

# Education and Support Standards for Pregnancy, Birth and Early Parenting:

Newfoundland and Labrador  
2005



*Photos Courtesy of Health Canada*



GOVERNMENT OF  
NEWFOUNDLAND AND  
LABRADOR  
Department of Health  
and Community Services



# Education and Support Standards for Pregnancy, Birth and Early Parenting:

Newfoundland and Labrador  
2005



GOVERNMENT OF  
NEWFOUNDLAND AND  
LABRADOR  
Department of Health  
and Community Services



This publication is also available on the Internet at the following address:  
<http://www.health.gov.nl.ca/health/publications/default.htm>

© Department of Health and Community Services, Government of Newfoundland and Labrador, 2005



## Table of Contents

Acknowledgements.....	<b>iv</b>
Introduction.....	<b>1</b>
Background and History .....	<b>1</b>
Existing Education and Support Programs for Pregnant Woman and Families .....	<b>3</b>
Healthy Baby Clubs .....	<b>3</b>
Early Childhood Development Initiative .....	<b>3</b>
Healthy Beginnings.....	<b>4</b>
Education and Support Standards for Pregnancy, Birth and Early Parenting: A New Approach .....	<b>5</b>
Defining the Concept—Education and Support for Pregnancy, Birth and Early Parenting.....	<b>8</b>
Goals .....	<b>8</b>
Guiding Principles.....	<b>8</b>
Standards and Indicators.....	<b>11</b>
Evaluation and Accountability .....	<b>17</b>
Conclusion .....	<b>17</b>
Appendix A Circle of Health©: PEI’s Health Promotion Framework.....	<b>18</b>
Applying the Circle of Health Framework to Education and Support for Pregnancy, Birth and Early Parenting.....	<b>19</b>
Populations.....	<b>22</b>
Appendix B Key Messages.....	<b>23</b>
Appendix C Evidence to Support the Standards .....	<b>24</b>
References.....	<b>28</b>

## Acknowledgements

The Newfoundland and Labrador Provincial Perinatal Program and the Department of Health and Community Services wish to acknowledge the members of the Childbirth Education Review Project Advisory Committee (Phase 2) who contributed their knowledge and experience in the development of this document.

Clare Bessell  
Nurse Educator  
NL Provincial Perinatal Program

Pamela Browne  
Nurse Midwife/ Lactation Consultant  
Labrador-Grenfell Regional Integrated  
Health Authority

Lorraine Burrage  
Program Director  
NL Provincial Perinatal Program

Sandra Carpenter  
Parent and Child Health Coordinator  
Central Regional Integrated Health Authority

Linda Carter  
Consultant, Wellness Division  
Department of Health and Community  
Services

Hope Colbourne  
Healthy Baby Club Coordinator  
St. Anthony, NL

Claudine Kean-Dobbin  
Parent and Child Health Coordinator  
Labrador-Grenfell Regional Integrated  
Health Authority

Janet Doyle  
Prenatal Education Coordinator  
Women's Health Program  
Eastern Regional Integrated Health Authority

Susan Earles  
Public Health Nurse  
Western Regional Integrated Health Authority

Janet Murphy Goodridge  
Project Coordinator

Colleen Kearley  
Parent and Child Health Coordinator  
Eastern Regional Integrated Health Authority

Annette Parsons  
Public Health Nurse  
Labrador-Grenfell Regional Integrated  
Health Authority

Cathie Royle  
Consultant, Prenatal and Early Child  
Development  
Department of Health and Community  
Services

Recognition and thanks are also extended to the key stakeholders throughout the province for their feedback throughout the consultation process.

The Childbirth Education Review Project Advisory Committee would also like to thank Kathy Inkpen, Core Program Coordinator, Public Health/Health Promotion, Nova Scotia Department of Health for her advice and guidance in the preparation of the standards. Her willingness to share the Nova Scotia resources with our committee was invaluable.



## Introduction

This paper presents the new education and support standards for pregnancy, birth and early parenting for Newfoundland and Labrador. While acknowledging that there are variations in how programs and services are implemented in each region, these standards will promote provincial consistency in the goals, indicators and targets for pregnancy, birth and early parenting education and support programs. The background and history of prenatal education programs in the province is outlined followed by an overview of existing education and support programs for pregnant women and their families. This information provides a context for the shift towards the development of standards. It also examines the broader population health and health promotion strategies necessary to achieve these standards.

The standards have been developed in the context of other existing provincial health directives, including: the Primary Health Care Strategy *Moving Forward Together: Mobilizing Primary Health Care: A Framework for Primary Health Care Renewal in Newfoundland and Labrador (2003)*<sup>1</sup> and the *Provincial Wellness Strategy: Framework Document (2003)*<sup>2</sup>.


The standards emerged following a review of the key issues affecting pregnancy and birth outcome for women, infants and families in Newfoundland and Labrador; and an analysis of the current issues relating to the delivery of prenatal education programs. The review was completed by members of the Childbirth Education

Review Project Advisory Committee. These issues are also highlighted in the paper. The guiding principles and goals for education and support programs are identified. Specific strategies or approaches to achieve the standards are outlined in Appendix A using the *Circle of Health*<sup>®</sup>: *Prince Edward Island's Health Promotion Framework*—a useful tool to guide strategic health promotion planning<sup>3</sup>.

## Background and History

Prenatal education programs in this province are currently offered to pregnant women and their families using a program called *A New Life*. This program was introduced in 1995 following several years of development. *A New Life* consists of a series of booklets for parents and a *Facilitator's Guide and Professional Reference*<sup>4</sup> for use by public health nurses and childbirth educators. The booklets were adapted from a similar program used in Nova Scotia. *The Facilitators Guide and Professional Reference* was developed by a provincial childbirth education committee. *A New Life* was developed to provide a universal program with standardized provincial resources for prenatal education programs offered in the province. While the resources to support *A New Life* are standardized, the premise allows for considerable flexibility for individual assessment and the application of appropriate adult education principles.

The original parent and professional resources for this program were



developed in the early 1990s. Childbirth educators, public health nurses and other perinatal health care providers expressed concern about the lack of up-to-date information presented in *A New Life*. Various individuals, organizations and government departments throughout Canada have, in recent years, developed new guidelines, policies and practices regarding prenatal care and education and support services for pregnant woman and families. There was, therefore, an urgent need to revise and update the program and accompanying professional resources to reflect this new information and best practice guidelines. Increasingly, health care providers have access to a variety of other evidenced-based resources to meet their information needs. There are also excellent resources that are geared to the diverse needs of sub-groups of the population.

*A New Life* has evolved over the years and is now implemented in a variety of ways throughout the province. There are one-on-one sessions; Healthy Baby Club group sessions facilitated by resource mothers, public health nurses, and nutritionists; formal prenatal education classes with hospital-based nurses and public health nurses; and small group sessions in hospital and community health settings. As well, individual health care providers such as physicians, midwives and nutritionists who are not directly involved in formal prenatal education programs play a key role in disseminating information and providing counseling and support to pregnant women and their families. Private providers—for example, midwives, doulas and registered nurses—offer prenatal education and support services in some regions.

This project has been undertaken in three phases. A priority for Phase 1 was to revise the current booklets for parents. The revisions ensured that the information was current, evidenced-based and reflected the local birth environment in Newfoundland and Labrador.

*A New Life* has not been comprehensively reviewed or evaluated since its inception. In addition, there have been significant changes since the 1990s in the range of programs and support services available for pregnant woman and their families in this province. Phase 2 of this project examined the range of education and support services available, and developed new standards to direct future approaches. Two new professional resources were purchased to support facilitators of education and support programs. It is anticipated that Phase 3 of the project will focus on a provincial education strategy to inform key stakeholders of the new standards and resources. The development of an evaluation framework will also be completed in this phase.

Finally, it is recognized that prenatal education programs are only one component of the care and support necessary throughout pregnancy, birth and early parenting. Women access a variety of resources—from the web, books, videos, television, magazines, family members and friends. There is a need to review the current prenatal education program in light of the many other programs and services presently offered, and to reflect a broader population health and health promotion approach to education and support for pregnancy, birth and early parenting.



## Existing Education and Support Programs for Pregnant Woman and Families

A range of programs targeting pregnant women and their families have evolved since *A New Life* was introduced in 1995. This section presents a brief overview of the key funded initiatives.

### Healthy Baby Clubs

In the mid-1990s, Healthy Baby Clubs, funded by Health Canada's Canada Prenatal Nutrition Program (CPNP), were established in targeted communities throughout the province. Subsequently, Healthy Baby Clubs expanded to other communities in the province through funding from The National Child Benefit (NCB) and Early Child Development Initiative (ECDI). The Healthy Baby Clubs play an important role in supporting pregnant women with the greatest potential for poor pregnancy outcomes. They are also instrumental in increasing awareness of the value of community-based pregnancy support initiatives and the strength of partnerships in building community capacity.

The provincial Healthy Baby Clubs offer:

- peer support
- information and skills training relating to healthy pregnancy, birth and parenting for participants
- breastfeeding support
- food supplements
- supportive environments for pregnant women and families with newborns

### Early Childhood Development Initiative

In June 2001, the Government of Newfoundland and Labrador announced *Stepping into the Future: Newfoundland and Labrador's Early Childhood Development Initiative (ECDI)*<sup>5</sup>. This initiative offers increased community supports and services to pregnant women, infants, children and families. The ECDI in conjunction with the federal, provincial and territorial governments, identified four areas requiring action:

- promotion of healthy pregnancy, birth and infancy
- improving parenting and family support
- strengthening early childhood development, learning and care
- strengthening community supports

As part of the ECDI program, the Mother Baby Nutrition Supplement (MBNS) provides a monthly benefit payable to eligible low-income families with children under the age of one. This financial support is intended to assist with the nutritional costs of healthy eating during pregnancy and throughout a child's first year. Information and community supports for prenatal and postnatal care are strengthened through referrals to Health and Community Services and Family Resource Programs. This leads to the distribution of educational materials regarding healthy lifestyles and nutrition for applicants; provincial distribution of program brochures,

posters and advertising; links to related community service providers; and information exchange on programs and services available for families.

Family Resource Programs promote the well-being of children and families through the implementation of a variety of community-based programs focusing on healthy child development, parenting skills, social support and community capacity building. The Healthy Baby Clubs are based within the Family Resource Programs, thus enabling families with infants and young children to be linked to other support programs and services in the postpartum period. Under the core area of action “strengthening early childhood development, learning and care,” early childhood literacy, kinderstart programs, and childcare services including childcare subsidies all come under the ECDI funding source.

## Healthy Beginnings

In 1998, the *Healthy Beginnings Program*<sup>6</sup> was introduced in the province by the Department of Health and Community Services. This program was developed to assist public health nurses to identify, through a universal screening methodology, individual families and their children who require specific follow-up from birth to school entry. *Healthy Beginnings* is designed to meet the needs of all postpartum families. Included in this program is a planned approach to assessment and follow-up of priority families. The goal of the program is to promote optimal physical, cognitive, communicative and psychological development in priority children.

## Education and Support Standards for Pregnancy, Birth and Early Parenting: A New Approach

Standards were developed to ensure a comprehensive, coordinated approach to education and support programs and services for women and their families through preconception, pregnancy, birth, the first several weeks postpartum and the early parenting period. These standards\*, ensure that current programs and services meet provincial requirements for quality care for core education and support programs. A continuum of responsive and integrated services throughout this period is essential for all women and families, but it is most important for those at risk for adverse health outcomes. The education and support standards complement existing provincial and national professional practice standards.

Education and support in preparation for pregnancy, birth and early parenting is only one component of the education and support provided throughout the broad reproductive

health continuum, and should not be viewed in isolation. Opportunities for education and support occur at all stages of a woman's reproductive lifespan. While the primary focus of the standards is on the prenatal period, efforts should also be directed at improving the health of the reproductive population during the preconception period. Interventions during this time encourage women and their partners to be as healthy as possible when pregnancy begins.

The new standards were developed through a collaborative process with members of the Childbirth Education Review Project Advisory Committee. A review of the literature and a cross-country scan of selected key informants in other Canadian provinces (completed in Phase 1) informed the process. Two key documents were instrumental in guiding the development of the new standards: *The Nova Scotia Public Health Services Department Draft Prenatal Education and Support Standards*<sup>8</sup> and the *Ontario Ministry of Health/ Public Health Branch Mandatory Health Programs and Services Guidelines*<sup>9</sup> (section on Reproductive Health Programs), draft 2001.

These standards highlight the role of the Department of Health and Community Services, Regional Integrated Health Authorities and other key stakeholders in ensuring that there are a range of appropriate programs and services for the target population throughout Newfoundland and Labrador. The standards are intended for use by planners and facilitators in



\* **Standard:** A standard is a document, established by consensus and approved by a recognized body, that provides, for common and repeated use, rules, guidelines, or characteristics for activities or their results, aimed at the achievement of the optimum degree of order in a given context<sup>7</sup>

### Standards should:

- be consistent with strategic priorities of the health system
- be founded on intended results and outcomes
- be based on best available evidence
- focus on areas that should not show significant variation between geographic areas
- respect the need for flexibility to adapt to unique region/ community needs
- complement (not duplicate) existing evaluative and regulatory systems (e.g., accreditation)

### Key Stakeholders

- *community and hospital-based health care providers, e.g., physicians, midwives*
- *private providers*
- *Family Resource Programs and Healthy Baby Clubs*
- *community-based agencies*
- *educational institutions (university, colleges)*
- *other government departments, e.g., Education, Human Resources, Labour and Employment (HRLE)*

Regional Integrated Health Authorities and other stakeholder groups. The Department of Health and Community Services assumes a leadership role throughout this process in identifying current and emerging health issues of relevance to this population. In this regard, the standards were developed following a comprehensive review of the key issues affecting pregnancy and birth outcomes and the delivery of prenatal education programs in this province.

The standards that emerged through the review process reflect the key issues identified in Table 1. The standards assist stakeholders in developing strategies that will lead to improved

health and well-being for pregnant women and their families. While some of the standards require that Regional Integrated Health Authorities provide a program or service directly, other approaches may involve collaboration with other government departments and non-government sectors. This ensures that programs and supports are present in other areas that impact healthy pregnancy and birth outcomes—schools, workplaces, businesses and communities.

The new standards provide an opportunity to integrate a range of strategies in meeting the education and support needs of pregnant women and their families. It is well recognized

**Table 1**

**The review process identified the need to address the following priority issues:**

- Improved coordination, communication and collaboration among key stakeholders.
- Early and easy access to quality education and support programs for all pregnant women and their families.
- Early identification and referral of women and families at risk\* for adverse health outcomes to prenatal care, and education and support programs.
- Enhanced public education to inform, educate and empower women and their families about healthy lifestyles and behaviours and the necessary supports and services.
- New approaches and opportunities to facilitate education and support programs. A move away from provider to facilitator is recommended.
- Enhanced and timely professional development opportunities for health care providers and other key stakeholders.
- Evidenced-based resources for health care providers, facilitators (e.g., volunteer staff, peer support workers) and participants.

\* **At risk includes:** women living in poverty, pregnant adolescents, women who are isolated without support, women in abusive situations, women who misuse alcohol, nicotine, and other substances, and women with gestational diabetes, high blood pressure, or obesity



that formal prenatal classes are only one method of providing education and support, and will only meet the needs of a self-selected population. The new standards encourage a shift away from traditional, formal prenatal education programs to a blending of health promotion strategies with significant inter-sectoral collaboration. For example, other strategies may include: Healthy Baby Club programs; one-on-one sessions with the public health nurse or other providers; home visits; telephone support; public media and health promotion campaigns such as prenatal health fairs; mother champions; policy development; improved community and workplace

supports and resources; peer support initiatives; school programs; early referral from health care providers; and prenatal risk assessment.

- Consideration of the impact of key determinants of health (e.g., income and social status, education, social support) on the capacity of at-risk women and families to participate fully and effectively in education and support programs.
- Recognition that the transition to parenting is a time of physical and psychological changes and challenges. Parents need to be prepared for new roles and responsibilities.
- Low breastfeeding initiation rates in Newfoundland and Labrador (66.7% initiation in hospital). Duration rates are not available; anecdotally however, it is acknowledged that many women discontinue breastfeeding in the early weeks after birth.
- Data collection and monitoring of relevant health indicators to determine achievement of goals and targets, and to inform and guide policies and programs.
- Program evaluation to assess for changes and quality improvement.

## **Defining the Concept— Education and Support for Pregnancy, Birth and Early Parenting**

Education and support programs promote wellness, prevent illness and enhance birth outcomes by providing information, resources and support to women and their families throughout the continuum of preconception, pregnancy, birth and the transition to early parenting. Informed decision making about health issues is facilitated. Women and their families' capacity to adapt to the changes and challenges of this time is strengthened.

### **Goals**

#### **Education and Support Programs for Pregnancy, Birth and Early Parenting Aim to:**

- ⇒ enable women, their partners and families, to achieve a healthy pregnancy, optimal birth outcome and positive adaptation to parenting
- ⇒ contribute to a coordinated and effective system of education and support programs throughout the reproductive continuum
- ⇒ enhance the capacity of communities to support pregnant women and their families by creating healthy, supportive environments
- ⇒ enhance the capacity of women, their families and communities to nurture healthy child development
- ⇒ increase parenting knowledge, confidence and skills

## **Guiding Principles**

Fundamental to this discussion is the belief that pregnancy and birth are normal, healthy life processes, and unique experiences for each woman and her family. The following statements reflect the principles that have been developed to guide the new standards. The strategies that evolve from the standards should reflect these principles.



Table 2

### Guiding Principles

- **Population Health Focus** Improving the health of the target population depends on how effectively the determinants of health are integrated into policies and programs for women and families preparing for pregnancy, birth and early parenting.
- **Health Promotion Focus** Education and support programs are guided by strategies that enable individuals to increase control over and improve their health.
- **Multi-factored** Education is only one of several factors that contribute to a healthy pregnancy, birth outcome and healthy child development.
- **Cultural Sensitivity and Inclusion** Education and support occurs within the social and cultural context of the woman's family and community.
- **Flexibility** Education and support programs are implemented in a flexible manner in a variety of settings—for example, community health centres, schools, homes, Family Resource Centres, health units, nursing stations.
- **Healthy Parent-Child Attachment** Education and support nurtures healthy parent-child attachment.
- **Active Decision Making** Education and support programs encourage women and their families to be active partners in decisions affecting their health and well-being.
- **Strengths-focused** Education and support programs focus on women and families' strengths rather than deficits, thus building confidence and capacity.
- **Collaboration and Coordination** Education and support programs link women and their families to other families, professionals and community-based programs and resources.
- **Multi-disciplinary** Individuals from a variety of professional and personal backgrounds facilitate education and support programs.
- **Builds on Existing Supports** Education and support programs complement and build on existing supports and services for pregnant women and their families.
- **Evidenced-based** Standards and strategies are based on available evidence and best practices.
- **Equity** Education and support programs aim to reduce the differences in health status that are associated with factors such as income, social status, age, education and poverty.
- **Sustainability** Education and support programs are developed and implemented in a way that ensures stability of human resources, efficient use of financial resources and long-term affordability.
- **Accessibility** Education and support programs are reasonably located, user-friendly and available in a timely manner.
- **Evaluation** is an integral component of all health promotion initiatives.

**Table 3**

**Education and Support Standards for Pregnancy, Birth and Early Parenting**

1. Leadership and collaboration is required from all key stakeholders in the development and implementation of an integrated, coordinated approach to education and support programs and services.
2. Early and easy access to education and support programs and services is achieved for all pregnant women and their families.
3. A process is established for assessing all pregnant women and their families for their education and support needs.
4. Education and support programs are delivered through multiple routes and methods to best meet the needs of the pregnant woman and her family.
5. Pregnant women and their families at risk for adverse health outcomes are identified and referred to appropriate supports and services based on need.
6. Accurate, evidenced-based and consistent key messages about preconception, pregnancy, birth and the transition to parenting are developed and shared with the target population.
7. Facilitators require initial and ongoing professional development to acquire and maintain the competencies (knowledge, attitudes, skills) to facilitate education and support programs.
8. Current, evidence-based resources to support program delivery are available and accessible.
9. Policies and programs that address the impact of the broader determinants of health on pregnancy, birth and the transition to parenting are present in government and non-government sectors.
10. Programs and services that facilitate a successful transition to parenting are available and accessible for all women, and their families.
11. Education and support programs reflect the global standards for breastfeeding as outlined in the WHO/UNICEF Baby-Friendly™ Initiative.
12. A standardized system of data collection, analysis and interpretation of relevant indicators is developed for provincial surveillance of education and support programs; and for evaluating program quality.

**Note:** Appendix C includes a list of references to support the standards.



## Standards and Indicators

The following section of the paper outlines each of the standards and the relevant indicators—criteria for measuring the extent to which the standard has been achieved. Key stakeholders responsible for ensuring that the standards are achieved are also identified. See Table 3 on page 10 for a complete list of the standards.

Standards	Indicators
<p><b>Standard 1.</b> <i>Leadership and collaboration is required from all key stakeholders in the development and implementation of an integrated, coordinated approach to education and support programs and services.</i></p> <p><b>Responsibility:</b> Lead—Regional Integrated Health Authorities; other key stakeholders</p>	<ul style="list-style-type: none"> <li>• evidence of partnerships (e.g., establishment of a steering committee/coalition with key stakeholders)</li> <li>• number of sectors involved in education and support programs (e.g., Education, Labour)</li> <li>• existence of a document outlining policy for delivery of education and support programs in an agency/organization/region</li> <li>• identification of individual(s) with overall responsibility/accountability for implementing standards or education and support programs</li> </ul>
<p><b>Standard 2.</b> <i>Early and easy access to education and support programs and services is achieved for all pregnant women and their families.</i></p> <p><b>Responsibility:</b> Lead—Regional Integrated Health Authorities; other key stakeholders</p>	<ul style="list-style-type: none"> <li>• number and proportion of pregnant women seeking prenatal care* in the first trimester</li> <li>• number and proportion of women with continuous prenatal care*</li> <li>• number and proportion of women participating in education and support programs in the first trimester</li> <li>• variety of education and support programs available in local community (e.g., Healthy Baby Club, breastfeeding and parenting groups)</li> <li>• number and proportion of pregnant women availing of programs</li> <li>• information provided to pregnant women about education and support programs by primary provider (e.g., physician, midwife)</li> <li>• number and proportion of women who had preconception education</li> </ul>

\* **prenatal care:** *regular routine health care provider visits recommended for women before and during pregnancy; the purpose of prenatal care is to detect any potential problems early, to prevent them and to direct women to appropriate services as necessary*

\* **continuous prenatal care:** *pregnant woman maintains regular appointments with primary health care provider throughout pregnancy as per recommended protocol*

*Standards*

**Standard 3.** *A process is established for assessing all pregnant women and their families for their education and support needs.*

**Responsibility:** Lead—Regional Integrated Health Authorities; other key stakeholders

*Indicators*

- a formal process is established for assessment
- key determinants of health are included in assessment (e.g., income and social status, social support networks, education, personal health practices, coping skills, etc.)

**Standard 4.** *Education and support programs are delivered through multiple routes and methods to best meet the needs of the pregnant woman and her family.*

**Responsibility:** All facilitators of education and support programs

- mother and partner satisfaction with programs and services (e.g., barriers to access, i.e., location, time, transportation and childcare, availability, physical environment, options)
- variety of individuals facilitating education and support programs (e.g., midwives, physicians, public health nurses, private providers, peer support workers)

**Standard 5.** *Pregnant women and their families at risk for adverse health outcomes are identified and referred to appropriate supports and services based on need.*

**Responsibility:** Lead—Regional Integrated Health Authorities; Department of Health and Community Services; health care providers (e.g., physicians, midwives, nurse practitioners, regional nurses); other key stakeholders

- a formal process is established to identify those at risk
- list of criteria used to screen at-risk pregnant women (e.g., income, education, social support networks, personal health practices, medical conditions, coping skills)
- number and proportion of pregnant women with at-risk characteristics identified and availing of education and support programs



### Standards

**Standard 6.** *Accurate, evidenced-based and consistent key messages (see Appendix B) about preconception, pregnancy, birth and the transition to parenting are developed and shared with the target population.*

**Responsibility:** Lead—Department of Health and Community Services in collaboration with Regional Integrated Health Authorities; other key stakeholders

### Indicators

- pregnant women receive information on a variety of topics (e.g., key messages and information about risk and health promoting behaviours)
- number and proportion of pregnant women smoking during pregnancy
- number and proportion of pregnant women who report smoking cessation during pregnancy and remain non-smoking (e.g., after six months)
- number and proportion of pregnant women exposed to environmental tobacco smoke
- number and proportion of women who report using folic acid prior to pregnancy
- number and proportion of women who report using folic acid during pregnancy
- number and proportion of women intending to breastfeed
- number and proportion of pregnant women who report consuming alcoholic beverages during pregnancy
- number and proportion of pregnant women who report a reduction in alcoholic beverages during pregnancy
- number and proportion of pregnant women who report using illicit or non-prescribed substances during pregnancy
- number and proportion of pregnant women seeking addiction counseling
- number and proportion of pregnant women who report healthy eating practices during pregnancy
- number and proportion of pregnant women who report being physically active during pregnancy
- maternal self-efficacy beliefs\*

\* **maternal self-efficacy beliefs:** refer to a mother's expectations about the degree to which she is able to perform competently and effectively as a mother<sup>10</sup>

*Standards*

**Standard 7.** *Facilitators require initial and ongoing professional development to acquire and maintain the competencies (knowledge, attitudes, skills) to facilitate education and support programs.*

**Responsibility:** Lead—Regional Integrated Health Authorities; Healthy Baby Clubs (CPNP, ECDC, NCB); Department of Health and Community Services

*Indicators*

- access to continuing education opportunities in the workplace, i.e., whether education sessions are available to staff
- number and proportion of staff attending education sessions
- number and proportion of staff educated on new standards
- number and proportion of staff oriented to new professional resources

**Standard 8.** *Current, evidence-based resources to support program delivery are available and accessible.*

**Responsibility:** Lead—Department of Health and Community Services; Regional Integrated Health Authorities; other key stakeholders

- a list of professional education resources available in the region
- usage rates for new professional resources (CPNP and BC resources)
- a formal process is in place for reviewing and updating professional resources
- a formal process is in place for reviewing and updating *A New Life* parent booklets
- usage rates for *A New Life* parent booklets

**Standard 9.** *Policies and programs that address the impact of the broader determinants of health on pregnancy, birth and the transition to parenting are present in government and non-government sectors.*

**Responsibility:** Lead—Department of Health and Community Services; other government sectors, e.g., Education, Human Resources, Labour and Employment, Justice; municipal governments; community-based agencies

- a comprehensive strategy with inter-sectoral collaboration is in place to guide the province in implementing policies, programs and initiatives that will lead to improved health and well-being for pregnant women and their families (preconception through to early parenting)
- advocacy opportunities are identified and acted upon
- supportive policies are in place

**Note:** *Facilitators also have a responsibility to ensure their competence in their practice setting and to identify ongoing professional development needs.*



### Standards

**Standard 10.** *Programs and services that facilitate a successful transition to parenting are available and accessible for all women and their families.*

**Responsibility:** Lead—Regional Integrated Health Authorities; health care providers; community-based agencies, e.g., Healthy Baby Clubs, Family Resource Programs

### Indicators

- a variety of postpartum programs and supports is available and accessible in local community
- a formal process is in place to ensure a seamless transition from hospital to community (e.g., care plan for community follow-up is developed in partnership with family)
- an inventory of community resources is available for new families

**Standard 11.** *Education and support programs reflect the global standards for breastfeeding as outlined in the WHO/UNICEF Baby-Friendly™ Initiative.*

**Responsibility:** Lead—Department of Health and Community Services in collaboration with Regional Integrated Health Authorities

- existence of a breastfeeding policy outlining minimum standards of care
- types of approaches used to educate and support women who have made an informed decision not to breastfeed, (e.g., no group instruction, WHO/UNICEF Code compliant resources)
- number and proportion of pregnant women intending to breastfeed
- content of prenatal breastfeeding education (e.g., exclusive breastfeeding for six months,\* benefits of breastfeeding and human milk, risks of breastmilk substitutes)
- number and proportion of women breastfeeding at birth and six months
- professional support materials are current, accurate, appropriate and WHO/UNICEF Code compliant
- Regional Integrated Health Authority is free from the promotion of breastmilk substitutes, bottles, artificial nipples and pacifiers
- peer breastfeeding support initiatives in place, or documentation showing how women are linked to community-based peer breastfeeding initiatives

\* The definition of breastfeeding is consistent with the Breastfeeding Committee for Canada's definition.

*Standard 11 continued*

*Standards*

*Standard 11 continued*

*Indicators*

- women perceive attitudes of facilitators as supportive of breastfeeding
- women are aware of community supports and resources for breastfeeding
- breastfeeding policy outlines how staff are supported while breastfeeding

**Standard 12.** *A standardized system of data collection, analysis and interpretation of relevant indicators is developed for provincial surveillance of education and support programs; and for evaluating program quality.*

**Responsibility:** Lead—Department of Health and Community Services and Newfoundland and Labrador Provincial Perinatal Program; Regional Integrated Health Authorities; community-based agencies

- a standardized tool for data collection is developed and implemented or integrated in existing program
- Regional Integrated Health Authorities participate in standardized data collection activities as per protocol (e.g., CRMS)
- annual reports are generated



## Evaluation and Accountability

An evaluation plan will be developed to monitor the achievement of the standards and to assess the impact of a province-wide education strategy around the new standards for education and support programs, and the new professional resources. While recognizing that the education and support standards encompass a wide range of programs and services offered to pregnant women and their families, this initial evaluation plan will focus primarily on the prenatal education and support component, and the transition to early parenting. Specific targets or benchmarks will be developed for the indicators on the standards presented here.

The responsibility for ensuring that these standards are achieved lies with the Regional Integrated Health Authority Boards and other key stakeholders with the leadership and support of the Department of Health and Community Services. An accountability framework will be developed to clarify roles and responsibilities in implementing the standards and in the monitoring and evaluation components. There is a need to ensure that the standards are implemented in a flexible way that reflects the unique needs of the local community or region.

Finally, the changing demographics (population decline; uneven rates of population change; aging population and out migration) in this province need to be considered in developing appropriate strategies, and in allocating resources in an equitable manner. There may be additional resources required

in some regions to implement the standards. The reallocation of existing resources may also be necessary to better support women and families in most need of education and support.

## Conclusion

This paper has presented the history and background of prenatal and childbirth education in the province and the current funded programs directed at pregnant women and their families. The current issues affecting pregnancy and birth outcomes and the delivery of education and support programs are identified. This information provides the context for understanding the shift in the development of standards for education and support programs for pregnancy, birth and early parenting.

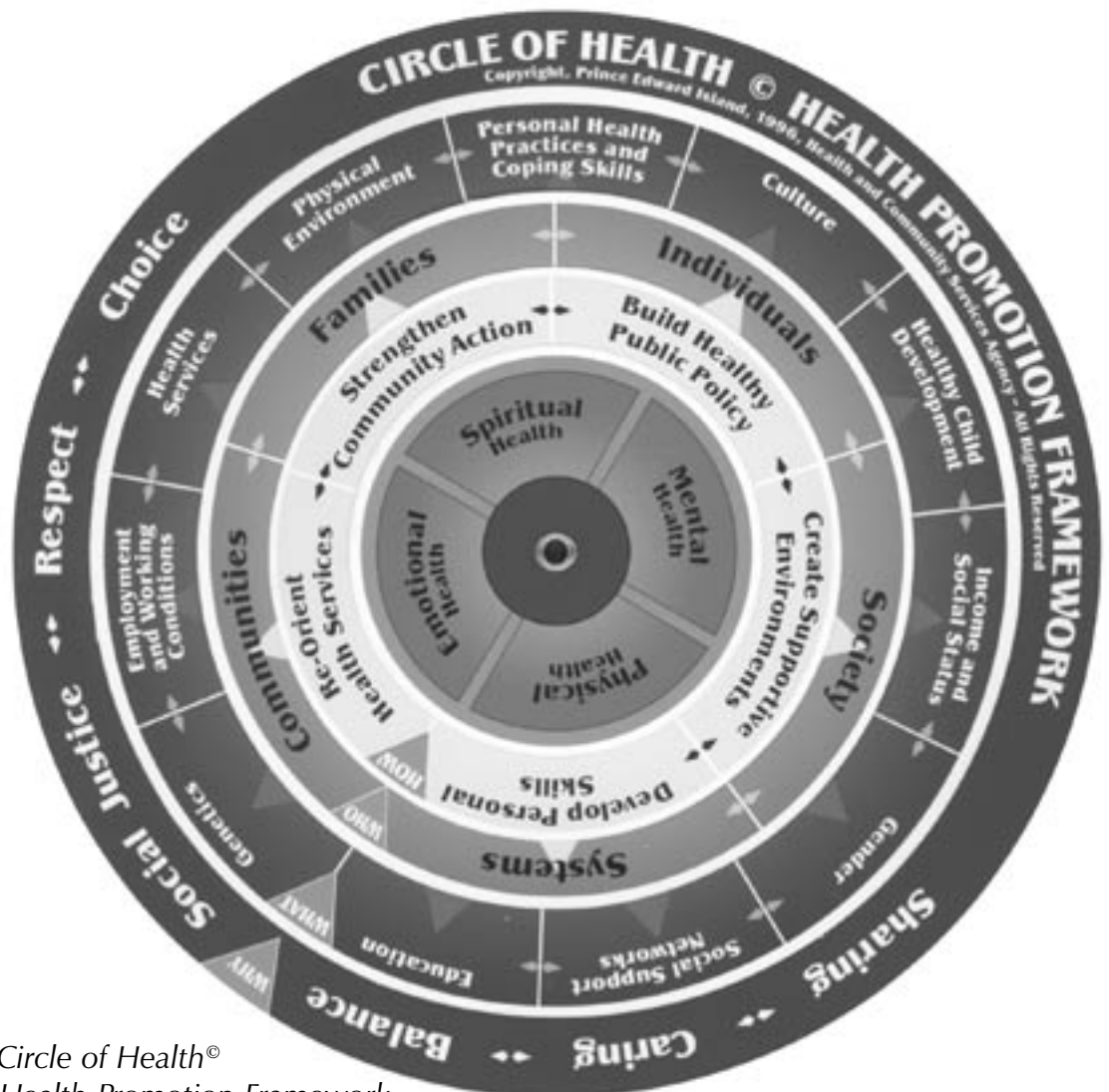
The standards provide a solid foundation for the Department and Health and Community Services, Regional Integrated Health Authorities and other key stakeholders to respond in a coordinated and integrated manner to the education and support needs of pregnant women and their families. The standards provide a valuable opportunity to move away from isolated interventions solely within the health sector to more integrated, inter-sectoral collaborative initiatives that address the full range of factors affecting health. The *Circle of Health® Prince Edward Island's Health Promotion Framework* included in Appendix A, provides a structure to organize the complex array of strategies to achieve the standards.

## Appendix A

# Circle of Health©: PEI's Health Promotion Framework

Health promotion is one of the guiding principles of health delivery in Canada. Health promotion is the process of enabling people to increase control over, and to improve their health<sup>11</sup>. The *Circle of Health©: Prince Edward Island's Health Promotion Framework (1996)* has been selected as the framework to guide the development of appropriate strategies to achieve the education and support standards. The *Circle of Health* framework was developed to serve as a supporting structure to “promote a common understanding of health

promotion using a compelling visual image; assist people to locate links, relationships and contributions in health promotion work; and provide direction for strategic planning and resource allocation for health promotion” (p.8). The visual image of a compass was selected as the framework symbol. The design reflects the framework dimensions—Values, Strategies, Populations and Determinants of Health. The final circular design—Circle of Health—also reflects the First Nation medicine wheel



Circle of Health©  
Health Promotion Framework



components of holistic health—mental, spiritual, emotional and physical.

The framework is supported by the values of Respect, Social Justice, Sharing, Choice, Caring and Balance. Values are the foundation of the framework—the base and the centre pivot. Values provide a basis for accountability, and give direction and support to individual and community capacity building.

The strategies necessary to improve health are the five strategic areas identified in *The Ottawa Charter for Health Promotion*<sup>12</sup>:

- Build Healthy Public Policy
- Create Supportive Environments
- Strengthen Community Action
- Develop Personal Skills
- Reorient Health Services

The target population groups include: individuals, families, communities, systems and society. Action is taken on the determinants of health as outlined in the *Strategies for Population Health*<sup>13</sup> with the addition of two determinants: gender and culture. The determinants include:

- income and social status
- social support networks
- education
- employment and working conditions
- physical environments
- genetics
- personal health practices and coping skills
- healthy child development
- health services

This framework serves as a practical tool as we assess and evaluate needs in relation to education and support for pregnancy, birth and early parenting, and develop appropriate, consistent and comprehensive health promotion strategies. Using this framework as a guide will also encourage other sectors to assess the health impact of their programming—ultimately leading to more supportive environments and healthy public policy for this population.

### **Applying the Circle of Health Framework to Education and Support for Pregnancy, Birth and Early Parenting**

Regional Integrated Health Authorities and other community-based agencies involved in education and support programs will benefit from understanding the range of inter-sectoral collaboration and variety of health promotion strategies required to achieve the standards. Table 4 includes a list of strategies to achieve the standards. The relevant standard(s) addressed through the strategy is identified. **It is not expected that one group or agency take on all of these strategies. However, it is important that those responsible for education and support programs and services ensure that the strategies are implemented across the province.**

## How should we take action to improve the health and well-being of pregnant women and their families?

**Table 4**

### Build Healthy Public Policy

<b>Strategies</b>	<b>Standards</b>
Work with policy makers across government and private sectors to increase awareness of the impacts of their policy decisions on pregnant women and young families	1, 9
Ensure that a gender-inclusive analysis* is given to the development of government policies and programs	9
Advocate for and assist in the development of policies and programs that support breastfeeding and family-friendly workplaces	9, 10, 11,
Advocate for and assist in the development of policies and programs that ensure healthy work environments for pregnant women	9
Establish policy to support continued school attendance in pregnant teens and teen parents	5, 9
Establish healthy public policy to decrease exposure to environmental hazards	9
Ensure all pregnant women have easy access to affordable, healthy foods	5, 9
Establish prenatal food and vitamin supplementation programs for at-risk groups and individuals	5, 9
Advocate for safe and affordable housing	9
Establish subsidy programs for childcare and transportation to avail of education and support programs	4, 5, 9
Support Regional Integrated Health Authorities as they work towards Baby-Friendly™ designation	11
Develop appropriate provincial screening programs to identify pregnant women who are at risk for adverse outcomes, and remove barriers to reaching them	5, 9

### Create Supportive Environments

<b>Strategies</b>	<b>Standards</b>
Develop and guide realistic and accurate preconception, pregnancy and birth messages within government and non-government sectors	6
Collaborate within government and with other partners to alleviate effects of poverty	9
Work with community-based partners to ensure access to affordable, quality childcare	9
Use local media to deliver accurate, evidenced-based preconception health messages	6
Promote and advocate for realistic and appropriate media representation of issues relating to pregnancy, birth and early parenting	6
Promote a community culture that is welcoming of children and families	9, 10

\* **gender-inclusive analysis:** recognizes that to the extent a policy has an impact on people, it will very likely have different impacts on women and men because they have different roles in society and different life experiences. Gender-inclusive analysis identifies differences arising out of the gender division of labour, and out of unequal access to power and resources, and assumes that these differences can be changed<sup>14</sup>



## Strengthen Community Action

<b>Strategies</b>	<b>Standards</b>
<i>Encourage community-based partners to prioritize initiatives that are focused on the needs of pregnant women and young families</i>	<b>1, 9, 10</b>
<i>Provide outreach to community-based health care providers and other stakeholders to raise awareness of programs and services</i>	<b>1, 2, 3, 5, 6, 7</b>
<i>Link with community partners or coalitions to address issues such as Fetal Alcohol Spectrum Disorder, low breastfeeding rates, parenting enhancement, violence, poverty and benefits of early and continuous prenatal care</i>	<b>1, 9, 10</b>
<i>Involve local businesses and services in offering incentives such as transportation, free milk, prenatal vitamins, food and grocery certificates</i>	<b>9</b>
<i>Identify local “champions” to act as change agents and leaders in the community, and to promote programs</i>	<b>4, 6</b>
<i>Develop and distribute an inventory of community resources and services for pregnant women and their families</i>	<b>8, 10, 11</b>
<i>Recruit volunteers to participate in programs such as Breastfeeding Buddies, Grannies for New Mothers, childcare services, Crying Clubs and Healthy Baby Clubs</i>	<b>4</b>
<i>Link with other community health and wellness initiatives to identify specific areas for collaboration</i>	<b>1</b>

## Develop Personal Skills

<b>Strategies</b>	<b>Standards</b>
<i>Develop and implement early pregnancy education and parenting programs that reflect the unique circumstances and needs of the community</i>	<b>1, 2, 4</b>
<i>Provide information, support and resources to make informed decisions about positive personal health practices</i>	<b>6</b>
<i>Strengthen personal skills to support choices and empowerment</i>	<b>6</b>
<i>Acknowledge and respect the impact of cultural values, beliefs and attitudes on health practices and behaviours</i>	<b>3, 4</b>
<i>Develop Web-based resources to strengthen knowledge and skills</i>	<b>6, 7, 8</b>
<i>Promote effective parenting skills and practices</i>	<b>10</b>
<i>Use multiple health communication strategies to inform target population of key messages</i>	<b>4, 6, 7</b>
<i>Collaborate with other sectors and partners to ensure availability of smoking prevention and cessation programs</i>	<b>1, 5, 6, 9</b>
<i>Collaborate with the education sector in developing appropriate reproductive health strategies for all students</i>	<b>1, 6, 8</b>
<i>Support health literacy programs</i>	<b>6, 9</b>
<i>Provide outreach to school personnel and students to ensure programs are offered at appropriate times to encourage participation</i>	<b>1, 2, 3, 4, 5</b>
<i>Develop provincial and regional education strategies to provide information, resources and skill development opportunities to all key stakeholders</i>	<b>1, 7, 8</b>
<i>Explore opportunities for inter-sectoral collaboration on education initiatives</i>	<b>1, 7</b>

## Reorient Health Services

<i>Strategies</i>	<i>Standards</i>
<i>Ensure education and support programs are available and accessible to all families through an integrated, coordinated network of services and providers</i>	<b>1, 2, 3, 4, 5</b>
<i>Offer programs and services through multiple channels and methods to increase availability and access</i>	<b>3, 4, 5</b>
<i>Provide services in a variety of locations and settings during days, evenings and weekends</i>	<b>4</b>
<i>Consider options for in-home support such as family visitors, telephone support and Web-based technology</i>	<b>4</b>
<i>Promote and support the development of peer educator programs</i>	<b>4, 10</b>
<i>Advocate for community programs and initiatives that provide opportunities for social support for pregnant women and new parents—especially in rural, isolated communities</i>	<b>10</b>
<i>Establish specific mechanisms for ensuring ongoing collaboration among key partners and stakeholders</i>	<b>1, 2</b>
<i>Offer preconception care programs in school, workplaces and community-based agencies</i>	<b>6, 9</b>
<i>Integrate preconception health messages at all health care provider appointments and contacts</i>	<b>6</b>
<i>Provide “true consultation”* to at-risk groups to ensure that program planning meets their needs</i>	<b>2, 3, 4, 5</b>
<i>Provide continued funding and support for community-based initiatives such as Healthy Baby Clubs</i>	<b>4</b>

\* **true consultation:** seek advice from pregnant women “where they are” in their communities, e.g., face-to-face; involve women from the outset in program planning, design and evaluation

## Populations

### Who should be the target of our actions to improve health?

**Individuals:** Women who are at risk because of social and medical factors, e.g., pregnant women who do not access prenatal care and education and support services; all individuals planning a pregnancy and all pregnant women and their partners.

**Families:** Families of pregnant women, especially partners and grandmothers as they are influential in supporting breastfeeding and parenting practices.

**Communities:** Municipalities, regional groups, religious communities, multicultural groups, service groups, i.e., Rotary, Kiwanis, Community Coalitions and Family Resource Centre Programs.

**Systems:** Education; Health and Community Services; Municipal governments; HRLE and Justice.

**Society:** Newfoundland and Labrador population.



## Appendix B

### Key Messages

**Specific key messages from the following content areas will be developed and shared with the target population:**

- benefits of early access to preconception and prenatal care
- promoting and supporting healthy lifestyle, behaviours and practices, e.g., healthy eating, smoking cessation, avoidance of alcohol and other substance use, healthy activity
- promoting healthy workplaces and home environments, e.g., no exposure to environmental tobacco smoke
- physical and emotional changes associated with pregnancy, labour and birth and postpartum
- fetal growth and development
- preparation for breastfeeding, benefits of exclusive breastfeeding, risks of not breastfeeding
- awareness of pre-term birth signs and symptoms
- enhancing communication with providers
- physical and emotional changes of postpartum, postpartum depression
- strengthening community supports and supportive relationships
- healthy adjustment to parenting roles and responsibilities
- promoting healthy parent-child attachment
- community information sources/services for preconception, prenatal and postpartum health, parenting and breastfeeding

## Appendix C

### Evidence to Support the Standards

A list of references providing evidence to support the standards is included below:

#### Standard # 1

Federal/ Provincial/Territorial Advisory Committee on Population Health (ACPH) Working Group on Healthy Child Development (1999). *Investing in Early Child Development: The Health Sector Contribution*. Ottawa, ON: Minister of Public Works and Government Services Canada. <http://www.hc-sc.gc.ca/hppb/childhood-youth/>

MacLellan, D., Bradley, D. & Brimacombe, M. (2001). Stakeholder evaluation of a high-risk prenatal nutrition intervention program in Prince Edward Island. *Canadian Journal of Dietetic Practice and Research*, 62(4), 182-187.

Rivard, M. (2003). *Making Connections: Linking Theory and Practice within the Canada Prenatal Nutrition Program*. Halifax, NS: Population and Public Health Branch, Atlantic Regional Office, Health Canada.

#### Standard #2

Lee, H. & Shorten, A. (1999). Childbirth Education classes: understanding patterns of attendance. *Birth Issues*, 8 (1), 5-11.

Paredes, S., Woodford, E., Hopkins, A., MacDonald, M., Ho, A. & Andersson, N. (1999). *Perinatal Care and Caring in Eastern Nova Scotia: The First LoPHID Cycle*. Sydney, NS.

#### Standard #3

Camiletti, Y.A., & Alder, R. (1999). Learning needs as perceived by women less than or equal to 16 weeks pregnant. *Canadian Journal of Public Health*, 90(4), 229-232.

Carolan, M. (2003). The graying of the obstetric population: Implications for the older mother. *JOGNN*, 32(1), 19-27.

Gagnon, A.J. (2000). Individual or group antenatal education for childbirth/parenthood. *The Cochrane Library* [4], Oxford: Update Software.

Hoskins, R., Donovan, C., Merhi, S., Pascual-Salcedo, M., Cockcroft, A. & Andersson, N. (2000). *Examining Prenatal Services: Eastern Newfoundland Health and Community Services Region: LoPHID Project*. Holyrood, NL, Health and Community Services Eastern.

McVeigh, C. (1997). Motherhood experiences from the perspective of first-time mothers. *Clinical Nursing Research*, 6(9), 335-348.

Stamler, L.L. (1998). The participant's views of childbirth education: Is there congruency with an enablement framework for patient education? *Journal of Advanced Nursing*, 28(5), 939-947.

Standing, T., El-Sabagh, N. & Brooten, D. (1998). Maternal education during the perinatal period. *Clinics in Perinatology*, 25(2), 389-402.

Sullivan, P. (1993). Felt learning needs of pregnant women. *The Canadian Nurse*, 89(1), 42-46.

#### Standard #4

Bhagat, R., Johnson, J., Grewal, S., Pandher, P., Quong, E. & Triolet, K. (2002). Mobilizing the community to address the prenatal health needs of immigrant Punjabi women. *Public Health Nursing*, 19(3), 209-214.

Doran, L. (2001). *Canada Prenatal Nutrition Program: Models for Effective Delivery*:



*Interview Results.* Ottawa, ON: First Nations Inuit Health Branch, CPNP, Health Canada.

O'Reilly, J. (2004). Achieving a new balance: Women's transition to second-time parenthood. *JOGNN*, 33(4), 455-462.

Rising, S., Kennedy, H.P & Klima, C.S. (2004). Redesigning prenatal care through CenteringPregnancy. *Journal of Midwifery and Women's Health*, 49(5), 398-404.

Standing, T., El-Sabagh, N. & Brooten, D. (1998). Maternal education during the perinatal period. *Clinics in Perinatology*, 25(2), 389-402.

## Standard #5

Bloom, K.C., Bednarzyk, M.S, Devitt, D.L., Renault, R.A., Teaman, V. & Van Look, D.M. (2004). Barriers to prenatal care for homeless pregnant women. *JOGNN*, 33(4), 428-435.

Chandra, P.C., Schiavello, H.J., Ravi, B., Weinstein, A.G. & Hook, F.B. (2002). Pregnancy outcomes in urban teenagers. *International Journal of Gynecology and Obstetrics*, 79(2), 117-122.

Collins, J. & Hammond, N. (1996). Relation of maternal race to the risk of preterm, non-low birth weight infants: A population study. *American Journal of Epidemiology*, 143(4), 333-337.

Copper, R.L., Goldenberg, R.L., Das, A., Elder, N., Swain, M., Norman, G., Ramsey, R., Cotroneo, P., Collins, B.A., Johnson, F., Jones, P., Meir, A., & National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network (1996). The preterm prediction study: Maternal stress is associated with spontaneous preterm birth at less than thirty-five weeks gestation. *American Journal of Obstetrics and Gynecology*, 175(5), 1286-1292.

Fraser, A.M., Brockert, J.E., & Ward, R.H. (1995). Association of young maternal

age with adverse reproductive outcomes. *New England Journal of Medicine*, 332(17), 1113-1117.

Mohsin, M., Wong, F., Bauman, A. & Bai, J. (2003). Maternal and neonatal factors influencing premature birth and low birth weight in Australia. *Journal of Biosocial Science*, 35(2), 161-174.

Sword, W. (2000). Influences on the use of prenatal care and support services among women of low income. *National Academies of Practice Forum*, 2(2), 125-33.

Sword, W. (1999). A socio-ecological approach to understanding barriers to prenatal care for women of low income. *Journal of Advanced Nursing*, 29(5), 1170-77.

Sword, W. (1997). Enabling health promotion for low-income single mothers: an integrated perspective. *Clinical Excellence for Nurse Practitioners*, 1(5), 324-32.

## Standard #6

Albrecht, S.A., Maloni, J.A., Thomas, K.K., Jones, R., Halleran, J. & Osborne, J. (2004). Smoking cessation counselling for pregnant women who smoke: Scientific basis for practice for AWHONN's SUCCESS project. *JOGNN*, 33(3), 298-305.

Jackson, C.P. (1995). The association between childbirth education, infant birthweight and health promotion behaviours. *The Journal of Perinatal Education*, 4(1), 27-33.

Kramer, M.S. (1999a). Nutritional advice in pregnancy. *The Cochrane Library [3]*, Oxford: Update Software.

Kramer, M.S. (1999b). Regular aerobic exercise during pregnancy. *The Cochrane Library [3]*, Oxford: Update Software.

Lumley, J., Oliver, S. & Waters, E. (1999). Interventions for promoting smoking cessation during pregnancy. *The Cochrane Library [3]*, 1-2, Oxford: Update Software.

Lumley, J., Watson, L., Watson, M. & Bower, C. (1999). Periconceptional supplementation with folate and/or multivitamins for preventing neural tube defects. *The Cochrane Library* [3], Oxford: Update Software.

Mackey, M.C., Williams, C.A. & Tiller, C.M. (2000). Stress, pre-term labour and birth outcomes. *Journal of Advanced Nursing*, 32(3), 666-674.

McFarlane, J., Parker, B. & Soeken, K. (1996). Abuse during pregnancy: associations with maternal health and infant birth weight. *Nursing Research*, 45(1), 37-42.

Newburn-Cook, C., White, D., Svenson, L., Demianczuk, N., Bott, N. & Edwards, J. (2002). Where and to what extent is prevention of low birth weight possible? *Western Journal of Nursing Research*, 24(8), 887-904.

Ventura, S.J., Hamilton, B.E., Mathews, T.J. & Chandra, A. (2003). Trends and variations in smoking during pregnancy and low birth weight: Evidence from the birth certificate. *Pediatrics*, 111(5), 1176-1180.

### Standard #7

Association of Registered Nurses of Newfoundland and Labrador (2002). *Guidelines for Registered Nurses in the Role of Childbirth Educator*. St. John's, NL.

Canadian Nurses Association (2001). *Position Statement: Quality Professional Practice Environments for Registered Nurses*. Ottawa, ON.

Canadian Nurses Association (2000). *Guidelines for Continuing Nursing Education Programs*. Ottawa, ON.

Canadian Nurses Association (1998). *Educational Support for Competent Practice*. Ottawa, ON.

Geber, J. (1998). *Perinatal Education Guidelines*. Vancouver, BC: British Columbia

Ministry for Children and Families with the British Columbia Reproductive Care Program.

International Childbirth Education Association (1999). ICEA position paper: The role of the childbirth educator and the scope of childbirth education. *International Journal of Childbirth Education*, 14(4), 33-39.

### Standard #8

Canadian Nurses Association (2001). *Position Statement: Quality Professional Practice Environments for Registered Nurses*. Ottawa, ON.

McDougall, D., Selwood, B., Clough, L., Mahabir, G., & Walters, S. (2003). *Growing Babies... Growing Parents: An Evidence Based Perinatal Resource*. Vancouver, BC: BC Women's Hospital & Health Center and Vancouver Coastal Health Authority.

### Standard #9

Best Start (2003). *The Impact of Poverty on Pregnant Women: A Guide for Program Managers*. [http://www.beststart.org/resources/anti\\_poverty/pdf/prog\\_mgr\\_guide.pdf](http://www.beststart.org/resources/anti_poverty/pdf/prog_mgr_guide.pdf)

Best Start (2002). *Reducing the Impact: Working with Pregnant Women who Live in Difficult Life Situations*. [http://www.beststart.org/pract\\_prod/anti\\_poverty/reduce.pdf](http://www.beststart.org/pract_prod/anti_poverty/reduce.pdf)

Canada Action Program for Children/Canada Prenatal Nutrition Program, Government of Canada (2001). *The CAPC/CPNP Think Tank: Reaching and Maintaining the Focus Population*. Ottawa, ON.

Heaman, M., Sprague, A. & Stewart, P. (2000). Reducing the preterm birth rate: A population health strategy. *JOGNN*, 30(1), 20-29.

Health Canada, Government of Canada (2004). *Population Health Promotion: An Integrated Model of Population Health and*



*Health Promotion*. <http://www.hc-sc.gc.ca/hppb/phdd/php/php2.htm>

Health Canada, Government of Canada (2004). *Population Health Approach*. <http://www.hc-sc.gc.ca/hppb/phdd/approach/approach.html>

Health Canada, Government of Canada (2001). *The Population Health Template Working Tool*, Strategic Policy Directorate, Population and Public Health Branch, Ottawa, ON.

### Standard #10

Gillieatt, S., Ferroni, P. & Moore, J. (1999). The difference between sanity and the other. A study of postnatal support groups for first-time mothering. *Birth Issues*, 8(4), 131-137.

Leitch, S. (2002). *Postpartum Depression: A Review of the Literature*. St. Thomas, ON: Elgin St. Thomas Health Unit.

Midmer, D., Wilson, L. & Cummings, S. (1995). A randomized, controlled trial of the influence of prenatal parenting education on postpartum anxiety and marital adjustment. *Family Medicine*, 27(3), 200-205.

Moran, C.F., Holt, V.L. & Martin, D.P. (1997). What do women want to know after childbirth? *Birth*, 24(1), 27-34.

Nelson, A.M. (2003). Transition to motherhood. *JOGNN*, 32(4), 465-477.

### Standard #11

Kistin, N., Benton, D., Rao, S. & Sullivan, M. (1990). Breastfeeding rates among Black urban low-income women: Effect of prenatal education. *Pediatrics*, 86(5), 741-746.

The Breastfeeding Committee for Canada. (2002). *The Baby-Friendly™ Initiative in Community Health Services: A Canadian Implementation Guide*. Toronto, ON.

The Breastfeeding Committee for Canada. (2003, 2004). *Guidelines for WHO/UNICEF Baby-Friendly™ Initiative in Canada: Practice Outcome Indicators for Baby-Friendly™ Hospital (The Ten Steps) and Baby-Friendly™ Community Health Services (The Seven Points)*. Toronto, ON (available on the BCC website <http://www.breastfeedingcanada.ca>)

World Health Organization (1998). *Evidence for the Ten Steps to Successful Breastfeeding*. Geneva.

### Standard #12

Goodstadt, M. S., Hyndman, B., McQueen, D. V., Potvin, L., Rootman, I. & Springett, J. (2001). Evaluation in health promotion: synthesis and recommendations. In I. Rootman, M.S. Goodstadt, B. Hyndman, D. V. McQueen, L. Potvin, J. Springett and E. Ziglio (Eds). [Electronic version] *Evaluation in Health Promotion: Principles and Perspectives* (pp.517-533). Geneva: WHO Regional Publications European Series, No. 92.

Health Canada (2003). *Canadian Perinatal Health Report*. Ottawa, ON: Minister of Public Works and Services, Canada. <http://www.hc-sc.gc.ca/pphb-dgsp/rhs-ssg/index.html>

Judd, J. Frankish, C.J. & Moulton, G. (2001). Setting standards in the evaluation of community-based health promotion programmes—a unifying approach. *Health Promotion International*, 16(4), 367-380.

Nutbeam, D. (1998). Evaluating health promotion—progress, problems and solutions. *Health Promotion International*, 13(1), 27-44.

## References

- <sup>1</sup> Department of Health and Community Services, Government of Newfoundland and Labrador (2003). *Moving Forward Together: Mobilizing Primary Health Care: A Framework for Primary Health Care Renewal in Newfoundland and Labrador*. St. John's, NL.
- <sup>2</sup> Department of Health and Community Services, Government of Newfoundland and Labrador (2003). *Provincial Wellness Strategy: Framework Document*. St. John's, NL.
- <sup>3</sup> Health and Community Services Agency, Government of Prince Edward Island (1996, 2003). *Circle of Health® Prince Edward Island's Health Promotion Framework*. Charlottetown, PEI: The Quaich INC.
- <sup>4</sup> Department of Health, Government of Newfoundland and Labrador (1995). *A New Life: Facilitator's Guide and Professional Reference*. St. John's, NL.
- <sup>5</sup> Government of Newfoundland and Labrador (2003). *Stepping into the Future: Newfoundland & Labrador's Early Childhood Development Initiative. Annual Report 2002-2003*. St. John's, NL.
- <sup>6</sup> Department of Health and Community Services, Government of Newfoundland and Labrador (1998). *Healthy Beginnings: Supporting Newborns, Young Children & Their Families: Program Plan*. St. John's, NL.
- <sup>7</sup> Government of Nova Scotia Department of Health (2003, 2004). *Processes and Procedures Supporting the Department of Health Role in Setting Health System Standards*, prepared by the Quality Division. Halifax, N.S.
- <sup>8</sup> Public Health Services Department, Government of Nova Scotia (2004). *Prenatal Education and Support Standards* (draft). Halifax, NS.
- <sup>9</sup> Ontario Ministry of Health /Public Health Branch, Government of Ontario (2001). *Mandatory Health Programs and Services Guidelines* (draft). Toronto, ON.
- <sup>10</sup> Teti, D.M; & Gelfard, D.M., (1991). Behavioural competence among mothers of infants in the first year: The mediational role of material self-efficacy. *Child Development*, 62, 918-929.
- <sup>11</sup> Epp, J. (1986). *Achieving Health for All: A Framework for Health Promotion*. Ottawa, ON.
- <sup>12</sup> World Health Organization (1986). *Ottawa Charter for Health Promotion*. Copenhagen.
- <sup>13</sup> Minister of Supply and Services Canada (1994). *Strategies for Population Health: Investing in the Health of Canadians*. Ottawa, ON.
- <sup>14</sup> Women's Policy Office, Government of Newfoundland and Labrador (2003). *Guidelines for Gender Inclusive Analysis: An integrated approach to policy/program development*. St. Johns, NL.





*Photos Courtesy of Health Canada*