

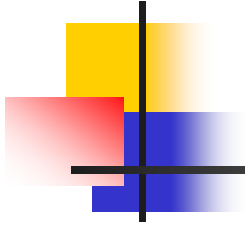


# Evaluating community-based early childhood development initiatives:

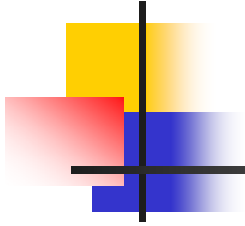
---

David Dunt\* , Margaret Kelaheer  
University of Melbourne

Centre for Health Policy, Programs  
& Economics



Growing recognition of the influence of the social environment on the development of the brain in the early years has led to a new activism aimed ultimately at overcoming intergenerational poverty



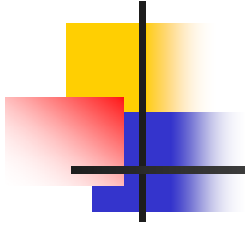
Led to a number of initiatives to improve health, educational and developmental outcomes in socio-economically disadvantaged children

### Targeted case management

- Early Head Start (US)

### New services/programs & community based

- Sure Start (UK)



- Best Start, a community-based initiative focussing on early childhood development in 11 disadvantaged communities in Victoria



# Best Start Initiative

---

- Based on community partnerships – an auspice body (usually a LGA) & other relevant agencies (MCH, preschools, schools, parent groups)
- Partnerships add value by
  - Needs assessment (Action plan) define projects that addressing important gaps in services
  - Using social marketing, cross-service promotion and co-ordination and some new services (playgroups, parent reading groups)
  - Particularly focusing on vulnerable and underserved groups



# The community partnerships could choose from several activity areas nominated by DHS

---

## Seven health outcome areas

- Breastfeeding,
- Women smoking during pregnancy
- Immunisation
- Attendance at Maternal Child Health Centre,
- Attendance at hospital ED for specific conditions,
- Children's diet and physical activity and

Community safety

## Four educational outcome areas

- Parents reading to their children,
- Participation in preschool/kindergarten,
- Absences from primary school,
- Reading abilities.



## The principal research questions

---

- Do the (Maternal and Child Health) projects initiated by Best Start partnerships improve access to Maternal and Child Health (MCH) Services?
  - 3.5 year ages and stages visit important for detecting developmental delay, promoting [preschool attendance



# Study design

---

- Quasi-experimental design to assess changes in MCH attendance rates (and proxy measures)
- before and after the introduction of Best Start projects
- at sites with MCH projects and a suitable comparator (outlined shortly).





## Instruments and procedures (1)

---

- Several – mixed methods (MDS template, site visits, service cooperation inventory, group s disadvantaged parents)
- Statewide MCH attendance indicator dataset (2000-2001 to 2004/2005)
- 1739, 1437 vs 45,497, 45,953).



## Instruments and procedures (2)

---

- **Parent's Survey:** Mail questionnaire to parents of 3 year old children with official enrolment form for 4-year old kinder (Early & late cross-sectional surveys (1666 , 1838) with similar characteristics to families in same LGA).



## Instruments and procedures (3)

---

### Parent's Survey - measures

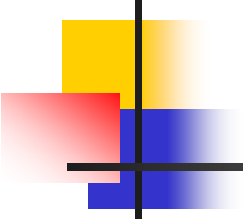
- access to information about MCH,
- confidence will attend the MCH 3.5 years attendance &
- parental confidence



# Data Analysis - logistic regression

---

- Attendance dataset
  - Comparator - all other metro or rural LGAs without MCH Best Start project
  - Controlled for Indigenous status, education, country of birth and proficiency in reading English - taking into account clustering by site
- Parents surveys
  - Comparator – Best Start sites without MCH projects
  - Controlled for health care card, indigenous status, education, country of birth and proficiency reading English .



# MCH attendance results – changes across Best Start period

## Changes in attendance at MCH 3.5 year visits (2001/02-2004/05)

Predictors	Number (%)	
	2001/02	2004/05
Best Start	1,739 (37.2%)	1,437 (57.5%)
Rest of the state	45,497 (49.3%)	45,953(56.8%)

\*  $p < 0.05$



## MCH attendance results – multivariate analysis

### Effect of Best Start MCH projects on MCH 3.5 year visits compared to the rest of the state

Predictors	Adjusted Odds ratio (95%CI)
Year-2004/05 vs 2001/02	1.35 (1.19-1.54)*
Best Start sites	0.65 (0.39-1.08)
<b>Best Start *Year</b>	<b>1.69 (1.12-2.55)*</b>

\* p<0.05

# Parent survey results – changes across period

## Changes in MCH proxy indicators parent survey across Best Start period

MCH proxy indicators			Early	Late
Seen information about 3.5 year Visit	No MCH projects	<b>N</b>	<b>382</b>	<b>336</b>
		%	42.2%	32.7%
	MCH project	<b>n</b>	<b>956</b>	<b>1186</b>
		%	49.2%	51.0%
Confident child will attend 3.5 year Visit	No MCH projects	<b>n</b>	<b>386</b>	<b>333</b>
		%	83.2%	85.6%
	MCH project	<b>n</b>	<b>956</b>	<b>1184</b>
		%		
Confident a good parent	No MCH projects	<b>n</b>	<b>405</b>	<b>337</b>
		%	95.8%	94.4%
	MCH project	<b>n</b>	<b>1234</b>	<b>1480</b>
		%	94.7%	97.0%

## Parent survey results – multivariate analysis

The effect of Best Start MCH projects and partnership scores on MCH proxy indicators - Adjusted Odds Ratios (95% CI)

	Seen information about 3.5 year visit	Confident child will attend 3.5 year visit	Confident in being a good parent
<b>Model 1</b>	<b>n=2679</b>	<b>n=2676</b>	<b>n=3224</b>
Early/Late	0.65 (0.54-0.78)	1.38 (1.1-1.75)	0.7 (0.56-1.09)
MCH projects	1.13 (0.8-1.59)	0.89(0.54-1.47)	1.01 (0.79-1.29)
<b>MCH* Early/Late</b>	<b>1.76 (1.2-2.57)*</b>	<b>0.73 (0.58-0.92)*</b>	<b>1.94 (1.16-3.24)*</b>

\*p<0.05





## Conclusions (1)

---

- Do the projects initiated by Best Start partnerships improve access to Maternal and Child Health (MCH) Services?  
**YES by improving parent's access to information and overall parental confidence**



## Conclusions (2)

---

- These results suggest that there may be considerable value in community-based initiatives and partnership approaches.
- But with caveats
  - Best results
  - Difficult to generalise –particular communities, particular histories