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Healthy Baby Monitoring: Relationship with Women's Knowledge Levels and Health Literacy Levels in Primary Care

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ABSTRACT

We aimed to determine the knowledge levels of women of reproductive age regarding healthy baby monitoring, assess their health literacy levels, identify the influencing factors, raise awareness on the topic, and address any deficiencies if present.

Sociodemographic data, healthy baby monitoring survey questions, and Adult Health Literacy Scale results of women aged 18-49 appling to primary healthcare services were recorded. For group comparisons, the Mann-Whitney U test and Kruskal-Wallis test were used. Continuous data were expressed as mean ± standard deviation (SD) values and categorical data as number (n). A p-value of <0.05 was considered statistically significant.

The mean age of the participants (n=196) was 29.22±8.52. A total of 123 participants were married, and 105 had children. Twenty-seven mothers reported receiving support regarding infant care. The mean score for healthy baby monitoring was significantly higher among participants whose income exceeded their expenses, those aged 24–31 and 32 years or older, those who graduated from secondary school, civil servants, mothers, and among those with one child compared to others. The average AHLS score was higher and showed a significant difference among university graduates, civil servants, singles, those without children, and those with one child. A significant positive correlation was found between the healthy baby monitoring score and the AHLS score (r=0.538, p=0.00).

Easily accessible and flexible educational programs should be offered to women aged 18-49 at the primary healthcare services. Additionally, responsibilities should be distributed among families, and interactive monitoring and vaccination programs should be established.

Keywords: Primary care, healthy baby monitoring, health literacy

Introduction

After a healthy pregnancy, regular and high-quality monitoring of infants' health between the ages of 0 and 1 is essential for the protection and improvement of their health. Therefore, monitoring infants is just as important as monitoring pregnant women (1,2). Healthy baby monitoring is a child health service where the growth and development of all infants are tracked, their health is evaluated, and preventive healthcare practices are provided. The aim of healthy baby monitoring is to prevent certain diseases and disabilities during infancy, reduce preventable deaths, support development, and ensure that infants grow up to live as healthy children. According to the protocols, ten healthy baby monitoring visits are recommended to be made after birth, within the first 48 hours, on the 15th day, 41st day, and at the 2nd, 3rd, 4th, 6th, 9th, and 12th months (3,4). Approximately 90% of babies in Turkey receive care from healthcare personnel at least once during this period (5). Although this rate is high, it does not provide information about the quality and continuity of the monitoring. Healthy baby monitoring rates are also an indicator of families' health literacy (HL). Health literacy is essential for individuals to properly manage their own and their family's health (6). All monitoring can only be properly and timely carried out if individuals have high levels of HL (7).

In this study, we aimed to determine the knowledge levels of women aged 18-49 regarding healthy baby monitoring, assess their health literacy levels, identify the influencing factors, raise awareness on the topic, and address any deficiencies if present.

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Material and Method

Our study was conducted prospectively at a primary care family health centre (FHC). Approval was obtained from the local ethics committee (decision no: 16-06, date: 20/07/22) and the study was conducted in accordance with the Helsinki Declaration. After verbally informing the eligible participants, their consent was obtained using an informed volunteer consent form. For the purpose of our study, a face-to-face survey consisting of a total of 44 questions was prepared by appropriately reviewing the literature. This included an 11-item sociodemographic questionnaire, a 10-item healthy baby monitoring form, and a 23-item Adult Health Literacy Scale (AHLS).

The first section of the survey to be administered to participants consists of questions regarding sociodemographic characteristics, medical history, birth history, family life, and healthy baby monitoring. The second section includes questions related to the 23-item AHLS.

The Healthy Baby Monitoring Knowledge Form consists of 10 questions. For the scoring of the survey, each correctly answered question was awarded 1 point. According to the scoring criteria set by the researchers, a knowledge score ranging from 0 to 10 was created. The minimum score is 0, and the maximum score is 10.

The AHLS consists of 23 questions, including 22 questions related to health information and medication use, and 1 question about knowing the location and names of organs. The scale includes 13 yes/no questions, four fill-in-the-blank questions, four multiple-choice questions, and two matching questions. The scores obtained from the scale range from 0 to 23. As the score increases, the level of HL also increases. The AHLS has been shown to be a valid and reliable scale for assessing HL and can be safely used in adult individuals (8).

Statistical Analysis: Statistical analyses were performed using SPSS 22.0. The study population consists of 2390 women aged 18-49. Using power analysis with a population size of N=2390, a 95% confidence interval, a 5% margin of error, and an effect size of 0.25, a representative sample of 211 participants was obtained. After excluding 11 participants who provided incomplete answers and four individuals who later changed their decision and opted out of the study, our research was completed with 196 participants. The data collection took place over a 6-month period. Women who had difficulty in communication, did not seek primary healthcare, were under 18 or over 49 years old, or had an active psychotic disorder were excluded from our study. The normality of the data distribution was evaluated using the Kolmogorov-Smirnov test. For group comparisons, the Mann-Whitney U test was used for binary group comparisons, and the Kruskal-Wallis test was applied for comparisons with three or more groups. Pearson correlation analysis was conducted for intergroup correlations. Continuous data were expressed as mean ± standard deviation (SD) values, minimum-maximum values and categorical data as numbers (n). $P < 0.05$ was considered statistically significant.

Results

The average age of the participants (n=196) was 29.22±8.52 years. The age range of the participants was between 18 and 48 years. Among the participants, 72 had a middle school or lower education level, 53 were high school graduates, and 71 were university graduates. One hundred twenty-three participants were married, and 105 had children. Twenty-seven mothers were receiving support for baby care. One of the women in the study had adopted her child. Additionally, 33 participants had given birth at home and had no history of hospital admission.

The mean AHLS scores showed no significant difference between participants with middle school and high school education. However, significant differences were found among other subgroups (p=0.000). There was a significant difference between those who were not employed and those in the civil servant and student groups (p=0.000). A significant difference was also found between married-single/divorced and childbearing-no child groups (p=0.000, p=0.000). When comparing by delivery method, women who had cesarean sections had higher AHLS scores, which showed a significant difference (p=0.000) (Table 1).

The mean healthy baby monitoring scores, when analysed by age groups, showed that the 18-23 age group had the lowest scores, and there was a significant difference (p=0.000). Regarding income, participants with income lower than their expenses had the lowest scores, and a significant difference was observed with the group whose income was higher than their expenses (p=0.006). There was a significant difference between the civil servant and student groups in terms of occupational status (p=0.017). A significant difference was found between the married-single/divorced and childbearing-no child groups (p=0.007). When compared by delivery method,

Table 1: The mean AHLS Scores and Comparisons Based On The Participants' Sociodemographic Questionnaire Responses

Category		N	AHLS Score (Mean ± Std. Deviation)	Healthy Baby Monitoring Score (Mean ± Std. Deviation)
Age	18-23	63	16.04±2.49	3.50±1.88
	24-31	65	15.92±3.09	4.63±1.83
	32 and above	68	14.17±4.55	4.60±1.97
	p**		0.964	0.000**
Education Level	Illiterate-Primary School	40	10.62±3.10	3.77±1.65
	Middle School	32	14.75±3.27	4.62±2.15
	High School	53	16.01±2.24	4.28±1.98
	University graduate	71	17.80±1.74	4.35±2.00
	p**		0.000**	0.273**
Economic Status	Income is less than expenses	88	14.92±3.43	3.78±1.71
	Income equals expenses	57	15.75±3.65	4.50±1.81
	Income exceeds expenses	51	15.66±3.83	4.80±2.32
	p**		0.125**	0.006**
Occupation	Not working	110	13.92±3.88	4.28±1.89
	Public servant	24	18.08±2.01	5.45±2.39
	Worker/Farmer	7	17.00±1.63	4.28±1.70
	Self-employed	9	15.77±2.81	4.11±0.60
	Student	46	17.02±1.96	3.60±1.84
	p**		0.000**	0.017**
Marital Status	Married	123	14.49±3.98	4.48±1.96
	Single/Divorced	73	16.80±2.22	3.87±1.90
	p*		0.000*	0.007*
Having Children	Yes	105	14.40±4.14	4.63±1.90
	No	91	16.45±2.47	3.82±1.94
	p*		0.000*	0.001*
Children Count	One child	8	17.00±2.97	5.12±1.55
	Two children	40	15.42±3.09	4.82±1.63
	Three children	43	13.16±4.84	4.32±1.98
	Four or more	14	13.85±3.86	4.78±2.54
	p**		0.051**	0.479**
Delivery Status	yes	104	14.36±4.13	4.63±1.91
	No (adopted child)	92	16.47±2.47	3.83±1.93
	p*		0.000*	0.001*
Type of Delivery	Cesarean	43	16.16±3.45	5.30±2.06
	Vaginal birth	53	13.32±4.09	4.26±1.68
	Both	8	11.62±4.30	3.50±1.41
	p**		0.000**	0.004**
Hospital Admission History	Yes	81	14.55±4.10	4.60±1.91
	No	115	15.01±3.80	4.41±2.09

	p*		0.442*	0.587*
Type of Family	Nuclear family	166	15.40±3.58	4.31±2.05
	Extended family	30	15.06±3.77	3.96±1.35
	p*		0.709*	0.592*
Does the Baby Receive Care Support?	Yes	27	14.59±3.46	4.51±1.74
	No	169	15.47±3.62	4.21±1.99
	p*		0.153*	0.429*
Type of Baby Care Support	Mother support	12	13.83±3.12	4.41±2.06
	Mother-Grandmother support	11	15.00±3.57	4.63±1.74
	Caregiver support	4	15.75±4.57	4.50±0.57
	p**		0.505**	0.966**

*Mann-Whitney U
**Kruskal Wallis, AHLS: Adult Health Literacy Scale

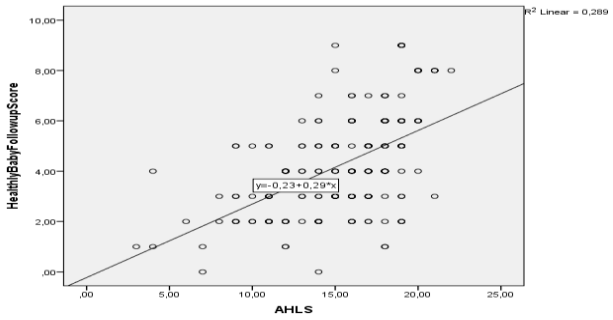
Table 2: The Mean AHLS Scores and Comparisons Based On The Responses To The Healthy Baby Monitoring Questions

Healthy Baby Monitoring Questions	Response Status	N(%)	AHLS Score (Mean ± Std. Deviation)	p*
How many check-ups are there between the ages of 0-1?	Correct	41 (20.9)	17.04±2.73	0.001
	Incorrect	155 (79.1)	14.90±3.68	
What are the lower and upper limits of growth and development percentiles?	Correct	65 (33.2)	16.23±3.73	0.003
	Incorrect	131 (66.8)	14.92±3.47	
When is the heel prick test performed?	Correct	140 (71.4)	15.56±3.52	0.250
	Incorrect	56 (28.6)	14.83±3.79	
When is the hearing test performed?	Correct	84 (42.9)	16.36±3.26	0.000
	Incorrect	112 (57.1)	14.59±3.67	
When is the first eye exam performed?	Correct	137 (69.9)	15.87±3.26	0.007
	Incorrect	59 (30.1)	14.15±4.07	
When is the congenital hip dislocation examination performed?	Correct	75 (38.3)	16.20±3.11	0.018
	Incorrect	121 (61.7)	14.83±3.80	
In which months are the vaccines for 0-1 year olds administered?	Correct	88 (44.9)	16.68±2.90	0.000
	Incorrect	108 (55.1)	14.27±3.77	
When should iron supplementation be started in term (full-term) infants?	Correct	59 (30.1)	16.71±3.01	0.000
	Incorrect	137 (69.9)	14.77±3.69	
When should vitamin D supplementation be started in infants?	Correct	94 (48.0)	16.20±3.28	0.001
	Incorrect	102 (52.0)	14.57±3.73	
When should routine blood tests be taken for infants between 0-1 year of age?	Correct	47 (24.0)	17.06±2.72	0.000
	Incorrect	149 (76.0)	14.81±3.69	

*Mann-Whitney U, AHLS: Adult Health Literacy Scale

women who had cesarean sections had higher healthy baby monitoring form scores, which showed a significant difference (p=0.004) (Table 1).

The mean AHLS scores and healthy baby monitoring scores of the participants, based on the sociodemographic questionnaire responses, and their comparisons are detailed in Table 1.



*Pearson Correlation Analysis, AHLS: Adult Health Literacy Scale

The highest correct answer in the healthy baby monitoring questions was given to the question 'When is heel blood taken?' (n=140), and the highest incorrect answer was given to the question 'How many check-ups are there between the ages of 0-1?' (n=155). Furthermore, although the participants who answered the question about the date for heel blood collection incorrectly had lower AHLS scores, there was no significant difference between them and those who answered correctly (p=0.250). For all other questions, those who answered correctly had higher AHLS scores, and there was a significant difference (p<0.01). The group that correctly answered the question 'When is a routine blood test taken between 0-1 years?' had the highest mean AHLS score (Table 2).

The mean AHLS scores and comparisons based on the participants' responses to the healthy baby monitoring questions are detailed in Table 2.

When evaluating the correlation between the average healthy baby screening score and the average AHLS, a moderate and statistically significant positive correlation was found between the two scores (r: 0.538, P=0.000). Additionally, 28.9% of the variation in the healthy baby screening score can be explained by the higher AHLS (R^2 = 0.289) (Figure 1).

Discussion

This study was conducted based on the monitoring protocols of the Turkish Ministry of Public Health. The knowledge levels regarding healthy baby monitoring protocols, health literacy levels, and influencing factors among women of reproductive age (18-49 years) were examined in this study. Although the concept of HL is not new globally, there is a lack of sufficient research in this area in our country. However, it is encouraging to see an increase in the number of studies conducted in recent years. Studies have shown that the level of HL is insufficient both in our country and in many countries around the world. The rates of low or problematic HL levels have been found to be 64.6% in our country and 47% globally (9,10).

In our study, the participants' healthy baby monitoring and health literacy (SOY) scores were analysed by correlating them with categories such as age, education level, economic status, occupation, marital status, number of children, hospital admission history, type of family and baby care support.

In the literature, looking at research studies, Aktürk's study found that as age increased, the HL level decreased. A significant difference was found between the groups (11). In studies conducted in the United States and Kosovo, although different age groups were categorised, it was found that as age increased, the HL level decreased (12,13). In our study, when examining the age groups of women and their HL levels, it was found that the 18-23 age group had the highest HL level, and as age increased, the HL levels decreased. However, there was no significant difference between the groups (p=0.964). We believe that this may be due to a decrease in education level with increasing age, as well as a reduction in the correct usage of technology and the internet.

In Şahinöz's study, there was no significant difference between age groups; however, as age increased, the knowledge levels about baby development also increased (14). In our study, the knowledge levels of women in the 18-23 age group were found to be the lowest, and there was a significant difference. Şahinöz attributed this to the fact that as mothers' ages increase, their babies also progress developmentally, leading to a greater need for and acquisition of new information. In addition to this comment, it should also be noted that there are fewer marriages at a young age, and the average age of married individuals is higher.

In our study, as the education level increased, the health literacy HL level also increased, and a significant difference was found between the groups (p=0.000). In many studies in the literature, the health literacy HL level increases in parallel with the education level (15,16). A high level of education has had an impact on health literacy HL levels, just as it influences many other areas.

Toros et al. demonstrated that lower educational levels impact the effectiveness of healthy baby monitoring (17). In our study, women who were illiterate or had only completed elementary school had the lowest levels of knowledge about healthy

baby monitoring. However, there was no significant difference (p=0.273). Additionally, the group with higher income than expenses had higher levels of knowledge about healthy baby monitoring compared to the group with lower income than expenses, and this difference was statistically significant (p=0.006). This situation can be explained by the increase in educational level along with the improvement in economic status, as well as the easier access to accurate health information.

The civil servant group, students, and single women had higher HL levels, and significant differences were found within their respective categories (p=0.000). In the studies conducted by Aktürk and Çimen, it was found that married women had higher health literacy levels. They attributed this to women taking on the responsibility of not only their own health but also the care of their children and spouses (11,18). In our study, the higher health literacy levels of civil servants and students can be explained by their education level. Additionally, we believe that the higher health literacy level among the single population is influenced by the socio-cultural factors of the region we are in.

The civil servant group, students, and married women had higher levels of knowledge regarding healthy baby monitoring, and significant differences were found within their respective categories (p=0.017, p=0.007). This situation may be attributed to the higher education levels of civil servants and students. Additionally, we believe that married women's higher levels of knowledge could be due to their responsibility for not only their own health but also the care of their children and spouses. Ulusoy et al. found in their study that the working population had a higher level of knowledge regarding healthy baby monitoring (19). In the study by Karabekiroğlu et al., it was found that single individuals had a higher level of knowledge regarding healthy baby monitoring, although no significant difference was observed (20). The difference between our results and the literature may be attributed to the preferences of the population included in the study.

The women who did not have children and those who had a cesarean section had higher HL levels, and significant differences were found (p=0.000). Moreover, as the number of children increased, HL levels tended to decrease gradually. In terms of hospital admission history, type of family, and receiving baby care support, there were no substantial differences in HL levels across these categories. Interestingly, the mother-caregiver category had the highest HL levels in providing baby care support, which may be due to the more direct involvement and responsibility they have in their children's well-being. In Aydın's study, women who underwent cesarean sections had higher health literacy levels, while Kerkez's research found that women without children had lower health literacy levels. Additionally, both studies showed that as the number of children increased, health literacy levels also increased (21,22). The differing results of our study compared to the literature may be attributed to the region where the research was conducted, lifestyle, and sociocultural differences.

Women who have children and those who have had a cesarean delivery showed higher levels of knowledge regarding healthy baby monitoring, and significant differences were found (p=0.001, p=0.004). Women with one child had the highest level of knowledge. However, no significant difference was found according to the number of children (p=0.479). In the categories of hospital admission history, type of family, and receiving baby care support, the levels of knowledge regarding healthy baby monitoring were similar to each other. Similarly, in providing baby care support, the mother-grandmother category had the highest average score. This can be explained by women needing to conduct mandatory research and learn new information as they become mothers. Additionally, it should be considered that women with children are called to primary healthcare services for vaccinations and follow-ups for the 0-1 age group in accordance with national health policies, where procedures are carried out.

Limitations: The memory factor in answering the questionnaires used in our study could be considered a limitation. This study was conducted on a population affiliated with a family health centre in a specific region. The socio-cultural, economic, and demographic structure of the research area may not be evenly distributed compared to the national population. However, an attempt was made to achieve realistic results by generalising family structures using multiple-choice options. However, the answers given in our survey were assumed to be correct. The main aim of our research is to compare the levels of knowledge regarding monitoring procedures and HL levels. The monitoring procedures and HL levels were compared using data obtained from the same population and sampling method, which can be considered a strong point of this study.

The knowledge levels of women of reproductive age regarding healthy baby monitoring are still not at the desired levels. However, it is encouraging

that this issue shows a correlation with health literacy levels. Our primary goal should be to ensure that every baby benefits equally from healthy baby monitoring. In this regard, primary care physicians should be encouraged through the development of supportive policies. Information gaps among women aged 15-49 should be addressed through standardised guidelines and flexible model-based education. By providing easily accessible, readable, and trackable up-to-date resources to women of reproductive age, the rates of healthy baby monitoring can be increased. Studies conducted in this area are quite limited in the literature. There is a need for comprehensive research at the national level. Additionally, the impact of the pandemic period and its aftermath on healthy baby monitoring should be evaluated, identifying which services were disrupted, and what can be done for missed monitoring during that time. New strategies should be developed to address potential negative scenarios that may arise in the future.

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