

## Functionality of the support to the family of children with pneumonia



*Funcionalidade do apoio à família da criança com pneumonia*

*Funcionalidad del apoyo a la familia del niño con neumonía*

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### ABSTRACT

**Objective:** To know the composition and functioning of the social support used by the family of children with pneumonia.

**Methods:** A qualitative study was carried out with fourteen families of children under five years old hospitalized for pneumonia, coming from regions of greater social vulnerability in a city in the state of São Paulo, from November 2015 to May 2016. The theoretical reference used was the Calgary Family Assessment Model, and the Bardin Thematic Content Analysis was used as method.

**Results:** The nuclear family and the extended family constitute the social support used; the support network accessed includes the Primary Health Care, Emergency Care Units and hospitals, observing intersectoral referral and counter-referral failure.

**Final considerations:** The family reorganization proved to be relevant and effective in times of crisis; the families seek the secondary level of health care to solve the illness of their child.

**Keywords:** Pneumonia. Delivery of health care. Pediatric nursing. Social support. Family.

### RESUMO

**Objetivo:** Conhecer a composição e o funcionamento do apoio social utilizado pela família da criança adoecida por pneumonia.

**Método:** Pesquisa qualitativa, realizada com quatorze famílias de crianças menores de cinco anos internadas por pneumonia, provenientes de regiões de maior vulnerabilidade social de um município do interior paulista, no período de novembro de 2015 a maio de 2016. Utilizou-se como referencial teórico o Modelo Calgary de Avaliação Familiar, e a Análise de Conteúdo Temática de Bardin como método.

**Resultados:** A família nuclear e a extensa constituem o apoio social utilizado; a rede de apoio acessada engloba a Atenção Primária de Saúde, Unidades de Pronto Atendimento e hospitais, observando falha na referência e contra-referência intersectoriais.

**Considerações finais:** A reorganização familiar mostrou-se relevante e efetiva em períodos de crise; as famílias buscam no nível secundário de atenção à saúde a resolutividade para o adoecimento de seu filho.

**Palavras-chave:** Pneumonia. Assistência à saúde. Enfermagem pediátrica. Apoio social. Família.

### RESUMEN

**Objetivo:** Conocer la composición y el funcionamiento del apoyo social utilizado por la familia del niño enfermo por neumonía.

**Método:** Investigación cualitativa, realizada con catorce familias de niños menores de cinco años internados por neumonía, provenientes de regiones de mayor vulnerabilidad social de un municipio del interior paulista, en el período de noviembre de 2015 a mayo de 2016. Se utilizó el modelo Calgary de evaluación familiar como referencial teórico, y el análisis de contenido temático de Bardin como método.

**Resultados:** La familia nuclear y la extensa constituyen el apoyo social utilizado. La red de apoyo accedida engloba la Atención Primaria de la Salud, Unidades de Atención de Emergencias y hospitales, donde se observa una falla en la referencia y contra-referencia intersectoriales.

**Consideraciones finales:** La reorganización familiar se mostró relevante y efectiva en períodos de crisis. Las familias buscan en el nivel secundario de la atención a la salud la resolutividad para la enfermedad de su hijo.

**Palabras clave:** Neumonía. Prestación de atención de salud. Enfermería pediátrica. Apoyo social. Familia.

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## ■ INTRODUCTION

Pneumonia is the leading cause of death in children under five years old and one of the most prevalent diseases in childhood, having killed almost 1 million children under five years old by 2015 in the world, about one child every 35 seconds, more than malaria, tuberculosis, measles and AIDS combined<sup>(1)</sup>.

In Brazil, although the reduction of the mortality rate is related to the improvement of the economic conditions of the population, to the access to health care and the national availability of antibiotics and vaccination policies, to the reduction of infections of the lower respiratory tract, especially pneumonia, it remains the third cause of mortality over the years, reaching a total of 75,602 deaths, which corresponds to 5.6% of the total deaths in the country<sup>(2)</sup>. For this reason, the interest remains in research with a focus on respiratory diseases<sup>(2-4)</sup>, with the acute diseases being a concern in nursing studies<sup>(4)</sup> in order to strengthen the provision of care so that it becomes more effective.

It is in this situation of sickness that the child, conducted by the family, goes through several services of the health care network, such as primary health care units, emergency care units, secondary or tertiary hospitals, looking for solution, being fundamental the coordination of the care of the child with pneumonia, making possible the early diagnosis and treatment, as well as the continuity of the care<sup>(4)</sup>.

Given the clinical complexity of the child and the understanding that the family care practices are part of a framework of social relations, health professionals should consider it in their therapeutic plans. The family nucleus, in the face of the care demands of the child with pneumonia and with a view to supplying them, mobilizes resources internal and external to it, which involve the social network.

In discussing family relationships in this text, it is understood as the set of bonds established between the individuals that make up the family nucleus of the child and between those with the extended family<sup>(5)</sup>. In this sense, the support network can be understood by the different relationships with care institutions. Social support, in turn, is understood as a resource provided by the people who interact with the family, such as family, friends, neighbors, and it may occur in different forms such as emotional, affective, informational and positive interaction<sup>(6)</sup>. The components of this network interact and join forces to support the family in facing the child's disease<sup>(5)</sup>.

In the search for reestablishing the health of the child, the health services must provide a guarantee of care qualification, involving the family, which must be supported by the professionals to perform their role<sup>(5)</sup>.

Family-based nursing research, which focuses on chil-

dren, involves themes related to social support and chronic illness<sup>(7-10)</sup>, primarily. This study seeks to innovate by offering a look at the child and their family relating it to the social support they receive during the acute illness. The question that guided this study was "How is the social support network for children with pneumonia?". Thus, the objective was to know the composition and functioning of the Social Support used by the family of the child with pneumonia.

## ■ METHOD

Descriptive study of a qualitative approach, which seeks to understand the meaning of the experience of social relations<sup>(11)</sup>. In order to know the structure and functioning of the family of the child with pneumonia, the Calgary Family Assessment Model (MCAF)<sup>(12)</sup> was chosen for data collection.

Fourteen families of children hospitalized with pneumonia participated in the study at a Teaching Hospital in a city in the state of São Paulo. The criteria for selecting the participants were: a) family of children under five years old; b) to live in a region of high social vulnerability, according to the Paulista Index of Social Vulnerability. Participants were identified from the first letter of kinship - mother (M), father (F), grandmother (G) ou aunt (A) - established with the child, followed by (F) representing family and the order in which the interview was conducted.

The potential participants of the study were retrospectively analyzed, based on the analysis of the medical records of the emergency care unit and pediatric hospitalization, related to hospitalizations of the hospital in 2014.

Seventy-eight families were surveyed, 22 of them living in a region of high social vulnerability, a criterion chosen because of the association evidenced by the literature between poverty and illness. Poverty and inequalities are still a serious problem for health indicators, being its eradication, inclusive economic development and the preservation of the planet the key to the health and well-being of the world's population<sup>(13)</sup>.

Of the 22 families, 5 were not found due to change of address, the father of 1 of the families did not allow its participation, other 2 families were disregarded by data divergent to the objective (discovered only in the interview), which totaled 14 families. The household was the place of choice for the interviews, aiming to gather the largest number of family members, and to know their reality closely, thus obtaining more representative data, carried out from November 2015 to May 2016.

For data collection, it was used the genogram and ecomap according to the MCAF<sup>(12)</sup>, along with the semi-structured interview. The main objective of the genogram is to aid in the evaluation, planning and family intervention, and

it allows to clearly observe which members constitute the family, besides the identification of the main diseases, facilitating the therapeutic plan<sup>(12)</sup>. The ecomap presents the relationship of the family with its members, community and services<sup>(12)</sup>. In this sense, it allows to know the social supports used by the family.

The semi-structured interview was composed of guiding questions, seeking to understand the functioning and family organization in the tasks performed, the role of each member, and the way the problems were identified and solved, always with focus on the child with pneumonia and the care related to him/her. The interviews were recorded and transcribed, and the data were collected according to the MCAF<sup>(12)</sup>, in the search for social support in the situation of pneumonia from the structure and family functioning.

The MCAF comprises three main categories: Structural, Developmental and Functional. The structural category comprises the structure of the family and the elements that can be evaluated in its subcategories are: Internal (family composition, gender, sexual orientation, birth order, subsystems and limits), External (extended family and wider systems) and Context (ethnicity, race, social class, religion and spirituality and environment)<sup>(12)</sup>.

Regarding the category of development, this refers to the development of the life cycle of each family, classifying its subcategories in: Stages, Tasks, and Links. The functional category refers to how the individuals in the family interact, and it can be explored in two subcategories: Instrumental functioning (activities of daily living) and Expressive functioning (types of communication, problem solving, roles, beliefs, influence and power, alliances and unions)<sup>(12)</sup>.

The data from the interviews were categorized according to the dimensions of the MCAF, such as the thematic content analysis of Bardin<sup>(14)</sup>. This method involves a set

of techniques developed in three stages: pre-analysis, in which it was carried out the floating reading, organization of the material and formulation of hypotheses and objectives; exploitation of the material, which is the moment of codification and classification into categories; treatment of the results obtained and interpretation<sup>(14)</sup>.

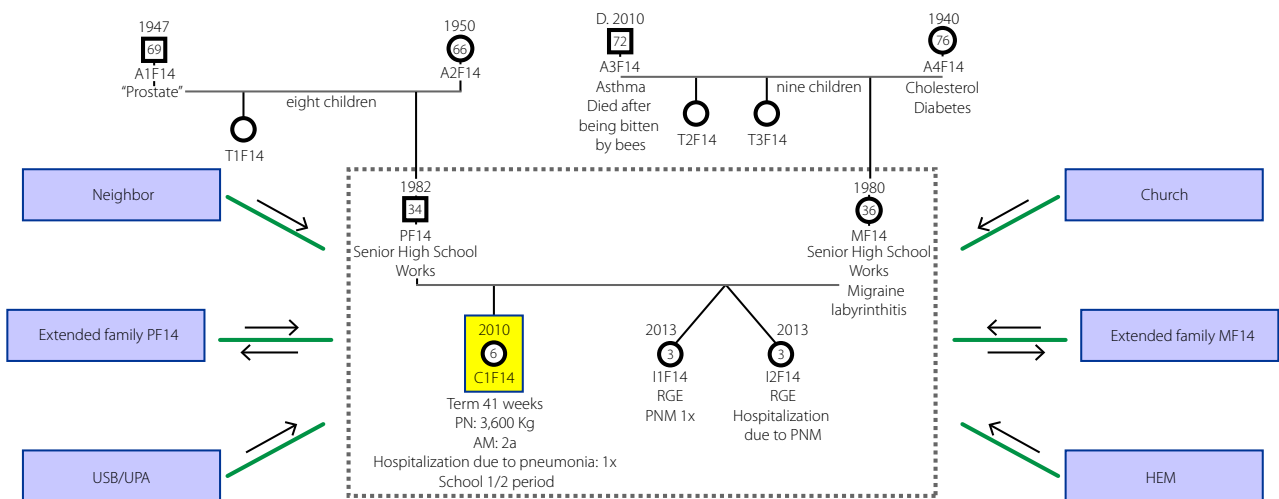
It is important to mention that this study is part of a master's thesis entitled: Pneumonia and Social Vulnerability: a look at the family<sup>(15)</sup>, whose research project was approved by the Committee of Ethics in Research with Certificate of Presentation for Ethical Appreciation (CAAE) 32621014.6.0000.5504. The ethical precepts of Resolution 466/12 that regulates the development of research involving human beings have been respected. All the participants have signed the Free and Informed Consent Term.

## ■ RESULTS

From the analysis of the interviews emerged the social supports used by the family of children with pneumonia, as well as the difficulties experienced in relation to the care network during this trajectory.

Following the MCAF, these supports are anchored by the Structural and Functional categories. The first describes the people who are part of the family, the bond between them, and the context in which they live. The second category refers to the activities performed by the family and its functional dynamics. In this sense, the data were organized into two categories and their respective subcategories: Potentialities of the Social Support and Difficulties regarding the care network.

Figure 1 exemplifies the genogram and ecomap of a participating family, chosen for presenting the various types of support portrayed in the results.



**Figure 1** – Ecomap and Family Genogram 14.  
Source: Authors.

## Potentialities of the Social Support

The child's illness due to pneumonia demands a family reorganization in order to meet the needs of the child at different times. The family relationships are rebuilt to share the child care and for the coping with the disease. Thus, the nuclear and extended family presents itself as support, as well as it establishes relationships with members of the community.

The family understands the social support in terms of the relationships it builds in trying to understand what is happening, and also to share the care of the child and during the experience in the face of illness. In this sense, the support comes from "Family interaction", "Relationship with the community" and "Strengthening through spirituality", subcategories that express the family experience.

### Family interaction

The illness of the child due to pneumonia has its consequences mitigated by the support received, which is referred to by relatives as support that helps to overcome the obstacles. The family support proved to be the basis for the ease of care of the child with pneumonia; the nuclear and extended family is restructured for care by mobilizing and seeking support mechanisms and placing themselves as support for problem solving.

The family itself integrates the support relationship to face the process of illness. Initially, the support comes from people who are closer to the child's family, from the family members present in the daily life, and then from those who are less present. The maternal grandmother was mentioned by the families as the main source of support. She was identified as a source of safety and hope for the child's improvement, in addition to participating in the moment of recognition of the disease, care guidelines, providing love that comforts in the difficult situation.

*When she was hospitalized, her sister stayed here at my mother's house, and I stayed every day [at the hospital][...] but I did not want to come home. My mother would just go for me to take a shower (MF1).*

*My mother helps, when [referring to the hospitalization period] it is necessary to stay with the kids (MF7).*

*My mother spent two days with him during the day [referring to the period of hospitalization] (MF9).*

There was a sense of gratitude in the family for the people who offer and become support in the moment of

caring for the child. The family values all types of support received and praises the one that provides comfort in difficult times.

*When CIF2 was hospitalized [referring to pneumonia], one night I stayed, and the other night he stayed (FF2). [...] And my grandmother would take care of everything here at home. (MF2).*

*There was a period when she was hospitalized [referring to pneumonia], I was sick, and it was my sister who stayed with her, and her grandmother from her father (MF5).*

*A more expensive drug or my sister helps, because she is her godmother, or my mother helps. It is always them, you know? Or also my aunts and her father (MF5).*

*My grandmother was going to work in my place, because there was no one to go [...] [referring to the period of hospitalization] (MF8).*

*Actually, I was always there [in the hospital], and a sister of mine, it was a time when she came out here, but it helped a lot, she helped me take care of CF14 (MF14).*

### Relationship with the community

The care provision to the child with pneumonia brings feelings of fear and insecurity to the family, which are softened by the narrowing of the bonds established by the family's interaction with the people around them. There was a movement of support from people not so close.

Some people who, in some way, live with the family, who observe the difficulties that exist in the process of caring for the child with pneumonia, show solidarity and understand the need to offer support. In this sense, neighbors were also considered an important source of support for children and families in a mobilization to provide emotional and structural support.

*This neighbor from the front has already helped me a lot. [...] especially when they were sick [referring to pneumonia], and he was working out [...] Since I live here, she helps me in what I need. She helped me look after, take care (MF14).*

*My granddaughter really got worse. [...] high fever [...] Then I ran into the neighbor, she said: For God's sake, give him a shower, he's really fainted. [...] run and put water in the tub, while I call the mother [...] then we took him, I had already showered him, I saw that he was going to die, I had never*

*seen a person like that [before the hospitalization for pneumonia](GF8).*

### **Strengthening through spirituality**

It refers to the support perceived by the family in something bigger, that is in control and can help in overcoming the difficulties. Spirituality can be an important support for coping with suffering in the process of having a family member ill, providing comfort and support, rescuing hope. Here they are presented in the form of spirituality and religiosity, some beliefs have emerged still in the form of rituals, which are transmitted from generation to generation, and it acts as an aid to a larger force to intervene on behalf of the child.

*Religion helps me because I have faith, I have faith that God can do everything, He is the doctor of the doctors, then, in an illness, it's obvious that I'm going to look for medicine, of course [...] but I believe that God can enter with the supernatural and heal, because I have already [...] I know people for whom God has already done this. My son, he does not have anything else. He was doing treatment with the pulmonologist, he had asthmatic bronchitis, had that, had this [...] and with a simple prayer he was healed [...] he is healed [...] he has nothing and not even the doctor understood why (MF4).*

*When sick, ask God to care for them, bless them [...] and he has heard us, you see? God has heard us a lot [...] if they do not get better, we keep asking (MF14).*

*I made (a spell) for bronchitis that my aunt taught me [...] this was with a nail, you nail the nail on the wall and as the child grows, the bronchitis fades away [...] I have made it (MF8).*

### **Difficulties related to the care network**

The access to health care by public health services was an obstacle to the family's experience, as well as the relationship with professionals. There were several situations in which the family referred to the lack of support from the health services, among them: difficulty accessing public services, prolonged waiting, difficulty in scheduling appointments, low resolubility, lack of specialized medical care, lack of commitment of the workers of the different services, difficulty related to transportation and inefficient welcoming in relation to the need of these families.

In order meet the lack of support from a health facility, the family accesses other means in order to seek improve-

ment of the clinical condition of the child, being they private medical services and/or health institutions of greater complexity. The "Lack of Structural Support from the Service", the "Lack of Commitment of Professionals" and "Difficulties related to public transportation", were the obstacles most reported by the families in the attempt to receive care, expressing the subcategories.

### **Lack of Structural Support from the Service**

The health services presented structural disorganization of the work regarding the registration of the families of the territory, lack of adequacy of the consultation schedule in response to the population demand, lack of medication, as well as difficulties in meeting the needs of the assisted families. The lack of support from the referral service linked to the low resolution and lack of bond with the professionals led to the discredit of the care provided and the search for specialized services.

*It is very precarious here [...] there is never vacancy, because it is not a hospital, it is a family health unit [...] you have to schedule with the nurse and then see the doctor. [...] you hardly ever get it, they say that there is no vacancy [...] but the first place I go is the hospital, in the family health unit, it does not help (TF5).*

*When there are health problems, I go to the hospital [...] When I step into the emergency unit, they send me there [...] the most they do is offer medication to lower the fever and send us there [...] I just go to the hospital, straight away, I already go to see the pediatrician (MF4).*

*They do not even make the home visits [...] They do not even make the little card, they were supposed to come see the address where my sister is living, It has been a year since my sister moved, So we went there (FHU) for them to come here at home, in the address, the little card, they didn't even come, because you need the card to schedule the appointment (AF5).*

*I went there (FHU), and I asked them to make a card, then they gave me a card., but there was no vacancy for consultation [...] the doctor, in fact, was not yet seeing anyone (MF5).*

*There is never drugs in the unit, then we always buy it [...] (MF5).*

*[...] sometimes, in her case, the medicine that there is in the unit does not solve it, so we have to buy it (AF5).*



### **Lack of Commitment of Professionals**

The sickness of the child weakens the family that needs more than anything that the situation of the child is assessed and referred to a resolution, with professionals who show real concern about the child's health problem. However, the health professional's posture does not meet the needs of the family, in addition, in certain situations, they present attitudes that disqualify and discredit the caregiver, causing a revolt and delaying the resolution of the child's illness.

*When it was pneumonia and I took her there (CIF14) she had abdominal pain and the doctor said she was hungry. I was very angry with her, she told me to give her food. She was in a lot of pain, I took all three, the three of them were bad... she [doctor] said no, it was the cough, she gave her a cough medicine (MF14).*

*At the hospital, it was the second time I went there. [referring to the period of pneumonia] [...] the doctor said that CIF14 was not being serious, I started crying in there [...] so if I get there today to be attended and it is with him, I do not want it (MF14).*

### **Difficulties related to public transportation**

In the search for solving their conditions, the families seek health services outside their area of reference, which requires the use of public transportation, which is not always accessible for financial reasons, due to the distance, or in relation to the frequency of the transport times.

*The hospital is far away, inconveniently located, it is not possible [...] you need to go by bus to the bus station and then walk the rest of the way [2.3 Km = 29 minute walk], CIF6 walks, she walks well, she does not complain about walking, sometimes I take her a little on my lap to distract, disguise the fatigue, then we keep walking from the bus station to there (MF6).*

*We have to go by bus or ask someone to take us, it is far [...] to go to the hospital, it is difficult [...] (PF7).*

*Well, the emergency care unit is very far, I had to get out of here at three or four o'clock in the morning because he had a fever, and because there was not an ambulance, they asked: "Oh, isn't there a neighbor who can bring you?" [...] Then I go alone, about 7 blocks up, I go on foot, I think it is far, because I go with him on my lap. I find the Hospital easier, because every time I need to go there, I always have an ambulance (MF9).*

## **DISCUSSION**

The family is a system in constant motion. Situations such as the disease here exemplified by the pneumonia of a child, a member of this family, promote imbalance, to which the family responds, seeking to being able to reorganize and balance again. On these occasions, relations with different types of support intensify.

The family articulates to meet the needs of the child. Initially, it seeks those who are closer, in its internal and extensive structure. The apprehension of the family composition and organization was based on the genogram that allows us to approach the family structure, dynamics and family relationships<sup>(12)</sup>.

Caring, considered a feminine role due to gender relations and the different responsibilities related to socially constituted inequalities<sup>(16)</sup>, is assumed by the family, and the support received in this regard is generally offered by close female figures, such as the grandmother, who takes care of the sick child as well as of the others who stay at home, besides collaborating in some financial needs. Similar to these results, another study reveals that the extended family exerts inter-family support, which manifests itself through relations of trust and emotional support, as well as instrumental support, exerting a basis role in moments of crisis<sup>(7)</sup>.

The family produces indispensable and specific health care, which unfold through affective interactions, necessary for the full development of the child. This study reveals that in the search for the child's health, the family finds informal support necessary to cope with the troubled time.

In the illness, the support to the family occurs in its different dimensions: emotional, affective, instrumental, informational and positive interaction. In this way, the support comes from several people, with whom the family has some bond, such as: family, neighbors, friends and health professionals who interact by adding forces, with the purpose of helping the family in this moment of stress<sup>(8)</sup>.

The acute illness is for the family a moment of crisis, in which suffering affects the different members, indicating the need for family assessment<sup>(12)</sup>. For the MCAF, the look at the extended family beyond the structure, seeking to understand relationships and bonds, allows a broad assessment of the quality and quantity of available support, resulting in a deeper assessment, seeing the multiple perceptions of the relations and, as a consequence, the multiple views of support<sup>(12)</sup>.

The results of this study corroborate the literature when they demonstrate the important support role of the ex-

tended family in times of crisis due to the disease, helping both in the direct child care and in the financial support. The extra-family support, represented here by neighbors, is also triggered.

In the search for emotional support and confidence in something greater, the family relies on faith/spirituality, which helps in the acceptance, adaptation and consolation of the family in relation to the disease. Authors point out that through faith/spirituality, less painful forms of coping and consolation are sought. In addition, family members who have faith feel more secure and able to experience this situation<sup>(8)</sup>. Studies elucidate the importance of spirituality in the lives of relatives of children who are sick and/or hospitalized, pointing to faith and hope as support in relieving the pain and suffering caused by illness in everyday life<sup>(17)</sup>, results that are also evidenced in this study.

As for the support of larger systems, it is in health institutions that the family seeks resolution. For Wright, this search is in the relationship with several institutions and members outside the family, who have a significant relationship, allowing a positive interaction or not<sup>(12)</sup>, it is in this way that, in spite of the hierarchical organization of these units, families end up looking for the different levels of care at random, almost always seeking the specialist in the intention of solving their problems, which reflects a behavior based on the biomedical model, in contrast to the health care model<sup>(18)</sup>.

More often, the Primary Health Care is attended by the family in order to follow-up the growth and search for preventive actions, such as vaccination; however, they do not always show resolution when the child becomes ill. This frail relationship with the health services is pointed out by the family as disrespect and professional disbelief<sup>(9)</sup>.

Researches point out that the articulation of the Health Care Networks is compromised by the lack of communication, associated with the lack of knowledge about the functioning of the services, which are also observed in this study. The efficacy of the referral and counter-referral process related to effective multiprofessional care, especially at hospital discharge, providing integrated, humanized care for the continuity of health care should be carried out. The comprehensive care of the user requires professionals who are involved, motivated, with systematized actions and in a multiprofessional team, being necessary to carry out referral and counter-referral processes in order to improve the service provided to users<sup>(19)</sup>.

The referral movement from basic units to those of greater complexity is highlighted by some families; however, others report feeling lost at the time of the child's illness, "sent from one side to another" and end up looking

initially for the units of greater complexity, as situations tend to repeat. The pediatrician is seen as the only professional who can solve moments of acute crisis, and its absence in the emergency care units, or even their lack of readiness in the basic units, leads to the search of this professional in units of greater complexity, which constitutes a routine behavior.

A study reveals that the difficulty of access to appointments, waiting times, the shortage of professionals, the difficulty of identifying them, and their unfriendly and disrespectful approach are aspects pointed out by the family as barriers to bonding<sup>(20)</sup>, difficulties that are present in the speeches of the families of this research. Another point mentioned in the literature and which corroborates the findings of this study is the geographical question between the health service and the home, which makes access difficult<sup>(20)</sup>. This difficulty of access goes through the referral and professional embracement, directing also to the public transportation pointed out as an obstacle by the families researched in the search for services beyond the attached territory.

The relationships established with the health system, although problematic and fragmented, are identified as a source of support for the child's care<sup>(20)</sup>. Understanding what happens to the child during their illness empowers the family to perform the daily care. However, for family and children to build this knowledge, health professionals should be available to dialogue, listen and support<sup>(10)</sup>.

For the authors, the family reorganization demanded by the child's illness due to pneumonia demonstrated the strong participation of the extended family, mainly the grandmothers, followed by the neighbors. This family support is sought more immediately, due to its proximity to the nuclear family. The health services, in turn, were listed as intricate, elucidated mainly by the lack of bond with the reference units and by the lack of communication between the care levels, providing poor care at the time of diagnosis.

## ■ FINAL CONSIDERATIONS

The objective of this study was reached, as it is believed that it has revealed the composition and functioning of the Social Support by the family of children with pneumonia. It was possible to apprehend the family as a system in constant movement, seeking a balance in a situation of adversity. When facing the unexpected illness of the child, the support of family, friends, formal and informal institutions constitute a network of relationships that support the family to meet their care demands.

The support network formed in the established interactions contributes to the decision making of the family in its choices and decisions. The search for care at the levels of greater complexity for a resolution in the treatment of their child appears in the families involved, since the support received in the care path traveled does not constitute a network, evidencing the failure of the intersectoral communication.

The fragmentation of the support network makes it difficult for the family to seek support to meet the child's health needs. The family needs an articulated network that strengthens and sustains the care provided to the child. However, it is observed that, although public health policies are guiding in the sense of strengthening the family, they feel that their needs are not met and, in the absence of resolubility of the primary health care, they look for higher levels of complexity, which also fragments the support provision for the family. In this sense, the study evidenced the deficiency in the referral and counter-referral process, demonstrating difficulty in bonding with the service, and generating dissatisfaction regarding the care offered.

On the other hand, the health professional as part of this system, needs to understand the family reality, and the support demanded by it, which may allow them to offer comprehensive and assertive care. The Calgary Family Assessment Model enables nursing professionals to take a closer look at the structure, development, and functionality of the family. These dimensions make it possible to carry out a detailed family diagnosis in order to organize the care provision and provide support that meets family needs. The purpose of knowing how support is provided to the family of the child with pneumonia through the Calgary family assessment model allowed a broad look at the near and distant, formal and informal networks of these families, seeking to understand the relationships between the various members of the support network, especially of the health service, its different equipment and its relations with the family. In this context, the Calgary Family Assessment Model is an instrument of care that can be used in the practice of nursing professionals in order to contribute to the development of skills to carry out the family approach.

Regarding the limits, this study reflects the support of families from regions of greater social vulnerability, and of children with pneumonia who were hospitalized in a hospital of small complexity, not being extended to other realities. Therefore, it is suggested that other studies with families of children with acute respiratory disease are carried out, encompassing care in basic care with a focus on the family/health professionals interaction to address these pathologies that are so prevalent in the childhood.

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