

June 2024

Since 2001, First 5 California (F5CA) has provided children's books and other free resources to 5.4 million families across California through the *Kit for New Parents*. The purpose of the *Kit* is to provide new parents resources and information about caring for their baby as well as information about resources available in the community. The *Kit*, which is free to families, contains two parenting information books, two children's books, and other flyers and supports for new parents and caregivers. It is available in English, Spanish, Chinese, Korean, and Vietnamese. Families can order a *Kit* from F5CA (<https://first5parentingkits.com/>) to be shipped directly to their home, or they can obtain a *Kit* from a local service agency or community organization. For example, partners like hospitals, First 5 County Commissions, and home visiting programs can order *Kits* in bulk to distribute to parents in the communities they serve.

In July 2022, F5CA contracted with the American Institutes for Research (AIR) and its partners, Social Policy Research Associates (SPR) and Allen, Shea & Associates, to conduct a study to understand the distribution of the *Kit* to families across the state and the experiences and outcomes of families that receive the *Kit*. As part of the study, all parents and caregivers who received a new *Kit* in fall 2023 were invited to complete a survey. Those who completed a survey in the fall received a follow-up survey approximately 3 months later. We also drew on data from the California Health Interview Survey (CHIS), an annual, statewide survey of families that asks about the *Kit for New Parents*. (More details on these data sources can be found in the Data Sources box at the end of the brief.)



This brief presents data from these surveys to address the following questions:

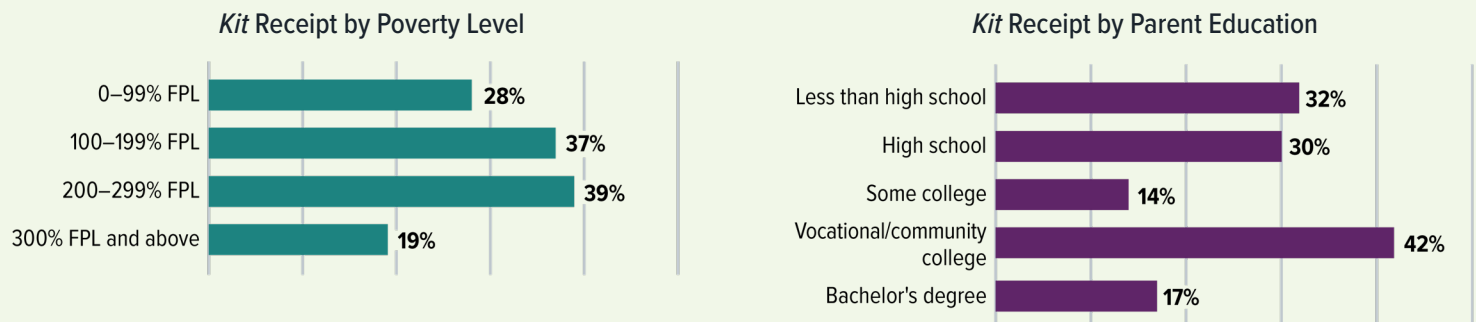
1. Who receives the *Kit for New Parents*?
2. How do parents receive the *Kit*?
3. To what extent do parents use the *Kit*?
4. What do parents think of the items in the *Kit*?
5. How does the *Kit* influence parenting knowledge and behavior?

Who Receives the *Kit*?

The *Kit* is intended as a universal resource, available to all families. However, the *Kit* may serve as a more critical set of tools for some families than others, for example, first-time parents or parents with lower incomes. In 2022, approximately 23% of families with a child 5 years old or younger reported having received a *Kit* in the last 12 months. Using the CHIS data for 2021 and 2022, we compared the characteristics of families that do and do not receive the *Kit* to understand the diversity of families receiving the *Kit*.

Under-resourced families are more likely to receive the *Kit* than well-resourced families, but the families with the fewest resources are not the ones most likely to receive the *Kit*. Families with low or low-middle incomes—those living at 100–199% and 200–299% of the federal poverty level (FPL)—appear to receive the *Kit* at slightly higher rates than those with higher incomes (Exhibit 1). Those living below the FPL (which equates to an income of less than \$24,860 for a family of three) also receive *Kits* at a lower rate than those just above the FPL. Similarly, parents with a college degree are less likely to receive a *Kit* than those with just a high school diploma or less. But the group most likely to receive a *Kit* are those parents with a vocational or community college degree, suggesting greater access for those with limited (but not completely lacking) educational and economic resources.

Exhibit 1. Percentage of Families With a Child 5 Years Old or Younger That Received the *Kit*, by Poverty Level and Parent Education, 2021–2022



Families that identify as Latino and families that speak Spanish as their primary language received *Kits* at the highest rates. Nearly three out of 10 families with a child 5 years old or younger that identify as Latino received a *Kit* (29%), compared to 21% of families that identify as White and 15% of families that identify as Asian (Exhibit 2). The difference is even more pronounced by language group, with 37% of families that speak Spanish as their primary language reporting receiving a *Kit*, compared to only 18% of English speakers and 19% of speakers of Asian languages. Bilingual speakers also received *Kits* at relatively high rates.

Exhibit 2. Percentage of Families With a Child 5 Years Old or Younger That Received the *Kit*, by Race/Ethnicity and Home Language, 2021–2022



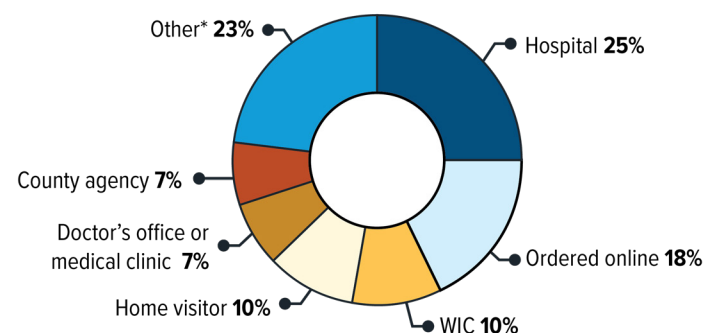
How Do Parents Receive the *Kit*?

We learned about strategies used by local agencies to distribute *Kits* to families (see [Kit Distribution brief](#)), and parent responses to survey questions about how they actually receive their *Kit* largely confirm these findings.

About four out of five parents received their *Kit* from a local service agency or community organization.

Parents can order the *Kit* online through First 5 California's website to be delivered directly to their home, or they can obtain a *Kit* from a local organization that has bulk-ordered *Kits* from the state. In total, 82% received their *Kit* from a local organization, most commonly from a hospital (25%), Women, Infants, and Children (WIC) office (10%), or home visitor (10%) (Exhibit 3).

Exhibit 3. Percentage of Families That Reported Receiving the *Kit* From Various Types of Organizations or Online

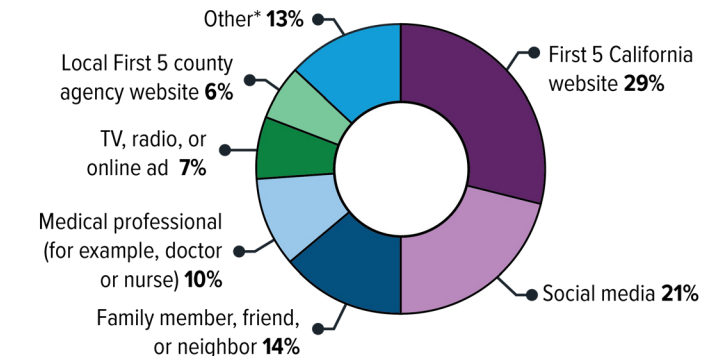


Note. *N* = 1,868.

*Other sources include family resource centers; libraries; community events or resource fairs; parenting workshops/classes; community centers; social workers; and family, friends, or neighbors; among others.

Only 18% of parents surveyed ordered their *Kit* online. Parents who ordered their *Kit* online learned about it through a variety of sources, including the First 5 California website (30%), social media (22%), a family/friend/neighbor (14%), or a medical professional (11%) (see Exhibit 4).

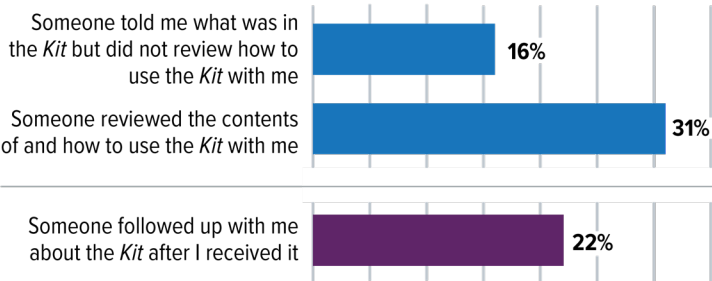
Exhibit 4. Percentage of Parents Ordering the *Kit* Online Who Learned About the *Kit* From Various Sources



Note. N = 359.
*Other includes other professional (such as social worker, home visitor, or teacher), informational email or newsletter, and other uncategorized.

Some parents received guidance on using the *Kit*; many did not. Approximately one in three parents reported that someone reviewed the contents of the *Kit* and how to use the *Kit* with them (31%). An additional 16% of parents said someone told them what was in the *Kit* but did not review how to use the *Kit*. Not surprisingly, parents who received the *Kit* from a local service agency or community organization were more likely to have someone review the contents of the *Kit* with them than those who ordered it online. In addition, only 22% of parents reported that someone followed up with them after they first received the *Kit* (see Exhibit 5).

Exhibit 5. Percentage of Parents Who Reported Receiving Some Guidance or Follow-Up on the *Kit*



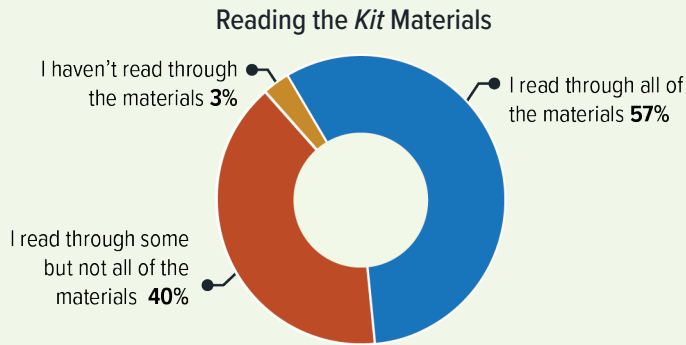
Note. N = 1,854.

To What Extent Do Parents Use the *Kit*?

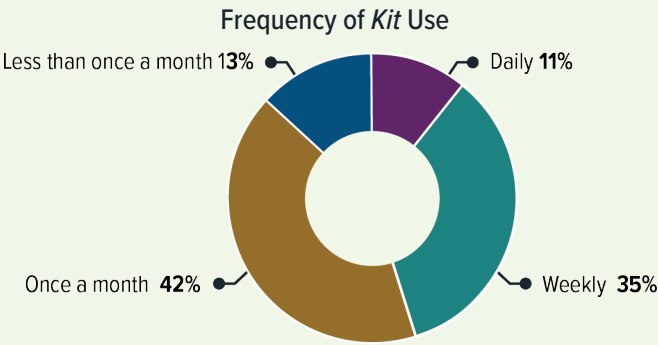
Parents were asked several questions to learn more about whether they read through the materials and how useful they found each resource. In addition, parents were asked for recommendations about additional information to include in the *Kit*.

Nearly all parents reported using the *Kit*. Within 3 months of receiving the *Kit*, all but 3% of parents reported that they had read through at least some of the *Kit*'s materials, and over half of parents said they had read through all of the materials (57%) (Exhibit 6). Nearly half of parents surveyed reported frequent use of the *Kit*—using it on a weekly (35%) or even daily (11%) basis. An additional 42% of parents reported using it about once a month (Exhibit 6). The *Kit* is also a broader household resource for many families, as most parents who said they have older children reported using the resources and materials from the *Kit* with their older children as well (79%).

Exhibit 6. Percentage of Parents Who Read the Materials by the Follow-Up Survey and Who Used the *Kit* With Different Frequencies



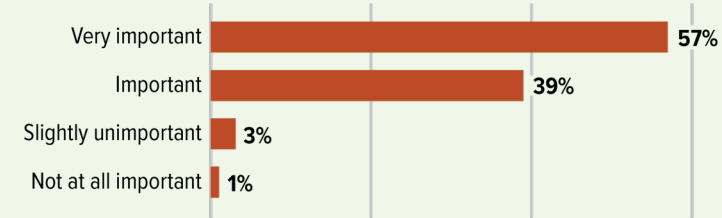
Note. N = 779.



Note. N = 749.

The language the *Kit* was written in was important for enabling parents to access its content. Almost all parents who received the *Kit* in a language other than English reported that receiving it in their language was important for enabling them to use the contents. Nearly four out of 10 survey respondents received a *Kit* in a language other than English, including Spanish (36%), Chinese (1%), Korean (0.26%), and Vietnamese (0.16%). Most of these parents (96%) reported that having the *Kit* available in their home language was important, including 57% who said it was very important (Exhibit 7).

Exhibit 7. Parent Perceptions of the Importance of Receiving a *Kit* in a Language Other Than English



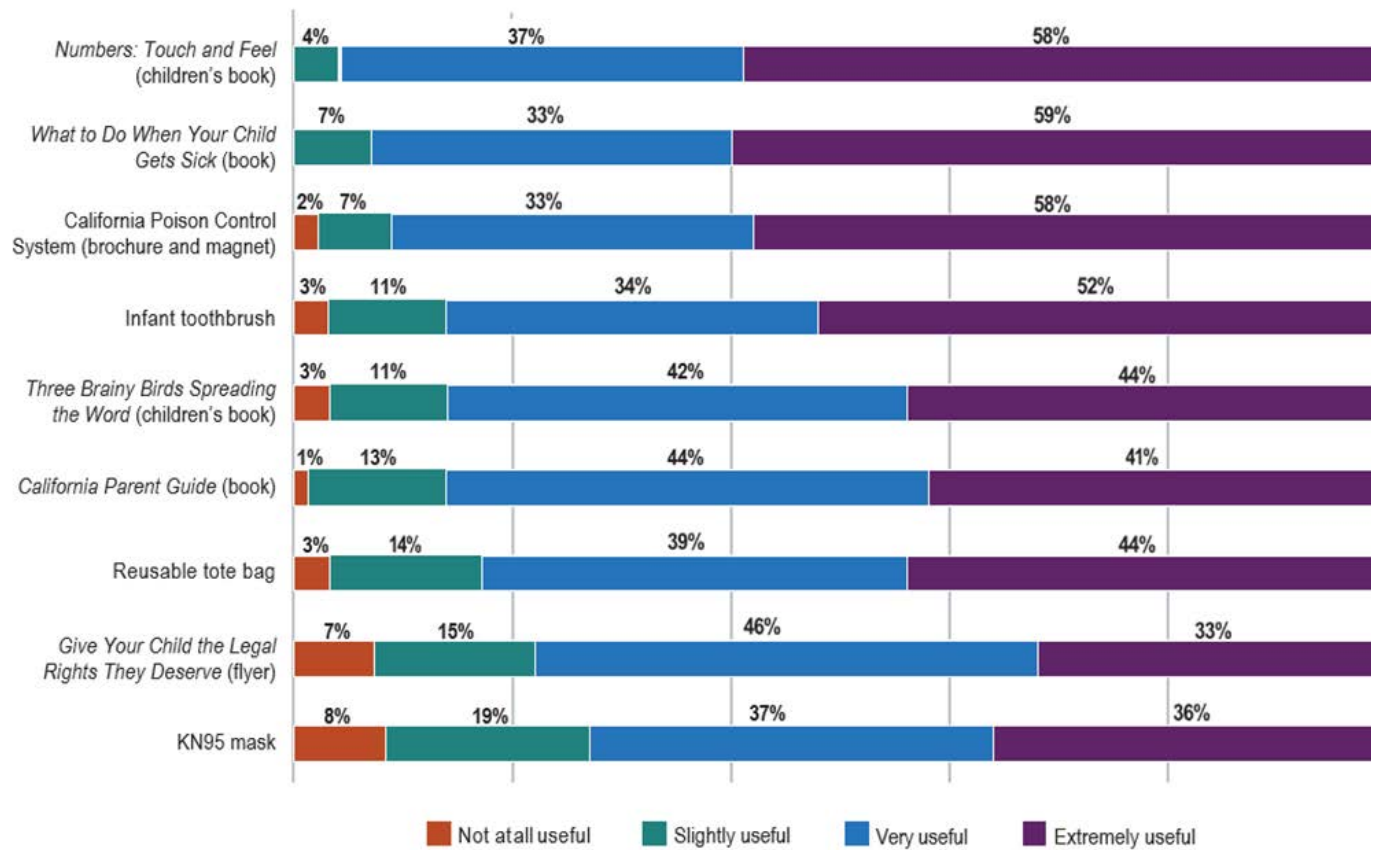
Note. N = 216. Responses are from those who received the *Kit* in a language other than English.

What Do Parents Think of the Items in the *Kit*?

The *Kit* contains a range of items, from books, to flyers, to physical resources like a toothbrush. We asked parents about the utility of each item; their responses are described below.

Overall, parents found the items in the *Kit* very useful. The majority of parents found each of the materials and resources in the *Kit* useful. The most highly rated items include the book *What to Do When Your Child Gets Sick*, the *Numbers Touch and Feel* book, and the California Poison Control System brochure and magnet, with nine out of 10 parents rating these items *very useful* or *extremely useful* (see Exhibit 8). The lowest rated items were the legal rights brochure, which encourages parents to establish a legal declaration of parentage, and the KN95 mask; these were rated as not at all useful or only slightly useful by 22% and 27% respectively.

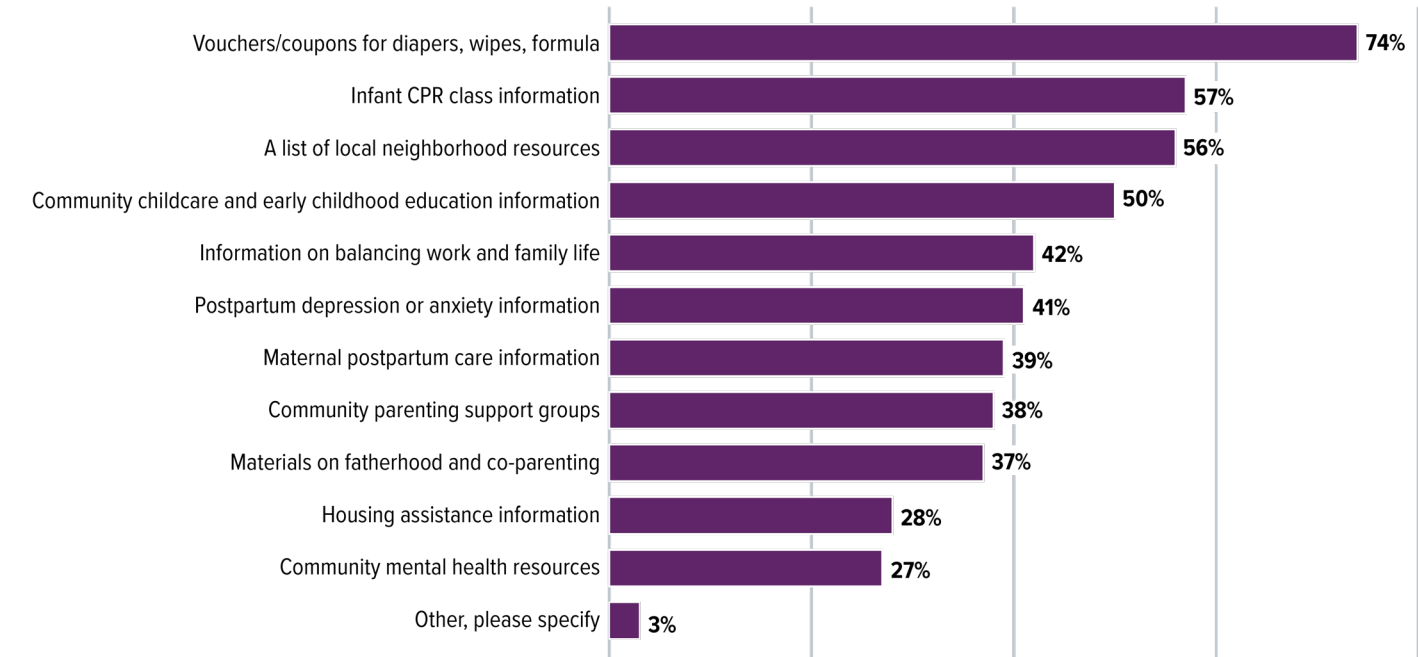
Exhibit 8. Parent Ratings of the Usefulness of the *Kit* Items



Note. N = 792.

While most parents found many of the *Kit* items useful, many parents reported that they would like additional items in *Kit*. The items most parents would like added to the *Kit* include vouchers/coupons for diapers, wipes, and formula (74%), a list of local neighborhood resources (56%), and information about infant CPR classes (57%). Other commonly requested items include information on balancing work and family life, postpartum depression and anxiety, postpartum care, and materials on fatherhood and co-parenting. There were also requests for community-specific resources like information on local parenting support groups and childcare and early childhood education options (see Exhibit 9).

Exhibit 9. Additional Items That Parents Thought Should Be Included in the *Kit*



Note. N = 792. Respondents were asked to check all that apply. Other items included grandparent-specific resources, educational toys, more samples of baby products, lists of local lactation consultants, breast milk storage bags or vouchers, information about sleep training, baby food recipe books, information about getting a breast pump through insurance, gift cards, developmental milestones information, and information about what to do in the first 30 days after birth.

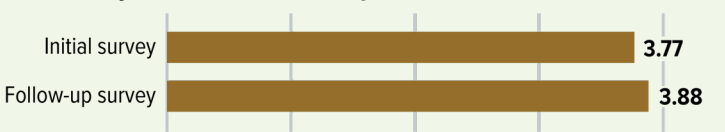
How Does the *Kit* Influence Parenting Knowledge and Behavior?

To estimate the effects of receiving the *Kit* on parents’ knowledge, beliefs, and practices, we use two approaches. First, using the CHIS data, we compare health behaviors and outcomes for families that did and did not receive the *Kit* to determine if outcomes differ for the two groups. Second, drawing on the study survey sample, we compare parent responses to questions about parenting beliefs and behaviors at the time of *Kit* receipt to their responses 3 months later to determine if their responses change after exposure to the *Kit*. In both analyses, we use statistical controls to account for differences in outcomes that may be due to demographic differences (e.g., parents’ age, gender, race, highest education, income, and primary language) rather than use of the *Kit*. The results of these analyses are described below.

Parents who received a *Kit* described some better family health outcomes. After accounting for demographic differences between the groups, we found several significant differences in health outcomes captured in the CHIS data between those who did and did not receive a *Kit*. For example, consistent with First 5 California’s charge to support smoking cessation, parents who received a *Kit* were more likely to report that they stopped smoking in the last year. Children also show better health outcomes: compared to families that did not receive the *Kit*, families that received a *Kit* in the last year were more likely to describe their child as being in excellent general health. Children whose families received a *Kit* were also more likely to have had a developmental screening, which is critical for early detection and intervention for developmental concerns. In addition, although there were no differences in the number of visits to the emergency department in the last year, children in families receiving a *Kit* were more likely to have visited the emergency department for a dental emergency in the last year compared to those not receiving a *Kit*.

After receiving the *Kit*, parents reported greater access to community resources. The study’s parent survey asked parents to rate their ability to access resources in their community through six items (e.g., *I know where to find resources for my family*, and *I am comfortable finding the help I need*). Parents rated how often they felt this way on a 5-point scale: *rarely or never*, *a little of the time*, *some of the time*, *good part of the time*, and *always or most of the time*. Three months after receiving the *Kit*, parents reported greater access to resources in the community compared to when they initially received the *Kit*. This difference was statistically significant (ES=0.12¹—Exhibit 10). This finding suggests that the *Kit* may have given parents more information (as intended) about resources in the community and how to access them

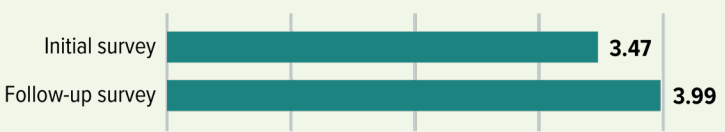
Exhibit 10. Adjusted Mean Scores on Parents’ Access to Community Resources on Receipt of the *Kit* and 3 Months Later



Note. $N = 745$. These scores represent the estimated adjusted means on the initial and follow-up survey for all parents who completed both surveys. These were calculated using a two-level hierarchical linear model that controlled for an individual’s age, gender, race, education, income, and primary language. On this scale, 1 = rarely or never, 2 = a little of the time, 3 = some of the time, 4 = a good part of the time, and 5 = always or most of the time. These differences were statistically significant at $p < 0.001$.

Parents reported using more safety behaviors after receiving the *Kit*. Parents were asked about their use of various home safety practices to protect their baby (e.g., *putting covers on electrical outlets* and *taping electrical cords to the floor or wall*). After having the *Kit* for 3 months, parents reported using more safety measures in the home compared to when they initially received the *Kit* (ES=0.21—Exhibit 11). This difference was statistically significant. It is important to note that this may also reflect a change in their child’s safety needs between the initial and follow-up surveys (e.g., their child began crawling), rather than the impact of the *Kit* on parents’ safety decisions.

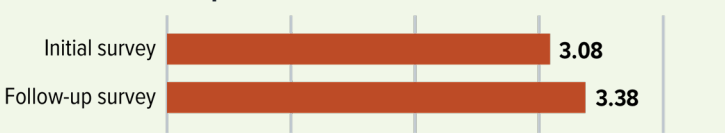
Exhibit 11. Adjusted Mean Scores for Parent-Reported Use of Home Safety Behaviors on Receipt of the *Kit* and 3 Months Later



Note. $N = 733$. These scores represent the estimated adjusted sum scores on the initial and follow-up survey for all parents who completed both surveys. These were calculated using a two-level hierarchical linear model that controlled for an individual’s age, gender, race, education, income, and primary language. Sum scores were calculated for six items on this scale in which 1 = yes, 2 = no or not yet, and not applicable was coded as missing. These differences were statistically significant at $p < 0.001$.

Parents reported higher levels of parent engagement behaviors after having the *Kit* for 3 months. On the survey, parents were asked to rate how often they do specific activities with their child (e.g., *read books*, and *take your child along while doing errands, like going to the post office, the bank, or the store*). As shown in Exhibit 12, after using the *Kit* for 3 months, parents reported engaging in these behaviors more frequently with their child compared to when they initially received the *Kit*. This difference was statistically significant (ES=0.50—Exhibit 12). This finding suggests that parent involvement increased after receiving the *Kit*.

Exhibit 12. Adjusted Mean Scores of Parent Engagement on Receipt of the *Kit* and 3 Months Later

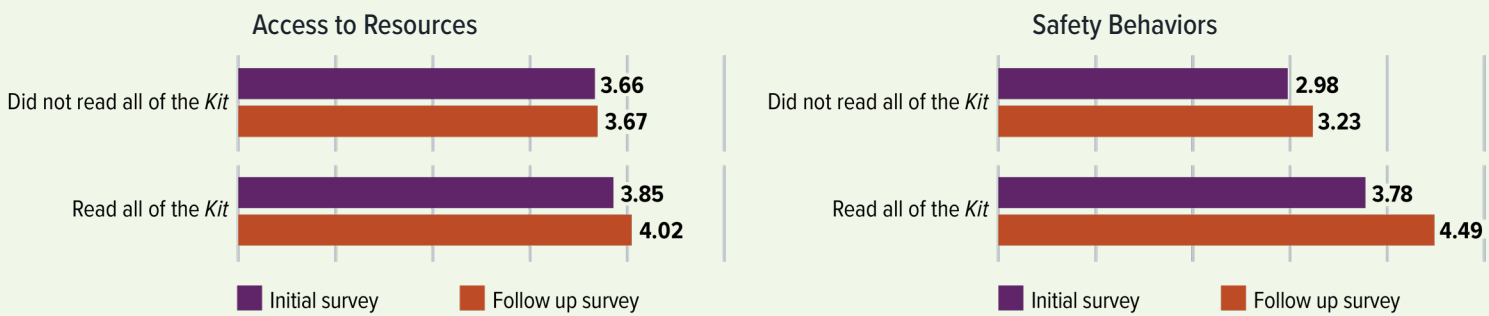


Note. $N = 509$. These scores represent the estimated adjusted means on the initial and follow-up survey for all parents who had a child on the initial survey and who completed both surveys. These were calculated using a two-level hierarchical linear model that controlled for an individual’s age, gender, race, education, income, and primary language. On this scale, 1 = not at all, 2 = once or twice a week, 3 = 3 to 6 times a week, and 4 = every day. These differences were statistically significant at $p < 0.001$.

¹ “ES” refers to “effect size,” which is a standardized metric for expressing the difference between two outcomes. It is the difference in the outcome between the two conditions divided by the outcome’s standard deviation. An effect size less than .2, such as the one in the figure, is considered small.

Parents who used the *Kit* more demonstrated even more positive outcomes. As reported above, 57% of parents said they read through *all* of the *Kit* by the follow-up survey. These parents showed greater growth on their reported access to community resources from the time they received the *Kit* to the 3-month follow up survey, compared to parents who did not read the materials or only read some of the materials (ES=0.17—Exhibit 13). Likewise, the parents who read through all of the *Kit* materials also showed greater increases in their use of home safety practices by the follow-up survey, compared to those who did not report reading all of the materials. These findings provide further evidence of the influence of the *Kit* on parents’ awareness and use of community resources and their parenting practices (ES=0.18—Exhibit 13).

Exhibit 13. Change in Parents’ Reports of Their Access to Community Resources and Use of Safety Behaviors After Receiving the *Kit*, for Those Who Did and Did Not Read All of the *Kit* Materials



Note. *N* = 745 for access to resources; *N* = 733 for safety behaviors. Outcomes were calculated using a two-level hierarchical linear model that controlled for an individual’s age, gender, race, education, income, and primary language. The level one model included a binary covariate for the follow-up survey, a binary covariate for whether a parent read the *Kit*, and an interaction covariate between the follow-up survey and whether a participant read the *Kit*. These differences were statistically significant at *p* < 0.05 and *p* < 0.001, respectively.

We also compared outcomes among parents who reported using the *Kit* with outcomes for those who did not use the *Kit* using the CHIS data and found that parents who used the *Kit* were more likely to support healthy eating—by offering their child more fruits and vegetables—and were more likely to read to their child every day.

General parenting knowledge and confidence did not change after parents received the *Kit*. Parents were asked the extent to which they agreed with five statements related to parenting knowledge (e.g., *Reading to babies helps them learn, even before they can talk*). Similarly, parents were asked to rate how often they feel confident as a parent (e.g., *I feel I am a good parent* and *When problems arise with my child, I handle them pretty well*). After using the *Kit* for 3 months, respondents reported similar levels of parenting knowledge and parenting confidence, indicating no statistically significant improvement on these measures after receipt of the *Kit*. However, it is important to note that parenting knowledge and confidence were already high at the time of receipt of the *Kit*.

In addition, other outcomes examined through the CHIS data showed no statistically significant differences based on *Kit* receipt, including child’s weight, visits to the doctor or dentist, number of children’s books in the home, and frequency with which the parent played music or sang songs with the child.

Conclusions

The study revealed that more than one in five families (23%) in California received a *Kit for New Parents* in 2021 and 2022, and many of these *Kits* reached families with limited education and financial resources. Families can obtain a *Kit* in various ways, but our results highlight the importance of interactions between parents and others in the community for learning about, accessing, and using the *Kit*. Most parents received the *Kit* from a local agency or community organization, frequently through their hospital, a governmental agency (e.g., Office of Vital Records or Department of Public Health), or WIC. Even for those parents who ordered a *Kit* online, most mentioned learning about it from someone—such as through social media, a friend/family/neighbor, or a health care provider. We learned from organizations distributing the *Kit* (see [Kit Distribution Brief](#)) that these *Kits* have become an important tool for their work with new parents.

We also found that translation of the *Kit* into multiple languages is especially important. Almost all parents who received the *Kit* in a language other than English reported that receiving their *Kit* in their home language (Spanish, Chinese, Korean, or Vietnamese) was important for enabling them to use the contents of the *Kit*. The importance of language access is also reflected in the high percentage of *Kits* received by Spanish-speaking families. These results suggest that for *Kits* to be useful, it is important to ensure that they match the language needs of the community in which they are being distributed.

Finally, we found some evidence of the benefits of receiving the *Kit* among families with young children. Families that received the *Kit* were more likely to report their child was in excellent health, compared to those who did not receive the *Kit*. We also observed changes in parent reports of their beliefs and behaviors over the 3 months after they received the *Kit*, specifically in terms of access to community resources, use of safety behaviors, and parent engagement. In addition, results suggested that changes in access to resources and safety behaviors were even more pronounced among those who read *all* of the *Kit* materials.

Limitations

There are several important limitations to note. First, sample sizes for some of the CHIS analyses and some of the survey analyses were small, which affects the precision of the reported results. In addition, not everyone who was invited to complete a survey did so, and some bias

may be introduced by lack of response from some groups. For example, parents who really liked the *Kit*—reviewed all the materials, referred back to the materials often, and interacted with a local service agency or community organization about the *Kit*—may have felt more motivated to complete the survey. Likewise, a busy parent who never had the time to open the *Kit* or explore all the contents may have been less likely to complete the survey. This potential response bias may have inflated reviews of the *Kit* materials. Finally, while we can control for many variables in our analysis, we are unable to account for all infant care and parenting education materials and training that a parent or caregiver may have received between the initial and follow-up survey, and thus cannot conclude that observable changes in behaviors are completely due to parents' use of the *Kit*.

Future Directions

Despite the study's limitations, the findings presented here suggest that the *Kit* is a valuable resource for parents and caregivers in California, and future investments and investigations can further explore how to implement the *Kit* to best meet parents' and caregivers' needs. Ideas and recommendations for next steps include the following:

- Continue to invest in the *Kit for New Parents*, and work to expand access to families, including the most vulnerable families living below the federal poverty level.
- Further investigate the low uptake of the *Kit* among speakers of Asian languages to ensure linguistic and cultural responsiveness of the *Kit* and to develop targeted distribution strategies. In addition, given the importance of language access, it might be worth exploring what additional communities are most in need of specific translations.
- Consider refining the contents the *Kit* in response to parent feedback, prioritizing practical hands-on items that are relevant for all families, such as the books and poison control information.
- Provide additional resources—including community-specific resources—within the *Kit*. For example, many parents asked for vouchers or coupons for baby care items like diapers and wipes; others requested information about infant CPR classes and other local resources.

These efforts, together with ongoing evaluation and enhancement of the resources in the *Kit* and strategies for distribution, will ensure the continued effectiveness and relevance of this important resource for parents and caregivers statewide.

Parent Survey

The *Kit for New Parents* parent survey was administered using the online platform, Alchemer, and was accessible on a range of devices, including computers and smartphones. The research team produced flyers that were included in every *Kit* that was distributed by ALOM, the statewide *Kit* fulfillment contractor, starting in May 2023. The flyers were available in English, Spanish, Chinese, Korean, and Vietnamese; each flyer included a QR code and web link, and a unique passcode to the survey in the corresponding language. Participants were asked to complete the initial survey as soon as they received their *Kit* prior to reviewing the *Kit* contents. The initial survey launched in spring 2023, and 1,619 parents completed the survey by October 2023 and provided their contact information. These parents received an email invitation to participate in the follow-up survey. In total, 751 parents completed the follow-up survey, for a response rate of 46%.

The survey sample represents parents and caregivers from 52 counties, including large urban counties as well as small rural counties across the state. Sixty-eight percent of the sample were parents or caregivers of one or more young children, and about one third were pregnant or were soon to become parents through adoption or other means (31%). Most survey respondents identified as female (91%), and 46% had a bachelor's degree or higher. Our sample was generally low income, with 54% reporting a household income of \$50,000 or less. Over half of the sample identified as Hispanic or Latinx (56%); smaller percentages identified as White (25%), Asian or Asian American (19%), American Indian or Alaska Native (1%), Native Hawaiian or other Pacific Islander (0.5%), or other (2%).

Analyses of parent and family outcomes were limited to parents who responded to the survey at both points in time. To account for differences in outcomes for parents with different characteristics, we controlled for parents' age, gender, race, highest education, income, and primary language in all analyses.

California Health Interview Survey

The California Health Interview Survey (CHIS) is a state-level, representative parent survey conducted by the UCLA Center for Health Policy Research. It has been administered nearly every year since 2001. It focuses on health and health behaviors, and includes a subsample of families with children 5 years old and younger, which was the source used for the analyses presented here. The CHIS is conducted in English, Spanish, Mandarin, Cantonese, Vietnamese, Korean, and Tagalog.

In addition to examining characteristics of families receiving the *Kit*, we also conducted outcome analyses using the CHIS data comparing those who received the *Kit* with those who did not receive the *Kit*. To account for demographic differences between these groups, we used propensity score weighting, which uses demographics and other observable characteristics (e.g., gender, age, race/ethnicity, region, poverty, parental education) in the estimation of differences in outcomes between groups.