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Records of childcare in primary care: descriptive study

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ABSTRACT

AIM: To investigate on the registry of medical records how childcare is performed by the teams of the Family Health Strategy, working at a Basic Health Unit the city of Maringá, Paraná. **METHOD:** Data were collected in January 2011, starting from the consultation of medical records of 181 children born between July 2008 and January 2010, in which relevant data were observed on children monitoring during the first year of life. **RESULTS:** The nurse was responsible for 51.9% of the childcare consultations. It was further observed that the rate of unfilled charts in various fields was high. **DISCUSSION:** The number of childcare attendances made by nurses demonstrates its importance in monitoring the health of children. **FINAL CONSIDERATIONS:** It is believed that the implementation of a standard form to record the childcare consultations should minimize the underreporting of the follow-up activities to children for facilitating and systematizing the annotation.

Keywords: Child Care, Primary Health Care, Family Health; Nursing.

INTRODUCTION

The Family Health Strategy (FHS) is one of the cornerstones of action in the health sector. The basic characteristic of the proposal is to provide primary care, aiming fundamentally at health promotion and the reduction of health problems, thus increasing the population's access to health services⁽¹⁾.

One of the activities of the FHS is childcare, which aims to ensure systematic monitoring of the growth and development of children and adolescents in order to raise the quality of life, defending and guiding favorable behaviors and especially, sensitizing and raising awareness on the part of the children's caregivers⁽¹⁾.

As much as health indicators show that infant mortality rates have decreased in the last decade, they are still considered to be high. In most cases, death could have been avoided. Thus, the fault lies in the lack of a concentrated effort with regard to the organization of childcare, and the offering of assistance in the Basic Health Units (BHU). Thus, primary care and the actions associated with health monitoring set the basis for the organization of child health care⁽²⁾.

The BHU must provide a humanized and welcoming service for the child and his family, especially his mother, in which the primary responsibility is for newborn screening, for the guarantee and encouragement of breastfeeding, nutritional surveillance, immunization, assistance in case of prevailing childhood diseases, care and prevention of oral diseases, promotion of mental health and prevention of accidents, abuse, domestic violence and child labor^(2,3).

In terms of these responsibilities, child care is crucial for the prevention of several diseases during the first years of life. For this, an early start, preferably within the first month of life, and at least eight visits during the first year, are essential⁽²⁾.

The recording of these activities is an essential element in the health care process. The documentation of care and its outcomes through written records is an effective communication tool for the (re)planning, continuity and evaluation of services provided

to clients. In addition, it works as a source of information for legal issues, research, education and other related activities⁽⁴⁾. Thus, the accurate and complete registration of information, in addition to a dialogue with the family over the notes taken, are basic requirements for the records to fulfill their role as an instrument of communication, monitoring and promotion of child health⁽⁵⁾.

Given the above, we defined as the objective of the study: to investigate, from records in the form of medical charts, the way childcare is performed by FHS teams working at a BHU in Maringá, Paraná, and to identify which activities are performed routinely by professionals in childcare.

METHODOLOGY

This is a descriptive, quantitative research, undertaken in a UBS in the city of Maringá, located in the northwestern region of Paraná, with a population of 349,860 inhabitants. In the health field, there are fifteen hospitals, totaling 1,161 beds, of which 681 are affiliated to the Unified Health System (UHS). There are also four Emergency Departments, of which two are public, 27 BHU and 68 FHS teams with a coverage of 89.2% of the population⁽⁶⁾.

The BHU studied has seven FHS teams, with 9,871 registered families. The estimated population of the coverage area is of 31,194 people. The size of the sample under study was calculated based on the total number of children born in the city, from July 2008 to January 2010, residing in the area of the FHS teams of BHU. There was considered to be an estimation error of 5%, confidence interval of 95% and another 10% for possible losses. Thus, 181 children participated in the study. Data collection occurred in January 2011, when all children in the study were at least one year old.

Proportional stratification was used to set the number of children of each team that was included in the study. This operation was conducted in order to evenly divide the

research participants. Consequently, each team was asked to provide a list of all registered children to be randomly selected.

The data relating to the first year of life of the children were collected directly from their medical records and registered on a spreadsheet made specifically for the study, based on the main responsibilities that must be performed by the FHS teams, according to Health Care Basic Operating Norm (HCON 01)⁽²⁾.

In the medical record, the information of interest basically referred to the child's history and physical examination, which included family history and maternal obstetrics, an assessment of child growth and development, vaccination status, disease diagnosis, features of lactation breastfeeding in the first year of life, and the guidance provided to the mother. It also detailed the number and types of care offered to children during the first year of life, and a record of the child's age along with anthropometric data (weight, height and head, chest and abdominal size) in each health care team service. It also registered the familiar profile with the purpose of identifying the socio-familial environment in which the child was being raised. All information collected from the medical records referred exclusively to the first year of the child's life. The sessions considered in the study were of two types: childcare (performed by the doctor or nurse) and medical consultation.

The development of the study occurred in accordance with the criteria of Resolution 196/96 of the National Health Council and the project was approved by the Standing Committee on Ethics in Research with Human Beings at the State University of Maringa (Opinion No. 545/2010). Since this research is carried out in terms of document consultation, waiver of the Terms of Consent was requested.

RESULTS

The age of the children in the study ranged from 12 to 30 months, with a slight predominance of females (50.2%). It was found major deficiencies in the records concerning the anamnesis variables, as noted in Table 1.

Table 1: Distribution of the registry of the anamnestic assessment in medical records of children in Maringá-PR, June 2008 to January 2010.

| Anamnesis Data | Medical records | | | | Total | |
|---------------------------------|-----------------|------|-----|------|-------|-----|
| | Yes | | No | | | |
| | N | % | N | % | N | % |
| Prenatal realization | 49 | 27,1 | 132 | 72,9 | 181 | 100 |
| Complications in pregnancy | 18 | 9,9 | 163 | 90,1 | 181 | 100 |
| Gestational age | 44 | 24,4 | 137 | 75,6 | 181 | 100 |
| Maternal DST | 12 | 6,6 | 169 | 93,4 | 181 | 100 |
| Delivery type | 74 | 40,8 | 107 | 59,2 | 181 | 100 |
| Hospital delivery | 15 | 8,3 | 166 | 91,7 | 181 | 100 |
| Guthrie test | 17 | 9,3 | 164 | 90,7 | 181 | 100 |
| Other examinations of the child | 102 | 56,3 | 79 | 43,7 | 181 | 100 |
| Presence of anomalies | 01 | 0,5 | 180 | 99,5 | 181 | 100 |

Regarding the immunization of children in the first year of life, it was found that, in general, only in little more than half of all medical records was there a registration of the doses of vaccine the children had received (Table 1).

| Vaccine | Single dose | | 1 st Dose | | 2 nd Dose | | 3 rd Dose | |
|----------------|-------------|------|----------------------|------|----------------------|------|----------------------|------|
| | N | % | N | % | N | % | N | % |
| BCG | 106 | 58,5 | — | — | — | — | — | — |
| Hepatitis B | — | — | 22 | 12,1 | 106 | 58,5 | 99 | 54,6 |
| Quadrivalent | — | — | 105 | 58,0 | 103 | 56,9 | 93 | 51,3 |
| Polio vaccines | — | — | 112 | 61,7 | 100 | 55,2 | 90 | 49,7 |
| Rotavirus | — | — | 96 | 53,0 | 91 | 50,2 | — | — |
| Yellow fever | 91 | 50,2 | — | — | — | — | — | — |
| Triple viral | 82 | 45,3 | — | — | — | — | — | — |

Picture 1: Vaccination coverage, recorded in medical records, in the first year of life of children accompanied by a BHU of Maringá, Paraná, June 2008 to January 2010.

With regard to the care of children, it was found that there were 112 consultations in the first month of life. Of these, 94 (83.9%) were performed by the physician, in which case 35 (37.3%) corresponded to the medical consultation related to some health problem, and the others (59 - 62.7%) corresponded to childcare. In turn, the childcare service, which is scheduled and timed, was performed in 77 (42.5%) infants in the first month of life. Of these, 59 cases (76.6%) were assisted by a doctor and only 18 children (23.4%) by nurses (Table 2).

However, a reverse situation occurred in the following months, as the nurse started to perform a greater number of consultations. It also appears that, especially after six months, there was a strong decrease in the number of childcare services provided, and an increase in the number of visits such as medical consultations, motivated by health problems.

Table 2: Distribution of records of care provided in the first year of life, according to health professionals in charge. Maringá, Paraná, June 2008 to January 2010.

| Período | Childcare | | | | Medical Consultation | | Total number of services | |
|------------------------|-----------|------|-------|------|----------------------|------|--------------------------|-----|
| | Physician | | Nurse | | N | % | N | % |
| | N | % | N | % | | | | |
| 1 st month | 59 | 52,7 | 18 | 16,0 | 35 | 31,3 | 112 | 100 |
| 2 nd month | 19 | 27,5 | 18 | 26,1 | 32 | 46,4 | 69 | 100 |
| 3 rd month | 10 | 20,0 | 14 | 28,0 | 26 | 52,0 | 50 | 100 |
| 4 th month | 12 | 26,1 | 15 | 32,6 | 19 | 41,3 | 46 | 100 |
| 5 th month | 07 | 17,5 | 12 | 30,0 | 21 | 52,5 | 40 | 100 |
| 6 th month | 07 | 17,5 | 10 | 25,0 | 23 | 57,5 | 40 | 100 |
| 9 th month | 04 | 4,8 | 27 | 32,6 | 52 | 62,6 | 83 | 100 |
| 12 th month | 03 | 3,6 | 17 | 20,2 | 64 | 76,2 | 84 | 100 |
| Total | 121 | 20,3 | 131 | 22,0 | 272 | 45,7 | 524 | 100 |

Considering only the total number of routine child consultations performed, it was found that the nurse was responsible for 51.9% of the visits. However, according to the total number of records in the medical charts, only 252 childcare services were carried out for 181 children. This means that fewer than two visits were performed per child during the first year of life.

There was also a small number of annotations in the records regarding child nutrition during the first six months of life. Of the data available, we can perceive a prevalence of exclusive breastfeeding, compared to other types of lactation (Table 3).

Table 3 - Type of breastfeeding in the first six months of life of children followed in childcare in a BHU of Maringá, Paraná, from June 2008 to January 2010.

| Type of breastfeeding | 1 st month | | 2 nd month | | 3 rd month | | 4 th month | | 5 th month | | 6 th month | |
|-----------------------|-----------------------|------------|-----------------------|------------|-----------------------|------------|-----------------------|------------|-----------------------|------------|-----------------------|------------|
| | N | % | N | % | N | % | N | % | N | % | N | % |
| EBF* | 53 | 29,3 | 28 | 15,5 | 11 | 6,1 | 16 | 8,9 | 08 | 4,4 | 01 | 0,5 |
| PBF** | 08 | 4,4 | 03 | 1,6 | 07 | 3,9 | 08 | 4,4 | 06 | 3,4 | 12 | 6,7 |
| No BF*** | 05 | 2,7 | 03 | 1,6 | 03 | 1,6 | 03 | 1,6 | 03 | 1,6 | 01 | 0,5 |
| No record | 115 | 63,6 | 147 | 81,3 | 160 | 88,4 | 154 | 85,1 | 164 | 90,6 | 167 | 92,3 |
| Total | 181 | 100 |

* Exclusive Breastfeeding; ** Predominant breastfeeding; *** breastfeeding.

Information regarding the introduction of solid foods was only identified in 46 (25.4%) medical charts, among which it was observed that one child (0.5%) was introduced to this type of food at four months of life; another seven children (3.8%) at five months, and the other 11 children (6.0%) at six months.

Regarding nutritional assessment during the first year of life, only 115 (63.5%) records showed a record of this parameter. The data available showed a greater proportion of children with proper weight for their age, in that 98 children (85.2%) had their percentiles in the normal range of the growth curve. In eleven medical charts a record of nutritional risk assessment was found. Within these, nine children (7.8%) had low weight for their age and two were overweight. Children who were underweight were the premature ones, or the ones who, from the sixth month, struggled to adapt to the new alimentation.

Regarding anthropometric measurements, we observed that 100% of medical charts had records of weight and height during primary care, yet there was a decrease in the records of head, chest perimeter and abdominal circumference, with respective values of 113 notes (62, 3%), 58 notes (32.0%) and 44 notes (24.3%).

Anthropometric data were recorded mainly in the first six months of life. After this period, only records of weight and height prevailed. Waist circumference showed annotation in all months, with decreasing rates only in children near a year old, when they presented risk factors for overweight.

The assessment of neuropsychomotor development (NPMD) was recorded in 87 medical charts (48%), with higher prevalence in the first month of life in 42 medical charts (23.2%), and in the second month, in 16 (8.8%).

Information related to health complications during the first year of life showed a greater proportion of upper airway infections (URTI), with 71 records in medical charts (39.2%), including four children (5.6%) who developed pneumonia. Other adverse events were bronchiolitis, nine cases (4.9%), heart murmur and anemia, five cases each (2.7%), and gastroesophageal reflux, abdominal cramps and phimosis, two cases each (2.2%). Despite the high number of health complications recorded, only eight medical charts (4.4%) contained notes about hospitalization, and the reason for admission was recorded in only one medical chart (0.5%).

Another important finding was the absence of records in the charts on the socio-demographic profile of the family, such as notes on maternal education, family income and the number of persons living in the same household.

DISCUSSION

The number of charts with records incomplete and even absent in relation to several factors can be considered to be high. In many cases, there was no record of substantial information with regard to the continuity of care by other professionals of the healthcare team such as complications during pregnancy, presence of sexually transmitted disease

(STD) in the mother, and the presence of congenital anomalies in the children. Some authors also suggest that prenatal care should be recorded both in the medical chart and on the mother's card, as well as in the infant's medical chart, in order to allow systematic monitoring of the woman and her son later, since it of different professionals involved in care⁽⁷⁾.

It should be emphasized that the realization of the Guthrie Test and other tests such as the newborn screening test and infant's first eye exam, which are established by the Ministry of Health, should be noted even in the event of normal results, so that their realizations are confirmed.

There were few records in the medical charts of the immunization status of the children in the study. However, the data on immunization coverage in the country in 2006 indicates, with few exceptions in the northern region, an excellent coverage in all federative units, with frequent rates of 100% of vaccines⁽⁸⁾. In Maringá, in 2008, according to the Book of Primary Care, 98.1% of the children were up to date with the basic vaccination schedule and, in 2009, there was a slight decrease, since 97.9% of the children were updated with their immunization schedule⁽⁶⁾. Precise knowledge of vaccination coverage in children under one year is one of the necessary elements of the epidemiological surveillance program, in that it lets one view the increasing number of susceptible individuals in the population, as well as monitoring to what extent the high level of immunization constitutes an effective barrier to the transmission of immunopreventable diseases⁽⁹⁾.

Therefore, the results of this study reflect an underreporting of information on the vaccination status of the children surveyed. Moreover, the data also suggest that the monitoring of immunization is only partially recorded, since, when performing childcare, healthcare professionals are not giving due importance for updating the basic vaccination

schedule in the chart of children. This, in turn, is a reflection of the fragmentation of care, as the medical chart should gather all the information related to the health or illness of the child, in order to allow full monitoring of the situation.

The reduced number of childcare consultations (17.4%) is alarming. This data reveals, in general, that not even two visits per child were carried out during the first year of life, while official documents reiterate the need to perform at least eight child visits in this period⁽²⁾.

The number of childcare consultations carried out for the 181 children in the study goes against the current proposal for primary care in health promotion. With a strong decrease in the number of childcare consultations, especially after six months, medical consultation attendances have become more and more frequent. This fact is probably related to the end of maternity leave and mothers returning to employment activities. Hence the importance of health professionals, especially nurses, with regard to raising the awareness of the family about the importance of childcare and establishing ties in the first months of the child's life, so that, in the event of the mother not being able to take the child to a doctor, other family members can take charge. Hosting and bond formation are necessary skills for the process of strengthening the work of primary care⁽¹⁰⁾, especially in terms of the health care of children.

In this perspective, a study conducted in Juiz de Fora and Minas Gerais, which aimed to understand the perception of nurses about nursing consultation in primary care, found that this activity is recognized by the professional as a way to establish closer ties with the user in order to recognize their health needs which, if executed under favorable conditions, promotes the development of effective interventions that meet the needs of the population, respecting the principles of the Unified Health System (UHS)⁽¹¹⁾.

Guidance with regard to the actions of the professionals who deal with children in primary care are available in the Schedule of Commitments with regard to Comprehensive Child Health and Infant Mortality Reduction⁽²⁾, which recommends a minimum calendar associated with monitoring the health of the child, involving a multidisciplinary team composed of community health workers, technicians and assistants in nursing, nurses, pediatricians and family doctors, whose actions can be individual or collective. In contrast, as seen in this study, only physicians and nurses were involved in performing the monitoring of childcare.

As demonstrated in a study conducted in Belo Horizonte (Minas Gerais) (5), the monitoring of the child in BHU is conducted, in most cases, by a single professional: either by a pediatrician or a general practitioner (61.0%) or by a nurse (32.0%), since these are the professionals who are most qualified and skilled when it comes to offering comprehensive health care for children. However the other health professionals on the team must be involved in this care from the perspective of multidisciplinary and comprehensive health care, in which case the FHT professionals should articulate their knowledge with the unique aspects of the users⁽¹⁰⁾.

In nursing, what hinders the keeping of complete and frequent records, in most cases, is the low socio-educational level of some professionals, especially those of a technical level, the complexity of language, the small number of workers in the teams, the high demand for services, the low value of the profession, and the limited investment in training/education⁽⁴⁾. Nevertheless, considering that the written record is the most concrete and permanent proof of professional performance and quality of care, it must always feature in terms of the issues discussed in health institutions⁽⁴⁾.

A study undertaken in Belo Horizonte (Minas Gerais) also showed a low level of annotation in the charts of children associated with childcare at the BHU, especially regarding the breastfeeding methods, with 58.0% of records being kept⁽⁵⁾, which is a rate higher than the 36.4% found in this study. The EBF up to six months of age was registered in only one (0.5%) medical chart. This result is below the one found in a study conducted in the city of Campo Mourão (Paraná)⁽¹²⁾, and another in the city of Pelotas (Rio Grande do Sul)⁽¹³⁾, in which the records revealed a prevalence of EBF at six months of age of 34.0% and 35.0%, respectively.

In turn, the percentage of over 60% in terms of records containing nutritional assessments details attracts attention. This is justified by the fact that children are included in the Milk Program and Family Grant Program and the annotation of these assessments is a requirement for receiving the benefit.

Food monitoring and nutritional assessment are easily applied and are effective methods in the diagnosis of collective nutritional conditions of the local population, supporting, therefore, the actions of the promotion of a healthy diet⁽²⁾. However, the fact that these people are included in governmental programs leads us to the assumption that it is a large group in terms of social vulnerability, meaning that there is a need to monitor the food and nutrition situation in order to early identify the nutritional risks for subsequent decision taking⁽¹⁾. This should also result in a greater concern with the monitoring of the general health condition of these children.

A study held in Belo Horizonte (Minas Gerais) showed that head circumference was marked on the chart in only 30.7% of the records⁽⁵⁾, demonstrating, as in the present study, that weight and height are anthropometric measurements that have priority registration. However, it is always a responsibility of the nurse to assess and record anthropometric data in childcare, because their determination on physical examination allows the evaluation of the child's body growth and its nutritional status (malnutrition, obesity, eutrophy), as well as the provision of clinical evidence that aid in the diagnosis of certain pathologies⁽¹⁾.

A greater concern in the evaluation of the NPMD was also observed only in the first two months of life. It is likely that this evaluation is conducted during the visits, but not recorded in the charts. A cross-sectional study, performed in Belo Horizonte with 355 children monitored by UHS, revealed that only 18.9% of NPMD assessments were recorded on medical charts⁽⁵⁾. Other authors have been drawing attention to the need for focusing more effectively on the assessment of the NPMD. In Belém (Pará), for example, a study with professionals working in primary care, showed that about 70.0% of them performed routine NPMD assessments, but only 32.0% used some tool to systematize attendance⁽¹⁴⁾. In Feira de Santana (Bahia) it was observed that fewer than 8% of 2,190 children had complete NPMD records in the charts⁽¹⁵⁾. The nurse must be attentive so that the health team correctly registers the assessment of the NPMD in the charts, aiming at a multidisciplinary approach with regard to child care.

Regarding the complications suffered by children in the first year of life, it was found that the URTI were most commonly found. These are, in many places, the main causes of illness of children, and for the demand for health services⁽¹⁶⁾. However, hospitalizations were underreported, for, according to the Ministry of Health, from January to December 2010, there were 1,103 hospitalizations of children under one year in the city of Maringá, with a prevalence of 26.0%⁽⁶⁾.

This reality of incomplete records was also found in a survey about the quality of the annotations of 130 records of a university hospital, and it has been identified that the records, despite being adequate as to their format and legibility, proved to be incomplete and fragmented regarding the contents analyzed⁽⁴⁾.

Among the risks to the health of children, low maternal education is a frequently associated factor⁽⁵⁾. However, the family profile was not registered in any medical chart, which would be essential for monitoring based on the proposal of the FHS, which seeks to incorporate the social and cultural context in which the individual lives.

Working with children imposes some difficulties, and the family is one of them, because no work is done with the child alone. Nurses who work in childcare must have this

understanding, seeking to create links leading to continuous and effective care, thus achieving prevention and health promotion. The Primary Care must acknowledge the wide variety of health-related needs of the patient, and provide the resources to approach them, emphasizing preventive intervention and health promotion.

Thus, childcare emerges as a timely tool for monitoring full child growth and development, aiming at the aspects of prevention and health promotion to ensure that the child reaches adulthood without unfavorable influences brought from childhood⁽¹⁾.

CONCLUSION

Childcare in primary care should be performed with regard to all the children of the area enrolled at the BHU, especially the monitoring in the first year of life. This should be done by all professionals of the healthcare team, focusing on the early diagnosis of pathologies, and thus promoting health and the prevention of diseases. However, it was found that only 17.4% of routine child consultations that should be undertaken in the first year of life were recorded in the medical charts of the children. This fact leads us to infer that either the childcare is not reaching all children in the area of coverage of the BHU, or it is performed, but not recorded, which hinders the continuity of care, as well as the obtaining of data to support the planning of activities to be undertaken with the population as a whole.

Of all the children who were assisted by the Childcare department it was found that the nurse was responsible for more than half of the cases, demonstrating the importance of this professional in monitoring the primary care of children, as long as s/he offers systemized quality care. However, a troubling aspect was the fact that the records, independent of the professional who was responsible for them, were inadequate in terms of disconnection, fragmentation or lack of information. The health care team needs to be sensitized to the importance of records on medical charts and, thereafter, they should

the number of children to be attended and plan the assistance, to enable their successful completion.

It is believed that the implementation of a standard form to record routine child consultations can minimize the underreporting of the activities in the monitoring of the child, by facilitating and systematizing annotations.

It is noteworthy that the nurse can choose to have a performance that denies or reinforces the biological model of health care by valuing or not, activities and actions such as child care, aimed at health promotion and disease prevention. It is also important to reiterate that the child belongs to a family unit. Therefore, meeting the family and understanding the relationships that it involves, becomes essential as a qualifying agent of assistance.

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