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64

MOBILITY OF PEOPLE WITH PHYSICAL DISABILITIES IN THE MARAJÓ ARCHIPELAGO ACCORDING TO ICF

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Background: The International Classification of Functioning, Disability and Health (ICF) is part of the Family of International Classifications of the World Health Organization (WHO) and acts as a tool for describing and organizing information about the functioning and disability of people with and without disabilities, providing a language standard. Marajó is a region with infrastructure peculiarities and disabled people who face very specific and little-known challenges there.
Objectives: Classify the mobility of people with physical disabilities in the Marajó archipelago according to the ICF.
Methods: Cross-sectional study, with a quantitative approach, referring to the activity profile of physical PCD residents in the municipalities of Marajó. The subjects were selected by convenience through the dissemination of the action in Basic Health Units visited by the group of the "Abrace o Marajó" Project between August 2021 and January 2022. The participants underwent a structured interview where they answered an adapted checklist, based on the ICF biopsychosocial model, which provides a standardized language. The ICF data used are related to the "activity and participation" domains, with a focus on mobility.
Results: The study included 51 physically disabled persons, with a predominance of age between 40 and 59 years (39.22%), men (54.90%), browns/mulattoes (62.75%). Most respondents had mobility problems, with 88.24% having difficulty walking (d450), 84.31% having difficulty lifting and carrying objects (d430), 78.43% having difficulty using transportation (d470), 64.71% using some locomotion device (d465), and 41.18% with impaired fine use of the hands (d440). These data suggest that the mobility deficit combined with the lack of accessibility may be one of the factors that most interfere with the lives of these participants, as it limits and/or restricts their participation in daily activities.
Conclusion: Disabled persons residing in Marajó have several limitations and/or restrictions on participation in day-to-day activities related to lack of mobility, the main limitations are those with the highest percentages, that is, walking, lifting, and carrying objects, and using means of transport. In this regard, it is vital to adopt public policies aimed at improving the infrastructure of streets and sidewalks in order to facilitate access for this population, thus promoting an increase in the level of activity and participation.
Implications: This study can contribute to the visibility of the needs of disabled persons who live in Marajó and the implementation of public policies to assist this population, as well as to understand their main difficulties and what accessibility measures can bring more autonomy.
Keywords: ICF, Disabled, Physically

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65

INCREASED MORTALITY RISK DUE TO THE COMBINATION OF DEPRESSION AND 25(OH) D DEFICIENCY IN ENGLISH OLDER ADULTS

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Background: Depression is one of the most disabling diseases. It affects approximately 5.7% of older adults. In parallel, there is a high prevalence of vitamin D deficiency in this population, and it advantages the development of depressive symptoms. There are few studies about the influence of the association of depression and vitamin D deficiency on mortality.
Objectives: To investigate whether the combination of depression and vitamin D deficiency increases the mortality risk in older adults.
Methods: It is a cohort study with data from wave 6 (2012-3) of the English Longitudinal Study of Ageing, a population-based study with adults aged 50 years and over, living in England. Depression was measured by the Center for Epidemiologic Studies – Depression (CES-D-8) with a cut-off point of $\geq$4 symptoms, and deficiency of vitamin D ($<$25 nmol/L) was estimated by the blood levels of 25-hydroxyvitamin D [25(OH)D]. Thus, four groups were formed: depression/25(OH)D deficiency, no depression/no 25(OH)D deficiency, depression/without 25(OH)D deficiency, and no depression/with 25(OH)D deficiency. Follow-up time was the interval between the wave 6 interview and the last contact (wave 7 or wave 8) or death, and the maximum was 60 months. Stata 14.0 was used to perform Kaplan-Meier curves and Cox regression. The adjustments were by age group, sex, wealth, physical exercise, smoking, alcohol consumption, body mass index, basic and instrumental activities of daily living, and chronic and circulatory diseases.
Results: Of the 5,050 participants, 22.5% had depression, and 15.1% had 25(OH)D deficiency. When combining the outcomes, 4.85% had depression/25(OH)D deficiency and 67.2% had no depression/25 (OH)D deficiency. The combination depression/25(OH)D deficiency was more prevalent in women, lower wealth quintile, sedentary, smokers, obese, with difficulties in activities of daily living, and with chronic and circulatory diseases. At the end of the follow-up, the survival rate was 19.1% (95%CI:3.3–44.8) in those with depression/25(OH)D deficiency and 50.4% (95%CI:36.0–63.1) in the opposite group. In the adjusted analysis, the risk of death was 78% (95%CI:1.17–2.70) higher in the depression/25(OH)D deficiency group compared to the no depression/without 25(OH)D deficiency group. The other groups (depression/no 25(OH)D deficiency, no depression/ with 25(OH)D deficiency) had no significantly increased risk of death. Sensitivity analysis confirms the importance of grouping because depression alone is a risk factor for mortality (HR:1.33; 95%CI:1.02–1.73), while 25(OH)D deficiency alone is not (HR:1.26; 95%CI:0.95–1.68).
Conclusion: The grouping of depression and 25(OH)D deficiency is an independent mortality risk in older adults. The maintenance of adequate levels of 25(OH)D in this population is a challenge because there is a reduction in its metabolism in the skin and difficulty in consuming source foods. Thus, it is imperative to pay attention to the screening of depressive symptoms and 25(OH)D deficiency.