A solid start for the Dutch first thousand days-approach: insights into program adoption, monitoring and cross-sectoral collaboration

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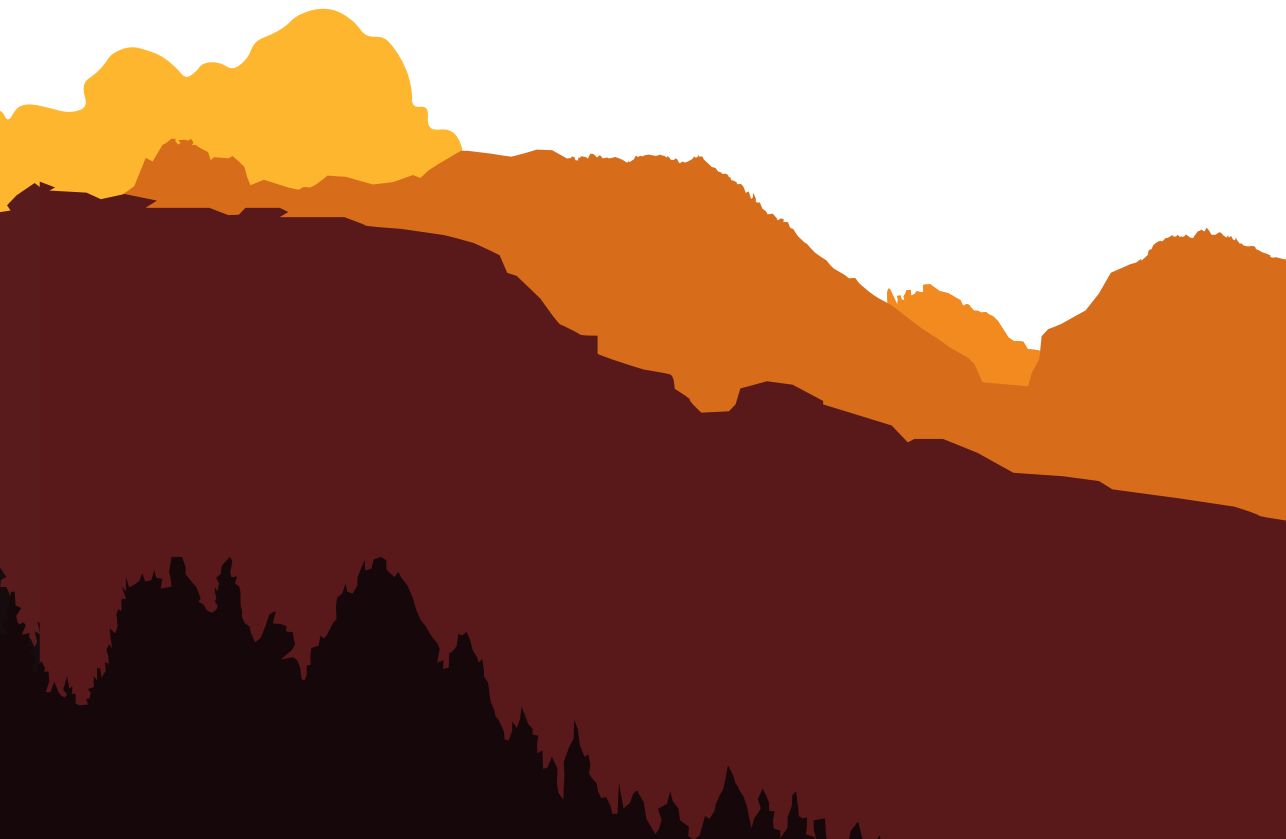

SUMMARY

In 2018, the nationwide action program Solid Start was launched by the Dutch Ministry of Health, Welfare and Sport, aiming to ensure the best possible start for all children during the first thousand days of life. The 'first thousand days' refer to the period from conception to a child's second birthday, which lays the foundation for health and wellbeing in later life and across generations. Children's development and opportunities during this period are influenced by medical factors, but also strongly depend on social risk and protective factors. Addressing health inequities and vulnerability in early life therefore requires integrated and preventive approaches which prioritize collaboration across the medical and social sector. The action program Solid Start promotes cross-sectoral collaboration and focuses particularly on (future) parents and children in vulnerable situations. Since 2019, the National Institute for Public Health and the Environment has been commissioned to monitor the action program Solid Start. This thesis forms the scientific basis of the monitor.

In **Chapter 1**, the rationale, context and aims of this thesis are described in more detail. The main objective of this thesis was to provide insight into the adoption of the Dutch nationwide action program Solid Start, thereby focusing on monitoring and cross-sectoral collaboration. Three research questions guided our research: 1) What is vulnerability during pregnancy, and how to operationalize vulnerability for monitoring? 2) Which indicators can be used to monitor Solid Start on a local level? 3) What are the developments and experiences with Solid Start, specifically regarding cross-sectoral collaboration?

Chapter 2 and 3 focused on monitoring vulnerability during pregnancy. **Chapter 2** provided more insight into vulnerability by identifying classes of pregnant women with similar risk and protective factors, and studying the relation with adverse outcomes. Data were derived from routinely collected data sources in DIAPER (acronym for Data-InfrAstructure for ParEnts and childRen) and self-reported data of the Public Health Monitor. Results showed five classes: multidimensional vulnerability, socioeconomic vulnerability, psychosocial vulnerability, high care utilization, and the healthy and socioeconomically stable-class. Women in the multidimensional vulnerability-class shared multiple risk factors in various domains (psychosocial, medical and socioeconomic risk factors) and lacked protective factors. These women in the multidimensional vulnerability-class more often had adverse outcomes, as compared to the healthy and socioeconomically stable-class. The three classes with risk factors in one domain and protective factors in others did not experience worse outcomes. These results point to the importance of considering the co-existence of multiple risk factors and protective factors that may act as positive exposures or buffering mechanisms promoting resilience.

In **Chapter 3**, we explored the possibility to predict multidimensional vulnerability at population-level using solely nationwide routinely collected data (without self-reported data). Additionally, we reviewed the relevance of adding self-reported data, and identified the most important predictors. Results showed the feasibility of using readily available routinely collected data to predict vulnerability, providing a robust foundation for

longitudinal monitoring and policy making. Nevertheless, results also showed that self-reported data was of added value in the predictions, and self-reported health variables were found to be important predictors to multidimensional vulnerability.

In **Chapter 4**, we described the development of an indicator set to monitor the action program Solid Start on a local level. Experts preferred an indicator set that covers both processes and outcomes, both parents and children, and both risk and protective factors. The final indicator set comprised nineteen indicators within the three phases of the Solid Start program: preconception, pregnancy and after birth. Topics included poverty, psychological/psychiatric problems, stress, smoking, vulnerability, preconception care, low literacy and premature birth. The indicators focused on social determinants of health rather than specific clinical aspects. Additionally, a development agenda was set with topics and indicators that lacked nationwide data or clear operationalization (e.g. stress, unintended pregnancy, loneliness). In the local monitoring of the action program Solid Start, the indicator set can enhance the conversation between policymakers, managers, professionals and other stakeholders about the local situation and developments to prioritize local interventions and policies.

Chapter 5 described the developments and experiences with the action program Solid Start, with a specific focus on cross-sectoral collaboration. This study took place during the program's own first thousand days (i.e. 2019, 2020 and 2021). Quantitative results showed an increasing number of local coalitions Solid Start that involved diverse stakeholders from the medical and social sector, and a growing number of municipalities with plans of action, objectives, ambitions and activities. Qualitative results showed various positive experiences, but also challenges and needs for improvement. Initiating the action program Solid Start increased the sense of urgency for the importance of the first thousand days and stimulated professionals to get to know each other, resulting in more collaborative agreements. Coalition-development varied due to municipalities' unique challenges, focus and historical contexts. Some facilitators for local coalitions Solid Start were an active coordinator as driving force and a shared societal goal. Moreover, stakeholders appreciated the program's strong local focus and opportunities for learning together. However, the action program Solid Start appeared not yet fully incorporated into all professionals' everyday practice. Most common barriers related to systemic integration at macro-level, including limited resources and collaboration-inhibiting regulations. Stakeholders suggested various needs to ensure the program's sustainability, including sustainable funding, supportive regulations, responsiveness to stakeholders' needs, ongoing knowledge development and learning, and better and more client involvement.

Chapter 6 outlines a general discussion with main findings, a reflection on these findings, methodological considerations and recommendations for research, policy, practice and education. We highlight six lessons learned into the adoption of the action program Solid Start (lesson 1 & 2), monitoring (3 & 4) and cross-sectoral collaboration (5 & 6):

1. The adoption was facilitated by a unifying narrative and dedicated champions at all levels
2. National governmental stewardship with strong local focus is a promising combination
3. Considering both risk and protective factors is important for a comprehensive perspective
4. Monitoring requires longitudinal cross-sectoral data and indicators
5. Fostering normative integration is a fundamental first step to collaborate
6. Processes of learning are indispensable in cross-sectoral collaboration

This thesis' monitoring efforts showed a growing link between research, policy and practice. Future research should prioritize participatory methods, realist approaches and engaging experts-by-experience. We also recommend optimizing the use of routinely collected data and studying early effects of the action program Solid Start. For future practice and policy, we advise to create a long-term perspective, integrate the action program Solid Start into everyday practice and stimulate learning processes at different levels. Despite opportunities for improvement, this thesis implies a solid start for the Dutch first thousand days-approach.