

Giving Children the Earliest Head Start:

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Developing an Individualized Approach to
High-Quality Services for Pregnant Women

Technical Assistance Paper No. 3

Prepared by Early Head Start National Resource Center @ ZERO TO THREE



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families
Administration on Children, Youth and Families
Head Start Bureau



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This document was developed by the Early Head Start National Resource Center (EHS NRC) @ ZERO TO THREE in collaboration with the Head Start Bureau. The contents of this paper are not intended to be an interpretation of policy. The information in the Early Head Start program profiles are offered to assist programs in the effort to develop and implement high quality services for pregnant women and families with infants and toddlers.

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The prenatal period of growth and development is critical to optimal child development in the first three years of life and beyond. From conception to age three, human development occurs more rapidly than at any other time in life. Fetal development, like all stages of development, is progressive, involves critical periods, and benefits from supportive practices administered through a range of supports and services offered as early as possible. Inadequate prenatal care is associated with a host of health and developmental problems — low birth weight, premature delivery, birth defects, poor growth. Furthermore, these babies are at an increased risk of learning, social, and behavioral problems. Thus, Early Head Start (EHS) is poised to make a significant and long-lasting impact on the future of America's most vulnerable children.

Elements of Quality: The Head Start Program Performance Standards

The *Head Start Program Performance Standards* specify the supports and services that must be offered to expectant families enrolled in Head Start programs serving pregnant women. These services include comprehensive prenatal and postpartum health care, prenatal education, and breastfeeding education and accommodations.

The *Performance Standards* that govern services to pregnant women are located in the Family and Community Partnerships section (45 CFR 1304 Subpart C) of the *Performance Standards*¹. The *Performance Standards* identify which services must be provided by the EHS grantee, and which services grantees must assist pregnant women in accessing through community referrals.



Laconia EHS, Laconia, NH

¹ The *Performance Standards* in 45 CFR 1304 Subpart D, **Program Design and Management** also apply to grantees serving pregnant women. The *Performance Standards* in 45 CFR 1304 Subpart B, **Early Childhood Development and Health Services** only apply to children and **do not** apply to pregnant women. The regulations governing the Home-based Program Option in 45 CFR 1306 refer to services for children and **do not** apply to services to pregnant women.

Comprehensive Prenatal and Postpartum Health Care

Early Head Start grantee and delegate agencies must assist pregnant women to access comprehensive prenatal and postpartum care, through referrals, immediately after enrollment in the program. This care must include:

- (i) Early and continuing risk assessments, which include an assessment of nutritional status as well as nutrition counseling and food assistance, if necessary;*
 - (ii) Health promotion and treatment, including medical and dental examinations on a schedule deemed appropriate by the attending health care providers as early in the pregnancy as possible; and*
 - (iii) Mental health interventions and follow-up, including substance abuse prevention and treatment, as needed.*
- 45 CFR 1304.40(c)(1)(i)(ii)(iii)**

Collaboration with community partners is essential to the design and management of a high-quality EHS program serving pregnant women. Some examples of potential community partners include: health clinics, transportation services, counseling and other mental health programs, doula services, or translation services for non-english speaking families.

Pregnant women must be connected to health care providers, and ultimately a “medical home.” A medical home is a place where an individual will receive routine health care, and ideally, establish an ongoing relationship with a familiar health care provider. A pregnant women will need a medical home to have her health monitored during pregnancy, to gather information on the status of her developing child, and where she will continue to receive medical care following the delivery of her baby. Oral health and a regular source of dental care are equally important during pregnancy. The baby will also need a medical home for well-baby checkups and immunizations.

Along with resources that allow EHS parents to access comprehensive health care, they must also receive information on good eating habits and proper diet. The effects of a healthy diet translates into the creation of cells which evolve into the developing child’s tissue, muscle, and bone. All of the child’s organs and the brain begin to develop in the earliest weeks of pregnancy. Optimal health and nutrition allow parents, very early on, to positively influence their child’s future. EHS programs are required to make an assessment of nutritional status and, if necessary, help families find resources to obtain adequate food.

In addition to partnering with community health and nutrition programs, EHS should join forces with agencies that address families’ housing and social service needs. Stressors such as unstable housing or violent communities pose significant threats to any parent’s ability to care for herself and her child. Parents may need help securing safe and appropriate housing. Expectant parents and families with very young children should be educated about the risk of lead poisoning that is commonly found in low-income communities. Examples of potential community collaborations include: health care clinics for lead screening, homeless shelters, local churches for food and clothing donations, or family support centers for adult education or job training.

Community mental health partners also support services to expectant parents. Substance abuse prevention or treatment, and other mental health concerns are critically important to the healthy development of the growing fetus and the parent’s ability to appropriately care for their baby. Free or low-cost counseling and treatment programs may be available through religious organizations, county departments of Health and Human Services, or local nonprofit agencies.

The *Health Services Advisory Committee* is a vital resource for addressing the issues affecting local families. EHS programs can tailor the composition of the group to ensure that expertise and linkages to local resources are represented. Members of the *Health Services Advisory*

Committee can assist with developing health care guidelines, locating community resources, and establishing important linkages for services to pregnant women.

Community partnerships are critical to providing the prenatal and postpartum health care that is required by the *Head Start Program Performance Standards*. Since most of these services are rendered outside of the EHS grantee, it is imperative that EHS programs develop effective systems for planning services, communicating pertinent information with all the involved parties, and record-keeping and tracking to ensure that services were rendered and in a timely manner and to monitor the outcome of the referrals.

Prenatal Education

Grantee and delegate agencies must provide pregnant women and other family members, as appropriate, with prenatal education on fetal development (including risks from smoking and alcohol), labor and delivery, and post-partum recovery (including maternal depression). 45 CFR 1304.40(c)(2)

The *Performance Standards* identify the major topics to be covered in prenatal education efforts. These include information about:

- typical fetal development, including the risks of smoking and drinking alcohol;
- what to expect during labor and delivery; and
- postpartum recovery, including maternal depression.

Prenatal education can take many forms: written materials, informal conversation, structured classes, videotapes, one-on-one instruction, or group meetings with other expectant parents. The role of EHS staff is to serve as an advocate and liaison between expectant

parents and service providers². EHS program activities may range from providing transportation to community-based prenatal classes, to providing referrals to substance abuse treatment programs, or using written materials to explain the stages of fetal development.

Written or audiovisual materials are popular and useful tools for explaining many of the physical changes that occur during pregnancy and child birth. It is a challenge for EHS staff to sift through the vast array of materials, identify the best resources, and carefully select what will most effectively meet the individual and diverse needs of participating families, as well as how the information should be delivered. The needs and resources of participating families, the individual expertise of EHS staff members, community partners, and the *Health Services Advisory Committee* are critical links in planning an effective approach to prenatal education. (Please see Appendix A for an example of a creative approach to prenatal education.)



Children's Home Society of Washington, Auburn, WA

Breastfeeding Education and Accommodations

Grantee and delegate agencies must provide information on the benefits of breastfeeding to all pregnant and nursing mothers. For those who choose to breast feed in center-based programs, arrangements must be provided as necessary. 45 CFR 1304.40 (c)(3)

The medical evidence for the benefits of breast milk is so compelling that the American Academy of Pediatrics issued a statement in 1998 urging mothers to breastfeed for at least the first year of life. Pregnant or nursing mothers enrolled in EHS must receive information on the benefits of breastfeeding. It is also helpful to have other family members involved in these efforts so that the mother is fully supported and necessary accommodations can be made to ensure that breastfeeding is successful. Some parents may need the additional support of a lactation specialist, who is trained to address the problems that can arise in the breastfeeding process.



Children's Home Society of Washington, Auburn, WA



Heartland Programs, Salina, KA

Early Head Start programs must also ensure that the facilities they use for center-based activities, including group socializations, are conducive to breastfeeding. This means that mothers have a place they can breastfeed comfortably, and the storage and handling of breast milk can be accomplished according to the recommended health and safety guidelines.

Developing an Individualized Approach

Programs that serve expectant parents are challenged to meet the varied and complex needs of mothers and fathers during such an important time in the life of the family. The needs of families vary based on family and cultural differences, personality and coping styles, health and medical status, stage of the pregnancy, and a host of other variables. There are many resources to help EHS staff successfully meet this challenge. The key is *individualizing* the approach to fully engage parents, fulfill the requirements of the *Performance Standards*, and give each baby the best possible start in life.

Prenatal Planning

The *Head Start Program Performance Standards* **do not** require that programs use a specific curriculum for pregnant women. There is no single tool that will be appropriate for all families. The development of an approach to services for pregnant women is best defined in the broadest terms as the goals and process for learning. At its best, this approach provides a framework within which individual needs are met. The *Performance Standards* describe a process for developing a Family Partnership Agreement [45 CFR 1304.40 (a)(2)] that can provide a framework for developing services for pregnant women. This approach would include:

- identifying the goals for participating families;
- creating the strategies through which they will achieve these goals;
- determining EHS staff and parent responsibilities; and
- developing a timeline to carry out the plan.

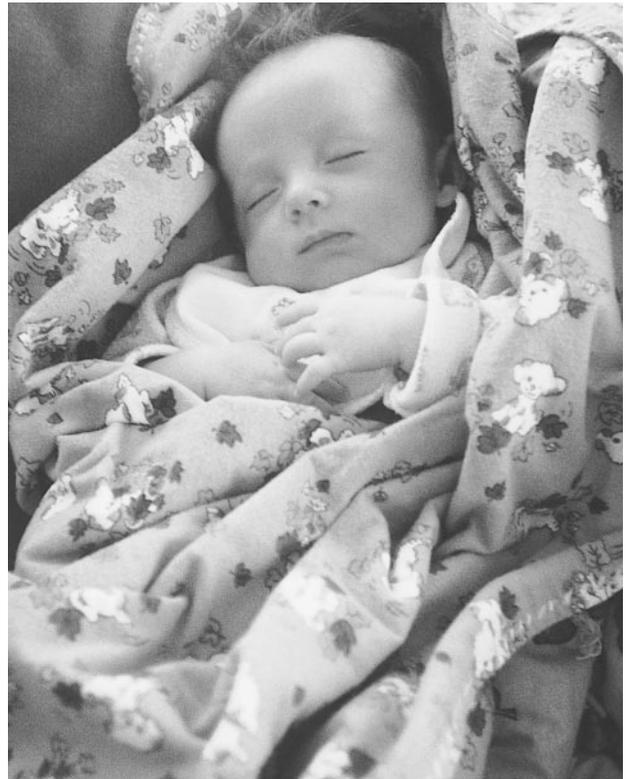
This comprehensive approach allows EHS programs tremendous flexibility to be truly responsive to the individual needs of participating families, programs, and communities.

Prepackaged Prenatal Materials

There are prepackaged materials for pregnant women on the market. These resources can be valuable tools for EHS programs. Be creative and take from them what is appropriate for your program, and meets the needs of your particular community and the individual mother and family you are working with.

Postnatal Transition Planning

The postnatal period is a unique time for every family as its' newest member takes his or her place in the world. Emotions run from one extreme to the other, and all members of the family experience a certain amount of upheaval and adjustment. During this time, EHS programs are required to arrange for health staff to visit the newborn (within two weeks after birth) to ensure the well-being of the mother and child [45 CFR 1304(i)(6)]. This individual may be staff of the EHS program, or may be with a public health or other collaborating community agency. Selecting the appropriate staff requires sensitivity to the individual family's needs, and the mother's existing relationships with EHS staff and community health providers. The two week visit does not exclude other contacts, such as telephone calls, depending on the needs of the family and available resources in the community.



West Medford EHS, Medford, OR



Tennessee Cares EHS, Paris, TN

This first postnatal visit is an opportunity to assess the family's interests and needs and to continue developing a manageable plan to transition the infant into the appropriate EHS program option. This transition plan would include the types of support the family may need, timelines for meeting these needs, and the roles that EHS staff will play to assist the family. For example, the most pressing need may be to support the mother's desire to breastfeed by collaborating with a lactation specialist who can assist with any problems she is experiencing. Alternatively, a mother may be experiencing a degree of postpartum depression that requires mental health consultation. Perhaps she is feeling isolated and lonely and would find it helpful to talk to a home visitor each week. Or she may be feeling exhausted and overwhelmed and prefer to postpone home visits until her physical and emotional strength have returned. Each of these scenarios is an example of individualizing the EHS services in the postnatal period to effectively support parents in their most important new role.

Another important aspect of this transition planning is the transition of the child into the appropriate EHS program option. Family circumstances and preferences will dictate the type of program services most appropriate for the infant. For example, home-based services may be a desirable option until the time that the parents return

to work and have the need for child care. At that time center-based or family child care partnerships may be the best arrangement. Issues of health and safety are paramount. For example, very young infants (less than 6 weeks old) or premature infants should not be exposed to crowded environments and may be too young for group socializations. Mothers who need to return to work prior to 6 weeks postpartum must be supported in making the best child care decisions for their young infants. Anticipating future needs maximizes the EHS program's ability to be responsive to family circumstances. **Prior to** the birth of the child, EHS staff, in collaboration with program administrators, need to consider programming issues such as: how space will be made available in center-based programs; how home visitor caseloads will be affected; and how the group socializations for infants will build upon the goals of the home-based services and meet the needs of parents with newborns.

How Do You Create an Individualized Approach?

1. Respond to the mandates of the Head Start Program Performance Standards

The requirements of the *Head Start Program Performance Standards*, outlined above, provide the essential elements of **what** EHS programs must provide or help families access: comprehensive prenatal and postpartum health care, prenatal education, and breastfeeding education and accommodations. It is up to each program to determine **how** these will be accomplished.

2. Consider the community and population being served by EHS

What does the Community Assessment reveal about the potential needs of expectant parents in your community? For example, can pregnant women in a rural community access an Obstetrician/Gynecologist in the community or must she travel significant distances for

medical care? How can EHS bridge the limited access to prenatal care? Alternatively, if the Community Assessment identified a high rate of teenage pregnancy, how will the EHS program meet the unique needs of pregnant teens? The short and long term goals of the EHS program are one part of the overall approach to developing effective services for expectant parents.

The *Health Services Advisory Committee*, composed of both parents and volunteers from the community, is a key component in the development of a comprehensive approach to services for pregnant women enrolled in EHS. Ideally, health professionals from the field of obstetrics and gynecology are active participants. As discussed above, the members of this committee can provide important linkages to community resources, in addition to bringing their individual expertise in selected areas relevant to the needs of pregnant women.

3. Determine the unique needs of participating families

Every pregnant woman enrolled in EHS has a *Family Partnership Agreement* which is a rich source of information for individualizing program services. The *Performance Standards* describe a collaborative process of developing a plan that is driven by the parents' identification of family strengths, needs, resources, and goals. Since each *Family Partnership Agreement* will be unique, so will the plan for achieving those goals. EHS staff play an important part in helping parents determine how their goals will be defined in measurable terms, timelines for achieving those goals, the process for how the goal will be achieved, and how it will be determined that a goal has been met. Answering these and similar questions will help determine if services should be provided through home visits and/or other service delivery options, how often these activities will occur, and so on.



EOC Early Head Start, St. Joseph, MO

Tying It All Together

Develop Management Systems

Management systems and procedures only exist to support program services. It is easy to overlook this aspect of program planning in the drive to establish effective relationships with families. Yet these systems are the critical supports that allow the vision of EHS to come to life.

The following five management systems are identified in section **45 CFR 1304.51** of the *Performance Standards*. Consider how services to pregnant women are integrated into each key area. It is important to remember that each of these systems are interrelated and influence each other.

Program planning: Services to expectant parents, like all EHS programming, is tied to the Community Assessment. Written plans identify both long and short term objectives and goals that meet the identified needs in the Community Assessment.

Communications: Effective communication systems ensure that pregnant women receive comprehensive services, and that community partners are well prepared to support EHS efforts. It is important to consider how information can be shared in a timely manner, and that appropriate confidentiality guidelines are established. Effective communication with the governing bodies

ensures that members have adequate time to review and reflect on information and materials, participate in decision-making, and respond to grantee needs. Communication between staff members, and staff and family also require a thoughtful approach. Both formal and informal mechanisms provide the opportunity to share information that contributes to the quality of the services. A climate of open communication is built over time and requires mutual trust and respect.

Record keeping: Many of the services for pregnant women are delivered in partnership with community agencies. Up-to-date and comprehensive records are necessary to ensure that these services are of high quality, delivered in a timely manner, and that any follow-up activities are carried out appropriately. Record keeping is also essential in documenting how services are meeting the *Performance Standards* and other federal or state regulations; following the progress of individual families; and to identify the emergence or resolution of specific issues across the entire program.

Reporting: Formal, written reports of program progress for services to expectant parents provide governing bodies and staff with the information needed to continually assess and improve the quality of program services.

Self-assessment and monitoring: High-quality services to expectant parents require on-going review and reflection to remain responsive to families needs. Seek both formal and informal feedback on how program services are having an impact. Use this information to build on program strengths and identify areas to improve.

Consider Staff Development Needs

Working with expectant parents requires specialized knowledge of a broad array of topics that cross many fields of study: fetal and infant development, reproductive health and child birth, lactation, mother and infant nutrition, substance abuse, family functioning, and

mental health. Staff who are hired to work with pregnant women in EHS come from varied backgrounds and have different levels of knowledge, experience, or comfort addressing these topics. A wide variety of training and professional development experiences are necessary to meet staff development needs. Reading material, formal course work, conferences or workshops, “shadowing” more experienced staff, and role-playing are some of the experiences to consider. Delivering information in a variety of ways creates staff development experiences that build on each other over time.

The role of reflective, or supportive supervision is central to effective staff development. Reflective supervision refers to a collaborative relationship between supervisor and staff members that provides regular opportunities to reflect on the work of providing high-quality services to expectant families. This opportunity provides a safe environment in which staff can openly discuss challenges, celebrate achievements, brainstorm solutions, identify needs, and deepen their understanding of working effectively with families.

Remain Flexible and Responsive

Individuals, families, and communities change. In fact, the ability to change is the very quality that makes work with families and children so rewarding. There is no one recipe or formula that will guarantee success for all families. However, there are many resources and tools available to design a program that is truly responsive to the needs of expectant families enrolled in the EHS program. In fact, services to expectant parents are where the potential to have the greatest impact can be realized. By supporting children and their parents at the earliest stage of parenthood, our most vulnerable children are afforded the *best* start in life.

Early Head Start Program Profiles

The program profiles in this section provide an overview of two EHS grantees' particular approach to serving pregnant women in EHS. The Clermont County Head Start describes their process for developing a comprehensive approach to structure their prenatal education efforts. The Drake University EHS describes their unique partnerships in community collaboration and diverse staff development efforts. All EHS programs are empowered to develop services to meet the needs of their own communities, thus each program model is unique.

Clermont County Head Start, Child Focus Learning Center Cincinnati, Ohio

Community Profile: Clermont County is a rural county located in southwestern Ohio. The population continues to be predominantly (about 98%) white with the remainder being African American, Asian/Pacific Islanders and Eskimo/American.

The culture native to Clermont County is the white, Appalachian culture. Education and income levels do not seem to improve from one generation to the next. In Ohio, there is a severe poverty concentration in the Appalachian population. According to a report from the Cincinnati Health Care Foundation, the poverty rate in Clermont County is currently 8%. Unemployment rates are currently 0%.

Welfare reform has left many families without healthcare coverage leading to more children who are not receiving needed health care. Medical providers are faced with more uninsured patients and decreased reimbursement creating the need to cut services,

implement new policies regarding fee arrangements and other cost-cutting strategies. Information revealed during a recent Healthy Baby Coalition meeting shows fewer women are accessing prenatal care in the first trimester, in some instances, not until the third trimester, and that fewer are keeping routine postpartum visits.

Comprehensive Prenatal and Postpartum Care: Clermont County Early Head Start serves 84 children and their families ages birth to three as well as pregnant women. The program goals are to promote the physical, cognitive, social and emotional growth of infants and toddlers and prepare them for future growth and development; support parents – mothers, fathers, guardians – in their role as primary caregivers and educators of their children, and in meeting family goals and achieving self-sufficiency across a wide variety of domains; strengthen community supports for families with young children; and develop highly trained, caring and adequately compensated program staff.

Upon enrollment into the EHS program, pregnant women are assisted with locating a medical provider, healthcare coverage, transportation and other needs as indicated. Clermont County EHS developed a prenatal plan to deliver comprehensive services in a home-visiting model. The importance of routine prenatal care is stressed throughout the plan. Mothers complete a nutritional assessment upon enrollment which is reviewed by the Nutrition Services Manager who makes direct contact with mothers regarding deficiencies or other concerns. This is shared with the home visitor or advocate working directly with that mother to provide follow-up. The material focuses largely on the importance of prenatal care as well as the need for mother to address health issues. For example, mothers are assisted with locating a dental provider, health and dental care coverage and transportation as indicated. Our agency has a strong

substance abuse prevention component headed by the Prevention Manager who is easily accessible for assistance as needed. The material includes information regarding fetal development, including risks and hazards during pregnancy due to substance abuse, labor, delivery and postpartum issues. The Health Services Manager conducts a joint home visit with the indicated staff person within two weeks of the child's birth.

Development and Format of the Pregnancy Curriculum:

Our approach to serving pregnant women was developed by the Health and Nutrition Services Managers and approved by an Assistant Professor of Pediatrics at Children's Hospital Medical Center. We utilize a multimedia approach in a structured format to provide prenatal education on array of topics, including fetal development, nutrition, breastfeeding, maternal changes, hazards during pregnancy, and postpartum issues.

Several factors led to the development of this approach. Many important factors impact pregnancy outcomes including health and nutritional status, hazards during pregnancy such as smoking and alcohol consumption, compliance with routine prenatal appointments and others. Some of our goals are to reinforce the importance of keeping all prenatal visits and following health recommendations, and to provide specific clinical information regarding maternal changes, fetal development, nutrition during pregnancy and other health-related information. The staff who work with pregnant women have an early childhood and child development background, rather than training in clinical or health-related fields. The Pregnancy Curriculum provides a tool to deliver this specific clinical information in an integrated, discussion-based approach using teaching tools written and designed by clinical professionals. Regular home visits allow EHS staff to track medical appointments, provide opportunities for dialogue around how prenatal health visits went and follow through on any recommendations, and promote healthy habits in a case management approach.

The structured format consists of monthly planning guides to assure all topics are covered during the pregnancy. There is no specific order for this, however, for organizational purposes all topics are assigned to a specific month of the pregnancy. Each month is further broken down into various activities and experiences which are to be covered over the course of the month.

In addition to the monthly guides, the materials include a section on postpartum information, and an array of materials about the perinatal period including videos, books, pamphlets and other teaching tools available through our lending library. A portable TV/VCR is available to show videos in the home as needed. We also purchased flip charts for educating families on specific perinatal topics. These materials include the *With Child Flipchart*, *Postpartum Flipchart*, and *Breastfeeding Flipchart*. These provide realistic visual aides to compliment the written materials and verbal information shared with the family. Other materials that we have included in our curriculum consist of the *Help Me Grow* publication from the Ohio Family and Children First Initiative obtained from the Ohio Department of Health. We also utilize the *Great Beginnings Calendar* published by the United Dairy Council.

Our county is fortunate to have prenatal services provided through several agencies regarding breastfeeding, childbirth preparation and postpartum services. We include these agencies as resources in the Pregnancy Curriculum for referrals as needed.

Pregnancy Curriculum Evaluation: Of the 20 pregnant women served by utilizing the Pregnancy Curriculum who gave birth in the 1998-99 program year:

- **100%** of pregnant women **accessed prenatal care** in the first trimester;
- **92%** kept all **prenatal appointments**;
- **61%** made a positive **lifestyle change such as** decreased caffeine intake, decreased number of cigarettes smoked each day or quit smoking, and increased exercise;
- **100%** kept all **postpartum follow-up** and first newborn doctor visits;

The evaluation process was done with a survey tool that rated each section of the material on a scale from one to five. Percentages were then computed from those responses. As reflected above, the results are very complimentary. EHS staff are also surveyed on an annual basis to determine their assessment of using these materials with families. Staff reported this approach to be very useful for parent education.

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Drake University Early Head Start Des Moines, Iowa

Background Information: Drake University has been a grantee administering the Head Start program since 1977. Drake University Head Start serves eligible three- to four-year-old children and their families in Boone, Jasper, Marion, Polk, Story, and Warren counties in central Iowa. In 1991, Drake University received funding to operate a Parent & Child Center in Polk County. The Drake University Parent & Child Center operated five years prior to converting to an Early Head Start program site as part of Wave II. Drake University Early Head Start is currently funded to serve 63 pregnant women, infants, toddlers and their families (53 with Federal funds and 10 with State funds) in Polk County.

Community Information: Polk County has the fourth highest infant mortality rate among counties in the United States³. Approximately 25% of medically uninsured Iowa women are between the ages of 15 and 44 (Healthy Iowans 2000). There are high rates of smoking, low-birth weight babies, and low rates of breast-feeding initiation and duration.

The Prevent Child Abuse Council of Iowa estimates that 30% of the Iowa population is at-risk due to poverty and other hardships. With approximately 6,000 births per year in Polk County, an estimated 1,800 families are identified as at-risk. In Polk County, there are only three programs, including Drake University Early Head Start, offering comprehensive services to families with a total enrollment of 225 families. There are, therefore, an estimated 1,575 families with children under three years of age with unmet needs for support services in Polk County.

Des Moines has the highest number of methamphetamine abusers per capita of any city in the nation. To date, Des Moines has one of the highest arrest rates for possession and/or production of methamphetamine in the United States. Physicians in the Des Moines metro area have reported an increase in the number of infants born drug-affected.

The Hispanic/Latino community in Des Moines continues to grow in geometric proportions. Hispanic Educational Resources reports that there are more than 28,000 Hispanic families living in Des Moines comprising more than 12% of the population. Currently, 25% of the families enrolled in Drake University Early Head Start speak only Spanish. In all of Polk County, there is only one comprehensive support program for families with children under the age of one year with bilingual staff. In addition, Des Moines serves as a refugee hub. The need for translation and interpretation services in our community is overwhelming.

At least two free health care clinics in the Des Moines area expect to close their doors within the next year due to lack of funding and volunteer health care providers.

The infant mortality rate among African Americans in Polk County has increased from an average of 22 infant deaths to 23 infant deaths per 1,000 live births.

³ Iowa Infant Mortality Prevention Center, Infant Mortality Prevention Consortium Quarterly Review Meeting on April 28, 1998.

Comprehensive Prenatal and Postpartum Care: In an effort to impact as many pregnancies as possible due to the high infant mortality rates in our community, Drake University Early Head Start has a Perinatal Support Specialist (PSS). The PSS works with women during pregnancy and six months postpartum with follow-up visits at 9 and 12 months. If a woman already participating in Early Head Start becomes pregnant, the specialist working with her family will work with her in concert with the PSS (See staff development section for additional information). Some families choose to transition to another EHS specialist and continue with Early Head Start (as space is available) while other families transition to other programs.

Our program offers a monthly support and education group for pregnant women and postpartum women with infants. In addition, our program offers a monthly support group for fathers and other significant male caregivers.

We have developed our own tool for assessment combining a variety of resources. This assessment has an initial contact component as well as a component for each trimester. The assessment was developed using a strength-based approach. In terms of the nutrition assessment, we have a collaborative agreement with WIC. We make sure each pregnant woman is receiving WIC services. WIC, in turn, provides us with a copy of each woman's nutrition assessment. This practice ensures that WIC services are in place, the assessment is completed, a dietician reviews the assessment and follow-up services are provided for each woman. If a pregnant woman refuses to participate in WIC, we utilize a nutritional assessment we developed in concert with WIC, and maintain a contract with a dietician to review these assessments and make recommendations for follow-up.

If a pregnant woman is not receiving prenatal care, we connect her to a medical home for prenatal care **immediately**. Prenatal care and dental care are critical aspects of our work with a pregnant woman. We have Prenatal Exam Records that physicians and midwives

complete each trimester and the pregnant woman returns to her specialist. The pregnant woman and her specialist review the Prenatal Exam Record together prior to the appointment and the pregnant woman completes a section with any questions she has to review with her health care provider. Mental health interventions are employed as appropriate on an individualized basis.

Community Partnerships: We have a number of partnerships in the community to support pregnant women. In terms of community resources, we individualize referrals and connections to other community resources depending on the needs of each pregnant woman and her family. Examples of our partnerships include, but are not limited to those listed in Table 1.

Table 1

Drake University EHS Community Partnerships*

Agency	Primary Collaboration
Healthy Start	Translation services
Refugee Services	Translation services and cultural training for staff
Young Women's Resource Center	Car seats and support services for pregnant women
OB/GYN physicians, midwives	Consultation
Perinatologist	Consultation and free testing
La Clinica	Perinatal care, consultation, translation, and assistance with Department of Human Services paperwork for Latina women
Creative Visions	Support and assistance for African American teens
House of Mercy	Free lead screening and substance abuse treatment
Lutheran and Catholic Services	Counseling
Doulas in Des Moines	Free doula services

*All of the agencies/individuals listed above provide referrals to Early Head Start as appropriate.

Access to prenatal care continues to be a challenge in our community. Several free and/or sliding scale fee clinics are expected to close due to lack of funding and/or lack of volunteer health care providers. In addition, when a woman is identified late in pregnancy without prenatal care; it is not uncommon to have difficulty locating a health care provider that can schedule an appointment before her due date. As a result, Drake University Early Head Start has been working with other community partners to establish a free ob/gyn and pediatric clinic to serve women and children in Polk County. As a result, the Heart & Hands: Women & Children's Health Center was established and co-located within the same facility as Drake University Early Head Start. Renovations on the clinic space are currently underway.

The overall goal of Heart & Hands: Women & Children's Health Center is to increase the accessibility and utilization of well-woman, prenatal, postnatal, newborn and well-child health care. This clinic will serve women and children from families with low incomes as well as homeless and at-risk women and children. This health center will focus on preventative and client-centered care. Heart & Hands Health Center staff will work collaboratively with other health care providers and outreach programs such as EHS, Healthy Families/HOPES and Healthy Start to promote continuity of care. In addition, there will be an emphasis on education to empower families to make informed choices and be proactive concerning their care and health. Ultimately, the aim of the Health Center is to promote wellness, improve the health of women and children, increase utilization of health care services by low-income women and their families and reduce infant mortality and morbidity.

A certified nurse midwife and a pediatric nurse practitioner as primary care providers will staff the clinic. Nurse-midwives are certified to care for women from puberty until death as well as newborns through the age of one year. Pediatric nurse practitioners are able to care for children through adolescence. Contracted consulting relationships with physicians will facilitate the referral of clients requiring additional or specialized

care. In addition, the established relationship and rapport between Health Center staff and clients will ensure better client compliance in accessing specialized medical care from a physician. Care provided by advanced nurse practitioners is comprehensive and more cost effective than the same services provided through most medical clinics. In addition, studies show that clients have found advanced nurse practitioners to be more accessible both in terms of availability of appointment times and in the amount of time devoted to each visit. This is a distinct advantage in working with low-income families who frequently have accessibility problems as well as additional needs for health education.

This project owes its feasibility to the unique partnering of community agencies and services, the availability of certified nurse-midwives and pediatric nurse practitioners and the interest, enthusiasm and commitment of many agencies and professionals. A very significant benefit to this project is a community-based site. This church also serves as the site for the EHS program so pregnant women and families with young children are already accustomed to participating in activities in this building. The services already in place through the EHS Program dovetail and enhance those which would be provided through the clinic. As a result, EHS and the Health Center staff will function as a multidisciplinary team.

First and foremost, we work with pregnant women to be their own best advocate in obtaining and negotiating services. Feedback from a pregnant woman and her family provides important information regarding the appropriateness and timeliness of services she received (or did not receive). We also attend appointments and visit other agencies with pregnant women to ensure the appropriate provision of services and to provide support. We obtain consents to release information as appropriate to communicate with providers and community partners. Moreover, the EHS staff participate on many community committees, boards, work groups and forums to ensure the appropriate provision of services to pregnant women, children and their families in Polk County.

Prenatal Education: The approach to perinatal education is highly individualized. We do not follow a particular, formalized curriculum although we have access to a variety of curricula. The information provided and manner of presentation is highly dependent on the pregnant woman's circumstances, needs and interests. Our assessment tool helps to identify strengths, needs and interests as well as support that can be provided by staff. Some of the factors considered include:

- Needs and resources of the pregnant woman and her family
- Expectations, knowledge of pregnancy, labor and delivery
- Gestation
- Age of the pregnant woman
- Parity and the previous past experience(s) with pregnancy and birth.
- Complications in current or previous pregnancy.
- Primary language
- Feeding choices (breast or bottle)
- Prenatal care
- Newborn care
- Nutritional status
- Substance use or abuse
- Support systems
- Resources

We have a number of materials in Spanish as well as for work with pregnant teens. We are also continually reviewing and obtaining new and different curricula as well as additional materials as resources.

Staff Development: First and foremost, the qualifications in job descriptions require degrees and experience. For example, the Perinatal Support Specialist qualifications are as follows:

1. Education: B.A. or B.S. in infant & toddler development, family development, social work, psychology, human services or related field or B.A., B.S. or R.N. in pediatric or maternal health nursing or a related field preferred.
2. Experience: Minimum of three years of experience working with pregnant women, infants, toddlers and/or their families.

In addition, we have a multidisciplinary team within Drake University Early Head Start. Staff from different areas of expertise serve as a resource to one other. We have staff with education and/or experience in health, early childhood education, infant and toddler development, psychology, social work, cultural studies, and adult learning. In addition, there is a great deal of experience working with low-income and at-risk populations among staff members.

Our professional development plans and continuing education are critical to ensure skilled and well-trained staff. This is especially true for the other specialists as they work with pregnant women and their families. Planning for professional development and further education is comprehensive addressing perinatal and newborn care as well as other issues impacting the expectant family.

The following examples illustrate professional development opportunities in our agency:

Certified Breastfeeding Educator Training: The Early Head Start Coordinator, the Perinatal Support Specialist, two Early Education Specialists, the Family Development Specialist and the Male Involvement Specialist have participated in training and are certified as breastfeeding educators. (Note: All specialists are home visitors.) All staff maintain this certification through ongoing professional development activities in regard to breastfeeding. This training better prepares staff to promote and support breastfeeding women and their families.

Certified Doula Training: The Early Head Start Coordinator, the Perinatal Support Specialist, two Early Education Specialists, the Family Development Specialist and the Program Assistant have participated in training and are in the process of completing the requirements for certification as a doula. This professional development opportunity provides important training regarding labor, delivery and postpartum period for staff to share with pregnant women and their families. In addition, EHS staff can serve as a professional labor assistant and provide support during labor and delivery.

Certified Infant Massage Instructor Training: The Early Head Start Coordinator, the Perinatal Support Specialist, two Early Education Specialists, the Family Development Specialist and the Program Assistant have participated in training and have completed the requirements for certification as Infant Massage Instructors. The Male Involvement Specialist will be participating in this training in the next six months. Staff teach infant massage on an individualized basis during home visits. Infant massage classes are offered during the prenatal/postpartum classes and other parent child activities.

Certified ChildBirth Educator Training: Currently, we are reviewing two different certification programs for staff training.

Other Services for Expectant Families

Slings: Expectant families participating in Drake University Early Head Start receive a sling and training on proper use upon the birth of their infant. Research shows that infants that are carried in a sling during the first six months of life, actually cry less from 6 to 12 months of age. Again, this is a tool that increases contact between parent and infant and promotes bonding and attachment.

Breast Pump Loaner Program: Drake University Early Head Start has a breast pump loaner program for breastfeeding women to support breastfeeding. We provide the kits, training, on-going support and the loaner pump for the duration of breastfeeding. We have a variety of pumps available to best meet the needs of each breastfeeding woman. We make referrals to lactation consultants as appropriate. We have a high breastfeeding initiation and continuation rates in our program.

Contact:

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Selected Resources

For Services to Pregnant Women

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Appendix A

My Pregnancy Memory Book: A Week by Week Journal

This resource was developed by *Hand in Hand Early Head Start* in Waterloo, Iowa. It is reproduced here as an example of one approach to introducing topics for prenatal education, and as a vehicle to address a variety of physical, social, and emotional issues that arise during pregnancy and childbirth. This is a condensed version of the format that is used with families. The actual journal provides space for writing and reflecting on the questions posed, a bibliography, handouts for each month of pregnancy, and answers to commonly asked questions.

Week 1: This is the week of your last menstrual period. The first day of significant bleeding is considered the start date of pregnancy because it's easier to remember than the date of conception.

Week 2: In anticipation of a new life, the uterus forms a blood-rich lining of tissue called the endometrium.

Week 3: This is the week of ovulation. If during this week the sperm and egg meet, a new life is started.

Week 4: This is the week that the fetus will begin to develop. By the end of this week you will have missed a period, though slight staining is possible.

Week 5: The embryo is now the size of an apple seed. This is the week that most women suspect they are pregnant; a home test can often confirm it. Schedule an appointment with a doctor. ***Who was the first person I told I was pregnant?***

Week 6: The embryo now looks more like a tadpole than a human. Baby's heart, no bigger than a poppy seed, has started beating. If you haven't already, you may begin to experience some nausea, vomiting, sore breasts, fatigue and frequent urination. ***What physical changes have I noticed in my body so far?***

Week 7: The embryo is the size of a raspberry. Dark spots are appearing where the eyes and nostrils will be. The arms and legs are beginning to form. ***What are my fears about parenthood?***

Week 8: The embryo has slightly webbed fingers and toes. Your expanding uterus is now the size of a peach. ***If I could give you any gift in the world, what would it be?***

Week 9: The baby is now about the size of a strawberry and is constantly moving, though you won't feel it yet. ***What changes am I making to prepare for you?***

Week 10: The baby's genitals are now beginning to form, but it's too soon for your doctor to tell the sex from an ultrasound. ***What are my hopes and dreams for you?***

Week 11: The baby is now swallowing and kicking. Fingernails and hair begin to fill in. You and your doctor can hear the heart beat with a special stethoscope. Your uterus is now the size of a grapefruit. ***What is something I want to teach you someday?***

Week 12: Your nausea may now begin to go away. The baby is fully formed from tooth buds to toenails. The odds of miscarriage drop considerably at this point. ***What things am I doing to communicate to you?***

Week 13: Your baby will squirm if your abdomen is prodded, though you can't feel the movement. ***What were my thoughts when I first heard your heart beat?***

Week 14: Your baby is now the length of a crayon and has fingerprints. ***What exercises am I doing to keep you and me healthy?***

Week 15: Hair and eyebrows begin to grow. The baby's skin is covered with ultrafine hair that usually disappears before birth. ***What is the best advice I have gotten so far and who was it from?***

Week 16: Your baby continues to grow. Most women need maternity clothes by now. ***What is my favorite outfit to wear and where did I get it?***

Week 17: Your baby's lungs are working and the heart is pumping blood through the body. ***Sometimes I wonder about.....?***

Week 18: Within the next couple of weeks, you may begin to feel your baby move. Your baby is now able to suck its thumb. ***What unusual dreams have I had?***

Week 19: An ultrasound may be done around this time. During this sneak preview, you may see the baby kick, roll, or even such his thumb. If the baby is in the right position, it's possible to tell if it's a boy or girl. ***I've been thinking about names. Here are some ideas!***

Week 20: The top of your uterus now reaches your belly button. The baby is about six inches long and weighs about nine ounces. ***What family traditions do I want to pass on to you?***

Week 21: Your baby has grown a coat of a waxy, furry substance called vernix. Ask about childbirth classes if you haven't already. ***Which holiday traditions will I pass on to you?***

Week 22: Sudden loud noises may set off a startle reflex in your baby, causing its heart rate to rise and arms and legs to kick. ***What movements have I felt and what do they remind me of?***

Week 23: At about one pound, your baby is proportioned like a newborn, though still scrawny. ***What foods am I craving?***

Week 24: Your baby's hearing is fully developed. You may be given a test for gestational diabetes between now and 28 weeks. ***I know it's important to talk to you at this time. I like to tell you about....***

Week 25: If you feel something in your midsection that resembles a dripping faucet, this is your baby having hiccups! ***To keep you healthy, these are some of the foods I am eating...***

Week 26: The baby weighs about one and a half pounds and is about nine inches long. ***I know you love music. What songs am I sharing with you?***

Week 27: Most women have gained 16-22 pounds by this point. Your baby weighs about 2 1/2 pounds and is about 15 inches long. ***So far, I've gained _____ pounds. What am I doing to make myself more comfortable?***

Week 28: Your baby's eyelids have opened and it will try to shield its eyes with its hands if a light is shone inside the uterus. ***What were my thoughts about your ultrasound pictures?***

Week 29: Space starts to get tighter and the baby will do less tumbling, but you will still feel plenty of stretching and kicking. ***I have noticed your are most active when....***

Week 30: The baby has eyelashes and any hair with which he or she will be born. ***When I think of you, I see.....***

Week 31: Now is the time to select a pediatrician for your baby. You may want to check into pre-registering at the hospital. ***These are the preparations I am making for your arrival....***

Week 32: Your baby now has fat developing for the first time under the skin. ***What is my favorite baby gift I have bought or received for you?***

Week 33: You should be gaining about a pound a week now; roughly half of that goes right to your baby. Your baby gains 50% of its birth weight during the next seven weeks, while the skin grows plumper and pinker. ***How is this pregnancy affecting my sleep?***

Week 34: Most babies settle into the head-down position now. This is also a good time to think about what you will take with you to the hospital. ***What will I take with me to the hospital?***

Week 35: Your doctor will probably check you weekly until you deliver. Be sure to write down your questions and take them with you to your appointments. ***Here are some questions I have before you arrive...***

Week 36: Your uterus is now a thousand times its original size. The baby is beginning to position itself for birth. ***What comments am I receiving about my pregnancy?***

Week 37: By the end of this week your pregnancy has come full term. Baby could be born any day. ***What fears do I have about my delivery?***

Week 38: Most of the baby's waxy vernix and downy hair have disappeared, although some babies may still have some at birth. ***Who have I invited to be with me during your delivery?***

Week 39: The average full-term newborn is 20 inches long and weighs about 7 1/2 pounds. Take it easy. If you feel tired, rest. ***I want to be a good mom to you. Here are some things I think it takes....***

Week 40: Don't worry if your baby isn't born by your due date. Only 5% are. Most doctors wait two weeks before considering a pregnancy overdue. But it won't be long before the miracle that nature started so many weeks ago is finally nestled in your arms. ***I knew it was time for you to be born when...***



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