

Original articles

Knowledge and experience of Family Health Team professionals in providing healthcare for deaf people

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ABSTRACT

Objective: to explore the communication of family health team professionals in providing healthcare for deaf people.

Methods: this cross-sectional study was comprised of 39 Family Health teams located in urban and rural areas. A census was conducted and some questionnaires were applied to the Family Health Professionals (31 doctors, 30 nurses, 27 dental surgeons and 4 pharmacists) from the Family Health Support Centers.

Results: the great majority of the personnel (60.8%) reported being aware of the existence of Brazilian Sign Language, but none of the interviewees had used it to communicate. Most of the Family Health Team personnel (68.5%) had provided care to a deaf person at some time. However, none of them had taken a complementary course or received any specialized training.

Conclusion: the relational dimension is fundamental in developing individual therapy plans. From this perspective, the communication barriers that deaf people face can compromise the necessary bonding for healthcare, which may adversely affect early diagnosis, timely treatment, and adherence to required treatment.

Keywords: Hearing Loss; Health Care; Deafness; Family Health Strategy; Communication Barriers

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INTRODUCTION

The social protection system, from the perspective of the formation of a welfare state in Brazil, is based on social security (including social security, health, and social assistance) and has an impact on the construction of a society that seeks to respond to the redistributive ideal and the universalization of citizenship¹. Within this perspective, the Brazilian Unified Health System (SUS) is a strategy of the social welfare state with a redistributive institutional profile², constitutionally based on social justice and the ideal of equality of results, which is ensured through broad, universal, and equitable public policies.

In an unequal society, the negative impacts of residual social protection systems and financial austerity mechanisms on health policies widen inequalities and compromise social justice^{3,4} with deleterious effects, especially for the most vulnerable social groups⁵⁻⁷. Public policies such as SUS are not exempt from reproducing mechanisms of exclusion and, therefore, institutions and their agents can paradoxically diminish the advances of social protection, especially those related to the principle of equity and universality⁸.

Other legal instruments have been formulated to constrain the harmful effects of social inequalities and vulnerabilities accentuated by aspects such as ethnicity^{9,10}, gender¹¹, and disability^{12,13}, among other conditions that often impair the access to health services. In this regard, the National Health policy for people with disabilities¹⁴ is focused on the inclusion of individuals with disabilities in the entire network of SUS services, recognizing the need to implement a process that responds to the complex questions involving health care for this social segment in Brazil^{3,12}.

In the case of deaf people, the difficulty in accessing health care is intensified by inefficiency in the communication between the professional and the deaf user^{15,16}. Thus, deaf people seek health services less frequently than normal-hearing people, because of fear, mistrust, and frustration¹⁷, aside from the symbolic violence¹⁸ resulting from the lack of preparation and knowledge of health professionals about these individuals^{13,16}. Moreover, deaf people face difficulties in describing their symptoms to health professionals, especially those who are not accompanied by someone who can communicate with them¹³.

Conversely, the sheltering of the deaf person¹⁹, through adequate communication in the health service, is an indispensable tool to increase adherence and regular search for care¹⁵. Therefore, given the

complexity of communication between deaf people and health professionals, there is a need for including this into the debate on the role of the Brazilian Sign Language (LIBRAS) in the development of skills in the work process in the production of health care^{15,20,21}.

Thus, aiming at overcoming such inequalities and improving the quality of public services in SUS, this study evaluated communications that occur when attending deaf people from the perspective of Family Health Staff in Vitória da Conquista.

METHODS

This study was approved by the Research Committee of the Municipal Health Secretariat of Vitória da Conquista according to Letter No. 079/2013, dated 11/20/2013, and by the Research Ethics Committee of the Multidisciplinary Institute of Health of the Federal University of Bahia, according to Opinion No. 477,283, dated 12/17/2013. All respondents agreed to participate in the survey and signed an informed consent form.

In order to evaluate communications with deaf people from the perspective of health professionals from Family Health Units (FHU), a cross-sectional study was conducted, considering 39 teams covering FHU from an urban area and rural areas of Vitória da Conquista, Bahia. In September 2013, the municipality of Vitória da Conquista had an estimated population of 316,000 inhabitants²². According to data from the history of primary healthcare coverage²², there were 509 Community Health Agents (CHA), 35 Family Health Center (FHC) teams (38% coverage), 30 Oral Health teams, and 4 Family Health Support Centers (FHSC).

A convenience sampling process was used to define the sample size for all professionals (physicians, nurses, and dentists) of FHC and all pharmacists of FHSC. Data from the FHU, FHSC teams, and their professionals were made available by the Municipal Health Department.

We chose FHSC professionals for this investigation because we understand that FHU should be the preferred gateway for all people when they seek medical assistance in the health care system, regardless of their living condition. Therefore, the difficulties identified at this point in the health care system signal and serve as markers for the evaluation of the quality and scope of primary health care (PHC). The inclusion of FHSC pharmacists, in turn, was intentional, because they are essential professionals for patient safety policy, especially during pharmaceutical assistance ensuring safe and rational use of medicines²³.

The decision regarding the professional census is justified by the limited number of deaf people seeking health services¹⁹, as well as by the “low” number of deaf people in the population³. In this way, we sought to collect a data set that could sensitively comprehend the challenges of assistance to the disabled population, specifically the deaf people, in the third largest municipality of Bahia.

Questionnaires were administered to 88 professionals of FHU (31 physicians, 30 nurses, and 27 dentists) and four FHSC pharmacists. In this respect, among the 108 professionals who worked at the FHU, 20 professionals (18.5% loss) did not respond or were not found (e.g., holidays, away from work, among others), and all the four pharmacists who worked at FHSC were included.

Therefore, this was an observational and exploratory case study²⁴ of descriptive nature. A self-applied questionnaire was used, with questions related to a) profile and training of interviewees; b) training in communicating with deaf people; c) health care for deaf people; and d) perception of professionals about communication during care for deaf people.

Data were collected by the researcher and eight other field assistants, who were recruited and oriented to carry out suitable data collection. Regarding the rural area data, questionnaires were directly sent to professionals at the Municipal Health Department (before they were sent to their respective FHU), and for the urban area data, the research team went directly to the FHUs. Data were coded and computed in EpiData statistical software for descriptive analysis. Fieldwork was carried out from December 2013 to January 2014.

RESULTS

Most professionals interviewed in all job categories were female, except for pharmacists. In this regard, nursing stood out by being mostly comprised of women (97%). No major variations were observed in the training time for professionals, and most of them (69.6%) completed undergraduate studies more than five years ago. Moreover, approximately 30% of the

professional had more than 15 years of graduation (Table 1).

Over half of the respondents (55.4%) had more than five years of experience in PHC services, in FHU or FHSC, whereas only about 18% of them had less than two years of experience. One-fourth of these professionals were younger than 30 years, and most of them (60.8%) were between 30 and 40 years old; thus, the profile of professionals working in FHU and FHSC was of young adults.

In the second set of questions about practices and knowledge in dealing with deaf people (Table 2), most professionals (60.8%) reported being aware of the existence of LIBRAS, although none of them reported communicating through it. Nevertheless, data revealed that 68.5% of the professionals working in the FHU or FHSC had attended a deaf person at some point.

Regarding training for communicating with deaf people, data showed a predominance of professionals with continuing contact (3.3%) during undergraduate studies. Furthermore, none of the professionals took any complementary course or received any training through continuing health education offered by health service managers.

Among the 63 professionals who had already attended a deaf individual in the health unit, the vast majority believed they had conducted an adequate consultation, although approximately 40% admitted that doubts raised by deaf users were not adequately answered. A concerning finding in this same group of interviewees was that about 61% of professionals faced some difficulty in conducting the consultation and 81% were not adequately prepared to attend this population. Another fact that drew our attention was that even when facing limitations in the care process, according to these professionals, no deaf user was annoyed with the professional during the consultation and vice versa.

Finally, when professionals were asked about “how satisfied” they were when conducting the consultation, less than half of them were satisfied. On the contrary, about 70% of professionals believed that deaf users were satisfied with the consultation received.

Table 1. Profile of Family Health Clinic personnel, Vitória da Conquista, Bahia, 2014

Variables		N (92)	%
Occupation (gender)			
Doctor	Males	12	39
	Females	19	61
Nurse	Males	1	3
	Females	29	97
Dentist Surgeon	Males	10	83
	Females	17	17
Pharmacist (FHSC)*	Males	3	75
	Females	1	25
Training time (years)			
≤ 2		15	16.3
> 2 a ≤ 5		13	14.1
> 5 a ≤ 10		18	19.6
> 10 a ≤ 15		19	20.7
> 15		27	29.3
Length of experience in FHU/FHSC (years)			
≤ 2		17	18.4
> 2 to ≤ 5		13	14.3
> 5 to ≤ 10		21	22.8
> 10		30	32.6
Does not know/did not answer		11	11.9
Age (years)			
< 30		23	25
> 30 to ≤ 40		33	35.8
> 40 to ≤ 50		16	17.4
> 50		8	8.7
Does not know/did not answer		12	13.1

Note:* FHSC - Family Health Support Center; FHU - Family Health Unit.

Table 2. Knowledge and experience of professionals in the care for deaf people in Family Health Clinics, Vitória da Conquista, 2014

Variables	Yes n (%)	No n (%)
Knowledge of LIBRAS		
Knows or has heard of LIBRAS.	76 (82.6)	16 (17.4)
Knows that LIBRAS is the official language of deaf people.	53 (57.6)	39 (42.4)
Communicates through LIBRAS.	0 (0)	92 (100)
Has received training during undergraduate studies on strategies to communicate with deaf people.	3 (3.3)	89 (96.7)
Participated in any training course that addressed the communicational aspects with deaf users.	0 (0)	92 (100)
Undergone continuing education on communication with deaf people while in service.	0 (0)	92 (100)
Attended a deaf user at FHU/FHSC.	63 (68.5)	29 (31.5)
Health care for deaf people at FHU/FHSC*		
Considers that the consultation has been fully carried out.	52 (82.5)	11 (17.5)
Considers that the user's questions have been answered.	37 (58.7)	26 (41.3)
Faced some difficulty during the consultation.	41 (65.1)	22 (34.9)
Got annoyed/"lost patience" while attending a deaf user.	0 (0)	63 (100)
During the consultation, deaf users have already been annoyed/"lost patience."	0 (0)	63 (100)
Feels ready to attend a deaf user.	12 (19)	51 (81)
Satisfaction Level*		
Professional was satisfied with the care provided to the deaf person.	30 (47.6)	33 (52.4)
Deaf user was satisfied with the consultation at FHU/FHSC.	43 (68.2)	20 (31.8)

Note: Only those who had already attended any deaf user at FHU/FHSC.

* FHSC - Family Health Support Center; FHU - Family Health Unit.

DISCUSSION

To organize a public and universal health system that respects the principle of universality, different interventions for disease prevention, health promotion, as well as the cure and rehabilitation of diseases must be accessible to different users²⁵, regardless of their living condition from the perspective of integral care²⁶.

In this respect, FHCs have as premise facilitating people's access to the health care system, being the preferential pathway, through routine and continuous contact with proximity^{26,27}. However, the partial coverage by FHCs in the municipality under study contradicts the scope of primary care actions reaching the whole population. Moreover, the coverage of FHSC in medium and large municipalities has been a challenge for the achievement of universality in Brazil²⁸.

Among the challenges to access care in the FHSC, we highlight the provision of physicians (recruitment and retention)²⁹, as well as the adequate training of professionals to ensure the reliability of care at the primary health care⁶ and, most importantly, austerity policies⁴. The municipality we evaluated had an incongruity. Even though all teams were mostly comprised of physicians and other members of the FHSC had an adequate training time and permanence in the teams, contrary to what was expected, all these professionals expressed a lack of minimal training to deal with the deaf population. Such findings, even unwanted, agree with different Brazilian^{21,30} and international studies^{17,31}.

This empirical evidence shows the partial quality of care in the FHSC and exposes some level of selectivity since restrictive accessibility to deaf people hinders the universal right to health and contradicts the comprehensive perspective of PHC. Another critical issue is that even predominantly located in territories with greater social vulnerability, PHC teams in Brazil still reproduce mechanisms of inequity, since there is greater difficulty in accessing the most vulnerable population, either due to life conditions¹⁸, ethnic issues^{9,32}, social stratum³³, or sexual orientation³⁴. Such findings are also found in PHC, even in high-income countries^{7,10,11}.

Some aspects diminish the right to social protection, impairing access to the deaf population, and exposing them to inadequate service assistance and communicational accessibility^{15,19}. This was discovered after the interviewed professionals revealed that they attend deaf people in the FHU without training and, consequently, facing difficulties regarding clinical behavior and felt unprepared for an appropriate approach to these obstacles.

In contrast, about half of the professionals stated that they were satisfied with the care provided to deaf people and the majority believed that deaf users were also satisfied with the consultation received. However, these data do not ensure that there was an actual understanding by the user since this was the perception of the professional, nor does it mean that the quality of the consultation was equivalent to the quality desired or required by the deaf user. Similarly, these results can indicate an idealized understanding of the health care process centered on professional work and little association with the perspective of interrelationship and inter-subjectivity.

Therefore, the relational aspect is a fundamental part in the development of individual therapeutic projects³⁵; notably, the professional-user meeting needs that are conducted with knowledge going beyond the technique which can permeate the field with sensible communication ensuring the provision of health care³⁶. From this perspective, communication barriers faced by deaf people compromise the development of the relationships required in health care, which can negatively affect early diagnosis and timely treatment²¹.

Exploring this issue by investigating the perception of deaf users interface with health services and their relationship with professionals reveals a very distinct perspective from the perceptions of professionals in Vitória da Conquista. In this regard, various studies have shown that deaf people seeking health services, face many difficulties and, therefore, are dissatisfied with the care provided^{13,37}. Among the barriers to accessibility mentioned in different studies^{16,17,19,38}, deaf people indicate restriction of their autonomy, compromised privacy and ethical conflict due to the need for family interpreters, absence of professional interpreters in health institutions, discrimination, prejudice, stigmas and stereotypes in health services, inattention and inability of professionals to seek for communicational and attitudinal alternatives, and lack of sheltering and invisibility of their needs, among other challenges.

Another noteworthy finding in this study was that professional training during undergraduate studies did not provide them with tools to deal with social groups that need other means and resources of communication, specifically deaf people. There are several other issues in this area since the Convention on the Rights of Persons with Disabilities¹² reaffirms the historical social achievements in the Brazilian State and recognizes that "disability is an evolving concept and that disability results from the interaction between people

and the barriers due to attitudes and the environment that prevent the full and effective participation of these people in society on equal opportunities with others” (p.17).

Therefore, the whole society should be held responsible for the inclusion of people with disabilities, and, therefore, it is up to managers to provide continuing service education and, on the other side, it is up to professionals to seek appropriate and reliable ways to overcome ineffective communicational relationships with deaf people. Within this perspective, responsibility shifts from deaf people, who are often at a socio-economic “disadvantage,” to institutions and their agents, keeping in mind that the inalienable human rights of inclusion and accessibility are often omitted or neglected.

Finally, the lack of adequate qualification to work with deaf people is contrary to Decree no. 5.626/2005³⁹, which regulates the full inclusion of deaf people in health services, ensuring comprehensive health care by professionals trained to use LIBRAS, and provides translation or interpretation for deaf people or those non-users of the Brazilian Sign Language, providing them with a quality and accessible service, “actually” ensuring the universality and equity of care.

Equity is the guiding principle for attaining inclusive and universal policies that enable social justice and equality of results. From this perspective, it can be seen that there is a long way ahead for agents (managers and health professionals) in SUS, specifically to ensure that vulnerable populations have access to FHC.

Deaf people face barriers to health care access imposing considerable constraints that reveal the carelessness and lack of professional preparation in the work process, thus implying a PHC that is restrictive to the diversity of needs and demands of the population. In this respect, public managers must commit to providing continuing training for health service professionals so that they can adequately deal with specific demands, such as those of deaf people.

Finally, we understand that the existence of health policies focused on individual demands represents an important trace of care quality because competent professionals who can meet the needs of vulnerable populations will certainly be more attentive to the demands of the entire population.

CONCLUSION

This study assessed the experiences and perspectives of professionals in a medium-sized municipality,

revealing the challenges faced in municipalities in the interior of Brazil. However, further qualitative studies also considering the perspective of deaf people, will certainly provide other elements to expand the debate and formulate policies that are more coherent and sensitive to the demands of this population.

Moreover, we emphasize that although accessibility is an important barrier, the communicational aspect within the relationship between professionals and deaf users was shown to impair the provision of health care and individual therapy.

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