

# Pregnancy Outreach Program



## Handbook



*Working together to give  
babies the best start*

Revised 1997/98



BRITISH  
COLUMBIA

Ministry for Children and Families  
Regional Support Division



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## I. PROGRAM DESCRIPTION

### A. Introduction and Rationale

The Pregnancy Outreach Program, sometimes referred to as POP, is an important part of the Government of British Columbia's effort toward the prevention of low birth weight, one of the most pressing issues in prenatal care in the Province and in Canada. Low birth weight (less than 2500g at birth) and prematurity (less than 37 weeks gestation) are widely considered to be the most important risk factors for infant morbidity and mortality. Low birth weight infants are forty times more likely to die in the first four weeks of life and five times more likely to die in their first year. Low birth weight infants are three times more likely to have neuro-developmental handicaps, such as mental handicap, cerebral palsy, vision and hearing impairment, or learning disabilities. As well, low birth weight infants are more susceptible to common pediatric illnesses like respiratory infections.

In Canada, the cost of health care for a low birth weight infant has been estimated to be from \$500 to \$1000 per hospital day (1). The average number of days of hospitalization increases with decreasing birth weight. The cost of care over the lifetime of one handicapped low birth weight child is over \$1.5 million.

Mothers who are economically, socially and educationally deprived are most at risk for having a low birth weight baby. Specific risk factors include low pre-pregnant weight, poor prenatal weight gain, poor nutrition, smoking, and alcohol and drug use. Experts agree that the prevention of low birth weight should focus on these modifiable risk factors, and over the longer term on education and socio-economic status.

High risk prenatal counselling programs are not new to Canada. The Montreal Diet Dispensary has been providing nutrition counselling and food supplements to low income women since 1948. Vancouver's Healthiest Babies Possible began in 1975. The Ontario Ministry of Health has published a resource document (1) identifying community-based programs located in Canada and the United States, which are aimed at preventing low birth weight. In 1994 Health Canada published a list of prenatal health promotion programs in Canada, many of which work with high-risk clients (2). A review of these programs (3) found that they had common characteristics which had been used successfully. These characteristics included: a strong outreach component, support for clients' basic needs (including providing food and vitamin supplements), flexibility, cultural appropriateness, collaboration of health and social services, a community development approach, inclusion of behavioural issues, and a mix of educational strategies.

#### **Impact on Birth weight**

High-risk prenatal counselling programs have resulted in a positive effect on birth weight and pregnancy outcomes. A study of the Montreal Diet Dispensary evaluated differences in birth outcomes between 522 sibling pairs. Each mother had participated in the Montreal Diet Dispensary nutrition counselling program during the pregnancy of her second born, but not of the first born member of the pair. After adjustment for parity and gender, the intervention infants weighed an average of 107 grams more than their matched sibling, and the rate of low birth weight was 50% lower among the intervention infants (4).

The Special Supplemental Food Program for Women, Infants and Children (WIC) in the United States has been providing nutritional supplementation and education to high-risk pregnant women

since 1972. A study published in 1984 (5) found that when WIC participants were compared to non-WIC women, the program produced an increase in mean birth weight and a 4% decrease in the incidence of low birth weight. Another study published in 1993 (6) found that participation in WIC resulted in significantly reduced rates of low and very low birth weight.

Norwood (7) studied the pregnancy outcomes of participants in a maternity support program (First Steps) compared to those of non-participants. The program provided nutrition assessment and counselling, as well as various social support interventions. Norwood found that more program participants quit smoking than non-participants. In addition, women who had more than two program contacts gave birth to infants who required less time in neonatal intensive care.

The Healthiest Babies Possible Program in Toronto provides dietary assessment and counselling, as well as milk for its clients. The program aims to improve health knowledge and behaviour of high-risk pregnant women, so that pregnancy outcomes are improved. According to a study by Mendelson et al (8) women who participated in the program significantly improved the quality of their diets. In Saskatoon, an evaluation of the Healthy Mother, Healthy Baby program (9) determined that a high percentage of the clients (84%) had inadequate diets and that substantial change was demonstrated through the course of involvement in the program.

Qualitative reports and quantitative reports of BC's Pregnancy Outreach Program, as well as annual provincial status reports (10-13) have shown consistently positive results. Pregnancy Outreach Program clients report that the Program provides them with information and support. The Program is successful in reaching the target group, and reaching them early enough and keeping them in the program long enough to have an effect. The Program is successful in achieving the objectives of decreasing alcohol and drug use, improving nutrition, and encouraging breastfeeding.

#### **Impact on Health Care Costs**

Programs which aim to reduce low birth weight can have enormous financial benefits. Burtlehaus and Dickie (14) reported a case study of a client enrolled in the Healthiest Babies Possible program in Vancouver. The case study cited involved the nutritional care provided to a 15 year old client who was severely underweight pre-pregnancy and had lost weight in the first trimester. Regular nutrition counselling and food supplements resulted in a positive outcome. The intervention cost \$572.45 and resulted in a savings of \$70,680 (hospital costs for a low birth weight baby).

Buescher et al (6) determined that participation in WIC resulted in savings. For each dollar spent on WIC an average of \$2.91 was saved in Medicaid. The savings are attributed to reduced costs for newborn medical care because of improved birth weights and pregnancy outcomes.

Matsumoto (15) also provided support for the important role of WIC in reducing infant mortality and lowering health care costs. Matsumoto states that according to a WIC/Medicaid study, WIC participants and their children were healthier during and immediately after pregnancy compared to non-WIC women. It was estimated that for every dollar spent on a pregnant woman participating in WIC, \$1.77 to \$3.13 was saved in medical costs.

**Summary**

The benefits of preventive programs such as BC's Pregnancy Outreach Program can reach beyond the client and the immediate cost savings of improving the health of pregnancies. The 1993 Pregnancy Outreach Program Qualitative Evaluation Report (13) illustrated this fact in reporting the responses of client's friends and family, as well as community service workers and clients themselves. The data showed that BC's Pregnancy Outreach Program is reaching high-risk pregnant women and that positive changes in lifestyle are not only occurring in clients, but also in their immediate circle of family and friends. The ripple effect of healthier mothers and healthier babies can be seen in healthier families and communities; the value of which is immeasurable.

## B. Program Description

The Pregnancy Outreach Program provides education and support to high-risk pregnant women who tend not to access traditional prenatal health services.

The Program began in 1988 with the funding of pilot sites in eight communities: Cranbrook, Duncan, Nanaimo, Port Alberni, Prince George, Surrey, Terrace, and Williams Lake. Evaluation showed that the pilot sites were successful. The Pregnancy Outreach Program was reaching women who had not previously been reached effectively by health professionals. Clients were making significant lifestyle changes, and gaining self esteem and control over their health.

In 1991/92, based on the success of the eight pilot sites, the Program was introduced in Campbell River, Kamloops, Quesnel, Smithers, and Victoria (Esquimalt). In 1992/93, the Ministry of Health allocated additional funding to the Pregnancy Outreach Program provincial budget, which was used to enhance funding to the fourteen existing sites and to expand the program to eight new sites: Burnaby, Delta, Fernie, Mission, Nelson, Prince Rupert, Salmon Arm, and Ucluelet. See Appendix A for addresses of existing Pregnancy Outreach Programs and other comprehensive prenatal nutrition programs in BC. See Appendix B for sample descriptions of three representative Pregnancy Outreach Programs.

Funding for the Pregnancy Outreach Program is provided on a contract basis to community agencies which have well established links to the target group. As Sponsoring Agencies are not necessarily in the "health care business", they rely on mandatory Local Advisory Committees of health professionals, including Health Unit representation, and community leaders for program consultation. Health Regions/Units/Departments also support programs through the provision of information and resources related to relevant public health and perinatal issues.

Programs are staffed by a Coordinator, either a Registered Nurse (RN) or a Registered Dietitian/Nutritionist (RDN), a Resource RN or RDN, to complement the discipline of the Coordinator, Outreach Workers (lay counsellors) and volunteers. As the team approach is crucial, the programs must provide both nursing and nutrition directed services. However, the Outreach Workers are the primary service providers. The extensive use of Outreach Workers provides a culturally appropriate peer approach, which is key to the success of the Pregnancy Outreach Program.

Lifestyle issues are the primary focus of the counselling provided by the Program. Particular attention is paid to nutrition, smoking, and alcohol and drug use. All clients are assessed for physical, substance misuse, and psychosocial and economic risk factors before they are accepted into the Program (see Appendix C, *Individual Prenatal Risk Identification* and *A Guide for the Use of Individual Prenatal Risk Identification*)

Counselling and support offered by the Pregnancy Outreach Program (refer to section I.D, Service Model) consists of five major areas:

- Drop-ins (group sessions) provide clients with easily understood information through guest speakers, socialization with peers, and a meal or snack.
- Individual counselling on-site or on an outreach basis provides clients with opportunities for personalized support.
- Food supplements are provided for low income clients.
- Vitamin/mineral supplements are provided for low income clients.
- Clients are referred to other appropriate community services.

During the Pregnancy Outreach Program's relatively short history the enthusiasm for the Program from clients, physicians, community agencies, First Nations organizations, and Health Regions/Units/Departments throughout the Province has been strong and is growing.

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British Columbia Ministry of Health. Community and Family Health. Pregnancy Outreach Program: 1992/93 Status Report. Victoria, March 1994.

British Columbia Ministry of Health. Community and Family Health. Pregnancy Outreach Program: 1993/94 Status Report. Victoria, May 1995.

British Columbia Ministry of Health. Prevention and Health Promotion. Pregnancy Outreach Program: 1994/95 Annual Report. Victoria, January 1996.

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British Columbia Ministry of Health. Prevention and Health Promotion. The Impact of Prenatal Behaviour Modification on Maternal and Infant Outcomes: British Columbia's Pregnancy Outreach Program. Victoria, September 1995.

Review of the Nutrition Component of the Pregnancy Outreach Program: A Survey of Pregnancy Outreach Program Coordinators, Victoria, April, 1995

Yawn, Barbara. Low Birth Weight Prevention: Issues and Challenges. Toronto: The Hospital for Sick Children Foundation, October 1990.

United States General Accounting Office. Early Intervention: Federal Investments Like WIC Can Produce Savings. Washington, D.C., April 1992. (GAO/HRD-92-18 can be ordered from the U.S. General Accounting Office P.O. Box 6015, Gaithersburg, MD 20877 (phone (202) 512-6000 fax (301) 258-4066))

### Videos

British Columbia Ministry of Health. Pregnancy Outreach Program: A Baby Doesn't Get a Second Chance to Make a First Impression. Victoria, 1992.

## C. Goals and Objectives

The goal of the Pregnancy Outreach Programs is to promote positive health practices that contribute to the health of newborns and mothers. The strategies used to achieve this goal are outreach, education, and support to at-risk parents.

There are specific objectives which describe changes in the behaviour of the participants, and are measures of the Program's success.

### 1. Improve Nutrition

- 1.1 To encourage an appropriate weight gain for pregnancy using standards for underweight, average, and overweight women. Special attention should be provided to teenage pregnancies and multiple births.
- 1.2 To increase the number of servings from each food group to the minimum recommended in the *BC Food Guide for Pregnancy* (refer to section IV.C, Nutrition).
- 1.3 To encourage an adequate intake of those foods rich in protein, iron, calcium and folic acid, nutrients important to fetal development.
- 1.4 To encourage the development of a well-balanced meal pattern for the woman and her family and the consumption of regular meals.
- 1.5 To improve food security by providing food supplements, meals or snacks at drop-ins, and/or referral to community resources as required.

### 2. Decrease Smoking

- 2.1 To eliminate or at least decrease the number of cigarettes smoked by those pregnant women who smoke, and to maintain this behaviour throughout the pregnancy.
- 2.2 To reduce exposure to secondhand smoke during pregnancy (at home, in the workplace, and socially).

### 3. Decrease Alcohol Use and Drug Misuse

- 3.1 To decrease the number of alcoholic drinks consumed by pregnant women who drink, to decrease the incidence of binge drinking, to maintain the decrease throughout the pregnancy and to encourage and support abstinence.
- 3.2 To reduce drug use to only those drugs approved by a physician.
- 3.3 To identify women at risk for alcohol and drug abuse by using the *T-ACE Questionnaire* (see Appendix D), and by taking a history of personal and family alcohol and drug use for all clients.
- 3.4 For clients with identified risk for substance misuse, to ensure referral to appropriate counselling and intervention in conjunction with the local Alcohol and Drug Services.

**4. Raise Self-Esteem**

*To support and acknowledge lifestyle goals the client has set for herself.*

**5. Encourage Breastfeeding**

- 5.1 To encourage breastfeeding during program contact so that clients have the knowledge they need to breastfeed on hospital discharge and are supported to continue for at least six weeks.

**6. Promote Dental Health**

- 6.1 To encourage all pregnancy women to seek regular dental care and maintain good oral health habits
- 6.2 To identify women in urgent dental need.
- 6.3 To ensure referral for appropriate care in consultation with the Health Unit/Department dental hygienist, for clients with urgent dental needs.

**7. Encourage Physical Activity**

- 7.1 To encourage participation in some form of physical activity, that is approved by a physician, e.g. walking or swimming, at least three times per week.

**8. Encourage Early Physician Care**

- 8.1 To encourage client to access prenatal care by a physician, prior to her second visit to the program.
- 8.2 To encourage client to attend regular prenatal visits with physician.
- 8.3 To ensure referral to physician for treatment and intervention for any client with an emergent medical concern.

**9. Promote Social/Community Support**

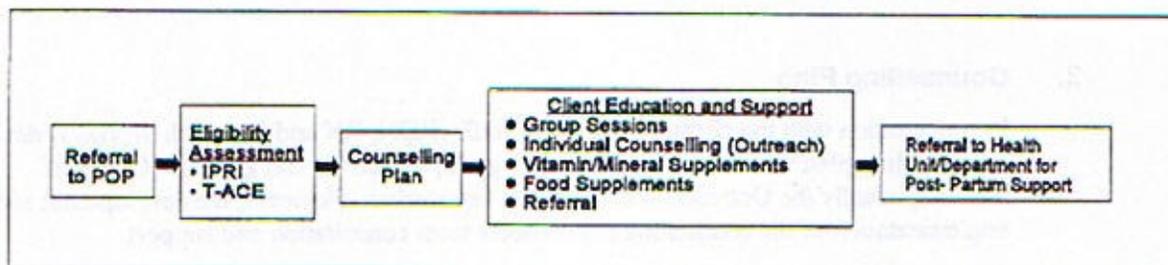
- 9.1 To encourage the participation of the client's family and friends in the program.
- 9.1 To encourage client to access applicable services/ programs available in the community during pregnancy and after birth of the baby.
- 9.2 To provide opportunities for client to meet other individuals, who may be experiencing similar situations.

It is crucial that the Pregnancy Outreach Program service be client-focused. In collaboration with the client, the client's needs are determined, and the specific objectives to be targeted by the Program staff are identified. Usually, three is the maximum number of objectives that a client and Outreach Worker can realistically work together on at one time.

## D. Service Model

The service model for the Pregnancy Outreach Program is shown in Figure 1.

Figure 1. Service Model for Pregnancy Outreach Program



\* Acknowledgments and outcomes of referral may be provided to Referral Source.

### 1. Referral

Potential clients are most commonly referred by self-referral, Government and community agencies, or physicians.

### 2. Eligibility Assessment

- Women are assessed for eligibility within fourteen days of referral using *Individual Prenatal Risk Identification (IPRI)*. See Appendix C for the *IPRI* and *A Guide for the Use of Prenatal Risk Identification*, and Appendix D for the *T-ACE Questionnaire*.
- In order to be enrolled in the Program, a women must have at least one risk factor, according to the criteria in *A Guide for the Use of Prenatal Risk Identification* (see Appendix C).
- Priority for enrollment is given to women at less than 28 weeks gestation and/or women at-risk for substance misuse, as identified by the *T-ACE Questionnaire* (see Appendix D).
- The Coordinator is involved with and/or reviews all eligibility assessments.

*IPRI* and *A Guide for the use of Prenatal Risk Identification* (see Appendix C), including the *T-ACE Questionnaire* (see Appendix D) are used to establish eligibility. Eligibility is based on the existence of at least one risk factor (physical, substance misuse, psychosocial or economic) which may have an adverse effect on the outcome of the pregnancy. The Coordinator participates in and/or reviews all eligibility assessments to ensure that the women are consistently assessed according to the criteria in *A Guide for the use of Prenatal Risk Identification* (see Appendix C).

Given that pregnancies are only nine months long, programs have a limited time span in which to influence the outcome of the pregnancy. It is important that women be contacted as soon as possible following referral. In order to make the most effective use of available resources and to have the greatest impact on lifestyle behaviours and pregnancy outcomes, priority is give to women who are less than 28 weeks gestation. However, participants at-risk for substance misuse, as identified by the *T-ACE Questionnaire* (Appendix D), should

be admitted at any time in their pregnancy because alcohol and drugs are damaging at all stages.

During the eligibility assessment, staff may initiate the collection of more detailed information regarding client needs and background using the *Client Data Sheet* (see Appendix E). The information is used to support client counselling and program evaluation and monitoring activities.

### 3. Counselling Plan

In consultation with the client, the program staff (RDN, RN and Outreach Workers) develop a counselling plan with the client, including, goals, objectives and actions. One staff member, usually the Outreach Worker, is the key worker. However, the development and implementation of the counselling plan reflects team consultation and support.

The counselling plan is based on a detailed assessment of the client's health and social status using the *IPRI* (see Appendix C), *T-ACE Questionnaire* (see Appendix D), *Client Data Sheet* (see Appendix E), and other assessment tools and techniques appropriate to the client group (refer to section III, Client Characteristics and section IV, Client Counselling). Goals, objectives and actions are established in partnership with the client. The counselling plan is flexible, and is adjusted to accommodate the client's accomplishments and changing counselling needs.

If the client agrees, it is strongly recommended that feedback be given to the referral source (see Appendix F for a sample *Feedback to Referral Source* form). The purpose of the feedback is to enhance communication among the client's support network. As well, it promotes the application of consistent counselling approaches, and the provision of accurate and consistent health information from various support services.

However, it is important to consider whether an exchange of any particular information will deter the client from disclosing lifestyle factors which could influence the pregnancy outcome (e.g., fear of child apprehension because of drug misuse). What specific information would be shared should be discussed with the client and follow the guidelines set out in the *Freedom of Information and Protection of Privacy Act* (refer to section II.D, Confidentiality Issues).

### 4. Client Education and Support

There are five standard components to the Pregnancy Outreach Program service. These components were selected based on supporting evidence in the literature and on the experience of high-risk counselling programs. The five components and the specific standards established for the Pregnancy Outreach Program are:

- a) Group Sessions to encourage peer support.
  - Culturally appropriate group sessions are offered a minimum of once every two weeks.
  - Group sessions include a healthy meal or snack, containing at least two of the four Food Groups.

- b) Individual Counselling based on the client's counselling plan is provided on an outreach basis.
- A minimum of five individual counselling sessions are provided for the client.
  - An individual counselling session is defined as "a meaningful one-to-one interaction between a program staff member and the client, which supports the client's needs and is consistent with the client's counselling plan".
  - Outreach is defined as "the provision of individual counselling in the location which best suits the client's needs, provided confidentiality is maintained".
- c) Prenatal Vitamin/Mineral Supplements are provided for clients in financial need.
- d) Food Supplements for clients in financial need.
- A minimum food supplement of the equivalent of 3 servings from the Milk and Milk Products Food Group and 3 servings from the Fruit/Vegetables Food Group per day is provided (approximately equal to 6ℓ of milk per week and two 355 ml. cans of frozen orange juice per week).
  - Any exceptions to this standard based on special local needs must be approved by the RDN at the Health Unit or delegate. Approved program exceptions to the standard must be documented and retained on file for one year, for review by the Contract Manager
  - The standard may be modified on an individual basis to meet the needs of clients with special therapeutic or cultural considerations, according to the documented assessment and recommendations of the Resource RDN or RDN Coordinator.
- e) Referral
- With their permission, clients are referred to the local Health Unit or Medical Health Services Centre (on reserve) prior to their 'due date'.
  - With their permission, clients are referred to other community services as needed.

a) **Group Sessions**

Group sessions are an essential component of the Pregnancy Outreach Program. The programs are required to have a group (drop-in) session a minimum of once every two weeks. For the clients who participated in the Qualitative Evaluation in 1993, fellowship at the group sessions was clearly the most popular aspect of the program.

Spouses, children, and friends attend group sessions with the clients, as well as "graduate" mothers. There may be a presentation on a topic selected by the clients, such as healthy eating, budgeting and shopping skills, breastfeeding, or the effects of second hand smoke. During the discussion that usually follows the presentation, there is a great deal of exchange, support, and interaction among the women. The pregnant clients learn by watching the behaviour of the "graduates" with their babies.

An important part of the group session is the provision of a healthy meal or snack. This provides a source of nutrients to many low income clients. The food often serves to draw clients to the drop-in, and provides an opportunity for modelling and learning about nutrition concepts. Food preparation can also be a learning, a social and/or a cultural event. The importance of nourishment to the success of the drop-ins was

clearly recognized as the Program evolved. This was acknowledged by the Coordinators who agreed that a nourishment containing at least two of the four Food Groups be a mandatory part of the group sessions.

Coming to the drop-ins and being part of the Program is often the first step for many of the clients in taking control of their lives and reaching out for help. Getting and giving information, listening and being listened to, and learning new things gives the clients a sense of self-worth and dignity they might not otherwise experience. They receive positive feedback about themselves, talk about common problems, and know that people genuinely care about them and what is happening in their lives.

**b) Individual Counselling**

Individual counselling is an essential component of the Pregnancy Outreach Program. An individual counselling session is defined as "a meaningful one-to-one interaction between a program staff member and the client, which supports the client's needs and is consistent with the client's counselling plan".

Individual counselling sessions will range greatly in time spent in the sessions and on topics covered. Topics will depend upon the client's counselling plan and the client's needs at the time. Individual counselling sessions give the client an opportunity to ask questions about anything that may be troubling her, as well as allowing the counsellor to provide specific information pertinent to individuals and to offer support for the client in the achievement of her goals. As nutrition is a risk factor with most clients, it is strongly recommended that counselling sessions include a diet recall and weight measurement as diet indicators.

Individual counselling may be difficult if the client is uninterested or difficult to locate, however the counsellor should continue in attempting to offer this service to the client unless the client indicates that they do not want to participate in the Program. All program staff may provide individual counselling to the client, however the majority of individual counselling is usually provided by the Outreach Worker. A minimum of five counselling sessions are provided to the client.

Outreach is defined as "the provision of individual counselling in the location which best suits the client's needs, provided confidentiality is maintained". This includes the program site (in the office, or during drop-ins), the client's home, a restaurant, a mall, or wherever the client is most comfortable (and as long as client confidentiality is maintained). This part of the service is appreciated by clients who do not have personal transportation, who live in a town without public transit or who live in remote areas. Even with public transit available, it may be difficult for clients to afford the fare, bundle up young children or brave inclement weather to come to a centre. The outreach service is essential and is a major factor in the success of the Program.

**c) Vitamin/Mineral Supplements**

Vitamin/mineral supplements for low income clients are an essential component of the Program. Iron requirement during pregnancy exceeds the amount of iron which can be obtained via diet. Calcium intake is often inadequate in women. Low income women are often at nutritional risk, and this is exacerbated by the demands of pregnancy. Substance abusers and adolescents are at high risk for vitamin B<sub>6</sub> deficiency. See section IV.C, Nutrition Counselling, for more detail on supplementation.

**d) Food Supplements**

Food supplements for women in financial need are an essential component of the Pregnancy Outreach Program. The importance of food supplements in providing nutrition to low income pregnant women has been well documented. The Pregnancy Outreach Program standard for the minimum required food supplement is the equivalent of 3 servings from the Milk and Milk Products Food Group and 3 servings from the Fruit/Vegetables Food Group per day for clients in financial need.

Milk and juice is the most common food supplement. The standard provides approximately 6 $\frac{1}{2}$  of milk per week and two 355 ml. cans of frozen orange juice per week to clients in financial need. Alternatively, some programs provide skim milk powder, and fresh fruits and vegetables, or may enhance their food supplements to include eggs, and other foods.

Any exceptions to this standard based on special local needs must be approved by the RDN at the Health Unit/Department or delegate. Approved program exceptions to the standard must be documented and retained on file for one year, for review by the Contract Manager. The standard may also be modified on an individual basis to meet the needs of clients with special therapeutic or cultural considerations, according to the documented assessment and recommendations of the Resource RDN or RDN Coordinator.

Vouchers or the food itself may be delivered to the client's home as part of a counselling session, or she may be required to visit the site to pick them up. Food vouchers may serve as a "hook" for clients who might not otherwise get involved with the Program. The clients originally come only for the food, but they return each week and leave with an expanded network of friends and a great deal of knowledge. See Appendix G for samples of food vouchers.

**e) Referral**

To ensure that there is continuity of client service, all Pregnancy Outreach Program clients are referred to either their local Health Unit or Medical Services Health Centre (on reserve) prior to their 'due date'. Clients must give their consent prior to referral.

The Pregnancy Outreach Programs are in touch with many other resources in their communities and will refer as necessary depending on the needs of the client. Referral to community services such as Friendship Centres, YM/YWCA, La Leche League, Homemakers, Food Banks, Twin Clubs and the Salvation Army are common. Clients may also be referred to Alcohol and Drug Services, the local Mental Health Centre, community kitchens, Ministry for Children and Families and/or Nobody's Perfect.

Nobody's Perfect is a parenting program designed for parents who are young, single, low income, low-education and who are socially, culturally and/or geographically isolated, and who have children 0-5 years of age. The program and materials are designed to assist parents with their parenting skills. The goals of the program are to help the participants increase their knowledge and understanding of children, effect positive change in their behaviour towards children, increase their self-image and coping skills, and increase mutual support among the parents. This is achieved by providing parents with accurate, up-to-date information on their children's health, safety, development and behaviour, and by encouraging confidence in their ability to be good parents. Information on local availability of Nobody's Perfect can be obtained

by contacting the local Health Unit, Mental Health office or Ministry for Children and Families office.

**Resources**

**A Baby Doesn't Get a Second Chance to Make a First Impression. Pregnancy Outreach Programs. Nutrition Section. BC Ministry of Health 1993. (pamphlet)**

**A Baby Doesn't Get a Second Chance to Make a First Impression. Pregnancy Outreach Programs. Nutrition Section. BC Ministry of Health 1993. (video)**

## II. PROGRAM ADMINISTRATION

### A. Roles and Responsibilities

The following paragraphs outline the roles of the partners in the Pregnancy Outreach Program. Responsibilities within individual programs are shared at many levels, including the Sponsoring Agency, Local Advisory Committee, Contract Manager and Provincial Advisory Committee. The aim of this sharing of responsibilities is to maintain the client focus and to reflect individual community needs and resources.

#### 1. Ministry for Children and Families

The Ministry for Children and Families, through the Nutrition Services Consultant, Regional Support Division, has provincial responsibility for policy, standards, evaluation and monitoring for the Pregnancy Outreach Program. This role is performed in consultation with the Pregnancy Outreach Program Provincial Advisory Committee and other partners, including local Health Regions/Units/Departments, other provincial Ministries and Health Canada. Specific functions include:

- Maintaining the Pregnancy Outreach Program Handbook, as a current provincial standards and key resource document for the Program.
- Coordinating the annual provincial evaluation, including collation and analysis of client data and distribution of results.
- Monitoring of service delivery and client outcome indicators, and other evaluative information from a provincial perspective, to ensure that services are delivered in an effective and efficient manner to the target client group.
- Coordinating provincial planning for the Pregnancy Outreach Program.
- Chairing the Pregnancy Outreach Program Provincial Advisory Committee.
- Planning for resource allocation, as required.
- Providing expert advice and a provincial perspective to Government officials, Health Regions/Units/Departments, Sponsoring Agencies and other stakeholders on issues associated with the Pregnancy Outreach Program.
- Liaising with other jurisdictions and stakeholders on intra-ministerial, inter-ministerial and inter-governmental initiatives associated with the Pregnancy Outreach Program.
- Facilitating and/or coordinating the development, implementation and evaluation of educational resources and training for the Pregnancy Outreach Program.

#### 2. Sponsoring Agency

The Pregnancy Outreach Program is delivered through community based agencies usually on a contract basis with the Ministry for Children and Families (see Appendix H, Sample Schedule 'A' and Commitment to Pregnancy Outreach Program Principles and Standards). A Sponsoring Agency is selected on the basis of its acceptability to and effectiveness with the high-risk target group, and its stability within the community. The Sponsoring Agency assumes overall responsibility for the administration of all components of the program - its assets, liabilities, policies and contracts.

As the Sponsor of the Pregnancy Outreach Program, the Agency:

- Assumes responsibility for fulfilling the expectations/deliverables of the contract;
- Directs the operations and activities of the program, including formulation of policy, planning and decision making, as required to achieve Program objectives;
- Convenes a Local Advisory Committee of health professionals and community representatives, separate from the Sponsoring Agency Board of Directors, to provide expert consultation to the Program;
- Assumes responsibility for personnel policies and procedures to deal with employees and volunteers on issues including recruitment and orientation, training, performance appraisals, job responsibilities, hours of work, wages and benefits, liability insurance;
- Administers the funding of the program and assumes all responsibility for financial decision making and fiscal control;
- Takes a leadership role in fund-raising and promotion activities in the community;
- Liaises with the Contract Manager to review issues of administration, service delivery and evaluation; and
- Maintains strong lines of communication between Sponsoring Agency Board of Directors, Local Advisory Committee and the program staff.

### 3. Local Advisory Committee

The Local Advisory Committee utilizes the expertise of its members to make recommendations to the Sponsoring Agency on issues affecting the delivery of the local program. A minimum of two meetings per year are held to review program progress (e.g. local program statistics and provincial evaluation information), to advise the Sponsoring Agency on the direction of the program for the upcoming year, and to review issues and goals unique to the program.

It is essential that the Local Advisory Committee be separate from the Sponsoring Agency Board of Directors. However, the Local Advisory Committee can be an already existing group, such as the community perinatal committee or Nobody's Perfect steering committee, with expanded membership.

Local Advisory Committee includes representation from the following groups and organizations:

- Sponsoring Agency Board of Directors
- Program Staff, usually the Coordinator
- Health Unit (Public Health Nurse, Nutritionist and/or Dental Hygienist)
- Medical Community (family practice physician)
- Alcohol and Drug Services
- Aboriginal, Metis and/or Representative Ethnic Organizations
- Ministry for Children and Families
- Former Clients and/or Client Advocates

Existing programs have experienced the value of involving representatives from the following community and government agencies:

- Mental Health
- Child Development Centre
- Multi-Cultural Association
- Family Life Association
- Women's Resource Centre
- Service Clubs
- Church groups
- Schools
- Business community

Coordinators are resource people to the Committee (e.g., provide verbal and written status reports, identify issues and concerns, etc.). The Sponsoring Agency Director assumes primary responsibility for official communication with the Sponsoring Agency Board of Directors, but may delegate this role depending on the nature of the issue and/or requested decision. It is recommended that neither the Sponsoring Agency Director or the Coordinator serve as chair of the Local Advisory Committee. Also, to avoid conflict of interest, it is strongly recommended that the role of Health Unit representative to the Local Advisory Committee and Contract Manager be filled by different individuals.

It is beneficial to consider skills, as well as affiliations, in the selection of Committee members. A range of skills including clinical expertise, counselling expertise, information technology, evaluation and statistical analysis, community development, fundraising, marketing and promotion, advocacy and media experience provide valuable support to the program and the sponsoring agency. In addition, those who have a grass roots understanding of the client group and their issues are a particular asset to the Committee.

The Local Advisory Committee establishes terms of reference and annual objectives, in accordance with the guidelines in the POP Handbook. The role of the Committee may include, but is not limited to the activities outlined below. The Committee should also be prepared to address urgent and emergent issues, as they arise.

- Providing professional direction and consultation on clinical issues (as a group or as individuals);
- Providing community linkages to ensure the program is sensitive to community needs;
- Reviewing and strengthening the links between the program and other government and community agencies;
- Advocating for the program in the community;
- Consulting to the Sponsoring Agency on the development, implementation and evaluation of related services;
- Consulting to the Sponsoring Agency on service delivery, including the management of urgent and emergent local issues, and local program evaluation and monitoring;
- Supporting the program through referrals and access to resources;
- Providing the Sponsoring Agency with ongoing evaluations of the service delivery;
- Assisting in promotion, marketing and fund-raising in cooperation with the Sponsoring Agency;

- Liaising with the Contract Manager as required by the Sponsoring Agency;
- Assisting in selection of staff, for example, developing selection criteria and interviewing candidates;
- Orienting program staff to the Committee member's role and the resources which they provide to the community;
- Training and development of program staff;
- Facilitating the development, implementation and evaluation of local program resources.

#### 4. Contract Manager

The Contract Manager is responsible for negotiating, monitoring, and evaluating the contractual obligations of the Sponsoring Agency within the standards prescribed by the Pregnancy Outreach Program Handbook (see Appendix H, Sample Schedule 'A' and Commitment to Pregnancy Outreach Program Principles and Standards) and other government financial and administrative policies and standards. The clauses in the standard Ministry for Children and Families contract and the sample Schedule 'A' for the Pregnancy Outreach Program (see Appendix H) are subject to change, and it is the responsibility of the Contract Manager to be informed about all current government policies and standards related to contracts with non-government agencies.

As funding for service delivery is regional and the services delivered by the Pregnancy Outreach Program are within the realm of public health, the Contract Manager is usually a Public Health Nurse Administrator/Assistant Administrator or Community Nutritionist within the local Health Unit. To avoid conflict of interest, it is strongly recommended that the role of Contract Manager and Health Unit representative to the Local Advisory Committee be filled by different individuals. However, the contract management role does not preclude the provision of professional expertise on public health and perinatal issues, as a part of the community nutrition or public health nursing role within the Health Unit.

The role of the Contract Manager in monitoring administrative, financial and service delivery aspects of the contract includes the following activities:

- Maintaining current knowledge of Pregnancy Outreach Program principles and standards (see Appendix H, Commitment to Pregnancy Outreach Program Principles and Standards) as outlined in the Pregnancy Outreach Program Handbook and communicated by Nutrition Section;
- Negotiating and coordinating the preparation and implementation of the contract (see Appendix H, Sample Schedule 'A') between the Ministry for Children and Families and the Sponsoring Agency, in consultation with regional administration and/or financial personnel;
- Providing Sponsoring Agency with a copy of *A Contractor's Guide to the Freedom of Information and Protection of Privacy Act* (refer to section II.D, Confidentiality Issues);
- Arranging for general liability insurance through the Government Master Insurance Plan (see Appendix I, General Liability Insurance - Government Master Insurance Plan), if required by the Sponsoring Agency;

- Site visits, which may include program staff and client interviews, regarding service delivery issues, and observation of program activities;
- Reviewing existing documentation including client records; service delivery, administrative and financial, records and reports; program statistics and other evaluative information;
- Requesting and reviewing additional documentation and information, as necessary to monitor the contractual obligations of the Sponsoring Agency (see Appendix J, Sample Program Monitoring Report);
- Reviewing and approving proposed annual program budget and interim financial statements;
- Reviewing the annual provincial evaluation and other provincial evaluative information;
- Providing advice on administrative and service delivery issues, including contractual issues associated with the *Freedom of Information and Protection of Privacy Act*, at the request of the Sponsoring Agency Director or delegate (refer to section II.D, Confidentiality Issues);
- Providing administrative, financial and service delivery information related to the contract management role to the Health Unit, and to Nutrition Section with the approval of the Health Unit, as requested;
- Addressing the Sponsoring Agency Board of Directors at the request of the Sponsoring Agency Director regarding contract management issues.

Contract Managers can seek further direction either regionally regarding administrative and financial aspects of contracts in general or the contract with the Sponsoring Agency specifically, or provincially through Nutrition Section on issues pertaining to service delivery standards.

## 5. Health Unit

Health Unit support and involvement is vital to the success of the Program. As leaders and experts in the realm of community-based public health services and initiatives, the Health Unit is a focal point for coordination of perinatal supports and resources. As a required member of the Local Advisory Committee, a Nutritionist, Public Health Nurse or Dental Hygienist is the key Health Unit liaison. Other Health Unit staff also provide advice and resources to the local program, in accordance with their area of professional expertise.

Specifically, Health Unit staff provide assistance to the program by:

- orienting Pregnancy Outreach Program staff to Health Unit services,
- assisting with the recruitment and selection of professional staff,
- presenting topics at drop-ins,
- sharing resources,
- providing postpartum care to Pregnancy Outreach Program clients,
- facilitating networking among regional Pregnancy Outreach programs, and
- providing health statistics (including copies of birth notices for Pregnancy Outreach Program clients).

The Pregnancy Outreach Program targets high-risk pregnant women who do not access traditional prenatal health services. It is crucial that Pregnancy Outreach Program and Health Unit Services are complementary and respond to the individual client's needs. The aim is to avoid duplication, competition and fragmentation of service, so as to not overwhelm and confuse the client.

## 6. Provincial Advisory Committee

### *Purpose*

The Provincial Advisory Committee supports the development and maintenance of effective pregnancy outreach programs in B.C. The role of the Committee is to:

- provide advise to the Ministry for Children and Families for the use of provincial funding
- maintain a current policy and standards handbook for the Pregnancy Outreach Program in direct collaboration with the membership of the B.C. Association of Pregnancy Outreach Programs. Ensure that these standards are supported by current evidence and accepted by practitioners
- provide interpretation of the annual provincial POP evaluation and develop an action plan to address issues arising from this evaluation
- provide expert advise on training, resource development and other support provided to the projects on a provincial basis
- link/collaborate with Canadian Prenatal Nutrition Program, and other government and non government organizations whose program and policies affect pregnancy outcome
- advocate for resources for the programs and facilitate expansion of the programs in areas of need
- provide advise on the integration of POP with other services directed at the same population groups
- linkage with local advisory committees for input when appropriate

### *Membership*

The membership will reflect the comprehensive nature of the program and include representation from:

- Nutrition Services, Public Health Nursing and Alcohol and Drug Programs, Ministry for Children and Families
- Health Canada, a Prenatal Nutrition Program
- Healthiest Babies Possible Program, Vancouver Health
- B.C. Association of Pregnancy Outreach Programs
- Aboriginal Health Council
- Ministry for Children and Families
- a POP lay counsellor, project coordinator and contract manager will be included

### *Meetings*

A minimum of two meetings will be held annually

## B. Staffing and Liability Issues

### 1. Policies

The Sponsoring Agency must document and enforce policies related to the following issues:

#### a) Staffing

- Workers' Compensation coverage for all staff;
- Vaccination for communicable diseases for staff and volunteers (in consultation with the local Health Unit);
- Criminal record checks for prospective employees and volunteers, including a Criminal Records Review under the *Criminal Records Review Act* and a police check;

A Criminal Records Review is required by law for all people working with children under 19 years of age. This Review is done through the Ministry of the Attorney General and screens for offences involving children (physical and sexual abuse), murder, assault and drug trafficking. See Appendix K for a summary of the process involved in complying with the *Criminal Records Review Act*. For more information regarding the Criminal Records Review and/or a copy of *Criminal Records Review Act, Implementation Information and Guidelines for New and Existing Contractors* contact the Criminal Records Review, Security Programs Division, Ministry of the Attorney General (250) 356-5486.

For a review to screen for other types of offences a police check is done which involves a different process. For information regarding a police check contact your local RCMP or police.

#### b) Client Records

- Management and safeguarding of client information and records.

The custody and control of client records is defined by the contract between the Sponsoring Agency and the funder, in most cases the Ministry for Children and Families. The Sponsoring Agency has 'custody' or physical possession of client records. The Ministry for Children and Families, has 'control' or authority to manage, restrict, regulate or administer the use or disclosure of a record.

Policies must be consistent with the provisions of the *Freedom of Information and Protection of Privacy Act*, *A Contractor's Guide to the Freedom of Information and Protection of Privacy Act* (provided by Contract Manager) and *Code of Practice for Ensuring the Confidentiality and Security of Health Records in BC* (see Appendix L).

Records should be written with the expectation that the client will read them. Inappropriate editorial comments should be avoided.

Client records should be protected by keeping them in locked cabinets or drawers. Clients need to be aware that information they share with Pregnancy Outreach Program staff is confidential unless they sign a release which identifies to whom (agency or individual) this information will be given.

Storage and disposal of client records should be governed by the policies of the Sponsoring Agency and the *Code of Practice for Ensuring Confidentiality and Security of Health Records in BC* (see Appendix L for more information).

Client records are more than a current status report to help the program staff plan individualized service. They are a means of demonstrating that the contracted service is being provided, and as such are subject to review by the Contract Manager. As legal documents, it is strongly recommended that policies associated with client records be subject to regular review by the Sponsoring Agencies legal counsel.

A sample chart audit is included in Appendix M.

See section II.D, Confidentiality Issues for more information and resources.

c) **Liability**

- Adequate insurance on all vehicles (including those of volunteers) used to transport clients;
- Availability and correct installation of *Canadian Motor Vehicle Safety Standard* certified infant and child car seats for transporting children;
- Adequate liability insurance coverage for Sponsoring Agency and Local Advisory Committee members regarding service delivery (see Appendix I, General Liability Insurance - Government Master Insurance Plan).\

2. **Personnel**

Pregnancy Outreach Programs are staffed by a **Coordinator (RDN or RN)**, one or more **Outreach Workers**, and a **Resource Nurse (RN) or Nutritionist (RDN)** to complement the discipline of the Coordinator. The program team may also include a lactation consultant or other health professionals. **Volunteers** assist program staff.

The Coordinator and Outreach Workers are employees of the Sponsoring Agency. The Resource professional is generally employed or contracted by the Sponsoring Agency. However, if a Resource RN or RDN is not available in the community, the Health Unit may consider assigning a staff member to act as the Resource RN or RDN. To avoid conflict of interest, it is strongly recommended that the role of Resource RN or RDN and Contract Manager be filled by different individuals.

a) **Coordinators**

The Pregnancy Outreach Program requires the services of a health professional, a Registered Dietitian/Nutritionist (RDN) or a Registered Nurse (RN), preferably with community-based experience. The Coordinator is responsible for the overall coordination, administration and supervision of all facets of Pregnancy Outreach Program services. The Coordinator is also responsible for the standard of services and is accountable to his/her employer, the Sponsoring Agency. Community marketing is another key responsibility of this position.

The Coordinator may provide direct counselling to higher risk clients, however, this is not his/her primary job function. The Coordinator participates in or reviews eligibility assessments and counselling plans, and delegates the responsibility for remaining client visits to the Outreach Workers. See Appendix N for a detailed job description.

**b) Outreach Workers**

Outreach Workers are primarily involved with direct outreach services to clients, as the primary service provider under the supervision of the Coordinator. The day-to-day activities of the program (food supplements, drop-ins) are also duties of the Outreach Workers. See Appendix N for a detailed job description.

Outreach Workers are an essential component of the Program. Traditionally, prenatal services have been provided primarily by physicians and public health nurses. As many potential clients of the Pregnancy Outreach Program do not access these traditional service providers, an alternative service was sought.

Outreach Workers generally bring to the job their life experiences rather than a recognized formal training program. Outreach Workers may be employed because of their knowledge of the culture and/or language of the potential program clients. Outreach Workers are often members of the community being served (young, single, low income, First Nations, etc.). This familiarity with the target client environment enhances the Outreach Worker's ability to understand the client, build trust and encourage behaviour change. Some Outreach Workers may have para-professional training in counselling with experience in social or human service work.

A minimum standard of training must be provided for Outreach Workers by the Sponsoring Agency. This includes completion of *Within Our Reach: A Self-Study Training Program for Perinatal Outreach Workers*, in-depth review of the *Nutrition Education and Counselling Resource Manual* and familiarization with all facets of the Pregnancy Outreach Program (see Appendix O, Checklist for Pregnancy Outreach Program Staff Orientation). Members of the Local Advisory Committee may assist in the training and orientation of the Outreach Workers. Content areas of the training include fetal growth and development, nutrition, communication skills, normal pregnancy changes, birth control, breastfeeding, alcohol and drug misuse, and available community agency services.

**c) Nursing and Nutrition Directed Services**

All disciplines contribute skills and expert knowledge unique to their professions. It is recognized that there are overlapping areas of general knowledge. Nurses have general knowledge of nutritional needs during pregnancy and lactation, but do not have the in-depth knowledge to identify and counsel women with specific high-risk nutrition problems. In turn, Nutritionists have general knowledge of the physical and emotional changes which occur during pregnancy, but do not have the in-depth knowledge and experience to identify and counsel women with specific high-risk problems.

Both disciplines have the skills to provide direct, effective interventions. When they recognize, value, and use the specific expertise of the other, they extend to their client a quality service.

Where the Coordinator of a Pregnancy Outreach Program is a RN (preferably with community experience):

- all clients referred for or identified with critical nutritional risks (refer to section IV.C, Nutrition) should have been referred to the Registered Dietitian/Nutritionist (RDN).
- regardless of their nutritional status, all clients have the option of consulting with the RDN.

Where the Coordinator is a RDN (preferably with community experience):

- all clients referred for or identified with critical medical risks should be referred to a Registered Nurse (RN).
- regardless of their medical status, all clients have the option of consulting with the RN.

More detail on the role of the resource professional is given in Appendix N.

d) **Volunteers**

There are many skilled, hard-working people in the community interested in contributing to the Pregnancy Outreach Program. Volunteers can be recruited to provide important non-counselling functions, and are an integral part of the service delivery. See Appendix N for a sample description of the role of Volunteers.

3. **Care for the Caregiver**

Another issue which Pregnancy Outreach Program staff should be aware of is the importance of caring for themselves as caregivers. Because of the demands high-risk clientele place on caregivers, lack of attention to caring for oneself can lead to increasing stress, which, if unheeded, will lead to burnout. It is prudent to develop an understanding of stress prevention.

Resources

**Books**

Lerner, Harriet G. *Dance of Anger*. Harper and Row, New York, 1989.

Woolfolk, Robert I. and Frank C. Richardson. *Stress, Sanity, and Survival*. New American Library, New York, 1979.

**Pamphlets**

Ray, Veronica. *Striking a Balance: How to Care Without Caretaking*. Hazelden Foundation, 1989. (Hazelden Educational Material, Pleasant Valley Road

P.O. Box 176 Center City MN 55012-0176 phone: 1-800-328-9000)

## C. Site Considerations

Program site location and facility design are critical factors for service access and client acceptance. The significance of these factors cannot be down played. Considerable thought and analysis should be paid to the following.

### 1. Location

- Distance from clientele's neighbourhoods;
- Public transportation routes and services;
- Proximity to other services ( e.g. doctor's office, malls, community agencies, public services, grocery stores, etc.).

### 2. Space

- Adequate space including private counselling rooms and group activity areas;
- Appropriate/safe child care and play area(s);
- Cooking/serving area with fridge, stove, large sink, and counter space;
- Secure storage space for program records, materials, and clothing.

### 3. Environment

Client feedback has stressed the importance of creating a comfortable environment, one in which clients can make their own space. Creating a homelike setting is desirable, for example, having comfortable couches instead of office chairs is appreciated.

Facility type and design should be considered. Conventional office space and classroom type structures are not conducive to this service. Consider store fronts, older homes, a church basement, or whatever will be most acceptable to clients.

## D. Confidentiality Issues

### 1. Freedom of Information and Protection of Privacy Act

By virtue of the Sponsoring Agency entering into a contract with the Provincial Government, its records, specific to the Pregnancy Outreach Program, are subject to the *Freedom of Information and Protection of Privacy Act*.

The intent of the *Act* is to make public bodies more accountable to the public, while at the same time protecting personal privacy. This is achieved by:

- Giving the public a right of access to records (e.g. POP financial statements),
- Giving individuals a right of access to, and a right to request correction of, personal information about themselves (e.g. client viewing her POP file),
- Specifying limited exceptions to the right of access to personal information; for example, where it can be proven by the agency that the disclosure of information could reasonably be expected to cause immediate and grave harm to the client's safety, or mental or physical health; or, for example, where disclosure of information could reasonable be expected to threaten the safety, or mental or physical health of another person.
- Providing for an independent review of decisions made under the *Act*, and
- Preventing the unauthorized collection, use or disclosure of personal information by public bodies (e.g. sharing personal information about a client with stores honouring food vouchers).

Under the *Act*, information can be shared with another public body (e.g. Ministry for Children and Families, Health Unit, Alcohol and Drug Services, Mental Health Centre), without permission from the client, as long as it meets the following two provisos:

- for providing continuity of care of the client; or,
- providing there is a reasonable and direct connection between the services offered by the Pregnancy Outreach Program and those to be offered by the agency to whom you have referred, the information is necessary for the agency to offer a "legally authorized program of the public body" (e.g. postpartum follow-up, alcohol and drug counselling, mental health counselling).

The client should be advised up front as to how information will be treated by the Program and told that the purpose of sharing information is to enhance communication among the client's support network, in order to promote the application of consistent counselling approaches, and the provision of accurate and consistent information from all sources. The client should also be told which agencies or health organizations she can expect that the information can be shared with. In some cases this process may inhibit the client from disclosing various lifestyle behaviours. The client should be told that all reasonable efforts will be made to obtain her consent when her information is being released.

There are also requirements established under the *Act*, for the release of information which is to be used for research or statistical purposes. Under the *Freedom of Information and Protection of Privacy Act*, names can not be disclosed unless the research purpose cannot be accomplished without this individually identifiable information. The Pregnancy Outreach Program has established a process that ensures that the names of the clients are not required.

A copy of *A Contractor's Guide to the Freedom of Information and Protection of Privacy Act* is provided by the Contract Manager. Additional copies of the Contractor's Guide are available from:

Crown Publications Inc.  
521 Fort St.  
Victoria, BC V8W 1E7  
Phone: (250) 386-4636  
Fax: (250) 386-0221

For more information regarding the *Freedom of Information and Protection of Privacy Act* contact:

Information and Privacy Branch  
2nd Floor, 553 Superior Street  
Victoria, BC V8V 1X4  
Phone: (250) 387-1992.  
Fax: (250) 387-1358

## 2. Protecting Client Confidentiality

All Program staff and volunteers have a shared responsibility in protecting the rights of clients to confidentiality and privacy. In order to learn and feel supported, the client must trust that these rights are protected.

Privacy should be considered in choosing the program site. It is important also to have a floor plan which allows privacy for individual counselling. However, privacy and confidentiality depend as much on the sensitivity and attitude of the program staff as on the ability to provide private space for counselling.

Practices for maintaining records and obtaining consents should be in line with the policies of the Sponsoring Agency responsible for the Program and with the *Freedom of Information and Protection of Privacy Act*. Where a policy does not exist or where greater protection of client information is required, a policy should be developed by the Sponsoring Agency.

## 3. Client Records

Client records are maintained as a tool to assist program staff in providing a service that is client-specific, as well as for evaluation. Each individual record identifies the client's specific needs and strengths as determined in consultation with the client, plans and strategies to meet these needs, and results of the plans and strategies.

It is not necessary to write extensive notes outlining every visit with the client. Records should include information such as the date and location of the client contact, results of the plans/strategies, newly-identified risk factors and resultant plans of action, referrals to other agencies, etc. Some information (e.g. weight gain, cigarettes smoked) is best maintained in a more visible format such as a chart or graph, which then forms part of the record.

Clients should be aware that when information is collected for statistical purposes, identifiers, such as name and address, are not included. This ensures the client's anonymity. The information collected is used solely for evaluation and monitoring of the Program.

#### 4. Care Card Number

Under the *Freedom of Information and Protection of Privacy Act*, a person must be informed regarding the collection of 'personal information', or information that alone or in combination, would reveal the identity of a particular individual, e.g. care card number. A *Contractor's Guide to the Freedom of Information and Protection of Privacy Act* provides more detailed information on the collection of personal information.

The client care card number is collected on the *Client Data Sheet* (see Appendix E) which is used to collect information for routine evaluation/monitoring purposes. The care card numbers are not specifically required to fulfill this purpose. However, in order to show that the Program is actually having an effect on pregnancy and infant outcomes, it would be necessary to use care card numbers to track the use of health services by the clients and by their children after birth. Clients can be assured that this would be done without any reference to the client's name, and that access to personal information using care card numbers is strictly protected by the Ministry for Children and Families.

Another more immediate advantage to using the care card number, is that clients who move and leave one program, can be re-identified when they start at another program in their new area. This will improve the likelihood that information will be available on the birth outcomes for the program monitoring and evaluation purposes.

Clients who may not have a care card can be given information on how to obtain one.

If a client refuses to give her care card number, this does not, in any way, preclude her from the services offered by the Pregnancy Outreach Program.

## E. Client Loads

### 1. Target/Actual Client Load

The 'target client load' refers to the number of enrolled clients with 'due dates' during a fiscal year, to which the Sponsoring Agency is expected to provide services. The 'actual client load' refers to the number of enrolled clients with due dates during a fiscal year, to which the Sponsoring Agency actually provides services. Services include those outlined in the service model (refer to section I.D, Service Model).

The target client load is referenced in the Schedule 'A' of the contract. The actual client load is monitored by the Contract Manager and through the provincial evaluation/monitoring activities.

The 'due date' criteria was established to provide a consistent means of monitoring client loads across all program sites. The target client load is considered to be a 'target' because some clients will be carried over from the previous fiscal year, and some clients will be carried over to the next fiscal year, and these two numbers are bound to be different from year to year. However, if the actual client load were averaged over a few years, it is expected that this number would be close to the target client load.

The original target client load for individual programs reflected the number of clients that the Sponsoring Agency proposed it would serve in the funding proposal. This number reflected a community needs assessment, including considerations like the low birth weight rate, and was subject to review and adjustment by the Provincial Advisory Committee, based on relative need throughout the Province and available funding. Since that time, target client loads for some programs have been adjusted in response to analysis of evaluation/monitoring information and provincial funding enhancements.

The target client load does not necessarily represent the total number of women in a community who are referred to and eligible for service. In some communities, the demand for service may exceed the funded capacity of the program. Some programs have been successful in securing funding from alternative Government and community-based sources. Other programs have established policies for waitlisting.

### 2. Waitlists

There may be times when a program already has a full complement of client, i.e., actual client load exceeds target client load). If a program is unable to enrol any newly-referred pregnant women, it may become necessary to initiate a waitlist.

The decision to waitlist clients is a critical issue and should be implemented in consultation with the Contract Manager and the Local Advisory Committee. Eligibility assessment practices should be reviewed to ensure that the *IPRI* criteria are being consistently and accurately applied (see Appendix C, *IPRI* and *A Guide for the Use of Individual Prenatal Risk Identification*).

It is also recommended that the Sponsoring Agency develop policies to manage any excess demand for service. These may include enrollment of women who are not at risk for substance misuse at less than 28 weeks gestation, priority enrollment for women at highest risk and referral to alternative service options, including:

- Public Health Nursing at Health Unit,
- Medical Services Health Centre (on reserve),
- Mental Health or Alcohol and Drug Services,
- community-based prenatal classes with consultation to the instructor, and/or arranging for a 'buddy', and
- partial service delivery, e.g. one or a combination of group sessions, vitamin and mineral supplements, food supplements and referral.

It is important to document the demand for service and to inform the Contract Manager regarding the status of the waitlist. It may be necessary to submit a proposal for additional funding. As well, the Sponsoring Agency may wish to explore funding options from alternative sources.

### III. CLIENT CHARACTERISTICS

The characteristics of Pregnancy Outreach Program clients vary widely. However, data collected since 1990 indicates that in general Program clients tend to be young, have a low income, and not to have finished high school. The following data from the 1995/96 Status Report is representative of client characteristics.

average client age was 22 years old

- 21% of clients were under 18 years old
- 37% were single
- 29% were Aboriginal in origin
- 66% had less than a high school education
- 91% were low income (either on income assistance or low income but not on assistance)

In order to be accepted into the Program all clients must be assessed and have one or more risk factors (see Appendix C, *Individual Prenatal Risk Identification*). Data from the 1995/96 Status Report indicates which risks are the most common.

- 71% of clients had financial problems
- 54% had inadequate nutrition
- 53% smoked cigarettes
- 37% were single parents
- 36% were underweight prior to their pregnancy
- 36% had inadequate housing
- 28% used alcohol
- 25% were under 18 or over 35 years of age
- 28% had a previous pregnancy loss
- 26% were described as isolated (ethnic, language and/or social)
- 22% had a poor rate of weight gain

## A. Clients With Low Literacy Skills

Given that many clients of the Pregnancy Outreach Program have not completed high school, it is important that their reading ability be assessed prior to initiating counselling. Studies show that literacy and income are major factors affecting health and mortality.

Outreach Workers can help combat the health problems related to low literacy by:

- identifying clients who may have trouble reading;
- choosing posters and pamphlets that are written at an appropriate reading level and/or language;
- referring clients to agencies that deal with adult literacy and education.

### 1. Identifying The Client with Limited Literacy Skills

Identifying a client with limited literacy skills may be as simple as asking "can you read?" However, careful observation and awareness on the part of the program staff is often required. Remember that literacy is a continuum - almost everyone can read some words.

Some client behaviours that may be indicative of low literacy are:

- always brings a family member or friend with them;
- very compliant, nods all the time;
- disinterested, non-participant (even if activity doesn't depend on literacy skills);
- needs to know what the package or item looks like;
- acts confused, asks unrelated questions;
- always uses the excuse "I forgot my glasses".

### 2. Developing Written Materials for Clients with Low Literacy Skills

Some points to consider when developing materials for low literacy clients:

- use point form, "bullets", especially for important or main points (like on this page);
- don't use small type - minimum 12 point, and 14 point type size is even better;
- use a serif-style type face (Times Roman, Courier, etc, like this) rather than a sans serif type face (ie Arial, Helvetica, like this);
- justify your text flush left, and ragged right (like this page, not like newspaper columns);
- use lots of margin/white space;
- use headings to break the text into chunks;
- choose short, strong, common words (limit words with three or more syllables);
- place a relevant picture near words that may be unfamiliar;
- keep sentences and paragraphs short (6-10 words per sentence, 16 maximum);
- keep the print style constant, and use upper and lower case letters, not just upper (some words may be recognized as much by their shape as by their phonetic sound);
- use a positive tone, and make the passage "sound" conversational;
- give concrete, familiar examples for concepts ("vegetables such as carrots and peas");
- be specific and direct: say what you mean.

### 3. Other Tactics to Assist Clients with Low Literacy Skills

- use lots of visual aids such as pictures, demonstrations, drawings, food labels, and packages to relate ideas.
- learn by doing: take clients on shopping tours to show them products; prepare food from recipes; and, prepare baby formula as a group.

- use demonstrations or video presentations where possible.
- have clients make their own posters after seeing videos or having a speaker. Let them use their own words. Learn how you can communicate with them.

### **Literacy Groups in British Columbia**

Literacy B.C., a non-profit agency located in Vancouver, can help you find out about resources in your area, or send you more information.

Literacy B.C.  
Ste. 662 - 510 West Hastings St.  
Vancouver, B.C. V6B 1L8

Call 1-800-663-1293 toll-free in B.C. or,  
in the Lower Mainland,  
Phone (604) 684-0624  
Fax (604) 684-8520

### **Resources**

Doak, C., Doak, L. and Root, J. Teaching Patients with Low Literacy Skills, J.B. Lippincott, 1985.

National Cancer Institute. Making Health Communication Programs Work, Public Health Services, NIH Office of Cancer Communications. Publ. No. 89-1493, April 1987.

Nutrition Education and Counselling Resource Manual for Counsellors Working with Pregnant Women. Options: Services to Community Society, Surrey BC 1996.

West Coast Reader, Box 16058, 3017 Mountain Highway, North Vancouver, BC, V7J 3S9 (604) 984-1756. This is a newspaper for adults who are improving their English skills.

### **Resources developed for clients with low literacy skills**

Tips for Healthy Eating, BC Dairy Foundation 3236 Beta Avenue Burnaby, BC V5G 4K4 phone (604) 294-3775 or 1-800-242-6455; fax (604) 294-8199 . Developed in cooperation with Surrey's Healthiest Babies Possible.

The Hangover That Lasts a Lifetime. BC Fetal Alcohol Syndrome Group. BC Ministry of Health.

Good Eating: How To Plan Good Food. Williams Lake Project Literacy, BC Ministry of Health. Nutrition Section, Victoria.

Health Files - a series of one page fact sheets on a wide range of public and environmental issues (i.e. second hand smoke, folic acid, HIV testing in pregnancy, pregnancy and oral health, Rubella and pregnancy, etc). Available at all health unit and department offices and on the Internet, under "General Health Information" on the Ministry of Health's home page (<http://www.hlth.gov.bc.ca>).

## B. Aboriginal Clients

About 30% of Pregnancy Outreach Program clients are First Nations people. In some communities this percentage is much higher. The following is a brief discussion of issues which Program staff need to be aware of when providing service to First Nations people.

### 1. Background

The most culturally diverse and geographically dispersed groups of First Nations/Aboriginal people in Canada are located in British Columbia. BC is home to 17 percent of the Aboriginal population in Canada, with about 50% of the Aboriginal population residing off-reserve in urban areas. There are 196 bands and 34 tribal councils in British Columbia.

The terms 'Aboriginal', 'First Nations', 'Native', 'Metis', 'non-Status', 'Indian' as under the Indian Act, are different terms referring to Aboriginal people. The best way to use any of these terms is to ask an Aboriginal person what they prefer to be called (e.g., a Nuu-chah-nulth person may prefer to be called Nuu-chah-nulth or perhaps by their home village name).

Primary sources of information about Aboriginal people in your area are Friendship Centres, Bands, and Tribal Councils. Secondary sources of information in communities include Housing Societies, Treatment Centres, Aboriginal Women's Groups, Cultural and Education Centres, and provincially based organizations such as the BC Association of Friendship Centres, the Native Courtworkers Association, Indian Homemakers Association, the United Native Nations and the First Nations Congress. This list is in no way exhaustive.

In Vancouver, there is an estimated Aboriginal population of 40,000. The Urban Representative Body of Aboriginal Nations (URBAN Society) can assist in providing information on the many urban-based Aboriginal organizations located in the Lower Mainland. Also, the Ministry of Aboriginal Affairs has a *Guide to Aboriginal Organizations and Services in BC*.

### 2. Historical Background

Canada's First Nations people have special needs as a result of the nature and manner of government policy towards them. In the past this policy was to remove Native people from the land to make way for agricultural settlers from Europe. Additional policy decisions were to:

- set Native people apart on reserves where missionaries taught the values and skills of non-native society;
- create special legislation defining government programs to be provided for status Indians and treaty Indians, and eligibility for the programs;
- establish a bureaucratic organization for the administration of Indian affairs;
- adopt a policy of assimilation of Natives into Canadian society.

There has been a long history of interference into Native family life, based on the idea that Natives should be assimilated into the larger society. Policies of assimilation were carried out in the context of religion and education, and were mainly aimed at the young. For maximum effect, children were moved as far as possible away from the influence of Native culture. It was believed that Native children educated in this way would gladly give up their status and take their place as enfranchised Canadians. It was believed that eventually Natives would disappear as a distinct culture and political group.

To accomplish this, missionary schools were built, usually on reserve. These schools were expanded to make room for larger groups of children on a residential basis. Into the 1960's

many Native children lived most of the year away from their families in residential schools. Prior to the Second World War, close to fifty percent of school aged children were educated in these institutions.

Native family life is organized around the extended family, and Native culture is people oriented. The placing of children in residential schools had a major impact on Native culture:

- structure and quality of family life suffered;
- skills were lost as children were educated in a way of life far different than the traditional Native lifestyle;
- parenting skills diminished or were lost;
- problems of self-concept and identity emerged as Natives were taught to view their own culture as inferior and uncivilized.

Residential school systems began to be phased out after the Second World War. However, many existed well into the 1970's. Subsequently, child welfare services were extended which led to further separation of parents from their children. Applying the values and standards of the dominant culture through child welfare services has resulted in Native children being removed from their families and Native families failing to qualify as foster or adoptive parents. Child welfare authorities did not recognize or use the strengths of Native culture and family life when planning for Native children.

Native families continue to be separated and sometimes destroyed. Severe depression occurs in both parents and children as the family is unable to change the situation and be reunited. For many people despair and self-destructive behaviour become part of the pattern. When separated from their families and culture, identity problems emerge for many Native children. They are pushed toward new values and ways of behaving so that, in time, the child knows two worlds but does not belong to either. All of this has resulted in an understandably hostile and distrustful attitude among Native people towards non-Native child welfare workers.

At the present time, economic and political policies have resulted in inadequate, over-crowded housing, poor health, many families living well below the poverty line with unemployment rates three to four times the national average. Social disorganization has resulted in alcoholism, family breakdown, high rates of crime, delinquency, and suicide. However, Native people are now demonstrating a powerful desire to break the cycle of dependence on the dominant culture and assume control over their own lives. The effects of this are beginning to be felt.

### **3. Guidelines for New Programs**

The following are suggestions for Programs which have Native people as part of their client base:

#### **a) Hiring Staff**

When hiring staff, the staff should be made aware that part of the client base is Native. They should be able to accept Native culture and have respect for Native people as a whole. It is preferable that an Outreach Worker be Native if a large proportion of the clients are Native. Information should be available on suitable facilitators in your area at the local Friendship Centre, Tribal Council, or Band Office.

**b) Orientation**

When working with Native people there is a need to get background information on Native culture(s) of the area.

There should be Native awareness training as part of the orientation to the Program. The importance of being respectful of Native cultures and beliefs has to be stressed. The orientation can take the form of cross cultural training or workshops.

**c) Welcoming**

It is important to make Native people feel welcome by treating them with respect and respecting their culture. This can also be enhanced by a number of other means: by having posters and art work that are Native, and by having Native people as part of the staff.

As Native culture is people oriented, it is important to determine the following, during your initial contacts:

- what family is the person from (i.e. is this a chief's family),
- where do they place in the family, and
- what area/community are they from?

**d) Elders**

Elders are very important in Native culture, they are the history and the future of Native people. Elders pass the history on by talking and telling stories. They should be encouraged to participate in the Pregnancy Outreach Program as volunteers, to give talks, etc. When elders are brought in and treated with respect, it emphasizes that Native clients are important to the program. This will help to increase the self esteem of the clients by reinforcing their beliefs in their culture.

Permission to tape the presentations by Native elders should be obtained on initial contact, if you wish to record the presentations. The presentations can be recorded by either videotape or cassette recorder. These would then be on file and available to other Pregnancy Outreach Programs. This is important because Native people tend to move all over the Province, often far from their families. If the sessions with the elders are taped, they can be exchanged so that Native people could be informed of their own traditions, not just the traditions of the area they are living in.

**e) Parenting Skills**

Native elders should be encouraged to be involved in the Program. They can give talks on Native parenting skills (i.e. what is done, why it is done that way, what are the characteristics that are encouraged in children). Both men and women should be invited to give the talks. The men can talk about the role of the father before the baby is born and his role in child rearing.

**f) Prenatal Care**

Invite elders to speak about the old ways, what was the practice when they were pregnant, what foods they ate, etc.

**g) Nutrition**

The BC Native Food Guides (available from your local Health Unit) can be used as a broad reference to determine the nutrient value of traditional Native foods. Talk to Native people in the area to determine what the traditional diet was, find out if any of the foods are still available and used. Invite elders to come in to the Program to talk about traditional foods and nutrition from a Native perspective.

Clients can be encouraged to harvest wild foods like berries, fish, rosehips, etc., that are nutritious and do not cost anything but time. Native foods can be used to prepare a meal or snack at least once a month for drop-in.

**h) Cross Cultural Events**

There are many different events in Native culture that can be used in the Pregnancy Outreach Program. Some examples are: talking circles, elders presentations, Native parenting skills workshops, and pipe ceremonies. There are more ideas and guidance that Native people in your area can give you to help make these events successful.

**Resources**

Martens, Tony. *The Spirit Weeps*. Edmonton Nechi Institute, 1988.

McEnvoy, Maureen. *Let the Healing Begin - Breaking the Cycle of Child Sexual Abuse in Our Communities*. Nicola Valley Institute of Technology, 1990.

Tennant, Paul. *Aboriginal Peoples and Politics*. University of British Columbia, 1990.

Woititz, Janet. *Adult Children of Alcoholics*. Health Communications, 1983.

*Nuxalk Food and Nutrition Handbook - A Practical Guide to Family Foods and Nutrition Using Native Foods*. Nuxalk Food and Nutrition Program. Health and Welfare Canada 1984.

*Catalogue of Diabetes Education Resources for First Nations Peoples*. Health and Welfare Canada. Medical Services Branch, Ontario Region.

*BC Baby-Friendly Initiative: Resources Developed Through the BC Breastfeeding Resource Project 1996*. (available from local hospitals and Health Units)

*National Database on Breastfeeding Among Indian and Inuit Women. Survey of Infant Feeding Practices from Birth to Six Months*. Health Canada 1990.

*Interior BC Native Food Guide*. Health and Welfare Canada.

*Coastal BC Native Food Guide*. Health and Welfare Canada.

*Resource Guide on the Prevention of Fetal Alcohol Syndrome 1995*. (available from the California Urban Indian Health Council P.O. Box 188350 Sacramento, Calif. 95818).

**Videos**

*The Bonding Circle of Breastfeeding*. Association of Iroquois and Allied Indians. 1992. (available from Medical Services Branch of Ontario 3rd Floor 1547 Merivale Rd. Nepean, Ont. K1A 0C8)

Something to Celebrate 1984 (video on Fetal Alcohol Syndrome specifically for an Aboriginal audience, available from Medical Services).

Preventing, Coping, Living: Fetal Alcohol Syndrome 1993 (available from the Saskatchewan Institute on Prevention of Handicaps 1319 Colony St. Saskatoon, Saskatchewan S7N 2Z1 phone: (306) 655-2512 fax: (306) 655-2511)

## C. Clients from Various Ethnic Backgrounds

The Pregnancy Outreach Program provides service to a growing number of women from a variety of ethnic backgrounds, this is particularly true of programs located in large urban centers, but is also occurring in smaller communities. Ethnic groups which are represented include: Indo-Canadian, Chinese, Vietnamese, Filipino, Somalian and Central American. In order to be most effective in meeting these client's needs, the Pregnancy Outreach Program must adapt the message of a healthy lifestyle to the appropriate language and cultural traditions of the individual client.

One of the best ways of adapting the Program is to employ Outreach Workers who come from the same ethnic background as the clients. This facilitates communication and acceptance by the client. Guest speakers from different cultural backgrounds can also facilitate communication. Written material and videos in the appropriate language are helpful. Several of the Pregnancy Outreach Programs have developed or have obtained teaching aids applicable to different cultural groups. For ideas contact the Pregnancy Outreach Program in Burnaby or Surrey - Delta - White Rock, or the Healthiest Babies Possible Program in Vancouver.

An understanding of cultural differences by all staff is important. The following is a very brief summary of some of the common beliefs and practices of four different ethnic groups. This information has been supplied by Pregnancy Outreach Programs working with these clients. For more detailed information see the resources listed at the end of this section.

### 1. Indo-Canadians

#### a) Characteristics of Family Structure

Most Indo-Canadians live in an extended family situation. Usually the oldest son arrives in Canada, bringing his parents and wife. Later his brothers and their wives will join the family. Many of these families belong to the Sikh cultural group. Many Indo-Canadian Pregnancy Outreach Program clients are new immigrants, newlywed and in their twenties. They live with their "in-laws", while their own family is still in India. In India pregnant women often go back to live with their own family to deliver their babies and for 1 to 1½ months postpartum. However, this may not be possible for women living in Canada. Consequently, clients may be anxious, lonely and feel a lack of support.

Typically, the mother-in-law and oldest males in the household have the strongest influence upon the client. Household members generally seek advice from the oldest persons in the house.

Some young couples are now living on their own, often without any extended family nearby. They may be confused about whether to follow their families advise or other suggestions they are receiving. These women usually receive good support from their partners and are looking for a lot of information on pregnancy and birth.

#### b) Characteristic Dietary Patterns and Rules

The principle of hot and cold foods influences the diet of Indo-Canadians, particularly the diet of pregnant women. During pregnancy foods considered too hot or too cold are avoided to prevent shock to the system. Hot food is considered to have a cleansing effect and may be avoided for fear of miscarriage. As well, traditionally, pregnant women stay away from the influence of smoking and alcohol, and people using these

substances. After birth, hot foods are recommended to help cleanse the body, but cold foods are usually still avoided.

The consumption of milk products is encouraged during pregnancy and after birth.

Many Indo-Canadians are vegetarians. Traditionally, the diets of both vegetarians and non-vegetarians are well balanced. However, in Canada income level may restrict the acquisition of foods. Vegetables are usually prepared by cooking for an extended time. To help increase the vitamin content of meals, suggest regular consumption of dark green and orange vegetables as well as salads and raw cut-up vegetables. Encourage women to experiment with locally grown fruits and vegetables.

**c) Taboos and Expectations During Pregnancy and the Postpartum Period**

During pregnancy Indo-Canadian women may avoid wearing black clothing, meeting unhappy people (e.g. widows) or visiting graveyards. This is to make sure that the pregnancy will have a happy ending and to protect the baby from perceived negative influences. In many families, the pregnant woman will be expected to keep up with her chores as before the pregnancy. For the first month, postpartum women are encouraged to stay warm and indoors, as well as to avoid housework.

Older women in the family are usually supportive of breastfeeding. For infants who are perceived to be thin, supplements of formula may be encouraged.

**d) Suggestions for Counsellors**

If counselling in the client's home where extended family members are present, try to include all members of the family during the initial session by talking directly with them. This will help gain their confidence and trust. On future visits, once the people with authority appear at ease with you, you can ask for privacy with your clients. The counsellor usually is considered a person with status and privacy will usually be granted.

Try to leave some written material following the counselling sessions. Low literacy English material can often be used. This material may be useful for the woman when sharing with her family what she has learned.

**2. Filipinos**

**a) Characteristic Family Structure**

The Filipino population in Canada is primarily Catholic and tends to have large families, with children born in fairly rapid succession. Often grandparents are living with their children. Pregnancy is considered a very special time in a woman's life.

**b) Characteristic Dietary Patterns and Rules**

Cheese and dairy products are not commonly eaten. Traditional dietary sources of calcium are dried fish (including bones) and tofu. Ice cream is enjoyed. While some Filipino women are lactose intolerant, most will tolerate 3 cups of milk per day if introduced gradually.

For all meals rice and noodles are preferred over bread. Cooked vegetables are preferred to raw vegetables or salads. Desserts are commonly eaten only at special occasions (the exception being chocolate ice cream). Tea and coffee are used. Protein sources include all meats, especially fish and tofu. Lentils, dried beans and peanut butter are rarely eaten. Coconut milk, fish sauce, anchovy paste and soy sauce are common condiments.

**c) Taboos and Expectations During Pregnancy and the Postpartum Period**

Ugly looking foods (e.g. pigs knuckles) may be avoided during pregnancy. Breastfeeding is tried but often bottle-feeding is introduced soon after the baby is brought home from the hospital, especially when the mothers go back to work early..

**3. Central and South Americans**

**a) Characteristic Family Structure**

The extended family is very influential. In their countries of origin grandmothers often live in the same home as the pregnant woman and share the duties of child care. Women living in Canada often do not have this support and may feel very isolated. Often refugees from Latin America have been victims of violence and require patience and persistence to gain their trust.

**b) Characteristic Dietary Patterns and Rules**

Generally the diet is high in carbohydrates. Corn, wheat tortillas and rice are eaten. They may also eat a large amount of "sweetbreads" such as cinnamon buns. A belief is that food cravings must be satisfied to guard against damaging the fetus. The financial status of the family determines how much meat is eaten. The majority of protein is derived from legumes. Typically, women will choose familiar tropical fruits and will prepare home-made sweetened fruit drinks. common vegetables include salads, carrots, corn, green beans and green peppers, plantain and potatoes. Dairy products are generally enjoyed when they are available.

**c) Taboos and Expectations During Pregnancy and the Postpartum Period**

Generally there is a forty day postpartum period in which the newborn is not taken outside. The abdomens of newborns are often bound to prevent hernias.

Mothers are encouraged to stay away from drafts and keep their head, ears and feet covered. They are also encouraged to eat foods such as hard cheeses, chocolate, and warming foods such as tortillas, and to avoid cold foods such as pork. Some women wear a special girdle following birth.

Most Latin American clients will choose to breastfeed and received good support from their families and their communities.

#### 4. Vietnamese

##### a) Characteristics of Family Structure

Most Vietnamese immigrants came to Canada as refugees, after an average of 2-5 years in refugee camps. For a person from Vietnam the family is the main source of identity, and loyalty to the family is primary. Traditionally Vietnamese women have less influence in the family than men. In Canada the change of roles, values and status in the family can create conflict between family members, sometimes leading to marital conflict and abuse. Many clients are single parents coping with isolation, lack of support and, in some cases, post traumatic stress from their refugee camp experiences. Even clients sponsored and supported by their husbands feel isolated and miss their extended family network.

##### b) Characteristic Dietary Patterns and Rules

Vietnamese women choose their foods following the concept of yin and yang, hot and cold. During pregnancy women believe that their body is out of balance, so they choose their foods carefully to regain equilibrium.

A typical meal would include rice or rice noodles, port (chicken or fish) and cooked green leafy vegetables. Fish sauce, lemon grass, ginger and garlic are used to flavor foods. Milk and dairy products are not commonly used. However, during pregnancy milk can be introduced gradually and is usually well tolerated up to 3-4 servings per day. A spoonful of sweet and condensed milk can be added to create a familiar flavor. A few women will experience symptoms of lactose intolerance and will require alternate sources of calcium.

##### c) Taboos and Expectations During Pregnancy and the Postpartum Period

Some Vietnamese women will avoid eating slippery foods such as bananas which they believe cause miscarriage. Western medicines such as vitamins are considered to be hot and very strong and they may be reluctant to take them during the prenatal period. Counsellors could suggest taking prenatal vitamins with a cold food such as orange juice to restore the balance.

Some Vietnamese women believe that colostrum is bad for the baby because it is too cold. They will choose to feed the baby rice water or formula until their milk comes in. Women who have come through the refugee camp experience may be reluctant to breastfeed. They feel weakened by the poor nutrition and health they experienced in the camps.

During lactation, Vietnamese women avoid cold foods such as raw vegetables and fruit. Root vegetables, such as taro root, potatoes and carrots and hot soups such as papaya soup are usually acceptable.

Traditionally women believe that alcohol, usually beer, taken prenatally will help them to have a fairer skinned child and postpartum will help to clean their systems. In Canada more are aware of the harmful effects of alcohol on the unborn child.

d) **Suggestions for Counsellors**

Counsellors need to be sensitive to the beliefs and customs of the client when offering suggestions. Following cultural traditions affords emotional and psychological support. Many of the women also believe that these practices protect their future health.

**Resources**

Waxler-Morrison, N., Anderson, J. and Richardson, E. *Crosscultural Caring: A Handbook for Health Professionals in Western Canada*. UBC Press 1990.

Newman, J. *The Melting Pot: An Annotated Bibliography and Guide to Food and Nutrition Information for Ethnic Groups in America*. Garland Publishing 717 Fifth Ave. Suite 2500, New York, NY 10022.

*Cross-Cultural Counselling: A Guide for Nutrition and Health Counsellors*. 1986 (available from National Maternal and Child Health Clearinghouse 38th and R Sts. NW., Washington, DC 20057) free

Barer-Stein, Thelma. *You Eat What You Are*. McClelland Stewart Toronto 1979.

BC Baby-Friendly Initiative: Resources Developed Through the BC Breastfeeding Resource Project 1996 (contains a resource list and section on breastfeeding practices in different cultures - available from local hospitals and Health Units).

Ethnic Foods List (available from BC Dairy Foundation Imperial Square, 3236 Beta Avenue Burnaby, BC V5G 4K4, phone (604) 294-3775 or 1-800-242-6455 fax (604) 294-8199).

Donaldson, Diane *Serving Socially Disadvantaged Clients During the Childbearing Years*. Vancouver Community College, Continuing Education, Nursing and Health.



## IV. CLIENT COUNSELLING

The following section includes an outline of general counselling suggestions when working with high risk clients as well as an in-depth discussion of specific areas of risk. Specific risks are reviewed, assessment outlined, and some direction in counselling is given. Referral to appropriate resources and agencies is encouraged. *Within Our Reach: A Self-Study Training Program for Perinatal Outreach Workers* provides more comprehensive information on counselling.

### A. General Counselling Suggestions

Treat the client with respect.

Assure the client that all information shared is confidential.

Offer the client the choice of where to meet - her home, the program site, or another convenient location.

Include family members or friends who may also be present. If however, their presence inhibits the client, suggest an alternate location for the next visit. Determine if the client requires assistance (i.e. financial) in order to get to the other site.

Clients may break appointments or be difficult to keep in touch with for numerous reasons. Keep trying to offer the service unless the client indicates that they do not want to participate in the Program.

If possible, provide counselling in the client's preferred language. Does the client know English well enough to understand the information and suggestions that you are giving? (Additional information is offered in the section 'Clients with Low Literacy Skills', and 'Clients from Various Ethnic Backgrounds')

Listen to the clients' concerns. If the client is focusing on the need to find a place to live, she may not be receptive to counselling on health issues at that moment.

Provide a link between the client and appropriate community resources which can assist her.

Priorize goals for counselling. Set goals with the client (must be specific to each client). When a client has many problems, it is tempting to try to tackle them all at once. Instead, prioritize concerns and set achievable goals in one or two important areas.

Limit information to the essentials. The client must know enough to understand why the behaviour is a problem, have the relevant information to assist in changing the behaviour, and must want to change the behaviour.

Communicate clearly. Use simple language, taking into account the client's present knowledge. Avoid jargon, technical vocabulary, and long explanations. Have the person restate or demonstrate the information or instruction given.

Offer encouragement and praise. Don't be discouraged/disappointed with slow change.

Encourage the client to attend drop-ins and interact with her peers.

## B. General Prenatal Health

### 1. Overview

Pregnancy represents a major developmental stage in a woman's life cycle. It is a time of enormous physical and emotional change during which women may experience loss of control, engendering feelings of anxiety, and sometimes guilt. For some women pregnancy is a positive affirmation of their sexuality and womanhood; for others it represents an affront to their sense of self. It is a time when many women re-evaluate their life's goals and priorities, while reflecting on how they were mothered and envisioning mothering their children. Unresolved emotional problems with parents and other family members may resurface during this time.

A woman's ability to cope with the many physical and emotional changes of pregnancy and the attitude with which she approaches parenthood will affect her ability to mother her child effectively. The support, or lack of support, she receives from her family and friends is also of key importance.

### 2. Assessment

*Baby's Best Chance Parent's Handbook on Pregnancy and Baby Care, and Perinatal Educational Guidelines* lists common changes that a woman can experience while she is pregnant. Many women experience all of these changes, others experience very few. This assortment of physical and emotional changes can be a real source of worry to pregnant women. Information on why the changes are taking place, reassurance that these changes are normal, and some practical comfort tips are often sufficient to ease a woman's anxiety.

There are some physical changes which can serve as a warning that pregnancy is not progressing as it should and the client should be referred to their physician immediately. It is vital to be alert to the following:

- dizziness, headaches, dimness or blurring of vision
- sudden or severe swelling of the feet, hands or face
- sudden weight gain
- frequent or uncontrollable vomiting
- abdominal pain or rigidity
- any bleeding from the vagina, bowel or bladder.

A woman's response to her pregnancy will depend not only on the degree of physical discomfort she experiences, but also on her attitude toward the pregnancy and her current personal situation. Areas which Program staff may want to explore include:

- Was this a planned pregnancy?
- How much support is she getting from the people closest to her?
- Does she have at least one consistent source of emotional support?
- What is her financial situation?
- Does she feel too young or too old?
- Is this a first pregnancy or are there other children to consider?
- Is she feeling good about being pregnant? How have things been going for her?

The following observations may indicate that a woman is having difficulty dealing with her pregnancy:

- persistent negative feelings about the pregnancy
- repetitive questioning of her own ability to parent and on-going apprehension about the care of the baby
- depression or periods of weeping which do not go away
- lack of any concrete preparation for the baby's arrival; e.g., acquiring clothing, crib, etc. (however, in some cultures it is not customary to acquire baby things prior to the birth, e.g. some Aboriginal cultures)
- concerns regarding her relationship with her partner.

### 3. Action Plan

One of the developmental tasks of pregnancy is the mother's acknowledgement that the fetus is a separate individual whose general well-being is highly dependent on her health-related behaviours, (e.g. nutrition, smoking, alcohol use). The mother must be able to comprehend that what she takes into her body has a direct effect on the child within. In addition to this recognition, the mother must have a willingness to protect her fetus from harm.

There is some general information that all pregnant women should receive. However, prior to providing this information, it is important to assess the woman's existing knowledge base, her educational level, her health beliefs, and her ability and willingness to act on the information. Awareness of the above factors should allow staff to provide information in a manner which is sensitive to the client's needs. As well as providing information, staff should be prepared to work with the client to actually effect a change in behaviour, e.g. a plan to quit or reduce smoking.

Working with and from the client's perspective, the client should be assisted to:

- a) Achieve an appropriate weight gain for pregnancy;
- b) Eat at least the minimum number of servings from each of the food groups as recommended in the "BC Food Guide for Pregnancy";
- c) See a physician for early and continuing care;
- d) Establish a daily exercise routine, based on an understanding that exercise will increase her energy level, improve her outlook, and relieve some of the physical discomforts she may be experiencing;
- e) Refrain from consumption of alcoholic beverages during the entire pregnancy, on the basis that there is no safe level of drinking;
- f) Decrease or stop cigarette smoking;
- g) Limit her exposure to second hand smoke [Note: Several Pregnancy Outreach Program staff have indicated that many clients will refrain from drinking alcohol and even stop smoking, but because of social life patterns, will spend time in public liquor establishments with friends or in commercial bingo halls where smoking is excessive];
- h) Drugs or medication of any kind during pregnancy should only be taken with her doctor's knowledge;

- i) If she has had contact with anyone who has rubella (German Measles), she should notify her doctor. If she contracts this disease, especially in the first six weeks of pregnancy, there is a risk that the baby could develop congenital heart disease, blindness, deafness, and/or mental retardation.
- j) Cats may carry toxoplasmosis, a parasite that could harm an unborn child if the mother becomes infected while pregnant. For this reason, it is advisable for pregnant women to wear rubber gloves when changing cat litter, wash their hands afterwards or preferably, delegate this task to someone else over the course of her pregnancy.
- k) Wear a properly placed seat belt during vehicle travel;
- l) Discuss her feelings with someone she trusts, and if possible develop a relationship with another pregnant woman;
- m) Plan to breastfeed her newborn; and
- n) Attend Prenatal Classes.

Overall, the message to the woman should be affirmation of her own personal strengths, her contribution to the pregnancy, and her ability to cope with the challenges of parenthood. Many of the topics mentioned here are discussed in greater detail in the following counselling sections of this Handbook. Also, a list of resource materials specific to teenage mothers is provided at the end of this section.

Resources that are available include, as mentioned previously, the *Baby's Best Chance* publications, and the *Baby Basics Video*. *Baby's Best Chance Parents' Handbook of Pregnancy and Baby Care* provides important prenatal and early postpartum information and is made available, free of charge, to expectant parents throughout British Columbia. To obtain a copy, a pregnant woman receives a prescription from her doctor and exchanges it for a copy of the book at the local Pharmasave, People's Drug Mart or Uniform Drug Store or from her Health Unit if there are no participating drug stores in the local area.

*Celebrating Pregnancy* and *Celebrating New Life* are client resources that are specifically designed for at-risk pregnant women and provide messages that are consistent with *Baby's Best Chance* publications. These resources are primarily available through Pregnancy Outreach Program and Canada Prenatal Nutrition Program sites, as well as through Health Regions/ Units/Departments.

*Baby's Best Chance Video* covers important issues between the time of conception and the first few weeks after childbirth. Key content issues addressed are: healthy lifestyle (exercise, nutrition, safety); baby's development; smoking and alcohol awareness; and the childbirth experience (labour, delivery, types of birth). There is also a look at a prenatal class, as well as tips on breastfeeding and baby care during the first few weeks at home. The video is 70 minutes in length. This video is available on loan from local libraries or Health Regions/Units/Departments. Many prenatal instructors also have a copy of this video. The provision is made for individuals to make their own copy from the original.

The *Baby Basics Video* covers the first days at home, feeding, growth and development, etc. This video is available through libraries and Health Regions/Units/Departments to meet the needs of parents requiring early information on their new infant. Some hospitals in BC have also incorporated segments of this video on their closed circuit television systems.

## Resources

### General Resources for Pregnancy

British Columbia Ministry of Health. *Baby's Best Chance Instructional Guide*. Victoria, 1987.

British Columbia Ministry of Health. *Baby's Best Chance Parent's Handbook of Pregnancy and Baby Care*, 3rd Edition. Victoria, 1992.

*Within Our Reach: A Self-Study Training Program for Perinatal Outreach Workers*. Open Learning Agency 1996.

Donaldson, Diane. *Serving Socially Disadvantaged Clients During the Childbearing Years*. Vancouver Community College, Continuing Education, Nursing and Health.

*Celebrating Pregnancy! Caring For Yourself ... Caring For Your Baby* Canada Prenatal Nutrition Program. 1996. (available from the Canada Prenatal Nutrition Program 757 Hastings St. W. Suite 440 Vancouver, BC V6C 9Z9)

*Celebrating New Life! Caring for Yourself ... Caring for Your Baby*. Canada Prenatal Nutrition Program. 1996. (available from Canada Prenatal Nutrition Program 757 Hastings St. W. Suite 440 Vancouver, BC V6C 9Z9)

*Complete Book of Mother and Baby Care*. The Canadian Medical Association. The Reader's Digest Association. Montreal 1992.

Nilsson, Lennart. *A Child is Born*. Delacorte Press/Seymour Lawrence. Bantam Doubleday Dell Publishing Group, Inc. New York, New York, 1990.

Eisenberg, Murkoff and Hathaway. *What to Expect When You Are Expecting*. Workman Publishing Co. 1991.

Simkin, Whalley and Keppler. *Pregnancy, Childbirth and the Newborn*. Meadowbrook Press 1991.

Hotchpen, Tracy. *Pregnancy and Childbirth*. Avon Books 1990.

Todd, Linda. *Labour and Birth: A Guide for You*. International Childbirth Education Association, 1987. (available from ICEA P.O. Box 20048 Minneapolis, Minnesota 55420 phone: 1-800-624-4934).

Roberts Shaprio, H., Kuba, L.M., Harmon, M.D. and Burks, T. *The Lamaze Ready Reference Guide For Labor and Birth*. International Childbirth Educators Assoc. 1990 (available from ICEA P.O. Box 20048 Minneapolis, Minnesota 55420 phone: 1-800-624-4934).

### Resources on Teen Pregnancy and Parenting

The Special Delivery Club. (available from the North Kingston Community Health Centre 400 Elliot Ave. Kingston, Ont. K7K 6M9 phone: (613) 542-2813).

Barr, Linda and Monserrat, Catherine. *Teenage Pregnancy: A New Beginning*. New Futures, Inc. Albuquerque, New Mexico, 1992.

Barr, Linda and Monserrat, Catherine. *Teenage Pregnancy: A New Beginning*. (Exercise Booklet) New Futures, Inc. Albuquerque, New Mexico, 1986.

Barr, Linda and Monserrat, Catherine. *Working with Childbearing Adolescents*. (For use with *Teenage Pregnancy: A New Beginning*) New Futures, Inc. Albuquerque, New Mexico, 1980.

- Berg, Toni. Breastfeeding Something Special for Mother and Baby. (For use with Teenage Pregnancy: A New Beginning) New Futures, Inc. Albuquerque, New Mexico, 1989.
- Brinkley, Ginny and Sampson, Sherry. Young and Pregnant: A Book For You. Pink Inc! 1989. (available from International Childbirth Educators Assoc.)
- BC Alliance Concerned with Early Pregnancy and Parenthood, Information Services #202-3102 Main St. Vancouver, V5T 3G7
- Dad, It's Your Baby Too. A Guide for Expectant Fathers. (available from the March of Dimes Birth Defects Foundation, National Office, 1275 Mamroneck Ave. White Plains, New York 10605 (914) 428-7100).
- Lindsay, Jeanne Warren. Teenage Couples: Caring, Commitment and Change. Morning Glory Press. 1995.
- Lindsay, Jeanne Warren. Teenage Couples: Coping with Reality. Morning Glory Press. 1995.
- Lindsay, Jeanne Warren. Teenage Couples: Expectations and Reality. Morning Glory Press. 1996.
- Lindsay, Jeanne Warren and Brunelli, Jean. Teen Parenting: Your Pregnancy and Newborn Journey. Morning Glory Press. 1994.
- Lindsay, Jeanne Warren and McCullough, S. Discipline from Birth to Three. Morning Glory Press. 1993.
- Lindsay, Jeanne Warren. Teens Parenting: The Challenge of Toddlers. Morning Glory Press. Buena Park, CA, 1992.
- Lindsay, Jeanne Warren and Rodin, S. Teen Pregnancy Challenge: Book 1 Strategies for Change. Morning Glory Press. 1989.
- Lindsay, Jeanne Warren. and Rodin, S. Teen Pregnancy Challenge: Book 2 Programs for Kids. Morning Glory Press. 1989.
- Pollock, S. Will the Dollar Stretch: Teen Parents Living on Their Own. Morning Glory Press. 1996.
- Arthur, S. Surviving Teen Pregnancy. Morning Glory Press. 1991.
- A catalogue of Morning Glory Press books can be ordered from:  
Morning Glory Press  
6595 San Haroldo Way  
Buena Park. CA 90620-3748  
phone: (714) 828-1998  
fax: (714) 828-2049

#### Resources on High Risk Pregnancies

- Rich, Laurie A. When Pregnancy Isn't Perfect: A Lay Person's Guide to Complications in Pregnancy. Dutton/Penguin Group 1991.
- Semchyshyn, Stefan and Colman, Carol. How To Prevent Miscarriage and Other Crises of Pregnancy. Collier Books.
- Johnstone, Susan and Kraut, Deborah. Pregnancy Bedrest: A Guide for the Pregnant Woman and Her Family. An Owl Book, Henry Holt and Co. New York 1990.
- Borg, Susan and Lasker, Judith. When Pregnancy Fails. Bantam Books 1989

Frankly Speaking: A Book For Cesarean Parents. C/Sec Inc. 1989. (available from International Childbirth Educators Assoc.)

Noble, Elizabeth. Having Twins. Houghton Mifflin Co. 1991.

### Pamphlets

How Your Baby Grows (available from the Saskatchewan Institute on Prevention of Handicaps)

Stress and Pregnancy Information Sheet March of Dimes 1992 (available from the Saskatchewan Institute on Prevention of Handicaps)

Pregnant Women and Workplace Chemicals. Occupational Health and Safety. 1991 (available from the Saskatchewan Institute on Prevention of Handicaps)

Preterm Labour Fact Sheet 1995 (available from the Saskatchewan Institute on Prevention of Handicaps)

Sudden Infant Death Syndrome Health File, B.C. Ministry of Health June 1995 (available from local health units/departments)

Sweet Dreams ( Canadian Foundation for the Study of Infant Deaths - available from local health units/departments)

There are many other pamphlets available from the Saskatchewan Institute on Prevention of Handicaps either free or at a minimal cost, for a free catalogue:

Saskatchewan Institute on Prevention of Handicaps

1319 Colony St.

Saskatoon, Sask. S7N 2Z1

phone (306) 655-2512

fax (306) 655-2511

### Videos

British Columbia Ministry of Health. Baby's Best Chance Video. Victoria, 1990.

British Columbia Ministry of Health. Baby Basics Video. Victoria, 1989.

Project Future: (3 videos) Your Pregnancy, Your Plan

Giving Birth to Your Baby

Your New Baby, Your New Life

(available from Canadian Learning Inc. 63 Mack Ave. Scarborough, Ont. M1L 1M5 phone:(416) 691-9094 fax:(416) 691-8833)

Lifestyle Choices: Your Health, Baby's Health Access Network 1987 (available from the Saskatchewan Institute on Prevention of Handicaps)

Journey To Birth 1985 (available from the Saskatchewan Institute on Prevention of Handicaps)

Take Care: Understanding Preterm Labor 1991 (available from the Saskatchewan Institute on Prevention of Handicaps)

Bittersweet Experience (available from Lifecycle Productions Inc. P.O. 183 Newton, MA 02165 phone: (617) 332-9205)

Videos about Teen Pregnancy (available from the Saskatchewan Institute on Prevention of Handicaps)

Rockabye 1990  
Playing For Keeps 1990  
Teen Moms Talking 1992  
Teen Rebel, Teen Mom

Other Resources

Total Pregnancy Weight Gain (poster)  
(available from Calgary Health Services, Nutrition Division,  
P.O. Box 4016, Station 'C'  
320 - 17 Ave. S.W. Calgary, Alta. T2T 5T1)

The Growing Uterus. (a series of posters) Childbirth Graphics.

The Four Trimesters of Childbearing (series of posters) Childbirth Graphics.

Labour and Birth. (series of posters) Childbirth Graphics.

Your Pregnancy Calculator. (wheel used for determining due date) Childbirth Graphics.

Childbearing/The Classic Series. Childbirth Graphics 1985.

Knitted Uterus/Baby Model. Childbirth Graphics.

Childbirth Graphics materials are available from:

Directional Learning Canada  
480 Washington St.  
Elora, Ont. N0B 1S0  
phone: (519) 846-5397  
fax: (519) 846-9791

## C. Nutrition

### 1. Overview

Nutrition in pregnancy has been extensively researched. It is well recognized that adequate nutrition influences the health of pregnant women and their infants. Both maternal nutritional status and maternal diet can significantly influence pregnancy outcome. Severe overall undernutrition increases the risk of infertility, growth retardation and miscarriage (1). During the first trimester, severe energy restriction is associated with an increase in premature births, increased spina bifida and hydrocephalus. Energy deprivation in the second and third trimesters results in growth retardation (1,2). More recent evidence points out the need for optimal nutrition prior to conception as well. Thus poor nutrition prior to, and during pregnancy is related to poor pregnancy outcome and subsequent infant morbidity and mortality.

There are many factors which may place women at nutritional risk during pregnancy. Clients with more critical nutritional risk factors should be referred to the Resource Nutritionist or Coordinator (RDN) for an in-depth assessment. Depending on the outcome of the assessment and the counselling plan, the RDN may provide temporary or ongoing support to a client, in addition to that provided by the Outreach Worker.

Critical nutritional risk factors include:

- history of poor diet/inadequate nutrient reserves, e.g. refugees, women with chemical dependencies, frequent pregnancies, and anemia
- underweight or overweight pregravid
- anorexia or bulimia
- inadequate weight gain for pregnancy/rapid weight gain
- increased nutrient requirements, e.g. young teen, twin pregnancy
- medical complications, e.g. severe nausea and vomiting, gestational diabetes, etc.
- restricted food choices, e.g. due to food allergies, lactose intolerance, vegan diet, etc.

The following risk factors negatively influence a client's nutritional status, but may not require the Resource Nutritionist and can be addressed by the Outreach Workers.

- little understanding of nutrition or the importance of eating well during pregnancy (e.g. limited education, learning disabilities, FAS, mental illness)
- poverty
- inability to prepare basic food/never learned to cook, especially when combined with poverty

### 2. Assessment

The following are key components of nutritional assessment.

- a) Review medical history for special dietary needs and discuss current health concerns and prenatal lifestyle (e.g. nausea, constipation, heartburn, anemia, other medical conditions). Review results of any prenatal diagnostic or laboratory tests (i.e. hemoglobin, glucose tolerance). Women who smoke or use alcohol and/or drugs may have specific nutrient needs which require attention.

- b) Explore food preferences as affected by culture, lifestyle, budget and food preparation skills.
- What does she like/dislike to eat?
  - Any food allergies or lactose intolerance?
  - Pica?
  - Special diets such as vegetarian?
  - Does she like to cook? Have adequate kitchen facilities?
  - Does she do the shopping? Where does she shop? Does she make a list of the things she needs? Is she able to afford everything she puts on her list?
  - How often does she eat out? Where does she usually go?
  - Does she walk a lot? Is she physically active?

For teenagers or women living in extended families, it is important to explore whether they can influence the choice of foods purchased and prepared for the family. It may be important to include other key family members in some counselling sessions.

- c) Assess current food intake:
- i) Complete a 24-hour food recall of actual food intake for the day preceding the interview (see Appendix Q for a sample form). Food recalls should be obtained from all clients at least twice a month.
    - 3 dimensional food models supplemented with various sized glasses, bowls and plates should be available so clients can estimate the amount of food eaten. Many clients are unaware of average portion size.
    - include water intake as well as other beverages to assess fluid adequacy and caffeine intake (see the *Nutrition Education and Counselling Resource Manual* for the caffeine content of some foods).
  - ii) Total the number of servings in each food group and compare to the recommendations of the BC Food Guide for Pregnancy

BC Food Guide For Pregnancy

	Recommended Number of Daily Servings
Grain Products	8 - 10
Vegetables and Fruit	6 - 10
Milk Products	3 - 4
Meat and Alternatives	2

- iii) In order to determine whether a client is at nutritional risk, based on their food intake, it is important to find out whether the 24-hour food recall represents a typical day. General information should be obtained on the overall eating pattern and usual intake of a particular food or food groups.  
Food Frequency questionnaires may provide a useful cross-check.
- iv) Assess whether food choices include regular selections of food rich in iron and folic acid, nutrients of particular concern for optimal fetal development.

d) Assess the current use of vitamin/mineral supplements.

e) Assess the financial status and adequacy of the food budget.

Over 90% of Pregnancy Outreach Program clients have an inadequate income. However, if you are unsure about the client's financial status it may be useful to ask some of the following questions.

- Are you receiving Social Assistance?
- Do you use the food bank (if applicable to community)?
- How often do you shop?
- Is your fridge ever empty?

f) Obtain accurate height and weight measurements.

Clients should be weighed a minimum of twice a month and their weight plotted on a prenatal weight gain graph (see S for sample graphs). Plotting the weight allows program staff to pick up any rapid changes in weight and is a good visual education tool for the mothers.

A good quality portable weight scale, a metal measuring tape, and a right angle headboard for heights are essential.

g) Using the Body Mass Index (BMI), establish whether the client was underweight, normal weight or overweight pregravid. Women entering pregnancy underweight are more likely to have a LBW baby and should be followed closely.

$$\text{BMI} = \frac{\text{Weight (kilograms)}}{\text{Height (in meters)}^2}$$

Underweight	BMI <19.8
Normal Weight	BMI 19.8 - 26.0
Overweight	BMI 26.1 - 29.0
Obese	BMI >29.0

h) Establish a realistic weight gain goal, together with your client, based on the pregravid BMI and taking into account their weight gain to date. A weight gain range is more appropriate than a single target weight, as a wide range of gestational weight gain is compatible with desirable pregnancy outcome.

**Recommended Total Weight Gain Ranges for Pregnant Women  
Based on Pre-Pregnancy BMI \***

Pregravid Weight Status	Recommended Prenatal Weight Gain
underweight BMI < 19.8	12.5 - 18 kg
normal weight BMI 19.8 - 26	11.5 - 16 kg
overweight BMI 26.1 - 29	7 - 11.5 kg
obese BMI > 29	7 - 9 kg

- \* Currently, there are no accepted standards of weight for height (BMI) for adolescents. Adult BMI values may be used provisionally to classify teens as underweight, normal weight, overweight and obese. Adult BMI values should not be used for those who become pregnant within two years of menarche (1). Because adolescents may give birth to smaller infants for a given weight gain than do older women, they should strive for weight gains in the upper end of their BMI category (1,9).
  - \* There is evidence from several studies that encouraging higher weight gains in smokers may offset the tendency towards lower infant birth weight (2). Thus, smokers should also aim for prenatal gains at the high end of the ranges for recommended weight gain.
  - \* Weight gain in twin pregnancy should exceed that for a singleton because of greater increases in maternal tissues and intrauterine weight. The recommended weight gain is 16 to 20.5 kg for a successful outcome of a twin pregnancy (11).
  - \* Excessive weight gain in pregnant women is associated with an increased rate of high birth weight. This in turn may lead to an increased risk of forceps or cesarean delivery, birth trauma and asphyxia and mortality. These effects seem to be more pronounced in short women (less than 157 cm). Therefore, these women should gain weight in the lower range associated with their BMI.
- i) Recommended Rate of Weight Gain in 2nd and 3rd Trimester

The rate of weight gain is also important, as a smooth, progressive weight gain is reflective of a gain of lean and fat tissues (1,2,12). Again, depending upon a woman's prepregnant BMI, the recommended rate of weight gain in the second and third trimester is variable. These rates of gain are:

Rate of Gain (Trimesters 2 - 3)

Pregravid Weight Status	Recommended Weekly Weight Gain
underweight	0.5 kg
normal weight	0.4 kg
overweight	0.3 kg
obese	individualize

Inadequate weight gain should be investigated. Weight gain is considered inadequate in overweight and obese women who gain less than 0.5 kg per month or in normal weight and underweight women who gain less than 1 kg per month during the second and third trimesters. The most frequent cause of inadequate weight gain or of weight loss during the first trimester is nausea and vomiting. Factors to consider in inadequate rates of gain in the last two trimesters include loss of appetite, malabsorption syndromes, infection, low income, psychosocial stress, eating disorders, substance misuse and excessive physical activity.

Excessive weight gain is considered to be 3 or more kg per month (1). Dietary assessment is required to determine if the gain is due to excessive food intake or to fluid retention. A sudden increase in weight gain after the 20<sup>th</sup> week of pregnancy may indicate pregnancy induced hypertension (PIH). Weight reduction should never be

used in pregnancy. Rather, if the excessive weight gain is due to excessive intake, the woman's diet should be reviewed and she should be encouraged to participate in some regular exercise (unless it is contraindicated medically).

Prenatal weight gain grids provide a visual impression of the progress of weight changes over time (see Appendix R, Sample Weight Gain Graphs). Using these graphs abnormal weight changes can be easily detected and food intake adjusted accordingly.

### 3. Action Plan

As a client's nutritional status may change it is important to monitor progress throughout the pregnancy. As part of the Pregnancy Outreach Program prenatal weight gain and food intake are assessed regularly. A food recall and weight should be taken on each client at least twice a month. Any concerns regarding a client's nutritional status are referred to the Resource Nutritionist or Coordinator/Nutritionist. Nutrition counselling can then be provided by the Nutritionist and/or by the Outreach Workers.

When a client has many nutritional problems, it is tempting to try to tackle them all at once. Instead, prioritize concerns and set achievable goals in one or two important areas. Once key issues have been addressed, there is an opportunity to provide more general nutrition education regarding balanced meals/snacks and healthy food choices.

The Pregnancy Outreach Program can also work towards improving food security for clients. Supermarket tours to enhance shopping skills, community kitchens and meal/snack programs at drop-ins are examples of effective strategies. Clients can be assisted to enrol with local food banks and to organize an emergency shelf to ensure food is always on hand (see the *Nutrition Education and Counselling Resource Manual* for suggestions). Food supplements of milk and juice and vitamin/mineral supplements are supplied by the Pregnancy Outreach Program for clients in financial need.

For more information on nutrition counselling for pregnant women see: *Nutrition Education and Counselling Resource Manual for Counsellors Working With Pregnant Women* (available from OPTIONS: Services to Communities Society, Unit #100, 6846 King George Hwy., Surrey, BC V3W 4Z9 phone (604) 596-4321)

### 4. Nutrition Issues

#### a) Weight Gain

There is strong evidence in the literature linking gestational weight gain, particularly during the second and third trimesters, with fetal growth (1,2,3). Low gestational weight gain increased the risk of giving birth to a low birth weight baby. The infant is then at risk for alterations in body growth and possibly neuro-behavioral development, and is at increased risk for mortality. There is also evidence that inadequate maternal weight gain before 24 weeks gestation is associated with small for gestational age newborns, especially in teenage mothers (4). Other researchers have found an association between low first or second trimester weight gain and low birth weight (1).

Recently some studies are suggesting a link between impaired fetal growth and the development of cardiovascular disease and diabetes in adult life (5,6,7). Goldberg (7) also proposes that hypertension, alterations in clotting factors, Syndrome X and chronic obstructive lung disease arise because of impaired fetal growth. It is theorized that

early defects in the development, structure and function of organs later interact with diet and environmental stresses to cause these diseases. These theories are criticized by others as being speculative at this time.

Because adolescents may give birth to smaller infants for a given weight gain than do older women, they should strive for weight gains in the upper end of their BMI category (1,9). Research has shown that the simultaneous occurrence of maternal growth and fetal growth is associated with a smaller fetus (8). Evidently the still-growing mother does not seem to mobilize fat stores for fetal growth later in pregnancy. Scholl et al (10) reported that low weight gain in early pregnancy (before 24 weeks) in teens was associated with a greater risk of delivering a newborn small for gestational age. Thus adolescents should be closely monitored for weight gain during pregnancy. Encouraging adequate weight gain is a challenge with this population because many teens are weight conscious and may wish to restrict weight gain (9). Total energy and iron intake tend to be inadequate in teens (8). Thus, nutrition counseling should address energy and iron intake as well as weight gain.

b) **Anemia**

Anemia due to iron or folate deficiency occurs frequently in pregnant women, with iron deficiency being the most common (13-15). It has been reported that 29 - 84% of young Canadian women do not meet the RNI for iron (15). Anemia occurring early in pregnancy is associated with increased risk of preterm delivery and low birth weight. It is not clear whether iron deficiency anemia per se is the cause of preterm delivery or whether the iron deficiency anemia is the result of poor diet which in turn might be the true cause of the preterm delivery (13). Iron deficiency anemia in the second and third trimesters had little effect on prematurity and birth weight.

Hemoglobin values indicative of anemia:

Nonpregnant, 12 through 14 years of age

Hb below 11.8 g/dL (118 g/L)

Hct below 35.5 vol % (or 0.35)

Nonpregnant, 15 years or older

Hb below 12.0 g/dL (120 g/L)

Hct below 36.0 vol % (or 0.36)

Pregnant, weeks 1-13

Hb below 11.0 g/dL (110 g/L)

Hct below 33.0 vol % (or 0.33)

Pregnant, weeks 14-28

Hb below 10.5 g/dL (105 g/L)

Hct below 32.0 vol % (or 0.32)

Pregnant, weeks 29+

Hb below 11.0 g/dL (110 g/L)

Hct below 33.0 vol % (or 0.33)

Hypovolemia (inadequate plasma volume expansion during pregnancy) is defined as:

Between 24 and 34 weeks gestation

Hb above 13.9 g/dL (139 g/L)

Hct above 41.9 vol % (or 0.419)

Measurement of the mean corpuscular volume (MCV) can distinguish between iron deficiency anemia and folate deficiency anemia. Iron deficiency is characterized by smaller than normal red blood cells, or reduced MCV levels. Folate deficiency is characterized by larger than normal red blood cells or a high MCV. A deficiency of vitamin B<sub>12</sub> can also cause elevated MCV levels, thus this should be considered in women who do not consume any animal products.

Smokers and those who live at high altitudes experience an increase in hemoglobin. Consequently, anemia may be underdiagnosed in these people. Because of this, hemoglobin values can be adjusted for smoking and altitude according to the guidelines in Nutrition During Pregnancy and the Postpartum Period (2).

c) Fat

The role of fatty acids in the health of the fetus/infant is a recent topic of inquiry. The n-3 fatty acids are known to be essential in fetal development. DHA (n-3 FA) is concentrated in the brain and retinal tissues and accumulates in late fetal and early neonatal life (19,20). Maternal consumption of DHA or conversion of LNA (linolenic acid) to DHA is needed to supply the fetus with DHA. Animal studies have shown that the composition of brain and retinal tissue is dependent on dietary DHA. Any deficit of DHA results in functional change, which may not be reversible, in these tissues. Good food sources of DHA are seafood and fatty fish.

It is not known whether fat restricted, energy adequate diets are safe or efficacious in pregnancy. Likely, if total energy, protein and trace nutrients are adequate and essential fatty acids provided, the fat restricted diet should pose few problems. Very low fat diets are not recommended as they would be deficient in essential fatty acids and fat soluble vitamins (20). Also the bulk associated with a very low fat diet is difficult for pregnant women to eat, and may result in inadequate energy ingestion.

d) Gestational Diabetes

Gestational diabetes occurs in 1 -3% of pregnancies. It is recommended that all pregnant women be screened for glucose tolerance between 24 and 28 weeks gestation. Women with a) a previous history of gestational diabetes, macrosomia, unexplained stillbirth or malformed infant; b) a family history of diabetes; c) obesity; d) aged 35 or older; and e) glycosuria; should be screened for diabetes before pregnancy or at the first prenatal visit.

Abnormal glucose levels:

1-hour, 50 gm oral glucose loading test:

venous plasma glucose above 140 g/dL (7.8 mmol/L) one hour after the glucose load

3-hour, 100 gm oral glucose tolerance test (two or more of the following venous plasma concentrations must be met or exceeded):

fasting, 105 mg/dL (5.0 mmol/L)

1-hour, 190 mg/dL (10.6 mmol/L)

2-hour, 165 mg/dL (9.2 mmol/L)

3-hour, 145 mg/dL (8.1 mmol/L)

## c) Socioeconomic Status

It is important to assess a pregnant woman's socioeconomic status as this may uncover factors which have nutrition implications. Low income is related to poor maternal weight gain, low birth weight and higher perinatal mortality.

## f) Substance misuse

Substance misuse (alcohol, cigarettes, drugs, caffeine, herbal remedies, megadoses of vitamins/minerals) can have direct toxic effects on the mother and her fetus. Also altered food intake, absorption, excretion or metabolism of nutrients may occur because of substance misuse. (See Section E, Alcohol and Other Drug Use During Pregnancy)

- alcohol causes fetal damage, however the mechanism is not known. It may be due to the toxic effects of the alcohol, a by-product of alcohol metabolism, nutrient deficiencies associated with alcohol abuse or a combination of these, or some other unknown mechanism. Because of its deleterious effects alcohol use during pregnancy is contraindicated.
- smoking during pregnancy impairs fetal growth and is associated with an increased incidence of miscarriage, stillbirth, prematurity, neonatal death and other complications. This may be due to poor diets of smokers, toxic effects of inhaled substances, vasoconstriction caused by nicotine or may be due to the indirect effect of a restriction of the mother's weight gain. Good weight gains should be encouraged in smokers as well as a diet emphasizing vitamin C, beta carotene and zinc.
- drug use is associated with inadequate nutrient intake and absorption, poor health, smoking and alcohol abuse. Cocaine, heroin and methadone have an impact on maternal and fetal health. Some studies indicate that marijuana adversely affects fetal development. Recent evidence indicates that marijuana use is associated with an increase in preterm delivery. Caffeine may pose potential harm to the fetus if consumed in large amounts. It is recommended that caffeine intake be limited to 300 mg/day, approximately the amount in 2 cups of brewed coffee. (See Appendix S)
- herbal remedies are generally contraindicated during pregnancy because of their medicinal properties. Herbal teas from chamomile, blackberry, ginger, raspberry, strawberry leaf, rosehips, mint and lemon are deemed safe in pregnancy.

## g) Pica

Pica, or compulsive eating of nonfood items, is occasionally seen in pregnant women. Pica may cause inadequate intake of required nutrients or result in ingestion of toxic substances. Low hemoglobin levels and anemia have been observed in pregnant women with pica. Also pica has been reported to be associated with an increased incidence of pregnancy induced hypertension.

h) Psychological Problems and Mental Handicap

Mental handicap (eg., Fetal Alcohol Syndrome), psychiatric (eg., schizophrenia) and psychological problems such as depression, eating disorders or stress may result in inappropriate nutrient intake, and/or risk-taking behaviours. Consequences of this include poor weight gain, low birth weight, prematurity and increased morbidity and mortality.

i) Supplementation

A dietary assessment is useful in determining which women would benefit from vitamin/mineral supplementation (1,2,4). Dietary studies of pregnant women have shown that they frequently consume less than the recommended amounts of vitamins B<sub>6</sub>, D, and E and the minerals iron, calcium, zinc and magnesium (1). All pregnant women should be encouraged to eat a wide variety of nutritious foods in order to obtain the many nutrients needed to support a healthy pregnancy, even if they are taking a vitamin/mineral supplement.

### *Iron*

Iron needs in pregnancy exceed the amount of iron obtained via diet and maternal iron stores. Therefore, 30 mg of iron is recommended daily, beginning in the second trimester.

When laboratory evidence of anemia is determined, iron supplementation of 60 to 120 mg/day is recommended. When more than 30 mg of iron is needed the dose should be split and taken at different times in the day to enhance absorption. It has been shown that both 30 mg and 60 mg of iron inhibit subsequent iron absorption for 3 - 24 hours. Therefore, at least 3 hours should elapse between doses. Administration of iron on an empty stomach between meals or at bedtime will facilitate its absorption. Ascorbic acid will also enhance the absorption of nonheme iron.

High doses of iron will impair zinc absorption. According to the literature, high iron doses will inhibit the absorption of concurrently administered zinc when a multivitamin/mineral supplement is taken on an empty stomach (2). Therefore, an additional iron supplement should not be taken at the same time as a vitamin/mineral supplement.

### *Folate*

Folate, also known as folic acid or folacin, is very important for fetal growth and development because it is required for protein synthesis, cell division and replication. Studies have shown that adequate folate prior to conception reduces the incidence of Neural Tube Defects (NTDs), congenital heart problems, orofacial birth defects and small-for-date infants. A healthy diet and supplementation with 0.4 mg folate daily is recommended periconceptually and while breastfeeding.

A total daily intake of 0.6 mg of folate has been shown to reduce by 50% the first-time occurrence of NTDs such as anencephaly and spina bifida as well as cleft palate. These defects occur early in the first trimester, often before a woman knows she is pregnant. All women in their childbearing years should eat a folate-rich diet including plenty of

whole grains and folate-fortified grain products, with dark green or orange vegetables and fruit. Dietary surveys indicate, however, that most women consume only about 0.2 mg folate daily. Therefore a healthy diet and a folate supplement of 0.4 mg daily is recommended for all women who could become pregnant, to begin at least one month prior to conception and continue through pregnancy and lactation.

Populations at increased risk of having an NTD affected pregnancy include: women who have had a previous NTD affected pregnancy, women with a family history of NTDs, women who have diabetes or taking anti-epileptic drugs or those with an intestinal malabsorption disorder such as celiac disease. Ethnic origin may be another risk factor. Worldwide, Sikh infants are at much greater risk for NTDs. All of these women may require a prescription for a daily folate supplement of 4.0 mg/day and should be referred to their family doctor and/or the Medical Genetics Program in Vancouver at (604) 875-2157.

### Calcium

Studies have shown that dietary calcium intake is often inadequate in women. Extra calcium is necessary in pregnancy to meet the needs of the growing fetus. There is concern that inadequate amounts of calcium will result in adverse long-term effects on bone mineralization in women younger than 25 years of age (1,21). See *Nutrition Education and Counselling Resource Manual* for ideas on increasing the calcium intake of lactose intolerant women.

Calcium supplements vary in the amount of elemental calcium that they contain, as well as in their absorbability. The following illustrates the amount of calcium supplement needed to provide 600 mg calcium.

Supplement	Calcium Content	Amount Needed to Provide 600mg Calcium
Calcium carbonate	40%	1500 mg
Calcium citrate	24%	2500 mg
calcium lactate	14%	4275 mg
calcium gluconate	9%	6675 mg

Calcium citrate, lactate and gluconate do not neutralize stomach acid. However, calcium carbonate (e.g. Tums) does neutralize stomach acid and this can potentially interfere with iron and B vitamin absorption. Therefore calcium citrate may be the best source of calcium in a calcium supplement. Calcium citrate is best absorbed in the fasting state.

Calcium phosphate is poorly absorbed and interferes with iron absorption, hence it is not recommended. Also not recommended are calcium supplements derived from bone meal, dolomite or oyster shell because of possible contamination with toxic elements.

Calcium intake has recently been linked to hypertensive disorders of pregnancy (21,22,23). Trials using calcium supplements suggest that calcium salts at 1 - 2 grams calcium per day may be helpful in decreasing hypertensive disorders in pregnancy. The amount of calcium which was effective was above normal, suggesting a pharmacological action rather than a simple increase in calcium supply (21).

### *Vitamin D*

Vegans should receive 10 ug of vitamin D daily. Women who consume low levels of vitamin D fortified milk should take 5 ug per day.

### *Vitamin B<sub>6</sub>*

No scientific evidence exists for the use of vitamin B<sub>6</sub> supplementation to relieve nausea and vomiting in pregnancy (2). If women do decide to take B<sub>6</sub> they should not exceed 100 mg/day. Higher levels have been known to produce toxic effects. Substance abusers, pregnant adolescents and multiparous women are at high risk for B<sub>6</sub> deficiency. A B<sub>6</sub> supplement of 2 mg/day is recommended for these women (4).

Toxicity limits for supplements (2):

Vitamin A > 8,000 IU/day

Vitamin D > 400 IU/day

Vitamin C > 2,000 mg/day

Vitamin B<sub>6</sub> > 100 mg/day

Iodine > 11 mg/day

#### j) Pregnancy, HIV and Nutrition

According to the BC Center for Disease Control, 5 out of every 10,000 pregnant women in BC are HIV positive. Little information is available with respect to the nutritional needs of pregnant women who are HIV positive or who have AIDS. Practitioners will need to keep abreast of the literature to guide the prenatal care of these women and develop appropriate resources and referral networks to provide optimum care.

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### Resources

#### General Reference Books/Articles For Nutrition in Pregnancy

Nutrition Education and Counselling Resource Manual for Counsellors Working with Pregnant Women. Options: Services to Community Society Surrey BC 1996.

BC Dietitians' and Nutritionists' Association. Manual of Nutritional Care, 4th Edition, 1992.

Institute of Medicine. Nutrition During Pregnancy and Lactation. An Implementation Guide. Part I Weight Gain, Part II Nutrient Supplements. National Academy of Press. Washington D.C. 1990.

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Swinney, B. and Anderson, T. Eating Expectantly: Essential Eating Guide and Cookbook for Pregnancy. Fall River Press. Colorado Springs, Co. 1993.

Quick Healthy Recipes 1992. (available from Lise Chapdeleine CLSC Limoilou, 825, des Capucins, Quebec, G1J 3S0 (418) 648-0567)

Health and Welfare Canada. Nutrition Recommendations. 1990.

Health and Welfare Canada. Nutrition in Pregnancy, National Guidelines. Ottawa, 1987.

Health and Welfare Canada. Nutrient Value of Some Common Foods. 1987.

(these Health Canada publications can be purchased by contacting: Canada Communication Group, Publishing Ottawa, Ont. K1A 0S9, phone (819) 956-4800 fax (819) 994-1498)

Reiff, D.W. and Reiff, K.K.L. Eating Disorders. Nutrition Therapy in the Recovery Process. Aspen Publishers, Inc. Gaithersburg, Maryland 1992 (contains a chapter on pregnancy and eating disorders).

### Pamphlets

Canada's Food Guide. Health Canada

Interior BC Native Food Guide. Health Canada.

Coastal BC Native Food Guide. Health Canada.

Folic Acid: The Vitamin that Helps Protect Against Neural Tube (Birth) Defects (fact sheet) Health Canada

(the above publications are available free from Publications Health Canada Ottawa, Ont. K1A 0K9 phone (613) 954-5995 fax (613) 941-5366)

Eating for Two: Nutrition During Pregnancy. March of Dimes Birth Defects Foundation. (available from the March of Dimes Birth Defects Foundation, National Office, 1275 Mamronck Ave. White Plains, New York 10605 (914) 428-7100))

Folate: What Every Woman Should Know. Nutrition Program, Boundary Health Unit. Surrey BC  
Folic Acid: How Can This Vitamin Help You Have a Healthy Baby? (available from the Spina Bifida Association of Canada 220-388 Donald St. Winnipeg, MB R3B 2J4 1-800-565-9488)

Folic Acid and the Prevention of Neural Tube Defects Fact Sheet 1994 (available from the Saskatchewan Institute on Prevention of Handicaps 1319 Colony St. Saskatoon, Sask. S7N 2Z1 phone(306) 655-2512 fax(306) 655-2511)

Folic Acid: How Can This Vitamin Help You Have a Healthy Baby? Folic Acid Project Alliance 1995 (available from the Saskatchewan Institute on Prevention of Handicaps)

### Nutrition and Low Income Issues

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Corporation of the District of Burnaby, Health Dept. Eat Well For Less: Recipes for Low Cost Cooking. D.W. Friesen and Sons Ltd. 1990 (available from the Burnaby Health Unit 6161 Deer Lake Avenue, Burnaby, BC V5G 4A3 (604) 294-7292)

Marquis, Sandra. Good Food Here and Now: Healthy Food Choices on a Low Income. BC Ministry of Health 1990. (available from Health Units across BC)

The Thrifty Kitchen: Terrific Low-Cost Eating Surrey Food Bank Advisory Council 1994. (available from the Surrey Food Bank 10732 - 135th Ave. Surrey, BC V3P 4C7 (604) 581-5443)

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- Community Kitchens Leader's Guide
  - Community Kitchens Cookbook and Shopping Guide
  - Building Food Security in Canada: A Community Guide for Action on Hunger
- (available from Kamloops Foodshare South Central Health Unit, Kamloops, BC V2B 7Z9 (250) 828-4411)

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The Food Experience: A Facilitator's Manual. City of York Health Unit 1990. (available from the City of York Health Unit, 504 Oakwood Ave. City of York, Ont. M6E 2X1 (416) 394-2436)

Videos

Nutrition for Building Better Babies. McIntyre Media. 1-800-565-3036

Eating for a Healthy Baby: Prenatal Nutrition. Vancouver Health Department. Available in English and Punjabi (available from Vancouver Health Dept. 1060 W. 8th Ave. Vancouver, BC V6H 1C4)

Inside My Mom. March of Dimes (available from March of Dimes Birth Defects Foundation National Office 1275 Mamroneck Ave. White Plains, New York 10605 phone: (914) 428-7100).

Diabetes Resources

Good Health Eating Guide. Canadian Diabetes Association 1994. (available from the Canadian Diabetes Assoc. 1091 W. 8th Ave. Vancouver, BC V6H 2V3 (604) 732-1331)

Catalogue of Diabetes Education Resources for First Nations People. Health and Welfare Canada, Medical Services Branch, Ontario Region.

How to Have a Healthy Pregnancy and a Healthy Baby. 1995 (available from Medical Services Branch, Health Canada).

Other ResourcesDial-A-Dietitian

Telephone lines manned by Registered Dietitian/Nutritionists. Excellent resource for both staff and clients.

Greater Vancouver: 732-9191

Toll free in BC: 1-800-667-3438

Food Models

Directional Learning Canada Limited  
480 Washington Street  
P.O. Box 369  
Elora, Ontario  
N0B 1S0  
(519) 846-5397

Lact-Aid Hot Line: 1-800-387-5711

For free patient starter kits of lact-aid (a lactose enzyme for treating milk and dairy products) for individuals with lactose intolerance.

Quality portable weight scales:

The Scale Shop  
107 - 318 East Kent South  
Vancouver BC V5X 4N6  
(604) 322-0345

BC Dairy Foundation resource materials:

BC Dairy Foundation  
Imperial Square  
3236 Beta Avenue  
Burnaby BC V5G 4K4  
phone (604) 294-3775 or 1-800-242-6455  
fax (604) 294-8199

- FoodTrack - Check on Balance
- FoodTrack Wipe-Off Board
- FoodTrack Poster
- FoodTrack - Check on Balance Overheads
- FoodTrack: Fibre
- Food Track - Check on Caffeine
- FoodTrack Leader's Kit
- Serving Size Poster
- Ethnic Foods List
- Food Pictures
- Tips for Healthy Eating (designed for low literacy and special needs audiences)
- Calcium Calculator
- Instructor's Guide for Handling Common Concerns (concerns re. calcium)
- Osteoporosis - Are You At Risk?
- Today's Reference Guide to Dairy Foods
- Milk, Your Window on Health Poster
- Lactose Intolerance Sheets
- Lactose Maldigestion - A Misconception
- Food Chart for Breastfeeding Moms

BC Ministry of Health/Ministry for Children and Families resource materials:

Available from your local Health Unit.

- Supermarket Education Kit. 1991.
- Good Food Here and Now. 1990. (Resource guide on food budgeting, shopping skills, low cost recipes.)
- Good Eating. How To Plan Good Food (Basic nutrition information for low literacy clients.)

Nutrition Bingo with Native Foods (available from Medical Services Branch)

## D. Smoking/Secondhand Smoke

### 1. Overview

Cigarette smoking has been shown to decrease infant birth weight and increase the risks of perinatal morbidity and mortality. Maternal smoking during pregnancy is associated with intrauterine growth retardation and a higher incidence of spontaneous abortions, stillbirths and placental complications. Infants of smokers show an increased rate of both sudden infant death syndrome and death from respiratory disease. Increased levels of smoking are associated with increased risk. Learning difficulties and attentional problems have been associated with prenatal exposure. The mechanism and the contribution of other factors (i.e., alcohol and other drugs) is under continuous research.

Etiology (the cause of these conditions) may include direct toxicity of carbon monoxide, nicotine and/or other constituents of tobacco, chronic fetal hypoxia, or reduced blood flow to the uterus affecting transfer of nutrients to the fetus. Passive smoking (secondhand smoke) is also associated with negative effects for the child both during pregnancy and after birth.

The earlier during pregnancy a woman gives up smoking, the greater the reduction in risk of a low birth weight infant. With early, complete cessation during pregnancy, the risk may be reduced to a level similar to that of the nonsmoker.

### 2. Assessment

Pregnancy Outreach Program staff will need to assess the:

- a) Smoking behaviour
  - number of cigarettes smoked per day
  - type of cigarettes smoked
  - how long the client has smoked
  - The age at which she began
  - smoking triggers or what causes the client to smoke, i.e. finishing a meal, talking on the phone, drinking coffee or alcoholic beverages, work breaks, working under pressure or stress, etc.
  - contact with people who smoke in the home, at work, or in social situations
  - knowledge level of the effects of smoking on maternal health and pregnancy outcome.
- b) History of smoking cessation attempts
  - previous attempts to quit smoking
  - methods utilized to attempt to quit smoking
  - what it was about these methods that did not work
  - why the client continues to smoke
  - current desire and motivation level for behaviour change.
- c) Smoking cessation resources available in the community.

### 3. Action Plan

- a) At the initial interview assess the client's smoking behaviour, previous smoking cessation attempts, and current motivational level.
- b) Provide information and education about the effects of smoking on maternal health and pregnancy outcome.
- c) Discuss with the client the alternatives available for smoking cessation.
- d) Set goals for smoking cessation with the client and outline a plan of action. Specific activities that could be implemented are:
  - document all cigarettes smoked and identify smoking triggers
  - make smoking more difficult by decreasing the accessibility of cigarettes, i.e. change brands, hide cigarettes, remove smoking accessories
  - develop a reward system
  - find alternatives to smoking such as knitting, exercising, and walking
  - avoid smoking situations
  - develop coping mechanisms such as relaxation
  - encourage the client to let people know that she is attempting to quit smoking.
- e) Assist the client in choosing the most appropriate smoking cessation method and link her up with the related resources in the community.
- f) Involve any significant others who also smoke in the smoking cessation plan if possible.
- g) Coordinate a buddy system for clients attempting to quit smoking by linking them with other clients, volunteers and/or Outreach Workers. The client may choose a friend or significant other to be this support person.
- h) Facilitate or encourage the development of a support group for these clients.
- i) Provide ongoing support and follow-up to clients involved in smoking cessation.

### Resources

#### Books/Reports

Greaves, Lorraine. Background Paper on Women and Tobacco (1987): An Update (1990). Health and Welfare Canada - Tobacco Programs Unit, 1990.

Smoking and Pregnancy Resource Kit 1992 (available from the Saskatchewan Institute on Prevention of Handicaps 1319 Colony St. Saskatoon, Sask. S7N 2Z1 phone (306) 655-2512 fax (306) 655-2511)

Baby and Me, Smoke Free. Smoking Cessation in Pregnancy Techniques for Health Professionals. (available from U. S. Department of Health and Human Services. Public Health Service. phone: (303) 331-8572).

Smoking Cessation in Pregnancy. Abbreviated Prenatal Counselling Protocols for WIC Educators and/or Health Care Professionals. (available from U.S. Department of Health and Human Services Public Health Service phone: (303) 331-8572).

### Video

British Columbia Ministry of Education. Smoking Against Your Will. Provincial Educational Media Centre, Victoria.

### Cessation Assistance

British Columbia Cancer Society 1-800-663-2524  
565 W. 10th Ave. Vancouver, BC V5Z 4J4

- 'Fresh Start' program
- When a Woman Smokes
- pamphlets and other education resources

British Columbia Lung Association 731-5864 or 1-800-665-5864  
2675 Oak St. Vancouver, BC V6H 2K2

has these Self Help Guides (available for minimal or no cost):

- Freedom From Smoking In 20 Days
- A Lifetime Of Freedom From Smoking
- Freedom From Smoking For You and Your Baby (book & cassette)
- Smoking and the Two of You

British Columbia and Yukon Heart Foundation 736-4404 or 1-800-663-2010

1212 W. Broadway Vancouver, BC V6H 3V2

pamphlets and other educational resources.

BC Doctors' Stop Smoking Project 1-800-665-2262

BC Medical Association 736-5551

#115 - 1665 West Broadway

Vancouver, BC V6J 5A4

Canadian Council on Smoking and Health (613) 567-3050

170 Laurier Ave. W. Ste 1000 Ottawa, Ontario K1P 5V5

- A New Start in Life: About Smoking and Pregnancy
- Taking Control: an action handbook on women and tobacco

March of Dimes Birth Defects Foundation (914) 428-7100

National Office

1275 Mamroneck Ave.

White Plains, New York 10605

- Give Your Baby a Healthy Start: Stop Smoking.

### Other resources

Smokers' Information and Treatment Centres

Local Health Unit

Physicians

Local Community Agencies that offer cessation classes

Seventh Day Adventist Church

## E. Alcohol and Other Drug Use During Pregnancy

### 1. Overview

*Fetal alcohol syndrome (FAS)* is a term used to describe a set of signs and symptoms seen in some children exposed to alcohol in utero. There are three groups of characteristics present in a child born with FAS:

- growth deficiencies- low birth weight, disproportional low weight to height, small stature
- facial abnormalities - small eye openings, drooping eyelids, depressed nasal bridge, thin upper lip, flattened groove between the nose and upper lip
- central nervous system damage - which may include intellectual impairment, developmental disabilities, learning disabilities, impulsivity, short attention span, hyperactivity, and poor coordination.

In addition, individuals impacted by FAS may have other health problems such as abnormalities of the skeleton, cleft lip and palate, heart defects, other internal organ problems, and vision and hearing problems. Other related conditions are *partial FAS* and *alcohol related neurodevelopmental disorder (ARND)*, which describe the presence of one or two of the features of FAS, in those born to women known to have used alcohol during pregnancy. These latter two terms encompass the features previously described as possible *fetal alcohol effects (FAE)*.

The impact of FAS and other alcohol related birth defects are long term. Some of the effects characterizing exposed children include developmental disorders, small head circumference, intellectual impairment, memory difficulties (difficulty in both registering and retrieving information), impaired reasoning from cause to effect, difficulty predicting and understanding consequences, learning difficulties (difficulties in math, reading spelling, problem solving and comprehension), attention deficits and hyperactivity, adaptive and social behaviour difficulties such as over-friendliness, need for physical contact, immaturity, problems with change in routine, and appearance of capability without the actual abilities.

A recent study from Seattle found that youth and adults affected by FAS and partial FAS were at higher risk for "secondary disabilities" such as mental health problems, school drop-out, trouble with the law, inappropriate sexual behaviour and alcohol and drug problems. Individuals with FAS may also exhibit positive characteristics such as being happy, friendly, spontaneous, trusting, loving, determined, caring, helpful, affectionate, creative and artistic. Note that there is a great variability in characteristics of those affected by FAS and these lists are not exhaustive.

No one can predict with certainty which infants born to mothers who drink will be affected, nor can anyone predict how severe these effects will be. Not every woman who drinks during pregnancy, even though she drinks heavily, will have a child with full FAS. Other factors which influence the risk for FAS are malnutrition, smoking, use of other drugs, the mother's overall health, exposure to environmental toxins, stressful life events, and various individual genetic and resiliency factors. It is estimated the risk for full FAS ranges from 10-40% in alcohol dependent women. Basic science research supports the clinical observations that the greatest damage is associated with higher blood alcohol levels that often arise from either binge drinking or chronic daily drinking.

Determining a threshold below which alcohol use is safe is highly controversial. Researchers in the US and Europe have measured effects on growth and development at levels above 100-120 grams per week of absolute alcohol (equal to approximately one standard Canadian drink

per day) Since no one knows exactly how much alcohol a pregnant woman can safely drink, it is recommended that women abstain from drinking during pregnancy. If abstaining is not achievable, reducing use is important. We do know that the range and severity of problems to the developing fetus increases with the amount of alcohol consumed. Drinking regularly, or daily during pregnancy (sometimes called chronic drinking) is considered to be of high risk. Drinking alcohol to the point of intoxication on an occasion (sometimes called binge drinking) is also of high risk.

Current research indicates that the problems associated with prenatal exposure to drugs varies widely and is strongly confounded by concurrent alcohol and tobacco use, other risk taking behaviours, inadequate prenatal care, poverty, malnutrition, and other maternal stressors, (eg., trauma and abuse). See Appendix S for an overview of the effects of alcohol and other drugs on pregnant women, the developing fetus and on infants when breastfeeding.

## 2. Assessment

It is important to create an open, non-judgmental, respectful context in which to ask questions about alcohol and drug use.

Questions from standardized screening tools such as the T-ACE, TWEAK and AUDIT can be used to ask about alcohol and drug use. Informally asking questions which relate to level and impact of use can also be effective. Some general questions about use, appear in the booklet *Hidden Majority* published by the Addiction Research Foundation of Ontario, referenced at the end of this section.

It is important to understand that women are often reluctant to discuss their alcohol and other drug use due to the stigma attached to use by women, denial common in those who are dependent on alcohol and other drugs, and fear of losing custody of children if they are suspected of misuse of alcohol and other drugs.

It has been found that people respond best to frank discussion of use, which acknowledges both the pros and cons of alcohol and drug use; helps them see the impact alcohol and drug is having on their life; and builds motivation to change. It has also been found that frank discussion of both the risk and protective factors relating to having a child affected by alcohol or other drug use is helpful in helping women assess their use in pregnancy. Many women know of someone who had a healthy child in spite of their use of alcohol and drugs, thus honesty about risk and protective factors is important to the credibility of our counselling.

A woman is at higher risk of having a child affected by FAS or other neurodevelopmental disabilities if she:

- drinks to intoxication on an occasion (often called binge drinking), or
- drinks regularly or daily (often called chronic drinking), or
- uses other drugs (prescription or street), and
- is malnourished,
- has poor health overall health,
- is not accessing prenatal care,
- is living in a stressful home situation, or
- has had a previous child affected by FAS.

### 3. Action Plan

- Be informed about FAS and other alcohol and drug related birth defects. Some excellent current resources are listed below. Share this information openly with all women (and their support network) who may access your services.
- Work from the values of respect, understanding, compassion and hope when discussing alcohol and other drug use with women.
- Be informed about women and alcohol and drug misuse - the influences on women's use, the treatment and self-help resources available to women in your community, and how to do brief motivational counselling with her about stopping or reducing her use.
- Provide services in a place where it is safe to discuss alcohol and other drug use and alternatives to use.
- Provide clear information on substance use in pregnancy. Have information about women and alcohol and drug use available in your program. There are posters, pamphlets, and videos available.
- Stress the positive of abstaining or cutting down. Remind women of the importance of nutrition and other positive health practices which reduce risk.
- Keep the messages clear, simple and realistic.
- Stress the positive - "If you stop drinking now you have a better chance of having a healthy baby."
- Don't predict the outcome of particular pregnancy.
- Help women develop motivation for reducing risk and provide ongoing hope.
- Recommend treatment for alcohol and drug problems when goals for stopping or reducing use are not easily achieved.
- Be sensitive to the range of issues which may be related to women's use such as legal/custody problems, housing instability, poor health, depression, history of abuse and/or family violence, sexually transmitted diseases, etc.
- Be sensitive to women's fear of losing their children if she admits to having a problem, and her shame and denial about having an alcohol/drug problem.

**For additional information on FAS contact:**

**Alcohol and Drug Information and Referral Service**

Toll-free 1-800-663-1441

Local phone (604) 660-9382

Provides toll-free information and referral to treatment services and agencies for those who are seeking assistance with alcohol and other drug misuse. Provides information resources for communities and individuals to deal with alcohol and other drug concerns. Available 24 hours a day, 7 days a week.

BCFAS Resource Society

c/o Sunny Hill Health Center for Children  
3644 Slocan Street  
Vancouver, BC V5M 3E8  
Phone: (604) 467-5591

The BCFAS Resource Society began in 1986 to address prevention of FAS and other drug related disabilities. Historically they have represented health, education and legal professionals whose mandate is to provide professional education on FAS and other drugs, coordination of biomedical, psychological and behavioural research (including forensics) and advocacy for other professional and lay groups who are addressing FAS/FAE provincially, nationally, and internationally.

FAS/E Provincial Prevention Coordinator

Sunny Hill Health Centre for Children  
3644 Slocan Street  
Vancouver, BC V5M 3E8  
Phone: (604) 434-1331, local 230  
Fax: (604) 431-7395 or (604) 436-1743  
E-mail: clegge@sunnyhill.bc.ca

In order to provide a coordinated approach to dealing with foetal alcohol syndrome (FAS), Alcohol and Drug Services funds the position of Provincial FAS Prevention Coordinator. The goal of this position is to reduce developmental delays, birth defects, and death due to prenatal alcohol and other drug misuse. The coordinator provides an information and referral service for the public on how to access information, resources, expertise and services related to FAS/E. The coordinator also helps with networking among health, education, justice and social service agencies.

FAS Provincial Coordinator on Early Intervention with Women

Aurora Centre, Children's and Women's Health Centre of BC  
4500 Oak Street, 5th Floor  
Vancouver, BC V6H 3N1  
Phone: (604) 875-2017  
Fax: (604) 875-2039  
Email: npoole@w.womenhosp.bc.ca

Coordinates initiatives relating to early identification and treatment of women who are at risk of having a FAS affected child. Provides information and support with the goal of preventing FAS, to service providers in alcohol and drug treatment programs, pregnancy outreach programs, women's services, hospitals and other programs serving women.

FAS/E Support Network

14326 Currie Drive  
Surrey, B.C. V3R 8A4  
Phone: (604) 589-1854  
Fax: (604) 589-8438

The FAS/E Support Network provides information, support, consultation, and advocacy services for individuals, families, professionals, and the broader community around prevention, intervention and treatment issues pertaining to alcohol-related birth defects (FAS/E). Included in the services are the WARMLINE, FAS support groups and publications such as *About FAS/E*, *Layman's Guide to FAS*, and *FASNET Assessment Tools*.

Prevention Source BC

#210 2730 Commercial Drive  
Vancouver, BC V5N 5P4  
Toll-free: 1-800-663-1880  
Phone: (604) 874-8452  
Fax: (604) 874-9348  
E-mail: [bcpre\\_info@mindlink.bc.ca](mailto:bcpre_info@mindlink.bc.ca)

The Resource Centre provides a toll-free information service for residents of the province seeking information about prevention contacts, organisations, programs, materials and research in the area of substance misuse. The Centre also has a collection of prevention resource materials for on-site use. Included in this collection are a variety of FAS and NAS resource materials.

Regional Resource Centre Health Canada

Medical Services Branch, Pacific West Region  
#304 - 11155 West Pender St  
Vancouver, BC VE6 4J4  
Phone: (604) 666-2416  
Fax: (604) 666-2689

Resources are available to First Nations parents, groups and educators. There are videos, kits, manuals, displays and brochures dealing with FAS and the effects of alcohol on pregnancy. We provide distance loan services support to front line workers in and for First Nations communities in BC.

Substance Exposed Resource Team (SERT)

Sunny Hill Health Centre for Children  
3644 Slocan Street  
Vancouver, BC V5M 3E8  
Phone: (604) 434-1331, local 221  
Contact: Norma Carey

The SERT team is comprised of health professionals at Sunny Hill Health Centre who provide education and training to hospital staff and families on the medical management of infants experiencing alcohol or other drug withdrawal (Neonatal Abstinence Syndrome, NAS). Currently this team is developing training protocols for pediatricians and other early intervention specialists throughout BC's new regionalised system.

Society of Special Needs Adoptive Parents (SNAP)#1150 - 409 Granville Street

Vancouver, BC V6C 1T2  
Toll-free: 1-800-663-7627  
Phone: (604) 687-3114  
Fax: (604) 687-3364  
Email: [74757.3473@compuserve.com](mailto:74757.3473@compuserve.com)

SNAP is a provincial organization dedicated to assisting special needs adoptive families through mutual support, information sharing and advocacy. SNAP provides support groups and on-to-one contact resources parents throughout BC. The Society operates a toll-free (in BC) telephone contact line and publishes a quarterly newsletter and booklets such as *Parenting Children Affected by FAS: A Guide for Daily Living*. SNAP also maintains a large resource library of books, periodicals, reports, audio tapes and videos.

YWCA Crabtree Corner FAS/NAS Prevention Project

101 East Cordova Street

Vancouver, BC V6A 1K7

Phone: (604) 689-2808

Fax: (604) 689-5463

YWCA Crabtree Corner FAS/NAS Prevention Project offers FAS/NAS educational workshops, a resource lending library, a peer support group for moms with children with FAS/NAS and information and crisis counselling. Crabtree Corner has published posters and pamphlets as well as three guides: *FAS/FAE and NAS Community Prevention Guide*, *Guide for Parents, Caregivers and Others Caring for Children with FAS/FAE and NAS* and *FAS/FAE and NAS Guide to Resources*.

ResourcesBooks and Manuals

*FAS/FAE/NAS Prevention Guides* (3 booklets 1989) Available from

YWCA Crabtree Corner, 101 East Cordova, Vancouver V6A 1K7

Phone: (604) 689-2808 Fax: (604) 689-5463

*FAS and Other Alcohol Related Birth Defects* (2nd edition 1996) Available from

Alberta Alcohol and Drug Abuse Commission (AADAC), Suite 200-10909 Jasper Avenue,

Edmonton, AB T5J 3M9

Phone: (403) 427-7319 Fax: (403) 422-5237

*Fetal Alcohol Syndrome Diagnosis, Epidemiology, Prevention and Treatment*,

Institute of Medicine National Academy Press (1996)

*Hidden Majority - A guidebook on alcohol and other drug issues for counselors who work with women* (1996) Available from

Addiction Research Foundation of Ontario (ARF) 33 Russell Street, Toronto ON M4S 2S1

1-800-661-1111

Videos

*What is FAS?* (1989) Program 1

*Preventing FAS* (1989) Program 2

*Living and Learning with FAS* (1990) Program 3

Produced by BC FAS Resource Society

Available to POPS programs from Local Health Units and through Magic Lantern Videos.

*David with FAS*

Available from: National Film Board of Canada 1-800-267-7710

*Caring Together*

Available from:

Native Physicians Association in Canada 103-1785 Alta Vista Drive Ottawa ON K1P 6L1

Phone: (613)521-6582 Fax: (613) 521-6259

Pamphlets

*Alcohol and Pregnancy* - Available at no cost from:

Health Canada Publications Tunney's Pasture Ottawa ON K1A 0K9

Phone: (613) 954-5995 Fax: (613) 941-5366

*Alcohol and Pregnancy: Know the Facts* - Available at no cost from: Alcohol Awareness Program BC  
Liquor Distribution Branch 2625 Rupert Street Vancouver BC V5M 3T5 0K9 Phone: (604) 252-3000  
Fax: (604) 252-3464

*You Can Make a Difference to Your Child's Health* Available from:

YWCA Crabtree Corner 101 East Cordova Vancouver V6A 1K7

Phone: (604) 689-2808 Fax: (604) 689-5463

*Having a Healthy Baby! There's so Much to Think About* Available from Health Canada (Address above)

*The Hangover that Lasts a Lifetime* Available from:

Union of Ontario Indians General Delivery Curve Lake ON K0L 1R0

Phone (705) 657-9383 Fax: (705) 657-2341

Booklets

*Give and Take - A booklet for pregnant women about alcohol and other drugs*

Available from:

AWARE (Action on Women's Addictions - Research and Education)

Box 86 Kingston ON K7L 4V6

Phone (613) 545-0117

*Women and Alcohol* - Available from ARF or AWARE (both addresses above)

*Making Connections - A booklet about women and prescription drugs and alcohol*

Available from AWARE (address above)

For additional information on resources, contactFAS/FAE Information Service

Canadian Centre on Substance Abuse

Suite 300 75 Albert Street

Ottawa, Ontario K1P 5E7

Toll-free: 1-800-559-4514

Phone (613) 235-4048

Fax (613) 235-8101

Webpage: [www.ccsa.ca/fasgen.htm](http://www.ccsa.ca/fasgen.htm)

FASLINK is a listserv for discussion with other individuals interested in FAS/E. To join the FASLINK, e-mail a message to [List@ccsa.ca](mailto:List@ccsa.ca) and type *join faslink* as the body of the message.

A national information service provided by the Canadian Centre on Substance Abuse through its National Clearinghouse on Substance Abuse. Information is available in French or English.

## F. Mental Health

### 1. Assessment

There are key indicators which would alert counsellors to possible mental health related problems that may affect birth outcome and parenting ability.

#### a) History of Mental Illness

- diagnosed mental illness
- verbal admission of mental illness and/or problems
- suicidal or history of suicide attempts
- patient of psychiatrist or mental health counsellor.

#### b) Use of Medications Prescribed for Mental Illness

- ongoing prescription, e.g. lithium, haldol, CPZ
- consult with physician to establish need for continuing drug throughout the pregnancy and to determine whether the drug must be taken on a regular basis.

#### c) Emotional Adjustment

Certain behaviours may suggest rejection of the pregnancy and possible rejection of the infant:

- mother's preoccupation with her physical appearance
- negative self perception
- increasing anxiety, significant changes in mood
- excessive emotional withdrawal
- excessive physical complaints
- absence of any response to the fetus' movements
- lack of preparation during the last trimester
- emotional immaturity, unmet childhood needs of the mother.

#### d) Sources of Social and Emotional Support

Assess whether these are present or not present, positive or negative, supportive or destructive forces.

- husband, committed partner
- family, including extended family
- friends
- special activities
- support group(s)
- cultural reinforcement and practices.

#### e) Stress and Coping Ability

The following are stress factors which can be used to predict postpartum difficulties:

- first birth
- financial situation and employment status
- children, at home, number and ages
- parenting alone all or much of the time (are there other family members at home or available for baby care)

- prior history of parenting difficulties
- educational level of woman and partner
- illness during pregnancy and apart from pregnancy
- no previous experience with babies.

f) **Attitudes**

Assess whether these are positive or negative attitudes:

- woman's attitude toward the pregnancy
- partner's/spouse's attitude toward the pregnancy
- other family members' attitude toward the pregnancy
- planned versus unplanned pregnancy
- healthy lifestyle, including changes or attempts at changes
- alcohol and cigarette use, or any other drugs
- crisis management.

g) **Knowledge and Acceptance of Developmental Tasks of Pregnancy**

- physical changes
- emotional changes
- nutritional needs.

## 2. Action Plan

Pregnancy, like many other life stressors, demands significant adjustments. It is "normal" for people to experience some problems in adapting to major changes. In pregnancy, hormonal factors may induce emotions uncharacteristic of the woman. Respect and support are recommended as key aspects of the Pregnancy Outreach Program counselling

The presence of a combination of several of the above outlined indicators over a length of time may warrant the need for additional personal counselling, especially when the following key risk factors are present:

- evidence of emotional difficulties and/or a high level of stress
- wanting a baby primarily to meet emotional needs
- emotional and social isolation
- unstable, abusive and/or neglectful family background
- current involvement with an addicted or violent partner

A woman who may be having suicidal thoughts, exhibiting signs of possible mental illness, or evidencing serious emotional difficulties, should be referred to a mental health professional or mental health centre through their family physician. Self referrals also can be made to the local Mental Health Centre, whose staff are usually available for general consultation.

### Resources

Visit your local Mental Health Centre.

For information on Postpartum Depression contact:

Pacific Postpartum Society

(604) 255-7999

## G. Dental Health

### 1. Overview

During pregnancy, women are more susceptible to both gingivitis and dental decay. Both of these conditions can have a negative impact on general health due to the presence of localized infection, as well as affecting the woman's nutrition because of pain or discomfort when chewing. Women involved with the Pregnancy Outreach Program may have dental problems associated with limited exposure to dental care, lack of preventive dental information, and poor nutrition and dental habits.

Dental intervention for these women allows for a positive health impact in two ways:

- Improvement of the mother's dental health through introduction to preventive techniques, screening for dental treatment need with referral, and support in seeking the necessary dental care in the private practice setting.
- Improvement in the dental health of the new baby and other family members in the home through instruction in the use of fluorides, the importance of parental involvement in daily oral hygiene with instruction in these skills, and encouragement to seek regular dental care for themselves and their children. Regular dental care for the parent during pregnancy is essential for their overall health.

### 2. Assessment

The areas that may lead to an increase in dental problems during pregnancy are very identifiable. If the client has any of the following conditions, the Dental Health Services staff at the local Health Unit can provide individual or group preventive dental health counselling at program drop-ins:

- Poor oral hygiene, sometimes resulting from a combination of fatigue, tension and hormonal action, or the inability to brush due to an extremely strong gag reflex, can contribute to gingivitis and tooth decay.
- Morning sickness, which includes vomiting, has a very erosive action on tooth enamel due to the teeth being exposed to stomach acid. If this condition exists, mothers should be sure to rinse with water thoroughly after each episode. If the condition persists, rinsing with a fluoride rinse after vomiting is recommended.
- Frequent food intake can promote tooth decay, particularly if the foods chosen are retentive, or contain sugars, carbohydrates or cooked starches.
- In discussion with clients the following questions may be used to identify those most in need of dental support, although all clients could benefit from contact with the dental staff. A "yes" response signals the need for a referral to a dentist.
- "Has it been more than two years since your last dental visit?"
- "Do your gums bleed when you brush your teeth or at any other time?"
- "Do you have teeth that hurt or cause you pain?" ( i.e., "Do your teeth hurt when you eat or chew your food? Do you teeth hurt or keep you awake at night?")

**3. Action Plan**

Should the above questions identify a need for dental treatment, and the client would benefit from support in obtaining dental care, you should contact the dental hygienist at the Health Unit. The Dental Hygienist will then assess the severity of need and help in obtaining access to care. This may involve identifying available dental coverage. Often clients are unaware of the coverage available to them through the provincial government, Indian Affairs, or even private dental plans as a result of their partner's employment. If there is no dental coverage available, and the need for treatment is urgent, the dental hygienist may know of other means of accessing oral care.

**Resources**

**Pamphlets**

Health Files available through the Ministry of Health

- Pregnancy and Oral Health
- Infant Dental Care
- Dental Care for Toddlers
- Fluoridation Facts

## H. Fitness

### 1. Overview

For the majority of women, exercising through pregnancy is safe for both mother and baby. However, women should discuss their intention to either continue to exercise, or to begin an exercise program, with their doctor, midwife or obstetrician. Clients should be advised that if at any time through their pregnancy or postpartum they feel discomfort or have unusual symptoms, they should stop exercising and visit their health care provider. Physical activity counselling may be done by the program staff, or other health professional or community fitness professional that has pre and post natal training.

Physical activity is an important part of a healthy pregnancy. The benefits may include:

- coping with the many physical and emotional changes of pregnancy
- increasing self confidence and improving self image
- maintaining a positive attitude toward and controlling weight gain
- improving appearance (especially posture) and increasing energy
- alleviating many of the discomforts of pregnancy
- increasing the strength of many muscles that can help make the delivery easier
- increasing the speed of return to pre-pregnancy shape, and
- most importantly, having fun.

### 2. Assessment

The following are some conditions which may exclude women from being active during pregnancy: significant metabolic or cardiopulmonary disease, diabetes, uncontrolled hypertension before pregnancy, and a history of miscarriage. There are other conditions/symptoms that may arise during pregnancy that will indicate a need to stop exercise. Referral to a physician is the best way to ensure that physical activity is a safe and positive experience.

### 3. Action Plan

Advise clients if they are just starting with an exercise program to start slowly, increase the activity gradually and "listen to your body" and aim to exercise at least three times per week. Studies suggest that you can still attain an increased level of fitness even if you begin your exercise program during your pregnancy. Walking, swimming and stationary bicycle riding are excellent starting points. If a particular exercise makes your body uncomfortable, it usually indicates that the exercise is not being done correctly or is just not appropriate.

Those who are active before getting pregnant can usually maintain their activity without any difficulty.

There are many resources available, including the *Baby's Best Chance Parents Handbook of Pregnancy and Baby Care* and *Video*, that will provide some guidance for an exercise program. Most community fitness professionals can give practical suggestions, or access pre and post natal resources on how to set up a safe exercise program. However, whenever possible, search out a fitness professional who has had extensive experience with pregnant women or is a recognized pre/post natal fitness instructor.

Physical activity not only contributes greatly to the health of the pregnancy but also is an enjoyable way for a partner or friend to share in the experience.

## Resources

### Books

Artal, R. and Wiswell, R.W. Exercise in Pregnancy. Williams and Wilkins. Baltimore, 1986.

Canadian Institute of Child Health. Moving and Growing: Exercise From Birth to Two Years. Ottawa, 1983.

Fitness and Amateur Sport Canada. Fitness and Pregnancy: A Leader's Manual. Ottawa, 1982.

Noble, Elizabeth. Essential Exercises of the Childbearing Year, 3rd Ed., Houghton Mifflin Co., 1988.

Hanlon, Thomas W, Editor, Human Kinetics. Fit for Two: The Official YMCA Prenatal Exercise Guide, 1995

Katz, Jane. Water Fitness During Your Pregnancy. Human Kinetics, 1995.

### Articles

1994 American College of Obstetricians and Gynecologists (ACOG) Guidelines

O'Neill, et al. The cardiorespiratory response to walking in trained and sedentary pregnant women. Journal of Sports Medicine and Physical Fitness, pp 40-43, 1993.

Wolfe, L.A., et al. Effects of pregnancy and chronic exercise on respiratory responses to graded exercise. Journal of Applied Physiology, vol. 76, pp 1928-1936, 1994.

## I. Breastfeeding

*"As a global goal for optimal maternal and child health and nutrition, all women should be enabled to practise exclusive breastfeeding and all infants should be fed exclusively on breast milk from birth to 4-6 months of age. Thereafter, children should continue to be breastfed, while receiving appropriate and adequate complementary foods, for up to two years of age and beyond. This child-feeding ideal is to be achieved by creating an appropriate environment of awareness and support so women can breastfeed in this manner.*

*Attainment of this goal requires, in many countries, the reinforcement of a "breast-feeding culture" and its vigorous defense against incursions of a "bottle feeding culture." This requires commitment and advocacy for social mobilization, utilizing to the full the prestige and authority of acknowledged leaders of society in all walks of life."*

- Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding  
August 1, 1990, Florence, Italy, WHO/UNICEF

*Exclusive breastfeeding (i.e. no feedings other than breastmilk), provides all the nutrients for the optimal growth and development of infants up to 4-6 months of age. Breastfeeding should be maintained when solid foods are introduced. Ideally, infants should be breastfed up to and including the second year of life. Breastfeeding benefits to the infant include providing ideal nutrient levels and immunological protection, facilitating jaw and dental development and helping develop close interactions between infant and mother. Breastfeeding benefits to the mother include maternal bonding and reducing risk of post partum anaemia and breast cancer.*

*Breastfeeding decreases the risk of infants developing respiratory and gastrointestinal illnesses compared to infants not receiving breastmilk. Breastfeeding costs significantly less than feeding infants artificial breastmilk substitutes (formulas), an important factor for families with limited incomes.*

-Policy Guidelines for Formula Feeding Healthy Full Term Infants  
During the First Year of Life, B.C. Ministry of Health  
Prevention and Health Promotion Branch, October, 1995

### 1. Overview

The experts, including the Canadian Pediatric Society recommend:

- ideally, all infants should be breastfed
- breastfeeding should be the only source of nutrients for the first four to six months of life
- breastfeeding should continue for as much of the first year of life as possible. The World Health Organization now recommends that breastfeeding be continued for up to two years or beyond. Other foods must however be consumed to meet the nutritional needs of the older infant/child.

### Why Breastfeed?

#### a) Biological Specificity

- nutrient composition of milk meets growth requirements of the species
- human milk supports rapid infant brain development with a dose effect evident when nursing continues beyond two years.

b) **Health Benefits**

Human milk provides:

- for optimal growth and development (including maturation of the gastrointestinal tract)
- antibodies to protect against infection
- defences against intestinal and respiratory disease
- protection against allergic responses
- over one hundred critical components, many of which cannot be duplicated in formula.

c) **Emotional Benefits**

The emotional benefit of enhanced bonding between mother and child as a result of breastfeeding is an important advantage which should be stressed.

d) **Natural Part of the Reproductive Continuum**

From conception through pregnancy, breast changes occur in preparation for lactation regardless of the mother's feeding choice. From birth to weaning, baby is nourished at breast, initially receiving colostrum, then transition milk, and from approximately two weeks on, mature milk which continues to change as the baby grows.

A significant decision to be made during pregnancy is what method of infant feeding to use. Research shows that human milk is the superior food for infants and that the earlier women decide to breastfeed, the more likely they are to have a successful nursing experience.

The goal of Pregnancy Outreach Program staff therefore should be to encourage breastfeeding by providing information, support and the environment for mothers to model this skill.

## 2. **Assessment**

Attitudes toward breastfeeding vary, but must be recognized and addressed. It is important to sense how clients feel about breastfeeding and to explore ways to have them re-evaluate possible negative feelings about the process. Clients may feel uncomfortable with the concept of breastfeeding because of:

- lack of knowledge of the benefits
- lack of understanding of the process
- anticipated personal embarrassment
- lack of comfort with their bodies
- resistance or misinformation from others
- lack of support from partner/family

### 3. Action Plan

During pregnancy and the early postpartum period, clients should receive instruction on:

- cost of formula versus breastfeeding
- how breastfeeding works - the structure of the breast and process of lactation
- breastfeeding techniques including positioning, latching and removing the baby from the breast.
- variation on births, breasts and babies which may necessitate different breastfeeding techniques
- realistic expectations - new babies require much time and energy no matter how they are fed
- mother care - sufficient rest, food, and fluids
- problem solving - who to call for practical support and sound information
- common concerns and questions about breast milk - quantity/quality, and returning to work or school.

There is a need for expert advice and ongoing support if and when difficulties. In many communities the specialized services of an International Board Certified Lactation Consultant are now available. When breastfeeding problems occur, mothers need prompt positive action and emotional support and understanding.

Pregnancy Outreach Program staff should:

- maintain an environment where women feel comfortable in breastfeeding their infants
- establish contact and liaison with local certified lactation consultants, La Leche League leaders, or breastfeeding support groups
- provide an up-to-date reference and lending library of sound breastfeeding information
- maintain a supportive role with the breastfeeding client
- support the mother in her decision on how to feed her baby, whether it is breast or bottle, after promoting breastfeeding as the gold standard of infant feeding.

### Resources

(see the BC Baby-Friendly Initiative binder for a comprehensive list of resources)

BC Baby-Friendly Initiative: Resources Developed Through the BC Breastfeeding Resource Project 1996 (comprehensive binder of information available at local hospitals and Health Units, includes many references and information on the WHO International Code of Marketing of Breast Milk Substitutes, Baby-Friendly Hospital Initiative and Baby-Friendly Community Initiative).

Breast Feeding Advocacy Kit

and Breastfeeding, Anytime, Anywhere (poster)

(available free from Publications Health Canada Ottawa, Ont. K1A 0K9  
phone (613) 954-5995 fax (613) 941-5366)

Huggins, Kathleen. *The Nursing Mother's Companion*. Revised Edition. Harvard Common Press, 1990.

La Leche League. *The Womanly Art of Breastfeeding*. A Plume Book, The Penguin Group, Illinois. 1991.

Riodan, Jan. *A Practical Guide to Breastfeeding*. C.V. Mosby Co., 1991.

Woessner, C., Lauwers, J. and Bernard, B. *Breastfeeding Today: A Mother's Companion*. Revised Edition. Avery Pub. Group: New York, 1991.

La Leche League International. *The Breastfeeding Answer Book*. Franklin Park, Illinois. 1991.

Gotsch, Gwen. *Breastfeeding: Pure and Simple*. La Leche League International. Franklin Park, Illinois. 1994.

Renfrew, Mary, Fisher, Chloe and Arms, Suzanne. *Bestfeeding: Getting Breastfeeding Right for You*. Celestial Arts. 1990. (available through La Leche League Canada)

National Database on Breastfeeding Among Indian and Inuit Women. *Survey of Infant Feeding Practices from Birth to Six Months*. Health Canada 1990.

Definition of a Baby Friendly Hospital. UNICEF Canada (available from UNICEF Canada 443 Mount Pleasant Rd. M4S 2L8 (416) 482-4444)

### Videos

*The Bonding Circle of Breastfeeding*. (1991) Association of Iroquois and Allied Indians. 1992. (available from Medical Services Branch of Ontario, 3rd Floor, 1547 Merivale Rd. Nepean, Ont. K1A 0C3)

*Best Start: All the Right Reasons* (1988)

*Best Start: Loving Our Children. Loving Ourselves. Mothers Teaching Mothers in Chicago's Breastfeeding Peer Counsellor Program* (1994)

*Best Start: No One Loves Them Like You* (specifically for teens)

(Best Start videos are available from Best Start Inc. 3500 East Fletcher Ave. Suite 308, Tampa Florida, USA 33613 1-800-277-4975)

### Pamphlets

*Eat Well, Be Active, Feel Good While Breastfeeding*. BC Ministry of Health 1993.

*Hints on Breastfeeding*. BC Ministry of Health 1994.

*Breastfeeding Your Baby is a Natural Part of Mothering and Medical Research Has Proven It's Best*. La Leche League International.

*How To Breastfeed Your Baby*. Breastfeeding Committee of the International Childbirth Educators Association. (available from ICEA P.O. Box 20048 Minneapolis, Minnesota 55420 phone: 1-800-624-4934)

*Continue the Tradition* (a promotional pamphlet for First Nations families available from Health Canada, Indian and Inuit Health Services, Atlantic Region, Suite 634, 1557 Hollis St., Halifax, Nova Scotia B3J 1V6 (902) 426-7283)

La Leche League Canada Information Sheets - over 39 information sheets, topics include:

Positioning Your Baby at the Breast

Sore Nipples

Does Breastfeeding Take Too Much Time?

Practical Hints for Working and Breastfeeding

(available from local La Leche League leaders)

*Breastfeeding Your Baby* (available in five languages - from the Vancouver Health Department and BC Women's Hospital)

Ten Great Reasons to Breastfeed

Ten Valuable Tips for Successful Breastfeeding

(available free from Publications Health Canada Ottawa, Ont. K1A 0K9

phone (613) 954-5995 fax (613) 941-5366)

Why Breastfeeding? Benefits of Breastfeeding (a one page fact sheet prepared by the Ministry of Health; available at all health unit and department offices and on the Internet, under "General Health Information" on the Ministry of Health's home page (<http://www.hlth.gov.bc.ca>).

#### Breastfeeding Services

Local La Leche League Leaders can be found in most communities

Lactation Consultant Service, BC Women's Hospital phone: (604) 875-2282

Lactation Consultant Service, Royal Columbian Hospital phone: (604) 520-4551

Breast Milk Service. BC Children's Hospital phone: (604) 875-2345 Local 7607

Vancouver Breastfeeding Centre phone: (604) 875-4678

Why it matters: Women who are struggling to pay for their pregnancy program in the United States are often facing financial hardship. This is especially true for women who are pregnant and living in poverty. The program provides financial assistance to help women pay for their pregnancy program. For more information, see the program's website at [www.pregnancyoutreach.org](http://www.pregnancyoutreach.org).

Program description: The program provides financial assistance to help women pay for their pregnancy program. The program is available to women who are pregnant and living in poverty. The program provides financial assistance to help women pay for their pregnancy program. For more information, see the program's website at [www.pregnancyoutreach.org](http://www.pregnancyoutreach.org).

## V. PROGRAM EVALUATION

### A. Why Evaluate the Pregnancy Outreach Program

Every program needs to be evaluated to determine if it is providing the service that was intended and is producing the effects it intended to achieve.

Evidence of the success of the Pregnancy Outreach Program is needed to obtain continued funding and maintain the support of referral sources.

Evaluation tries to assess the impact of interventions on clients. At the same time the evaluation attempts to address the many challenges of the Program, such as the variation between the sites, the type of clients, and the difficulty in measuring the Program impact on pregnancy and birth outcomes.

## B. Content of the Provincial Evaluation

An overall evaluation of the Pregnancy Outreach Program was planned by the Provincial Advisory Committee when the first Guidelines for the Program were being developed. The evaluation was concerned with three areas: implementation, effectiveness, and acceptance/satisfaction.

- a) Information on program implementation was obtained from all agencies through their submission of a program status report and client data forms.

The implementation questions addressed in the evaluation process (through statistical analysis of the client data forms and program status reports) were:

- Is the Program reaching target groups?
- Is the Program reaching clients early enough, and keeping them in the Program long enough, to have an impact on pregnancy outcome?
- To what extent is the Program being integrated with existing services in communities?

- b) The effectiveness of the Program is evaluated by assessing any changes in reported health behaviours of clients. The forms used to collect the information are the *Individual Prenatal Risk Identification* (see Appendix C) which determines eligibility, and the *Client Data Sheet* (see Appendix E) which tracks the progress of the client. Completed forms on computer paper or diskette are forwarded to Nutrition Section for analysis using an EPI Info database. A program status report, based on analysis of the client information, is produced for each fiscal year (April 1 - March 31).
- c) The acceptance/satisfaction component of the evaluation was undertaken in 1990 and 1993 and culminated in the Qualitative Evaluation Reports. These evaluations required interviewing clients at various sites, and surveying staff, Advisory Committee members, and other people involved with the Program. People were asked about their experiences, attitudes and opinions of the program in their area.

Evaluation of the Pregnancy Outreach Program has produced exciting results:

- The Pregnancy Outreach Program is effectively reaching women never reached before;
- Clients are making significant lifestyle changes;
- Clients are gaining self-esteem and control over their own health;
- The Pregnancy Outreach Program is valued by clients and professionals;
- The Pregnancy Outreach Program is supported by the communities.

Copies of recent evaluation reports are available from:

Ministry for Children and Families  
Regional Support Division  
PO Box 9719  
Stn Prov Govt  
Victoria BC V8W 9S1  
Phone: (250) 952-6024  
Fax: (250) 952-6059

The Pregnancy Outreach Program's evaluation is a dynamic process. As the Program evolves and expands there are new and challenging research questions to be answered. Monitoring and evaluation are integral components of the Program and are crucial for its continued success and growth.

### C. Completion Rate

The completion rate is one of the service delivery indicators used to monitor client retention, and to assess issues associated with intensity and duration of service. The completion rate refers to the % of enrolled clients who;

- (i) stay in the Program to delivery/end of pregnancy, and
- (ii) have greater than or equal to five individual counselling sessions.

These two pieces of data items are recorded by program sites on the *Client Data Sheet* (see Appendix E). The completion rate for the Province and program sites is generated by collating these two data items using the EPI Info database.

While service delivery contracts are based on the 'target client load', or the number of enrolled clients with 'due dates/ during a fiscal year (refer to section II.E, Target/Actual Client Load), the completion rate has an impact on client outcomes, and is associated with the ability of a program to meet the needs of clients.

An annual review of a site's completion rate and related information (e.g. reasons for leaving before delivery/end of pregnancy) is one way of assessing the effectiveness of services that are being delivered locally. The provincial completion rate reflects the collective experience of all programs, and can serve as an informal standard against which to measure local performance.

## D. Management of Client Data For Provincial Evaluation

The following guidelines for the management of client data have been established;

- to protect the clients' rights to privacy under the *Freedom of Information and Protection of Privacy Act*,
- to promote effective and efficient processing of client data, and
- to facilitate the use of current information for planning activities related to the Pregnancy Outreach Program.

### Guidelines for Program Sites:

- (i) Client data includes an *Individual Prenatal Risk Identification* (see Appendix C), including the *T-ace Questionnaire* (see Appendix D), and a *Client Data Sheet* (see Appendix E) for every woman who is referred to the Program, regardless for whether or not she becomes an enrolled client. The information should be as complete and accurate as possible, according to the nature of the woman's involvement with the Program. Refer to section I.D, Service Model for more information on the flow of client information.
- (ii) Client data is submitted for every woman who is referred to the Program and has a 'due date' during the fiscal year reporting period (April 1 to March 31). This includes women who were;
  - referred but not assessed,
  - assessed but not enrolled,
  - enrolled but did not stay in the program to delivery/end of pregnancy,
  - enrolled but did not have greater than or equal to five individual counselling sessions, or
  - enrolled, and stayed in the program to delivery/end of pregnancy and/or had greater than or equal to five individual counselling sessions.
- (iii) Client data may be submitted on paper or on computer diskette.

### Submission of client data on paper:

- (a) Client data on all women with 'due dates' between April 1 and December 15 are submitted in one package before January 15 of the same fiscal year.
- (b) Client data on all women with 'due dates' between December 16 and March 31 are submitted in one package before April 30 of the next fiscal year.
- (c) Site copies of client data are maintained in client or program files.
- (d) Site copies of client data are not to be incorporated into client files until confirmation of receipt of client data has been received from the Ministry for Children and Families.

### Submission of client data on computer diskette:

- (a) Data on women with 'due dates' between April 1 and March 31 are submitted in one package before April 30 of the next fiscal year.
- (b) A print-out on all women with 'due dates' between April 1 and December 15 is submitted before January 15 of the same fiscal year.
- (c) A print-out on all women with 'due dates' between April 1 and March 31 is submitted before April 30 of the next fiscal year.

- (d) The print-outs include the Record Number; Client ID Number; Due Date; Client Began Program (yes or no); and Did Client Stay in Program to Delivery/End of Pregnancy (yes or no); for all women referred/enrolled.
  - (e) All computer diskettes are checked for viruses, and cleaned if necessary, prior to submission.
  - (f) All computer diskettes are labelled 'Pregnancy Outreach Program Client Data', as well as with the site location and fiscal year.
  - (g) All computer diskettes are packaged in a protective diskette mailer.
  - (h) All client data should be stored on the hard-drive, as well as on an additional back-up copy of the computer diskette.
  - (i) Do not 'mark client for deletion'.
- (iv) All data is to be sent to the Nutrition Services Consultant, Regional Support Division, Ministry for Children and Families.
- (v) Program sites should stay up-to-date with record keeping and/or data entry. This enhances the validity of the information. It also ensures the availability of current information at any time during the year for promotion and evaluation purposes, and local reporting requirements (e.g. Contract Manager, Local Advisory Committee, Board of Directors and Provincial Advisory Committee).

**Guidelines for Ministry for Children and Families:**

- (i) Nutrition Services Consultant, Regional Support Division, Ministry for Children and Families confirms receipt of client data package with POP Coordinator within 3 business days.
- (iii) Nutrition Services Consultant maintains a written record of date of receipt and date of confirmation of receipt of client data packages.
- (iv) Nutrition Services Consultant ensures that all client data is maintained in a secure location, according to the requirements of the *Freedom of Information and Protection of Privacy Act*.
- (v) Nutrition Services Consultant destroys all paper client data and erases all computer diskette client data after all client data has been entered and processed on an EPI Info database, and the provincial evaluation results have been approved for release by the Provincial Advisory Committee.

## VI. PROGRAM MOBILIZATION

### A. Community Development

#### 1. What is Community Development?

"Community development is people taking charge of their own futures. It is people identifying commonly felt problems and needs, and taking steps to resolve the problems and meet the needs. It is people struggling to make their community a better place to live out their lives than it ever was before."<sup>1</sup>

Each Pregnancy Outreach Program site grew from the efforts of a group of concerned community members who saw a need in the area of prenatal health and initiated a process to address that need. This process focused on involving a good cross-section of the community, drawing on resources within, and looking at viable options to improve prenatal health care, thereby making the community a better place to live for all members.

In BC a number of Pregnancy Outreach Program sites have been developed, each in its own unique way reflecting community input and approach. What community groups have discovered is that such efforts require learning more about themselves, looking at better methods to communicate, and understanding the decision-making process within the community make-up.

Overall, effective community development requires planning and ongoing evaluation. Looking inward for solutions entails careful analysis of the potential and the means to tap into it.

The following is one community development process which covers practical steps to follow in mobilizing the community to support and participate in a new or ongoing Pregnancy Outreach Program site. It is the format which the Building Better Babies group in Nanaimo utilized effectively. The group's efforts, experience, and accomplishments are detailed to illustrate how such a process is applicable for community groups wanting to make a difference and bring about change.

It is important to note that the essential ingredient of the entire process is the value system of the community which keeps all the steps in line and the people working together. The value to promote health and well-being has to exist in order to effectively implement a plan to improve prenatal health. The participants must feel strongly that prenatal health is an issue for all people.

#### 2. The Process: Nanaimo Pregnancy Outreach Program: A Case Study

##### a) Defining the Issue

For change to occur the issue needs to exist and be clearly defined. Determining that the way things are is not the way they have to be creates the initiative to do something about the issue. For example, the Building Better Babies group in Nanaimo found the data on perinatal mortality alarming and outlined clearly that in their community this was unacceptable and change was in order.

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<sup>1</sup> *Four Worlds Development Project*, Lethbridge, Alberta, 1984.

It is important to note that not all groups or programs are as far along in this process as Building Better Babies was when it started. A booklet entitled *Healthy Communities: the Process* (available from Ministry for Children and Families) outlines five phases in this process, including the Entry phase. Getting to know the structure and environment of the organization and community you are working with is vital to overall success.

b) Involvement of Key Individuals

Every community has individuals who are the "movers and shakers" - those who play a significant role in community affairs, whether they are of high profile or are fairly invisible. The task is to identify some of these individuals and find a means to get them on board. Their support may be very important throughout the process.

The original members of the Building Better Babies group had immediate success in getting the support of the area's Medical Health Officer, whose input appeared to legitimize the action within the health service field, generating broad support. Further, an active campaign was initiated aimed at informing well-known health professionals in both the private and public sectors and receiving their formal support. This approach resulted in the group receiving a community-wide support base from the health and human services agencies.

c) Network

Finding allies and resources can increase the impact of the work many times over.

Some of the major advantages of connecting with other groups include:

- access to information which could greatly assist the Program
- access to skilled individuals
- legitimisation - getting the idea accepted sooner since more people and groups support it
- a sense of solidarity, a strength in numbers, promoting or defending the Program
- a broader base of funding and other resource potential
- ongoing support which will be needed once the Program is underway.

There is a need, however, to formalize the roles of such partners to ensure that "ownership" does not become an issue later. This may have the effect of redefining the Program's goals and possibly losing the original focus and ultimately the Program. Outlining and agreeing to "who does what" and "who has which responsibility" will provide clear guidelines.

The Building Better Babies group, which included initially only staff members of the Health Unit, reached out to involve other health professionals in the community, including nutritionists, nurses, and family physicians. At this time, meetings were arranged with human service professionals, including social workers, counsellors, family support workers, etc., outlining the need to address the issue and requesting support, direction, advice and general comments. Initial feedback indicated general support for some form of intervention both short term and long term. Many suggestions on further action were conveyed, including some direction in funding resources. Valuable contacts within the community were also accessed. One final outcome was a strong commitment from many agency staff to be available on a regular basis to contribute in appropriate ways to the process. Later, a number of these

individuals became members of the Advisory Committee and contributed significantly to an excellent referral process.

d) Personal Development

People should be encouraged and supported to look within themselves for the skills needed to deliver the Program. Workshops, seminars in communication, organizational processes, and decision-making, could increase the overall efficiency of the Program simply because the members are more skilled.

In looking at what development was necessary to further the cause and work, the Building Better Babies Group sought ways to avail members of current information on perinatal health. Research materials, articles, magazines, handouts, medical journals, etc., were accessed and distributed. Other systems of service were looked at to consider viable alternatives, for example, the Montreal Diet Dispensary and Vancouver's Healthiest Babies Possible. The focus became one of establishing avenues, or channels of relevant, current knowledge, available to the group and community.

e) Constructing a Vision

In order for growth and change to occur, people need a vision of what can happen or what they want to happen. To do this, Program members must look at:

- how things used to be
- how things got to the point they are now
- what needs to be done to create a better situation

For the Pregnancy Outreach Program, this entailed evaluating what had not worked, looking at the results, and determining the kind of Program needed to improve perinatal health.

The Building Better Babies group recognized that there were existing prenatal health services available, but these were not being accessed by a large number of women from different cultures and from low socio-economic backgrounds. Data clearly showed the results of this disconnection and pointed to areas requiring change. The group looked at identifying methods to take a good service and make it more accessible. Issues such as location, building design, clinic setting and Program delivery design were considered and set out for change. Members set up priorities, created an ideal to shoot for, and designed methods to accomplish this.

f) Core Group Development

With networking and the involvement of a diverse group of interested people, a core group develops. Ideally, this group would be made up of representatives of different interest groups in the community, but with a common goal.

This step was a turning point for the Building Better Babies members: as a formal move, it re-emphasized the goals and the issue. Forming an advisory committee created an identity for the members and created a "reason for being". A "name" was given to a movement and the support which was always there before became reality as formal

representation from many different agencies and interest groups gave the sense of vast potential. At this point regular meetings were scheduled, objectives were set out, duties were delegated, and responsibilities were outlined. Members (original and new) began to include this prenatal work activity in their personal agendas and calendars. The Building Better Babies committee was born and had a place!

g) Stating Goals and Plans

The simple process of stating goals has to be followed by a clear decision and agreement on "who will do what". This will prevent moving responsibilities around and expecting "someone else to do it".

With the formation of an advisory committee, the Building Better Babies group had the arena to formalize their goals and to establish the framework to achieve their goals. The concept of "outreach" was clearly established and the required activities set out. Program design and delivery process were discussed and set up. Standards of service were looked at, client load potential, referral issues, etc. were matters reviewed and mapped out. Most importantly, time frames were established to include evaluation and resources were listed.

h) Formalizing Organization

The volunteer action and efforts must at some point be formalized. This may entail an existing organization assuming sponsorship if appropriate and timely, or creating a legal entity. This is required to:

- show concrete direction and change, while establishing a new point of achievement
- begin attracting required funds and other resources
- possibly begin to hire professional staff, if appropriate.

Following considerable review by members, the Building Better Babies group decided to seek sponsorship with an existing service agency in the area. The group considered a number of organizations which could easily incorporate a specific health service into its existing service administration.

After lengthy (2 1/2 months) dialogue, the group became aligned with a Native Service organization, Tillicum Haus Native Friendship Centre. This was another turning point and a significant move for the members and the Program. It also created an immediate influx of resources and support as a facility was made available, start-up funds accessed, contributions began to flow, cash donations increased significantly (charitable tax number), funding potential from other sources increased and part-time resource staff were hired. This was also the start-up of actual service delivery as a drop-in time was established. The months of work and planning were finally being put to the test!

i) Building Unity

For a Program to be and remain successful, there needs to exist real unity. Differences are evident in any group or community that must be faced and dealt with over time. Taking time aside from the work and planning to conduct special workshops or retreats can be an immense help to resolving such issues together.

Formalizing a process is indeed a turning point and was so for the Building Better Babies group. While the Sponsoring Agency and the group experienced considerable success in outlining expectations and establishing objectives, the reality was that there existed many differences. A Native organization was assuming responsibility of a Program largely initiated and controlled by non-Native health professionals. The potential for misunderstandings and conflict was immense.

It was recognized that both groups brought considerable value and resources to the Program and that to successfully combine the two would create an effective service to the community. Unity was a goal which was looked at each day and several activities were followed to achieve it. Formal sessions were set up to raise issues and deal with them openly, as well as informally when they arose. Group processes were followed and used effectively. The function and role of the advisory committee was respected. And finally, the inclusion of the traditional "Talking circle" on a regular basis, appeared to bring people to a common ground.

j) Learning

As with personal development, certain skills may be required to continue the process. Seminars focusing on agency requirements (legal, moral, ethical) may be helpful to the group in learning about other systems such as government regulations (civic, provincial) which may not be seen as directly appropriate to the issue at hand (Pregnancy Outreach) though part of the overall process.

Once under the sponsorship of the Native Friendship Centre, the Building Better Babies Program had the resources to increase its information and knowledge base. Seminars and workshops were established on a regular basis to focus on service requirements, standards of service, data collection and evaluation. Further, larger conferences such as Native Health Issues were convened which attracted other communities on Vancouver Island and the Lower Mainland. Cross-cultural events were organized to encourage understanding and sensitivity within the membership and the community.

k) Taking Action

The effort to put the planning into practice needs to be direct and unwavering. Outlining dates and times is important to maintain the push. Letting up at this critical time may put all the efforts back a few months, causing disillusionment and despair. Move!

The commitment to long term action was implemented at this stage. The sponsor gave a commitment of funding to follow through with service objectives for a minimum of one year. This was important as planning required an understanding of a working time frame. The group set out to accomplish certain objectives and saw the necessity of commitment despite the uncertainty of on-going funding.

l) Evaluation

Evaluation involves looking back at what the group/organization has accomplished, asking whether the objectives were met, analyzing the outcome, and addressing failures to determine whether it is time to re-group or time to move on.

Evaluation was a task the Building Better Babies group set as a priority. In the early stages of development, the members recognized their action was a response to an evaluation of existing data. They understood and appreciated the validity and role of evaluation and took steps to incorporate it into their Program. The group members and Sponsoring Agency also understood that the Program would be under intense scrutiny from the outside and from mainstream health services. The group understood the necessity of evaluation in gathering any future support.

With assistance from the Health Unit and the Ministry of Health, the Building Better Babies Program was able to implement appropriate data collection related to client intake. Though the evaluation process involved collecting data over a long time frame it was nevertheless undertaken. Program design and delivery were also examined. On a regular basis, the community was polled to determine the effectiveness and accessibility of the service. Clients were asked for comments on the service and associated personnel. The Sponsoring Agency conducted internal reviews of the Program including such issues as effectiveness in the Native community, accessibility, appropriateness of service, etc.

Overall, the evaluation process gave the group and sponsor a clear message to continue with the Program. It confirmed the need to expand an approach that was long overdue.

m) Summary

This model is only a tool to use, a framework to consider. It outlines the basic steps. Each community is different, thus other resources and methods must remain a part of each unique process.

## B. Community Marketing

For the Pregnancy Outreach Program, community marketing may be that activity which:

- keeps in touch with clients and responds to their needs, while respecting their distinctive backgrounds, cultures, and communities
- focuses on increasing the acceptability and support of the Program's concept, purpose and role in community health intervention
- generates a broad support base for the Program including funding and resources.

Encompassing a variety of promotional tools, community marketing has the potential to reach all of the target population, including clients, other community organizations, health professionals, and potential support sectors.

In considering available resources and time, it can be helpful to prioritize the use of promotional tools and look at major options first, then follow up with additional strategies.

### 1. Primary Promotional Tools

#### a) Program Brochure

The basic brochure should be easily understood, attractive and sensitive to target groups. A comprehensive message to existing or potential targets could address the following questions:

- What are the purposes of the program?
- What services are offered?
- What benefits do these services provide?
- How do potential clients make contact?
- Who do clients first talk to?
- What happens after initial contact?
- Who uses the services?
- What is the typical routine? How many appointments/visits?
- How long is the period of service?
- Are all services in one location?
- What are the hours of operation? Are there after-hours services?
- What are the referral procedures?
- Is there a fee for the service?
- Where is the program located?
- What outside organizations are affiliated with the program?

Illustrations, photographs, and artwork can be used with considerable impact, particularly if it reflects the service, the clientele, and the staff.

The effectiveness of the brochure depends on the message, not necessarily on the funds available and expended.

#### b) Pregnancy Outreach Program Promotional Video and Brochure

The video and brochure were developed in response to a request for promotional materials that could be used by communities to introduce the program to community

service groups and/or agencies with the aim to obtain referrals and to promote fundraising.

These resources are aimed at the following target audiences:

- professionals in social and health service areas who can provide referrals to the program
- community service groups/agencies in a position to assist financially or with supplies and referrals

The results of focus testing indicate that to increase the effectiveness of the presentation, presenters should also give information specific to their particular program or community (i.e. statistics of the number of clients, effectiveness of the program to date, recognition to agencies that have already contributed to the program, etc.).

The video and brochures are provided to programs by Regional Support Division, Ministry for Children and Families.

Communities who are in the process of determining the interest and need for a Program in their area, can borrow the video from their local Health Unit.

c) The Newsletter

The newsletter allows the Agency and program to expand on relevant information and can focus on current events and special occasions. It can also cultivate a growing list of readers and subscribers, thereby increasing the base of support. A newsletter publication can:

- acknowledge or celebrate the contribution of people in the community
- profile the program's successes
- focus on specific services, listing different parts of the overall service
- announce upcoming special events, and review past activities
- ask for community commentary, input to improve services
- expand on the philosophy of the Agency/Program
- advertise other community services related to the Agency or program, and
- solicit support, volunteers, and funds.

Overall, the newsletter can evaluate the past, deal with the present, and look to the future, while informing and involving the community.

d) The News Release

Any message or announcement in the media will not only provide specific information to the community, but will also contribute to the overall goal of promoting the Program.

The release should be brief, factual, and relate to key targets of the Program. It can provide information about a current situation or the future as opposed to dwelling on past activities.

The gist of the message should be summarized in the first paragraph, with supportive information in the concluding statements.

The writer must be identified in the release, along with the date it was written. Newspaper editors appreciate facts and brevity. A clear press release will raise the interest of the newspaper personnel, thereby providing the possibility of a follow-up story and added publicity.

e) Press Pictures

Most local papers are very willing to include pictures recognizing donations or events, in their Community sections. This opportunity not only gives focus to the Program/Agency but also to the donor.

Contact your local paper to determine their policy on this practice. Also request information such as the availability of their photographers/reporters, whether pictures can be taken on site, and their press deadlines (if a weekly newspaper). If you take the picture yourself, ask whether the film should be black and white or colour, the particular ASA, (some papers will even provide you with the necessary film).

If you are responsible for taking the picture, ensure that the accompanying message is accurate: names of individuals (and where they are positioned in the picture), organization/agency being represented, and the explanatory comments, such as how much money or type of donation given, what the money will be used for, etc. Remember people like their names spelled properly and the organization's proper name noted!

Provide the newspaper with your name and telephone number, so that they can contact you if they have any questions about the picture and insertion.

## 2. Secondary Promotional Tools

In addition to the basic tools, other strategies can be employed which may entail minimal expense and time. Nevertheless, they can be very effective in raising the profile of the Program. These strategies include:

- open house and tours
- displays, fairs, exhibits
- information, pamphlet racks
- posters
- video tape productions
- community cable television noteboard
- bulletin boards
- direct mail inserts, enclosures
- billboards
- volunteer appreciation events
- speakers' bureaus
- seminars, workshops, meetings
- handbooks, manuals
- contests
- large attractive sign at Program site
- public service announcements on radio and television
- questionnaires, surveys.

### 3. Attracting Clients

A worthwhile and valued service has the potential to fulfil its mandate only when it is accessed by those clients in need. Too often, well planned, comprehensive programs fail simply because their value is not understood or experienced by the target population.

Several approaches can be utilized to draw clients to the Program:

- a) Target your program information by considering where the clients may have access to notices, posters, brochures, etc. List potential points of contact clients may have on a daily, weekly, and monthly basis. Such places could be recreation centres, drop-in centres, day cares or play-schools, laundromats, food banks, other human service agencies, child development centres, and government offices such as Canada Employment and Immigration, Ministry of Social Services, and Ministry of Health. Once you have posted your information, regularly check back to ensure it is still in place and is up to date.
- b) By maintaining a liaison with other service agencies, you can promote the Program and its benefits. Potential clients may consider participating in your program if encouraged or referred by personnel they have known and trusted for some time. Existing programs have experienced successful referral relationships with Mental Health, Health Units/Departments, Alcohol and Drug Programs, Hospitals, Social Services, Women's Centres, etc.
- c) Clients in the program generally become strong advocates if asked to encourage friends and/or relatives to join them. Informal, word-of-mouth is very effective and will reach clients when no other methods will.
- d) The success of a Pregnancy Outreach Program depends, in part, on the approaches used to encourage appropriate referrals from physicians. It is important that the program Coordinator have personal contact with physicians. Dr. Lianne Raynor, Medical Advisor to Building Better Babies in Nanaimo, has stated "Physicians use a service more readily if Program validity and ease of referral are evident".

Validation can be provided by endorsement from:

- a physician, i.e. a program medical advisor
- the local Health Unit (i.e., the community nutritionist and public health nurse)
- the hospital dietitian.

Also, there must be assurances that the staff is qualified and well trained, i.e. presence of a qualified nutritionist or registered nurse. This can be carried out by an information letter, memo, announcement at meeting etc.

- e) To effect ongoing referrals, the following strategies are recommended:
  - make certain that services provided are clearly defined, i.e. provision of supplemental milk, diet counselling, etc.
  - provide a list of appropriate indications for referral, i.e. history of low birth weight babies, teen pregnancy
  - make telephone referral available
  - provide good follow-up communication (see Appendix F)
  - provide occasional reminders that the service is available, i.e. update memos.

## C. Fund-Raising

### 1. Overview

Effective fund-raising requires planning, a focused effort, and a sound knowledge of the market and the methods for reaching that market.

Non-profit, service agencies are experienced at fund-raising.

A proven strategy and follow through are necessary to succeed.

The following questions should be addressed:

- a) Which individuals, governments, corporations, and foundations are likely to consider our application?
- b) What motivation do prospective donors have for giving? Do they expect to benefit directly as a result of our program or do they expect broader community benefits? What are the net financial costs to them of making a gift?
- c) What other organizations are competing with us for donations and grants? What is distinctive about our organization?
- d) How much money might prospective donors and grantors potentially give to our organization?
- e) What do we have to do to contact these prospective donors?
- f) When is the most appropriate time and what is the most appropriate place to contact donors?
- g) What appeals (actions) would be most likely to motivate prospective donors to make a donation?
- h) Is it cost effective?
- i) Exactly how will our organization use the funds raised?

### 2. Fund-Raising Methods

#### a) Lotteries

While it is considered inappropriate by some for non-profit groups to condone gambling, lotteries are very popular today and generate a significant amount of funds. Casinos and bingos raise money not only from active supporters, but also from individuals who would not normally contribute. Further, a non-profit organization in British Columbia can apply for a license allowing one Bingo weekly, thereby providing a regular inflow of funds. Raffles and sweepstakes can be effective, however, both are labour intensive.

#### b) Charitable Benefit

An excellent publicity event, the "benefit" can focus on a social event, sports, entertainment, etc. Benefits are labour intensive and can also be risky if ticket sales are slow.

c) Proposals to Possible Funders

Proposal writing to corporations, foundations, and governments is still preferred by most agencies as a means of securing funding to enhance and support existing programming.

A skilled writer/researcher can be very effective in approaching sources of funding. This method, however, requires a large investment of time.

Community partnerships, joint proposals, and letters of endorsement from key influencers will help in building support for your proposal

d) Gift in Kind

Making public appeals for certain goods such as used furniture, clothes and food stuffs can have an impact on a specific service. The potential of this process should not be overlooked.

e) Third Party Efforts

Special interest groups such as local Service Clubs/Associations could be approached to raise funds on an Agency's behalf. Such groups have a charity objective within their constitution and target an annual donation amount. Such groups greatly appreciate publicity for their associations and usually have a large number of members available to provide the person-power required.

### Summary

The key factor in fund-raising is planning and focusing on clear objectives. There are many approaches, however, the successful ones always give a lot of attention to every stage of implementation of the strategy.

A poorly planned campaign may not only affect the present outcome, but also discourage donors and volunteers from participating in future efforts.

Note: A Pregnancy Outreach Program may be part of a large Sponsoring Agency organization, and, as such, will not be the only program involved in fund-raising activities. Therefore, staff members, local advisory committees and volunteers will need to respect the financial management requirements of the Sponsoring Agency. In other words, before starting out on any fund-raising excursions, no matter how exciting or innovative, check with your Sponsoring Agency's management. You may be adversely affecting the Sponsoring Agency's overall fund-raising process, or better yet, the Agency may already have your Program in line for the next fund-raising drive!

### Resources

#### Books

Brentlinger, M. and Weiss, J. *The Ultimate Benefit Book: How to Raise \$50,000-Plus for Your Organization*. Cleveland, Ohio: Octavia Press, 1987. This book offers suggestions on the how-to of creating a concept, developing a budget, recruiting help, maximizing profits; the book provides planning aids; and describes 20 benefits that netted significant profits.

Canadian Research and Publication Centre. Handbook of Grants and Subsidies of Federal and Provincial Governments. Montreal, Quebec, 1984. This handbook is available in the reference section of public libraries. Information is updated as received.

Dunn, T.G. How to Shake the New Money Tree: Creative Fund-Raising for Today's Non-Profit Organizations. New York: Viking Penguin Inc., 1988. This book offers instructions on how to write a fund-raising letter, hold special events, organize volunteers, generate new fund-raising ideas, and how to apply these suggestions to your specific organization.

Setterberg, F. and Schulman, K. Beyond Profit: The Complete Guide to Managing the Non-Profit Organization. New York: Harper and Row Publishers, 1985. This book provides ideas on how to manage a non-profit organization with strategies on topics from fundraising to publicity.

Young, Joyce. Fundraising for Nonprofit Groups. Self Counsel Press. 1992. s rangin

## D. Media

Making the media work for your program will assist in the effort to promote good prenatal health and raise the profile of the service.

It is possible to get good press if you are conscious of the specific steps which must be taken. Being aware of the process will enable you to highlight the components of the Program you feel are important and reduce the risk of having a reporter or editor not only miss important elements but possibly misrepresent your situation.

### 1. Process

- a) Make a list of editors, writers, reporters, etc. who may be interested in your story. For the Pregnancy Outreach Program, a paper's "lifestyles" editor is generally sensitive to issues of health and will find your program to be of interest.
- b) Call and arrange for an appointment. Face-to-face contact establishes you as a person not just a voice.
- c) At the initial meeting don't ramble on about your subject unless the media representative asks questions. Instead, you ask questions:
  - What are the deadlines?
  - What are the newspaper's or station's interests?
  - What about photos?
  - Who is good at covering this area?Ask every question a beginner would ask. Generally novices get better treatment. Everyone likes to help the newcomer!
- d) Work hard to retain contacts, but don't be a pest.
- e) Present good stories and solid information.
- f) After initial contact, arrange for an interview and site visit.
- g) Prepare colleagues, provide photo opportunities.
- h) Prepare your thoughts and ideas. Don't rely on off-the-cuff responses.
- i) If the coverage was inadequate or misrepresentative, talk to the reporter or editor. Some clarification may be in order. Do not blow up at the person covering your story. Give her/him another opportunity.
- j) Send a thank you note, outlining what you felt was effective.
- k) Maintain contact.

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# **APPENDIX A**

## **ADDRESSES OF PREGNANCY OUTREACH PROGRAMS AND OTHER COMPREHENSIVE PRENATAL NUTRITION PROGRAMS IN BRITISH COLUMBIA**

## ADDRESSES OF PRENATAL PROGRAMS FOR HIGH-RISK CLIENTS

### PREGNANCY OUTREACH PROGRAMS

Pregnancy Outreach Program, Burnaby  
Burnaby Family Life Institute  
32-250 Willingdon Avenue  
Burnaby, B.C.  
V5C 5E9  
(604) 299-9736  
(604) 299-9731

Babies Best Chance, Campbell River  
Campbell River Family Services  
487 10th Avenue  
Campbell River, B.C.  
V9W 4E4  
(250) 287-2421  
(250) 287-4268

Better Babies, Cranbrook  
Cranbrook Home Support Services  
207 14th Street North  
Cranbrook, B.C.  
V1C 3W3  
(250) 489-5011  
(250) 489-5905

Healthiest Babies Possible, Delta, Surrey, White Rock  
OPTIONS: Services to Communities  
10256 154th Street  
Surrey, B.C.  
V3R 5Y7  
(604) 583-1017  
(604) 572-7413

Cowichan Valley Healthiest Babies Possible, Duncan  
HIIYE 'YU LELUM (House of Friendship)  
Box 1015  
Duncan, B.C.  
V9L 3Y3  
(250) 748-2242  
(250) 748-2238

Best Babies, Esquimalt  
Esquimalt Neighbourhood House  
511 Constance Avenue  
Victoria, B.C.  
V9A 6N5  
(250) 385-2635  
(250) 384-2078

Better Babies, Fernie  
Fernie Women's Resource Centre and Drop-in  
Box 2054  
Fernie, B.C.  
V0B 1M0  
(250) 423-4687  
(250) 423-3633

Baby's HeadStart, Kamloops  
Kamloops Home Support Services Association  
396 Tranquille Road (250) 554-3134  
Kamloops, B.C. (250) 554-1833  
V2B 3G7

Babies Best Chance, Mission  
Women's Resource Society of the Fraser Valley  
Box 3044 (604) 826-5589  
Mission, B.C. (604) 820-8495  
V2V 4J3

Building Better Babies, Nanaimo  
Tillicum Haus Native Friendship Centre  
927 Haliburton Street (250) 753-6578  
Nanaimo, B.C. (250) 754-1390  
V9S 6N4

Special Delivery, Nelson  
Nelson & District Home Support Services Society  
905 Gordon Road (250) 352-2911  
Nelson, B.C. (250) 352-7242  
V1L 3L8

Building Healthier Babies, Port Alberni  
Family Health Centre  
3435 Fourth Ave. (250) 723-1391  
Port Alberni, B.C. (250) 723-4808  
V9Y 4H1

Healthiest Babies Possible, Prince George  
Northern Family Health Society  
103 - 490 Quebec St. (250) 561-2689  
Prince George, B.C. (250) 562-5459  
V2L 5N5  
Internet:nfhs@netbistro.com

Pregnancy Outreach Program, Prince Rupert  
Friendship House Association of Pr. Rupert  
Box 512 (250) 627-1717  
Prince Rupert, B.C. (250) 627-7533  
V8J 3R5

Babies Best Chance, Quesnel  
Quesnel & District Child Development Centre  
395 Elliot Street (250) 992-3495  
Quesnel, B.C. (250) 992-6010  
V2J 1Y4

Pregnancy Outreach Program, Salmon Arm  
Shuswap Community Health Care Society  
Box 2138  
Salmon Arm, B.C.  
V1E 4R2

(250) 832-0091  
(250) 832-1191

BABY Project, Smithers  
DZE L K'ANT Friendship Centre  
Box 2920  
Smithers, B.C.  
V0J 2N0

(250) 847-8959  
(250) 847-5144

Building Healthy Babies, Terrace  
Terrace Child Development Centre  
2510 South Eby Street  
Terrace, B.C.  
V8G 2X3

(250) 635-9388  
(250) 638-0213

Healthy Baby Program, Ucluelet  
Nuu-chah-nulth Health Board  
Box 759  
Ucluelet, B.C.  
V0R 3A0

(250) 726-4313  
(250) 726-7552

Prenatal Outreach Program, Williams Lake  
Cariboo Friendship Society  
99 South 3rd Avenue  
Williams Lake, B.C.  
V2G 1J1

(250) 392-3583  
(250) 398-6115

#### **OTHER COMPREHENSIVE PRENATAL NUTRITION PROGRAMS:**

Healthiest Babies Possible, Vancouver  
East Unit Vancouver Health Dept.  
2610 Victoria Dr.  
Vancouver, B.C.  
V5N 4L2

(604) 872-2511  
(604) 872-2368

Sheway, Vancouver  
Sheway  
455 East Hastings St.  
Vancouver, B.C.  
V6A 1P5

(604) 254-9951  
(604) 254-9948

**For information on Canada Prenatal Nutrition Program Sites, and Community Action Plan for Children Comprehensive Prenatal Nutrition Program Sites**

**contact:**

**Health Canada  
Health Promotion and Programs Branch  
440 - 757 West Hastings Street  
Vancouver, B.C.  
V6C 1A1**

**(604) 666-2596**

**(604) 666-8986**

## **APPENDIX B**

### **DESCRIPTIONS OF THREE REPRESENTATIVE PREGNANCY OUTREACH PROGRAMS**

## SPECIAL DELIVERY

### **Nelson and Kaslo District Pregnancy Outreach Program**

This program, which began in 1992, is located in Nelson B.C., in the southern interior, and serves the Central Kootenay and Kootenay Lake Health Districts. The total population of the area is approximately 30,000 people, but it is primarily rural and the population is spread over a large geographic area. There are no First Nation reserves in the area. The target population has been identified by the community as mainly young, low-income women who tend not to access traditional health services. There is a large population of "alternative lifestyle", transient young people in the area. The program was originally funded for 25 clients per year, but has grown, and is currently funded for 45 per year, with increasing numbers of referrals every year.

The Sponsoring Agency is Nelson and District Home Support Services, which provides the home support services for the elderly, but also has a large family services component, and has been extremely supportive of the program. The program is coordinated by an RN, who is also a Lactation Consultant. The Coordinator works 12 hours per week. One Outreach Worker works out of Nelson itself, at 12 hours per week, and the other Outreach Worker works out of one of the isolated communities at the other end of the Lake, at 6 hours per week. Alternate professional services (Nutritionist) are provided by the Health Unit Community Health Nutritionist. She reviews all the food records, using a computer analysis of nutrients within a 24 hour food recall. The Nutritionist also gives talks at the drop-ins. She acts as a resource person to Program staff.

Group drop-ins are held once a week at a house near downtown Nelson. They usually include a topic or speaker and lunch. Staff try to meet individually, at least briefly, with the clients during the group time. Clients who do not attend the drop-ins are usually seen in their own homes. Transportation is often a problem for clients who live in outlying areas, as a result much of the Outreach Workers' time is spent in travel.

Originally groceries were given as a food supplement, but due to the increase in client load, the program is using a voucher system. Lots of baby clothes and equipment are donated by the community to the program. Prenatal vitamins are currently being partially donated by Shoppers' Drug Mart.

Program staff work closely with the Public Health Nurses, prenatal classes, Outreach School, and the Advocacy Center in Nelson. There is a comprehensive Postpartum Support Program in this area and clients are referred to this or to the CAPC Program after the birth.

## HEALTHIEST BABIES POSSIBLE

### Surrey, Delta, White Rock Pregnancy Outreach Program

Healthiest Babies Possible offers services to clients in Surrey, Delta and White Rock. The main office for the program is in Surrey, with one other office in Delta at the local Sikh Gurdwara (Sikh Prayer Center). The total population for the three municipalities covered by the program is 407,724. Healthiest Babies Possible (HBP) was formed by the combination of two programs. The Surrey/White Rock program began in 1988/89, and was later combined with the Delta program which was started in 1992/93. The Sponsoring Agency is OPTIONS: Services to Communities Society. This Agency operates between 50 and 65 programs in the community.

Clients tend to be young and low income. Over 50% of clients have not graduated from high school. In Delta 48% of clients are Indo-Canadian. About 10% of clients are First Nations. The number of Somalian and Vietnamese clients has been increasing.

Healthiest Babies Possible offers three drop-in sessions (called Lunch Clubs) over a two week period. Drop-ins take place every Friday (alternating between Surrey and Delta) and every second Tuesday at the Sikh Gurdwara location. At the Surrey and Delta locations a free hot lunch is served (non-pregnant persons are asked to contribute \$1.00 for the meal), and a guest speaker is invited to talk about various issues concerning the clients. Crafts are scheduled for special events. Partners, support persons and children are welcome to attend. At the Sikh Gurdwara location a traditional lunch is prepared and served in the Gurdwara cafeteria, then the group moves to the program office for the guest speaker. Most of the talks are given in Punjabi. Transportation is offered for this Lunch Club as many women are not familiar with the bus system.

The program staff consists of one full-time Nutritionist Coordinator and 3.2 FTE Outreach Workers. Resource Nurses are provided by the Boundary Health Unit. 0.5 FTE is shared between two nurses (0.4 for English speaking nurse and 0.1 for Punjabi speaking nurse). The Resource Nurse sees all clients at least once during the pregnancy, usually around the seventh month, and covers the specifics of labour and delivery, breastfeeding and contraception.

Food vouchers are given to each client at every counselling session and at every Lunch Club. With these vouchers, clients can purchase milk and frozen orange juice. In the case of allergy/intolerance, blank vouchers are given out, so that the client can buy substitutes. Bus tickets are also given to clients who otherwise could not afford to attend the Lunch Club.

Healthiest Babies Possible is closely involved with other local programs including: Family Place, Outreach Support to Parents Program, Nobody's Perfect, the pregnant teens and teen moms school program and the local Food Bank.

## CARIBOO PRENATAL OUTREACH PROGRAM

### Williams Lake

This Pregnancy Outreach Program is situated in central British Columbia in Williams Lake. The program is located near the center of town in a small house. The sponsoring agency is the Cariboo Friendship Society. The program began in 1989.

The client group is mostly young, 33% are teenagers. Between 30 and 45% of clients are Aboriginal. Most clients are low income, either on Social Assistance or working poor. Many clients come from or live in abusive situations.

The program is open Monday to Thursday 8:30 a.m. to 5:00 p.m. The Outreach Worker works all four days, the Nurse Coordinator works three days a week and the Resource Nutritionist works 4 hours per week. All staff attend drop-ins.

Drop-ins occur weekly. Drop-ins begin at 11 am with an educational session, topics covered include: stress management, pre and postnatal exercises, Ministry of Social Services information, anger management, dental hygiene, infant feeding, Fetal Alcohol Syndrome and more. Once a month the topic is nutrition related and is led by the Resource Nutritionist. Nutrition topics include Shop Smart Tours, cooking, and games such as Food Jeopardy.

A substantial lunch is served at the drop-in at noon. All recipes are low cost and easy to prepare. Recipes are made available to clients and any leftover food is given to clients to take home. After lunch clients are seen individually to review food recalls and address any other issues. The program Coordinator, Resource Nutritionist and Outreach Worker all see clients at this time.

Food supplements are given out weekly to low income clients. Supplements are in the form of vouchers redeemable for milk, cheese, yogurt, fresh fruit or vegetables.

Other community groups use the house in which the program is situated. These groups include: Nobody's Perfect Parenting Program, Alcohol and Drug Programs, Multiple Birth Support groups, prenatal groups, craft groups and teen groups.

The program maintains a clothing depot of donated used maternity and baby clothes, baby furniture and strollers. The program also houses the baby car seat rentals for Williams Lake.

There is a community garden on the property designed and built for pregnant women and young families. The garden includes a fenced playground, picnic tables and raised garden beds. Education sessions centered on the garden involve not only gardening, but also cooking, canning and preserving. Fresh produce is given to clients and is served at drop-in lunches.

## **APPENDIX C**

### **INDIVIDUAL PRENATAL RISK IDENTIFICATION AND A GUIDE FOR THE USE OF INDIVIDUAL PRENATAL RISK IDENTIFICATION**



Date: \_\_\_\_\_

Location: \_\_\_\_\_

Client ID # \_\_\_\_\_

SEE GUIDE FOR DEFINITIONS AND EXPLANATION.

Code	Description	Yes	Explanation
<b>Physical Factors</b>			
PF1	Previous pregnancy loss	<input type="checkbox"/>	_____
PF2	Illness / condition with impact on pregnancy	<input type="checkbox"/>	_____
PF3	Pre-pregnancy weight - body mass index (BMI)	<input type="checkbox"/>	_____
PF4	Rate of weight gain	<input type="checkbox"/>	_____
PF5	Inadequate nutrition	<input type="checkbox"/>	_____
PF6	Previous child with anomaly	<input type="checkbox"/>	_____
PF7	Previous child requiring neonatal intensive care	<input type="checkbox"/>	_____
PF8	Multiple pregnancy	<input type="checkbox"/>	_____
PF9	Birth interval	<input type="checkbox"/>	_____
PF10	Grand multipara - 5 or more pregnancies	<input type="checkbox"/>	_____
PF11	Established genetic risk	<input type="checkbox"/>	_____
PF12	Age 17 and younger / 36 and older	<input type="checkbox"/>	_____
<b>Substance Abuse / Misuse</b>			
SA1	Cigarette smoking	<input type="checkbox"/>	_____
SA2	Alcohol use	<input type="checkbox"/>	_____
SA3	Inappropriate use of over the counter and prescription drugs	<input type="checkbox"/>	_____
SA4	Other drug use	<input type="checkbox"/>	_____
<b>Psychosocial and Economic Factors</b>			
PE1	Single parenthood	<input type="checkbox"/>	_____
PE2	Delayed access to prenatal care	<input type="checkbox"/>	_____
PE3	Refusal of / resistance to appropriate services	<input type="checkbox"/>	_____
PE4	Isolation - ethnic, language & social	<input type="checkbox"/>	_____
PE5	Limited learning ability / illiterate	<input type="checkbox"/>	_____
PE6	Marital problems / unstable relationship / family violence	<input type="checkbox"/>	_____
PE7	Mental health problems	<input type="checkbox"/>	_____
PE8	Low self-esteem	<input type="checkbox"/>	_____
PE9	Inability to cope / anxiety regarding pregnancy and baby	<input type="checkbox"/>	_____
PE10	Unrealistic expectations	<input type="checkbox"/>	_____
PE11	Unwanted pregnancy / denial of pregnancy	<input type="checkbox"/>	_____
PE12	Financial problems	<input type="checkbox"/>	_____
PE13	Inadequate housing	<input type="checkbox"/>	_____

# A GUIDE FOR THE USE OF INDIVIDUAL PRENATAL RISK IDENTIFICATION

## PURPOSE

The purpose of this form is to provide a tool which will identify some of the major factors that can influence the outcome of the pregnancy and at a quick glance provide the risk factors specific to the individual client. The Program Coordinator can use it as a checklist when determining the care plan for the client. It is intended to complement the prenatal assessment of the physician by highlighting lifestyle factors in particular.

The guide is not meant to be an all inclusive source of information of risks in families and pregnancies. It compiles in a single document basic information to assist professionals in the early identification of risks with the ultimate goal of reducing perinatal morbidity and mortality.

Personal experience, knowledge and intuition on the part of the professionals are as important, if not more, than whatever guide or form is used. The guide should be used with the knowledge and understanding of risks, situations and their effect on health to arrive at a decision for appropriate intervention.

The comprehensive multidisciplinary approach to care should be a sound principle to adopt. It will ensure that all points of intervention are covered and appropriate preventive measures are taken through community outreach and other family health programs of the health agency.

The lists of risk factors noted on the forms are not meant to be all inclusive. They are intended to cover the most frequent problems producing risk.

## DEFINITIONS

In general, the risk factors that will increase the chances of morbidity and mortality are of a physical, nutritional, mental/emotional, socio-economic or occupational nature. For the purpose of this guide, the following definitions have been adopted:

**risk:** an increased probability of adverse outcomes

**high risk groups:** groups with increased probability of adverse outcomes

**high risk families:** families whose circumstances indicate

**families:** high risk factors which may interfere with optimum family life and functioning

**high risk pregnancy:** a pregnancy in which the mother and/or the fetus has an increased probability of maternal and fetal morbidity or mortality prenatally and intranatally

**high risk infant:** newborn or infant with familial, maternal and perinatal factors that may lead to an increased probability of morbidity and subsequent disabilities

The risks are provided as a check list for coordinators to ensure they are discovering the risks that may be encountered with the perinatal client. A brief description of each risk is provided to help understand the risk factors.

## PHYSICAL FACTORS

		YES	NO
PF1	Previous pregnancy loss	<input type="checkbox"/>	<input type="checkbox"/>
PF2	Illness/condition with impact on pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
PF3	Pre-pregnancy weight - body mass index (BMI)	<input type="checkbox"/>	<input type="checkbox"/>
PF4	Rate of weight gain	<input type="checkbox"/>	<input type="checkbox"/>
PF5	Inadequate nutrition	<input type="checkbox"/>	<input type="checkbox"/>
PF6	Previous child with anomaly	<input type="checkbox"/>	<input type="checkbox"/>
PF7	Previous child requiring neonatal intensive care	<input type="checkbox"/>	<input type="checkbox"/>
PF8	Multiple pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
PF9	Birth interval	<input type="checkbox"/>	<input type="checkbox"/>
PF10	Grand multipara - 5 or more pregnancies	<input type="checkbox"/>	<input type="checkbox"/>
PF11	Established genetic risk	<input type="checkbox"/>	<input type="checkbox"/>
PF12	Age 17 and younger/ 36 and older at time of delivery	<input type="checkbox"/>	<input type="checkbox"/>

### **PF1: Previous pregnancy loss**

Previous pregnancy loss - abortion (both spontaneous and elective), stillbirth, neonatal and infant death (up to 365 days old), such as SIDS are significant factors. Depending on the cause of such loss the same conditions may be either present or occur again for another reproductive loss. The level of risk depends on the causative factor.

**PF2: Illness/condition with impact on pregnancy**

The following conditions would lead to unfavourable outcome of pregnancy if close medical surveillance is not provided: poorly controlled diabetes or hypertension, chronic renal failure, congenital or rheumatic heart disease, and very rapid weight gain. Other conditions may have an impact on pregnancy if not controlled by routine medical care, e.g. mild hypertension, gestational diabetes, and urinary tract infections. Many conditions may lead to premature labour, congenital anomalies, intrauterine growth retardation, and other associated morbidities. These include infections (rubella, STD, toxoplasmosis, genital herpes), abnormal presentation, surgical procedure during pregnancy, uterine and associated malformations, toxemia, anemia, bleeding, diabetes, hypertension, obesity, renal disease, isoimmunization, etc. The risk and its effects are related to the severity of the condition.

Other conditions such as blindness, deafness and physical handicaps can affect the mother in pregnancy. The level of risk will depend on the individual's abilities, compensating mechanisms, and support structure.

**PF3: Pre-pregnancy weight**

$$\text{Body Mass Index (BMI)} = \frac{\text{wt (kg)}}{\text{ht}^2 (\text{m}^2)}$$

The underweight woman has a BMI under 19.8. A BMI of over 29 indicates obesity.

A woman's nutritional status prior to and during pregnancy are important factors that influence the health of the fetus and the baby. The mother's pre-pregnancy weight and weight gain during pregnancy are two factors which affect the infant's birth weight and thus the infant's health.

"No widely accepted standards of weight for height exist for adolescents. Except for very young girls or those who conceive within 2 years of menarche, adult BMI recommendations may be used provisionally to classify girls as underweight, moderate weight, overweight and obese."

Nutrition During Pregnancy. National Academy of Sciences. 1990.

Note: 1 pound = 0.45 kilograms  
1 inch = 2.54 centimetres  
1 foot = .3048 meters

**PF4: Rate of weight gain**

Inadequate weight gain: 2nd and 3rd trimester

- if weight gain less than 1 kg/month for women beginning pregnancy with an acceptable BMI (BMI = 19.8 - 26)
- if weight gain is less than 0.5kg/month for obese women (BMI > 29)

Rapid weight gain: 2nd and 3rd trimester

- if weight gain is greater than 3 kg/month

Measurement should be carefully evaluated to avoid measurement or recording errors, or differences due to clothing, boots, shoes, etc. Inappropriate rate of weight gain may lead to low birthweight infants and related problems.

Underweight women (BMI < 19.8) are certainly at risk if their weight gain is less than 1 kg/month and overweight women (BMI > 26-29) if their weight gain is less than 0.5 kg/month. The literature does not identify specific guidelines for these populations.

Rapid weight gain may indicate fluid retention, multiple gestations, or excessive food intake. For the underweight woman (BMI < 19.8) with a weight gain > 3 kg/month, clinical judgement is required to determine whether this represents a health risk or is a result of 'catch-up' weight gain.

**PF5: Inadequate Nutrition**

Consistently less than the minimum recommended servings in 1 or more food groups, as outlined in the "B.C. Food Guide for Pregnancy":

- less than 8 servings of Grain Products
- less than 6 servings of Vegetables and Fruit
- less than 3 servings of Milk Products
- less than 2 servings of Meat and Alternatives

*The Baby's Best Chance: Parents' Handbook of Pregnancy and Baby Care* provides essential information with regards to nutrition requirements for the pregnant woman. The "B.C. Food Guide for Pregnancy" outlines the appropriate numbers of food group servings for adequate calories and nutrients. A deficiency can represent a serious risk to the development of the fetus and to the mother's health.

The assessment of the four food groups should be based on the client's reporting of her typical daily intake. It is recommended that the consulting nutritionist be involved in the nutrition screening aspect of the initial interview.

**PF6: Previous child with anomaly or disorder**

This includes conditions with impact on development of the child; e.g. chronic heart disease, neural tube defects (i.e. spina bifida), cleft palate, fetal alcohol syndrome, fetal alcohol effects; and conditions which are more readily corrected or have only minor functional impairment, e.g. ventral-septal defects

with spontaneous closure, minor orthopaedic abnormalities, uncomplicated pyloric stenosis, etc.

Cerebral palsy, mental retardation, congenital anomalies ... if the same perinatal conditions still exist, they may lead to the same risk in the present pregnancy.

Established genetic risk - either from previous pregnancies or from a familial history i.e., muscular dystrophy, cystic fibrosis, etc. is significant.

**PF7: Previous high risk infant**

High risk infants that were premature (<37 weeks), postmature (>42 weeks), or had a low birthweight (<2500 grams).

**PF8: Multiple pregnancy**

Prenatal mortality resulting from twin births is as high as 14%, the greatest mortality resulting from premature birth. Special emphasis should be placed on nutritional counselling for multiple pregnancy.

**PF9: Birth interval**

Although the optimum birth interval has not been defined, the incidence of fetal growth retardation and prematurity is consistently high when the birth interval is less than two years. Spacing allows time for the mother's body to recover and to be in optimal health before becoming pregnant again.

**PF10: Grand multipara**

Parity alone or combined with maternal age is significant. Higher risk of morbidity occurs at the first pregnancy and at the fifth pregnancy or more.

**PF11: Age 17 and under/age 36 and over at time of delivery**

Pregnant women 17 years of age and younger risk low birth weight infants. Pregnant women 36 years of age and over risk infants with chromosomal abnormalities.

**SUBSTANCE ABUSE/MISUSE**

		YES	NO
SA1	Cigarette smoking	<input type="checkbox"/>	<input type="checkbox"/>
SA2	Alcohol use	<input type="checkbox"/>	<input type="checkbox"/>
SA3	Inappropriate use of over the counter and prescription drugs	<input type="checkbox"/>	<input type="checkbox"/>
SA4	Other drug use	<input type="checkbox"/>	<input type="checkbox"/>

**SA1: Smoking**

Cigarette smoking has been shown to decrease infant birth weight in direct proportion to the amount smoked. Cigarette smoking increases the risks of perinatal morbidity and mortality. The growth-retarding effect of cigarette smoking and higher incidence of spontaneous abortions, stillbirths or placental complications among women who smoke during pregnancy may be due to several factors including direct toxicity of carbon monoxide, nicotine and/or other constituents of tobacco, reducing blood flow to the uterus affecting transfer of nutrients to the fetus, or suboptimal maternal food intake. Passive smoking (secondhand smoke) may also be a cause of concern during pregnancy due to the oxygen depleting effect of carbon monoxide.

**SA2: Alcohol use**

There is no known safe level of alcohol consumption for pregnant women. It is not possible at this time to say what is the minimum level of alcohol consumption that may endanger the fetus. Heavier alcohol misuse (such as maternal dependency) may lead to the fetal alcohol syndrome: low birth weight, failure to thrive, mental handicap, facial congenital anomalies, developmental delays, hyperactivity, etc. Alcohol (2 or more drinks per day or binge drinking) and other drug use (including tobacco and cocaine), may independently increase the risk of spontaneous abortion and low birth weight infants. When combined, fetal risk is greatly increased.

Use of the T-ACE questions is recommended to determine the risk of alcohol misuse.

- Note: 1 Drink = 12 oz beer  
 = 5 oz wine  
 = 1 mixed drink (1.5 oz. or 'hard' liquor)  
 Binge = consuming 5 or more alcoholic drinks on any one occasion

**SA3: Inappropriate use of over the counter and treatment drugs**

Drugs may affect the intake, absorption, metabolism and/or utilization of nutrients in the body, thereby influencing maternal nutrition status. The effect that a drug has on the fetus depends on many factors including the type of drug, the amount taken by the mother, the stage of pregnancy at which it is taken, and the frequency and duration of its use. Some drugs are known to have or strongly suspected of having any teratogenic effect in humans. Women should discuss with their family physician before taking any medications.

Determine the pregnant woman's use of any drugs, including the use of herbs.

**SA4: Other drug use (including cocaine, opiates, solvents, and poly-drug use)**

Any needle drug use, any use of cocaine or crack, poly drug use, daily use of other drugs, for example tylenol #3 (codeine), hash, marijuana is to be considered a significant risk to the infant.

## PSYCHOSOCIAL & ECONOMIC

**Social Environment:** The effects of maternal social environment on the outcome of pregnancy are recognized to be both multiple and profound. 'Social environment' is described as the summation of numerous factors, including the family's standards of health and hygiene, housing and financial status, emotional and social support and so on. The effects may be direct or indirect and may be difficult to separate within the context of socio-economic status. It is the inter-relationship of these factors, rather than any single factor, that works to affect the outcome of the pregnancy.

	YES	NO
PE1 Single parenthood	<input type="checkbox"/>	<input type="checkbox"/>
PE2 Delayed access to prenatal care	<input type="checkbox"/>	<input type="checkbox"/>
PE3 Refusal of/resistance to appropriate services	<input type="checkbox"/>	<input type="checkbox"/>
PE4 Isolation - ethnic, language and social	<input type="checkbox"/>	<input type="checkbox"/>
PE5 Limited learning ability/illiterate	<input type="checkbox"/>	<input type="checkbox"/>
PE6 Marital problems/unstable relationship/family violence	<input type="checkbox"/>	<input type="checkbox"/>
PE7 Mental health problems	<input type="checkbox"/>	<input type="checkbox"/>
PE8 Low self-esteem	<input type="checkbox"/>	<input type="checkbox"/>
PE9 Inability to cope/anxiety regarding pregnancy and baby	<input type="checkbox"/>	<input type="checkbox"/>
PE10 Unrealistic expectations	<input type="checkbox"/>	<input type="checkbox"/>
PE11 Unwanted pregnancies/denial of pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
PE12 Financial problems	<input type="checkbox"/>	<input type="checkbox"/>
PE13 Inadequate housing	<input type="checkbox"/>	<input type="checkbox"/>

### PE1: Single parenthood

The frequency of cases of low birth weight infants and the perinatal mortality rates of infants born to unmarried mothers is higher than those of children of married women. Marital status alone is not necessarily an indicator of potential risk for mother and fetus so much as it is an indicator of an unwanted/unplanned pregnancy. These pregnant women, especially if unwed or teenagers, tend to neglect antenatal care and leave advice unheeded. Statistically, pregnancy complications occur more frequently in unmarried than in married women. The increased amount of risk can be associated with multiple social problems. Single parenthood still has an influence, but to a decreased amount, if financial and emotional support is present.

### PE2: Delayed access to prenatal care

Early access to medical care and return follow-up visits are essential for risk identification and monitoring. Some of the factors to consider are no medical care by 20 weeks, frequent

missed appointments, no follow-up on medical advice and no attendance at prenatal classes in a primipara.

### PE3: Refusal of/resistance to appropriate services

Refusal of or resistance to appropriate services, such as Ministry of Social Services, poses obvious threats to the client's receiving appropriate medical care and support for the mother and the fetus. This refusal or resistance can be due to a lack of trust on the part of the pregnant woman due to past experiences within her family or community or previous requests for help may have been unmet in the past.

### PE4: Isolation Ethnic, language, social, and/or geographical

Ethnic or language isolation can tend to deprive mothers of available information and resources. This can apply to immigrant and refugee status women as well as Aboriginal women.

Social isolation i.e., lack of supports, possibly new to area, can create a void in resources, either classes or physicians, which can put a mother at risk of not being assessed early and receiving adequate care and attention. Social isolation in itself is a stress and must be dealt with in conjunction with the stress of pregnancy.

Geographic isolation can be an issue in remote areas as well as for mothers with limited transportation options and the location of facilities and programs.

### PE5: Limited learning ability/illiterate

Limited learning ability/illiteracy especially if associated with other risks is significant. Problems can range from severe communicative disability to a limited ability to understand. These people may not have access to information nor an understanding of the importance of education regarding pregnancy, childbirth and child care.

### PE6: Marital problems/unstable relationship/family violence

**Marital problems/unstable relationship:** Marital discord, lack of partner support, lack of extended family support may lead to a higher incidence of reproductive loss, low birth weight (preterm, small for dates) nutritional problems, absence of maternal child bonding, neglect and abuse resulting in developmental delays and other associated morbidities.

**Family violence/abuse:** Determine if the woman is currently in an abusive relationship, if there are affects on the emotional or physical health of the woman, or if there is a possibility of repetition during pregnancy or shortly thereafter.

Evidence of neglect - history of abuse/neglect, for example lack of positive parenting in the past, history of negative foster home placements.

A family history of abuse/neglect (emotional or physical) tends to repeat itself from generation to generation and where there is abuse present in the home, the new baby is in high risk of being abused and neglected.

**PE7: Mental health problems**

Mental health problems, current and previous occurrence(s), may shed light on one's family background, coping mechanisms, self-esteem and reactions to stress or crisis. As the pregnant woman strives to develop a degree of comfort with the many changes in social context and psychologic equilibrium, there often occurs a surfacing of old conflicts that were never adequately resolved in earlier developmental periods. For example, pregnant clients may experience conflicts of autonomy with their mothers, renewed rivalry with siblings, or active uncertainty about sexuality and disturbing fantasies about past relationships, each of which had been adequately dealt with prior to pregnancy but which now result in troubling family interactions or marital discord. Manifest problems in adjustment prior to pregnancy, such as marital discord, economic difficulties, poor self-concept, and neuroticism may be exacerbated by pregnancy. Anxiety allowed to go unallayed may lead to maladaptive mother-child interaction.

**PE8: Low self-esteem**

Low self-esteem can manifest itself in a pregnant woman having no confidence in herself, her body, her decision-making choices. Exhibition of depression, lack of self-worth or motivation, and uncaring of self and other people. She may even choose to be in an abusive relationship or refuse to avail herself of advice and information.

**PE9: Inability to cope/anxiety regarding pregnancy and baby**

Coping potential is the ability of the individual and family to adapt to stress. When individuals experience stress, they may use a variety of methods to cope. With an intense perception of threat, defense mechanisms such as denial, projection, rationalization, displacement and intellectualization may occur. The prolonged denial of the high-risk status of the pregnancy may result in failure to comply with therapeutic regimes. Anxiety regarding the pregnancy and baby may manifest itself in many expressed irrational fears and distortions. Women who are having difficulty accepting pregnancy and developing a relationship with the growing fetus may present with extreme anxiety about the condition of the baby and will be hypervigilant in looking for signs that 'something is wrong' with the pregnancy.

**PE10: Unrealistic expectations**

Unrealistic expectations of roles of mother and or father, baby and significant others can lead to frustration, stress, neglect and abuse. Another psychosocial maladaptation of pregnancy is failure to make adequate, concrete plans for postnatal care of the baby. The absence of family members or friends to assist in the care of the baby or, at the other extreme, passivity and

over reliance on family members are signs of difficulty in adapting to pregnancy, as is unrealistic planning or inadequate preparation for managing the baby at home.

**PE11: Unwanted pregnancy/denial of pregnancy**

Pregnant women who have an unwanted pregnancy or unplanned pregnancy and/or who deny the pregnancy, can tend to neglect antenatal care and leave advice unheeded. The stresses in these women are very high.

**PE12: Financial problems**

Unemployment, very low income, and/or receiving social assistance may lead to a higher incidence of reproductive loss, low birth weight, nutritional problems, neglect and abuse resulting in developmental delays and other associated morbidities.

**PE13: Inadequate housing**

While this can be a difficult risk to assess, some of the features to be considered may be: lack of facilities (bathroom, cooking, bedroom, etc.), space/overcrowding, hazardous living conditions, pest infestation, etc.

For 'street people', this is a significant risk, as well as for others with an unstable functional household unit - where there is significant moving of the family and/or many people coming and going out of the house. This can be a high stress factor for the pregnant woman and her family.

Acknowledgements to:  
Ottawa Health Department and Ontario Ministry of Health  
FORM 5070 REV88 OCTOBER NA-RISK2.CHP

Ministry of Health and  
Ministry Responsible for Seniors  
HLTH2007 93/06

# APPENDIX D

## T-ACE QUESTIONNAIRE

# T-ACE Measurement

T-ACE is a measurement tool of four questions that are significant identifiers of risk drinking (i.e., alcohol intake sufficient to potentially damage the embryo/fetus).

For the Pregnancy Outreach Program the T-ACE is completed at intake. The T-ACE score has a range of 0-5. The value of each answer to the four questions is totalled to determine the final T-ACE score.

<p>1. How many drinks does it take to make you feel high?</p> <p>0 less than or equal to 2 drinks 2 more than 2 drinks</p>	<p><b>T</b>olerance</p>
<p>2. Have people annoyed you by criticizing your drinking?</p> <p>0 no 1 yes</p>	<p><b>A</b>nnoyance</p>
<p>3. Have you felt you ought to cut down on your drinking?</p> <p>0 no 1 yes</p>	<p><b>C</b>ut Down</p>
<p>4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?</p> <p>0 no 1 yes</p>	<p><b>E</b>ye Opener</p>

Source: Sokol, Robert J., "Finding the Risk Drinker in Your Clinical Practice" in *Alcohol and Child/Family Health: Proceedings of a Conference with Particular Reference to the Prevention of Alcohol-Related Birth Defects*, edited by Robinson, G. and Armstrong R., Vancouver, B.C., December 1988.

Note: For the purposes of the Pregnancy Outreach Program Evaluation - a client is at risk for alcohol use if she has a positive T-ACE (a score of 2 or greater).

# **APPENDIX E**

## **CLIENT DATA SHEET**



TO BE COMPLETED IN CONJUNCTION WITH INDIVIDUAL RISK IDENTIFICATION TOOL

PROGRAM LOCATION	
CLIENT ID NUMBER	CARE CARD NUMBER

REFERRAL DATA	
<b>SOURCE OF REFERRAL</b> <input type="checkbox"/> (1) HEALTH UNIT <input type="checkbox"/> (4) ALCOHOL & DRUG <input type="checkbox"/> (7) OTHER <input type="checkbox"/> (2) PHYSICIAN <input type="checkbox"/> (5) COMMUNITY GROUP <input type="checkbox"/> (3) SOCIAL SERVICES <input type="checkbox"/> (6) SELF	REFERRAL DATE (DD/MM/YY) _____ WEEKS GESTATION _____

INTAKE DATA	
INTAKE ASSESSMENT DATE _____	DUE DATE (DD/MM/YY) _____
CLIENT BEGAN PROGRAM <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF NO, WHY DID CLIENT NOT BEGIN PROGRAM? <input type="checkbox"/> (1) NOT HIGH RISK <input type="checkbox"/> (2) REFUSED/NOT INTERESTED <input type="checkbox"/> (3) OTHER	IF (3) OTHER, WHY DID CLIENT NOT BEGIN PROGRAM? _____

COMMENTS _____ _____ _____
-------------------------------------

CLIENT CHARACTERISTICS	
AGE _____	MARITAL STATUS <input type="checkbox"/> (1) MARRIED <input type="checkbox"/> (2) COMMONLAW <input type="checkbox"/> (3) SINGLE <input type="checkbox"/> (4) RELATIONSHIP

FIRST LANGUAGE <input type="checkbox"/> (1) ENGLISH <input type="checkbox"/> (2) OTHER (SPECIFY) _____
---

<b>ETHNIC BACKGROUND</b> <input type="checkbox"/> (1) CAUCASIAN (Not Identifiable) <input type="checkbox"/> (5) VIETNAMESE <input type="checkbox"/> (2) NATIVE INDIAN <input type="checkbox"/> (6) LATIN AMERICAN <input type="checkbox"/> (3) INDO-CANADIAN <input type="checkbox"/> (7) OTHER <input type="checkbox"/> (4) CHINESE	<b>IF ETHNIC BACKGROUND IS 2 (NATIVE INDIAN), STATE CLIENT'S STATUS</b> <input type="checkbox"/> (1) STATUS INDIAN ON RESERVE <input type="checkbox"/> (4) NON-STATUS <input type="checkbox"/> (2) STATUS INDIAN OFF RESERVE <input type="checkbox"/> (5) UNKNOWN <input type="checkbox"/> (3) METIS
--	---

<b>EDUCATION</b> <input type="checkbox"/> (1) GRADE 8 OR LESS <input type="checkbox"/> (3) COMPLETED GRADE 12 <input type="checkbox"/> (5) UNIVERSITY GRADUATE <input type="checkbox"/> (2) GRADE 9 - 11 <input type="checkbox"/> (4) SOME POST-SECONDARY
---

<b>EMPLOYMENT STATUS</b> <input type="checkbox"/> (1) EMPLOYED - OCCUPATION _____ <input type="checkbox"/> (2) STUDENT <input type="checkbox"/> (3) HOMEMAKER <input type="checkbox"/> (4) UNEMPLOYED
---

<b>FINANCIAL SITUATION</b> <input type="checkbox"/> (1) RECEIVING INCOME ASSISTANCE <input type="checkbox"/> (2) LOW/INADEQUATE INCOME BUT NO SOCIAL ASSISTANCE <input type="checkbox"/> (3) NOT LOW INCOME
--

<b>SPOUSE'S/PARTNER'S FINANCIAL SITUATION</b> <input type="checkbox"/> (1) RECEIVING INCOME ASSISTANCE <input type="checkbox"/> (3) NOT LOW INCOME <input type="checkbox"/> (2) LOW/INADEQUATE INCOME BUT NO SOCIAL ASSISTANCE <input type="checkbox"/> (4) NOT APPLICABLE
--

<b>T-ACE SCORE</b> 0    1    2    3    4    5
---

**PAST PREGNANCY DATA**

NUMBER OF

PREGNANCIES (G) \_\_\_\_\_

DELIVERIES (P) \_\_\_\_\_

TERM DELIVERIES (T) \_\_\_\_\_

ELECTIVE ABORTIONS (AE) \_\_\_\_\_

SPONTANEOUS ABORTIONS (A/S) \_\_\_\_\_

LIVING CHILDREN (L) \_\_\_\_\_

STILLBIRTHS (S) \_\_\_\_\_

LOW BIRTH WEIGHT (LBW) \_\_\_\_\_

**ATTENDED PRENATAL CLASSES DURING A PREVIOUS PREGNANCY?**

(1) YES     (2) NO     (3) DON'T KNOW/UNDECIDED     (4) NOT APPLICABLE

**HAS CLIENT EVER PREVIOUSLY BEEN A POP CLIENT?**

(1) YES     (2) NO     (3) DON'T KNOW

**CLIENT MONITORING**

	PRE-PREGNANCY	PROGRAM INTAKE	LAST VISIT BEFORE DELIVERY
DATE OF ASSESSMENT (DD/MM/YY)	_____ _____ ____	_____ _____ ____	_____ _____ ____
WEIGHT	_____	_____	_____
BODY MASS INDEX (BMI)	_____	_____	_____

**MEAL PATTERN**

NUMBER OF MEALS PER DAY \_\_\_\_\_

NUMBER OF SNACKS PER DAY \_\_\_\_\_

*(NB: A meal includes foods from 3 to 4 food groups; a snack includes foods from 1 to 2 food groups)*

**FOOD INTAKE (number of servings per day based on 24 hour recall)**

GRAIN PRODUCTS \_\_\_\_\_

VEGETABLES AND FRUIT \_\_\_\_\_

MILK PRODUCTS \_\_\_\_\_

MEAT AND ALTERNATIVES \_\_\_\_\_

**FLUIDS (number of 250 mL (8 oz) cups per day)**

COFFEE (perc or drip, caffeinated) \_\_\_\_\_

COFFEE (instant, caffeinated) \_\_\_\_\_

TEA (caffeinated) \_\_\_\_\_

COLAS (caffeinated) \_\_\_\_\_

OTHER: POPS AND SWEETENED FRUIT DRINKS (EG, KOOLAID, TANG) EXCLUDING FRUIT JUICES \_\_\_\_\_

WATER \_\_\_\_\_

**KEY NUTRIENTS (number of servings per day based on 24 hours recall)**

IRON RICH FOODS \_\_\_\_\_

EXCELLENT SOURCES \_\_\_\_\_

OTHER SOURCES \_\_\_\_\_

FOLATE RICH FOODS \_\_\_\_\_

GOOD SOURCES \_\_\_\_\_

OTHER SOURCES \_\_\_\_\_



**PROGRAM OUTCOME**

**OUTCOME OF PRESENT PREGNANCY**

- (1) SINGLE LIVE BIRTH     
  (3) STILLBIRTH     
  (5) THERAPEUTIC ABORTION  
 (2) MULTIPLE LIVE BIRTH     
  (4) SPONTANEOUS ABORTION (MISCARRIAGE)

WEEKS GESTATION	INFANT BIRTHDATE (DD/MM/YY)	BIRTHWEIGHT (GRAMS)	TWIN WEIGHT (GRAMS)
-----------------	-----------------------------	---------------------	---------------------

MEDICAL COMPLICATIONS

DID CLIENT STAY IN PROGRAM TO DELIVERY/END OF PREGNANCY?  YES  NO

IF NO, WHY NOT?

**BREASTFEEDING?**

AT HOSPITAL DISCHARGE:  (1) YES       (2) NO       (3) DON'T KNOW

AT ONE MONTH CONTACT:  (1) YES       (2) NO       (3) DON'T KNOW

IF NO TO EITHER BREASTFEEDING MEASURE, WHY NOT?

ALCOHOL USE FOLLOW-UP SHEET FILLED OUT?  YES  NO

SMOKING USE FOLLOW-UP SHEET FILLED OUT?  YES  NO

COMMENTS

**SMOKING DATA**

**TRIGGERS**

- (1) SOCIAL ACTIVITIES   
  (2) STRESS   
  (3) TIME OF DAY (ie, after meal)   
  (4) BOREDOM   
  (5) EMOTIONAL FACTORS  
 (6) OTHER

NUMBER ATTEMPTS AT CESSATION

METHODS

DO OTHER MEMBERS OF YOUR HOUSEHOLD CURRENTLY SMOKE?

- YES   
  NO

ARE YOU EVER EXPOSED TO "SECOND-HAND" SMOKE?

- YES   
  NO

IF YES TO SECOND HAND SMOKE, WHEN EXPOSED?

WHERE?

PERSONAL GOALS

- (1) NO CHANGE   
  (2) REDUCE   
  (3) QUIT

COMMENTS

**ALCOHOL DATA**

HX. OF USE BY

- (1) SIBLINGS     (2) PARENTS     (3) SPOUSE/PARTNER

TRIGGERS

- (1) SOCIAL     (2) STRESS/SADNESS     (3) OTHER

AGE STARTED

COPING METHODS

HOW MANY DRINKS DOES IT TAKE YOU TO FEEL THE EFFECTS OF ALCOHOL?

HOW MANY DRINKS CAN YOU HOLD?

DRINKING PATTERNS

- DAILY     BINGE (= 5 or more alcohol drinks on any one occasion)

IF DAILY, AVERAGE NUMBER PER DAY

IF BINGE, FREQUENCY OF BINGING

NUMBER OF DRINKS/BINGE

NUMBER OF DRINKS/BINGE

(1) 1/MONTH

\_\_\_\_\_

(4) 2/WEEK

\_\_\_\_\_

(2) 2/MONTH

\_\_\_\_\_

(5) >= 3/WEEK

\_\_\_\_\_

(3) 1/WEEK

\_\_\_\_\_

PAST HX OF TREATMENT

- YES     NO

IF YES, WHEN? (DD/MM/YY)

WHERE?

PERSONAL GOALS

- (1) NO CHANGE     (2) REDUCE     (3) ABSTAIN

COMMENTS

# **APPENDIX F**

## **FEEDBACK TO REFERRAL SOURCE SAMPLE FORM**

## FEEDBACK TO REFERRAL SOURCE

TO: \_\_\_\_\_  
\_\_\_\_\_

DATE: \_\_\_\_\_

### REPORT ON:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Due Date: \_\_\_\_\_

This client has been referred to the Pregnancy Outreach Program and was assessed on

\_\_\_\_\_, 199\_\_\_\_

She has  been accepted into the Program.  
 not been accepted into the Program.

She has  been put onto food supplement program.  
 not been put onto food supplement program.

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ (client's name) has consented to the release of this information. Client's signature: \_\_\_\_\_

For further information, please contact \_\_\_\_\_

Coordinator at \_\_\_\_\_

Signature: \_\_\_\_\_

# **APPENDIX G**

## **SAMPLE FOOD VOUCHERS**

**PREGNANCY OUTREACH PROGRAM FOOD VOUCHER**



Valid at \_\_\_\_\_

store for the month of \_\_\_\_\_

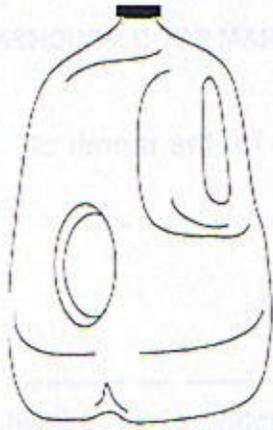
Please provide \_\_\_\_\_

with up to \$5.00 of any combination of the following products:

- |              |                     |
|--------------|---------------------|
| White Milk   | Lactaid Milk        |
| Brick Cheese | Frozen Orange Juice |
| Yogurt       | Pure Apple Juice    |
| Fresh Fruit  | Fresh Vegetables    |

Voucher # 001 Authorized By \_\_\_\_\_

Bill to: Pregnancy Outreach Program, Box 1234, British Columbia, XXXXXX phone: \_\_\_\_\_



**PREGNANCY OUTREACH PROGRAM FOOD  
VOUCHER**

Valid at \_\_\_\_\_ store for the month of \_\_\_\_\_

Please provide  
\_\_\_\_\_

with 6 liters of milk and 2 (355 ml) cans of frozen  
orange juice.

Voucher # 001 Authorized By \_\_\_\_\_

Bill to: Pregnancy Outreach Program, Box 1234, British Columbia, XXXXXX phone: \_\_\_\_\_

## **APPENDIX H**

**SAMPLE SCHEDULE "A" (SERVICES) CONTRACT  
AND  
COMMITMENT TO PREGNANCY OUTREACH  
PROGRAM PRINCIPLES AND STANDARDS**

## **SAMPLE**

### **SCHEDULE "A"** **Services**

#### **Background:**

This contract is to provide for a Pregnancy Outreach Program offering counselling and peer support to high risk pregnant women who do not access traditional prenatal health services.

#### **Services:**

##### **The Contractor will:**

- 1) Provide services in accordance with the Pregnancy Outreach Program Handbook, Ministry for Children and Families, with particular emphasis on the points outlined in the "Commitment to Program Principles and Standards", Appendix H. A copy of the handbook will be provided to the contractor.
- 2) Submit audit and evaluation information as required by the Ministry for Children and Families, including an unaudited statement of accounts and a Program Status Report twice a year, on or before October 30 and April 30.
- 3) Comply with all aspects of the "Service Delivery Model" as outlined in the Pregnancy Outreach Program Handbook, Ministry for Children and Families.
- 4) Ensure that the project staff includes an alternate professional (Resource Nutritionist or Nurse) to complement the discipline of the Program Coordinator.
- 5) Have in place policies regarding the storage and disposal of client records in compliance with the Freedom of Information and Protection of Privacy Act and the Document Disposal Act.
- 6) Comply with the requirements of the Criminal Records Review Act.

#### **(b) TERM:**

The term will be from \_\_\_\_\_ to \_\_\_\_\_ .

# PREGNANCY OUTREACH PROGRAM

## COMMITMENT TO PROGRAM PRINCIPLES AND STANDARDS

The Sponsoring Agency will provide a Pregnancy Outreach Program offering health counselling and peer support to high risk pregnant women who do not access traditional prenatal health services. The goal of the program is to promote positive health practices that contribute to the health of newborns and mothers. The specific objectives are to:

- improve nutrition
- decrease smoking
- decrease alcohol use and drug misuse
- raise self esteem
- encourage breastfeeding
- promote dental health
- encourage physical activity
- encourage early and continuing physician care
- promote social/community support

The sponsoring agency will provide services according to the Pregnancy Outreach Program Handbook and, specifically, comply with the following critical components of the program:

### CLIENT ELIGIBILITY

- women are assessed for eligibility within fourteen days of referral
- women must meet the criteria for at least one risk factor using the Individual Prenatal Risk Identification Tool (refer to Appendix C of the Handbook) to be eligible for enrollment in the Program
- priority is given to clients less than 28 weeks gestation and/or women at-risk for substance misuse
- the Coordinator participates in and/or reviews all eligibility assessments

### COUNSELLING PLAN

A counselling plan is developed jointly by program staff, in consultation with the client. Goals are established in partnership with the client. The plan is adjusted to accommodate the client's accomplishments and changing needs

### CLIENT SERVICE

1. Group Sessions to encourage peer support
  - are given a minimum of once every two weeks
  - a healthy snack/meal containing at least two of the Four Food Groups is provided
2. Individual Counselling based on clients' needs and counselling plan
  - clients receive a minimum of five individual counselling sessions
3. Vitamin/Mineral Supplements for clients in financial need
4. Food Supplements for clients in financial need
  - a minimum of food which will provide 3 servings from the Milk and Milk Products Food Group and 3 servings from the Fruit/Vegetable Food Group per day (approximately equal to 6l of milk and two 355ml cans of frozen orange juice per week)
5. Referral to the local Health Unit or Medical Services Health Centre prior to the clients' due date, with the client's permission

## PROGRAM ADMINISTRATION

1. The Ministry for Children and Families is responsible for setting standards and policy for the Pregnancy Outreach Program and for evaluation and monitoring of the Program.
2. The Sponsoring Agency assumes responsibility for fulfilling the terms of the Contract and delivering the Program in accordance with the standards and guidelines outlined in the Pregnancy Outreach Program Handbook. A Sponsoring Agency is selected on the basis of its acceptability to and effectiveness with the target group, and its stability within the community. The Sponsoring Agency is responsible for the administration of all components of the program—its assets, liabilities, policies and contracts.
3. A Local Advisory Committee of health professionals and community representatives is responsible for providing expert advice to the Sponsoring Agency on Program issues. A minimum of two meetings are held per year to review program progress, advise the sponsoring agency on program direction for the upcoming year, and to review issues and goals unique to the program.

It is essential that the local Advisory Committee be separate from the Sponsoring Agency Board of Directors. It is recommended that neither the Sponsoring Agency Director nor the coordinator serve as Chair of the Local Advisory Committee; the role of Health Unit/Department Representative to the Local Advisory Committee and Contract Manager be filled by different individuals.

4. The Contract Manager is responsible for negotiating and monitoring the contractual obligations of the Sponsoring Agency in accordance with standards and guidelines outlined in the Pregnancy Outreach Program Handbook. This includes monitoring the administrative, financial and service delivery aspects of the contract.
5. Health Unit/Department support and involvement is important to the success of the Program. It is critical that Pregnancy Outreach Program and Health Unit/Department services are complementary. The aim is to avoid duplication, competition and fragmentation of service, so as not to overwhelm and confuse the client.

## PROGRAM STAFF

1. The Coordinator shall be a Registered Nurse (RN) or a Registered Dietitian/Nutritionist (RDN)
  - reporting to the Sponsoring Agency Senior Administrator, the Coordinator has the overall responsibility for all facets of the Program operation
2. Outreach Workers are responsible for providing outreach services to clients
  - Outreach Workers are provided with the standard of training as outlined in the Pregnancy Outreach Program Handbook
3. A Resource RN or a RDN (complementing the discipline of the Coordinator) acts as a resource to the program and counsels clients as requested

Sponsoring Agency: \_\_\_\_\_ Date: \_\_\_\_\_

Agency Representative: \_\_\_\_\_

# **APPENDIX I**

## **GENERAL LIABILITY INSURANCE GOVERNMENT MASTER INSURANCE PLAN**

## THE MASTER INSURANCE PROGRAM Reduces the Cost of Risk in Contracts

When the Province contracts for services, contract administrators, seeking to minimize the risk to government, include an indemnity clause in their contracts. With this clause, government requires contractors to indemnify and hold the government harmless for any losses the contractors incur as a result of their own activities in carrying out the agreement. To ensure that contractors are able to fulfil this indemnity, the government requires them to provide evidence that they have adequate liability insurance.

Because of the cyclical nature of the commercial insurance market, contractors providing public services often find that comprehensive general liability insurance is very difficult to obtain, or when available, is costly. In 1988 Risk Management Branch (RMB) identified this problem in a study undertaken on behalf of the Deputy Ministers, Committee on Social Policy. To address it, we developed the Master Insurance Program (MIP). Under MIP, the service provider, while still required to indemnify the Province, can obtain comprehensive general liability insurance through the Government.

### Who Is Eligible

The Master Insurance Program is available only to those contractors providing services to the public on behalf of the Province, it is not available to those providing services to government. As a result, most service providers covered by MIP are contractors to the social program ministries such as Health, Social Services, Attorney General, Women's Equality and the Ministry of Skills, Training and Labour. All these ministries participate in MIP.

The coverage MIP provides covers a contractor ONLY while performing activities on behalf of the Province. Sometimes contractors (e.g. hospitals) are not eligible for MIP coverage because the activities they perform under their government contract are only a fraction of their total operation. Since they must have liability insurance to cover the remainder of their activities, which are ineligible for MIP, it is not practical or necessary for them to obtain MIP coverage. In other cases, the service provider may be part of a national or international body, such as the Red Cross, which provides its own liability insurance.

MIP coverage is broad. In addition to the usual exposures insured under a comprehensive general liability (CGL) policy, the program provides directors and officers liability coverage and counsellors' malpractice coverage, neither of which are normally included on a CGL policy in the commercial insurance market. The limit of insurance provided under the MIP program is \$2 million. If service providers feel that this limit is not adequate, they can purchase excess coverage from the commercial market, usually at a reasonable cost.

### Cost Savings

While MIP coverage is provided to the service providers at no cost to them, it does not cost the government any more money either. In fact, the program has saved the Province a great deal of money over the years it has been in operation. Prior to the inception of the program, service providers passed the cost of their liability insurance on to the Province in their fees. These costs ranged from \$500 to \$5,000 per year depending on the size of the contract. There are now in excess of 9,000 contracts covered by MIP. Even using the lowest premium of \$500, the potential cost to government for insurance equivalent to MIP exceeds \$4.5 million. The cost of the program has been a fraction of that.

### Benefits of MIP

MIP has proven to be an excellent risk management tool for both service providers and government. It has ensured that:

- Both parties to a contract have reduced their cost of risk by lowering total insurance.
- Service providers have a more comprehensive coverage package than those available in the commercial insurance market.
- Both parties are secure in the knowledge that adequate coverage is in place.

This Information was taken from: "*At Risk: A Publication of the Risk Management Branch*" Volume 5, Issue 4, March 1995.

# **APPENDIX J**

## **SAMPLE PROGRAM MONITORING REPORT**

**PREGNANCY OUTREACH PROGRAM  
PROGRAM MONITORING REPORT  
(Sample)**

Site Name \_\_\_\_\_

Please answer the following questions either with a "yes" or "no" or with the appropriate information for the current fiscal year.

		YES	NO
<b>A. Client Eligibility</b>			
1.	<i>Individual Prenatal Risk Identification</i> , including the <i>T-ACE Questionnaire</i> and <i>A Guide for Using Individual Prenatal Risk Identification</i> are used to establish client eligibility?	_____	_____
2.	The Program Coordinator reviews all client assessments?	_____	_____
3.	Priority is given to clients at less than 28 weeks gestation?	_____	_____
	- How many clients did the program accept who were past 28 weeks gestation?	_____	_____
4.	What percentage of client assessments are completed within 14 days of receipt of referral?	_____	_____
<b>B. Client Service</b>			
1.	Drop-Ins		
	a. Are offered at least every two weeks?	_____	_____
	b. Include a healthy snack/meal?	_____	_____
2.	At least five individual counselling sessions are offered per client?	_____	_____
3.	Vitamin/Mineral supplements are supplied to clients with a low income?	_____	_____
4.	Food supplements which provide a daily minimum of 3 servings from the Milk and Milk Products Group and 3 servings from the Fruit/Vegetable Group are supplied to clients with a low income?	_____	_____
<b>C. Program Staff</b>			
1.	The Program Coordinator is a Registered Nurse (R.N.) or a Registered Dietitian/Nutritionist (R.D.N.)?	_____	_____
	- how many hours per week does she normally work?	_____	_____

2. Outreach Workers

a. Are responsible for providing outreach service to clients? \_\_\_\_\_

b. Have been provided with the standard of training as outlined in the Pregnancy Outreach Program Handbook? \_\_\_\_\_

- how many Outreach Workers are employed with the program and how many hours per week do they each work? \_\_\_\_\_

3. A Resource R.N. or R.D.N. (complementing the discipline of the Coordinator) is available to act as a resource to the program and counsel clients as requested? \_\_\_\_\_

- how many hours/week does he/she work for the program? \_\_\_\_\_

4. Volunteers assist in non-counselling functions? \_\_\_\_\_

**D. Program Statistics**

1. Total number of women referred to the program whose due date fell within the current fiscal year (April 1 - March 31)? \_\_\_\_\_

2. Total number of women enrolled in the program whose due date fell within the current fiscal year (April 1 - March 31)? \_\_\_\_\_

3. Number of pregnant women who were referred but were not enrolled in the program? \_\_\_\_\_

- reasons why they were not accepted:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. If the program maintains a waitlist, how many women are currently on it? \_\_\_\_\_

5. Does the program submit annual client data to the Ministry of Health? \_\_\_\_\_

**E. Local Advisory Committee**

1. Meets at least twice a year? \_\_\_\_\_
2. Is there representation from:
  - Health Unit/Department? \_\_\_\_\_
  - Alcohol and Drug Program? \_\_\_\_\_
  - Aboriginal Agency and/or Ethnic organization? \_\_\_\_\_
  - GP or Obstetrician? \_\_\_\_\_
  - Social Services? \_\_\_\_\_
  - Former client/client advocate? \_\_\_\_\_
3. Attach minutes of Advisory Committee meetings

**PLEASE ATTACH YOUR COMMENTS ON ANY QUESTIONS ANSWERED "NO".**

# **APPENDIX K**

## **CRIMINAL RECORD CHECKS**

## The Criminal Records Review Act

The Criminal Records Review Act (CRRRA) is designed to help prevent physical and sexual abuse of children (under 19 years of age) by requiring criminal record checks of individuals working with children directly, or having, or potentially having, unsupervised access to children in the ordinary course of employment, or in the practice of an occupation. This act applies to all POP workers.

Successful applicants for designated positions will be required to complete and sign the Authorization for Criminal Record Check form. If the applicant does not sign the Criminal Record Authorization form they cannot be hired for a position working with children. A copy of the Authorization form will be sent to the Criminal Records Review agency at Security Programs Division, Ministry of Attorney General for a check against provincial Corrections data and processing by the RCMP through the Canadian Police Information Centre. Where there is no match the agency will advise the employer. Where there is a match the agency will ask the individual to provide fingerprints to their local police for verification by the RCMP in Ottawa. Again, if there is no match the agency will advise the employer. However, if there is a match the agency will forward the information to an independent Adjudicator who informs all parties of the determination of risk. An individual has the right to appeal the Adjudicator's decision through the appeal process established in the Act, and must provide notification of intent to appeal within 14 days of receipt of the decision.

Adapted from: *Criminal Records Review Act. Implementation Guide.* Security Program Division. Ministry of Attorney General. 1995

# **APPENDIX L**

## **STORAGE AND DISPOSAL OF CLIENT RECORDS**

## Client Records

Safe guarding of client records is the responsibility of the Sponsoring Agency, and records should be maintained according to Agency policies and following the Code of Practice for Ensuring the Confidentiality and Security of Health Records in B.C.

In 1995 the following was adopted by the Ministry of Health:

### **A Code of Practice for Ensuring the Confidentiality and Security of Health Records in British Columbia**

Every individual who creates, handles, or destroys a health care record shall protect the privacy of the individual.

The principal of every health care agency shall:

- Establish management practices, including written policies and procedures, to safeguard the collection, dissemination, storage and disposal of health care records;
- Make available the written policies to the public on request;
- Ensure that health records are protected by security safeguards against:
  - Loss
  - Access, use, modification, disclosure and
  - Misuse;
- Be responsible for ensuring all staff are trained to implement the agency's health record policies and procedures.

Any contract between the Ministry of Health or a health care agency and a provider, service provider, firm or another public body for services involving a health care record, shall include a storage and disposal clause within the contract that requires secure storage and disposal to protect the privacy of the individual to whom the health care record relates

Adapted from: *Review of the Storage and Disposal of Health Care Records in British Columbia B.C.* B.C. Ministry of Health and Ministry Responsible for Seniors. 1995. (available from Office of the Provincial Health Officer 2nd Floor, 1810 Blanshard St. Victoria, B.C. V8V 1X4 phone: (250) 952-0876 fax: (250) 952-0877)

# **APPENDIX M**

## **SAMPLE CHART AUDIT**

## CHART AUDIT QUESTIONS

Client records provide a tool that identifies what has been done with a client, how effective it has been, and what should be done in the future. To increase the possibility of success, this record must be client-oriented ... reflecting what the client feels, what the client is willing to do, etc.

The following identifies the sort of items that were looked for when a member of the Provincial Pregnancy Outreach Program Advisory Committee completed a chart audit during a site visit, but could also be used as a self-audit:

### Forms:

- Is there a record for each client?
- What type of forms are used (borrowed from another program, developed on-site, etc.)?
- Has the Coordinator charted on the initial assessment of the client?  
Has the Coordinator made any subsequent insertions?
- Has the Outreach Worker noted her contacts with the client?
- Has the identified risk factor(s) been dealt with (i.e. if nutritional risk, is there a nutritional assessment and charting by the nutritionist; if the risk is alcohol related, is there a referral to Alcohol and Drug Programs and were there any noted results)?
- If vitamin supplements are given, is there a consent from the family physician?
- If information regarding the client was shared with another agency, is there signed permission from the client?
- Was the client referred to any agency upon discharge from the program?

### Filing System:

- Are there files?
- Are the files kept in a locked cabinet?
- Is the locked cabinet used only for Pregnancy Outreach Program files?  
Who has access to this cabinet?

Are all files in the file cabinet (or are some in a brief case, some at home, etc.)?

# **APPENDIX N**

## **SAMPLE JOB DESCRIPTIONS AND ROLE OF VOLUNTEERS**

## SAMPLE JOB DESCRIPTION

### COORDINATOR, PREGNANCY OUTREACH PROGRAM

The Pregnancy Outreach Program Coordinator will be responsible for ensuring that the program operates in a successful manner, that program objectives are achieved and that there is adherence to the accepted standards of service. The Coordinator will be responsible for supervising all staff and volunteers. The Coordinator will assist in financial planning, budget development and fund raising. The Coordinator is responsible for reviewing all client initial assessments and charts and consulting with clients as needed.

#### Major Areas of Responsibility

##### 1. Supervisory

- a) Responsible for ensuring that the program operates in a successful manner, reflective of the clients' needs and adhering to the accepted standards of service.
- b) Responsible for ensuring that all support staff, resource personnel, and volunteers provide clients with the accepted standard of service.
- c) Responsible for all services, programs, special functions, related to and delivered under the program.
- d) Responsible for the training and evaluation of all program support staff, resource personnel, and volunteers, as related to job duties.
- e) Assists in hiring of program staff and recruiting of volunteers.
- f) Responsible for internal evaluation of service.

##### 2. Financial

In consultation with the Sponsoring Agency's Financial Manager and Senior Administrator:

- a) Responsible for authorization of accounts payable within the program.
- b) Responsible for monitoring the program budget and establishing future budgets.
- c) Responsible for inventory control within the program.
- d) Assists with fund raising and grants as related to program.
- e) Advises Financial Manager and Senior Administrator of budget needs and adjustments.

##### 3. Operational

- a) Responsible for intake assessment including application and use of Prenatal Risk Identification Tool and T-ACE questionnaire.
- b) Coordinates counselling by program staff, assisting as necessary with clients.

- c) Responsible for marketing of the program, networking, community contact, media relations.
- d) Coordinates meetings relevant to the day-to-day operations, including Local Advisory Committee meetings.
- e) Oversees weekly drop-in programs.
- f) Reviews all charting, is responsible for completing quality assurance audit of charts.
- g) Responsible for all correspondence.
- h) Responsible for organizing case conferencing with appropriate professionals.
- i) Communicates with Contract Manager as required.
- j) Attends Sponsoring Agency staff meetings and participates in activities as appropriate.
- k) Prepares the annual program Status Report and any other reports as necessary.

#### 4. Advisory

- a) Attends Local Advisory Committee meetings and Sponsoring Agency meetings on request.
- b) Attends Pregnancy Outreach Program teleconferences/meetings.
- c) Communicates with other health agencies, especially the Health Unit/Department, regarding general or specific health issues in the community as required.

#### Supervisor

Sponsoring Agency Senior Administrator

#### Qualifications

The incumbent will be a recognized health professional (RN or RDN). The incumbent will have a background in community health service and previous administrative experience.

## SAMPLE JOB DESCRIPTION

### OUTREACH WORKER, PREGNANCY OUTREACH PROGRAM

The Pregnancy Outreach Program Outreach Worker will provide individual counselling and support to high-risk pregnant women who are clients of the program throughout their pregnancy in order to help them have the healthiest pregnancy possible. The Outreach Worker will consult with the Coordinator regarding all clients. The Outreach Worker will assist in drop-ins, and assist the Coordinator with administrative duties as required.

#### Major Areas of Responsibility

##### 1. Supervisory

- a) In the absence of, or at the direction of the Coordinator, may supervise activities of volunteers.

##### 2. Financial

- a) Assists the Coordinator with budgeting and financial planning within the program, as requested.
- b) Assists the Coordinator with inventory control within the program.

##### 3. Operational

- a) Meets with clients throughout their pregnancies.
- b) Charts any contacts with the client, and keeps information in the client files up-to-date.
- c) Provides the client with up-to-date prenatal information which will assist them during their pregnancy.
- d) Acts as an advocate for the client and as a liaison between the client and any other services which may assist the client.
- e) Provides the client with program food supplements and vitamin/mineral supplements as required and following the policy of the Program.
- f) Meets with the Program Coordinator on a regular basis to review all client files.

- g) Will bring any problems or questions regarding clients to the Coordinator's attention.
- h) Will assist in planning, preparing and supervising the drop-ins.

4. **Advisory**

- a) Attends Local Advisory Committee meetings as requested.
- b) Submits reports to the Coordinator as required.
- c) Assists the Coordinator with reports and evaluations.

**Supervisor**

Pregnancy Outreach Program Coordinator

**Qualifications**

The incumbent will have life experiences that will assist in daily contact with clients (same cultural group, knowledge of language of group, member of client group).

The incumbent will have a positive personal health style.

The incumbent may have para-professional training in counselling.

The incumbent should have literacy skills appropriate to the needs of the program.

## **DESCRIPTION OF RESOURCE NURSE OR RESOURCE NUTRITIONIST ROLE**

Both the Resource Nurse and the Resource Nutritionist are required to complete the following tasks and by doing so each provides specialty skills based on his/her professional background. The aim is to complement the knowledge and expertise of the Pregnancy Outreach Program Coordinator who is either a nutritionist or a nurse.

The tasks of the Resource Nurse and Nutritionist include:

- a) Reviews charts as requested by the Coordinator.
- b) Consults with program staff regarding any clients identified with either a nursing or nutrition risk factor and provide direct client counselling as requested.
- c) Provides staff training, as required.
- d) Acts as a resource to the program staff on all issues pertaining to their area of expertise, providing up-to-date information on issues and counselling strategies.
- e) Attends drop-ins as requested as a resource person or guest speaker.
- f) Acts as a liaison for the program with other community services/agencies.
- g) Assists in marketing the program as appropriate.

## DESCRIPTION OF THE ROLE OF VOLUNTEERS

Volunteers are an integral part of the Pregnancy Outreach Program.

Potential duties may include:

- Caring for children while mothers are in counselling sessions;
- Transporting clients to the program site;
- Preparing meals and snacks;
- Collecting, sorting, and storing maternity and infant clothing for distribution;
- Hosting social programming;
- Attending to reception duties at drop-ins;
- Providing translating services;
- Teaching basic shopping skills;
- Demonstrating cooking techniques and methods;
- Providing clean-up services on activity days.

Volunteers have the right to:

- Receive appropriate orientation and training;
- Be given jobs which are worthwhile and challenging;
- Receive direction and support from supervisors;
- Be treated as non-paid staff members;
- Be informed of the program's ongoing issues and events;
- Receive appropriate recognition on a regular basis;
- Experience jobs which promote learning and growth;
- Be trusted with necessary confidential information;
- Be reimbursed for expenses incurred on behalf of the program.

# **APPENDIX O**

## **CHECKLIST FOR POP STAFF ORIENTATION**

## CHECKLIST FOR POP STAFF ORIENTATION

Employee Name \_\_\_\_\_

Start Date of Employment \_\_\_\_\_ Date Orientation Completed \_\_\_\_\_

Orientation to Program	Date Completed
Introduction to Agency Staff (roles and responsibilities)	
Introduction to POP Staff	
Job Description	
Hours/Days of Work	
Probation Period/Performance Appraisals	
Time Sheets	
Mileage/Vehicle Insurance	
Payroll System	
Keys	
Office Supplies	
Telephone	
Photocopier	
Filing System	
Fax	
First Aid	
Emergency Procedures	
Orientation to Pregnancy Outreach Program	Date Completed
POP Handbook	
Qualitative and Quantitative Reports	
Nutrition Section, Ministry of Health	
Role of the Pregnancy Outreach Program Coordinator	
Role of Outreach Workers	
Role of Complementary Professional	
Role of Advisory Committee	





# **APPENDIX P**

## **SAMPLE CONSENT FORM**

**SAMPLE CONSENT FORM**

**RELEASE OF INFORMATION FROM THE  
PREGNANCY OUTREACH PROGRAM**

I, \_\_\_\_\_ hereby give my permission to the  
Pregnancy Outreach Program to contact the following agencies for the purpose  
of sharing information regarding the service being provided to me through the  
Pregnancy Outreach Program.

- \_\_\_\_\_ Doctor
- \_\_\_\_\_ Ministry of Social Services
- \_\_\_\_\_ Health Unit
- \_\_\_\_\_ Alcohol and Drug Program
- \_\_\_\_\_ School Counsellor
- \_\_\_\_\_ Hospital
- \_\_\_\_\_ Mental Health
- \_\_\_\_\_ Other (please specify) \_\_\_\_\_
- \_\_\_\_\_ Other (please specify) \_\_\_\_\_

I understand that I can cancel this permission in writing at any time.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

# APPENDIX Q

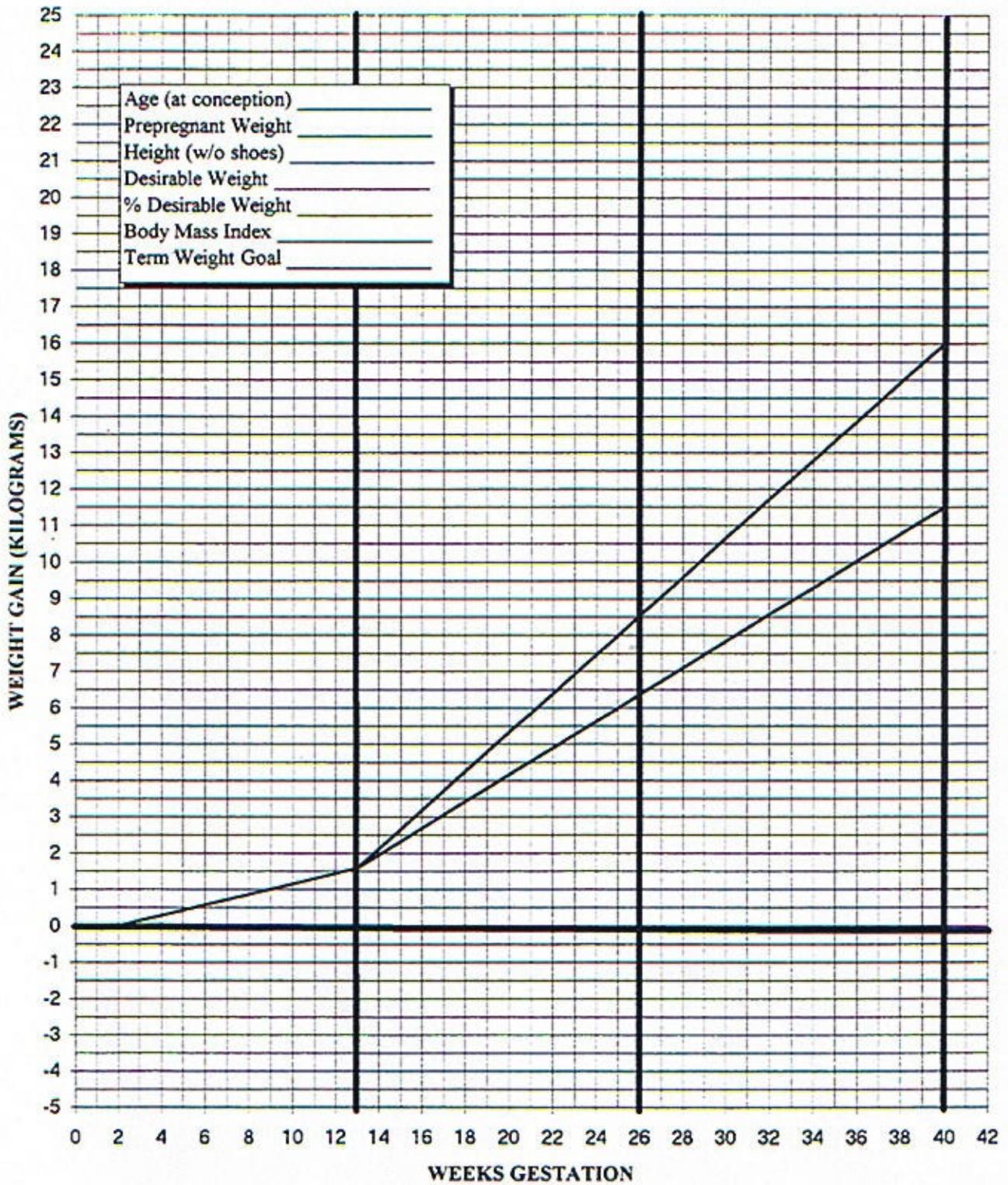
## SAMPLE 24 HOUR FOOD RECALL



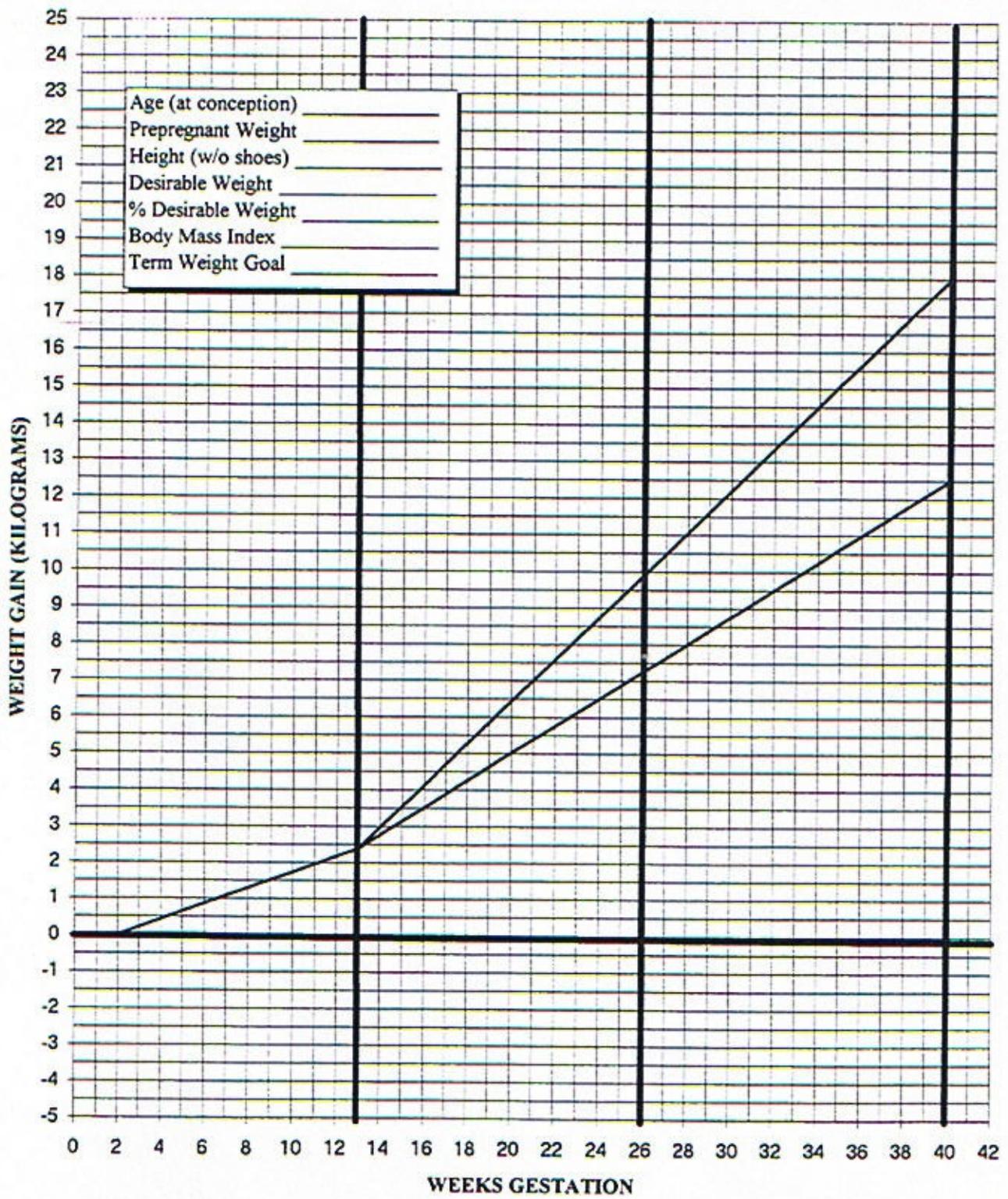
# APPENDIX R

## SAMPLE WEIGHT GAIN GRAPHS

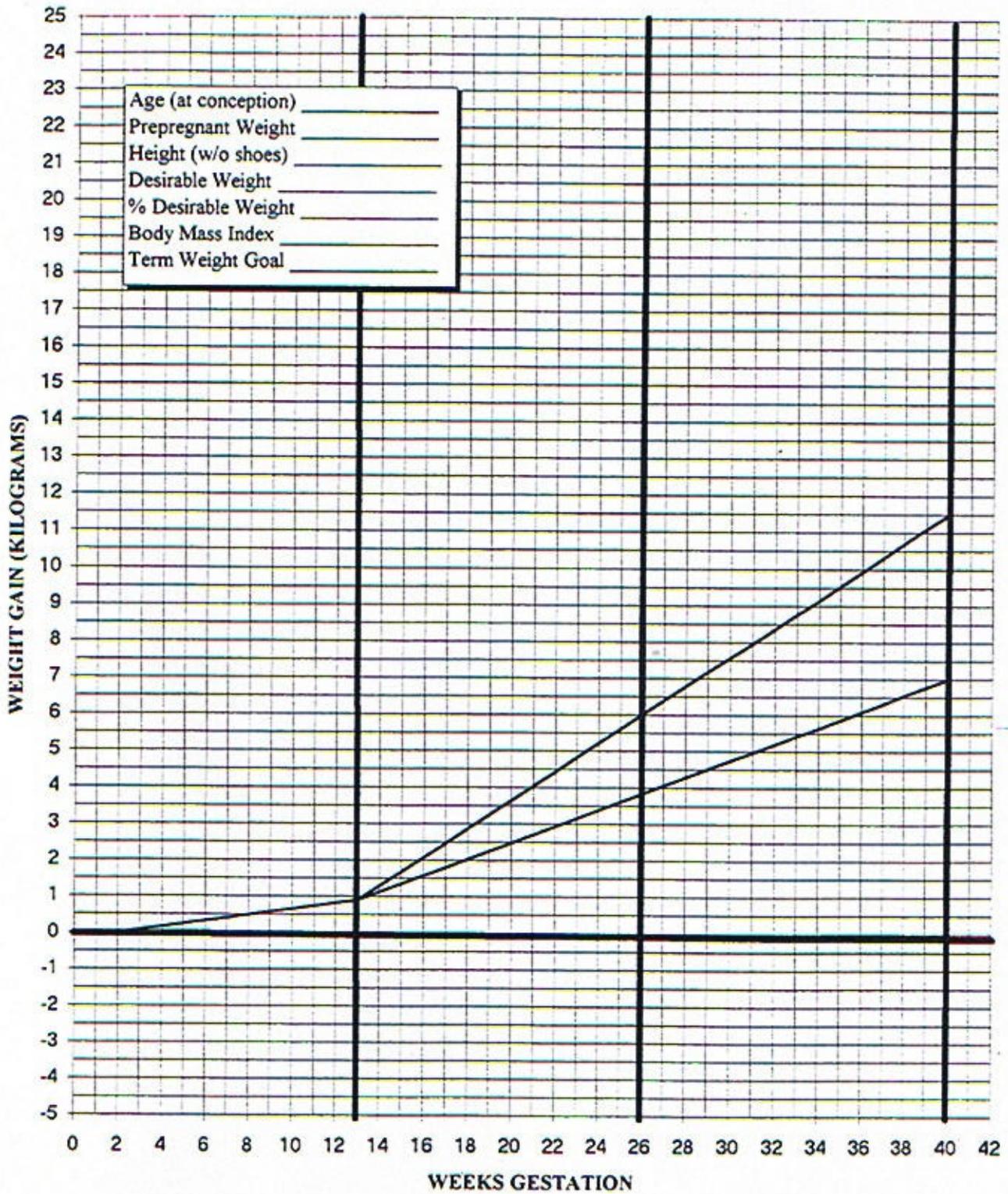
### Prenatal Weight Gain Grid for Normal Weight Women



### Prenatal Weight Gain Grid for Underweight Women



### Prenatal Weight Gain Grid for Overweight Women



# **APPENDIX S**

## **EFFECTS OF ALCOHOL AND OTHER DRUGS ON MOTHER AND NEWBORN**

## EFFECTS OF ALCOHOL AND OTHER DRUGS ON MOTHERS AND NEWBORNS

When a woman is pregnant and uses drugs, the drugs pass to the fetus through the placenta. When breast-feeding, the drugs are fed to the baby through the breast milk. It is best to stop all alcohol and other drug use in the period before becoming pregnant, during pregnancy & while breast-feeding.

DRUG	EFFECT ON MOTHER DURING PREGNANCY	EFFECT ON FETUS	EFFECT ON BREASTFEEDING
Alcohol	May be damaging to all parts of body. Risk of miscarriage, stillbirth and premature delivery.	Risk of baby born with Fetal Alcohol Syndrome (FAS) or other alcohol-related birth defects (ARBD). These may involve growth deficiencies, brain injury, facial anomalies, skeletal abnormalities, heart defects, vision and hearing problems and many other problems. There is a great deal of variability related to the timing of the alcohol use, the amount of alcohol used, use of more than one substance that can cause birth defects, and many other factors. The impact of FAS and other ARBDs are long term.	Less breast milk produced. Alters the taste of milk. Baby can be irritable and drowsy. Alcohol passes into baby's body and developing brain affecting growth and development.
Tobacco	Risk of miscarriage or premature delivery and bleeding.	Risk of low birth weight. Risk of early death for premature newborns or SIDS. Possible risk of later attention deficit and developmental delays.	Less milk is produced, so breast-feeding may be difficult.
Marijuana	May affect memory and concentration, and result in respiratory problems.	Risk of baby born small-for-date. Marijuana is often used with other drugs, such as alcohol and tobacco, so baby gets combined effects of drugs. Possible risk of later attention deficit and developmental delays.	Drug is passed to breast milk. Less milk is produced so breast-feeding may be difficult.
Cocaine and Crack	Risk of miscarriage or premature birth. May cause weight loss, damage to heart and risk of strokes. Risk of HIV/AIDS with needle use.	Risk of baby born small-for-date. Kidney, urinary system and limbs may be malformed. Risk of stroke. Risk of neonatal abstinence syndrome (NAS)*. Possible later learning problems.	Baby shows signs of use, e.g. irritability, wakefulness, raised blood pressure. Failure to thrive.
Opiates: (e.g. Heroin, Methadone)	Risk of miscarriage and stillbirth. Risk of complications during pregnancy and childbirth. Risk of medical problems such as anemia, cardiac disease, diabetes, pneumonia and hepatitis. Risk of HIV/AIDS with needle use.	Risk of baby born small-for-date. Risk of infections. Risk of neonatal abstinence syndrome (NAS). Risk of SIDS. Possible later learning difficulties.	Baby may be drowsy. Failure to thrive. Breast feeding not advised.
Solvents	May be damaging to all parts of the body. Causes disorientation and agitation. May cause severe breathing problems. Risk of miscarriage or premature birth.	Risk of low birth weight. Risk of physical deformities. Possible later learning difficulties. More research is needed to understand impact of solvents in isolation from use of other drugs. Some researchers have described "fetal solvent syndrome" with features similar to FAS.	More research is needed. Will pass into breast milk.

\* NAS describes the presence of short-term withdrawal symptoms in infants exposed to drugs in utero. Some of the symptoms include wakefulness, irritability, diarrhea, vomiting, respiratory distress and lack of sucking.