FROM BABIES TO BOARDROOMS... CAPC AND CPNP CONTRIBUTIONS TO PUBLIC HEALTH

A Study of System-Level Involvement

PUBLIC HEALTH AGENCY *of* CANADA
Atlantic Regional Office

2005

Public Health Agency of Canada | Agence de santé publique du Canada

Canada

FROM BABIES TO BOARDROOMS...

CAPC AND CPNP CONTRIBUTIONS TO PUBLIC HEALTH

A Study of System-Level Involvement

Kathleen Flanagan

Prepared for
Public Health Agency of Canada
Atlantic Regional Office

November 2005

The opinions expressed in this publication are those of the author and do not necessarily reflect the views of the Public Health Agency of Canada.

Également disponible en français sous le titre : ***Du bébé au conseil d'administration... Les contributions du PACE et du PCNP à la santé publique – Une étude sur la participation au niveau du système***

For more information, contact:
Public Health Agency of Canada
Atlantic Regional Office
1525 - 1505 Barrington Street
Halifax NS B3J 3Y6
Tel: (902) 426-2700
Fax: (902) 426-9689
E-mail: atlantic-atlantique@phac-aspc.gc.ca
Website: www.atlantic.phac.gc.ca

ACKNOWLEDGEMENTS

The author wishes to acknowledge the work of the many CAPC and CPNP projects in the Atlantic provinces, whose evaluation reports not only documented the nature and extent of system-level involvement in the region but brought it to life through their stories and quotes. These reports also described the impact of these activities on individuals, projects, communities, and the system itself. As well, the author wishes to acknowledge the work of Dr. Natalie Kishchuk, who conducted the key informant interviews related to system-level involvement with CAPC and CPNP in the Atlantic Region. Both of these sources of evidence provided insights and an understanding of the contributions, challenges, and potential of CAPC and CPNP involvement in activities and work related to the broader system of governments and universities in the areas of policy, programs, and research/evaluation.

The author also wishes to thank the members of the Atlantic Children's Evaluation Sub-Committee (ACES), for their time, expertise, and participation. Their patience, feedback, and suggestions were very much appreciated. Special thanks is extended to the project representatives: **Joan Glode**, Atlantic Aboriginal projects; **Bernice Hancock**, Newfoundland and Labrador projects; **Julie Hickey**, New Brunswick and Francophone projects; **JoAnna LaTulippe Rochon**, Nova Scotia projects; and **Laura Quinn**, Prince Edward Island projects; to provincial government Joint Management/Program Advisory Committee representative **Claudette Landry**; and to the representatives of the Public Health Agency of Canada, including **Angela Berrette**, **Frances Ennis**, **Yolande Samson**, and **Judy Watson**.

And, finally, the author wishes to specifically acknowledge the support of Yolande Samson, Evaluation Consultant for the Public Health Agency of Canada, Atlantic Regional Office, and Chairperson of ACES. Her experience, expertise, and unfaltering support were indispensable to this work.

FOREWORD

For the past number of years, stakeholders involved with the Community Action Program for Children (CAPC) and the Canada Prenatal Nutrition Program (CPNP) in the Atlantic Region have participated in a collaborative effort to develop an evaluation and reporting system that captures the richness and complexity of the impacts of these initiatives. As members of the Atlantic Children's Evaluation Sub-Committee (ACES), our role in working with the Public Health Agency of Canada (PHAC) during the development of this framework was facilitated by the thoughtful contributions of the many people who participated and was enriched by the multiple perspectives we bring as representatives of projects, provincial governments, and PHAC.

Based on the new evaluation and reporting system, the projects' 2005 evaluation reports described how CAPC and CPNP's core elements – supportive environments, participation and involvement, and capacity building – impact individuals, the projects, communities, and the broader system. The results of the synthesis of these project evaluation reports, as well as other sources of information, will be used to produce an Atlantic CAPC/CPNP Regional Evaluation Report.

This system level study is the first attempt in the Atlantic Region to document the level of CAPC and CPNP involvement with the broader system of governments and universities in the areas of public policy, program practice, and research and evaluation. System-level involvement had been reported in project evaluation reports by 30 CAPC and CPNP projects from all four Atlantic provinces. A survey of key partners in governments, universities, and other provincial organizations had also been done through a contract. The information from these two sources is now available for analysis, which will provide us with important findings and enable us to review the outcomes and revise, if necessary, the indicators for the system-level work.

As members of ACES, we have been pleased to provide direction to this work. We recognize that the broader system plays a key role in influencing the environment for pregnant women, children, and families, especially those who are experiencing difficult situations. The analysis of the impact of CAPC/CPNP system-level work has the potential to contribute to the ongoing development of initiatives for young children at the national, provincial, and municipal levels.

We also hope that the information in this report will assist projects and system-level partners to more fully understand the implications of system-level activities within the scope of health promotion and public health and to work together to develop an action plan for future work.

Members of the Atlantic Children's Evaluation Sub-Committee (ACES), 2005

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

EXECUTIVE SUMMARY

There is a growing sense of excitement in the Atlantic Region about the significance of early analysis of the recent (2005) program evaluation reports of the projects funded by the Community Action Program for Children (CAPC) and the Canada Prenatal Nutrition Program (CPNP) in each of the four Atlantic provinces. CAPC and CPNP are funded by the Public Health Agency of Canada (PHAC).

In 2005, the projects' evaluation reports described how CAPC and CPNP's core elements – supportive environments, participation and involvement, and capacity building – impact individuals, the projects, communities, and the broader system. For purposes of these reports, system-level work refers to work beyond the community level involving governments and universities. It focuses on activities in which the potential for change would involve a broad population over a large geographical area.

This report was written following a careful review of the system-level influences reported by a total of 30 CAPC and CPNP projects from all four Atlantic provinces. A survey of 21 key partners in governments, universities, and other provincial organizations was also done. A parallel activity was the preparation of a literature review to better understand the significance of the potential influences and impacts of this type of work.

Both CAPC and CPNP strive to reach parents and families who may be facing challenges in meeting the needs of their children. The two programs share common principles and goals. CAPC (1992) focuses on children from the prenatal period to six years old; CPNP (1995) focuses specifically on the prenatal and postnatal periods (i.e., from pregnancy to one year of age).

The Atlantic CAPC and CPNP regional evaluation has attempted to document project involvement, assess contributions made to system-level change within the context of the core elements, and assess the influence of projects' activities and involvement in defining future directions. Throughout the Atlantic Region, the core elements of CAPC and CPNP are reflected in system-level work. For example:

- **Supportive Environments** (*when people feel valued, respected and safe, and which can contribute to learning, empowerment, and mutual benefit*) were evident when projects played an advisory role for new initiatives, provided a platform from which others were able to launch new programs, or provided a point of contact with pregnant women, children, and families for other professionals.
- **Participation and Involvement** (*when people develop or enhance their confidence to participate, become involved, and contribute in whatever ways are comfortable and of mutual benefit*) were evident when projects participated on regional and provincial committees focused on matters related to pregnant women, young children, and their families, participated in research projects, or participated in focus groups regarding

the development of public health goals for Canada and the mandate of PHAC.

- **Capacity Building** (*when people's capacities for learning, mutual support, and action can be further developed and enhanced*) was evident when projects reported increased staff confidence about system-level work in research and policy or a shift in the system's perspective to a focus on the strengths of families, or when projects' participation on provincial initiatives and health coalitions laid the groundwork for further discussions around challenges faced by pregnant women and families with young children.

CAPC AND CPNP, SOCIAL CAPITAL, AND PUBLIC HEALTH

Projects in the Atlantic Region have successfully positioned themselves as integral parts of the networks for children and families in all Atlantic provinces. Their linkages are complex and interwoven and include federal/national and provincial/regional/municipal components, with research and evaluation included at all levels. The relationships are multi-dimensional and demonstrate how these community-based children's initiatives have the potential to provide a vehicle for a collective voice for children and to support collaborative efforts across sectors.

Projects and system partners identified mutual benefits from their system-level work. These benefits include enhanced relationships, the ability to maximize resources, a better understanding of one another's perspectives, mutual skill development, voices of families being heard, and the empowerment of all who were involved. These mutual benefits support the empowerment of projects and the system, and result in the empowerment of individuals and communities. Such community capacity lends itself to collective action – in this case, on behalf of pregnant women, children, and families. This process of reciprocity has the potential to become stronger over time, as projects and the system continue to work together by building supportive environments, promoting participation and involvement, and continuing to build capacity at all levels. Social capital refers to these types of connections among individuals, i.e., social networks and the reciprocity and trustworthiness that arise from them.

Research has demonstrated that higher social capital and social cohesion lead to improvements in health conditions. Research also indicates that the positive effects of integration and social support can act as a buffer to the effects of known health risks such as smoking, obesity, hypertension, and physical inactivity. In short, the evidence of the positive effects of social integration on health is very strong.

CAPC and CPNP have a key role to play in building social capital in communities:

- The ***core elements*** of CAPC and CPNP provide the environments that allow projects to support the development of public policy, program practice, research, and evaluation.
- CAPC/CPNP/system involvement results in ***mutual benefits***, including enhanced relationships; better use of resources; mutual development of skills in facilitation, building consensus, and evaluation and research; and more informed decision making for policy, program, and research development.
- These results provide a greater sense of ***empowerment*** for those involved to take on new challenges, work for change, and be active citizens in their communities. Such community capacity leads to ***collective action and builds social capital***.
- Social capital is a key determinant of health and contributes directly to supporting ***public health for Canadians***.

CHALLENGES

Projects identified challenges to the system-level part of their work, including budget issues, the need to balance competing demands on their time and resources and differing philosophies and visions, as well as the need to reinforce an "assets-based" approach to working with pregnant women and parents. Confidentiality issues were cited by both projects and system partners as a common challenge which was not unique to CAPC and CPNP, but nevertheless had to be dealt with. Government partners cited legislative requirements, public policy direction, and lack of clarity regarding roles and respective responsibilities as challenges to their work with CAPC and CPNP. It was generally felt, however, that the strong relationships developed as a result of system-level work would enable all partners to address these in a positive manner.

CONCLUSIONS

This study of system-level involvement tells us that CAPC and CPNP are:

- key players in the delivery of child and family programs and are firmly established and well integrated in the broader network of policy, program, and research initiatives for pregnant women, children, and their families
- helping to create supportive environments for individuals, projects, communities, and the system through opportunities to share perspectives, expertise, and resources
- contributing to the development of policy, practice, and research development at the system level because the core elements of the programs create conditions that contribute to system-level change
- building community capacity across Atlantic Canada – capacity that affects the public health of the community – as well as providing the system with a means to work toward improved public health for Atlantic Canadians.

CAPC and CPNP projects have reached a level of maturity that is only just beginning to allow them to blossom into their full potential. Their position in the community allows the federal government a presence as a partner in promoting collective action, as well as strengthening the role of the federal government to facilitate inter-sectoral collaboration and cross-sectoral partnerships and to promote relevant research, evaluation, and knowledge exchange.

When citizens are empowered, there is an increase in community capacity and more and more opportunities for collective action. These are the kinds of things that build social capital – the "glue" that holds communities together. CAPC and CPNP's work with individuals, communities, and systems is a solid contribution to building social capital and public health in Atlantic Canada.

INTRODUCTION

The Atlantic Community Action Program for Children (CAPC) and Canada Prenatal Nutrition Program (CPNP) evaluation and reporting system provided projects with a unique opportunity to describe and assess how the core elements of these two initiatives impact the many individuals who participate in their programs. Projects described how their day-to-day program activities – intended to provide supportive environments, encourage participation and involvement, and build capacity – actually helped the projects themselves to grow. Projects also had the opportunity to share their observations about how the core elements of their programs influenced changes in the communities in which they are located.

And finally, the evaluation framework asked projects to report on how the core elements of their programs were reflected in their work with the broader system. In doing so, projects were guided by *Valuing Our Work: A Resource Kit on the Evaluation and Reporting System for CAPC and CPNP in the Atlantic Region* to consider "system level" as including their involvement with governments and universities beyond the local community level and where the potential for change would involve a broad population over a large geographical area. In reporting on their system-level involvement, projects demonstrated how they contributed to and influenced program, policy, and research development. Using this social ecological perspective, projects were able – for the first time – to more clearly describe the richness and complexity of the nature of their work.

This report was developed following a careful review of the system-level influences reported by:

- CAPC and CPNP projects across the Atlantic Region, including their interviews with system partners and stakeholders
- a survey of 21 key partners in governments, universities, and other provincial organizations. Key informants were researchers, academics, and/or government representatives who had worked with CAPC and/or CPNP in varying capacities for at least five to seven years or who were very knowledgeable about CAPC and CPNP. For this survey, key informants were nominated by projects, national program staff, and members of Joint Management/Program Advisory Committees.[1]

A total of 30 projects from all four Atlantic provinces reported on system-level involvement and activities. A parallel activity was the preparation of a literature review to better understand the significance of the influences and impacts of this type of work.

The members of the Atlantic Children's Evaluation Sub-Committee (ACES) found the implications of system-level involvement to be especially timely, given the recent discussions at many levels concerning the public health of Canadians, crime prevention, social inclusion, and social justice. Clearly, the work of the CAPC and CPNP projects has much to contribute to these deliberations. Therefore, a description of the work

undertaken at the system-level is the first step in the dissemination of the evaluation results.

This report is intended to provide an overview of the involvement of CAPC and CPNP at the system level for federal, provincial, and territorial government policy tables and, in particular, PHAC; Joint Management Committees across Canada; CAPC and CPNP Boards of Directors; National CAPC/CPNP Committees; and researchers and academics. In doing so, the report will demonstrate how CAPC and CPNP are:

- key players in the delivery of child and family programs
- firmly established and well integrated in the broader network of policy, program, and research initiatives for pregnant women, children, and their families
- helping to create supportive environments for individuals, projects, communities, and the system
- contributing to the development of practice, policy, and research at the system level
- building capacity across Atlantic Canada by providing the system with a means to work toward improved public health for its citizens.

This study of system-level involvement among CAPC and CPNP projects in the Atlantic Region reveals both opportunities and challenges. These two programs were developed in response to extensive research documenting the importance of the early years as a determinant of health and as a critical link in promoting a culture of life long learning. CAPC and CPNP were announced as part of the Government of Canada's approach to meeting the challenges posed by the 1990 World Summit on Children.

The CAPC and CPNP initiatives were created by the system – and they continue to be funded and managed by the system. In short, these initiatives are already part of the broader system, providing unique opportunities for all involved. In the Atlantic Region, the projects have a strong presence in local communities, and solid relationships with pregnant women and families with young children. In each of the Atlantic provinces, CAPC and CPNP projects are part of the broader framework of children's health, population health promotion, and public health. Through their system-level involvement, they are able to facilitate and participate in a rich exchange of multi-sectoral perspectives on issues related to the healthy development of children and their families. These opportunities create potential for all stakeholders to build collective action across the Atlantic Region.

This study of system-level involvement also identifies challenges – from the perspective of projects and system-level partners. These will need to be addressed in order to further enrich the value of this work and to maximize its potential to contribute to the public health of Canadians. The system and the projects are resources for one another. In the coming years, all stakeholders will need to continue to work together to build on the efforts of the last 10 years, use their evidence and experience to inform policy development, and collaborate to translate knowledge into practice and research.

THE PROGRAMS: CAPC AND CPNP

Internationally, the last 10 years have seen an enormous growth in compelling evidence to support the wisdom of investments in early childhood development. Across Canada, this has been accompanied by historic intergovernmental agreements and initiatives that give priority to the development of policy, practice, and research in areas related to programs and services for pregnant women, children, and families.

CAPC and CPNP have been part of the landscape of programs and services for pregnant women, children, and their families during this period of remarkable interest and investment. CAPC and CPNP are national programs funded by PHAC. The programs have common goals related to improving the health and social development of pregnant women, young children, and their families.

CAPC and CPNP Guiding Principles

- ✓ ***Children First (CAPC)***
- ✓ ***Mothers and Babies First (CPNP)***
- ✓ ***Strengthening and Supporting Families***
- ✓ ***Equity and Accessibility***
- ✓ ***Flexibility***
- ✓ ***Community-Based***
- ✓ ***Partnerships***

Both programs strive to reach pregnant women, parents, and families who may be living in any number of difficult situations and who may be facing unique challenges in meeting the needs of their children and families as well as their own needs. CAPC focuses on children from the prenatal period to six years old; CPNP focuses specifically on the prenatal and post natal periods (i.e., from pregnancy to one year of age).

HOW DO THE PROGRAMS WORK?

CAPC and CPNP programs are delivered by non-profit organizations or community coalitions. In Atlantic Canada, these coalitions recognized the need to strengthen local infrastructure and proposed to apply the programs' principles to a family resource centre model. Family resource centres in cities, towns, and villages – along with outreach sites in rural and remote areas – now offer programs and services for pregnant women, young children, and their families.

Partnerships and collaborative activities are essential components of the programs. PHAC works in partnership with provinces and territories to manage the two programs and to support the funded projects. Both programs are managed by a unique intergovernmental management structure that allows for shared federal, provincial or

territorial responsibility for decision making. Priorities for investments, management structures, and operating principles are outlined in Joint Protocol Agreements. In the Atlantic Region, these agreements have created and supported Joint Management Committees (Newfoundland and Labrador, Prince Edward Island, and New Brunswick) and a Program Advisory Committee (Nova Scotia).

Across the region, federal and provincial partners work together as the Atlantic Joint Management Committee. This group has collaborated on program development, provided joint training, shared lessons learned, developed common resources and communication tools, and coordinated program evaluation.

PROGRAM EVALUATION IN THE ATLANTIC REGION

CAPC and CPNP have a solid history in the Atlantic Region. Since the early days of both programs, (1992 and 1995, respectively), there has been a strong evaluation component at the national, regional, and project levels. From the outset, program evaluation was seen as a participatory learning process for all involved, rather than as something that is "done" to a person or an organization.

The Atlantic provinces collaborated on a regional evaluation of CAPC beginning in 1995. The approach to evaluation reflected the program's priorities of participation and involvement. Those who were involved with the projects – including parents, staff, volunteers, community partners, and federal and provincial governments – were all part of the evaluation effort. These key stakeholders participated in deciding what needed to be evaluated, what questions to ask, what methods should be used, and what results were most meaningful.

The voices of parents were at the centre of the evaluation model, and their stories were used as evidence of how the program worked or could be improved. The final report, *'Moving Along*, *Growing Strong'* was released in December 1997 and made two things very clear: CAPC works, and participatory evaluation is worth the effort.

> ***"One of the CAPC strengths is that it creates an opportunity for parents to further explore and/or confirm their capabilities, apply them to emerging needs and interests, and become more active participants in their community."***
>
> ***– Moving Along, Growing Strong, 1997***

The key stakeholders involved with CAPC and CPNP in the Atlantic Region learned a valuable lesson from their experience with the CAPC 1997 evaluation. While the evaluation focused on improvements to the health and well-being of children 0-6 and their families who were living in difficult situations, those involved in the evaluation effort realized that they, too, had experienced change as a result of their involvement with the project. This was true for staff and volunteers at the project level, community partners, federal and provincial government representatives, and the evaluators themselves. This lesson had a profound influence on the development of a new framework for CAPC and CPNP program evaluation.

GETTING TO THE HEART OF CAPC AND CPNP

The 1997 CAPC evaluation report had barely been released when the members of ACES returned to the table to reflect on the experience, review lessons learned, and consider how to improve the evaluation process. ACES includes federal and provincial government representatives and project representatives from each of the Atlantic provinces as well as Atlantic representatives for Aboriginal and Francophone projects.

While partners were generally pleased with the 1997 evaluation, two key conclusions emerged from these discussions:

- Projects were becoming overburdened with reporting and evaluation requirements – many of the same questions were being asked by CAPC and CPNP, but in separate processes, and regional and national evaluation questions were often repetitive.
- There needed to be a better way to capture the richness and complexity of the impacts of both CAPC and CPNP.

A solid theoretical framework supports the work of the projects in the Atlantic Region and has informed the subsequent development of the core elements of the CAPC and CPNP programs. This framework integrates four bodies of knowledge:

- a social ecological approach to healthy child development, which recognizes that many factors contribute to child development
- population health promotion, which focuses on health in the broadest sense, including physical, mental, social, emotional, and spiritual health
- an empowerment approach, which acknowledges that change can occur at individual, interpersonal, and political levels and which is committed to enhancing and building the capacities of people, by people, and for people
- social and economic inclusion, which holds that all people should have access to the social and economic benefits of living in our society.[2]

ACES embarked on a process to discover the core elements of CAPC and CPNP that contribute to the capacity of these programs to address the needs of pregnant women, children, and families facing difficult situations. In honouring the programs' principles,

ACES launched an inclusive and participatory process with project staff, volunteers, and other stakeholders across the Atlantic Region. Informed by literature reviews on health promotion, population health, and social ecological approaches, stakeholders participated in a regional Think Tank in October 2000 to discuss, debate, and reach a consensus on the core elements of CAPC and CPNP.

During the following year, literature reviews were completed on each of the recommended core elements, and stakeholders reconvened in September 2001 to develop a common set of outcomes and indicators for each of the core elements. Data collection tools were drafted, and then pilot tested for reliability and validity. During 2002, consultations were held on the draft *Resource Kit*, which included information on the evaluation and reporting system, outlined timelines for all reporting and evaluation requirements, and provided other resources to support projects in their evaluation efforts. During the spring of 2003, training sessions were held so that projects would be ready to begin collecting data and preparing for their new evaluation.

THE CORE ELEMENTS

Stakeholders in the Atlantic Region reached a consensus on three core elements that they felt best described their beliefs about how CAPC and CPNP support the foundation for individual change, for personal and group empowerment, and for community action:

One core element does not exist separately from the others. They are all interrelated and interdependent. They represent a continuum of opportunities, experiences, challenges, and benefits that can result in changes among individuals, families, CAPC and CPNP projects, communities, and the system.

– At the Heart of Our Work, 2002

Supportive Environments – evident when there are places where people can feel valued, respected, and safe, and which can contribute to learning, empowerment, and mutual benefit.

Participation and Involvement – evident when people develop or enhance their confidence to participate, become involved, and contribute in whatever ways are comfortable and of mutual benefit.

Capacity Building – evident when people's capacities for learning, mutual support, and action can be further developed and enhanced. When people develop and enhance their capacities, they can feel empowered to take action as individuals. This, in turn, can set the stage for people with common interests to take action within communities and the system.

It should be noted that, initially, a fourth core element (social action) was proposed. During the ongoing collaborative discussions regarding the outcomes and indicators for the core elements, there was a consensus that social action was reflected in each of the other three core elements. Consequently, social action was integrated with the other core elements.[3]

LEVELS OF CHANGE: A SOCIAL ECOLOGICAL APPROACH

The theoretical framework and body of knowledge that supports the CAPC and CPNP initiatives in the Atlantic Region – as well as the core elements of these initiatives – draws on a social ecological understanding of child development.

The social ecological approach recognizes that many factors contribute to children's development. This approach acknowledges that it is not sufficient to focus all resources and activities on children alone. Children depend on their parents for love and guidance, security, and support. Children also live in communities, which have a strong influence on families and on the types of activities, opportunities, and supports available to parents and families. And communities are part of and influenced by the broader system, by the policies and practices that enable communities to function and thrive.

CAPC and CPNP projects are able to provide linkages for pregnant women, children, and families to their communities and to the broader system. Interventions for pregnant women, children, and families can occur through mobilizing group and community resources. In doing so, the projects themselves become part of the dynamic and may also be influenced and impacted by the changes and developments at each of the other levels.

> ***When people develop and enhance their capacities, they can feel empowered to take action as individuals. This, in turn, can set the stage for people with common interests to take action within communities and the system.***
>
> ***– Valuing Our Work*, *2003***

In recognition of the above, CAPC and CPNP projects evaluated how the core elements of their programs – supportive environments, participation and involvement, and capacity building – influenced change at the individual, project, community, and system levels.

GROWING UP IN INTERESTING TIMES

The 1990 World Summit for Children provided an early opportunity for all governments, organizations, and individuals to become motivated and focused on the challenge of providing better lives for children. After playing a leadership role in the Summit, Canada launched a series of steps toward achieving a "brighter future" for children. Such efforts included:

- the ratification of the United Nations Convention on the Rights of the Child (1991)
- the introduction of the Child Tax Credit (1992) with a targeted benefit based on income and family size, which replaced the Family Allowance benefit for all families
- an "Action Plan for Children" (1992), which defined key roles for children, parents and caregivers in both setting the broad agenda and implementing specific programs.

The Child Development Initiative was introduced in May 1992 as part of the federal system's "Brighter Futures" program. This initiative involved the introduction of a group of long-term programs designed to address conditions of risk during the earliest years in a child's life. These programs were structured as prevention, promotion, protection, and partnership.

CAPC was announced in 1992 as part of Canada's broad response to the World Summit and as the focus of the "partnership" stream. This program was designed to be implemented in a unique partnership with provinces and territories to focus on children from the prenatal period until six years of age – the early childhood years. By this time, early childhood development had been firmly established as a key determinant of health, with a long-lasting and profound impact on health, well-being, and coping skills.

These federal announcements were well received by provinces and territories, particularly in the Atlantic Region. During these years, each of the Atlantic provinces was immersed in close examination of their health and social service systems. Faced with increasing financial pressures to sustain a health system that concentrated on remedial interventions and the concept of health as "the absence of disease," provinces eagerly embraced the possibilities of shifting to a system that focused on promotion, prevention, and early intervention. An emphasis was being placed on determinants of health, a social ecological understanding of the kinds of things that impact a person's overall health, and the concepts of empowerment and social capital.

A developmental phase allowed provinces and territories to define their provincial priorities for investment and to carefully review the potential for duplication or overlap of services. Once these decisions were made, the first CAPC community-based projects opened their doors in 1994. In 1995, Health Canada launched CPNP, which focused on women and their children through the prenatal and postnatal periods. For the most part, CPNP funding in the Atlantic Region was allocated to existing CAPC projects.[4]

CAPC and CPNP have had the advantage of "growing up" in interesting and exciting times. During the 10 years following the introduction of these two initiatives, Canadians have seen the launch of a number of new initiatives and intergovernmental decisions regarding policy, practice, and research on behalf of young children. For example, at the national level, these have included:

- National Children's Agenda
- National Child Benefit
- Aboriginal Head Start Programs
- National Longitudinal Survey of Children and Youth (announced as part of "Brighter Futures")
- First Ministers' Early Childhood Development Initiative
- National Crime Prevention Strategy (with a focus on early childhood development)
- Multilateral Framework Agreement on Early Learning and Child Care (2003)
- Child Care Visions program (research)
- Understanding the Early Years Research Project
- Centres of Excellence for Children's Well-Being
- Aboriginal Early Learning and Child Care (in progress)
- Early Learning and Child Care Initiative (2005)
- Pan-Canadian FASD Initiative
- First Nations and Inuit Health (FNIHB) FASD Program

At the same time, provinces and territories were involved in significant policy shifts that recognized the need to invest in the early years. For the first time, partners outside of the traditional children's sector were becoming vocal about the wisdom of supporting the early years. The World Bank, chambers of commerce, medical organizations, and police and crime-prevention groups – to name a few – were advocating for more attention and more investments in early childhood development. Technological advances in neuro-scientific research were confirming what many people knew instinctively, based on their own experiences: early experiences last a lifetime.

In the Atlantic Region, CAPC and CPNP "grew up" in provincial environments that involved the launch of such strategies as Newfoundland and Labrador's Social Strategic Plan and Prince Edward Island's Healthy Child Development Strategy. CAPC and CPNP projects provided platforms to launch new programs funded by Nova Scotia's investments through the Early Childhood Development Initiative. Projects in New Brunswick were key players in developing strategies for life-long learning and research on literacy development.

The CAPC and CPNP project evaluation reports and the *System Level Key Informant Interview Analysis Report* outline these and many more examples of involvement with system partners in the development of policy, practice, and research across the Atlantic Region.

CAPC AND CPNP CONTRIBUTIONS AT THE SYSTEM LEVEL

As stated earlier, for the purposes of the Atlantic CAPC and CPNP regional evaluation, there is a consensus that "system level" moves beyond the local community and involves policies, practice, and/or research that exist, for example, within governments or universities.

The study of system-level involvement as part of the Atlantic CAPC and CPNP regional evaluation aims to:

- document the extent and nature of projects' involvement in working toward change at the system level
- assess the contributions made to system-level change within the context of the core elements
- assess the influence of projects' activities and involvement in defining future directions.

> ***"CAPC staff have noted that there has been an increase in the number of participants who have demonstrated a significant interest in the field of childhood education. Several parent participants have started distance education programs, and they report that this is something they never viewed prior to involvement at the family resource centre as offering meaningful career opportunities."***
>
> **– CAPC/CPNP project**

The Atlantic CAPC and CPNP regional evaluation framework recognizes that change is most often the result of complex processes involving multiple contributions made by many partners. Generally it is not possible – or even advisable – to attribute change to any one particular organization, person, or event.

Rather, the Atlantic CAPC and CPNP evaluation intends to document the types of system-level activities that CAPC and CPNP have been involved in. As well, the evaluation intends to assess the nature and extent of the influence that CAPC/CPNP may have had at the system level. The projects' involvement may include contributions toward the development and/or review of policy directions, may inform current practice and research, and may influence how project and system partners work together.

CAPC AND CPNP INVOLVEMENT IN SYSTEM-LEVEL ACTIVITIES

Information regarding the types of project involvement at the system level was obtained from two sources of evidence:

1. **A review of CAPC and CPNP project evaluation reports.** This review identified the nature and level of the projects' involvement in system-level activities in the areas of policy, practice, and research/evaluation. As well, this review included consideration of the impacts of such involvement – on CAPC and CPNP and also on the system. In preparing these reports, projects were guided by a set of common outcomes, indicators, and data collection questions that were outlined in the evaluation and reporting system resource kit *Valuing Our Work* produced by PHAC in collaboration with members of ACES. *(See Appendix A for a list of the data collection questions used by projects for system-level involvement.)*

   This aspect of the overall evaluation considered each of the core elements in relation to the broader system:
   - **Supportive Environments** is about creating environments that encourage projects and system representatives to work together for the benefit of pregnant women, children, and families.
   - **Participation and Involvement** is about projects and system representatives taking advantage of opportunities to work together on child- and family-related issues. This may include the sharing of information and collaboration on joint initiatives.
   - **Capacity Building** is about system changes occurring that support healthy child development. These changes may occur as system representatives and projects work together to jointly plan and implement programs or to decide on directions for future research and policy.

   In addition to projects' ability to interview their own system partners who were involved in their work, all projects had access to the *System Level Key Informant Interview Analysis Report,* and many projects used this information in their own summaries of system-level work.

2. **A review of the findings of the *System Level Key Informant Interview Analysis Report*** (Kishchuk, 2005). This report included:
   - key informant interviews with representatives of program stakeholders in all Atlantic provinces, who represented a cross-section of federal and provincial government officials; researchers/academics; and nongovernmental organizations, coalitions, or volunteers. As well, key informants represented a mix of program, policy, and research/evaluation expertise and experience.
   - findings from system-level changes associated with CAPC and CPNP, according to each of the core elements

- the identification of system-level results and challenges. (*See Appendix B for a list of the data collection questions used in system-level key informant interviews.)*

The review of these two sources of evidence provided examples of how projects are involved with the broader system including different levels of governments, post-secondary institutions, and research projects. The broad categories of types of involvement – including inter-agency collaboration, advice/consultation, and research/evaluation – have all influenced the development of policy, practice, and research and evaluation in the Atlantic Region, some examples of which are described below.

Policy

- New Brunswick projects participated in discussions with government officials regarding the impact of program policies on low income families.

- Newfoundland and Labrador projects influenced new policies related to breastfeeding, influenced school board policy regarding the use of space in new schools for family resource programs, and were key partners in various aspects of the province's "Rural Perspectives" policy.

> ***"There will never be enough milk, for instance, to give to all the pregnant women who lack the resources to purchase milk and grow a healthy baby. With this in mind, [we] know there are bigger questions to consider, like 'Why does Mom not have these necessary resources?' Because the organization dares to ask itself those bigger questions, it recognizes its responsibility for working within the system to effect change."***
>
> **– CAPC/CPNP project**

- Nova Scotia projects have contributed to the province's Health Policy Task Force and to the development of child welfare program policies and the design of service delivery mechanisms.

- Prince Edward Island projects collaborated with provincial government representatives and other community organizations to implement the province's Healthy Child Development Strategy and have provided input to various legislative and policy reviews.

Practice

- New Brunswick projects have provided and received referrals from other community based agencies, provided complementary and convergent efforts for prevention and promotion, and demonstrated significant inter-agency collaboration. Francophone projects have achieved greater recognition from system partners, have partnered with the school system to better address the needs of pregnant women, children, and families, and have found an increase in referrals from other system partners.

- Newfoundland and Labrador projects have provided training placements for students from early childhood education and nursing and organized and hosted events for partners. One example is the Think Tank on Children with Aggression. They have also contributed to Best Practices for Breastfeeding, worked closely with regional staff (public health nurses, nutritionists, school board staff), participated on various multi-sectoral and advisory committees, and demonstrated significant inter-agency collaboration.

- Nova Scotia projects have played a key role in the implementation of components of the province's Early Child Development Initiative (e.g., coordinated language programs, provided information for parents on child care options, collaborated on a parenting strategy, provided training for unlicensed child care providers and provided training placements for students from post-secondary educational programs), have participated in significant work with other "networks" (both provincially and nationally), have been involved in numerous presentations at conferences and delivered workshops, and have influenced system responses to identified needs of program participants (e.g., teen moms, nutrition, food preparation).

- Prince Edward Island projects have played a key role in the design and delivery of a home visiting program for new parents, provided training placements for students from early childhood education and nursing programs, participated in regional accreditation for health authorities, established a provincial network of family resource centres and a community alliance for advocacy, worked with local organizations to develop employment and training opportunities for women, and worked with justice organizations in providing parenting education to young parents involved with the criminal justice system.

> ***"It fits so well with our programs...it's an ideal example of primary health care in practice...what they are doing with families captures the essence of primary health care practice."***
>
> **– Community partner**

Evaluation and Research

All projects in Atlantic Canada have been active in promoting a participatory style of program evaluation and in advocating for evaluation and research approaches that are sensitive to the needs of pregnant women, children, and families. The participatory style of program evaluation is also consistent with the design and values inherent in the programs. All projects have

> ***"Staff [of CAPC and CPNP] have a knowledge of the families and communities in which they work. They have been a very strong and supportive 'starting point' for Understanding the Early Years data sharing."***
>
> **– System partner**

participated in training sessions related to the Atlantic CAPC and CPNP evaluation framework and have worked with various research and evaluation consultants in carrying out their evaluations. As well, one project representative from each province participates in ACES, and is responsible for communicating with other projects on issues and matters related to evaluation. This includes collaborating in the evaluation design and implementation, as well as the dissemination of evaluation results.

In addition:

- New Brunswick projects have collaborated with local universities in developing approaches to child and family literacy initiatives and have participated as key partners in a provincial demographic study of the CAPC and CPNP priority population, including the identification of the range of services for children and families and parental preferences for such services.

- Newfoundland and Labrador projects have participated as partners in Understanding the Early Years research, provided opportunities for university research students for the study of child development, and participated in focus groups on various matters related to children and families.

- Nova Scotia projects have had extensive involvement in the implementation of a province-wide food costing survey, have been involved in program evaluation for related initiatives, and have participated in data collection at the community level.

- Prince Edward Island projects have participated as partners in Understanding the Early Years research, have been involved in program evaluation in partnership with the National Crime Prevention Strategy, have participated in the evaluation of a community capacity building strategy for early language development, and have worked with others in promoting an expansion of early years research at a local university.

"We could not be as successful without the involvement of the family resource centres...they are able to network in their communities to get people to come out...much of this is done in partnership with the public health nurse...we don't know what we would do without them now."

– Health partner

CORE ELEMENTS AND SYSTEM-LEVEL ACTIVITIES

While the description of system-level activities may be summarized according to their relationship to the development and implementation of policy, practice, and research and evaluation, these activities also demonstrate how the core elements of CAPC and CPNP are reflected in system-level work. For example:

Supportive Environments are evident when projects:

- play an advisory role for new initiatives in a health region, province, or the Atlantic Region
- provide consultation regarding legislative and program reviews
- provide a platform from which other funders are able to launch new programs for pregnant women, children, and families (e.g., home visiting, language acquisition, school readiness, employment training, parenting)
- provide coordination for home visiting programs
- provide a point of contact with pregnant women, children, and families for other professionals, including public health nurses, speech language pathologists, educators, and researchers.

Participation and Involvement are evident when projects:

- participate on regional and provincial committees focused on matters related to pregnant women, young children, and their families, including health, social/community services, justice, education, employment, housing, and substance abuse
- partner with provincial governments in the delivery of early childhood related initiatives, including Fetal Alcohol Spectrum Disorder (FASD), home visiting, parenting, language acquisition and literacy, and child care information and support
- work with partners through information sharing and on-site opportunities to reach families dealing with low income, limited education, and social isolation
- participate in research activities, including data collection, focus groups, and the dissemination of findings
- participate in focus groups regarding the development of public health goals for Canada and the mandate of PHAC.

Capacity Building is evident when projects report that:

- staff have increased confidence and knowledge about the complexity of system-level work at the research and policy levels and an increased understanding of how to work within the broader platform of system-level activity
- there has been a shift in the system's perspective to one of focusing on the strengths of families and an emphasis on facilitation rather than teaching
- there are changes to policies regarding program delivery, so that programs are now more sensitive to the needs of pregnant women, parents, and families, better able to address unmet needs, and reflect best practices

- projects' experiences in working with provincial strategies and health coalitions (e.g., Rural Perspectives project, Early Childhood Development Initiative, Healthy Child Development) lay the groundwork for further discussions with provincial representatives around barriers facing pregnant women and families with young children who live in rural and remote communities or who are coping with poverty, social/cultural isolation, limited education, family violence, substance abuse, disabilities, and/or other challenges
- the number of opportunities to collaborate with other provincial organizations is multiplied, with increased capacity for all involved
- there is an increased awareness, understanding, and use of participatory evaluation strategies among projects and their partners.

(*See Appendix C for more detail regarding the core elements and system-level activity.)*

WHAT DOES IT ALL MEAN?

CAPC AND CPNP: INTEGRAL PARTS OF BROADER NETWORKS

Evidence from the Atlantic CAPC and CPNP regional evaluation reflects a wealth of activities and relationships involving participants, staff, and volunteers from CAPC and CPNP projects and representatives of municipal, provincial, federal, and academic systems. Projects in the Atlantic Region have successfully positioned themselves as integral parts of the networks for children and families in each of the four Atlantic provinces. As well, some projects are also involved in regional and national networks. The linkages are complex and interwoven,[5] and include federal and national partners, provincial/regional/municipal partners, communities, and CAPC and CPNP projects. All have direct working relationships and have developed partnerships via committee structures; funding relationships; program and policy initiatives; and/or opportunities for research, training, and evaluation. *(See Appendix D for a more complete description of these types of relationships.)*

Figure 1 shows the interconnectedness of the partners involved in the community-based programs for pregnant women, children, and families. As explained above, these relationships are multi-dimensional and complex. However, these relationships demonstrate how community-based children's initiatives such as CAPC and CPNP have the potential to provide a vehicle for a collective voice for pregnant women, children, and families and to support collaborative efforts across sectors.

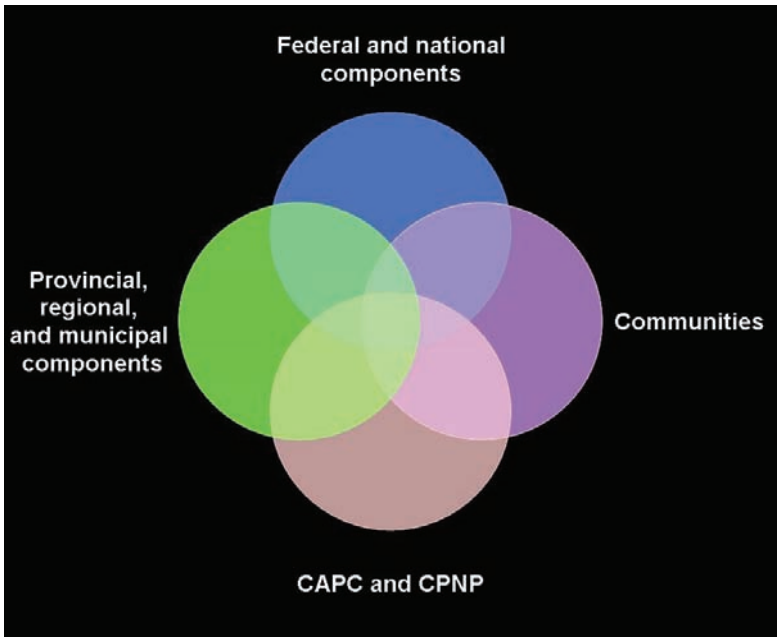

Figure 1: CAPC/CPNP and System Relationships

MUTUAL BENEFITS

Given the context of the current Atlantic CAPC and CPNP evaluation framework, it is not sufficient to merely examine the contributions and influences of CAPC/CPNP to system-level change. The framework itself was built on the premise of an empowerment-based evaluation strategy that recognizes the reciprocal nature of the empowerment process.

> ***"The fact that we've been here for ten years is an indication that this process works, and that the system sees it as well."***
>
> **– Key informant**

Throughout the CAPC and CPNP evaluation reports and the *System Level Key Informant Interview Analysis Report*, project staff, system partners, and key informants consistently described the mutual benefits to all as a result of their experiences in working with one another. Given the conceptual framework within which CAPC and CPNP operate, it is not surprising that this type of reciprocity has been acknowledged. There is an understanding that at each level – individual, project, community, and system – there is something to be contributed and something to be learned, supporting a greater capacity to change and grow.

Projects, system partners, and key informants identified many types of mutual benefits that can lead to collective action, and that may be summarized as including the following:

An enhanced quality of relationships, which results in a greater openness to consider the perspectives of others and a greater understanding of one another's realities in terms of work environment and demands. Experiences in working with one another enables both project and system partners to have a much better understanding of one another's "system" whether community-based; academic; or municipal, provincial, or federal levels of government. With an enhanced quality of relationships, there is increased credibility and trust and a greater sense of shared commitment to common objectives. All of these benefits and collective actions contribute to opening the door to even more opportunities for collaboration.

The ***ability to maximize resources,*** which allows project and system partners to make the best use of one another's financial, human and information resources. Project and system partners alike have noticed that with a better understanding of one another's programs, there is an increase in mutual referrals. Also, they have found that their referrals are more appropriate, which saves all partners valuable time.

A ***mutual understanding of one another's perspectives***, which results in a greater understanding on the part of the system as to realities faced by families and a greater awareness of the benefits of an assets-based approach. Projects now have a better appreciation for how the system works, for the need to have credible evidence, and for what the realities and complexities are in the process of developing either public policy or program policy.

> ***"Sharing of expertise works both ways."***
>
> **– A partner's perspective**

As a result of system-level activities, ***voices of families are heard*** which enables all partners to better address their mandates. Parents are respected, and their opinions are valued. Projects are better able to articulate the impact of policy and program decisions on their work and on the families involved. System partners are better able to understand priorities and to determine the "fit" between public policy directives and "on the ground" implementation. All are able to better assess and analyse the impacts of system-level decisions and initiatives, which allows for more strategic, collective, and effective responses.

> ***"It has changed the way we do day to day business...in that families have support in another partner. We can have access to the people we support in the one catchment area. Before, in providing a service to the community, we would have to provide the supports to families one on one...now with a number of supports it enables health promotion to be done in a group setting. It is time efficient for the workers...it is the working together that is providing support to families."***
>
> **– Public Health partner**

A shared access to training and professional development, which allows all partners to benefit from hearing the same messages. New ideas can be explored together, with multiple perspectives considered as part of the dialogue. These opportunities allow for a more complete exploration of a concept, rather than limiting the ideas to one partner or organization. Different types of experience and expertise can challenge and stretch understanding and ideas. As well, the experiences of shared training and professional development allow for the best use of resources and further contribute to the quality of relationships.

Mutual skills in facilitation, consensus building, evaluation, and research were realized by partners as a result of their interactions. Experienced facilitators modelled techniques in engaging participants, managing conflict, and building consensus. Partners have also participated in multi-sectoral discussions, and have had the opportunity to hear a broad scope of opinions and observe a range of styles of interactions.

In Atlantic Canada, federal partners have provided expertise, resources, and thoughtful leadership to ACES, which has resulted in a ***greater collective understanding of program evaluation*** and an awareness among partners of the importance of sensitive approaches to evaluation. Project and system partners have contributed to this work and have participated in training sessions on evaluation models. In turn, they share these lessons with their staff, Boards of Directors, and other system partners, who are able to bring new perspectives and ideas to other program and policy areas. Individuals, project staff, and members of Joint Management/Program Advisory Committees have all had opportunities to participate in focus groups and interviews demonstrating respectful and participatory styles of engagement.

> ***"There has been a tremendous increase ...in activities associated with system-level work. This involvement has afforded opportunities for staff and parents to work on local initiatives and issues in partnership with a broad number of stakeholders to contribute to change simultaneously at the local, community, regional, and provincial levels."***
>
> **– CAPC/CPNP project**

Empowerment of individuals, projects, communities, and the system occurs as relationships are developed and enhanced. All partners develop and experience greater awareness and competencies, on both professional and personal levels. As a result, there is a more informed, sensitive, and effective response from projects and the system to the needs of pregnant women, children, and families. Such capacity increases the likelihood of collective action on the part of all involved, supporting the development of social capital throughout the Atlantic Region.

CAPC AND CPNP, SOCIAL CAPITAL, AND PUBLIC HEALTH

BUILDING SOCIAL CAPITAL

Basically, the concept of social capital is that a person's family, friends, and associates form an important asset that may have a significant effect on personal productivity and well-being.

> ***"...yes, it's been really positive. It is one area of my work where I can truly see community capacity...the group work and working with community and the support families get from one another. I'm truly able to practice population health and community capacity building...taking the theoretical and applying it in the CPNP project."***

Social capital refers to these types of connections among individuals, i.e., social networks and the reciprocity and trustworthiness that arise from them. In that sense, the amount of social capital is related to the quality and depth of relationships between people in a family or a community.

One of the key lessons learned from the 1997 Atlantic regional CAPC evaluation was that all players involved in community-based, collaborative programs are capable of change. Therefore, program impacts can go beyond changes in program participants within projects. This has lead to an understanding that the scope of change is broader and includes social and structural changes to the communities and system themselves.

> ***A growing body of research suggests that where trust and social networks flourish, individuals, firms, neighbourhoods, and even nations prosper economically. Social capital can help to mitigate the insidious effects of socioeconomic disadvantage.***
>
> ***– Bowling Alone, 2000***

The mutual benefits to CAPC and CPNP and the system (enhanced relationships, sharing of resources, building trust, understanding one another's perspectives) support the empowerment of the projects and the system. In doing so, individuals and communities are also empowered. For example, parents become active participants who can not only bring strengths to the program itself, but who are also able to effect positive changes to their individual and shared environments. System-level partners are also empowered, in that such relationships allow them to be more effective in carrying out the mandates of their respective organizations.

Such community capacity lends itself to collective action – in this case, on behalf of pregnant women, children, and families. Mutually supportive and respectful relationships; a sense of trust among and between partners; and an appreciation for others' perspectives, challenges, and strengths all provide for conditions that support this

collective action. These kinds of connections build social capital, which, in turn, has benefits for CAPC, CPNP, and the system.

Figure 2 demonstrates the ongoing and regenerating nature of the process. The projects' system-level work results in mutual benefits to both CAPC/CPNP and the system. The nature of these benefits empowers individuals, projects, communities, and the system, resulting in increased community capacity and opportunities for collective action. As collective action builds social capital in communities across the Atlantic Region, the benefits of social capital have a positive impact on citizens and also provide benefits to CAPC/CPNP and the system.

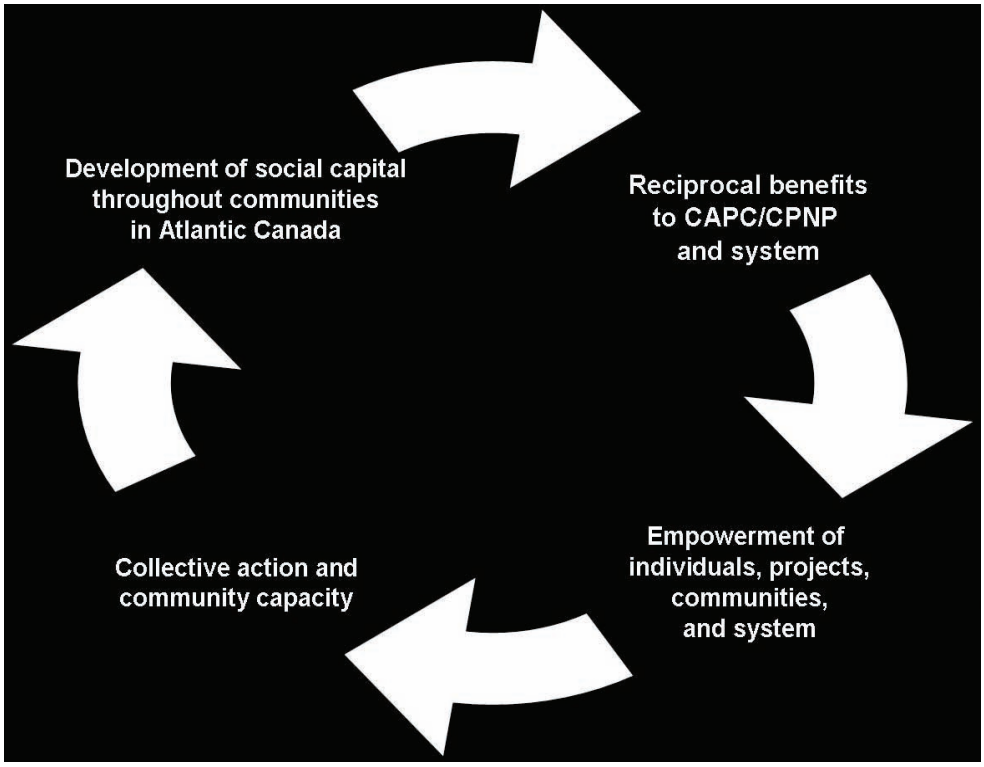

Figure 2: Reciprocal Cycle of Benefits

This process of reciprocity has the potential to become stronger over time, as projects and the system continue to work together by building supportive environments, promoting participation and involvement, and continuing to build capacity at all levels.

The relationship between social capital and health has been documented since 1901, when Emile Durkheim identified a relationship between suicide rates and the level of social integration. Since then, research has continued to demonstrate that higher social capital and social cohesion lead to improvements in health conditions. The World Bank notes that social capital can impact health through a variety of methods and describes a number of ways in which trusting relationships, combined with formal and informal social networks, have an influence on health.

Table 1 considers examples of how social capital impacts health (as suggested by the World Bank) in relation to the impact of system-level involvement on the work of CAPC and CPNP projects. It is clear that system-level involvement has enhanced the ability of CAPC and CPNP to make significant contributions in this area.

Social capital supports communities to:	***System-level involvement has enhanced the ability of CAPC and CPNP projects to:***
access health education and information	• provide current information to parents on issues related to pregnancy, breastfeeding, child development, healthy lifestyles, and access to community resources • involve health system and other professionals in CAPC and CPNP programs and events • increase the sharing of information and resources related to pregnant women, children, and families
design better health care delivery systems	• influence programs and practice that recognize and build on program participants' strengths and are sensitive to the needs of vulnerable pregnant women, children, and families
act collectively to build and improve infrastructure	• participate as active members of the community in committees, networks, and councils • establish provincial networks and organizations focused on pregnant women, children and families
advance prevention efforts	• work with health promotion and public health partners in the prevention of FASD, obesity and promotion of healthy lifestyles
address cultural norms that may be detrimental to health	• establish partnerships with Francophone, First Nations, Métis, and multicultural organizations to promote culturally relevant dialogue and practice at all levels • participate in the development of culturally relevant policies and programs for pregnant women, children, and families

Table 1: Social Capital and System-level Involvement

Social capital operates through psychological and biological processes to improve individuals' lives. Mounting evidence suggests that people whose lives are rich in social capital cope better with traumas and fight illness more effectively.[6] For example, Health Canada noted that "research conducted in Manitoba following the Red River flooding in 1997 demonstrated the positive effect of social capital on the communities' ability to respond effectively to the catastrophe."[7] "Communities with a higher level of social, human, and physical capital reacted more effectively to the flooding."[8] Community connectedness is, therefore, not just about warm fuzzy tales of civic triumph. In measurable and well-documented ways, social capital makes an enormous difference to our lives.[9]

International research supports the consideration of social capital as a determinant of health. Robert Putnam of Harvard University has explored interstate differences in social capital, as measured in association memberships, political activism, and volunteering. He found that such variables are positively correlated with educational performance and child welfare and negatively related to tax evasion, crimes of many types, health problems, and mortality.[10] Michael Woolcock of the World Bank has reported on urban studies showing that the incidence of crime is lower and employment prospects better where the density of social networks is greater.[11]

Canadian research has reported that social capital in neighbourhoods can mediate the negative impacts of long-term family poverty and other indicators of family stress on child development.[12] Using data from the National Longitudinal Survey of Children and Youth, researchers found that social capital had a statistically significant effect on the slope of the relationship between long-term poverty and children's physical health. These researchers have recommended that a holistic picture of the social context of parenting must include the social capital of neighbourhoods.

Since the 1990s, there has been an emphasis on determinants and on developing indicators related to aspects of life that had not been measured to any extent until that time, and whose link with health had not been clearly specified. These are the effects that the immediate social environment (family and friends), social networks, mutual trust, civic participation, community engagement and other factors can have on the health of individuals. The majority of these indicators are associated with a micro-social scale (the community) and constitute an effort to link the individual to the social.

– Social Capital as a Health Determinant, 2002

According to Robert Putnam's research, there is a strong positive relationship between the public health index and the social capital index as well as a negative relationship between the social capital index and the global index of the causes of mortality.[13] In addition, the author emphasizes that the positive effects of integration and social support can act as a buffer against the effects of known health risks such as smoking, obesity, hypertension, and physical inactivity. In short, the evidence of the positive effects of social integration on health is very strong.

PUTTING IT ALL TOGETHER

Clearly, CAPC and CPNP have a key role to play in building social capital in communities. Their contributions – resulting in the empowerment of individuals, projects, communities, and the system – contribute directly to collective action, social capital, and public health.

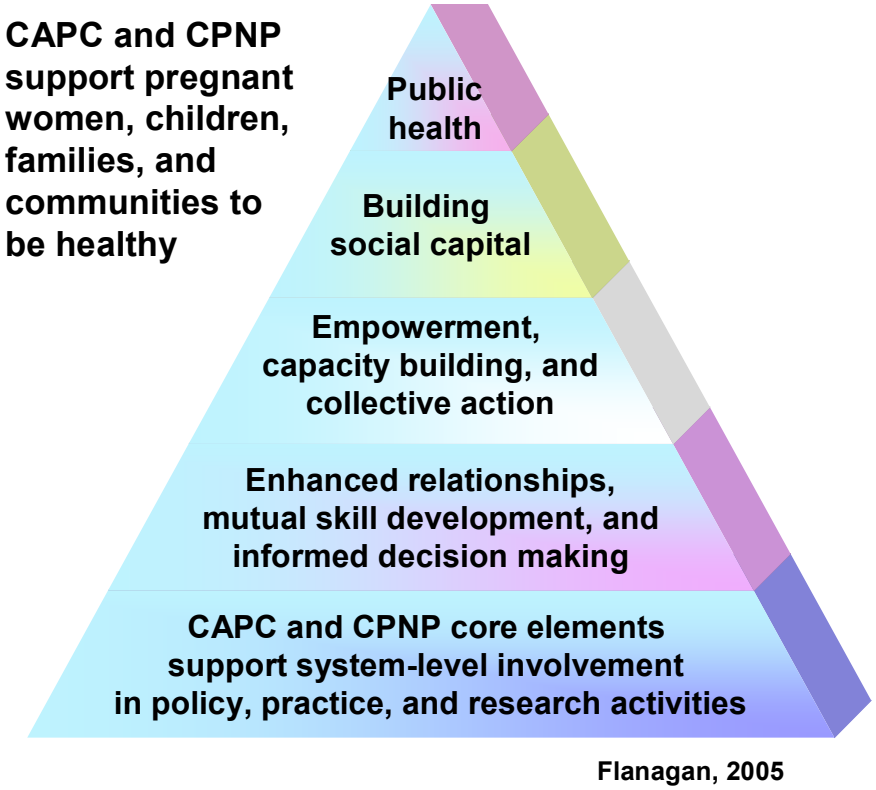

Figure 3: CAPC and CPNP Core Elements Supporting Public Health

Figure 3 demonstrates the impact of CAPC and CPNP on public health:

- The **core elements** of CAPC and CPNP provide the environments that allow projects to support the development of public policy, program practice, and research and evaluation. At the system level, this work is done in collaboration with regional,

municipal, provincial, and federal government partners and with universities and other academic organizations.

- CAPC/CPNP/system involvement results in **mutual benefits**, including enhanced relationships; increased respect and credibility for everyone; a greater understanding of one another's perspectives; better use of resources such as shared access to training; mutual skill development in facilitation, building consensus, and research and evaluation; and more informed decision making for policy, program, and research development.

- These results provide for a **greater sense of empowerment** for those involved to take on new challenges, work for change, and be active citizens in their communities. Such community capacity leads to **collective action and builds social capital**.

- **Social capital** is a key determinant of health and contributes directly to supporting **public health for Canadians**.

CHALLENGES

CAPC/CPNP projects – while very enthusiastic about their involvement at the system level – nevertheless faced challenges in this part of their work. Almost all projects mentioned the "time crunch" – and their need to balance the demands of their work with pregnant women, children, and families against the time needed to attend meetings, prepare presentations, and other types of activities involved with system-level work. This was particularly true for small projects with limited numbers of staff. Projects indicated concern with becoming "stretched too thin" and worried about burnout for staff.

Projects also acknowledged the differences between working in a community-based organization and working in a government system. While decisions could be made quickly in a community organization, most often system partners – especially those working in government systems – took a considerable amount of time to work through various levels within their systems in order to obtain final approval for action. While projects realized that the two systems were structured differently, the pace of decisions, action, and change was often something taken into consideration when projects needed to justify the amount of time devoted to system-level activities. In two different provinces, at least one project posed the question as to whether the time needed to devote to system-level work was indeed worth the investment.

Although the constant challenges related to the lack of time and financial and human resources were common to many centres, some projects also identified that differing philosophies were sometimes barriers to collaborative work. Projects often noted the need to reinforce an "assets based" approach to working with families – reflective of the principles of CAPC and CPNP. Others identified that "hidden agendas" and issues related to confidentiality also posed difficulties in their work with system partners. Interestingly, system partners also reported that they, too, felt challenged by client confidentiality issues, particularly when there were service linkages between community and government organizations. The system-level

> ***"We need to learn that the system is not an elusive being, but an entity that is made up of people. Learning how not to be intimidated and how to work most effectively within this system is the first step toward systemic change.***
>
> ***Collective action for change is a long term goal. [We] have learned that a conscious investment of time is needed to support the work in this area. That means that system-level work is not something that is done only if time allows, but rather it becomes a regular piece of the ongoing work of the Executive Director."***
>
> **– CAPC/CPNP project**

respondents noted, however, that these confidentiality issues were not specific to CAPC or CPNP but were inherent in much of their work with nongovernmental partners. Confidentiality appears to be a recurring theme associated with partnerships and is an issue between and within various parts of the system and community-based organizations themselves.

Partners from provincial governments identified that legislative requirements and public policy direction often presented challenges in their work with CAPC and CPNP partners. They explained that while CAPC and CPNP are designed to reach the most vulnerable families, provincial government systems must make services accessible to all families. This challenge was further compounded in provinces in which CAPC and CPNP do not reach all parts of the province. In those cases, system partners found some limitations in working with the projects if all communities were not represented at the table. As well, system partners noted that a lack of clarity regarding contexts, roles and responsibilities, and accountability were challenges to their work with CAPC and CPNP.

The issue of funding was raised as a challenge to CAPC/CPNP/system-level partnerships – but with some very different perspectives. Projects clearly identified that their "static" budgets – which have not been increased in many years – meant that they were constantly put in a position of "having to do more with less." This impacted their ability to introduce new programs and deal with human resource issues and ultimately limited their ability to effectively work at a system level. While many projects had been able to secure additional resources from other places, they did feel that their funding was diminishing in value as the years went on.

System-level stakeholders did agree that funding for CAPC and CPNP projects was an issue, but they also felt that CAPC and CPNP projects had substantial, predictable funding that was generally not available to other community-based programs. Some felt that this funding had enabled CAPC and CPNP projects to develop a strong presence at the community level. In fact, some system partners felt they were limited in their work with all community partners since only CAPC and CPNP projects had funding that would allow them to accommodate expanded services.

Although both projects and system-level partners identified challenges and limitations to their collaborative work, for the most part, it appears that the relationships developed through their shared experiences allowed them to work through their differences in an atmosphere of open dialogue in a trusting environment. These relationships – which continue to be strengthened as a result of ongoing and meaningful partnerships between CAPC and CPNP and system representatives – have the potential to address the challenges noted above in years to come.

CONCLUSIONS

WHAT DOES THE STUDY OF CAPC AND CPNP PROJECTS' INVOLVEMENT WITH SYSTEM-LEVEL ACTIVITIES TELL US?

The evaluation reports from 30 CAPC/CPNP projects in the Atlantic Region have provided a description of the extent of their work with system partners and in system-level initiatives. As well, the projects' evaluation reports have provided information about the effects of such involvement on their participants, staff, and volunteers. The evaluation reports also provided feedback from project partners through interviews and quotes.

In addition, the *System Level Key Informant Interview Analysis Report* presented information from 21 key informants from governments, universities, and provincial organizations describing their involvement – and the impact of their experiences – with CAPC and CPNP projects and programs.

These impacts have been considered within the context of empowerment, collective action, and social capital, along with research on the effects of social capital on health and well-being. As a result, the following conclusions are presented:

1. **CAPC and CPNP are key players in the delivery of child and family programs.**
   Key informants and system-level partners have noted that projects have a significant presence in communities and are "the best available vehicle for a provincial department to connect organizations with a common, networked approach to reach and support families facing challenges."[14]

2. **CAPC and CPNP are firmly established and well integrated in the broader network of policy, program and research initiatives for pregnant women, children, and their families.**
   Reports from projects are rich with examples of how their work is closely linked with related government and research initiatives at the national level and within their own provinces and regions. As national initiatives, CAPC and CPNP were established by the system, are funded and managed by the system, and are key players in the various system initiatives that have been introduced in the last 10 years. At the local level, CAPC and CPNP projects were also established with system support and funding and continue to be monitored by the system.

   Clearly, projects provide a means for the system to anchor new programs within a strong community network. Key informants clearly stated that CAPC and CPNP are closely tied to the work they do on behalf of pregnant women, children, and families and provide substantial support to the work of the system.

3. **CAPC and CPNP are helping to create supportive environments for individuals, projects, communities, and the system through opportunities to share perspectives, expertise, and resources.**
   The emphasis on partnerships, as stated in the National Guiding Principles of CAPC and CPNP, is reflected in the examples of projects' efforts to work in partnership at the community, regional, provincial, and national levels. Projects contribute a significant amount of time and effort to providing advice, participating in consultations, and collaborating with other organizations and levels of government in the development of new programs and resources. This allows all partners to maximize their resources, develop a better understanding and appreciation of one another's perspectives, and provide opportunities for innovative ideas and responses.

4. **CAPC and CPNP are contributing to policy, practice, and research development at the system level because the core elements of the programs create conditions that contribute to system-level change.**
   Many projects have focused on building supportive environments, promoting participation and involvement, and building capacity at the system level. In doing so, they have had a strong influence on the development of policies that are responsive to the needs of pregnant women, children, and their families; program practices that acknowledge and build on the strengths and wisdom of parents; and research that is participatory, inclusive, and respectful of pregnant women, parents, and families.

5. **CAPC and CPNP are building community capacity across Atlantic Canada – capacity that affects the public health of the community.**
   As national program initiatives that were established in response to the system's awareness of the wisdom of investing in the early years, CAPC and CPNP have matured. This maturation has occurred during a period of significant progress in understanding the nature and impact of early childhood development. The collegial nature of CAPC and CPNP relationships with system partners is reflected in the reciprocal nature of the benefits to each. Enhanced relationships, a growing sense of trust and loyalty, and an appreciation and understanding of one another's perspectives contribute to a sense of empowerment for individuals, projects, communities, and the system. This empowerment directly affects community capacity, provides opportunities for collective action, and builds social capital.

6. **CAPC and CPNP are providing the system with a means to work toward improved public health for Atlantic Canadians.**
   There is compelling international research linking social capital and public health. By playing a key role in contributing to the development of social capital in communities, CAPC and CPNP projects are able to provide the system with a solid and effective means of addressing public health issues such as nutrition and food security, healthy pregnancy, breastfeeding, mental and emotional health, physical activity, injury prevention, smoking cessation, and the promotion of healthy lifestyles. The supportive environment, opportunities for participation and

involvement, and examples of capacity building evident in the work of CAPC and CPNP projects create conditions that may address some of these long-standing public health issues in Atlantic Canada.

WHERE TO FROM HERE?

CAPC and CPNP projects have reached a level of maturity that is only just beginning to allow them to blossom into their full potential. Across the region, projects are recognized and respected as key elements of the community. Their position in the community highlights the presence of the federal government as a partner in promoting collective action as well as strengthening the role of the federal government to facilitate inter-sectoral collaboration and cross-sectoral partnerships and to promote relevant research, evaluation, and knowledge exchange.

These projects are well positioned to mobilize community efforts to address goals and objectives intended to improve the health and well-being of Atlantic Canadians. The recently adopted *Health Goals for Canada*[15] clearly indicate the importance of children being able to reach their full potential and to grow up happy, healthy, confident, and secure. These Health Goals also emphasize the importance of belonging and engagement, supportive families and friendships, and the opportunity to participate in decisions that affect personal and collective health and well- being. The impacts of CAPC and CPNP system-level involvement have the potential to make a significant contribution to these aspirations. *(See Appendix E for a complete description of the Health Goals for Canada.)*

CAPC and CPNP projects have gained both experience and expertise in developing and sustaining community-based initiatives for pregnant women, children, and families. They have done so in collaboration and partnership with related health services and programs, other community organizations, and other levels of government. These types of partnerships have taken time to develop, nurture, and mature. They have been possible because of the financial and human investments made in CAPC and CPNP programs.

The federal government is now in the position of being able to realize the benefits of this investment. Across the Atlantic Region – and across Canada – PHAC has an opportunity to focus on pregnant women, children, and families facing risk to their healthy development and to play a key role in mobilizing collective action on behalf of families.

This report has attempted to demonstrate how CAPC and CPNP projects have been involved in system-level activities on behalf of pregnant women, children, and families and how that involvement has resulted in strong and trusting relationships and empowerment for those involved. When citizens are empowered, there is an increase in community capacity and more and more opportunities for collective action. These are the kinds of things that build social capital – the "glue" that holds communities together and strengthens their capacity to effect change.

Research is very clear on the benefits of social capital – to individuals, to families, to communities, and to health. CAPC and CPNP's work with individuals, communities, and the system is a solid contribution to building social capital and public health in Atlantic Canada.

APPENDIX A
DATA COLLECTION QUESTIONS USED BY PROJECTS FOR SYSTEM LEVEL INVOLVEMENT

CAPC/CPNP projects were provided with a collection of possible questions to use in carrying out their evaluations. These questions were part of the tools provided in *Valuing Our Work - A Resource Kit on the Evaluation and Reporting System for CAPC and CPNP in Atlantic Canada*.

Projects were encouraged to select questions related to the particular outcomes and indicators chosen for measurement. It was suggested that projects could also adapt the questions into specific tools such as a guide for a focus group or a storytelling circle.

Questions from the *Project Level Questions* Tool Related to Involvement in the System:

28. In your experience, have governments, academics, or other parts of the system sought out CAPC or CPNP perspectives on programs, policies, or research? If yes, please describe.

29. Has your project been involved in helping to make changes in the system? If yes, please describe.

30. Does your project work involve the developing or enhancing of policy or research related to children and families? If so, please describe.

31. Does your project allocate human and financial resources to work with the system? Please comment.

32. a) Has being involved with system level work affected the way you or your organization operate?
    b) If so, how?
    c) Describe any challenges you've faced in being involved in system change.
    d) How have you addressed these challenges?

33. What do you perceive to be the systemic barriers in moving CAPC/CPNP work forward?

34. Do you have any overall comments on CAPC/CPNP work as it relates to the system?

APPENDIX B
DATA COLLECTION QUESTIONS
USED IN SYSTEM LEVEL KEY INFORMANT INTERVIEWS

1. Context of system level work

1.1 Briefly describe your work as it relates to programs, policies or research regarding children and families.

1.2 Briefly describe the kind of involvement or work experience you and/or your organization have had with CAPC/CPNP in the past five to seven years.

2. Roles, contributions and challenges

2.1 For each significant experience that you and CAPC/CPNP representatives have been involved in over the past five to seven years, please describe:

a) the program, policy or research that was the focal point of your work,
b) your involvement in the process,
c) CAPC/CPNP's involvement in the process,
d) any specific contributions that you feel were made by CAPC/CPNP,
e) any movement toward system level change that took place as a result of this work (*this includes changes to policies, practices or research - for example, within governments and universities - that take place beyond the local community level. System level change affects the broader population of people over a larger geographical area.*)

2.2 Overall, would you characterize the system level changes that you have just described as aiming to:

a) build supportive environments for those involved in early childhood development? (The environments can be those surrounding children and parents/caregivers, staff and volunteers, organizations and agencies, or inter-organizational systems)
b) support participation and involvement in system-level change, by parents/caregivers, staff and volunteers, organizations and agencies, or inter-organizational systems?
c) build capacity for system-level action, in parents/caregivers, staff and volunteers, organizations and agencies, or inter-organizational systems?

2.3 Did you encounter any systemic challenges or barriers that hindered the inclusion and effective participation of CAPC/CPNP in the work you have described?

a) If so, please describe these challenges or barriers.
b) Were you able to address them? If so, please describe your approach.

2.4 Describe any challenges you may have experienced working with CAPC/CPNP on system level activities.

a) Were you able to address these challenges? If so, please describe your approach.
b) If you were not able to address these challenges, do you have any recommendations or strategies to share that may be helpful for future consultation or collaboration?

3. Future directions

3.1 Has your collaboration with CAPC/CPNP influenced the way you or your organization works or will work in the future? If so, how?

3.2 Has collaborating with CAPC/CPNP influenced the kind of work you do or will be doing in the future related to children and families? If so, how?

4. Conclusion

4.1 Do you have any other comments?

APPENDIX C
CORE ELEMENTS AND SYSTEM-LEVEL ACTIVITY

SUPPORTIVE ENVIRONMENTS

- Projects have played an advisory role for new initiatives in the region or province.
- Projects have provided consultation regarding legislative and program reviews.
- Projects have participated in the ongoing implementation of provincial initiatives for pregnant women, children, and families as part of a collaborative effort with other community partners and governments – often taking the lead role.
- Projects have provided a platform from which other funders are able to launch new programs for pregnant women, children, and families (e.g., home visiting, language, school readiness, employment training, parenting).
- Projects have provided environments for post-secondary students to have work placements through courses of study in related fields (e.g., early childhood education and nursing).
- Projects have provided a point of contact with pregnant women, children, and families for other professionals, including public health nurses, speech language pathologists, educators, and researchers.
- Projects have provided coordination for home visiting programs.
- Projects have produced or been involved in the production of training materials (e.g., videos, resource manuals).
- Projects have provided environments for research on issues related to pregnant women, children, and families (e.g., literacy, food security, demographics, income assistance, breastfeeding).
- Projects have provided coordination and delivered and participated in professional development sessions, conferences, and workshops.
- Projects have collaborated with other community-based organizations in developing funding proposals and in the delivery of programs with complementary and convergent goals and objectives.

PARTICIPATION AND INVOLVEMENT

- Projects have participated on regional and provincial committees focused on matters related to pregnant women, young children, and their families, including health, social/community services, justice, education, employment, housing, and substance abuse.
- Projects have partnered with provincial governments in the delivery of early childhood related initiatives, including Fetal Alcohol Spectrum Disorder (FASD), home visiting, parenting, language and literacy, and child care information and support.
- Projects have worked with partners to reach families dealing with low income, limited education, and social isolation through information sharing and on-site opportunities.

- Projects have partnered with other agencies and governments in the delivery of early intervention and prevention programs (e.g., car seat safety, maternal nutrition, speech language, FASD).
- Projects have participated in research projects, including data collection, focus groups, dissemination of findings, promotion of evaluation, and training sessions regarding evaluation activities.
- Projects have participated in focus groups regarding the development of public health goals for Canada and the mandate of the Public Health Agency of Canada.
- Projects have participated in annual strategic planning sessions to establish provincial priorities for policy and program development.
- Projects have participated in case conferences to provide input to case plans for selected families.
- Projects have been involved in participatory research (e.g., as food costers, trainers, and mentors in the NS Food Security projects, and Milky Way research).
- Projects have worked with education partners in the promotion of literacy and school readiness.

CAPACITY BUILDING

- Staff have increased confidence, knowledge, and understanding about system-level work at the research and policy levels, the complexity of this, and how to work within this broader platform.
- Staff have increased knowledge, strategies, and tools on how to involve parents and community members in activities at local, regional, provincial, and national levels.
- There has been a shift in the system's perspective to one of focusing on the strengths of families and an emphasis on facilitation rather than teaching.
- The system is now very aware of the presence of family resource centres, and works with them as key players in the network of services and programs.
- Projects' work with other early years agencies across the region at regional tables has resulted in individual system representatives having different perspectives about how to best work with pregnant women, children, and families.
- Projects have introduced new programs that have subsequently been "adopted" by system-level partners and sustained through new policy and program efforts.
- Projects have influenced changes to program policy to increase the sensitivity to the needs of pregnant women, parents, and families, to address unmet needs, and to reflect best practice.
- Participants are experiencing increased inclusion in activities that affect their lives (e.g., food costing research and job experience activities). This, in turn, is increasing their confidence and building on their capacity to contribute a voice to issues that are important to them.

- Projects' experiences in working with provincial strategies and health coalitions (e.g., Rural Perspectives project, Early Childhood Development Initiative, Healthy Child Development) have laid the groundwork for further discussions with provincial representatives around barriers facing pregnant women and families with young children who live in rural and remote communities or who are coping with poverty, social/cultural isolation, limited education, family violence, substance abuse, disabilities, and/or other challenges.
- There is an increased mutual awareness of resources and knowledge.
- There are increased opportunities for collaboration with provincial and federal government agencies and ministries, including health, community services, education, development, and employment.
- The number of opportunities to collaborate with other provincial organizations has multiplied and increased capacity for all involved.
- There is an increased capacity to mobilize parents, understand their needs, and be able to present this perspective.
- There is an increased capacity to develop program resources and to develop and deliver presentations, workshops, and other types of facilitated professional development opportunities.
- There is an increased awareness, understanding, and use of participatory evaluation strategies among projects and their partners.
- There is an increased awareness in the education system of the benefits of positive early childhood experiences, resulting in increased partnerships, flexibility regarding program policies, and expanded opportunities for ongoing involvement (e.g., projects are included in plans for new school expansion).

APPENDIX D
EXAMPLES OF INTERCONNECTED RELATIONSHIPS AMONG FEDERAL/NATIONAL, PROVINCIAL/REGIONAL/MUNICIPAL, COMMUNITY, AND CAPC AND CPNP PROGRAMS

Federal/national components of the system include the Government of Canada and its various ministries, national nongovernmental organizations, and nationally based academics and researchers.

Provincial/regional/municipal components of the system include provincial governments and their various departments; regional health boards, school boards, and municipal governments; provincial nongovernmental organizations; universities and community colleges; and academics/researchers.

- These two components have relationships with each other through partnerships on Joint Management or Program Advisory Committees and partnerships through related federal/provincial/territorial initiatives such as the Early Childhood Development Initiative, Early Learning and Child Care, Fetal Alcohol Spectrum Disorder (FASD), Understanding the Early Years, and the National Longitudinal Survey on Children and Youth.

Communities include community organizations; local schools, hospitals, and community health centres; community councils; churches and other faith-based organizations; and other early childhood programs.

- Both the federal/national and provincial/regional/municipal components of the system have relationships with communities (e.g., through various funding agreements, ongoing national research such as Understanding the Early Years, and other health related initiatives such as FASD, smoking cessation, labour market development, employment, training, and job creation).

CAPC and CPNP involve the national programs; the funded projects; and the individuals, staff, and volunteers who are integral to the functioning of each of the funded projects.

- Federal/national components of the system have relationships with CAPC and CPNP with respect to funding agreements, program evaluation, program management, national research, and links between CAPC/CPNP and other federal/national program priorities (e.g., Aboriginal Head Start, Labour Market Development Agreements, the National Longitudinal Survey of Children and Youth, and the First Ministers' Early Childhood Development Initiative).

- Provincial/regional/municipal components of the system have relationships with CAPC and CPNP through their linkages with other provincial strategies and initiatives; through provincial involvement in defining priorities for investments and participation on Joint Management or Program Advisory Committees; through partnerships in program delivery; through collaboration in provincial/regional/municipal consultations, data collection, and surveys; and through partnerships in training and the development of resources.

- Communities have relationships with CAPC and CPNP through the many jointly delivered programs, partnerships, and volunteer efforts that support their complementary and convergent goals and objectives.

APPENDIX E
HEALTH GOALS FOR CANADA
as reported on www.healthycanadians.ca

At the annual meeting of Federal, Provincial and Territorial Ministers of Health in October 2005, Ministers further demonstrated their commitment and leadership in advancing public health through agreement on a set of goals for improving the health of Canadians. The Health Goals for Canada were developed collaboratively with Canadian governments, public health and other experts, stakeholders and citizens. Ministers agreed that the goals would inform each provincial and territorial government in development of their own initiatives. To help strengthen public health, Healthy Living Targets seek to obtain a 20% increase in the proportion of Canadians who are physically active, eat healthy food and are at healthy body weights.

BACKGROUND

- In the context of accelerating work on a pan-Canadian Public Health Strategy and engaging across sectors, First Ministers committed to "improving the health status of Canadians through a collaborative process." In September, 2004, First Ministers directed Ministers of Health to take the lead on developing health goals for Canada. Federal Minister Carolyn Bennett, Minister of State (Public Health), and Manitoba Minister Theresa Oswald, Minister Responsible for Healthy Living, were appointed to co-lead this process.
- Improving the health of Canadians will require the participation and collaboration of individuals, groups, organizations and employers. With that understanding, the consultation phase of the goals initiative included roundtables with public health stakeholders, experts and ordinary citizens in each province and territory so that Canadians could tell us about their concerns, priorities and visions for a healthy Canada. All of these inputs were used to draft an overarching goal and nine health goals.
- The goals statements are broad and meant to express the collective hopes and expectations of Canadians when it comes to their health. The goals are intended to be guideposts indicating a path to improve the health and quality of life of Canadians rather than a detailed map that lays out exactly how to get there.
- Work towards achieving these goals will take place on multiple fronts. While individuals, communities, regions and governments each have a role to play, they will approach this role from different perspectives and with different interests and priorities. While we hope that the goal statements will be embraced in all parts of Canadian society, it will be up to each government, community and individual to put them into effect in meaningful and relevant ways.
- According to the agreement entitled « Asymmetrical Federalism that respects Québec's jurisdiction » which accompanies the « 10-Year Plan to Strengthen Health Care », Québec intends to determine its own objectives, standards and criteria. Thus,

Québec did not participate in the process to develop health goals for Canada and did not contribute to the development of the documents relating to this process, although it may share the general objectives described in them.

OVERARCHING GOAL

As a nation, we aspire to a Canada in which every person is as healthy as they can be – physically, mentally, emotionally, and spiritually.

HEALTH GOALS FOR CANADA

Canada is a country where:

Basic Needs (Social and Physical Environments)
Our children reach their full potential, growing up happy, healthy, confident and secure.

The air we breathe, the water we drink, the food we eat, and the places we live, work and play are safe and healthy - now and for generations to come.

Belonging and Engagement
Each and every person has dignity, a sense of belonging, and contributes to supportive families, friendships and diverse communities.

We keep learning throughout our lives through formal and informal education, relationships with others, and the land.

We participate in and influence the decisions that affect our personal and collective health and well-being.

We work to make the world a healthy place for all people, through leadership, collaboration and knowledge.

Healthy Living
Every person receives the support and information they need to make healthy choices.

A System for Health
We work to prevent and are prepared to respond to threats to our health and safety through coordinated efforts across the country and around the world.

A strong system for health and social well-being responds to disparities in health status and offers timely, appropriate care.

ENDNOTES

1. Natalie Kishchuk, *System Level Key Informant Interview Analysis Report,* Atlantic Regional Office, Public Health Agency of Canada, Halifax, 2005, p. 3.

2. Frances Ennis and Yolande Samson, *At the Heart of Our Work: The Theoretical Framework and Core Elements of a Reporting and Evaluation System for the Community Action Program for Children (CAPC) and the Canada Prenatal Nutrition Program (CPNP) in Atlantic Canada,* Atlantic Regional Office, Population and Public Health Branch, Health Canada, Halifax, 2002, p. 3-4.

3. Manitoba applied the concept of core elements as developed in the Atlantic Region to their CAPC and CPNP program evaluation but decided to include social action as a distinct (fourth) core element.

4. In New Brunswick, CPNP funding was awarded to the Victorian Order of Nurses for a province-wide project. This funding was intended to complement New Brunswick's Early Childhood Development Initiative, which had goals and objectives similar to the new federal program.

5. The examples given in these sections are meant to be illustrative only.

6. Robert Putnam, *Bowling Alone: The Collapse and Revival of American Community,* Simon and Schuster, New York, 2000, p. 288-290.

7. Buckland and Rahman, 1999, as cited in Solange van Kemenade, *Social Capital as a Health Determinant: How is it defined?* Policy Research Division, Population and Public Health Branch, Health Canada, Ottawa, 2003, p. 21.

8. Solange van Kemenade, *Social Capital as a Health Determinant: How is it defined?* Policy Research Division, Population and Public Health Branch, Health Canada, Ottawa, 2003, p. 21.

9. Putnam.

10. Ibid.

11. Michael Woolcock. Cited in "How Human and Social Capital Contribute to Economic Growth and Well Being – Highlights of an HRDC-OECD Symposium," *Applied Research Bulletin,* Vol.7, No.1, 2001, p. 13-15.

12. Author's personal notes.

13. Author's personal notes.

14. Kishchuk, p. 13.

15. Health Goals for Canada were endorsed by federal, provincial, and territorial ministers of health at their annual meeting in October 2005.

BIBLIOGRAPHY

Bangkok Charter for Health Promotion in a Globalized World, Report from 6th Global Conference on Health Promotion, Bangkok, Thailand, August 2005. www.who.int/healthpromotion/conferences

Barter, Ken, *Capacity Building as a Core Element of Evaluation: A Literature Review*, Atlantic Regional Office, Population and Public Health Branch, Health Canada, Halifax, 2001.

Buckland, Jerry and M. Matiur Rahman, "Community-based Disaster Management during the 1997 Red River Flood in Canada," *Disasters,* Vol. 23, No. 2, 1999. Cited in Solange van Kemenade, Social Capital as a Health Determinant: How is it defined? Policy Research Division, Population and Public Health Branch, Health Canada, Ottawa, 2003. http://www.hc-sc.gc.ca/sr-sr/alt_formats/iacb-dgiac/pdf/pubs/hpr-rps/wp-dt /2003-0208-social-meas-mes/2003-0208-social-meas-mes_e.pdf

Bullen, Paul and Jenny Onyx, *Measuring Social Capital in Five Communities in NSW*: *a practitioners guide*, Management Alternatives for Human Services, NSW, Australia, 1998. www.mapl.com.au/A2.htm

Canadian Institute of Child Health, *The Health of Canada's Children: A CICH Profile, Third Edition,* Canadian Institute of Child Health, Ottawa, 2000. http://www.cich.ca/Publications_monitoring.html#Profile3

Ennis, Frances and Yolande Samson, *At the Heart of Our Work: The Theoretical Framework and Core Elements of a Reporting and Evaluation System for the Community Action Program for Children (CAPC) and the Canada Prenatal Nutrition Program (CPNP) in Atlantic Canada,* Atlantic Regional Office, Population and Public Health Branch, Health Canada, Halifax, 2002. www.atlantic.phac.gc.ca

Erben, Rosemarie, Peter Franzkowiak, and Eberhard Wenzel, "People Empowerment vs. Social Capital – From Health Promotion to Social Marketing." Paper presented at the 11th National Health Promotion Conference "Building social capital in the 21st century," May 23-26, 1999, in Perth, WA. Published in *Health Promotion Journal of Australia*, Vol. 9, No. 3, 1999. http://www.ldb.org/perth99.htm

Federal/Provincial/Territorial Special Task Force on Public Health, *Partners in Public Health*, F/P/T Special Task Force on Public Health, 2005. http://www.phac-aspc.gc.ca/publicat/healthpartners/pdf/partnersinhealthmainreport_e.pdf

Field, John, "Social capital and lifelong learning," *the encyclopedia of informal education* website, London, 2005. http://www.infed.org/lifelonglearning/social_capital_and_lifelong_learning.htm

Gutiérrez, Lorraine M., Kathryn A. DeLois, and Linnea GlenMaye, "Understanding Empowerment Practice: Building on Practitioner-Based Knowledge," *Families in Society: The Journal of Contemporary Human Services,* Vol. 76, No. 9, 1995. Cited in Barter, Ken, *Capacity Building as a Core Element of Evaluation: A Literature Review*, Atlantic Regional Office, Population and Public Health Branch, Health Canada, Halifax, 2001. (Internal document - limited distribution).

Hay, David, Brian Bell, Judi Varga-Toth and Tatyana Teplova, *Assessing the CAPC/CPNP Joint Management Infrastructure as a Model for FPT Collaboration: Looking Back and Moving Forward,* Research Report F/52, Canadian Policy Research Network, Ottawa, 2005. http://www.cprn.org/en/doc.cfm?doc=1331

Hayward, Karen and Ron Coleman, *The Tides of Change: Addressing Inequity and Chronic Disease in Atlantic Canada, A Discussion Paper*, Atlantic Regional Office, Population and Public Health Branch, Health Canada, Halifax, 2003.

Hyyppä, Markku T. and Juhani Mäki. "Individual-Level Relationships between Social Capital and Self-Rated Health in a Bilingual Community," *Preventive Medicine,* Vol. 32, No. 2, 2001. Cited in *Isuma - Canadian Journal of Policy Research,* Vol. 2, No. 1, Spring 2001. www.isuma.net/v02n01/index_e.shtml

Jensen, Lisa and Stephen Kisely, *Public Health in Atlantic Canada: A Discussion Paper,* Atlantic Regional Office, Public Health Agency of Canada, Halifax, 2005.

Jenson, Jane, *Mapping Social Cohesion: The State of Canadian Research*, Canadian PolicyResearch Network, Ottawa, 1998. http://www.cprn.org/en/doc.cfm?doc=180

Jones, Charles, Linn Clark, Joan Grusec, Randle Hart, Gabriele Plickert, and Lorne Tepperman, *Poverty, Social Capital, Parenting and Child Outcomes in Canada*, Applied Research Branch, Human Resource Development Canada, Ottawa, 2002. http://www.hrsdc.gc.ca/en/cs/sp/sdc/pkrf/publications/research/2002-002357/SP-557-01-03.pdf

Kawachi, Ichiro, Bruce Kennedy, Kimberley Lochner, and Deborah Prothrow-Stith, "Social capital, income inequality and mortality," *American Journal of Public Health,* Vol. 87, No. 9, 1997.

Kishchuk, Natalie, *System Level Key Informant Interview Analysis Report,* Atlantic Regional Office, Public Health Agency of Canada, Halifax, 2005. (Internal document – limited distribution).

McClenaghan, Pauline. "Social Capital: exploring the theoretical foundations of community development education," *British Educational Research Journal*, Vol. 26, No. 5, 2000.

Morrison, Sharon D., Rosalyn Howard, Christina Hardy, and Betria Stinson, "Social Capital, Health and HIV Awareness of Girls in a Rural Caribbean Community," *The International Electronic Journal of Health Education*, Vol. 8, 2005. www.aahperd.org/iejhe/2005/morrison.pdf

OECD (Organization for Economic Co-operation and Development), *The Well-being of Nations: The Role of Human and Social Capital*, Paris, 2001. http://www.oecd.org/els/pdfs/EDSMINDOCA003.pdf

O'Hanlon, Ann and Madine VanderPlaat*, Moving Along, Growing Strong: The Final Report of the Atlantic Community Action Program for Children (CAPC) Regional Evaluation*, Atlantic Regional Office, Health Promotions and Programs Branch, Health Canada, Halifax, 1997. http://www.phac-aspc.gc.ca/canada/regions/atlantic/Publications/Moving_along/index.html

Onyx, Jenny and Rosemary Leonard, *The relationship between formal and informal volunteering: A social capital framework*. Presented at the International Society for Third Sector (ISTR) Fifth International Conference, Capetown, South Africa, 2002. www.jhu.edu/~istr/conferences/capetown/volume/onyx.pdf

Putnam, Robert, *Bowling Alone: The Collapse and Revival of American Community,* Simon and Schuster*,* New York, 2000. http://www.bowlingalone.com/

Raven, Pauline, Michelle Rivard, Yolande Samson, and Madine VanderPlaat, "Empowerment-based evaluation*:* Research and social change." Cited in Munford, Robyn, and Jackie Saunders (eds.), *Making a Difference in Families: Research that Creates Change*, Allen and Unwin, Australia, 2003.

Samson, Yolande, JoAnna LaTulippe-Rochon, Frances Ennis, Anne Guy, and Michelle Rivard, *Valuing Our Work: A Resource Kit on the Evaluation and Reporting System for CAPC and CPNP in Atlantic Canada,* Atlantic Regional Office, Public Health Agency of Canada, Halifax, 2003.

Stone, Wendy and Judy Hughes, *Social Capital: Linking Family and Community?* Presented at the Family Strengths Conference, Newcastle, December 2-5, 2001. www.aifs.gov.au

Turnbaugh Lockwood, Anne, *Community Collaboration and Social Capital: An Interview with Gary G. Wehlage*, North Central Regional Educational Laboratory, United States of America, 1996. www.ncrel.org/cscd/pubs/lead21/2-1m.htm

University of Prince Edward Island, Institute of Island Studies Web site, *Collaborative Research in Population Health: Proceedings from the Inter-Island Study of Population Health Meeting*, University of Iceland, Reykjavik, 2001. www.upei.ca/~iis/pophealth.htm
van Kemenade, Solange, *Social Capital as a Health Determinant: How is it defined?* Policy Research Division, Population and Public Health Branch, Health Canada, Ottawa, 2003. http://www.hc-sc.gc.ca/sr-sr/alt_formats/iacb-dgiac/pdf/pubs/hpr-rps/ wp-dt/ 2003-0207-social-defin/2003-0207-social-defin_e.pdf

Whitty, Pam, *Theoretical Program Assumptions Based on Research/Literature and Stakeholder Experience – Further Defining and Enhancing the Program Models and Developing Relevant and Appropriate Reporting and Evaluation Systems for CAPC and CPNP in Atlantic Canada, Supportive Environments: A Literature Review*, Atlantic Regional Office, Population and Public Health Branch, Health Canada, Halifax, 2001. (Internal document - limited distribution).

Woolcock, Michael. Cited in "How Human and Social Capital Contribute to Economic Growth and Well Being – Highlights of an HRDC-OECD Symposium," *Applied Research Bulletin,* Vol. 7, No. 1, 2001.
http://www.sdc.gc.ca/en/cs/sp/sdc/pkrf/publications/bulletins/2001-000004/page07.shtml