interface
comunicação, saúde, educação
https://www.interface.org.br
eISSN 1807-5762

Review

The therapeutic itineraries of vulnerable populations at Covid-19: a scoping review

Os itinerários terapêuticos de populações vulneráveis na Covid-19: uma revisão de escopo (resumo: p. 18)

Los itinerarios terapéuticos de poblaciones vulnerables en la Covid-19: una revisión de alcance (resumen: p. 18)

Deborah Nimtzovitch Cualhete[a]
<cualhete.deborah@unifesp.br>

Greice Herédia dos Santos-Moura[b]
<moura.santos@unifesp.br>

Carlos Roberto de Castro-Silva[c]
<roberto.castro@unifesp.br>

[a, b] Pós-graduanda no Programa de Pós-Graduação Interdisciplinar em Ciências da Saúde (Mestrado), Departamento de Políticas Públicas e Saúde Coletiva, Instituto Saúde e Sociedade, Universidade Federal de São Paulo (Unifesp). Avenida Ana Costa, 438, Ap 71. Santos, SP, Brasil. 11060-002.
[c] Departamento de Políticas Públicas e Saúde Coletiva, Instituto Saúde e Sociedade, Unifesp. Santos, SP, Brasil.

With the objective of investigate the therapeutic itineraries followed for search the health care by the brazilian population in a situation of social vulnerability during the covid-19 pandemic, a scope review was carried out from July to September 2021, as proposed by the Joanna Briggs Institute, in the BVS, PubMed, EMBASE, Scielo, PsycInfo, Scopus and Web of Science databases within the 2020 and 2021 clippings. 11 articles were analyzed and divided into three categories: strategies care of population; health offerings; difficulties in accessing healthcare. Results explained gaps and potentialities existing on therapeutic itineraries in the search for health care for populations in a situation of social vulnerability and how these aspects became more evident in this pandemic period. There was a movement of this vulnerable populations to overcome the daily difficulties that determine the unfavorable conditions for health care.

Keywords: Covid-19. Therapeutic itineraries. Vulnerable populations. Scoping review.

Cualhete DN, Santos-Moura GH, Castro-Silva CR. The therapeutic itineraries of vulnerable populations at covid-19: a scoping review. Interface (Botucatu). 2022; 26: e220210 https://doi.org/10.1590/interface.220210

Introduction

It is observed that confronting the new coronavirus (Covid-19) presents a huge challenge for governments and societies, especially in the Brazilian context, marked by social inequity. The pandemic has exposed the collective vulnerability and the concomitant need for universal care; thus, the effects of this scenario demand new theoretical-methodological references, which comprehend their impacts and build new coping strategies[1,2]. In this panorama, populations living in situations of social vulnerability have difficulties in the search for health care. This circumstance arises from a reality of social inequality that accompanies the development of the country[3-6].

The movements triggered or paths taken by people in search of care, with a view to preserving or recovering health, are mainly defined by the socio-anthropological literature as Therapeutic Itineraries (TI)[7]. This path covers different spaces of (in) formal care, taking into account the subject who is inserted in spaces of limiting determinations of their potential development[8]. Thus, it is imperative to seek an understanding of the dynamics that involve the search for care in an expanded and contextual conception of this process[9].

In this study, the concept of vulnerability is considered in its multi-determined genesis. This is a term that is not restricted to the precariousness of income, but to the weaknesses of relational affective bonds and inequalities in access to public goods and services due to various conditions. Considering only the individual aspect in the process of social vulnerability, incurring in the blaming of the subjects, is as simple as abandoning the personal and subjective dimensions of individuals in the treatment of their living conditions[10].

The various aspects of social, individual and institutional nature are highlighted in the search for health care of populations in situations of social vulnerability, in order to overcome radical and binary positions[7,8,11,12] from the perspective of care ethics[13-16]. In this way, unraveling the meanings of care and the implications of the weaknesses that permeate the guidelines of the trajectories of these subjects.

The present construct was inspired by the deepening of the guiding axes that underlie the research group called Social Inequality Research Laboratory (LEDS) of Unifesp, whose objective is to strengthen the university's social participation faced with the different demands of society. The findings discussed in this study aim to investigate the therapeutic itineraries followed in the search for health care by the Brazilian population in a situation of social vulnerability during the Covid-19 pandemic.

Method

In the present study, the methodological framework for Scoping Review proposed by the Joanna Briggs Institute (JBI)[17] is used. This method becomes relevant because it contributes to the promotion of discussions on central and comprehensive issues on Health issues. This allows mapping evidence and identifying knowledge gaps through access to different data sources explored in the literature. The work was developed following a protocol based on the Prisma-Scr[18] guidelines (Preferred Reporting Items for Systematic Reviews and Meta-Analysis Extension for Scope Reviews).

The guiding question of this research – "What are the therapeutic itineraries taken in the search for health care by the Brazilian population in a situation of social vulnerability during the Covid-19 pandemic?" – was built based on the Population, Concept and Context (PCC)[19] strategy for a Scoping Review, where P – Social Vulnerables; C – Therapeutic Itinerary; C – Covid-19.

The bibliographic survey was carried out from July to November 2021, selecting studies that show strategies and discussions on the search of care for vulnerable populations during the pandemic in Brazil. Qualitative and quanti-qualitative studies, published in Portuguese, English and Spanish, were included, and all modalities of scientific production in the scientific databases used were considered, as this is an incipient topic.

The research was carried out taking into account 2020 and 2021, as those are the years of discovery and primary in research on Covid-19. Were excluded materials that did not address specificities or experiences of vulnerable groups in Brazil, which addressed hypothetical health care strategies – without specificity or detailing itineraries of vulnerable groups – or generalists – continental and/or country data – and with a date of pre-pandemic data collection.

Research strategy

The research strategy was developed by the main authors and reviewed by a specialist on the subject, combining Health Sciences Descriptors (DeCS[19]) from keywords and synonyms of the guiding question. It is important to note the lack of more precise descriptors on this topic in the researched databases; therefore, the use of free terms in the search strategy of this review. Still, the works located demonstrate the relevance of studies on itineraries for the reflection on the implications that permeate the search for care of the studied population.

With the descriptors and free terms, Boolean operators AND and OR were used to compose the search strategies used in scientific databases in the Health and multidisciplinary areas: VHL, PubMed, EMBASE, Scielo, PsycInfo, Scopus and Web of Science. The following strategy was developed: #1 AND #2 AND #3 (Table 1).

Table 1. Research Strategy. São Paulo/SP, Brazil (2021)

PCC Strategy	Boolean descriptors and connectors
Population	#1 ("Therapeutic Itinerary" OR "therapeutic itineraries" OR "Delivery of Health Care" OR "Health Services Accessibility" OR "Health Knowledge" OR "Health Attitudes" OR "Health Practic" OR "Public Health Systems" OR "Health Services" OR "Social Support" OR "Health Resources" OR "patient Acceptance of Health Care" OR "Healthcare")
Concept	#2 ("socioeconomic factors" OR poverty OR "Social Condition" OR "Social Inequality" OR "Health Inequality" OR "Social Inequalities" OR "Health Inequalities" OR "Social Inequity" OR "Health Inequity" OR "Social Inequities" OR "Health Inequities" OR "Social Equity" OR "Health Equity" OR "Social Equities" OR "Health Equities" OR "Social Vulnerability" OR "High Social risk" OR "Social High Risk") AND
Context	#3 ("Coronavirus Infections" OR Covid-19 OR coronavirus) AND (brazil OR bras$) AND Brasil OR Brazil OR brasi$

Selection of studies and data mapping

The studies were selected for this review in a three-step process (Figure 1). The second screening stage consisted of two authors who worked individually with the review of titles, abstracts and keywords. At the end of this stage, the authors met to discuss disagreements on the inclusion or exclusion of studies. This whole process was reviewed and evaluated by a third author.

The third eligibility stage consisted of a thorough and careful reading of the articles by two independent researchers, who classified the studies as Relevant (R), Irrelevant (I) or Doubtful (D). The studies included were cataloged and exported to the Rayyan[20] software and, subsequently, divided for thorough reading among the authors and data extraction.

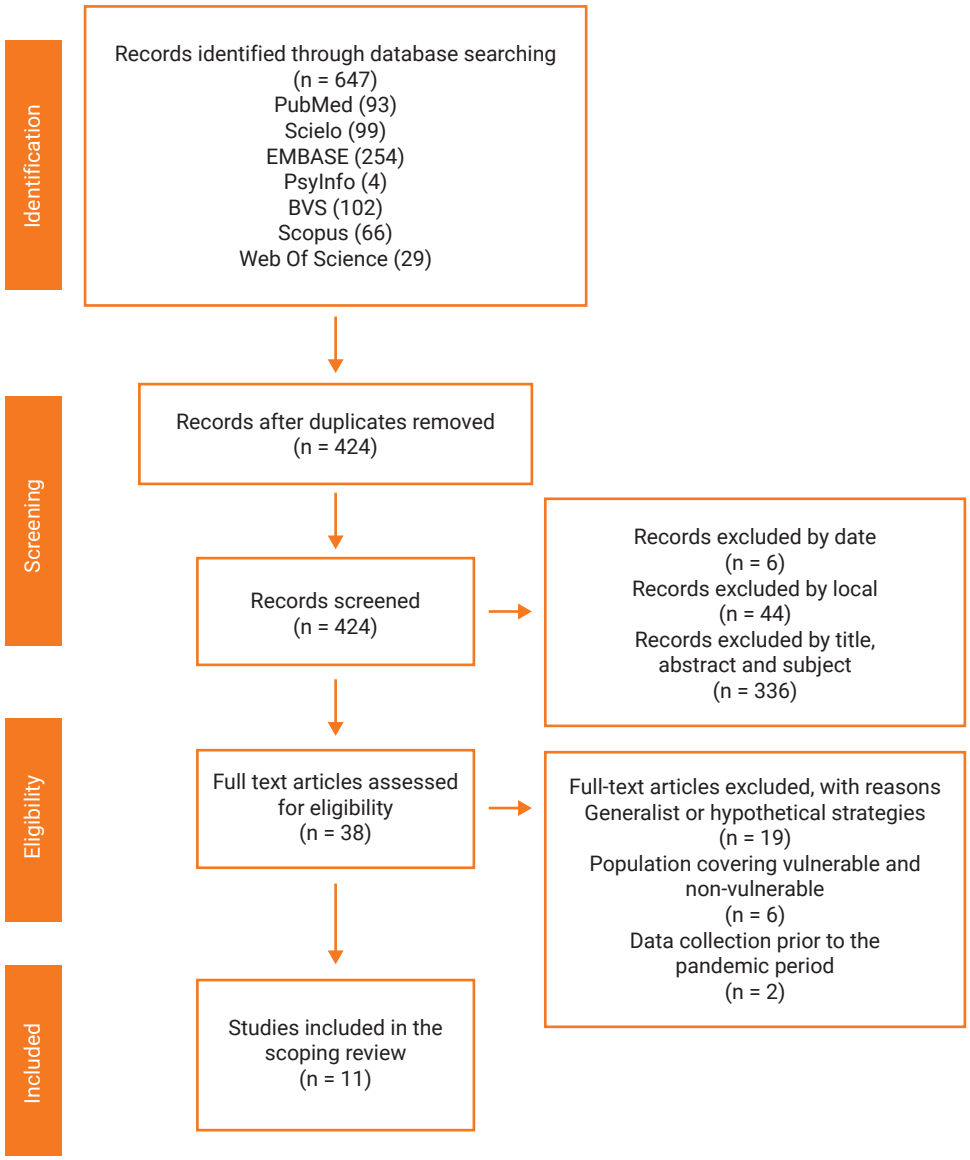

Figure 1. PRISMA flow diagram showing the studies included and excluded. São Paulo/SP, Brazil (2021).

Results

647 studies were found, and 223 articles were excluded due to duplicity. Of the 424 studies, 38 were selected for full reading and, after the analysis, 11 were selected.

The 11 selected studies were analyzed using an instrument constructed by the researchers, following the JBI guidelines[17], in which were identified the research publication journal, authorship, country, year, objective, methodological detail, population detail, main results and conclusions about the population's strategies in the search for care, provision of services and challenges in accessing health. To present the results, the analyzed publications were called Studies and enumerated from E1 to E11[21-31].

Table 2 presents the studies analyzed, highlighting method, language and database.

Table 2. Studies analyzed according to identification, year of publication, method, language and database. São Paulo/SP, Brazil (2021).

Identification	Year	Método	Method	Database
E1[21]	2021	Qualitative	Portuguese	Web of Science
E2[22]	2021	Qualitative	Portuguese	Web of Science
E3[23]	2021	Qualitative	Portuguese	Pubmed
E4[24]	2021	Qualitative	English	Pubmed
E5[25]	2021	Qualitative	English	Pubmed
E6[26]	2021	Qualitative	Portuguese	Scielo
E7[27]	2021	Qualitative	Spanish	Scielo
E8[28]	2020	Qualitative	English	Scielo
E9[29]	2020	Qualitative	English	Embase
E10[30]	2020	Qualitative	English	Pubmed
E11[31]	2020	Quantitative and Qualitative	Portuguese	Scielo

Table 3 shows the specificities within what this review proposes, gathering information on which population was studied, objectives, main results and conclusions of the studies.

Table 3. Studies analyzed according to population, objective, main results and conclusions. São Paulo/SP, Brazil (2021).

Identification	Population studied	Objective	Main results and conclusions
E1[21]	Families in situation of social vulnerability	Highlight how the Covid-19 pandemic impacts the lives of families in their relationship with social protection, with a focus on health policy.	Faced with the Covid-19 pandemic, what is found is the fragile social protection. A country marked by deep social inequalities reveals how families have difficulties and impossibilities to comply with social isolation and how they are exposed to community contamination from the pandemic.
E2[22]	Women in vulnerable situations	Dialogue on violence against women, a patriarchal pandemic prior to the COVID-19 pandemic, and discuss the conditions of women at this time of disease proliferation.	The present time has the marks of our historical and social formation, formation based on slavery, in a capitalist and heteronormative elite that perpetuated social, ethnic-racial and gender inequalities. What was explicit in several facts during the pandemic.
E3[23]	Population with disabilities.	Identify and systematize the literature on the situation of people with disabilities in the first months of the COVID-19 pandemic.	The result of the review pointed to three thematic categories: vulnerabilities of people with disabilities facing the pandemic; rights of people with disabilities in this context; and measures to protect and access information on COVID-19 aimed at people with disabilities.
E4[24]	Homeless population	Reflect on the challenges that affect homeless people in Rio de Janeiro, Brazil, due to the COVID-19 pandemic.	The results showed the worsening of the situation of extreme vulnerability and poverty already experienced by the homeless population before the pandemic. Lack of places to wash hands; insufficient assistance services.
E5[25]	Women's leadership of favelas	Present how female leaders in the favelas of Rio de Janeiro/Brazil have been protagonists in meeting the demands arising from COVID-19	Female leaders in favelas often assume the roles of local authorities to ensure food security, hygiene measures, communication between residents, assistance to the vulnerable, etc. They make politics with resistance and solidarity for effective transformations.
E6[26]	LGBTQIA+* (*) Update of this term in the review aiming at the respective development of the definition.	Investigate how the health of lesbian, gay, bisexual, transvestite, transsexual and intersex (LGBTI) people has been affected in the context of the COVID-19 pandemic, through the perception of activists from organized civil society, in the State of Rio Grande do Sul (RS), Brazil.	There were effects on community mobilization; access to health services; mental health; and situations of violence and social protection. It is concluded that the interventions of this population support the guarantee of the right to health and preservation of public policies to this population.
E7[27]	Homeless population	Unveil power relations, from the perspective of governmental mentality and biopolitics, to highlight the emergence of the notion of homeless population, in this pandemic scenario.	Notions of precariousness that circumscribe life on the streets is a shared condition, in search of clues about forms of resistance and the right to appear. Bodies on the streets defy the sanitary, unsanitary, irregular, disoriented and normalized order as a subspecies - are updated during Covid-19.
E8[28]	Racialized populations	Reflect on the behavior of the pandemic in relation to the black population in Brazil, in dialogue with decolonial contributions and critical readings on racism.	It points to the importance of local resistance movements, operated from the place that these subjects occupy, the urban spaces precarious by action/omission of the state - the favelas.
E9[29]	Population of the favela of Paraisópolis-São Paulo	Report the experience of the Paraisópolis community facing COVID-19	Community experience has shown positive results in preventing and combating COVID-19. The *G10 Favelas* aims to implement the Paraisópolis model in other Brazilian favelas.
E10[30]	Indigenous population - Terena de Buriti	Discuss fundamental aspects in the establishment of preventive measures in the fight against COVID-19 among indigenous people in view of the motivations for seeking health services in the villages of the Buriti Indigenous Land, Mato Grosso do Sul, Brazil.	Indigenous people seek health facilities to attend health care programs and to talk about the motivations that lead them to take care of their health. These aspects underpin the discussion of the indigenization process facing the pandemic.
E11[31]	Population deprived of liberty	Analyze the effects of the pandemic on prisons and how governments and civil society have organized themselves in order to reduce the consequences on these places.	Inequality in the Brazilian Penitentiary System reproduces that of society in general, in which there is more access to tests for the new coronavirus when occupying a position of social or financial privilege.

Discussion

Based on these results, our discussions on Therapeutic Itineraries were guided from three categories by the researchers after reading and discussing all the analyzed studies: Strategies of Population Care Itineraries, Health Care Offers for Populations and Difficulties in Accessing Care in Health. The phenomenon of this study – health strategies, or the search for care[7,8,11]– was treated based on care ethics[7,13-16,32,33] as reference for the construction of social public policies that value unique experiences and the quality of the bond.

Strategies for population care itineraries

The study of meanings linked to the strategies of seeking care, as well as the nature of intersubjective relationships in the decision-making process of the subject in the illness process[34], analyzes the weight of cultural determinism and personal autonomy of choice in the attempt to solve health problems[35]. It reconciles, therefore, the individual and the collective, the material and the immaterial of this trajectory[12].

In this review, the study that deals with the indigenous population[30] brings references from the *indigenization* in health processes. It refers to a movement that prioritizes the identification of individualized strategies focused on a certain population. In health, it seeks greater effectiveness of promotion, prevention and treatments. It is understood that this process happens when investigating the most diverse strategies implemented by women from favelas in Rio de Janeiro and São Paulo[29] to overcome the inequalities that residents of these places experience, prioritizing the needs of each family/individual[25].

Following this perspective, the automatic submission of the individual to social structures is discarded and an attempt is made to understand what is intricate in the process of signification of the experience of becoming ill in heterogeneous societies[7,12]. This broadens the critique of conceptual dichotomies (body-mind; individual-society; objective-subjective) and opens up the possibility for comprehensive approaches (symbolic interactionism, phenomenology, etc.) in care itineraries[8].

In the studies read for this scoping review, it was possible to observe that the communities propose to overcome this dichotomy in the search for resoluteness in health[21,23-25,30]. As an example, we cite the study on the village Terena da Buriti[30], where, through interviews, community members report looking for health units to talk about the motivations that lead them to take care of their health. By allowing this dialogue, the study states that it will be possible to know better what stimulates this population in this itinerary, in order to increase the effectiveness of the promotion, prevention and treatment of these individuals.

The requirement for the realization of social rights, according to studies on families in social vulnerability[21] and disabled population[23], explains the overcoming of constitutional unaccountability that currently happens in the state. The practices of familism and the struggle of the disabled population, for example, become means to demand provision and

social protection of its actors, in view of objective conditions that bring social security. Faced with a panorama such as Covid-19, it is essential to protect and guarantee rights, subsidized and executed by the government at all levels[21,23].

The movements triggered or paths taken by people in search of care, with a view to preserving or recovering health, are mainly defined by the socio-anthropological literature as Therapeutic Itineraries (TI)[7,9]. Cabral *et al*.[11] state that the study on TI aims to understand events that permeate the evaluation and decision of people when tracing a certain trajectory in search of treatment. These trajectories can mobilize different resources and do not always follow predetermined flows.

Demetrius *et al*.[9], bring the negative and positive notions of health in their research on TI. The first is characterized by an emphasis on the disease and treatment choices aimed at healing. Based on establishing aprioristic paths and guided by a logic of consumption, in which demands and offers of biomedical care practices are outlined to respond to them, it ends up reducing the subject to biological levels, disregarding their subjectivity and the entire political, cultural and historical context[7].

On the other hand, the positive notion seeks to understand what health is for the person before the existence of the disease. Thus, it takes into account senses and meanings that involve the entire health-disease process and seeks to cover different spaces of (in) formal care. This is because it understands the subject in the biopsychosocial and spiritual dimensions, inserted in spaces of determinations that limit their potential development. Therefore, it is imperative that we seek to understand dynamics that involve the search for care in an expanded and positive conception of health-disease processes[9].

By rescuing studies of homeless populations in two studies of this review, the dynamics that permeate the routine of these individuals can be observed[24,27]. In both articles, the word "survival" stands out in the strategies of the search for health care. This is because 80.3%[24] of them use services only in very serious cases. It is seen how the positive coverage in health is important in understanding the trajectory of these subjects and, consequently, expanding access to health devices[24,25,27,28].

This episteme is seen as a potential to expand discussions to a dimension of looking at the social relationships that are constituted in everyday life and apprehend intrinsic aspects of the health-disease-care process[24-31]. That is, the therapeutic itineraries go beyond the biological and technical dimension of care and elevate to a relational and even symbolic dimension, linked to all the points that circulate in these encounters[7,27].

If, on the one hand, the scientific literature evidences this biomedical posture marked by dichotomies that lead to the domination, demarcation and normalization of bodies in health care processes, on the other hand, there is a growing progress in research in the field of health that investigates afflictions and situations that permeate the illness of individuals[7,25,26,29]. Considering that collective actions in health seek to grasp the cultural, individual and family meanings of getting sick, a new purpose emerges in this branch: dealing with a less generic subject[8].

From this review, a scope permeated of changes in the routines of vulnerable populations is observed. When studying about female leaders in situations of vulnerability[22,25], it is evident how the individual dimension (stress, household overload, reduced family income, increased consumption of psychoactive substances) is related to the worsening of violence and consequent emotional overload, which are added and intensified when facing the demands of coping with the pandemic. From this, there are national movements and campaigns[21-23,28] in favor of the urgent need to rescue the care of this population, which has its human rights violated.

For Boff[14], caring is what makes us human and connects us, confronting "[...] the paradigm of modernity that resides in the will to power as domination, as a hand that grasps and appropriates"[14] (p. 392). As seen in the vulnerable groups in this study[21-23,26,30], the caregiver seeks the promotion of well-being and the provision of the needs of the other, who is in a fragile condition, in order to compensate relational and affective practices increasingly centered on the power and individualistic dimension[13,16,33].

It was possible to observe, in this review, examples of collective actions that deal with the care of the subject according to specificities that permeate their routines, such as Oliveira's study[29] on G10 Favelas. Movement led by residents of the Paraisópolis favela – São Paulo – who work to promote cultural, sports and educational activities in the community, having expanded their performance in the search for health care during the pandemic. Similar activism was found in the reports of women from the favelas of Rio de Janeiro[25] and in dialogues with racialized populations[28,29] who live on Brazilian suburbs.

In this sense, theoretical discussions about care itineraries are interweaving several areas of knowledge, such as Anthropology, Sociology, Psychology and Health, highlighting the cultural perspective that involves this path[7,8,11,12]. The importance of this subsumption is observed when knowing, for example, strategies of religious entities with the population deprived of liberty, providing support through the knowledge of the precarious conditions that lead them to the need of gathering and sharing belongings for cleaning and carrying out other basic daily activities[31].

Health Care Offers for Populations

A number of policies covering vulnerable social groups were highlighted in this review[21-23,25,29,30]. During the Covid-19 pandemic, movements were observed to increase the effectiveness of these policies, such as taking telemedicine to indigenous villages to increase the prevention against the new coronavirus[30]. Still, from the experiences of women in situations of vulnerability[22,25] the description of racialized populations[28], deprived of liberty[31], homeless[27], disabled[23] and vulnerable families[21], it is concluded that these politicizations remain fragile.

The Deleuzian concept of agency[36] has numerous dimensions that are involved in the action processes of search for care and, therefore, the health offer becomes a challenge. In an attempt to solve such difficulties, it is necessary to interdict dualisms, allowing the escape of conceptions that elevate objectivist regimes of deterritorialization. When thinking about the agencies of care practices, the multiplicities involved in the material, semiotic and social flows of the becoming-individual and even the becoming-system are rescued[37].

At this juncture, the reading on the strategies of the homeless population is recalled[24,27]. Despite statutes that point to guaranteeing the protection of this population, such as the Brazilian National Health System (SUS) and the Unified Social Assistance System (SUAS), the fact is that non-governmental programs, through conversation and emotional support, stood out in the strategies to face the coronavirus. The daily subsistence demand of the populations studied becomes an aspect that increasingly distances these subjects from the "becoming-individual" and, consequently, from the "becoming-system"[21,23,24,27,37].

It was possible to observe movements that emerged to compensate for the gaps in these processes that apprehend the meanings and permeate the trajectory of each of these vulnerable populations, such as the Community Network Activists[25,29], who highlight the actions of women living in Brazilian favelas. It is important to highlight the existence of other state programs such as the Specialized Reference Centers and Community Health Agents, which are pre-existing in the pandemic scenario and contributed to support these populations[21,22,25,27-29] in the welcoming guided by the recognition of their difficulties during Covid-19[27,23,30].

Thus, care is based on three ontological assumptions: care as an inherent human condition; the vulnerability of the human being; and the relational subject[14,16,33]. The ethics of care takes a look at the physical and symbolic reality, seeing the subject in vulnerability and the relations of power and domination that prevent them from developing to their full potential[14,15].

Difficulties in accessing health care

Although the World Health Organization (WHO), in 1949, had already conceptualized health as "[...] a complete state of physical, mental and social well-being, and not merely the absence of disease"[38] (p. 1), this construction was not exempt from the dispute that occurs in any other political process[3]. This is seen in the underfunding and scarcity of meeting the demands of the suburbs, among other obstacles resulting from these nuances[27-29,31]. However, the subject's reaction in this condition is not merely external and reflexive, it is contingent and begins to be mediated by signs that model it, as well as its history[3,25-27,30].

According to Nunes[28], there was no planning from the government for the specificity of vulnerable families[21], racialized population[28] and population from favelas[25,29]. Even with the existence of CF/1988[39], which establishes health as the right of all and the duty of the state, it is still highlighted in the routine of these subjects unemployment, hunger, lack of basic sanitation, difficulty of access to education and housing precariousness, and the pandemic ended up raising such demands.

Regarding the use of digital technologies in this period, studies with vulnerable populations showed the difficulties of adherence to remote teaching and care[25,27-29]. The LGBTQIA+ population was an exception in this aspect, reporting positive adaptation to the digitalization of strategies for the promotion and prevention of health care. However, this statement is based on a single study on this population; therefore, this resourcefulness cannot be generalized, and it is imperative to apprehend the different socio-historical and cultural contexts that make these subjects vulnerable[26].

This fragility in the institutional political sphere generates a series of mismatches in the maintenance of strategies for health care[24-31]. In this sense, the search for care becomes a source of frustration among users, since the social determination of this system limits care in the health-disease process, leading to a lack of democratization in social and health policies[27,28,31].

Saldanha *et al*.[23], in their study on the population with disabilities, recalls the environmental, institutional and attitudinal barriers that permeate the routine of these subjects, emerging a series of aggravating factors of health conditions, which result in high levels of vulnerability, making this population more susceptible to Covid-19. The study emphasizes that the government's health measures to face the pandemic have intensified obstacles and increased the exclusion of this population, in such a way that it becomes an emergency to create specific policies to guarantee their rights.

Maria de Lourdes Pintasilgo (1930-2004) has her legacy marked by discussions on care ethics[15,16,32]. For her, the neoliberal ways of life that give rise to individualism and make people less concerned with each other and with the environment, distances subjects from co-responsibility that, paradoxically, afflicts freedom and citizenship. Thus, for the parliamentarian, care is fulfilled in everyday praxis, in order to seek ways so that the desirable becomes closer to being possible[15,16].

Molinier and Paperman[40] discuss the concept of "emotional capitalism". They explain that the habits generated by neoliberalism not only produce goods and services, but are imbricated in affective relationships. These new ways of life, in which it can be seen the consumption of emotions and emotions being consumed, lead to a culture of detachment, from a rational calculation of gains and losses. This process becomes a challenge for the development of a society of care, since the choices made by who will take care – of who, how and why – end up shaping the bonds and reflecting on care itineraries[40,41].

It is emphasized that all users aim for a stable trajectory in the search for care. However, this is an entirely subjective phenomenon, as their choices express individual and collective constructions about the process of becoming ill and can be forged under the influences of different factors and contexts[27,28,30]. In this sense, the discussion about the meaning of "experience" becomes fundamental for the study of care itineraries[7].

This word is used in many different senses. Here, however, its representative meaning is focused on a "lived experience"[7]. Gerhardt[12] focuses on this meaning when discussing the "freedom" of choice in the search for care. The author emphasizes that, when talking about representations, it is understood that this freedom is relative, as it brings subjective and contextual implications that permeate these trajectories[24,27,35].

As seen in the studies of this review, historically, indigenous peoples, homeless and racialized people suffer various inequalities related to access and quality of health services[24,27,28,30]. This is a process that comes from a structural racism, which distances the resolution of health problems and increases the risks of contamination during the pandemic[24-31].

These populations are subject to physical, psychological, political and social violence that materializes in the impossibility of food security, lack of basic sanitation and decent housing, in addition to the predominance of precarious jobs and the need to use overcrowded public transport[24,25,27-30]. In the case of the prison system population, there is also overcrowding, unhealthy environments, difficulties in contact with family members and solidarity entities that help with food donations and hygiene items, fundamental in this period[31].

The problem is beyond the existence of health services, it lies in the quality of care, the dynamics and social structure that cover these populations. Despite the initiatives aimed at protection, some forms of assistance end up collaborating with the condition of vulnerable groups[27]. This shows that the disease is not an independent system, but a configuration according to the space where it is formulated. It is therefore necessary to broaden the look at the complex issues that cross this process, needing to go beyond institutionalized and formal procedures[12,28,30].

Only from the structure of care, such as wanting and desiring – essential foundations of care – can human dimensions be exercised. It is from responsibility and care that this ethical and committed path to human existence will make it possible to change the malaise that accompanies today's society. Global ethics must guide the paradigmatic change of collective life, characterized by being an ethic of responsibility, of future, of care[16,32].

Final considerations

This review explains the gaps and potentialities in the therapeutic itineraries in the search for health care for populations in situations of social vulnerability. Despite the imprecision of the descriptors on therapeutic itineraries, which limited the appearance of some vulnerable groups in this review, it was possible to approach and deepen dimensions that strengthen the unfavorable conditions of part of these populations, as well as the strategic practices for solving health problems, both individual and collective.

Thus, this scope review on care itineraries in the Brazilian context is consecrated to the realization of new understandings about macropolitical phenomena in providing new parameters of how public policies have responded to the needs of individuals in their realities. Therefore, resignifications and changes are necessary in the health care model of these populations, which overcome dichotomous and dominant structures, so that the approximation of specificities and singularities is possible and feasible.

Authors' contribution

All authors actively participated in all stages of preparing the manuscript.

Funding

This study was financed in part by the Coordenação de Aperfeiçoamento de Pessoal de Nível Superior (Capes) – Finance Code 001, the beneficiaries are authors Deborah Nimtzovitch Cualhete and Greice Herédia dos Santos Moura. Also financed in part by the Conselho Nacional de Desenvolvimento Científico e Tecnológico (CNPq) - 06/2019 - Bolsas de Produtividade em Pesquisa, the beneficiary are author Carlos Roberto de Castro e Silva.

Conflict of interest

The authors have no conflict of interest to declare.

Editor
Antonio Pithon Cyrino
Associated editor
Willian Fernandes Luna

Translator
Amanda Borges

Submitted on
10/25/21
Approved on
04/27/22

References

1. Barata RB. Como e por que as desigualdades sociais fazem mal à saúde. Rio de Janeiro: Editora Fiocruz; 2009.
2. Pires LN, Carvalho L, Xavier LL. Covid-19 e desigualdade no Brasil [Internet]. Rio de Janeiro: Cebes; 2020 [citado 20 Out 2021]. Disponível em: http://cebes.org.br/2020/04/covid-19-e-desigualdade-no-brasil
3. Sawaia BB. Expressões da Pandemia. São Paulo: NEXIN/PUC-SP/CNPq; 2020.
4. Mendonça MHMD, Silva Junior AGD, Cunha CLF, Latgé PK. A pandemia Covid-19 no Brasil: ecos e reflexos nas comunidades periféricas. APS Rev. 2020; 2(2):162-8.
5. Sposati A. Covid-19 revela a desigualdade de condições da vida dos brasileiros. Rev NAU Soc. 2020; 11(20):101-3.
6. Universidade Federal de São Carlos - UFSCAR. Boletim coletividades – sociologia na pandemia. São Carlos: Programa de Pós-Graduação em Sociologia, Departamento de Sociologia, UFSCar; 2020.
7. Gerhardt TE, Pinheiro R, Ruiz ENF, Silva Junior AG. Itinerários terapêuticos: integralidade no cuidado, avaliação e formação em saúde. Rio de Janeiro: CEPESC/IMS/UERJ – ABRASCO; 2016.
8. Pinho PA, Pereira PPG. Itinerários terapêuticos: trajetórias entrecruzadas na busca por cuidados. Interface (Botucatu). 2012; 16(41):435-50. Doi: https://doi.org/10.1590/S1414-32832012005000026.
9. Demétrio F, Santana ERD, Pereira-Santos M. O itinerário terapêutico no Brasil: revisão sistemática e metassíntese a partir das concepções negativa e positiva de saúde. Saude Debate. 2019; 43(spe 7):204-21.
10. Carmo MED, Guizardi FL. O conceito de vulnerabilidade e seus sentidos para as políticas públicas de saúde e assistência social. Cad Saude Publica. 2018; 34(3):e00101417.
11. Cabral ALLV, Martinez-Hemáez A, Andrade EIG, Cherchiglia ML. Itinerários terapêuticos: o estado da arte da produção científica no Brasil. Cienc Saude Colet. 2011; 16(11):4433-42.
12. Gerhardt TE. Itinerários terapêuticos em situações de pobreza: diversidade e pluralidade. Cad Saude Publica. 2006; 22(11):2449-63.
13. Boff L. O cuidado essencial: princípio de um novo ethos. Incl Soc. 2005; 1(1).
14. Boff L. O Cuidar e o ser cuidado na prática dos operadores de saúde. Cienc Saude Colet. 2020; 25(2):392.
15. Castro-Silva CR. Ética do cuidado e política: contribuições do legado de Maria de Lourdes Pintasilgo. Saude Debate. 2019; 43(spe 5):262-72.
16. Pintasilgo ML. Para um novo paradigma: um mundo assente no cuidado. Porto: Afrontamento; 2011.
17. The Joanna Briggs Institute. The Joanna Briggs Institute reviewers' manual 2015: methodology for JBI scoping reviews [Internet]. South Australia: The Joanna Briggs Institute; 2015 [citado 28 Abr 2022]. Disponível em: https://nursing.lsuhsc.edu/JBI/docs/ReviewersManuals/Scoping-.pdf

18. Pham MT, Rajić A, Greig JD, Sargeant JM, Papadopoulos A, McEwen SA. A scoping review of scoping reviews: advancing the approach and enhancing the consistency. Res Synth Methods. 2014; 5(4):371-85.

19. Santos CMV, Pimenta CAM, Nobre MRC. A estratégia PICO para a construção da pergunta de pesquisa e busca de evidências. Rev Lat Am Enfermagem. 2007; 15(3):508-11. Doi: https://doi.org/10.1590/S0104-11692007000300023.

20. Ouzzani M, Hammady H, Fedorowicz Z, Elmagarmid A. Rayyan—a web and mobile app for systematic reviews. Syst Rev. 2016; 5(1):210.

21. Santos R, Wiese ML. SUS e proteção social: desafios postos às famílias frente à pandemia da Covid-19. Humanidad Inov. 2021; 8(35):196-209.

22. Mesquita AP, Silva GF, Leoncio AKS. A violência contra as mulheres em tempos de pandemia: reatualizando a caça às bruxas. Humanidad Inov. 2021; 8(35):181-95.

23. Saldanha JHS, Pereira APM, Santos AOCD, Miranda BS, Carvalho HKSD, Nascimento LC, et al. Pessoas com deficiência na pandemia da Covid-19: garantia de direitos fundamentais e equidade no cuidado. Cad Saude Publica. 2021; 37(9):e00291720.

24. Nunes NRA, Rodrigues A, Cinacchi GB. Health and social care inequalities: the impact of Covid-19 on people experiencing homelessness in Brazil. Int J Environ Res Public Health. 2021; 18(11):5545.

25. Nunes NRA. The power that comes from within: female leaders of Rio de Janeiro's favelas in times of pandemic. Glob Health Promot. 2021; 28(2):38-45.

26. Kauss B, Polidoro M, Costa A, Canavese D. "Semente para Luta": ativismos, direito à saúde e enfrentamentos de pessoas LGBTI na pandemia da covid-19. Saude Soc. 2021; 30(3):e201026.

27. Marçon L, Silva PC, Justino J, Oliveira CFd, Carvalho SR, Dias TM. Formas de gobernar la vida en la calle durante la pandemia: discursos, tecnologías y prácticas. Salud Colect. 2021; 17:3338.

28. Oliveira RG, Cunha AP, Gadelha AGDS, Carpio CG, Oliveira RB, Corrêa RM. Racial inequalities and death on the horizon: covid-19 and structural racism. Cad Saude Publica. 2020; 36(9):e00150120-e.

29. Oliveira Andrade R. The Brazilian slums hiring their own doctors to fight covid-19. BMJ. 2020; 369:m1597. Doi: https://doi.org/10.1136/bmj.m1597.

30. Ribeiro AA, Rossi LA. Covid-19 pandemic and the motivations for demanding health service in indigenous villages. Rev Bras Enferm. 2020; 73 Suppl 2:e20200312. Doi: https://doi.org/10.1590/0034-7167-2020-0312.

31. Carvalho SG, Santos ABS, Santos IM. A pandemia no cárcere: intervenções no superisolamento. Cienc Saude Colet. 2020; 25(9):3493-502.

32. Magalhães I. A dimensão do cuidar e a ressignificação do espaço público no pensar e agir de Maria de Lourdes Pintasilgo. Ex Aequo. 2010; (2):37-51.

33. Boff L. Saber cuidar: ética do humano - compaixão pela terra. Petrópolis: Editora Vozes; 2014.

34. Rabelo MCM, Alves PCB, Souza IMA. Experiência de doença e narrativa. Rio de Janeiro: Editora Fiocruz; 1999.

35. Bellato R, Araújo LFS, Castro P. O itinerário terapêutico como uma tecnologia avaliativa da integralidade em saúde. In: Pinheiro R, Silva Junior AG, Matos RA, organizadores. Atenção Básica e integralidade: contribuições para estudos de práticas avaliativas. Rio de Janeiro: Cepesc; 2008. p. 169-85.

36. Cordeiro MP, Spink MJP. Por uma psicologia social não perspectivista: contribuições de Annemarie Mol. Arq Bras Psicol. 2013; 65(3):338-56.

37. Tavares FRG, Bonet O. Itinerário terapêutico e práticas avaliativas: algumas considerações. Atenção Básica e Integralidade: contribuições para estudos de práticas avaliativas em saúde. Rio de Janeiro: CEPESC – IMS/UERJ – ABRASCO; 2008.

38. Organização Mundial da Saúde. Constituição da Organização Mundial da Saúde (OMS/WHO) – 1946. Geneva: WHO; 1946.

39. Brasil. Constituição (1988). Constituição da República Federativa do Brasil. Brasília, DF: Senado Federal; 1988.

40. Molinier P, Paperman P. Descompartimentar a noção de cuidado? Rev Bras Cienc Polit. 2015; (18):43-57. Doi: 10.1590/0103-335220151802.

41. Tronto J. Particularisme et responsabilité relationnelle en morale: une autre approche de l'éthique globale. In: Gilligan C, Hochschild A, Tronto J. Contre l'indifférence des privilégiés. À quoi sert le care. Paris: Payot; 2013.

Com o objetivo de investigar os Itinerários Terapêuticos percorridos pela população brasileira em situação de vulnerabilidade social na busca do cuidado em saúde durante a pandemia da Covid-19, foi realizada uma revisão de escopo de julho a novembro de 2021, conforme proposta de Joanna Briggs Institute, nas bases BVS, PubMed, Embase, Scielo, PsycInfo, Scopus e Web of Science, dentro do recorte de 2020 e 2021. Foram analisados 11 artigos subdivididos em três categorias: estratégias de cuidado das populações; ofertas em saúde; e dificuldades de acesso à saúde. O resultado explicitou lacunas e potencialidades existentes nos Itinerários Terapêuticos nessa busca do cuidado em saúde e como esses aspectos ficaram mais evidentes no período pandêmico. Percebeu-se um movimento por parte dessas populações vulneráveis para superar dificuldades cotidianas que determinam as condições desfavoráveis para os cuidados em saúde.

Palavras-chave: Covid-19. Itinerários de cuidado. População vulnerável. Revisão de escopo.

Con el objetivo de investigar los itinerarios terapéuticos recorridos a la búsqueda de cuidado de salud por parte de la población brasileña en situación de vulnerabilidad social durante la pandemia de Covid-19, se realizó, entre julio y noviembre de 2021, una revisión de alcance, conforme propuesta del Joanna Briggs Institute, en las bases BVS, PubMed, EMBASE, Scielo, PsycInfo, Scopus y Web of Science dentro del recorte de 2020 y 2021. Se analizaron 11 artículos subdivididos en tres categorías: estrategia de cuidado de las poblaciones; ofertas de salud; y dificultades de acceso a la salud. El resultado dejó claras las lagunas y potencialidades existentes en los itinerarios terapéuticos a la búsqueda del cuidado de salud de las poblaciones en situación de vulnerabilidad social y cómo esos aspectos quedaron más en evidencia en el período de la pandemia. Se percibió un movimiento por parte de esas poblaciones para superar dificultades cotidianas que determinan las condiciones desfavorables para los cuidados de salud.

Palabras clave: Covid-19. Itinerarios de cuidado. Población vulnerable. Revisión de alcance.