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Mothers of Rotterdam: Scaling a Social Services Program in the Netherlands

Nanne Boonstra, board chair for Mothers of Rotterdam, eagerly anticipated his afternoon meeting. It was a warm day in July 2017 and Boonstra, along with the rest of the board, was to learn the details of a scaling strategy proposal for the fledgling social service program that helped the city's disadvantaged pregnant women.

Mothers of Rotterdam had attracted attention in the city and Boonstra's employer, Stichting De Verre Bergen Rotterdam, the venture philanthropy foundation that was funding the program, was interested in whether it was feasible to scale the pilot program throughout Rotterdam. Other stakeholders—most notably the Bernard van Leer Foundation, a Netherlands-based global venture philanthropy foundation—hoped the program might be replicated elsewhere in the Netherlands or even within other European countries.

Though scaling the program had been a priority for Stichting De Verre Bergen since it joined Mothers of Rotterdam as a partner in 2016, Boonstra knew that some stakeholders were concerned about scaling too early—before research determined if the program was effective and for whom. "The people in the program say, 'We already know that it works you don't have to convince us.' But at the same time, if the [design and] execution is not perfect we need to improve it before scaling to other cities," said Boonstra.[1]

He hoped that Andersson Elffers Felix, the consulting firm hired by the Bernard van Leer Foundation to design the scaling strategy, would be able to answer their many questions about how best to move forward. How do you turn an innovative start-up program into a structured professional program without losing the passion and energy that comes from its founders? How do you go from a start-up to a more structured, formalized organization? Is the program's inventor the right person to scale the program? How long does a program need to run to determine whether it is effective? Is it necessary/advisable to scale the program in Rotterdam first, and focus on replicating the program in other cities afterwards or can this happen in parallel? Is there a risk of other cities trying to copy the program without guidance from the Rotterdam staff and "not getting it right"? These and a myriad of additional questions were on Boonstra's mind as he headed off to the meeting.

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*This case was written by Laura Winig, Senior Case Writer, in collaboration with Julie Boatright Wilson, Harry Kahn Senior Lecturer at the Harvard Kennedy School (HKS).**Funding for this case was provided by the Bernard van Leer Foundation. HKS cases are developed solely as the basis for class discussion. Cases are not intended to serve as endorsements, sources of primary data, or illustrations of effective or ineffective management. KS1269*

Barend Rombout and Bureau Frontlijn

In early 2002, Leefbaar Rotterdam, a right-wing populist political party[2] based in the municipality of Rotterdam, the Netherlands, won majority representation during the city's local council elections, unseating the Labor Party which had held power for 30 years. After the election, the city of Rotterdam announced it wanted to reduce the number of impoverished and unemployed immigrants coming to Rotterdam. "We have a lot of people coming into the city who just go on welfare," said the leader of Leefbaar Rotterdam, Ronald Sorensen.[3] The city council announced plans to speed up deportations of illegal immigrants and evict "anti-social residents" from the city's public housing.[4] The new government blamed immigrants for the excessive consumption of social services in the city.

Soon after, Barend Rombout, a 25-year veteran of the Rotterdam police force, was asked to "clean the streets" along his neighborhood beat. "So we did house calls," said Rombout, who visited home after home, looking for criminal activity and illegal immigrants.[5] In the process, Rombout discovered pervasive social problems had taken hold in Rotterdam. "I saw poverty, fire [hazards], illegal prostitution, drugs, etc.," said Rombout. He was particularly struck by the high level of poverty and drug addiction among young women with children—many homeless and lacking clothing and supplies to raise their families.

Rombout was very familiar with the city's ills. "I [worked] in the center of Rotterdam . . .where everything was going on—prostitution, gambling clubs and drugs. There was plenty to do on those four square kilometers," he said.[6] He had also served with the seaport police handling drug investigations. Over the years, Rombout said his experience with law enforcement taught him that punishment is an ineffective tool. "There must also be help and support. . . If you put someone in the corner without a way out, things go wrong."[7] As he grew more and more interested in helping those he encountered on his beat, he decided it was time to leave the police force.[8]

Rombout approached Rotterdam's city council along with a recommendation: to establish an independent agency aimed at reducing poverty by enabling impoverished women to learn basic life skills. He believed that doing so would also improve the health and wellbeing of their young children. The city council agreed and in 2006, Rombout was put in charge of Bureau Frontlijn (frənt-ˌlīn) a new, independent agency of the municipality of Rotterdam (see **Exhibit 1** for a general timeline of events). He was assigned 11 employees and a handful of student interns and given a budget of €1 million, approximately .03% of the city's annual operating budget.

Rombout published a vision statement for his fledgling agency: "The government must protect its weakest citizens, even if that goes against the interests of that government." He explained that he believed the government had a moral duty to do so, even if it did not always meet the government's financial goals. "In case of the most vulnerable citizens I believe you should look first at their interest with the objective to sustainably solve the problems that they have," he said.[9]

Rombout explained that Frontlijn took a comprehensive approach to helping impoverished women: "We go into the neighborhood and talk to the family and family members—child, mother, father and

brothers—everyone is involved. Most of the services and supports we develop ourselves or if we take our clients to another agency we go with them, guide them," said Rombout. His agency's method was to address a client's emergent crisis first (lack of housing, for instance) and then teach life skills ranging from budgeting to parenting.

Rombout insisted that Frontlijn staff meet with clients inside their homes. "The mayor said, 'You only go on public roads.' But I said, 'No, the misery comes from the houses, not from the street,'" said Rombout.[10] In doing so, he and his team discovered residents living with a host of problems. "We had outlined various situations. For example, unsafe electrical stoves, four on a cord. Do we want that? No of course not. We made [reports] on the basis of photos: look, this is going on. Soon everyone agreed that you had to look behind the front door [if] you wanted to be able to solve such problems," he said.[11] Rombout also noted that because his team spent many hours with each client family, they had an opportunity to spot problems that traditional social workers might not. "Compared to standard assistance, we may have ten or twenty times more contact with people," he said.[12]

At Rombout's direction, Frontlijn insisted on providing customized services, as opposed to the traditionally-offered one-size-fits-all public services. His contrarian spirit gave him a reputation within Rotterdam's government as, in the words of one of his supervisors, "lice in the fur." He remarked: "Bureaucracy has the tendency to want everything to be the same for everybody and has great difficulty with exceptions. Customization is difficult to deliver." Still, Frontlijn's status as a quasi-independent organization—along with its reliance on a growing network of partners[a]—allowed him to gain ongoing support from the city council. "Collaboration creates more mass," said Rombout.

In 2009, Bureau Frontlijn was put under the direction of Ineke Bakker, General Director of Youth, Education and Society for the municipality of Rotterdam, who was responsible for the city's social services. Bakker found Rombout's unconventional approach to managing social services delivery refreshing. "When you work as a civil servant, you have to have some people like Rombout to be alert to what's happening on the street," said Bakker.[13] "And as a police officer, he has the right balance between being firm, stern and empathetic, compassionate," she said. Indeed, Rombout, a physically imposing but gentle man was described as a "socially oriented manager who can combine purpose and humanity." Rombout believed a fresh approach to social service delivery was needed and said the government suffered from "organizational inbreeding": "Within the government we all put the same people who think the same way in the same places. And who is going to be a manager? The one who has not been bothered. That is not the intention, you have to make someone a manager who is difficult. That person may not do everything right - I do not do everything right either - but I do say: let another sound be heard."[14]

Rombout's approach led Boonstra to describe Frontlijn as an entrepreneurial, innovative agency. "They have a tendency to change the execution of the program every week or month. That is how they like to work "Ooh, this sounds like a good idea, let's do that." They try things as experiments," said

[a] Rombout recruited dozens of partner organizations to provide services to his client families, including housing associations, welfare organizations, hospitals, midwives, maternity care providers, birth centers, health care professionals, child welfare institutions, police and schools.

Boonstra. He noted that Frontlijn's role within Rotterdam's government was to develop new interventions, new approaches to solving entrenched problems. "They show the regular institutions when they are not doing things right. That is the reason why Frontlijn was created," said Boonstra.

City of Rotterdam

Rotterdam, a major port city, was the second largest city in the Netherlands, with a population of 580,000 in 2008. See **Exhibit 2** for a map of the city's neighborhoods. Compared to other Dutch cities, Rotterdam had a larger proportion of lower educated persons, a higher unemployment rate and household income below the national average. The city hosted a large immigrant community, many of whom migrated from former Dutch colonies, including Suriname and the Antilles. A 2008 study on Rotterdam's culture noted that it was a city inhabited by citizens with a strong work ethic and a "direct" nature. The study also characterized Rotterdam as a city of "youth and minorities."[15]

Klaar voor een Kind: Ready for a Baby Program

While Rombout was discovering social ills in Rotterdam's neighborhoods ranging from drug abuse and domestic violence to poverty and homelessness, Dr. Eric Steegers, professor of Obstetrics and Prenatal Medicine at Erasmus Medical Center in Rotterdam (Erasmus MC), was struck by the high rates of perinatal[b] mortality and morbidity in the city. Curious about the disparity between the rates in Rotterdam and the rates in nearby Nijmegan, where he had most recently been working, Steegers began to compile data from other Dutch cities and found that the rates in Rotterdam were significantly higher. He created a heat map[c] of Rotterdam (see **Exhibits 3a and 3b**) depicting the prevalence of perinatal mortality and morbidity at the neighborhood level. "There were some neighborhoods with rates that were four or five times higher than the Dutch national average," said Steegers.[16] "In fact, there are some neighborhoods in Rotterdam where the prevalence was comparable to that in underdeveloped countries."

Initially, Steegers believed the data was explainable due to a large population of non-Western immigrants in the high-prevalence neighborhoods, but as he investigated further, he discovered that the risk of perinatal mortality and morbidity was highest among poor Netherlands-born women. "Then we understood—it is a problem of poverty," said Steegers. "For the first time in the Netherlands we realized that the outcome of pregnancy is not only related to medical and obstetrical risks, but it is also related to social problems due to poverty," he said. There were 8,000 babies born each year in Rotterdam of which 45% were born into poverty.[d]

Steegers met with Jantine Kriens, deputy governor of Public Health, Welfare and Social Security for

[b] Perinatal mortality and morbidity referred to low birth weight and prematurity among newborns during the period of time from 20 weeks of gestation (pregnancy) through a newborn infant's first days of life.
[c] A heat map is a representation of data in map form where data values are represented as colors.
[d] In the Netherlands, the poverty line is US$14,088 for a single person up to US$26,556 for a family of four. In 2015, 2.5 million people—about 14% of the population—lived below the poverty line which the government defined as income which provided the "bare minimum" need to secure food and housing in the country. ("Poverty in the Netherlands," The Borgen Project, October 5, 2016, https://borgenproject.org/poverty-in-the-netherlands/, accessed January 18, 2018.)

Rotterdam, to present his heat map and discuss the findings. “She said, ‘High perinatal mortality and morbidity rates are not only your problem but also my problem as a municipality.’ She understood that it would affect the health of future generations of the city,” said Steegers. As a result, Kriens made improving perinatal health a city priority and asked that the Area Health Authority for Rotterdam and Erasmus MC work together to develop a program to address the problem. In 2008, the two organizations jointly launched Klaar voor een Kind—the Ready for a Baby program.

The primary aim of the program was to improve birth outcomes by offering women pre-conception care and by broadening the scope of their care to include women’s social environment and needs. The program was broadly supported by the Midwifery Academy of Rotterdam as well as local midwives, gynecologists, pediatricians, family physicians, maternity care and pediatric clinics, and social service support organizations.

Ready for a Baby was one of the first programs in the Netherlands to link healthcare delivered in the community with medical research. “It is important to combine applied science with traditional research in healthcare,” said Steegers, who noted the value of using research findings to support policy decisions. “Integrating academic research with practice moves the knowledge out into the field much more quickly,” he said. Steegers also believed it was important for research hospitals like Erasmus MC to share their research findings with central government and municipal policy makers. “You look at your results much more closely and force yourself to seek a practical application—much more quickly than would ordinarily be done—for the benefit of society,” said Steegers.

Steegers had begun to conduct impact studies on the Ready for a Baby program and found there was significant political support for using the data to drive investments of public resources for scaling decisions—though some lawmakers questioned why the country should have to wait for data results before implementing a program they assumed would be effective.

By 2011, the program was deemed a success—a best practice between policymakers, medical practitioners and the community—and began to scale to other cities throughout the Netherlands. In 2013, the city announced that Rotterdam would expand Ready for a Baby, folding it into a new, broader program, Stevige Start (A Solid Start) scheduled to launch in early 2016.

The Mothers of Rotterdam Pilot

In 2013 Rombout attended a professional conference where he met a colleague of Steegers’, gynecologist Tom Schneider, who was responsible for high-risk pregnancy care at Erasmus MC. Schneider told Rombout that he believed that in addition to medical care, many of his pregnant patients needed social services. Rombout needed little convincing as Frontlijn was already providing services to many pregnant women. Indeed, in the 2010s, professional midwives—who were responsible for managing the majority of births in Holland—began reporting an increase in the number of pregnant women with complex socio-medical issues in Rotterdam. “Schneider couldn’t find any agency he could refer them to,” said Rombout.

By then, Frontlijn had been running an intensive social service counseling program for many years,

so Schneider asked Rombout if Frontlijn could take on the cases of some of the women he treated in his medical practice. “When someone has given birth, there is no one else to call to address non-medical issues except Frontlijn,” said Bakker, “Erasmus could call Frontlijn and say the mother and baby are arriving home tomorrow—can you provide soup, clothing, etcetera? Frontlijn is the only service provider that Erasmus can reach day and night to get these things in order,” said Bakker.

Schneider referred ten pregnant women—each facing a serious social problem such as drug addiction or domestic violence—to Rombout. “Tom Schneider introduced Frontlijn into the hospital. He said to the women, ‘I can only give you medical services but I have someone who can help with your social problems. Is it ok if he comes to visit you in your home and teach you some new skills?’” said Rombout.

By the end of the year, Schneider and Rombout agreed that Erasmus MC and Frontlijn would launch a formal pilot program to provide social support services to pregnant women; Erasmus MC would refer women to Frontlijn which would provide services. Schneider sought support from Steegers, while Rombout convinced Bakker to allow him to pilot a small program—which he dubbed Mothers of Rotterdam—to serve 100 women on a budget of €150,000. Hugo de Jonge, the new deputy governor of Public Health, Welfare and Social Security who succeeded Jantine Kriens, agreed to the proposal on one condition: that in 2015 Frontlijn would relinquish its role in the program so that services could be provided by the city’s about-to-be-launched neighborhood-based social service teams. “I agreed to that knowing that the neighborhood teams would not be ready in one year,” said Rombout.

Mothers of Rotterdam Program Objectives

The Mothers of Rotterdam program was designed to support at-risk pregnant women with an intensive counselling program to improve their ability to care for and raise their children and help them overcome challenges related to income, housing, life skills, domestic violence and physical and mental health. What made the program unique in the Netherlands was a medical and non-medical risk assessment conducted early in pregnancy, and the bundling of health services with parenting and life skills counselling during the pregnancy and for the first three years of the baby’s life. Specifically, the program’s objectives were to improve pregnancy outcomes (reducing incidences of premature births, low birth weight, low Apgar test scores and birth defects), promote a close bond between mothers and their children, improve mothers’ parenting skills and promote a healthy lifestyle. The program posited that if women could be taught life skills that enabled their economic self-sufficiency and increased the likelihood they would deliver and raise healthy children, government expenditures for their care would decrease while tax revenue (from their wages) would increase, providing a measurable benefit to the city of Rotterdam.

Program Operation and Management

Operationally, the program had three objectives: 1) implement an intensive counseling program; 2) provide these counseling services to women across seven “life domains” including job/income, housing, domestic/life skills, domestic violence, education, safety and physical and mental health; 3) conduct a research study of the program. Two project leaders, reporting directly to Rombout at Frontlijn, were

responsible for developing the program methodology, overseeing implementation and ensuring that the program objectives were met.

The Mothers of Rotterdam agreement called for the program to adopt Frontlijn's general operating methodology which specified that clients be visited intensively (on average, one or two home visits per week) and offered practical counseling and training on basic life needs and skills. To complement Frontlijn's original techniques, Mothers of Rotterdam added services—making prenatal home visits, encouraging women to make doctor appointments, organizing social networking gatherings among expectant mothers, and encouraging the use of contraception after childbirth. In addition, three Mothers of Rotterdam staff members received training on how to identify and help victims of domestic violence and child abuse. Generally, if a required service or intervention was already offered by the city of Rotterdam or a local organization, Mothers of Rotterdam would consult with the provider and facilitate an introduction and registration. If no service providers existed or if the client was not qualified for services, the program would provide services itself.

Becoming a Mothers of Rotterdam Client

A potential client could be referred to Mothers of Rotterdam by obstetric care providers, other medical service providers, social workers, municipal agencies or by the pregnant woman herself. Women were referred to the program for many reasons, including homelessness, unsafe living conditions, low income/poverty, high debt, domestic violence, parenting issues, lack of health insurance, drug or alcohol addiction, mental health issues, and high levels of stress.

After a potential client was referred to the program, she was registered and a case supervisor scheduled an intake meeting. During the meeting, the case supervisor conducted a detailed assessment and developed an action plan and goals for each area of concern. The case supervisor also decided—based on the complexity of the case—whether the client would be assigned a team comprised of student interns, professional staff or a combination of the two. The case supervisor would then review the plan of action with the client and, if it met with her approval, both would sign it.

The program was divided into four phases based on the child's age, each approximately one year in duration: pregnancy and birth, the first year of life, children aged 1 to 2 years and children aged 2 to 3 years. In phase one, the program consisted of performing an evaluation of the mother-to-be's existing skills and supports and emphasized developing a long-term action plan. While the first priority was to resolve acute crises (such as homelessness), the plan was designed to help the women progress toward self-sufficiency. The second phase focused on helping mothers bond with their newborns and consisted of doctor visits, participation in mothers' groups and weekly home visits from Mothers of Rotterdam teams. At this stage, mothers began to receive job counseling services. Phase three emphasized the development of parenting skills (reading aloud to children and encouraging play groups, for instance) while the fourth phase, after-care, consisted of follow-up care to ensure the mothers had met their plan objectives.

Demand Exceeds Capacity

The Mothers of Rotterdam pilot program had launched in the Carnisse neighborhood of the city (see **Exhibit 2** again for a map of the city's neighborhoods) in 2014. Though the program was supposed to include only 100 women, Schneider's practice, a local hospital and another obstetric practice referred 250 pregnant women to Frontlijn. It soon became clear that demand for the program far exceeded their expectations and Frontlijn struggled to provide services for all 250 women. As a result, Rombout returned to Bakker to seek additional funding to expand the pilot. Bakker asked Stichting De Verre Bergen, to fund the pilot. "The government doesn't always have money for long-term projects. Stichting de Verre Bergen wants to support long-term projects that have an impact in the city and they picked Mothers of Rotterdam," said Bakker.

The foundation, which invested about €20 million annually in programs designed to address social problems in Rotterdam, agreed to invest €7.5 million in Mothers of Rotterdam. The funds would be disbursed over a six-year period provided that the municipality agreed to have researchers at Erasmus MC conduct a four-year controlled study to measure the program's impact and effectiveness. "It took 18 months to collaboratively develop an investment proposal for the Board of De Verre Bergen," said Boonstra, who authored the proposal, noting that funding was scheduled to begin to flow into the program in July 2015, after the completion of the pilot.

Healthcare and Social Services in the Netherlands in 2015

The Netherlands had three levels of government—central, provincial and muncipal. The central government was responsible for collecting most taxes, including taxes on income, property, goods and services and businesses. The central government then distributed funds to the country's 12 provincial and 458 municipal governments. Though the provinces bore legal authority over the municipalities, the municipalities themselves were responsible for local transportation, housing, education, public works—though they had little ability to levy taxes.[17]

In the Netherlands, the responsibility for healthcare was shared between the central government and municipalities. The healthcare delivery system was designed to support three goals: make healthcare accessible to everyone, make medical insurance compulsory and similarly available to all, and provide high quality healthcare to all the country's residents.[18] The Netherlands invested approximately €70 billion on healthcare annually for its 17 million residents—an average of €4,118 per resident.[19]

The Dutch healthcare system was governed by four basic healthcare-related acts: the Health Insurance Act, the Long-Term Care Act, the Social Support Act and the Youth Act. The first two, which accounted for the bulk of the country's healthcare budget, were managed at the central government level and the latter two at the municipal level.[20]

Centrally Managed Healthcare Programs

All residents of the Netherlands were entitled to a basic health insurance package for which insured adults paid an annual premium of approximately €1,200 (in 2016). For children under 18, the

government paid the premiums and lower-income people were given a health insurance allowance from the government to make the insurance affordable.[21] The central government was responsible for supervising healthcare services covered under the Health Insurance Act,[22] though private insurance companies were charged with implementation and as such, the Dutch healthcare system operated as one of "regulated competition."[23]

In addition to the compulsory basic insurance package, health insurers offered supplemental insurance for additional care, which roughly 90% of the Dutch population elected to purchase.[24] The government played no role in regulating or setting coverage rules for this private, supplemental insurance that included among other services, expanded maternity care.[25]

Municipally-Managed Healthcare Programs

In 2015, the Netherlands made a significant change to its social service delivery structure when local municipal authorities in the Netherlands were assigned primary responsibility for administering and implementing the Social Support Act 2015 and the Youth Act 2015, which replaced the country's centrally-administered program.[26] The genesis of the transfer of responsibility from the central government to the municipalities was the belief that local authorities were "closer to the people" and therefore able to provide more effective, higher-quality care.[27] At the same time, believing the municipalities would operate social service programs more cost effectively, the national government significantly reduced social services budgets.

The municipalities, faced with the daunting task of administering and implementing social services, embraced the central government's stance of encouraging people to draw on their own resources and supports—such as family and religious institutions—before turning to the municipalities for services. "In the rearranging of our social domain, we moved toward a stance where we really focus on empowering residents to take responsibility for themselves," said Imke Verburg, project leader for Andersson Elffers Felix.[28] "We had a very elaborate welfare system in the Netherlands that had institutionalized a lot of care and support that often could have been just as effective or even more effectively provided by volunteers, people around you, informal structures, etc. with fewer professionals and institutions involved," she said.

Under the Social Support Act 2015, municipalities became responsible for providing services to people with disabilities, which was broadly defined to include those with physical, mental or psychological disabilities, including clients with learning disabilities and the elderly. Municipalities were expected to provide both general services aimed at the community as a whole—such as shopping transportation for the elderly or homeless shelters—as well as services tailored to each client's unique needs. These services ranged from home cleaning to personal care.[29]

The Youth Act

The Youth Act 2015 made municipalities responsible for supporting children and adolescents (up to 18 years old) and their families in situations where family members were coping with developmental, parenting or psychological problems and disorders. The goal was to make it easier for municipalities to

provide integrated care for children.[30] Municipalities were also responsible for child protection services, including reporting on domestic violence and child abuse.

Social Work in Rotterdam, 2015

Within Rotterdam, the Maatschappelijke Ondersteuning in de Wijk (MOW) was responsible for offering a wide range of social services, including housing and welfare, life skills training, addiction counseling, geriatric services and the like. The department employed 1,500 workers—a large workforce by Dutch municipal government standards. "We offer social work services for people with multiple problems, low income people, those who lack knowledge about how to raise children, or how to manage themselves or their households," said MOW Director Anne Coenen.[31]

Traditionally, social services in the Netherlands had been managed by the central government but after this responsibility was delegated to the municipalities, to deliver services promised under the Social Support Act and Youth Act, many cities in the Netherlands established neighborhood teams that were located within neighborhoods throughout a municipality. The teams, comprised of social workers, were designed to serve as a local direct access point for clients who could seek services from their neighborhood team directly or often, were referred by a doctor or other social service provider.

Potential clients met with a neighborhood team member who assessed the client's needs and determined which needed services could be provided by the client's personal network (i.e., friends, family, religious organizations and the like) and general community services versus those that would need to be customized for the client. The social worker then prepared recommendations for the client. If the recommendations called for customized services, those services could be provided on either a contracted basis (where the municipality provided the service) or if the client preferred, they could purchase services themselves using funds provided by the municipality.[32] The municipalities were provided with funding from the central government and each municipality's leaders were accountable to their own town council for the expenditures.[33]

Like most cities, in 2015 Rotterdam empowered MOW to staff neighborhood teams to arrange and deliver services. Coenen assembled 42 neighborhood teams, each comprised of 15 professionals. Each team was assigned to one or more of the city's 92 neighborhoods and was comprised of generalist social workers as well as experts in elder care, early childhood development, financial management, household management and employment. These neighborhood teams were predominantly (80%) comprised of professionals from commercial, for-profit businesses who were contracted by the city to provide social work services. "We ask them to deliver services because they have specialties or training in early childhood development, geriatrics or other service areas," explained Coenen. The remaining 20% of team members were social workers directly employed by MOW. Though the social workers were all professionals, trained in their own fields, Coenen provided work process training to enable them to deliver a consistent quality of services. "We train them on the interview process and our computer systems," said Coenen.

Using cross functional, "street"-based neighborhood teams to deliver social services was a new

concept in the Netherlands and at first, the teams struggled to find their footing. “They had to improvise . . . and they did it a bit their own way, not always the way we wanted it to be. But they learned from each other, talked about their cases and helped each other develop interventions. They did this very well and worked together very quickly,” said Coenen.

The teams relied on referrals from local religious, volunteer and sports organizations as well as general practitioners (primary care physicians) to identify new clients. “The teams need to make contact with them because that’s how you find people who need help,” said Coenen.

Launching Mothers of Rotterdam

In the meantime, the Mothers of Rotterdam pilot concluded in February 2015 and the partners—the Municipality of Rotterdam, Bureau Frontlijn, Erasmus MC and now, Stichting De Verre Bergen—decided to continue the program. They signed an agreement in July 2015 and Rombout used the spring and summer of 2015 to build relationships with all the hospitals of Rotterdam as well as the city’s obstetrics practices. He also invited most of the prenatal service organizations to collaborate with the Mothers of Rotterdam program. “Most of them signed an agreement to work together,” he said.

By February 2016, a program plan was officially in place. Bureau Frontlijn was responsible for the daily operation of the program and for collaborating with city institutions such as MOW’s neighborhood teams and care providers; Erasmus MC’s Obstetrics and Gynecology and Public Health departments and Erasmus University’s Orthopedagogy departments were charged with jointly administering a quasi-experimental study design with a goal of putting its findings into practice; and Stichting De Verre Bergen, as developer and funder would help ensure the program became established within Rotterdam. “It is unusual to have a collaboration between a university, university hospital, university of applied sciences, a nonprofit organization and a municipality to organize something like this,” noted Steegers. The partners agreed to work collaboratively and in consultation with one another toward their shared mission of making the Mothers of Rotterdam program a success.

In the meantime, Stevige Start launched in spring 2016. The program sought to bridge the gap between social and medical services and focused on providing counseling and support services to improve the city’s rate of healthy births and improve the overall health and wellbeing of children through early childhood. Parents received customized support, ranging from service referrals and counseling to intensive support for highly vulnerable parents, provided by Mothers of Rotterdam, which had become part of Stevige Start.

Research Study

The research study, conducted by Erasmus MC, was designed to determine if the Mothers of Rotterdam program was effective. Researchers wanted to learn if the program’s screening and assessment model resulted in admitting highly vulnerable women into the program and whether the program’s approach to providing services improved the women’s autonomy and confidence in the government’s provision of social services. They also wanted to know if the program was effective in causing women to follow both medical and social service advice and whether the program’s multi-

disciplinary approach itself made the medical and non-medical care more effective.

To conduct a statistically reliable study, the researchers wanted to enroll 300 highly vulnerable pregnant women[e] per year from 2016 to 2018 in the Mothers of Rotterdam program (treatment group) with an additional 300 per year recruited into the control group (to be served by the city through Coenen's neighborhood teams). Each woman in the treatment group would be provided with medical support, counseling and social support—on average 525 hours of provider services—up to their child's third birthday; women in the control group would receive the social work services traditionally offered by the city through its neighborhood teams.

The research study protocols were officially approved by the Medical and Ethical Review Committee at Erasmus in January 2016 and the research study began immediately after. Though the Mothers of Rotterdam program was planned to run until 2021, Erasmus had committed to releasing the results of its research in 2019 (by then, half of the women would have completed the full program).

Neighborhood Teams in 2017

By 2017, the neighborhood teams had been working in Rotterdam for two years. Coenen acknowledged that expectations for the teams were high. "When we started with these teams, everybody said they will be the solution for every problem," said Coenen. "Every city in the Netherlands has these teams and we think these teams will make the difference. And I think in some ways they will. But we have to put more effort into changing the way they work," said Coenen. She noted that the professionals on her teams were enthusiastic and performed well and were working to better align their work with the city's goals.

The neighborhood teams had continued the city's general approach to service provision where clients would meet with social workers in a central office location and social workers would decide which services were appropriate to offer to each client. "But nowadays, we need to let people make their own decisions and do as much as possible to be self-sufficient," said Coenen. "Even after two years, the way the teams help is by taking control and making decisions for the client rather than helping the client by empowering them to find the solution," she said.

Though the teams were becoming more proficient at evaluating their clients' social service needs, Coenen acknowledged that embracing a method that shifted the responsibility from service provision to encouraging self-sufficiency and self-empowerment could be difficult for her social workers. "They chose this profession because they want to help people. They did it one way for many years but we now see it differently in the Netherlands: you should help people make their own decisions – which is what we call 'Zelfredzaamheid,' self-actualization, the ability to cope independently," said Coenen. Rombout thought the challenge was more institutional: "There is a difference in the mindset of the professionals. They do what they think they must do in accordance with legislation and policy. Mothers of Rotterdam looks at the specific needs of the individual. That is a very different approach," said Rombout.

[e] "Highly vulnerable" referred to women experiencing a combination of medical and non-medical (social) risk factors.

Looking Forward: Beyond 2017

By 2017, Bureau Frontlijn was running the Mothers of Rotterdam program in most of the city's neighborhoods—though Frontlijn was unable to serve every potential client, given the small size of the agency. Though the city's plan was to scale the Mothers of Rotterdam program more broadly in the city and bring it under the aegis of Coenen's department, the decision was not final. "That could be, but it isn't decided yet. We need to understand what kinds of demands Mothers of Rotterdam adds to the organization," said Coenen. She wondered whether her teams, comprised primarily of generalist social workers, could effectively implement such an intensive program aimed at a small subset of the population her agency was expected to serve.

Rombout noted that the neighborhood teams took a different approach to identifying and serving clients—one that he felt would not work for vulnerable mothers. "Our mothers don't seek out services—we find *them*. Now, if you want help, you have to report to the counter and complete a questionnaire to ask for help from the neighborhood teams. The neighborhood teams won't find vulnerable women that way. It is very difficult for some people to ask for help—that's why we look for them. We find vulnerable women through other organizations that they already trust," said Rombout, adding that he believed the neighborhood teams would need to change their operating method if they wanted to be as effective as Mothers of Rotterdam. "The neighborhood teams only support clients for a three to six month maximum term," said Rombout. "That is insufficient for vulnerable mothers," he said. In the end, Rombout believed that Mothers of Rotterdam should remain a stand-alone program.

Scaling Mothers of Rotterdam

By May 2016, scaling the Mothers of Rotterdam program had become a priority for its stakeholders. The Bernard van Leer Foundation, a private foundation focused on developing and sharing knowledge about effective early childhood development programs, became a program partner specifically to support the creation of a scaling strategy for Mothers of Rotterdam.

To draft the strategy proposal and help guide the scaling process, the Bernard van Leer Foundation hired Andersson Elffers Felix, a consulting firm with experience in scaling innovations in the public sector. By then, Mothers of Rotterdam's leadership team was considering a dual scaling strategy to be executed concurrently: scale the program within Rotterdam (broaden the existing program to reach more women within the city) and adapt the program and research to scale to other Dutch cities. They estimated that the program model could benefit 25,000 young children of disadvantaged women in the Netherlands each year.

It was still unclear if the service delivery model employed in Rotterdam—which appeared to be working—would work at a larger scale or in another municipality. Indeed, though some questioned whether there was sufficient evidence of program effectiveness to begin a scaling effort, others felt the need to urgently aid vulnerable pregnant women and acknowledged there was the political will to capture funding at a time when local governments were actively developing new local policies to support vulnerable populations. "Because of decentralization, there is a current opportunity—room,

openness, willingness to experiment," said Op het Veld, a partner at Andersson Elffers Felix. "There is momentum."

Rather than wait for the completion of the research to have definitive evidence, Op het Veld advocated for an approach that took the most valuable elements of the Mothers of Rotterdam program and used them to conduct small scale experiments in other municipalities. "The approach to an evidence-based intervention is long and attached to certain (scientific) preconditions. It would be a shame to wait," she wrote in her proposal.

Op het Veld believed that they had to start by developing a communication strategy to share what had become a common understanding among those in the Mothers of Rotterdam program: that taking care of vulnerable pregnant mothers and investing in a child's first thousand days were crucial for their development. "This is when the foundation is laid for a healthy future. This is not a [well-told] story currently in the Netherlands, so our work starts with telling this story in the Netherlands for all the municipalities," said Op het Veld.

Next, she felt that the valuable elements of the Mothers of Rotterdam program had to be adapted to make them fit to other municipalities for their own local infrastructure and existing programs. Finally, Op het Veld believed that the city of Rotterdam should become an ambassador to other municipalities so they could see the program working. "The last is one of the hardest parts because Mothers of Rotterdam operates outside of the regular part of the municipality and there is no real ownership of the program within the municipality of Rotterdam," said Op het Veld.

While Rombout supported scaling the program, he believed that those who wanted to adopt his approach could encounter many of the same challenges he had faced: "Government says, we can't provide all the help, we don't have the money, you have to do it yourself. In every city it is the same," said Rombout. Indeed, other cities would need to adjust their programs to account for demographic and other differences between the served populations, avoid duplication with existing services, build political support, find funding and most importantly, fuel client demand for services.

Verburg, however, believed that other municipalities might encounter other challenges to program adoption than Rotterdam faced. "In the setting of Rotterdam, and the local organization of the municipality, it was helpful to have someone like Barend Rombout. I don't think it is a prerequisite to have someone forcing a solution though we will need someone in the municipality to really take ownership. It could also be a political leader within a municipality or a program leader, for example," said Verburg. She did note that some aspects of the Mothers of Rotterdam program might seem counterintuitive to other cities considering its adoption. "Other municipalities suggest that Fronlijn's staff are so young, they might not be equipped to handle the population's challenges. But Barend has found that because they are young, it makes them more relatable to the mothers. Because when they confront the mothers about say, drug use, their youth makes them less intimidating or frightening to the mother. She feels less judged and may be less likely to drop out of the program," said Verburg.

Rombout felt he could address the concern most often voiced: could another city successfully launch a similar program without Rombout in the lead? "My kind of pioneering matters only in the first

phase, when you actually *have* to pioneer. To push through, to deal with the setbacks, to take risks, to keep going when the going gets tough," he said. "We have a proven approach now, and such a pioneer is not necessary anymore. You do not have to reinvent the wheel anymore in terms of methodology. We had to pioneer institutionally *and* invent the wheel. Other cities only have to create the right organizational setting," said Rombout.

After reviewing Op het Veld's proposal during the board meeting, though many of Boonstra's questions were answered, he still felt there were challenges to consider. "One challenge in scaling up is that the problem has to be big enough in the cities. If there are too few vulnerable women in a municipality then there is no use putting up the program." But the most significant challenge was, absent a Rombout/Steegers-led partnership, how to foment cooperation between the social service and medical sectors. "We need an integrated approach—social obstetrics—that has to be central. And that looks easy on paper, but in practice these two worlds are completely separate. When you're educated as a healthcare professional, you often know nothing about debt management or housing. That's really difficult, to get the social and medical domains to work together. Our exceptionality is we have Erasmus University with expertise with Eric Steegers and we have this crazy guy Barend Rombout. They don't stop. That's difficult to copy to different cities," said Boonstra.

Exhibit 1: Mothers of Rotterdam Timeline of Events

2006 Rombout founded Bureau Frontlijn.

2008 Erasmus MC and the City of Rotterdam launch Ready for a Baby program.

2011 Ready for a Baby program begins to scale into other cities in the Netherlands.

2013 Rotterdam announces the Ready for a Baby program will be expanded and folded into a new program, Stevige Start, in 2016.

2013 Frontlijn and Erasmus MC agree to pilot Mothers of Rotterdam.

2014 Mothers of Rotterdam pilot program launched in Carnisse neighborhood.

2015 Frontlijn is scheduled to turn over its Mothers of Rotterdam service delivery responsibilities to Rotterdam's neighborhood teams.

2015 De Verre Bergen agreed to provide €7.5 million in funding (over 6 years) to Mothers of Rotterdam.

2015 The Netherlands passed the Social Support Act and Youth Act to delegate most healthcare and social service provision to the municipalities. The municipalities create neighborhood teams to handle service provision.

2015 Mothers of Rotterdam pilot concluded and the partners agreed to continue the program.

2016 By February, Mothers of Rotterdam completed its program plan.

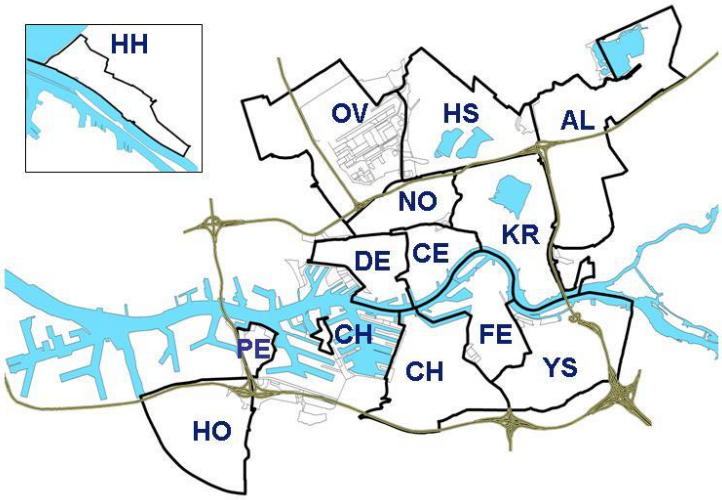
2016 In spring, Stevige Start launched. Mothers of Rotterdam officially begins operating under the auspices of the Stevige Start program.

2016 Erasmus MC's research study protocols approved and research begins.

2017 Scaling strategy proposal presented to Mothers of Rotterdam board of directors.

2019 Initial results of the research study due to be released.

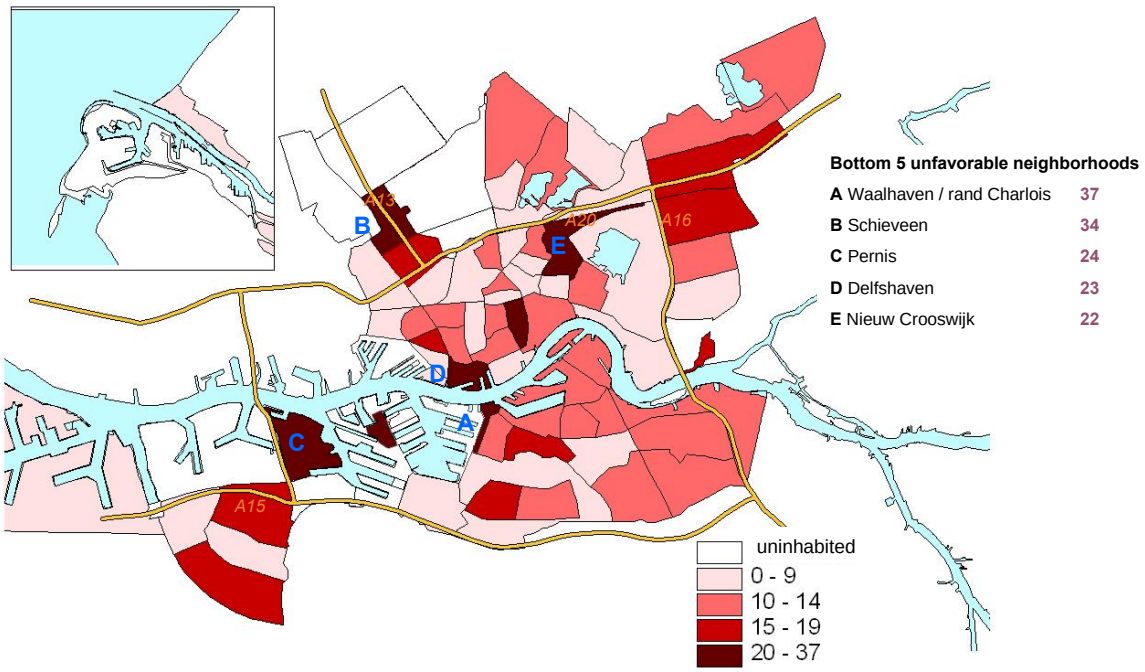
Exhibit 2: Neighborhood Map



HH: Hoek van Holland
KR: Kralingen-Crooswijk
OV: Overschie
HO: Hoogvliet
HS: Hillegersberg-Schiebroek
PE: Pernis
AL: Prins Alexander
CH: Charlois (Carnisse)
NO: Noord
FE: Feijenoord
DE: Delfshaven
YS: IJsselmonde
CE: Stadscentrum

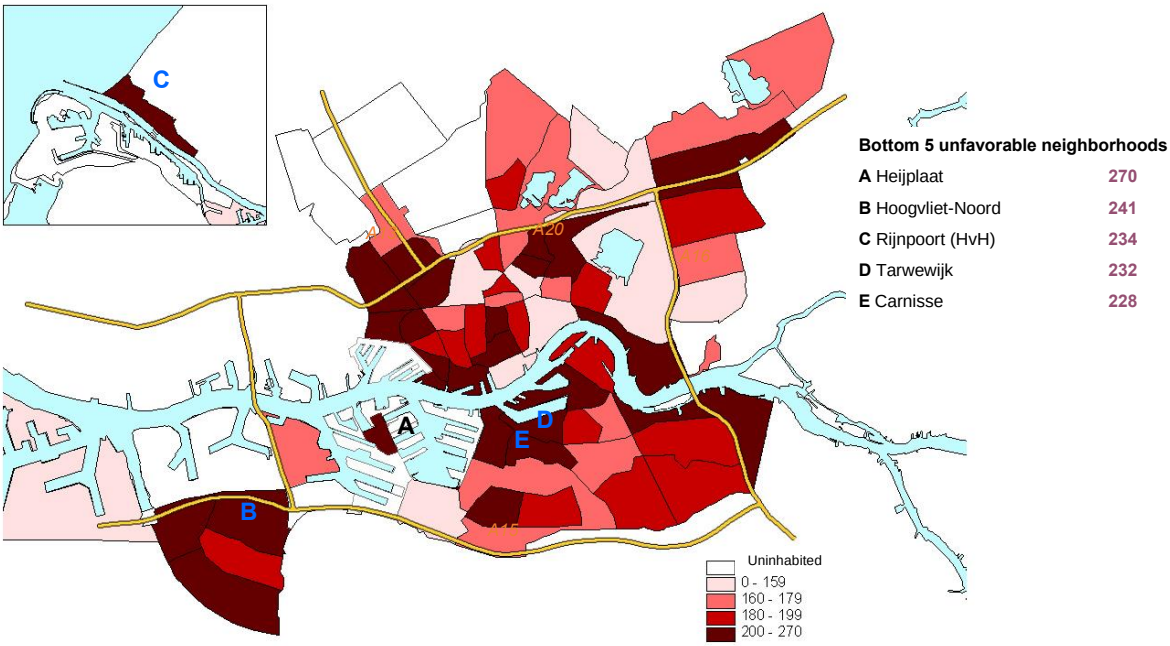
Source: Erasmus Medical Center. Used with permission.

Exhibit 3a: Perinatal Mortality Rates Across Neighborhoods in Rotterdam (per 1000 births, 2000–2006)



Source: Adapted from Poeran J, Denktas S, Birnie E, Bonsel GJ, Steegers EA, Urban perinatal health inequalities, *The Journal of Maternal-Fetal & Neonatal Medicine*, 2011; 24:643-6. Reprinted by permission of the publisher (Taylor & Francis Ltd, http://www.informaworld.com).

Exhibit 3b: Perinatal morbidity Across Neighborhoods in Rotterdam (per 1000 births, 2000–2006)



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