ACKNOWLEDGEMENTS

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We acknowledge VicHealth (Victorian Health Promotion Foundation) in providing support for the original development of this initiative during 2007-2012.

We also acknowledge the authors of the Impact Evaluation and Economic Outcome Evaluation, whose work has been used throughout this final report of the Baby Makes 3 project.

SUGGESTED CITATION

## ACRONYMS

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<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ATSI</td>
<td>Aboriginal and Torres Strait Islander</td>
</tr>
<tr>
<td>CALD</td>
<td>Culturally and Linguistically Diverse</td>
</tr>
<tr>
<td>DJR</td>
<td>Department of Justice and Regulation</td>
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<tr>
<td>EMR</td>
<td>Eastern Metropolitan Region</td>
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<tr>
<td>GBLTIQ</td>
<td>Gay, Bi-Sexual, Lesbian, Transgender, Intersex, Queer</td>
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<tr>
<td>GSC</td>
<td>Great South Coast</td>
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<tr>
<td>HADS</td>
<td>Hospital Anxiety and Depression Scale</td>
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<tr>
<td>IPV</td>
<td>Intimate Partner Violence</td>
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<tr>
<td>LGA</td>
<td>Local Government Area</td>
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<tr>
<td>MCHN</td>
<td>Maternal and Child Health Nurse</td>
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<td>MCHS</td>
<td>Maternal and Child Health Service</td>
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<td>MCRI</td>
<td>Murdoch Children's Research Institute</td>
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<tr>
<td>NPG</td>
<td>New Parent Group</td>
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<tr>
<td>PVAW</td>
<td>Prevention of Violence Against Women</td>
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<tr>
<td>VAW</td>
<td>Violence Against Women</td>
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1 Executive Summary

1.1 BACKGROUND TO THIS REPORT

Becoming a new parent is a key transition point in the life course that presents important opportunities to address the drivers of violence against women. ¹ The first 1,000 days - the period from conception to age two years – is recognised as the time when foundations are laid for health across the life span. There is now evidence that shows one in five mothers (20%) experienced emotional and/or physical abuse by an intimate partner in the first 12 months postpartum, and one in four mothers (25%) experience family violence in the first four years after having their first child.²

*Baby Makes 3* is a program designed to support new parents negotiate their gendered roles and identities in their transition to new parenthood. *Baby Makes 3* is an innovative, direct participation program³ designed to impact gender equitable relationships. Through the building of knowledge and skills in equal and respectful relationships, the education sessions are designed to influence attitudes and norms about equitable parenting and women's empowerment, with the ultimate aim of contributing to the prevention of violence against women (PVAW) through gender transformative practices.

This is the final report of a three-year project funded by the Victorian Department of Justice and Regulation (DJR). Carrington Health, in Melbourne's Eastern suburbs, managed the project in partnership with local governments and their Maternal and Child Health Services (MCHS). This report draws together the findings of the three-part evaluation placing them in the context of recent reports on the effectiveness of programs for the prevention of violence against women and children.

1.2 IS BABY MAKES 3 WORTHWHILE?

Measurement of the social impact of policies, programs and funded activities is of increasing interest to organisations, businesses and governments, who seek to know what results have been achieved with a view to improving future performance.⁴ In PVAW, the social impact of prevention programs is beginning to show a social return on investment although reports emphasise that attention must be paid to not only to replicating successful techniques for prevention, but to testing, adapting and evaluating them in different contexts and settings in approaches that are not only evidence-based, but also evidence-building. In these ways, *Baby Makes 3* is evidence building.

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¹ Our Watch, Australia’s National Research Organisation for Women’s Safety (ANROWS) and VicHealth 2015. Change the story: A shared framework for the primary prevention of violence against women and their children in Australia, Our Watch, Melbourne.


There is strong evidence demonstrating the link between mothers having their first baby and their increased risk of experiencing intimate partner violence. Both physical and psychological abuse during pregnancy have been linked to adverse birth outcomes. Therefore, becoming a new parent is a key transition point in the life course that presents important opportunities to address the drivers of violence against women.

Further, there is strong evidence that primary prevention activities are most effective when they are part of multi-faceted and mutually reinforcing packages of policies and programs, delivered over time with repeated messages. The program benefits of Baby Makes 3 should not be viewed in isolation of other primary prevention work such as respectful relationships curriculum in schools. In fact, it is critical that young people are exposed to this education in schools, then receive the reinforcement of Baby Makes 3 when they become parents. The effectiveness of mutually reinforcing PVAW messages delivered through both respectful relationships in schools, and Baby Makes 3, means that primary prevention efforts will be far more effective.

Moreover, there do not appear to be other programs targeting the key life stage of becoming a new parent, especially as the transition to pregnancy and new parenthood are known as carrying increased risk for gender inequitable behaviours and indeed, of violence against women. Traditional notions of parenthood – and particularly the gendered roles and identities associated with care for children – can exert a powerful influence on how new parents approach and negotiate their parenting roles. The decisions that couples make during this key stage of life sets up patterns of behaviour that can become entrenched, and have important consequences on the level of equality within their relationship. In turn, these impact on women's opportunities for workforce participation and their economic independence.

Importantly, the Baby Makes 3 program targets messages at new fathers, not just new mothers, given that working with both parents is a core component of respectful relationships. There is now robust and compelling evidence demonstrating fathers’ potential to positively influence their children's health outcomes, social success and academic achievements. There are no other programs targeted at new parents so without Baby Makes 3, there is a vacuum of interventions targeting new parents in the key life stage of becoming a new parent.

Baby Makes 3 is a logical extension of respectful relationships education currently being incorporated into school curricula, and has the potential to become part of national action that builds on this program as well as other workplace PVAW programs. Indeed, new parents participating in Baby Makes 3 describe the benefits from having tools and resources to engage with the meaning of positive and gender-equitable parenting practices. Broader research shows that when individuals are empowered to challenge violence-supportive attitudes and behaviours and promote gender equality, they form more respectful and equal relationships. However, there is an urgent need for professional development of Maternal and Child Health Nurses (MCHN) and their services to ensure that they have the knowledge and skills to support Baby Makes 3 and to promote gender equity more broadly through their daily practice. MCHNs have the potential to be a strong link or potentially a weak link in the program’s effectiveness. Given the prevalence of violence during pregnancy and

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6 Our Watch, Australia’s National Research Organisation for Women’s Safety (ANROWS) and VicHealth 2015. Change the story: A shared framework for the primary prevention of violence against women and their children in Australia, Our Watch, Melbourne.

7 Our Watch, Australia’s National Research Organisation for Women’s Safety (ANROWS) and VicHealth 2015. Change the story: A shared framework for the primary prevention of violence against women and their children in Australia, Our Watch, Melbourne.

the early years of children's lives, curriculum development about gender equity should be a core part of Maternal and Child Health Nurses' education, and continuing professional development.

The impact of Baby Makes 3 is limited if the principles and key messages are not reinforced by MCHS as they see the same new parents in the months and years following parent's introductions to NGPs and Baby Makes 3. Conversely, the benefits of Baby Makes 3 as a prevention initiative would accrue if the reach of its key messages is maximised, reinforced and normalised by simultaneous complementary reinforcement in other settings. The core messages of Baby Makes 3 are important for all primary providers who could also be normalising them and ensure that their conversations are inclusive of fathers as well as mothers. This is particularly pertinent for primary providers with whom new parents are in regular contact, such as General Practitioners, allied health providers, and workplaces.

Baby Makes 3 has also built a local workforce of skilled facilitators with expertise in primary prevention of violence against women. This workforce would also make good facilitators for other gender equity programs because of their transferable skills, and could potentially be used across other PVAW programs in workplaces or schools.

The impact evaluation collected both quantitative and qualitative data that measured the attitudes and behaviours of parents who had attended the Baby Makes 3 program and their views and experiences of program delivery. Parents who participated in the interviews described the benefits of having tools and resources to engage with the meaning of positive and gender-equitable parenting practices. This supports the findings of other research showing that when individuals are empowered to challenge violence-supportive attitudes and behaviours, and promote gender equality, they form more respectful and equal relationships.

The economic evaluation of Baby Makes 3 showed that over time, the program resulted in some changes to parents' attitudes to gender roles and gender equality, which was also characterised by changes in behaviour of 'who does what at home'. The actual cost of Baby Makes 3 was estimated at $325 per couple in metropolitan areas and $582 in non-metropolitan areas. The economic evaluation concludes that any impact of Baby Makes 3 could lead to a reduction in lifetime prevalence of VAW, and that this potential demonstrates that there are great opportunity cost savings of $10.6 million to the health sector and $219.9 million to the justice system in Victoria. Even a 1% reduction in prevalence has an estimated health sector cost saving of $2.1 million and criminal justice sector cost saving of $44 million. The costs of violence to government and society support a strong social return on investment of interventions that can be demonstrated to reduce VAW incidence and risk by focusing on the determinants of violence.

This report demonstrates that Carrington Health's development and implementation of Baby Makes 3 has been a worthwhile project that is worthy of a scaled up implementation. However, primary prevention programs such as Baby Makes 3 require coordinated and sustained efforts with long-term funding and commitment across a range of levels including communities of new parents, Maternal and Child Health Services and other primary health providers, local governments and state governments which fund them.
1.3 SUMMARY OF RECOMMENDATIONS

The following table summarises the recommendations that have been developed in this report and are discussed in Section 4.

<table>
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<th>#</th>
<th>Recommendation</th>
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<tr>
<td>1</td>
<td>Review Maternal and Child Health policy and program guidelines and frameworks to embed gender equitable approaches, inclusiveness and engagement with new fathers as well as new mothers. This should be embedded into MCH policy at both State Government and Territory level using a systems approach, with the objective of this becoming the standard for MCHS service delivery.</td>
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<td>2</td>
<td>Review Maternal and Child Health Nurse education and professional development for its content and teaching about gender inequity, the gendered drivers of violence against women and the key messages of Baby Makes 3. Undertake negotiations with provider Universities to embed this content in MCHN courses.</td>
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<td>3</td>
<td>Provide support through industry-linkage types of research funding (such as that provided by the Australia Research Council) to support research and development (R&amp;D) projects in the scaling up of Baby Makes 3 and the broader field of PVAW. These should be collaborative between higher education researchers and other parts of the national innovation system, and undertaken with the objective of acquiring new knowledge and building evidence.</td>
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<td>4</td>
<td>Fund the scaling up of Baby Makes 3 into LGAs and MCHS across Victoria, ensuring that the quality and integrity of the program is maintained as it is introduced into LGAs and MCHS currently unfamiliar with the program. This should be a phased approach based on the readiness of the individual MCHS.</td>
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<td>5</td>
<td>The Victorian Government through the Department of Education and Training should commit to supporting the state-wide scale-up of Baby Makes 3 through both policy and programs. This will ensure continued evidence building on violence prevention and respectful relationships education for new parents, and will reinforce the messages that young people receive at school through the Respectful Relationships program.</td>
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<td>6</td>
<td>Develop more flexible approaches among MCHS to New Parent Groups to engage new fathers early and increase their willingness to participate in Baby Makes 3. The principles of father-inclusiveness could also be reviewed in the context of the broader sector of early childhood services to improve gender equitable service delivery and engage in gender transformative practices.</td>
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<td>7</td>
<td>Consider the development of a national or state approach to the continued development of a skilled workforce in PVAW, building on Carrington Health's experience and knowledge.</td>
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<td>8</td>
<td>Work with Carrington Health to develop potential approaches to embedding the core messages of Baby Makes 3 across all primary health providers, particularly those with whom new parents have increased contact.</td>
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<td>9</td>
<td>Work with Carrington Health to tailor Baby Makes 3 to priority population groups to build the evidence about effective processes and approaches to engage stakeholders in development and delivery.</td>
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2 INTRODUCTION

Violence against women (VAW) is a complex social problem in Australia that is increasingly recognised as a major cause of injury, death and mental health problems for women. In 2009, the cost of VAW to Australian society was estimated to be $13.6 billion, and without appropriate actions on prevention, by 2021-22, this cost is estimated to rise to $15.6 billion per annum\(^9\), with three-quarters of a million Australian women affected. Violence against women is a major, society-wide, public health issue.

The term ‘violence against women’ covers a range of forms of violence that may be criminal or non-criminal in nature. It is predominately recognised as behaviours intended to exercise power and control over women. This violence includes physical, emotional, economic, social, sexual and spiritual violence. In addition to the physical, emotional and social harms resulting from gender based violence, there are also multiple, serious, long-term effects for its victims.

Confusion and ambivalence about violence against women is commonplace. Australia is investing in research to better understand what drives violence against women, and what works to prevent it, particularly through VicHealth\(^10\), ANROWS\(^11\) and Our Watch\(^12\). Programs and actions are focused on redressing the drivers which grow from deeply-held societal beliefs about gender roles, stereotypes, value systems, and power relationships. The drivers for violence against women are recognised as:

- Tolerance for, and the condoning of, violence against women
- Men’s control of decision-making and limits to women’s independence in public and private life
- Rigid gender roles and stereotyped constructions of masculinity and femininity
- Male peer relations that emphasise aggression and disrespect towards women.\(^13\)

Gender stereotypes are based on socially constructed norms, practices and beliefs. They reflect underlying gendered power relations that exist in all societies. Gendered stereotypes and gender roles can be rigid but when societal efforts focus on them, they have been shown to shift and change over time.

For individual women and communities to be safe, respectful and free from violence, effective, evidence-based primary prevention is required, focused on these drivers. Prevention work encompasses a variety of strategies aimed at preventing new instances of violence across whole populations before they occur, by addressing the underlying causes, as well as changing attitudes and behaviours. Prevention works best when programs are mutually and constantly reinforcing, multi-faceted, and with responsibility taken by all sectors including health and social sectors, education including schools and universities, justice, and governments at all levels.\(^14\)


\(^10\) Victorian Health Promotion Foundation (VicHealth)

\(^11\) Australia’s National Research Organisation for Women’s Safety to Reduce Violence Against Women and their Children: http://anrows.org.au

\(^12\) Our Watch is an inter-government agency established to drive nation-wide change in the culture, behaviours and attitudes that lead to violence against women and children: http://www.ourwatch.org.au/Who-We-Are

\(^13\) Our Watch, ANROWS and VicHealth 2015. Change the story: A shared framework for the primary prevention of violence against women and their children in Australia, Our Watch, Melbourne.

\(^14\) Our Watch, ANROWS and VicHealth 2015. Change the story: A shared framework for the primary prevention of violence against women and their children in Australia, Our Watch, Melbourne.
Changing attitudes towards violence against women has begun to focus on young people, based on a growing evidence base\textsuperscript{15} that shows:

- Some young people are struggling to accept equality in their relationships.
- The vast majority of young people see violence against women as serious and against the law, but a quarter are willing to excuse violence if the man regrets his behaviour, or if his anger ‘made him’ lose control.
- Some young people are willing to excuse violence if the victim or offender is affected by alcohol.
- Almost half of those surveyed said it was acceptable in some situations to track a partner electronically without their consent – for example, installing tracking software into mobile phones or computers or setting up hidden webcams to monitor them.
- More than one in five young people believe men should take control in relationships and be head of the household.
- One in five young people believe there are times when women can be blamed for sexual assault; 20 per cent of young people believe women often say “no” when they mean “yes”, compared with 13 per cent in their parents’ generation.
- 57 per cent of young people believe the myth that anger is the cause of violence.\textsuperscript{16}

These data tell us we should be concerned about how young people understand relationships and what they think is acceptable, which in turn, contribute to a culture of support for violence. Young women in particular are vulnerable to violence and to its long-term impact on their health, education and employment.

2.1 WHY TARGET NEW PARENTS?

Becoming a new parent is a key transition point in the life course that presents important opportunities to address the drivers of violence against women.\textsuperscript{17} Traditional notions of parenthood – and particularly the gendered roles and identities associated with care for children – can exert a powerful influence on how new parents approach and negotiate their parenting roles. The decisions that couples make during this key stage of life set up patterns of behaviour and can have important consequences on the level of equality within their relationship, together with impacts on women’s participation in the workforce and future economic independence.\textsuperscript{18}

There is now robust and compelling evidence that demonstrates fathers’ potential to positively influence their children’s health, social success and academic achievements. A key feature of studies examining parental influences on child development published in the last five years is the separation of independent father and mother effects. A fathers’ influence on children’s cognitive development, social skills, mental health, literacy and maths achievement is found to be separate to that of mothers’, to operate in different pathways to that of

\textsuperscript{15}VicHealth, 2014. \textit{Young Australians’ Attitudes to Violence against Women}. Victorian Health Promotion Foundation, Carlton South, Victoria.

\textsuperscript{16}VicHealth, 2014. \textit{Young Australians’ Attitudes to Violence against Women}. Victorian Health Promotion Foundation, Carlton South, Victoria.

\textsuperscript{17}OurWatch, ANROWs and VicHealth, 2015. \textit{Change the story – a shared framework for the primary prevention of violence against women and their children in Australia}, Our Watch, Melbourne.

mothers or to compensate for deficiencies in mothers’ parenting. The research demonstrates how the inclusion of fathers and their close involvement from birth can support infant and child development.

There is also strong evidence demonstrating the link between mothers having their first baby and their increased risk of experiencing intimate partner violence. A recently published study from the Murdoch Children’s Research Institute (MCRI) showed that one in five mothers (20%) experienced emotional and/or physical abuse by an intimate partner in the first 12 months postpartum, and one in four mothers (25%) experience family violence in the first four years after having their first child. Other studies have also found the frequency and severity of intimate partner violence to be higher during pregnancy. VicHealth reported findings from the ABS Personal Safety Survey showing that:

- More than one-third of women (36 per cent) who had experienced violence by a previous partner and 15 per cent by a current partner reported that the violence occurred during pregnancy as well as at other times
- Around one in six women (17 per cent) who had experienced violence by a previous partner and seven per cent by a current partner reported that the violence first happened when they were pregnant.

The case for fathers’ negative contribution to children’s development is equally compelling. There are significant health consequences for both mothers and babies who experience family violence. The MCRI study has shown that women who were afraid of an intimate partner during pregnancy were more likely to experience physical and psychological health problems, such as vaginal bleeding during pregnancy, urinary and faecal incontinence, depressive symptoms and anxiety symptoms. Women experiencing family violence are also twice as likely to give birth to a baby with a low birth-weight (<2,500 grams), and babies born with a low birth-weight and/or small for gestational age are at higher risk of developing a range of chronic conditions such as diabetes and hypertension earlier in their life span than babies born in the normal weight range.

Women who experienced abuse by an intimate partner in the first 12 months postpartum were more likely to report depressive symptoms in the first year after having their baby. Almost 40% of women who experienced physical and emotional abuse in the first 12 months reported depressive symptoms in the year after childbirth, compared with 12% of women who did not experience abuse by an intimate partner. These findings have

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19 Fletcher, R., May, C., St George, J., Stoker, L., and Oshan, M. 2014 Engaging fathers: Evidence review. Australian Research Alliance for Children and Youth (ARACY), Canberra.

20 Murdoch Children’s Research Institute, 2015 Policy Brief 2: Health consequences of family violence – Translating evidence from the Maternal Health Study to inform policy and practice, Melbourne


23 VicHealth, 2011 Preventing violence against women in Australia Research summary - Addressing the social and economic determinants of mental and physical health, Melbourne.

24 ABS 2006, Personal safety survey, Cat. no. 4906.0, Australian Bureau of Statistics, Canberra

25 ABS 2006, Personal safety survey, Cat. no. 4906.0, Australian Bureau of Statistics, Canberra

26 Fletcher, R., May, C., St George, J., Stoker, L., and Oshan, M. 2014 Engaging fathers: Evidence review. Australian Research Alliance for Children and Youth (ARACY), Canberra.

27 Murdoch Children’s Research Institute, 2015 Policy Brief 2: Health consequences of family violence – Translating evidence from the Maternal Health Study to inform policy and practice, Melbourne
implications for Maternal and Child Health Services and the MCHNs whose practice should be cognisant of these risks for women’s health.

The transition to new parenthood is therefore a key stage in the life course that is not just an important transition point but one which presents particular opportunities to address the drivers of violence against women.28

2.2 ABOUT BABY MAKES 3

Baby Makes 3 is a direct participation program designed to influence more equal gender roles among new parents because the transition to new parenthood is understood as a time when equal and respectful relationships need to be firmly established. Baby Makes 3 is based on theories about the causal pathways between gender inequity and violence against women. Baby Makes 3 builds on gender analysis which examines the differences in women and men’s experience of becoming parents, including those that lead to social and economic inequity for women, and builds understanding in new parents about the impact of a new baby on gender relationships.

Carrington Health (formerly Whitehorse Community Health Service) developed the Baby Makes 3 project in 2008 with funding from VicHealth and undertook an initial three-year pilot. The project received funding from the DJR Community Crime Prevention grants in 2012 for Reducing Violence against Women and their Children that enabled the project to be scaled up and run over three years from January 2013 – December 2015. The project was delivered in partnership with Maternal Child Health Services and the seven Local Government Areas of the Victorian Eastern Metropolitan Region (EMR) who manage MCHS. This provided nineteen pilot sites, through which the program aimed to reach over 1,200 new parents attending MCH New Parent Groups (NPGs).

Baby Makes 3 is a primary prevention of violence against women program that aims to promote equal and respectful relationships between men and women during their transition to parenthood. The project objectives29 are to:

1. Deliver Baby Makes 3 group programs to over 1,200 first time parents across the Eastern Metropolitan Region of Melbourne
2. Increase the capacity of first time parents to build equal and respectful relationships in response to the lifestyle and relationship changes that follow the birth of a child
3. Increase the capacity of Maternal Child Health professionals and Local Governments to promote equal and respectful relationships during the transition to parenthood.

2.3 BABY MAKES 3 PROGRAM MODEL

Baby Makes 3 is a three x 2-hour group program for first-time parents delivered in partnership with MCHS which are managed and jointly funded by Victorian Local Governments and the Department of Education and Early Childhood. Baby Makes 3 is a primary prevention project that aims to influence relationship dynamics


29 Whitehorse Community Health Service 2012, Application to Reducing Violence against Women and their Children Grants, Whitehorse Community Health Service, Box Hill
between new parents, and to prevent violence against women by promoting equal and respectful relationships during the transition to parenthood.

*Baby Makes 3* was programmed as an extension of NPGs as an opt-out model, with all new parents encouraged to attend the sessions. Although New Parent Groups are aimed at both fathers and mothers, it is mostly mothers who attend because they are held during the day. To enable working parents to attend, *Baby Makes 3* sessions were scheduled in the evenings or on weekends.

The facilitators were recruited as private contractors or casual employees. Particular professional background or training were not essential requirements of becoming a *Baby Makes 3* facilitator. Rather, applicants were selected based on their level of facilitation expertise and experience as well as their understanding of gender equality. The backgrounds of the facilitators were varied including:

- MCH nurses
- Other staff from local council/shire
- Children and family services
- Social workers/counsellors
- Local health and welfare organisations.

The project utilised existing resources that had been developed by the earlier VicHealth funded project, to deliver the 2013-15 *Baby Makes 3* project. These resources included the Implementation Guide, Training Guide, Group Program Guide, Parent Handouts, evaluation tools, situational assessment template, communication materials (letters/brochures) for parents.

Each session of *Baby Makes 3* for new parents is co-facilitated by a male and female facilitator, recruited on the basis of their suitability and experience. A position description for the appointment of facilitators was developed with selection criteria, and a three-step process was then used to identify suitable candidates:

- Expression of Interest (via a phone call with the Project Manager)
- Written application
- Interview.

Project management staff interviewed applicants. All selected facilitators undertook a two-day training course provided by both male and female project managers who oriented them to the program with some content about gender equity. Facilitators were then expected to follow the Group Program Manual that set out the detailed contents for each session, accompanied by PowerPoint slides and handouts. Facilitators were required to undertake pre-reading and to develop their skills in the *Baby Makes 3* content through role playing on the second day of the training and observing parent groups via a training DVD. Facilitators practiced delivering the material in front of an audience, and were evaluated by the group.

In delivering the *Baby Makes 3* sessions, facilitators worked in male/female pairs; had to be available to work after hours, in consecutive weeks; and ideally were a parent. They were also required to use the program guide and must have successfully completed the training.

The project was guided by a Steering Committee comprising of project stakeholders and was chaired by the Department of Justice and Regulation, South East Regional Office. The Steering Committee met quarterly from mid-2013 to July 2015 and included representatives from Women's Health East, Eastern Community Legal Centre, Regional Family Violence Prevention Partnership, Regional DJR and VicHealth’s GEAR project (Generating Equality and Respect), demonstrating the link to other organisations doing family violence prevention work.
A parallel project was also funded by DJR for Baby Makes 3 to be implemented in Warrnambool Victoria in the Great South Coast (GSC) Region for which the lead agency was Warrnambool City Council. The project was delivered across five LGAs. The two projects were conducted in tandem with regards to joint resource development, training, recruitment of facilitators and parents and promotion of the program. However, the evaluations that inform this report were conducted only for the Carrington Health project, with the Warrnambool project team managing their own evaluation.

2.4 EVALUATION FRAMEWORK FOR BABY MAKES 3, 2013-2015

The overall project evaluation aimed to answer the following questions:

1. Is the Baby Makes 3 project transferable to other areas? What are the different models for implementing Baby Makes 3 into differing contexts?
2. How does Baby Makes 3 impact on gender equity for participants?
3. Is Baby Makes 3 cost-effective relative to current practice?

The evaluation of Baby Makes 3 comprised three separate evaluation components:

- A process evaluation which assessed the implementation of Baby Makes 3
- An impact evaluation, which was primarily a qualitative study of the parents who had attended the Baby Makes 3 program
- An outcome economic evaluation.

The impact evaluation and outcome economic evaluation reports are available from Carrington Health, separately to this report. The process evaluation is attached to this report in Appendix A to provide further detail and context on how the project was delivered by Carrington Health. Keleher Consulting undertook the process evaluation, and two different research groups from Deakin University undertook the impact and economic outcome evaluations, obtaining ethics approval from Deakin University Human Research Ethics Committee. Participation in any aspect of the evaluations was opt-in or voluntary for participants, facilitators, and MCH staff.

This final Baby Makes 3 project report draws together key findings of the process, impact and outcome evaluations, comparing the findings with recent reports from key agencies on the effectiveness of programs for the prevention of violence against women. This report is intended to generate knowledge not just about the findings of this project but also how and why the program has potential to be transferred into policy and scaled up across Victoria. The key components to the effectiveness of this are father engagement, MCHS capacity building and development, and a greater effort to embed the messages of Baby Makes 3 into the practices of other primary health providers to enable their greater participation in the primary prevention of violence against women.

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31 Turnbull B, Crisp B, Taket A, October 2015. Parents’ views of the Baby Makes 3 program and its impacts, Prepared for Carrington Health by the Centre for Health Through Action on Social Exclusion, School of Health & Social Development, Faculty of Health, Deakin University, Melbourne.

2.5 STUDY METHODS

2.5.1 Process Evaluation

The process evaluation was conducted in August - November 2015, once the Baby Makes 3 funded project was finalised. It addressed the implementation of Baby Makes 3 relative to the project intentions and design, and explains any changes that were made during implementation. The process evaluation was designed to assess the following key themes of Baby Makes 3:

1. The scope of project activities accomplished against the intention of the project
2. The quality of project delivery
3. The integrity/fidelity of project activities delivered
4. Reach to the target audience
5. Skills, experience and credentials of project staff and facilitators
6. External factors that influenced project delivery.

Data was collected via several methods:

- Review of project reports, interim evaluations and newsletters sent out over the duration of the project
- An in-depth interview with the project manager and project officer
- Focus group with the final Community of Practice meeting, which included 10 facilitators, of whom two left early but followed up with emailed responses
- Responses from an additional four facilitators who were not able to attend the Community of Practice meeting but responded to emailed questions
- An interview with the manager of the Warrnambool project (also funded by DJR) for comparative perspectives
- Attendance records of first-time parents at Baby Makes 3 groups
- Survey of MCH Coordinators with five out of seven coordinators providing responses
- Emailed questions to MCH Coordinators about their participation in Baby Makes 3.

2.5.2 Impact Evaluation

The impact evaluation was developed through both quantitative and qualitative methods, conducted from November 2014 to May 2015. This comprised a pre-post questionnaire triangulated from pre- and post-group questionnaires, post-group feedback forms and participant interviews. The interviews explored the views of parents who had attended the Baby Makes 3 program, focusing particularly on parents’ views of the program’s impacts on them and their experiences of program delivery. It was a naturalistic study that aimed to capture how the Baby Makes 3 program was understood by parent participants.

Interviews were completed with 24 participants of whom there were two known couples. All participants were members of a couple, meaning there were no single parents interviewed. All but two of the participants had attended all three Baby Makes 3 sessions, and all participants had attended the final session. Participants were from a wide variety of social and employment backgrounds and were not drawn solely from a particular socio-demographic subset.

Data were collected by way of semi-structured telephone interviews. Where possible, the interviewer was the same gender as the parent. The interview schedule included open-ended questions relating to some of the topics covered during Baby Makes 3, including expectations of new mothers, who does what at home and intimacy and couple relationships. It also included direct questions about the impacts of the program, parents’ views of program delivery, and suggestions for the future.
The limitation of the impact evaluation was the sample size of 24 - namely 18 mothers and 6 fathers - which did not reach the target sample of 30 couples. However, the data obtained was sufficient to identify themes and is consistent with the findings of the 2009-2011 Baby Makes 3 evaluation. In this report, we are able to weave the findings with those of the process and outcome evaluations as well as the major reports on the prevention of violence against women which have been released through 2014-2015.

2.5.3 Economic Outcome Evaluation

The rationale for the economic evaluation was to add to the current evidence base on the program costs and benefits, and to estimate the social return on investment to inform policy and future funding decisions of primary prevention initiatives of this kind. The economic outcome evaluation was conducted at four time points for the EMR program and at two time points for GSC. Questionnaires were distributed pre-group or baseline (beginning of the first session), post-group follow-up at 3 months, then 12 and 18 months (for EMR only) after the last program session.

Evaluation data were collected from 108 groups across EMR and 36 groups from Great South Coast (GSC) (i.e. the Warrnambool project). The overall response rate to pre-group evaluation collected in the first session was high at 915 participants, with slightly more mums (52%) than dads responding to the questionnaire. This is reflective of attendance because of single mothers participating in the program and the fact that parents were recruited via new parents groups which are predominately attended by mothers. Of the parents who attended the final session in EMR, 92% signed up for post-group evaluation. Of the parents who agreed to follow-up, 35% responded to the 3-month evaluation questionnaire (exceeding the target of greater than 30%), but less than 5% responded at 12-months and 18-months. In GSC, 31% of the parents who attended the final session signed up for post-group follow-up evaluation, of which 46% responded to the 3-month evaluation questionnaire.

Fewer dads than mums responded to post-group questionnaires. In EMR, the proportion of dads and mums participating in post-group compared to pre-group evaluation was 14% and 25% respectively, whereas in GSC, 9% of dads and 19% mums participated in the post-group evaluation.

The economic outcome evaluation did demonstrate that parents’ attitudes to gender roles and gender equality showed some changes over time, which is also characterised by changes in behaviour of ‘who does what at home’ (also evidenced in the impact evaluation).

The major limitations of the economic outcome evaluation were that the researchers used the Hospital Anxiety and Depression Scale, even though (and the researchers acknowledge) Baby Makes 3 was not designed to address mental health and wellbeing. The researchers say that ‘this health outcome was included in the economic evaluation to ensure data were collected on an outcome that could be used to predict longer term return on investment’. They go on to contend that ‘given that there is no change in the measures of depression of anxiety, we can demonstrate no social return on investment to Baby Makes 3.’ However in this report we examine the totality of the data which indicate that Baby Makes 3 is showing a social return on investment.


34 Gold L & Sia KL, 2015. Economic evaluation of the Baby Makes 3 program, prepared for Carrington Health by Deakin Health Economics Unit, Deakin University, Melbourne, p 51.
3 KEY FINDINGS FROM EVALUATIONS

3.1 PROCESS EVALUATION

The process by which Carrington Health delivered the Baby Makes 3 project was evaluated as effective and thorough. The project was very well scoped and recorded in a variety of project documents including the project plan, reports to DJR, and project newsletters/communiques. The quality of scoping out of project activities has underpinned the quality of project delivery, the integrity of delivery, the reach of the project, and the effectiveness of facilitation of Baby Makes 3 groups.\(^{35}\)

The project was clearly underpinned by good planning, attention to detail, continuing project support, and good record keeping. Facilitators had very good levels of support from the project team, which was a key aspect of ensuring quality delivery of the project. The project team also worked closely with MCH nurses and facilitators to try different methods to improve uptake and ensure that Baby Makes 3 was successful in their respective LGAs.

Good processes used through the Baby Makes 3 project facilitated the process evaluation and demonstrated that the Baby Makes 3 project was delivered with integrity and fidelity. The facilitators were well trained and proficient, and able to get the key messages of Baby Makes 3 across to the target audience of new parents and Maternal and Child Health Nurses.

3.1.1 Effectiveness of reaching new parents

Carrington Health made the decision to integrate Baby Makes 3 into local governments in the Eastern Metropolitan Region using MCHS as the setting. This was because the MCHS is a universal primary care service for Victorian families with children from birth to school age. All new births are referred to MCH, with 100% of new babies and parents receiving a home visit from a MCHN in 2013-14, 97.2% of new parents attending a MCH centre at 2 weeks, 97.3% at 4 weeks and 96% at 8 weeks.\(^{36}\) This means that contact regarding Baby Makes 3 should be possible with almost all new parents – there are no other services that would have this high level of contact with first-time parents.

The Baby Makes 3 project was very successful in reaching the intended audience. The project team adapted strategies as the project unfolded and worked closely with MCHS wherever possible, to ensure engagement with new parents in order to maximise their attendance and participation in Baby Makes 3 sessions. The project reached 1,305 new parents and achieved a retention rate of 74%, exceeding the targets set by the Steering Committee.

There were clear benefits to MCHS being the primary and key referral source for participants into Baby Makes 3. However, Carrington Health believe that there is also merit in other, additional referral sources to extend the reach of the program, especially given that parents from CALD backgrounds, ATSI, teenage mothers and GBLTIQ for example can be harder to reach. This could include some family services or enhanced parenting projects that sit around MCHS, and hospital antenatal parenting projects/programs.


3.1.2 The effectiveness of ‘normalising’ Baby Makes 3

Research has increasingly recognised that service orientation and accessibility for parents remain problematic, with many services retaining mother-focused approaches and resources. Father-inclusive practices are often ad hoc and practitioners frequently revert to a maternal orientation while overestimating father inclusion, therefore, policies and standards need to be supported by data collection systems which ensure that providers can objectively assess and report on father inclusion. Data management systems can also drive processes that sustainably integrate fathering into the delivery of family service.

Both the Baby Makes 3 project team and MCH Coordinators noted that uptake and participation rates of new parents was more successful when the program was presented and spoken about as ‘usual practice’, as it normalises the program for new parents. One MCH Coordinator commented that:

> I believe the focus on gender equity and discussions to promote respectful relationships between men and women are very timely when couples have their first child. This is a time when they are very focused on the best outcomes for their child. The MCH service is well placed to promote these important messages and recruit couples due to the Victorian legislation on Birth Notifications. Providing the sessions as a “usual” part of the First Parent Groups at the MCH Centres was a key to success. The visit from a Facilitator was helpful in engaging the families.

At a policy and service delivery level, practices that are inclusive of fathers recognise the importance of fathers in children’s developing sense of themselves, as well as in the future family roles of boys and young men. Practices that are inclusive of fathers will consider fathering as integral to service provision for families. This will include where families have diverse care arrangements for children such as single parent families, separated families and families where both parents have the same gender. To be inclusive of fathers is to keep the importance of fathers to their children in mind even when no father is present or the immediate focus is the needs of the mother.

3.1.3 Developing a skilled workforce in gender equity programs

Carrington Health was careful to select facilitators on the basis of identified competencies. The project team also recognised the need to provide ongoing support and development for facilitators to continue to build their skills through the Community of Practice meetings and providing skill-building communications to facilitators during the life of the project. The facilitators themselves were enthusiastic and committed to the project, and were thoughtful in their efforts to engage new parents, particularly new fathers. The combination of these efforts undoubtedly contributed to the success of the project in reaching its target audience and in the positive participant evaluations.

An unanticipated outcome of the training and professional development of the pool of facilitators in both the Eastern Metropolitan Region and the Great South Coast was that Baby Makes 3 has built a local workforce with expertise in primary prevention of violence against women. The Baby Makes 3 workforce could potentially

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be utilised across other PVAW programs, ensuring that the skills of expert facilitators are maximised, and not lost. The project team noted that Baby Makes 3 facilitators would also make good facilitators for other gender equity programs such as respectful relationship programs in schools or workplace training, because of their transferable skills. Our Watch states that ‘a national approach to primary prevention requires significant investment in workforce and organisational development and capacity building, both to meet existing demand for prevention activities in various settings safely and effectively, and to expand the reach and take-up of initiatives across the country.’

Many facilitators from Baby Makes 3 commented that they are already using the skills they developed through the program and were translating them into their other roles in diverse sectors and settings – from sports clubs, to schools, workplaces, local governments, health services and the media. This enables Baby Makes 3 facilitators to help embed prevention and gender equality efforts into their existing work and into the core business of their organisations.

### 3.1.4 Increasing the capacity of Maternal Child Health Services

One of the project objectives of Baby Makes 3 was ‘to increase the capacity of MCH professionals and Local Governments to promote equal and respectful relationships during the transition to parenthood.’

It was clear from the experience of the Baby Makes 3 project team that the relationship-building aspect with MCHNs is critical to the effectiveness of recruiting new parents into Baby Makes 3. Where relationships between the project team and MCHN were not strong, or in fact negative, there was a noticeable impact on the recruitment of parents. Some MCHS Coordinators showed resistance to the project at first, often due to competing demands on their time or a lack of awareness/understanding of the project. Significant partnership work was required to engage them and develop their enthusiasm for it. The power of using MCHN ‘champions’ for the project was also evident, and the team observed that some of the nurses came on board after these champions for the project talked about their experiences and support for Baby Makes 3. These MCHN champions then worked with the resistors in the MCHN team, and were proactive in working with the project team to improve support amongst MCHNs.

MCH Coordinators who responded to the email survey were in agreement that the Baby Makes 3 program has increased their engagement with new parents and provided ‘added value’ to the MCH program framework. Comments included:

*Baby Makes 3 is very helpful for new parents as it helps them understand how to communicate respectfully in a non-confrontational way. It is non-stigmatising...* We would recommend Baby Makes 3, as participants reported they enjoyed and benefited from the opportunity to jointly hear about and discuss these issues together.

*Baby Makes 3 has given first time parents an opportunity to strengthen and reassess their relationships after the birth of their baby. It gave clients the opportunity to improve their quality of relationship, hence their parenting. It has provided a way for dads to feel more a part of the MCH service and have the experience of being part of a group that is appropriate to their circumstances. Further, it has provided ongoing connections for the dads and families who attended. It has provided skills for the MCH nurse involved as a facilitator and indirectly improved the skills of the other staff.*

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40 OurWatch 2015, Change the Story – A Shared Framework for the Primary Prevention of Violence Against Women, p50

41 Whitehorse Community Health Service 2012, Application to Reducing Violence against Women and their Children Grants, Whitehorse Community Health Service, Box Hill.
It is evident from the evaluations that Baby Makes 3 needs a whole of setting approach. It is far more effective when key messages from the program are valued and reinforced by the MCH setting, rather than delivered in isolation within the three weeks of the program. Multi-setting approaches strengthen the impact of different prevention initiatives, from the effect of mutual-reinforcement. The impact of the Baby Makes 3 initiative will be diminished if it occurs in isolation, and if broader community or social and cultural norms and practices do not support its core messages. So, the effects of Baby Makes 3 as a prevention initiative will be strengthened if the reach of its key messages are maximised, and when its messages are reinforced by simultaneous complementary reinforcement in other settings, particularly through the range of primary providers with whom new parents are in contact.

3.1.5 Landing the messages of Baby Makes 3

A ‘Group Project Evaluation Form’ was given to parents who attended week 3 of Baby Makes 3. This Form asks parents to rate their level of agreement with the statements that Baby Makes 3 was enjoyable, relevant and helpful. On average, 92% of parents (both mothers and fathers) either agreed or strongly agreed that the program was enjoyable, relevant and helpful. The parents were also asked to rate the program overall. Over 76% of mums and 81% of dads rated the project either ‘very good’ or ‘excellent’.

As part of Quality Assurance monitoring, and to ensure that the program was being delivered as intended, at the end of week three, parents were asked the question, ‘What are the three main things you learned from Baby Makes 3?’ This was designed as a monitoring measure of how well the facilitators were imparting the key messages of the program. A thematic analysis of 1197 responses was collected from 399 parents, matched against the key messages of Baby Makes 3. The responses were grouped under nine categories:

- Change
- Communication
- Conflict
- Dad + baby
- Equality
- Expectations
- Intimacy
- Relationship
- Respect

All nine of the pre-identified key messages of the Baby Makes 3 program were reflected in the themes of the parent’s responses, with ‘change’ and ‘respect’ being the most common responses. Dads responded more than twice the rate of mums for ‘respect’ and ‘dad + baby’ categories.

The ‘Group Project Evaluation Form’ also asked parents to describe this program to another person who was thinking of doing it and to make comments about what they would say. The main themes that emerged from these comments were:

- A perception that the program was worthwhile
- The program provides insights
- The program improves the parent’s relationship e.g. provides tools, opens up discussions at home
- It was beneficial to share with others going through similar experiences
- The program provided an opportunity for dads to meet with other new dads.

This analysis was used as a quality assurance measure to monitor the delivery of the key messages of Baby Makes 3. It suggested that:
• Facilitators had been well trained
• Facilitators were getting the key messages across to new parents
• Participants were receiving the key messages of Baby Makes 3.

3.1.6 Summary of process evaluation

Overall, the Baby Makes 3 project has been delivered very effectively. Carrington Health has implemented the program across the EMR catchment, adapting to a range of variables where necessary whilst still ensuring that the program content and messages were consistent and that the facilitators maintained high standards of delivery.

3.2 IMPACT EVALUATION

The impact evaluation was a qualitative study, but quantitative data was also collected via pre and post-group questionnaires, and feedback forms. The qualitative study is reported here, with the findings triangulated with the quantitative data further on in this report.

The qualitative data was collected through interviews with new parents who had participated in Baby Makes 3. Key themes that emerged from the analysis were broadly about changes in awareness, attitudes, skills and behaviour in relation to four areas directly addressed by Baby Makes 3:

1. Expectations of mothers
2. Who does what at home
3. Intimacy and the couple relationship
4. Social connectedness

Parents who participated in the impact evaluation interviews described the benefits of having tools and resources to engage with the meaning of positive and gender-equitable parenting practices. This supports the findings of other research showing that when individuals are empowered to challenge violence-supportive attitudes and behaviours, and promote gender equality, they form more respectful and equal relationships.  

Each of these themes is discussed below with quotes included when they are illustrative of the major themes.

3.2.1 Expectations of mothers

The majority of parents reported an increased awareness of the expectations and pressures on new mothers and parents as a result of attending Baby Makes 3. This finding also emerged from the evaluation of the 2009 - 2011 Baby Makes 3 pilot program. Parents consistently reported an increased understanding of the external and internal pressures and expectations placed on new mothers by society, fathers and mothers themselves, and the realisation that the bar is set higher for mothers than for fathers.

You get the appreciation of what the mum goes through because I guess I go to work and I come home and my wife might say she's had a tough day and this and that, but you sort of don’t fully understand I guess. (Father 1)

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For me personally I think it was in the first week, it was really nice because at that stage I was still dealing with sort of my own expectations and what I thought society expected. To have it drawn out and to also have the comparison of how much we expect of mothers versus fathers, and talking in the program about what’s realistic and sort of for me to kind of feel like “Okay, I’m not doing too bad.” (Mother 7)

Specific examples of changes included increased awareness of pressures on mothers in relation to childbirth, breastfeeding and being expected to take on the responsibility for, and cope with, caring and household tasks.

My husband commented that he didn’t realise the pressure that the women felt to perhaps be all things to all people I suppose. Even before you have the baby there were outside pressures of try and have your labour without pain relief. People would make comments. You’ll feel a real sense of achievement if you do this and do that. He didn’t realise because he’s of the view, “just do what you want, who cares?” So I think there was a lot of discussion in Baby Makes 3 about the pressures that the women were feeling. So he’d probably be a bit more mindful of that. (Mother 6)

The data showed that new parents gained an increased understanding that having a baby is a partnership, which reflects Baby Makes 3’s intention to frame parenting as involving equal partners. New parents also began to recognise the pressure they had been placing on new mothers to take responsibility for caring and household tasks. Participating in Baby Makes 3 enabled new parents to check or affirm that they were doing the right thing and appropriately manage pressures and expectations as new parents.

What we thought were things that were quite universal, to understand that other people didn’t realise all those expectations, and weren’t as prepared and were probably struggling a little bit more. It was a real eye-opener to look around and see other people in the room, and it was probably a good judge to see how well we were going, to be honest. (Father 4)

3.2.2 Changes in behaviour in relation to expectations of mothers

A key finding from the impact evaluation of Baby Makes 3 was that fathers realised they developed an improved understanding of the expectations and pressure on new mothers, and reported changes in their behaviour as a result. This finding was also reflected in interviews with some mothers, who reported that their partners had reduced their own expectations and became more realistic about what mothers could achieve.

I think he’s been more realistic now when I say to him…’I just haven’t had time.’ Rather than giving me a hard time, he just says, ‘Yep, no problem.’ In the early days I think he’d crack a few jokes about, ‘well what have you been doing all day?’ I think he can see now that the day’s broken up into small sections and…when the baby’s asleep you’ve got to shower. You’ve got to eat. You’ve got to go to the toilet. You do the dishes. Maybe get something organised for dinner…He’s a lot more realistic about those things now. (Mother 3)

In terms of expectations, lower my expectations on things, whether it’s around the house or just things we can get done, because whilst you’d like them to be done, you know that (partner’s) still at home at the moment but (child) keeps her pretty busy. So yeah, just maybe lower them, lower the expectations and that’s not always easy. You want to have everything done because you think, surely the time would allow that, but sometimes it just doesn’t. (Father 5)
Parents also reported other changes in behaviour after attending Baby Makes 3, including:

- Fathers becoming more helpful in order to reduce the pressure and expectations on mothers;
- Fathers being intentional about providing adult interaction, in recognition of their partner's stay at home role; and
- Fathers prioritising family over work. This not only reduced the pressure on the mother to wholly fulfil the function of primary caregiver, but also challenged the expectation that the father's contribution to the family was purely as a breadwinner.44

Most important thing? I mean, family first. Work's a means to provide for your family. Certainly big changes for me probably also just trying to make sure I prioritise things. Certainly putting the 'like to do' after the 'need to do' and those sorts of things. So yeah that's probably the change for me, as a result of the program. It's those simple things...increasing the blue time [this was how time baby spends with father alone was shown in Baby Makes 3] and the challenge is always to continue to remind yourself to do these things. Sometimes you get wound up in the day-to-day life and you forget a lot of them. (Father 6)

Some mothers also reported that after attending Baby Makes 3, they lowered their own internalised expectations to assume responsibility for all caring and household tasks, and began to share that responsibility with their partners. Many of these changes challenge traditional gendered roles and expectations of women as carers and men as breadwinners, by constructing parenting as a shared responsibility.45 This gender equity message was central to Baby Makes 3.

3.2.3 Changes in awareness and behaviour about who does what at home

A large majority of parents interviewed reported an increased awareness of who does what at home as a result of attending Baby Makes 3. Parents were more aware that mothers were being expected to take responsibility for a greater share of domestic tasks, that mothers spent much more time than fathers with babies, and of the sheer amount of caring and household work that needs to be done.

I would say the biggest thing I guess was really thinking about what we, what each of us thought about what the other person was doing...It was really, I sort of thought well, I do all of that and he was of the impression that no, he did half of it. But that got us thinking and talking, I guess, about who does what around the house and takes on what responsibilities. (Mother 18)

We didn’t realise how much we were each doing until it was all written down on a piece of paper in front of us and that’s helped us both to see and understand that better too. (Mother 17)

Many of the changes were in fathers’ behaviour, with the strongest impact being that fathers began to spend more time alone with their babies.

There was one night in the program where they pointed out how little time fathers spend alone with their children and I think that impacted on my husband because the last couple of weekends he’s taken her out for a couple of hours on his own. (Mother 10)

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44 Turnbull B, Crisp B, Taket A, October 2015. Parents’ views of the Baby Makes 3 program and its impacts, Centre for Health Through Action on Social Exclusion, School of Health & Social Development, Faculty of Health, Deakin University, Melbourne.

45 Turnbull B, Crisp B, Taket A, October 2015. Parents’ views of the Baby Makes 3 program and its impacts, Centre for Health Through Action on Social Exclusion School of Health & Social Development, Faculty of Health, Deakin University, Melbourne.
In addition, parents reported that fathers were doing more domestic work and being more proactive in completing caring and domestic tasks. Mothers also reported being more proactive in communicating their needs for assistance.

We were talking about sometimes mums, we might ask the dad to do the bath or change a nappy but we actually still go and get everything ready and get the towel ready and we’re still kind of hovering, rather than letting them do it. And I think (partner), I did notice a change in him where he came home and rather than waiting for direction, he would sometimes just try and just do it all on his own, and take her out for walks and let me have a good break from her. (Mother 6)

Another key outcome from Baby Makes 3 was where fathers reported that they were now more realistic about what mothers could achieve, and applied less pressure on mothers to get everything done. By having a greater understanding of the all-consuming nature of parenting for mothers, some fathers took on responsibilities in order to give mothers time to themselves. Some mothers also actively sought ‘me-time’ (as opposed to using time alone to catch up on house work).

I actually think the most important thing for me was where it highlighted as to how much time that the fathers really spend with their children…I think that also really resonated not just with me but also my partner where we’ve made a concerted definite effort that (child) doesn’t just spend time with me, that he also spends time alone with his dad and has father/son time…it’s really important that he does get to spend time with daddy so that it’s not just all about mummy…in a lot of ways we’ve worked hard on that. So whether it’s a case of I’ve decided that I’m going to go to the gym, so it means that the bath and bedtime is done by daddy instead of mummy for a day or two days out of the week. That to me is something important; that it’s time that they get to spend together but it also means that I can go and do things for me, just solely for me and I get some time to myself. So I guess from that aspect it works both ways. (Mother 9)

It is important to recognise that changes in awareness and understanding of gendered expectations and roles in families is not always sufficient to create change. Some parents reported that they had experienced no change in expectations of new mothers and who does what at home. This was because they either had no expectations, or had already achieved what they felt was an appropriate balance before attending Baby Makes 3.

One mother described a negative change in who does what at home, revealing that awareness cannot always overcome structural constraints imposed by a society in which employers increasingly expect and reward long full-time hours in a masculine model of work. Such experiences also illustrate the barriers to gender equality, which are increased by entrenched and internalised gendered norms. These result in women assuming the primary carer role and men assuming the breadwinner role.

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46 Turnbull B, Crisp B, Taket A, October 2015. Parents’ views of the Baby Makes 3 program and its impacts, Centre for Health Through Action on Social Exclusion School of Health & Social Development, Faculty of Health, Deakin University, Melbourne.

47 Turnbull B, Crisp B, Taket A, October 2015. Parents’ views of the Baby Makes 3 program and its impacts, Centre for Health Through Action on Social Exclusion School of Health & Social Development, Faculty of Health, Deakin University, Melbourne.

However, those who felt that Baby Makes 3 resulted in no change in expectations of mothers or who does what at home, described benefiting from the program in other ways. These included:

- Gaining an increased understanding and consciousness of the issues
- Mothers experiencing reduced pressure and expectations from their partners and placing less pressure on themselves
- Enhanced couple and family relationships and communication, and
- Greater social connections.

### 3.2.4 Intimacy and the couple behaviour

A major theme that emerged in the impact evaluation was parent’s changes in knowledge, skills and behaviour in relation to intimacy and the couple relationship. This included improved communication and conflict resolution, and an increased focus on the couple relationship.

The themes of enhanced communication and conflict resolution were again consistent with the evaluation of the 2009-2011 pilot program. Many parents described engaging in more open communication with their partners after attending Baby Makes 3. Mothers felt they communicated more openly about topics that they would not have otherwise discussed, including expectations of mothers and who does what at home. This was similar to participants in the pilot program.

(“Baby Makes 3) opens the discussion for topics that you wouldn’t normally discuss. Until somebody mentions it, you wouldn’t have that conversation. And you might only have that conversation once, but it does make a difference over the weeks and months ahead when times do get stressful. You know, because it was a little bit strange and we had these tiny little babies and we’re talking about getting intimate with our partners and we’re like “Whoa. Gee. That’s not happening now. God.” You know. But months down the track you’ve had that conversation and it does make things a lot easier. (Mother 16)

The ability to communicate about issues that they otherwise would not have discussed is a key outcome from Baby Makes 3 which could well continue to have future impact for parents. Some parents felt they were better able to listen to their partners and communicate their needs. Other parents felt they were more able to negotiate, resolve conflicts and pre-empt problems.

“If there’s a problem, we need to talk about it rather than letting it fester because it’ll only get worse. So yeah that certainly showed to us that if we’ve got a problem, we’ve got to talk about it. (Father 5)

“I think the whole program in general was quite good at highlighting issues that babies can bring or problems that can arise so that we can be aware of them before they cause a big issue...So be aware of what can happen so you can see the beginning of an issue before it becomes an issue. (Mother 10)

As outlined above, it is important to note that some parents who felt there were no changes in their lives in relation to expectations of mothers and division of labour, nevertheless described more open communication about those issues, or discussion of issues they would not otherwise have talked about. These are in themselves important outcomes. Over time, ‘such conversations may function as negotiations that result in subtle shifts in understanding each other’s perspectives, relationship dynamics and division of labour, which may not have occurred had those conversations not taken place.’

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3.2.5 Increased focus on the couple relationship

A sub-theme from the analysis was an increased focus on the couple relationship after attending Baby Makes 3. Mothers described an increased consciousness of their relationship after participating in Baby Makes 3, reporting greater intimacy and a stronger relationship.

I think just that stopping to think about your relationship dynamic as a couple, because you’re constantly focusing on the baby. (Mother 15)

We had lots of discussions at the time and I think from there we made changes in the way we interacted together and how we interacted as a family and those changes have stayed…Like positive changes and we still have the intimacy request card up on the fridge. (Mother 17)

Some mothers also described experiencing a greater understanding of perspectives and contributions within the couple, as well as an affirmation of their relationship. Parents described making more time for each other, ensuring the time they spent together was quality time. They also reported making more effort to think of each other and themselves.

3.2.6 Social connectedness

A final important impact of Baby Makes 3 was the social connections that parents made and maintained as a result of the program. In particular, parents felt Baby Makes 3 was a valuable opportunity for fathers to connect with other fathers, families and babies.

I think having a child can be very isolating and not just for the mother but also for new dads. They can also find it isolating and women are more likely to talk, fathers aren’t. So I think this gives a positive way that men can connect with each other and be able to talk. Whether they make friendships or not out of that or what not probably doesn’t really matter but there’s that ability. (Mother 9)

Some mothers appreciated meeting the partners of other mothers in their New Parents Group, and some parents described maintaining social connections after Baby Makes 3.

It gave us a chance to all meet and get to know each other, and we’ve since had a few gatherings all together, and we’re trying to maintain that network. (Mother 16)

Whilst this impact falls outside the direct ambit of the project objectives, social connections and support networks are themselves important in addressing social isolation and limited access to support systems. Both of these are key contributing factors to violence against women. Engaging fathers is also important for gender equity. NPGs are still primarily for new mothers, indeed, MCHNs report that new fathers rarely attend. This doesn’t make for easy engagement of new fathers in Baby Makes 3 and suggests that there is scope for NPGs to be more flexible in their meeting times, such as Saturday mornings, alongside a range of strategies that encourage new fathers to become involved. The current practices of having NPGs during the week tends to reinforce gender stereotypes, as NPGs are overwhelmingly ‘new mothers’ groups’. A more flexible approach that is more inclusive of new fathers would reinforce messages about gender equality and the need to change gender stereotypes.

VicHealth 2007, Preventing violence before it occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria, VicHealth, Melbourne.
The analysis also revealed how structural constraints and entrenched gendered roles and norms in Australian society create barriers to achieving truly equal relationships in which men and women equally share paid and unpaid labour. In many ways, however, the changes in parents’ understanding, attitudes and behaviours outlined above, suggest a shift in their relationships towards the ‘equal value’ model of equality. In this model, parents assume different roles and responsibilities that are valued equally, with unpaid domestic labour and childcare being genuinely perceived as of equal value to paid employment. Similar to participants in the 2009-2011 pilot program, parents in the 2013-2015 program expressed a greater awareness and respect for mothers’ contributions to caring and domestic tasks, suggesting mothers and fathers placed greater legitimacy and value upon such contributions after participating in Baby Makes 3.

Both the process and impact evaluations showed that the group format of Baby Makes 3 is essential because of the way it encourages direct participation by mothers and fathers in the content of the program. The program provides a safe space and supportive, positive and engaging forum for new parents to share experiences, learn from each other and discuss issues that they may not have otherwise discussed.

The themes emerging from this analysis are consistent with and augment the existing evidence of the effectiveness of Baby Makes 3 in contributing to the primary prevention of violence against women. This study has provided a wealth of evidence of the ways in which Baby Makes 3 fostered changes in parents’ awareness, attitudes, skills and behaviour that are directly supportive of gender equity.

“It’s just a fantastic program, I think you know, it’s something that…everyone should do.” (Mother 2)

### 3.3 ECONOMIC OUTCOME EVALUATION

#### 3.3.1 Costs to Australia of Violence Against Women

Estimates of the economic costs of violence against women were initially made by Access Economics in 2004, then KPMG in 2009, and more recently by PwC. They provide estimates on the basis of inaction, or the total economic savings if the violence was eliminated.

The 2015 report from PwC updates the original data from 2004 and 2009, and using 2014-15 as a base year and then lifetime costs over 30 years to estimate the longer-term costs of VAW. The annual cost to the Australian economy for women experiencing all forms of violence in 2014-15 is estimated to be $21.7 billion, a

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52 Turnbull B, Crisp B, Taket A, October 2015. Parents’ views of the Baby Makes 3 program and its impacts, Centre for Health Through Action on Social Exclusion School of Health & Social Development, Faculty of Health, Deakin University, Melbourne.


54 Turnbull B, Crisp B, Taket A, October 2015. Parents’ views of the Baby Makes 3 program and its impacts, Centre for Health Through Action on Social Exclusion School of Health & Social Development, Faculty of Health, Deakin University, Melbourne.


rise on the KPMG estimates of 2009. This includes direct and indirect costs, such as cost of pain, suffering and mortality of victims/survivors, cost to future generations, health costs, justice costs, production-related costs, consumption-related costs and transfer costs. The costs are predicted to escalate to $32.3 billion in 2014-15 if no appropriate action is taken. The largest cost category is pain and suffering at $4.7 billion per year, with production related cost and health costs at $926 million and $617 million respectively.

In addition, data is now being provided on the potential savings from prevention. Cadilhac and colleagues highlight the health and economic benefits from a 5% reduction in lifetime prevalence of IPV against women in Australia (“Arcadian normal”, i.e., if Australia were to attain Denmark’s prevalence) of $337 million per year. This figure includes $147 million in home-based production savings (defined by non-paid household duties), $94 million in workforce production and $38 million in savings to the health sector.

3.3.2 Economic evaluation of Baby Makes 3

The economic evaluation considered the costs and outcomes of participants who completed the program and evaluation, as well as the cost and outcomes of individuals who withdrew for any reason. The primary analysis compared the change in outcomes over time (pre-post group differences) by intention-to-treat among participants as of November 2013 who have baseline data. To receive the intervention, participants would have attended at least one of the three Baby Makes 3 sessions. It is assumed that participants who chose to complete the post-group evaluation would have completed at least two Baby Makes 3 sessions, one of these being the third session. Estimates of the change in outcomes over time were made by matching pre-group and post-group data of the dads and mums. Parent data was matched using their date of birth (dd/mm), program venue and the approximate dates of the sessions attended.

There were not substantial changes in attitudes compared with the previous evaluation in that attitudes around nurturing and home care did not show significant change in either evaluation. On the other hand, attitudes to gender equality and breadwinner role showed different changes over time between the earlier evaluation and this study. In the previous evaluation, the question that related specifically to the concept of gender equality (question 4) showed statistically significant change over time (t=1%); where participants (dads and mums) tended to more ‘strongly agree’ than ‘agree’ after Baby Makes 3 that gender equality is an important part of healthy relationship. While this trend remained for GSC parents and EMR dads in the current evaluation at the group level, mums in EMR showed a small decrease in agreement between pre- and post-group. In addition, in this evaluation the average response to fathers’ role as breadwinner tended to more ‘strongly disagree’ after Baby Makes 3, which indicate that support for traditional gender role was relatively


61 Intimate Partner Violence (IPV) is a specific form of violence against women. The broader term ‘violence against women’ is more commonly used.


weak. While this trend was sustained for both matched pre- and post-group dads and mums in EMR, there was only a small change for mums in GSC.\textsuperscript{64}

The economic evaluation also assessed the cost-effectiveness of Baby Makes 3 by examining the total cost of the program and its outcomes in terms of participant measures of attitudes and behaviours. The evaluation was not set up to measure the association between changes in attitudes and behaviour and impact on risks for VAW.

The evaluation indicated that there is a cost difference between Baby Makes 3 delivered in metro and regional areas, demonstrating economies of scale which is largely due to higher opportunity cost of travel and time for staff and parents based in regional locations.

Parents’ attitudes to gender roles and gender equality showed some changes over time, which is also characterised by changes in behaviour of ‘who does what at home’. Short-term health and wellbeing impact of Baby Makes 3 in terms of improved measures of depressive and anxiety symptoms was not demonstrated on HADS.\textsuperscript{65}

A scenario analysis was conducted of the cost savings to government and society that would result from any impact of Baby Makes 3 in reducing lifetime prevalence of IPV. Recent literature showed that any reduction of IPV could achieve health and economic benefits in Australia. Applying this concept to the scenario in which any impact of Baby Makes 3 (by itself or as a suite of programs) could lead to a 5% reduction in lifetime prevalence of IPV, demonstrates that there are great opportunity cost savings of $10.6 million to the health sector and $219.9 million to the justice system in Victoria.\textsuperscript{66} Even a 1% reduction in prevalence has an estimated health sector cost saving of $2.1 million and criminal justice sector cost saving of $44.0 million.

The costs of violence to government and society support a strong social return on investment of interventions that can be demonstrated to reduce IPV incidence/ risk. Recognising the importance of preventing violence before it occurs, and the need for coordinated and sustained efforts, primary prevention interventions collectively have the potential to reduce the prevalence of IPV and its consequences for the individuals and the community.

Weighing up the cost against the short-term impacts on attitudes and behaviour seen in this evaluation indicate that Baby Makes 3 may be cost-effective if $325 per couple in metropolitan areas and $582 in non-metropolitan areas, is regarded as worthwhile investment against these demonstrated changes.\textsuperscript{67}

\textsuperscript{64} Gold L & Sia KL, 2015. Economic evaluation of the Baby Makes 3 program, prepared for Carrington Health by Deakin Health Economics Unit, Deakin University, Melbourne.

\textsuperscript{65} Gold L & Sia KL, 2015. Economic evaluation of the Baby Makes 3 program, prepared for Carrington Health by Deakin Health Economics Unit, Deakin University, Melbourne.

\textsuperscript{66} Gold L & Sia KL, 2015. Economic evaluation of the Baby Makes 3 program, prepared for Carrington Health by Deakin Health Economics Unit, Deakin University, Melbourne.

\textsuperscript{67} Gold L & Sia KL, 2015. Economic evaluation of the Baby Makes 3 program, prepared for Carrington Health by Deakin Health Economics Unit, Deakin University, Melbourne.
4 DISCUSSION AND RECOMMENDATIONS

4.1 MATERNAL AND CHILD HEALTH POLICY ABOUT GENDER EQUITY AND PVAW

MCHNs are frontline, primary health care workers who deliver direct services, based in communities across Victoria, to new parents and their babies. The Services are universally available at no cost to users. They play a critical role in supporting new parents through the transitions that occur when a new baby arrives, and play a key role in connecting families and communities to the health and social care systems.

Since the 1990s, MCH policy has been primarily about meeting targets under the ‘Key Ages and Stages’ Framework. There is no requirement in that Framework for MCHNs to include the health of mothers, or the parent’s relationship. However, calls for a broad-based movement for change, to embed the prevention of violence against women across sectors and settings in shared efforts to challenge gender stereotypes and roles, and to strengthen equal and respectful relationships, indicates a need for change on the guidelines and framework for Maternal and Child Health Nurses and MCH Services.

Father-inclusive practice responds to the needs of families as a system by including fathering in all aspects of the planning and implementation of services such as MCHS in a manner that enables families to make optimal use of their internal family resources. Research clearly demonstrates that without deliberate measures to develop and incorporate father-inclusive practice into all aspects of service delivery, service providers will overwhelmingly concentrate their efforts on mothers and children only. Research also shows this may result in both lower levels of satisfaction for families using the service and poorer outcomes for children, mothers and fathers.

The process evaluation of Baby Makes 3 showed that while some MCHNs were enthusiastic and supportive about the program and keen to be involved, others were not so supportive, and indeed, a few were actively resistant. Many who were unsure became more supportive during the professional development sessions provided by Baby Makes 3 project staff, but it became clear during the implementation of the project that MCHNs were not always familiar with the theory, principles and practices of gender equity and respectful relationships education and the gendered drivers of violence against women. MCHNs and MCHS are part of the prevention infrastructure required for the leadership and coordination necessary to drive broad, deep and sustainable social change about VAW.

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72 There are two postgraduate courses in Victoria for Division 1 nurses to gain the qualifications necessary to become registered as an MCHN. http://www.mchnv.com/courses-for-child-and-family-health-nursing/
Maternal and Child Health Services have the potential to be a strong link or potentially a weak link in the program’s effectiveness. The evaluations found that not all Maternal and Child Health Nurses were initially supportive of the Baby Makes 3 program being integrated into their New Parent Groups and some actively resisted involvement due to time pressures.

Maternal and Child Health Nurses are the primary health provider who see almost all new parents in the first week after their baby is born. They then regularly see new parents and are influential in encouraging them into support groups, commonly called ‘New Parent Groups’ which in reality are still ‘New Mothers’ Groups’. Mostly these groups are held during the week which tends to exclude working fathers. There is a real need for gender transformative practices to begin with the birth of a new baby (if not before) and be reinforced by primary health providers through the early years and beyond.

It was clear from the experience of the Baby Makes 3 project team that the relationship-building aspect with MCHNs is critical to the effectiveness of recruitment of new parents into Baby Makes 3. Where relationships between the project team and MCHN were not strong, or were in fact negative, there was a noticeable impact on the recruitment of parents. Some MCHS Coordinators showed resistance to the project at first, often due to competing demands on their time or a lack of awareness/understanding of the project. Significant partnership work was required to engage them and develop their enthusiasm for it. The power of using MCHN ‘champions’ for the project was also evident, and the team observed that some of the nurses came on board after these champions for the project talked about their experiences and support for Baby Makes 3. These MCHN champions then worked with the resistors in the MCHN team, and were proactive in working with the project team to improve support amongst MCHNs.

There were clear benefits to MCHS being the primary and key referral source for participants into Baby Makes 3. However, Carrington Health believe that there is also merit in other, additional referral sources to extend the reach of the program, especially given that parents from CALD backgrounds, teenage mothers and GBLTIQ for example can be harder to reach. This could include some family services or enhanced parenting projects that sit around MCHS, and hospital antenatal parenting projects/programs.

It is evident from the evaluations that Baby Makes 3 needs a ‘whole of setting approach’. It is far more effective when key messages from the program are valued and reinforced by the MCHS setting, rather than across the three weeks. The impact of the Baby Makes 3 initiative will be diminished if it occurs in isolation, and if broader community or social and cultural norms and practices do not support its core messages. Conversely, the effects of Baby Makes 3 as a prevention initiative will be strengthened if the reach of its key messages is maximised, and when its messages are reinforced by simultaneous complementary reinforcement in other settings, particularly through the range of primary providers with whom new parents are in contact.

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**Recommendation 1**

Review Maternal and Child Health policy and program guidelines and frameworks to embed gender equitable approaches, inclusiveness and engagement with new fathers as well as new mothers. This should be embedded into MCH policy at both State Government and Territory level using a systems approach, with the objective of this becoming the standard for MCHS service delivery.

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4.2 THE BABY MAKES 3 PROGRAM IS EVIDENCE BUILDING

Baby Makes 3 is evidence building. Carrington Health have shown ongoing commitment to building evidence through short and long term evaluations of Baby Makes 3, over more than six years. The program development of Baby Makes 3 has focused on strengthening the evidence basis for interventions about gender equity with new parents. More broadly, evidence building efforts seek to bridge what is sometimes a gap between research, policy and programming.

Evidence building happens through partnership building, conducting reviews and syntheses of existing evidence, enhancing research capacity and initiating studies to produce primary data usually in partnership with other key players. Major reports from PWC, Our Watch and VicHealth make the point that the field of PVAW evidence is emerging. When a field is emerging, there may be uncertainty about the strength of evidence about effectiveness including cost-effectiveness. Thus, attention must be paid to not only to replicating successful techniques for prevention, but to testing, adapting and evaluating them in different contexts and settings in approaches that are not only evidence-based, but also evidence-building. It is crucial that programs are funded with the intention of continuing to build evidence to be able to measure short and longer-term impacts and change in the underlying drivers of VAW.

During the DJR funded project, Carrington Health worked closely with researchers on the study designs, seeking to build evidence. However, rather than expecting the program provider to manage the research processes, it could be preferable to use an arms-length approach between the researchers and the program providers. Of course, university staff can provide rigorous study design, data collection and analysis, it is important that university proposals are peer-reviewed to ensure that they are high quality, and use study designs and measures that are focused on change in gender equitable attitudes, relationships and social norms. So the overall program incorporates partnerships between program providers and universities but allows the program providers to concentrate on implementation, quality and scaling up and ensures the evaluation research is high-quality, fit-for-purpose and focused on building evidence.

Recommendation 2

Review Maternal and Child Health Nurse education and professional development for its content and teaching about gender inequity, the gendered drivers of violence against women and the key messages of Baby Makes 3. Undertake negotiations with provider Universities to embed this content in MCHN courses.

Recommendation 3

Provide support through industry-linkage types of research funding (such as that provided by the Australia Research Council) to support research and development (R&D) projects in the scaling up of Baby Makes 3 and the broader field of PVAW. These should be collaborative between higher education researchers and other parts of the national innovation system, and undertaken with the objective of acquiring new knowledge and building evidence.
4.3 SCALABILITY OF BABY MAKES 3

At a state-wide level, there is potential for the Baby Makes 3 intervention to be coordinated across settings to reinforce and sustain change. This would require an infrastructure that includes mechanisms for coordination and quality assurance, an expert workforce, political leadership, policy reform for MCHS and shared monitoring, reporting and evaluation frameworks across the state. Effective strategies, programs and initiatives require appropriate resourcing to enable quality development, testing and evaluation, and ultimately to scale-up or systematise initiatives such as Baby Makes 3 for sustainability over the long-term.

To ensure community ownership of prevention work, and the inclusion of diverse perspectives, building trusted and transparent relationships between government and local services is important through design, implementation and monitoring. There were varying degrees of stakeholder engagement required with different LGAs to garner effective support for Baby Makes 3. With some LGAs, this required 12 months or more of partnership building to develop the relationships required to get the project running effectively. This issue is tied to the readiness of the organisation to embed Baby Makes 3. As part of the project set-up and planning, it is clearly important to assess the readiness of the LGA to embed Baby Makes 3 into their service. Carrington Health has developed an audit tool to enable organisations to assess their readiness for Baby Makes 3, including whether adequate resourcing and funding is in place. It is not feasible to expect MCHS to incorporate Baby Makes 3 into their existing service without additional funding and resourcing.

A program such as Baby Makes 3, and the key messages it delivers to people in a key life stage, namely the transition into new parenthood, is ideally set within health, family and community services in local government. Health and social service programs can provide an important means of reaching groups that are outside other settings, such as first-time parents. Nationally consistent yet locally-driven prevention of violence against women strategies can be particularly effective, especially where supported or mandated by complementary state and territory level activity.

Baby Makes 3 should be considered as a program with the potential to be mandated at a state or national level, but delivered locally via MCH (or other relevant) services in local government. For Baby Makes 3 to be rolled out on a larger scale in Victoria, the quality assurance processes used by Carrington Health would need to be adapted as necessary, particularly to the project’s implementation across large geographical areas. Given their experience and knowledge, Carrington Health should also be actively involved in supporting government to assess the readiness of individual MCHS through a phased approach to scaling up.

Recommendation 4  
Fund the scaling up of Baby Makes 3 into LGAs and MCHS across Victoria, ensuring that the quality and integrity of the program is maintained as it is introduced into LGAs and MCHS currently unfamiliar with the program. This should be a phased approach based on the readiness of the individual MCHS.
4.4 **BABY MAKES 3 IS A LOGICAL EXTENSION OF RESPECTFUL RELATIONSHIPS EDUCATION**

*Baby Makes 3* has the potential to become part of national action for the inclusion of respectful relationships education. Currently, respectful relationship education for school children is being incorporated into school curriculum through the Victorian Department of Education, with the development of learning materials and efforts to ensure consistency in teacher training to support implementation. The Victorian Department of Education and Training also manages and funds MCHS. Just as State and Territory governments are responsible for ensuring its quality delivery of respectful relationships education in schools, so they should be responsible for new parent education as a sequel that reinforces those key messages.

If it is critical that young people are exposed to this education in schools, then it is critical that those young people receive the reinforcement of *Baby Makes 3* education when they become new parents. It would also enable a foundation to be built for each new baby to learn what an equal and respectful relationship means and looks like, so that the core messages of these programs are part of their lifelong learning.

Further, Local Governments are now being seen as an important sector for the integration of prevention of violence work and are coordinating programs in schools, across the community, and in sporting clubs. The work of local governments should also include the rollout of new parent education about gender equitable relationships to ensure continuous reinforcement of key messages, especially as Victorian local governments’ auspice Maternal and Child Health Services.

During a time when traditional gender norms and roles tend to influence couple relationships, the themes emerging from the evaluations indicate that *Baby Makes 3* plays an important role in raising awareness of gender inequality in relationships and reinforcing the opportunity to share and test knowledge and understandings about relationships, with other parents. This consciousness-raising enabled some couples to make changes in their relationships that reflect a greater value for the responsibility women tend to assume for caring and household tasks, an increased understanding that parenting is a partnership, and a greater consciousness and focus on open communication, conflict resolution and intimacy in couple relationships. These changes are suggestive of increased respect and a gradual shift towards equality in relationships between new parents.

Since the first evaluation in 2009-2011 and now in the 2013-15 *Baby Makes 3* program, new parents have described the benefits of having tools and resources to engage with the meaning of positive and gender-equitable parenting practices. These messages are an extension of the material that many of those same people would have been taught during respectful relationship education in schools, making *Baby Makes 3* an important reinforcement. For many new parents, the opportunity to engage with the key messages of *Baby Makes 3* will be a new experience as not all schools have respectful relationship curriculum, so it is doubly important that all new parents are exposed to the *Baby Makes 3* program. Both the respectful relationships curriculum in schools and *Baby Makes 3* demonstrate that when individuals are empowered to challenge violence-supportive attitudes and behaviours and promote gender equality, they form more respectful and equal relationships.

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4.5 THE IMPORTANCE OF TARGETING NEW FATHERS

Baby Makes 3 is a program that directly targets messages at new fathers, not just new mothers. The program sessions transmit messages about why fathers need to take equal responsibility for parenting and their children's development, and the meaning of gender equitable relationships.

There is now robust and compelling evidence that demonstrates fathers’ potential to positively influence their children's health, social success and academic achievements. A key feature of studies examining parental influences on child development published in the last five years is the separation of independent father and mother effects. A fathers’ influence on children's cognitive development, social skills, mental health, literacy and maths achievement is found to be separate to that of mothers’, to operate in different pathways to that of mothers or to compensate for deficiencies in mothers’ parenting. The research demonstrates how the inclusion of fathers and their close involvement from birth can support infant and child development. A gender equitable relationship will also challenge gender stereotypes and positively influence women's participation in the workforce and future economic independence.

It is also important to note that in the absence of Baby Makes 3, there are no other programs targeted at new parents and focused on the couple's relationship (as opposed to ‘caring for baby’). Therefore, without this program being available, there is a vacuum of interventions targeting new parents in the key life transition of becoming a new parent. Without Baby Makes 3 for new parents, the good work done by respectful relationship curriculum in schools lacks the reinforcement needed about gender equitable relationships at key life transition stages.

Aspects of the Baby Makes 3 project delivery have highlighted the extent to which new parent groups (NPGs) and MCHS more broadly, are still targeted largely towards mothers, rather than both mothers and fathers. This is discussed further below. In order to ensure that the key messages of gender equity from Baby Makes 3 are embedded and mutually reinforced, NPGs do need to become much more inclusive of fathers from the outset. This would also serve to reinforce the effectiveness of marketing Baby Makes 3 as ‘usual business’.

Recommendation 6

Develop more flexible approaches among MCHS to New Parent Groups to engage new fathers early and increase their willingness to participate in Baby Makes 3. The principles of father-inclusiveness could also be reviewed in the context of the broader sector of early childhood services to improve gender equitable service delivery and engage in gender transformative practices.

Recommendation 5

The Victorian Government through the Department of Education and Training should commit to supporting the state-wide scale-up of Baby Makes 3 through both policy and programs. This will ensure continued evidence building on violence prevention and respectful relationships education for new parents, and will reinforce the messages that young people receive at school through the Respectful Relationships program.

4.6 A LOCAL WORKFORCE WITH EXPERTISE IN GENDER EQUITY PROGRAMS

Our Watch emphasises the importance of developing an expert workforce as part of the prevention infrastructure. Baby Makes 3 has built a local workforce of skilled facilitators with expertise in primary prevention of violence against women. This workforce would also make good facilitators for other gender equity programs because of their transferable skills, and could potentially be utilised across other PVAW programs, ensuring that the skills of expert facilitators are maximised, and not lost. Examples could include gender equity training in workplaces or respectful relationship programs in schools.

Many facilitators are already using the skills they’ve developed through the program and translating these into their other roles in diverse sectors and settings. This enables Baby Makes 3 facilitators to help embed prevention and gender equality efforts into their existing work and into the core business of their organisations. There is certainly an opportunity to build up a pool of facilitators who are skilled in delivering programs targeted at the prevention of violence against women. Carrington Health has developed a wealth of experience and knowledge regarding the effective professional development of facilitators, including approaches to quality assurance and methods to build on the skills of this workforce and ongoing learning through the Community of Practice concept.

Recommendation 7 Consider the development of a national or state approach to the continued development of a skilled workforce in PVAW, building on Carrington Health's experience and knowledge.

4.7 BABY MAKES 3 IN ISOLATION VERSUS A MULTI-SETTING APPROACH

Baby Makes 3 is an innovative program that targets a key life-stage when gender equitable attitudes and behaviours are formed and patterns are established in a couple’s behaviour. There is mounting evidence that primary prevention activities are most effective when they are part of a multi-faceted and mutually reinforcing packages of policies and programs, delivered over time to people across all life stages, with repeated messages. The program benefits of Baby Makes 3 should not be viewed in isolation of other primary prevention work. In particular it should be noted that there do not appear other programs targeting the key life stage of new parents, especially as the transition to pregnancy and new parenthood are now shown as carrying increased risk for gender inequitable behaviours and indeed, of violent behaviours by men towards women.

Multi-setting approaches strengthen the impact of different prevention initiatives, from the effect of mutual-reinforcement. The impact of the Baby Makes 3 initiative will be ‘dampened’ if it occurs in isolation, and if broader community or social and cultural norms and practices do not support its core messages. Conversely, the effects of Baby Makes 3 as a prevention initiative will be strengthened if the reach of its key messages is maximised, and when its messages are reinforced by simultaneous complementary reinforcement in other settings, particularly through the range of primary providers with whom new parents are in contact.


The core messages of Baby Makes 3 are important for all primary providers, as a normal part of new parent business. Many agencies in this setting have a longstanding history in leading community development and cross-sector initiatives. As they provide direct services across the population, they have strong potential to influence individuals and communities. Benefits would accrue if Maternal and Child Health Nurses, General Practitioners, allied health practitioners, workplaces, and early childhood providers in contact with new parents, used the key messages of Baby Makes 3 in their everyday business, and the messages of Baby Makes 3 were normalised. These health and social service programs also provide an important means of reaching groups that are outside other settings and were harder to reach under the Baby Makes 3 program model, such as young parents and people from CALD, ATSI and GBLTIQ backgrounds.

Over the course of the project delivery of Baby Makes 3, Carrington Health has identified several areas of need for continued development of the program. This includes tailoring the Baby Makes 3 content and delivery for ATSI, CALD, GBLTIQ and teenage parents. Carrington Health is currently supporting pilot studies with the Koolin Ballit (ATSI) project (DHHS funded from July 2015-June 2017), and the CALD project, which is being delivered in partnership with InTouch Multicultural Centre Against FV, and Kildonan UnitingCare (Broadmeadows). This is funded by the Federal Government under their ‘Communities for Children’ program lead by the Department of Social Services.

Embedding Baby Makes 3 into local governments was also effective as local governments are the entities closest to individuals and communities, and can therefore influence social and community change. They are well placed to respond to local concerns and to lead primary prevention activities through existing mechanisms and via a range of partnerships. They have a reach and mandate to support people at different stages of life such as young people, new parents, and seniors, different faith and cultural groups and marginalised groups. This report has identified the importance of assessing an organisation’s readiness to incorporate Baby Makes 3 and/or its core messages into their service, as well as developing appropriate resources to scale up the program. Carrington Health is ideally placed to actively continue supporting the wider roll-out of this program and it is recommended that any wider development of Baby Makes 3 takes advantage of their knowledge and experience and is inclusive of Carrington Health.

**Recommendation 8** Work with Carrington Health to develop potential approaches to embedding the core messages of Baby Makes 3 across all primary health providers, particularly those with whom new parents have increased contact.

**Recommendation 9** Work with Carrington Health to tailor Baby Makes 3 to priority population groups to build the evidence about effective processes and approaches to engage stakeholders in development and delivery.

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4.8 SOCIAL RETURN ON INVESTMENT FROM BABY MAKES 3

Social return on investment (SROI) is about measuring the extent to which social impacts are achieved by funding, programs, and policies. SROI is about assessment of both a range of values as it is about cost-benefit. There is value in organisations seeking to create social change to become more sophisticated in assessing performance against social impact.

SROI places emphasis on the involvement of stakeholders in evaluation, blended with cost-benefit analysis tailored to social purposes. It tells a story about how change is being created, places a monetary value on that change and compares it with the costs of inputs required to achieve it. Thus, the SROI ratio represents the social value created for each $1 invested, rather than an actual financial return.

As discussed in Section 3.2.1, there are significant health and economic benefits of a reduction in prevalence of violence against women. The actual cost of Baby Makes 3 was estimated at $325 per couple in metropolitan areas and $582 in non-metropolitan areas. The cost benefits of reducing the prevalence of violence against women and children are significant.

The economic evaluation concludes that any impact of Baby Makes 3 could lead to a reduction in lifetime prevalence of VAW, and that this potential demonstrates that there are great opportunity cost savings of $10.6 million to the health sector and $219.9 million to the justice system in Victoria. Even a 1% reduction in prevalence has an estimated health sector cost saving of $2.1 million and criminal justice sector cost saving of $44.0 million.

The PwC report adds further points that are pertinent to assessing the value of Baby Makes 3 and to discern the lessons than can be learned from the 2013-15 project:

- Investment in rigorous evaluation has been limited, and there is no standardised approach to evaluation of prevention programs of violence against women.
- Prevention programs to promote change take time so programs need to be provided and evaluated with longer-term follow-up. The next roll-out of Baby Makes 3 would benefit from stronger cohort evaluations and more rigorous quasi-experimental evaluation designs that take account of cohorts from different social contexts and social strata.
- Individual-level change must be supported by environmental change, which for Baby Makes 3, means that strengthening and development of Maternal and Child Health and Local Governments is critical to the effective implementation and scaling up of Baby Makes 3.

The costs of violence to government and society support a strong social return on investment of interventions that can be demonstrated to reduce VAW incidence and risk by focusing on the determinants of violence. Primary prevention requires coordinated and sustained efforts with long-term funding and commitment across a range of levels including communities of new parents, Maternal and Child Health Nurse staff and other primary health providers, local governments and state governments which fund them.

79 Social Ventures Australia (SVA) Consulting, 2012. Social Return on Investment, Lessons Learned in Australia. Sydney,
81 Gold L & Sia KL. 2015. Economic evaluation of the Baby Makes 3 program, prepared for Carrington Health by Deakin Health Economics Unit, Deakin University, Melbourne.
5 CONCLUSION

Carrington Health had three project objectives in their delivery of Baby Makes 3, namely to:

1. Deliver Baby Makes 3 group programs to over 1,200 first time parents across the Eastern Metropolitan Region of Melbourne
2. Increase the capacity of first time parents to build equal and respectful relationships in response to the lifestyle and relationship changes that follow the birth of a child
3. Increase the capacity of Maternal Child Health professionals and Local Governments to promote equal and respectful relationships during the transition to parenthood.

This report has illustrated the evidence that Carrington Health has successfully delivered against all three of these objectives. They have delivered the Baby Makes 3 program with integrity and fidelity, with a strong focus on quality assurance, whilst being agile and adaptable to the individual needs to all MCHS involved. The program received very positive ratings from parents who participated, with evaluation feedback confirming that the key messages of the program landed and resonated with both mothers and fathers.

Parents who participated in the impact evaluation interviews described the benefits of having tools and resources to engage with the meaning of positive and gender-equitable parenting practices. This supports the findings of other research showing that when individuals are empowered to challenge violence-supportive attitudes and behaviours, and promote gender equality, they form more respectful and equal relationships.²³

The economic evaluation also demonstrated that Baby Makes 3 had achieved some attitudinal change in new parents over time. A scenario analysis was conducted of the cost savings to government and society that would result from any impact of Baby Makes 3 in reducing lifetime prevalence of IPV. Applying this concept to the scenario in which any impact of Baby Makes 3 (by itself or as a suite of programs) could lead to a 5% reduction in lifetime prevalence of IPV, demonstrates that there are great opportunity cost savings of $10.6 million to the health sector and $219.9 million to the justice system in Victoria. Even a 1% reduction in prevalence has an estimated health sector cost saving of $2.1 million and criminal justice sector cost saving of $44.0 million.

Carrington Health has also invested heavily in building on their experience delivering Baby Makes 3 to increase the capacity of MCH professionals and Local Governments to promote equal and respectful relationships during the transition to parenthood. This has been through the delivery of numerous professional development workshops, with positive feedback from participants that they understand the key messages of Baby Makes 3 and more importantly, how to integrate these messages into their respective service delivery.

APPENDIX A - BABY MAKES 3 PROCESS EVALUATION

The Baby Makes 3 Process Evaluation is attached.
Carrington Health

_Baby Makes 3 - Process Evaluation_

Prepared for: Carrington Health
Prepared by: Helen Keleher and Emma Hutcheson, Keleher Consulting
10 November 2015
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EXECUTIVE SUMMARY

*Baby Makes 3* is a three-week group program for first time parents being delivered by Carrington Health (previously Whitehorse Community Health Service) in partnership with Maternal Child Health services in the Eastern Metropolitan Region (EMR) of Melbourne, as part of their New Parent Groups. This report is a process evaluation of the *Baby Makes 3* project delivered by Carrington Health, which addresses the implementation of *Baby Makes 3*, assesses the fidelity of project implementation relative to the project intentions and design, and explains any changes that were made during implementation.

The process by which Carrington Health delivered the *Baby Makes 3* project has been evaluated as very effective and thorough. The project was very well scoped and recorded in a variety of project documents including the project plan, reports to DJR, and project newsletters/communiques. The quality of scoping out of project activities has underpinned the quality of project delivery, the integrity of delivery, the reach of the project, and the effectiveness of facilitation of *Baby Makes 3* groups.

The project was clearly underpinned by good planning, attention to detail, continuing project support, and good record keeping. Facilitators had very good levels of support from the project team which was a key aspect of ensuring quality delivery of the project. The project team also worked closely with MCH and facilitators to try different methods to improve uptake and ensure that *Baby Makes 3* was successful in their respective LGAs.

This has also facilitated the learnings through this process evaluation and demonstrated that the *Baby Makes 3* project was delivered with integrity and fidelity. The facilitators were well trained and proficient, and able to get the key messages of *Baby Makes 3* to the target audience, whose feedback also demonstrated that they received the key messages of *Baby Makes 3*.

The *Baby Makes 3* project was also very successful in reaching the intended audience. The team adapted strategies as the project unfolded and worked closely with MCH wherever possible, to ensure engagement with new parents in order to maximise their attendance and participation in *Baby Makes 3* sessions. The project reached 1305 new parents and achieved a retention rate of 74%, both of which exceed the targets set by the Steering Committee.

Carrington Health recognised the importance of selecting facilitators on the basis of identified competencies. The project team also recognised the need to provide ongoing support and development for facilitators to continue to build their skills through the Community of Practice meetings and providing skill-building communications to facilitators during the life of the project. The facilitators themselves were enthusiastic and committed to the project, and were thoughtful in their efforts to engage new parents, particularly new fathers. The combination of these efforts undoubtedly contributed to the success of the project in reaching its target audience and in the positive participant evaluations.

Overall, the *Baby Makes 3* project has been delivered very effectively. Carrington Health has implemented the program across the EMR catchment, adapting to a range of variables where necessary whilst still ensuring that the program content and messages were received by the new parents who participated.
INTRODUCTION AND BACKGROUND

*Baby Makes 3* is a three-week group program for first time parents being delivered by Carrington Health (previously Whitehorse Community Health Service) in partnership with Maternal Child Health services in the Eastern Metropolitan Region (EMR) of Melbourne, as part of their New Parent Groups. *Baby Makes 3* is funded by the Community Crime Prevention’s Reducing Violence against Women and their Children Grants. The project in Eastern Metropolitan Region runs over three years (January 2013 to December 2015) and involves delivering Baby Makes 3 in selected Maternal Child Health centres across the EMR (Whitehorse Community Health Service 2012).

This report is a process evaluation of the *Baby Makes 3* project delivered by Carrington Health. The process evaluation addresses the implementation of *Baby Makes 3*, assesses the fidelity of project implementation relative to the project intentions and design, and explains any changes that were made during implementation. The impact and outcome evaluation assesses what was achieved, presenting indicators and measures, data sources, and methods used for the evaluation.

This report is not just for accountability, but is particularly for knowledge generation about how the findings of this project can be transferred into policy about new parent programs, father engagement, MCH and practices for the primary prevention of violence against women.

**Gender equity and the prevention of violence against women (PVAW)**

Men’s violence against women is a complex social problem in Australia. Too many Australian women and children experience violence every day, which grows from deeply-held beliefs about roles and stereotypes, value systems, and power relationships.

The term ‘violence against women’ covers a range of forms of violence that may be criminal or non-criminal in nature. It is predominately recognised as behaviours intended to exercise power and control over women. This violence includes physical, emotional, economic, social, sexual and spiritual violence. In addition to the physical, emotional and social harms resulting from gender based violence, there are also multiple, serious, long-term effects for its victims. The statistics around violence against women and their children are now well established.

The primary prevention of violence against women encompasses a variety of strategies aimed at preventing new instances of violence across whole populations before they occur, by addressing the underlying causes. It is a public health approach that recognises violence against women as a public health issue.

The underlying causes of violence against women are understood as gender inequity, and gender roles that reinforce sexism and stereotypes. Gender equity is the process of being fair to women, men and gender diverse people, to overcome negative attitudes to diversity and disadvantage, and direct resources and programs towards social change to strengthen gender equity.

Gender stereotypes are based on socially constructed norms, practices and beliefs. They reflect underlying power relations that exist in all societies. Gender stereotypes are prescribed notions and generalisations about the traits that women/girls and men/boys are assumed to possess. Gendered roles can be rigid but they do shift and change over time. The *Baby Makes 3* project is designed to influence more equal gender roles.

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1. Women’s Health West & VicHealth 2014
among new parents because the transition to new parenthood is understood as a time when equal and respectful relationships need to be firmly established.

**Program theory of Baby Makes 3**

*Baby Makes 3* is based on theories about the causal pathways between gender inequity and violence against women. Gender analysis examines the differences in women and men’s lives, including those that lead to social and economic inequity for women. *Baby Makes 3* takes this analysis and builds understanding in new parents about the impact of a new baby on gender relationships.

**About Baby Makes 3**

*Baby Makes 3* is a three x 2-hour group program for first time parents delivered in partnership with Maternal Child Health Services (MCH), as part of local governments. It is a primary prevention project that aims to influence relationship dynamics between new parents, and to prevent violence against women by promoting equal and respectful relationships during the transition to parenthood.

Carrington Health (formerly Whitehorse Community Health Service) developed the *Baby Makes 3* project in 2008 and undertook an initial 3 year pilot for this program. Following a submission process in 2012, the project received funding from the DJR Community Crime Prevention grants for Reducing Violence against Women and their Children. The funding enabled the project to be scaled up and run over three years from January 2013 – December 2015. The project was delivered in Maternal Child Health Services in the seven Local Government Areas of the Eastern Metropolitan Region (EMR) in Melbourne across nineteen pilot sites. The project aimed to reach over 1000 new parents. To achieve these aims, partnerships were essential. In this project, those partnerships were between Carrington Health (the project lead agency), and Maternal and Child Health Services (MCH) and the Local Governments which manage them.

**Project Objectives**

The *Baby Makes 3* project objectives were:

1. To deliver *Baby Makes 3* group program to over 1,000 first time parents across the Eastern Metropolitan Region of Melbourne;
2. To increase the capacity of first time parents to build equal and respectful relationships in response to the lifestyle and relationship changes that follow the birth of a child; and
3. To increase the capacity of Maternal and Child Health professionals and Local Governments to promote equal and respectful relationships during the transition to parenthood.

**Project Evaluation Questions**

The overall project evaluation aimed to answer the following questions:

1. Is the *Baby Makes 3* project transferable to other areas? What are the different models for implementing *Baby Makes 3* into differing contexts?
2. How does *Baby Makes 3* impact on gender equity for participants?
3. Is *Baby Makes 3* cost-effective relative to current practice?

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3 Primary prevention projects are aimed at preventing a problem before it occurs.
**Baby Makes 3 Project Model**

*Baby Makes 3* is a three x 2 hour group program, delivered to first-time parents over three weeks. The project utilised existing resources for delivering the *Baby Makes 3* project including the Implementation Guide, Facilitators Training Guide, Group Program Guide, Parent Handouts, evaluation tools, situational assessment template, communication materials (letters/brochures) for parents, and learning activity materials for the Community of Practice. Project resources and reports are listed in Appendix 1.

Each session of *Baby Makes 3* for new parents is co-facilitated by a male and female facilitator, recruited on the basis of their suitability and experience. A position description for the appointment of facilitators was developed with selection criteria, and a three step process was then used to identify suitable candidates:

1. **Expression of Interest** (via a phone call with the Project Manager)
2. **Written application**
3. **Interview**

Applicants were interviewed by *Baby Makes 3* project management staff. In order to ensure that Carrington Health had the ‘right’ people, they reserved the right to not approve facilitators post-training. All facilitators undertook a two-day facilitator training workshop provided by the project manager who took them through the project and included some content about gender equity. Facilitators followed the Group Program Manual which set out the detailed contents for each session, with handouts and powerpoint slides. Facilitators were required to undertake pre-reading and to develop their skills in the *Baby Makes 3* content through role playing on day 2 of the training. Facilitators practiced delivering the material in front of an audience, and were evaluated by the group.

In delivering the *Baby Makes 3* sessions, facilitators worked in male/female pairs, had to be available to work after hours, in consecutive weeks, and at least one of the pair had to have been a parent. They were also required to use the program guide and must have completed the training.

The project was guided by a Steering Committee comprising project stakeholders and was chaired by the Department of Justice and Regulation, South East Regional Office. The Steering Committee met quarterly from mid 2013 to July 2015 and included representatives from Women’s Health East, Eastern Comm Legal, Regional FV Prevention Partnership, and Regional DJR, demonstrating the link to other organisations doing family violence prevention work.

A parallel project was also funded by DJR for *Baby Makes 3* to be implemented in Warrnambool Victoria for which the lead agency was Warrnambool City Council, in the Great South Coast Region of Victoria across 5 LGAs. These projects were very much conducted in tandem with regards to joint resource development, training, recruitment of facilitators and parents and promotion of the program. The evaluations that inform this report were conducted only for the Carrington Health project, with the Warrnambool project team managing their own evaluation. Nevertheless, Keleher Consulting did interview the Warrnambool project manager and have included some points of reflection in this report.
PROCESS EVALUATION

This section presents the process evaluation of the Baby Makes 3 project managed by Carrington Health between 2013-2015. The process evaluation was designed to assess the following key themes of Baby Makes 3:

1. The scope of project activities accomplished against the intention of the project
2. The quality of project delivery
3. The integrity/fidelity of project activities delivered
4. Reach to the target audience
5. Skills, experience and credentials of project staff and facilitators
6. External factors that influenced project delivery.

Methods

The process evaluation was based on data collected via several methods:

- Review of project reports, interim evaluations and newsletters sent out over the duration of the project
- An in-depth interview with the project manager and project officer
- Focus group with the final Community of Practice meeting including 10 facilitators of whom two left early but followed up with emailed responses
- Responses from an additional four facilitators who were not able to attend the Community of Practice meeting but responded to emailed questions
- An interview with the manager of the Warrnambool project (also funded by DJR) for comparative perspectives
- Attendance records of first-time parents at Baby Makes 3 groups.
- Survey of MCH Coordinators with five out of seven coordinators providing responses.

Facilitators were asked the following questions in a focus group and via surveys:

<table>
<thead>
<tr>
<th>TABLE 1: QUESTIONS FOR FACILITATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Questions for facilitators</strong></td>
</tr>
<tr>
<td>1. Were you able to deliver all aspects of the course materials (i.e. the project guide)? If not, why not?</td>
</tr>
<tr>
<td>2. What components were you most likely to drop (e.g. if under time constraints)?</td>
</tr>
<tr>
<td>3. How do you rate the quality of course materials?</td>
</tr>
<tr>
<td>4. What are the strengths of the Baby Makes 3 materials?</td>
</tr>
<tr>
<td>5. Were there any gaps in the course materials?</td>
</tr>
<tr>
<td>6. How could recruitment of parents be improved?</td>
</tr>
<tr>
<td>7. Were there any external factors that affected the delivery of the project? What were they?</td>
</tr>
<tr>
<td>8. Were the venues suitable? What makes a suitable venue?</td>
</tr>
<tr>
<td>9. What do you see as the core facilitation skills for Baby Makes 3?</td>
</tr>
</tbody>
</table>
Of the 23 male and female Baby Makes 3 facilitators who were recruited over the life of the project, fourteen in total responded to the process evaluation. Saturation was achieved, which is the point in data collection when no new or relevant information emerges.

During the interviews and focus group, the consultants took comprehensive notes. Analysis of the responses was conducted thematically in relation to project scope, quality, reach, skills and the influence of external factors. Discussion of each of these six overarching themes is presented below.

The following questions were sent to MCH Coordinators to obtain feedback:

**TABLE 2: QUESTIONS FOR MCH COORDINATORS**

<table>
<thead>
<tr>
<th>Questions for MCH Coordinators</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In what ways has Baby Makes 3 been worthwhile for your service?</td>
</tr>
<tr>
<td>2. What were the challenges in the planning, promotion and delivery of Baby Makes 3 in your service?</td>
</tr>
<tr>
<td>3. What would you do differently to make Baby Makes 3 sustainable in your service?</td>
</tr>
<tr>
<td>4. What would you say about Baby Makes 3 to your colleagues?</td>
</tr>
</tbody>
</table>

These questions were sent to the seven MCH Coordinators in EMR and Keleher Consulting received five responses.

The following sections of this report assess the following key themes of the Baby Makes 3 process evaluation:

1. The scope of project activities accomplished against the intention of the project
2. The quality of project delivery
3. The integrity/fidelity of project activities delivered
4. Skills, experience and credentials of facilitators
5. External factors that influenced project delivery
THEME 1: THE SCOPE OF PROJECT ACTIVITIES ACCOMPLISHED AGAINST THE INTENTION OF THE PROJECT

The scope of project activities is about the elements of the Baby Makes 3 project, so that readers can understand what was required to successfully run the project in relation to the intention of the project.

The scope of the project was designed with the following parameters:

- *Baby Makes 3* was to be delivered across all 7 MCH services in the EMR. Each MCH service operates across multiple centres (ranging from 8 – 17 sites). Implementation sites and the number of *Baby Makes 3* programs delivered were negotiated with each local government.
- Models for implementing *Baby Makes 3* were expected to differ between local government areas to account for geographic differences. However, implementation at all sites was conducted and guided by the *Baby Makes 3* Implementation Guide and Facilitator’s Guide to ensure project integrity and to support sustainability.
- Project planning, implementation and evaluation were planned in conjunction with Warrnambool City Council, which was the lead agency of the *Baby Makes 3* project in the Great South Coast (GSC) Region.

**Project team**

The project team included 1.0 EFT Project Manager for the three-year duration of the project, and a 0.6 EFT project officer from Nov 2014 - December 2015, plus a Data Support Volunteer who gave six hours per week from Nov 2013 to July 2015.

**Work streams**

Five work streams were developed during the project, namely:

1. Partnerships
2. Evaluation
3. Capacity building
4. Evidence
5. Sustainability.

These five work streams and the related activities are detailed below at a high level.

**TABLE 3: PROJECT WORK STREAMS**

<table>
<thead>
<tr>
<th>Work stream</th>
<th>Description of activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partnerships</td>
<td>• Initial consultation meetings with stakeholders</td>
</tr>
<tr>
<td></td>
<td>• Agree project governance structure and establish project steering committee</td>
</tr>
<tr>
<td></td>
<td>• Plan communications with project partners and stakeholders</td>
</tr>
<tr>
<td></td>
<td>• Develop and obtain formal agreements with local government</td>
</tr>
<tr>
<td></td>
<td>• Develop implementation plans for each MCHS</td>
</tr>
<tr>
<td></td>
<td>• Engage Family Violence and Counselling Services</td>
</tr>
<tr>
<td></td>
<td>• Work in partnership with other Crime Prevention projects</td>
</tr>
<tr>
<td>Work stream</td>
<td>Description of activities</td>
</tr>
<tr>
<td>-------------</td>
<td>---------------------------</td>
</tr>
</tbody>
</table>
| Evaluation  | • Development of the evaluation framework  
• Recruitment of external project evaluators to conduct economic evaluation  
• Undertake any baseline data collection requirements  
• Conduct ongoing evaluation activities  
• Evaluation collation and analysis |
| Capacity Building | • Deliver information workshops on *Baby Makes 3* and/or Prevention of Violence Against Women (PVAW) general training  
• Establish a ‘Train the Trainer’ (TTT) project for *Baby Makes 3* facilitators  
• Establish a ‘Community of Practice’ for *Baby Makes 3* facilitators  
• Identify and plan other capacity building activities with local government |
| Evidence    | • Resource development  
• Sharing learnings within the EMR and the Great South Coast Region |
| Sustainability | • Train *Baby Makes 3* facilitators for each LGA (to ensure skills, resources are retained within each LGA enabling them to sustain the project beyond the life of the project funding)  
• Build the capacity of MCH services and staff in relation to internal support and knowledge of BM3 concepts needed to effectively deliver BM3  
• Ensure the integrity and timeliness of evaluation data which demonstrates the program's success and impacts in order to gain support and ongoing funding (e.g. health economics, cost/benefit analysis to demonstrate the project’s value)  
• Embed *Baby Makes 3* within local government plans and policy  
• Embed *Baby Makes 3* content within DET New Parent Group program  
• Pilot, refine and evaluate different implementation models to identify sustainable approaches and ensure the program’s effectiveness within a range of settings  
• Strengthen existing partnerships with MCH services and develop partnership models that support program delivery |

**Summary**

In summary, the project was very well scoped and recorded in a variety of project documents including the project plan, reports to DJR, and project newsletters/communiques. The following sections demonstrate how the quality of scoping out of project activities has underpinned the quality of project delivery, the integrity of delivery, the reach of the project, and the effectiveness of facilitation of *Baby Makes 3* groups.
THEME 2: THE QUALITY OF PROJECT DELIVERY

This section is about the quality of the project as it relates to the skills, experience and manner in which the facilitators delivered the project including their skill in using the techniques or methods prescribed by the project, and their enthusiasm, preparedness, and attitude. It also considers the extent to which Baby Makes 3 was implemented as intended.

Answers to the following discussion points were sought:
- Project integration
- What were the kinds of problems encountered in delivering the project – were there enough resources from the beginning to do it well? Was it well managed?
- Were staff trained or educated to the right level of the project design?
- Support and motivation
- Was adequate time allocated?
- Stakeholder management (local government, MCH Managers/Coordinators, MCHNs for recruitment)
- Project champion(s)

Invitations to new parents

Baby Makes 3 was incorporated into New Parent Groups (NPGs) at each MCHS pilot site across seven LGAs. NPGs are part of usual care/standard practice offered to first-time parents. MCH determine the couple's status in terms of the mother's status as a first time parent. Therefore, some fathers who attended Baby Makes 3 did have other children but it was important that they not be excluded from attending.

It was intended that parents were first informed about Baby Makes 3 at the MCHN home visit (usually at 2 weeks post birth). Following this appointment, first-time parents received an invitation to join a NPG which included the three Baby Makes 3 sessions. The Baby Makes 3 parent information brochure was included with the invitation letter. The brochure presented Baby Makes 3 as a ‘healthy relationship’ project and listed the topics covered over the three weeks. It was an ‘opt out model’ embedded in the existing NPG program, added to the end of existing 6-week NPG programs. It was intended that the MCHN running the NPG would continue to promote Baby Makes 3 during the NPG sessions.

The Baby Makes 3 group sessions were intended as a mainstream project for all first time parents, not as a specialist therapeutic project for couples experiencing relationship strain. It was therefore not appropriate for couples in those situations to attend Baby Makes 3. By providing information about Baby Makes 3 prior, and on multiple occasions, parents had the opportunity to self-select out of the group if they didn’t think it would be helpful to them. Referral to a counselling or family violence service for those couples experiencing relationship strain was recommended by the MCHNs.

Implementation Models

It was evident that one implementation approach did not suit every MCH pilot site. The local context differed between LGAs resulting in different challenges, attendance and uptake rates between pilot sites. LGAs differ by birth rates (whether they were stable and this determined the number of NPG/Baby Makes 3 sessions), demographics of parents (e.g. CALD, age, employment), and geography (travel distance to MCH centres). One of the key project aims therefore was to identify a range of methods/approaches for implementing Baby Makes 3 in different LGA’s and demographic contexts. Whilst the effectiveness of each of these models in improving uptake of the project was not formally evaluated, success factors were monitored by the project team. These included a number of shared ‘success factors’ that were identified, such as:
• Asking parents to register
• Sending SMS reminders to parents to confirm attendance
• Planning groups in advance (6-12months) to avoid last-minute changes to dates (impacting on venue/ facilitator availability) and to ensure that parents were given enough notice i.e. Baby Makes 3 was included on the NPG invite (with 8 weeks notice), sending the message that Baby Makes 3 is part of ‘usual practice’ and to allow working parents to make arrangements to finish early
• Strategies that helped to ‘put a face to the project’, which proved to be particularly effective in increasing attendance numbers (e.g. Having a Baby Makes 3 staff member or a MCHN confident in promoting Baby Makes 3 attend the NPG)

Based on the experience of Carrington Health in delivering the Baby Makes 3 program, the following table describes the key elements for the ideal recruitment pathway to maximise attendance and enable all staff involved to deliver the program as smoothly as possible.
<table>
<thead>
<tr>
<th>Stage</th>
<th>Why/rationale</th>
<th>How/what (menu of options)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Pre-planning</strong></td>
<td>• Pre-planning <em>Baby Makes 3</em> sessions and dates well in advance (6-12 months) enables the project team/MCH to schedule dates well in advance and align without any conflicts&lt;br&gt;• Enables facilitator availability to be secured and invitations to be sent out with plenty of notice&lt;br&gt;• Venues can be booked well in advance</td>
<td>• Schedule sessions on weeknights (Tues - Thurs), avoid public holidays and Christmas/Easter holidays, local council immunisation sessions that will conflict with 2/4/6 month immunisations for babies&lt;br&gt;• Some areas may wish to run sessions on Saturday mornings to fit with dad’s work commitments</td>
</tr>
<tr>
<td><strong>2. Enough lead-in time</strong></td>
<td>• Giving new parents sufficient lead-in time and notice of the dates enables them to plan around the session times, therefore increasing the likelihood that they will commit to attending&lt;br&gt;• Also enables project team/MCH to identify early on if numbers are going to be too low for the sessions to go ahead, and mitigate accordingly (e.g. invite parents from neighbouring MCH site)&lt;br&gt;• Enables project team/MCH to organise/confirm room bookings in advance and notify parents of the location</td>
<td>• Give at least 8 weeks notice in advance of the <em>Baby Makes 3</em> sessions&lt;br&gt;• Include session dates and program information/brochure on the NPG invite&lt;br&gt;• MCHN to verbally promote the program prior, e.g. home visit/2 week/4 week/6 week appointments and early on in NPG</td>
</tr>
<tr>
<td><strong>3. Promotion at NPG</strong></td>
<td>• Promoting <em>Baby Makes 3</em> at NPGs gives parents the opportunity to ask questions and enable them to understand what they’re going to be attending&lt;br&gt;• It also gives parents enough information to opt out if they choose to do so, e.g. if they are already experiencing relationship issues&lt;br&gt;• Enables MCHN to trouble shoot with parents any logistical issues that might prevent them from attending, e.g. mum’s concerns about taking the baby out in the evening and disrupting their routine</td>
<td>• MCHN who is confident, familiar and supportive of the program to promote it at NPG - this is especially effective when the nurse speaks of other parents who really enjoyed the program, or where she helps to troubleshoot logistical issues&lt;br&gt;• Check that parents have received the information brochure, encourage them to show this to their partner&lt;br&gt;• Facilitator or project staff to attend NPGs to jointly promote the program with the MCHN&lt;br&gt;• Facilitator meeting new parents prior by co-leading Family Nights with MCHN (where they’re being run)</td>
</tr>
<tr>
<td><strong>4. Timely confirmation of numbers</strong></td>
<td>Making every effort to confirm numbers prior to the scheduled sessions enables the project team/MCH to identify early if numbers are going to be too low (e.g. &lt;6 couples) to mitigate accordingly</td>
<td>• Facilitators phoning parents prior to the session to introduce themselves&lt;br&gt;• Male facilitator phoning dads to promote the program&lt;br&gt;• SMS reminders sent to parents 1 - 2 days prior&lt;br&gt;• MCHN phoning parents to remind them of <em>Baby Makes 3</em>&lt;br&gt;• Circulating RSVP list to parents (week 3-4 of NPG)</td>
</tr>
</tbody>
</table>

Throughout all stages, it is very effective if *Baby Makes 3* is presented and spoken about as ‘usual practice’, as it normalises the program for new parents.
Facilitators and project staff agreed that it was important that they become familiar with the needs of MCH centres and NPGs in each site in advance of running the sessions, and that could only be achieved by a good partnership with the MCHNs from that site. Meeting with the NPGs parents, so as to explain the Baby Makes 3 program and answer questions about the commitment being asked of new parents were critical for facilitators who could then tailor the implementation model with a view to maximising attendance.

The effectiveness of the project implementation is discussed in more detail below in the section ‘Theme 3: Reach to the Target Audience’ and ‘Theme 4: The integrity/fidelity of project activities delivered’.

**Community of Practice**

Community of Practice forums/meetings were attended by all facilitators and the project team. The meetings had multiple purposes:

- to unpack/reinforce the key messages
- to discuss strategies and share experiences of delivering the program in a way that supported the principles
- to assess quality
- to provide peer and project support
- to share learnings
- for formative evaluation which allowed for appropriate adjustments to be made to the program.

Two Community of Practice forums were scheduled per year which and a total of five Community of Practice forums were held. Records of those meetings were circulated and used to develop new resources, adapt the facilitator training and to share with other LGAs adopting Baby Makes 3. The project team kept and circulated these records so that facilitators could refer back to them when preparing for group sessions. The regular communications and follow up by project staff after sessions and the Community of Practice were also important inputs to maintaining program quality. The Community of Practice meetings were highly valued by facilitators.

**Summary**

In summary, the quality of the project was clearly underpinned by good planning, attention to detail, continuing project support, and good record keeping. Facilitators had very good levels of support from the project team which was a key aspect of ensuring quality delivery of the project. The project team also worked closely with MCH and facilitators to try different methods to improve uptake and ensure that Baby Makes 3 was successful in their respective LGAs. These aspects of the project are highlighted frequently in the following sections.
THEME 3: REACH TO THE TARGET AUDIENCE

Process evaluation is also concerned with who a project or program reached, and the extent to which those people were the target audience for the project.

The initial target for Baby Makes 3 was 2,000 first time parents, but this was revised in May 2014 to 1,000 first time parents (Project Objective 1). This was because program funding and timeframes meant that it would not be possible to run the number of groups required to reach this original target. The target number of groups was increased from 125 groups to 137 groups at the end of 2013 to compensate for some group cancellations.

By the time the project sessions were finalised, a total of 108 groups had been reached across 7 LGAs in the EMR, with 1,305 parents attending. An additional 29 groups were scheduled but subsequently cancelled for reasons discussed below. So of the 137 groups scheduled, 21% did not go ahead. In year 1, the highest rates of cancellation were in the LGAs of Whitehorse (33%), Maroondah (29%), Knox (26%), Yarra Ranges (25%) and Manningham (23%) but when the ‘success factors’ were put in place the rates of cancellation markedly improved. The remaining two LGAs, Monash and Boroondara, had much lower cancellation rates with 5% and 6% respectively. It should be noted that not all reasons for cancellation can be avoided - unavoidable factors included low birth rates in some pilot sites, sick babies or parents, building works at some sites, and extreme weather conditions.

Table 6 illustrates the reasons cited for the cancellation of scheduled Baby Makes 3 groups and shows a range of factors that influenced decisions to cancel.
Table 6: Group Cancellations

<table>
<thead>
<tr>
<th>Reasons for group cancellations</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low birth rates - NPG cancelled</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Small NPG i.e. &lt;4 couples attending NPG</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Outcome: Baby Makes 3 group cancelled 1-2 weeks prior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expected &gt;4 couples but &lt;2 couples attended Baby Makes 3 group, therefore cancelled at session 1</td>
<td>1</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>NPG large enough but &lt;4 couples interested or able to attend</td>
<td>0</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Parents given &lt;2 weeks’ notice of Baby Makes 3</td>
<td>4</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Lack of facilitator availability (due to end of project)</td>
<td>N/A</td>
<td>N/A</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total groups cancelled</strong></td>
<td><strong>7</strong></td>
<td><strong>13</strong></td>
<td><strong>9</strong></td>
</tr>
</tbody>
</table>

Baby Makes 3 groups were cancelled if there were less than 4 couples in the new parent group, and these couples were then redirected to a neighbouring site where a Baby Makes 3 group was scheduled. There were two reasons for this:

1. Effective running of the project (to meet targets)
2. Effective running of the program (given that a quorum is required for the material to work), and to allow for drop off in attendance.

The ideal number for a session is considered to be 8-10 couples but the project would often over-register for sessions (up to 12-14 couples) to allow for drop off. In the Warrnambool project, groups proceeded if there were at least three couples attending, because of lower population demographics in rural areas, and to ensure new parents had access to Baby Makes 3.

The key sources for evaluating a couple’s experience were the post-group feedback forms and reflections of the group facilitators. The evaluation data presented below was obtained from the 108 Baby Makes 3 group projects that were conducted in the Eastern Metropolitan Region MCHS across the project period. This represents a reach of 1305 first time parents.

Retention Rates

The following table illustrates the overall retention rates for each LGA, and total retention rate for the project. Note that week 1 attendance rates have been used as the baseline data, with retention being calculated by comparing week 2 and week 3 attendance to week 1.
The Baby Makes 3 Steering Committee were aiming for a retention rate of 70%, therefore this target has been exceeded with an overall retention rate of 74%. This is a pleasing outcome for the project, as feedback from MCH indicates that 70% retention at NPGs is considered to be good, given the high number of variables that affect attendance by parents with newborn babies at either NPG or Baby Makes 3.

Effectiveness of using MCHNs to recruit parents into Baby Makes 3

Carrington Health made the decision to integrate Baby Makes 3 into the local MCH, as this service is a universal primary care service for Victorian families with children from birth to school age. All new births are referred to MCH, with 100% of new babies and parents receiving a home visit from a MCHN in 2013-14, 97.2% of new parents attending a MCH centre at 2 weeks, 97.3% at 4 weeks and 96% at 8 weeks. This means that contact regarding Baby Makes 3 should be possible with almost all new parents – there are no other services that would have this high level of contact with first-time parents. It was these rates of contact with new parents that were used to determine the target rates of participation for Baby Makes 3.

Baby Makes 3 was embedded in the New Parent Groups, which new parents typically start attending when their baby is 4-6 weeks old. Because Baby Makes 3 started after 6 weeks of NPG session, this means that by the time the new parents start Baby Makes 3, their babies could be 2 – 4 months old. This timescale did sometimes have a negative impact on the attendance of parents at the first Baby Makes 3 session, because not all new parents attend their NPG group every week, and some drop out completely. The parents who had already dropped out of their NPG were therefore far less likely to attend the Baby Makes 3 program. This was particularly noticeable with first generation migrants, single and teenage parents.

### TABLE 7 - RETENTION RATES

<table>
<thead>
<tr>
<th>LGA</th>
<th>Week 1 attendance #</th>
<th>Week 2 retention rate</th>
<th>Week 3 retention rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monash</td>
<td>151</td>
<td>93%</td>
<td>77%</td>
</tr>
<tr>
<td>Knox</td>
<td>186</td>
<td>81%</td>
<td>69%</td>
</tr>
<tr>
<td>Boroondara</td>
<td>89</td>
<td>82%</td>
<td>65%</td>
</tr>
<tr>
<td>Whitehorse</td>
<td>81</td>
<td>93%</td>
<td>67%</td>
</tr>
<tr>
<td>Yarra Ranges</td>
<td>54</td>
<td>83%</td>
<td>74%</td>
</tr>
<tr>
<td>Maroondah</td>
<td>62</td>
<td>65%</td>
<td>60%</td>
</tr>
<tr>
<td>Manningham</td>
<td>66</td>
<td>67%</td>
<td>64%</td>
</tr>
<tr>
<td>TOTAL FOR EMR</td>
<td>1227</td>
<td>80%</td>
<td>68%</td>
</tr>
</tbody>
</table>

Overall retention rate is 74%

---

One MCH Coordinator commented that:

“I believe the focus on gender equity and discussions to promote respectful relationships between men and women is very timely when couples have their first child. This is a time when they are very focused on the best outcomes for their child. The MCH service is well placed to promote these important messages and recruit couples due to the Victorian legislation on Birth Notifications. Providing the sessions as a “usual” part of the First Parent Groups at the MCH Centres was a key to success. The visit from a Facilitator was helpful in engaging the families.”

The dependence in the current Baby Makes 3 model, on MCHNs to recruit first time parents into the project was not always successful. Written information was provide to MCHNs at pilot sites but this was not always sufficient to engage them. Baby Makes 3 project staff found that visiting the MCHNs worked better at building a sense of partnership between MCHS and the Baby Makes 3 project, as they could talk through the specifics of the project for that site and develop a more effective relationship by meeting face to face.

The effectiveness of MCH nurses in recruiting participants came down to the engagement of individual nurses with Baby Makes 3, their confidence, their support for Baby Makes 3, and the quality of rapport they had with new parents on which to draw. Some MCHNs who were not familiar with the content of the Baby Makes 3 project seemed to lack confidence in encouraging new parents to attend, whilst others simply forgot to mention the project during appointments and new parent groups. One of the key learnings from this project is that the nurses’ familiarity with and understanding of the program and their enthusiasm for it was a key to their promotion of the program to new parents. The success of recruiting parents was highly dependant on the level of engagement of the MCHN with the program, i.e. did they feel confident to promote Baby Makes 3? Were they familiar enough with the program, given that it’s difficult to promote something that you don’t understand? It was critical that MCHNs were advocates for the program and the level of enthusiasm and personal promotion offered by MCHNs had a direct impact on parent’s decision as to whether or not they would attend.

A theme from the feedback from MCH Coordinators did relate to the challenge of training all the MCH nurses about the program, as they felt that each nurse must have a good understanding of the program to participate in either a recruitment/promotion or facilitator role. However, they stated that thorough planning with the MCH program and communication with the project team reduced any challenges to a manageable level.

Other issues with MCHS included:

- Invitations not being sent out;
- Invitations being sent out with the wrong dates; and
- A lack of communication about Baby Makes 3 during the NPG sessions which affected uptake.

In order to mitigate against these issues, a range of new measures were put into place by the Baby Makes 3 project team. These included:

- Publication of a flowchart detailing the invitation process;
- Group schedules being regularly circulated and updated for each council;
- Appointing a single MCH contact person being responsible for sending and checking invitations
- Gaining agreement for Baby Makes 3 staff to attend NPGs to introduce the program directly to parents.

In the areas where there was a clear lack of uptake into the Baby Makes 3 groups, the Project Manager or Project Officer started attending NPGs in person to promote the program directly to new parents. MCH Coordinators also acknowledged that some nurses did not know how to do promote the program, or felt
uncomfortable promoting it to the NPG, but this was improved when the project team started visiting the NPGs to ‘spruik the course’.

It was evident in some of these sessions that not all the MCHNs were actively engaging with the NPG when the project team were there. This meant that the nurse was not always demonstrating their support for the Baby Makes 3 project, or observing how the project team introduced the project with a view to learning about it. However, this was more the anomaly than the norm. In the majority of cases the MCHNs were very engaged and supportive of Baby Makes 3, effectively ‘co-promoting’ the program and using their rapport with the parents to encourage them to attend. An example of this was when new mothers expressed concerns around the viability of attending Baby Makes 3 sessions because of the disruption to baby’s evening routines, these MCHNs often proactively helped to problem solve with the mothers about getting there, reassuring them and offering tips to manage with the baby whilst attending the three nights. They also assisted with negotiations relating to the timing of the sessions and room availability.

It is clear from the experience of the Baby Makes 3 project team that the relationship-building aspect with MCHNs is critical to the effectiveness of recruitment of new parents into Baby Makes 3. Where relationships between the project team and MCHN were not strong, or in fact negative, there was a noticeable impact on the recruitment of parents. Some MCHS Coordinators showed resistance to the project at first, often due to competing demands on their time or a lack of awareness/understanding of the project. Significant partnership work was required to engage them and develop their enthusiasm for it. The power of using MCHN ‘champions’ for the project was also evident, and the team observed that some of the nurses came on board after these champions for the project talked about their experiences and support for Baby Makes 3. These MCHN champions then worked with the resistors in the MCHN team, and were proactive in working with the project team to improve support amongst MCHNs.

In summary, there were varying degrees of stakeholder engagement required with different LGAs to garner effective support for Baby Makes 3. With some LGAs, this required 12 months or more of partnership building to develop the relationships required to get the project running effectively. This issue is tied to the readiness of the organisation to embed Baby Makes 3. As part of the project set-up and planning, it is clearly important to assess the readiness of the LGA to embed Baby Makes 3 into their service.

Despite these issues, there are clear benefits to MCHS being the primary and key referral source for participants into Baby Makes 3. However, Carrington Health believe that there is also merit in other/additional referral sources to extend the reach of the program, especially given that parents from CALD backgrounds, teenage mothers and GBLTIQ for example can be harder to reach. This could include some family services or enhanced parenting projects that sit around MCHS, and hospital antenatal parenting projects/programs. However, many hospitals in Melbourne charge a fee for parents to attend antenatal parenting projects/programs, so they will not reach those who cannot pay to attend antenatal classes.

MCH Coordinators who provided feedback to Keleher Consulting were all in agreement that the Baby Makes 3 program has increased their engagement with new parents and provided ‘added value’ to the MCH framework. Comments included:

“Baby Makes 3 is very helpful for new parents as it helps them understand how to communicate respectfully in a non-confrontational way. It is non-stigmatising...We would recommend Baby Makes 3, as participants reported they enjoyed and benefited from the opportunity to jointly hear about and discuss these issues together."
“Baby Makes 3 has given first time parents an opportunity to strengthen and reassess their relationships after the birth of their baby. It gave clients the opportunity to improve their quality of relationship, hence their parenting. It has provided a way for dads to feel more a part of the MCH service and have the experience of being part of a group that is appropriate to their circumstances. Further, it has provided ongoing connections for the dads and families who attended. It has provided skills for the MCH nurse involved as a facilitator and indirectly improved the skills of the other staff.”

Experience of Warrnambool project

The Baby Makes 3 project team in the Great South Coast region experienced different challenges with regards to recruitment of parents into the project. Several of the rural LGAs that participated had very low birth rates – often only 3 or 4 births per year and not all necessarily to new parents. They were also less willing to travel long distances to attend Baby Makes 3 sessions in nearby areas, particularly at night. This does raise the question as to how Baby Makes 3 could be adapted, or how else the key messages from Baby Makes 3 could be presented, to reach parents more effectively in rural areas.

The Warrnambool project manager had prior relationships with the MCH services. He found this assisted with MCHN support of the project and their willingness to promote new parents to attend Baby Makes 3. However, the Warrnambool project observed a significant drop off between invitations being sent out to new parents and their actual attendance – this pattern was consistent across all LGAs. One factor that caused this was noted to be where the MCHN had a neutral or less supportive view of the Baby Makes 3 project. In order to mitigate the drop off rates, the Warrnambool Project Manager started attending NPGs in person to introduce himself and the Baby Makes 3 project. He would also collect mobile numbers and SMS the parents afterwards. Similar to the EMR project, this method did improve uptake in the majority of LGAs.

Summary

In summary, the Baby Makes 3 project was very successful in reaching the intended audience. The team adapted strategies as the project unfolded and worked closely with MCH wherever possible, to ensure engagement with new parents in order to maximise their attendance and participation in Baby Makes 3 sessions. The project reached 1305 new parents and achieved a retention rate of 74%.
THEME 4: THE INTEGRITY/FIDELITY OF PROJECT ACTIVITIES DELIVERED

Program integrity is about how well the program was delivered as it was planned. Process evaluation includes integrity data which contributes to the internal validity of Baby Makes 3. In other words, fidelity refers to the extent to which the delivery of a program conforms to program manuals and guidelines for implementation. A high-fidelity intervention is one that is delivered as intended, making allowance for adaptation for the specific needs of particular groups. A low-fidelity program is one that is delivered quite differently to the intentions of the program materials.

The section assesses the extent of adherence by facilitators to the Baby Makes 3 project content as it was presented in the program guides and other materials, and whether:

- All core components of the project were delivered
- The number of sessions were implemented as planned, and the content was delivered according to the Group Program Manual
- New parent participants were asked to rate the content
- The locations and logistics of project delivery were appropriately conducted.

**Delivery of Baby Makes 3 core components**

All facilitators reported that in all of their sessions, they followed the Group Program Manual that set out the detailed contents for each session, with handouts and powerpoint slides, and found them very clear in their intent and able to be presented as written. All facilitators agreed that they followed the project materials faithfully and were able to maintain the integrity of the content.

The project team closely monitored not only the quality of project implementation but also the fidelity of the delivery of content. Given that the group dynamics varied depending on how many couples were in attendance (which could vary from 3-4 couples, to 8-9 couples), it was important that facilitators were given the skills to tweak the program where circumstances required it. This was also sometimes necessary to cater for diversity in the group such as single mothers, same sex couples or parents from CALD backgrounds), without undermining the delivery of the program material.

High level facilitator skills were identified as very important for effective facilitation, and several facilitators commented that whilst ‘going to uncomfortable conversations’ was initially a difficult aspect of the program delivery, it was a very important one as these were often the conversations that resulted in ‘light-bulb moments’ for new parents. Given that an objective of the Baby Makes 3 program is to influence attitudinal change, this was a critical aspect. Bringing the group back to a comfortable place after these more difficult conversations was also a skill that the facilitators agreed became easier with practice. Facilitator skills is discussed in further detail in the next section, ‘Theme 5: Skills, experience and credentials of facilitators’.

As mentioned earlier, a key focus of the Community of Practice meetings was to unpack and reinforce the core messages of Baby Makes 3 and allow facilitators to share their experiences of delivering the program in a way that support the principles of the program material. Therefore, the Community of Practice for facilitators was key to a successful implementation model. Whilst attendance at Community of Practice meetings was part of the job description for facilitators, and they were paid to attend, facilitators all commented that they enjoyed the support of the Community of Practice and found it very beneficial to their roles and performance. For Carrington Health, these meetings were a worthwhile investment and there was consistently good attendance.
The Community of Practice was one key activity for program fidelity. Other activities included:

- Observations of practice during training and at groups by the project manager with feedback provided
- Reflective activities at the Community of Practice meetings
- Feedback between facilitators which was recorded on evaluation forms and returned to the Project Manager
- Informal/incidental feedback
- Mentoring between facilitators about their experiences, male facilitators catching up outside Baby Makes 3 to share experience of delivering the program
- Resources such as the Training DVD which was given to each facilitator to use as a refresher.

The Project Manager for Carrington Health also put in significant effort to ensure that facilitators were delivering the program as it was presented in the Program Manual. The Project Manager provided extensive resource-intensive support to facilitators to ensure the project sessions were delivered effectively, smoothly and with integrity. The Project team also checked in with facilitators before, during after each group to capture timely feedback on what went well and what could have been improved.

For Baby Makes 3 to be rolled out on a larger scale in Victoria, these quality assurance processes will need to be adapted as necessary, particularly to the project’s implementation across large geographical areas. The facilitators also commented on how they built their skills and become more proficient as they delivered more sessions.

The Community of Practice for facilitators in the Warrnambool project experienced different challenges relevant to a rural setting. It was difficult for the Warrnambool Project Manager to catch up with facilitators as frequently as he would have liked, as he had a large pool spread across an expansive geographical area. Therefore it was harder to bring people together, and more expensive as it was necessary to pay travel time to facilitators.

Results of project evaluation forms

A ‘Group Project Evaluation Form’ was given to parents who attended week 3 of Baby Makes 3. This Form asks parents to rate their level of agreement with the statements that Baby Makes 3 was enjoyable, relevant and helpful. Their responses are summarised in Table 8. Most participants either agreed or strongly agreed that the program was enjoyable, relevant and helpful with the female participants only slightly more likely to agree with these statements than male participants. Parent responses were also used as a measure for monitoring the quality of delivery of the program.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Mums</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Baby Makes 3 group was enjoyable</td>
<td></td>
<td>&lt;1%</td>
<td>3%</td>
<td>51%</td>
<td>44%</td>
</tr>
<tr>
<td>Dads</td>
<td>&lt;1%</td>
<td>&lt;1%</td>
<td>5%</td>
<td>59%</td>
<td>35%</td>
</tr>
<tr>
<td>The Baby Makes 3 group was relevant to my situation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mums</td>
<td>2%</td>
<td>1%</td>
<td>8%</td>
<td>44%</td>
<td>45%</td>
</tr>
<tr>
<td>Dads</td>
<td>1%</td>
<td>&lt;1%</td>
<td>10%</td>
<td>52%</td>
<td>36%</td>
</tr>
<tr>
<td>The Baby Makes 3 group was helpful</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mums</td>
<td>1%</td>
<td>1%</td>
<td>6%</td>
<td>53%</td>
<td>39%</td>
</tr>
<tr>
<td>Dads</td>
<td>1%</td>
<td>&lt;1%</td>
<td>8%</td>
<td>57%</td>
<td>34%</td>
</tr>
</tbody>
</table>
The parents were also asked to rate the program overall. Over 76% of mums and 81% of dads rated the project either ‘very good’ or ‘excellent’. Their responses are summarised in Table 8 below.

<table>
<thead>
<tr>
<th>Participants</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mums</td>
<td>&lt;1%</td>
<td>3%</td>
<td>20%</td>
<td>42%</td>
<td>34%</td>
</tr>
<tr>
<td>Dads</td>
<td>&lt;1%</td>
<td>3%</td>
<td>15%</td>
<td>47%</td>
<td>34%</td>
</tr>
</tbody>
</table>

Assessment of parents’ responses to the question “what are the 3 main things you learned from Baby Makes 3?”

As part of QA monitoring, and to ensure that the program was being delivered as intended, parents were asked the question, ‘What are the three main things you learned from Baby Makes 3’? Results provided here are a monitoring measure of how well the facilitators were imparting the key messages of the program. A thematic analysis of 1197 responses was collected from 399 parents, matched against the key messages of Baby Makes 3. The responses were grouped under nine categories of:

- change
- communication
- conflict
- dad + baby
- equality
- expectations
- intimacy
- relationship and
- respect.

All nine of the pre-identified key messages of the Baby Makes 3 program are reflected in the themes of the parent’s responses, with ‘change’ and ‘respect’ being the most common responses. Dads responded more than twice the rate of mums for ‘respect’ and ‘dad+baby’ categories.

The ‘Group Project Evaluation Form’ also asked parents to describe this program to another person who was thinking of doing it and to make comments about what they would say. The main themes that emerged from these comments were:

- A perception that the program was worthwhile
- The program provides insights
- The program improves the parent’s relationship e.g. provides tools, opens up discussions at home
- It was beneficial to share with others going through similar experiences
- The program provided an opportunity for dads to meet with other new dads.

This analysis was used as a quality assurance measure to monitor the key messages of Baby Makes 3. It suggested that:

- Facilitators had been well trained
- Facilitators were getting the key messages across
- Participants were receiving the key messages of Baby Makes 3.
Summary

In summary, the good record-keeping throughout the project has facilitated the learnings through this process evaluation and demonstrated that the *Baby Makes 3* project was delivered with integrity and fidelity. The facilitators were well trained and proficient, and able to get the key messages of *Baby Makes 3* to the target audience, whose feedback also demonstrated that they received the key messages of *Baby Makes 3*. 
THEME 5: SKILLS, EXPERIENCE AND CREDENTIALS OF FACILITATORS

The recruitment and training of facilitators was managed centrally by Carrington Health which was required to obtain a VCAT exemption to allow the recruitment of equal numbers of male and female group facilitators. Initial recruitment was via an expression of interest process, with 37 interviews conducted. The recruitment of facilitators was a collaborative process with the VicHealth funded Monash City Council and MonashLink Community Health Service ‘Generating Equality and Respect’ (GEAR) project. The position description, interview questions and scoring matrix, and interview panels were conducted jointly.

The position description for the appointment of facilitators was developed with selection criteria, and was explicit in describing the project from a gender equity perspective. A three step process was then used to identify suitable candidates:

1. Expression of Interest (via a phone call with the Project Manager) - note that the candidate's facilitation experience and familiarity of gender equality issues was informally discussed at this point
2. Written application
3. Interview

17 facilitators were initially recruited for Baby Makes 3 with a further six facilitators recruited 12-18 months into the project to backfill some facilitators who left the program due to natural staff attrition. The average employment period for a facilitator was about eighteen months, necessitating a rolling program of recruitment and training.

The 17 facilitators hired at the beginning of the program, combined with the facilitators from Warrnambool attended a 2-day training workshop provided by the project staff from both EMR and Warrnambool (who had been previously trained by David Digapony, the developer of the Baby Makes 3 program) The purpose of the training was to introduce facilitators to the Baby Makes 3 project using the facilitator's training program manual, enable them to develop confidence in their delivery and ensure quality would be maintained, and provide direction for the administrative tasks for which the facilitators were responsible.

Carrington Health was also responsible for facilitator supervision and professional development of their competence through group observation, feedback mechanisms and community of practice meetings. As the recruiter, Carrington Health had the authority to monitor the performance of facilitators and terminate their contracts if they weren’t doing a satisfactory job. This was one reason why Carrington Health chose to use a ‘contractor model’ for the employment of facilitators.

Key skills for facilitators

Key skills that have been identified as essential to the facilitator role include:

- A sound understanding of gender equity, roles and norms. It was also important that facilitators reflected gender equity during training and with their co-facilitator when delivering groups.
- A high level of facilitation skills - experience as a facilitator was key to ensure that their delivery was confident. Facilitation skills as distinct from didactic teaching skills. This was explored during the interview to gauge if they were aware of the difference.
- Initiative and problem solving skills – this was particularly relevant for managing logistics and issues that may arise at sessions that were conducted after hours
- Given that the language in the current program manual is hetero/nuclear family, facilitators needed the ability to adapt the content and adjust the language of the program when required, for example when single mothers or LBGTQI parents were in the group.
It is important to note that whilst the *Baby Makes 3* program was designed to be inclusive, the language in the program manual is hetero-normative, tailored for couples and reflective of a western view of family. This is addressed during the training and future iterations of the program manual will be updated accordingly.

All respondents to the process evaluation affirmed that the gender balance of facilitators is essential for the delivery. Not only do they bring complementary perspectives to the program, its an opportunity to reflect gender equality, and the involvement of a male facilitator is considered to be critical for engagement of new fathers.

One issue that arose consistently across all LGAs in relation to the recruitment of facilitators was where the MCH Coordinators requested that their staff (MCH nurses) be trained as facilitators. In this instance, the MCHN were still required to go through the formal recruitment process (as described above). Sensitivities around recruitment arose when the MCH services asked their staff to apply. If those staff were not appointed, the partnership with the MCH and this nurses promotion of the program to parents was at risk. To ensure that facilitators selection was unbiased and transparent, an external person (non-MCH) was included on interview panels.

The Warrnambool project used a different method to Carrington Health to recruit facilitators for *Baby Makes 3*. They initially recruited a pool of 22 facilitators, and the Project Manager then allocated them to different sessions and locations. There were positives and negatives to this approach. It meant that all facilitators were trained at once, there was always an available facilitator to run a session even at the last minute if someone had called in sick. The downside was that they had a number of facilitators who completed the training but didn’t deliver as many sessions as they would have liked. Their confidence may also have been affected by the delay between training and being offered sessions to facilitate. Two of the facilitators in Warrnambool were also MCHNs, and whilst they didn’t actually deliver any *Baby Makes 3* sessions, it did ensure they had a good knowledge of *Baby Makes 3* and were therefore very supportive in recruiting new parents.

The project team noted that *Baby Makes 3* facilitators also make good facilitators for other gender equity programs because of their transferable skills. Examples could include gender equity training in workplaces or respectful relationship programs in schools. There is certainly an opportunity to build up a pool of facilitators who are skilled in delivering programs targeted at the prevention of violence against women.

When asked how the management and employment of facilitators could be scaled up, the idea of a regional pool of facilitators was supported, employed either by a regional organisation, peak body of Local Government or an NGO. Facilitators made the point that consideration needs to be given to the costs of travel for facilitators so appointing facilitators who live locally to the project sites is practical.

### Summary

In summary, the *Baby Makes 3* project recognised the importance of selecting facilitators on the basis of identified competencies. The project team also recognised the need to provide ongoing support and development for facilitators to continue to build their skills through the Community of Practice meetings and providing skill-building communications to facilitators during the life of the project. The facilitators themselves were enthusiastic and committed to the project, and were thoughtful in their efforts to engage new parents, particularly new fathers. The combination of these efforts undoubtedly contributed to the success of the project in reaching its target audience and in the positive participant evaluations.
THEME 6: EXTERNAL FACTORS THAT INFLUENCED PROJECT DELIVERY

There were a range of factors that influenced the delivery of Baby Makes 3 sessions, some of which were unavoidable and others which were subsequently addressed throughout the course of the project. Unavoidable factors included low birth rates in some pilot sites, sick babies or parents, building works at some sites, and extreme weather conditions. Factors which were addressed during the course of the project in order to mitigate impact included facilitator turnover, scheduling (such as avoiding public holidays or less than two weeks notice being given of the scheduling of the program, gaps of overlap between NPG and Baby Makes 3), and low levels of engagement with Baby Makes 3 by some MCHNs.

Baby Makes 3 sessions were typically run in the same building as NPGs which are run on weekdays. In some cases the MCH centres were too small to accommodate a Baby Makes 3 group, so Baby Makes 3 was held elsewhere, which did seem to impact adversely on attendance.

Project staff and facilitators proved nimble in their responses to these factors. Sessions were relocated as necessary, and new facilitators recruited and trained to increase the pool of facilitators to give greater flexibility. Little can be done about inclement weather but there were suggestions that sessions be conducted on Saturday mornings rather than winter evenings.

Because the Baby Makes 3 sessions took place in the evenings, parents were promised a light meal or supper at some sites, which facilitators were required to organise. The provision of food during the Baby Makes 3 sessions was an anticipated administrative burden for facilitators and stretched their time and resources were stretched. One pair of facilitators cooked food at home to minimise costs (although this was discouraged), others ordered takeaway pizzas (where the budget allowed). Trying the balance the expense of providing dinner with keeping the project affordable was challenging - this was discussed and brainstormed during facilitator training and during Community of Practice meetings.

Summary

In summary, there were a range of factors that influenced the delivery of Baby Makes 3, many of which were unavoidable and others that were subsequently addressed throughout the life of the project to mitigate their impact. There were some logistical aspects of the program will need greater consideration if scaling up the Baby Makes 3 program to ensure the implementation is practical and feasible.
CONCLUSION

The process by which Carrington Health delivered the Baby Makes 3 project has been evaluated as very effective and thorough. The project was very well scoped and recorded in a variety of project documents including the project plan, reports to DJR, and project newsletters/communiques. The quality of scoping out of project activities has underpinned the quality of project delivery, the integrity of delivery, the reach of the project, and the effectiveness of facilitation of Baby Makes 3 groups.

The project was clearly underpinned by good planning, attention to detail, continuing project support, and good record keeping. Facilitators had very good levels of support from the project team which was a key aspect of ensuring quality delivery of the project. The project team also worked closely with MCH and facilitators to try different methods to improve uptake and ensure that Baby Makes 3 was successful in their respective LGAs.

This has also facilitated the learnings through this process evaluation and demonstrated that the Baby Makes 3 project was delivered with integrity and fidelity. The facilitators were well trained and proficient, and able to get the key messages of Baby Makes 3 to the target audience, whose feedback also demonstrated that they received the key messages of Baby Makes 3.

The Baby Makes 3 project was also very successful in reaching the intended audience. The team adapted strategies as the project unfolded and worked closely with MCH wherever possible, to ensure engagement with new parents in order to maximise their attendance and participation in Baby Makes 3 sessions. The program was delivered to 1305 new parents and achieved a retention rate of 74%, both of which exceed the targets set by the Steering Committee.

Carrington Health recognised the importance of selecting facilitators on the basis of identified competencies. The project team also recognised the need to provide ongoing support and development for facilitators to continue to build their skills through the Community of Practice meetings and providing skill-building communications to facilitators during the life of the project. The facilitators themselves were enthusiastic and committed to the project, and were thoughtful in their efforts to engage new parents, particularly new fathers. The combination of these efforts undoubtedly contributed to the success of the project in reaching its target audience and in the positive participant evaluations.

There were some factors which impacted on the delivery of Baby Makes 3, many of which were unavoidable and others that were subsequently addressed throughout the life of the project to mitigate their impact. There were some logistical aspects of the program will need greater consideration if scaling up the Baby Makes 3 program to ensure the implementation is practical and feasible.

Key learnings from this process evaluation are:

- There is a significant amount of coordination time required to deliver Baby Makes 3 effectively, particularly with regards to promotion, operational planning, building readiness into the MCH service, quality assurance and maintaining partnerships.
- The importance of both having the right people as facilitators, and having quality assurance measures in place - particularly given that poor delivery could potentially do harm to vulnerable parents, not just have a neutral effect.
- Baby Makes 3 needs a ‘whole of setting approach’ - it is far more effective when key messages from the program are valued and reinforced by the MCH setting, rather than delivered in isolation across the 3 weeks.
The evaluation has also reinforced the following aspects of Carrington Health’s delivery model:

- The program must be delivered by both a male and female facilitator
- Training for facilitators needs to be delivered over two days (rather than condensed into one), as the role play activities on Day 2 are crucial for building confidence and quality assurance
- The value of the Community of Practice meetings, for learning, troubleshooting and improving delivery of the program.
- The value of using MCH as a key referral source for new parents. It is recognised that there are limitations on reach if the project is solely relying on MCH for recruitment, however given the rates of contact between new parents and MCH in the early months of a baby’s birth, they should continue to be a main referral source.
- There are both pros and cons to using MCHN as facilitators. The most important aspect for all facilitators is that they have the right skills to deliver Baby Makes 3.

Overall, the Baby Makes 3 project has been delivered very effectively. Carrington Health has implemented the program across the EMR catchment, adapting to a range of variables where necessary whilst still ensuring that the program content and messages were received by the new parents who participated.
APPENDIX 1: LIST OF BABY MAKES 3 PROJECT MATERIALS

The following is a list of all program materials used to deliver Baby Makes 3:

4. Baby Makes 3 Training DVD
5. Parent Invitation Letter – template
6. Site Checklist
7. Baby Makes 3 Group Equipment List
8. Counselling Services Handout
9. Frequently Asked Questions Handout
10. Parent Registration Form
11. After-Hours Guideline
12. Parent Information Brochure

The following key documents and reports were produced over the course of the Baby Makes 3 program delivery:

1. Annual and Progress Reports to DJR
2. Interim Evaluation Report – May 2014
4. Project Communiques # 1 July 2013
5. Project Communiques # 2 Oct 2013
6. Project Communiques # 3 June 2014
7. Project Communiques # 4 Feb 2015
8. Project Communiques # 5 Sept 2015
9. Community of Practice # 1 Meeting Notes – Dec 2013
10. Community of Practice # 2 Meeting Notes – May 2014
11. Community of Practice # 3 Meeting Notes – Sept 2014
12. Community of Practice # 4 Meeting Notes – Dec 2014
13. Community of Practice # 5 Meeting Notes – July 2015
14. Steering Committee Meeting Minutes – Sept 2013
15. Steering Committee Meeting Minutes – Dec 2013
16. Steering Committee Meeting Minutes – May 2014
17. Steering Committee Meeting Minutes – Sept 2014
18. Steering Committee Meeting Minutes – Nov 2014
19. Steering Committee Meeting Minutes – Feb 2015
20. Steering Committee Meeting Minutes – July 2015
Pre-group Questionnaire

We are keen to evaluate the effectiveness of the Baby Makes 3 program. To help us do this, we would like you to complete this questionnaire. We will repeat this questionnaire after the end of the program.
To help us see if there have been any changes please write your date and month of your birth (not the year) below. This will allow us to match your pre and post responses.

**My date of birth:** (day) (month)  
I am a ☐ mum ☐ dad

**Place where BM3 program held**  
Today's date __________

### Attitudes towards parenting - please indicate (✓) whether you agree or disagree with the following statements

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>With the exception of birthing and breastfeeding, a father can do everything that a mother can do</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>2</td>
<td>The parent who stays home to care for the children should also be responsible for the housework</td>
<td>☐</td>
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<tr>
<td>3</td>
<td>Mothers are more nurturing than fathers</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>4</td>
<td>Gender equality is an important part of a healthy relationship</td>
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<tr>
<td>5</td>
<td>It is more important for a mother than a father to stay at home and care for an infant</td>
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<tr>
<td>6</td>
<td>The most important role a father can play is to be a 'breadwinner'</td>
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</tbody>
</table>

### Who does what at home? - Please indicate (✓) who does the following activities...

<table>
<thead>
<tr>
<th></th>
<th>Always Mum</th>
<th>Mostly Mum</th>
<th>More Mum than Dad</th>
<th>Shared equally</th>
<th>More Dad than Mum</th>
<th>Mostly Dad</th>
<th>Always Dad</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Caring for infants</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>1 Childcare activities such as changing nappies, dressing, bathing, feeding etc...</td>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td><strong>Nurturing infants</strong></td>
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<td>2 Nurturing activities such as soothing, comforting, responding to crying, etc...</td>
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<td>☐</td>
<td>☐</td>
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<tr>
<td><strong>Physical activities</strong></td>
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<td>3 Activities such as playing with child, taking for a walk in the pram, creative interaction, etc...</td>
<td>☐</td>
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<tr>
<td><strong>Breadwinner</strong></td>
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<td>4 Providing an income etc...</td>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td><strong>Provider</strong></td>
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<td>5 Activities such as grocery shopping, clothes shopping etc...</td>
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<td>☐</td>
<td>☐</td>
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<tr>
<td><strong>Housework</strong></td>
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</tr>
<tr>
<td>6a Housework activities such as cleaning, tidying, washing up, washing, etc...</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>6b Kitchen duties such as planning and cooking meals etc...</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td><strong>Managing the household</strong></td>
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<tr>
<td>7 Activities such as paying bills, organising family/social activities, appointments, decision making, etc...</td>
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<td>☐</td>
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</table>

Please turn over...
This section asks about your wellbeing. Please read each item and place a tick in the box under the reply which comes closest to how you have been feeling in the past week. Don’t take too long over your replies: your immediate reaction to each item will probably be more accurate than a long thought out response.

<table>
<thead>
<tr>
<th>I feel tense or 'wound up':</th>
<th>Most of the time</th>
<th>A lot of the time</th>
<th>From time to time, occasionally</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
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<td>☐</td>
<td>☐</td>
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</table>

<table>
<thead>
<tr>
<th>I still enjoy the things i used to enjoy:</th>
<th>Definitely as much</th>
<th>Not quite so much</th>
<th>Only a little</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>I get a sort of frightened feeling as if something awful is about to happen:</th>
<th>Very definitely and quite badly</th>
<th>Yes, but not too badly</th>
<th>A little, but it doesn’t worry me</th>
<th>Not at all</th>
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<tbody>
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<table>
<thead>
<tr>
<th>I can laugh and see the funny side of things:</th>
<th>As much as i always could</th>
<th>Not quite so much now</th>
<th>Definitely not so much now</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Worrying thoughts go through my mind:</th>
<th>A great deal of the time</th>
<th>A lot of the time</th>
<th>From time to time, but not too often</th>
<th>Only occasionally</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>☐</td>
<td>☐</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>I feel cheerful:</th>
<th>Not at all</th>
<th>Not often</th>
<th>Sometimes</th>
<th>Most of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I can sit at ease and feel relaxed:</th>
<th>Definitely</th>
<th>Usually</th>
<th>Not often</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>☐</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>I feel as if i am slowed down:</th>
<th>Nearly all the time</th>
<th>Very often</th>
<th>Sometimes</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
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<td>☐</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>I get a sort of frightened feeling like 'butterflies' in the stomach:</th>
<th>Not at all</th>
<th>Occasionally</th>
<th>Quite often</th>
<th>Very often</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>I have lost interest in my appearance:</th>
<th>Definitely</th>
<th>I don’t take as much care as i should</th>
<th>I may not take quite as much care</th>
<th>I take just as much care as ever</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>I look forward with enjoyment to things:</th>
<th>As much as ever</th>
<th>Rather less than i used to</th>
<th>Definitely less than i used to</th>
<th>Hardly at all</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>I get sudden feelings of panic:</th>
<th>Very much indeed</th>
<th>Quite often</th>
<th>Not very much</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
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<td>☐</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>I can enjoy a good book or radio or tv program:</th>
<th>Often</th>
<th>Sometimes</th>
<th>Not often</th>
<th>Very seldom</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I feel restless as if i have to be on the move:</th>
<th>Very much indeed</th>
<th>Quite a lot</th>
<th>Not very much</th>
<th>Not at all</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
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<td>☐</td>
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</tbody>
</table>

Thank you.
Group Program Evaluation Form

1. I am a: □ mum □ dad Today’s date _______________ Venue _______________

Please indicate (✓) whether you agree or disagree with the following statements ...

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. The Baby Makes 3 Group Program was enjoyable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. The Baby Makes 3 Group Program was relevant to my situation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. The Baby Makes 3 Group Program was helpful</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. The three main things I have learned from this program are:

6. How would you describe this program to another person who was thinking of doing it?

7. Any additional comments?

8. How would you rate the program overall?
   □ poor         □ fair         □ good         □ very good  □ excellent

Thank you!

VERSION 15/6/2013