Welcome!

We are so glad you are here!

We will get started shortly.
In the meantime, we invite you to intentionally enter this space.

Silence your cell phone

Close the door

Close browser windows

Check your audio and video

Stretch

Take a few deep breaths

Emotionally release your to-do list

Take a bio break

Fatherhood Learning Academy — Session 1

Tuesday, July 27, 2021 || 2:00pm to 4:00pm ET

HEALTHY start TA & SUPPORT CENTER

NICHQ National Institute for Children's Health Quality

Fatherhood Learning Academy

July 27, 2021

HEALTHY start TA & SUPPORT CENTER

NICHQ National Institute for Children's Health Quality

Agenda

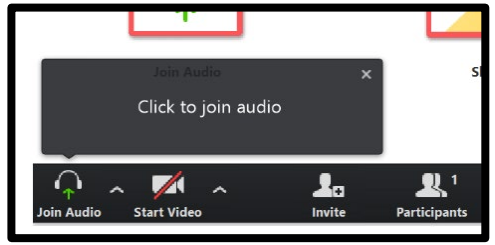
Housekeeping	Lisa Hong, NICHQ
Welcome & Introduction to the Healthy Start Fatherhood Learning Academy	Kenn Harris, NICHQ
Overview of the Fatherhood Learning Academy	Dr. Jeffery Johnson, NPCL
Homework & Next Steps	Danisha Charles, NICHQ

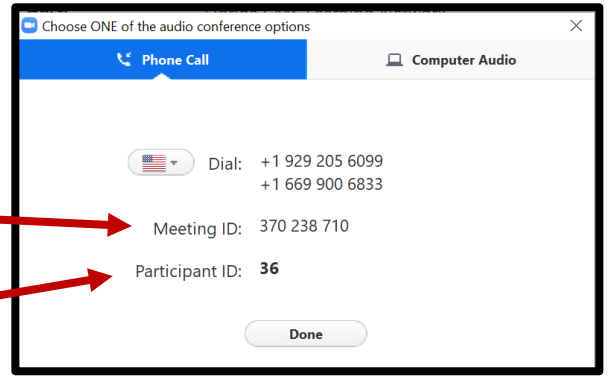
Meeting Logistics

- This session is being recorded.
- All participants are muted upon entry. We ask that you remain muted to limit background noise.
- Members are encouraged to participate in the discussion by typing your comments or asking questions using the chat box.

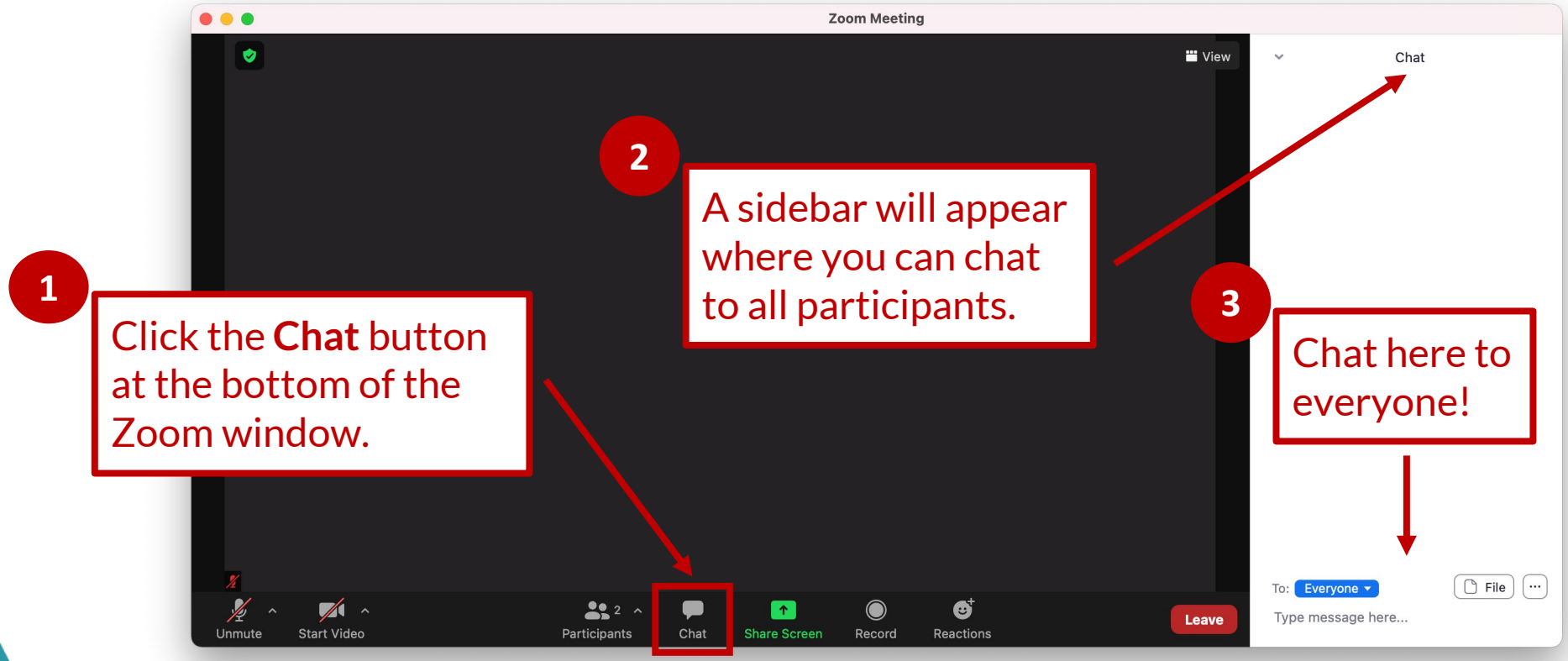
Connecting to the Audio Conference

- Join the Zoom Meeting by **clicking the Zoom Meeting link** & launching the Zoom application
- An audio conference box will appear
  - If you do not see the box, click '**Join Audio**'
- From the audio conference box, select '**Phone Call**' or '**Computer Audio**'
  - If using the phone:
    - Dial one of the given numbers next to "**Dial**"
    - You will be prompted to enter the **Meeting ID**
    - Then you will be prompted to enter the **Participant ID**





How to Chat


1
Click the **Chat** button at the bottom of the Zoom window.
2
A sidebar will appear where you can chat to all participants.
3
Chat here to everyone!
Zoom Meeting
View
Chat
Unmute
Start Video
Participants
Chat
Share Screen
Record
Reactions
Leave
To: Everyone
File
Type message here...


Welcome to the
Healthy Start
Fatherhood
Learning Academy!

Healthy Start Learning Academies

Healthy Start Learning Academies provide an opportunity for HS grantees to participate in curriculum-based courses on specific topics associated with the four HS approaches and 19 HS benchmarks. Learning Academies build HS staff knowledge and prepare them to apply their learnings to their HS program's day-to-day activities.

Learning Academy Structure

- Monthly virtual sessions
- Required readings
- Homework assignments
- In the future, all sessions will be posted on EPIC in an e-learning format for those who cannot attend the live sessions

Fatherhood Learning Academy

Goal:

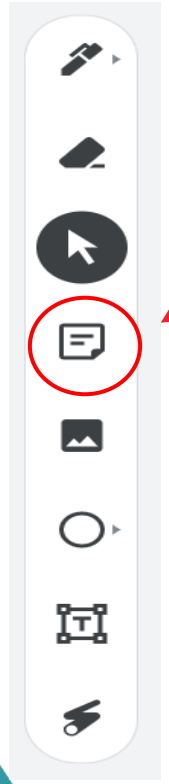
To examine the breadth and depth of fatherhood movement in the 20th and 21st century, deeply examining the policies and practices that have influenced fatherhood programming that have either encouraged or impeded father engagement.

Fatherhood Learning Academy Schedule

Session #1	July 27, 2-4 pm ET
Session #2	August 24, 2-4 pm ET
Session #3	September 28, 2-4 pm ET
Session #4	October 26 26, 2-4 pm ET
Session #5	November 23 26, 2-4 pm ET

Fatherhood Learning Academy Feed Forward

Use the Jamboard to share your thoughts throughout the Learning Academy session



- Click the link in the chat box to access the Jamboard.
- Look to the left-hand toolbar and click the **Sticky Note** button.
- Type your response and click **Save**. Once a sticky note is posted, you can move it around on the board.
- There will be a separate page for each stage.

Welcome & Introduction to the Healthy Start Fatherhood Learning Academy

Kenn Harris
Healthy Start TA & Support Center

Pre-Session Readiness Assessment

Healthy Start Fatherhood

fatherhood within a MCH program

An Introduction to the Fatherhood Leaning Academy

Kenn L. Harris, Executive Project Director & Engagement Lead,
National Institute for Children's Health Quality (NICHQ)

Tuesday, July 27th 2021
Fatherhood Learning Academy

Connecting fathers to participants, pregnancy and birth

Infant Mortality
Maternal Mortality

1st Time Fatherhood is a required component in an MCH program

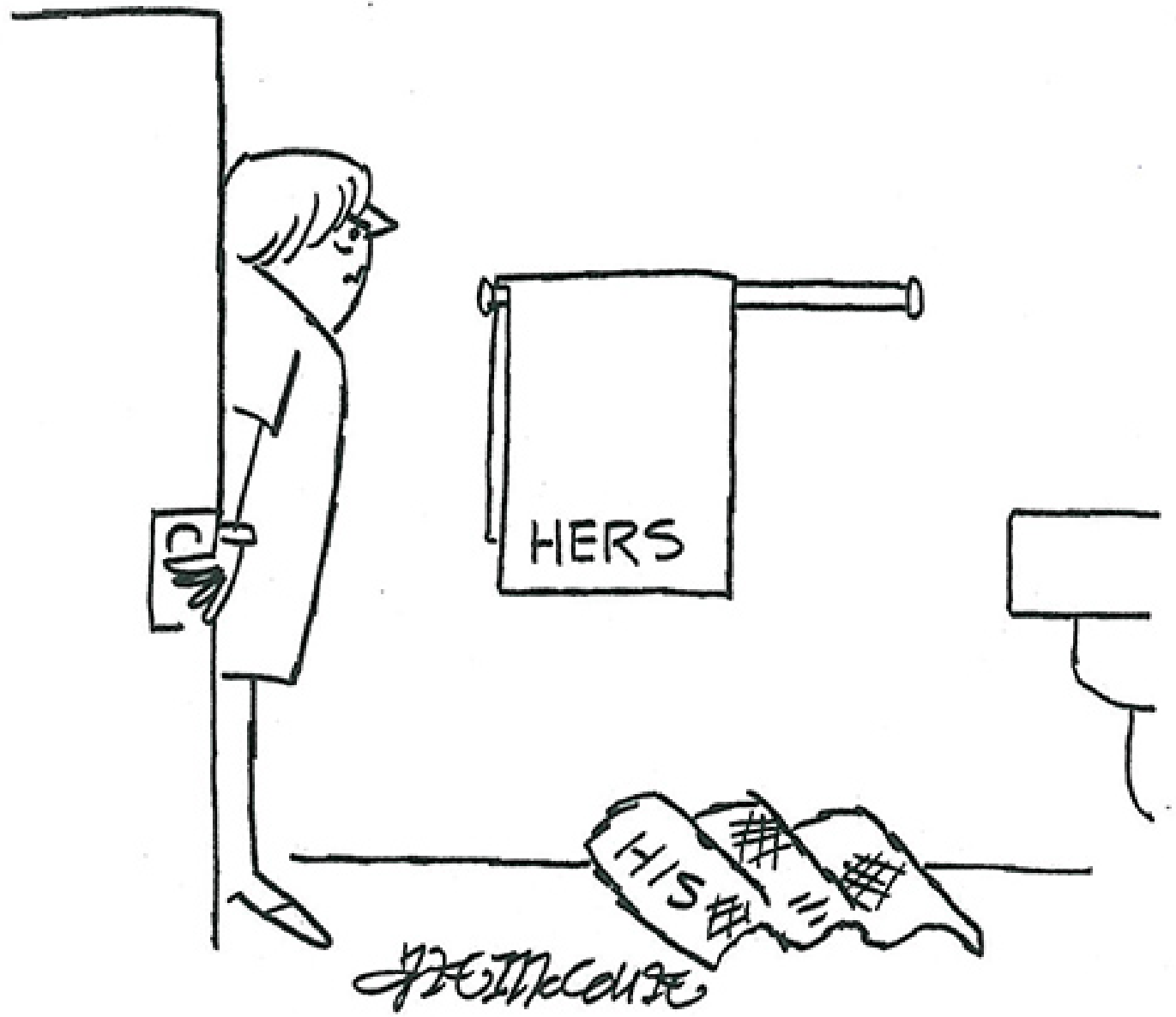
Healthy Start Fatherhood

Fatherhood within a MCH framework

10,000 – 30,000 dads


NO easy task to include men in a system not deigned for them
Connection.

design.



utilization.

the country ranked poorly at 21st in infant mortality among industrialized nations.

1991

The rate of infant deaths for African American babies was 17.6/1000 live births versus 8.9/1000 for Caucasian babies.

NICHQ | Kenn L. Harris, Executive Project Director & Engagement Lead,
National Institute for Children's Health Quality (NICHQ)

Telling the Story

The Healthy Start Initiative

"A Community-Driven Approach to Infant Mortality Reduction"

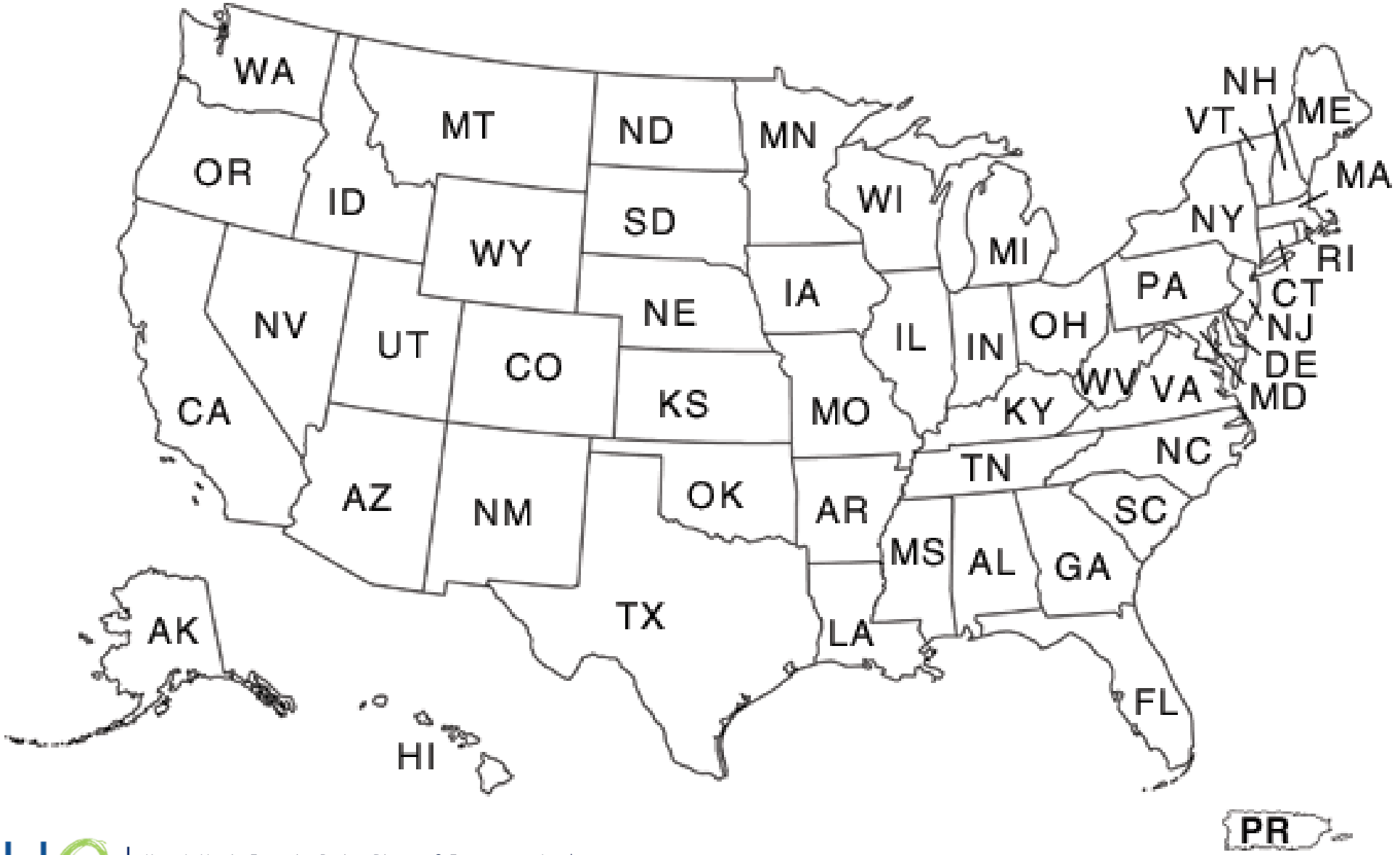
- Problem
- Who's going to address
- How we are going to do it
- What we want to do
- Belief
- Strategy

- 1991-1996
- 1997-2001
- 2001-2005
- 2005-2009
- 2009-2014
- 2014-2019
- 2019-2024

HRSA Maternal & Child Health

Dr. Thurma McCann, MD, MPH
First Director, Division of Healthy Start
Maternal and Child Health Bureau

NICHQ | Kenn L. Harris, Executive Project Director & Engagement Lead,
National Institute for Children's Health Quality (NICHQ)



Kenn L. Harris, Executive Project Director & Engagement Lead,
National Institute for Children's Health Quality (NICHQ)

Right from the start!

Integrating Male Involvement/ Fatherhood into Healthy Start

NICHQ | Kevin L. Harris, Executive Project Director & Engagement Lead, National Institute for Children's Health Quality (NICHQ)

Promote Father Involvement, HS sites have engaged in efforts to involve fathers in program activities

1991

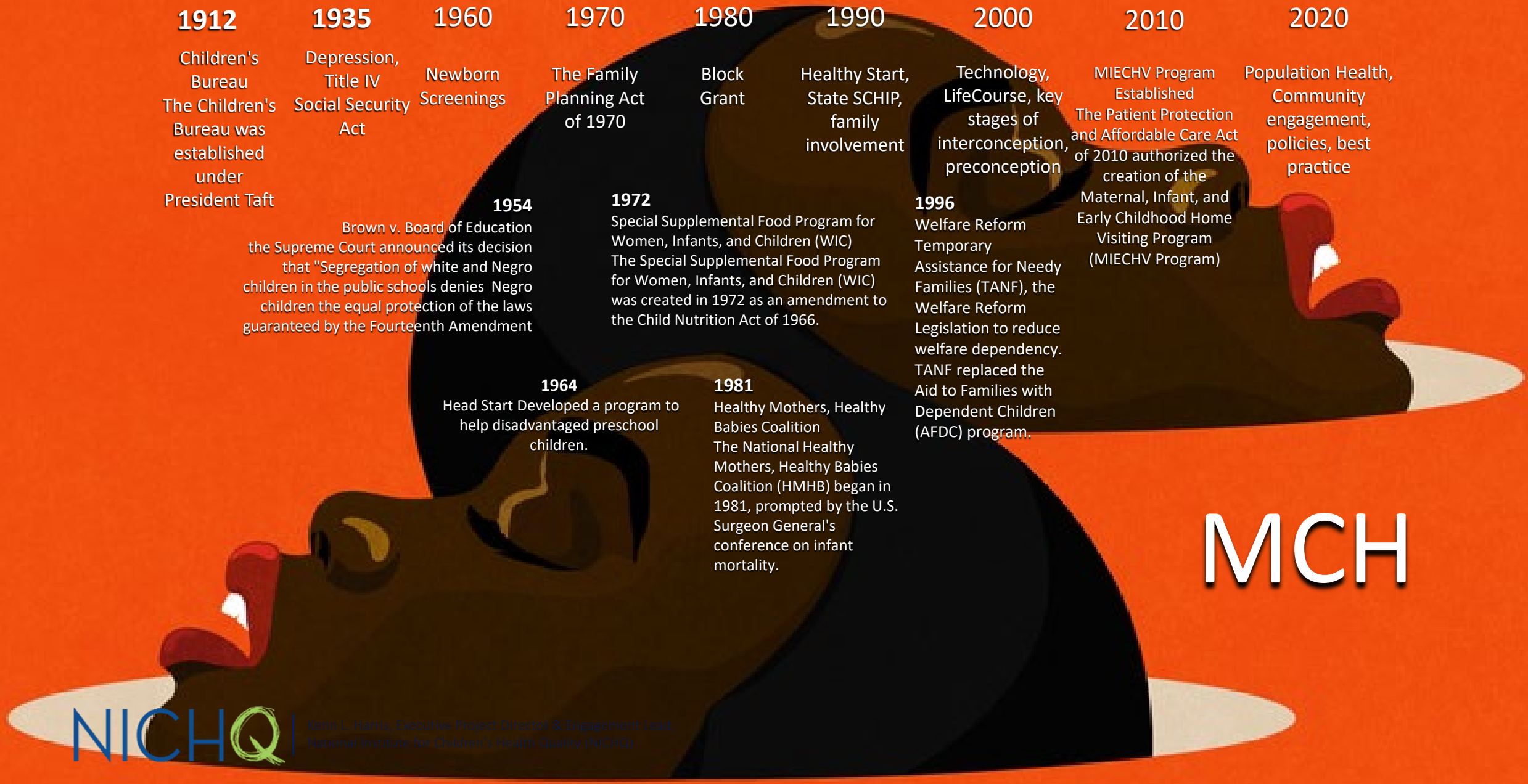
Since the START

increasing paternal involvement with children, and to promote responsible fatherhood.

improving the well-being of children by increasing the proportion of children growing up with involved, responsible, and committed fathers

involving fathers in providing practical **support during pregnancy** and in raising children, as well as helping parents develop supportive and effective relationships with each other and their children.

NICHQ | Kenn L. Harris, Executive Project Director & Engagement Lead, National Institute for Children's Health Quality (NICHQ)



NICHQ | Kenn L. Harris, Executive Project Director & Engagement Lead, National Institute for Children's Health Quality (NICHQ)

building fatherhood

[Frederick Douglass]

It is easier to build strong children than to repair broken men.

black fathers

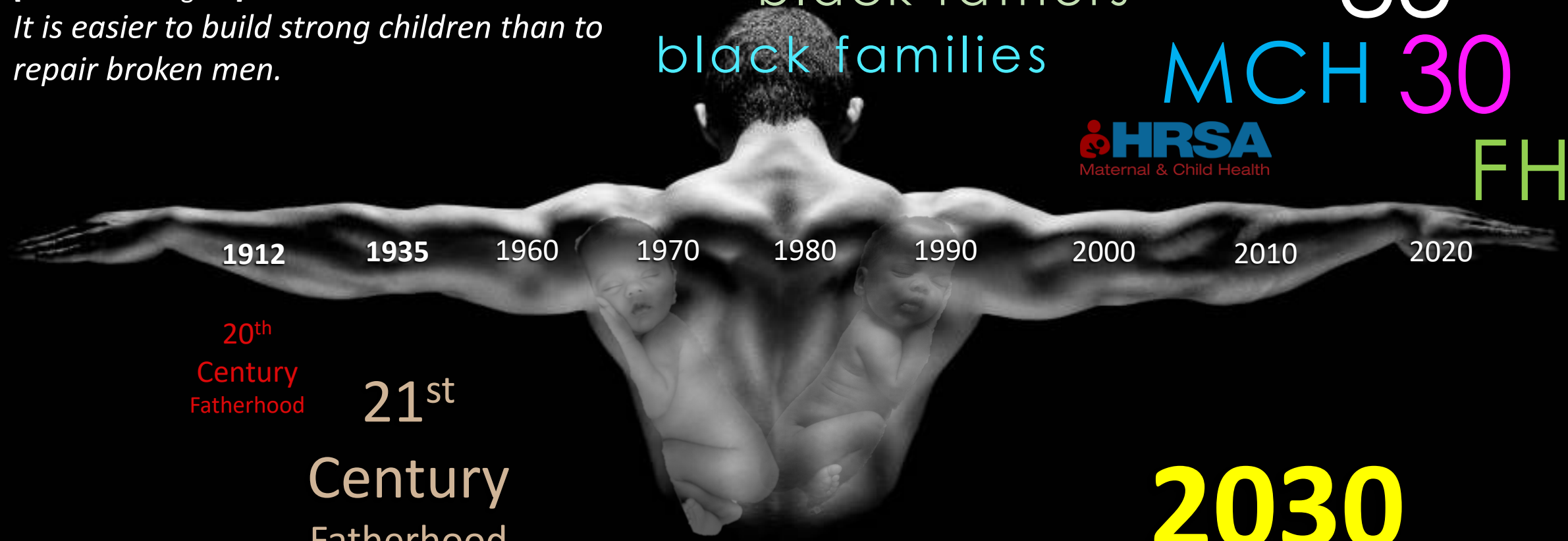
black families

85

MCH 30

FH

HRSA Maternal & Child Health



20th Century Fatherhood

21st Century Fatherhood

2030

NICHQ | Kenn L. Harris, Executive Project Director & Engagement Lead, National Institute for Children's Health Quality (NICHQ)

LOOK BACK

LOOK BEYOND

1st Time Fatherhood a Required Component!

1991-1997
"HS MCH"

1997-2001
"Replication and 9 Core Services"

2001-2005
"IC & Maternal Depression"

2005-2009
"Lifecourse"

2009-2014
"Evidence-based Practice & Workforce Development"

2014-2019
"Collective Impact & Community Health Workers/Fatherhood"

2019-2024
"Innovation/Transformation/SDOH&E Fatherhood/ Maternal Mortality"

2024

LOOK NOW

#FathersMatters!

Too many, too small, too soon

Disparities remain in 2021

Infants

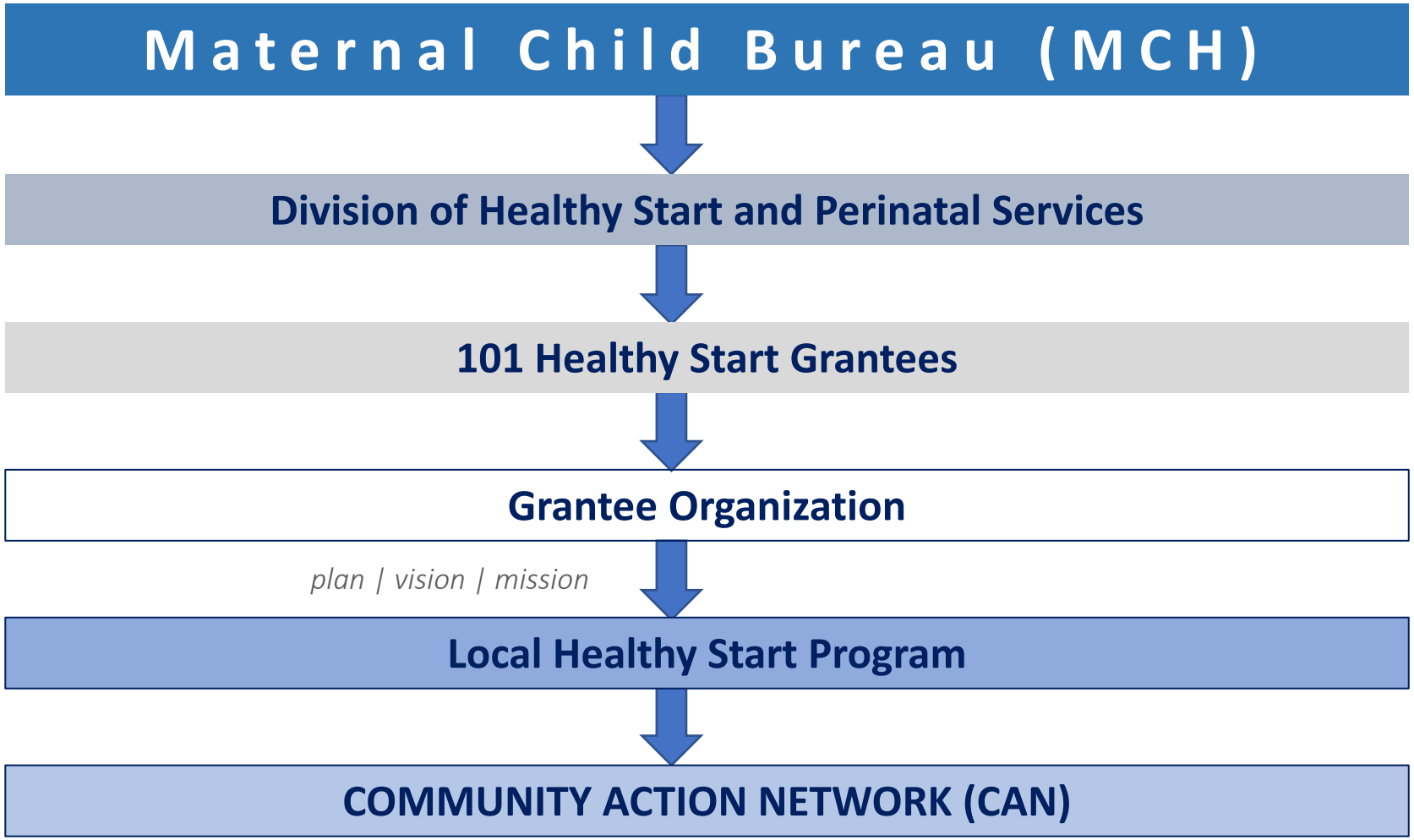
Children

Mothers

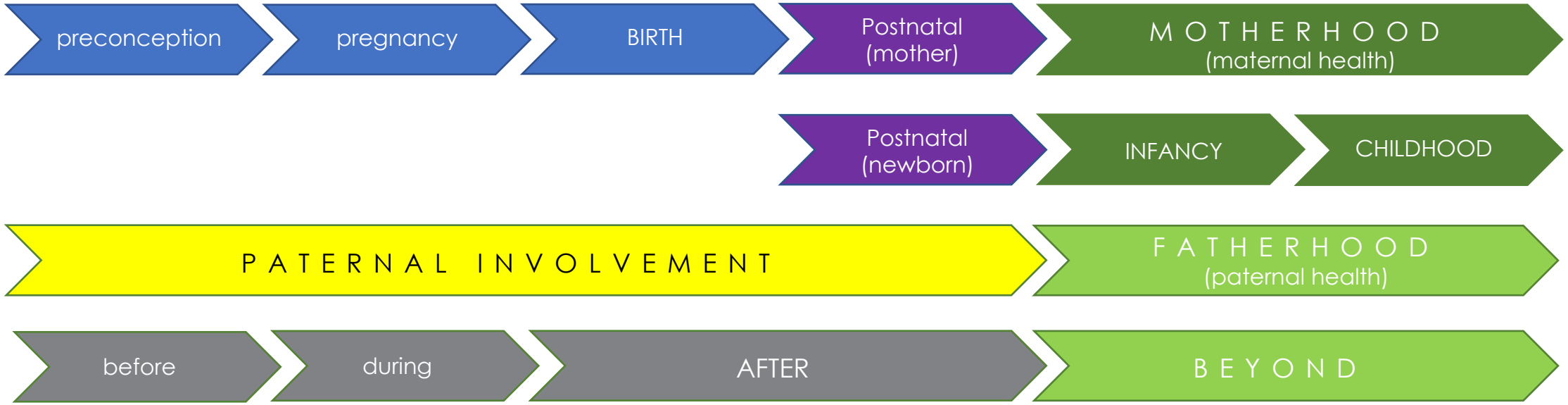
Kenn L. Harris, Executive Project Director & Engagement Lead,
National Institute for Children's Health Quality (NICHQ)

Inclusion

- Resources dedicated to father inclusion
- Fatherhood a required component
- Expectation for integration and serving 100 fathers/partners
- Responded to NOFO father inclusion in program design
- Implementation of services for fathers/partners
- Build community partnerships to sustain father engagement

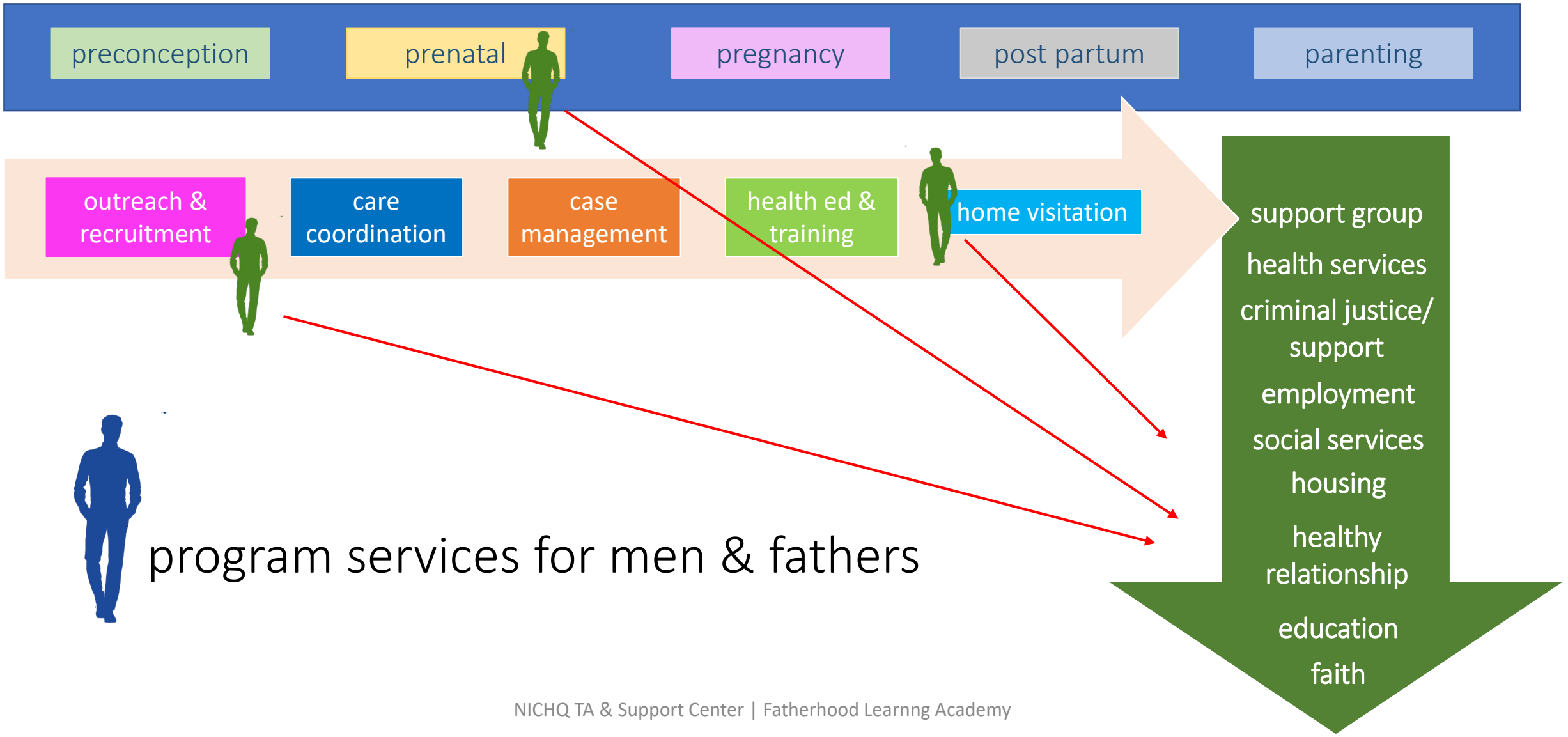


"Continuum of Care"



Graphic enhanced from The Partnership for Maternal, Newborn & Child Health (PMNHC) to includes fathers

https://www.who.int/pmnch/about/en/



program services for men & fathers

Chief Executive Officer for the National Healthy Start Association, Past Member, HHS Secretary's Advisory Committee on Infant Mortality (SACIM)

Kenn L. Harris, Executive Project Director & Engagement Lead,
National Institute for Children's Health Quality (NICHQ)

Co-Creators of Core Adaptive Model for Fatherhood (CAM©)

Kenneth R. Scarborough, Consultant, National Healthy Start Association (NHSA)Former Chief Program Officer and Director, Ready4Work at Operation New Hope

Kenn L. Harris, Executive Project Director, National Institute for Children's Health Quality (NICHQ), Director, SHSPP Technical Assistance & Support Center (TASC)

Definition of Fatherhood

The state or responsibility of being a father: also a term referenced to describe the "movement" that looks at programs and efforts that focus on fathers and their impact on children's well-being

Fatherhood is: The state of embracing being a father/parent

Fatherhood is: An execution on a practice within family (community) that's rooted in a commitment to core values, practices and principles grounded in beliefs that support the growth and nurturance of a child(ren) across the life course that includes cultivating and providing a healthy environment (space) of love, support and guidance that protects them from factors that threaten their health and well-being (a covering).

Fatherhood is: A protective factor over children (and family) given by a man that provides shelter; protection and a healthy, loving environment in which a child will be nurtured to grow into adulthood.

Healthy Start provides **male involvement/fatherhood Program** that provide *opportunities for men to engage in the well-being of children, supports healthy relationships between parents, and provides an opportunity for self-sufficiency and the economic stability of the family*. Through the engagement of fathers, HS grantees **strive to improve men's health and provide support for strengthening life skills**.

Individual | Intergroup | Program | Organizational | Community | **Societal**

BREADTH of Male Involvement/ Fatherhood

DEPTH of Male Involvement/ Fatherhood

DO

THINK

VALUES

BELIEFS

Core Adaptive Model for Fatherhood (CAM©)

Answers these broad questions (“breadth”)

- What does it look like?
- How does it function?
- How are men included in MCH program?
- Are men involved/getting services?
- How does the program engage men?
- What types of data is being collected?
- Are they evaluating and measuring impact?

Core Adaptive Model for Fatherhood (CAM©)

Answering Deeper Questions ("Depth")

- What is the impact on birth outcomes for mothers and infants?
- Is there an impact on the life of mother before, during, after and beyond pregnancy?
- Is he connected/involved in the life of the infant before, during, after and beyond pregnancy?
- Are children ready to learn in the early years?

The CAM© was informed by research and examination of practice

Evidence-based

Promising practice

Practice that's promising *– as the CAM© works with projects over time moving them to model programs*

laying the foundation

Allio et al. BMC Pregnancy and Childbirth 2013, 13:60
http://www.biomedcentral.com/1471-2393/13/60

BMC Pregnancy & Childbirth

RESEARCH ARTICLE Open Access

A community perspective on the role of fathers during pregnancy: a qualitative study

Amina P Allio[1*], Cindi A Lewis[2], Kenneth Scarborough[3], Kenn Harris[4] and Kevin Fiscella[5]

Abstract

Background: Defining male involvement during pregnancy is essential for the development of future research and appropriate interventions to optimize services aiming to improve birth outcomes. Study Aim: To define male involvement during pregnancy and obtain community-based recommendations for interventions to improve male involvement during pregnancy.

Methods: We conducted focus groups with mothers and fathers from the National Healthy Start Association program in order to obtain detailed descriptions of male involvement activities, benefits, barriers, and proposed solutions for increasing male involvement during pregnancy. The majority of participants were African American parents.

Results: The involved "male" was identified as either the biological father, or, the current male partner of the pregnant woman. Both men and women described the ideal, involved father or male partner as present, accessible, available, understanding, willing to learn about the pregnancy process and eager to provide emotional, physical and financial support to the woman carrying the child. Women emphasized a sense of "togetherness" during the pregnancy. Suggestions included creating male-targeted prenatal programs, enhancing current interventions targeting females, and increasing healthcare providers' awareness of the importance of men's involvement during pregnancy.

Conclusions: Individual, family, community, societal and policy factors play a role in barring or diminishing the involvement of fathers during pregnancy. Future research and interventions should target these factors and their interaction in order to increase fathers' involvement and thereby improve pregnancy outcomes.

Keywords: Pregnancy, Father involvement, Healthy start and fathers

Background

Paternal involvement (PI) has been recognized to have an impact on pregnancy and infant outcomes [1-6]. When fathers are involved during pregnancy, maternal negative health behaviors diminish and risk of preterm birth, low birth weight and fetal growth restriction is significantly reduced [1-4,6]. PI has also been associated with infant mortality up to one year after birth [2]. When these findings were stratified by race, several studies report that the risks of adverse birth outcomes and subsequent infant mortality were markedly higher for African-American mothers [1,2,4,7].

Whether measured through proxies such as paternal information on birth certificates, maternal report of paternal activities (support, presence at pregnancy-related health appointments), or marital/partnership status, findings point to the important contributions fathers can make to improving birth outcomes [1-4,6-9]. Researchers have proposed that the mechanisms through which PI affects birth outcomes are primarily linked to the impact fathers can have on influencing maternal behaviors and reducing maternal stress through emotional, logistical and financial support [6]. For example, pregnant women with involved partners have been found to be more likely to receive early prenatal care and to reduce cigarette smoking [9,10]. Other studies have suggested that support from fathers serves to alleviate the

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Full list of author information is available at the end of the article

VIEWPOINT

The Health of Young African American Men

Stephen A. Martin, MD, EdM
Department of Family Medicine, Boston Medical Center, Boston, Massachusetts; and Boston University School of Medicine, Boston, Massachusetts.

Kenn Harris
New Haven Healthy Start, The Community Foundation for Greater New Haven, New Haven, Connecticut.

Brian W. Jack, MD
Department of Family Medicine, Boston Medical Center, Boston, Massachusetts; and Boston University School of Medicine, Boston, Massachusetts.

Editorial and Viewpoint

Supplemental content at jama.com

Deaths in Ferguson, Missouri; New York City; Sanford, Florida; and other areas have focused international attention on young African American men. In a recent campaign, young African American men draw attention to key overlooked facts that describe their demographic: 1 of 3 goes to college, 3 of 4 are drug free, 5 of 9 have jobs, 7 of 8 are not teenaged fathers, and 11 of 12 finish high school.[1] How can clinicians help address existing health disparities and add to these positive outcomes?

Young African American men experience little benefit from the considerable health care spending in the United States. Their situation reflects a poor investment and calls attention to a blind spot in policy. African American men have a life expectancy 4.7 years less than their white counterparts, the lowest of any major demographic group in the United States. Heart disease and cancer each contribute roughly a year of reduced comparative life expectancy for African American men.[2] Another year of reduced life expectancy is related to homicide: 75 of 100 000

> Young African American men experience little benefit from the considerable health care spending in the United States.

African American men aged 15 to 29 years die from homicide each year, well in excess of the rates of 4 per 100 000 for white men and 23 per 100 000 for Hispanic men.[3] During ages 1 through 14, homicide is either the second or third leading cause of death for African American males; from ages 15 through 34 it is the leading cause of death.

Is this excess mortality due to long-standing low socioeconomic status? The answers involve a complex calculus of poverty, geography, race, education, and family structure. Sixteen-year-old African American men living in cities, for example, have a 50% to 62% chance of survival to age 65 compared with urban white counterparts who have an 80% likelihood. Appalachian white men have less excess mortality than African American men, despite being 37% poorer.[4]

Disproportionate rates of incarceration among African American men also detract from their overall health.[5] African American men are 6 times more likely to be imprisoned than white men, and current trends would suggest that 1 of every 3 African American men born today will be incarcerated. An especially unfortunate indictment is that African American men are half as likely to die if they are in prison compared with those who are not; incarcerated white men, in comparison, die at a higher rate than those who are not incarcerated.[6] The effect of mass incarceration on individuals' employment, voting, housing, credentials (such as drivers' licenses), and certainly health is profound and still poorly understood.

Although there have been calls for action from public health to address these overall disparities, much of the medical field has been more silent. Traditional models of medical practice generally stand apart—in place, time, and perspective—from the experiences and needs of young African American men. Instead of the traditional routes of enrolling in primary care, lower-income African American men more readily connect with health care through military service, prison, or emergency departments. Health care systems are not well designed to acknowledge, attend to, and successfully address the health issues that are most salient: violence, trauma, shootings, and the psychological anguish that accompanies them. Shortages of primary care practitioners in certain areas certainly add to this problem. Even when clinicians are available, they may recognize risks but have little to offer to ameliorate them.

Well-child care visits, the most common interaction youth and adolescents have with medical care, have limited success influencing behaviors. The American Academy of Pediatrics' violence prevention program, Connected Kids: Safe, Strong, Secure, was developed in 2006.[7] However, the United States Preventive Services Task Force has not found evidence to update its recommendation for counseling to prevent youth violence from its 1996 finding of "insufficient evidence"; the topic has been made inactive.[8] African American boys and men thus face 2 mismatches: funding that overwhelmingly favors health care over more effective social supports, and a traditional health care model that is limited in its ability to help. The care youth and men need most is the care least available.

Considering these barriers, are there effective practices that clinicians can implement? First, advocacy efforts are needed for public health and social supports to achieve health improvements at scale. These approaches require substantially more robust funding and emphasis; US public health is funded with only 3 cents of the health dollar.

Second, the advantages medical care can provide should be strengthened. Unlike violence prevention, engagement in health care can positively influence those disparities amenable to effective medical treatment, such as human immunodeficiency virus (HIV), cardiovascular disease, and mental health. Intentional changes in practice—patient-centered medical homes,

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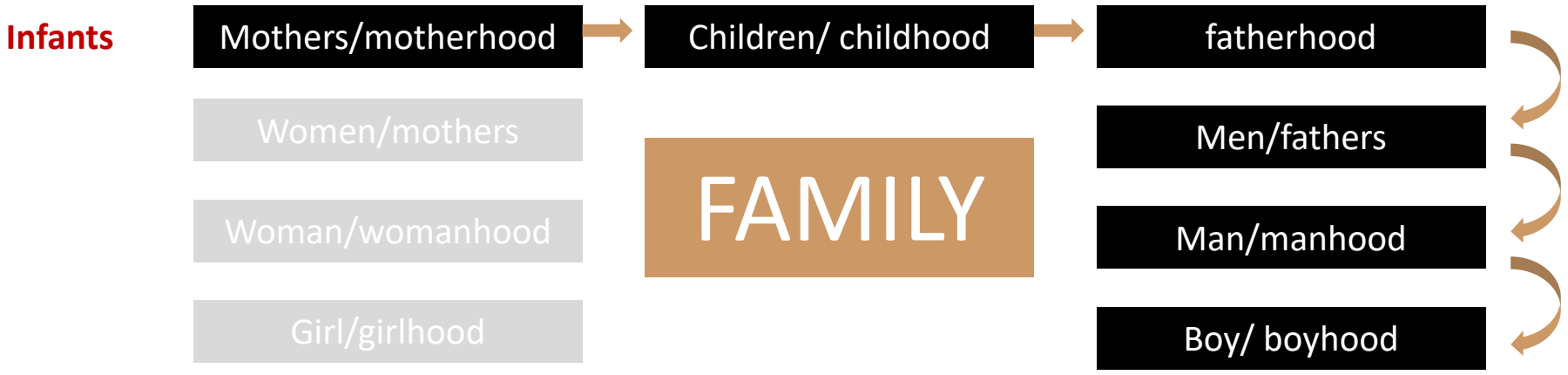
NHSA Dads Matter Initiative

- Core Adaptive Model for Fatherhood (CAM©) and Male Involvement **offers three levels of adaptable service models** depending on the resources of your project.
- The CAM® for NHSA is built around **core elements, key objectives and measures** that are based on national evidenced-based and promising practices integrated with lessons-learned from practice, research and evaluation conducted with Healthy Start sites over two decades.
- The CAM® for NHSA culminates in the **creation of a comprehensive plan (ROADMap)** for fatherhood/male involvement program success that is specific, measurable, attainable, and realistic and time-bound that can be valuable in creating, growing and funding future fatherhood/male involvement work and services.

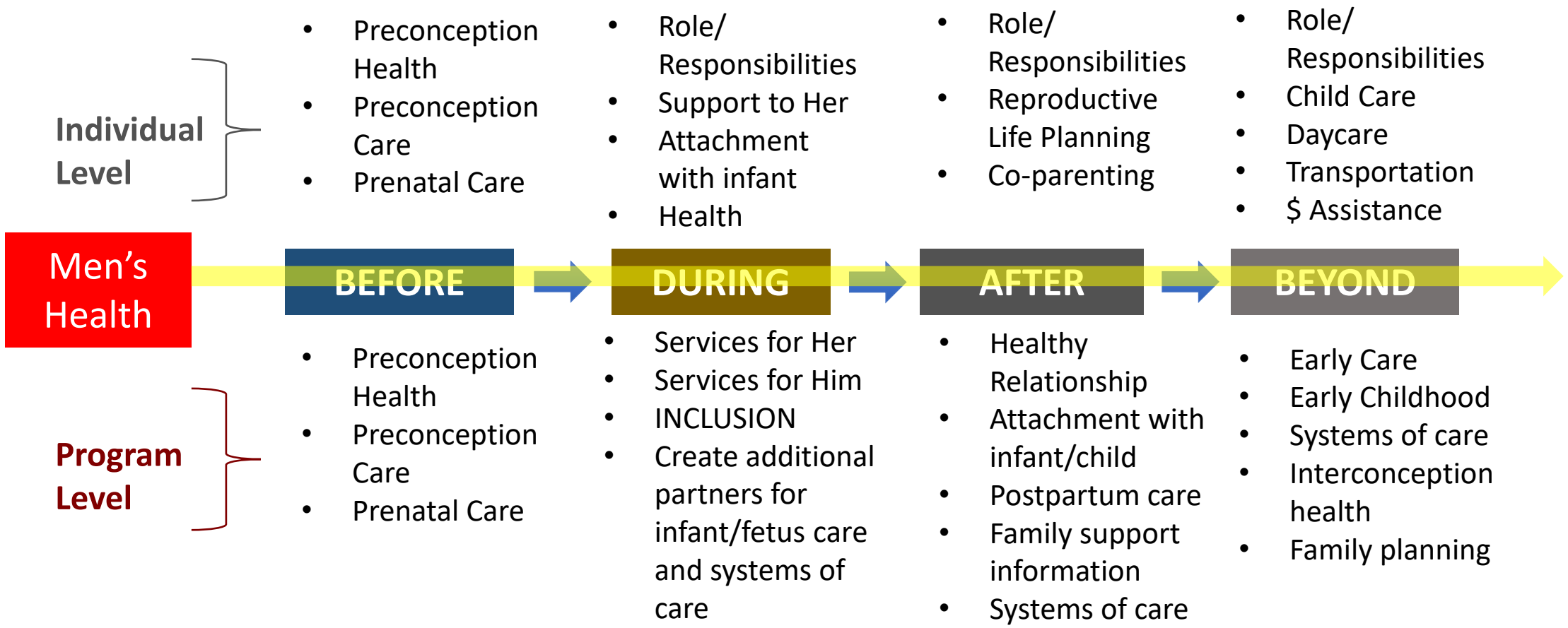
Kenn L. Harris & Kenneth Scarborough, Co-Creators of Core Adaptive Model for Fatherhood (CAM©)

Case for LIFECOURSE

- Importance of Fathers/ Fatherhood (what research is telling us)
- Impact of Fatherlessness (what we know)



MALE INVOLVEMENT
WhereDadsMatterInitiative
NATIONAL HEALTHY START ASSOCIATION



A created continuum of MI/ Fatherhood: before pregnancy, during pregnancy, after pregnancy and beyond pregnancy

Engagement Opportunities across LIFECOURSE

Core Adaptive Model for Fatherhood (CAM©)

MALE INVOLVEMENT
WhereDadsMatter*Initiative*
NATIONAL HEALTHY START ASSOCIATION

Promote father involvement *Improve parenting (co-parenting)*

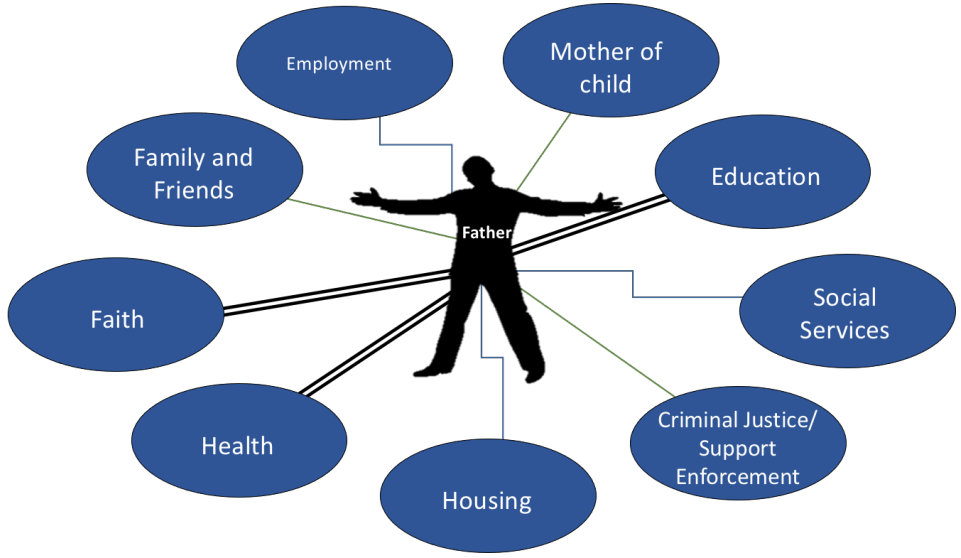
Men's Health → BEFORE → DURING → AFTER → BEYOND

Core Adaptive Model for Fatherhood (CAM©)

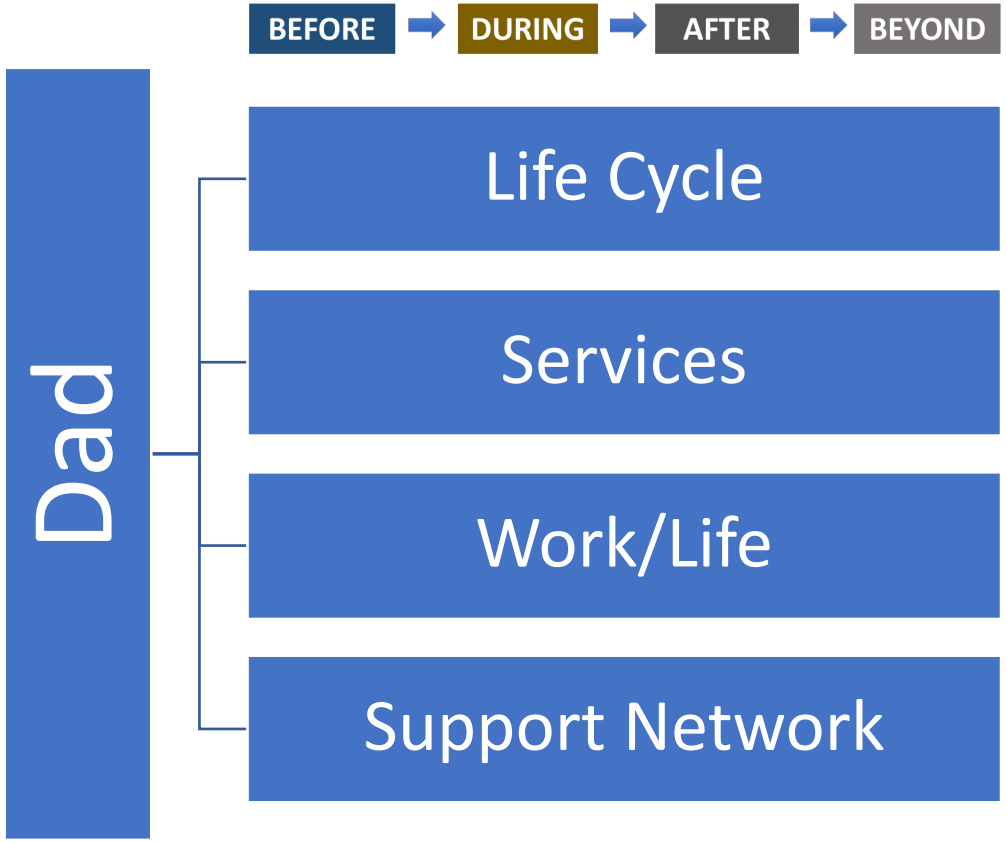
NHSA CAM© Model for Fatherhood/Male Involvement based on **A Community Perspective on the Role of Fathers During Pregnancy: A Qualitative Study** - Amina P. Alio, Cindi A. Lewis, Kenneth Scarborough, Kenn Harris and Kevin Fiscella, BMC, Childbirth and Pregnancy, 2013

Connection

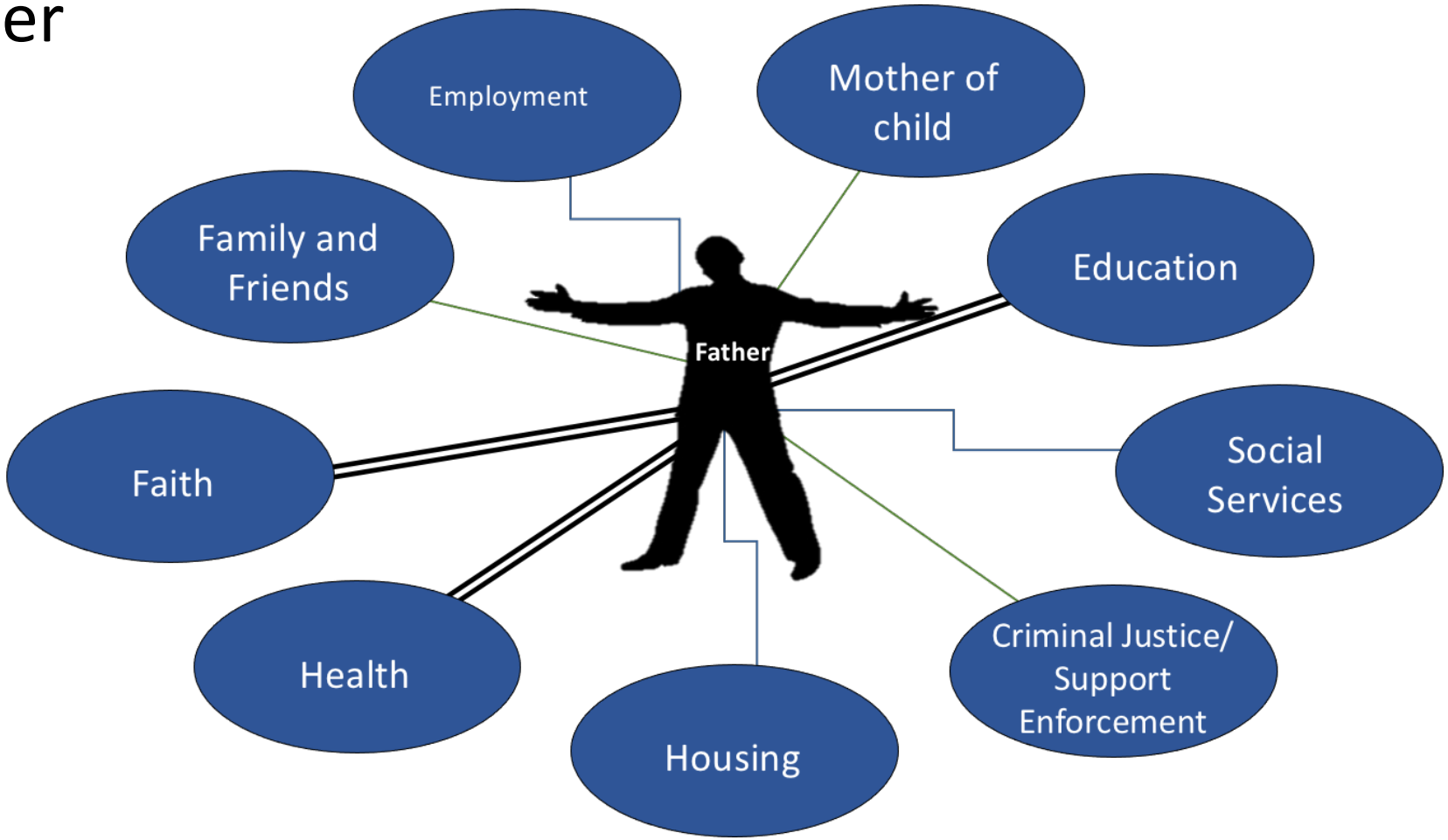
Father Connection



Father Engagement

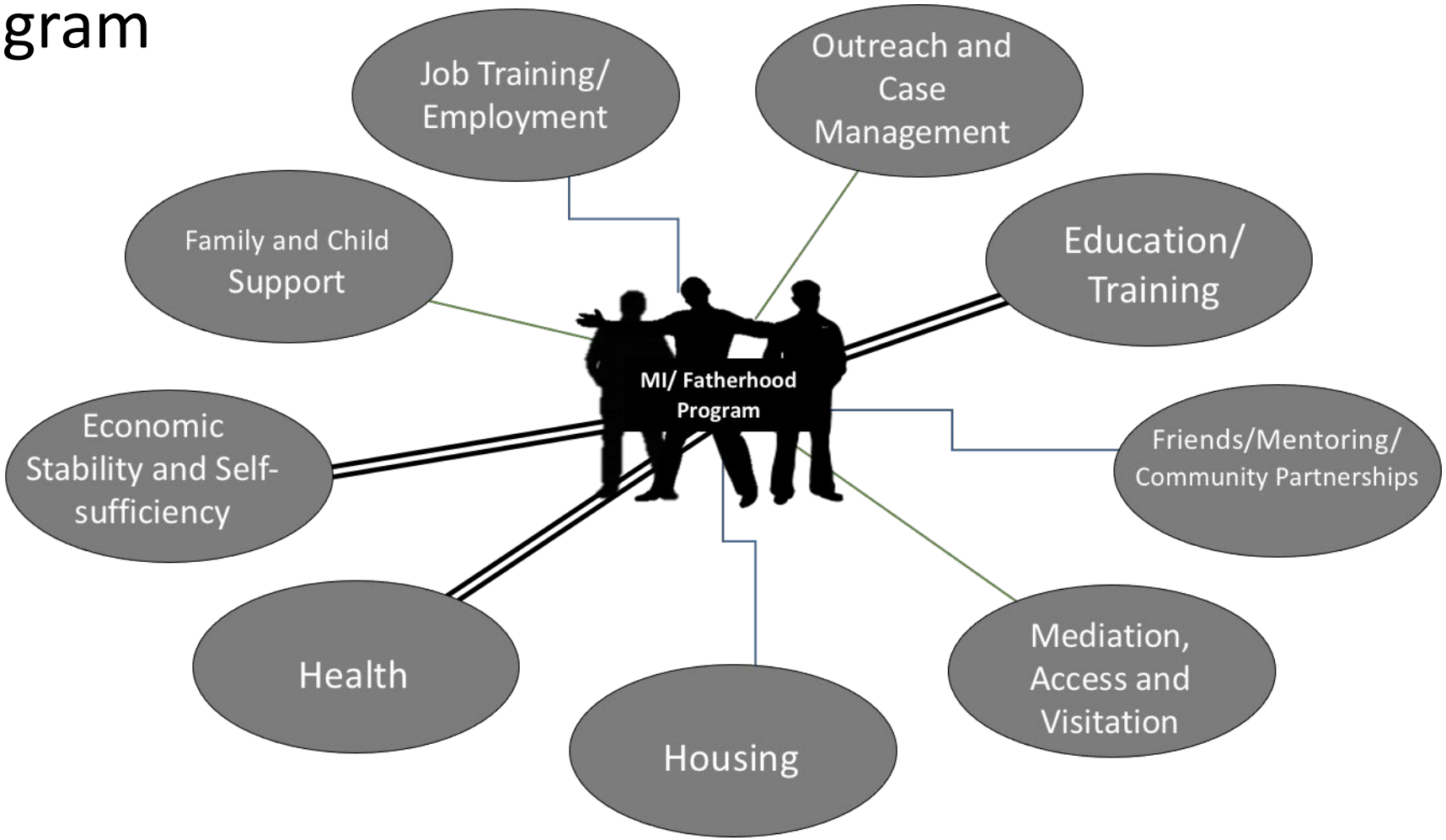


for father



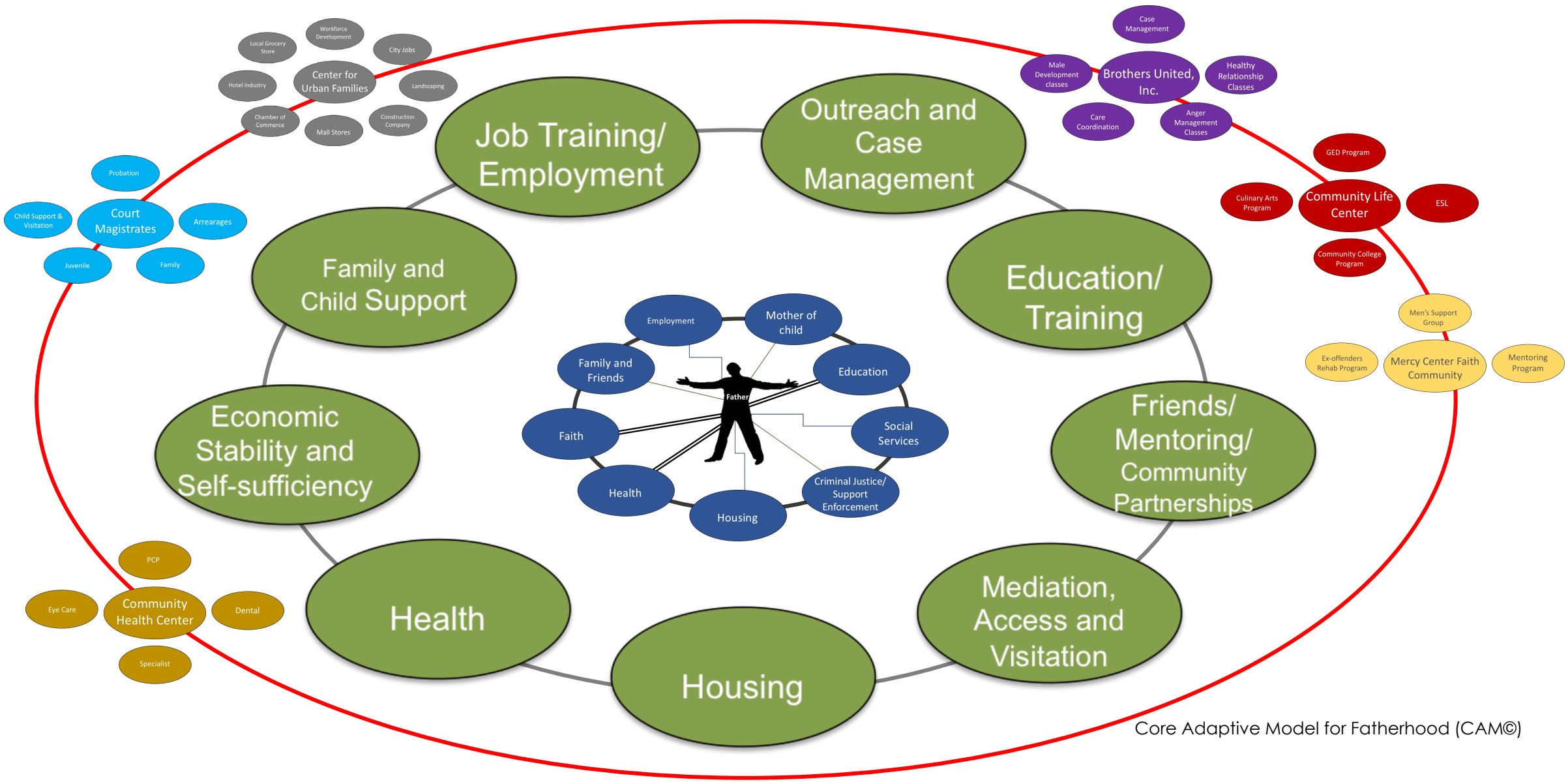
Core Adaptive Model for Fatherhood (CAM©)

for program



Core Adaptive Model for Fatherhood (CAM©)

The CAM Partnership Alignment Constellation (The CAM*PAC™*)



Core Adaptive Model for Fatherhood (CAM©)

4 Approaches

- ❑ Recruitment
- ❑ Outreach
- ❑ Enrollment
- ❑ Services
- ❑ Partner Engagement

3 Benchmarks

- ❑ Involvement during pregnancy
- ❑ Participation in pediatric appointment
- ❑ Reading by a parent/family member

E5^{s}

e. Parent education

i. Describe how your program *(and/or identified partners)* will deliver parenting education, including timing, standardized curricula, tools, staff, and materials proposed for use.

ii. Discuss how your program *(and/or identified partners)* will promote protective factors such as nurturing and attachment, appropriate limit setting, knowledge of child development, parental resilience, social connections, and concrete support for parents.

iii. Identify and justify your program's *(and/or identified partners)* proposed evidence-based models and approaches.

iv. Describe how your program *(and/or identified partners)* will include partners of women participants who are co-parenting in parent education, activities and events.

v. Describe how you *(and/or identified partners)* will collaborate and integrate with other community organizations providing parenting education (e.g., home visiting, Early Head Start, Strengthening Families).

B3s Benchmarks

1. (xiv.) Increase proportion of HS women participants that demonstrate father and/or partner involvement (e.g., attend appointments, classes, etc.) during pregnancy to 90 percent.

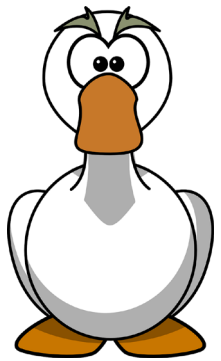
2. (xv.) Increase proportion of HS women participants that demonstrate father and/or partner involvement (e.g. attend appointments, classes, infant/child care) with their child participant to 80 percent.

3. (xvi.) Increase the proportion of HS child participants aged <24 months who are read to by a parent or family member 3 or more times per week to 50 percent.

"The level of father involvement in the MCH space means different things to different people.“
- Scarborough

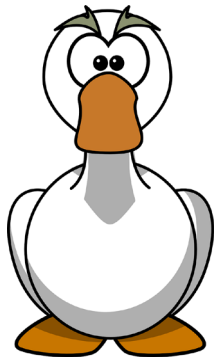
19 Healthy Start Benchmarks

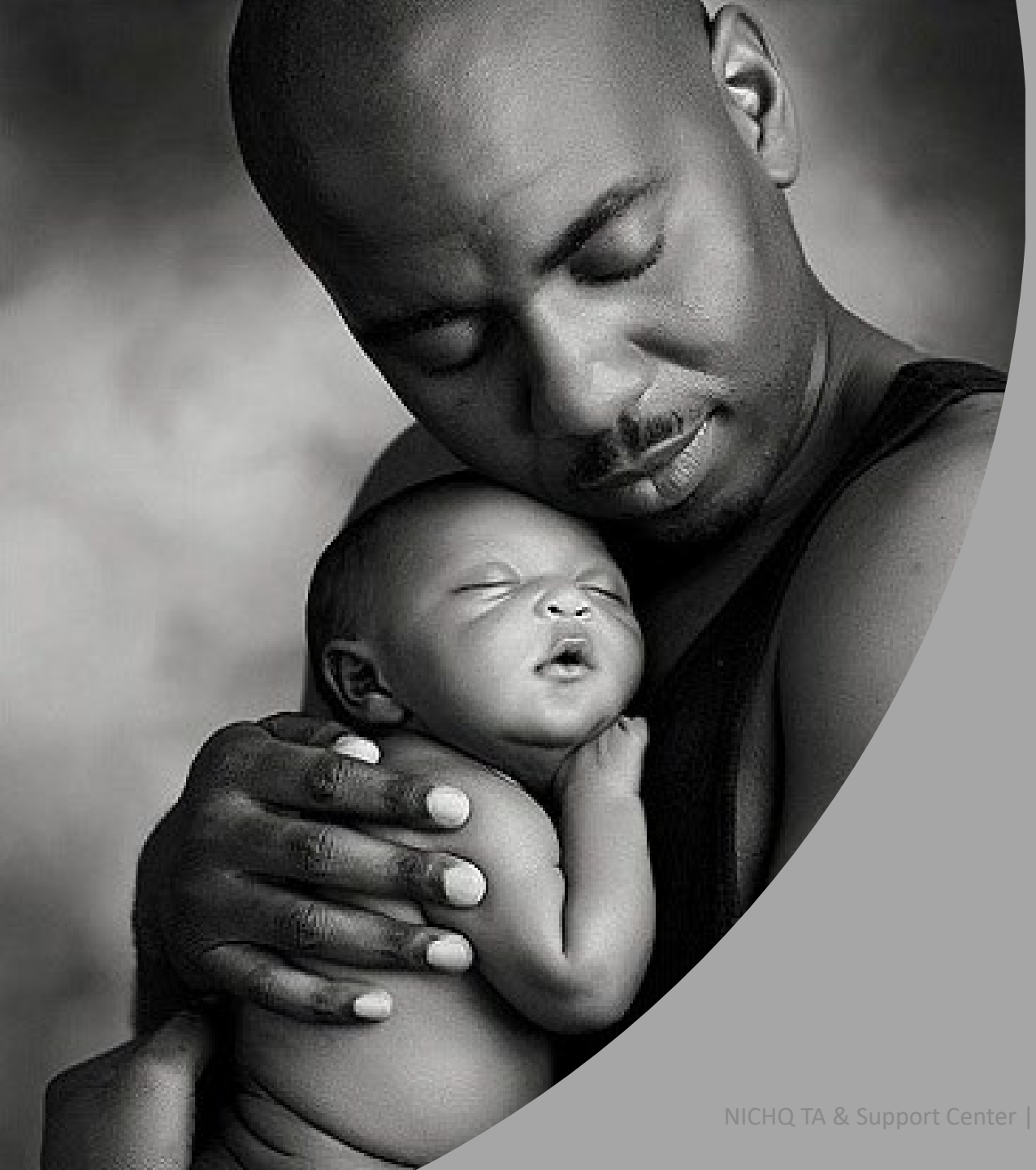
1. Increase the proportion of HS women and child participants with health insurance to 90 percent (reduce uninsured to less than 10 percent).
2. Increase the proportion of HS women participants who have a documented reproductive life plan to 90 percent.
3. Increase the proportion of HS women participants who receive a postpartum visit to 80 percent.
4. Increase proportion HS women and child participants who have a usual source of medical care to 80 percent.
5. Increase proportion of HS women participants that receive a well- woman visit to 80 percent.
6. **Increase proportion of HS women participants who engage in safe sleep practices to 80 percent.**
7. **Increase proportion of HS child participants whose parent/ caregiver reports they were ever breastfed or pumped breast milk to feed their baby to 82 percent.**
8. **Increase proportion of HS child participants whose parent/ caregiver reports they were breastfed or fed breast milk at 6 months to 61 percent.**
9. **Increase the proportion of pregnant HS participants that abstain from cigarette smoking to 90 percent.**
10. Reduce the proportion of HS women participants who conceive within 18 months of a previous birth to 30 percent.



19 Healthy Start Benchmarks

11. Increase proportion of HS child participants who receive the last age-appropriate recommended well child visit based on AAP schedule to 90 percent.
12. Increase the proportion of HS women participants who receive depression screening and referral to 100 percent.
13. Increase proportion of HS women participants who receive intimate partner violence (IPV) screening to 100 percent.
14. Increase proportion of HS women participants that demonstrate father and/or partner involvement (e.g., attend appointments, classes, etc.) during pregnancy to 90 percent.
15. Increase proportion of HS women participants that demonstrate father and/or partner involvement (e.g. attend appointments, classes, infant/child care) with their child participant to 80 percent.
16. Increase the proportion of HS child participants aged <24 months who are read to by a parent or family member 3 or more times per week to 50 percent.
17. Increase the proportion of HS programs with a fully implemented Community Action Network (CAN) to 100 percent.
18. Increase the proportion of HS programs with at least 25 percent community members and HS program participants serving as members of their CAN to 100 percent.
19. Increase the proportion of HS programs who establish a QI and performance monitoring process to 100 percent.





Healthy Start programs will be able to tell the story of how fathers support pregnancy; contribute to better birth outcomes; and create optimal opportunities for infants to thrive

Role of fathers in HS

NATIONAL BESTSELLER
Slavery by Another Name
"Shocking. . . . Eviscerates one of our schoolchildren's most basic assumptions: that slavery in America ended with the Civil War."
—The New York Times
The Re-Enslavement of Black Americans from the Civil War to World War II
Douglas A. Blackmon

NEW YORK TIMES BESTSELLER
The New Jim Crow
Mass Incarceration in the Age of Colorblindness
MICHELLE ALEXANDER
WITH A NEW FOREWORD BY CORNEL WEST

Kenn L. Harris, Executive Project Director & Engagement Lead,
National Institute for Children's Health Quality (NICHQ)

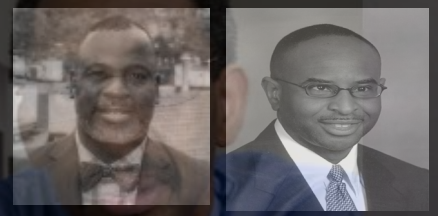
HS will be able to tell the story of what fatherhood looks like in an MCH framework

10,000 – 30,000 dads

#FatherhoodMatters!

HS will be able to tell the story of what fatherhood looks like in an MCH framework

10,000 – 30,000 dads



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Thank you!

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Fatherhood Learning Academy Dean

Dr. Jeffery Johnson
President & CEO,
National Partnership for Community Leadership

Overview of the Fatherhood Learning Academy

Dr. Jeffery Johnson
President & CEO, NPCL
Dean, Fatherhood Learning Academy

Learning Objectives

- Better understand how fatherhood can be integrated into current MCH practices to improve pregnancy, birth, and child outcomes potentially.
- Learn how policies have historically shaped fatherhood (child support enforcement and incarceration).
- Equip male involvement/fatherhood practitioners with teachings that will assist them in creating community-based strategies that help advance fatherhood work and build fatherhood programs; and,
- Learn how to evaluate fatherhood work by lifting evidence-based practices while also practice that is promising.

Course Readings

- **Your Journey To Co-Parenting**. Authors: Dr. Jeffery Johnson and Monica Johnson. NPCL Inc. (2021) – *This will be made available to you.*
- **Failing Our Fathers: Confronting the Crisis of Economically Vulnerable Nonresident Fathers**. Authors: Monique Jethwani, Ronald B. Mincy, and Serena Klempin. Oxford University Press. (2015)
- **"Turning The Corner On Father Absence"**, Authors: Morehouse Institute and the Institute for American Values (1999)
- **"An Evaluability Assessment of Responsible Fatherhood Programs. Final Report."** Authors: Burt Barnow, David Stapleton, Gina Livermore, John Trutko, and Jeffery Johnson. The Lewin Group Inc. (1997)

Fatherhood Learning Academy
Session Topics

Session 1	**Overview of the Fatherhood Learning Academy**
Session 2	**Implementing Fatherhood at the Community Level**
Session 3	**Managing Data and Program Evaluation: Cornerstones of Fatherhood Programming**
Session 4	**Child Support**
Session 5	**Diversity and Fatherhood**

Breakout Session

Breakout Session

- **Goal**: To begin your collaboration
- **Breakout Activity**
  - Groups of 4
  - Introduce yourselves and share your email address
  - Choose your group name
  - Choose your Notetaker for this session
  - Choose your Spokesperson for this session
  - Practice the homework assignment

Breakout Session — Report Out

- **Goal**: To begin your collaboration
- **Breakout Activity**
  - Groups of 4
  - Introduce yourselves and share your email address
  - Choose your group name
  - Choose your Notetaker for this session
  - Choose your Spokesperson for this session
  - Practice the homework assignment

Post-Session Readiness Assessment

Survey

- Please scan the QR code or visit https://link.nichq.org/FatherhoodLASession1 to complete the survey
- Your responses will help shape the future Learning Academy sessions!

Homework & Next Steps

Danisha Charles
Healthy Start TA & Support Center

Your Journey To Co-Parenting

By Dr. Jeffery Johnson and Monica Johnson

The TA & Support Center is pleased to provide one copy of this book to each Healthy Start project participating in the Fatherhood Learning Academy.

To request a copy for your project, your Project Director must complete the request form by following the link in the chat box or scanning the QR code.

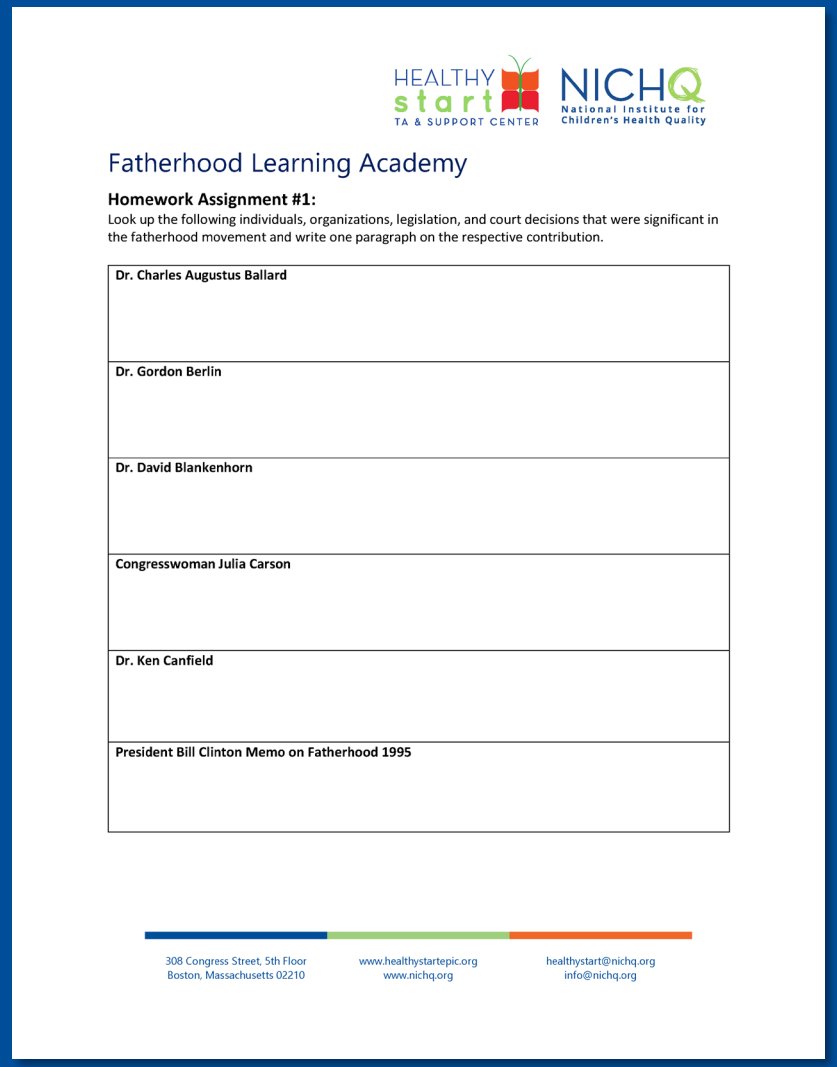
HEALTHY start TA & SUPPORT CENTER

NICHQ National Institute for Children's Health Quality

Homework Assignment #1:

Coordinate and virtually meet with your breakout group to complete the following worksheet which includes a list of individuals, organizations, legislation, and court decisions that were significant in the fatherhood movement. Look up each and write one paragraph on the respective contribution.

Please complete this assignment and be prepared to review it at the next session on August 24.



HEALTHY start TA & SUPPORT CENTER NICHQ National Institute for Children's Health Quality

Fatherhood Learning Academy

Homework Assignment #1:

Look up the following individuals, organizations, legislation, and court decisions that were significant in the fatherhood movement and write one paragraph on the respective contribution.

Dr. Charles Augustus Ballard
Dr. Gordon Berlin
Dr. David Blankenhorn
Congresswoman Julia Carson
Dr. Ken Canfield
President Bill Clinton Memo on Fatherhood 1995

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info@nichq.org

HEALTHY start TA & SUPPORT CENTER NICHQ National Institute for Children's Health Quality

Healthy Start CoLab

- Connect with your fellow Learning Academy participants on the Healthy Start CoLab!
- If you do not have a CoLab account, please email healthystart@nichq.org

Next Healthy Start Fatherhood Learning Academy Session:

Tuesday, August 24 from 2-4 pm ET

Healthy Start
Deadlines & Events

HEALTHY start TA & SUPPORT CENTER

Can be found on the EPIC website or
bit.ly/hs-deadlines-and-events

August 2021

Deadlines:
Aug 15 HSMED-II Report (CSV or XML) Due
Aug 31 Aggregate Report (Excel) Due

Events:
Aug 2 Networking Café: Father/Male Recruitment and Retention
Aug 2 Healthy Start & WIC Webinar
Aug 16 TIROE CoP Learning Session #4 – *COP members only*
Aug 17 4th Trimester Webinar Series Session #3
Aug 18 Healthy Start COIN Meeting #9 — *COIN members only*
Aug 24 Fatherhood Learning Academy Session #2
Aug 26 CAN Learning Academy Session #4

www.healthystartepic.org

HEALTHY start TA & SUPPORT CENTER
NICHQ National Institute for Children's Health Quality

Thank You!