ORIGINAL ARTICLE

Child poisoning in a socially vulnerable community: Perceptions of Family Health Strategy professionals

Intoxicação infantil na comunidade em situação de vulnerabilidade social: percepções de profissionais da Estratégia Saúde da Família

Intoxicación infantil en una comunidad socialmente vulnerable: percepciones de los profesionales de la Estrategia de Salud de la Familia

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ABSTRACT

Introduction: to understand how Family Health Strategy professionals perceive child poisoning and care practices in a socially vulnerable community. **Methods:** the research adopted a qualitative approach based on Paulo Freire's dialogic framework. This consisted of face-to-face interviews with 15 health workers from Family Health Strategy teams in a municipality in the Northwest of Paraná State, Brazil. Audio recordings of the interviews were transcribed and submitted to Bardin's Content Analysis. **Results:** perceptions were organized into three subject categories: child poisoning and the home environment: how accidents occur; professional practice for care, referral and prevention of child poisoning; and limiting factors for health promotion and child poisoning prevention practices in the area. **Conclusion:** the health workers' perceptions reveal that they do not consider the family, embedded within its sociocultural context, as the center of professional action, with few of them referring to care in the context of health promotion and illness prevention.

Descriptors: Poisoning; Child Health; Social Vulnerability; Primary Health Care; National Health Strategies.

RESUMO

Introdução: *Compreender como profissionais da Estratégia Saúde da Família percebem a intoxicação infantil e as práticas de cuidado desenvolvidas em comunidade em situação de vulnerabilidade social.* ***Métodos:*** *Pesquisa de abordagem qualitativa baseada no referencial dialógico de Paulo Freire. Foi desenvolvida por entrevistas face a face, com 15 profissionais integrantes de equipes da Estratégia Saúde da Família de um município do Noroeste do Paraná, Brasil. As entrevistas foram áudio gravadas, transcritas e submetidas à Análise de Conteúdo de Bardin.* ***Resultados:*** *As percepções foram articuladas em três categorias temáticas: Intoxicações infantis e o ambiente domiciliar: como os acidentes ocorrem; Prática profissional para atendimento, encaminhamento e prevenção das intoxicações infantis; e Limites para a prática de promoção e prevenção das intoxicações infantis no território.* ***Conclusão:*** *As percepções revelam os profissionais não considerarem a família inserida em um contexto sociocultural como centro da ação profissional, poucos referiam ao cuidado no contexto da promoção da saúde e prevenção.*

Descritores: *Intoxicação; Saúde da Criança; Vulnerabilidade Social; Atenção Primária à Saúde; Estratégia Saúde da Família.*

RESUMEN

Introducción: *conocer la percepción de los profesionales de la Estrategia de Salud de la Familia sobre la intoxicación infantil y las prácticas asistenciales desarrolladas en una comunidad en situación de vulnerabilidad social.* ***Métodos:*** *se trata de una investigación cualitativa basada en el marco dialógico de Paulo Freire. Fue desarrollada a través de entrevistas cara a cara con 15 profesionales de equipos de la Estrategia de Salud de la Familia de un municipio del Noroeste de Paraná, Brasil. Las entrevistas se grabaron en audio, se transcribieron y se sometieron al análisis de contenido de Bardin.* ***Resultados:*** *las percepciones se articularon en tres categorías temáticas: Intoxicaciones infantiles y entorno familiar: cómo se producen los accidentes; Práctica profesional para la atención, derivación y prevención de las intoxicaciones infantiles; y Límites a la práctica de la promoción y prevención de las intoxicaciones infantiles en el territorio.* ***Conclusión:*** *las percepciones revelan que los profesionales no consideran a la familia dentro de un contexto sociocultural como el centro de la acción profesional, pocos se refirieron a la atención en el contexto de la promoción y prevención de la salud.*

Descriptores: *Intoxicación; Salud Infantil; Vulnerabilidad Social; Atención Primaria de Salud; Estrategias de Salud Nacionales.*

INTRODUCTION

Accidental poisoning is defined as the set of harmful effects, represented by clinical or laboratory signs, resulting from the interaction of one or more toxic agents with the biological system[1]. This factor is accounts for approximately 3.0% of children admitted to emergency services[2,3].

In this age group, intoxications are primarily accidental and occur at home within a multifactorial context for the occurrence and severity[2,4]. In addition to aspects related to the age, stage of development, and sex of the child, the family environment, inequality, and social vulnerability conditions related to income, work, parents' educational level, a greater number of children, and housing, e.g., small houses and few rooms as well may be associated with its occurrence in childhood[5,6].

Social vulnerability is not unique to a specific person or group, but applies to those who find themselves in living situations that can be improved[7]. Understanding the family and domestic environment of children in socially vulnerable situations requires the mobilization of health workers, especially those on the Family Health Strategy (FHS) (*Estratégia Saúde da Família* – ESF) team, as child poisoning takes on different characteristics depending on the different environments in which it occurs[8].

Proposals for comprehensive health care for children and families should seek to intervene in these situations through educational practices that involve listening, meeting their needs, and allowing for autonomy. This means looking beyond simple assistance-based care to include them in social networks in order to minimize the risk factors[9,10]. However, most studies that analyze care for child poisoning target the epidemiology and treatment of poisoning, with less focus on the health workers' educational practices regarding health promotion and poisoning prevention[6,11].

This study is based on the premise that child poisoning is a condition sensitive to Primary Health Care (PHC) interventions. Well-coordinated interventions in the community involve receiving, listening to and referring to the different demands/needs of children, families and the neighborhood, which contributes to the parties involved taking joint responsibility for health[12,13].

In this context, the following question arises: how do Family Health Strategy professionals perceive child poisoning in the community in which they work? In search for answers to this question, the established aim of this study was: to understand how health workers from the Family Health Strategy team perceive child poisoning and care practices in socially vulnerable communities.

METHODS

The study adopted a qualitative approach, guided by the principles of Paulo Freire's dialogical framework[10] and based on the *Consolidated Criteria for Reporting Qualitative Research (*COREQ)[14].

The study was conducted in two Primary Health Care (PHC) services located in the Northern part of a medium-sized municipality in Northwest Paraná State, Brazil. The healthcare facilities are located in an area with high rates of structural violence, drug circulation, abuse and social inequality[15], characterizing it as a socially vulnerable community. This area has significant numbers of child poisoning cases when compared to other areas of the municipality[4].

Fifteen health workers from four FHS teams in the area being investigated participated in the research: three nurses, one technician, one nursing assistant and 10 community health workers (CHW). These participants were selected for convenience, since they work directly

with child and family healthcare and play a leading role in the health education process in the community. The criterion for eligibility was to be an active health worker in the FHS teams, with at least one year of experience on the job. Health workers who were away on vacation or some other type of legal leave during the data collection period were excluded.

A field researcher approached potential participants individually during a 21-day period in February 2021. The approach involved the researcher explaining the purpose of the study and inviting the individual to participate, with emphasis on the voluntary nature of participation. Upon acceptance, the participant and researcher immediately retreated to a secluded location within the facility to conduct the interview, or the interviews were scheduled for a convenient date and time.

The in-depth interviews lasted an average of 25 minutes and were guided by a semi-structured script, with questions about the participant's sociodemographic and professional background and two guiding questions: "*Tell me about your perception of the occurrence of child poisoning in the area*" and "*What is your professional experience with the subject and what actions do you take to prevent child poisoning?*" After each interview the reports were further supplemented with field diary records. The researcher spoke with each health worker on at least two occasions. At the last meeting the participants read through the transcript of the recording to validate the content and make any necessary alterations.

The text *corpus* was created from the content of each interview. The interviews were recorded using digital media after the participants had given their permission by reading and signing a Informed Consent.

Following the Content Analysis guidelines[16], the narratives were transcribed and enriched with reports from the field diaries before "floating reading" of the full text, and establishment of core meanings. Subsequently, the text was organized into subject categories capable of portraying the reality experienced.

The material was interpreted in the light of Freire's framework[10] through a dialogical and critical perspective of health care.

The study was approved by the Research Ethics Committee, under report nº 3.402.106/2019 and CAAE nº 12853519.2.0000.0104/2019. All participants signed duplicate copies of the Informed Consent. To maintain anonymity the participants were referred to by the first letters of their professional category followed by an Arabic numeral, in the order in which the interviews were conducted.

RESULTS

Regarding the profile of the 15 participants, only two were male: one nurse and one CHW. The age group ranged from 27 to 71 years and the median time of professional experience in the health area was 14 years (SD = 5.71). The CHWs, the nursing technician and the nursing assistant had all completed high school education, and one CHW had taken a *Lato Sensu* specialization in popular communication. All of the nurses had *Lato Sensu* postgraduate degrees in the areas of family health, urgency/emergency, evidence-based health and coping with alcohol and other drugs.

Ten health workers reported that they received training and that the content was related to the role they would play within the team. With regard to continuing education, 60% of respondents reported having participated in training courses after joining the FHS teams. None of the interviewees reported having participated in health education activities focused on child health and/or prevention of childhood accidents.

Content analysis resulted in three categories: Child poisoning and the home environment: how accidents occur; Professional practice for care, referral and prevention of child poisoning; and Limiting factors for health promotion and child poisoning prevention practices in the area.

Child poisoning and the home environment: how accidents occur

Child poisoning in the home environment was related to milestones in the child's development, with the mothers and other family members being considered responsible for the occurrence of these accidents and for the inadequate storage of toxic products. The health workers associated poisoning with the stage of the child's development and the risk of accidents occurring with the presence of toxic products within reach of children.

> *Children are like that, if you don't pay attention, they end up hurting themselves. This week a child came into the unit who had ingested Quiboa* [Sodium Hypochlorite]. (CHW9)

> *You can't take your eyes off a child for a minute, they're always up to mischief. We get such a shock sometimes!* (Ass1)

It was observed that the mothers were mentioned in two contexts in the health workers' responses. Firstly, they were mentioned as the target public for advice on

measures to prevent toxicological occurrences. Secondly, they were mentioned as being jointly responsible for the process of children getting ill.

> *We must advise mothers to be attentive, especially through group activities for mothers.* (CHW9)

> [...] *the mother let the child eat Quiboa* [Sodium Hypochlorite]*, so it is necessary to provide her with information on what to do in this case.* (Tec1)

The families were also blamed for incidents of poisoning at home, due to inadequate storage of chemical products. Situations that require changes in behavior were pointed out.

We have the classic, chemical products, cleaning products stored in colorful food containers or soft drinks bottles, which attract children's attention and which are not stored separately. So, this type of storage is important for us to emphasize. It's like with the dengue mosquito, we can't resolve this situation and there are families who still keep chemicals within the children's reach and in food packaging that the child identifies as food. (Nur3)

Professional practice for care, referral and prevention of child poisoning

Professional practices for care and referral in cases of chemical poisoning was based on initial stabilization measures and referral to the relevant emergency care units. It is understood that the PHC service does not have the materials, equipment and human resources required to provide full assistance.

Only the CHWs mentioned performing some kind of practice aimed at preventing childhood accidents, and one nursing assistant reaffirmed that the CHWs are responsible for providing guidance on correct storage of toxic products.

> [...] *last year we worked with the teachers of the school in our area, so that later the teachers could teach the children. It was like training for the teachers. Afterwards, we held a lecture in the evening for the parents.* (CHW1)

> *The CHWs are always advising to get things off the floor or keep them out of reach of children.* (Ass1)

The nurses were observed to approach the theme from a viewpoint of applying healing practices for a poisoning event that has already occurred, with little focus on prevention, as described here:

> *If gastric lavage is needed, we have the tube, but not every health worker is qualified to do this.* (Nur1)

> *It is very important to address this issue, because sometimes when a poisoning case arrives, we do not know what to do and the basic unit is also not prepared if a child needs gastric lavage.* (Nur2)

A nursing technician recalled that the FHS team treated a case of a child poisoned by a household cleaning product. Initial care was provided, and the child was referred to the appropriate specialized service. She emphasized that her role, in this case, was to offer welcomed and support to the family in face of the desperation of the accident. At the same time, a CHWs reported that few care practices are available in the primary care service in the case of a poisoning incident, as it is understood that when these accidents occur, they are emergencies and therefore must be referred to Emergency Care Units (ECU). Because these cases are attended at the ECU, the FHS health workers end up not finding out about the incidents.

A nurse who has worked with the same ESF team for a long time reported that the approach to the community and the bond established over the years was seen as facilitated the dialogic relationship process with the families.

I really like this work, talking, giving advice to teenagers, because I've been working here for 14 years. Today there are teenagers that I saw being born. So, we have a certain intimacy with the family, we know them by name. It makes it much easier for us to work with and advise the families. (Nur2)

Limiting factors for health promotion and child poisoning prevention practices in the area

This category represents the causal condition for the phenomenon under study. Health promotion and poisoning prevention practices in the area studied are limited by a lack of knowledge of incidents of childhood poisoning, by a lack of training or qualifications on the subject and by the teams' work processes, which are designed to meet the vertical demands of health management.

The health workers reported having encountered "few" cases of poisoning in children during their years of work in the FHS. However, they believe it is important to address the issue. One CHW drew attention to the fact that this is the first time in 14 years of experience in the FHS that the topic of child poisoning has been addressed with the team.

I think it's important and it's the first time that someone has addressed it and is working on it here in the unit. At least in 14 years I don't remember any other time. It is a neighborhood that has a lot of children! (CHW4)

The research shows an important gap in relation to specific prevention practices for child poisoning, which can be explained by the health workers' lack of knowledge of the cases and the lack of counter-referral and inter-institutional communication, which is preventing an expansion of health care.

In addition to the lack of knowledge of poisoning cases in the area and the absence of counter-reference and inter-institutional communication, it was also possible to highlight other limiting factors for the development of educational activities targeting childhood poisoning. One of the other factors that was most often mentioned was the team's work process, which is designed for a specific demand and based on vertically established targets, as well as the absence of training or qualifications on the subject.

There could be more information, and more training and qualifications on this topic. There isn't much, but I think there isn't much exactly because the health workers who work in the basic unit are already overstretched, they are really at the limit. They manage to provide the daily services, attending 300 people, 400 people a day. Sometimes they even serve more than one ECU. So, there is no way for them to do more. If suddenly a case arrives, we see the concern of the health workers there to do their part. But they don't get too attached or worried about that, saying "well, if it happens, we'll deal with it". But there is definitely a lack of training. (CHW6)

DISCUSSION

The socioeconomic and demographic profile of the health workers was similar to that observed in other regional and national studies, with regard to aspects such as feminization, a higher schooling level than required for the profession and an increase in workers who have *Lato Sensu* postgraduate courses[4,17].

The lack of references to training in child health/childhood accident prevention indicates weaknesses that could directly interfere with the effective implementation of educational actions targeting childhood poisoning[1].

In the first subject category it was evident that childhood poisoning incidents were associated with the children's growth and development phase, and that the families were considered responsible for poisoning incidents. These families were perceived as showing little availability or interest in behavioral changes. Nonetheless, educational practices for this event should be based on an approach that discusses socio-environmental determinants and the vulnerability of the families, as well as demanding greater attention from caregivers when children are at risk of accidents[18].

The responses that blame the families themselves for putting their children at risk are in opposition to Freirean discourse, as they do not show belief in transformational education and in the capacity of the families for behavioral change[10,19]. It is known that educational interventions should be built from the base of society, through a participatory and co-responsible approach, with cross-cutting and universal interventions, targeting community participation and involving environmental changes and the implementation of public policies[18,20].

Although child poisoning care practices have been the subject of necessary and important discussions in the scientific community, this trend has not been followed by health services. Even adopting the FHS as a guide for the PHC, they still follow an assistance-based, cure-focused logic, as demonstrated in the second subject category. There is minimal investment in illness prevention and promotion of children's health and little discussion of the factors that can lead to the occurrence of these accidents[4,8].

The social, economic and cultural issues in which the individuals are embedded should be considered in order to develop educational activities related to child poisoning[20]. It is necessary to prioritize a humanized practice, which favors health promotion, and which is anchored in Freirean principles — dialogue, participation and autonomy — as a possibility for reorganizing care and educational practices in healthcare[10].

In the analyzed context, only the CHWs mentioned practices aimed at preventing poisoning, highlighting the potential for educational actions, but without drawing on Freire's theoretical framework.

It is emphasized that family health and child health actions are closely related to health promotion, prevention and recovery practices. Therefore, the much-needed renewal of health practices in general, and particularly health education practices, could improve poisoning prevention by bringing the field of health and possibilities of sickness into "real life", into unsafe environments and into weak regulatory policies[13,21,22].

Only one professional mentioned that the bond with the families facilitates the dialogical relationship process. Health education guided by Freirean principles enables not only the strengthening of bonds and trust between health services and users, but also the strengthening of

spaces for dialogue and construction of knowledge and practices. In these spaces users and health workers can discuss coping strategies for problems together, in order to propose alternatives to make comprehensive and remedial health practices a reality[9,22].

In the third subject category, a lack of training and qualifications on the subject was pointed out as a limiting factor for the development of educational activities to target child poisoning. This situation may be associated with the demand for training or qualification subjects established by the municipal management, which often does not match the reality of the community assigned to the FHS[4].

In turn, the implementation of health education as an emancipatory practice based on dialectics and reflection requires professional training[23]. This must be developed in harmony with the diversity of social and cultural situations in which communities are embedded[24].

The first step of this entire professional training process involves understanding the health workers' perceptions as a starting point for transforming this reality, as well as recognizing that they arise from a lived and experienced process, through praxis[10,24].

Another factor that possibly contributes to the lack of knowledge about cases of child poisoning in the community is the FHS teams' work process and the lack of counter-referral and inter-institutional communication. One study[25] identified that many health teams do not take responsibility for implementing the referral and counter-referral system, contributing to making the transmission of information unfeasible and hindering the relationship of mutual trust, continuity, and completeness of care. When it comes to a vulnerable community, this context should trigger additional reflection on the importance of communication between the different professionals/services on the health of the child and their family members, making the referral and counter-referral system effective to the continuum of care.

Regarding the implications of this research for professional nursing practice in the context of the FHS's activities, it is worth highlighting dialogical action aimed at meeting health needs. It is the nurse's responsibility to get to know and establish interventions that go beyond administration of first aid to the poisoned person. This occurs through the process of action-reflection-action and coordination of knowledge and practices between health workers and families, especially with regard to care for child poisoning in contexts of social vulnerability.

Despite its important contribution to the scientific literature, this study is limited by the context in which the research was conducted, as it is a study of FHS teams in a municipality with its own specific characteristics.

FINAL CONSIDERATIONS

The perceptions of FHS health workers regarding child poisoning in a socially vulnerable community imply an underestimation of the magnitude of the event. It also implies a disregard at the center of professional action for the sociocultural context in which families are embedded and for the capacity for the knowledge of these families to enhance changes in behaviors towards risk.

This situation can be attributed to the fact that health workers are overloaded with health subjects and health problems/needs, the lack of communication between these professionals, and a lack of access critical discussion of consolidated information on situations that are sensitive to PHC interventions, including childhood poisoning and a lack of access.

These data point to the need for a new outlook towards the families and demand more involvement on the part of health workers and managers towards the frameworks that underlie them. This requires both singular and plural reconstruction, with a focus on the multiple dimensions of care for child poisoning, especially in socially vulnerable contexts.

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CONFLICT OF INTERESTS

None.

CONTRIBUTIONS ROLES – CRediT

CCFSR: conceptualization; data curation; formal analysis; investigation; methodology; project administration; supervision; visualization; writing – original draft and writing – review & editing.

GAS: formal analysis; investigation; writing – original draft and writing – review & editing.

PKGCL: formal analysis; investigation; writing – original draft and writing – review & editing.

MTGMT: validation; visualization; writing – original draft and writing – review & editing.

SMTI: validation; visualization; writing – original draft and writing – review & editing.

MLFO: conceptualization; methodology; supervision; validation; visualization; writing– original draft and writing - review & editing.

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