The Netherlands

Experienced mothers are the key

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This article is about the keys roles that experienced mothers play in Moeders Informeren Moeders (MIM – Mothers Inform Mothers), a community-based early childhood care and development support programme. The project, operated by the Nederlands Instituut voor Zorg en Welzijn (NIZW), is based on the fact that experienced mothers from the same neighbourhood (peer group mothers) can readily support first time mothers and their babies. This idea has its roots in the Irish 'Community Mothers Programme' and the 'Child Development Programme' from the United Kingdom. Operating through the existing networks of local care organisations, MIM targets mothers from socially vulnerable environments who are not readily reached by regular healthcare services. The core of the project is a home visiting programme, centred on the development of babies and the well-being of the new mothers, and carried out by volunteer experienced mothers who are trained and supported by community nurses. Essentially, MIM has been developed as a part of the regular healthcare provision offered to new mothers. Slightly modified versions of the MIM approach are geared to specific target groups, such as rural populations, migrants, refugees and travelling people. Currently, there are MIM programmes in two large towns, six medium sized towns and three small towns in The Netherlands.

The Netherlands: *young mothers playing with their children.*
Moeders Informeren Moeders Project
Photo: NIZW – Nederlands Instituut voor Zorg en Welzijn

The Netherlands is a small, densely populated country. Approximately 15.2 million people live in the country and 3.7 million of these are under the age of 19. Preventive child health and welfare services for all children up to the age of 18 are a legal right, and are carried out by municipal or regional health authorities for school going children, and by community nursing agencies or general practitioners for babies and preschool children. Traditionally, healthcare professionals have had 'expert care provider' roles associated with the medical model. However, child healthcare has changed and community nurses are now embracing new concepts such as community-based models that include social and pedagogical support.

The aim of child healthcare services for preschool children in The Netherlands can be described as:

> the promotion and safeguarding of the healthy physical, mental and social development of the population of preschool children. This starts from the parents' personal responsibility, aiming to influence relevant health determinants, namely physical factors, health behaviour and relevant environmental factors, including the system of care itself.

One objective that can be made operational is

> to promote at an individual and group level, the personal competence and the responsibility of parents with regard to their children, if necessary by advancing their understanding of the health and (potential) development of their child and by increasing their competence.[1]

This includes stimulating behaviour that promotes good health.

The MIM programme tries to implement this objective, using an ecological model of development as characterised by Bronfenbrenner who recognised the importance of parents' roles in children's development, but equally recognised the importance of the environment in which families live:

> Whether parents can perform effectively in their childrearing roles within the family depends on role demands, stresses and support emanating from other settings. Parents' evaluation of their own capacity to function, as well as their view of their child, are related to such external factors as flexibility of job schedules, adequacy of childcare arrangements, the presence of neighbours and friends who can help out in large and small emergencies, the quality of health and social services and neighbourhood safety.[2]

What is MIM?

Against this background, the MIM programme has been developed as an innovative early childhood development and parent support programme that is based on a synthesis of nursing, pedagogical and health promotional theories. It forms part of the regular national child health and welfare service provisions, supporting inexperienced parents with parenting, helping them to cope and to stay abreast of their children's development, and helping to prevent childrearing problems. The programme aims to: enhance the ability of women to cope with their new born babies; enhance social support; encourage mothers to adapt their behaviour after receiving health educational information; increase the number of women breastfeeding; and make women feel in control of their lives. One key element is a focus on reinforcing mothers' sense of self-esteem, thereby improving their ability to parent without outside support.

The core of the project is a home visiting programme that centres on the development of babies and the well-being of the new mothers. We call them 'programme mothers'. The home visits are carried out by volunteer experienced mothers ('visiting mothers'). The visiting mothers are trained and supported by community nurses, and they address the same range of topics as in the Wellbaby Clinics run by the regular preventive child health and welfare services. However, within a home visit these topics are discussed from a pragmatic angle, in a context which is meaningful to the programme mother.

The programme mothers come from a multitude of countries in Europe, Asia, Africa and South America. Most have had ten years of formal education (intermediate and vocational level) and live on the earnings of their spouse. However, a few are double earners and a few live on social welfare payments. The programme starts early, ideally just before confinement. All first time mothers living in the participating areas are offered the programme but special attention is given to socially disadvantaged groups, members of immigrant communities and children in need.[3] Approximately 30 percent of all first time mothers participate in the programme, which is in line with the set target of the community nursing agencies.

The visiting mothers come from the target groups that they serve. They are well equipped to answer questions that expectant and new mothers may have, and MIM makes sure that they also have a close understanding of what the new

mothers are going through. For example, a visiting mother of twins is matched with a programme mother of twins. Programme mothers with a baby suffering from a severe allergy or a baby born prematurely, are matched in the same way to appropriate visiting mothers.

Preparation and reflection; sensitivity and respect

Community nurses, specialised in child healthcare and welfare, coordinate the programme in each area. They are responsible for recruiting both programme and visiting mothers to participate in the programme, and for matching them up according to educational or other significant common background variables. These variables include education, or specific experiences such as having premature babies. The community nurses prepare each visiting mother individually and, after two or three preparation sessions, she starts her home visits to her programme mothers. After each visit the visiting mother meets the community nurse for further support, based on her experiences during the visit.

Working with the community nurses, the visiting mothers plan for each visit using a discussion paper. They may use this during the visit, or to document their visit afterwards. The programme mothers will be given this document during the next visit and will thereby accumulate a complete record of all developments. The visiting mothers adapt MIM materials to suit the programme mothers they visit, using their own standards and experiences. Their approach is to give as little advice as possible. Rather, they support the young mothers in finding their own answers to day to day questions and in resolving problems when they arise.

As well as individual support from community nurses, visiting mothers benefit from group sessions every six or eight weeks. Some of these are run by the visiting mothers themselves, some by the community nurses. However, the main objective is always that the visiting mothers share and discuss experiences that are important for all of them, thereby learning through and from each other. An example of this reflective learning concerned a child who smacked another child. The assaulted child turned the other cheek (literally) and was struck again. Her mother was worried about this and did not know how to react so she asked her visiting mother for her views. In a group discussion, the visiting mothers discussed the topic because it might arise with any of their programme mothers and because it dealt with the difficult area of personal norms on violence.

Other topics in the group sessions have included special information that the mothers need to know about the MIM programme – such as how to use MIM tools – new activities for mothers with young children in the neighbourhood, and information about health and the local health service.

In practice, there are a maximum of 18 monthly home visits over an 18 month period and in each, the visiting mother uses two aids: a home visiting checklist of childcare related topics, which is used to introduce any topic the programme mother might be interested in; and a sequence of cartoons. The cartoons depict either different childcare related scenes, or the choices that can be made about a specific topic. The visiting mother develops a discussion with the programme mother about the contents of a cartoon and this is the starting point for an exploration of the programme mother's current attitudes, knowledge or behaviour. (see opposite page)

So far, so good

An action-research review of the MIM project shows how programme mothers of different social background benefited. For example, they showed increased self-confidence, felt more independent and were better able to make their own choices. Some stated that the programme caused them to treat their children differently than they had expected before starting with MIM. Paying systematic attention to the development of their babies made them more sensitive to incremental steps in their children's development. They also felt they had become more aware of the impact of their actions, and more active in positively rearing their children. Programme mothers also participated more in other activities organised for them and their

children, such as information meetings and playgroups.

Mothers mentioned several factors that motivated them to participate in the MIM programme. For example, some mothers liked to hear and read all about babies and childrearing and wanted to share their own experiences with others. Others reflected on their lack of social contacts in the neighbourhood: MIM gives them the opportunity to meet other mothers. Some mothers were confused by the volume of information that they had been given from many different sources. Before their participation in MIM, it had been difficult for them to make the choices that they felt were most appropriate to their own circumstances. The visiting mothers helped them to untangle the confusion.

Perhaps the most telling indication of MIM's impact can be gauged by hearing about the experiences of some of the mothers themselves. Joanka Prakken has assembled some of these in *Ik dacht in het begin dat ik geen goede moeder was (In the beginning, I thought that I was not a good mother).* Here are her examples of programme mothers from the city of Breda.

Claudia became a first time mother some nine months ago – in fact she had twins. And, as Claudia will emphatically tell you, a first baby raises many questions, doubts and uncertainties. Claudia talks fast, stumbling over her own words as she tells you her story:

> *Twins! You don't know what's happening to you! It started when they both were on a different feeding regime – it took me all day to feed them and I never had a moment to myself!*

> *And then there was the crying: some sixteen hours a day – from stomach cramps as they found out later.*

Claudia had the feeling that she didn't perform well as a mother. And everyone who was supposed to assist her had different opinions and gave her different advice:

> *I could really have flown into a rage against those know-it-alls: "Just let the babies cry" they told me, "it's their crying hour". But they only had one*

Using the cartoons

The cartoons contain seven different themes about childrearing and child development: social-emotional development of the child and social-emotional support of the mother; physical development; play; feeding; cognitive development; language and safety. These are areas in which the mothers themselves have influence.

During the home visit the programme mother talks about her experience with the baby and the questions she has or problems she has met. Together with the visiting mother she looks for cartoons that match her questions or interests. For example, as a result of discussions about breastfeeding based on one cartoon, a mother from Sri Lanka discovered that she could request the use of a room and free time for breastfeeding her child during her Dutch language lessons.

The cartoons also help mothers to cope with the unexpected. For example, most babies develop special bonds with the people who care for them and are most often with them. But, at the age of about nine months, they may get angry or upset when they see a stranger. A new mother may not expect this and believe that her child is acting abnormally. She can discuss this with her visiting mother while the cartoon shows her that her child's behaviour is normal.

The Netherlands: *cartoons to open up discussions*
Moeders Informeren Moeders Project

The Netherlands: *the MIM Coordinators' Handbook*
Moeders Informeren Moeders Project

child each who maybe cried for just an hour. I had twins who were only quiet when I was feeding them. How could they imagine themselves in my situation?

But then Claudia heard about the Moeders Informeren Moeders (MIM) programme. Through mim Claudia came into contact with Milia, a mother of three year old twins. Milia, unlike Claudia, keeps calm, and has been able to give Claudia more self-confidence:

If you become a first time mother, you're insecure. You face the same problems over and over again and wonder whether you are doing well. A baby is not always so great. It's not easy to say this, certainly not against your own surroundings.

A mother can tell me her story. I don't come to Claudia to tell her how she should do it. I see myself as a sort of colleague mother who can depend on her experience as a mother. We talk and I try to really understand what she thinks is important, what she wants for her children or what bothers her. I let her come up with solutions herself. Every child is different, so what worked with my children, might fail with her's. Often she already knows what is good for her babies: all she needs is for me to confirm it

Renate is another mother from Breda, who participated in MIM. She lives in a district of the city in which there are many young families with small children. Newcomers are from various social backgrounds and there is little contact between them. Renate believes that mim can help mothers to make contacts between themselves. Her family lives far away and her friends who live in the neighbourhood have no children.

Some programme mothers have progressed to become visiting mothers, among them is Carolina Kleinjan:

My motivation comes from my past experience: I benefited from the programme and wanted to give something in return. My first contact with MIM was when my first child was born and I was asked to enter

the programme as a programme mother. At the time, the programme had just started in The Netherlands and was still developing. After nine months my visiting mum stopped working in the programme for personal reasons but, in our last conversation, she suggested to me that I should become a visiting mother myself. At first I did not think I had enough experience.

Then, after giving birth to my second child, the MIM co-ordinator in Breda, Annette phoned and asked me if I would like to participate? I said yes – I wanted to help mothers in the same way that my visiting mother had helped me. As a visiting mother I try to support other mothers in making their own decisions. Helping them to trust their own intuition and showing them how their child is developing are some of the other things we try to do.

Others added their own reasons for becoming visiting mothers. These included: to help other first time mothers to enjoy their babies; to give support and make programme mothers trust their own intuition; to help young mothers make social contacts; and to give programme mothers the important experience of having someone listen to them.

In terms of the impact on them as people, visiting mothers show increased self-sufficiency and enhanced self-esteem. They participate more in social activities within and outside the programme, some have moved into further education, and others have either already moved into paid employment or expect to do so.[4]

Conclusions

After several years of developing, operating and reflecting on the MIM project, several lessons have emerged. The most important are:

- the fact that the programme is home-based increases the confidence of the programme mothers;
- developing the programme in partnership with the target group ensures that the programme is well suited to the target group;
- working through visiting mothers from the programme mothers' peer group solves many of the problems of reaching those living in disadvantaged/multiple problem circumstances;
- the MIM approach produces self-reliant and self-confident mothers;
- it also clearly enhances the personal development of the visiting mothers;
- from a professional perspective, the programme has been instrumental in enhancing our quality assurance activities; and
- a clear understanding of the range and type of questions that programme mothers ask the visiting mothers has had a direct influence on practices at Wellbaby Clinics. For example, both nurses and doctors now pay more attention to the needs and questions of the parents; and they adapt advice to fit the specific situation of the family and the development of each child.

In general, we believe that MIM – like other community-based programmes – helps to stimulate and enable new mothers as they support the health promoting and child development behaviour. It does this by empowering parents and supporting them both personally and as the people who are most important in their developing children's lives.

Notes

1. Winter M de, Balledux J de Mare, and Burgmeijer R, *Screening in child health care: a report of the Dutch Working Party on Child Health Care* (1995); Radcliffe Medical Press; Oxford/New York.
2. Bronfenbrenner U, *The ecology of human development: experiments by nature and design* (1979); Harvard University Press; Cambridge, USA.
3. Children in need are defined as those with disabilities and those whose health or development, in the broadest sense, would be impaired or limited without the provision of such services.
From Hanrahan M and Prinsen B *Let´s talk. Mothers Inform Mothers: A Dutch community-based early-childhood care and development support programme* (1998); NIZW; Utrecht, The Netherlands.
4. In Prakken J, *Je hebt het over mensen. Vernieuwing in de praktijk;* (1995); NIZW, Utrecht, The Netherlands.