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FAMILY´S SOCIAL SUPPORT NETWORK AND THE PROMOTION OF CHILD DEVELOPMENT
REDE DE APOIO SOCIAL FAMILIAR E A PROMOÇÃO DO DESENVOLVIMENTO INFANTIL
RED DE APOYO SOCIAL FAMILIAR Y LA PROMOCIÓN DEL DESARROLLO INFANTIL

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The aim of this study was to describe the family perception about bonds, network and social support in terms of care and promotion of child development of children smaller than five years old. Seven families in social vulnerability, linked to the health system of Distrito Federal, Brazil, were interviewed. It is a qualitative descriptive study, structured on the Systemic Social Network Theory. Narrative analysis occurred by using the qualitative thematic content analysis. The results were categorized into two themes: "family social network" and "bonds and social support: family perception". The social network used is minimal, with density of relations between mother, child and grandmother, under the financial support from the father. There is proximity of housing to the health service, but cultural dissonance in relations with its employees. Health professionals need to integrate in their caring practice the micro social and the macro social context of families as determinants of health and child developmental conditions.
Descriptors: Family; Child development; Social support; Social vulnerability.

Este estudo teve por objetivo descrever a percepção da família sobre os vínculos, a rede e o apoio social para cuidado e promoção do desenvolvimento da criança menor de cinco anos de idade. Para tanto, entrevistou-se sete famílias em vulnerabilidade social vinculadas ao sistema de saúde do Distrito Federal. Trata-se de estudo qualitativo, descritivo, sob o referencial da teoria de Rede Social Sistêmica. A análise das narrativas deu-se pelo método qualitativo de análise de conteúdo temática. Os resultados foram categorizados sob dois temas: "rede social familiar" e "vínculos e apoio social: percepção da família". A rede social utilizada é mínima, centrada na densidade das relações entre mãe, criança e avó, sob o sustento financeiro do pai. Há proximidade da moradia ao serviço de saúde, porém dissonâncias culturais nas relações com seus profissionais. Os profissionais de saúde precisam integrar em suas práticas o contexto microssocial e macrossocial das famílias enquanto determinantes das condições de saúde e de desenvolvimento infantil.
Descritores: Família; Desenvolvimento infantil; Apoio social; Vulnerabilidade social.

El objetivo de este estudio fue describir la percepción de la familia acerca de los vínculos, la red y el apoyo social para la atención y promoción del desarrollo de los niños menores de cinco años de edad. Siete familias que hacían parte del sistema de salud del Distrito Federal, Brasil, fueron entrevistadas. Esta es una investigación cualitativa, descriptiva, utilizando el referencial de la Teoría de Red Social Sistémica. Las narraciones fueron analizadas por el método cualitativo de análisis de contenido temático. Los resultados se agruparon en dos temas: "red social de la familia" y "lazos y apoyo social: la percepción de la familia". La red social utilizada es mínima, centrándose en la densidad de las relaciones entre la madre, el niño y su abuela, con apoyo financiero del padre. Hay proximidad de las viviendas a los servicios de salud, pero con disonancia cultural en las relaciones con sus profesionales. Los profesionales de salud deben integrar en su práctica de cuidado el contexto micro y macro social de la familia como determinantes de la salud y el desarrollo infantil.
Descriptores: Familia; Desarrollo infantil; Apoyo social; Vulnerabilidad social.

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INTRODUCTION

The family, a primary social environment of the child, is the main source of stimulus for their development[1], being the interactions influential of the same[2]. In this context, the bond[2] and the transmission of affection[1] between the child and their caregiver is considered a protective factor, while the family structure loss, a risk factor[2].

The family unit, in front of the child's care demands and to supply them, mobilizes resources and strategies[1], among which is the social network. This is understood as the "set of beings with whom interacts in a regular way, with whom talk, with whom exchange signals, which materialize, that make people real"[3]. And, in this sense, the personal social network is the "sum of all the relationships that an individual perceives as significant or define as distinguished from the anonymous mass of the society"[2-4]. It can contribute to the well-being and coping and adaptation processes[3].

From the understanding that family care practices inscribe in a network frame of social relations[3], healthcare professionals should consider it in their therapeutic projects[4,5]. The promotion and stimulus of child development, direct health practices[2] and have a close articulation with the professional support of the family in the identification, access and use of their social network. These aspects need special attention in contexts of social vulnerability, where is common female-headed households and due, largely, to early and unwanted pregnancies, family instability and abandonment[6].

Thus, it is important to broaden the understanding of the articulation between the social network and family care to children in vulnerable social contexts, i.e. where experiences social exclusion affecting the rights[7]. The relationships established, either with friends, more distant family, community, or those with social facilities, such as health services, plays a fundamental role in the child development[8] with recommendations to apprehend them and mobilize them focusing on attention to child health[9].

The present study has as its object, the childcare in the context of social vulnerability under the question "how families in a socially vulnerable situation, articulate the social network in the care of their children?" The objective was to describe the family's perception about the bonds, the network, and the social support for care and promotion of child development less than five years old.

METHOD

It is a study of qualitative approach, by proposing an exploration that valued the phenomenon as it is experienced, to understanding the meanings and interpretations of the same regarding their meanings[10].

Seven families in a context of social vulnerability, containing children less than five years of age in their unity, were part of the study. Other adopted criteria were: both fathers older than 18 years of age and the child at childcare follow-up in service of Primary Health Care (PHC) belonging to the Paranoá Regional Health. As exclusion criteria, the inability of the family member to generate comprehensible narrative was adopted. Thus, seven mothers, two fathers, and a grandmother participated in the interview.

The Paranoá Regional Health covers the East surrounding of Brasilia, Federal District and integrates three cities: Paranoá, Itapuã, and São Sebastião. Such region has significant social vulnerability index, the majority of the population has low-income, not completed primary school or are illiterate[11]. Concerning the child population, children minority (4.9%) has a nursery or kindergarten (one in the region), so when parents need to be absent, about 41% of them stay at home under the care of relatives, friends, acquaintances or alone[11].

The access to families was via health units of PHC, at the waiting time for the childcare consultation. At the first contact, the information about the survey were provided and made the invitation to participate in it. With the interest in the participation, it was

scheduled a day, time and location of choice. All interviews were performed in a private place in the health unit, respecting the family's choice.

All ethical recommendations in the research involving human beings were followed. The research started after the approval by the Ethics Research Committee of the State Secretary of the Federal District - FEPECS/SES/DF, under protocol number 153 841, and the participation of the subjects was officialized by reading and signing the Informed Consent Form (ICF).

The data collection was performed in 2014, using the interview strategy, developed in two stages. At first, there was the construction of the genogram and Minimum Relations Map (MMR)[3]. A genogram is a tool used to evaluate the internal structure of the family[12], while the MMR maps the social network through the exploration of social relationships: friendship; family; labor and study relations; and community relations: health system and social agencies. In this exploration, the MMR adopts three proximity degrees: relations with greater commitment degree, intermediate committed relationships, and casual relationships[3]. These, in turn, are categorized as the following structural characteristics: size, density, composition, dispersion, homogeneity/heterogeneity and network functions[3].

After the first stage, the interview was developed from the questions: “looking at your genogram who you consider that more contribute to the care and development of your child?; How they contribute?”; “Among the resources that you identified, which one you consider that more help in caring for the child?” Why?; “Do you miss some service or resource to care and promote the healthy development of your child?”. Aspects such difficulties and facilities, presence or absence of resources and feelings about the care and development of children were explored throughout the interview.

All interviews were audio-recorded, transcribed in full and subsequently analyzed from steps advocated by content qualitative analysis method[10], by the Systemic Social Network Model[3].

The conduction of the analysis involves the following systematic steps: data codification; data categorization and integration into thematic nuclei[10]. There were reading and rereading of interviews with the identification of family conceptions about the bonds and social support and its influence in the care and promotion of children's healthy development. Such elements were analyzed and integrated considering: the structural characteristics of the family and its social network and the relations established by the family with the social support systems.

RESULTS

Families demonstrated as characteristics of its internal structure: nuclear formation, the composition of young adults with maternal age between 18-39 years and paternal between 18-37 years and low education, ranging from incomplete elementary school to incomplete high school. In three families cohabited in the same residence, members of the extended family: maternal grandparents, maternal uncle and daughter-in-law. Except a family that had a teenage son, the others were in the stage of young children with children of one month and 10 days to four years old. Mothers were the primary caretakers of children, so that only one of them was a member of the labor market.

The results were categorized into two themes: “family social network” and “bonds and social support: family perception.”

- Family social network

Figure 1 shows the MMR revealed by the study.

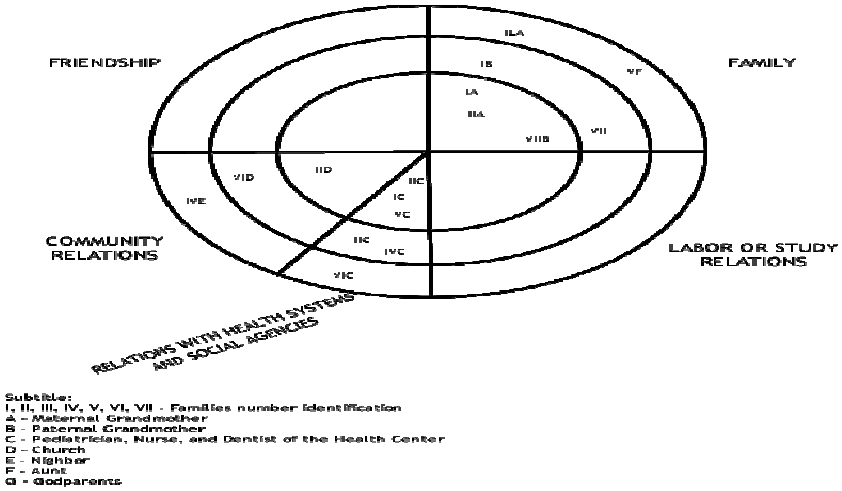
As for size, data concerning the number of persons or social institutions that composes the network, it identifies the predominance of a minimum or small network, ranging from four to 10 people or social institutions identified as significant for the child's care.

Regarding the density, i.e., the degree of connection between the members and the effectiveness of the network, it was observed that when analyzing the network as a whole, identifies a low density, while, at focusing the family subsystems, identifies a higher density

in the mother-child relationship, in the mother-grandmother relationship and grandmother-grandson relationship.

In the composition or distribution of the people who composes the network, a centrality in the family is observed, represented by direct relatives with whom the child has a daily relationship (mother, father, siblings and grandparents) and members of the extended family who have a constant relationship, but with lower proximity and commitment degree with the child (uncles, aunts and godparents).

Figure 1: Minimum Relations Map (MMR) demonstration of the Family's Social Support Network for the care and promotion of child development in the first five years of the life of the families interviewed in the study, Distrito Federal, 2014.



In the area of community relations there is an emphasis on health systems (primary care professionals) and to a lesser extent, religious entities, neighbors, and friends, in contrast to the absence of relationships identified as significant with education systems (nursery or kindergarten), agencies or social organizations.

In the study and labor relationships, the failure to recognize significant people who work directly to support the health and child development promotion is evident. However, resources from work allow the father to play the role of financially support the family.

Concerning the scattering of important people composing the network, the geographical distance was indicated as a barrier. It stands out-migration and the limitation of financial resources as enhancer's events of distance and the fragmentation of the family network. Thus, people who have a closer relationship are those who live nearby. The proximity between the health service and the place of residence of the family was seen as the primary facilitator factor of access and bond to monitor the growth and development of children.

The social network outlined by the family has the demographic and socio-cultural homogeneity as predominant characteristic: the low education of parents and important members caring for the child; low income; the multiplicity of children between the network components and the effective composition of young adults with a small representation of older or elderly people. Health professionals, as a subgroup with different social and cultural characteristics, intersect the family network, making it heterogeneous, and act as intermediaries of social practices aimed to childcare early in life.

Among the main functions of the family network, the highlights are: emotional support, spiritual support; cognitive guide; social regulation and material and services aid. The emotional and instrumental supports for childcare are common functions of the family network. The social regulation and

cognitive function guide are effective about health professionals. People linked to religious entities also have the function of cognitive guides, transmitting spiritual support and beliefs that shape certain behaviors, educational practices, and health care. The health system, represented by the professionals working in the PHC, has a principal function the material and services aid, such as growth and development consultations; vaccination; the dental appointments, and in the child's illness situation: emergency care and access to examinations, medicines, and treatments.

- Bonds and social support: family perception

Childcare early in life alters the dynamics, diversity and scope of the family social network. Social support and the family strengthening are understood as a result of the relations established in four dimensions, from which the subject is presented: family relationships; labor relationships; community relations and relations with health services.

* Family relationships

Set of bonds established between individuals that compose the child's immediate family nucleus and among these, the wider family network or extended family.

The small child is conceived as vulnerable and dependent, which determines to be the attention family focus. This, in turn, is meant as the first and main relational space and health favoring and child development. In this context, the mother has the function to supply the child's needs, through its constant presence; feeding; the daily hygiene and comfort; the stimulus provided through dialogue, contact and games; and management of health complications.

Childcare as a principal function of the maternal bond relies on socially constructed concepts to be careful to female responsibility and the power of breastfeeding being practiced exclusively by the mother. These attributes restrict the childcare division with others.

The mother is the principal bond and social support for the child to grow and develop healthily. This is how the family defines the maternal function and, in turn, is how the mother describes its role and predominant roles within the family. Based on this, the other members of the family assume an intermediate or peripheral position in the network of care and promotion of child development, with less frequent contacts, lower intensity of relationships and bonds and less commitment to children's well-being. In this relational context are the present father, grandparents, and godparents as crucial people in children's lives and who exercise direct or indirect influence on its development.

The father has the predominant role in providing the economic sustenance. The work reduces their time of interaction with the child, however, when they are present, assumes, with varied degree of commitment, the responsibility, sharing the care demands with the woman. The way the father assumes his role about the children and the woman depends on their values and skills to organize the activities of daily life to find time and emotional availability to interact with the child, as pointed out in the speeches:

I do not usually let him (son) to anyone, neither with my mother, because he (son) is very young, breast chest yet, but when my husband is at home he is helping me, to care, to exchange, this kind of thing (mother, family 6)

The mother takes care of him (grandson), sure, she's the mother, she has to take care of... mee too, second right, mother (maternal grandmother, family, 3)

I talk, I encourage him (son)... the godmother also, my friend sees him often because lives nearby, my sister a couple of times a month because she lives far away... they come, play with him, help to care, give a lot of gifts... my mother in law too. (mother, family 7)

Grandmothers, maternal and paternal, are the main sources of support. However they are accessed in moments, identified by the mother, as of dire need. They are seen as important people for the child; however, the contact and support are conditioned to the urgency of the situation, the availability, and geographical proximity.

The dependence on informal support for childcare is questioned by the mother, as it evaluates that the conditions and resources of the women who composes the network (aunts, grandmothers, godmothers, friends, neighbors) are sometimes extremely scarce. Such finding prevents the aid request in the extended family and the pursuit of formal

alternatives such as nursery and kindergarten, which are presented as possibilities. However, the lack of confidence in the quality of care offered in these environments and difficult access challenges on this path and in the attempt to expand the support network, as noted in the following description:

My mother helps, but it's very rare, very difficult, if she really needs (daughter) stays with my mother, but only when is not possible to take her (daughter) together, because it is very difficult, because she (grandmother) doesn't live near me, she doesn't' live here in Paranoá (mother, family 2)

Childcare is a social process, built and rebuilt according to the needs identified by the mother. It demands mother's skills that underlie the cognitive, emotional and instrumental fields, as well as material and financial resources. Among the main difficulties perceived by mothers are: the fear of bathing in the early days of life; the management of colic; the absence of nocturnal rest; overload with household activities; surveillance and prevention of accidents, disease management, and financial issues for care. In this context, feelings of loneliness and despair are reported by the mother, and insecurity in decision making about the best way to care for the child, as in the speeches:

Only my mother bathes her because I don't do it. I'm afraid. Then my mother comes home to bathe her... but the most difficult is that she has a lot of colic's and then I'm desperate thinking about what I'll do... she has a lot of colic's and doesn't sleep at night and.. I stay awake alone to look after her (mother, family 1)

The hardest... is the care that must have all the time to keep from falling, do not hurt, and when she is sick... (mother, family 4)

It is so hard, we pay rent, and he (son) can't breastfeed, so we have to buy milk, and milk is expensive (mother, family 7)

* Work relations

Labor relations involve bonding with individuals and institutions capable of generating formal or informal support for family care and provide the child's development. The importance of the bond with work, for these families, focuses on this as a means of acquiring the resources for basic needs of housing, comfort, clothing, adequate feeding, and transportation. People of working relationships are not identified as members of the family social network.

In the context of work, the main change occurs in the bond of the woman. By becoming a mother and assume the responsibility for childcare, women in this study have decided to break their ties with the work to devote themselves fully to childcare. However, the woman begins to live a conflict between her maternal duties and the financial need of the family. Although the child benefits with their presence, financial resources become scarcer and may cause difficulties.

The man, father, in turn, assumes the responsibility for the family's financial support and strengthens their bond with the job. When needs exceed the resources, the woman feels the obligation to assist financially, when resorts to informal work. Also is viewed as an alternative, to share the support function with the child's godparents.

The woman plans to return to work and study, knowing the importance of this support for health and ensuring better living conditions for the child. The goal for a return to work is guided: in the age of the child weaning; at the age that the child is less vulnerable to disease and greater independence and continuity of care security. However, the lack of community resources, financial conditions and formal or informal support for care of small children, makes women give up the continuity of the work or their study prospects, definitely breaking the bond and perpetuating a low educational status and income in the family, as stated in the speeches:

I left my service right, because there was nobody to look after him, so I miss my job, but I left because I need to care him (son),... now only my husband is working (mother, family 4)

To improve the care I have to work too. ... When she turns six months, I'll work, right? (mother, family 1)

* Community Relations

Encompasses the set of interactions and bonds that are established by the family in the community with people and social institutions. The community has a structuring role in family relationships and the child development process. It has the potential to provide new dimensions of interaction and broaden the relational space of the family, depending on the history, of the time and how

the family interacts and integrates to their community.

Community relations as well as bonds and social support, articulated in this context, focus on those established with health services and with the church. Relations with neighbors and friends are restricted, and those who act as support are rare.

Relations with the educational systems are inexistent. The family attributed this to the lack of access (non-existence of a vacancy) and the lack of trust in institutions in the community. As regards the private sector, the financial condition is impeding the access.

Leisure activities are restricted to the residence and visiting relatives who live nearby. It turns out that with the difficulty of the family find useful features in their social environment, seen in the following speeches:

We (parents and children) usually go to church, three days a week, and to my mother's house, just... (mother, family 6)

The nursery right... lack of... I'm trying to arrange a school for her, there is no vacancy... ... she is about five years old right... (mother, family 5)

The bond with health systems, although present and considered important, it is seen as tenuous. The difficulty of access to appointments, the waiting time, the shortage of professionals, the difficulty of identifying them and they are little welcoming and respectful approach, are aspects identified as barriers to bonding. On the other hand, geographical proximity between the health service and the residence facilitates the access and the welcoming approach of some professional favors the bond.

The dialogue between the professional and the family is identified as an important resource for strengthening the bond, being valued and perceived as a source of social support, those caring professionals that allow the family to expose their questions; that answer questions and teach child care, as pointed out:

I have no complaints, doctors are good, attentive, ask how is she... they help a lot... when she was one month, she lost weight, she was losing a lot of weight because I didn't know the correct breastfeeding, I thought she was nursing, and she was not sucking, then she got a kilo and a little, then they referred me to the hospital, where is only collected breast milk, there is a very good doctor who referred me, taught me the right manner, then she was taking weight, now she is normal, but without him (doctor) she was hospitalized. They took me to the milk bank, I was guided there, the doctor was very good, he called me at home to know how she was, with that concern that I had never seen a doctor, I was surprised (mother, family 2)

On the other hand, the professional is not seen as support when adopts a hierarchical and possessive posture: the opening absence for questions and listening unavailability; child medicalization without seeking to understand the problem; and neglect against the child and family situation. This approach makes the family remain in silent, facing the fear of being mistreated and shame due to this, keeping their doubts, concerns and needs. Professional neglect often takes the family to disengage finally from the public health service and look for alternatives in the private sector, even with limited financial resources. Especially in children's disease situations, families perceive themselves alone, as noted in the descriptions:

I did not like... I took him (son) to the doctor, and he gave remedy but did not touch him, he did not examine anything, asked what he had, I said, and then he wrote on a piece of paper and finished.. they do not give opening, only make their questions, they ask, you answer and sends you away (mother, family 5)

We cannot ask anything because she (professional) is rude with us, is very difficult because sometimes we have doubt, and we never ask... when he had pneumonia, I thought they (professionals) would help me more, but did not help, they only told me that he had nothing, and then I went to the private hospital, and they told me that he was at the beginning of pneumonia, then I had to turn me alone at home, buy medicine, I had to turn on myself, my husband and I (mother, family 4).

The relations established with the health system, although problematic and fragmented, have been identified as the main, sometimes only, community support for the care and promotion of children's healthy development. However, the quality and the kind of support found in this social system vary. When identified as a support source, the content focuses on information and explanations provided to acquire knowledge to take better care of the child, quoting the correct management of breastfeeding and infant feeding; the identification and treatment of intestinal infections; the management of fever; the offer of vaccination services, growth and development consulting

and odontology for children.

Growth and development appointments are identified as an important service for the certification of children's well-being. The children's well-being, often, reduces to the understanding of appropriate weight and height. These anthropometric indicators are parameters used by the family, and the healthcare professional to assess the quality of care offered to children in the residence, revealing a limited perception of child development.

DISCUSSION

The family social network influences on health, constitution and development of the child. The mapping of the social network and the perception of the family about the established bonds and supporting dimensions revealed areas of weakness and lack of basic resources for the enhancement of health actions in the interests of promoting child development.

There is the structural weakness of the social network regarding the small amount of people identified as a support source; the connection degree: high-level density between the mother-child and low among the other members of the network; the difficulty of access to people, services and social resources; and the predominant socio-cultural characteristics: low education, working conditions and income.

Small or minimal networks are less effective in excess demands or long-term stress situations and can generate overload[3]. Social networks change up throughout the life cycle[13] and from the normative events the transition to parenthood[13] the migration[3,14] and changes in labor relations, as when the mother leaves, can reduce the size of the network and the availability of social support, facts found in this study.

It is known that families with small children face multiple demands and daily challenges to reconcile financially and household tasks, and perform their basic functions of protection, feeding, comfort, and socialization[15]. The effects of transitions may be more significant when difficulties and instabilities are already present in family life due to their low socio-cultural conditions, financial deprivation and absence of resources to deal with additional stressors [6,16].

It is important to consider the family as the primary environment and parents as a social nucleus of child development promotion. To the extent that family instability influences the access to resources and their psycho-emotional well-being, this process affects the quality of care and consequently the children's well being[16]. It can be inferred that the absence of a support network sensible to the family's needs, at this stage of their life cycle, may potentiate the stressors, generate overload and compromise the variety and quality of bonds, of parental care, the interactional experiences and stimulus for the child's development.

Concerning cohesion, the high density leads to strict relationships, whereas a low-density level also reduces the effectiveness of the network by the absence of concern for others[3]. This finding indicates that family needs are partially neglected, which may imply a risk factor[3]. Data found in this study.

The dispersion or geographical distance between members of the social network affects the accessibility and the network sensitivity to the individual's variations need for support[3]. It can be affirmed that the socio-cultural characteristics, especially the limited financial resources, leverage the distance, restrict contacts and access, creating and maintaining a social network hosted to the region of families residence. The homogeneity of the network has advantages regarding the socio-cultural identification facility among individuals, but the ability to provide support is limited[12]. A heterogeneous network facilitates the activation and use of support systems, expanding the contents and opportunities for interactions, the experiences, and lerning[3].

Among the dimensions of support practiced by the family social network, identifies the instrumental support, financial or material support and health services support and cognitive support exercised both by close relatives of the child as by health professionals. There is a strong relationship

between the perceived instrumental support and accessed by the mother and child health[17]. Mothers who have financial support, availability for childcare and support in the home care, experiences greater social satisfaction and well-being, resulting in higher benefits for children health[17]. On the other hand, low maternal social support can contribute to the intergenerational transmission of risk and social difficulties[6,17]. The decrease in material needs increases the sense of personal control and reduces parental neglect[18].

There is the absence of resources for leisure activities and the bond with educational centers as important determinants of health and child development. Many children less than five years do not reach their potential of development, mainly because of poverty, nutritional deficiencies and inadequate stimulation and learning opportunities[19]. The quality of the early childhood environment and the ability to access and benefit from intervention programs are seen as closely protection mechanisms related to maternal education[19]. However, the availability of social facilities focused on education, proved to be incipient in number and the bond quality in the studied population.

The results validate elements of the social network of family support evidenced in previous studies, especially regarding the presence of two types of networks - networks of formal support, represented by the relations with professional and informal support networks, represented by personal relations established in family and community[5]. At the informal support network to extended family, especially grandparents and, with a lesser degree of commitment other female members, have an interest in the care and promotion of child development[5]. In the informal networks, cohesion and social control, when present in the community, generate greater social support, which is related to more effective parenting styles, especially concerning the quality of parent-child communication and surveillance[20].

CONCLUSION

The study provides an understanding about the structure and dynamics of the network and the family and social support in the care and promotion of child development in the context of social vulnerability. Such understanding allowed the identification of dimensions of social support and, consequently, areas of strength and weakness with implications in family functioning and therefore in the child development.

The health care professional should consider the micro-and macro-social context of families as determinants of the living conditions, health and child development. To this end, it is necessary to change the paradigms and care practices with: 1) the adoption of social networking concepts and social support; 2) incorporation of instruments exploring the social environment, such as the genogram and MMR; 3) the recognition of the impact of social networking on child development, particularly in situations of social vulnerability and migration; and 4) interventions focused on building effective networks, which enable families potentiating their resources and access the support they need. This expanded vision contributes to child development and has the potential to empower families in social vulnerability.

This study, exploring the social network on childcare, demonstrated the relevance of assigning the value to this element in child health care practices. It is emphasized that further research should seek to advance on issues related to social network and family child care, seeking understanding of how social networking can be addressed and explored in health care aimed at promoting child development.

Also, equipment linked to education, have proved as fragile in the studied scenario, without more dense exploration of the relation Health, Education and promotion of child development, a fact that needs to be explored in other studies. Years of maternal study have a direct correlation with environments for child development promotion and in this sense; relations with educational equipment proved as fragile in

the study and deserve further exploration.

Among the study limitations, it was obtained a transverse understanding of the dynamics of the family social network, from an interpretative qualitative methodological perspective limited to the context of a region of the Brazilian Midwest. Thus, they suggest further research in other methodological approaches and/or with populations of different Brazilian regions.

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CONTRIBUTIONS

Aline Oliveira Silveira was responsible for the study conception, elaborated the methodological delineation and contributed in the analysis, interpretation and discussion of the data and in the article writing. **Rafaella Costa Bernardes** contributed to the collection, analysis, discussion of the data and article writing. **Monika Wernet** and **Tatiana Barcelos Pontes** contributed to the writing and critical review of the article. **Aline Araújo de Oliveira Silva** collaborated in collecting and analyzing data.