different barriers, tend to limit their full inclusion in all spheres of social life on equal terms with the rest of the

population. The study in question focuses on the perspectives of physical PWD, whose participation in society is limited due to complete or partial changes in one or more body segments, causing loss or abnormality of structure or of limb function.<sup>3</sup>

The National Health Policy for People with Disabilities has, among its guidelines, the promotion of quality of life and organization of care services for PWD, instrumentalization of human resources and integral health care for this population.<sup>3</sup> Despite the recommendations of this policy, there are numerous social, economic and cultural obstacles, experienced by these people, for their full insertion in society,<sup>4</sup> including the access to health care services.

The barriers experienced by PWDs are aggravated when they live in rural contexts. In these settings, the population has a lower level of education, low income and difficult access to health services due to the geographical distance from urban centers, in addition to the low coverage of the health care network, which negatively affects their quality of life.<sup>5</sup>

With regard to access to health services in the rural context, Primary Health Care (PHC) is the service that is present in most Brazilian cities. Family Health Strategy (FHS) is a gateway to other levels of health care, which is even more evident in the rural context. When considering the interface between the health of PWDs and the access to PHC services, it is relevant to mention that PWDs are more likely to show conditions of health deficit, whether they are physical or psychological demands, which require from these services more efforts than in situations involving people without disability.<sup>6</sup>

The daily work of the FHS teams seeks to resolve the demands and complaints of the registered population. Its focus of attention and care is centered on families and communities, aiming at preventing and promoting health, in addition to clinical care. The level of resolvability of FHS is closely related to the welcoming and bond in the relationship between the professional and the user.<sup>7</sup>

Welcoming is one of the main guidelines of the National Policy for Humanization of the Unified Health System (SUS, as per its Portuguese acronym) in Brazil. It is defined as the reception of the user in the service and the responsibility of the professionals for this user, based on listening to needs and distresses. It seeks the guarantee of a resolvable care and the articulation with other health services for the continuity of care, whenever necessary.<sup>8</sup>

This welcoming provides a better relationship between users and health professionals, fostered, among others, by affection, friendly postures and respect. By welcoming and listening to the user, we can provide the establishment and strengthening of a fundamental bond with the humanization of care and resolvability of the demand presented by the user and its family.<sup>9</sup> It is a technology that seeks to qualify the listening and reduce the fragmentation of the provided care.<sup>10</sup>

In view of the challenges of the health sector in developing care actions for PWDs living in the rural context, in particular, the act of welcoming, this study had as its research question: what are the perceptions of people with physical disabilities living in the rural context about the welcoming provided by the Family Health Strategy teams? In order to answer it, the objective is to analyze the perceptions of people with physical disabilities living in the rural context about the welcoming provided by the Family Health Strategy teams.

## Method

This is a descriptive study with a qualitative approach. This approach is employed in investigations that seek the history, relationships, representations, beliefs, perceptions and opinions of human beings about themselves, their ways of living and constructing their artifacts, as well as their feelings and thoughts.<sup>11</sup>

The study setting consisted of six cities in the north and northwest regions of Rio Grande do Sul, Brazil, belonging to the 15<sup>th</sup> and 19<sup>th</sup> Regional Health Coordinators. The choice of these cities is justified because they are small in population and 70% of their inhabitants live in a rural

context. In these cities, there was little information on the number of people with disabilities living in the rural area, despite the evidence of the existence of this population. We should underline that the total number of FHS units in the cities where the study was held was eight. In four of these cities, the FHS units were not located in the rural context.

In order to organize and produce information, firstly, we made contact with the coordinating nurses of all FHS units in the cities where the study was held. These, together with the community health workers (CHW), prepared a list of 28 possible study participants, that is, the indication was made by nurses and CHW of the cities.

The inclusion criteria listed for this research were: having congenital or acquired physical disability; demonstrating cognitive conditions to answer the interview; being over 18 and living in a rural context. The exclusion criterion established was: having an intellectual, mental or sensory disability. We excluded two possible participants because they had both physical and intellectual disabilities. Thus, based on the criteria, 13 PWDs took part in the research. We should highlight that none of the invited participants refused to participate in the study.

The CHW of the micro-area of registration of the participants performed the previous scheduling of the interview with them, as well as accompanied the responsible researcher to her home to carry out the production of information. Upon arriving at the home and checking the presence of other people, especially neighbors, the production of information was rescheduled. Moreover, we should mention that neither CHWs nor family members of the PWDs remained with them during the production of information. These procedures sought to reduce the possibility of bias in the study, as well as not harming the principles of research ethics.

The production of information took place through a semi-structured interview based on a script containing closed questions in relation to the sociodemographic characteristics of the participants and open questions related to their perceptions about welcoming, as this was conducted by the FHS team, difficulties and potentialities perceived regarding the welcoming

process. The interviews lasted an average of 25 minutes. The information was recorded with the consent of the participants, thus guaranteeing its reliability. The period of production of the plausible information was from January to May 2019, ending when the internal logic of the object of study was understood.<sup>12</sup>

In order to systematize and analyze this information, we chose to use the thematic content analysis, covering the following stages: pre-analysis, exploration of the material and treatment of the obtained results and interpretation. In the pre-analysis, the listening to the interviews, floating reading and constitution of the corpus were conducted according to the objective of the study. In the exploration of the material, the coding process took place through similar words or phrases in the speeches, allowing the constitution of the nuclei of meaning, which were later grouped and allowed the constitution of the categories. In the treatment of results and interpretation, inferences and interpretations were made based on national and international literature.<sup>11</sup> From the analysis, two thematic categories were raised: Welcoming: affection, fondness, dialogue and trust in the relationship with health professionals; Welcoming: resolvability of demands, access and accessibility to health services in the rural context.

The study follows the guidelines of Resolution n° 466, dated December 12<sup>th</sup>, 2012, of the National Health Council, having been approved on August 9<sup>th</sup>, 2017 by the Institutional Research Ethics Committee, under Opinion n° 2.208.566. The information was produced after the participants read, explained and signed the Free and Informed Consent Form. In order to guarantee anonymity, the statements were identified by the letter “P” referring to the participant, followed by an ordinal number corresponding to the order of participation in the research.

## Results

Regarding the sociodemographic profile of the participants, 11 were male and two were female. The age ranged from 38 to 84 years. As for education level, eight had incomplete

elementary education; three complete high school; and two complete elementary school. With regard to income, nine participants mentioned that it came from disability retirement and from agriculture. Only four participants had the Continuous Cash Benefit (BPC, as per its Portuguese acronym) as their source of income. Henceforth, we will discuss the thematic categories raised from the semi-structured interviews.

### **Welcoming: affection, fondness, dialogue and trust in the relationship with health professionals**

This category reveals that the participants related the welcoming to the demonstration of fondness and affection. Thus, they described the way in which they were received by the health professionals of the FHS teams.

*Welcoming is when you arrive [...] to be well received, welcomed by professionals from both areas [...] Doctor, Nurse, Nursing Technician, Nursing Assistant, Pharmacist. At the unit, this is grade 10 [...] my bond with the unit is very strong, I feel very welcomed. (P6)*

*We are received very well [...] I know two doctors [referring to the team's doctors] but the others, not [...] There, at the health center, I'm well treated [...]. (P9)*

Through the testimonies of the participants, it was possible to identify that there were professionals with whom they felt more welcomed and with whom they had a closer relationship. They highlighted nurses, CHWs and physicians.

*Nurse and community health worker because they have a closer friendship, knowledge. (P1)*

*I talk more with the nurse at the health center, I know better [...]. (P4)*

*[...] the Nurse, because you get there and tell the story [referring to its demand] for her [...] she goes and checks if she has a form to assist you. (P5)*

*I like very much the nurse [...] we know better, have a friendship [...] if I go to the health center, I prefer to consult with him [...] not that others are not good, but I prefer to consult with him. (P8)*

*[...] I have a lot of friendship with doctors and nurses. (P9)*

*I like more the doctor [...]. (P13)*

The welcoming was revealed by the participants because of the freedom they felt when talking to health professionals. When they felt free, they were able to express their demands in relation to the health and illness process, as well as doubts and expectations.

*Yes [referring to the dialogue with the professionals] my problems, my pains, my diseases [...] I feel at ease. (P2)*

*I always feel very comfortable asking questions [...] our relationship is pretty good. (P6)*

*I don't hide [...] I don't hide what I feel, I say [...] I'm not ashamed. (P7)*

One of the testimonies shows that dialogue is a fundamental element in the care process. This allows the rapprochement between health professionals and PWDs.

*[...] this doctor is very attentive [...] there are people who go there [referring to the family health unit] just to talk to him because he has patience with people. (P11)*

This category allowed us to identify that the welcoming process was perceived by PWDs as the way in which they were received by the professionals of the FHS teams and by the relationship of dialogue and trust established with them. In this relationship, the participants also indicated professionals with more welcoming attitudes and with whom they established a closer relationship.

## **Welcoming: resolvability of demands, access and accessibility to health services in the rural context**

From this category, we can identify that the welcoming process was related by PWDs to the resolvability of their demands. This resolvability took place from the behaviors of the FHS teams themselves or from the referrals to other services.

*[...] the problem is solved in one way or another [...] I never stopped being treated [...] no one ever failed to solve the problem [...]. (P6)*

*[...] at the health center, as much as possible, they end up solving it there; and if they can't, they send it to another place [referring to another city]/[...] or solve it there or they manage to refer it. (P8)*

*[...] I'm very well treated and my things are always resolved [...] I go when I need to have a consultation, request medication, renew a prescription. (P10)*

*I've always been well treated [...] the doctor always sends me to repeat the exams. (P11)*

*[...] I was always well treated, they always solved everything [...]. (P12)*

Although some participants highlighted the good service and the resolvability of the demands shown, other testimonies revealed difficulties in guaranteeing access to services. These were related, in particular, to the unavailability of free exams, lack of medication, limited medical care and absence of a system of medical forms.

*[...] sometimes you have the need to take an exam there and you no longer have it [...] I have an X-ray there to do and it's stopped because I am unable to pay. (P3)*

*[...] we get there, go to the doctor, get the prescription, but there is no remedy available [...] they are not all resolved [referring to the care demands] some have to solve it on their own. (P5)*

*[...] there's never any remedy, I have never been able to get a remedy there during my life [...]. I never can also reach a doctor, because I have to go at five in the morning to get a form to be able to get a prescription [...] furthermore, when you have a doctor, because now I think there is no doctor [...] they tell you that a new doctor comes to assist us, but only supports seven forms a day [...] what's the use of seven cards in a population [...] so, for me, there is no use going to the health center. (P7)*

*It's just that you've to be there early to get a form, and they only have 16 forms and I was the number 17; therefore, I couldn't get it [...] and then you have to arrive early, everything because of the order of arrival. (P10)*

PWDs also exposed challenges with regard to accessibility to health services. In the cities in which there was no FHS unit in the rural context, in order to reach this service, the physical PWDs needed to call the Health Department and request transportation, which often took too much time.

*[...] sometimes the health car that we call takes too long [...]. (P2)*

In other cities, although there were FHS units in rural communities, they had important limitations for the accessibility of PWDs. Among them, we can highlight the absence of handrails and ramps.

*There is no handrail [...] we've a access close to the ground [...] when it rains, the crutches slide [...] a person must come in holding me back because it's smooth, slippery. (P5)*

*There is no wheelchair [...] I get there, I go up there by car; then they open the chair, weigh me and put me in the chair [...] you've to go, but, in most cases, I stay in the car [...] the doctor comes over there [referring to the car]. (P13)*

In this category, PWDs revealed the welcoming by relating it to the resolvability of their demands, which, in most cases, were met. Conversely, they pointed out some difficulties in access and accessibility to health services.

## Discussion

For PWDs, the welcoming of the FHS team refers to the relationships of fondness and affection, which does not differ from the perspective of welcoming, according to which their purpose turns, among others, to qualified listening and the commitment to offer competent, quality and resolute care.<sup>12</sup> Participants reported that being well received by professionals is also characterized as welcoming. This perception was also highlighted by a study typified as integrative literature review, according to which the perceptions of users allowed to prove that they related the welcoming to the good receptivity by the team.<sup>13</sup>

In the care process, many axes are considerable for the welcoming to be effective, with emphasis on the close relationships between the professional who performs the welcoming and the user cared for.<sup>12</sup> In the testimonies, the participants reported the importance of maintaining bonding relationships with the professionals, especially nurses, CHW and physicians, with the justification that these professionals fostered the construction of friendly relationships, the establishment of dialogue and the resolvability of their health demands. In this perspective, they mentioned the consultation space with the nurse, which refers to the perception that the consultation may imply the welcoming.

The establishment of bonding and accountability relationships between the Primary Care team and the community registered in the territory is highlighted as an element that permeates the work process at this level of health care.<sup>14</sup> The bond is a process of rapprochement that generates affective bonds between two human beings: the health professional trained to care for

and the user who seeks care for their care needs.<sup>8</sup> This process is constructed from welcoming and opening postures to the other's problems and the empathic relationship.

In addition, the bond articulates concepts of humanization, accountability, acceptance and integrality. Accordingly, it allows professionals to know beyond the health needs, the context in which users and families live<sup>15</sup>, thus recognizing their social determinants and singularities.

When it comes to establishing a bond between professional and user, CHWs are those who are closest to the interviewees, since they establish greater contact with families and the community, both in urban and rural contexts. Nevertheless, in the latter, considering the specificities of the geographical distance in relation to the FHS units and other health services, the role of the CHW becomes even more important, as this is often the first health professional that the user calls when he/she has some demand.

When they live in the territory in which they operate, they are available to their community both during office hours and outside. The practices of CHW involve health promotion and surveillance actions, such as active search.<sup>16</sup> Its work process is guided by a broad scope based on care and bonding relationships.<sup>17</sup>

Dialogue was another element mentioned by the participants, due to the possibility of having freedom to express their complaints during the service, without feeling ashamed of their problems. This result is satisfactory and positive, both for the PWD, who feels free and at ease to dialogue, as well as for the professional, who, based on this freedom of expression and dialogue, manages to outline a therapeutic plan that meets the demands of this user. Accordingly, we should underline that the quality of professional-user communication associated with a solid bond and the sensitivity of the professional to identify the context of the user in its fullness, promotes an integral health care.<sup>18</sup>

With respect to the resolvability of the demands of the physical PWDs living in the rural context, we could infer that this happens partially. Accordingly, some participants reported the

lack of available medication, medical care reduced to a limited number of forms, impossibility of carrying out free exams and scheduling care through forms.

The testimonies of the participants who associated the welcoming process with the resolvability of demands of an essentially biological nature, such as exams and access to medicines, reveal the hegemony of the biomedical, curative and biologicist model. This model, in addition to being reproduced in many health care practices by professionals, also ends up being incorporated by users, in this case, physical PWDs, when they seek attention to their health demands. In this context, the National Health Policy for People with Disabilities within the scope of SUS highlights the relevance of meeting their demands, whether related or not to the disability that they have, seeking an integral health care.<sup>3</sup> This will be feasible if it is possible to overcome the viewpoint that favors the recognition of PWD only by its biological condition.

Some participants reported the need for scheduling through forms, which had a daily limit in the setting under study. In addition, in order to reach assistance through forms, they had to arrive at the unit very early and, even so, occasionally, they were not successful. When considering that, of the total number of cities in the study in question, only two had FHS units in the rural context, the difficulties of access for PWDs are aggravated, due to the travel time from the rural to the urban context. Difficulties of physical PWDs living in rural areas to access health services were also reported in a study developed in Peru, being greater than in the urban setting.<sup>19</sup>

In Brazil, PHC, by means of FHS, has evolved in relation to population coverage, seeking to break with the medical care model and become a preferential gateway to SUS.<sup>20</sup> Nevertheless, the guarantee of access to health is not yet materialized for a large part of the Brazilian population, among which, we can mention the population living in the rural context.<sup>21</sup>

These reflections reveal the urgency of revising care and service strategies, especially when users live in the rural context and have some disability, with a view to providing access to these users, one of which is to meet spontaneous demand. Accordingly, we should underline

that this refers to the availability of the health service, thus enabling its appropriate use to achieve the best health results.<sup>22</sup> As the restriction on the number of records does not allow users to be assisted, the access to this health service is harmed.

Considering the limitations of access on the part of the rural population to health services, it would be important for the FHS teams to seek to break with inflexible schedules and begin to meet spontaneous demand and on the same day on which these users arrive at the unit. This would demonstrate greater sensitivity to the demands of the rural population, which tends to face long distances to reach the health service.<sup>21</sup>

Despite the limitations, the interviewees recognized and valued the effort that the FHS team undertook to welcome them and seek to resolve their demands. These findings are in line with a study that aimed to understand the satisfaction of users with the access and the welcoming of PHC in Ribeirão Preto/São Paulo, Brazil. This paper revealed that, although users pointed out weaknesses in health care, such as delays in scheduling consultations and meeting demands, they positively evaluated the welcoming, attention and dialogue provided by the PHC professionals.<sup>23</sup>

In two cities, although there were FHS units in the rural context, these establishments did not allow adequate accessibility to physical PWDs due to the inadequate infrastructure, both internal and external. The testimonies revealed that this infrastructure prevented the accessibility of PWDs in a wheelchair, since one of these had to be assisted in a car. Moreover, they suggested that the smooth floor material made it difficult to use crutches. With this, PWDs needed help from other people, thus reducing their autonomy. In the direction of these findings, a study that aimed to evaluate the physical accessibility of the reception of PHC units and its relationship with the welcoming identified that access ramps and floors were some items that were more likely to be inaccessible in rural than in urban areas.<sup>24</sup>

Accessibility is considered the possibility that the user has or not to reach the health service. In the study in question, access and accessibility are considered complementary

concepts<sup>22</sup>. Thus, as PWDs have difficulties in accessing health services, their access to health is also undermined/limited.

From this perspective, a study developed in Bangladesh revealed that physical PWDs faced mobility-related barriers to access PHC services, including requiring the help of other people to reach these services.<sup>6</sup> In order to promote accessibility, health units need to have environmental adaptations in line with the needs of PWDs, thus contributing to their autonomy and independence, whether total or assisted.<sup>25</sup>

Still in relation to infrastructure, a quantitative study developed in India concluded that ramps, corridors and wheelchairs are some of the barriers to the accessibility of PWD in PHC centers, which are not adequately equipped to assist these people.<sup>26</sup> In a qualitative investigation seeking to explore the perspectives of health professionals in the provision of PHC services for physical PWD in the rural area of Ghana, these, in their majority, pointed out that the inaccessible facilities constituted an important obstacle to the provision of services to users with physical disabilities. They also revealed that the units were designed without considering the needs of people using assistive devices, such as a wheelchair.<sup>27</sup>

Difficulties in accessing services are also revealed by the lack of transportation provided by the health sector, which is often time-consuming, in addition to the need to travel to another city to carry out health exams. These data reveal the daily lives of people living in rural contexts, permeated by obstacles such as geographical distance and lack of transportation. Added to these barriers, we can mention the limits that physical disability imposes such as, for example, mobility difficulties.

The accessibility of users to health services and their impact on user access are still a challenge for SUS, even after 32 years of implementation of this public health policy. When considering the rural context and the particularities of physical PWDs, the accessibility

challenges tend to be accentuated. These challenges hinder integrality in health and contribute to maintaining the inequities to which these people are subjected.<sup>28</sup>

In Brazil, the process of democratization of health based on the SUS model has contributed to the inclusion of PWDs in public health policies.<sup>29</sup> Nevertheless, the panorama shown in the study in question reinforces that their health remains part of an agenda that is little accepted in this System, thus disregarding, besides the principle of integrality, the principles of equity and universal access to health.<sup>30</sup>

The study has limitations such as the limited number of participants in a specific rural context, but it brings contributions with subsidies to help us to think about new practices for the inclusion and accessibility of physical PWDs living in the rural context in relation to their rights, especially the right to health. Among these practices, these people are served based on spontaneous demand, thus providing care for their needs when they seek the PHC service. Moreover, we should emphasize the readjustment of the infrastructure of the FHS units with the purpose of providing the accessibility of the physical PWDs through ramps and handrails.

## **Conclusion**

The findings of this study introduce different elements that corroborate with the welcoming framework, since the physical PWDs living in the rural context refer to demonstrations of fondness, affection and a relationship of trust and closeness with the professionals and with the health care provided by the teams. Accordingly, they felt more welcomed especially by the nurses, CHW and physicians.

The welcoming was also pointed out by the participants as the possibility to openly dialogue with professionals about their health needs. It was also related to the immediate resolvability of their demands by the teams or referral to other services. Despite this, some participants mentioned that these demands were not always met, especially in relation to the

availability of medications, exams, medical care and scheduling of care through the system of forms, which reveals the predominance of the biomedical model in their ideas.

The reports of the study participants also showed that welcoming is related to accessibility to health services. Although, there were FHS units in rural contexts in some cities, their internal and external infrastructure made it difficult and/or impossible for physical PWDs to access these establishments, especially those using wheelchairs and crutches.

The results contain relevant elements to support local health managers and professionals working in Primary Health Care services, with a view to structuring the local agendas, considering the particularities of the rural context, in order to provide the welcoming of physical PWDs in their integrality. Therefore, it is imperative to consider their perceptions and representations as tools for the formulation of actions by the health sector, thus contemplating the institutional guarantees envisaged in the SUS principles and guidelines, and, mainly, seeking the achievement of health as a citizenship right.

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