Original Research Article

Actions, Potentialities, and Limitations of the Brazilian Network of Care for People with Disabilities: A Qualitative Study

Sháyra Anny Moura Barbosa[1], Pedro Paulo[2], Rayane Moreira de Alencar[3]

1 Universidade de Pernambuco (UPE), Petrolina, Pernambuco, Brazil
2 Universidade Estadual da Paraíba, Campina Grande, Paraíba, Brazil
3 Universidade Regional do Cariri (URCA), Crato, Ceará, Brazil
* Correspondence: pedro_roes@outlook.com

ABSTRACT

Introduction: The Care Network for Persons with Disabilities aims to provide comprehensive and continuous care to this population, structured through components of primary care, specialized rehabilitation care, and hospital care, including urgent and emergency care. In this context, the Care Network should be anchored in the guidelines of decentralization and regionalization of health to promote equal access.

Objective: To understand the actions aimed at people with disabilities, and the strengths and limitations of the Care Network for Persons with Disabilities in the IX Health Region of Pernambuco, Brazil.

Materials and Methods: This is a qualitative narrative study, guided by Critical Disability Theory, conducted with five regional health managers and five primary care coordinators working in the IX Health Region of Pernambuco. Data were collected through semi-structured interviews and subjected to thematic content analysis.

Results: Three thematic categories emerged, condensing the main topics addressed by the participants: (1) "We don't stop to think about this; it's rare and difficult": actions aimed at people with disabilities; (2) "Specialized Rehabilitation Centers need to be opened": potential of the Care Network for People with Disabilities; and (3) "Recife is a long way away, isn't it?": limitations of the Care Network for People with Disabilities.

Conclusion: the health system in the IX Health Region perpetuates a fragmented and unequal care model, which reinforces the marginalization of people with disabilities.

Keywords: People with disabilities; Health Care; Health Services; Comprehensive Health

Editor: Solomon Mekonnen

Article History:
Received: September 02, 2025
Accepted: December 26, 2025
Published: December 31, 2025

Citation: Sháyra Anny Moura Barbosa, Pedro Paulo, Rayane Moreira de Alencar. Actions, Potentialities, and Limitations of the Brazilian Network of Care for People with Disabilities: A Qualitative Study. DCIDJ. 2025, 36:4. doi.org/10.20372/dcidj.916

INTRODUCTION

The enactment of the 1988 Federal Constitution (CF) represented a milestone in the consolidation of health as a right for all and a duty of the State, through the creation of the Unified Health System (SUS), based on the principles of universality, comprehensiveness, and equity (Brazil, 1988). Years later, the Brazilian Law for the Inclusion of Persons with Disabilities, also called the Statute of Persons with Disabilities, reinforced this commitment, establishing the guarantee of comprehensive care for Persons with Disabilities (PwD) at all levels of complexity within the scope of the SUS (Brazil, 2015).

According to the Continuous National Household Sample Survey (PNAD Contínua), Brazil had approximately 18.6 million people with disabilities in 2022, representing 8.9% of the population aged two and over. In Pernambuco, approximately 949,000 people are estimated to have disabilities, representing 10.1% of the population in this age group. Nationally, the Northeast region has the highest proportion, reaching 10.3% of the population, corresponding to approximately 5.8 million individuals. Visual impairment is the most prevalent, followed by physical, hearing, and intellectual disabilities (IBGE, 2022).

Despite this significant prevalence, PwD face significant barriers related to health, education, employment, and income. In the health field, Ordinance No. 4,279/2010 (Brazil, 2010) guided the organization of Health Care Networks (RAS), defining as a priority the Care Network for Persons with Disabilities (RCPCD), formally established by Ordinance No. 793/2012, which established its implementation in the SUS through the creation, expansion, and articulation of care points (Brazil, 2012; Brazil, 2014).

The RCPCD is structured into three components: Primary Care, Specialized Care in Rehabilitation for hearing, physical, intellectual, visual, ostomy, and multiple disabilities, and Hospital and Emergency Care. These components must operate in an integrated manner, with regulated access and coordination between the different services, in order to ensure comprehensive care (Brazil, 2012). However, studies indicate that, despite legal support, the RCPCD remains a public policy that lacks structural investment and the strengthening of professional performance, resulting in fragmented care and compromised comprehensiveness (Farias et al., 2023; Miranda et al., 2024; WHO, 2011).

The national and international literature on disability mostly presents analyses focused on specific dimensions, such as the role of Primary Care, policies segmented by type of disability, accessibility, functionality, inclusive education, insertion into the labor market, and the use of assistive technologies (Miranda, 2024; Almeida et al., 2024; Macedo et al., 2025; Macedo, Leite & Gimenez, 2024; Mota & Bousquat, 2023). However, there are gaps in research on the RCPCD as a structuring and articulating network of care in the SUS, especially in regional contexts.

In this context, analyzing the RCPCD in the IX Health Region of Pernambuco is relevant, given the high prevalence of PwD in relation to the total population and the need for effective actions to ensure comprehensive and quality care. The RAS (Regional Health Programs) are an essential strategy for strengthening the management and organization of services in different regions (Barbosa, Rodrigues & Alencar, 2025; Brazil, 2010).

The IX Health Region presents critical indicators for the organization of the Care Network, including a high proportion of persons with disabilities, unequal distribution of rehabilitation services, extensive territorial dispersion, long distances from the state capital Recife (up to 640 km), and dependence on informal interstate care flows (Barbosa, Rodrigues & Alencar, 2025). These characteristics make the region an emblematic example of the structural inequalities that shape the provision of care for persons with disabilities in Northeast Brazil.

Thus, this study aimed to understand the actions aimed at people with disabilities, as well as to identify the potentialities and limitations of the Care Network for People with Disabilities in the IX Health Region of Pernambuco.

MATERIAL AND METHODS

This is a qualitative, narrative study guided by Critical Disability Theory, which examines in depth social inequalities, access to resources, and discrimination processes that directly impact the lives of people with disabilities (Pereira Spiniele, 2024). The *Standards for Reporting* guidelines were followed in the preparation and reporting of the study.

Qualitative Research (O'Brien et al., 2014), aiming to ensure transparency, systematicity and rigor in the description of procedures.

The research was conducted in the IX Health Region of the state of Pernambuco, Brazil, whose headquarters are located in the municipality of Ouricuri and encompassing the cities of Araripina, Bodocó, Exu, Granito, Ipubi, Moreilândia, Parnamirim, Santa Cruz, Santa Filomena, and Trindade. During the research period, from October 2019 to February 2020, this region had an estimated population of 327,866 inhabitants, distributed across eleven municipalities (IBGE, 2019). The location was chosen because it has a structured Health System (RAS) that offers services ranging from Primary Care to High Complexity Care.

Ten participants participated, distributed in two segments: Segment 1, composed of managers linked to the IX Regional Health Management, including the Manager, the Health Care Coordination, the Microcephaly Supporter, the Health Regulation Supporter and the Health Planning Supporter; and Segment 2, formed by Primary Care coordinators from five municipalities in the region. The selection of participants followed an intentional approach (*purposive sampling*), being invited initially by email and, later, by face-to-face contact.

The sample of ten participants was appropriate for the qualitative design, whose purpose is to explore perceptions and experiences in depth rather than produce statistical generalization. The intentional selection of strategic managers enabled the capture of diverse perspectives on the organization of the Network, and theoretical saturation was reached when additional interviews no longer contributed substantive elements to the emerging categories, as recommended in qualitative health research (Rahimi & Khatooni, 2024).

Individuals who had held the position or served as legal representatives for at least three months were considered eligible, a period defined to allow familiarity with the service network. Individuals on leave due to vacation or any other type of leave, as well as those unavailable for the interview, were excluded. Two coordinators were on leave, and three were unable to participate due to unavailability.

Data collection was conducted through semi-structured interviews, guided by a script developed by the authors and composed of trigger questions. The guiding question was: "What health actions aimed at people with disabilities are carried out in the municipality/health region, and what are the strengths and limitations identified in the network?" With consent, the interviews were audio-recorded, transcribed verbatim by the interviewing researcher, and reviewed by another team member. Preliminary analyses and interpretations were discussed with two researchers, ensuring triangulation of perspectives. Each interview was conducted individually, in a private location chosen by the participant, and lasted an average of 30 minutes.

To ensure anonymity, alphanumeric codes were assigned, with the letter "A" for regional managers and the letter "B" for municipal managers, followed by the interview sequence number. Data collection ended at theoretical saturation. Before the actual start, a pilot test was conducted to verify clarity, feasibility, and any adjustments to the instrument.

The analysis of the material followed the Thematic Content Analysis, according to Bardin (2011), fulfilling the steps: (1) pre-analysis, with exhaustive reading and organization of the corpus; (2) exploration of the material, identifying registration units and context, relevant excerpts and emerging categories; and (3) treatment and interpretation of the data, searching for underlying meanings and articulating them to the adopted theoretical framework.

Methodological rigor was ensured through the criteria of credibility, reliability, dependability, and transferability (Forero et al., 2018). The results were organized into thematic categories, illustrated by excerpts from the interviews and interpreted in light of Critical Disability Theory.

Although the analysis followed the principles of Thematic Content Analysis, the interpretative stage was strengthened by an analytical logic inspired by the SWOT matrix, widely used in policy and service network evaluations. This framework enabled the synthesis of findings in terms of strengths, weaknesses, opportunities, and threats that influence the functioning of the Network, without modifying the original corpus or analytical procedures, while expanding the strategic understanding of the phenomenon under study (Helms & Nixon, 2010).

As this is a qualitative study, the results do not aim at statistical generalization, but rather at an in-depth understanding of the processes and perceptions that structure the Care Network within the investigated context. The intentional sampling of strategic participants allowed the capture of central elements of network organization, whose findings are analytical and potentially transferable, rather than representative of other regions. The validity of the interpretations is grounded in analytical depth, internal coherence, and theoretical saturation.

This study was approved by the Research Ethics Committee (CAAE No. 20541019.2.0000.5191) and followed the guidelines of Resolution No. 466/2012 of the National Health Council.

RESULTS

Of the 10 study participants, seven were female, and the average age was 38. Three thematic categories emerged, condensing the main topics addressed by the participants: (1) "We don't stop to think about this; it's rare and difficult": actions aimed at people with disabilities; (2) "Specialized Rehabilitation Centers (CERs) need to be opened": potential of the Care Network for People with Disabilities; and (3) "Recife is a long way away, right?": limitations of the Care Network for People with Disabilities.

Category 1 – “We don’t stop to see this, it’s rare, it’s difficult”: actions aimed at people with disabilities

In this category, health actions aimed at people with disabilities stood out, which are mostly punctual and scattered, without a continuous and integrated strategy.

Most of those interviewed highlighted the work of the Family Health Support Center (NASF) and services such as the Pernambuco Specialized Care Unit (UPAE), but the lack of resources and limited staff make it difficult to provide adequate and comprehensive care.

> *"Look, very little, it's just occasional. So, we've already had some kind of video conference that talks about it, it's... the UPAE that does rehabilitation that is kind of specific for patients with microcephaly, but who have other disabilities, so there's the UPAE, and some municipalities do it occasionally, like, one or another, but nothing routine, like, nothing that we have a specific time for it" (A1).*

> *"There's Recife, we have meetings that are held at the Disability Network so we can see decrees, but nothing very routine, so we don't stop to see that, it's rare, it's difficult" (A2).*

> *“[...] The assistance is more like this, it is punctual, it is not specifically directed, it is part of the general flow, but there is special attention, a special list and there are also some children who need diapers and milk” (B5).*

> *"I don't know if there are any within the municipality, not that I know of. Video conferences are always held here and occasionally they are for people with disabilities, but there are no actions aimed solely at people with disabilities" (B1).*

It is recognized that there is a gap in the implementation of consistent and frequent policies and actions for people with disabilities, with these actions being limited and dispersed, rather than part of a broader or structured approach to care.

Interviewees revealed that there is no routine programming or ongoing strategy aimed at people with disabilities, although some teams, such as the NASF, are making efforts to meet demand, as reported below:

> *"Yes, they do some things, like the municipalities that when there is a specific month they do specific activities" (A5).*

> *"Yes, we do. We have the support of the NASF at the units, and with the support of the NASF, these actions are carried out. Some at the unit itself, others right here at the Secretariat. We experience the Week of Persons with Disabilities very well [...]" (B3).*

> *"Well, in the municipality there are no actions that are... totally focused on them, what exists is the NASF team that provides this care to them in the units and at home. […] however, they are also unable to provide full support because it is a small team and there is a large number of these patients in the municipality" (B4).*

Another important factor identified was the perception of the Psychosocial Care Center (CAPS) as a place to serve PwD.

> *"In the municipality there is monitoring by professionals such as speech therapists, psychologists, physiotherapists, psychiatrists and there is CAPS, aimed at people with disabilities [...]" (B2).*

The indication of CAPS as a place of care highlights the way in which PwD are sometimes understood in public policies and health services.

Category 2 – "Specialized Rehabilitation Centers to be opened": potential of the Care Network for People with Disabilities

This category describes positive, but cautious, perceptions about the potential of RCPCD, highlighting important advances, but also highlighting challenges in the process, with emphasis on the implementation of CER III, monitoring of children with microcephaly and the proper functioning of the regulatory flow.

According to managers, the implementation of CER III offers great hope for improving resolution in the health region, providing more effective and regionalized care, as well as expanding diagnosis and care for people with disabilities. This demonstrates the quest for a more robust and integrated structure, capable of meeting demands that are currently resolved in a fragmented manner or late.

> *"Look, we have the potential to open the CER […]. So this gives us another perspective, so we will be able to resolve some things that could have already been resolved here in the region and we will be able to achieve resolution, I think, right? […]" (A2).*

> *"The potential we have is that this is central. The municipalities are close, so this CER III will be a powerful force for this rehabilitation. That's all (laughs)" (B1).*

> *"So, I think we have potential, because we have good professionals, we have the physical space for this, so with the CER I think we can open up the range a little more for this specifically [...]" (A2).*

Other potentialities include monitoring children with microcephaly and ensuring the proper functioning of the regulatory flow, despite the challenges.

> *"I don't really know how to tell you this, because this microcephaly trend came about because of these children, right? [...]. So, the potential I can say is that there was a different perspective here, the state saw this issue, unfortunately, because of this fatality that happened and then everything turned around here. So, it was a very broad, very beautiful perspective that the state had for these children" (A5).*

> *"The potential is that through our monitoring, this issue of microcephaly and this list that classifies, right, these children, we know where they are, because of this today we have a rehabilitation service that serves not only microcephaly but also other syndromes" (A1).*

> *"[...] and as a benefit, I think that the flow via regulation has worked, although it can't cover everyone, but there isn't, like, so much confusion around this sector, since we work with confusion, right? So it has worked well, it's a flow that continues well […]" (B5).*

Although the implementation of CER III, the monitoring of children with microcephaly, and the regulatory flow can be seen as progress, these efforts do not yet reflect structural or transformative change.

Category 3 – "Recife is a long way away, isn't it?": limitations of the Care Network for People with Disabilities

This category highlighted the difficulty in accessing referral services in Recife, the lack of specialized professionals, inadequate infrastructure, low salaries, and hiring difficulties. The delay in implementing CER III and government negligence were also highlighted as obstacles, in addition to the lack of guaranteed rights and insufficient empowerment of Primary Care in caring for PwD.

> *"[...] so everything we need to improve, like, a little more assistance, goes to Recife and it's 640 km from some municipalities, from others it's even further, so 640 km for you to resolve something that you could resolve here. So, I think that's it" (A2).*

> *"Okay, we have speech therapy, we have... physical therapy, but this issue of orthoses and prosthetics, Recife is a long way away, right? Very far for us who are from the countryside, which in the case of the eleven municipalities, it's a huge distance, right? So, if it were closer, it would be much better for the users, right? Because with that distance sometimes, for example, a child or even you leaving here with an adult, some people say, 'No, I'm not going because it's far. No, I don't want to. Isn't it here? And over there in Ceará, I can't?' Because we border Ceará, so they think we should be sending them to Ceará. They don't understand, you know? That, like, our reference is Pernambuco and we have to send them to Recife [...]" (B3).*

> *"I just think that I could come here a little bit more, instead of everything being in Recife, come here, you know?" (B1).*

> *"We don't have anything that we can forward and resolve, have resolution in the region, in the entire region, forward to Recife" (B5).*

> *"[...] it is also a suffering for the family not to have this support nearby, not in (name of municipality) or in neighboring municipalities. So, they end up being very dependent on the state, the Ministry for this service and, whether we like it or not, we fail to provide adequate assistance to these families" (A1).*

A reality of profound inequalities in access and quality of care for people with disabilities in the IX Health Region is evident. The distance from Recife, where specialized services are concentrated, represents a significant barrier, generating long and tiring commutes for patients and their families.

Another limitation cited in the reports was the difficulty municipalities had in offering comprehensive assistance to PwD due to the absence of some key professionals for rehabilitation in the municipality.

> *"[…] there is a limitation on professionals, due to the workload and salary, we limit ourselves a bit […] on a recent visit there was a specific place to do BERA, the only thing missing was the booth, they were already seeing a booth but there was no speech therapist, why? Because the pay is low and the workload is long, so this is a limitation, the issue of workload and salary" (A4).*

> *"And the limitations, because some specialties are very difficult to find, such as occupational therapists, this limits our care, our rehabilitation, which, by not having a professional, ends up harming the service and the patient" (B3).*

> *"In relation to what we have today, we could get a neuropediatrician, which is a difficulty we have in the region, not only here, but at the state level because this issue of specialists is also difficult" (B2).*

> *"So I think the weaknesses are because it is a smaller region, because it doesn't have university services, it doesn't have professional training services, but there is also the will of the people" (A5).*

Furthermore, the delay in implementing CER III, which was in the process of being implemented and was scheduled to begin operating in 2019, was mentioned in the interviews.

> *"[...] and the CER that is built in the municipality that already has it set up, it is already to receive resources, just missing completion and can't move forward . It's been a long time, a really long time and it should already be funded, if they had started to assemble it would already be funded, so it would already be funded, it would already be good and it would be of great value to the entire region, because we have nowhere to run [...]" (A3).*

> *"[...] When CER III opens, it will enhance this Network because it will be specifically for these users. We will have people from different areas, but unfortunately, we expected it to open in 2019. It didn't. It's not something that depends on us; we don't know what stage it's at. The last time we heard from him was when he came to CIR, specifically to purchase equipment, and they said it was close to being operational, but since then, we haven't heard anything about the situation at this center [...]" (A4).*

The delay in opening CER III highlights the inefficiency in implementing important projects for specialized care, leaving municipalities even more dependent on urban centers to meet essential demands.

Furthermore, government negligence towards RCPCD was cited by respondents.

> *"It's a network with great potential for growth, due to the number of people who can benefit from it. However, it's largely neglected by the federal government, states, and municipalities. What we can see is that they alone can't build a network that can meet these people's needs. I think it needs to be discussed more, with more specific actions for these people." (B2)*

It is evident that these entities are unable, on their own, to structure a network that adequately meets the needs of this population, reflecting a structural failure and the need for greater debate and more targeted and specific actions for the inclusion and care of people with disabilities, aiming at the development of a robust and accessible care network.

The lack of guarantees for some rights, such as the right to come and go and the right to health, were also cited.

"The difficulty is really accessibility, right? Many don't have it, many don't have it, the vast majority don't have the right to come and go, it's... that's it! I see that the biggest problem with these disabled patients is really accessibility, it's the rights, the rights they don't have, the vast majority don't even have the right to come and go. In many municipalities, they also don't have the right to health care because of a lack of services. For example, in ours, I can say with certainty that we guarantee at least speech therapy, physical therapy, and a psychologist, but I know that other municipalities don't have them. Qualified professionals, in our municipality, yes, but in many others, unfortunately, they don't have these professionals either [...]" (B4).

The lack of guarantees for basic rights, such as accessibility, is a critical issue, reflecting a RCPCD that still lacks substantial progress in both the planning and implementation of public policies.

Another challenge encountered was the lack of empowerment of Primary Care in caring for PwD.

> *"I think we don't empower Primary Care enough. Primary Care doesn't end up working as hard as it should. Of course, Primary Care already has a lot of work to do, it already has a whole care process, but sometimes we let them go to specialized services too often and lose the connection between these patients and Primary Care" (B5).*

Primary Care, by not being sufficiently trained and structured to deal with the complexity of disabilities, ends up relegating people with disabilities to the specialized system, which could be avoided with more comprehensive and preventative care.

DISCUSSION

Although Brazil has a robust legal framework to guarantee the rights of people with disabilities, the results of this study show that the RCPCD in the IX Health Region of Pernambuco remains marked by isolated actions, fragmentation, and a lack of continuous planning. This discontinuity is not only operational but also reflects structural inequalities and the persistent inability to transform policies into effective practices. This scenario is central to Critical Disability Theory, which understands disability as a social construct permeated by institutional, symbolic, and structural barriers that limit full participation and the exercise of rights (Spinieli , 2024).

The first category revealed that, although initiatives such as the NASF (National Family Health Strategy) and some activities carried out in health units exist, there is no regular, systematized strategy aimed at people with disabilities. The episodic nature of these actions, already identified in other contexts (Campos, Souza & Mendes, 2015; Ferreira, Mota & Bousquat, 2023), maintains a reactive logic of care, dependent on campaigns, commemorative dates, or specific mobilizations. Furthermore, the reference to the CAPS (National Center for Social Assistance) as a place to care for people with disabilities reinforces a pathologizing conception, which associates disability with psychiatric disorders. This view, also present in previous studies (Almeida, 2012; Cubas, 2016; HRW, 2018), runs counter to inclusive guidelines and contributes to the perpetuation of stigma, as opposed to a rights-based and socially inclusive approach (Blikstein & Reis, 2023).

In the second category, the implementation of CER III emerged as the main potential for regionalizing and improving care, reducing reliance on travel to Recife and increasing resolution. More than just a new physical space, this service has the potential to reorganize patient flows, promote early diagnosis, and enable interdisciplinary rehabilitation integrated into the network (Brazil, 2012a; Brazil, 2020; Lopes, 2021).

However, delays and bureaucratic obstacles compromise the realization of this expectation, perpetuating the specialized access gap (Dubow, Garcia & Krug, 2018). Another positive point highlighted was the regulatory flow, which interviewees considered functional. This finding deserves attention because it demonstrates that, even in contexts with structural limitations, it is possible to implement effective organizational mechanisms when there is clarity of processes, integration between services, and well-defined agreements (Andrade et al., 2023; Ferreira, Mota & Bousquat, 2023).

The third category encompassed the most critical limitations: a distance of up to 640 km from Recife to access specialized services, a shortage of professionals with specific training, inadequate infrastructure, and low salary attractiveness. These factors restrict access, discourage the retention of professionals, and exacerbate territorial inequalities, a reality also observed in other regions of the country (Soratto et al., 2017; Pinafo et al., 2020; Vaz, 2020; Maciel et al., 2020). The lack of universities and training centers in the region exacerbates this situation, reducing the local supply of professionals and limiting the capacity for team renewal (Haddad et al., 2010; Melo, Moysés & Moysés, 2010).

Another relevant finding was the low empowerment of Primary Care (PC) in caring for PwD. When PC does not fully exercise its role as care coordinator, opportunities for close monitoring, disease prevention, and reduction of unnecessary referrals to specialized levels are lost (Schultz & Alonso, 2016; Almeida et al., 2017). This weakness maintains the centralization of services, disconnects care from the territory, and favors dehumanization, as disability is treated as an isolated problem rather than as an issue within the community context (Machado et al., 2018; Lopes, 2021).

From a critical disability perspective, the results are not limited to "operational failures," but also highlight forms of institutional oppression that materialize as accessibility barriers, the disempowerment of Primary Care, and the medicalization of disability. The RCPCD imposes positive duties to remove barriers and provide reasonable accommodations; when care remains episodic and specialist-centered, this normative framework is violated and inequity is perpetuated. The pathologization detected in CAPS referrals echoes the critique of the hegemonic "medical model"; international literature proposes a reorientation toward rights-based approaches and the removal of barriers (not the "correction" of the body), with concrete effects on the care experience (Hogan, 2019; WHO, 2022).

These limitations are symptoms of a health system that, instead of guaranteeing the rights of PwD, perpetuates inequality by failing to provide equitable and comprehensive access to services. The lack of a more comprehensive and integrated vision for people with disabilities highlights how the system, even in its current form, tends to reinforce the structural barriers these individuals face. In this context, empowering Primary Care means redistributing clinical and organizational power to where people live, reducing dependence on urban centers, strengthening the continuity and coordination of care, and mitigating stigma and exclusion.

Therefore, the analysis indicates that consolidating an effective RCPCD in the IX Health Region requires overcoming isolated measures and adopting strategies that promote: the regionalization of services, the strengthening and capacity-building of Primary Care, the guarantee of fundamental rights, and the swift implementation of structures such as CER III. True integration between levels of care, combined with an approach that recognizes disability as a matter of social justice, not just clinical, is essential to breaking the cycle of exclusion and building a continuum of inclusive and equitable care.

CONCLUSIONS

Based on the framework of Critical Disability Theory, which problematizes inequalities in access to health services and highlights the importance of decentralizing and regionalizing care, it was possible to understand that the health system in the IX Health Region of Pernambuco still perpetuates a fragmented and unequal model, reinforcing the marginalization of PwD. The lack of integrated and continuous planning, evidenced, for example, by the delay in implementing CER III, constitutes a significant structural limitation to the effectiveness of the RCPCD, compromising the comprehensiveness of care.

The main finding of this research was the identification of a persistent cycle of inequality in access to specialized care, fueled by interconnected factors such as geographic distance from referral services, the shortage of qualified professionals, and inefficient implementation of public policies. These factors reverberate in the violation of basic rights, including accessibility and the constitutional right to health, keeping PwD in a position of vulnerability and dependence.

As a limitation of the study, the decision to interview primarily managers tends to institutionalize the narrative (emphasis on administrative flows, norms, and bottlenecks), potentially underrepresenting experiences marked by barriers (transportation, communication, stigma) experienced by users and families. Methodologically, this creates a risk of elite bias and an interpretive "blind spot," even under rigorous criteria. For future studies, we recommend including multiple voices (PwD, family members, frontline professionals), using theoretical sampling, and practicing systematic team reflexivity to deepen understanding of the demands and challenges of RCPCD.

Ethical Approval

This study was approved by the Research Ethics Committee under protocol CAAE 20541019.2.0000.5191.

Informed Consent

All participants provided written informed consent.

Conflict of Interest

The authors declare no conflict of interest.

Data Availability Statement

Due to the qualitative nature of the data and the possibility of identifying participants, full interview transcripts are not publicly available. De-identified excerpts supporting the analysis may be obtained from the corresponding author upon reasonable request.

REFERENCES

Almeida, AP de, Menezes, L. dos SA, Palmeira, PA, Pedreira Neto, BS, Santos, AJS dos, Gobato , AA & Senário, FFF (2024). The role of assistive technologies in special education: Tools and resources for learning. *Ibero-American Journal of Humanities, Sciences and Education* , 10(8), 2074–2092.

Almeida, MHM, Pacheco, S., Krebs, S., Oliveira, AM, Samelli , A., Molini-Avejonas , DR, Toldrá , RC, & Oliver, FC (2017). Evaluation of primary health care by users with and without disabilities. *CoDAS* , 29(5), e20160225.

Almeida, NMC (2012). *Labyrinths and mosaics: Institutionalization of childhood with disabilities* (Doctoral Thesis, Pontifical Catholic University of Rio de Janeiro).

Almeida, PF, Santos, AM, & Souza, MKB (Orgs .). (2017). Primary health care in care coordination and health regions. *Ciência & Saúde Coletiva* , 22(11), 3443–3449.

Andrade, GKS, Marcon, SS, Batiston , AP, Neves, ET, Vieira, VC de L., Sá, JS de, & collaborators. (2023). Health network for children with Zika virus from the perspective of professionals. *Gaucha Nursing Journal* , 44, e20230043.

Barbosa, SAM, Rodrigues, PP, & Alencar, RM (2025). Care network for people with disabilities in a health region. *Contributions to the Social Sciences* , 18(2), e15647.

Bardin, L. (2011). *Content analysis* . São Paulo: Editions 70.

Blikstein, F., & Reis, AOA (2023). Study on the reception of children and adolescents in institutions for people with disabilities. *Health and Society* , 32(2), e220539.

Brazil. (1988). *Constitution of the Federative Republic of Brazil* . Brasília, DF: Presidency of the Republic.

Brazil. (2010). *Ordinance No. 4,279* of December 30, 2010: Establishes guidelines for the organization of the Health Care Network within the Unified Health System (SUS). Brasília, DF: Presidency of the Republic.

Brazil. (2012). *Ordinance No. 793* of April 24, 2012: Establishes the Care Network for Persons with Disabilities within the Unified Health System. Brasília, DF: Presidency of the Republic.

Brazil. (2012). *Ordinance No. 835* of April 25, 2012: Establishes financial incentives for investment and funding for the Specialized Care Component of the Care Network for People with Disabilities within the Unified Health System. Brasília, DF: Presidency of the Republic.

Brazil. (2012). *Resolution No. 466* of December 12, 2012: Approves the guidelines and regulatory standards for research involving human beings. Brasília, DF: Presidency of the Republic.

Brazil. (2015). *Law No. 13,146* of July 6, 2015: Institutes the Brazilian Law for the Inclusion of Persons with Disabilities (Statute of Persons with Disabilities). Brasília, DF: Presidency of the Republic.

Brazil. Ministry of Health. (2020). *Care network for people with disabilities within the SUS* : instructions on auditory, physical, intellectual and visual rehabilitation. Brasília, DF: Ministry of Health.

Brazil. Ministry of Health. Secretariat of Health Care. (2014). *Implementation of Health Care Networks and other SAS strategies* . Brasília, DF: Ministry of Health.

Brazilian Institute of Geography and Statistics. (2019). *Estimates of the resident population for Brazilian municipalities and federative units with a reference date of July 1, 2019.* Rio de Janeiro: IBGE.

Brazilian Institute of Geography and Statistics. (2019). *IBGE cities* . Rio de Janeiro: IBGE.

Brazilian Institute of Geography and Statistics. (2022). *Continuous National Household Sample Survey: general characteristics of households and residents 2022* . Rio de Janeiro: IBGE.

Campos, MF, Souza, LA de P., & Mendes, VLF (2015). The Unified Health System's care network for the health of people with disabilities. *Interface – Communication, Health, Education, 19* (52), 207–210.

Cubas, JM (2016). *Access to mental health services for children and adolescents with intellectual disabilities and/or mental disorders in foster care* (Master's Dissertation, Pontifical Catholic University of Paraná). Polytechnic School, Curitiba.

Dubow , C., Garcia, E. L., & Krug, S. B. F. (2018). Perceptions of the Care Network for People with Disabilities in a Health Region. *Saúde em Debate* , 42(117), 455–467.

Farias, TMO, Albuquerque, MSV, Oliveira, RS, Lyra, TM, Miranda, GMD, & Oliveira, PR (2023). The limited access of people with disabilities to health services in a northeastern capital. *Ciência & Saúde Coletiva* , 28(5), 1539–1548.

Ferreira, H. A., Mota, P., & Bousquat, A. (2023). Implementation of the Care Network for People with Disabilities: on the periphery of São Paulo's governance. *Health and Society* , 32(2), e210894.

Forero, R., Nahidi, S., De Costa, J., Mohsin, M., Fitzgerald, G., Gibson, N., et al. (2018). Application of four dimensions criteria to assess rigor of qualitative research in emergency medicine. *BMC Health Services Research* , 18, 120.

Forero, R., Nahidi , S., De Costa, J., Mohsin , M., Fitzgerald, G., Gibson, N., McCarthy, S., & Aboagye-Sarfo , P. (2018). Application of four dimensions criteria to assess rigor of qualitative research in emergency medicine. *BMC Health Services Research , 18* , 120.

Helms, M. M., & Nixon, J. (2010). Exploring SWOT analysis: Where are we now? *Journal of Strategy and Management*, 3(3), 215–251.

Hogan, A. J. (2019). Social and medical models of disability and mental health: evolution and renewal. *CMAJ*, 191(1), 16-18.

Human Rights Watch. (2018). *"They Stay Until They Die":* A Life of Isolation and Neglect in Institutions for People with Disabilities in Brazil. New York: Human Rights Watch. Rights Watch.

Lima, MLLT, & Lima, MLC (2013). Evaluation of the implementation of a State Physical Rehabilitation Network in Pernambuco from the perspective of the National Policy for Reducing Morbidity and Mortality from Accidents and Violence, 2009. *Epidemiology and Health Services, 22* (4), 597–607.

Lopes, LJS (2021). A look at the health care network: Organization and challenges of the Care Network for People with Disabilities. *Research , Society and Development , 10* (14), e494101422219.

Macedo, G., Leite, P. L., & Gimenez, R. (2024). Inclusive education and intellectual disability in Brazil: Integrative literature review. *Postgraduate Journals in Developmental Disorders, 24* (1), 50–93.

Macedo, MS, Saldanha, JHS, Tavares, LRC, Ribeiro, KSQS, Silva, SLA, Ferrari, FP, Nogueira, RR, & Almeida, MMC (2025). Models of organization of primary care and care practices for people with disabilities in Brazil. *Ciência & Saúde Coletiva, 30* (2), e16312023.

Machado, M. H., Vieira, A. L. S., Oliveira, E. S., Lemos, W., & Wermelinger , M. (2010). Training of health professionals in Brazil: An analysis from 1991 to 2008. *Journal of Public Health* , 44(3), 383–393.

Machado, WCA, Pereira, JS, Schoeller, SD, Júlio, LC, Martins, MMFPS, & Figueiredo, NMA (2018). Comprehensiveness in the Care Network for People with Disabilities. *Text & Context Nursing, 27* (3), e4480016.

Maciel, FJ, Machado, WCA, Barbosa, IB, Oliveira, SRA, Assis, MMS, & Pinto, ML (2020). Spatial analysis of specialized care in the Care Network for People with Disabilities in Minas Gerais. *CoDAS , 32* (3), e20180104.

Mello, ALSF, Moysés, ST, & Moysés, SJ (2010). The health-promoting university and changes in professional training. *Interface – Communication, Health, Education, 14* (34), 683–692.

Miranda, GMD (2024). Access of people with disabilities to health services: Perceptions of professionals and managers. *Health and Society, 33* (2), e230582.

Miranda, GMD, Köptcke, LS, Albuquerque, MSV, Santos, MPR, Carvalho, MEL, Reichenberger , V., Kuper , H., & Lyra, TM (2024). Access of people with disabilities to health services: The perception of primary health care professionals and managers. *Health and Society, 33* (2), e230582.

Mota, PHS, & Bousquat, A. (2023). Challenges for implementing the Care Network for People with Disabilities in a health region: A look from the political, organizational and structural dimensions. *Health and Society, 32* (2), e220608.

O'Brien, BC, Harris, IB, Beckman, TJ, Reed, DA, & Cook, DA (2014). Standards for reporting qualitative Research : A Synthesis of recommendations . *Academic Medicine, 89* (9), 1245–1251.

Pereira Spinieli , AL (2024). Between epistemologies and transformations sociales : The construction of it critical theory of disability . *Revista Inclusiones , 11* (4), 25–40.

Rahimi, S., & Khatooni, M. (2024). Saturation in qualitative research: An evolutionary concept analysis. *International Journal of Nursing Studies Advances,* 6, 100174.

Schultz, TG, & Alonso, CMC (2016). Care for children with disabilities in Primary Health Care. *UFSCar Occupational Therapy Notebooks* , 24(3), 611–619.

World Health Organization. (2011). *World report on disability 2011* . Geneva: WHO.

World Health Organization. (2022). *Global report on health equity for persons with disabilities 2022*. Geneva: WHO.