

FAMILY CONDITION AS AN ELEMENT OF CHILDREN'S VULNERABILITY TO NUTRITION DISORDERS¹

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ABSTRACT

This study aims to understand family condition as an element of children's vulnerability to nutrition disorders. It is a descriptive, qualitative research conducted in a capital city in southern Brazil from March to December 2015. A total of 21 nutritionists from Family Health Support Centers participated by means of semi-structured interviews. Reports were interpreted through dialectical hermeneutics, with the aid of the Interface de R pour Analyses Multidimensionnelles de Textes et de Questionnaires free software. Three empirical categories emerged as elements of children's vulnerability to nutrition disorders, namely: "Families' living conditions", "From maternal illness to social expectations about being a mother", "From health service organization to maternal condition challenges". It is concluded that recognizing vulnerability elements concerning mother and family, on the part of health services, would allow for a practice supported by the comprehension of children as social beings with rights and dependent on forms of care that characterize this life period. A child's assistance as to food and nutrition is the responsibility of their family, the State and society in general, rather than solely maternal.

Keywords: Health vulnerability. Infant nutrition. Family.

INTRODUCTION

A human being's peak physical and intellectual development is linked to the quality of food and nutrition⁽¹⁾. Children younger than two years old grow rapidly and this phase is characterized by introduction of and adaptation to new foods⁽²⁾. Food choice is influenced by factors such as family environment, maternal behavior, lifestyle, information provided by health professionals and the media through food advertising⁽²⁾. Such aspects have an impact mainly on the quality and quantity of food offered to children, oftentimes interfering negatively with breastfeeding maintenance⁽²⁾.

Poor nutrition in the first years of childhood may result in short stature, which may reduce a child's physical and cognitive development, compromising their capabilities for the rest of their life. Poor nutrition impairs the development of neural connections, becoming a vicious cycle that affects the acquisition of skills and learning throughout life. The latter are based on primary capabilities established between preconception and early childhood, with multigeneration effects⁽¹⁾.

Thus, proper nutrition is a core strategy for health promotion as well as disorder prevention in children below two years old, and essential for human development. In case of inadequacy, early

intervention is of paramount importance, as neural plasticity starts to decline after early childhood. Mitigating the effects of deprivation suffered during childhood in the brain becomes increasingly harder, leading to impacts in life⁽²⁾.

Knowledge about elements of children's vulnerability to nutrition disorders is relevant, especially in the context of humanitarian emergencies, and highlights a need for minimizing the negative effect of poor nutrition in the life of every child, particularly the most vulnerable ones.

Therefore, there must be special attention to those children who are not reaching their development potential and who are experiencing disparities in the course of their lives. Thus, providing elements able to subsidize and follow up improvements in the quality of life of these children is essential to achieve sustainable development goals. To do so, proper health, food and nutritional safety, as well as responsive care, must be guaranteed⁽³⁾.

Adverse conditions that interfere with a child's development – such as precarious family relations, when the necessary care is not provided – may bring difficulties for the entire life⁽³⁾ and are considered as elements of vulnerability to nutrition disorders⁽⁴⁻⁵⁾. Vulnerability can be understood as a complex set of conditions that expose communities and children to

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health aggravations⁽⁴⁻⁷⁾.

In this sense, researches founded on the concept of vulnerability and that follow up nutritional profile changes around the world are relevant as they help to understand multidimensional arrangements that interfere with the health of communities and populations, addressing elements of vulnerability that can compromise a child's development, health and quality of life⁽⁵⁾.

Vulnerability can be expressed by means of three different and correlated dimensions: individual, concerning behavioral and cognitive aspects; social, related to social and economic conditions; and pragmatic, which deals with the structure of policies and actions⁽⁵⁻⁸⁾. Therefore, this study aims to understand family condition as an aspect of children's vulnerability to nutrition disorders from the viewpoint of nutritionists.

MATERIALS AND METHODS

This is a descriptive, qualitative study that aims to answer the guiding question: What are the elements of children's vulnerability to nutrition disorders concerning family condition? The research was conducted in a capital city of southern Brazil, from March to December, 2015, with 21 nutritionists that are part of teams from all 29 Family Health Support Centers [*Núcleos de Apoio à Saúde da Família*] (NASF). Of the 29 nutritionists, six were on sick leave at the time, while two had no room in their schedule for data collection.

Criteria for inclusion of participants were: being connected to the NASF team, working in the territory comprehending the health units, and being inserted in the Brazilian National Register of Health Establishments [*Cadastro Nacional de Estabelecimentos de Saúde*]. Exclusion criteria were: being absent from work with a medical certificate or due to leaves during the research.

Data were collected by means of semi-structured interviews, with the core question being: Describe a situation in which you noticed that nutrition disorders have affected or compromised a child's health. What could be done to change this situation? How and why?

The interviewees were invited to participate in the research via e-mail. The interviews were conducted at the participants' workplace and, after transcription, were made available to all research subjects. All interviews were conducted by the researcher and

recorded with average duration of 1 hour and 15 minutes in places with adequate acoustics and on dates and at times scheduled according to the participants' availability.

For data interpretation, methodological steps were followed – namely, data ordering, categorization and final analysis –, which allow understanding results. Dialectical hermeneutics was adopted as a conceptual framework for data analysis, while the theoretical framework was provided by vulnerability dimensions⁽⁴⁻⁶⁾.

In the data ordering step, the *Interface de R pour Analyses Multidimensionnelles de Textes et de Questionnaires* free software (IRaMuTeQ®) was used, which has a lexical basis to process transcribed speeches and select more frequent words in a text, helping in data reading and organization. The central word is the most repeated one, while surrounding ones correlate with the central element⁽⁸⁾.

Data processing results generated six categories. Each category corresponds to the processing of texts and sub-texts selected by the software. After this phase, text segments that matched with the same central theme and/or idea were manually grouped and brought closer to each other, generating three categories of elements of children's vulnerability to nutrition disorders: "Families' living condition"; "From maternal illness to social expectations about being a mother"; "From health service organization to maternal condition challenges".

This study is part of a broader project titled "Children's Vulnerability to Nutrition Disorders from the Viewpoint of Nutritionists". The research was approved by the Research Ethics Committee [*Comitê de Ética em Pesquisa*] (CEP) of Federal University of Paraná's Health Sciences Sector, under Legal Opinion No 832521, as well as by the co-participating institution.

RESULTS

The group of participants was made up of 21 female nutritionists aged between 29 and 43 years old, with completed higher education and service time ranging from 4 to 12 years.

Data from the interviews were ordered by the software and presented as word clouds and dendrogram, the latter being a graphic representation that helps in data classification and categorization.

[illegible]

She was a totally needy child; her father and mother died. But, to this day, here at the health unit, we raise funds to help buy her food, because she has nothing to eat. Her grandmother is ill and the only one that takes care of her. She only eats because of daycare. She is a little 2-year-old warrior. (Nut 17)

The mother is a teenager and her child has no father. She did not want that baby, and the grandmother demands from this girl things she has never learned how to do; the grandmother demands but does not teach, she thinks that the girl will learn on her own; this grandmother humiliates the mother, who then lets all this distress out. (Nut 19)

Understanding of and interest in questions concerning food care, especially those associated with the desire to breastfeed and with food introduction for children below two, are fundamental to ensure proper nutrition. Dada show a gap between what is advised and what mothers are able to do – an important situation to be taken into account when it comes to infants.

A health professional can even guide this mother; but sometimes she does not do what she is supposed to because she does not know how, she does not have information either as an option or for not wanting to learn, and she does not want to breastfeed. (Nuf 2)

with the mother, myths about breastfeeding, inadequate introduction of supplementary food.

[...] the father argues with the mother because she does not cook properly; the 6-year-old brother says he cannot eat anything, that he resents his 3-year-old brother because he cannot eat anything; because of him, the grandmother offered an herb mix and hen egg yolk [...] (Nut 2)

She started to offer other types of food and other industrialized things to the 4-month-old baby, things that should not be offered [...] (Nut 13)

You have mothers who do not want to breastfeed, and you have mothers who breastfeed for only a year or two, who do not want to give food because it is easy, they are here with me, I do not need to go there and cook. (Nut 17)

Another element presented was the act of cooking and preparing foods being considered as an important condition to ensure an adequate nutrition, but with new meanings in the contemporary world.

From Maternal Illness to Social Expectations About Being a Mother

Maternal absence, whether due to illness or death, is understood by nutritionists as an element of vulnerability to nutrition disorders. Maternal depression and a fragile bond between mother and child directly interfere with care and the act of breastfeeding. These conditions, according to the nutritionists, need to be discussed and inserted as determining factors for the proposition of public policies in order to guarantee the food and nutritional safety of children below two.

The girls at the health unit were horrified, the father commented [...], it seems that the mother has depression, so she would only eat junky food and ended up offering it to the kid. That mother did not have a strong connection with the health unit; I think she lacked that, she was poorly instructed and ill. (Nut 7)

A mother without conditions to take care of her child [...] she has no bonds with the child, she holds her son as if he was a bag of dirty clothes. (Nut 19)

The last meal had been at 5 pm; the mother gave the child a banana, but the child ate on the next day only, at 9 am, again; I cried with sadness and referred the case to the team; I learned that she had food and even conditions, but the mother had depression, the psychologist said. (Nut 6)

These data reveal a dichotomy between the family's responsibility and the absence of adequate public policies for coping with situations of family vulnerability and children's care.

From Health Service Organization to Maternal Condition Challenges

This category encompasses contradictions between the families' right to proper information on food care, and difficulties in organizing services in order to the meet the needs of families for children's care.

During medical appointment, the professional is right there, by your side, weighing the baby. The mother hears but cannot pay attention to what we are saying because she is undressing the child, and the nurse is weighing them, the doctor is asking questions; there is no time, childcare is chaos for me. (Nut 18)

These data show the fragility of service organization aimed at providing quality information in an appropriate manner. The speeches expressed limitations as to welcoming and active listening between professional and family member, which reveals a gap between discourses.

Mothers who do not want to go to the health unit usually do not want to breastfeed anymore, so they come but do not listen, and our role is to change their mind and show the advantages, the risks of interrupting breastfeeding. It is a daily battle against what doctors say. (Nut 15)

The kind of question doctors ask: "Are you breastfeeding, mom?". If she says: "Of course I am", the counseling stops there; if she is breastfeeding, there is no need for counseling, it is all fine. This is an element of vulnerability, because they say that for people to go home quickly, because they see that long line outside. (Nut 17)

We surely have mothers we love to advise, but we also have those that we advise but they have a bit more trouble understanding and applying what we say at home. I think that talking too much make them more nervous and hinder the possibility of them doing what is right. (Nut 8)

The study participants manifested the importance of a nutritionist's role in providing good results for children's food care but evidence a reality that does not allow for an attention considered adequate.

We have to work hard with mothers because some of them cannot afford buying anything but find a way to buy junky food. I am sure that, if we knew about these cases earlier, we would have time to indicate what they should buy; the problem is that when we learn about this kind of thing, the whole situation of nutrition disorder is already installed. (Nut 9)

About children below six months, mothers ask when they can eat, for example, yogurt, this is what they ask most frequently. I think we need a strong campaign for a greater understanding. We see kids at the age of 2 years old and obese already because health units lack nutritionists. (Nut 6)

I see that mothers buy everything they see on TV and that they want their children to have that, so they see everything that small kids should not be eating and then buy that. I think the media has a huge influence. (Nut 8)

The discourses evidence that the absence of nutritionists in a number that is enough to ensure access

to quality information associated with the influence of the media on eating habits is a conditioning aspect when it comes to choosing foods for children.

DISCUSSION

Category “Families’ living condition”, as an element of children’s vulnerability to nutrition disorders, reveals a contradiction between family roles expected by society and what families manage to do.

There is a direct relationship between unemployment of parents, lack of physical access to food and social vulnerability. Results show the accountability of the maternal figure that neglects the care of her child to work and guarantee an income, which causes the interruption of breastfeeding and hinders an adequate food introduction for the child⁽¹¹⁾.

The dichotomy between professionals’ expectations, based on guidelines to promote exclusive breastfeeding until six months, and the social reality experienced by families, mainly when it comes to mother with formal jobs without guarantees of labor rights, leads to coping situations and a clear feeling of exhaustion and powerlessness for these professionals. They describe this condition as common but little addressed by public policies⁽¹¹⁾.

There is no time or space for an active listening on the part of professionals for them to learn about the reality of families and how they are configured, as well as their needs and priorities as to food care. Promotion of dialogue spaces may be decisive for an extended care focused on families.

Food and nutrition, as constitutional rights, are the basis for the elaboration of public policies targeting access to food, with special attention to low-income families. Such constitutional rights, supported by law, seem to be distant from the reality of the population, revealing a contradiction between what is set forth in documents and what actually happens in communities and their surroundings⁽¹²⁾.

Thus, family condition, when not understood, is reflected on the practice of health professionals, considering that, for the participants of the present research, breastfeeding and nourishing children properly are a woman’s task. Therefore, failure to do so in an appropriate and sufficient manner raises criticisms directed at mothers, especially if the latter refuse to comply with technical precepts passed on and, above all, if the foods provided are industrialized, easy to prepare and unhealthy⁽¹³⁾.

Understanding that what is being eaten is oftentimes a strategy, to which mothers and/or caregivers have access, has a particular and contextual logics that is historically built, since individuals apprehend and reinterpret technical discourses based on their culture and exclude information that is not compatible with their social reality⁽¹⁴⁾. Thus, professionals must consider that the organization of families around childcare is influenced by culture and relations of consumption, social insertion and socioeconomic condition, as well as myths, traditions and popular knowledge regarding the food habits of families and the valuation or devaluation of these experiences.

These aspects are relevant to food practices in all generations and, consequently, to infant nutrition, with greater impact on households headed by women and mothers that take care of their children on their own, who have studied for less than four years and have informal jobs, a fact that corroborates the findings of this research⁽¹¹⁻¹⁵⁾.

Recognizing the aspects that influence food practices of families can be a protecting element for a healthy food care that reduces vulnerabilities, especially in cases of families that live in unfavorable social conditions.

Comprehending the social dimension of family practices as to infant nutrition configures a possible path to adjusting it, thus preventing the constitution of negative interferences with practices by valuing positive interferences⁽¹³⁾. This perspective can strengthen the maternal role and the promotion of healthy infant nutrition.

In category “From maternal illness to social expectations about being a mother”, as an element of vulnerability to nutrition disorders, according to data, maternal illness is expressed as an element with significant impact on the ability to meet infant care demands, especially breastfeeding. The literature shows an association between anxiety for maternity and the several and new activities assigned to the maternal role as stressors capable of triggering mental disorders – including postpartum depression⁽¹⁴⁾.

Pregnancy adversities and idealized maternity perpetuate, in society, the view of pregnancy as a stage of accomplishments and joys in a woman’s life, which justifies these mothers’ worry about judgments and misunderstandings on the part of society, including health professionals, especially professionals with whom mother have no bonds.

Thus, these women do not reveal or share their difficulties, uncertainties and sadness for oftentimes

feeling guilty due to contradictory emotions, which refer to demands related to the proper care of their children.

Maternity – preconceived as a natural act for which women are instinctively prepared – comes with strong contradictions, because the mother, in her many roles, needs at all times to distance herself from her convictions and desires and build secondary justifications for their real choices.

On the other hand, this condition is guided by a discourse based on a non-contextual comprehension supported by health policies, which “often highlight responsibilities focused exclusively on individuals”, which is not different in the health eating discourse when verticalized and uncritical⁽¹²⁾.

Women with a little active support social network are more likely to develop depressive symptoms, and comprehension by health professionals is required concerning a woman’s routine and its relationship with maternity and changes related to this condition⁽¹³⁻¹⁵⁾.

The maternal desire of not “wanting to breastfeed” is another situation pointed out by professionals in this research as being an “inappropriate attitude from a mother”. However, broader discussions are needed about the recognition of difficulties experienced by mothers in the process, understanding that they may act inappropriately, as choices are determined by previous experiences, especially with other children, a fact that attributes symbolisms to certain foods or eating manners⁽¹⁵⁾.

Multiparous mothers are more likely to fail to comply with nutritional orientations, which interferes with their behavior and with the follow-up of children below two, who are still very dependent on care. In such conditions, qualified and extended listening can bring this mother to the center of care much more as a speaker than a listener – which, therefore, can enable the sharing of new experiences, including with health professionals.

In this category, the mother is once again taken as the primary caregiver, a perspective that needs to be discussed in order to contemplate new actors so that adverse maternal conditions are not determinant to the child’s health, thus broadening responsibilities and ensuring the food and nutritional safety of children below two.

As for category “From health service organization to maternal condition challenges”, as an element of children’s vulnerability to nutrition disorders, there is an evident need for changes in the construction of public policies and in the organization of food and nutrition services and actions so that they are comprehensive and recognize all food care potentialities and difficulties

experienced by families at all care levels, starting with educative and preventive actions for high-complexity curative measures towards improving the population’s overall living condition.

These actions should take into consideration the multiple aspects around the occurrence of nutrition disorders, especially in primary care, where a contextual relation is more evident and the nutritionist provides nutritional counseling in individual and collective contexts. These professionals experience the dialectical relationship between the contradiction imposed by the objective social reality, the scientific evidence on infant nutrition and the healthcare model⁽¹⁶⁾ with its fragilities and challenges.

Health promotion and disorder prevention actions should be founded on the objective reality of society and social groups, thus leading to a greater discussion so as to understand complex questions such as early breastfeeding interruption and the reasons for this condition^(17,18). Therefore, it is necessary to support and encourage, in a more effective way, new individual and collective approaches in order to promote healthy eating practices⁽¹⁸⁾.

It is worth highlighting the importance of public policies and laws that encourage healthy eating habits within the context of social reality, mainly by controlling the advertising of unhealthy foods targeted at children and adolescents, as an immediate preventive measure for health promotion and disorder prevention, especially with a focus on health needs and aligned with the most evident occurrence of priority with epidemiological basis⁽¹⁸⁾.

These pieces of evidence reinforce the importance of incorporating comprehensive and reflexive counseling actions for infant nutrition and encouraging the search for resolution of existing issues, as well as valuing positive conditions in permanent health promotion practices, which are present in the most basic agenda of childcare policies for all those involved with the food care of children below two years old.

FINAL CONSIDERATIONS

The recognition of vulnerability elements related to mother and family on the part of health services would allow for a service supported by the comprehension of a child’s condition as a social being with rights and dependent on forms of care that characterize this life period. Children’s food and nutritional care is the responsibility of families, the State and society in general, rather than exclusively maternal.

The application of this type of analysis evidences challenges present in the current care model so as to overcome cure-oriented and emergency actions, besides indicating elements that are external to the health sector and that interfere with the social determination of health, which need to be considered

in order to meet the real needs of individuals and communities.

FINANCING

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A CONDIÇÃO FAMILIAR COMO ELEMENTO DE VULNERABILIDADE DA CRIANÇA PARA AGRAVOS NUTRICIONAIS

RESUMO

This study aims to understand family condition as an element of children's vulnerability to nutrition disorders. It is a descriptive, qualitative research conducted in a capital city in southern Brazil from March to December 2015. A total of 21 nutritionists from Family Health Support Centers participated by means of semi-structured interviews. Reports were interpreted through dialectical hermeneutics, with the aid of the Interface de R pour Analyses Multidimensionnelles de Textes et de Questionnaires free software. Three empirical categories emerged as elements of children's vulnerability to nutrition disorders, namely: "Families' living conditions", "From maternal illness to social expectations about being a mother", "From health service organization to maternal condition challenges". It is concluded that recognizing vulnerability elements concerning mother and family, on the part of health services, would allow for a practice supported by the comprehension of children as social beings with rights and dependent on forms of care that characterize this life period. A child's assistance as to food and nutrition is the responsibility of their family, the State and society in general, rather than solely maternal.

Palavras-chave: Vulnerabilidade em saúde. Nutrição do lactente. Família.

LA CONDICIÓN FAMILIAR COMO ELEMENTO DE VULNERABILIDAD DEL NIÑO A LOS TRASTORNOS NUTRICIONALES

RESUMEN

Este estudio tuvo el objetivo de comprender la condición familiar como aspecto de vulnerabilidad del niño para trastornos nutricionales. Se trata de una investigación descriptiva cualitativa, realizada en una capital del sur de Brasil, de marzo a diciembre de 2015. Participaron 21 nutricionistas de los Núcleos de Apoyo a Salud de la Familia a través de entrevistas semiestructuradas. La interpretación de los relatos fue hecha por la hermenéutica dialéctica con soporte software Libre *Interface de R pour analyses Multidimensionnelles de Textes et de Questionnaires*. Surgieron tres categorías empíricas como elementos de vulnerabilidad del niño para trastornos nutricionales: "La condición de vida de las familias", "De la enfermedad materna a la expectativa social del ser madre", "De la organización del servicio de salud a los desafíos de la condición materna". Se concluyó que el reconocimiento de los elementos de vulnerabilidad relativo a la madre y a la familia por parte del servicio de salud posibilitaría una actuación basada en la comprensión de la condición del niño como ser social de derechos y dependiente de los cuidados que caracterizan este período de la vida. El cuidado alimentario y nutricional infantil se constituyó como responsabilidad de la familia, del Estado y de la sociedad en general y no solo una responsabilidad exclusivamente materna.

Palabras clave: Vulnerabilidad en salud. Nutrición infantil. Familia.

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