RESEARCH ARTICLE

FAMILIES IN SOCIOECONOMIC AND CLINICAL RISK AND SOCIAL SUPPORT

Famílias em risco socioeconômico e clínico e o apoio social

Familias en riesgos socioeconómicos y clínicos y apoyo social

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Abstract

Purpose: Identify the relation between the socioeconomic and clinical risk conditions of families and the social support acknowledged by families. **Method**: This was a pilot study based on a random sample survey. **Results**: A total of 59 families participated in the study: eight at low risk, 28 at medium risk and 23 at high risk. The members from families at high risk were shown to perceive receiving more instrumental support, but there is no evidence that religious, emotional and family support were related to socioeconomic and clinical risks. This suggests that socioeconomic differences and clinical risk do not influence the scores attributed to those types of support. However, there is evidence that the perception of families at higher risk levels was higher in relation to support received from friends and neighbors. **Clinical Relevance:** The characteristics of social support should be considered by those who organize and deliver care to families.
Key words: Social Support; Health Promotion; Family Nursing

Resumo

Objetivo: Caracterizar os tipos de apoio social relatados por familiares e relacionar o tipo de apoio referido com o grau de risco socioeconômico e clínico das famílias atendidas pela Estratégia de Saúde da Família. **Método**: Trata-se de um estudo de campo, com abordagem quantitativa, realizada por meio de um questionário para levantamento de dados. **Resultados**: Um total de 59 famílias participou do estudo. Os membros de famílias de alto risco demonstraram perceber que recebem mais apoio instrumental. Não houve evidência de que os apoios religiosos, emocionais e familiares estivessem relacionados aos riscos socioeconômicos e clínicos. Isto sugere que as diferenças socioeconômicas e o risco clínico não interferem no valor atribuído a esses tipos de apoio. Famílias de alto risco apresentaram maior percepção em relação ao apoio recebido de amigos e vizinhos. **Relevância Clínica:** As características do apoio social devem ser consideradas por aqueles que organizam e oferecem assistência às famílias.
Descritores: Apoio Social; Promoção da Saúde; Enfermagem Familiar

Resumen

Objetivo: Caracterizar los tipos de apoyo social relatados por familiares y relacionar el tipo de apoyo referido con el grado de riesgos socioeconómicos y clínicos de las familias atendidas por la Estrategia de Salud de la Familia. **Método**: Un estudio de campo con aproximación cuantitativa fue efectuado mediante un cuestionario para levantamiento de datos. **Resultados**: Al total, 59 familias participaron. Los miembros de familias de alto riesgo demostraron percibir que reciben mayor apoyo instrumental. No se encontró evidencia de una relación entre apoyo religioso, emocional y familiar con los riesgos socioeconómicos y clínicos. Eso sugiero que las diferencias socioeconómicas y el riesgo clínico no interfieren en el valor atribuido a esos tipos de apoyo. Familias de alto riesgo mostraron mayor percepción respecto al apoyo recibido de amigos y vecinos. **Relevancia Clínica:** Las características del apoyo social deben ser consideradas por aquellos que organizan y ofrecen atención a las familias.
Descriptores: Apoyo Social; Promoción de la Salud; Enfermería Familiar

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INTRODUCTION

A proposal for health promotion addressed to a given community should consider the environmental, social and economic determinants related to the organization of families. The family has been identified as a basic unit in which health behavior, health values, and health risk perceptions are developed, organized and performed[1]. Recognizing the influence of social support on individuals' health status and health behavior enables nurses to help families to develop abilities to be more successful, and strengthen the supportive resources available to their members[2-3].

Empirical studies carried out in Sweden[4], the USA[5-6], Israel[7], Great Britain[8], Canada[9], and Italy[10] have shown the relationship between social support and socioeconomic conditions, and health condition and health promotion, in different populations such as: children, pregnant adolescents, men, the elderly and individuals with chronic diseases. Studying the relationship between conditions of socioeconomic and clinical risks and social support can enable the development of instruments for health promotion interventions.

The concept of social support is part of several theoretical frameworks and practice models. Several authors consider social support a temporal term, that is, its meaning can vary over one's course of life[11]. Social support is usually defined as the existence or availability of people whom one can rely on, people who let one know that they care about, value and love him or her[12]. Social networks are generally understood in structural terms, focused on the structural underpinnings of support, and described as linking to and interacting with surrounding social institutions such as family, neighborhood and other organizations[1,13]. Social support, on the other hand, focuses on the interpersonal exchanges among selected network members. Social support requires the existence of social relationships that vary according to structure, strength, type and some conditions, such as reciprocity, accessibility and mutual confidence; social relations provide for inclusion, as well as emotional, material and cognitive resources, among others. As a result of social bonds, individuals can remove themselves somewhat from their problems; giving

information is inherent to all support resources; interactions can occur intentionally or unintentionally and can exert a positive or negative influence, which is affected by the acknowledgement of individual needs and how support is perceived; it depends on characteristics of whom offers and receives support[11,14].

For research purposes, one has to select a concept that includes relevant aspects, coherent with the objective to be achieved. One way to address social support is to break it into its components and evaluate its different dimensions in their contribution to health. Social support, defined as the level with which interpersonal relationships correspond to certain functions can be broken down into four classes: appraisal, emotional, informational and instrumental support. Appraisal support refers to expressions and feelings of acknowledgement; emotional support refers to affection, love, empathy, respect; the informational category is related to suggestions, information, advice and opinions; and instrumental support refers to financial help, time dedicated to helping and the availability of resources, goods and services[1]. In addition to family, friends and neighbors, social support can also take the form of organized community involvement.

Faith, religion and spirituality are considered important resources for strengthening the family to cope with moments of crisis. The terms 'faith', 'religion' and 'spirituality' are frequently considered synonymous but their meanings are not the same. Religion refers to the belief one holds in a divine or supernatural force and is linked to a specific doctrine. Spirituality is a philosophical orientation that produces behaviors and feelings of hope, love and faith, providing a meaning for life[15]. There are currently many instruments designed to measure social support, however, an instrument that could specifically identify friends, neighbors and family members as sources of support was not found in the literature, nor even an instrument addressing the perception of family members related to spiritual or religious support. For this reason, as well as considering that these sources of support are very important in Brazilian culture, an instrument found in the literature and already validated for Brazilian Portuguese was adapted for this study[19-20]. Based on this adaptation, this study relates conditions of socioeconomic and clinical risks and social support.

Hence, the object of study of this project was constructed with the general objective of identifying the relationship between conditions of socioeconomic and clinical risks of families and their members' perception of support. The specific objectives are: characterize the types of social support reported by family members and relate the type of support reported by families with their level of socioeconomic and clinical risks.

Background

Brazil has severe inequalities in its distribution of wealth and a large part of its population lives in poverty without access to goods essential to good health. The main determinants of these inequalities are related to the ways social life is organized, global factors of a social, economic and political nature, and indirectly impacting the health of groups and people[16]. The Family Health Strategy (FHS) developed by the Brazilian government mainly targets the health of individuals, families and the community with a focus on health promotion. The governmental program developed by the State Secretary of Health and School of Public Health of Minas Gerais is implementing the Master Plan of Primary Health Care as a way to reorganize the public service network. This program is characterized by planning, organizing and monitoring actions intended to obtain better health indices and improve the quality of health care. Individuals of the community are registered and classified through indicators of socioeconomic and clinical risks. This method enables one to recognize socioeconomic and clinical risk factors stratified by levels, which indicate the real needs of families[17].

METHOD

Design, Sample and Setting

This was a pilot study based on a random sample survey carried out in a neighborhood in the interior of Minas Gerais, Brazil. A total of 162 families lived in the neighborhood, totaling 622 individuals. A simple random sampling without replacement with stratification for variable socioeconomic and clinical risks was used to select the sample, considering a confidence level of 95% and sample error of 10% (Table 1). The sample totaled 164 individuals, members of 59 families classified according to socioeconomic and clinical risks. One family considered of medium risk did not answer the questionnaire because they moved and were not replaced. Ethical approval was obtained from the local research ethics committees, and institutional permission and access were jointly obtained.

Table 1 - Number of families according to the level of socioeconomic and clinical risks and sampling calculation. 2009

Risk	Number of families	Sampling universe	Number of drawn families
Low	20	12.3%	8
Medium	80	49.9%	29
High	62	38.3%	23
Total	162	100%	60

Instrument and Data Collection Procedures
Risk Indexes

An instrument proposed by the school of Public Health of Minas Gerais[17] was used to classify socioeconomic and clinical risks. The following are socioeconomic indicators of family risk: families whose head is illiterate; families in extreme poverty with monthly per capita income under R\$ 60.00 (R\$ 60.00 is equivalent to US\$ 35.00 according to exchange rate in March 2010) absence of appropriate water supply. The identification of socioeconomic risks is scored as follows: none of the risk factors = 0, presence of one of the risk factors = 1, two risk factors = 2, and three or more risk factors = 3 (Chart 1).

The clinical conditions factors are identified in the families in which one or more members present one of the following conditions: children at risk (underweight; preterm; severe malnutrition; positive neonatal screening for hypothyroidism; phenylketonuria, anemia, cystic fibrosis; diseases of vertical transmission such as toxoplasmosis, syphilis, AIDS; important intercurrences during the neonatal period; inadequate growth and development and unfavorable development of any disease); adolescents at high risk (sexually transmissible diseases; early pregnancy; eating disorders, use and abuse of legal and illegal substances, victim of sexual exploitation, depression, mental disorders, adolescents who run away from home or live on the streets); adults at high or very high risk (hypertension, diabetes, tuberculosis, leprosy or at risk of serious mental disease); pregnant women who use legal or illegal drugs, previous

Chart 1 - Criteria to classify families according to the level of socioeconomic and clinical risks

Final score for risk classification			Socioeconomic criteria			
			No risk factor	1 or 2 risk factors	2 or more risk factors	3 or more risk factors
		P	0	1	2	3
Clinical Criteria	None of the members have any condition or pathology	0	0	1	2	3
	Only 1 member has 1 condition or pathology	1	1	2	3	4
	2 or more members have 1 condition or pathology	2	2	3	4	5
	1 or more members concomitantly have 2 or more conditions or pathologies	3	3	4	5	6

Source: Escola de Saúde Pública do Estado de Minas Gerais [ESPMG] (2008)

perinatal death, habitual abortion, infertility, preeclampsia, eclampsia, gestational diabetes, labor with fetal death, heart disease, kidney disease, blood disorders, hypertension, bleeding during pregnancy; elderly older than 80 years; elderly older than 60 years with several pathologies using many medications, with total or partial immobility, urinary or fecal incontinence, postural instability, cognitive impairment; elderly with frequent hospitalizations, dependent on daily basic tasks and elderly living alone or in institutions[17]. The identification of clinical risk factors is scored as follows: none of the family members present condition of clinical risk = 0; only one of the members is at condition of clinical risk = 1; two or more members have a clinical condition = 2; one or more members have concomitantly two or more clinical conditions = 3 (Chart 1).

The level of family risk was obtained through the sum of two scores, socioeconomic factors and clinical condition, which defines the final score. Subsequently, scores were interpreted and families were classified as: no risk, low risk, medium risk and high risk (Chart 2).

Chart 2 - Interpretation of scores for the classification of families according to socioeconomic and clinical risks

Total Score	Risk Level
0	No risk
1	Low risk
2 – 3	Medium risk
> 4	High risk

Social Support Survey

The development of different questionnaires capable of evaluating social support has been one of the objectives of research in the psychosocial and health fields. One of the most applied questionnaires and which offers the best reliability and reproducibility is the Medical Outcomes Study – Social Support Survey (MOS-SSS) developed by Sherbourne and Stewart[18]. They developed a relatively short 19-item survey of functional social support that represents multiple dimensions of support: emotional, informational, tangible, affectionate and positive social interaction. The adaptation and validation of this instrument for Brazilian Portuguese was carried out by Griep et al.[19-20]. An instrument whose questions were based on the work of Griep et al.[19-20] and previous qualitative studies[2,21-22] was developed for this study. The focus is on measuring the perceived availability of functional support because, as recommended by Sherbourne and Stewart[18], a person's perceptions about available support are the most important.

Aware of the benefits families received from the National Institute of Social Security – INSS, (an agency of the Ministry of Social Security in Brazil), we chose to verify instrumental support. The benefits are: retirement by age, disability; retirement by time of contribution, special benefit, sickness and accident allowance; imprisonment allowance; death pension; maternity allowance; family allowance; allowance to the elderly and disabled; professional rehabilitation. The Brazilian social security is a public insurance whose function is to ensure that income sources of workers and their families are maintained even when they temporarily (disease, accident, maternity) or permanently (death, disability and old age) lose their capacity to work. It is a legal right of every worker and the resources come from a monthly contribution of formal employees and employers. Payment originating from any kind of work was not considered instrumental support.

The questionnaire contained 13 items addressing instrumental support, that is, related to INSS pension benefits, for which respondents could answer Yes (1 point) or No (Zero points).

The emotional support dimension contained eight items that would measure the expression of affection, empathetic understanding, and the encouragement of expressing feelings. Questions concerning the frequency with which respondents identified someone was helping them in the event they were confined to bed, had someone to confide or talk to about themselves or their problems, someone who understood their problems, someone they could count on to listen to them when they needed to talk, someone to give them information, to help them to understand a situation, or whether there was someone to offer them affection, or someone to prepare the meals and help them with house chores. Informational support was included in emotional support. We divide emotional support asking them whether they perceived the help they received from friends, neighbors and family when facing hardships. Four questions related to support from friends and neighbors were asked.

We sought to know the dynamics of the families from their perspective. The family support dimension contained six items designed to measure whether family members trusted each other; respected the privacy of each other; gathered to celebrate dates or have fun; talk to each other, whether they believed the family is capable of giving support in difficult situations.

In terms of spiritual and religious support, we investigated whether family members identified themselves with any religious group and whether they had faith or devotion to something. Five questions addressed religious support; answers were either: Yes (score=2), Sometimes (score=1) and No (score=0). To simplify and make the questionnaire more objective for working class people, answers were limited to a choice of three alternatives for each question.

Keeping the perspective of the Family Nursing theoretical framework, the questionnaire was applied to all members of the family randomly drawn from the sample, excluding children younger than 12 years of age.

During the first stage of data collection, families were visited by one of the researchers, who explained to all members of each family the study's objectives and its importance. The most convenient days and times to apply the questionnaire were also scheduled in this first stage. At the same time, the study's objectives and procedures were presented to those responsible for Family Health Services and to the whole team, whereas the importance of every family member adhering to the study was emphasized. Informed consent was obtained from all the adult participants and children older than 12 years of age, who indicated their ability to consent. Participants were also ensured confidentiality and the right to refuse answering any question or withdraw from the study at any time. The questionnaire was applied through interviews carried out between December 2008 and January 2009 in the participants' households, since their homes were considered an environment favorable to the interview. The researcher registered the answers. All those living in the house registered in the Family Health Unit's file were considered family members.

RESULTS

Data were stored in two Microsoft Office Excel spreadsheets. The individual answers of each member of the studied families were registered in the lines of the first spreadsheet, and all the studied variables were included in the columns. This file totaled the complete register of 164 responses that corresponded to the individual members of the drawn families. Data for each family – the average between the obtained results and the number of members in a family for each studied variable – were registered in the second spreadsheet. This file totaled the register of 60 responses corresponding to the total number of families included in the sample. Only one family did not answer the questionnaire after being drawn from the sample.

Table 2 presents the number and average of people by family: M=3.25 ± 131 Standard Deviation (DP) and Median (Md) = 3.00, Minimum result = 1.00 member per family and Maximum = 7.00 members per family. Table 3 shows the list of INSS benefits received by each member of families. Table 4 presents the list of families who receive or do not receive instrumental support; 62.7% reported they did not receive any benefit. Table 5 presents the values attributed to support reported by families. The maximum expected value for religious support was 10, for emotional support 16, for support from friends and

neighbors 8 and for family support 12.

Table 2 - Number of people per family. 2009

Number of people per family	N.º of families	%
1.00	7	11.7
2.00	9	15.0
3.00	17	28.3
4.00	19	31.7
5.00	6	10.0
6.00	1	1.7
7.00	1	1.7
Total	60	100.0

Table 3 - List of INSS benefits received by family. 2009

List of benefits by family member	Number of families	% of families	% valid
0.00	37	61.7	62.7
0.20	1	1.7	1.7
0.25	3	5.0	5.1
0.33	7	11.7	11.9
0.33	1	1.7	1.7
0.50	4	6.7	6.8
0.75	2	3.3	3.4
0.80	1	1.7	1.7
1.00	2	3.3	3.4
Total	59	98.3	100
No answer	1	1.7	-
Total	60	100	100

Table 4 - List of families who receive or do not receive INSS benefits.2009

INSS benefits	N° of families	% of families	% valid
No	37	61.7	62.7
Yes	22	36.7	37.3
Total	59	98.3	100.0
No answer	1	1.7	
Total	60	100.0	

Table 5 - Support reported by families. 2009

Types of support	M	MD	SD	MIN	MAX
Religious support	7.86	8.00	1.59	2.00	10.00
Emotional support	14.04	15.33	2.98	1.00	16.00
Support of friends and neighbors	3.87	2.30	2.30	0.00	8.00
Family support	10.20	11.00	2.39	0.00	12.00

M=mean; MD= median; SD=standard deviation; MIN=Minimum; MAX=Maximum

The Kruskal-Wallis non-parametric test (ANOVA non-parametric) was used to compare variables: number of people by family, INSS benefit, type of support (religious, emotional, friends and family support) and families' groups of risk. A level of significance of p d" 0.05 was adopted.

Statistically significant differences between different groups of risk and number of people per family ($X^2 =1.49$ and p=0.47) were not found. The *post hoc* Dunn test indicated significant difference in the relation between the families' type of risk and benefits received from the INSS ($X^2=6.91$ and p=0.03); the high-risk group presented values significantly higher than the medium risk group. The low-risk group did not present significant differences in relation to any group. Significant differences were not found between the perception of support reported by family members and the group of risk to which families belonged to when religious support ($X^2=2.68$ and p=0.26), emotional support ($X^2= 2.58$ and p=028) and family support ($X^2 =2.19$ and p=0.33) were compared to group of risk. According to the Dunn *post hoc* test, there was a significant difference in the relation between the families' types of risks and the perception of support from friends. The medium risk group presented values significantly higher than the high and low-risk groups ($X^2=7.19$ and p=0.03).

DISCUSSION

As presented in this project, this study proposed to investigate social support in the family health promotion strategy. We stress that the questionnaires were answered by all members of families revealing the perception of their members about received support. Thus, the questionnaire does not reveal whether families in fact receive the support but rather it reveals whether they perceive they receive or fail to receive the different types of support. From this perspective, this is an unedited study because it seeks representation through the report of the largest possible number of family members, excluding only children younger than 12 years of age, which adds to the studies found in the literature whose reports are from a single member in the family.

Based on the results obtained in this study, the families in the studied neighborhood have an average of 3.25 members. There was no significant difference in the number of members per family concerning the different groups of risk. The average number of family members between the different groups of risk varied from three (low-risk families) to 3.2 (high-risk families). Since the classification by risk includes the socioeconomic situation of families, we expected significant differences.

The socioeconomic, cultural and environmental conditions of a given society generate an economic and social stratification of individuals and groups of populations, conferring upon them distinct social status, which in turn, reflects health differences[23].

The research process documented that family members recognize social support in the following dimensions: instrumental support, religious support, emotional support, family support and support from friends and neighbors, indicating that support is perceived by all groups classified according to the criteria of socioeconomic and clinical risks.

We sought to verify whether families received instrumental support by checking whether they received Social Security benefits. Public insurance has important repercussions on the population's health because it mainly covers families with the poorest living conditions and complements their budget, thus, is important to facilitate their access to conditions that promote health. This emphasis is in agreement with the recommendations of the Final Report of the National Commission on Social Determinants of Health[23], which acknowledges the depreciation of social capital as an important mechanism through which socioeconomic inequalities negatively impact health condition.

In the studied neighborhood, 88% of families were classified as being in medium and high-risk conditions. We verified through the Duncan test that the high-risk group presented values significantly higher than the medium-risk group concerning the benefits of social security, while the low-risk group did not present significant differences. Hence, we can suggest that the socioeconomic conditions associated with unfavorable clinical conditions are related to the presence of instrumental support. The literature suggests that instrumental support can function as a protective cover, meeting the support needs of families at higher risk[5].

The authors of a study addressing the association between socioeconomic status, support and support networks concluded that the lack of networks and social support is more frequently associated with socially and economically disadvantaged people[24]. In the same way that support and social support networks should contribute to the development of equitable health, we verified that the families perceive and report that the social

security benefits represent an important support to them.

We note that significant differences were not found between the different groups of family risk and the perception of religious support, which suggests that socioeconomic differences and clinical risks do not interfere in the value attributed to religious support. All groups scored highly concerning perception of religious support, indicating this is an important support for all the families. Religion is an important element in the promotion of family health[25]. Consequently, perception of religious support should be included in the families' assessment so as to define the diagnosis of support to families and also potential interventions.

There were no significant differences in the perception of emotional support between the different groups of risk, which means that family members who belong to different risk groups consider this support of equal importance. The manifestations of positive behaviors and attitudes, involving relationships of understanding, empathy and solidarity are essential aspects of emotional support confirmed in the literature[26].

There is no evidence that family support is related to family risk. All groups scored highly in regard to this support, suggesting that this type of support is perceived in all families, regardless of their level of risk. According to the studied literature, family support, social relationships and ties are mechanisms that positively influence health promotion[6, 27].

There is evidence that the support of friends and neighbors is related to family risk. The medium-risk group presented values significantly higher than the high and low-risk groups. It suggests that in neighborhoods in which conditions of family risk exist, the support of friends and families should be considered in family health promotion. A study carried out in the USA concerning the presence of social cohesion within the neighborhood, family support, support of friends and family cultural conflicts were positively associated with the self-evaluation of physical and mental health in a sample of Latin individuals living in the USA[6].

Another study carried out in two Canadian communities, where the association between health condition and social integration in social networks of people older than 65 years of age was evaluated, also

positively related the support of friends to health condition. The association between social relationships and health varied in the two communities. The reported self-evaluation of health was better for those with a high level of social integration and a strong network of friends in both communities. The authors concluded that social networks, support and integration have a positive association with health and the nature of this association can vary among populations and cultures[9]. A study addressing elderly individuals and their relationship with friends, partners and neighbors showed that social connections are positively associated with health condition. These perceived social connections can be relatively important for well being and health[27].

The literature suggests that there is a strong relation between health promotion and the importance of knowing social support, highlighting the importance of studies addressing support as an essential resource for life and health. Verifying social support in the instrumental, religious, family and emotional dimensions and friends and neighbors is a relevant concern. Many characteristics of the manifestations of social support interfere in the lives and health of people.

CONCLUSIONS

Among the positive objectives achieved with this study we highlight the application of a questionnaire with easily understandable questions, which elicit objective responses, answered with no hesitation. Meeting all the family members generated empathy between researcher and families. We perceived, during data tabulation, a tendency of the members of a same family to provide similar answers.

The measurement of informative support can be noted as a limitation of this study. The questions about advice, suggestions, and information were presented in the same set of questions concerning emotional and family support and support from friends and neighbors, hindering statistical analysis of this type of support. We suggest that the analysis of the informational support dimension be deepened in another study. Access to information is a determinant of health whose importance is not always acknowledged, though it should be. Access to sources and flows of information increases knowledge and the ability to act, enabling the adoption of

healthy behaviors and social mobilization to improve life conditions. On the other hand, the lack of access to knowledge and information for a large part of the population significantly hinders individuals' capacity to make decisions and act in favor of their health and that of the collective.

For future studies, we suggest the adoption of a margin of error lower than 10% to calculate the sample, which enables statistical results closer to the population's composition.

We sought to discuss the results emphasizing differences and similarities in relation to the literature, however this task was hindered by the scarcity of studies of this kind and by the characteristic of social support, which is a multifaceted construct with different dimensions, impeding comparison among results. Despite efforts of Brazilian researchers in recent years to include social, economic, and cultural aspects in epidemiological studies, and given social determinants in the health-disease process, dimensions related to social support are still poorly explored.

The findings permitted identifying, among the families living in this neighborhood and who were classified as low, medium and high-risk in socioeconomic and clinical terms, the perception of family members about social support in the following dimensions: instrumental, religious, emotional, friends and neighbors and family in their daily routine. The characteristics of social support should be considered by those who organize and deliver care to these families.

The care practice of families is permeated with uncertainties and lacks precise instruments to approach the family, whereas the definition of family health itself has not reached consensus. The study of social support can be a theoretical methodological instrument to be developed in order to acquire a better understanding of the family and consequently result in indicators of intervention to promote health.

Such knowledge can qualify health professionals, especially nurses, to care for the individual and also move the family towards self-realization, a condition that is essential to populations, at socioeconomic and clinical risk, to cope with difficulties.

Further studies addressing the perception of social support are needed as an essential resource to provide elements that enable the development of a flexible and dynamic plan for interventions for families and define public policies focused on health promotion.

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