

ORIGINAL ARTICLE

CHILD HEALTH BOOKLET: CARE COORDINATION AND ACCESS TO HEALTH CARE

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ABSTRACT

Objective: analyze factors associated with filling in child health booklets to promote care coordination and access to health care.

Method: quantitative study conducted between January and June 2016, in a city in the state of São Paulo. A total of 284 mothers were interviewed and the booklets of their children were examined; results with $p < 0.05$ were considered significant.

Results: low completion was identified for prenatal (5%), newborn data (40%), newborn screening (10%) and discharge (6%). Maternal education ($p=0.006$) was a factor associated with proper filling in of newborn data.

Conclusion: the booklets were not a source of data for continued newborn care in the city investigated. Care coordination is strengthened by continued post-birth care and keeping adequate records. Filling in this instrument, incorporated into the practices of health services and professionals at every point in the childcare network enhances healthcare access.


DESCRIPTORS: Children's Health; Personal Health Records; Health Promotion; Assessments in Health; Patient Care Continuity.


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CADERNETA DE SAÚDE DA CRIANÇA: COORDENAÇÃO DO CUIDADO E ACESSO À SAÚDE**RESUMO**

Objetivo: analisar fatores associados ao preenchimento da caderneta de saúde da criança para fomentar a coordenação do cuidado e acesso à saúde.

Método: estudo quantitativo, realizado entre janeiro e junho de 2016, em município paulista. Entrevistadas 284 mães e observadas as cadernetas de seus filhos; considerados significativos resultados com $p < 0,05$.

Resultados: identificou-se baixo preenchimento para pré-natal (5%), dados do recém-nascido (40%), exames de triagem neonatal (10%) e alta hospitalar (6%). Escolaridade materna ($p=0,006$) foi fator associado ao correto preenchimento de dados do recém-nascido.

Conclusão: a caderneta não tem sido fonte de dados para seguimento da atenção ao recém-nascido no município investigado. Favorecer continuidade da atenção após o nascimento e a execução de registros adequados potencializa a coordenação do cuidado. O preenchimento desse instrumento, incorporado às práticas dos serviços e dos profissionais de saúde em todos os pontos da rede de atenção à criança, traz contribuições ao acesso à saúde.

DESCRIPTORIOS: Saúde da Criança; Registros de Saúde Pessoal; Promoção da Saúde; Avaliação em Saúde; Continuidade da Assistência ao Paciente.

CUADERNO DE SALUD INFANTIL: COORDINACIÓN DEL CUIDADO Y ACCESO A LA SALUD**RESUMEN**

Objetivo: analizar factores asociados al hecho de completar el cuaderno de salud infantil para fomentar la coordinación del cuidado y el acceso a la salud.

Método: estudio cuantitativo que se realizó entre enero y junio de 2016, en municipio de São Paulo. Se entrevistaron 284 madres y se observaron los cuadernos de sus hijos; considerándose significativos resultados con $p < 0,05$.

Resultados: se identificó bajo índice de relleno para prenatal (5%), datos del recién nacido (40%), exámenes de selección neonatal (10%) y alta hospitalaria (6%). Escolaridad materna ($p=0,006$) fue factor asociado al hecho de completar correctamente los datos del recién nacido.

Conclusión: el cuaderno no viene siendo fuente de datos para la atención al recién nacido en el municipio investigado. Favorecer la continuidad de la atención tras el nacimiento y la realización de registros adecuados potencializa la coordinación del cuidado. Completar el cuaderno de salud infantil, además de las prácticas de los servicios y de los profesionales de salud en todos los puntos de la red de atención al niño trae contribuciones importantes al acceso a la salud.

DESCRIPTORES: Salud del Niño; Registros de Salud Personal; Promoción de Salud; Evaluación en Salud; Continuidad de la Asistencia al Paciente.

INTRODUCTION

The scope of the National Integral Child Healthcare Policy, enacted in 2015, is to protect the health of children, through the adoption of integral care, especially in early childhood in coordinated networks that cover prenatal to follow-up in primary care⁽¹⁾.

To ensure continuity of care between different healthcare points, this policy recommends the qualified discharge of newborns from maternity wards to first contact in the primary care network, through proper completion and delivery of the Child Health Booklet (CHB), which will serve as a road map and passport for continuity of their health care⁽²⁻⁴⁾.

The CHB was implemented as a free means of viewing and overseeing a child's growth and development. It contains records of the most significant events of the child's health from prenatal to pediatric follow-up and constitutes an important vehicle of communication between families and health professionals. In addition, it belongs to the family, which enables its use among various healthcare services and helps coordinate care of the child⁽³⁻⁵⁾.

Care coordination – an attribute of primary health care – is a way to integrate and provide continuity of care received by different professionals and services. It is useful for providing access to information, accountability for the care given and the history of an individual's trajectory in health services. It assumes that proper care is offered at the other points of the care network, in addition to incorporating part of the concepts of access and comprehensiveness⁽⁶⁾ with integration between the primary care network and specialized services, in order to respond to people's health needs⁽⁷⁾.

The Starfield Theoretical Framework⁽⁸⁾ was adopted, which claims that the existence of a communication mechanism among health professionals is essential for care coordination. To fulfill its purpose, the CHB must be filled out by all health professionals. To ensure effective monitoring of children's health is a challenge in practice, since it requires correct and complete filling out of the data to make the CHB an actual instrument of communication, surveillance, education and health promotion⁽⁸⁾.

In Brazil, studies on the CHB mention significant weakness and flaws in the registration of data. In Mato Grosso, 95.4% of the booklets were not completely filled in⁽²⁾. In Minas Gerais, the most predominant weakness was in the records of children under the age of one, where less than 25% of the booklets had entries on head circumference by age and weight by age⁽⁸⁾ and almost one-half of the CHB had less than 60% of the items filled in⁽⁹⁾.

Of the information recorded in maternity wards, birth weight was filled out the most (64.5%) and in primary care immunization was the most frequently registered field (94%). In addition, information in maternity wards was entered more often than in primary care and other services ($p < 0.001$)⁽¹⁰⁾, similar to the findings of another study⁽⁴⁾. In São Paulo, only 9% and 8% of the growth and development graphs, respectively, were filled out with adequate data⁽¹¹⁾.

The city under investigation in this study has a child healthcare program which, even in maternity wards serving users from the Unified Health System (SUS), schedules initial newborn care in the primary care network by the seventh day of life with a nurse and up to the tenth day with a physician. To have a document in hand, in the first care session after discharge from the maternity ward, which contains prenatal, delivery, birth and hospital discharge data of the newborn provides nurses with information for care continuity. For this reason, it is crucial to fill it in correctly.

Nurses play an important role by working with mothers and children during this stage of life. They are active in the primary care network, guiding prenatal care, as well as in maternity wards for assisting with deliveries and births, and after discharge they receive mothers and babies in health units. Although nurses are not the only professionals who fill in this document, they have the potential to support actions, among team members, that

promote completing records in child health booklets. They also raise awareness about this important instrument, in terms of its potential to reduce infant morbidity and mortality and enable care access and the building of bonds between families and health professionals⁽¹²⁻¹³⁾.

Given the relevance of entering health data for the follow-up of newborns in the primary care network, this study seeks to examine factors associated with filling in the child health booklet to promote care coordination and access to health care.

METHOD

This cross-sectional descriptive study was carried out in two of the five health districts of a northeastern city in the state of São Paulo. Districts with the highest number of births in the two years prior to the data collection were chosen, i.e., those with a greater demand for children's health care in the primary care system.

Of the total number of births in the city, around 57% were children who use the SUS and whose first care consultation was scheduled in health units through the child healthcare program⁽¹⁴⁾.

The study participants were parents/guardians of children under five years of age, residing in the city and belonging to the areas of coverage of the health units of the health districts selected. The inclusion criteria were: individuals 18 years of age or older who spontaneously brought their child to the immunization room of the health units within the period the study was carried out and who brought the CHB with them.

In terms of data, the main researcher filled out a questionnaire with 23 questions in relation to sociodemographic data, the child's identification and the use of the CHB. Direct observation of the booklet by the researcher and how it was filled in followed a road map based on the Manual of Use⁽¹⁵⁾, examining items with the potential to assist health professionals during initial primary care. When observing the CHB, it was noted on the road map if the item was "filled in", for adequately registered fields, or "not filled in" when left blank or partially completed.

The maternal variables investigated were: age; parity; education; monthly household income; work outside the home; and place of residence. The children variables included: date of birth; sex; gestational age; type of delivery; Apgar score at the fifth minute of life; birth weight; length at birth; hospital of birth; monitoring of growth and development.

The data was collected for three consecutive days in each health unit, during the hours of operation of the immunization room.

After double entry on electronic spreadsheets and validation, the data was processed by the Statistical Package for the Social Sciences (SPSS), Version 22.0. The dependent variable was filling in the CHB and the independent variables were comprised of the mothers' and children's data. Possible associations between filling in the CHB (dependent variable) and the mothers' and children's characteristics were analyzed, using the Pearson's chi-square and Fisher's exact tests, with a significance level of 0.05.

The project was approved by the Research Ethics Committee, under Protocol No. 1.386.436 and Ethical Consideration Presentation Certificate No. 50437415.6.0000.5393 (11/18/2015), after approval by the Municipal Department of Health.

RESULTS

The two health districts, which were the fields of this study, had 18 health units. A

total of 520 parents/guardians of children under five years of age were approached. Of these, those who did not bring the CHB (149) and those who did not agree to participate (87) were excluded. Therefore, 284 met the inclusion criteria. A total of 155 (54.6%) belonged to District A and 129 (45.4%) to District B, with a mean of 17.7 children per health unit. Among those who were approached and participated, 250 (88%) were mothers of the children. Henceforth, the participants will be referred to in this study as "mothers/interviewees".

Among those interviewed, 122 (43%) were married or lived with a partner; 246 (86.6%) were more than 20 years old, with a mean age of 27 years; and 138 (48.6%) had completed high school. More than one-half (54.6%) of the mothers did not work outside the home, and all of them lived in the urban area of the city. In terms of parity, 113 (39.8%) had only had one gestation; 137 (48.2%) one birth; and 232 (81.7%) had never had an abortion.

There were 238 (83.8%) children born full term; 246 (86.6%) with adequate weight, with a mean of 3,221 g; 151 (53.2%) were male and 117 (39.8%), at the time of the interview, were between six months and one year of age. Of the total, 199 (70.1%) were being monitored for growth and development in the health units. According to Table 1, pregnancy, delivery and puerperium data were more frequently filled out in relation to location and type of birth; the other information was not filled out in more than 95% of the CHB examined.

Table 1 – Filling out of pregnancy, delivery and puerperium data and newborn information in the Child Health Booklet. Ribeirão Preto, SP, Brazil, 2017 (continues)

Variable	Filled in		Not filled in	
	n	%	n	%
Newborn data				
Time of birth	197	69.4	87	30.6
Date of birth	203	71.5	81	28.5
Weight	202	71.1	82	28.9
Apgar at 1 minute	188	66.2	96	33.8
Apgar at 5 minutes	184	64.8	100	35.2
Gestational age	161	56.7	123	43.3
Blood type	30	10.6	254	89.4
Breastfeeding within the 1 st hour	21	7.4	263	92.6
Pregnancy, delivery and puerperium data				
Prenatal	17	5.8	277	94.2
Start of prenatal	16	5.4	278	94.6
Number of consultations	8	2.7	286	97.3
Pregnancy	17	5.8	277	94.2
Serologies	3	1	291	99
Immunization	4	1.4	290	98.6
Iron supplementation	12	4.1	282	95.9
Location of the birth	161	54.8	133	45.2
Type of birth	162	55.1	132	44.9

Serologies in maternity ward	2	0.7	292	99.3
Complications	-	-	294	100
Neonatal Screening				
Ortolani maneuver	11	3.9	273	96.1
Red reflex	22	7.7	262	92.3
Guthrie test	18	6.3	266	93.7
Newborn hearing test	169	59.5	115	40.5
Discharge Data				
Date	18	6.3	266	93.7
Weight	17	6	267	94
Feeding	18	6.3	266	93.7
Problem notes	-	-	284	100

Of the newborn data, less than 60% of the information was filled out for time, date and location of the birth, weight, and length, head circumference, sex and Apgar at the 1st and 5th minutes. Information about newborn screening and auditory screening records were found in less than one-half of the CHB.

The fields for notes on newborn screening at birth, such as the Ortolani maneuver and red reflex test, were filled out in less than 10% of cases. Newborn discharge data was not contained in more than 90% of the CHB.

In the analysis of the association between the mothers' and children's variables and filling in the CHG for pregnancy, delivery and puerperium (Table 2); newborn data (Table 3); and newborn screening (Table 4), there was a significant association between newborn data and maternal education (Table 3).

Table 2 – Distribution of the parent/guardian variables according to filling in data about pregnancy, delivery and puerperium in the Child Health Booklet. Ribeirão Preto, SP, Brazil, 2017 (continues)

Variables	Pregnancy, delivery and puerperium data			
	Filled in		Not filled in	p-value†
Parents/guardians				
Education (n=284)				1.000
Elementary	1	1.7	59	98.3
Secondary	4	2.2	182	97.8
University	-	-	38	100
Marital status (n=284)				0.302
Married	4	1.6	240	98.4
Single, divorced or widowed	-	-	24	100
Lives with partner	1	6.3	15	93.8

Age (years) (n=284)				1.000
< 20	-	-	29	100
20 to <35	4	1.9	202	98.1
≥ 35	1	2	48	98
Children				
Sex (n=284)				0,063
Female	5	3.3	146	96.7
Male	-	-	133	100
Gestational age (weeks) (n=281)‡				1.000
< 37	-	-	24	100
≥ 37	5	1.9	252	98.1
Birth weight (grams) (n=269) ‡				1.000
< 2,500	-	-	21	100
≥ 2,200	5	2	243	98

Note: †Fisher's Exact Test. ‡Variable with data loss.

Table 3 – Distribution of the parent/guardian variables according to filling in newborn data in the Child Health Booklet. Ribeirão Preto, SP, Brazil, 2017 (continues)

Variables	Newborn data			
	Filled in		Not filled in	p-value
Parents/guardians				
Education (n=284)				0.006‡
Elementary	34	56.7	26	43.3
Secondary	81	43.5	105	56.5
University	9	23.7	29	76.3
Marital status (n=284)				0.975‡
Married	106	43.4	138	56.6
Single, divorced or widowed	11	45.8	13	54.2
Lives with partner	7	43.8	9	56.3
Age (years) (n=284)				0.623‡
< 20	15	51.7	14	48.3
20 to <35	89	43.2	117	56.8
≥ 35	20	40.8	29	59.2
Children				
Sex (n=284)				0.929‡
Female	66	43.7	85	56.3
Male	58	43.6	75	56.4
Gestational age (weeks) (n=281)‡				0.856‡
<37	10	41.7	14	58.3

≥37	112	43.6	145	56.4
Birth weight (grams) (n=269)‡				0.132‡
< 2,500	6	28.6	15	71.4
≥ 2,500	113	45.6	135	54.4

Note: †Fisher's Exact Test. ‡Pearson's chi-square. §Variable with data loss.

Table 4 – Distribution of the parent/guardian variables and use of the CHB according to filling in newborn screening data in the Child Health Booklet. Ribeirão Preto, SP, Brazil, 2017

Variables	Newborn screening data			
	Filled in		Not filled in	p-value†
Parents/guardians				
Education (n=284)				0.761
Elementary	-	-	60	100
Secondary	4	2.2	182	97.8
University	-	-	38	100
Marital status (n=284)				0.241
Married	3	1.2	241	98.8
Single, divorced or widowed	-	-	24	100
Lives with partner	1	6.3	15	93.8
Age (years) (n=284)				0.725
< 20	-	-	29	100
20 to <35	3	1.5	203	98.5
≥ 35	1	2	48	98
Children				
Sex (n=284)				0.251
Female	3	2	148	98
Male	-	-	133	100
Gestational age (weeks) (n=281)‡				1.000
< 37	-	-	24	100
≥ 37	3	1.2	254	98.8
Birth weight (grams) (N=269)				1.000
< 2,500	-	-	21	100
≥2,500	4	1.6	244	98.4

Note: †Fisher's Exact Test. ‡Variable with data loss.

Finally, in regard to hospital discharge, only 6% of the CHB were partially filled in with data related to date, child's weight and type of feeding. Since this study was based on complete filling in of the fields, all those partially filled in were defined as not filled in.

DISCUSSION

The results indicate that little information was registered in the CHB. The low completion of relevant fields in relation to the items examined undermine the goal of this document, as an instrument that can travel between health services to provide continuity of care for children.

A study revealed that mothers have the habit of taking the CHB with them to their children's appointments⁽¹⁵⁾, which strengthens assessment of the care coordination attribute in primary health services.

For pregnancy, delivery and puerperium data, there was no association with the variables investigated. This data should be filled in the maternity ward, taking advantage of the presence of the mother and the information contained on her medical chart and Pregnancy Card⁽³⁾. Therefore, incomplete recording of prenatal information on the Pregnancy Card⁽¹⁶⁾ affects filling in data on the CHB and hinders care.

An association was identified between filling in newborn data and the education of the interviewees, similar to a study carried out in a city from the Center-West region of Brazil⁽²⁾, and gestational age, corroborating the findings of a survey in the capital of Minas Gerais⁽³⁾. High educational level of the mother is frequently associated with positive influences on the health of the child. In this aspect, the results of this study corroborate another study⁽²⁾ which identified a significant association between education of the interviewees and filling in of newborn data, although the findings were different in another investigation⁽⁴⁾.

A study revealed that incomplete maternal education is an important factor in the health of mothers and fetuses in another relevant document entitled the Live Birth Certificate⁽¹²⁾, where the authors recommend urgent joint efforts of health professionals and managers to register this information.

Based on the assumption that data should be filled out in the maternity ward to identify and assess the conditions of newborns, proper recording in the CHB could enhance the monitoring of children throughout the health network.

Other authors⁽¹⁷⁾ examined the effect of using electronic health records during pregnancy on the utilization of maternal-child health services by pregnant mothers and their babies. They discovered that over 34% of all the women from the analytical sample received prenatal care from professionals who used such records. Women who received prenatal care, primarily from a professional who adopted and used electronic health records, were more likely to receive baby care (0.05, $p = 0.04$) and make the appropriate number of visits during the first year of the child's life (0.03, $p < 0.01$)⁽¹⁷⁾.

In relation to newborn screening data, no association was verified between maternal and newborn variables and low completion of this information, as shown in another study⁽²⁾.

Absence of these records could indicate that newborn screening was not performed for lack of staff, in accordance with results obtained from the Northeast region of Brazil⁽¹⁸⁾, due to unequal distribution of these professionals among regions⁽¹⁹⁾ or even sub-use of this screening technology⁽²⁰⁾. Contrary to this evidence, the public maternity wards of the city studied had health professionals who could perform newborn screening.

Families need to receive guidance, especially mothers during prenatal care, regarding the tests performed in the maternity ward and which ones will occur in primary care, and that all of them should be recorded in the CHB. It is possible that mothers would then not only appropriate this instrument but also value it when their children receive care and insist on health professionals filling it out properly.

Discharge data of children was registered in less than 10% of the CHB examined. Knowing the weight and type of feeding at the time of discharge is extremely important for

the professional that will receive the mother and baby in the health units, because this data enables carrying out support and encouragement based on the specific aspects of each mother and newborn. This was also pointed out in a study which noted the maintenance of breastfeeding rates for preterm babies after discharge from the maternity ward⁽²¹⁾. Failure to document the type of feeding provided when the child leaves the hospital can weaken the continuity of such actions in the other points of the healthcare network.

Discharge data enables care continuity in primary care and, consequently, effective follow-up of children. Since the CHB is an important surveillance tool for children's health and a means of communication⁽⁷⁻⁸⁾ among healthcare networks, it should be incorporated into the practices of health professionals and families⁽⁴⁾. This is especially true in the case of nurses, since they provide a vital source of support and intervention in care, ensuring communication with other professionals and encouraging surveillance actions and child health promotion⁽²²⁾.

A limitation of this study is that it was conducted in only two of the city's five health districts. Its contribution lies in indicating data that could make this instrument a potential driver of care coordination for children, particularly in the link between maternity wards and the primary care network.

CONCLUSION

Incomplete recording of data, as identified in this study, hinders care continuity of children in the primary care network, since changes not identified in a timely manner, such as low birth weight, greater loss of weight after birth than expected, children who are not solely breastfed or early weaning, can have negative consequences. Although such information could be obtained in the newborn's first visit to the health unit, properly noting them in the maternity ward certifies the data in an official and reliable way, in a document that follows the child throughout their childhood.

It is crucial to instruct mothers during prenatal care and after the birth about the importance of this instrument. This could strengthen its use and help mothers appropriate the booklet as a passport of citizenship for children's health. It is necessary to encourage health professionals and organize health services to register data in all the fields of this document.

The study indicated that the CHB has not been a source of information for newborn follow-up care. Keeping proper records strengthens the care continuity of this population, which starts at birth, and can have an impact on access to health and child health promotion actions to prevent major diseases, reduce morbidity and mortality rates and improve health indicators during childhood.

Salvaging this tool is essential to help build bonds between health professionals and families during the growth and development process of children. Strengthening the recording of data expands access to healthcare and enhances healthcare coordination. Therefore, it is strongly recommended that filling in this important instrument be incorporated into the practices of health services at all points of the care network for children.

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