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ABSTRACT

Although support for parents has been common in Dutch policy and practice since the early 1990s, recent efforts are focusing on improving the match between supply and demand, improving coherence, and making it easier to identify and to access relevant support agencies; efforts are also focusing on prevention. This article examines how the Netherlands provides community based parental support. The article defines parenting support, considers the need of Dutch parents for such support, and describes related national policy, services, facilities, programs, and projects. The article focuses on the Mothers Inform Mothers program, a community-based, early childhood care and development support program targeted at high-risk groups, and describes the program's goals and methods, its stakeholders and participants, its evaluation and research activities, and its strengths and weaknesses. The article concludes by noting that programs such as Mothers Inform Mothers empower parents in such a way that they are not only active with their own children, but also initiate activities to change the physical environments in which they live. (Contains 21 references.) (KB)

CROSSING THE BORDER BETWEEN INDIVIDUAL AND COMMUNITY - COMMUNITY BASED PARENTAL SUPPORT IN THE NETHERLANDS

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Introduction

'An accessible and coherent supply of parenting support, which will be recognizable to parents, fits their demands and enhances their own capacities'. This is how the national government phrased the objectives of its policy in the 1993 document Supporting parents. Parenting support has been a common concept in Dutch policy and practice since the early nineties (NIZW International Centre, 1999). From the start many institutions have been involved in offering elements and parts of parenting support. This has not made it easier for parents who have questions on how to raise their children to find the way to the right expert. Therefore, parenting support in the Netherlands is now aimed at improving the match between supply and demand, improving coherence, and making it easier to identify and to access relevant support agencies. Additional aspects are strengthening social support structures around families (social networks) and widening the offer to parents with children in an older age group. The discussion in the Netherlands is focused primarily on the preventive effect of parenting support. Like Hoghughi (1998) explained for the United Kingdom it is thought that a timely and adequate offer of assistance and support can prevent at a later stage problems like educational disadvantages, psychosocial problems, juvenile delinquency and social exclusion.

In this article I am looking at the Dutch way to cross the border between individuals and their community by parenting support services and programmes based on a national parenting support policy. Having described the situation of upbringing of children in the Netherlands, we define the concept of parenting support. .Being parents primarily responsible for parenting we look at their need for support. Then we describe the national policy, the services, facilities,programmes and projects. Especially we have a look at one o fthese programmes called ' Mothers Inform Mothers', a Dutch community-based early-childhood care and development support programme which is targetted at high-risk groups. After describing the goals and methods of this programme, the stakeholders and participants, we have a look at the theoretical basis, the evaluation and the current research activities. The concluding remarks are on the strengths and weaknesses of MIM

Upbringing children and young people

In 1998, there were 3,8 million people between 0 and 19 in the Netherlands, while the total population consisted of 15.6 million people. Young people (0-19-year-olds) made up 24.3% of the population. The absolute number of young people is expected to rise slightly until 2005. However, influenced by the increasingly 'greying' population, the relative number of youngsters in the total population will continue to decrease.

The age distribution of 0-19-year-olds is as follows:

Age group	Boys	Girls	Total
0-4	473,400	473,400	969,400
5-9	504,300	481,800	986,100
10-14	474,000	453,400	927,300
15-19	473,200	449,200	922,400

Inhabitants of foreign descent from Morocco, Turkey, Surinam and the Netherlands Antilles nowadays play an important role in the composition of the population. The Dutch government has developed a special policy for migrant Dutch people, which pays attention to young people of ethnic minorities as well. Ethnic minorities in the Netherlands tend to have a younger population than the native Dutch: 38.5% is under 25. In future, this percentage will rise due to the higher birth rate in ethnic minority families and immigration because of family reunion.
The majority of children are raised within a family with two carers and more than one child. The average age at which first-time mothers gave birth is 29. This age is likely to increase in the years to come. Approximately one-third of marriages ends in divorce. At the moment, approximately 9% of children under 18 live in a single-parent family and about 110,000 children live in stepfamilies. Although a divorce negatively affects a child's well-being and school performance, the effects are minimal. Children that grow up in families where parents fight a lot, more often have behavioural problems. 16% of the pupils in secondary education do not like to be home. About 625,000 children and young people (0-18) grow up in a poor household. Poverty negatively influences certain aspects of children's lives: young people from poor households generally have a lower level of education and participate less in cultural activities. Finally the number of reports on child abuse and neglect is rising considerably. In 1990, 8,223 cases were reported, while in 1995 this had increased to 14,175. The true extent of the problem is estimated at 50,000 cases per year.

In the Netherlands a child's upbringing is primarily a responsibility of the parents. The Civil Code states that parents should care for, bring up and provide for their under-age children. The government has a conditional, supporting, protecting and sanctioning role. The Netherlands has no specific family policy, although there is ongoing lively public debate on the subject. A variety of regulations influences the family situation: child benefit, pregnancy and maternity leave, and child day care. One of the important services that can support parents in the upbringing of their children is the child health centre, a consultation centre for parent-and-child care. These centres are visited by 95% of the 0-1-year-olds and their parents, and 85% of the 1-4-year-olds and their parents to check on development and health. The centres also play a role in the early detection of developmental disorders.
The processes of immigration, emancipation, mutual equality and secularization and the increase in labour market participation by women have resulted in a wide variety of lifestyles. Marriage has become a less obvious form of living together. Unmarried cohabitation has grown to be accepted as customary. Having children outside marriage has become acceptable, although the arrival of a baby leads to a decision to marry after all. This pluriformity in lifestyles also caused a divergence in views on upbringing. However, the ideal of child-oriented parenthood is widely accepted. Children are no longer raised and cared for exclusively within the family. Childminders, nannies, home helpers, playgroup workers, day care workers and schoolteachers play an important role. They do not focus solely on the children, but try to involve parents, family members and residents in the community in its activities as well. In general, the changes in the upbringing of children go hand in hand with a liberalization of views and opinions. This has created more space for youth and caused the authoritarian view to lose ground. Nowadays, the term 'negotiating family' is used. Parents and children together decide on the choice of school, for example. Nearly all children are 'wanted' by their parents. Parents want what is best for their children and they want their actions in upbringing to be well considered and responsible. Against this background, they are open to suggestions and advice.

What is parenting support?
Parenting support is aimed at supporting the process of upbringing. It concerns improving the upbringing situation of children, in which parents and carers are the focal points. In brief: parenting support is meant to help parents in parenting. Usually the following activities are included in parenting support:

- to provide information on development and upbringing;
- to give pedagogical advice and initial pedagogical assistance;
- to detect developmental problems at an early stage and refer parents;
- to organize self-help and social support around children and parenting.

The promotion of child development focuses on the development of children in less favourable circumstances. This can include potential or existing lags in the development of children. Promotion of child development is used to prevent, to reduce or to remove these disadvantages. Disadvantages can be caused by social factors, socio-cultural factors, and factors in the family or in the child itself, for instance congenital defects or disabilities. Attempts are made to reduce the negative effects as much as possible through specific programmes. Socio-cultural programmes play a role when there is insufficient interaction between home and school environments. The result is that children start primary education with a disadvantage. In addition, their chances of success in school are considerably smaller and the gap between success and failure only widens. Child development promotion programmes are used to prevent or reduce the school disadvantages.
The functions of child development promotion are:
- general stimulation of the development of all young persons;
- direct stimulation of specific areas of development;
- reduction of disadvantage;
- stimulation of a smooth transition between home and school environments.

Parents and children particularly get into trouble when there are problems at different levels. Those problems cannot always be solved within the family; sometimes parents are unable to influence them. Consequently, children grow up in less favourable circumstances, which can cause developmental disadvantages or risks.
Parenting support and child development promotion not only focus on parenting competence and parents' attitudes, but also pay attention to the social support of families and their relationships with their environment (Mental Health Europe, 1999). The following dimensions are distinguished:
- parenting support: supporting the process of upbringing;
- child development support: supporting the developmental process of children and young people;
- influencing environmental factors: interventions in the social and pedagogical circumstances in the direct environment of parents and children;
- family support: ease of burdens and increase of strength in all fields of family action.

The professional field of social work and care is not always the most adequate system to anticipate problems. Very often parents are in need of information, recognition, emotional support or a listening ear. It is recognized that informal ways of support can be extremely successful. This has become clear from the results of several programmes in which volunteers and paraprofessionals play a part: programmes such as *Motivating Home Visits*, *Buddies Projects*, *Mothers Inform Mothers* and *Home Start*. The support is given by volunteers, who are mostly from the same target group or culture, and who are familiar with the cultural differences. This makes it much easier to gain entrance to the family and to give effective support (Penninx and Prinsen, 2000; Mental Health Europe, 1999).

Need for parenting support
A study of Dutch families in 1996 showed that a large majority of parents encounters no obstacles with the upbringing of their children. A minority has serious difficulties: an estimated 10 to 15% of the children has or causes problems (Rispens, Hermanns and Meeus, 1996). Despite the fact that the majority of parents have few problems, many do have questions regarding upbringing.

The way earlier generations were raised no longer suits contemporary demands. Authority is no longer accepted and the introduction of the negotiating family has reduced the opportunity to state clear limits. In addition, the risks of growing up have increased: There is a decrease in suitable living and playing space, an increase in violence in the immediate surroundings of children, and some children are exposed to emotional, physical, mental and pedagogical dangers that threaten their development.
70% of the parents indicate that they occasionally are in need of support in parenting. They often find this support in their immediate surroundings, from parents or relatives, neighbours, friends and other informal contacts. Sometimes, this is insufficient and parents start looking elsewhere for expert advice and support. Research shows that parents are not always able to find a satisfactory answer to their questions. Especially parents of Turkish and Moroccan origin are often dissatisfied with the support they receive from Dutch services (Leseman and Fahrenfort, 1998).
For parents of children between the ages of 0 and 12, the need for parenting support is focused primarily on difficult behaviour, contacts with other children, development of language and thought, bringing up children in two cultures, preparation for school, housing and environment, and family problems. With older children, most questions concentrate on leisure time activities, relationships with peers, alcohol and drug use, and rules and limits. In recent years, parenting support has mainly concentrated on parents of children aged 0 to 6 years old. Next to parenting support centres, toy libraries, educational play centres and children's centres, an important role is played by programmes that aim to prepare pre-school children and children just starting school for their participation in education. There is an increasing need for parenting support for parents with children in the ages of 6 to 12 and 12 to 18 years old.

National policy
The concept of parenting support was introduced in the Netherlands in the early nineties. Increasingly, people realized that the problems of and with young people at a later age could be traced back to their early childhood and early development. Also, the importance of prevention was emphasized, both to prevent damage to children and young people and to prevent the use of much more expensive forms of support and care at a later stage.

A large number of policies - ranging from health care and income policies to education, labour market, sports and justice policies - have an indirect impact on the life of children and young people. An example of this is town and country planning, where the traffic flow and the safety of and opportunities for playing can be in conflict in a neighbourhood lay out. Other policy decisions are aimed directly at children and young people. Several ministries develop policies that relate to parenting support like the Ministry of Health, Welfare and Sport, the Ministry of Education, Culture and Sciences, the Ministry of Justice, and the Ministry of the Interior.
From 1996 onwards, much attention has been paid to early intervention for the prevention of criminal behaviour. Factors in early childhood play an important role in delinquent conduct at a later age. These can be factors related to the individual (e.g. a low IQ, impulsive behaviour, hyperactivity, stimulus level), to the family (e.g. the relationships with and between parents, parental guidance, abuse and neglect), or to the social environment (e.g. low socio-economic status of the family, unemployment, living in a disadvantaged area, depending on social benefits). The threat of criminal behaviour should be prevented in three ways: a broad and coherent approach of problems, a targeted offer of assistance to families in trouble, and a less permissive offer of assistance to families where there are threats of child abuse or where children have behavioural disorders. In addition, the parenting skills of parents need to be developed or improved.
In 1998, the ministries of Health, Welfare and Sport, Justice, and Education, Culture and Sciences presented a joint policy document called *Towards a solid basis*, in which they stated their preference for a coherent community-directed approach to support disadvantaged families with

children under 18. The Ministry of the Interior followed suit with its integration policy for minorities and its urban policy.
The neighbourhood is regaining priority as a social framework. More and more often, community development projects and experiments are used as instruments for preventing or combating social disadvantages and for promoting the empowerment of individuals. Parents and children are an important target group. The neighbourhood can be an important starting point for a more coherent and comprehensive supply of basic care provisions. In parenting support projects there is a prevalence of neighbourhood-oriented approaches, where use is made of methods and programmes like *Caring Communities,* a programme concerning community building and community development, and *Communities that Care* that is focused on the prevention of youth delinquency.

Parenting support is given primarily by agencies in the realm of local youth policy. In principle, all the services targeted at youth and their parents can support the parenting process. Parenting support activities can be found in the municipal health process, in local compensatory policies in the field of education, in child welfare policies including child day care, in sports policies and in the municipal safety policies.
Municipalities are responsible for a local and preventive youth policy. In addition, provincial authorities and national authorities have tasks in the field of parenting support. These are often integrated in broader services in the field of child- and youth care. At a provincial level, much work is being done to create a recognizable and unambiguous entry into the youth care system through the Child- and Youth Care Services ('Bureaus Jeugdzorg'). Each region has a central, independent and quality- proofed entrance into child- and youth care. The Child- and Youth Care Services are open 24 hours a day and provide the single gateway to other services in child and youth care. Their main activities are care and assistance to parents, children and young people. In addition, attention is paid to consultation and training for workers who are usually the first to encounter questions and problems. The national authorities are responsible for the quality of and the national policy framework for preventive and curative youth care.

Services, facilities and programmes
There is a wide range of services available to guide and support parents and their children in the development towards adulthood. Most of these are general and open to all, for example:
- youth health care
- child day care and playgroups
- schools
- toy libraries
- sports and leisure organizations
- (municipal) mental health services (4-18 years)
- social work
- public libraries
- community work
- services for adult education
- advice and reporting centres for child abuse and neglect
- information services like parent information centres and help lines for parents.

Most of these organizations offer various forms of parenting support. The youth health care services, for example, are in charge of consultation centres for parent-and-child care, which parents with young children visit for periodical checks on the health and development of their child. In addition they offer parenting support by means of home visits, courses for parents, coffee mornings, and walk-in surgery hours. The Netherlands Institute of Care and Welfare is actively involved in the development of new approaches, programmes and methodologies for parenting support.

Some of the successful and effective programmes on parenting support being used in the Netherlands are:

- *Child- and youth care community networks*: a regular meeting of professionals in a neighbourhood to discuss children at risk and the possible action to be taken, to identify problems at an early stage and to take preventive action.
- *Home-Start*: volunteers offer support, friendship and practical assistance to families with young children who are under pressure, to prevent more serious or long-lasting problems in a family.
- *Mothers Inform Mothers*: for a period of 18 months after the birth of their first child, mothers are visited at home once a month by an experienced mother from the same neighbourhood (see later).
- *STEP programmes*: a series of child development programmes to promote the development of children. *Opstapje* is a programme for children aged 2-4 that presents new games and reading materials and teaches mothers how to offer these to their children, at home and in playgroups; *Opstap* is a programme that informs and coaches parents, individually or in groups, on stimulating the development of their child (4-6) and on general questions in raising their child, to increase the educational opportunities of disadvantaged children; and finally, there is a reading project in which parents, especially parents from migrant backgrounds, learn to pay more attention to the reading and speech skills of their school-age children, with materials that match the school programmes. Teachers explain the methods to groups of parents at school.
- *Opvoeden: Zo!:* a parent training course aimed at increasing parenting theory and skills and at exchanging experiences between parents of children aged between 3 and 12. Groups of parents meet five or six times and are trained by health visitors, childcare workers and teachers. There is a special course for migrant parents. A follow-up course of three or four meetings focuses on children with troublesome behaviour. A similar training is being developed for parents of 12–18-year-olds.
- *Parenting Information Centres*: advice centres for parents and professionals, formed by cooperation of experts and institutes in the field.
- *Practical Pedagogical Home Help*: individual support in the home for parents with disabled children, directed at practical advice and information with regard to dealing with a disabled child.
- *Video Home Training*: individual support for parents of 0-18-year-olds, in which interactions between children and parents are videotaped and analyzed, followed by suggestions for improvement in the communication skills to avoid future long-term problems.
- *Families First*: a family in a crisis situation receives intensive assistance for a period of four weeks, by a family worker who spends an average of 15 hours per week with the family in their home. The assistance links with the needs of the family and attempts to keep the family together and to avoid outplacement of one or more children.

Problems and challenges

The offer of parenting support programmes is elaborate and varied, but not always easy to picture. A number of general services are not easily accessible, which hinders their use. Moreover, the offer of services is not always matched adequately to the questions that parents have. The referral of families who need more intensive support or care does not function optimally, due to a lack of matching services and to waiting lists. The major challenge now is to realize a coherent offer of parenting support. Parents and their children need to be able to find an answer to their questions close to home. They have to receive assistance that matches their needs, and be referred to more intensive services when they need it. This also necessitates a closer connection between the various financing structures.

Another problem is that the offer of services does not reach some target groups of parents and children. Some groups of Dutch and migrant parents do not make use of the existing services because of unawareness or inaccessibility of these services, or because a fitting service is not

available to them. Creating a more coherent offer at community or neighbourhood level will only be possible if it can be combined with a clear financial structure. Parenting support takes place within the framework of preventive local youth policy as well as within regional youth care. The municipalities are responsible for local youth policy, but they need a proper insight in needs and opportunities. Services in the field of child and youth care, child and youth protection and child- and youth health care all contribute to parenting support, but they are directed from different levels. This increases the challenge to develop a policy that is wholesome for children and families and also meets the demand for coherence and coordination

Mothers Inform Mothers: a Dutch community-based early-childhood care and development support programme

One of the parenting support programmes in the Netherlands is the *Mothers Inform Mothers* programme (MIM): a network of local, community-based early-childhood care and development support programmes. It is carried out in eleven towns (two large, six medium and three small) in deprived areas in the Netherlands by the preventive child health services of nursing agencies. The aim of child health care services for pre-school children can be described as 'the promotion and safeguarding of a healthy, physical, mental and social development of the population of pre-school children, starting from the parents' personal responsibility, by means of influencing the relevant health determinants, namely physical factors, health behaviour and relevant environmental factors, including the system of care itself". One objective that can be made operational is 'to promote at an individual and group level, the personal competence and the responsibility of parents with regard to their children, if necessary by advancing their understanding of the health condition and (potential) development of their child and by increasing their competence' and also stimulating health-promoting behaviour (De Winter et al, 1995). The *Mothers Inform Mothers* programme tries to implement this objective.

Developing a community based support programme

In the past decade a wide array of early-childhood development support programmes have been designed. They aim to empower adults in their role of parents and prevent injuries, child abuse and/or psychosocial problems in children caused by negative experiences in early childhood. The focus of these programmes is on supporting the family in its own home environment, and on trying to bring about a change in this environment. The philosophy underlying these programmes relates to the concepts of health promotion, social support, and empowerment. The programmes focus on parents with different needs. HIPPY and MIM are primary prevention programmes, whilst Home Start and video home training are examples of a secondary prevention programme. Families First is focused on early treatment and can be seen as a tertiary prevention programme. Other local services to support parents are provided by the local crèche, child day care centre, toy library, family resource centre, day-fostering agency and the experienced-mothers network.

The MIM programme is especially targetted to high-risk groups like the parents who do not have their children fully vaccinated or migrants. Mortality and morbidity figures for Turkish and Moroccan children are found to be higher than those of Asian or Dutch children. However, a few decades ago, researchers hoped that by finding risk factors they would be able to delineate 'high-risk' groups and consequently would be able to design programmes to improve the prognosis of these groups. This hope turned out to be futile. Further study brought up the conclusion that the effect of the risk factors is not determined by their specific content or severity, but mainly by their number and by the burden they cumulatively impose on the family. An accumulation of various risk problems is necessary to unsettle the process of child rearing. Some examples of these risks are maternal mental-health problems, a lack of spontaneously positive interaction in infancy, low occupational status of the head of the household, lack of family support, low levels of maternal

education, disadvantaged minority status, stressful life events, living in inadequate housing conditions and single parenthood.

Why MIM?

When the development of the MIM-programme started in 1990, the well-baby-clinic consultation tended to concentrate on the babies' health and feeding problems rather than developmental and pedagogical matters. MIM has been developed because:

1 practice has shown that inexperienced mothers have many questions concerning the development of their baby for which the community nurse has no time;

2 it was felt that the predominantly working-class mothers experienced difficulty in reaching the predominantly middle-class community nurses. Communication problems hampered the access of these mothers to health education;

3 mothers were given information from many sources, but the result was that they experienced difficulty in making choices which they felt were most appropriate to their own circumstances.

After initially looking at the possibility of translating the Irish *Community Mothers* programme materials, the decision was made to adapt and develop the programme to Dutch circumstances. Whilst having similar aims as the Dublin programme (Hanrahan & Prinsen, 1997; Johnson, Howell & Molloy, 1993), MIM places more emphasis on pedagogical support.

What is MIM?

The *Mothers Inform Mothers* programme is an innovative early-childhood care and development programme and it is based on a synthesis of nursing, pedagogical, and health-promotional knowledge and theories. It is developed as a part of the regular child health and welfare services and it aims to support young parents with parenting, helping them to cope, staying abreast of their child's development and preventing child-rearing problems.

The programme also supports the aim of enhancing the ability of women to cope with their newborn baby, of encouraging them to adapt their behaviour after receiving health educational information, increasing the number of women breastfeeding, or making women feel in control of their lives. The main goal is focused on mothers by trying to reinforce their sense of self-esteem and thereby improving their ability to s self-supporting parent. The programme addresses the same topics as the regular preventive child health and welfare services during the sessions of the well-baby clinic, but these topics are discussed more from a pragmatic angle and placed in a context which is meaningful to the inexperienced mother (Hanrahan and Prinsen, 1998).

For short the MIM programme is:

- educational and social support for young inexperienced parents,
- experienced mothers visit the young mother (programme mother) with a first baby in her own home,
- there is a maximum of 18 home visits over an 18-month period,
- in each home visit, the experienced mother (visiting mother) uses two aids: the home-visiting checklist which acts as a discussion document, and the programme sequence of cartoons,
- a community nurse is the coach and facilitator of the visiting mothers.

Stakeholders and participants

The original stakeholders were local experienced mothers who were and still are prepared to support inexperienced mothers who are poor, stressed, or feeling isolated and unsure about their infant's development. They help them to use their own knowledge and instincts in order to reduce health or other risks which may impair their baby's development. The other stakeholders involved were the nurses, the management of community-nursing agencies and the Netherlands Institute of Care and Welfare.

The programme starts early, ideally just before confinement. All mothers of first children living in the participating areas are offered the programme, but special attention is given to socially disadvantaged groups, members of immigrant communities and children in need[1]. Approximately 30 % of all first mothers participate in the programme, which is in line with the target of the community-nursing agencies.
The inexperienced mother receives monthly visits in her own home, lasting approximately one to two hours. The mothers are often older than 25 years of age and come from a multitude of countries in Europe, Africa and South America. Most have ten years formal education (intermediate and vocational level) and live on the earnings of their spouse, a small percentage are double earners and a small percentage live from social welfare payments.
MIM uses experienced mothers to help provide educational support for new parents in learning effective primary health and educational practices. These mothers come from the same target groups that they serve. They are well equipped to answer questions that expectant and new mothers may have. They also have an understanding of what the new mothers are going through. An experienced mother of twins, for example, is matched with an inexperienced mother of twins. Mothers with a baby suffering from a severe allergy or a baby born prematurely, are matched the same way.

The visiting mothers use cheaply produced cartoons depicting either different scenes, or the choices that can be made about a specific topic. A discussion about the contents of a cartoon may act as a start for exploring the mother's attitude, knowledge or behaviour in relation to the advice she has received from different sources. Visiting mothers adapt the MIM-materials to suit the individual mother they visit. Both live in the same neighbourhood and usually have similar backgrounds. The experienced mother will use her own standards and experience as a mother to support and assist the young mother. In doing so, she will give as little advice as possible. Rather, she will support the young mother in finding her own answers to day-to-day questions and in resolving problems when they arise.
To help them plan their visits, the experienced mothers use a discussion paper which they are free to use during the visit, or which they use to document their visit afterwards. The inexperienced mother will get this document at the next visit. In this way, the inexperienced mother has a record of all developments which take place during the 18 months of the programme.

What is the role of nurses?
The activities of the well-baby-clinic team and the role of nurses working in the services are traditionally multidisciplinary. The process of promoting, monitoring and securing the health and welfare of the child and its parents involves the expertise of medical practitioners and community nurses in addition to nutritionists and early-education specialists. Nurses have proved to fulfil an important role as observers of the combined mental and physical aspects of health. In MIM the traditional role of community nurses has undergone some significant changes.
Nursing has changed in the past ten years and community nurses are now embracing new concepts such as community-based models which include social support. Nurses have to place their trust in volunteers who befriend and support inexperienced mothers in making up their own mind whether to act upon advice from the well-baby clinic or others in order to enhance the development of their babies. The visiting mothers make comparisons and evaluate themselves on a regular basis with questions on how they are doing. Instead of giving advice and information about the development of very young babies to inexperienced mothers, they are engaged in supporting and facilitating community networks of experienced mothers as the coordinator of the programme. The assistance provided by nurses is best thought of as surrogate support, extending the support available in the client's network and replacing that which is not available. The nurses stimulate the work of the

[1]Children in need are defined as those with disabilities and those whose health or development, in the broadest sense, would be impaired or limited without the provision of such services.

experienced mothers in supporting and enhancing the locus of control of the inexperienced mothers.
All nurses have a bachelor degree in nursing (or equivalent) and more than three years practical experience after graduation. The nurses are employed by the regional community-nursing agency. The coordinator is responsible for recruiting both experienced and inexperienced mothers according to educational or other significant common background variables. She prepares the volunteers for their work and matches the inexperienced mothers to the experienced mothers. She facilitates the monthly group meetings organized by the experienced mothers themselves. During these meetings the volunteers share their experiences and discuss ways and means of enhancing programme proceedings. They also share conflicting advice or other signals they may have encountered during the home visits from the inexperienced mothers' visit to the well-baby clinic. Other tasks performed by the coordinators are assuring the ongoing quality of care, representing the programme at workshops, seminars or conferences and having regular meetings with the members of the well-baby-clinic teams.

Theoretical basis of MIM
The basic concepts underlying the MIM programme are based on theories and concepts of nursing, social support, peer education, social learning and social comparison, empowerment and health promotion.

Nursing models
The nursing concepts used when developing the programme were mainly based on the work of King, Neuman and Orem (in: Arets & Slevin, 1995). King developed a model of goal realization. In this model, interaction between nurse and individual is one of the key elements. This interaction and the theory of goal realization which is closely connected to it is an open-system approach. According to King, there are three interactive systems that are essential to nursing. These are personal, interpersonal and social systems, jointly determining and achieving goals by way of perception, communication, interaction, and transaction. After nurse and individual have become acquainted, it is important that they each verbalize and check their perceptions. Together they can try to determine the goals via communication and interaction.
Neuman considers individuals, groups (meaning the closer family circle in particular), and the community from various perspectives and in continuous interaction with stress in that environment. The environment plays a central role in Neuman's model with both external and internal components which continuously influence the person. At the same time, the environment is influenced by the person, which results in the interaction that plays such an important part in her model.
The central theme in Orem's conceptual model is self-care, and the notion of the self-care deficit, which is closely related to it. Orem asserts that nursing intervention is legitimate when an individual has a self-care deficit and is therefore insufficiently capable of providing the therapeutically required self-care. In essence, the nurse and the individual work together, the nurse always promoting and encouraging the individual's involvement and maximum independence.

Social support and peer education
Most support of inexperienced parents is supplied by neighbours, family members, friends and a host of others. This is like a type of peer education. When these informal services are not enough, professional services are offered by volunteer groups, community centres or private enterprise. Social support has captured the attention of policy makers in the health and social services fields because mutual aid and informal care are indispensable complements to the programme provided by statutory social services and community- nursing agencies. Strengthening of social networks and social support is pivotal in a health promotion strategy. *Social support* is seen as a function of personal relations and is, in conventional terms, assistance given by lay persons who are part of

one's social network, rather than by nurses. More specifically, it is emotional, instrumental, informational and appraisal assistance provided by family, friends, neighbours, colleagues and self-help mutual-aid groups which can have positive and negative influence on the psychological and physical well-being of its recipients. Peer education is effective although not theory nor completely evidence based (Turner and Shepherd, 1999). However without the help and emotional aid given by the community's informal support systems, institutional resources would be overwhelmed, and indicators of health and well-being would decline precipitously.

Pedagogical and psychological support

MIM has also a pedagogical dimension based on social learning theory, attachment theory and a transactional model. In MIM this pedagogical dimension is linked with social comparison. *Social comparison* is a theoretical basis for determining whether people are similar in terms of health status, illness severity, stress mastery or coping stage. People will make upward comparisons with those coping better than they are (who serve as role models) and downward comparisons to enhance self-esteem and protection.

Social comparison can be defined as people's tendency to evaluate themselves and to elicit information about their characteristics, behaviour, opinions, and abilities through comparison with similar others. Social networks influence how their members seek help from nurses or other professionals, and use their services by buffering experiences of stress, thereby eliminating the need for help, providing support and services, by acting as screening and referral agents, and by transmitting values, attitudes and norms about seeking help. Lay networks also enhance, complement, or serve as alternatives to professional services.

Social learning theory approaches the explanation of human behaviour in terms of continuous reciprocal interaction between cognitive, behavioural and environmental determinants. Within the process of reciprocal determinism lies the opportunity for people to influence their destiny as well as the limits of self-direction. This concept of human functioning neither casts people into the role of powerless objects controlled by environmental forces, nor free agents who can become whatever they choose. Both people and their environment are reciprocal determinants of each other. Social competence and skills necessary for forming and maintaining relationships, including social problem-solving skills, empathy and comfort in intimate relationships, are qualities of a self-actualizing person. People who are low in perceived social support have poorer social skills and are not able to initiate or maintain relationships or communicate their needs. There is a general consensus among researchers on child development and developmental psychopathology that child rearing is a transactional process. Within this process, there is an ongoing interaction between children and educators characterized by mutual influencing of each others development. Bronfenbrenner (1979) proposed using an ecological model when health educational activities are developed: `Whether parents can perform effectively in their child-rearing roles within the family depends on role demands, stresses and support emanating from other settings. Parents' evaluation of their own capacity to function, as well as their view of their child, are related to such external factors as flexibility of job schedules, adequacy of child-care arrangements, the presence of neighbours and friends who can help out in large and small emergencies, the quality of health and social services and neighbourhood safety.'

Health promotion and empowerment

As in health promotion in general, community-based early-childhood and development programmes are working for and with individuals rather than on them, in the setting of everyday life. As knowledge is gained about the relationship between personal behaviour and environmental conditions, and risks to health, so has there been a growth in understanding the potential contribution of health education in supporting the health of very young children. Intersectoral collaboration and community participation are essential factors. Parents are seen as the experts on their own child and are encouraged to solve their own problems in child rearing. The strategy of

organizing women to reach out to other women builds on the strengths of local communities and their self-help traditions. The active and decisive role that experienced and inexperienced mothers play in the programme creates a basis of trust for the programme among the target groups. From the process evaluation we know that the mothers see the programme as their own and a discovery of ' being able to do more than I thought possible.' The result of this is empowerment: people regaining control over their own lives.

Evaluating MIM

A process evaluation was carried out in all programme locations and compared with the results of a previous action-research project which was carried out simultaneously with the developmental phase of the programme (Hanrahan, Prinsen and De Graaf, 1997). The experienced mothers were asked what motivated them to become a volunteer in the programme. They answered differently such as: sharing one's own experiences with others, helping to make contact in a new neighbourhood, preventing a feeling of insecurity after having your baby or preventing a feeling of loneliness and depression. They indicated that the number of visits to inexperienced mothers should be limited to not more than three per month, because 'I have a part-time job,' 'I need time at home,' 'I need time for adult education activities,' or 'I am engaged in other volunteer activities.' The experienced mothers all work under the aegis of the volunteers' charter in which all privileges, insurance, rules and regulations are outlined. All their expenses are reimbursed.

In the action-research study, emphasis was on the qualitative evaluation of the programme (Wolf, 1995). This would make it possible to use its results to improve the programme's implementation by adjusting the content, the tools employed and the methodology of various parts of the programme. The outcome is a transferable programme for support in child rearing and health promotion. The results of the study were instrumental in changing the contents and layout of the programme.

It is interesting to note that when comparing the MIM-participants with participants in similar programmes in Europe and the United States of America, the age profile in MIM is much higher. This is partly due to the lack of teenage pregnancies in The Netherlands caused by the high prevalence of use of modern, reliable methods of contraception (Ketting, 1997). The teenage mothers that are found are often married, with one or both parents born outside the country. Also in absolute numbers, the choice of when to start a family is often made after age 25. The average age for having a first baby in the Netherlands nowadays is 29.

Evaluations at program locations

To facilitate the start of each programme at a different location, the community-nursing agency looked for money from local authorities, charitable foundations or insurance companies. Process evaluations from the established locations showed the following results (Hanrahan & Prinsen, 1997):

- Inexperienced mothers from lower and upper income brackets were initially less successfully reached than those in the middle income brackets. This has changed over time with mothers from different social backgrounds participating in the programme.
- The largest groups of inexperienced mothers are Dutch. However, approximately 28% of women are foreign. They are migrant workers from Turkey and Morocco and fugitives and asylum-seekers from predominately a variety of non-European countries (Africa and Asia), and from the former Republic of Yougoslavia.
- The necessary money comes from a variety of sources. One of the nursing agencies has a long established programme and has funded the continuance by using efficiency measures within the preventive child health budget. Some agencies are receiving a subsidy from their local municipal authority, another one is using a combination of funding: a charitable foundation and the local authority. There is also one nursing agency which has re-arranged budget parameters

with permission from the regional health insurer. Indications are present that after the initial phase of establishing the local programme finance may be found by using efficiency measures and by participating in locally funded child health and welfare networks.

Current research activities

Evaluating community-based interventions using appropriate techniques is difficult and complex, because the research process does not always fit the practice under scrutiny. According to Vimpani (1996) approaches based on a variety of models have been initiated and evaluated in the last ten years. These were a parent-education model, a public-health model, a social-support model, a mental-health model and an interaction-attachment model. Overlaps among these models exist. For example, the public-health model includes social support and parenting as programme components. MIM is an example of a synthesis of an ecological, community-health and interaction-attachment model to facilitate health promotion and pedagogical activities.

An evaluation of the programme is in progress. It explores the question ' What is the efficacy of the programme?'. Evaluation will focus on nutrition (both mother & baby), dental health (baby) and mental health (mother). It will also establish the extent to which the intervention has reduced differences in socio-economic groups. The effect variables shall take into account the expected time lags between intervention and effect. When the effects are established it is imperative to determine the necessary activities prior to implementing the programme efficiently and effectively at new locations. An experimental design (community intervention trail) involving three groups is used (Koelen and Hanrahan, 1997). Due to practical constraints it is not possible to allocate mothers and babies randomly to these groups. Group one will be the intervention group. There are two comparison groups. The first groups are inexperienced mothers from the same location as the intervention mothers. The second and third group are mothers from different locations. All mothers are invited to use their local community health centre.

Community-based prevention programmes involve an ongoing process of decision making which requires a flow of regular inputs rather then one intervention - evaluation situation. Therefore, a combination of research techniques is required. As far as the measurement of health status, measuring perceived and actually received social support, knowledge and attitudes is concerned, scientifically validated instruments will be used. To reach non-Dutch-speaking participants in the programmes, it is envisaged using migrant health educational aides who will help the inexperienced mothers with answering the questions. These aides will be trained for their task so that their involvement will not influence the mothers answering the questionnaire(s). Where appropriate, routinely gathered information about the mothers and their babies will be noted on a research schedule.

Strengths and weaknesses of MIM

Discussing the program with managers and staff of community nursing agencies and the participants of an international working conference we have identified the main strengths and weaknesses of MIM (Hanrahan & Prinsen, 1997). There are strengths in the program as follows:

- It is developed in partnership with the target group. Disadvantaged mothers were participating at the developmental stage of the program.
- It is developed as a potential integral part of the child health care service, so there will be no lack of continuity.
- Its potential in reaching the target groups is high.
- The action research experiences and the results of the process evaluations are encouraging.
- Potential effect in lowering social-economical health differences seems to be present and MIM intervenes and interacts with mother/baby's health and welfare determinants (Arblaster, 1995).

There are also a few weaknesses and problems to overcome to get the program totally integrated in the statutory preventive child health package.

- There is not much body of knowledge from the nursing profession to warrant face value acceptance.
- Epidemiological research or an evaluation on the effects of the program has not yet been carried out. International research results concerning early childhood care and development support programs are available (Olds and Kitzman, 1990; Johnson, Howell & Molloy 1993).
- No study on the cost-effectiveness of the program has been carried out.
- The financial basis of the program within current budgets of health care agencies is difficult. Discussions on the positioning of the program is ongoing due to the presence of some pedagogical components in the program. At present a positioning of the program within preventive child health care is being advocated by the participating organisations. Preventive health is paid through general health contributions and child care activities which are part of the welfare system are funded by local authorities. To receive additional money to pay for the starting-up phase of MIM in a new organisation, the program has to compete with many other projects and activities.
- Reaching mothers living in multi-problem circumstances is slow and time consuming and getting results within a relatively short time is difficult.

MIM type programs empower parents in such a way that they are not only active with their own children, but starting also activities to change the physical environment in which they live. In MIM we see multiple outcomes and we are targeted at many beneficiary groups. Empowered parents may ask for specific health services and improved educational facilities. MIM is developed as an additional but potentially integral and community based part of the regular statutory parents and pre-school children's health services in the Netherlands. It is envisaged that its effectiveness will be tested so that with its results the decision to fund the program as an integral part of the national parent- child care and health services can be made. As a result of research-findings and innovations in child health care the program might be incorporated in the Dutch services system and implemented in the national parenting support policy .

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More information

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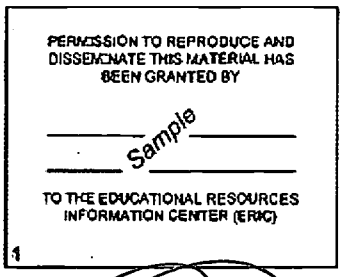	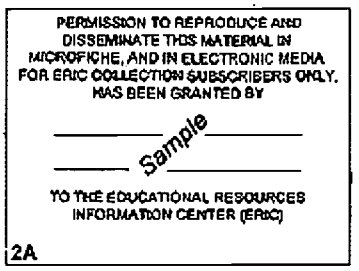	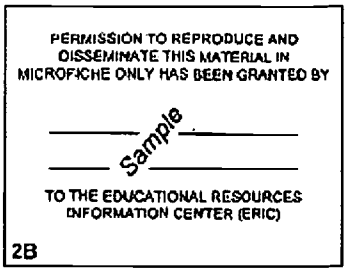
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