

Prenatal Development-Laying the Foundation for School Readiness

Track B – Child Health and Prenatal Services

17th Annual Virtual Birth to Three Institute

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These are the titles of each track:

- A. Inclusive Child Development
- B. Child Health and Prenatal Services
- C. Family and Community Partnerships
- D. Management and Professional Development
- E. Home Visiting and Family Child Care

Donna Britt: Welcome to everyone. I'm Donna Britt, a Senior Training Specialist for the Early Head Start National Resource Center. To begin, let's meet our guest speakers, Rachel Abramson and Janet Schultz. Rachel, would you begin please by introducing yourself?

Rachel Abramson: Sure. Thanks, Donna. Hello everyone. I am Rachel Abramson. I'm a Masters-prepared nurse and a lactation consultant based in Chicago. I've been a pediatric nurse and a postpartum nurse, and I've done nurse home visits across the west and south sides of the city. I am the Executive Director of Health Connect One, and I've provided leadership for that nonprofit organization for 27 years. Health Connect One is the national leader in developing respectful, community-based, peer- to-peer support programs for pregnancy, birth, breast-feeding, and early parenting. We work with underserved communities in 18 states, and also link frontline providers to policymakers to advocate for sustainability of their programs. Donna?

Donna: Thank you, Rachel. Now we'll have Janet introduce herself, and we'll ask her to take us right into our topic. Janet?

Janet Schultz: Thank you, Donna. It's a pleasure to be here, and good afternoon to everybody. I am a pediatric nurse practitioner with over 35 years of clinical and administrative maternal child health experience, working predominantly with young families of color, immigrant and migrant families, and most recently, with American Indian Alaskan native families. I spent the first 10 years of my professional career as a commissioned officer with the U.S. Public Health Service working in an underserved urban pediatric clinic with lots of pregnant young moms and their young children. I have been working with Head Start and Early Head Start over the past 25 plus years in various capacities: As a health coordinator, a director and a consultant. Currently, I am detailed to the Office of Head Start here in Washington DC, primarily supporting our American Indian Alaskan native grantees.

So, let's start with our program this afternoon. To begin with, we're going to be discussing all of these wonderful topics. Firstly, the regulations guiding the delivery of services to expectant families are found in the Head Start Program Performance Standard Family and Community Partnership Section, and we will be reviewing all of those pertaining to services to expectant families. We will review best practices to approaching mothers, babies and families in a holistic manner. We all know that nurturing relationships are the key to school readiness, and Rachel will give us lots of wonderful insights into this. I will be discussing the basics of staff development needs and those aspects that are critical for Early Head Start staff professional development plan. Rachel will then go on to talk about exciting, innovative practices to support families, and then we'll end with a question and answer period.

Okay, so let's get started with the first Standard here as they relate to expectant families. As boring as they may seem, it's really important to know which Head Start Program Performance Standards apply here. So, the first one tells us that Head Start Programs must conduct early and continuing risk assessments which will include an assessment of nutritional status, as well as nutrition counseling and food assistance, if necessary. Nutrition counseling is very important, as many of the Early Head Start families do not have access to the most nutritious food, whether they're remote or maybe in an urban area where food is not available, where good food is not available. Good nutrition results in healthy fetal development, which is so critical to laying the foundation for school readiness. Collaboration with their local WIC program is highly recommended. The Head Start Program Performance Standards provide guidance in this particular Standard in terms of what we must to do for prenatal care. Prenatal care consists of health promotion and treatment, including medical and dental exams, on a schedule deemed appropriate by the attending or local healthcare providers. Usually, these providers will follow the schedule recommended by the American Academy of Obstetrics and Gynecology, or ACOG, as we call it, and this must be done as early in the pregnancy as possible.

Donna: Janet, we always hear how important the physical care is in...in...during the prenatal care, but what about oral health?

Janet: Yes, that's a very good point, Donna. What is often forgotten is the importance of good oral health for the pregnant woman. When a woman has caries and poor oral health, she has a greater chance of premature delivery, which can affect brain development and ultimately, school readiness. It is so critical that a pregnant woman's oral health care needs are attended to as early in the pregnancy as possible.

So, let me tell you a story of Flora, and having been in the field for so many years, I've got lots of stories and I'm going to share lots of them with you this afternoon. This is a story of Flora. Flora was a 20-year-old, uninsured woman who recently came to the United States from Mexico. She was enrolled in Early Head Start during her second trimester, and had no previous prenatal care and rampant caries. Early Head Start's staff made two...three appointments at the volunteer dental clinic, which she did not keep, unfortunately. This particular clinic, as many volunteer or pro bono clinics across the country have, is a three strikes you're out policy, so, she was never seen. She went into premature labor at 36 weeks, and delivered her son, who was basically healthy, except for some initial respiratory problems which were resolved by day 10 of life. She finally received the much-needed dental treatment after delivery, and continued to practice good oral health with the ongoing support of the Early Head Start staff. Nine months later, she became pregnant again, this time delivering a healthy daughter at full term.

So, let's move on to a few more Standards pertaining to services to expectant families. Also, under this particular regulation concerning comprehensive prenatal health, Early Head Start staff see to it, as needed, that mental health intervention and follow-up are provided, and also documented. And these must include substance abuse prevention and treatment as needed. Many women with mental illness become pregnant in our program. Managing mental illness throughout a pregnancy is a delicate balance of the risks and benefits of the illness versus treatment and should be done in close collaboration with the mental health and obstetrics professionals.

The Head Start Program Performance Standards specifically address the need for prenatal education under this particular Standard here. For this Standard, grantees must provide information about typical fetal development, including the risks of tobacco and alcohol; labor and delivery; postpartum recovery; and maternal postpartum depression.

Donna: So, let's talk about the postpartum recovery period, specifically some innovative ideas that Early Head Start Programs can use. So many times, families focus lots of attention on mom during her pregnancy, but once the baby's delivered, the focus moves to the baby. So often we forget about the mother's needs. Is that something EHS programs need to address, Janet?

Janet: Yes, definitely. You've brought up an excellent point. Once a woman has delivered her baby, lots of attention is focused on the newborn, visitors coming to "ooh" and "aah" over what a beautiful baby she is, placing the mom on the back burner, so to speak. Lots of cute things are gifted to the baby by family members and friends. In my Early Head Start Program, we recognize the need to shower attention on the newly delivered mother as well as the baby. The home visitor serving the family would bring special gifts to the mom, such as a lovely scented lotion, soaps, pretty nursing gowns, chocolates, etcetera, in addition to some gifts for the baby. We have local organizations, such as churches, junior leaguers and others, donate these items as part of their community volunteer work, and it was a win-win situation for all involved. Also, Early Head Start staff needs to be able to recognize any early symptoms of postpartum depression. Postpartum depression can range from baby blues to full-blown depression. Here again it is so important to collaborate with local healthcare providers; so, lots of professional development is critical for all Early Head Start staff serving expectant families to ensure optimal fetal and brain development, which lead to school readiness.

Okay, so this question comes up: Is there a particular Early Head Start curriculum for school readiness? So, I'd like everybody to vote. We'll give you a few seconds, and we'll see who knows the right answer.

Donna: Do we have any responses, Kelly?

Janet. Okay. Good job. You're right on the right track. Okay, so, let's look at this Standard. Kelly, let's go on with our slides. Thank you. All right. So, let's look at this Standard in terms of developing an individualized approach. So, there is no specific curriculum but rather a framework for developing services to expectant families, which includes goal identification, strategies to achieve goals, Early Head Start staff and parent responsibilities, and the timeline to carry out the plan. So, within the context of this particular Standard, you are all quite familiar with the Family Partnership Agreement, and this is used, as we always do, serving all families in Early Head Start and Head Start Programs in serving expectant families. So, basically we are identifying goals for the participating expectant families in our program; we create strategies for which goals will be achieved; we determine the Early Head Start and parent responsibilities; and then we develop a timeline to carry out the plan because as we all know, time moves on; pregnancy is just a finite time, and we really want to establish benchmarks in terms of carrying out the plan to achieve the goals.

So, let me give you an example. This goal is the goal of the mother who states... who told her home visitor she would like to have a natural birth. She would also like the father of the baby, maternal and paternal grandmoms to be in the delivery room at the time of her baby's birth, and she wants video of the birth. Okay. Tall order here. She wants all these things done; so, how are we going to work with his family? What strategies would be used to achieve this goal of a natural birth?

So, who's responsible for what? The Early Head Start home visitor assigned to this family may want to take the lead in researching what is allowable at the particular hospital where the mom is scheduled to deliver. The mom and dad may be responsible for researching the childbirth education class schedule best suited for her due date, or her EBC, as we call it, and of course, to attend those as well as do their homework for the childbirth classes, which is basically to practice the techniques taught in class, such as breathing techniques. Together, the Early Head Start home visit with the parents may develop the birth plan. A timeline to carry out the plan needs to be developed, as we all know that as I just said, that pregnancy has a finite end, and the due date; so, it's best to align the childbirth education classes, preparing for the baby by getting necessary baby items, etcetera, with the date of the accomplishment of the goal.

So, just as a reminder, always consider the fact that the baby may come ahead of schedule; so, it's really important to be mindful of those months. So, now we've discussed the Head Start Program Performance Standards as they relate to the prenatal period. Now, let's move into what the regs have to say about the postnatal period.

Donna: Often, we see programs struggling with this particular regulation. Janet, can you share some insights into why this is important, and what programs can do to be in compliance with this regulation?

Janet: Sure thing, Donna. Here is the Standard. 1304.40(l)6, and by the way nobody has to memorize all these numbers. Too mind-boggling. But to get the gist of the Standard is really critical in terms of running a quality program for expectant families. So, this Standard provides guidance for planning postnatal transition. Programs often need to be creative to be in compliance with this regulation, such as collaborating with their local Healthy Start Program. So, here's what the standard says: Health staff visits family to ensure well-being of the newborn and mother, as well as the extended family. The two-week visit does not exclude other contacts, such as phone calls, hospital visits, shortly after delivery. Oftentimes, when you go to visit the mom and the newborn in the hospital, it really cements the relationship with that particular family that really is ongoing and very solid throughout the course of the family's enrollment in Early Head Start and hopefully Head Start. So, it is important to be sensitive to the family's needs and the mother's existing relationship with Early Head Start.

In this picture, you see two children. This is a particular situation whereby the family had children 16 months apart. The mom had a relationship with a Healthy Start nurse from her first pregnancy with her daughter. She then enrolled in Early Head Start during her second trimester while pregnant with her son, and was very connected with her Early Head Start home visitor, as well as the Healthy Start nurse whom she'd known for at least 16 months. It was important that the home visitor from Head Start and Early Head Start be respectful of the mother's relationship with her Healthy Start nurse while interacting

with this family. Always important not to be stepping on each other's toes. And again, if you don't have Health Start, if you don't have health staff on your... on your staff in your Early Head Start Program, because I know some of the smaller Early Head Start Programs, the managers wear many hats; so, then you would work very closely with collaborating community agencies, such as Healthy Start, which I just mentioned, and in tribal communities, Honor Our Children.

So, to get more information on the postpartum visit, don't forget to tune in on Thursday to webinar B4: "Meeting the Unique Needs of Families through the Required Postpartum Visit," and that will be, again, Thursday, June 6 from 2:00 to 3:30, Eastern Standard Time; so, keep tuned into that. All right.

Let's not forget that we need to discuss breast-feeding with our expectant families in Early Head Start. In 1304.40(c)(3), the Head Start Program Performance Standards are fairly prescriptive in what Early Head Start Programs must provide in terms of breast-feeding education and accommodation, and the information on the benefits of breast-feeding. It's very important to include all family members to ensure success. The nursing mom really, really needs the support of those around her, whether it be the father, whether it be grandparents, in order to be successful, and Rachel will talk much more in detail about that. For those moms who have challenging situations in nursing, the use of lactation specialists from the community can really be a godsend in terms of successful outcomes for nursing. For those of you who have Early Head Start children enrolled in center-based activities, it's really important that the areas whereby the mom can come to nurse her baby are conducive to breast-feeding. For those who are home-based Early Head Start Programs and you have group socialization, it's also important to have a private space for the mom to peacefully nurse her baby.

Donna: So, Janet, when should programs start addressing transition with families?

Janet: This work must be done as early in the pregnancy as possible, to assure the best outcome for all involved. It must be done prior to delivery, and if you see I've bolded prior to delivery because we can't do this last minute. It is really important to consider programming issues, such as availability of center-based slots, home visitor caseloads, group socializations, etcetera. You also want to assess the family's interests and needs. Is the mom returning to work full-time? Is the dad not able to help out with the baby, or maybe the dad is not around? Are one or the other parents going back to high school, if they're teen parents? Is the center-based Early Head Start option with wraparound childcare something that the family needs? So, it's really important to work with the family as early in the pregnancy as possible to transition the child to the best available option. And again, we want to continue the development of a manageable plan to transition the infant into the appropriate Early Head Start Program. And this is oftentimes a great challenge for many of our Early Head Start Programs in this country.

All right, so we're going to do a...have another question for you guys to answer. Now, don't be shy everybody. Go ahead and answer this. So: How can you create an individualized approach? Check all the correct answers here. Do you respond to the Head Start Program performance mandate? Do you consider community and population served by Head Start? Do you develop a generic approach to be used with all families? Go ahead and put your little checkmarks in there.

[Silence]

Donna: Kelly, whenever we have responses, if you'd show those please.

[Silence]

Donna: All right, guys. Don't be shy.

[Silence]

Donna: Hopefully, you're all talking about this sitting around with each other.

[Silence]

Donna: Okay, it's not showing on our screen. It is showing on our screen? Oh, it's showing on our screen. Looks like we have 52 percent respond to the Head Start Program performance standard mandate; 59 percent considered community and population served by EHS; and 14 percent develop a generic approach to be used with all families. Janet, do you have comments about those?

Janet: Excellent. Excellent, you guys. So, we definitely want to respond to the Head Start Program Performance Standard mandate and we want to consider community and the population served by the Early Head Start Program. We don't want to use a generic approach to be used with all families. We really want to use an individualized approach.

So, the take-home message, here, is we want...Early Head Start families want to determine the unique needs of participating families in their Early Head Start Program.

Donna: Janet, thank you for that information. Now, we're going to ask Rachel to share some information. So, many people think that having a baby means just going to the hospital and delivering a baby. But it is a lot more than that, isn't it, Rachel?

Rachel: Well, yes, Donna. Birth is a huge life event, and I'd like to pull back the focus for a couple minutes from the Head Start Program mandates to a broader look at the perinatal period. I think we'll be most effective if we look at pregnancy, birth and parenting the way that families do: As a whole, and in the context of relationships. Birth is a central, critical moment of life that connects to all other moments. You know, those of us who have had babies tell time by when we had which baby or when we were pregnant with our third. You keep going back to your birth in a way that sort of resonates and reverberates over time, really for all members of the family. And our family support programs, including Early Head Start, need to incorporate this experience. So, birth is not just an episode of medical intervention.

Birth is a key life event. And we really need to accompany families through their important experiences. As birth is a central moment of life, with lifelong implications, and human beings make meaning of our experiences through relationships, the continuity of those relationships throughout major transitions, like the development of a new family, gives us the best chance of helping the family grow and improving outcomes. I believe families experience programs, not just the structure of Early Head Start Programs, the home visits, the center-based care, the requirements of the program, but it's in the context of the relationships that you create with the parents that they have those experiences.

Donna: Rachel, we often hear from folks working in Head Start how difficult their job is, because not only do they need to be in compliance with the federal regulations, they are continuously faced with issues relating to domestic violence, poverty and issues with housing. How does this affect health and child development?

Rachel: Well, it's true, and it's no news to Early Head Start staff that health and development are tremendously shaped by the environment we live in. Poverty, racism, housing, social isolation, and violence have a huge impact on the life course, and particularly in the sensitive periods of pregnancy, birth and early childhood. These are called social determinants of health and development, and this approach recognizes that it's not just parents' choices that affect their children, but really, large societal forces that are beyond their control. The most important tool we have to improve the success of

families is nurturing relationships. These include consistent, trusting relationships that provide support to the mother, father, and the extended family, during pregnancy, birth, and the early days of parenting.

So really, nurturing relationships are the key to school readiness. And the core of our work should be to support consistent, responsive relationships between parents and their children. Research shows that the key to school readiness doesn't lie in knowing the ABCs, or knowing your numbers or colors at an early age, but really, the key lies in social emotional development, which brings children to school with curiosity, confidence, self-control, and a real joy in learning. Social emotional development emerges from those nurturing responsive relationships. Loving relationships give young children a sense of comfort and safety, confidence and encouragement. So, starting from birth, babies are learning who they are by how they're treated.

Donna: It sounds like the early bond between parents and children are critical to a child's emotional development. Rachel, can you tell us a little more about this?

Rachel: Well, that bond is called "attachment," and attachment is a deep and enduring emotional bond to another person. This early bond between parent and child really is critical to a child's emotional development. Parents who are available and responsive to their infants' needs establish a sense of security in their children. You cannot spoil a newborn baby. Babies cry for reasons, and need to be responded to. They need to be picked up, changed, fed, and cuddled.

Now, an insecure attachment during the formative years can significantly stress both the developing brain and body, resulting in long-term psychological and physical ailments. Parent-infant attachment actually begins during pregnancy in the prenatal period. We know that parents think about, dream about, and begin to imagine their baby long before the birth. Studies suggest that family support, greater psychological well-being, and believe it or not, having an ultrasound performed, are all factors associated with higher levels of maternal fetal attachment. Factors such as depression, substance abuse, higher anxiety levels, were associated with lower levels of maternal fetal attachment. There are prenatal approaches that can support parent infant attachment.

For example, the community-based family-administered neonatal assessment is a set of methods and activities that home visitors can use to promote emotional availability and engagement between parents and their unborn babies, and later with their newborns. The point is: We are wired biologically, psychologically, and physically to attach intensely to our babies, and you can see the intensity of that connection in this photo. This really is how the human race has survived. As our babies are born much less mature than babies of other mammals, you know, a little newborn colt, a baby horse, will get up

and run around the paddock right after she's born. But for humans who are much less able at birth, the quality and security of attachment are directly linked to infant development outcomes, and therefore, to school readiness.

Donna: Thank you, Rachel, for this important and wonderful information. Let's move, now, onto the... the discussion of professional development, which is a core principle of the Early Head Start Program. Janet, can you tell us about how programs would address this in reference to pregnancy and postpartum period?

Janet: Yes, certainly, Donna. It is most important to consider what your staff development needs are. If staff are young, they may not have experience or training in working with expectant families; so, their professional development...sorry, their professional development plan would address these particular items: Fetal and infant brain development; pregnancy; the various trimesters and what that means for the pregnant woman; the birth process; also sort of exploring, you know, what different people feel, they want to have that experience being; breast-feeding; the early postpartum period; toxic exposure: So, it's not chemicals, but it's issues of domestic violence; and unexpected events in atypical scenarios is really important, because unfortunately, not every pregnancy results in a healthy outcome. And then, of course, mental health issues for the infant and the mother.

Donna: So, let's talk about fetal and infant brain development. We've heard how important fetal and infant brain development is for school readiness. Rachel, can you help us better understand what the experts are talking about?

Rachel: Sure, Donna. Brain development in the fetus begins within weeks of conception. First, to support fetal movement, and then in the second trimester of pregnancy, in the development of other reflexes. And finally, by the end of the pregnancy, it's the beginning of the higher brain functions: Conscious experience, voluntary actions, actually thinking, remembering and feeling. The changes in the brain during prenatal and early postnatal development are just phenomenal, and we know that experience actually changes the structure of the brain. Every single experience increases the electrical activity in certain neural circuits, certain connections in the brain, and leaves others inactive. Those brain connections that are consistently turned on over time will be strengthened, like the experience of comfort, while those that are rarely used may be dropped away. Neuroscientists sometimes say: "Cells that fire together, wire together." So, early experiences actually build and change our brains.

Donna: Thank you, Rachel. Now, let's talk about pregnancy. So, how important is prenatal care to the healthy outcome?

Rachel: Well, healthy pregnancies actually begin with the health of the mother before conception. So, entering pregnancy at a healthy weight, taking a multivitamin with folic acid, and managing chronic diseases like high blood pressure, predict a healthier pregnancy. Early prenatal care really is critical to picking up problems, so that they can be treated and supporting a healthy pregnancy that goes the full 40 weeks.

Donna: It's interesting that you mentioned folic acid. When I worked in Kentucky, I was a part of the Governor's Early Childhood Task Force, and one of the committees that... that he formed was about health, and they focused on folic acid because they had a 1 1/2 times the national average rate of spina bifida. And of those numbers, about 70 percent of the babies born with the spina bifida could have been prevented, if they had been given folic acid. Through the use of the tobacco money and the pharmaceutical...and the cooperation with the pharmaceutical companies, they were able to make free to all of the families coming in to the local health department folic acid through the...through that health department, and they were able to see an increase in of about 13 percent of the families receiving prenatal care services and receiving that folic acid. As I was checking the progress in Kentucky's distribution of folic acid and the reduction of spina bifida, I was concerned to read about the number of babies being delivered before term. Rachel, do you think there is a clear understanding about how important it is to continue pregnancy for 40 weeks?

Rachel: Well, no, Donna; I think among parents and providers both, there is... there is an assumption that having the baby a few weeks early doesn't matter that much. And we even hear mothers talking about maybe having the baby early makes a baby smaller, makes the labor easier. But it's really clear from research that late, what we call "late pre-term infants," those that are born just 3 to 6 weeks early, have significantly more trouble with eating, sleeping, breathing, and maintaining their temperature. And they're more at risk of yellow jaundice and infections. Even in the last couple of weeks, the baby's brain and lungs are still developing. So, healthy babies really are worth the wait. And again, early, high-quality prenatal care is one of the best ways of supporting a healthy pregnancy that goes for a full 40 weeks. Prenatal care gives the healthcare provider a chance to diagnose and manage existing infection or chronic disease of the mother. For example, gestational diabetes, that is, diabetes or high sugar that occurs during pregnancy, can lead to problems with the birth, with the baby's health, and with an increased future risk of diabetes for both mother and baby. But if the gestational diabetes is managed during pregnancy, so the blood sugar levels stay at the normal level, there is no increased risk to mother and baby.

Finally, as Janet described, oral health should also be a part of health care during pregnancy, as gum infections and caries really may lead to preterm labor.

Donna: You've given us lots to think about related to prenatal care. Rachel, can you share some information about the birth? Why should Early Head Start staff prepare their families for the procedures related to childbirth?

Rachel: Well, preparation for birth begins in early pregnancy, and Early Head Start staff should definitely be involved in that process. It begins with a birth plan, which is a plan for where the birth will happen, who will be there, and what choices the mother can make about her care. The help that Early Head Start staff can give can do so much to help families get ready for this important moment, with education, connection to resources, and just listening to mother's concerns. Labor and birth is just really hard work. It can be a triumphant experience, or it can be traumatic, but human women birth best when they have support. We've learned what women knew for millennia that the support of an experienced woman sometimes called a "Doula," during labor and birth, decreases the need for medical intervention and C-sections, shortens labor, increases mother satisfaction with the birth process, and even improves breast-feeding rates.

So, for the health of both the mother and the baby, it is worth providing support for a low intervention birth. We know that medical interventions can save lives, but they're not without risks and side effects. Babies born by C-section may have more breathing and other medical problems than babies born via vaginal birth. C-sections can cause problems in future pregnancies, and once a woman has a C-section, she may be more likely in the future pregnancies, also, to have a C-section. The more C-sections one has, the more problems she and her baby may have, including problems with the placenta.

So, it really is best for everyone to aim for a normal, full-term, vaginal birth. So, this sounds somewhat dire, no? But, birth can also be an exhilarating experience, and after birth, the hour or two right after the baby is born, is really a critical moment for the baby and the mother to connect. It's called the "Golden Hour." Newborns should be given the opportunity to be skin-to-skin with their mothers at this time. That means the baby just wears a diaper, is chest-to-chest with his or her mother; mother's gown is off to the side, and baby and mother are covered with a blanket. This procedure makes a huge difference to successful breast-feeding, and it also significantly helps the newborn with sleep and breathing and brain cycles and adaptation to the environment outside the womb.

Donna: Rachel, you mentioned the rate increases in breast-feeding. There's so much more focus on breast-feeding, today, than ever before. What do we need to know about breast-feeding?

Rachel: Well, first of all, there're as many reasons to promote breast-feeding for the sake of the mother as for the baby. Breast-feeding is, of course, a very personal, intimate decision, but it's also one of the

most important decisions a family can make. Every mother should have the opportunity to make an informed and supported choice to give her milk to her baby for all the reasons that we hear all the time. No mother should have her provider or her support staff assume that she does not want to breast-feed or cannot breast-feed. And in fact, breast-feeding is increasing in this country, although racial and socioeconomic disparities still persist. Breast-feeding initiation increased in 2009 to almost 77 percent. That means, 77 percent of all women in America start to breast-feed their baby, at least give one feeding to their babies. Breast-feeding at six months increased to about 47 percent; almost half of all mothers are still nursing at six months. Breast-feeding at 12 months increased to a little more than 25 percent, so one in four mothers are still nursing at 12 months. The American Academy of Pediatrics recommends six months of exclusive breast-feeding for all babies, and then continuing breast-feeding with supplementation of...of solid foods for at least 12 months.

So, you can see we're actually way behind the... the American Academy of Pediatrics recommendations as a country, and we are even further behind in some of the populations that are served by Early Head Start Programs. But my organization, Health Connect One, has seen consistently, for more than 25 years, that if women and their families receive enough information and support, they are eager to breast-feed. With that support, we see consistently 80 to 85 percent breast-feeding rates in low income communities, among teens, and in African-American communities. And very often, all they need is really the basic breast-feeding information and the support of someone like them, someone who's a peer, like a breast-feeding peer counselor, who has experience and has gone through the same challenges that they have. The most important thing to know about breast-feeding is that it's natural, but it's a learned skill. Both mother and baby need to learn how to be successful. It doesn't happen automatically.

Research tells us that mothers and babies are more likely to be successful if they have that skin- to-skin contact during the hour or two after birth; if the baby receives no formula or pacifiers until breast-feeding is established, and that could be for six weeks after the baby is born; if the baby's latch is with a full, open mouth and feels comfortable to the mother, that's the best sign that the latch is right, if the mother is comfortable; and if the mother feeds frequently, and at first, around 8 to 12 feedings in 24 hours is the normal for breast-fed babies, because breast milk is so easily digested from the baby's stomach. And finally, human women need lots of support to breast-feed their babies successfully. So, again, the keys to success, skin-to-skin contact, first feeding within the 1 to 2 hours after birth, no formula or pacifiers until breast-feeding is established, a comfortable latch, frequent feedings, 8 to 12 in 24 hours, and support, support, support.

Donna: Not too long ago, the new mother and family had support from one or both grandmothers, and sometimes even great-grandmothers, to help them through the early weeks of the birth, right after birth. For many in our mobile society, that has changed. What are mothers saying about their experience in the early postpartum period now, Rachel?

Rachel: Well, birth is in many ways the same as it used to be, and as you mentioned, in many ways the context is different. Having a baby is a complicated experience. Lots of things are happening after the baby is born. Parents and other family members are adapting to the newly expanded family in their new roles. Mother is recovering physically from birth and adapting to a dramatic shift in the hormonal balance in her body. Mothers who have had a C-section, which is about one third of all women in this country, experience pain from the surgery, sometimes even for a couple of months. They're actually less likely to be breast-feeding at one week, and they tell us that they're more likely to experience several other health concerns after birth, including bladder and bowel difficulties, headaches, and backaches. New parents all may feel worried or overwhelmed, and between 50 and 80 percent of women experience some postpartum blues in the first 10 days. According to the Listening to Mother's survey, almost one in five mothers experience some degree of depression, of actual postpartum depression, in the first week postpartum. Newborns have normally irregular sleep and feeding schedules in the first week of life. It's a very messy, sleepless, sort of exhausting and unpredictable time, but normal newborns have very strong abilities to connect with their caregivers and to communicate their needs, if parents are helped to understand the meaning of their cues.

So, there's a lot going on in the first weeks after childbirth, and as you mentioned, Donna, there is often these days really not the kind of support that families used to have for this process. The old-style six weeks postpartum visit, you know, when you used to go back to the doctor after six weeks with your baby, that left mothers and families alone during this challenging time. There really is a need for intensive support, mostly in the first two weeks after birth; so, even with the mandatory two-week visit mandated by Early Head Start, there's a lot going on for those first two weeks. And then for the weeks after as well, families need basic information, assessments, breast-feeding support, counseling, and prescriptions for family planning. The American Academy of Pediatrics actually now recommends a postpartum visit at 3 to 5 days after the birth; so, you know that that's really the time that staff needs to be in touch with their families.

Donna: And the mental health issues...we all know how critical the mother's mental health status is to good child outcomes. Rachel, can you share with us any information about this?

Rachel: Well, when we think of mental health issues around pregnancy and early childhood, we usually talk about postpartum depression. But actually, maternal depression during pregnancy is, actually, just as common as postpartum depression. That's why we call it, excuse me, perinatal depression; so, 10 to 20 percent of women experience depression during the pregnancy as well as postpartum. And this really, seriously impacts maternal fetal attachment. Postpartum depression affects infant development, including social engagement; it affects the newborn's fear regulation; and physiological stress reactivity. That is how the babies respond to normal stress. These are foundations of social emotional growth.

So, you can see how important it is to screen for depression, both during pregnancy and afterwards, and to refer for support when mothers do show indications of... of postpartum depression. Also, pre-existing or newly occurring chronic mental health issues of the mother, besides depression, may have a huge effect on both mother and baby.

Donna: You've spoken now about the mother's mental health, but recently I've heard specialists in the field mention infant mental health. What's this all about?

Rachel: Well, when we consider mental health issues, we now talk also about infant mental health, which is the promotion of cognitive, emotional and social development during infancy. The infant mental health field has grown tremendously in the past decades, and focuses on supporting parent-child relationships by means of assessments, intervention, and consultation for parent-child programs. Janet, can you give us a sense of what it's like to work with a family impacted by mental health issues?

[Silence]

Rachel: And Janet, I think you'll have to un-mute yourself.

Janet: Sorry about that. [Laughter]. Okay. I've had the experience and pleasure of working for eight years with a young, smart Early Head Start mom with severe bipolar disease. She had multiple pregnancies during these years, and would elect to take herself off her medication, against her psychiatrist's orders, and as soon as she found out she was pregnant and stay off them while nursing her babies. She would repeatedly tell me that she was concerned about her babies fetal and brain development, and in particular, whether he or she would not be able to learn as well as other children who were not exposed to multiple medications during their fetal development. Unfortunately, once off her medications for a few days, her symptoms, whether it be mania or depression, would resurface and she was unable to care for herself, nor her other very young children. This family was at great risk and needed constant surveillance by many professionals and Early Head Start... Early Head Start staff to ensure healthy outcomes.

We know that pregnancy and delivery often increases the symptoms of bipolar disorder. Pregnant women or new mothers with bipolar disorder have a sevenfold higher risk of hospital admission, and a twofold higher risk for recurrent episodes, compared to those women who have not recently delivered a child or were not pregnant. A study published in the American Journal of Psychiatry found substantial

risks associated with discontinuing bipolar medication around the time of pregnancy. Women who discontinued medication between six months prior to conception and 12 weeks after conception were more than twice as likely to suffer a recurrence of at least one episode of the illness. So that looked at 85 1/2 percent compared with 37 percent who stayed on the medication. These same women experienced bipolar symptoms throughout 40 percent of their pregnancy, compared with only 8.8 percent of the time for women who continued medications throughout their pregnancy. Women who discontinued the medications abruptly were especially vulnerable to relapse. Our knowledge about the risks of untreated bipolar disease, the risks and benefits of specific medications, and the predictors of relapse during and after pregnancy is still evolving. Women who are considering taking medication during pregnancy should work very closely with their doctors. The FDA organizes drugs in categories according to their proven safety for women and the developing fetus.

So, for instance, you'll see medications rated in categories: A, those who have been shown in human studies to have no negative effects on either the mother or the child, to, basically, the most dangerous category, which would be category X. These medications should never be used by a pregnant woman. For example, lithium and first-generation antipsychotics, such as Haldol and Thorazine, are preferred mood stabilizers because they consistently show minimal risk to the fetus. Some anti-convulsions, anti-seizure medications for instance like Depakote and Tegretol, have been proven harmful to fetuses, possibly contributing to birth defects.

So, I know many of you are not health care providers, but I think this is important information to have when you are working with your Early Head Start family. So, all said and done, the bottom line here is that Early Head Start staff need to work very closely with mental health care providers, as well as prenatal providers, either obstetricians and nurse midwives, to ensure the best outcomes for mother and child. Now that you have a bit of information about exposure to some psychiatric drugs that could be toxic to the developing fetus, let's move on to other toxic exposures. Rachel?

Rachel: So, as we all know, pregnancy, birth and the early months of parenting are critical moments of growth and development. So, the exposure of mother and baby to toxic substances and experiences at these times has enormous consequences. This is a period when fetal and newborn brains are developing at really life-altering rates. Exposure to alcohol, tobacco, drugs, violence, and what we call, "toxic stress," chemically changes that development and can lead to increased risk of poor birth outcomes and also permanent damage of the brain's early architecture. And particularly under-recognized as toxic exposures are: Violence, whether in the home or in the community, and toxic stress, or chronic, extended and high-level, intense stress. These can have a huge impact on health and development, and it can take all the skills and support of Early Head Start staff to mediate this kind of toxic exposure.

Donna: We do know that not every pregnancy results in healthy outcomes. Janet, how do programs best deal with these unexpected events?

Janet: Well, all right. We all want healthy outcomes to pregnancy, but as we all know, that may not always be the case. Programs need to be prepared for all types of unexpected scenarios, such as threatened fetal demise which is an abruption or placenta previa; fetal demise which is a medical term for a miscarriage; stillborn babies; a late adoption decision. Let's say you've worked with an Early Head Start mom and she told you early on in her enrollment in the Early Head Start Program that she wanted to have her baby put up for adoption at delivery. However, at the birth of her baby, the nurse did not know that the baby was going to be put up for adoption and gave the baby to the mom to have the skin-to-skin contact that Rachel just spoke to us about and that's so important. And she decides to keep the baby. So, where is that baby going to go, you know, into what kind of arrangement, what kind of option in Early Head Start? And there is also the scenario of extreme prematurity, babies that are born very, very early in the pregnancy, and also multiple births.

So, for families who miscarry or where there's a stillborn delivery, it is really important to support the family for as long as possible within the Early Head Start Program. It would be nice if we could keep our family for 6 to 12 weeks after the event, as most families grieve after such a life event. Collaboration with other community partners is most helpful. Now, let me describe another scenario which I encountered while working in Early Head Start Program. This mother and her triplet daughters were born at 26 weeks gestation, were enrolled in Early Head Start when they were 3 to 4 months old, upon discharge from a local neonatal intensive care unit. They had many medical issues requiring many visits to pediatric specialists. By six months of age, they were diagnosed with severe cerebral palsy and developmental milestones, not to exceed 6 to 12 months in their lifetime, a diagnosis the mom would not accept. That would be hard for any mom. She set very unrealistic goals; for example, she believed that her girls would be able to hold a bottle at six months, and to this day, at age 15 years, the two surviving girls can't even feed themselves. The father of the baby was uninvolved and abusive both verbally and physically to the mom; so, not only are we dealing with a situation with an extreme prematurity, we're also dealing with the toxic exposure to violence.

After a few months of working with his family, it was apparent that she had mental health issues with depression as her major symptom. The children required 24/7 care, so, additionally she was totally sleep deprived. Intensive collaboration with local providers was necessary. She finally did receive the mental health care she needed and medications, thanks to the support of our home visitors. Three years later, she became pregnant again and although it was an unintended pregnancy, she was hoping for a son. The father of the baby was again extremely abusive, punching her in the stomach, leaving her to fall down a flight of steps in her second trimester. He wanted her to abort, but she refused. Unexpectedly, by the way she had very little prenatal care, she delivered a fraternal set of twin girls, each of whom

had, and still have, developmental challenges. One of the girls is autistic, and another child is developmentally delayed.

This is a good example of how challenging serving expectant families can be for Early Head Start staff. Here, they needed intensive professional development on how to handle this complicated situation, as well as regular reflective supervision, something I would highly recommend for all of you in your Early Head Start Program. That being said, challenges are worth the outcome.

This is a picture of a little baby that was born at 22 weeks of gestation. Her mom basically spent most of her pregnancy in the hospital in an upside down position. And this was her at 141 days of life. At age 4 years, she is doing remarkably well now. And the major difference between this little girl's outcome and that of the triplets-twin scenario I just spoke of, is the level of support afforded the pictured child versus that of the others. There is, and will continue to be, disparity in health and other related services. So, let's now talk about these disparities and innovative ways to tackle them.

Donna: We're all aware of the health disparities in our country. Are there innovative models to reduce these disparities, Rachel?

Rachel: The stubbornness of our country's ongoing disparities in maternal and child health and early learning has actually led to the development of a number of innovative models to support families most at risk for adverse health and development outcomes. These include a variety of high-quality home visiting models, group prenatal care programs, such as centering pregnancy, and a number of models that employ community-based, lay health and social service providers, or community health workers, to support families in their own communities.

Two examples of programs that my organization Health Connect One has worked with are community-based Doulas and breast-feeding peer counselors. Community-based Doulas are trusted women from the community being served. These are lay health workers who provide support during pregnancy, birth, and early parenting. Community-based Doula programs are now being replicated with support from Health Connect One in 50 organizations in 18 states. These programs support Early Head Start Performance Standards, particularly those around access to care, health promotion, prenatal education, maternal attachment, and breast-feeding.

So, community-based Doula and Early Head Start really is a great match. Health Connect One works with communities where families face huge challenges, very much the same communities served by Early

Head Start. We've found that tribal groups, immigrants, migrant families, and women of color really embrace this model for its traditional support of the childbearing year, for its peer-to-peer support of birthing mothers and families, and the health outcomes are really powerful, including 80 to 90 percent breast-feeding initiation rates, and high breast-feeding exclusivity and duration rates. Community-based Doulas have been successfully integrated into Early Head Start Programs as in the Rock-Walworth Comprehensive Family Services Doula Program in Beloit, Wisconsin. Community-based Doulas provide a weekly, face-to-face home visits, continuous physical and emotional support during labor, and that means the Doula is with the mother during the entire labor and birth, and support also in the first hours postpartum, that...that Golden Hour, and then intensive home visiting during the first weeks postpartum. The community-based Doula role is both alike and different than the Early Head Start home visitor role, as you can see with the comparison of the health services provided.

Another innovative model is the breast-feeding peer counselor model. Breast-feeding peer counselors are trained, experienced women from the same community as the mother who support the choice to breast-feed, provide information and support for a successful breast-feeding experience. We've worked in Chicago with the Chicago Urban League, which is a good example of a wonderful peer counselor program. The Urban League determined through a chart review that its breast-feeding rate was about 2 percent. After placement of a full-time breast-feeding peer counselor during the course of the year, the breast-feeding rate rose to more than 80 percent. Interestingly, they also started a male breast-feeding advocate program. The breast-feeding peer counselor was married to a male involvement staff person, and this made a huge difference in the interest in breast-feeding in the families that they served, and really the combination of mother support and father support, peer-to-peer support, was instrumental in the dramatic increase from a 2 percent breast-feeding rate to more than an 80 percent breast-feeding rate. So, these are really heroes who are available to their mothers 24 hours a day.

Donna: Thank you, Rachel, and we're getting really close to time, so Janet, do you have any final thoughts for our audience?

Janet: Yes. Let's never forget to include fathers. Father's Day is once again around the corner, and we see lots of mention about the importance of fathers at this time of the year. Just pick up a local newspaper advertising all kinds of gifts for dad. However, when Father's Day comes and goes, we often do not so readily think of them. It is critical to include fathers as well as extended family members and family friends as early in our relationships with expectant families as possible. In fact, just today, the Office of Head Start issued an information memorandum regarding improving father engagement in Head Start and Early Head Start; so, I urge all of you in this webinar to look at that. It hit your email boxes this morning.

All of these folks are needed to ensure healthy birth outcomes as one starting point for school readiness. Ultimately, families will leave their Early Head Start Programs and Head Start Programs, but they continue to thrive when we build the strength of the whole family and include their support system.

Donna: Thank you, Janet and Rachel, for sharing this wonderful information with our Early Head Start Program staff. It's now time for a few questions and answers, and I have the questions, and Janet and Rachel, I hope you have the answers.

The first question, and I'm going to let the two of you decide who would feel most comfortable answering it, is: How are we helping staff to support mothers with breast-feeding, but not alienating the moms who are not physically able to nurse? And it goes on to say breast is best and can really have...but can really have a negative impact on mothers who aren't able to nurse.

Rachel: Janet, can I take that one?

Janet: Absolutely.

Rachel: Well, I think it all comes down to supporting a mother's choice. I mean, this is...the mother's use of her body to nurture her baby, and there are very few mothers who cannot physically breast-feed their babies, but there may be mothers who have other issues, whether history of abuse, lack of support, you know, other issues in their lives that make it difficult for them to breast-feed. But every mother needs to have the informed and supported choice, and affirmed choice, whether or not to breast-feed her baby, and I think that kind of respect is really where it starts. And even if a mother breast-feeds only once, we need to support that choice, we need to let her know that she's given a golden gift to her newborn, and, you know, sort of celebrate the strength of that. I think for those mothers who... for those few mothers who medically, whether because of HIV or drug use or other factors, should not be breast-feeding their babies, and even HIV is debatable in global health, I think that we support their caring for their babies, their nurturing their babies, in all the other ways that that's possible. Particularly, holding the baby when the baby is feeding, not propping the bottle, all of those aspects of nurturing that are not just about nutrition and filling the baby's stomach.

Donna: Thank you for sharing that information, Rachel. Now, one more on breast-feeding: How can programs support a mom who wants to breast-feed, but cannot take any time off work or she will lose her job?

Rachel: That's a really common problem these days. As a society, we really do not support families the way we say we do, so working mothers really have a tremendous juggle and a tremendous challenge. Breast-feeding mothers can start out with exclusive breast-feeding, and I would recommend that as the best way to start out. Within a few weeks, if mother's going back, at four weeks, maybe around three weeks, you can start pumping milk, and trying a bottle.

There are lots of different ways to manage going back to work. Mothers can either pump at work and have caregivers give pumped breast milk to the baby during the day and then the mothers nurse at night. They can start to wean during the day when they're away from the baby and still nurse at night. Or they can nurse just for the time before they go back to work and then wean slowly as they're preparing to go back to work. So, all of these decisions and transitions really need some support, and a breast-feeding peer counselor, or if there are expert level problems, a lactation consultant or other lactation counselors with more clinical experience, are really important to incorporate into the mother's plans.

Donna: Thank you. Okay, I think this one says: Do you think there is a role for a generic checklist to make sure all important areas are at least considered? And I think this came in under Janet's talk when she was talking about generic plan or generic approach to the family. So, Janet, would you be interested in answering that?

Janet: Sure thing. We, when I was talking about a generic approach and we were talking about the curriculum issue and there is no set curriculum. Some programs use the Florida State curriculum which is good; it's a very good program, and I think a generic checklist would be okay, if it covers the Head Start Program Performance Standards that apply to services to expectant families; so, it's a good idea to go through the list of all of the standards that we cited here in this webinar and to ensure that at a minimum, these are covered in services to expectant families. And then obviously, some of the other innovative practices that we spoke of during our webinar today would be the icing on the cake, in terms of best practices.

Donna: Great. Thank you. Okay, another question: How should developmental screening be handled for babies born extremely premature and actually spend time in the NICU?

Janet: I can answer that one. What we do is we look at the... the extremely premature babies in terms of the screenings, the 45, 90-day screenings from the time that the child is discharged from the NICU. And for an extremely premature baby, you correct their age up to age 2 for most of the developmental screens. So, for instance, if a baby is born at...is born four months early, then you would correct, let's say

your Ages and Stages Questionnaire, by four months. So, if the child is eight months chronologically from the date that she was born at, that baby born at four months is really going to be screened with our screening tools that we use in Early Head Start at the four-month screening tool. Does that make sense?

Donna: I think as we're looking at has going up and down here, so I'm thinking it does, yes.

Janet: Okay, good.

Donna: And perhaps we can move on to the next question. It says: To elaborate on slide 12, which actually states the two-week visit does not exclude other contacts such as phone calls, hospital visits, shortly after delivery, and so on.

Janet: Okay, I can take that one. Yes, the two-week visit, the visit to the newborn and to the newly delivered mom must be done within the first two weeks of delivery of the baby. However, it doesn't mean that you can't do that earlier. For instance, in my program, when I was an Early Head Start director, as well as, a nurse practitioner for our newborns in collaboration with our local community healthcare provider, I would go out and visit the mom and the child in the hospital to make sure that everything was going okay, to make sure she wasn't having any questions that went unanswered in terms of nursing her baby. But then, I would follow-up with a home visit to make sure that everything was going smoothly in her own personal environment, in the home environment. So, if Head Start staff can do that, that's wonderful; however, some Head Start staff don't have health care professionals on their staff, such as myself as a nurse practitioner, and that's when we reach out to our colleagues in the healthcare community, such as Healthy Start or the public health clinics.

I worked very closely with Indian Health Service and there are public health nurses that can go out and do that...that visit to ensure the well-being of the mom and the child. What's so important within those first two weeks after delivery is to make sure, as Rachel so eloquently said, that the nursing mom is doing as well as she can, that the baby is getting the nutrition that he or she needs, that the baby is not unduly jaundiced, yellow jaundice; Rachel also mentioned that, because we do see that as the child gets a little bit older, in the first few weeks after delivery. And we want to make sure that the bilirubin does not go so high as to cause long-lasting effects; So, it is really important that there is some follow-up even after the home visit, after the hospital visit per se, within those first few weeks.

Donna: Great answers, Janet. Thank you. I...I really enjoyed that I have another question, this time I think it's about Doulas: What is the training for Doulas and are they used in all areas of the country?

Rachel: Well, there's a distinction between Doulas and community-based Doulas. There are birth Doulas who have a three-day training. There are a number of organizations who do that training, which is specifically for attendance at birth. DONA International is the largest of those organizations. Our program is a community-based Doula, which includes home visiting during pregnancy, attendance at the birth, and then home visiting and support of the family after the baby is born. So, the training is much more extensive. It's a 20-week training. We use a Train-the-Trainer model; so, Health Connect One partners with agencies around the country to train a team of local trainers, and it's usually a diverse team of clinical experts and community experts who actually work with partners to define the goals of their particular community, whether it's low birth weight or large for gestational age babies. And then they train the community-based Doulas and implement the program.

So, we generally work directly with organizations, not with individuals, and incorporate that training in our programs around the country. There are community-based Doula programs from Seattle to New York, Georgia, South Carolina; we're beginning one in Mississippi, Texas, the Southwest, so really all over the country. And I think our contact information will be on the slide at the very end, so you can get in touch with me, if you are interested.

Donna: I was going to ask that question, good. Thank you. So, one more: What do you see as the role of Early Head Start Programs regarding enrolled birth mothers who may decide to place the baby for adoption?

Janet: I'll answer that one. This is Janet. I believe that the role of the Early Head Start Program would be to ensure, to support the mom after her decision to, you know, obviously this was the best move that she has made in terms of considering all the possibilities of her life to support her decision in a very positive aspect. I would definitely recommend that there be some continuation of her enrollment in the program, at least for a few weeks, just to make sure, up to a month would be great, if that is possible, to make sure that she really is okay, because it is a hard thing to give your baby up for adoption. It's a wonderful thing in terms of, you know, having this child have a wonderful family that will be able to take care of that child, whereby, the birth mother felt she did not... she did not feel that she could do the best for that child; But, I believe that as an Early Head Start Program, we really do need to support that young woman or that woman who has made that decision and does not drop her from the roll the day she delivers, and that baby went into an adoptive parenting household.

Donna: Thank you for sharing that information. I do have...I'm going to combine the next two questions because we were almost out of time. The first part is: Who can do the two-week visit and the second part is what does "health staff" mean? So, I'm thinking that you can choose who answers that?

Rachel: I think that's a Janet question.

Janet: I will definitely answer that because we see that in monitoring reports all the time [laughter]. "Health staff" means somebody who has been trained in health, either a nurse; it can be an RN; it can be an LPN; folks who are community providers through a local clinic, through, you know, you might have pediatricians who have staff nurses who can go out. If the person does not have the experience to be able to ensure that the baby is doing well, the mother is doing well, then that person would not be the person to do the home visit, the health visit. There is a certain...there is some skills that are needed in terms of identifying; let's say, the child who does need to have a repeat bilirubin, the test for yellow jaundice.

There needs to be some clinical experience in terms of the mother's postpartum period, in terms of making sure that if she had a C-section that the wound is healing well, that she is doing well in terms of her bowel and bladder function, in terms of her postpartum bleeding; so, some of those real technical issues need to be addressed during the particular visit with the mom, within that two-week period. So, there is a level of expertise that is needed, and that is the reason behind not any, let's say the health coordinator who may have a little... who may be a certified nursing assistant who had previously worked in...in a nursing home prior to coming to work in the Early Head Start Program. She would not be the person to go out and do that, because she really didn't have the skills, experience or training in terms of identifying potential problems.

Donna: Thank you, and I think that the next webinar on Thursday will cover more information, if you're interested, and it appears that we've run out of time. Time flies when you're having fun, and it's over. So, I want to thank everyone who hung in there with us, and thank Rachel and Janet for participating and sharing this wealth of information, and we hope to hear from all of you on Thursday. Thank you very much.

Janet: Thank you all.