



National Collaborating Centres
for Determinants of Health
and Aboriginal Health

Centre de collaboration nationale
des déterminants de la santé
et de la santé autochtone

A Report on the Proceedings of the

Early Child Development Forum:

Exploring the Contribution of Public Health Early Child Home Visiting

OCTOBER 14-17, 2008
SASKATOON, SASKATCHEWAN

National Collaborating Centre
for Determinants of Health

National Collaborating Centre
for Aboriginal Health

www.nccdh.ca
www.nccah-ccnsa.ca

Contact Information

National Collaborating Centre for Determinants of Health (NCCDH)

St. Francis Xavier University

Antigonish, NS B2G 2W5

nccdh@stfx.ca

tel: (902) 867-5406

fax: (902) 867-6130

www.nccdh.ca

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Diana Daghofer, Wellspring Consulting

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Executive Summary

The National Collaborating Centre for Aboriginal Health and the National Collaborating Centre for Determinants of Health co-hosted the *Early Child Development Forum: Exploring the Contribution of Public Health Early Child Home Visiting* October 14-16, 2008, in Saskatoon, Saskatchewan. The objectives of the forum were to profile selected home visiting programs and explore the relationship between home visiting and health equity; explore knowledge from stories and scenarios to help apply “what works” to improve policy and practice; and identify and prioritize policy and practice issues that could be addressed by the Collaborating Centres.

The forum brought together more than 125 people from all provinces and territories to share knowledge and experiences about the contribution of early child development to long-term health. The participants included frontline providers (public health nurses, home visitors, and community health representatives), policy and program planners, senior government officials, academics, and researchers.

The forum included presentations and small group discussions designed to showcase home visiting programs from various jurisdictions across Canada and to explore research findings and experiential knowledge. Following the formal presentations, participants had the opportunity to identify and prioritize issues with respect to home visiting and early child development in Canada. The National Collaborating Centre for Aboriginal Health and the National Collaborating Centre for Determinants of Health are committed to addressing the priority issues identified by participants. While not all of these items fall within the knowledge synthesis, translation and exchange mandate of the National Collaborating Centres (NCCs), among them are issues that fall within the scope of the NCC program and will be addressed.

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Background

This report describes the proceedings of the *Early Child Development Forum: Exploring the Contribution of Public Health Early Child Home Visiting* held October 14-17, 2008, in Saskatoon, Saskatchewan. The forum was co-hosted by the National Collaborating Centre for Aboriginal Health and the National Collaborating Centre for Determinants of Health.

What are the National Collaborating Centres for Public Health?

The National Collaborating Centres were established in 2004 by the Public Health Agency of Canada to get evidence into the hands of public health decision makers. There are six National Collaborating Centres for Public Health (NCCPH) in Canada,¹ working together to ensure that Canadian public health professionals have access to the information they need to make good decisions. The NCCPH engage in “the exchange, synthesis and ethically sound application of research findings within a complex system of relationships among researchers and knowledge users as part of a large process to incorporate research knowledge into policies and practice to improve the health of the population” (Kiefer et al., 2005).

The National Collaborating Centre for Aboriginal Health, the National Collaborating Centre for Determinants of Health, and Early Child Development

It is well recognized that the early years of life are critical and have a significant impact on the eventual health and well-being of adults (Dodge, 2004; Irwin, Siddiqi, & Hertzman, 2007; Senate Subcommittee on Population Health, 2008). Therefore, healthy child development is a key “determinant of health.” Determinants of health are the social and economic factors that influence the health of Canadians.

¹ There are six National Collaborating Centres across Canada: the National Collaborating Centre for Determinants of Health in Nova Scotia, the National Collaborating Centre for Healthy Public Policy in Quebec, the National Collaborating Centre for Methods and Tools in Ontario, the National Collaborating Centre for Infectious Disease in Winnipeg, and the National Collaborating Centre for Environmental Health and the National Collaborating Centre for Aboriginal Health both in British Columbia.

The National Collaborating Centre for Aboriginal Health (NCCAH) and the National Collaborating Centre for Determinants of Health (NCCDH) have been working to synthesize, translate and exchange knowledge about early child development as a determinant of health. In order to share this knowledge with practitioners, policy makers and researchers, the NCCAH and NCCDH co-hosted the “Early Child Development Forum: Exploring the Contribution of Public Health Early Child Home Visiting” in October 2008 in Saskatoon, Saskatchewan.

Why Focus on Public Health Early Child Home Visiting?

The 2008/09 work of the National Collaborating Centre for Determinants of Health was informed by an environmental scan designed to identify priority issues in early child development. Among other issues, the scan identified public health early child home visiting as an important aspect of early child development programs and services; however, a lack of clarity regarding the evidence to support the practice of home visiting and a general lack of knowledge of the variety of home visiting programs across Canada was also identified.

Despite a wealth of peer-reviewed and grey literature published internationally on the topic of home visiting, there continues to be considerable debate and contradiction regarding the benefits of home visiting and the role of public health nurses versus paraprofessionals as home visitors. The literature indicates that a home visiting approach has been widely used in Canada and around the world. Numerous studies have evaluated the effectiveness of home visiting; however, there are mixed results (Olds, Sadler, & Kitzman, 2007). Some home visiting programs are shown to have positive outcomes while others show no differences with respect to health outcomes (Encyclopedia on Early Childhood Development, 2007). In addition, there is considerable variation in approaches to and quality of home visiting – programs differ in terms of length, intensity, components, level of training of the home visitor, and target audiences (Kitzman, 2004).

Given the identification of home visiting as an issue meriting further exploration and the wide availability, but lack of clarity, of literature in the area, the NCCAH and the NCCDH decided to host a forum designed to explore public health early child home visiting. This report details the proceedings of that forum.

The Forum

Planning

Margo Greenwood, Academic Lead of the National Collaborating Centre for Aboriginal Health, and Hope Beanlands, Scientific Director of the National Collaborating Centre for Determinants of Health, were the co-hosts of the *Early Child Development Forum: Exploring the Contribution of Public Health Home Visiting*.

Working collaboratively, the NCCAH and the NCCDH planned the forum. Members of the planning committee were Claire Betker, NCCDH; Raymonde D'Amour, Intersol Group; Diana Daighofer, Wellspring Consulting; Bernice Downey, NCCAH; Anna MacLeod, NCCDH; and Karen Weir, NCCDH.

Purpose and Objectives

The purpose of the forum was to facilitate knowledge synthesis, translation and exchange around effective strategies for home visiting and the contribution to early child development as a determinant of health.

The objectives of the forum were to:

- * profile selected home visiting programs and explore the relationship between home visiting and health equity;
- * explore knowledge from stories and scenarios to help apply “what works” to improve policy and practice; and
- * identify and prioritize policy and practice issues that could be addressed by the Collaborating Centres.

Participant Profile

More than 125 people from all provinces and territories gathered in Saskatoon in October 2008 to share their knowledge of and experiences with the contribution of

early child development to long-term health. They represented frontline providers (e.g., public health nurses, home visitors, and community health representatives), policy and program planners, senior government officials, academics, and researchers. (For a complete list of participants and contact information, see Appendix 6). In addition to information, the group shared their enthusiasm and the deep conviction that they were making a difference in the lives of children and families. Margo Greenwood, NCCAH co-host, summarized the overriding feeling when she said, “We all have a moral and ethical responsibility to ensure our children’s health. Optimal humanity begins with the optimal health of individuals, of our children. From there we build our families, our communities, and our nations.”

Structure of the Forum

Elder Mary Roy from the local Cree First Nations community began the forum with an opening prayer and welcomed the participants to the territory.

The forum, which ran for two and a half days, was facilitated by Raymonde D’Amour of the Intersol Group and included a mixture of presentations and small group discussion. Presentations focused on research findings and showcased home visiting programs from various jurisdictions across Canada. Following the formal presentations, participants had the opportunity to identify and prioritize issues with respect to home visiting and early child development in Canada.



Elder Mary Roy

Innovation

The National Collaborating Centre for Aboriginal Health and the National Collaborating Centre for Determinants of Health were committed to producing a forum that was “green” in nature, took into account the local context, and offered innovative and interactive opportunities for knowledge synthesis, translation and exchange. Several strategies were used to attain these goals including using memory

sticks instead of paper; developing a knowledge exchange fair; hosting a cultural evening; and featuring a performance by internationally renowned entertainer and child's right activist Raffi.

Memory Sticks. Rather than relying on large quantities of paper, participants received a memory stick loaded with forum materials. In addition, each presentation and the presenter's contact information were made available to forum participants at computer stations. Participants were encouraged to use their memory sticks to download presenters' PowerPoint slides at these stations. This green strategy was well received by participants.



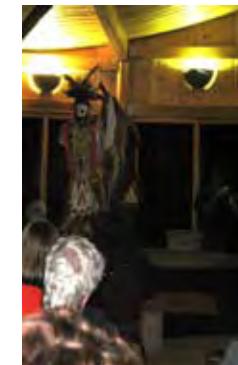
Knowledge Exchange Fair Participants

Knowledge Exchange Fair. The Knowledge Exchange Fair afforded participants the opportunity to showcase their programs. Participants were provided with a tabletop, poster board, and the chance to network with others from across the country engaged in early child development, public health and home visiting.

Participants were encouraged to visit the Knowledge Exchange Fair during breaks and at lunch time. The Fair was a success and participants commented on the valuable connections they made through the event.

Cultural Evening. In the interest of learning about the local context in which the forum was held, participants were invited to the Wanuskewin Heritage Park, a world-recognized site under the leadership and guidance of First Nations people, for a cultural evening consisting of dinner, storytelling, drumming and dancing.

Raffi. Internationally renowned entertainer and children's rights advocate Raffi brought the Early Child Development forum to a close. He shared a musical presentation about the concept of "child honouring," a children-first way of sustainability and a unifying principle for societal transformation. It is an integrated philosophy that links people, culture, and planet to simultaneously heal communities and restore ecosystems.



*A dancer
at the
Wanuskewin
Heritage Park*

Participants commented on the motivational quality of Raffi's presentation and left the forum motivated to continue working toward healthy child development.

Evaluation

More than 60 participants completed an evaluation, with an overwhelming majority indicating that they were "satisfied" (44%) or "very satisfied" (52%). Notable comments about the Early Child Development (ECD) Forum included:

- * "Best conference I have attended for public health nursing."
- * "We were able to learn from the experiences, challenges and evaluations of programs to assist us in our reflections regionally and provincially to move our ECD programs to another level in order to strive for excellence. It was an excellent opportunity for learning and sharing."
- * "...an example of knowledge translation in action."



Forum participants with Raffi

Early Child Development – Research Findings

Over the two and a half days of the Early Child Development Forum, five presentations were delivered addressing the state of early child development research. This section provides a brief overview of each of these presentations.

[Collaborative Public Health Practice: What's Your Role in Home Visiting?](#)

Dr. Megan Aston from Dalhousie University, Nova Scotia noted that 22 positive health outcomes derive from home visiting including improved physical, emotional, behavioural and developmental attributes in children, their mothers and their families. Challenges include procedural issues, such as difficulty engaging and retaining at-risk families, as well as negative outcomes, e.g., no appreciable effect on child abuse or neglect. Collaboration among home visitors takes advantage of knowledge and expertise from many sources. Effective home visiting usually has a strengths-based focus; is voluntary; features regularly scheduled home visits; follows a curriculum; and uses evidence-based practice.

[Total Environment Assessment Model of Early Child Development: TEAM-ECD](#)

Dr. Ziba Vaghri from the Human Early Learning Partnership (HELP) in British Columbia summarized the Life Course Approach to Health and Human Development, which shows that early intervention results in improved school outcomes, increased labour force productivity, reduced criminal justice costs, and reduced reliance on social services. Vulnerability increases as income decreases, but because brain development is most sensitive in the early years, that gradient can be mediated and mitigated if addressed early. Governments can also receive a far greater return on their investments by shifting away from the current focus on secondary and post-secondary school to invest in early child development.

Actions are more successful if they include strong inter-ministerial coordination, integration of ECD into the formal agendas of each sector, the use of existing health services to deliver programs, and scaling up existing models in local settings.

The Nurse-Family Partnership Program of Nurse Home Visitation

Dr. Susan Jack and Susan Szozda from McMaster University in Hamilton, Ontario, noted that the Nurse-Family Partnership (NFP) is a rigorously tested program with solid empirical and theoretical underpinnings. Evaluated trials showed consistent improvements in school readiness and reduced injuries for children who participated in the NFP. Women's prenatal health improved with fewer subsequent pregnancies and greater intervals between births. Arrests and incarceration among mothers and children, and child abuse and neglect were also reduced. The program increased fathers' involvement, increased employment, and reduced reliance on welfare and food stamps.

The Nurse-Family Partnership showed the greatest benefit to cost ratio among eight programs evaluated with a return of \$2.88 for every dollar invested. A pilot program in Hamilton used a personalized approach to strike a balance between the program's protocol and families' concerns, which may include mental health issues, unstable housing and trust issues. The NFP provides the strongest available evidence on the effectiveness of nurse home visitation and should be used to advocate for stronger public health practice.

Surveillance: From Knowledge to Action

Dr. Catherine McCourt from Ottawa and Dr. Cory Neudorf from Saskatoon outlined how the effective use of surveillance data can make a big difference to supporting health programs and addressing health inequities. Information on trends, patterns and disparities in health outcomes and determinants contribute to the evidence base for effective priority-setting in policies, programs, evaluation, and research.



Dr. Catherine McCourt, Ottawa

Dr. Neudorf described the influence of surveillance data on public health practice in Saskatoon. The Saskatoon Health Region (SHR) ramped up surveillance activities through a comprehensive community information system. It engaged various health, community and municipal groups to share information at small sub-population levels. An analysis of the findings uncovered wide health disparities between residents of low- and high-income neighbourhoods. The community groups agreed to work with the SHR to develop two action plans – one that addressed the health system and one to focus on the social determinants of health. Dr. Neudorf noted that solutions are complex, and while they can be led by health authorities, success requires strong partnerships with other organizations and the affected communities. A fundamental shift in attitudes and priorities in Saskatoon came about as a result of strong surveillance data on health disparities. With its strong ties to the community, public health is uniquely positioned to make this type of change happen anywhere in Canada.

Worthy of our Attention: The Care of Indigenous Children

Margo Greenwood from the NCCAH explored the challenge of respecting the diversity of Aboriginal individuals and groups. She discussed Indigenous ways of knowing and being, highlighting the fact that diverse approaches lead to varied solutions. The relationships between the self, the environment and the spirit (the spiritual and tangible) are foundational to Indigenous ways of knowing and being, and are essential to working with Indigenous children and their families.

A model of respect, relevance, reciprocity, and responsibility can be related to early child development. Home visiting is a process of establishing relationships: of respect for the diversity and uniqueness of each child, their families and cultures; of relevance to children and their families and communities; of reciprocity of sharing and learning from each other; and of responsibility to maintain positive relationships with each other and all beings.

Early Child Development – Learning from Experience

Six home visiting programs from across Canada were presented to highlight the vital role home visiting plays in early child development and the relationship between home visiting and health equity.

The following programs were showcased:

- * **KidsFirst** – The Saskatchewan Home Visiting Story
- * **Aboriginal Maternal Child Health**
 - First Nations Inuit Health, Health Canada
- * **Aboriginal Infant Development Program**
 - British Columbia
- * **Healthy Beginnings: Enhanced Home Visiting**
 - The Nova Scotia Story
- * **Families First and Strengthening Families**
 - The Manitoba Home Visiting Story
- * **Les services intégrés en périnatalité et pour la petite enfance**
 - The Québec Home Visiting Story



Dr. Alain Poirier, Québec

While focusing on the specific needs of their communities, each program had similar aims, addressing both physical and mental health to support and nurture children within healthy, well-functioning, empowered families and communities. They all promoted healthy child development, nurtured positive parent-child relationships and aimed to improve social support networks. Programs tailored their focus as their particular situations required. Some targeted nutrition, breastfeeding or healthy weight; others reduced substance use or violence. Start times also varied, but the overriding message was that early, sustained intervention was best.

The following is a summary of lessons learned from the showcased programs.

- * Focus on family relationships, including fathers, because “the strength of the relationship between the home visitor and the family predicts outcomes.”
- * Build on strengths and existing services in the community using home visitors as the link between families and community services.
- * Integrate programs into public health services. Use public health nurses as case managers to keep families connected with community and public health services throughout the program.
- * Ensure the program is community-driven, culturally appropriate and inclusive. Research and practice confirm that families stay involved when their cultural background is matched to that of home visitors. For Aboriginal families, build on traditional beliefs and practices.
- * Make enrolment voluntary.
- * Focus on flexible, innovative solutions to meet families’ specific needs.
- * Establish programs first where there are service gaps, funding inequities, and demonstrated feasibility, e.g., the community has the capacity to deliver them.
- * Follow principles of maternal child health and an established curriculum, if appropriate.
- * Use established, validated screening and assessment tools with trained and experienced staff.
- * Strike a balance between consistent delivery standards and guidelines, and opportunities to adapt to local community characteristics.
- * Accentuate the positives, praising parents’ skills and their values. Take into account the norms, values and belief systems of parents and the community.

- * Share information with parents, and use techniques such as role modeling, “normalizing” and active listening to support families. Focus on listening to learn rather than listening to respond.
- * Recognize a government-wide effort may be more effective. Quebec’s approach, guided by the Public Health Act, strategy and action plan, is showing results.
- * Act upon the social determinants of health by creating enabling environments through intersectoral projects. Involve a broad network of players and support innovative projects.
- * Work from a logic model or underpinning theory against which to measure outcomes.
- * Develop a clear, achievable implementation and evaluation plan. Because outcomes are difficult to measure (e.g., may be long-term, subject to a changing legislative environment), assess small changes in areas a program can influence.
- * Clarify roles and provide staff training early on.
 - Recognize challenges:
 - Sustainable funding remains an issue. Proposal-driven funding means that those with the capacity to submit proposals are funded with little regard for those most in need.
 - Arbitrary geographic boundaries pose ethical dilemmas as vulnerability exists everywhere.
 - Meeting training needs and retaining staff continue to be difficult.
 - Engaging and retaining families is an ongoing challenge.
 - Closer links are required with First Nations communities to ensure that potential clients are not missed.
 - Meeting changing needs, such as increasing immigration, is an ongoing challenge.

Sharing our Stories



Participants Sharing Stories

Recognizing that research and program descriptions are only part of the equation, forum participants were invited to share their stories. Specifically, participants were asked to tell a story about a time when home visiting made a positive difference to an individual or a family. Stories were written down and then shared in a small group setting. Each group chose one story to relay to the other participants. In a series of roundtables, forum participants had the opportunity to listen to two or three stories. A wide spectrum of stories was relayed. Some of the key messages from the stories included:

- * “Changing a person’s life today means changing their life forever.”
- * “Looking for outcomes at the population level misses the positive changes we are making in so many lives.”
- * “Powerful relationships develop over many years. Patience and understanding are key.”
- * “There is always hope. Believe in the client through nurturing relationships and regular contact.”

The National Collaborating Centre for Determinants of Health is currently in the process of collating the collected stories. These will be shared with forum participants in 2009/10.

Establishing Priorities

Following informative and motivating presentations from 22 researchers and practitioners, forum participants were given the opportunity to discuss priority issues with respect to home visiting and early child development in Canada. The identified issues were sorted and themed, and are listed here in order of priority:

- 1. Tools** – Based on a synthesis of existing evidence, validated, standardized screening tools are needed. Judgment is required to adapt tools to fit the family, community and culture.
- 2. Training** – Access to standardized, formal training that is adaptable to community needs is required in all provinces. Specifically, protocols for home visiting, knowledge of mental health issues and ethical issues, and safeguards for practitioners are required.
- 3. Business Case** – A robust business case that highlights the role of home visiting in increasing social and economic prosperity is required to support program development and funding, staff and community capacity building, and political aims such as development of a national child care strategy and the elimination of jurisdictional issues that hinder equity for First Nations children.
- 4. Workforce Development and Human Resources** – The ability to attract and retain qualified staff, meet training needs, and maintain consistent standards of practice and cultural safety is a challenge. To meet the needs of the community requires sufficient, qualified and supported staff operating in concert through a pan-Canadian early child development framework.
- 5. Models** – Effective models to deliver a continuum of home-visiting services will eliminate duplication of effort and assist practitioners to build on each other's knowledge and success. Models that provide service options for families that have been shown to be successful in reducing health inequities will result in more effective programs and evaluation.
- 6. Communication/Advocacy/Community of Practice** – Information on the determinants of health needs to be widely communicated, possibly through a website and listserv. NCCDH can play a role in providing data, particularly on poverty, to policy makers and other leaders.

7. **Evaluation** – Evaluation is important to provide the evidence required for sustainable funding. A common framework would ensure consistent evaluation.
8. **Striving for Excellence** – To achieve excellence in programs, key activities (e.g., best practices, quality assurance, practice guidelines) need to be identified and championed.
9. **Culture** – It is vital to recognize and articulate diversity, and work together across cultures. This is particularly important when setting policy for Aboriginal programs.

The National Collaborating Centres for Aboriginal Health and the National Collaborating Centre for Determinants of Health are committed to addressing the priority issues identified by participants. While not all of the items above fall within the knowledge synthesis, translation and exchange mandate of the National Collaborating Centres, there are issues that do fall within this scope and will be addressed in consultation with public health practitioners, policy makers and researchers.

The NCCDH is in the process of developing a home visiting business case, which will be disseminated to forum participants and other interested parties in 2009/10. In addition, the NCCDH has developed, and will deliver, a series of training workshops based on the Total Environment Assessment Model for Early Child Development (TEAM-ECD). Further, supporting current, and fostering new, communities of practice in the area of early child development and home visiting continues to be a priority of the NCCDH.

Setting our Direction

In closing the forum, Margo Greenwood, NCCAH, and Hope Beanlands, NCCDH, commented on what an uplifting and meaningful learning experience it had been. They committed to taking the recommendations for priorities to their advisory committees and to a retreat with the National Advisory Council and the Public Health Agency of Canada to inform the agenda for the 2009/10 year.

In moving forward, the National Collaborating Centre for Aboriginal Health and the National Collaborating Centre for Determinants of Health will continue to build upon the momentum from the Early Child Development Forum.

The NCCAH and the NCCDH are committed to supporting the public health community to create the conditions for children to thrive equally in their physical, social/emotional, and language/cognitive development.



Hope Beanlands and Margo Greenwood

Appendix 1:

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Appendix 2:

Summary of the Presentations

Early Child Development – Research Findings

Five presentations were made on the state of research for ECD. The PowerPoint presentations were made available to the participants.

Collaborative Public Health Practice: What is Your Role in Home Visiting?

Dr. Megan Aston is an Assistant Professor at the School of Nursing, Dalhousie University. Her research and teaching is focused on community and family health nursing.

In Dr. Aston's research on home visiting, she observed visits and then interviewed mothers. She has learned that healthy child development begins with a focus on the rights of the child and noted that home visiting is a way to meet families where they are.

In Canada, there is a history of home visiting that spans more than a century. Drawing on the research summarized in an NCCDH annotated bibliography on the issue, Dr. Aston noted 22 positive health outcomes of home visiting including improved physical, emotional, behavioural and developmental effects in children, their mothers and their families. Some challenges were highlighted, including procedural issues, such as difficulty engaging and retaining at-risk families, as well as negative outcomes. For example, home visits had no appreciable effect on child abuse or neglect.

Collaboration between the many players that contribute to home visiting takes advantage of knowledge and expertise from many sources. Effective home visiting usually involves a strengths-based philosophy; is voluntary; features regularly scheduled home visits; follows a curriculum; and uses evidence-based practice. Empowerment and social justice are effective underpinnings.

The NCCs have a strong role to play to get information from a variety of sources into the hands of practitioners. Support is also needed to determine how community agencies and programs can best connect, including public health, family resource centers and lay home visitors. Screening and assessment tools are needed that are locally, culturally and socially developed. Education for both public health nurses and

lay practitioners is required to ensure that home visiting is carried out in a way that empowers families and helps them to build on knowledge and strengths; create trust, support, and encouragement; and promote confidence.

Total Environment Assessment Model of Early Child Development: TEAM-ECD

Dr. Ziba Vaghri is the research associate leading the International Research and Initiatives Program of the Human Early Learning Partnership (HELP) at UBC. She is also a member of a team working on the development of a framework for monitoring child rights for the United Nations' Committee on the Rights of the Child.

The WHO Commission on Social Determinants of Health (CSDH) noted that the social determinants of health are responsible for almost half of the variations in health outcomes of populations. Its key recommendations are to:

- * Tackle the inequities in early child development is the easiest social determinant of health for economic leaders to understand. A Life Course Approach to Health and Human Development addresses early circumstances and results in improvements all along the way: better school outcomes, a more productive labour force, reduced criminal justice costs, and reductions in other strains on the social safety net.

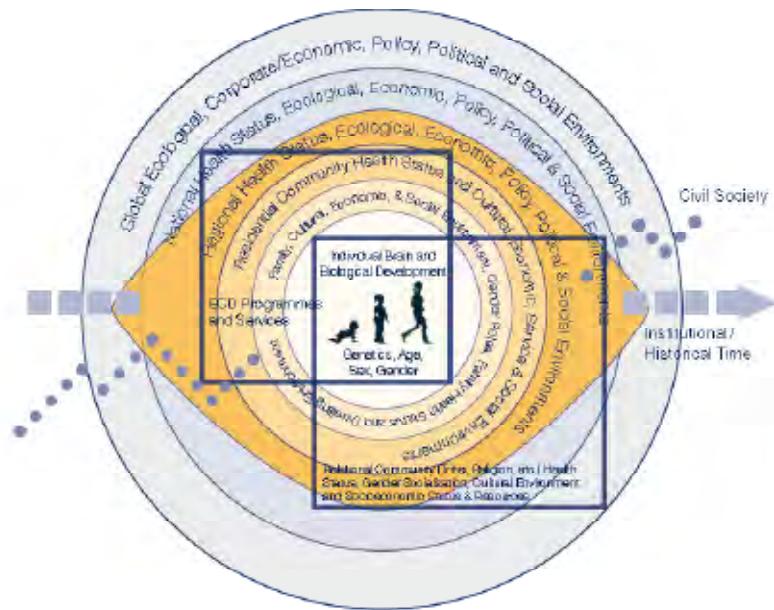
Dr. Vaghri pointed out that vulnerability increases as income decreases but that the gradient can be mediated and mitigated. A small window of opportunity exists in the early years. The *Total Environment Assessment Model for Early Child Development: Evidence Report* shows that ECD is primarily influenced by *nurturant* environments. Because of sensitive periods in brain development, early environments are the most powerful determinant of basic competencies, both at the family level and globally.

The TEAM-ECD model outlines a number of spheres of influence: the individual child, the family, the community, ECD services, and the regional, national and global community. For the individual child, stimulation, support and nurturance are key to development. The family is the fundamental source of nurturing, and mothers must be supported. Within communities, the physical environment – including places to play – and ECD services are critical. Governments must provide universal ECD programs that are fully integrated into social protection policies. While jurisdictions primarily fund secondary and post-secondary education, investment in ECD has a

far greater return and should form an integral component of a nation's long-term economic social strategy.

The WHO should strengthen its commitment to ECD as a key social determinant of health. A unified mechanism for monitoring ECD must be established internationally. It is a puzzle that, 'the conditions in which children are dying are the same conditions, in which children are surviving,' so more research is needed to determine what factors are buffering the survivors.

Successful actions on ECD include strong inter-ministerial coordination on early child development, the integration of ECD into the formal agendas of each sector, the use of existing platforms such as health services for delivery of programs, and the identification and scaling up of existing models in local settings.



TEAM-ECD Model

WHO Commission on Social Determinants of Health (2007). Early Child Development: A Powerful Equalizer²

² Siddiqi, A., Irwin, L.G., and Hertzman, C. (June 2007). Total Environment Assessment Model for Early Child Development: Evidence Report for the World Health Organization's Commission on the Social Determinants of Health. WHO: Switzerland.

Making a Promise to Make a Difference: The Nurse-Family Partnership Program of Nurse Home Visitation

Dr. Susan Jack is an Assistant Professor, School of Nursing at McMaster University and holds the Child Health and Reproduction New Investigator Personnel Award from the Canadian Institutes of Health Research. Susan Szozda is a member of the Nurse-Family Partnership team at Hamilton Public Health Services.

The Nurse-Family Partnership (NFP) is a rigorously tested program that began in the 1970s, with solid empirical and theoretical underpinnings. Dr. Susan Jack explained that it addresses low-income, first-time parents – usually unmarried teens – aiming to improve pregnancy outcomes, child health and development, and parents' economic self-sufficiency.

Across three trials of the program, results consistently showed improvements in school readiness and reduced injuries for the children involved. Women's prenatal health improved, and there were fewer subsequent pregnancies and greater intervals between births. The program also resulted in increased fathers' involvement, increased employment, and reduced reliance on welfare and food stamps. The program's greatest effects were found among those most vulnerable.

Results found 15 years after one NFP program included a 98% reduction in jail time among mothers and a 48% reduction in child abuse and neglect. Among children, arrests were reduced by 59% and identification as "persons in need of supervision" was reduced by 90%. Six-year results from another NFP program showed that children had higher IQs, better language development and fewer mental health problems. In a financial analysis, the NFP showed the greatest benefit to cost ratio among eight programs evaluated with a return of \$2.88 for every dollar invested. The program now operates in 25 US states, Australia, the UK, Germany, Holland, and Canada.

Ms. Szozda described a pilot program that tested the feasibility of the NFP and its acceptance among public health nurses and mothers in Hamilton. It assessed strategies to identify and recruit mothers, and retain them in the program. Methods for collecting outcome data and conducting a future cost analysis were also tested. The 2.5-year intervention focused on six areas: personal and environmental health, life course development, maternal role, family and friends, and health and human services.

Nurses' activities in the program aimed at behavioural change based on self-efficacy theory. While the program offers extensive guidelines for use, it is not delivered in a "cookbook" approach but calls upon professional judgment for adaptations to meet families' needs. There is a balance struck between the program's protocol and families' concerns, which may include mental health issues, unstable housing, negative social networks, and trust issues.

The NFP provides the strongest available evidence on the effectiveness of nurse home visitation. It is clearly an enhancement to universal programs and should be used to advocate for stronger public health practice.

Surveillance: From Knowledge to Action

Dr. Catherine McCourt is the Director of the Health Surveillance and Epidemiology Division with the Public Health Agency of Canada. Dr. Cory Neudorf is the Chief Medical Health Officer for Saskatoon Health Region and Clinical Associate Professor of Community Health and Epidemiology at the University of Saskatchewan.

Dr. McCourt pointed out that surveillance is one of six key functions of public health, noting the cyclical nature of data collection, analysis and interpretation, and communication for action. Effective health surveillance requires the active participation of stakeholders, both in expert input and the application of findings. It is based on indicators of health outcomes and determinants, and makes best use of existing data sources.

Information on trends, patterns and disparities in health outcomes and determinants contribute to the evidence base for effective priority-setting, policies, programs, and evaluation, and helps to set research priorities. Surveillance of a population identifies new and emerging health issues and threats, and can help guide priorities.

Examples abound where good data has led to effective public health action, including the ban on baby walkers resulting from injury surveillance. Currently, a working group is focused on improving the quality of care for First Nations mothers as a result of infant mortality data.

Dr. Neudorf described how surveillance data is greatly influencing public health practice in Saskatoon. Because of concerns that broad surveillance data was masking problems within specific pockets of need, the Saskatoon Health Region (SHR) ramped

up surveillance activities through a comprehensive community information system. They engaged various health, community and municipal groups to share information at small sub-population levels. St. Paul's Hospital conducted a needs assessment of inner city residents. An analysis of the findings uncovered wide health disparities between residents of low- and high-income neighbourhoods.

Initially, the reaction among health workers and the general public was one of shock, denial and anger. The inner city community and local workers were less shocked. All were motivated to change the situation and were interested in working together. The SHR developed a communications strategy to inform the community and engaged the community to develop two action plans – one that addressed the health system and another focused on the social determinants of health.

A survey of the community's awareness of the health disparities showed that while people were aware that poverty affects health they underestimated the extent of its impact. However, an overwhelming 91% said something could be done to address the disparity. Of the 30 policy options they were presented, the top three were:

- * Strengthened early-intervention programs for children and youth (82%)
- * Earning supplements to help people move off social assistance (82%)
- * More disease prevention programs (81%)

A coalition of health, education and community groups joined with municipal planners to develop an action plan to address health disparities. Meetings also took place with Aboriginal groups and inner city community representatives. The coalition identified common goals and initiatives. Initial focus areas include developing a school-based, inter-sectoral service delivery model, increasing employment options in partner agencies, and improving local services (primary health centres, leisure services, grocery stores and businesses). Partners recognize that change is needed in the way individuals are treated in regard to cultural sensitivity, transportation issues, home visits, and seamless delivery of services, communication and involvement. An action plan on social determinants of health is a key priority. Ongoing study and evaluation is also critical to success.

Surveillance of health disparities has led to a fundamental shift in attitudes and priorities in Saskatoon with interest from across Canada. Dr. Neudorf noted that solutions are complex, and while they can be led by health authorities, success requires strong partnerships with other organizations and the affected communities. With its strong ties to the community, public health is uniquely positioned to make this type of change happen anywhere in Canada.

Worthy of Our Attention: The Care of Indigenous Children

Margo Greenwood is the Academic Lead for the National Collaborating Centre for Aboriginal Health and Assistant Professor in both the Education and First Nations Studies programs at the University of Northern British Columbia

Margo Greenwood explored the ways in which the health and well-being of Indigenous children and their families can be supported. First Nations, Inuit and Métis early childhood development is a complex and nuanced issue that requires both an individual and collective response. There are no definitive answers. As Blackfoot scholar Leroy Little Bear pointed out, while we individually interpret our identities, we do so within collective cultural norms. With over 600 First Nations, many Métis communities and a number of Inuit settlements, the notion of cultural diversity is challenging, particularly for those involved in policy development and practice.

Dr. Greenwood explored the challenge of respecting the diversity of individuals and groups by recounting Mary's story that exemplified Indigenous ways of knowing and being. Because there are diverse ways of knowing and being in the world, there are many ways to address challenges.

Many Indigenous people around the world agree that relationships between all things and all beings are foundational to Indigenous ways of knowing and being. Mary's story is full of relationships between the self, the environment and the spirit including the spiritual and tangible relationships between ourselves, all beings and all things anchored in the land. They are equally important to the work we do with Indigenous children and their families.

Building relationships is key to the work of home visitors. Dr. Greenwood offered a model to consider in the development of meaningful relationships. She recommended four principles to work from and related questions home visitors can ask themselves:

Respect – What does it mean to be respectful? How can I be respectful? What are the protocols of the community? Am I hearing what the people are telling me? Who is the community? Who is the family?

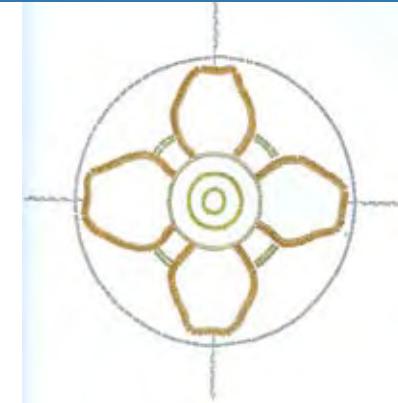
Relevance – Is this activity meaningful and useful to the community and families we are serving? How are the community and the family involved in planning and implementation? What are the communities' aspirations for their children?

Reciprocity – What have I taught the community? What have I learned from them? What have I given to the community?

Responsibility – Who am I accountable to? How am I being responsible to the relationships I am engaged in?

This framework can also be used to describe the domains of early child development – cognitive, socio-emotional, physical, and spiritual/cultural. At the centre of the circle are children and families surrounded by community, then nations, and cultures in the outer circle. The circles and petals are underpinned by Indigenous world views.

Home visiting is a process of establishing relationships; of respect for the diversity and uniqueness of each child, their families and cultures; of relevance to children and their families and communities; of reciprocity of sharing and learning from each other; and of responsibility to maintain positive relationships with each other and all beings. We all have a moral and ethical responsibility to ensure our children's health. Optimal humanity begins with the optimal health of individuals, of our children. From there we build our families, our communities, and our nations.



Early Child Development – Learning from Experience

Six home-visiting programs from across Canada that highlight the vital role home visiting plays in early child development and the relationship between home visiting and health equity were discussed.

KidsFirst – The Saskatchewan Home Visiting Story

Gail Russell, the Saskatchewan Ministry of Education; Dr. Nazeem Muhajarine, the University of Saskatchewan; and Pam Woodsworth, KidsFirst, Saskatoon, presented this showcase.

The KidsFirst program addresses children in very vulnerable situations, aiming to ensure that they are born healthy and remain that way. As Ms. Russell explained, the program's goals are to support and nurture children within healthy, well-functioning families; to support them to maximize their ability to learn, thrive and problem-solve; and to ensure that they are appropriately served by KidsFirst programs. KidsFirst services focus on promoting healthy child development, nurturing positive parent-child relationships, and improving social support networks. The program has a number of hallmarks of effective home visiting: it builds on strengths and existing services, and it is culturally appropriate, inclusive, voluntary, innovative, and flexible.

Wanting to provide services in all nine communities they serve as quickly as possible, the program team recognized that important steps were overlooked initially. The program did not work from a logic model or underpinning theory against which to measure outcomes. It had no clear implementation plan or process for collecting information. In consultation with the Ministry of Education and community partners, the team developed a strategic plan with 70 performance measures. It proved overwhelming for home visitors to capture this much data, so this was reduced to 24 measures and 23 key actions. The program has a baseline of information against which they can measure their impact in 25 result areas.

Objective evaluation is difficult as clear outcomes will only occur 20-30 years in the future. The changing legislative environment also makes it difficult to measure impact. Home visiting is only one variable of many. Ms. Russell suggested that programs be set up to measure small changes in areas the program can influence.

Ms. Woodsworth noted a number of challenges and opportunities with the KidsFirst program. Early on, the team focused on building meaningful community partnerships, something she feels they need to continue. The program model supported innovation using matrix management and interdisciplinary practice. The team was faced with unique challenges delivering services through a targeted program approach. The arbitrary geographic boundaries posed ethical dilemmas as vulnerability exists everywhere. While support staff is working in new ways to challenge the status quo, training needs are extensive as is staff retention. The economic boom Saskatchewan is enjoying provides opportunities for other less-demanding work at higher wages.

An evaluation of the KidsFirst program is being undertaken by Dr. Muhajarine. So far, an evaluation framework has been developed that outlines the purpose of the evaluation, the process to be followed and the content. This includes a program logic model; the principles, objectives, data sources, and collection methods; and a review of the assessment tool. Work is currently going on to determine an underpinning theory for the program with three areas being assessed: human ecology theory, the self-efficacy theory and the attachment theory.

Community profiles are being developed to capture community demographics, services being delivered and challenges. The profiles will help provide context and guidance to the evaluation process. A literature review of effectiveness of home-visiting programs is also being carried out looking at 91 review studies and meta-analyses. In the future, evaluation work will focus on quantitative research and case studies along with other qualitative measures.

Aboriginal Maternal Child Health – First Nations and Inuit Health, Health Canada

Penny Stewart is the Manager, Early Childhood Programs, BC Region, and Jocelyn Stocki is the Program Coordinator, Maternal Child Health, Atlantic Region, both of First Nations and Inuit Health, Health Canada.

The 2005 federal budget allocated \$110 million over five years to improve Aboriginal maternal child health. The program's goal is to support pregnant First Nations women and families with young children to enable them to reach their full potential. It provides home visits by nurses and lay family visitors during pregnancy, postpartum and early childhood; links children and families with special needs to services; and enhances health promotion programming. The program has links with programs on

oral health, mental health, injury prevention, diabetes, tobacco control, immunization, and HIV/AIDS. It aims to enhance traditional beliefs and practices.

Limited funding prevents introduction of the program everywhere, so the team started with communities that had the ability to deliver it while working with other communities to build their capacity. The program has been introduced in the Atlantic and BC regions. While there are common underpinnings, each program is geared to the specific needs of its population. Both programs are built on the principles of maternal child health, with the Atlantic Family Health Team following the *Growing Great Kids* curriculum and the BC Early Child Development unit adopting the *Investing in Kids* approach. Both programs have the support and involvement of First Nations advisors, either as co-managers (Atlantic) or as part of an advisory board (BC).

As Ms. Stewart explained, there is at least one project in each Atlantic province with six projects currently approved including four that operate as clusters with a common coordinator. Several programs are integrated with FASD/CPNP programming to provide seamless services. In BC, Ms. Stocki noted, 16 sites (6 clusters and 10 individual) serve 43 communities. Communities were selected based on service gaps, funding inequities, feasibility, and variety.

Looking forward, both regions hope to expand their programs. They recognize the importance of training, both for staff and interested communities, and the need to connect the communities through annual networking events. In the future, the Atlantic region plans to enhance links with all provinces while BC is exploring a new advisory process based on tripartite relationships.

Both programs aim to support parents and families through increased safe birthing opportunities close to their communities, detection and management of postpartum depression, increased breastfeeding rates and duration, and access to services and supports. They also work to improve relationships within families and parenting and self-care skills such as nutrition, physical activity and oral health. They aim to decrease isolation, family violence and abuse of tobacco, alcohol and other substances.

For children and infants, goals are to increase access to specialized services including assessment to identify complex needs and meet physical and mental developmental

milestones. They also aim to decrease infant mortality, infectious and other diseases, and injuries.

The program addresses clear needs and has been enthusiastically received. It has provided some valuable lessons for others. It is important to provide training earlier on and to explore partnerships and clarify roles at the outset. Some communities require considerable support, and successful implementation often depends on stable nursing support.

Aboriginal Infant Development Program – British Columbia

Presented by Jackie Watts, Nuuchahnulth Tribal Council and Vancouver Island Aboriginal Infant Development Programs of BC, and Jackie Corfield, Northern Region, Nuuchahnulth Tribal Council

The Aboriginal Infant Development Program (AIDP), established in 1992, now operates at 46 locations across British Columbia. The Provincial Advisor for AIDP was established in 2002 to provide leadership and support to the program. Its first priorities were to provide training and mentorship to AIDP workers to support culturally appropriate practices and to develop provincial standards, policies and guidelines.

Ms. Watts explained that the program's mission is to honour every child as a unique gift from the Creator by supporting the development of Aboriginal children within the context of the family, community and culture. The program offers culturally appropriate early-intervention and prevention support and services delivered in a way that is community based, community driven and culturally specific to best meet the needs of Aboriginal children and families.

The program uses the Ages & Stages Questionnaire, the Ages & Stages Questionnaire: Social Emotional, and Nipissing screening tools to help understand and monitor trends in children up to age six. The evaluation materials provide information on development and indicate the need for further assessment or referral. They also help to build positive relationships with parents and provide an opportunity to share developmental and child-safety information

Another useful tool is the Gesell Developmental Assessment Tool, which is used for children with special needs, mostly for referral sources. Training, practice and skill

are needed to administer the Gesell tool, so the Aboriginal Infant Development Tool offer in-service training every fall and spring.

According to the 2007 Aboriginal Infant Development Program survey, parents and families were the most common referral source followed by community health nurses, IDP workers, and social workers. Funding for the majority of AIDP programs (15 of 25) comes from the BC Ministry of Children and Family Development, followed by federal sources, including Aboriginal Head Start, the Health Services Transfer Agreement, and Brighter Futures. One program received independent funding.

Ms. Corfield described a “day” in her life as an infant development worker: She lives on the west coast of Vancouver Island and services remote villages, including Yuquot and Kyuquot. She uses a strengths-based approach focusing on making connections with families. Ms. Corfield meets families “where they are,” both literally and philosophically, drawing on concepts such as “Nobody’s Perfect” parenting. Her training is based on *Great Kids Inc.* and *Growing Great Kids*.

Among the skills Ms. Corfield uses are infant massage, responsive teaching, and speech and language therapy. Her expertise as an infant car seat technician has also proven useful.

Healthy Beginnings: Enhanced Home Visiting – The Nova Scotia Story

This showcase was presented by Kathy Inkpen, Coordinator for Family Health, Nova Scotia Department of Health Promotion and Protection; Darla Macpherson, Acting Director of Public Health Services; and Tanya Olscamp, Healthy Beginnings Enhanced Home Visitors Coordinator, Public Health Services, Nova Scotia.

Healthy Beginnings: Enhanced Home Visiting began with funding made available through the federal Early Childhood Development Initiative. Ms. Inkpen explained that the program builds on existing public health programs providing at-risk families with support for early child development from community home visitors. The program connects families to community services.

Public Health Services worked with partners in local implementation teams to determine the model for Enhanced Home Visiting in their communities. The program uses the Parkyn tool to identify families in need of the service, screening all mothers either in hospital or at home. The tool probes for a range of indicators known to

impact negatively on healthy child development including challenges with housing, drug, alcohol or tobacco use, low education, isolation, limited parenting knowledge and experience, and relationship difficulties.

Staff must be trained to use the tool. Scoring can also be a challenge as the Parkyn tool provides the same score for substance abuse whether the substance is tobacco or heroin. A score of nine or more indicates the need for an in-depth family assessment, which is done using the Nursing Child Assessment Satellite Training (NCAST). Each area trainer was provided with three weeks of onsite training on NCAST, which equipped them to provide a three-day certification program for staff. Staff could then perform in-depth, in-home assessments addressing life circumstances, community/life skills, parent-child attachment, and personal and professional support. The assessment is designed to identify short-term and/or long-term interventions.

Home visitors were given three weeks of training using the *Invest in Kids* curriculum. While it is a family-led, strengths-based approach, it did not provide all the tools required to support the children. The province opted to move to the *Great Kids Inc.* curriculum, an evidence-based program that also provides excellent tools to work with families. Careful consideration was given to properly introducing the families to the program and their home visitors. Home visitors faced challenges working with the children including the constant state of crisis in homes. They had little time to prepare and few effective tools.

The program had to address nurses' concerns regarding the focus on home visitors. The roles of the nurses and the home visitors needed to be better defined, and support and training provided to the nurses and home visitors. The evaluation of the program is ongoing.

As a member of the community, Ms. Olscamp brings a unique perspective to meeting the goals of the Healthy Beginnings program. To "promote healthy parent and child relationships," she notes the importance of accentuating the positives, praising the parents' skills and their values, and supporting parents' dreams and wishes for their children. Role modeling (e.g., sitting on the floor at child's level) and interactive activities are valuable. "The Protective Shield" activity asks what parents do every day to help their child build a protective shield for themselves.

To foster healthy child development, home visitors share information on ages and stages and use “normalizing” to support families. They help the family make the link between what they do and their child’s brain development using activities and tools such as models of brains showing the difference between nurtured, healthy brains and an un-nurtured brain.

Home visitors act as the link between families and community services. They empower families to take best advantage of the resources available to them, working closely with Family Resource Centres and linking to everything from food banks to dieticians, legal aid, doctors, housing, mental health, and many more services.

Effective home visitors provide parents with emotional support and encouragement. They practice active listening that focuses on listening to learn rather than listening to respond. Conversations are important to help the family identify values that are important to them and create motivation for parents to make choices that will support the family in being the best they want to be.

Enhanced Home Visiting builds on the strengths that already exist moving towards true collaboration with parents. Skilled home visitors find ways to comfortably talk about concerns or challenges without criticizing or telling the family what to do. They believe that all parents want to be good parents and focus on the father as well as the mother. They are flexible and have fun, creating environments that will nurture learning. Making toys with families is one such activity that is creative, cost-effective, appeals to dads, and creates opportunities for teaching. It reinforces parenting skills and builds self-esteem.

The first phase of the program’s evaluation focused on implementation according to provincial program standards. Phase II addressed quality assurance, identifying the program’s strengths and weaknesses. Ms. Macpherson noted that it showed that families valued their relationships with home visitors and the connection to family resource centres provided by the program. Areas for improvement included the provincial program standards and guidelines, screening tools, the assessment process, and the quality of the program’s database.

Phase III evaluation will focus on short- and mid-term outcomes for families, asking the question, “What difference has the program made?” Progress families are making

towards their goals will be measured through a family survey and storytelling sessions with home visitors and families.

Families First and Strengthening Families – The Manitoba Home Visiting Story

Marion Ross, Healthy Child Manitoba; Wanda Phillips-Beck, Assembly of Manitoba Chiefs; Darlene Girard, Winnipeg Regional Health Authority; and Dr. Mariette Chartier, Healthy Child Manitoba and University of Manitoba presented this showcase.

Families First evolved from a number of early child development programs offered as a result of the 1995 report, *The Health of Manitoba's Children*. The program focuses on enhancing parents' capacity to provide a nurturing and supportive environment for their children. It is delivered in partnership with the 11 Regional Health Authorities and is designed to augment existing public health services. In most regions, it is delivered as part of the work of a public health nurse (PHN) and the public health services offered to the community.

The program follows guiding principles designed to build positive relationships with families. It is voluntary and strengths-based, in that families are seen as capable partners. The family-centred approach engages all family members with a role in the child's development. It focuses on relationships including fathers because the strength of the relationship between the home visitor and the family predicts outcomes. Cultural context is part of the program's design and delivery.

The program includes a universal screening program with screens conducted on 95% of postpartum referrals and a small number (2%) of prenatal referrals. Families that score 3 or more on the initial screen are asked to complete a parent survey on their strengths and needs allowing Public Health Nurses (PHNs) to link the family to community supports that meet their circumstances. Eleven percent of births score positive on the parent survey and are offered the support of a *Families First* home visitor. The PHN continues to provide nursing and case management for families in the program.

Weekly home visits are provided by trained non-professional home visitors for the first 9–12 months with ongoing support offered for approximately three years. Home visitors are selected according to their personal characteristics, skills and willingness to work with diverse communities. Ms. Daro's research points to increased program

retention when the cultural background of home visitors is matched to that of families, a finding *Families First* can confirm.

Home visitors receive extensive training with the *Growing Great Kids* and *Growing Great Families* curricula along with their own 3- to 5-year-old curriculum, *Small Steps, Big Futures*. Wrap-around training uses *Invest in Kids* plus training on domestic violence, substance abuse, cultural competency, and child development. Home visitors receive weekly reflective supervision by PHNs. The program follows standards and service-delivery guidelines that strike a balance between consistent delivery and opportunities to adapt to local community characteristics.

The *Families First* program has been evaluated for more than eight years and follows the knowledge action cycle. Decisions are based on research and best-practice evidence. The screening form is based on the Parkyn tool, validated by the Institute of Health Policy. The parent survey assessment is based on the Kempe Family Stress Checklist. The Manitoba Centre for Health Policy evaluated the *Families First* screening process. It found that many families were being missed; about half from First Nations communities and others unaccounted for. Further, the very families not being screened were at higher risk. Of the 1407 children who were in care, 41.6% had not been screened. This highlighted the importance of finding better ways of working with First Nations communities. On a positive note, when a screen is administered, it has good sensitivity and specificity, meaning it can correctly identify families at risk.

Evaluation of the program showed that the families involved reported improved parenting; self-acceptance, environmental mastery and purpose in life; and social support and neighbourhood cohesion. There were no differences in literacy, rates of developmental delay, service use, or maternal depression between families in the program and those not involved.

Lessons learned from *Families First* include the benefit of integrating the program into public health from the beginning. Using PHNs as case managers is effective and keeps families connected with public health throughout the case duration. Programs should strive for excellence right from the start and ensure that they communicate at every level. Training needs to be customized to the specific program to be effective. Partnering with Aboriginal communities is critical as is the recruitment of suitable home visitors, who are key to fostering relationships with families.

Ongoing challenges for the program include the sustainability of training, continuing to strive for excellence; engaging and retaining families, particularly prenatally; and retaining home visitors.

The *Strengthening Families* program began in 2006. Sixteen sites are currently funded among Cree and Ojibway groups. According to Ms. Phillips-Beck, 75% (48 of 64) of First Nations in Manitoba receive no maternal child health services including 22 of 24 (91%) remote and isolated communities and 26 of 39 (66%) communities in rural and semi-urban/urban areas.

Strengthening Families' vision is that "every First Nation Community in Manitoba has strong, healthy supportive families living holistic and balanced lifestyles." It aims to empower families; promote the physical, emotional, mental, and spiritual well-being of individuals and families; promote trusting supportive relationships; and increase communities' capacity to support families.

The program provides on-reserve, targeted home visiting with community health nurses and paraprofessional staff. It offers support, advocacy, education, case coordination, and referral. The program accesses community services linking with programs and resources at various levels. Its group and education activities are open to all families with children under six years of age.

Strengthening Families maintains partnerships with a number of organizations to ensure high quality in training and delivery including Healthy Child Manitoba and Growing Great Kids. Evaluation is carried out in conjunction with the University of Manitoba Centre for Aboriginal Health Research. Communities participate in its design, implementation and data collection.

Challenges in operating the program include limited funding, which will end in 2010. The proposal-driven funding process means that those with the capacity to submit proposals are funded with little regard for those most in need. Turnover of nursing staff is an issue as is the program's capacity and control over training.

Showcase Quebec

Dr. Alain Poirier is the Assistant Deputy Minister and Chief Medical Officer of Health at the Ministry of Health and Social Services in Québec. He is a member of the NCCDH National Advisory Committee.

Dr. Poirier described the Québec program of integrated perinatal and early childhood services for vulnerable families (*Les services intégrés en périnatalité et pour la petite enfance* (SIPPE)). The program is part of an overall government effort to reduce disparities, guided by a Public Health Act, strategy and action plan. The preventive strategies implemented have already shown results.

A 2007 report by the Québec department of public health showed that poverty has an impact on children at every age. As a result, a new program was unveiled: *Healthy Schools, Healthy Cities*. Every community is charged with developing an action plan for children under the age of 18 focusing on home visiting and healthy weights.

The SIPPE program addresses the need for early, intensive and continued intervention. It begins from the 12th week of pregnancy, if possible, and continues until the child enters school. The program targets mothers under age 20 and families living in extreme poverty, working with the entire family and the community. Its goals are to maximize the potential for health and well-being, make the birth of children a successful life event, and reinforce the power to act among individuals and communities. Specific objectives are to reduce mortality and morbidity, support the optimal development of children, and contribute to improved living conditions for vulnerable families.

The program uses an ecological model that puts the family at the centre, supported by community resources and services, within the broader environment that takes into account norms, values and belief systems, public policies, and organization of services. Its two components focus on (1) assistance to families and (2) the creation of enabling environments.

Family support is provided through home visits, group activities with families and support in communities. Dedicated home visitors build a relationship of trust, and address both broad and specific issues facing the family, building on the family's strengths. Group activities support child development, alleviate families' isolation and promote their social integration. Home visitors participate in interdisciplinary teams

and create the link between the family, the team and the community. They promote the effective use of community resources accompanying families, if required.

The program helps create enabling environments through intersectoral projects that improve the living conditions of vulnerable families at the local, regional and national levels. Intersectoral action is the best way to act upon the social determinants of health, involve a broad network of players, and identify and support innovative projects. Examples of local action include community kitchens and gardens, parks and playgrounds, housing cooperatives, group purchasing, and micro-loans for freezers.

Adapting the program to meet changing needs, such as increasing immigration, is an ongoing challenge, as are sustainable financing, the retention of families and effective evaluation. Keeping the program within the policy goal of reducing poverty is a main focus.

Child Honouring

Raffi Cavoukian is a renowned Canadian songwriter and performer, author and entrepreneur. He is co-editor of *Child Honouring: How to Turn This World Around*.

Child Honouring is the “children first” way of sustainability, a unifying principle for societal transformation. It is an integrated philosophy that links person, culture, and planet for simultaneously healing communities and restoring ecosystems. Raffi’s business card describes child honouring as: “Redesigning society for the greatest good, by meeting the priority needs of the very young.”

The evidence is clear: early childhood shapes a lifetime of behaviour, and that is why the Council of Human Development (of which Raffi is a member) calls the early years the most important time in human development. Infants, through early relationships, gain their view of self and of the world, and their sense of what is possible.

Sources as diverse as the *Early Years Study 2* (2007) and the Rand Corporation’s *The Economics of Early Childhood Policy: What the Dismal Science Has to Say About Investing in Children* (2008) confirm the power of early experience on outcomes throughout life. From neurological development to developmental psychology to economic analysis, the value of focusing on early child development is clear. We have the opportunity to embrace a profound shift in human health: from treatment to prevention. Enter Child Honouring.

Child Honouring is a potent remedy for what ails our world – a timed release remedy that starts acting fast, grows stronger with use, and amplifies into the future. It is a most proactive vision of nurturing and respectful love as both duty and preventive medicine. Respectful love, the first Child Honouring principle (from *A Covenant for Honouring Children*) is the mirror in which one's innate loving power can actualize.

Child Honouring is a universal ethic, a clear expression of the Dalai Lama's call for a universal ethic for the world's billions, regardless of religion. It is a universal ethic to be expressed in a diversity of locally wise ways. Can you imagine a society whose "systems goal" is to honour its children?

Appendix 3:

Establishing Priorities

After reviewing presentations from 22 researchers and practitioners, participants used a variety of methods to prioritize the issues facing home visiting and ECD. Broad themes are listed here in order of priority as indicated by the participants.

1. Tools

Participants noted the importance of validated, standardized screening tools. They felt it was important to synthesize the existing evidence and make recommendations on tool use. However, they also stressed the value of nursing judgment, and the ability to adapt tools to fit the family, community and culture. Priorities were to:

- * validate tools, e.g., screening, assessment and evaluation
- * develop made-in-Canada tools, e.g., assessment and strengths-based screening
- * conduct an inventory of tools currently being used, including revisions, and test for validity and reliability
- * advocate for surveillance to address health disparities

2. Training

The need for standardized training, available in all provinces, was a high priority for participants.

Specifically, they felt the need for:

- * standardized formal training that is adaptable
- * protocols, knowledge of mental health issues, ethics, and safeguards for practitioners

3. Business Case

Participants see the practical need for a robust business case for home visiting that highlights its role in increasing social and economic prosperity. A business case would support the development and funding of programs; staff and community capacity building; and political aims, such as a national child care strategy and the elimination of jurisdictional issues that currently pose a huge structural barrier to equity for Aboriginal children. The business case would address:

- * sustainable funding models
- * an economic business case for home visiting and ECD
- * adequate, transparent funding allocations
- * funding disparities between Aboriginal and non-Aboriginal communities

4. Workforce Development/Human Resources

A number of human resource challenges exist within home visiting and ECD including attracting and retaining qualified staff, meeting training needs, reducing inconsistency in standards of practice, and ensuring cultural competence. The vast needs in the community can only be met with sufficient, qualified and supported staff. Priorities include the need to:

- * identify who home visitors are
- * establish required skills, knowledge and attitudes (competencies)
- * identify scope, roles and competencies (job descriptions)
- * identify best practices in recruitment and retention
- * establish a pan-Canadian ECD framework
- * promote interdepartmental collaboration

- * advocate for more “people power”
- * support PHNs to clarify their role to explicitly include the social determinants of health

5. Models

Models for delivering a continuum of home-visiting services will eliminate needless duplication of effort and help practitioners – whether they are lay home visitors or public health nurses – build on each other’s success. Consistent models will allow for more effective program evaluation. Those that provide the best service option for families and have been proven successful at reducing health inequities are of greatest interest. To determine the best model(s), participants would like to see the following explored:

- * different service delivery models, e.g., targeted versus universal, nurse-family partnership, infant mental health promotion project
- * the feasibility of family resource centres as a hub of services based on community needs
- * the integration of nurse family partnerships with lay home visitors
- * models that facilitate work across sectors to address health inequities

6. Communication/Advocacy/Community of Practice

Information on the utility of the determinants of health is not widely available to frontline workers or the general public, so participants see the need for a wide range of communication including a website and list serve. They see a strong role for the NCCDH to link existing evidence to practice and make data available to policy makers and other leaders, particularly as they relate to poverty. Participants suggest the following:

- * get information to public health practitioners and policy makers to build capacity to understand and take action on the social determinants of health
- * make knowledge more accessible: organize by topic, population, outcomes

7. Evaluation

Participants see evaluation as an important step to securing sustainable funding. It will provide the evidence to support policy makers in addressing poverty. A common evaluation framework would ensure that everyone is evaluating the same things. Priorities include the need to:

- * advocate for adequate evaluation budgets
- * build local capacity with participatory models of evaluation
- * disseminate evaluation results of ECD programs.

8. Striving for Excellence

In the effort to achieve excellence in programs, participants noted the need to identify key indicators and champion them. To do so, they suggest the following:

- * identify best practices
- * establish home-grown quality assurance
- * develop practice guidelines
- * synthesize current evidence on the best available curriculum.

9. Culture

Articulating diversity remains an important issue, particularly in the context of policy making for Aboriginal programs. There remains a need to:

- * work together across cultures
- * recognize diversity
- * address health inequities
- * contextualize job descriptions

Although raised in discussion, the following two categories were not rated as priorities by participants.

10. Relationships

Progress can be achieved by building relationships to:

- * promote intersectoral collaboration
- * foster partnerships at multiple levels: individual, organizational, governmental
- * create collaborative structures.

11. Continuum of Service/Implementation

Participants see the value of a continuum of service to make use of the most appropriate team member to get the job done – and meet the varying needs of families. The following are required:

- * a continuum of flexible ECD options to support families
- * ways to balance the need for privacy with the need for collaborative practice
- * best practices for a broad team approach with active involvement of all team members

Appendix 4:

Presenter Biographies

Megan Aston

Dr. Megan Aston, RN, PhD, is an Assistant Professor at the School of Nursing at Dalhousie University. Her research and teaching is situated primarily within Community and Family Health Nursing. She uses feminist poststructuralist theory to understand the complex therapeutic relations between nurses and their clients in a variety of settings. More specifically, she has been a principal investigator conducting research with public health nurses and new mothers to explore the social construction of motherhood and empowering relations during home visits. This has led to more recent research and theory/practice development with public health nurses and their role as social mediators with their clients.

Dr. Aston has served as principle investigator on research studies that explored the participatory and collaborative practices of public health nurses across Nova Scotia. Other qualitative research includes bereavement follow-up practices of nurses, influence of spiritual beliefs on women experiencing high-risk pregnancy, women's maternity care experiences, women's experiences with pessaries, obesity management by clients and health care providers, and the experience of using reflective writing by nursing students and faculty.

Hope Beanlands

Hope Beanlands, MN, MPA, PhD(c), RN, is the Scientific Director of the National Collaborating Centre for Determinants of Health located in Antigonish, Nova Scotia. Hope is a senior public health practitioner and a registered nurse with extensive experience in population health, public health, public health nursing, health policy, global health, primary health care, and health system reform and renewal. She has in-depth knowledge of population health issues and challenges; the determinants of health and the root causes of poor health status; and has extensive knowledge of the public policy process and health system reform initiatives. She has demonstrated leadership ability working with diverse populations and perspectives.

With over 30 years of provincial and federal government experience, she has managed or contributed to major policy changes in public health programming, including: assessment of population health status; health surveillance and communicable disease control; health promotion and primary health care reform/renewal; health human resources; public health nursing programming; and the development and introduction of electronic health records. While working for Health Canada as National Coordinator of First Nation and Inuit Health Information Systems, she gained in-depth knowledge of the disparity in health status between aboriginal and non-aboriginal Canadians and experienced first hand, the challenges of providing equitable health services for marginalized populations.

As a senior public health consultant, Ms. Beanlands has worked on health system reform projects funded by UNDP, CIDA, Health Canada and PAHO in China, Russia, Cuba, Grenada and Canada. Ms. Beanlands is currently a PhD candidate at the University of South Australia studying how people conceptualize health and the implications for the education of public health practitioners.

Raffi Cavoukian

Raffi Cavoukian is known to millions simply as Raffi: a renowned Canadian songwriter and performer, author and entrepreneur, once called “the most popular children’s entertainer in the western world” (Washington Post).

Spoofed by the Simpsons, featured in a NY Times editorial cartoon, Raffi’s career has provided the soundtrack for a growing generation, and now for their children. His CDs, books and videos have sold over 15 million copies in Canada and the US. A generation saw him perform “Down by the Bay” and his signature song – “Baby Beluga”. “Beluga grads” often tell him that they are now raising their own children with his music. In his three-decade career, Raffi has refused all commercial endorsement offers, and Troubadour Music, his own triple-bottom-line company, has never directly advertised or marketed to children. He is a passionate advocate for a child’s right to live free of commercial exploitation.

Raffi's most recent works for adults and youth: The anthology *Child Honouring: How to Turn This World Around* (co-edited with psychologist Dr. Sharna Olfman) its companion CD, *Resisto Dancing: Songs of Compassionate Revolution*. A new DVD, *Raffi Renaissance*, shows Raffi's evolution into a leading thinker and global troubadour.

With two honorary degrees, the Order of Canada, and the United Nation's Earth Achievement award, Raffi is a respected international figure, a global troubadour. He is a member of the Council of Human Development, and the Club of Budapest.

He is a keynote presenter, lecturing and networking to help create a viable future: a sustainable, child-friendly world for us and for those to come. His original philosophy, *Child Honouring*, is gaining support among eminent thinkers as a holistic organizing principle for a culture of peace. Raffi Cavoukian is a catalyst for change at a defining point in human history—with an idea whose time has come.

Mariette Chartier

Mariette Chartier is a research scientist with Healthy Child Manitoba and an assistant professor in Community Health Sciences at the University of Manitoba in Winnipeg, Manitoba. Her career includes a wide range of clinical nursing experiences, a career in mental health research and most recently early childhood policy development. Currently, she is leading a provincial evaluation of universal screening at birth and home visiting for at-risk families. Mariette has published in the area of child risk factors, child maltreatment and anxiety disorders.

Cheri Corbier

Cheri Corbier is a Community Health Representative from Manatoulin Island in Ontario and she is the President of the Board of Directors for the National Indian and Inuit Community Health Representatives Organization (NIICHRO).

Jackie Corfield

Jackie Corfield is the Infant & Early Development Program Consultant for the Northern Region of the Nuu-chah-nulth Tribal Council. Ms. Corfield is the mother of two boys aged 3 and 13 years. She lives in Gold River, which is located in the north west of Vancouver Island and she works in Kyuquot, Zebellos area. Ms. Corfield has been working with children for 15 years. She is from the Wickaninnish Beach and is a member of the Ucluelet First Nation.

Darlene Girard

Darlene Girard is the Team Manager for Healthy Parenting and Early Childhood Development with the Population and Public Health Program of the Winnipeg Regional Health Authority. Ms. Girard has been involved in the development, coordinating and delivery of the Families First program since its inception more than a decade ago. She currently oversees the delivery of the Families First program for the Winnipeg region as one component of a comprehensive public health strategy to support families parentally through school entry.

Margo Greenwood

Margo Greenwood is the Academic Lead for the National Collaborating Centre for Aboriginal Health located in Prince George, British Columbia. She is an Indigenous scholar of Cree ancestry with more than 20 years experience in the field of early childhood education. Professionally and personally, children have been the focus of her life. She has worked as a front line caregiver of early childhood services, designed early childhood curriculum, programs, and evaluations, and taught early childhood education courses at both the college and university levels. As a mother of three, she is personally committed to the continued well-being of children and youth in Canada.

While Dr. Greenwood's focus has been on all children, she is recognized provincially, nationally and internationally for her work on Aboriginal children. She has served with over 20 national and provincial federations, committees and assemblies, and has undertaken work with UNICEF, the United Nations, and the Canadian Reference

Group to the World Health Organization Commission on Health Determinants. In recognition of her years of work in early childhood, Dr. Greenwood was the recipient of the Queen's Jubilee Medal in 2002.

Currently, Dr. Greenwood is an Assistant Professor in both the Education and First Nations Studies programs at the University of Northern British Columbia (UNBC). Her current research interests include the structural impetus for the development and subsequent implementation of early childhood development programs and services in Canada and with the Kohanga reo in New Zealand; and cross-cultural communication and children's transition from preschool to the formal education system. In addition to her teaching and service commitments, Dr. Greenwood also directs a number of research institutes including the National Collaborating Centre for Aboriginal Health; the Centre of Excellence for Children and Adolescents with Special Needs, UNBC Task Force on Substance Abuse; and BC Initiatives, a Ministry of Health activity that is comprised of Aboriginal ACTNOW BC and Preschool Visual Screening.

Kathy Inkpen

Kathy Inkpen is the Coordinator for Family Health with the Nova Scotia Department of Health Promotion and Protection. Ms. Inkpen is passionate about public health and the early years. She is involved in many aspects of family health at the provincial and national level and is currently co-chair of the Breastfeeding Committee for Canada, Provincial/Territorial Implementation Committee. Ms. Inkpen lives in Halifax, Nova Scotia with her husband Steve and three children.

Susan Jack

Susan Jack, RN, PhD, is an Assistant Professor, School of Nursing at McMaster University and holds the Child Health and Reproduction New Investigator Personnel Award from the Canadian Institutes of Health Research. As a nurse, Dr. Jack has had extensive clinical experience home visiting at-risk clients in her past role as a public health nurse, working in both Edmonton, Alberta and then in Guelph, Ontario. She was also a Child Health Nurse Manager, responsible for implementing Ontario's provincial home visiting program, Healthy Babies, Healthy Children at the Wellington

Dufferin Guelph Health Unit. Her doctoral thesis work focused on the process by which high risk mothers engage with both public health nurses and family visitors in home visitation. Currently, Dr. Jack is the Project Director of a US based study funded by the Centers for Disease Control and Prevention to develop a nursing intervention to address the issue of intimate partner violence for clients enrolled in the Nurse Family Partnership Program and is one of the investigators involved in the first Canadian replication of the Nurse Family Partnership Program in Canada.

Darla MacPherson

Darla Macpherson is the Acting Director of Public Health Services in Nova Scotia. Ms. Macpherson has a Master of Nursing degree and is a Nurse Practitioner. She has worked as a nurse for 21 years. For 10 1/2 of those years she worked as a nurse in all aspects of acute care. Her favourite areas of nursing are maternal/child and palliative care because of the relationships she was able to establish with families.

Ms. Macpherson has now worked 10 1/2 years in community health including continuing care, Public Health and Primary Care. In that capacity she has “had the pleasure of implementing Enhanced Home Visiting in the Northern Districts of Nova Scotia.’

Catherine McCourt

Catherine McCourt is the Director of the Health Surveillance and Epidemiology Division in the Centre for Health Promotion with the Public Health Agency of Canada. She is based in Ottawa, Ontario. In this capacity, Dr. McCourt manages programs in national surveillance of child injury, child abuse and neglect and of maternal, fetal and infant health. She is a physician with specialization in community medicine and she has a Master’s in Health Administration.

Nazeem Muhajarine

Nazeem Muhajarine is a professor and Chair in the Department of Community Health and Epidemiology, College of Medicine, University of Saskatchewan, and a research faculty member in the Saskatchewan Population Health and Evaluation Research Unit (SPHERU). Dr. Muhajarine leads the healthy children research theme at SPHERU, working with other faculty members, research staff and graduate students investigating the social determinants of children's health. He is also the former co-director (academic) and founding member of the Community-University Institute for Social Research.

Dr. Muhajarine is a social epidemiologist whose major research interests include community and family influences in child development (evidence and methodology), the role of social and economic status in children's use of health care services, evidence of risk in the prenatal period, and developing community-university research partnerships to improve knowledge creation, transfer and application.

Dr. Muhajarine's current research projects include studies on the impact of family and neighbourhood contexts on young children's health and educational outcomes, the prevalence of antenatal depression, and evaluations of early childhood intervention programs. He is currently leading a team of researchers and decision-makers in an evaluation of KidsFirst, the Saskatchewan government's early intervention program for very vulnerable young children and their families, funded by the Canadian Population Health Initiative and the Saskatchewan government.

Dr. Muhajarine is a passionate advocate for greater inclusivity and relevance for academic research. His work has been recognized as exemplary, and he was awarded the 2006 CIHR Knowledge Translation Award for impact at a local/regional level. He lives in Saskatoon with his wife and two children.

Cordell Neudorf

Cory Neudorf is the Chief Medical Health Officer for the Saskatoon Health Region. He received his medical degree from the University of Saskatchewan, a Master of Health Science degree in Community Health and Epidemiology from the University

of Toronto, and is a fellow of the Royal College of Physicians and Surgeons of Canada with Certification in the specialty of Community Medicine. He is the past president of the National Specialty Society for Community Medicine, Chair-elect of the Canadian Public Health Association, and Chair of the Canadian Population Health Initiative Council. Dr. Neudorf is a Clinical Associate Professor in the Department of Community Health and Epidemiology at the University of Saskatchewan, College of Medicine.

Dr. Neudorf's research interests include health inequalities, health status indicators and surveys, Health status monitoring and reporting, and integrating Population Health data and Geographic Information Systems into public health and health planning.

Tanya Olscamp

Tanya Olscamp is the Healthy Beginnings Enhanced Home Visitors Coordinator, with Public Health Services, Nova Scotia.

Ms. Olscamp works and lives in the beautiful Annapolis Valley of Nova Scotia. Her current role is to provide reflective supervision to five Home Visitors. She was previously employed in several roles with Child Welfare in Nova Scotia. Ms. Olscamp's passion is Community Development and working to support healthy families...healthy communities!

Wanda Phillips-Beck

Wanda Phillips-Beck is a busy mother of three children ages 13, 9 and 4, two of whom are die hard hockey players, and a member of the Hollow water First Nation.

Since, 2006 she has been the Nurse Program and Practice Advisor for the Strengthening Families Maternal Child Health Program, Assembly of Manitoba Chiefs who has partnered with the Federal government to implement the MCH program. Prior to that, Wanda worked for First Nations and Inuit Health for 11 years as a Community Health Nurse in Northern Nursing Stations throughout Manitoba,

and more recently as the Acting Regional Nursing Officer and Regional Education Manager for e-Health Solutions with Health Canada. She is currently completing graduate studies in Community Health Sciences at the University of Manitoba, and her thesis is centered on support for First Nation Prenatal women who relocate temporarily to give birth outside their community. Her passion is her children. And hockey, of course!

Alain Poirier

Dr. Alain Poirier is a physician with a specialty in Internal Medicine and Community Health. He is an international consultant for the University of Montreal. In the past he has worked in a regional public health office south of Montreal and with the Institute of Public Health in Quebec.

Since 2003 Dr. Poirier has been the Assistant Deputy Minister and the Chief Medical Officer of Health at the Ministry of Health and Social Services in Quebec.

Dr. Poirier is a member of the National Collaborating Centre for Determinants of Health National Advisory Committee.

Marion Ross

Marion Ross is the Provincial Coordinator for Families First program in Manitoba. Prior to her provincial role, she was the Families First Coordinator in the Winnipeg Regional Health Authority. Ms. Ross has been the Provincial trainer for the Families First Core Family Support Worker training for several years. She brings 28 years of public health experience to her varied roles.

Gail Russell

Gail Russell has been working in early childhood development for the past five years. Prior to that, she was with the Ministry of Health in Saskatchewan, working with

health region boards on strategic planning and health services policy. Ms. Russell holds a Master of Arts Degree in Conflict Analysis and Management. The focus of her efforts is on evidence-based decision making and addressing the determinants of health.

Penny Stewart

Penny Stewart is the Manager of the Early Childhood Programs (Aboriginal Head Start, Fetal Alcohol Spectrum Disorder and Maternal Child Health) with First Nations & Inuit Health, Health Canada, BC region. Ms. Stewart has worked in community health in Newfoundland and BC and has a lengthy experience with home visiting programs including the implementation of "Healthiest Babies Possible" in the city of Vancouver. Since joining Health Canada in 1982, she has worked in a number of portfolios and has been directly responsible for the implementation of each of the children's programs in First Nations communities in BC from their beginnings. In the course of her work Ms. Stewart has visited all of the 204 First Nations communities in the province. She has a B.Sc. from McGill University and a M.Sc. in community nutrition from the University of British Columbia.

Ms. Stewart lives on a farm with her husband, llama, and border collie. She has two adult children.

Jocelyn Stocki

Jocelyn Stocki, BSc HNU, P.Dt., CDE, is the Maternal Child Health Program Coordinator with First Nations and Inuit Health, Health Canada, Atlantic Region. She is Registered Dietitian and certified diabetes educator. Ms. Stocki graduated from St. Francis Xavier University with a Bachelor of Science in Human Nutrition and completed a diploma of Integrated Dietetic Internship also through St FX University. Prior to moving back to Nova Scotia in the spring of 2008, she spent 5 years in Northern Manitoba working in both acute care and public health programs

Susan Szozda

Susan Szozda has been a Public Health Nurse for 23 years in the City of Hamilton, Ontario. She is currently part of the Hamilton Nurse-Family Partnership team which formed in April 2008 and started taking clients at the end of June, 2008.

Ms. Szozda has worked in Child and Family Health for 19 years. She has taught evening prenatal classes to couples for 10 years while raising her four children. Ms. Szozda has three daughters now attending university and one attending high school. She returned to home-visiting in 1999 with the expansion of the Healthy Babies Healthy Children home-visiting programme. Since then, her work has included post partum home-visits, intake assessment and long-term neighbourhood visiting. Ms. Szozda has enjoyed other assignments in her role as Public Health Nurse, these include: facilitate groups for mothers with their babies up to 1 year of age; train as a facilitator for “Incredible Years Parenting Programme” for parents of 3-6 yr olds with identified behaviour problems; Public Health Nurse liaison for local Maternity Centre and 2 area hospitals with obstetrical and pediatric services.

Ziba Vaghri

Ziba Vaghri is a nurse and a nutritionist in training. She began her career as a Registered Nurse. After few years of work as a health care professional in various countries, which gave her a rich experience in working within multi-ethnic settings, Dr. Vaghri returned to school and completed a doctoral degree in Human Nutrition with a special focus on Pediatric Nutrition at the University of British Columbia.

Presently Dr. Vaghri is the Research Associate leading the International Research and Initiatives Program of the Human Early learning Partnership. Her current interest lies in population-based monitoring of Early Child Development (ECD) in diverse parts of the world. She ascribes to the view that this could inform new initiatives in the various countries and provide direction to them in the framing of future policy around ECD.

Dr. Vaghri is a member of a team working on the development of a framework for monitoring child rights in early childhood for United Nation’s Committee on the Rights of the Child, UN-CRC.

Jackie Watts

Jackie Watts is a member of the Tseshah First Nation. She is a mother of 2 and grandmother of Tia. She is the Sr. Infant and Early Development Consultant and Supervisor for the Nuuchahnulth Tribal Council, Aboriginal Infant & Early Development Program and Family Ties (Pregnancy Outreach Program). For the past 3 years, Ms. Watts has been the Regional Advisor for Vancouver Island Aboriginal Infant Development Programs of British Columbia. She has worked in Aboriginal Infant Development Program with the Nuu-chah-nulth Tribal Council for 14 years as a supervisor and field worker.

Pam Woodsworth

Pam Woodsworth is a registered nurse who has worked for nearly two decades providing service to prenatal families and families with young children. Her work began as an Outreach Worker with Saskatoon's prenatal home visiting program, Healthy Mother Healthy Baby. For ten years she was Program Facilitator for the Food for Thought Program, a Canadian Prenatal Nutrition Program site. She began working with KidsFirst in 2002 as a Program Facilitator and has been Program Manager since July 2005.

Working from a strengths-based, health determinants perspective continues to fuel Ms. Woodsworth's understanding of the relevance of social justice, equity and empathy in influencing health and well-being among us all, including our most vulnerable citizens.

Appendix 5: Agenda



NATIONAL COLLABORATING CENTRE
FOR ABORIGINAL HEALTH
CENTRE DE COLLABORATION NATIONALE
DE LA SANTÉ AUTOCHTONE



National Collaborating Centre
for Determinants of Health
Centre de collaboration nationale
des déterminants de la santé

Agenda

EARLY CHILD DEVELOPMENT FORUM: EXPLORING THE CONTRIBUTION OF PUBLIC HEALTH HOME VISITING

October 14-17, 2008

SASKATOON INN AND CONFERENCE CENTRE

SASKATOON BALLROOM A AND MEZANNINE A

Purpose

Facilitate knowledge synthesis, translation and exchange around effective strategies for home visiting and the contribution to early child development as a determinant of health.

Objectives

- 1) Profile selected Home Visiting Programs, and explore the relationship between home visiting and health equity
- 2) Explore knowledge from stories and scenarios to help apply “what works” to improve policy and practice
- 3) Identify and prioritize policy and practice issues which could be addressed by the Collaborating Centres

Tuesday, October 14, 2008

18:00 - 20:00 Registration & Opening of the Knowledge Exchange Fair

19:00 - 21:30 Meet and Greet Reception (cash bar)
▪ Welcoming Remarks

Wednesday, October 15, 2008

07:00 – Registration

07:30 – 08:15 Networking Breakfast

08:30 – 09:30 **Opening Session**

- Elder Opening and Territorial Welcome
- Greetings from the Co hosts
Hope Beanlands, Scientific Director,
National Collaborating Centre for Determinants of Health &
Margo Greenwood, Academic Lead,
National Collaborating Centre for Aboriginal Health
- Review of the Agenda
Raymonde D'Amour, Facilitator, Groupe Intersol Group
- Setting the context: Early Child Development as a Determinant of Health
Hope Beanlands, Scientific Director,
National Collaborating Centre for Determinants of Health

Questions and Discussion

09:30 – 10:30 Session 1 – Early Child Development

- Collaborative Public Health Practice: What is your role in home visiting?
Megan Aston, PhD, RN
Assistant Professor, Dalhousie University
- Total Environment Assessment Model of Early Child Development: TEAM-ECD
Ziba Vaghri, RN, PhD
Research Associate, International Research and Initiatives Program, Human Early Learning Partnership (HELP), University of British Columbia

Questions and Discussion

10:30 – 11:00 Health Break / Knowledge Exchange Fair

11:00 – 12:00 Session 2 – Showcase

- The Saskatchewan Home Visiting Story
Gail Russell
Director, Early Childhood Development Unit, Early Learning and Child Care Branch
Saskatchewan Ministry of Education
Nazeem Muhajarine, PhD
Professor and Chair, Department of Community Health and Epidemiology, College of Medicine, Research Faculty, Saskatchewan Population Health and Evaluation Research Unit (SPHERU), University of Saskatchewan, Saskatoon
Pam Woodsworth
Program Manager, KidsFirst, Saskatoon

Questions for clarification

12:00 – 12:10 Interactive table discussion

12:10 – 13:10 Lunch / Knowledge Exchange Fair

13:10 – 13:50 Session 3 – Showcase

- Health Canada, First Nations and Inuit Health Branch Story
Penny Stewart
Manager, Early Childhood Programs, First Nations & Inuit Health, BC Region
Jocelyn Stocki, BSc, HNU, P.Dt., CDE
Maternal Child Health Program Coordinator, First Nations and Inuit Health, Health Canada - Atlantic

Questions for clarification

13:50 – 14:30 Session 4 – Showcase

- The British Columbia Aboriginal Infant Development Program
Jackie Watts

Early Child Development Forum:
Exploring the Contribution of Public Health Early Child Home Visiting

Sr. Infant and Early Development Consultant and Supervisor, Nuuchahnulth Tribal Council,
Aboriginal Infant & Early Development Program and Family Ties (Pregnancy Outreach
Program), Regional Advisor for Vancouver Island Aboriginal Infant Development Programs of
British Columbia
Jackie Corfield
Infant & Early Development Program Consultant, Northern Region of the Nuuchahnulth Tribal
Council

Questions for clarification

14:30 – 15:00 Health Break / Knowledge Exchange Fair

15:00 – 16:00 Session 5 – Showcase

- The Nova Scotia Home Visiting Story
Kathy Inkpen
Coordinator, Family Health, Nova Scotia Health Promotion & Protection
Darla MacPherson,
Acting Director, Public Health Services
Tanya Olscamp
Healthy Beginnings Enhanced Home Visitors Coordinator, Public Health Services

Questions for clarification

16:00 – 16:25 Interactive table discussion

16:25 – 16:30 Wrap-up day 2 / Invitation to visit the Knowledge Exchange Fair

17:30 – Buses leave for Wanuskewin Interpretation Centre

18:00 – 21:00 Dinner and Social Evening
Greetings from the NCC National Advisory Committees
Cultural Event
Community Health Representative Story

Thursday, October 16, 2008

07:00 – Registration

07:30 – 08:15 Networking Breakfast

08:30 – 08:45 Day 3 Gets Underway

08:45 – 09:30 Session 6 – Worthy of our attention: The Care of Indigenous Children
Margo Greenwood
Academic Lead, National Collaborating Centre for Aboriginal Health

Questions and Discussion

09:30 – 09:45 Health Break / Knowledge Exchange Fair

09:45 – 10:45 Session 7 – Showcase

- The Manitoba Home Visiting Story
Marion Ross
Provincial Coordinator for Families First Program, Healthy Child Manitoba Office
Wanda Phillips-Beck
Nurse Program and Practice Advisor, Assembly of Manitoba Chiefs
Darlene Girard
Team Manager, Healthy Parenting and Early Childhood Development
Winnipeg Regional Health Authority
Mariette Chartier R.N. Ph.D.

Research Scientist, Policy Development, Research & Evaluation, Healthy Child Manitoba
Office and Assistant Professor, Community Health Sciences, Faculty of Medicine, University of
Manitoba

Questions and Discussion

10:45 – 11:00 Health Break / Knowledge Exchange Fair

11:00 – 12:00 Session 8 – Sharing stories: Build on everyone's experience
▪ Interactive exercise at table groups

12:00 – 13:00 Lunch / Knowledge Exchange Fair

13:00 – 14:00 Session 9 – Plenary session on our shared stories: putting our best ideas forward

14:00 – 14:45 Session 10 – Making a Promise to Make a Difference: The Nurse-Family Partnership Program of
Nurse Home Visitation
▪ Susan Jack, RN, PhD
Assistant Professor, School of Nursing, McMaster University
Child Health and Reproduction New Investigator Personnel Award from the Canadian
Institutes of Health Research
Susan Szozda, RN, BScN
Public Health Nurse, Family Health Division, Public Health Services,
City of Hamilton Health Unit

Questions and Discussion

14:45 – 15:30 Session 11 – Surveillance

- Knowledge from Surveillance
Dr. Catherine McCourt
Director, Health Surveillance and Epidemiology Division,
Centre for Health Promotion,
Public Health Agency of Canada
- Improving Social Determinants of Health in Saskatoon: From Surveillance to Action
Dr. Cory Neudorf
Chief Medical Health Officer
Saskatoon Health Region
Saskatoon, Saskatchewan

Questions and Discussion

15:30 – 15:45 Health Break / Knowledge Exchange Fair

15:45 – 16:20 Session 12 – Bringing it all together
▪ Table group discussion

16:20 – 16:30 Wrap-up day 3

Dinner on your own

19:30 – 21:00 Optional Evening Activities
▪ Unnatural Causes: Is Inequity making us Sick? - Manitoba Room
▪ Red Moon Dialogues - National Collaborating Centre for Aboriginal Health DVD – British
Columbia Room
▪ A Virtual Tour of the Saskatoon Public Health Observatory – Alberta Room
▪ Saskatoon 'Health Bus' (provisional) – meet in Saskatchewan Room

Friday, October 17, 2008

07:30 – 08:15 Networking Breakfast

08:30 – 08:45 Day 4 Gets Underway

08:45 – 10:30 Session 13 – Conclude our exploration of early child development:
Setting our direction
Identify and prioritize policy and practice issues which could be addressed by the
Collaborating Centres

10:30 – 11:00 Break / Hotel check-out / Knowledge Exchange Fair

11:00 – 12:00 Session 14 – Child Honouring - Raffi

12:00 – 12:15 Next Steps, Evaluation and Closing Remarks
Margo Greenwood and Hope Beanlands

12:15 Forum Adjournment

Appendix 6:

Participant List

Lorraine Adam, Executive Director, Public Health Division, Manitoba, lorraine.adam@gov.mb.ca

Megan Aston, Assistant Professor, School of Nursing, Dalhousie University, Nova Scotia, megan.aston@dal.ca

Darlene Bachiri, Community Health Representative, Pictou Landing Health Care, Nova Scotia, darlene.chr@pchg.net

Hope Beanlands, Scientific Director, National Collaborating Centre for Determinants of Health (NCCDH), Nova Scotia, hbeanlan@stfx.ca

Suzanne Beaulieu, Program Consultant, Healthy Child Development, Public Health Agency of Canada, Ontario/Nunavut Regional Office, suzanne_beaulieu@phac-aspc.gc.ca

Claire Betker, Director of Research, Early Child Development, National Collaborating Centre for Determinants of Health (NCCDH), Nova Scotia, cbetker@stfx.ca

Kavita Bhatla , Senior Program/Policy Analyst, Children & Youth Division, Community Programs Directorate, First Nations and Inuit Health Branch (FNIHB), Ontario , Kavita_Bhatla@hc-sc.gc.ca

Bonnie Bogart-Hamilton, Consultant, National Collaborating Centre for Determinants of Health (NCCDH), Nova Scotia, bonniehb@nb.sympatico.ca

Debbie Bond, Manager, Winnipeg Regional Health Authority, Manitoba, dbond@wrha.mb.ca

Michelle Bowden, Program Consultant , Public Health Agency of Canada, Nova Scotia, michelle_bowden@phac-aspc.gc.ca

Jane Breckenridge, Director, Research Services, Atlantic Health Sciences Corporation, New Brunswick, breja@reg2.health.nb.ca

Wendy Bruins, Clinical Nurse Educator, Health Promotion and Prevention, Fraser Health, British Columbia, wendybruins@fraserhealth.ca

Lynlee Burleigh, Community Health Nurse, First Nations Inuit Health Branch, Health Canada, British Columbia, lynlee_burleigh@hc-sc.gc.ca

Susan Burns, Community Health Representative, National Indian & Inuit Community Health Representatives Organization (NIICHRO), Yukon, sburns@kdfnyk.ca

Brenda Carle, Project Officer, Office of Chief Medical Officer of Health, Department of Health, New Brunswick, Brenda.Carle@gnb.ca

Mariette Chartier, Research Scientist, Healthy Child Manitoba Office, Healthy Child Committee of Cabinet Government of Manitoba, Manitoba, mchartier@rainyday.ca

Edward Choice., Knowledge Translation Project Manager, National Collaborating Centre for Environmental Health (NCCEH), British Columbia, edward.choice@bccdc.ca

Heather Christian, Director of Healthy Development, Nova Scotia Department of Health Promotion and Protection, Nova Scotia, heather.christian@gov.ns.ca

Donna Churko, Public Health Nursing Supervisor, Regina Qu'Appelle Health Region, Kids First, Saskatchewan, donna.churko@rqhealth.ca

Suzanne Clair, Senior Program Advisor, Department of Health, New Brunswick, suzanne.clair@gnb.ca

Cheri Corbiere, Community Health Representative, Sheshegwaning Health Centre, NIICHRO, Ontario, chericorbiere@sheshegwaning.org

Jacqueline Corfield, Infant & Early Development Program Consultant, Aboriginal Infant Development Program, Nuu-chah-nulth Infant Development Program, British Columbia, jcorfield@nuuchahnulth.org

Rose Couch, Coordinator, Early Childhood, Nova Scotia Department of Health Promotion and Protection, Nova Scotia, rosemarie.couch@gov.ns.ca

Kathy Currier, Public Health Nurse, Clinical Supervisor, Interior Health Authority, British Columbia, kathy.currier@interiorhealth.ca

Elizabeth (Lisa) Daniels, Community Health Representative, National Indian & Inuit Community Health Representatives Organization (NIICHRO), British Columbia, Lisa.Daniels@cowichantribes.com

Deborah Dedam-Montour, Executive Director, National Indian & Inuit Community Health Representatives Organization (NIICHRO), Quebec, debbiedm@niichro.com

Elsabé du Plessis, Knowledge Translation Officer, National Collaborating Centre for Infectious Disease (NCCID), Manitoba, eduplessis@icid.com

Monika Dutt, Deputy Medical Health Officer, Athabasca, Keewatin Yatthe & Mamawetin Churchill River Regions, Saskatoon Health Region, Saskatchewan, monika.dutt@mcrha.sk.ca

Valerie Elliott-Carthew, Manager, Healthy Family Child Health, Toronto Public Health, Ontario, vellioott@toronto.ca

Dorothy Fewer, Director, Early Learning and Child Development, Central Regional Health Authority, Newfoundland, dorothyfewer@gov.nl.ca

Don Fiddler, Manager, Knowledge Translation Health Information & Analysis, First Nations Inuit Health Branch, Ontario, Don_Fiddler@hc-sc.gc.ca

Heidi Fisher Phillips, Program Manager, Regina Qu'Appelle Health Region, Kids First, Saskatchewan, heidi.Fisherphillips@rqhealth.ca

Pamela Forsyth, Knowledge Broker, National Collaborating Centre for Methods and Tools (NCCMT), Ontario, forsyp@mcmaster.ca

Tina Fraser, Research Manager, Aboriginal Health, National Collaborating Centre for Aboriginal Health (NCCAH), British Columbia, frasert@unbc.ca

Margaret Gander, Manager, Infant, Child and Youth, Vancouver Coastal Health Authority, British Columbia, margaret.gander@vch.ca

Rob Gates, Consultant, Early Childhood Development, Ministry of Education, Saskatchewan, rgates@sasked.gov.sk.ca

Joan Geber, A/Executive Director, Healthy Women and Children, Ministry of Healthy Living and Sport, British Columbia, Joan.Geber@gov.bc.ca

Susan Gillam, Chief Executive Officer, Western Regional Health Authority, Newfoundland, susangillam@westernhealth.nl.ca

Donna Gillard, Program Consultant, Parent and Child Health, Department of Health and Community Services, Newfoundland, DonnaGillard@gov.nl.ca

Darlene Girard, Team Manager, Healthy Parenting and Early Child Development, Winnipeg Regional Health Authority, Manitoba, dgirard@wrha.mb.ca

Margo Greenwood, Lead, National Collaborating Centre for Aboriginal Health (NCCAH), British Columbia, greenwom@unbc.ca

Calvin Hanselmann, Director of Research, National Association of Friendship Centres (NAFC), National Indian & Inuit Community Health Representatives Organization (NIICHRO), Ontario, chanselmann@nafc.ca

Paula Hennessey, Consultant, Intervention Services, Department of Health and Community Services, Newfoundland, phennessey@gov.nl.ca

Carolyn Hill-Carroll, Clinical Nurse Specialist, Winnipeg Regional Health Authority, Manitoba, chillcarroll@wrha.mb.ca

Kathy Inkpen, Coordinator, Family Health, Nova Scotia Department of Health Promotion and Protection, Nova Scotia, kathryn.inkpen@gov.ns.ca

Karen Isaac, Executive Director, British Columbia Aboriginal Child Care Society, British Columbia, karen@acc-society.bc.ca

Susan Jack, Assistant Professor, School of Nursing/Associate Member, Clinical Epidemiology & Biostatistics, McMaster University, Ontario, jacksm@mcmaster.ca

Nadine Johnson, Assistant Director, Early Childhood Development, Interior Health Authority, British Columbia, nadine.johnson@interiorhealth.ca

Steve Jreige, Evaluation Consultant, Public Health Agency of Canada, Nova Scotia, steve_jreige@phac-aspc.gc.ca

Eva Kigutaq, Family Services, Inuit Family Resource Centre, Tungasuvvingat Inuit, Ontario, familyservices@ontarioinuit.ca

Cathy Kimak, Regional Manager, Alberta Health Services, Capital Health, Alberta, cathy.kimak@capitalhealth.ca

Megan Klammer, ECD Program Consultant, Interior Health , British Columbia, megan.klammer@interiorhealth.ca

Randall Klaprat , Team Manager, Public Health, Winnipeg Regional Health Authority, Manitoba, rklaprat@wrha.mb.ca

Elaine Klassen, Clinical Nurse Educator, Public Health Nursing, Fraser Health, British Columbia, elaine.klassen@fraserhealth.ca

Grace Klassen, Manager, Public Health Programs, RHA Central Manitoba, Manitoba, gklassen@rha-central.mb.ca

Velma LaBillois-Petersen, Community Health Representative, Eel River Bar First Nation, National Indian & Inuit Community Health Representatives Organization (NIICHRO), New Brunswick, velma77@hotmail.com

Cecile Lalo, Community Health Representative, National Indian & Inuit Community Health Representatives Organization (NIICHRO), Quebec, cecile.michel@hotmail.com

Claudette Landry, Senior Program Advisor, Office of Chief Medical Officer of Health - Department of Health, New Brunswick, claudette.landry@gnb.ca

Brigitte La Pointe, Director, ACL Early Intervention Program, New Brunswick, brigitte.lapointe@nb.aibn.com

Anne Lebans, Regional Director Public Health and Wellness, Regional Health Authority - A, New Brunswick, anne.lebans@gnb.ca

Margaret Leighton, Research Assistant, Population Health Intervention Research Centre, Alberta, m.leighton@gmail.com

Audrey Loewen, Clinical Nurse Educator, Public Health Nursing, Fraser Health, British Columbia, a.loewen@fraserhealth.ca

Anna MacLeod, Project Manager , National Collaborating Centre for Determinants of Health (NCCDH), Nova Scotia, a.macleod@stfx.ca

Darla MacPherson, Acting Director, Public Health Services, Nova Scotia, darla.macpherson@cha.nshealth.ca

Fleur MacQueen- Smith, Research Officer, University of Saskatchewan, Saskatchewan, fleur.macqueensmith@usask.ca

Ann Manning, Director, Community Health and Nursing Services, Eastern Health, Newfoundland, ann.manning@easternhealth.ca

Carol McArthur, Program Coordinator, Community Health Representative, Portage College , Alberta, carol.mcarthur@portagecollege.ca

Donald McCabe, Director, Healthy Families, Reproductive and Infant Health, Toronto Public Health, Ontario, dmcca@toronto.ca

Catherine McCourt, Director, Health Surveillance and Epidemiology Division, Centre for Health Promotion, Public Health Agency of Canada, Ontario, catherine.mccourt@phac-aspc.gc.ca

Caralee McDaniel, Coordinator, In-Home Family Support Program, Dartmouth Family Resource Centre, Nova Scotia, cmcdaniel@dartmouthfamilycentre.com

John Millar , Executive Director, Population Health Surveillance & Disease Control Planning, Provincial Health Services Authority, British Columbia, jmillar@phsa.ca

Jane Moseley, Assistant Professor, School of Nursing, St. Francis Xavier University, Nova Scotia, jmoseley@stfx.ca

Nazeem Muhajarine, Research Faculty, SPHERU, University of Saskatchewan, Saskatchewan, nazeem.muhajarine@usask.ca

Sheila Murdock, Chief Executive Officer, Fisher River Cree Nation, Manitoba, sheila.murdocko4@msn.com

Cory Neudorf, Chief Medical Health Officer, Saskatoon Health Region , Saskatchewan, Cory.Neudorf@saskatoonhealthregion.ca

Darren Nickel, Program Evaluator, Kids First, Saskatchewan Population Health and Evaluation, University of Saskatchewan, Saskatchewan, darren.nickel@usask.ca

Valerie Nicholson, Public Health Coordinator, Central Department of Health, Primary Care Division, Prince Edward Island, venicholson@ihs.org

Deanne Noseworthy, Public Health Nurse, Winnipeg Regional Health Authority, Manitoba, dnoseworthy@wrrha.mb.ca

Stephanie O'Brien, Research Policy Analyst, Assembly of First Nations, Ontario, sobrien@afn.ca

Diane Oliver Scales, Clinical Manager, Public Health and Wellness, Labrador Grenfell Health, Newfoundland, diane.scales@lg.health.ca

Tanya Olscamp, Coordinator, Enhanced Community Home Visitor, Annapolis Valley Health, Public Health, Nova Scotia, Tolscamp@avdha.nshealth.ca

Cynthia Onyegbula, Manager, Maternal Child Health Program, Health Canada, Alberta, Cynthia_onyegbula@hc-sc.gc.ca

Johnmark Opondo, Medical Health Officer - Healthy Growth & Development Portfolio, Saskatoon Health Region, Saskatchewan, Johnmark.onando@saskatoonhealthregion.ca

Laurie Parton, Manager, Public Health, Yellowknife Health & Social Services Authority, North West Territories, lauree_parton@gov.nt.ca

Teresa Patzer, Public Health Nurse, Yellowknife Health & Social Services Authority, North West Territories, teresa_patzer@gov.nt.ca

Wanda Phillips-Beck, Nurse Program and Practice Advisor, Assembly of Manitoba Chiefs, Winnipeg, Manitoba, wphillips-beck@manitobachiefs.com

Michelle Pickles, Nurse Manager, Public Health Services Districts DHA 7 & 8 , Nova Scotia, michelle.pickles@publichealth.ns.ca

Ann Pischinger, Community Health Representative, Fort Smith Health and Social Services Authority, NIICHRO, North West Territories, ann_Pischinger@gov.nt.ca

Alain Poirier, Director national de santé publique et sous-ministre, Ministry of Health & Social Services , Quebec, alain.poirier@msss.gouv.qc.ca

Norine Poitras Cole, Program Consultant, Aboriginal Head Start, Public Health Agency of Canada, Saskatchewan, Norine_Poitras-Cole@phac-aspc.gc.ca

Vera Potts, Community Health Representative, Aakom-Kiyii Health Services Pukani Nation, NIICHRO, Alberta, vp@onehealth.ca

Arleen Quann, Public Health Nurse, Western Regional Health Authority, Newfoundland, arleenquann@westernhealth.nl.ca

Serena Rae, Program Consultant, Public Health Agency of Canada, Alberta, serena.rae@phac-aspc.gc.ca

Betty Reid-White, Director, Integrated Community Health Services, Eastern Health - Rural, Newfoundland, betty.reidwhite@easternhealth.ca

Lauralie Richard, Doctoral Student in Nursing, University of Montreal, Quebec, lauralie.richard@umontreal.ca

Marion Ross, Provincial Coordinator for Families First Program, Healthy Child Manitoba Office, Healthy Child Committee of Cabinet Government of Manitoba, Manitoba, marion.ross@gov.mb.ca

Ellen Rukholm, Executive Director, Canadian Association of Schools of Nursing, Ontario, erukholm@casn.ca

Gail Russell, Director, Early Childhood Development Unit, Early Learning and Child Branch, Ministry of Education, Saskatchewan, Gail.Russell@gov.sk.ca

Cathy Ryan , Representative, Canadian Pre-Natal Nutrition Program, West Winds Primary Health Centre, NIICHRO, Saskatchewan, cathy.ryan@saskatoonhealthregion.ca

Debbie Ryan , Clinical Nurse Practice Specialist, Eastern Health - Urban, Newfoundland, Debbie.Ryan@easternhealth.ca

Paula Salter, Program Consultant, Public Health Agency of Canada, Alberta, paula_salter@phac-aspc.gc.ca

Roseanne Sark, Community Health Representative, MiKmaq Confederacy of Prince Edward Island, NIICHRO, Prince Edward Island, rsark@mcpei.ca

Kim Scott, Public Health Nurse/Coordinator, Early Childhood Initiatives Program, Public Health , New Brunswick, kim.scott@gnb.ca

Cielo Smith, Manager, Regional Public Health, Department of Health and Social Services, Nunavut, cismith@gov.nu.ca

Rosalind Smyth, Project Manager, Department of Health and Community Services, Newfoundland, RSmyth@gov.nl.ca

Penny Stewart, Manager, ECD and Maternal Child Programs, First Nations and Inuit Health Branch, Health Canada, British Columbia, penny.stewart@hc-sc.gc.ca

Jocelyn Stocki, Maternal Child Health Consultant, First Nations and Inuit Health Branch, Health Canada, Nova Scotia, jocelyn.stocki@hc-sc.gc.ca

Susan Szozda , Public Health Nurse, Family Health Division, Public Health Services, City of Hamilton Health Unit, Ontario, Susan.Szozda@hamilton.ca

Kate Thompson, Nurse Consultant, First Nations and Inuit Health Branch, Office of Nursing, Health Canada, kate.thompson@hc-sc.gc.ca

Antoinette Turncliffe, Families First Home Visitor, Assiniboine Regional Health Authority, Manitoba, aturncliffe@arha.ca

Ziba Vaghri, Research Associate, International Research and Initiatives Program, Human Early Learning Partnership (HELP), University of British Columbia, British Columbia, ziba.vaghri@ubc.ca

Murielle Wade, Manager, Public Health , New Brunswick, murielle.wade@gnb.ca

Susan Walter, Program Leader, Vancouver Coastal Health Authority, British Columbia, susan.walter@vch.ca

Jackie Watts , Senior Infant and Early Development Consultant / Supervisor, Nuuchahnulth Tribal Council, Aboriginal Infant & Early Development Program & Family Ties (Pregnancy Outreach Program) Regional Advisor, Vancouver Island Aboriginal Infant Development Programs, British Columbia, jackie@nuuchahnulth.org

Karen Weir, Project Manager, National Collaborating Centre for Determinants of Health (NCCDH), Nova Scotia, kweir@stfx.ca

Jill Werle, Manager, Healthy Development Department, Public Health Services, Saskatoon Health Region, Saskatchewan, jill.werle@saskatoonhealthregion.ca

Barb Willet, Acting Executive Director, Health Nexus, Ontario, b.willet@healthnexus.ca

Pamela Woodsworth, Program Manager, Kids First, Saskatoon Health Region, Saskatchewan, pam.woodsworth@saskatoonhealthregion.ca

Joanne Wooldridge, Registered Nurse, MSN, Vancouver Coastal Health Authority, British Columbia, joanne.wooldridge@vch.ca

David Wu, Researcher and Community Liaison, British Columbia Aboriginal Child Care Society, British Columbia, david@aac-society.bc.ca