A Perinatal Intervention Program for Urban American Indians

Part 2: The Story of a Program and Its Implications for Practice

Sandra L. Prater, PhD
Carol L. Davis, RN, BSN, LCCE, FACCE

Abstract

This is the story of how a culturally aware staff successfully intervened with a clientele of another culture. A high infant mortality rate for American Indians in Milwaukee, WI, prompted a community health agency to initiate a program to address the problem. Efforts were made to educate the American Indian community about the importance of both prenatal and postnatal care. Part 1 of this report was published (Davis & Prater, 2001) and presented the design and implementation of the program, as well as program outcomes. Here, Part 2 describes aspects of the same program, including the personal story of a client and the results of an evaluation conducted by a three-person research team. Implications for practice are also presented. Among these are suggestions for hiring and retaining staff, locating and retaining clients, addressing cultural sensitivity, and identifying administrative actions that enhance program operation. The personal stories of two additional clients are included to illustrate the difficult reality of some clients' lives and the resulting necessity for flexibility and resourcefulness on the part of program staff. This program represents the positive impact that program workers had on the problem of American Indian infant mortality.

Journal of Perinatal Education, 11(2), 23-32; *American Indian, prenatal, perinatal, pregnancy, Lamaze Method*.

A perinatal intervention program was initiated a decade ago in Milwaukee, WI, to address the high infant mortality rate of American Indian infants in the city: 22.27 deaths per 1,000 live births from 1983–1986 (Wisconsin Department of Health and Social Services, 1987). Ameri-

SANDRA L. PRATER is a freelance social services researcher and consultant in Milwaukee, Wisconsin. Her areas of interest include minority health care issues and social welfare policies that impact women. CAROL L. DAVIS is a research nurse coordinator in Milwaukee, Wisconsin. She serves on the Wisconsin State Maternal Mortality Review Team and is chair of the Coalition for Improving Maternity Services (CIMS) Designation Committee.

can Indian women of childbearing age were targeted, and efforts were made to educate the American Indian community about the importance of both prenatal care during pregnancy and postnatal check-ups and immunizations after babies arrive. Over the three-year course of the program, 186 women and 152 children received case-management services.

Part 1 of this report presented design and implementation of the program, program outcomes, and implications for childbirth educators (Davis & Prater, 2001). Part 2 of the report, presented below, discusses the effectiveness of the program and implications for perinatal practice. Though housed in an agency short on funds and staff, this program impacted infant mortality primarily through the efforts of two program workers.

The Story of a Perinatal Intervention Program

The perinatal intervention program for American Indian mothers in Milwaukee can be viewed from several perspectives. They are:

1. Comparison of program outcomes with goals;
2. Medical outcomes for mothers and infants;
3. Lamaze class feedback from one class;
4. Formal evaluation from outside the agency; and
5. A client's personal story.

The overriding story, however, is of how workers of one culture successfully attracted members of another culture and contributed to their well-being. This is a timeless story with implications for many other settings.

Program Outcomes as Context for this Story

The goals of the perinatal intervention program were threefold: 1) to increase the number of American Indian women and infants (to age 1) who were monitored, 2) to increase the percentage of women entering prenatal care early in their pregnancies, and 3) to provide continuity of prenatal care for those mothers who traveled between reservations and Milwaukee.

Program Outcome #1. Increased numbers of targeted clients were served each successive year of the perinatal intervention program. In Year One, 180 indi-

viduals received case management: 96 mothers and 84 infants. In Year Two, the number of mothers served increased to 106, and the number of infants monitored increased to 96. The number of mothers served in Year Three increased to 132, while the number of infants dropped slightly to 92. When these statistics were placed in the context of American Indian births statewide at that time, they represented approximately 16% of American Indians (Wisconsin Department of Health and Social Services, 1989).

Program Outcome #2. The perinatal intervention program was successful in educating American Indian mothers regarding the importance of beginning prenatal care early in their pregnancies. Only 58% of American Indian mothers statewide entered prenatal care in their first trimester at that time, while 85% of white women entered care in their first trimester (Wisconsin Department of Health and Social Services, 1989). In the perinatal intervention program, 61% of pregnant American Indian women in the project area entered care in their first trimester in Year One, 73% in Year Two, and 70% in Year Three.

In the perinatal intervention program, 61% of pregnant American Indian women in the project area entered care in their first trimester in Year One, 73% in Year Two, and 70% in Year Three.

Program Outcome #3. At the time the perinatal intervention program was initiated, no mechanism existed in the state to ensure continuity of care for American Indian women who migrated between reservations and urban areas. The model of a network that included tribal and urban Indian clinics to provide prenatal care was a unique feature of the perinatal intervention program. Since the migratory phenomenon is universal throughout American Indian culture, such a model was considered necessary to a program seeking to improve the health status of American Indians (Ninham, 1989).

Although each of the six Wisconsin tribes (Chippewa, Menominee, Oneida, Potawatomi, Stockbridge-Munsee,

and Winnebago) has a separate and distinct culture, similar values exist in each culture that supported the purpose of the perinatal intervention program: 1) a reverence for life, 2) the recognition that children represent the future, 3) the need for a strong and healthy younger generation, and 4) the need to remain in harmony with nature by maintaining a healthy lifestyle (Ninham, 1989). An attempt was made to incorporate and emphasize these values in all aspects of the perinatal intervention program.

Program staff worked hard at building lines of communication with the 10 tribal clinics in Wisconsin. Forms were developed in anticipation of the numbers of American Indian mothers who would disrupt their prenatal care by migrating from reservation to urban area or vice versa. The high number of migrating mothers never materialized; only five women migrated during their pregnancies over the three-year course of the program (Verberg-Grennier, 1991).

A survey of a sample of program clients attempted to clarify the extent of client contact with reservations (N=43). Eighteen had visited a reservation three times or more in the previous year, described their visits to the reservation as regular, or said they often visited a relative there. Seventeen said they planned to visit a reservation several times, often, or on a regular basis during the next 12 months. Eleven had previously used a reservation clinic at some time for a variety of services (Zakhar, 1992). During this program, however, brief visits to the reservations were prevalent, but migration was not. Perhaps clients made an effort to stay in contact with staff and clinic services of this program, rather than supplement it with reservation care.

Health Outcomes for Mothers and Infants

The most important outcome of any perinatal program is healthy mothers and healthy babies. The American Indian mothers in this program successfully dealt with the threat of preterm labor, as no preterm births occurred. This compares to a Wisconsin statewide rate of 15% for American Indian women (Wisconsin Department of Health and Social Services, 1991). Perinatal intervention program staff estimated that up to 50% of the American Indian women they served experienced some preterm labor. Staff believed that helping women recognize and respond appropriately to the symptoms

of preterm labor was a major accomplishment of the program (Zakhar, 1992).

The American Indian mothers in the program had relatively few complications during their pregnancies, labor, and deliveries. Less than a 10% complication rate was reported (Verberg-Grennier, 1991). In general, the mothers in the program kept medical appointments and followed the advice of providers during the course of their pregnancies.

No infant deaths occurred and no low birth-weight babies were born to any woman who participated in the program. The average birth weight was 7 lbs. 5 oz. No fetal alcohol syndrome or fetal alcohol effect was diagnosed. However, one baby was born with congenital anomalies.

No infant deaths occurred and no low birth-weight babies were born to any woman who participated in the program.

By all indicators available, health outcomes of mothers and babies in the perinatal intervention program appear to be positive.

Evaluation by a Research Team

Staff Interviews. A three-person research team from outside the agency conducted 17 interviews of agency and program personnel (former and current) and reservation clinic personnel. Interview schedules varied depending on the subjects' program responsibilities and current employment status with the perinatal intervention program. Questions were general and open-ended. Interviewees were encouraged to take as long as they needed to answer questions and discuss issues. Among the 17 individuals who were interviewed, 10 were directly involved in providing perinatal services to American Indian women of child-bearing age (seven registered nurses, a social worker, the perinatal database manager, and outreach worker).

Staff suggestions for improving the perinatal intervention program fell into three categories:

1. Increase opportunities to develop cohesiveness as a team;

2. Define more clearly how the program fits into the organizational goals of the agency as a whole; and
3. Develop a guiding philosophy of service delivery and case management to which all team members contribute and with which all can agree (Zakhar, 1992).

Client Interviews. Forty-three mothers were paid \$5 for a face-to-face interview that took between 20-40 minutes. The interview questions were designed to elicit their level of satisfaction with the program and how the program may have caused them to change at-risk health behaviors. One of the research team members (first author) conducted most of the client interviews. Mothers reported a high level of satisfaction with their care. On a scale where 10 was the highest rating, mothers consistently rated the program, the nurses, and their obstetricians in the 8-10 range. It is important to note that, while the women were very satisfied with their doctors, without exception they rated nurse providers even higher.

Forty-two of the women said that the program made American Indian clients feel comfortable; one woman was unsure. Thirty-three women reported changes in personal behavior, such as changing their eating habits or those of their children (23), stopping or reducing smoking (16), stopping alcohol consumption (7), and improving their commitment to keeping their prenatal appointments with doctors.

These data suggest that American Indian mothers who used the services of the perinatal intervention program were satisfied with the providers and services. This is an especially important factor in a community that relies on word-of-mouth for information. A limitation is that the interviews took place in program offices with program staff nearby, which may have influenced the answers received.

Shirley's Story: A Client's Personal Experience

Shirley was a beautiful, slender, 17-year-old American Indian with long, dark hair. She stopped by the program's storefront center for a drop-in pregnancy test. The test was positive. Shirley was homeless and unemployed and knew little about pregnancy, prenatal care, or parenting.

In the nurse's office, Shirley covered her face with her hands and said, "How can I do this? I don't have my

own home or even my own groceries. My mom is an alcoholic and I just stay with my blanket roll wherever she finds to stay. I have nothing to call my own, and I don't know when or where my next meal will come from."

We promised to help Shirley. She left the center with WIC coupons to redeem for food, a temporary medical card, an appointment with a maternity care provider, and bus tickets to transport her to the appointment. We invited her to drop in anytime and view movies on healthy pregnancy, childbirth, breastfeeding, and parenting. She also had two return appointments with program staff: one appointment with the nurse for continued counseling and another appointment with the community health center's social worker who would assist with housing.

Shirley became a regular visitor to the program. By the time her baby was born, she lived in an apartment with her boyfriend who had found fulltime employment. At the initial postpartum home visit, the nurse discovered signs and symptoms of cesarean incision infection. We contacted the doctor, even though it was New Year's Eve, and an antibiotic was ordered. Shirley asked the nurse what her plans were for the holiday, then questioned, "Aren't you going to drink?" The nurse replied no, that drinking was not part of her celebrations. Shirley replied, "I thought everyone got drunk on New Year's Eve."

Shirley breastfed her baby and learned to care for her by participating in multiple interactions with program staff, watching videos, and observing her partner, who was from a large family and who was comfortable and experienced with children. In addition to receiving program incentives, Shirley won a wall hanging as a door prize at the program's "Celebrate Life" night. She hugged it to her heart, saying "I have never won anything in my life."

A year later, Shirley visited us early in a second pregnancy. She again kept her appointments and prepared for a vaginal birth after cesarean. She confided, "I am afraid my crotch will bust through." No fetal distress occurred this time, and another 8-pound baby girl, delivered over an intact perineum, joined the family. It was a joy to watch Shirley's mothering skills with this child as she explained how her partner had taught her to know what babies needed. Shirley and her partner attended the nurturing program together. Later, they were fre-

quently out in the community, attending ceremonies and teaching their girls traditional customs. During an interview with a member of the team that conducted an evaluation of the program, Shirley told the interviewer, "This program saved my life."

Lamaze Class Feedback

A sample of 11 people in one class completed a 5-item questionnaire evaluating a Lamaze course that consisted of six classes (see Table for the questions and raw data of class responses). The responses seemed to reflect satisfaction and a focus on preparing for birth. Lamaze classes are often thought of as a middle-class activity; thus, it is important to track how other groups respond to them. In this study, the respondents' answers might reflect familiarity with the *Mother-Friendly Childbirth Initiative* document (Coalition for Improving Maternity Services, 1996) although, due to the timeframe, these mothers had no access to that document, which suggests that the issues of childbirth span across time and cultural groups.

Implications for Perinatal Practice

Although the outcomes of this program are impressive, the story of the process by which they were accomplished is worth telling. Many implications of this perinatal intervention program are available for other perinatal practice. The lessons that we learned from this program may be relevant to a childbirth educator or nurse in a hospital, community, case-management, or research setting, to a social worker, or to a grant writer. We worked to "Secure the Future" (our program's motto) for American Indian infants. Securing the future with healthy babies is a concern for all of us.

Implications for Program Design

Administration. Our community health agency had the good fortune of having an executive director who identified with American Indian culture. He was familiar with the problem of high infant mortality in American Indian communities and with funding sources for addressing this problem. While drafting a proposal, it was important to us to be aware of the cultural beliefs of our target population and to place emphasis on articulating the problem and the strategies for addressing it. This

Table Lamaze Class Feedback—Questions and Raw Data of Class Responses

1. Please name one thing you learned tonight.
 - Comfort measures
 - How relaxation helps birthing
 - Process of birth
 - Relaxing with imagery
 - Releasing tension to touch
 - It helps to concentrate on a focal point; staying relaxed
 - I probably won't get sick in the delivery room
 - Medical terms like *efface* and feeling like I understand the process after seeing the physical aids
 - Learning new terms through a tic-tac-toe game
 - Technique for pushing the baby out
 - Verbal action helps out
2. What is one thing you liked about tonight's class?
 - Spending more time on practice
 - The thoroughness of subjects taught
 - Small class; could talk to each other
 - How to relax
 - Imagery for relaxation
 - The birthing process from the movie
 - More insights into pregnancy and the male role being brought out more
 - It was helpful to see the life-size pelvis, uterus, and baby along with the explanation of the fetal movement in labor
 - I liked everything, but I especially enjoyed learning about how well I am able to relax
 - Learning more
3. Was there any part of the class that you disliked or that dragged for you? Add any recommendations for making the class better.
 - No one answered negatively here. There were a few comments about hoping to see more movies and having more physical activity during the class.
4. Please estimate the amount of at-home practice.
 - Comments ranged from none to 1–2 hours per week.
5. Would you recommend childbirth preparation for others? Why?

Everyone answered positively and gave the following reasons:

 - The more prepared you are, the more enjoyable the birth will be
 - It helps to prepare for labor better than on your own
 - To be more involved and prepared
 - It is always a huge help to be prepared
 - There is a lot about childbirth that not everyone knows about
 - More involvement with partner
 - Taking part with others

awareness came from conducting a literature review and a needs assessment, as well as from collaborating with other organizations and agencies that shared our concern.

A Perinatal Intervention Program for Urban American Indians

Goals. The goals of our proposal provided a framework for service. We used the goals to guide the program activities so that they were flexible. We also designed the goals to contain features that were attractive to both grantors and targeted participants. Those designing a similar program must ask themselves the following questions: Does a common bond, such as healthy babies, serve the purpose of advancing a proposal? Are there state statistics that reveal disparities in your part of the country compared to other areas? Is there a current legislative goal in your state that you can help advance? Where do your goals coincide with those of another agency or organization, or county or state government? Based on one's answers, the next step is to seek linkages.

We also designed the goals to contain features that were attractive to both grantors and targeted participants.

Hiring Staff. We considered the program goals when staff openings were being filled. In our perinatal intervention program for urban American Indians, our goals dictated that staff be culturally competent, have knowledge and assessment skills to address infant mortality, and possess the desire to interact with members of the targeted community. A case manager's nursing experience with Indian cultures, labor and delivery, public health, and childbirth education over a 20-year career proved invaluable. Similarly, the outreach worker complemented the nurse's abilities with her knowledge of the local community and its customs. Her networking capability was critical to her success.

Attitude and creativity were also important and should be considered when conducting interviews for staff for a similar project. Ask applicants how they would handle specific situations. Determine if they can give someone the benefit of the doubt, such as a co-worker or a client, and how they might react if disagreements arise.

Creating the program. A program such as this one should aim to enhance the self-esteem of its participants and allow the vision and goals to have a realistic chance

at success. We envisioned healthier mothers and fewer lost infants. We asked ourselves the following questions that elicited the respective answers: Whose blessing can we get? We sought out the American Indian community through their 16 agencies in Milwaukee. What is a common bond to link us all together? A goal of healthy babies to secure the future is hard to ignore. How will we advertise our program? Following the advice of members in the American Indian community, we created a program logo and printed it on program materials. In addition, we used an educational approach of "did you know?" to signal our sensitivity to a culture that is steeped in tradition and the wisdom of its elders.

In our pre-program assessment, we asked ourselves: Where will we locate and are there barriers to service that we can eliminate or minimize? We housed our program at a convenient location: a WIC office on the second floor of a downtown business building that was widely used by American Indian mothers. We later moved to a ground-level storefront office in the heart of the American Indian community where our fulltime program shared space with the same part-time WIC office. This site for pregnancy testing and counseling services with both drop-in and appointment hours looked like a "baby-stroller brigade." Through careful planning, we met our goal of accessibility for the target population.

We further increased our visibility by asking the following question: What can we capitalize on or link to that is already in place in the community? We used the American Cancer Society's "Great American Smoke-out" to promote smoking cessation and March of Dimes' "Healthy Habits, Healthy Babies" month to recognize healthy habits during pregnancy. An event called "Celebrate Life" was held in March at which each woman who participated in the program was recognized and awarded incentive gifts. We asked: Is there anything we can borrow from someone else who has addressed this problem? We used preterm labor-prevention wallet cards designed by Mary Lou Moore, RN, PhD, LCCE, FACCE.

An event called "Celebrate Life" was held in March at which each woman who participated in the program was recognized and awarded incentive gifts.

We also asked ourselves: Can we provide incentives for our target population? We were able to obtain gifts beyond those provided by the two granting foundations that backed this program. From the community, we procured sleepers, receiving blankets, and provisions for second-hand clothing. We obtained coupons for free sandwiches at area restaurants, free haircuts at local shops, and discounts on diapers in area stores. A tribal council grant provided diaper service to those American Indian women who would commit to breastfeed their babies over the course of the first year.

Creating the program involved the viewpoints of many interested parties, including frontline staff. Nurses and other personnel who delivered direct patient services were part of the planning of the perinatal intervention program because the success of our endeavors depended largely on the skills and abilities of those who provided direct services. The wisdom gained through the experiences of these workers was invaluable when the project was in the planning stage. The program also afforded some leeway for service providers' decision-making that supervisors could allow. Evaluation of services and reporting guidelines were built into the program so that record-keeping and staff awareness were given attention.

Anticipating needs. The agency needs of the American Indian mothers who came to this program were not totally met by the nurse and outreach worker at the storefront site. Some clients received services from perinatal nurses at the main site of the community health center. The agency's social services department operated out of both sites and was utilized extensively. Case managers referred depressed and demoralized clients to outside counseling and therapy providers. Program staff dealt with problems related to Aid for Families with Dependent Children programs, health management organizations, food-stamp allocation, jobs, clothing, and household necessities. Food-pantry services were also utilized. Staff learned that it takes many resources for dealing with the needs of low-income women such as these.

Staff experiences with two mothers can be used to illustrate the extent of our need for resourcefulness and flexibility due to violent events in some of these young mothers' lives.

Anna's Story. Anna was 17, a junior in high school, and pregnant. She wanted to attend our evening Lamaze

classes, but her mother would not give her permission to attend. We brainstormed the problem and came up with an innovation. We would teach a series of Lamaze classes in Anna's school on Friday afternoons after regular classes were completed. Anna came to class along with her partner and a male friend. Several other couples also attended, all with parental consent.

A few weeks before Anna was due, right around the Christmas holidays, Anna called the nurse. The father of her baby was missing, and Anna was very worried. A few days later, the terrible news came: Anna's partner had been shot and killed by the male friend who had attended Lamaze classes with them. The nurse supported Anna through this ordeal and throughout the following year. Anna was able to deliver a healthy baby. The nurse intervened on Anna's behalf so that the timeline of completing her junior-year requirements could be relaxed. Anna passed and graduated the following year.

Carina's Story. Carina was in a relationship that she was afraid to leave because of domestic violence and threats. When she learned she was pregnant again, she was determined not to bring a second child into the violent household. A private adoption was arranged through her physician. On the day Carina was in labor, the program nurse was teaching the outreach worker how to provide labor support for Carina. The nurse also tried to help the father of the baby, who opted to stay in the hallway, remain calm and aware of the progress of the labor.

Carina had agreed to permit the adoptive parents to be present for the delivery. They arrived from out-of-state at labor's most inopportune time: Carina's cervix was dilated to seven centimeters, and she was experiencing multiple transition phase symptoms. Carina had never met the adoptive parents. They had never attended a childbirth class or asked anyone their questions about birth. This was an awkward time to meet someone and to learn about birth, but the poignancy of the moment made an impression. Carina and the adoptive parents each said a brief hello and expressed their gratitude to each other. The nurse gave her apprentice coworker instructions to maintain the established contraction ritual and call out if she needed help. The nurse and adoptive parents stood in the doorway where the nurse described what they might encounter through transition and nor-

mal birth. She informed them of the newborn's need for quiet time to gaze into the parents' eyes.

The doctor arrived and the nurse introduced the adoptive parents to him. She left for a moment to tell the baby's father that birth was eminent, then she slipped back into the delivery room for what she termed "an incredible delivery." This unusual chain of events had required flexibility on the nurse's part.

Another emotion-laden day had unfolded with a patient from the perinatal intervention program. No two patients were alike, or had the same stories, but each mother and her family captured our hearts.

Implications for Program Implementation

After plans are made to offer a service, the challenge is to make a connection with clients to implement the program's offerings. We found that interactions with the American Indian agencies in the area were well worth the investment of time. Most families in the community that we wanted to serve had some connection with at least one of the agencies, and word-of-mouth proved an effective way of attracting clients. Invitations to tribal leaders and dignitaries to attend traditional ceremonies of dedication for the program allowed them to see the program first-hand. On our part, visits to state reservations also proved important to the program's success.

Locating Clients. In developing a client base, we asked ourselves the following questions: Where are clients? Who will refer them? How will they find us without a referral? Who are key players in the community? What other service provides for the same population? We kept abreast of community events that potential clients would attend. We examined our program for the service that could act as a hook for us to be in a position to provide other services. We asked: How will our advertisements catch clients' attention?

Health fairs, powwows, and "Indian Summer" (an annual celebration of American Indian culture held on Milwaukee's lakefront) were effective places to distribute free coupons for a pregnancy test. The appointment for the pregnancy test served as an opportunity for health education that supported program goals, whether the test was positive or not.

Client Interaction Approach. While education related to making healthy choices was a central part of the

program, we learned that a "needs-of-the-day" approach was effective in a case-management framework. Once the patient's immediate felt needs (emotional, physical, or information-seeking) were met, she became open to additional services. This build-on approach also worked with health education topics. When the immediate questions were answered and the patient was satisfied with the response, that interaction served to open opportunities for discussions on additional topics related to pregnancy and birth. Clients' health needs were promoted in several ways. Staff worked to help them maintain a vision of a better future in their minds and reinforced the survival skills they knew they had. Clients were often reconnected to their culture, family elders, or church, or they were referred to other agencies for help.

Once the patient's immediate felt needs (emotional, physical, or information-seeking) were met, she became open to additional services.

Staff Cultural Awareness. Program staff was trained in cultural sensitivity. They gained an increased understanding of the history of abuse suffered by American Indians and the knowledge that non-Indians can hold the interests of the Indian culture in their hearts. The long history of abuse and exploitation made it necessary for program staff to build trust among the targeted population. We took the approach that trust-building starts with staff. We participated in team- and trust-building activities, such as meetings with open agendas, potluck meals, brainstorming sessions, and collaboration on program specifics.

Retaining Clients. Home visits seemed to be the tie that kept staff well-connected to clients. In addition to home visits, we identified other factors that allowed us to retain clients for service. Staff attributes played a role, including personalities, experience, cultural sensitivity, competence, and dedication to provide individualized services. Program incentives helped, as did consultation with elders of the community. Activities such as organizing celebrations where food was served, photographing clients and their families, and sending "good mail" were

ways to connect and stay connected. We also kept records to facilitate case management, such as negative and positive pregnancy tests and families that had added a newborn. We kept daily logs, charts, education flow sheets, referral forms, reservation contact forms, and tickler files for the chance to provide future service. (Copies of these forms are available by contacting the second author.)

Staff Retention. Retaining staff necessitated addressing key issues: job satisfaction, staff compensation, commitment to program/agency, leadership, and team-building. The outside evaluation showed that, although most staff expressed some level of dissatisfaction with their jobs, they were able to provide services to clients who were satisfied. Salaries in a community health center were not as high as staff could have received elsewhere, but they were motivated by the fact that they did not often have to work nights, weekends, or holidays. Other perks that helped offset the lower compensation were flexibility around work schedules, attendance at leadership conferences sponsored by grantors, and provision of other types of continuing education program attendance.

Implications for Program Evaluation

Administrative support and evaluations were required by the granting agencies and helped staff remain aware of program goals. In the community health center, as strapped as it was for operating revenue and often short-staffed, perinatal program staff who provided direct service to clients often had all they could handle to get through the day. Clients presented with multiple needs and often required a great deal of time and energy. Staff had little time to do more than to meet those needs, which made program evaluation activities difficult.

Administrative support. The program director encouraged perinatal staff to write a paragraph per day on the difference each had made. Staff was reminded to ask themselves what the program had done for the community each week. They were also asked to think about how their clients could improve the service. Each activity helped staff focus on their commitment to providing high quality services and on the process that unfolded while the provision of services occurred.

Required Evaluations. Granting agencies required regular reports, which included measurement of outcomes. All staff members (nurses, social workers, outreach staff) were asked to write monthly reports. These report requirements assured that staff would, on a regular basis, take the time to chart the program's progress.

Evaluation by Outside Group. Outside evaluations were also required by the funding agencies. For example, as reported above, in the third year of the perinatal intervention program, a three-member research team conducted interviews with staff, clients, and other community and state workers connected to the program. This evaluation by the research team included input from a nurse who is a health care system analyst and who provided important feedback for staff members and agency administration. It resulted in flow process charts that the staff was assisted to design. The consultant helped the perinatal staff recognize the need for a consistent operating model to which everyone could refer. See Figure for an example of a client intake flow sheet.

The outside consultant who led the research team that evaluated the perinatal intervention program also pointed out problems with regard to program data availability. The perinatal database at the community health center received selected data from the program, but data were not usefully integrated. For example, data on provider visits and class attendance were collected, but they were entered and stored in the agency minicomputer. This database served no useful purpose because the information it contained was not accessible to program staff. A more integrated approach to database entry and retrieval was instigated.

Conclusion

The perinatal intervention program described in this report serves as an example of the impact individuals using a well-planned program approach can have on a serious

We tell this story so that other providers who face similar challenges may take heart that progress can be made. . . .

A Perinatal Intervention Program for Urban American Indians

Figure Client Intake Flow Sheet

Additional flow sheets were developed for this program to monitor client services and follow up.

Janet Kraegel, RN, PhD, a health care systems analyst, helped program staff members develop this flow sheet.

health problem in their community. This, combined with staff commitment and enthusiasm, helped a long-suffering community begin the journey to secure the future—that is, to save their babies—even though funding was marginal. We tell this story so that other providers who face similar challenges may take heart that progress can be made and that human suffering can be lessened in a neighborhood or a community.

References

- Coalition for Improving Maternity Services (CIMS). (1996). The Mother-Friendly Childbirth Initiative. [On-line]. Available: www.motherfriendly.org/MFCI/mission.html.
- Davis, C. L., & Prater, S. L. (2001). A perinatal intervention program for urban American Indians—Part 1: Design, implementation, and outcomes. *Journal of Perinatal Education*, 10(3), 9–19.
- Ninham, M. (1989). *Proposal: American Indian maternal and infant care grant*. Unpublished.
- Verberg-Grennier, K. (1991). *Final Report: American Indian maternal and infant care project*. Unpublished grant report for R.W. Johnson Foundation.
- Wisconsin Department of Health and Social Services, Center for Health Statistics. (1987). *Maternal and child health statistics of Wisconsin*.
- Wisconsin Department of Health and Social Services, Center for Health Statistics. (1989). *Maternal and child health statistics of Wisconsin*.
- Wisconsin Department of Health and Social Services, Center for Health Statistics. (December, 1991). *Prenatal care in Wisconsin: Differences by payment source and race, 1990*.
- Zakhar, A. A. (1992). *Milwaukee Indian Health Centers' American Indian Infant Mortality Reduction Project: Three-Year Final Project Report*. Unpublished grant report for W.K. Kellogg Foundation.