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Evaluation of Public Health Well Baby/Child and Breastfeeding Clinics Using a Health Equity Lens

Michelle Sangster Bouck, MA, Program Evaluator
Joanne Simpson, RN, Public Health Nurse
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Background Information

- Decision made in 2012 to evaluate Well Baby/Child and Breastfeeding Clinics (WBCC)
- Health Inequity SAG looking for a program to pilot the new Health Equity Impact Assessment Tool (HEIA tool)
- Decision made to evaluate and complete HEIA tool simultaneously - mutually beneficial
- Recognized that the HEIA was being completed retrospectively, as opposed to pre-implementation (intended primary application of HEIA)

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WBCC Evaluation and HEIA

Evaluation

- Client Satisfaction & Program Quality
  - Allows us to look at the impact of WBCC on clients receiving services
- Reach
  - Learn more about who is coming and not coming to WBCC-demographics of clinic clients

Health Equity Impact Assessment

- Structured process to consider the implications of WBCC on priority populations
- Considers WBCC as part of a larger system

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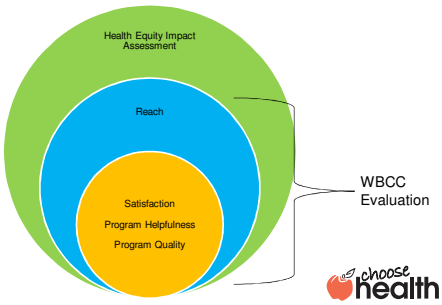
Micro & Macro Level Views



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Well-Baby/Child and Breastfeeding Clinics

Goals of WBCC

- Breastfeeding
- Early childhood development
- Parenting
- Social support
- Health & safety information for parents

Target Group

- Parents/caregivers of children birth to school-entry

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WBCC Evaluation 2012/13

Response Rate Clinic Surveys	Response Rate Telephone Interviews
93.8% (547/583)	78.6% (430/547)

	# of Completed Clinic Surveys	# of Completed Telephone Interviews
Final sample	547	430*

* Two partially completed telephone interviews, so two questions have 432 respondents.

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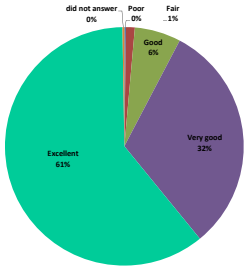
Overall Satisfaction



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What Participants Liked Best About the WBCC – Qualitative Findings

- Reassurance
- Accessibility
- Nurses
- Atmosphere
- Social Support

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What Participants Liked Best About the WBCC

"I like how you can confirm that everything was going in the right direction, especially being a new parent."

"I personally enjoy the information that they give me. To me its like I'm set for that month – more confident that everything was going well with my baby. They took on a one-on-one approach and made you feel good about things before I left."

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What Participants Would Improve

- Most had no improvements to suggest
  - ~ 1/3 of respondents
- Decrease wait times
- Change hours of operation
- Specific setting improvements
- Concerns about service

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What Participants Would Improve

"The new nurses overtalk you and I normally just come in for a weight check. The new nurses kind of push the Health Board standards where I follow what my doctor wants me to do. The old nurse was really good and she would help me find the best solution for my baby."

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Final comments

"I think that they are good, but I do think there are some problems. I've heard this from other moms as well. Usually there is a comment about something we are not doing right.

They provide information about things that you haven't asked about and don't really take the time to understand what you are really asking. But I would still say that it is a good resource and it has been helpful, but sometimes frustrating."

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Summary

WBCCs are providing a quality service

- Program quality indicators identify ways to make the service even better
- Qualitative comments support the quantitative findings
  - Focus on client identified needs
  - Listen to and understand their situation
  - Engage clients in their own decision-making

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Who Are We Reaching?

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Reach

Clinics are:

- **Not** reaching 1-4 year olds
- Providing a services to ~25% of population of parents with children under 1 year of age
  - High education level
  - Perceived adequate income

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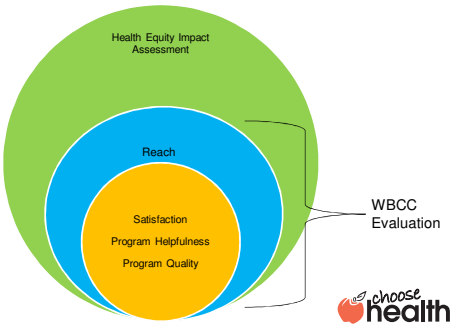
Where is the need greatest?



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Health Equity Impact Assessment (HEIA)

- Is a decision support tool that helps to identify how a program, policy or initiative will impact population groups in different ways
- Helps identify unintended potential health equity impacts (positive and negative) on specific population groups

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Marmot's Proportionate Universalism Theory

- To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage.
- Some groups will need more resources than other groups in order to attain the same health outcomes

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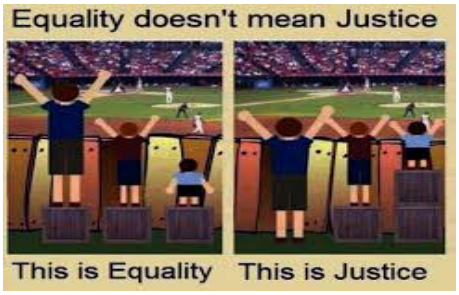

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Health Equity Impact Assessment (HEIA) Summary

1. What populations are not successful in achieving the outcomes that the WBCC wants to address?
2. What are effective strategies to improve the identified outcomes?
3. What are effective strategies to reach the identified priority populations?

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Yes/No Table

Program Goals	Breastfeeding	Child Growth & Development	Health Behaviours	Positive Parenting	Social Support
Aboriginal	YES	YES	YES	DON'T KNOW	YES
Age-related (young parents)	YES	YES	YES	YES	YES
Age-related (older parents)	NO	NO	NO	YES	DON'T KNOW
Disability	DON'T KNOW	DON'T KNOW	DON'T KNOW	DON'T KNOW	YES
Ethno-racial communities Immigrants	DON'T KNOW	NO	NO	DON'T KNOW	YES
Refugees Low income	DON'T KNOW	YES	YES	DON'T KNOW	YES
Francophone	DON'T KNOW	DON'T KNOW	DON'T KNOW	DON'T KNOW	DON'T KNOW
Homeless	DON'T KNOW	YES	YES	DON'T KNOW	DON'T KNOW

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What populations are not successful in achieving the outcomes that the WBCC wants to address?

Primary Priority Populations

- Children of low income/Low education parents
- Children of teen parents
- First Nations Children

Secondary Priority Populations

- Refugee children
- Children growing up in households with abuse
- Children growing up in rural households?

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Why a Priority Population?

Children of low income/Low Education Parents

- more likely to be low birth weight or premature
- more likely to have poorer health outcomes
- less ready to start school

Children of Teen Parents

- more likely to have low birth weights that lead to numerous developmental challenges
- have a higher risk of having children with language delays
- Lower breastfeeding rates

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Why a Priority Population?

Aboriginals

- complex interplay of multiple factors eg. poverty
- Higher risk of prematurity, low birth weight, diabetes, obesity, dental disease, SIDS, injury, chronic ear infections, TB
- Lower off-reserve rates of breastfeeding

Refugee children

- more likely to have serious problems associated with malnutrition, disease, physical injuries, brain damage, and sexual and physical abuse
- may be isolated or marginalized
- Interim Federal Health Cuts.

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Why a Priority Population?

Children growing up in households with abuse

- higher risk of injuries, a number of behavioral , social and cognitive problems later in life, and even death

Children growing up in rural households?

- in some areas exhibited less-healthy dietary practices, lower leisure time physical activity and higher smoking rates than their urban counterparts.
- not as well served and have more difficulty accessing health care services than people in urban centres

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What are effective strategies to improve the identified outcomes?

Breastfeeding

- Evidence to support face to face professional and peer breastfeeding support.
- Evidence to suggest that we need to continue efforts to work with our hospitals to reduce infant formula supplementation in-hospital (part of BFI initiative).

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What are effective strategies to improve the identified outcomes?

Child Growth and Development

- No evidence found to support drop-in services of the WBCC type for parents with children 1-4 years of age
- Limited evidence, suggestions include:
  - How care is provided impacts outcomes
  - Reach parents where they are – physician visits, child care, social and recreational venues
  - Multi-sectoral partnerships and approaches
  - Policy (wage and social assistant benefits)

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What are effective strategies to improve the identified outcomes?

Parenting

- Support for Triple P (children 2 – teen years)
- Support for high-risk home-visiting (Nurse-Family Partnership)
- Emerging support for social connectivity, social marketing, and parenting (empowerment vs education) strategies for the prenatal to age 1 population (Nurturing Matters, Peel Public Health)

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What are effective strategies to reach the identified priority populations?

- Little evidence on optimal strategies to reach the identified priority populations.
- Suggestions in literature:
  - Working collaboratively with community partnerships
  - Engaging people from priority populations to be involved in planning

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Well-Baby/Child & Breastfeeding Clinics are:

- Good quality, with room for improvement
- Reaching moms of higher education/income
- Not reaching parents with children > 1 year old
- Not reaching parents from priority populations

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Well Baby Clinics….Health Equity?

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Recommendations

1. Focus services where evidence and mandate is strongest

- Breastfeeding support
  - Evidence of impact for face-to-face strategies; professional and/or peer support
- Attachment
  - Evidence of need
- Shift from expert-driven care to client-centred care
  - Evidence of impact on self-efficacy, breastfeeding and child development outcomes

2. Narrow Target Group

- Parents of children <1; consider 0-3 or 0-6 months

3. Investigate best practices to reach more families and to reach them early in the postpartum period

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Recommendations

4. Address the Gap

   Investigate strategies and adapt programming to meet the OPHS goals for children aged 1 – school entry

   - Expand reach through community partners
     - Example: Engage in knowledge exchange with partners in contact with parents and young children (e.g. Health Care Providers, OEYC, Family Centres, Child Care Centres)
   - Reach people where they are
     - Example: Deliver Triple P parenting program where we will find parents of young children (e.g. workplaces, recreational centres, faith communities)

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Where we are now?

- Sharing information
- Identifying mitigating strategies
  - Breastfeeding appointments
- Community Early Years Partnership Plan
- Physician Champion Committee Plan
- Ongoing evaluation

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Thank you!

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