Manitoba First Nation Strengthening Families Maternal Child Health Pilot Project

5 Year Evaluation 2006-2010

REGIONAL RESEARCH & EVALUATION REPORT

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EXECUTIVE SUMMARY

Strengthening Families Maternal Child Health (SF-MCH) is the Manitoba regional component of the Canadian First Nation Maternal Child Health Program. The SF-MCH framework for programming and evaluation consists of a regional and a unique community cultural perspective on health and health programming. The goal of the evaluation of the 2006-2010 SF-MCH pilot project was to begin to express a process of community-driven programming and the priorities for maternal and child health programming. A comprehensive approach to maternal and child health that includes programming for 'strengthening families' within First Nation communities is built on community strengths and existing services and encompasses linkages between a wide-range of services and programs at the community and regional levels. SF-MCH programming includes: pre- and post-natal screening and assessment; early child development assessments; health promotion, education and intervention programming for individuals and families. At the core, SF-MCH is a nurse-facilitated home visitation program. Peer-support home visitors and nurses provide on-going home visitation supports to women and their families from the prenatal period up to first 6 years of a child's life.

The current report is a description of the 2006-2010 evaluation of the SF-MCH Pilot Project. Described is a developmental process evaluation that captures the process of developing a community-driven and consultative process of joint programming and evaluation between: Manitoba First Nation communities; the Manitoba Region Maternal Child Health Advisory Committee; the Assembly of Manitoba Chiefs; The Indigenous Health and Social Justice Research Group of the University of Manitoba; and Manitoba Region First Nation Inuit Health, Health Canada. Described in the report are: the process of developing community-based and regional evaluation frameworks; the development of the health and socio-economic information system, quality assurance program and program standards; health priorities for the region; and 2 program impact surveys. Finally, recommendations and the way forward are discussed.

RECOMMENDATIONS EMERGING FROM THE EVALUATION ARE:

Continued support and expansion of SF-MCH programming to all First Nation communities in the Province of Manitoba is recommended.

Central management through the Assembly of Manitoba Chiefs has been invaluable to raising SF-MCH programming standards to a level of excellence.

The 2010-2011 evaluation should begin to design a longitudinal cost-benefit analysis for SF-MCH focusing on prevention and intervention effects on community health and wellness throughout the lifespan.

Capacity building efforts that include education and training on all areas of programming and evaluation should be continued. These efforts should include face-to-face (individual and group-based), on-line, and on-the-job practical education opportunities).

In terms of the potential for capacity development in the communities, the role of the Manitoba Maternal Child Health Advisory Committee should be expanded.

Government should keep in mind that the continuing support of community-based programs is essential in maintaining trust between participants and programmers. Trust is an underlying and essential determinant of health.

SF-MCH is counteracting the effects of previous policies and practices of the Canadian government that have negatively impacted First Nation families. Ongoing research on such impacts of SF-MCH should be supported.

Intercommunity communications are proving to be essential to raising the standard of maternal child health programming in Manitoba. The peer support program with the unique skill sets of the program's manager is a definite asset to SF-MCH and has thus far revealed measurable improvements to the overall pilot project.

The SF-MCH Pilot Project has put considerable energy into the development of a uniquely Manitoba First Nation programming framework. Such activity is proving to be essential to our success in gaining the active participation of community members throughout the region. So far, hundreds of First Nation community members have participated in each of several regional-based workshops, surveys, focus groups, education and training opportunities hosted by the Assembly of Manitoba Chiefs and by the University of Manitoba. Development activities will mark the difference between this and other health promotion and health intervention programs. The processes of development should be evaluated and recorded.

There needs to be increased opportunities for meaningful engagement in the development of ongoing programming for youth. Although Elder involvement exists and has been central to the pilot program thus far, ongoing opportunities for Elder involvement would greatly enhance the development of an early childhood curriculum and health assessment processes in the long-term.

The Manitoba First Nation Maternal Child Health Advisory Committee is composed of experts in maternal and child health and development from communities across the province. The need for ongoing support of this committee cannot be overstated. The committee is invaluable in terms of understanding the needs and strengths of all Manitoba First Nation communities (with and without SF-MCH), cultural considerations, linkages between programs, and health priorities.

Base-line studies implemented over the pilot project years indicate a need for programming support to assist grandparents in their role as caregivers; recreational and other social service supports to children and youth and, in particular, to children with special needs.

Preliminary studies of the SF-MCH Pilot Project indicate a need to focus on the social determinants of health. Housing, food security, community safety (including play safe zones for children and peaceful homes) are critical determinants of health and are focal issues arising from the studies.

The Program in Practice Support Team housed at the Assembly of Manitoba Chiefs, apart from government, was able to move quit quickly and effectively in establishing quality assurance and operational procedures to support programs to strive toward achieving program standards. Government should regard this Peer Support model as a best practice.

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Nelson House Program
family graduate of MCHP


Keeseekoowenin MCH Program
Mom: Brett, Baby: Hailleys


Opaskwayak Cree Nation Family (Four Generations)


Sagkeeng MCH Program Mom & Child

INTRODUCTION

THE MANITOBA FIRST NATION STRENGTHENING FAMILIES MATERNAL CHILD HEALTH PILOT PROJECT (SF-MCH)

Strengthening Families is the Manitoba regional component of the National First Nation Maternal Child Health Program. This report is the regional evaluation of the pilot project phase of program development and implementation. The report covers an evaluation of process activities and the identification of key health impacts. Topics described in the first section of the report are: history of maternal child health program development including national and provincial activities, description of the regional and community-based programs, research and evaluation: theoretical, cultural, governance models, service linkages and jurisdictional connections. Each of these topics is further elaborated upon in subsequent sections.

NATIONAL EVENTS LEADING TO THE PROJECT'S DEVELOPMENT

An overwhelming amount of research in the past twenty to thirty years has reported on the massive health and social disparities that see indigenous women and children in Canada at the lowest end of the scale on every measure of wellbeing. Whether it is on reserve or in urban centres, compared to other Canadian populations and to indigenous males, this specific population carries the heaviest burden of illness and disease.

The inception of the National Maternal Child Health Project is significant for several reasons, as will become evident throughout this report. The project came to life at a remarkable period in Canadian political history, when governments of every level acknowledged not only that inequities between Canadian populations exist, but that in order to attend to the situation, which is very much a joint responsibility of the governments to be carried out as a coordinated effort, not only health but governance matters must be addressed. The national events that took place between 2004 and 2006 are pivotal to the creation of the project. The project that resulted is in turn, an action towards empowerment, capacity development, health, economic, and social transformation.

Between 2000 and 2005 there was a flurry of activity undertaken by federal, provincial and territorial governments towards the development of a Blueprint for Canadian Health. As important as these discussions were to a transformation of health for Canadians, all of the discussions excluded First Nations. The Council of the Federation, composed of provincial and territorial premiers, meets annually to discuss reconciling Canada's fiscal imbalance and addressing healthcare issues from a population health perspective. Since 2000, the First Ministers Health Accords, involving both the Council of the Federation and the Prime Minister, have translated into serious funding commitments. For example, in 2004, the Accord focused on fixing the problems of the healthcare system. At the meeting, a 10-year plan was presented with a focus on quality, accessibility and sustainability (Assembly First Nations, June 2005).

Throughout Canada, health service governance is rapidly becoming regionalized and there is a policy shift towards the enhancement of community-based care. There is a focus on improving efficiency, effectiveness, access, quality and accountability with health delivery. Additionally, there is a growing desire by citizens to participate in and make decisions about their health care *(Health Canada, http://www.hc-sc.gc.ca/hcs-sss/pubs/ehealth-esante/2000-plan-infostructure/index-eng.php)*. The commonalities in interests and requirements for health are substantial and if the needs exist within the general Canadian population, health statistics reveal an even greater urgency among First Nations. It is critical that federal, provincial and territorial governments include First Nations in their discussions on health and health care and there are several reasons to justify this need:

- The First Nation population is larger than the populations of 4 Canadian provinces;
- There is a historical relationship between Canada and First Nations;
- Treaty and inherent rights;
- The Canadian Constitution, section 35;
- Fiduciary responsibility;
- First Nation governments have responsibility in a majority of cases for the delivery of health services in their communities;
- First Nations have the power to exercise jurisdiction and by-law making authority in the area of maintaining public health and safety;

These responsibilities of governments and communities also translate into necessary determinants of health and social wellness. Health promotion and population health research has taught us that empowering communities and individuals to become involved in the politics of their lives is essential for wellness. Opportunities for engagement in education and employment and ongoing capacity development are critical both to individual and community health. These notions move from theory to action in the development, implementation and evaluation of the Maternal Child Health Project.

Other events also prepared the stage for the foundation of the Maternal Child Health Project. Both the Royal Commission on Aboriginal Peoples, in the mid-1990s, and the Romanow Commission, 2001, were significant national initiatives that raised implications for the federal, provincial and territorial relations in the areas of health care. Both recommended greater consolidation of funds targeted to First Nations, allowing greater flexibility in addressing community and regional priorities. As well, the initiatives recommended the development of partnerships among all involved in First Nation health. Ultimately, the benefit of the recommendations envisioned was an improved continuum of care for First Nation individuals and communities.

The historic Canada-Aboriginal Peoples Roundtable held April 19, 2004, elevated the profile of First Nation interests all over Canada. The Roundtable represented an unprecedented opportunity for members of the Federal Cabinet, Senate and House of Commons to engage with Aboriginal leaders from across the country. At the Roundtable, the federal government strongly committed to the development of a new relationship with First Nations based on a principle of collaboration that will to real transformation. The Prime Minister made four key commitments revealing a change in the process of engagement with Aboriginal peoples:

A Report on the Roundtable: Strengthening the Relationship, Canada-Aboriginal Peoples Roundtable (released May 2004);

Sectoral discussions on six priority areas with Aboriginal groups, provincial and territorial governments, sectoral experts and practitioners;

A policy retreat with members of the Cabinet Committee on Aboriginal Affairs, Aboriginal leaders, and;

The development of an Aboriginal Report Card to track progress

In September 2004, for the first time, Aboriginal leaders were invited to a Special Meeting with the First Ministers to discuss health priorities. While the notion of transformative change is still essentially a relatively abstract concept, it refers to changing the Canadian political system in general, and the health system in particular, at its core so that the root causes of social injustices and health inequities are corrected. By way of contrast, the policy of affirmative action is regarded as a band-aid solution that did not look deeply enough into the processes that create and aggravate the problems in the first place.

In March 2005, a Special Chiefs Assembly was held in British Columbia that helped secure an implementation of transformative change. This meeting moved forward work on the recognition and implementation of First Nation governments. The Assembly of First Nations Women's Council Statement on the responsibility of governments and community to women's

empowerment made at the meeting is also pivotal in terms of the creation of maternal child health programming and impacting transformative health *(Assembly of First Nations Women's Council, 2005: http://www.naho.ca/inuit/english/documents/AppendixC.pdf)*. Their statements remind Canadian governments and community leaders of women's struggle to be heard in light of ongoing oppression, colonization and paternalism. Their statement says:

> That the equality of men and women has always been a guiding factor and that both men and women must be involved in the struggle for an equitable society, and that building and strengthening partnerships among women and between men will become an integral part in all levels of decision making for the Assembly of First Nations.
>
> The AFN Women's Council is deeply concerned that First Nations women are among the poorest in our communities. That the policies and laws of Canada have actively oppressed First Nations women and diminished our traditional roles and responsibilities and compromised the respect for First Nations women in our communities.
>
> The impact of colonization and assimilation strategies aided in altering First Nations traditional values and social structures often replacing or enforcing the colonizers cultural values on First Nations societies. First Nations women's roles and responsibilities in the decision making process throughout North American societies were strategically targeted in the goal of assimilation and loss of culture. The impact of colonization on First Nation's women was doubly debilitating.
>
> Throughout North America and around the world Indigenous women traditionally help important social, economic, political and cultural roles. It has often been stated that "as historians, healers, life givers and transmitters of culture, women's rights and well being are essential to the survival of First Nations people.
>
> At (s) recent international women's forum (in Beijing), the United Nations Secretary General Kofi Annan stated that, "there is no tool for development more effective than the empowerment of women." The National Chief wholeheartedly agreed saying "we must act now to make sure it happens." This speaks directly to the theme of this Special Assembly "Our Nations, Our Governments, Choosing Our Own Paths."
>
> The Indian Act continues to perpetuate paternalistic views in eliminating First Nations status and membership. The AFN Women's Council recognizes the need for the application of culturally sensitive teachings and tools that will be instrumental in solving issues of women's oppression. It is First Nations women that impact on all parts of the circle.
>
> The Aboriginal Justice Implementation Committee findings regarding Aboriginal Women (In their report on the Justice System and Aboriginal Peoples) recommended the restoration of women's traditional responsibilities: The immediate need is for Aboriginal women to begin to heal from the decades of denigration they have experienced. But the ultimate objective is to encourage and assist Aboriginal women to regain and occupy their rightful place as equal partners in Aboriginal society (2005: 1-2).

The issue at the centre of all these events was articulated by Prime Minister Paul Martin at the Roundtable in 2004, "No longer will we in Ottawa develop policies first and discuss them with you later. This principle of collaboration will be the cornerstone of our new partnership." The distinct voice by First Nation women in government to the transformation of health is important to ensuring equity within First Nation communities. The relationship between governance, empowerment in daily living and a transformation in health is a foundation upon which the Maternal Child Health Project in Manitoba was and continues to be built.

In September 2004, the National Chief Phil Fontaine tabled a First Nations Health Action Plan at the First Ministers Meeting with a vision and six pillars. The overall goal of the Health Action Plan is a First Nation controlled and sustainable health system, adopting a holistic and culturally appropriate approach *(Assembly of First Nations, 2005; http://www.afn.ca/cmslib/general/Health-Action-Plan.pdf)*. While the Action Plan did not describe any specific implementable strategies, it did present a case for immediate action on health priorities on the part of governments in meaningful engagement with First Nations. At the meeting, the Prime Minister committed $700 million as an initial investment for the improvement of services for Aboriginal peoples, mainly First Nation communities. Elements of the Health Action Plan are:

- Sustainable financial base
- Integrated primary and continuing care
- Health human resources
- Public health infrastructure
- Healing and wellness
- Information and research capacity

In Spring 2005 the federal government announced several areas of follow-up funding. These were: $200 million Aboriginal Health Transition Fund; Integration and adaptation of services including national, regional and local initiatives; $100 million Aboriginal Health Human Resources Initiative; $400 million in upstream investments that include suicide prevention, diabetes, maternal child health and Aboriginal Head Start.

Regional engagement in the development of the Blueprint translated into a contribution of approximately $200 thousand from April to July/August for preparations. While each of the regional projects is unique, there are some commonalities. All of the regional activities involved integration, linkage and consolidation of relationships/partnerships within and between organizations, governments and community geographic areas.

The events leading to the First Nations specific Blueprint are vitally important to understanding our combined responsibilities for health equity and social justice in First Nation communities and the Maternal Child Health Program. The Blueprint is aligned with Aboriginal historical and rights-based relationship to Canada. Sustainability of our programming is dependent upon political commitment. The Blueprint is intended as an action-oriented agenda: Strengthening Families Maternal Child Health in Manitoba is a realization of that intention. Following the intent of the Blueprint, our pilot project aims to meet community needs thereby implementing strategies that are adaptable to individual and community complexities and that take into consideration the root causes of illness and lack of balance in one's life..

DEVELOPMENT OF THE MANITOBA FIRST NATION 'STRENGTHENING FAMILIES' MATERNAL CHILD HEALTH PILOT PROJECT

Following commitment to maternal and child health made in the First Minister's Meeting in September 2004 and the funding announcement in Spring 2005 at the Special Meeting of First Ministers and Aboriginal Leaders on Health, the Child and Youth Division of Community Programs Directorate, First Nations Inuit Health Branch (FNHB) released funds for the Maternal Child Health Pilot Project in 2006. Prior to the release of funds, a national Maternal Child Health Framework was drafted as well as a draft program planning and implementation guidelines developed. The national documents described a comprehensive approach to maternal child health services building on community strengths and existing programming. Services were said to include: reproductive health, screening and assessment of pregnant women and new parents on levels of risk and family needs, and home visiting (by nurses and paraprofessional home visitors) for the provision of follow-up and referral services. Families assessed with greater risk are to receive targeted services, for example, case management, intensive home visits, infant development programming for children with special needs and access to rehabilitation services.

The National Maternal Child Health Pilot Project's broad mandate to improve health and social outcomes of pregnant women and families with infants and small children would necessitate linkages and supports developed with programs and services at various levels from local to distal environments. Linkages would require thoughtful consideration of necessary collaboration between agencies at different jurisdictional and geographic levels to meet particular health and social needs. Creative engagement for the sake of health transformation would mean that individual and family assessments would lead to consideration of methods of healthcare from both western and indigenous traditions. Possible essential program linkages would include:

Aboriginal Diabetes Initiative (ADI)

Aboriginal Head Start on reserve (AHSOR)

Brighter Futures (BF)

Building Health Communities Program (BHC with Mental Health Crisis Intervention (MHCI))

Canadian Prenatal Nutrition Program (CPNP)

Children's Oral Health Initiative (COHI)

Fetal Alcohol Spectrum Disorder Initiative (FASD)

First Nations and Inuit Home and Community Care Program (FNIHCC)

First Nations and Inuit Tobacco Control Strategy (FNITCS)

Indian Residential Schools Mental Health Program

Injury Prevention

Medical Officer of Health

National Native Alcohol and Drug Abuse Program (NNADAP)

Nursing Services

Nutrition and Physical Activity Promotion (NPAP)

Youth Solvent Abuse Program (YSAP)

Non-insured Health Benefits Program

Midwifery Services

Physician and nurse services (prenatal care)

Secondary and tertiary care units

Social Assistance programs

Child and Family Services

Education Services

In Manitoba, collaborative involvement has been the key to programming since its inception. Understanding the complex relationship of variables that make up maternal and child health, not to mention of that in the context of healthy families and communities, lies within the expertise of various areas of formal and informal care, the development of programming brought in the active participation of various individuals and groups. Collaborative activities are described as follows:

In February 2006 all FNIH (Manitoba Region) consultants/managers were contacted as per their voluntary participation in an interview on linkages and collaboration with the Maternal Child Health Pilot Project. An interview guide was distributed prior to the meetings, along with the draft Framework and Planning and Implementation Guidelines for the Maternal Child Health Pilot Project. Thirteen consultants/managers participated in the interview process. Participating programs represented were: ADI, AHS, BF/BHC, COHI, FASD, FNITCS, MHCI, NNADAP and Nursing.

The next several activities were thoroughly designed and promptly implemented, allowing Manitoba to have its pilot project delivered in the communities well and in good time. Branch meetings were held in November with the consultants/managers and a presentation was made at the senior level to ensure support for staff participation at FHIH. A meeting was also held with nursing to determine the place within the regional structure for MCH. At that point, it was decided that MCH would be housed in the Nutrition and Diabetes Unit of the Community Programs Directorate, thus allowing the unit partners, CPNP and ADI to remain abreast of ongoing pilot project activities. Linkage and collaboration work was promoted with support from the Community Programs Directorate Integration Committee.

Very early in the process of pilot project development, FNIH Manitoba Region contacted the Assembly of Manitoba Chiefs to co-manage and implement MCH. The discussion also extended invitations to the Southern Chiefs Organization and Manitoba Keewatinook Ininew Okinowin. This partnership reflects a unique First Nation governance model that is discussed in greater detail later in the report in the section on governance. To ensure immediate participation, a call for nominations was distributed for representation on a Manitoba First Nation Maternal Child Health Advisory Committee. The call targeted Manitoba First Nation experts in maternal and child health and development. Sixteen individuals were appointed to the committee. Representation included: the FNIH Manitoba Region MCH coordinator, nursing clinical nurse specialist, Manitoba Health, First Nation Women's Council on Health, University of Manitoba and 2 Elders as ex officio members.

The Advisory Committee's initial task was not easy. In order to put the pilot project in motion, they had to implement its development in the communities, however, a finite amount of resources meant that not all of Manitoba's 63 First Nation communities would receive the opportunity. Knowing the challenges, the Advisory Committee settled on a proposal driven process. Funding to specific communities was largely based on a determination of existing capacity in the community to implement programming. This capacity requirement was critical to ensuring that the pilot project would successfully prove the potential that such programming has on transforming health. Failure at this point to make a difference may jeopardize future universality of programming. For this point, the joint responsibility of the region, in cooperation with the funded communities was substantial. As such, criteria set by the Advisory Committee included: documentation of successful implementation of programs, support through a band council resolution or equivalent, evidence of success in recruitment and retention of qualified staff, and the presence of infrastructure and program support in the communities.

Thirty-one letters were received from the communities. Of those, 16 were considered by the Advisory Committee eligible to proceed to the proposal-writing phase. To assist in the preparation of a proposal, communities received $7,000 and a proposal-writing workshop was held. All of the 16 communities attended the workshop, receiving information on proposal expectations. Of note, an in-depth discussion arose on the budget component of the proposal and the need to insert justification for all expenditure items. An evaluation distributed to the participants found the process was accepted as overwhelmingly positive, stating that the proposal-driven process was considered fair and inclusive. Some of the workshop participants suggested that the workshop concept should be considered a best practice. The deadline for proposals was March 10, 2006. April 1st was the target for the flow of funds to successful applicant communities.

Deciding to get an early start on the project, the Manitoba region incurred a risk by cash managing funds before an actual flow of resources was received. Several events challenged initial project implementation. As FNIHB Headquarters in Ottawa continued to tweak MCH, the Manitoba region pilot project was being communicated to local communities. Essentially, without national direction, Manitoba had begun development of its work plan and proposal-driven process.

The Maternal Child Health Pilot Project in Manitoba partnership model has four levels. The pilot project is funded by First Nation and Inuit Health and co-managed with the Assembly of Manitoba Chiefs. The Manitoba First Nation Maternal Child Health Advisory Committee was established by FNIH, AMC, SCO and MKO to advise on issues of overall program policy and work plan. Daily program management is conducted in collaboration between the regional nurse program and practice advisor at AMC and the MCH program manager at FNIH. Community-based staff administers the programs in the communities (currently managed in the communities by program nurse supervisors in all except one of the communities). Research and evaluation are conducted by the University of Manitoba International Indigenous Health and Social Justice Research Group, Department of Family Social Sciences in the Faculty of Human Ecology, in conjunction with the Centre for Aboriginal Health Research, Department of Community Health Sciences; Faculty of Medicine. MCH programming and evaluation flow in a creative collaboration that allow for immediate communication between the region and local community sites, understanding of program activities, health issues and priorities, identifying areas of need and opportunity and implementation of health promotion, education, prevention, service linkage or other strategy.

DESCRIPTION OF THE MANITOBA FIRST NATION 'STRENGTHENING FAMILIES' MATERNAL CHILD HEALTH PILOT PROJECT

In 2006, the Assembly of Manitoba Chiefs hosted a regional workshop that included more than 200 First Nation participants from the funded communities. The intention of the workshop was to share knowledge, information and perspectives about maternal and child health between communities and regionally. It was at this workshop that several community members initiated a lively discussion about having the Maternal Child Health Pilot Project reflect the true identities of the communities – individuals, families and cultures. The participants decided that the name from the pilot project fell short of the expectations for programming. To be a truly community-driven program that reflected the values, traditions, needs, strengths and aspirations of Manitoba First Nations, the name would have to be changed to one that showed families, governments, the Canadian public what we are actually about and what we are trying to do. What we are about encompasses more than the mother-child dyad. This is because the definition and development of mother assumes more than caregiver of biological children and the definition and development of children in the world takes in far more than dependent of a mother. Both are individuals tied to complex relations of people within multiple environments, changing in space and in time. So, to connect programming to real mothers and children, the workshop participants suggested that 'Strengthening Families' should be added to the name.

Conceptualizing family in First Nation Canada means to simultaneously address the core of indigenous social organization and the legacy of colonization. Establishing the name change essentially represents a break from past programming, self-definition of culture, and a reclaiming of family health care. The First Nation family follows a culture that is based not on separation and vertical hierarchy but on connectivity and interrelationships. Within an indigenous worldview, maternal and child health apart from the rest of family, community and ecology is unfathomable.

An appropriate definition of health was also considered. According to an indigenous perspective, health is more than an absence of illness, but what is this more? Two decades ago, Henry Lickers of the Mohawk Council of Akwasasne said, "The First Nations believed that the wealth of a person or community was measured in their good spiritual, physical and mental health. A person's work was related to the good that he or she could do for the community (Napoleon, 1992: 3). Hence, the concept of "strengthening" was added to the name, depicting a goal orientation for programmers in their work with family members. Aspects of overall health include: physical, spiritual, mental, and emotional health of individuals; as well as social, economic, political, environmental and cultural health of families and communities. Healthy communities are economically prosperous, the members are self-confident, they know how to make good things happen, they participate in political, economic and cultural life, and raise children with the anticipation that they too will develop into confident and contributing community members. 'Strengthening Families' is a uniquely Manitoban name that identifies our regional uniqueness, a community-driven participation and voice that propels from the name to every aspect of program governance, design, implementation, research and evaluation.

The Strengthening Families Maternal Child Health Pilot Project (SF-MCH) is a family focused home visiting program for pregnant women, fathers and families of infants and young children from birth to six years. Through services provided in the communities by nurses and professional home visitors, the program provides support to families, building on their strengths, moves towards realizing their aspirations, and addresses their needs, questions and

concerns. It also assists families in accessing related health and social services. Linkages focus on individuals within the family and on the family as a unit. The program turns one central activity: the home visit. Nurses and specially trained home visitors provide screening, assessment, education, health promotion, intervention and follow-up supports in the visits. SF-MCH delivers an early childhood education and parenting curriculum and coordinates with other services to meet the needs of children and families with complex needs. The overarching vision of the program in Manitoba is that all Manitoba First Nation communities have strong, healthy, supportive families that live holistic and balanced lifestyles.

SF-MCH OBJECTIVES ARE:

To promote the physical, emotional, mental and spiritual wellbeing of individuals within the family and families as a whole

To promote trusting and supportive relationships between parents and children, care providers and family and among resources within the community.

To increase the community's capacity to support families by education, health promotion and the provision of services

To provide the tools to empower families

Eleven Manitoba First Nation communities were funded in 2006 and another 5 received funding in 2007. Regionally funded positions housed at the Assembly of Manitoba Chiefs are: nurse program and practice advisor, peer resource specialist, and administrative/peer support assistant. All three provide professional nursing and program support to the 16 funded SF-MCH communities, engage actively in program research and evaluation, and work towards expansion of programming throughout the province. With this model, SF-MCH has been able to benefit from a standardized program model that respects individual community cultural variation.

A great deal of program, research and evaluation work has been conducted over the initial implementation years of the Manitoba region pilot project. In order to adequately describe each of these pieces of work, their relationship to the bigger picture of maternal child health programming in Manitoba and the methods and details of engagement of Manitoba First Nation peoples, each of the development and implementation topics will be described in detail, in turn.

MANITOBA FIRST NATION STRENGTHENING FAMILIES MATERNAL CHILD HEALTH PILOT PROJECT SITES

SF-MCH COMMUNITY PROFILES

COMMUNITY NAME	GEOGRAPHY (distance from urban centre)	ROAD ACCESS	URBAN CENTRE	TOTAL REGISTERED POPULATION	CULTURE	TRIBAL COUNCIL
Brokenhead	64 km	Year-round	Winnipeg	1625	Anishinabe (Ojibway)	Southeast Resource Development Council Corp (SRDC)
Cross Lake	254 km	Year-round	Thompson	6806	Cree	Independent
Dakota Tipi	92 km	Year-round	Winnipeg	300	Dakota	Independent
Keeseekoowenin	83 km	Year-round	Brandon	1033	Anishinabe (Ojibway)	West Region Tribal Council
Long Plain	120 km	Year-round	Winnipeg	752 (on reserve)	Anishinabe (Ojibway)	DOTC
Nisichawayasihk	87 km	Year-round	Thompson	4000	Cree	Independent
Norway House	289 km	Year-round	Thompson	5704	Cree	Independent
Opaskwayak	2 km	Year-round	The Pas	5034	Cree	Swampy Cree Tribal Council Incorporated
Peguis	185 km	Year-round	Winnipeg	8317	Ojibway and Cree	Interlake Tribal Council
Pine Creek	121 km	Year-round	Dauphin	2697	Anishinabe (Ojibway)	West Region Tribal Council
Rolling River	80 km	Year-round	Brandon	923	Anishinabe (Ojibway)	West Region Tribal Council
Roseau River	93 km	Year-round	Winnipeg	2173	Anishinabe (Ojibway)	Dakota Ojibway Tribal Council
Sagkeeng	126 km	Year-round	Winnipeg	6756	Anishinabe (Ojibway)	Independent
Swan Lake	159 km	Year-round	Winnipeg	1196	Anishinabe (Ojibway)	Dakota Ojibway Tribal Council
Tootinaowazibeeng	17 km	Year-round	Dauphin	1231	Anishinabe (Ojibway)	West Region Tribal Council
Waywayseecappo	160 km	Year-round	Brandon	2353	Anishinabe (Ojibway)	West Region Tribal Council

MANITOBA INITIAL 16 SF-MCH COMMUNITY PROFILES

The initial 16 Manitoba funded SF-MCH communities range in geography, i.e., distance from urban centres, thus, proximity to health and social services, and other amenities, recreational, education and employment opportunities and supports not accessible in the communities; road accessibilities; population densities, language, cultural backgrounds, history, traditions, and tribal affiliations. Infrastructures differ between the communities. Although variation between the communities does exist, not all First Nation communities in Manitoba have equitable access to health and social service programming.

The proposal-driven process allows for equal competition for resources but does not actually allow for equitable accessibility. The process assumes that all communities begin at a level playing field. They do not. Many First Nation communities, in particular, smaller communities do not have access to resources and expertise necessary to begin the competitive process. Differing histories and proximities to colonizing agents over several decades have left their scars. In order to ensure all communities are provided a chance to compete for necessary health and social service programs, supports are required for the "have-not" communities.

Maternal and child health programming, in the global community, is considered a determinant of health. In fact, access to holistic prenatal care just may be the defining determinant of healthy pregnancies and healthy babies (Eni, 2005). In less than 5 years of implementation of the pilot project, SF-MCH has already gone above and beyond in addressing health – of women, children and their families. SF-MCH offers capacity development opportunities for staff, pregnant women, mothers, and family members. Accessibility to education, training and empowerment of people to provide opportunities for active engagement in the community are determinants of health. The nature of this program is such that, if offered to the communities least likely to successfully be awarded funding in a proposal-driven process may actually achieve the greatest health benefits.

THE STRENGTHENING FAMILIES RESEARCH AND EVALUATION PILOT PROJECT

One of the primary tasks of the Advisory Committee was to figure out how to adequately evaluate the process and outcomes of the program. The Committee wanted an evaluation that would a) represent the strengths, interests and developments of the region, while b) reflect the unique characteristics, accomplishments, challenges and strengths of each of the community sites, and c) develop an evaluation program that would continuously build the capacity of communities to actively engage within the process.

In the spring of 2006, the Committee, including the AMC Nurse Program and Practice Advisor and MCH Program Manager at FNIH invited the Director of Research and Evaluation to a meeting to discuss the design of the regional evaluation. At this meeting, several groundbreaking decisions were made that would impact the long-term development of the Manitoba Strengthening Families Maternal Child Health Program. Each of these decisions is described below:

> The programming, research and evaluation components of SF-MCH would be co-developed overtime from the program's inception. SF-MCH would be created, it would unfold within a partnership between communities, regionally, and within collaboration of several organizations: AMC, FNIH, and the University of Manitoba.

Boundaries between programming and evaluation would be blurred in order to ensure that families and communities do not have to wait to receive the very best in service delivery that the SF-MCH can possibly offer.

Administrative data, collected as part of programming would be used for the purpose of program evaluation and would be accessible at the level of community programs. Participants, too, will have access to health information for the sake of engagement in the development of individual and family health plans. Data from the region would be housed at AMC and managed according to OCAP protocol.

The evaluation team will be composed of researchers at the University of Manitoba. The research team would be actively engaged in development activities that include all aspects from theoretical development to selection of appropriate methodologies, community fieldwork, and regional and community-based communication designs.

Education, training and capacity development, as in programming itself, would be an ongoing research and evaluation activity. Capacity development in this area is to be administered to community-based staff and to students of indigenous research and practice in the University.

Dissemination of knowledge is an ongoing responsibility of the research and evaluation team. Publication and presentation are necessary responsibilities of the team – to Manitoba Chiefs Task Force on Health, governments, institutions, communities, university and broader academic audiences.

Lines of communication are to be open between regional- and community-based staff and the research and evaluation team. This is to enhance opportunities for creative engagement as well as ensuring that necessary information is available in a timely manner.

DESIGNING THE EVALUATION FRAMEWORK

In June 2006 a workshop entitled "Designing the Evaluation Framework for the Manitoba First Nations Maternal Child Health Pilot Project" was held in Winnipeg. All of the community sites funded at that date were represented. Participants were: the Manitoba First Nation Maternal Child Health Advisory Committee (with 2 appointed Elder advisors), community health nurses and nurse supervisors, home visitors, the AMC nurse program and practice advisor and the MCH program advisor at FNIH. The research and evaluation team facilitated the workshop. The workshop established the groundwork for the partnership. This work was conducted, fine-tuned and adapted over the 5 years of the pilot project.

The purpose of the workshop was to begin to develop a plan for the evaluation of SF-MCH. This included developing a logic-model to use as a guide for programming, community relevant indicators of program success, and determining appropriate sources of data. The workshop was facilitated in terms of a guided discussion that incorporated the voices of all those who attended. Topics discussed at the workshop were:

Personal interpretations of SF-MCH (What does SF-MCH mean to you?)

Roles and responsibilities of the different staff positions

SF-MCH components of programming

Goals and objectives of each of the components

Supports necessary to achieve the goals for each of the components

Barriers to achieving success

Data requirements

Development of a communications strategy within and between communities and throughout the region

Ongoing development of the research and evaluation program (development of an evaluation sub-committee)

The workshop was a successful consensual process of engagement between individuals from different geographical and organizational spaces. A great deal of information was elicited from the participants. The challenge for such gatherings is to attend to the information shared, this includes hearing the quiet voices, drawing out what is relevant, what matters in communities, and to bring these articulations out in our practical work.

Personal feelings of empowerment, engagement in community politics, active participation in employment, and volunteerism are all central determinants of health. The process of development is an elemental determinant of wellness – it is the difference between planting your own garden and having one planted for you – as such, it was less important for our program to implement a ready-made program than it was to develop the program, even if it took five years to do it. The point was to discover programming within the communities.

The evaluation report on the SF-MCH pilot project is a report on the development of our partnership model relayed in several activities. These are:

1. Developing SF-MCH Program-Evaluation Conceptual Framework
2. Strengthening Families Culturally Oriented Practice Framework
3. The Maternal Child Health – Health Information System
4. Strengthening Families Quality Assurance/Peer Support Program
5. Identifying Key Health Issues in the Region
    a. Childbirth
    b. Infant Feeding
    c. FASD
    d. Infant Mortality
    e. Teen Pregnancy and parenting
6. Evaluation of Program Process, Outcomes and Impact (Community-Based Programmer and Participants Survey Findings)

The discussions on the activities are followed by recommendations on all aspects of design, delivery and evaluation of programming. Recommendations are based on evidence collected in the initial pilot phase of the SF-MCH project.

Brokenhead MCH Program Graduation

Long Plain MCH Event
Mom: Justyne, Baby: Kianna.

CHAPTER 1

DEVELOPING THE STRENGTHENING FAMILIES MATERNAL CHILD HEALTH PILOT PROJECT PROGRAM-EVALUATION CONCEPTUAL FRAMEWORK

This chapter explores the process of developing an evaluation's underlying principles and theoretical perspectives. The SF-MCH evaluation intertwines with the processes of developing the programs purpose, methods and activities. The evaluation design includes the impacts of programming, but also the impacts of engagement in the development of programs.

The Maternal Child Health Program across Canada is a new initiative and as such has and will require commitment to resources and shared expertise, creative space, experience, and knowledge acquisition for a meaningful unfolding of the program. Growing pains are to be expected. Given its newness, specifically in the context of an indigenous population, it would be inappropriate to apply any rigid standard or measurement of 'success' to programming. Instead, Kim Scott of Kishk Anaquot Health Research writing on the National Maternal Child Health Evaluation Strategy suggests, "MCH teams should consider 'success', in terms of progression or travel on the journey because this expression better recognizes the process of growth. Journeys require rest; travelers get lost, arrive in unexplored territories or circle back towards the beginning and start again. Initiated in the spirit of enhancing life outcomes for First Nations' children and their families, MCH must first focus on the attainment of early implementation objectives (2006: 1).

FNIHB committed to a bilateral process with the Assembly of First Nations on policy issues and long-term monitoring of all early childhood interventions implemented in First Nation communities. The AFN then consulted with their regional constituencies to discuss ongoing development and implementation protocol. The National Maternal Child Health Program team reports to the Director Child and Youth Division at FNIHB and the Director General of the Community Programs Directorate. In Manitoba, the regional communications and management protocol mirrors the national model having the regional SF-MCH team (co-managed between AMC and FNIH) reporting up through the regional to national FNIH(B) offices.

The national evaluation plan was prepared in a consultative process that included key stakeholders from community, regional and federal levels. Meetings in 2005 included volunteers from First Nation communities, FNIH regional representatives, representatives from Provincial and Territorial Organizations affiliated to the Assembly of First Nations and a representative from the Assembly of First Nations.

NATIONAL MCH EVALUATION GUIDELINES

The following information was provided to the regions by the national office, prepared by Kishk Anaquot Health Research. SF-MCH used this information as a starting point for the development of a grounded research-evaluation approach – grounded in terms emanating from the knowledge, experience, traditions, and interests of the Manitoba SF-MCH participants and staff.

The national guidelines advise on evaluation activities, anticipated outcomes, a logic model, evaluation plan development for process and impact evaluation and methodologies. Several of these evaluation topics are summarized in turn.

ACTIVITIES

Early developmental activities are to include consultation and development of MCH with First Nation organizations and communities. Program development activities would include: selection and design of specific training opportunities, culturally reflective performance measurement tools and evaluation strategies capable of supporting an evidence-based approach to program expansion.

In the communities, programming-evaluation service-related activities would ensure:

- Access to a continuum of services from pre-conception to early childhood
- Participation of fathers, Elders, extended families in support of pregnant women, mothers, children
- Identification and address of complex needs (screening, assessment, case management, access to specialized services)
- Development and strengthening of new and existing partnerships within communities and with provincial health systems
- Hiring and training of profession staff (e.g., community health nurses) and peer frontline workers
- Development of First Nation specific training in the programs with incorporation of traditional knowledge

ANTICIPATED OUTCOMES

These activities are assumed to create experiences that will lead to improvements in the following health areas:

Prenatal self-care

Access to social supports for women and young families

Participation of children with special needs in their communities

Parenting skill development within nurturing homes and supportive communities

Improved breast-feeding initiation and duration

Detection and management of postpartum depression

Oral health in parents and infants

Increased immunization rates

The underlying theory is that these activities and immediate and short-term outcomes will lead to longitudinal system goals such as:

First Nation families can count on enhanced MCH support services

MCH services on reserve will be comprehensive and integrated

Opportunities to bring safer birthing options closer to home are explored

- Reduced service gaps, particularly for children/families with special needs
- Culturally relevant, reliable, valid, easy-to-use performance measurement tools developed for MCH

Overtime, the desired outcomes for First Nation infants and young families include:

- Healthy birth weights and development of infant and child
- Decreased morbidity and mortality (e.g., injury related, respiratory infections and otitis media, dental decay)
- Reduced rates of family violence
- Reduced maternal risk

The ultimate goal of MCH is to "improve maternal, infant, child and family health outcomes so that young families can maximize their potential by providing community based MCH health services to First Nations from preconception through childhood" (National Strategy for Maternal Child Health in First Nation Communities by Kishk Anaquot Health Research, 2006: 5).

EVALUATION PLAN DEVELOPMENT

The MCH Treasury Board submission specifies that an evaluation plan is to be completed during the first year of operation and will be linked to the FNIHB 10-year evaluation strategy. A schedule was outlined for performance and evaluation reports. The information gathered from all of the reports will be used to renew the MCH mandate. Government policy on evaluation requires departments to embed evaluation into their management practices with specific consideration of a variety of issues related to planning, performance and accountability reporting particularly with respect to expectations identified and conveyed to the Treasury Board on those resulting from Cabinet decisions requesting evaluation information. The policy requires that departments consider program relevance, success and cost-effectiveness:

> Relevance | is the program consistent with departmental and government priorities and does it realistically address an actual need?
>
> Success | is the program effective in meeting its objectives, within budget and without unwanted outcomes?
>
> Cost effectiveness | are the most appropriate and efficient means being used to achieve objectives in comparison with other approaches?

National Standards and criteria used to judge the quality of the evaluation are:

> Meaningful stakeholder involvement (community voice and participation) is apparent throughout all aspects of the program.
>
> *There is a clear desire for meaningful participation at each stage of the evaluation process. It is anticipated that the evaluation strategy will be judged by the extent to which it engages First Nations in a meaningful way, answers key evaluation questions, shares community experience and provides for the future (Kishk Anaquot Health Research, 2006: 8-9).*
>
> The evaluation is First Nation ownership, access, control and possession of data (OCAP).
>
> *In keeping with emerging ethical standards for research with Aboriginal peoples, information resulting from the MCH evaluation should be owned, controlled and possessed by participating First Nation communities who will also retain full access to all information generated from community-based evaluations (ibid, 2006: 8).*
>
> A variety of opportunities with different skill levels for building evaluation capacity in the

communities (including use of local workshops or interactive websites where MCH teams could receive evaluation guidance, support and training)

SF-MCH PREPARING THE STAGE FOR A REGIONAL CONCEPTUAL FRAMEWORK

The conceptual framework for SF-MCH is developed in an ongoing consultative process with communities. Consultation occurs through open lines of communication between community- and regional-based programmers, university-based research and evaluation team, AMC and FNIH. FNIH does not engage in form of opinion or decision-making, rather supports First Nation community and organizational direction of programming. Building on and tweaking the national guidelines for programming, SF-MCH developed their own Program framework and prepared the following guiding principles:

Strength-based programming (building on community strengths)

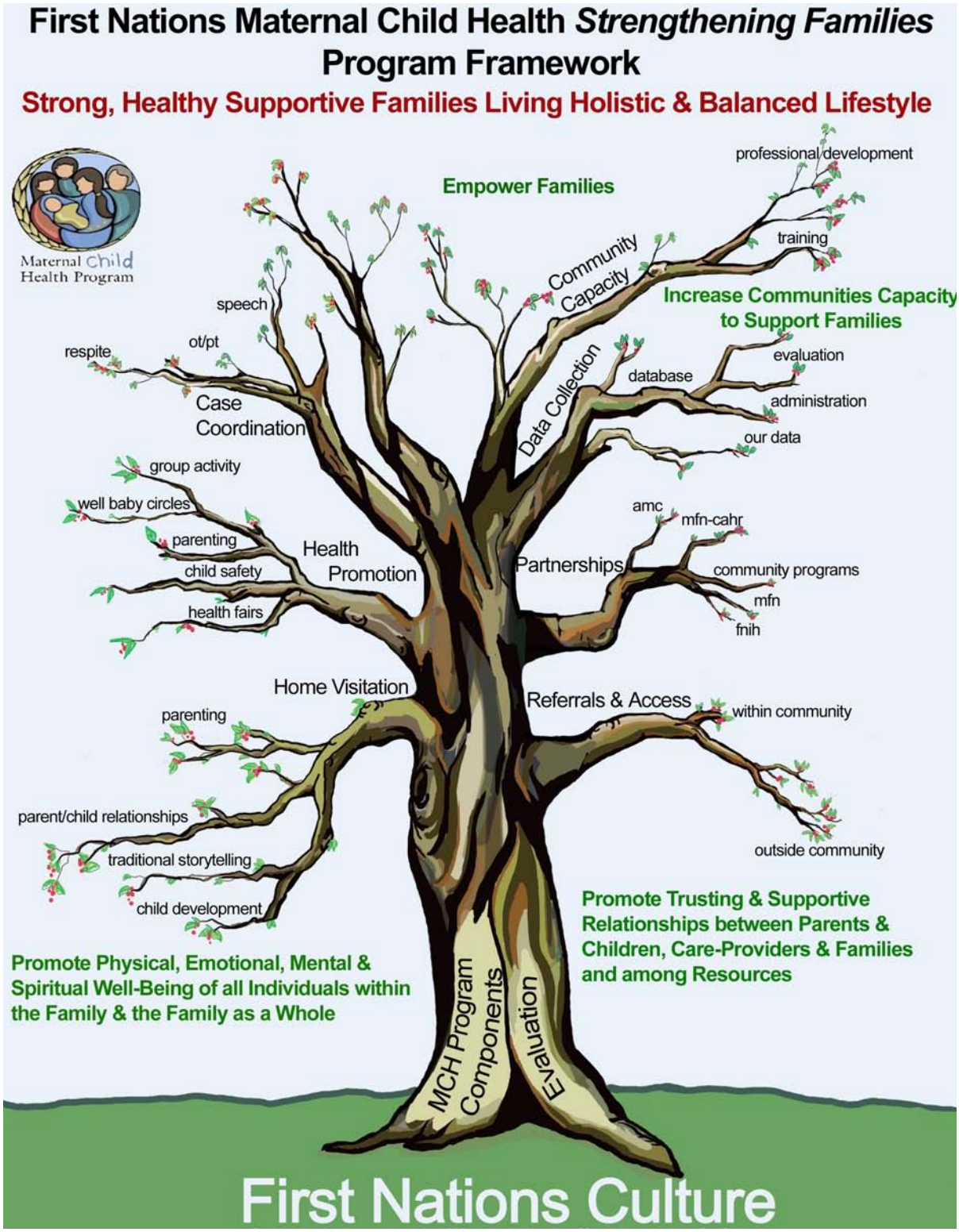
Family-centered service delivery

Relationship focused programming

Voluntary participation

Grounded in First Nation culture and traditions

Capacity building in the communities



The following diagram was developed collaboratially by AMC program staff, University of Manitoba, and MCH community representatives. The Roots of the tree represents the parallel relationship between program and evaultion that instrumental in guiding the development of the program through the formative five years.

Evaluation planning meeting Nov. 2006.

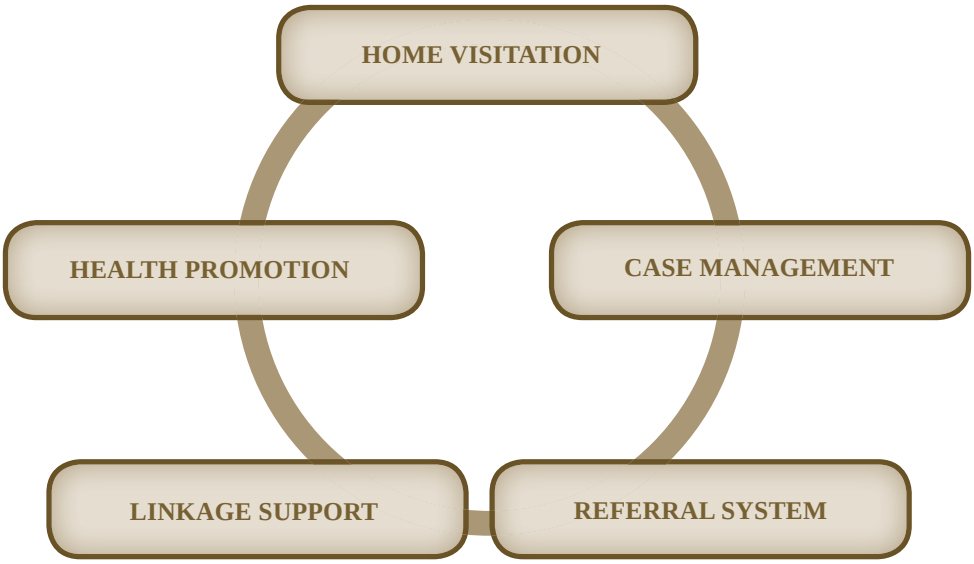
TARGET POPULATION

The intended population for SF-MCH is First Nation families with children 0-6 years. The program allows universal access but offers targeted programming to families with higher-risk or special needs. Home-visits are typically reserved for families with the highest need and health promotion group activities are more openly accessible.

PROGRAM MODEL – 5 CORE PROGRAM ELEMENTS

SF-MCH developed 5 core-program elements based on the program's designed purpose and community input. The five program elements are the mechanisms through which the purpose, goals and objectives are realized. The program's pivotal core element is **home visitation.** In the home visits, the other elements are delivered to families based on unique requirements (e.g., screening, assessment, **case management,** early childhood curriculum are all administered in the home environment). The early childhood curriculum presenting used is the Growing Great Kids Inc Curriculum, which offers education and support on various topics, i.e., attachment, bonding, parenting, safety, growth and development, prenatal health and general health. **Health promotion** activities are offered in the homes and inside group settings held at health or program centres. Topics include parenting, nutrition education, breastfeeding support, child safety, and healthy child development. **Linkages with community-based programs and support for families** provide opportunities for holistic, comprehensive service delivery to families. Programming also includes a **referral system** that allows for enhanced referral and access from and to other health and social services, programs, and resources in the community and the region.

THE FIVE CORE PROGRAM ELEMENTS



GETTING TO A CONCEPTUALIZATION OF SF-MCH: DOING THE GROUNDWORK IN MANITOBA

Since all of the other program elements build from and rely on successful home visitation, it is essential that we understand that element of our programming. The research surrounding home visitation programming comes primarily from programs implemented in non-indigenous

population in the North American mainstream. Therefore, there exists very little by way of research on home visitation programming within a Canadian First Nations context. It cannot be readily assumed that program research targeting non-Aboriginal populations is applicable in First Nations. It cannot even be assumed that programming developed within other indigenous contexts can be straightforwardly generalize-able in the Manitoba First Nation context. Accordingly, the Royal Commission on Aboriginal Peoples stated, "(T)he causes and dynamics of ill health among Aboriginal People are not the same as among non-Aboriginal people – and because illness is not the same, prevention, cure and care cannot be the same either" (2006). Because of this reality, First Nations-specific research for this type of programming is still in its infancy, and there are many questions regarding the design and implementation of appropriate programming. What should a Manitoba First Nation home visitation program look like? What are the theoretical underpinnings for such programming within cultural and community specific contexts? What are the meanings ascribed to maternal and child health events by the First Nations?

This section of the report details the process of conceptualizing a framework for the regional program. It describes all aspects of the complexity of this work from consideration of balancing scientific program and evaluation methods with traditional knowledge methods to consideration of a basis in First Nation governance and ethical protocol.

HOME VISITATION LITERATURE REVIEW

Home-visitation programming for mothers and children is a widespread early intervention strategy in most industrialised nations. It is typically offered free-of-charge, voluntarily, and embedded within comprehensive maternal child health and social systems *(Council on Child and Adolescent Health, 1998).*

The goals associated with home-visitation programs vary considerably. As outlined by *(Council on Child and Adolescent Health, 1998),* home-visitation programs began in the United States in the late 19th century. Public health nurses and social workers provided in-home education and health care to women and children, primarily in poor urban environments. At the beginning of the 20th century, the New York City Health Department implemented a home visitor program, using student nurses to instruct mothers about breastfeeding and hygiene. In the late 20th century, home-visitation programs have focused on families with special problems such as premature or low-birth-weight infants, children with developmental delay, teenage parents, and families at risk for child abuse or neglect *(Council on Child and Adolescent Health, 1998).*

Over the past 20 years research has grown substantially to support the effectiveness of home-visitation programming of all types towards improving an enormous array of health and social outcomes, including prenatal, postnatal and long-term effects for children and their mothers. For instance, home-visitation programs aimed toward "high-risk" families is said to be premised on epidemiological studies that point to greater health risks associated with social and economic disadvantages to infants (i.e., injury, abuse, neglect, health problems and a reduced likelihood of prenatal healthcare) *(Hodnett & Roberts, 2007).* Studies in the United States report benefits of home-visitation programming ranging from health improvements to moms and their infants and more supportive home environments *(Olds et al., 2004b; Olds et al., 2004a)* Other benefits of programs of this nature can include: lowered dependence on welfare and Medicaid, reduction in the use of substances, less arrest and incarcerations of the mothers *(Olds et al., 2007)* and efficient tracking of abuse and other causes of childhood injury for children birth to three years of age *(Duggan et al., 2000; Stone et al., 2006).*

In Manitoba, since 1999, the Healthy Child Manitoba Office has been funding and coordinating the province-wide off-reserve home-visiting program Baby First (now known as Families First). An important goal of the Manitoba program is to reduce the incidence of child maltreatment: "The maltreatment of children presents a significant threat to healthy child development. Given the devastating impact of maltreatment on children, it is imperative to prevent the occurrence of child abuse and neglect" *(Brownell et al., 2007).*

For more than thirty years, Canadian provinces and territories have been strengthening their maternal and child health programs because they have had such positive effects on the lives of children, women and their families. Almost 20 years ago, Dr. C. Henry Kempe suggested that to ensure a child's right to comprehensive care, every pregnant woman should be assigned a home health visitor to work with their family until the child begins school *(Council on Child and Adolescent Health, 1998).* Yet prior to 2004, and the introduction of the First Nation Maternal Child Health Program (National and Regional), there has been no comprehensive approach to the delivery of maternal and child health care services in First Nation on-reserve communities that compares to what is available to families throughout the rest of Canada.

Historically, First Nation communities were not given the flexibility to develop community-driven frameworks nor adequate resources to implement anything beyond emergency or crisis response treatment (a.k.a. 'putting out fires'). To exacerbate the situation is the wide health disparity that exists between Canadian First Nation and their non-First Nation counterparts.

Across Canada, First Nation individuals face various health and social risks that have been shown to contribute significantly to overall differences between First Nation and other Canadians in mental and physical health and social outcomes *(Guimond, 2008).* Current mortality rates for all age groups are higher among First Nations than other Canadians *(Guimond, 2008).* Fertility of First Nation adolescents is seven times higher than for other Canadian youth. The rate is estimated to be as much as 18 times higher for girls under the age of 15 years *(Guimond & Robitaille, 2008).* Elevated morbidity rates of childhood illnesses in First Nation communities include gastroenteritis, otitis media, respiratory infections and childhood-onset Type II non-insulin-dependent diabetes *(Martens, 2002).* Gestational diabetes and high birth weights are more common in First Nation communities *(Harris et al., 1997).* Lower immunization rates *(MacMillan et al., 1996; Tarrant and Gregory, 2001)* and higher prevalence of FASD *(Burd & Moffatt, 1994)* have been recorded in the health literature. In essence, within broader conceptualizations of health offered through population health promotion frameworks, research has validated that regardless of the health, economic, or social circumstance First Nation people fare worse than all other Canadians.

Low participation rates in existing prenatal care services for women on-reserve further informs the extent of health disparity and/or risk. For instance, a 2002 evaluation of the Canada Prenatal Nutrition Program *(Andersson et al., 2003)* found that while 90% of First Nations women living on-reserve had "theoretical" access to prenatal care counselling and other services, only about 50% of on-reserve women were taking advantage of these services. Moreover, it was found that prenatal care service uptake among First Nations women was concentrated among those considered to be lower risk levels, including: women who lived in non-remote communities; women who had graduated from high school; women who felt cared for during pregnancy and/or whose partners were supportive; and women who had access to child care. Among those women considered for the purposes of that study to be the most "vulnerable," only one in five were accessing any form

of prenatal counselling. The 2002-03 Manitoba Regional Report of the First Nations Regional Longitudinal Health Survey put the rate of participation in prenatal counselling/class attendance among First Nations women in that province at just 23%; that report did not include analysis by social risk factors. By way of comparison, as many as 60% of Canadian women attend some form of childbirth education class *(Enkin, 2008).*

> Perhaps more than any other group in Canada, Aboriginal people need the benefits to individuals, families and communities that are afforded by giving children a strong start in intervention during the "early years" is key to improving long term health status and to breaking the cycle of poor health in Canada's Aboriginal population. Early intervention to support neurobiological development influences the integrity of the biological pathways that are essential to life-long health and vitality. Research results have demonstrated that the quality of maternal child health care has immediate and long lasting effects on health status and quality of life across population groups and settings. This forms a foundation for other health programs (such as programs targeted at fetal alcohol syndrome, prenatal nutrition, immunization, early childhood development, etc.) to achieve maximum impact" *(Smith, 2002).*

Indeed, according to the principles of the Canada Health Act (1984), Aboriginal people deserve access to equal advances in health care practice. *"Yet current maternal child health care in on-reserve First Nation communities falls short of the standards set for the majority of the country" (Smith, 2002).*

It is evident that there is a definitive need for home-visitation programming in Canadian First Nation communities; however, the research towards understanding how to design a program in a manner that is effective in responding to this need is limited. Similarly to the Royal Commission on Aboriginal Peoples outlined above, the implications derived from Smith's 2002 review is: *"that delivery of maternal child health care is significantly different in Aboriginal versus non-Aboriginal populations… The reality of the health status, cultural and contextual differences requires that maternal child health care policy be very flexible and responsive to the unique situation, history, culture, strengths and readiness of each community."* In addition, the results from Smith and colleagues *(Smith et al., 2007)* study show that evaluation of outcomes of care for pregnant and parenting First Nation people must recognize and appreciate the unique experiences of individuals, families and communities within a broader historical context of First Nation people's lives. Yet how exactly do we turn the understanding that there are cultural and contextual differences into a home-visitation program?

There is some research available regarding a movement beyond theoretical responses towards programming models. For instance, home visits utilizing the peer support model in Manitoba First Nation communities through the Canadian Prenatal Nutrition Program were successful in terms of building rapport between nurses and paraprofessional home visitors and in terms of implementing healthy pregnancy practices. In some communities in Manitoba, the program has encouraged participation in traditional First Nation childbearing practices *(Eni, 2005).*

Further, a randomised, open trial of 57 First Nation households at the Six Nations Reserve in Ohsweken, Ontario evaluated a home-visit intervention program that focused on the promotion of healthy lifestyles in the community. The study reported some positive changes associated with the household-based intervention, e.g., changes in dietary practices and activity patterns *(Anand et al., 2007).*

Via analysis of chart audits and qualitative research technique, Martens evaluated the effectiveness of two breastfeeding initiatives at Sagkeeng First Nation in Manitoba: a prenatal instruction program delivered by a community health nurse and a postpartum peer counsellor program for breastfeeding women. She discovered a significant increase in breastfeeding initiation rates with program participation, greater satisfaction and confidence with breastfeeding, with fewer problems and more information *(Martens, 2002).*

Reflecting on the research, it becomes apparent that a First Nations home-visitation program design must begin with an understanding that mainstream literature may not have all the answers; i.e. a response to cultural and contextual appropriateness is essential. The national standards and criteria maintain that the program should be First Nation designed, driven, developed and implemented; but what exactly does this entail?

The foundational standards for the SF-MCH program come from several contemporary and/or "mainstream" programs such as: Prevent Child Abuse America; Families First; Growing Great Kids Inc.; and Health Families Arizona. In other words, even though SF-MCH is stabilised within a First Nations community-driven, collaborative approach, several core elements from similar programs designed and delivered in mainstream North American populations were chosen as the foundation for the SF-MCH program. At the same time, this does not mean that SF-MCH is in and of itself "mainstream."

The initial idea behind adopting mainstream foundational support into a First Nations program was for lack of alternatives: MCH is the first program of its kind directed towards First Nation communities. Second, it is important to note, a health program of any kind is not static – it is constantly adapting and changing. With this, one of the fundamental challenges in the continuous designing of the SF-MCH program is to somehow, in collaboration, figure out what is a healthy balance between borrowing and developing methodologies. What aspects of mainstream culture can be incorporated into programming to impact positive First Nation health profiles? What wisdoms are to be revived and cherished within First Nations communities? What should be incorporated into the programs, how, and by whom? In effect, what should a First Nation maternal child health program look like? These are all ongoing challenges and ongoing questions. It is pertinent that the program designers keep asking questions, keep searching for answers, and try to adapt and implement changes to the program accordingly.

Towards this end SF-MCH partners are involved in a continuous exploration into the underlying principles and theoretical perspectives guiding the future of the program. Programming content and method are also issues considered as we strive to understand the potential of programming to impact First Nations health. This means not only the delivery of program activities but the impact of actually developing activities. In addition, we are continuously exploring principles attached to both forming and maintaining meaningful collaboration. This means a collaboration that supports self-determination and self-governance discourses, and acknowledges First Nations social and cultural differences. It is also of great importance to expand linkages to not only involve, but also incorporate the voices of families living in the communities where programming activities are implemented and impact mothers, children and their families. The necessary process of including the voices of individuals and communities situated outside government or mainstream society allows for greater inter-cultural understandings as well as an emerging and continuing alternate set of questions. It enables us to better understand the balance between current ways of life with local traditions and aspirations; discover and revive culture and health within communities; and have communities actively engage in the process of health.

The dynamics of health are significantly different between indigenous versus non-indigenous populations in Canada, as are the cultural and contextual differences from where they arise. With this, the design and delivery of a home visitation program aimed at First Nations people must somehow acknowledge these differences. The research surrounding home visitation programming, however, emanates primarily from programs implemented in mainstream populations. The challenge, therefore, in designing a Manitoba home visitation program for First Nations communities lies in trying to balance evidence found in mainstream research while attempting to maintain First Nation cultural integrity which includes First Nation governance, active engagement and empowerment.

Although SF-MCH has incorporated core elements from mainstream programs, it responds to cultural integrity in a variety of ways. It is First Nations driven, supportive of self-governance, and formulated within a collaborative context. It involves the voices of families, and abides by the principles of self-determination. It is involved in the continuous exploration into the underlying principles and theoretical perspectives guiding the program.

The SF-MCH program is not static; rather it is a continuous endeavour whereupon knowledge is being gathered throughout all stages of the design and implementation process. It is hoped that as we work through the challenges and increase our knowledge we will be able to contribute to a body of research that is in desperate need of advancement. With this, SF-MCH believes that it may be possible in the future that the First Nations home visitation program will no longer be required to look towards mainstream programming and research to establish their foundational standards: First Nation standards will have been designed.

With a beginning in borrowing some of the traditions and methods from more established programs in the mainstream, SF-MCH has certainly come a long distance. In 2007, program standards and guidelines were developed and rewritten as part of the program's Quality Assurance and Peer Support Program in 2010. Although the curriculum implemented still borrows from the mainstream *Growing Great Kids Curriculum* community-based and regional programmers alike are becoming far more proficient at delivering uniquely Manitoba First Nation activities. Team meetings and workshops are held where curriculum activities are dissected in terms of their meaningful implementation in the communities. SF-MCH will in the next 2 years design and deliver a 100% fully community-based curriculum.

SF-MCH EVALUATION TYPES

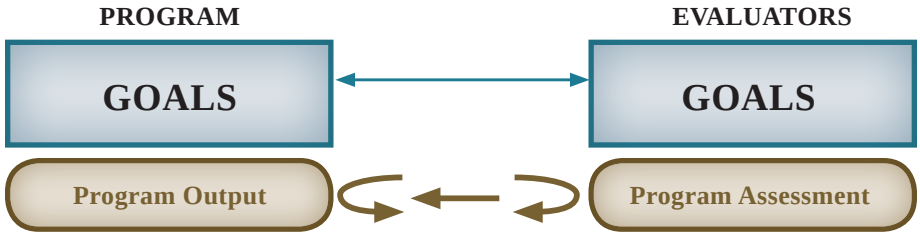
Discovering the voices of the Nations, conceptualizing the spaces wherein the different voices are heard, or potentially ignored, is an ongoing and challenging endeavour. Instilling a collaborative approach that involves powerfully unequal partners with diverse experiences, interests and vantages requires thoughtful consideration at many angels. What we search for in our programming is a 'true' collaboration, since it would be more problematic in the long-term to hold an illusion of collaboration and to operate as if agreement at different spaces exists. Our challenge in creating the approach was to consider that the space for programming was unfolding as a dynamic process with a need for standardization throughout the region, to allow for effectiveness and efficiency in service delivery, and variation, to allow fulfillment of unique community interests. The approach requires continuous collaboration – to be able to search, find, share, and alter meanings together.

Our evaluation plan was introduced at the early stages of program development, which, in itself, can make a significant contribution to program effectiveness and knowledge transfer. The forms of evaluation implemented are: process and intervention evaluation.

SF-MCH PROCESS EVALUATION

Typically, in a process evaluation, evaluators are separate from programmers, i.e., there does not need to be a shared vision in the development or implementation of program goals. The program administrators implement the program according to their intended goals and the evaluators assess the program according to those intentions. In this relationship, programmers may or may not heed the advice given to them by the evaluators; rather it is 'information to be considered.' SF-MCH has designed and implemented an approach whereby goals are developed in collaboration between community- and regional-based program administers and the research and evaluation team. Community members participate in the discussion and decision-making processes. The role of the research and evaluation team is to gather knowledge from published sources, design methodologies for knowledge sharing and evaluate the effectiveness of the methods used in terms of adequacy to engage and meeting process intensions. The figure below depicts the SF-MCH process evaluation approach.

SF-MCH PARTNERSHIP AND COMMUNITY ENGAGED PROCESS EVALUATION APPROACH



SF-MCH INTERVENTION EVALUATION

The partnership approach to evaluation holds true in interventional evaluation as well. Our intervention evaluation process is a cyclical process that informs as the program modifies so that with each piece of information there is the potential for modification, and the process is repetitive. Integral to the process is the sharing of common goals. All of the partners must share in the same overarching vision for the program. The figure below depicts the SF-MCH intervention evaluation approach.

SF-MCH INTERVENTION EVALUATION APPROACH

The goal of our work in intervention evaluation is to continually work towards consensus and effectiveness of programming. We've created a relationship of shared understanding and commitment. The research and evaluation team, through a variety of research initiatives that depend upon community active participation (which includes program participants as well as groups of comparative non-participants), report on areas of interest or concern in programming, known as a participatory critical assessment. The approach allows for determination of whether or not the program is reaching the intended, agreed upon goals. Problems at any place within the partnership may arise, leading to the need for discussion/re-evaluation. This is known as "goal misalignment" and means that specific areas of programming require reconsideration. In this way, community participants, programmers at community and regional levels and evaluators, alike, share in program evaluation. Goal misalignment may occur in one or a few communities within the region, signaling unique differences within those spaces that do no lend to the specific approach implemented throughout the region. In this case, discussion, re-interpretation of events occurs with that (those) community area(s). Evaluation tools are then created in collaboration with the community (communities) and regional staff to be administered by the community program staff interested in a re-assessment and the proper "modifications" are made and the program is "realigned." The cycle is repetitive and the movement is ideally fluid. With the SF-MCH framework, the evaluation acts in conjunction with, as opposed to separate from, ongoing and ever-changing processes of program development and implementation. There is no such thing as a complete or finished program. It must be constantly adapted to changes in the natural, social and economic environment; with this so too must evaluation.

Challenges have occurred in the implementation process. Most significantly are those that occur when communication breaks down or collaborators are properly informed or concerns are not filtered through the program delivery system (e.g., modifications are not made).

Since critical assessment is meant to promote program effectiveness, if disregarded, the program's level of success will falter. Repetition of this 'negative cycle' increases the program's likelihood of reaching a "crisis point." The intensity of a negative cycle is enhanced depending upon the number of aspects associated with the negativity and the length of time the issue(s) are left to digress. It is possible as well that only a segment of the program will enter into a crisis point and not necessarily the program in its entirety.

In addition, as outlined above, as the program maneuvers through its course, adapts and changes to the social and political environment, the notion of maintaining shared goals and common vision amongst the collaborative partnerships is precarious. In other words, what happens if there are several "visions" occurring simultaneously? Whose vision drives the program during this time? And where do the evaluators fit in?

In the duration, where consensus is not present (for the program in whole or in part) the evaluation process must continue to unfold. Yet how can the evaluation continue when the evaluation approach has, in essence, been destabilized? During this time the evaluation will go through a bit of a balancing act; i.e. it will keep trying to impact changes directly (through intervention evaluation) but when confronted with barriers (in part or whole) the evaluation approach by default becomes 'process evaluation'. And as to be expected, the evaluation component of the SF-MCH program has undergone some balancing and re-balancing with regards to its approach throughout the duration of the program.

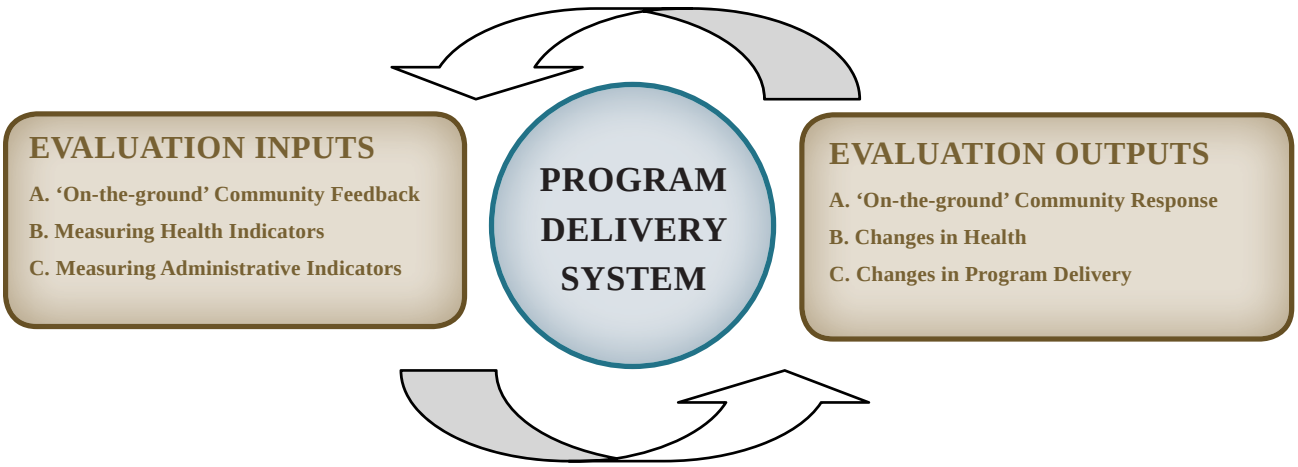
CRITICAL ASSESSMENT OF SF-MCH

Whether or not SF-MCH program's evaluation component takes the form of 'intervention evaluation' or defaults into 'process evaluation,' the main purpose of the evaluation in general is to critically assess and offer recommendations aimed towards increasing program effectiveness. In other words, regardless of where the evaluation stands in the larger context of program decision-making it must continue. With this, it is paramount that the evaluators have a working framework, not only to steer the evaluation initiatives, but maybe even more pressingly, to guide the search for meaning and understanding within the broader context of a First Nations home-visitation program.

Generally speaking, the process of evaluation of health programs rests largely on the selection and measurement of indicators. Health indicators allow researchers an opportunity to measure and compare specified health conditions (i.e., ones deemed relevant to the program or service delivery), within or across certain timelines and population groups. In essence, health is measured to see if the program is indeed making a difference (i.e., increasing health outcomes). Similarly, administrative data is compiled to measure program effectiveness i.e., expenditures, service provider ratios, duration of services, training strategies). With this latter type of data, the evaluators try to establish relationships between variations in program delivery via health outcomes.

Following most health program evaluation initiatives, the SF-MCH evaluation has incorporated health and administrative indicators into the theoretical critical assessment component of the evaluation. These indicators were developed in workshops that elicited the voices of the communities. This primarily means the voices of the families/caregivers living on-reserve in the 16 participating communities, as well as the healthcare paraprofessionals and professionals who work on the frontlines of programming. It is a 'grassroots' approach to evaluation, premised on the notion that in order to fully understand what is actually happening in the communities, it is paramount that interests are vocalized by community members and service providers, 'on-the-ground'. These voices are essential in both assessing and steering program effectiveness and to upholding, examining and further developing the program's theoretical perspective. The figure below illustrates the framework's critical assessment component.

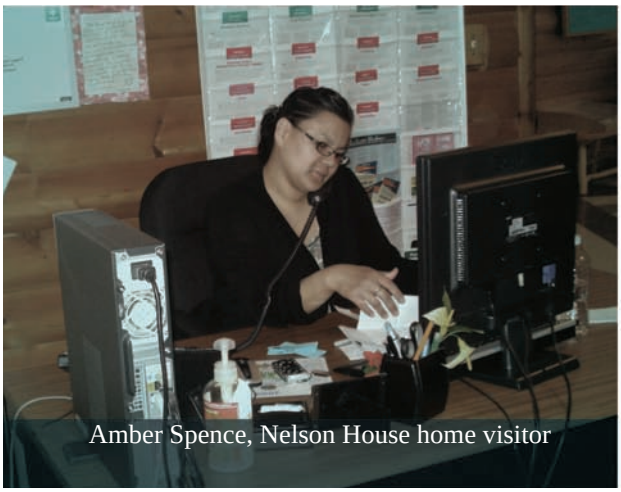
SF-MCH CRITICAL ASSESSMENT COMPONENT



There are three dimensions of critical assessment: evaluation inputs, evaluation outputs and, at the centre, the program delivery system. In an idealized approach, the evaluation inputs

would be filtered into the program delivery system (i.e., program modification) and the program would thus be adjusted reflecting critical evaluation. Once the program is modified accordingly, changes should logically occur at the other side (evaluation outputs). The outputs, within the movement of a fluid cycle, should reflect increased success of the program. To verify, the evaluation is cycled back again towards the evaluation inputs whereupon any new developments are (re)-measured.

Meaning making and the communication of meaning across time and space for the purpose of more effective health policy and program development and implementation is a messy but essential work. Collaboration is a process of discovery; and somewhere in this process is the search to find a meaningful link between programming, research and evaluation. The ultimate goal of the SF-MCH pilot project is to improve the health of First Nation women in pregnancy and childbirth, mothers, their children and families. The program's broadened reach incorporates fathers, siblings, grandparents and other family and community members into the health promotion model as is appropriate according to First Nation tradition. In order to meet this goal, SF-MCH has developed and continuously develops a collaborative model that is inclusive of diverse and knowledgeable knowledge from a variety of sources – notwithstanding such a collaborative approach, the program privileges the interests, concerns, and opinions of families and service providers using and delivering the program on-the-ground.



Amber Spence, Nelson House home visitor

Keeseekoowenin MCH Program
Mom: Laura Son: Tuscan

CHAPTER 2

STRENGTHENING FAMILIES-MATERNAL CHILD HEALTH PILOT PROJECT CULTURALLY ORIENTED PRACTICE FRAMEWORK

This chapter discusses the development of a uniquely Manitoban First Nation cultural framework for the SF-MCH program and evaluation. The cultural orientation of the program defines a region that includes unique community cultures of each participating program site.

DEVELOPING A CULTURAL PRACTICE FRAMEWORK

In order to orientate SF-MCH within Manitoba First Nation culture, a great deal of foundational work had to be implemented, focusing on discovery, reclamation and adaptation. Culture refers to many aspects of living, including the following ways of life: language (as the older human institution and the most sophisticated medium of expression); arts and sciences (as the most advanced and refined forms of human expression); thought (as the ways in which people perceive, interpret and understand the world around them); spirituality (as the value system transmitted through generations for the inner well being of human beings, expressed through language and actions); social activity (as the shared pursuits within a cultural community demonstrated in a variety of festivities and life celebrating events); interaction (as the social aspects of human contact, including the give-and-take of socialization, negotiation, protocol and negotiations) *(Shahla Arbabi Yazd Series, 2002-2003; http://www.roshan-institute.org/templates/System/details.asp?id=39783&PID=474552).*

The concept of culture has been intensively studied by social scientists, particularly by anthropologists and is at the root of the struggle for resurgence of indigenous self-governance. In 1871 Edward Burnett Tylor defined culture as:

> That complex whole which includes knowledge, beliefs, art morals, law, custom, and any other capabilities and habits acquired by man as a member of society (Jokilehto, 2005: 4)

Over time, the concept became increasingly complex and by 1952 American anthropologists A.L. Krober and C. Kluckholn cited 164 definitions of culture including for example: "learned behaviour", "ideas of the mind" a logical construct", " a statistical fiction", "a psychic defense mechanism" and a more recent definition of culture as "an abstraction from behaviour" *(Jokilehto, 2005: 4; http://cif.icomos.org/Heritage%20definitions.pdf).*

With the history of colonization of indigenous peoples in Canada, orienting a program in terms of a community or nation's culture includes archeological, sociological psychological, artistic, as well as linguistic work, to mention some of the work that needs to be done. However, besides discovery and reclamation, there is the work of borrowing culture from other peoples interacting with the community/nation. Culture includes an accumulation of experiences learned and then socially transmitted. As such, all of humanity share in that accumulation: human beings look for what makes sense in the world, what works, improves our worlds and allows us to develop further. Of course, there is a great deal of uniqueness in terms of culture interpretation, since what is most sensible or what works best is dependent upon individual, group, environmental and other factors, for example; accessible resources, expertise and experience.

The concept of culture was accorded a great deal of consideration in developing and implementing the pilot project in Manitoba. Recognizing the damage caused by colonizing health and social programs directed at indigenous people over the past over one hundred years, with residential schools, child welfare, tuberculosis sanatoriums and maternal evacuation practices, it was important that SF-MCH begin with a grounded cultural basis.

It seems paradoxical then that much of the practices of SF-MCH have been initially borrowed from other North American policies and curriculums. The evaluation team had to struggle to understand this programming decision. Over the pilot term however, it became clear that the community and regional program teams had made a superior decision to borrow what was available, tried and true in programming. From borrowing, SF-MCH has made increasing

strides in developing First Nation based programming throughout the region. Borrowing allowed the programmers time to understand how, for example, curriculums worked. By implementing what was available, by working through to a level of expertise in delivering a standard program, the programmers began to develop a creative space that allowed for the beginnings of a developmental phase. At this point, communities are beginning to implement program aspects, including curriculum activities that are based in their culture. In the next two years, it is anticipated that a Manitoba First Nation curriculum, home visitation and other program policies and procedures will be more fully designed and delivered.

A great deal of development activity took place in the pilot implementation phase. The following details this development work.

DEVELOPING FIRST NATION APPROPRIATE HEALTH INDICATORS FOR SF-MCH

Health indicators are measurements. They measure various aspects of health within a community or population. Each indicator is like a piece of a puzzle that contributes to a global picture of health. When indicators are tracked over time, the picture starts to unfold a story, allowing us to look into historical and interconnected dynamics *(National Aboriginal Health Organization, 2007; http://www.naho.ca/firstnations/english/documents/toolkits/FNC_HealthIndicatorsInformationResource.pdf).* Indicators can be expressed in two ways:

1. Health status: these are indicators that are used to measure different aspects of the health of a population (e.g., life expectancy, infant mortality, disability or chronic disease rates.
2. Health Determinants: these indicators measure factors that influence a population's health (e.g., diet, smoking, water quality, income, health services accessibility, education and employment opportunities, cultural and racial equity) *(ibid, 2007).*

Indicators are used to help answer questions such as:

How healthy is the community?
What factors affect health in the community?
Are our programs effective?
Are we moving towards our vision of health, or away from it?

SF-MCH Program indicators were developed overtime and adjusted to address program experience. The expansive focus on maternal child health programming on reserve invites a broad list of indicators. In order to make sense out of the broad array, indicators were prioritized and organized/linked in a way that allowed for clarity in service delivery. The indicators developed from 2006-2010 in several inclusive regional workshops are organized according to direct and indirect (i.e., improved relationships, empowerment of women and families) health impacts. Indicators targeted in programming are listed as follows:

INDIVIDUAL LEVEL INDICATORS

Prenatal health (physiological, psychological and social markers identified)

Postpartum health

Birthing health

Infant health and nutrition

Addictions

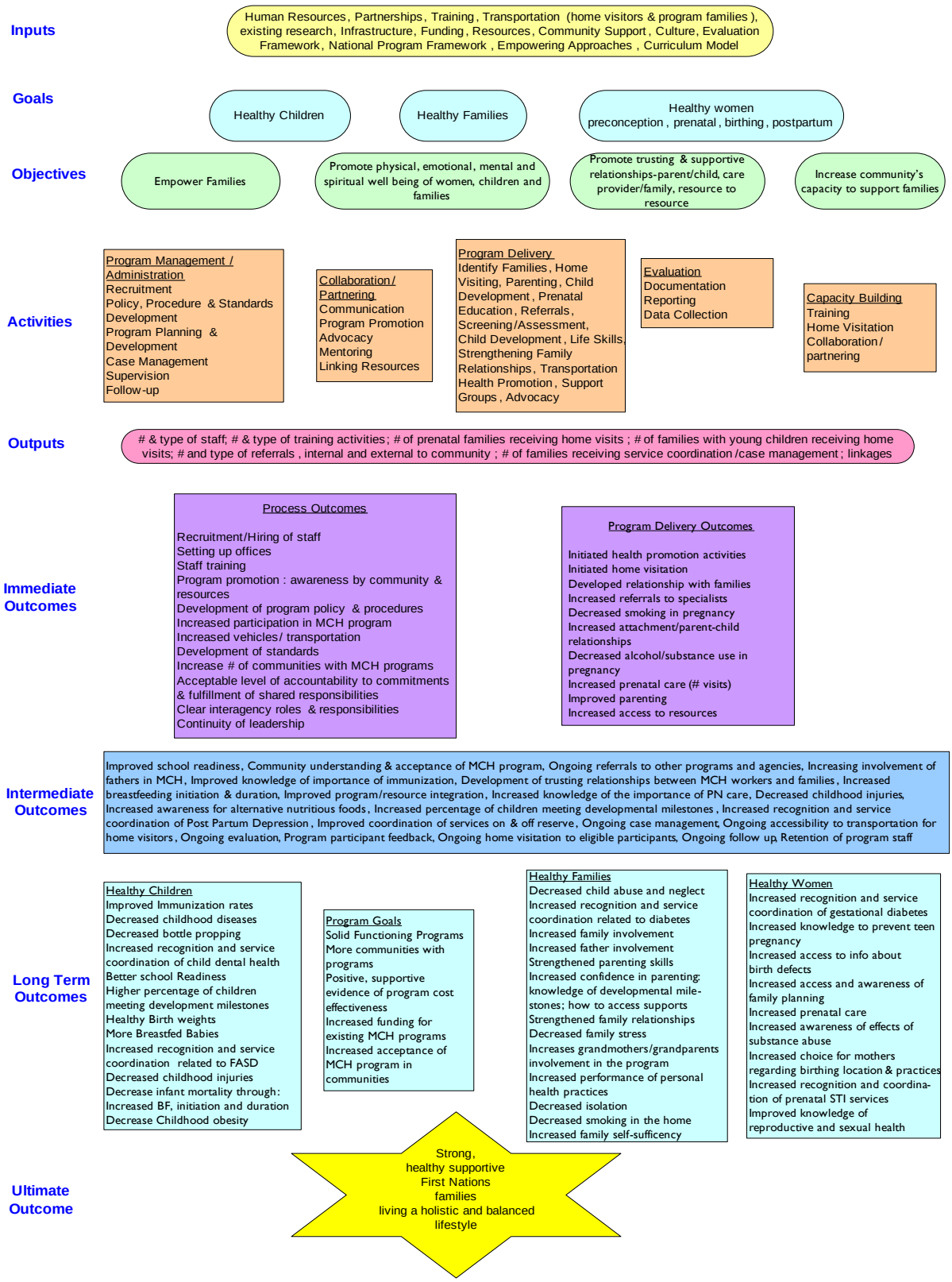
Child development/school readiness

FAMILY LEVEL INDICATORS

- Relationship
- Partner and familial support
- Violence
- Role model families
- Capacity development within the family
- Family wellness
  - Time spent doing family activities
  - Communication within the family
  - Respect for family members
  - Trust
  - Enjoyment
  - Creating your own activities with your family
  - Family literacy involvement
  - Family retreats
  - Preparing meals and sitting down for meals with your family
  - Setting and reaching goals as a family

COMMUNITY LEVEL INDICATORS

- Health promotion programming awareness and accessibility
- Linkages and supports across programs
- Cultural and language development opportunities
- Recreational activities – accessibility and participation
- Education and training involvement
- Employment opportunities and participation
- Volunteerism
- Camaraderie/trust
- Availability of information/sharing of information
- Opportunities to give and receive to and from community and Canadian society



Original logic model developed by Advisory Committee members, SF-MCH community staff, Health Directors. Evaluation planning meeting Nov. 2006.

UNDERSTANDING PARENTING IN MANITOBA FIRST NATION COMMUNITIES

In the spring 2007, the evaluation team designed a research study to understand parenting in Manitoba First Nation communities. Results of the study would assist the communities and the region in the development of specific program policies and activities tailored to the needs, interests, and strengths (or cultural specifications) of the communities in the region. Differences and similarities between communities would be reflected in programming. In the summer 2007, two First Nation student researchers of the evaluation team conducted sixty-five interviews with thirteen of the sixteen SF-MCH participating communities. The structure of the questionnaire was open-ended; however, the questions were posed in a manner that was meant to stimulate a natural flow of discussion between the researchers and the participants. The focus of the study was to discover what it is like to parent in the communities, i.e., what formal and informal supports and resources are available, what challenges exist in daily parenting, parental expectations and aspirations for children, service requirements, linkage and accessibility issues. Researchers were also interested in the unique requirements of children and families with special needs or heightened medical and/or social risk.

The interviews and subsequent qualitative data collected served as part of the evaluation regarding effectiveness of the SF-MCH pilot project. Knowing what it is like to parent in the participating communities, the evaluators are better equipped to understand participant expectations, therefore efficiency in programming, and effectiveness of the program to meet those needs and complement the strengths. Understanding the communities' interpretations of the concepts of 'family' and 'community' also provide the evaluation team a broader insight into the purpose and goals of SF-MCH. Community perspectives on parenting, the conditions of parenting and the intrinsic concepts tied to parenting are core components of cultural orientation in programming and evaluation.

University and First Nation ethical protocols (i.e., OCAP and University of Manitoba Medical Research Ethics) were followed explicitly. The interviews were digitally recorded and transcribed. The students, with the research and evaluation director, reviewed the transcribed interviews and checked them for accuracy. Interviews varied in length and content, yet all capture the parenting issues viewed by participants as important for their circumstances within the community.

The questionnaire was developed with regional and community participation. As well, the evaluation sub-committee of the Maternal Child Health Advisory Committee participated in its development. The 65 participants included 5 married couples, 9 men and 51 women. From this group, there were 10 grandparents, some of which assumed a primary care giving role. Participating communities were: Brokenhead Ojibway Nation, Dakota Tipi, Keeseekoowenin, Nisichawayasihk Cree Nation, Norway House Cree Nation, Opaskwayak Cree Nation, Peguis, Rolling River, Roseau River, Sagkeeng, Swan Lake, Tootinaowaziibeeng, and Waywayseecappo. The three non-participant communities (Cross Lake Cree Nation, Long Plain First Nation, and Pine Creek First Nation) told the evaluation team that they had not yet firmly established their pilot projects at the time of the interviews.

The participant selection process originally was to interview six people from each of the communities: 2 women, 2 men and 2 grandparents; taking into consideration representation of single parent and dual parent families, as well as other family arrangements. Prior to the interviews, evaluators asked the SF-MCH community health nurse (program supervisor) to select possible participants for the study. While it was not always possible to meet the 6-person per community prerequisite, the researchers were successful at reaching a wide enough sample of parents representing different family arrangements and levels of health and/or social risk.

The data analysis procedure consisted of a close review of the transcribed interviews by the research and evaluation director to pick out themes from the interviews and then to organize the themes by subject matter and relevance. The themes were reviewed several times for organization and content. The themes and how they are presented were then reviewed for analysis. Community and regional programmers, participants and the evaluation sub-committee of the advisory committee participated in analysis and interpretation of the themes. This qualitative analysis consisted of presenting what it is like to parent in the communities by using the language of the participants to describe community realities. The emerging themes and subcategories (expanded upon in detail in an SF-MCH report entitled, Understanding Parenting in Manitoba First Nation Communities (2009) are organized as follows:

THEME 1: INTERPERSONAL SUPPORT & RELATIONSHIPS

- Family
- Community
- Self Reliance
- The Insider/Outsider Predicament
- Connection to the Land

THEME 2: THE SOCIAL AND ECONOMIC FACTORS AFFECTING PARENTING

- Employment Security
- Education and Training
- Youth and Education
- Residential School System
- Access to Daycare/Childcare
- Housing Security
- Food Security
- Water Security
- Safety on the Streets

THEME 3: COMMUNITY INITIATIVES AND PROGRAMMING

- Access to Health Knowledge and Facilities
- Community Programming: General Feedback
- What Participants Would Like to See
- Sports and Recreational Activities
- Incorporating Culture & Language into Programming/Schools

From the study information collected, it is apparent that parenting in Manitoba First Nation communities is a beautiful and complex undertaking with extenuating and imposed circumstances within which many of the children are born. Systemic inequities and colonial interferences have created an environment of historical implications that affect the health of children and families in the communities. The caregivers involved in this study provided a deep and perceptive understanding of their experiences with the critical task of parenting future generations.

Topic areas, i.e., interpersonal supports and relationships, are key issues pertaining to parenting, and are expressed variably between families. It was also apparent through the interviews that while similarities do exist by which a 'Manitoba First Nation approach to parenting' can be described; parenting is largely contextual based on geographical/cultural location, diverging expressions of culture that have evolved through time, maternal and familial education, social and economic issues, and relationships with others in the community.

Personal and family connections to land and home, concepts of family and self-reliance were key were key concepts in understanding experiences of parenting in the communities. Insights into the social and economic factors affecting community members were shared including the criticality of housing conditions, employment opportunities and access to healthy affordable food and clean water. All of these represent the basic requirements of healthy living and are inextricably entwined with parenting. Access to quality, reliable services, e.g., daycare, can directly affect a parent's ability to provide income and support to children.

Also of critical importance are community initiatives and programming. Accessibility to meaningful health and social services as well as a parent's ability to provide feedback to different services were identified as vital to the supportive development of children and families. Such insight includes the ability to incorporate culture and language in a manner that is suitable for the context of each community, an issue raised directly in the interviews.

Such information as that gathered through the study is vital to tying a program specifically to the interests of a particular population. Through the process, parents are able to take a direct role in designing programming. This study began the process of programming and evaluation in Manitoba. With iterative feedback, SF-MCH is able to respond directly to the concerns and hopes of community caregivers of children. The methodology incorporated in this study is repeated in studies throughout program implementation to ensure a tight connection between community experience, programming and evaluation.

GRAND-PARENTING IN MANITOBA FIRST NATION COMMUNITIES

Somewhere at the time of transcription of the data collected for the 'Understanding Parenting' research study, the researchers decided that it was warranted to study the role of grandparents in the communities. This topic revealed itself to be important and quite complex in our population. A different set of themes emerged from the grandparent interviews, leaving a distinct message that community Elders were very much involved in primary childcare responsibilities and that they had a particular set of requirements needing to be fulfilled in order for them to better carry out their job. See paper entitled 'In Consideration of the Needs of Caregivers: Grandparenting Experiences in Manitoba First Nation Communities' (Eni, Harvey & Phillips-Beck, 2009) for expanded description of the themes. Nine specific themes emerged from the grandparent interviews. Themes included effects of past and present political policies (colonization and family disruption), poor health status of First Nation elders and children, lack of opportunities for self-determination (e.g., adequate housing, employment, education), high demands on the grandparents to carry various roles in the community due to the impacts of colonization and lateral violence in the communities (e.g., addictions, violence, and an inability to parent), the very particular benefits of the grandparent relationship, the need to support grandparents in order that they have the energy/good health to continue parenting involvement, health and social services to support Elder health and grandparent involvement in direct parenting. Themes that emerged from the data are:

Cultural transmission
Safety
Living with granny
House and home
School
A social network of kin
Presence (absence) of community support
The need to make a living
Health of grandmothers and their children

We have examined the social and economic circumstances within which grandparents strove to raise healthy children, including crowded and inadequate housing, low community and personal income levels, high rates of disease, low educational attainment, and lack of employment opportunities. In terms of access to the land and resources, traditional staples were diminished. In spite of these obstacles the grandmothers turned houses into homes, protecting children from unsafe situations posed by unsettled parents or community level vandalism/violence. Cultural transmission was a value and gift of the grandmothers to their grandchildren. Even those who had lost their cultures and languages as a result of colonization were students alongside their younger cares. The cultural values of reciprocity, extended family connection, and lifelong learning were evident here. Grandmothers reported their grandchildren felt safe and loved in their care. The grandmothers tried to help their grandchildren get through school, even though their own educational attainment may have been low. They solicited help in childrearing when they needed it. They were actively involved in their communities, at times involving themselves in community services and at other times lamenting the lack of formal supports.

PROGRAM AND POLICY IMPLICATIONS

The study revealed several implications for policy and research, noted for ongoing SF-MCH program development and implementation. Ongoing evaluation considers SF-MCH ability to realize these through direct and indirect programming impacts.

PROGRAM IMPLICATIONS

At present, SF-MCH targets supports directly on pregnant, new mothers, and their children. Through them, the program targets the interests of extended families. Since grandmothers are often involved with childcare, tangible supports to grandmothers ought to be available directly. Grandparents should be eligible for programs and services related to parenting, as well as having respite services and housework support. Some of our grandparents clearly needed respite and/or assistance getting to medical appointments. Some had many people for whom they were responsible, and caring for one grandchild meant help was needed to care for others (e.g., the child's parents and those intimately connected to the parents).

The grandmothers spoke about wanting to have recreational opportunities for their grandchildren, things that are accessible on foot and are safe for children. Expanded opportunities for children, youth, and respite care would alleviate some of the burdens carried by grandmothers. Employment opportunities for older teenage children are limited, and having something meaningful for teens to do would lessen grandmother worry about the young children in their

care. Implementing strategies of such a nature will require partnerships beyond the maternal and child health programs and across jurisdictional boundaries and funding envelopes.

POLICY TO HELP GRANDMOTHERS THEMSELVES

Grandmothers interviewed were in their 50s, still relatively young by Canadian standards. We wonder if they are sacrificing opportunities for their own development or satisfaction and how this balances with the perceived benefits of child rearing including cultural transmission and personal benefits. Although they did not complain about needing things for themselves, perhaps some might seek additional training, education or different work if they had support with parenting responsibilities or were not the primary and sole supporters. Caregivers also require care themselves, especially since these individuals have already parented at least one generation. Health, social and recreational supports must be provided to these women.

Clearly grandmothers, like others on reserves, need better housing, sanitation, and water. They need homes that are big enough for the people who live there, as crowded conditions spread disease and affect overall wellness. For health reasons, ridding homes of mold and creating a physical and nurturing environment that is adequate and safe needs to be a priority of the First Nations and federal government.

CULTURALLY APPROPRIATE AND FLEXIBLE FAMILY POLICY

These families are different from mainstream Canadian experiences, and the concept of "skipped generation" attached to this type of family arrangement in the mainstream is inadequate. For the most part, First Nation grandmothers are younger than their Canadian counterparts, and their offspring may be very young parents (e.g., early teens). Therefore the flow between and among generations is continuous: women become grandmothers while they are still raising children themselves, with grandchildren moving easily among various kin.

Since family life flows in a continuous stream from generation to generation, culturally appropriate and flexible policy is needed. Communities need to be supportive rather than punitive. Providing programming for parenting, for example, for grandmothers (and perhaps grandfathers, aunties, and uncles) can empower families across the life span.

One of the advantages of having evaluation run parallel with program development is that the program has already responded to various identified needs. Opportunities and support for teens, young and older adults are required to assist these age groups in contributing more creatively and meaningfully to family and community life.

THEORETICAL IMPLICATIONS

A critical and reflective analysis of theory was conducted following a writing of the Grandparenting study. This analysis was conducted in the usual SF-MCH fashion, including community, regional and advisory committee participation. It was decided that this is particularly significant for the purposes of this study, since it involved interpretation of the stories of Elders within a programmatic context.

The research evaluators began this study with an ecosystem or Medicine Wheel approach. This theoretical model was considered useful to describe grandmothers' experiences, to organize their voices into themes, and to show interrelationships among various aspects of their lives. The approach is also useful to accurately present participants' lived experiences. This is a vantage point that is based on balance and harmony among distinct, explicit and interdependent roles and responsibilities of men and women.

Indigenism, as defined by Hart (2007) is the recognition that the influences of persistent colonization continue to affect Indigenous peoples. These influences are absorbed by the body and manifest health outcomes and affect even our intimate relationships. Rather than being a reaction to the dominant worldview, as are post-colonization theories, Indigenism is grounded in a distinction from a mainstream societal experience of the world. A discovery of the worldviews and practices that constitute Indigenism is, in itself, part of the learning process, as research participants actively engage in a research method that is self-determined, co-designed and delivered by First Nation health researchers, community- based researchers, programmers, and family members.

In choosing this particular methodology, researchers can support Indigenous voices within a specific space and time; enhance a meaningful relationship between researchers, health practitioners and program participants; reflect First Nation core values and beliefs; recognize the role of researchers as subjective contributors to the generation and communication of knowledge; and remain practical to the everyday needs and desires of the study participants and their families.

Emanating from a place that is outside of the mainstream discourse through inclusion of voices of different, non-European perspectives can give researchers and participants in the research the power to direct a practical and academic work towards greater objectivity that escapes political bias and embraces the goal of social justice. Tuhiwai-Smith explains that this is a methodology which

> is expressed through and across a wide range of psychological, social, cultural and economic terrains. It necessarily involves the processes of transformation, of decolonization, of healing and of mobilization as peoples. The processes, approaches and methodologies – while dynamic and open to different influences and possibilities – are critical elements of a strategic research agenda (1999: 116).

Foucault referred to the silencing of other voices beyond the dominant white-male perspective as “subjugated knowledges” (1980a; 1980b). Including only a single voice into official government and academic discourses and relying on these as the basis for health and social policy and practice creates the illusion that what is written in the texts signifies all there is to know about the realities within which people live, breathe and feel. Researchers who omit the voices of the peoples living at the margins of mainstream society (as for example, in First Nation reserve communities located throughout provincial and national peripheries) create unbalanced, and in essence, false foundations for the development of policies, programs and services. The work of attending to the actual descriptions of everyday life by the people living in these communities, so far away from the Canadian centres, is a time consuming and difficult task. These data are not so readily available as are much of the quantitative and administrative data on Canadian populations; but the methodology offers a kind of analysis into real lives that is possible through no other means. It allows for a kind of research that has the potential for rebalancing our political system towards one that is socially just, equitable and humanitarian, and as such is a methodology that could be fully supported by the Canadian First Nation research agenda. With research that begins on side with the First Nation experience, researchers can express and share a multiplicity of perspectives and experiences and use these to reshape the patriarchal system so that is attentive to the needs, strengths and desires of the research participants, their communities and nations.

Within an Indigenous perspective, the goal is to discover a method of speaking as Indigenous peoples with a specifically defined set of values, traditions, ways of being in and interpreting the world, when in the end, political frameworks are created as per the paradigms of mainstream Canada. Embarking upon a community-initiated, community-lead and community-perspective research study that is meant to capture the essence of the modern-day grandparenting relationship, with implications to health and wellness, has revealed circumstances, value and belief systems that are qualitatively different from grandparenting relationships in the mainstream. In First Nation communities throughout Canada, many families and individual family members strive every day to free themselves from the legacy of colonialism and reclaim their cultures and traditions (for example, raising children within the context of loving, extended families) in spite of it all. Within the confines established by the Canadian governments and their institutions, First Nation peoples struggle to express an Indigenous way of being in the world – this poses a real challenge in doing practical First Nation health research. But by building in a framework that allows for a representation of the world that develops form within communities, First Nations can begin to own not only the programs they develop but the health outcomes that emerge from uniquely First Nation efforts.

Long Plain MCH Family
(Mom: Krystal, Baby: Drake, Son: Traytin).

Keeseekoowenin MCH Program Baby Jaden

CHAPTER 3

THE SF-MCH HEALTH AND SOCIO-ECONOMIC INFORMATION SYSTEM

This chapter describes the development of the SF-MCH health and socio-economic information system. The information system collects data from program participants in each of the SF-MCH sites. Information can be retrieved, summarized and used by community-based staff for programming. Information also assists programmers and researchers at the regional level.

DEVELOPMENT OF THE SF-MCH INFORMATION MANAGEMENT SYSTEM

The development of the Strengthening Families Information Management System, (SF-IMS) was an iterative process that began in 2006, with the initial decision to standardize program documentation and the development of a set of paper based forms. The longer term objective was to move to an electronic documentation system that would collect program administrative data, evaluation data and generate reports for the funding partner, Health Canada. In 2007, the forms evolved to a teleform format and after 6 months of pilot testing by communitiesthe form and process were evaluated by the University of Manitoba team. From this evaluation, data requirements for the program were refined in collaboration with a small "forms subcommittee" of community representatives and a decision was made by the Advisory Committee to move to an electronic format. Based on two years of testing and feedback from users and three iterations of manual and teleform tools, Function Four, Ltd, a private sector research/development/ information technology company was contracted by the Assembly of Manitoba to support the program administrative and practice needs.

The SF-IMS system was deployed in April 2009 and community program staff received training. Conceptually, the SF-IMS design includes the potential to include information from external databases, from other health and social services and programs at community, regional and federal levels (e.g. health, housing, education, RCMP, Child and Family Services databases) to bring together and increase the power of planning and evaluation data.

The data base was developed to comply with the principles of OCAP (Ownership, Control, Access and Possession). Each program participant signs consent to have their information collected; the data base is housed at secure site, the information is firewall with username and password protection. Each user is assigned a level of security that corresponds to their role. Communities collect and have own data, and no information is shared without written authorization of leadership or health director. The information is housed by Function Four, a privage IT Firm, AMC presently functions as the steward, but the community has ultimate ownership and control over their data. The University of Manitoba has access to data in aggregate form only.

The system remains in development although substantial enough to provide necessary functionality and security proving its worth to the overall project. Availability of the information system has allowed collection and use of information that if solely paper-based could not be used to support administrative decision-making, planning or evaluation. An additional result of the system's availability is the cultural and skill changes that impact all levels of staff as they participate in a modern information and technology supported health care service.

OVERVIEW

SF-MCH data includes: maternal (prenatal and postpartum), information pertaining to labour and delivery, breastfeeding; infant and child health information; nutrition; developmental screening information for children up to age six years; medical; demographic; socioeconomic information on program participants and their families; and information on program and service availability, accessibility and utilization. *(see appendix - data dictionary)*

The database design was driven by needs of users who participated in sessions to identify the data elements as well as the terminology and user interface. As such, input of information to the system follows the program model with users identified in one of the following categories: home visitor,

supervisor/nurse, coordinator, and administrative assistant.

Data is organized by focus child (service point) who is part of a family which is part of a community. Based on presenting needs, the file is opened as a pre-natal case, post-partum case or developmental case. Inherent in the system are tools that guide the worker through the structured process which in addition to initiating the record, ensures that the program, protocols are followed during the intake, screening and service delivery/reporting phases. The form, shown below, is comprehensive and leads the interviewer through the intake process. Similar forms/input screens are available for other facets of the program. *(Paper versions of the input forms are included in appendix).*

To maintain the integrity of the database, limits are placed on what role the supervisor in the community can edit. Any changes are sent through an approval process through the program and practice support team. A record is kept of the person who entered and last modified the information, at this time extensive logging is not available.

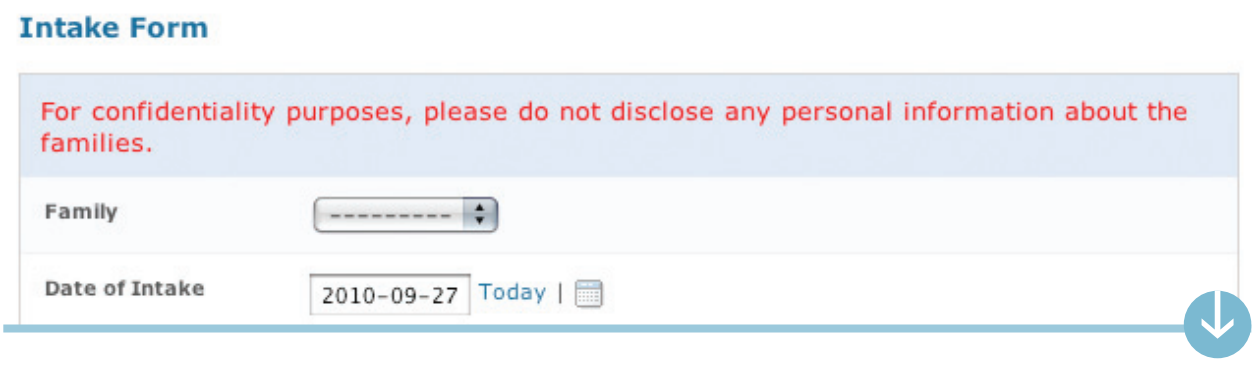
As part of the intake process, a screening tool is used to gather information to assist in ensuring that the appropriate intervention(s) are made available to the client. The information is appended to the information file of the family. Subsequent interactions with the client and family generate further input to the system. Staff is able to review and refer to a concise list of existing records for any family that they have created.

The data fields of the SF-MCH map to those of comparable provincial programming and contain identifiers common to most health and social service programs operating in the Province of Manitoba. Common identifiers including the status number, MHSC number and PHIN number are used to uniquely identify clients and family members.

A comprehensive consent form is available in the system that ensures that clients provide informed consent to any release of their data, either in whole or in part.

In addition to reports that serve program delivery and administrative purposes within the individual communities for use by community health directors, community data is constantly accessible for programming and research purposes. Data is anonymized with confidentiality of the participants protected. The OCAP compliant SF-IMS (described below) is proven to be of use at community and regional levels.

SF-MCH succeeded in creating this database as a “paperless” system, freeing home-visitors in the communities to focus on program delivery. The SF-IMS is an efficient system supporting higher-level practical, policy and research interests without taking away from program delivery (clinical and support interactions between community staff and program participants).



Caregiver 1:

Status ◯ Yes ◯ No

Not disclosed ◯ Yes ◯ No

Status # _____ *xxxxx-xxxxx*

Gender ◯ Male ◯ Female ◯ Unknown

Date of Birth _____ Today |

PN ◯ Yes ◯ No

PHIN # _____ *xxx-xxx-xxx*

MHSC # _____ *xxx-xxx*

Phone # _____ *(xxx) xxx-xxxx*

Address _____

City/Community _____

Province Manitoba

Postal Code _____ *(ex. R2M-1A1)*

Country Canada

Directions to home

_____

Relationship to Child

- ◯ MOB/partner
- ◯ FOB/partner
- ◯ Child(ren)
- ◯ Student/Young Adult
- ◯ Grandparents
- ◯ Extended Family (aunts/uncles, etc.)
- ◯ Foster Parents
- ◯ Elder
- ◯ Other

Cargeiver 2:

Status ◯ Yes ◯ No

Not disclosed ◯ Yes ◯ No

Status # *xxxxx-xxxxx*

Gender ◯ Male ◯ Female ◯ Unknown

Date of Birth Today |

PN Unknown

PHIN # *xxx-xxx-xxx*

MHSC # *xxx-xxx*

Phone # *(xxx) xxx-xxxx*

Address same as cg1 ---------

Address

City/Community

Province Manitoba

Postal Code *(ex. R2M-1A1)*

Country Canada

Directions to home

Relationship to Child

- ◯ MOB/partner
- ◯ FOB/partner
- ◯ Child(ren)
- ◯ Student/Young Adult
- ◯ Grandparents
- ◯ Extended Family (aunts/uncles, etc.)
- ◯ Foster Parents
- ◯ Elder
- ◯ Other

Emergency Contact:

First Name

Last Name

Phone # *(xxx) xxx-xxxx*

Relationship to Child

- MOB/partner
- FOB/partner
- Child(ren)
- Student/Young Adult
- Grandparents
- Extended Family (aunts/uncles, etc.)
- Foster Parents
- Elder
- Other

Education:

Caregiver1

- 0 - 7 years
- 8 years - less than high school degree
- high school
- college - no degree
- college degree or more
- Unknown

Caregiver2

- 0 - 7 years
- 8 years - less than high school degree
- high school
- college - no degree
- college degree or more
- Unknown

Source of Income/Occupation:

Caregiver1

- ◯ Employed Full Time
- ◯ Employed Part Time
- ◯ Unemployed Receiving EI
- ◯ Unemployed Receiving (SA)
- ◯ Unemployed Receiving Other
- ◯ Unknown

Caregiver2

- ◯ Employed Full Time
- ◯ Employed Part Time
- ◯ Unemployed Receiving EI
- ◯ Unemployed Receiving (SA)
- ◯ Unemployed Receiving Other
- ◯ Unknown

Household Environment:

Number of people living in household Under 18 (yrs) _____

Number of people living in household Over 18 (yrs) _____

Total number of bedrooms _____

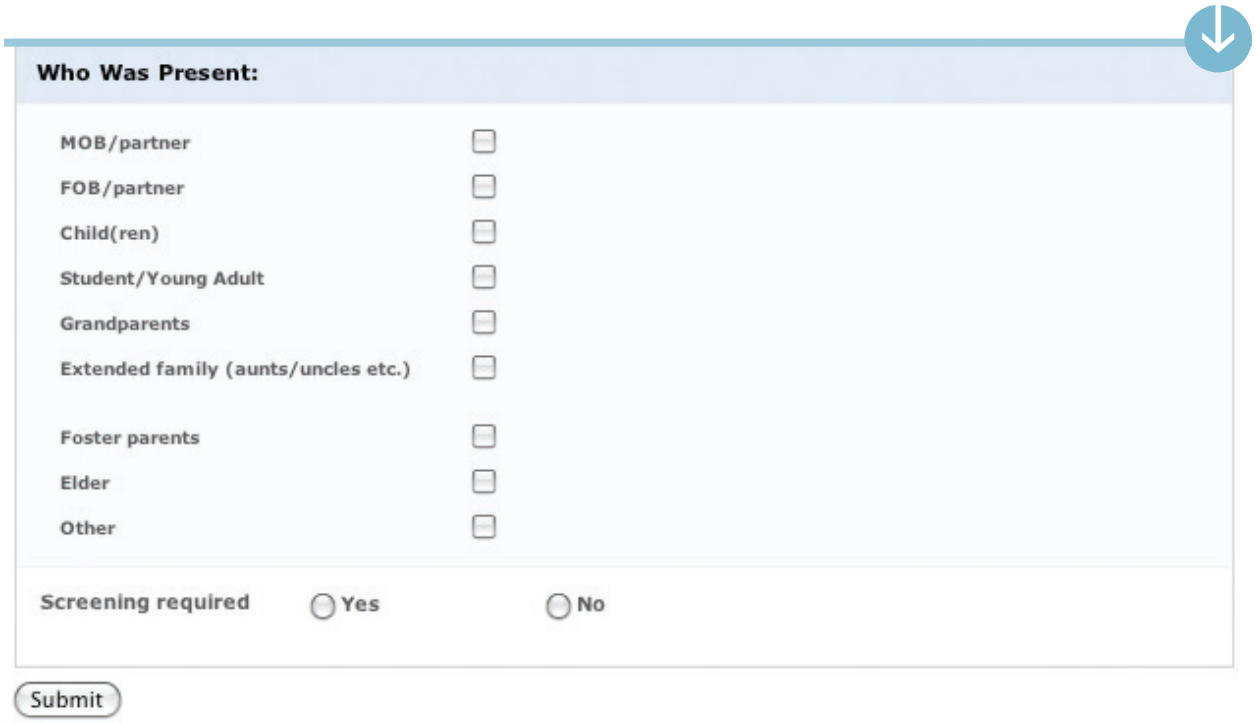
Smoking in house ◯ Yes ◯ No

SF Use:

Interviewer:

First name _____

Last name _____



TECHNICAL ASPECTS

The information system is web-based and the architecture readily supports online use including direct input by workers located in rural and remote communities. Because of the structure, the system would be able to accommodate remote data entry over the Internet should devices and connect ability become available. In determining the architecture and software tools the following considerations were used in the selection process: cost, functionality, ease/speed of development, platform independence.

The environment was chosen for the system from open source products in order to reduce the overall cost, facilitate more users as there are no per system license fees, thus allowing resources allocated to information services to be focused on functionality rather than software acquisition and license fees.

SF-MCH is hosted in a Red Hat Linux operating system using Apache Web Server. The web framework is Django, using Python programming language. Both the framework and programming language are robust and include many administrative tools and built-in functionality that speeds development and allowed the system to be up and running quickly as well as respond to user-defined changes.

The database selected is PostgreSQL , a powerful, industry standard open source product that is equivalent in functionality to Oracle, but with much lower cost of operation and development.

In order to roll out the system within the time and resource constraints a number of features have not been implemented at the present time, however the system architecture is designed to support online input using wired or wireless devices, extensive logging to ensure data integrity, security standards equivalent to those governing provincial systems. These features are planned for development and inclusion in the next phase of SF-MCH.

Further refinement, change management and user functionality will be an ongoing activitiy in the future, responding to community need, user feedback and program inprovement.

Opaskwayak Cree Nation MCHP Bike Safety Activity


Opaskwayak Cree Nation Family Fun Day
Children of MCH Program

CHAPTER 4

SF-MCH QUALITY ASSURANCE/PEER SUPPORT PROGRAM

This chapter builds on the SF-MCH Quality Assessment Program: Achieving Excellence in First Nation Community-Based Health Promotion Programming Report (Eni, 2010). Additional information is added in this chapter that is not available in the full report. The chapter is a description and evaluation of stage one of the quality assurance/peer support program: design and initial implementation.

QUALITY ASSURANCE PROGRAM DESCRIPTION

Peer Support within Manitoba's First Nations Strengthening Families Maternal Child Health (SF-MCH) Program is a strategy designed to assist First Nation communities with a SF-MCH program to strive toward a higher level of program delivery with the goal of improving maternal and child health outcomes through the enhancement of program effectiveness. It is essentially a quality assurance assessment process that examines of number of program delivery elements utilizing consistent measurement tools and protocols, yet maintains enough flexibility to allow for community variation via incorporation of individual or community cultural strengths. At the core, Peer Support it is truly about providing in depth program support to community programs - and not at all about monitoring or authoritative control. It is about employing the same philosophy that is expected by the individual practitioner – that is strength based; highlighting all that is being done well by the program. It is about lifting the spirits of community staff, and building their strengths, but is also about providing some meaningful feedback on how the program may rise to some of their challenges

The development of the Peer Support Program was an evolution process spanning 4 years, beginning with standardization of the Maternal Child Health core program components, followed by the creation and adoption of program standards; development of standardized documentation tools and the finally with development of an information management system and human resources to support both community and regional level work. Research in the area of quality assurance demonstrates that quality management influences positive outcomes for program participants and is most effective when initiated early in the development of the program and applied continually throughout the process of programming (Gray, 2005).

Peer Support is provided to the community program by Peer Support Specialists who have taken advanced training with Growing Great Kids, and through the development of a regional peer support network of community level program coordinators. This network also functioned as a continuous feedback mechanism and also acted as collaborative decision making body that dialogued on how the needs may be met. It essentially acted as the voice of the collective community. For the program and practice support team at the Assembly of Manitoba Chiefs, sometime the need was to arrange more training, or to design and deliver a workshop on a specific topic, or sometimes it simply function to validate that the programs are on the right track.

The peer support is a process that is still developing, based on the unique geography, demography and social environments of Manitoba First Nation Communities. The initial development of standards and advanced training was only just the beginning, data collection and information will be continued to be analyzed and interpreted alongside other program process indicators. The support was pilot tested in 2009, evaluated and expanded to the other community programs in 2010. The next step is to continue to grow the Peer Support Program through the development of the community's capacity self-evaluate their own programs and stay on the path of continuous improvement and deliver the best services possible.

The process evaluation of SF-MCH depends on clearly defined tenets and standards for the program and understanding of how and whether these have been implemented and supported as intended by the community- and regional-based staff respectively. Quality assurance requires vertical continuity (i.e., up-down movement between services and programs in different jurisdictions from the community, to regional, provincial and national levels). As well, it requires horizontal continuity (i.e., easy accessibility and open communication between programs and resources

within communities). SF-MCH has also designed a peer support program for communities within the Manitoba region to work together in areas of programmatic development, implementation and evaluation. The peer support program component can be an essential aspect of quality assurance for a region with several remote communities with small populations. Staff may feel isolated and may benefit from the overall support and direction that a regional peer support program can offer. Operationalizing programming turns ideas into workable and measureable activities. For example, in order to understand what is involved in maternal screening, several questions should be addressed, i.e., does the target population include all families with young children living in the communities or must a certain predetermined level of risk be specified? Is the decision to specify a level of risk vs. universal screening shared between communities or does each community follow a unique determination of eligibility into the program? What indications are assessed through screening? Are women screened for issues that are of central focus to SF-MCH or are other related issues also screened, allowing for informed referrals to other health and social services? What mechanisms are involved in the screening protocol? Are they carried out appropriately, in a timely fashion and by knowledgeable staff? Does the protocol defined in writing work in its delivery? If not, how so/ where are its strengths and shortcomings? The quality assurance program was developed by the Nurse Program and Practice Advisor at the AMC in partnership with the evaluation team to set the parameters for the process and, ultimately, the impacts evaluations.

Checks and recommendations are collaboratively developed in constant negotiation between the peer support team and community programmers. This is challenging work, as it requires the creation of more complex systems of health care delivery within the program and more complex interactions between programs at multiple levels and jurisdictions. The process brings with it, as well, greater transparency, therefore, reciprocal accountabilities and more specified roles. In essence, with a greater amount of work at the developmental stage and in reflecting on and putting into action clearly defined parameters, programmers should be more confident about what it is they do in the everyday work environment and how staff interact with one another. All of this should increase and enhance output and impacts of the programs. Accountability to community members, colleagues, bosses and funders should also be greatly improved. Ultimately, specificity in the role of community-based health promotion programs will raise awareness and respect of this work within the broader Canadian health care system – this last point is important for broad level support of the kind of work that SF-MCH can potentially offer.

DEFINITION OF QUALITY ASSURANCE

Quality Assurance is a set of activities conducted for the preparation of standards to monitor and improve program performance in order to provide effective and comfortable an environment as possible for the facilitation of health.

REASONS FOR IMPLEMENTING QUALITY ASSURANCE

There are several important reasons for implementing quality assurance in the SF-MCH program. The Program has reached an era of growing sophistication of health promotion concepts. We are better understanding of the balance between active community-participation, voice and consent on the one hand and accountability, clarity in roles and responsibility, the need for continued funds on the other. We understand the need to improve communication mechanisms between small, spread-out populations, geographical isolation, and requirements

for intercommunity, regional and national collaboration that depend on clarity in programming, clearly identifiable programming components, measurable impacts and the factors that cause them. We have a greater respect for the work of community-based specialists and the potential for change by peer/paraprofessional involvement in programming: we know that we need to articulate this work – what are community level staff doing and how are they doing it? What do they require in order to do their work better? What are the impacts of their work? What is their ultimate contribution to improving healthcare delivery and the health of Canadian First Nations and are these contributions measurable? Quality assurance allows for measureable progression towards realizing these concepts.

TENETS OF QUALITY ASSURANCE

The basic tenets of SF-MCH quality assurance program are outlined as follows:

1. Quality assurance is oriented towards meeting the needs and expectations and to empowering program participants and the community. This involves discovering participant and community needs, wants and expectations of the program, working towards meeting these expectations and promoting acceptance of program activities within the community. Program planning and quality improvement efforts are to be assessed according to these needs and expectations. Simultaneously, and in consideration to the fact that the programs turn on the contributions of the community-based nurses and home visitors, quality assurance requires that their needs and expectations be met.

2. Quality assurance focuses on systems and processes. With a focus on analyzing service delivery processes, activities and tasks as well as outcomes, quality assurance allows program providers to develop in-depth understandings of problems and their root causes. Rather than merely treating symptoms, we look for cures. This approach allows us to become more specific about what it is we need to do in our program to enhance maternal, paternal and child health and ultimately to impact the health of the overall community. In more advanced stages of quality assurance we can delve further by analyzing processes to prevent problems before they occur.

3. Quality assurance depends upon data for the analysis of service delivery processes. Simple quantitative approaches to problem analysis and monitoring are another important aspect of quality improvement. Data-oriented methods allow the quality assurance, peer support team to test its theories about root causes. Effective problem solving should be based on facts, not assumptions. SF-MCH has been continuously improving its health and socio-economic information database, clarifying elements of programs and their impacts.

4. Quality assurance encourages a team approach to problem-solving and quality improvement. Participatory approaches offer several advantages.

    a. The technical product is likely to be of higher quality because all team members from several program levels bring unique perspectives to the effort. Collaboration facilitates a thorough problem analysis and makes development of a feasible solution more likely. For example, various levels of governance, community, academic and commercial experience went into the development of the health information database: together program and acedemia studied aspects ranging from technical, privacy and governance issues, methods of data collection and analysis,

management, organization and linkage. With all of our vantages we are able to develop a state of the art database that is utilizable in several interrelated contexts.

b. Program providers in the communities are more likely to accept and support ongoing changes to a program they help to develop. Thus, participation in quality improvement builds consensus and reduces resistance to change. This is a fundamental piece to the capacity building component of SF-MCH: a bilateral education that includes day-to-day management of healthcare and overall provision of funded programming supported by measured impact and realized population health priorities. As such, we see quality assurance as both applied research and comprehensive management including assessment and prevention/early intervention programming.

QUALITY ASSURANCE/PEER SUPPORT PROGRAM ASSESSMENT

The Quality Assurance/Peer Support Program created by the Nurse Program and Practice Advisor at AMC, in partnership with the evaluation team, supported by First Nation and Inuit Health (FNIH) and the Advisory Committee, has been pivotal to successful SF-MCH development and implementation. A central problem in First Nation health and social service delivery, recognized by the Royal Commission on Aboriginal Peoples and expressed in interviews with SF-MCH community-level staff over the pilot project phase, is the delivery of services in remote and isolated communities by staff who feel they lack the direct support of peers and supervisors. Small communities instill programs supported by few staff members working alone on complex jobs that require bringing health promotion into people's homes, and often when they are feeling most vulnerable. Additionally, for several reasons including lack of resources and funding, First Nation communities rarely work together within the region or overall throughout the province unless some reason is provided for them to do so, i.e., province-wide training program offered through AMC or Health Canada.

The Quality Assurance/Peer Support Program allows for program standardization throughout Manitoba, peer support engagement in the communities, ongoing training and on the job support for nurses and home visitors, opportunities for inter-community support and engagement, shared development and implementation, goal setting and prioritizing. With this program, community-based staff no longer feels isolated on the day-to-day job site; rather, nurses and home-visitors feel that they are working as a part of a larger team. Ideas and strategies can be reviewed with a larger group of peers working towards common goals. Communities now work together without constant reliance on regional or national directives. By initiating inter-community work in this way, SF-MCH can expand beyond anything imaginable by a program dependent upon national or regional direction only. The new program has allowed a space for development on the ground. This new development work has brought communities to focus on creating programs that are based on the cultural, social, economic, health and wellness needs of their specific populations.

The Quality Assurance/Peer Support Program should be recognized as an excellence in practice model, possibly implemented in other Maternal Child Health Programs and across programs and services. We have also determined that joint community/peer support specialist goal setting and prioritizing is pivotal to the success of SF-MCH.

CONTEXTUALIZATION OF SF-MCH WITHIN HEALTH PROGRAM DELIVERY TO FIRST NATIONS

WHAT TYPE OF PROGRAM IS SF-MCH?

Population-based approaches to the delivery of preventive services have experienced successes in organizations with clearly defined responsibilities for specific populations (Margolis et al., 2001). In most communities, managed care plans concentrate on the health of their own program participants rather than on the care of all families in the community, and the responsibility for coordinating services to families is unclear. Typically, there is an understanding in the concept and relevance of 'linkage' or 'collaboration' but beyond its conceptualization, little to no operational work is established to put these ideas into practice.

In order to put the concept of linkage into action in SF-MCH, it is important to understand the intended flow and connection of the programs to one another in the communities, the expectations as they were originally drawn out at the federal level, and the method of delivery currently implemented in Manitoba communities.

At this point in the regional pilot project, not all collaborators have agreed upon the type of program that SF-MCH is intended to be. At the community-level, there is considerable advocacy for more group activities – which would fall under the auspices of a health promotion program. At the supervisory levels, both community and regional levels, home visits are seen as the necessary hub of programming, meaning that the program's focus is case-management, as specified in the standards.

The national programming guidelines do not lean one way or another. Rather, First Nation Inuit Health provides an organizational flow of community programs that helps regions in understanding how to enhance linkages and work towards improving the health of community members. The following describes how community programs are to be organized and connected.

COMMUNITY PROGRAMS

Community programs support a suite of community-based and community delivered programs, initiatives and strategies with the collective goal to improve health outcomes and reduce health risks in targeted areas:

Children and youth

Maternal and reproductive health

Chronic disease and injury prevention

Mental health and addictions

Among children and youth as well as maternal and reproductive health, community programs aim to improve maternal, infant and family health and to support the development of children in an effort to address the health and life course disparity between Aboriginal and mainstream Canadian children and adults. For chronic disease and unintentional injury prevention, community programs deliver services that reduce the rates of chronic disease, i.e., type-2 diabetes, to rates consistent with Canadian averages. Services delivered to improve mental health outcomes and addictions are geared to be sustainable, culturally appropriate and economically viable.

The following community programs are described as it is essential that SF-MCH has a clear appreciation of the parameters of each of the programs with which staff are engaging, through linkage of services, referrals, sharing of resources, and so on. The services of each of the programs can be maximized with clearer understanding regarding what each program can and cannot offer. SF-MCH linkage effectiveness is evaluated based on opportunities offered through the parameters of each of the programs listed below.

CHILDREN AND YOUTH, MATERNAL AND REPRODUCTIVE HEALTH

FETAL ALCOHOL SPECTRUM DISORDER (FASD)

The FASD program addresses health problems associated with alcohol and substance use by mothers during pregnancy. The main purpose of the program is 2-fold:

1. To reduce FASD incidence rates (i.e., the numbers of infants born with FASD), and
2. To support children diagnosed with FASD and their families to improve quality of life over the lifespan.

The goals are believed to be achievable through building awareness of FASD in the communities, targeted interventions for those considered "at risk" of having a FASD diagnosed birth, collaborative work within communities to address the broader determinants of health; education and training for front-line workers and health professionals, and earlier diagnosis and intervention for children (in partnership and within the readiness of families).

FNIH works in partnership with the Public Agency of Canada to develop screening and diagnostic tools and cost-effective approaches for accurate identification and surveillance activities. FNIH also partners with the Canadian Perinatal Surveillance System (CPSS) regarding the collection, analysis and dissemination of information relevant to FASD.

Public education and awareness activities focus on prevention by disseminating culturally appropriate information and resource materials. Prevention information is distributed through hosting or facilitating conferences, workshops and focus groups with communities and regions. Training for workers and families also supports this objective. Asset mapping, linkages between programs and multi-disciplinary team building are essential to capacity building.

The objectives of the FASD program are to:

1. Build awareness in the communities, particularly among young people.
2. Target interventions to women at risk of having an infant with FASD using prevention services.
3. Collaborate within communities to address the broader determinants of health.
4. Offer education and training to front-line workers and health professionals.
5. Provide early diagnosis and early intervention to children.

FASD services are directed towards on reserve populations, children 0-6 years of age, and childbearing women. Pregnant women at risk of drinking alcohol and/or consuming substances are the focus of programming.

Service providers are early childhood educators, community workers, administrators, parents

and community volunteers. Qualifications vary depending on the services provided. A performance measurement strategy for this and other community programs listed here are available: please refer to the Children and Youth Result-based Management and Accountability Framework, accessible through FNIHB reports.

CANADA PRENATAL NUTRITION PROGRAM (FIRST NATION INUIT COMPONENT)

The program primarily targets pregnant women and women with infants up to 12 months of age living on reserve. Community health and social service providers (e.g., community health nurses, community health representatives, and/or local program providers) deliver the program with additional services, at the regional level, by dieticians, nutritionists, and lactation consultants. The overall goal of the program is to improve maternal and infant nutrition. The program combines scientific evidence-based research with community priorities and cultural expressions/values. CPNP-FNIC supports activities related to:

1. Nutrition screening, education and counseling
2. Maternal nourishment
3. Breastfeeding promotion, education and support

The most common activities are group sessions, one-on-one nutrition education, provision of food or food vouchers, promotion of community gardens and community kitchens, and baby food –making workshops. The program also supports activities that improve women's access to the programs, i.e., childcare and transportation.

CPNP-FNIC objectives are to:

1. Improve the adequacy of prenatal and breastfeeding diets.
2. Improve access to nutrition information and services for women, particularly "high-risk" women.
3. Increase the likelihood that infants will be eating age-appropriate, nutritious foods at twelve months.
4. Increase breastfeeding rates and duration.
5. Increase knowledge and skill in participants involved in the program.

Provider qualifications include certification according to provincial legislation for dieticians, nutritionists, nurses and other professionals. Paraprofessionals do not require such qualifications. Job specific training is offered regularly throughout the year through the national and regional offices.

ABORIGINAL HEAD START ON RESERVE

Aboriginal Head Start on reserve is an early childhood intervention program that targets the needs of children up to six years of age (typically beginning at age 2 or 3). Early childhood educators, administrators, parents and community volunteers deliver the services. The primary program goal is to demonstrate that locally controlled and designed intervention strategies can prepare children for school readiness; provide a positive sense of identity and self-worth, a desire for learning, and opportunities for full and successful development. Aboriginal Head Start On Reserve supports holistic development of children through six core program elements:

1. Promotion and Protection of First Nation Language and Culture
2. Nutrition
3. Education
4. Health Promotion
5. Social Support
6. Parental and Family Involvement

A number of activities are delivered, several crossing goals of the other community programs for children and youth. These are: language classes, education activities to improve school readiness, education and awareness activities for the promotion of oral health, immunization, native foods, healthy nutrition and life style choices, and traditional cultural practices. Parenting, cooking and community kitchen classes and workshops are offered to parents of children enrolled in the program. Building community human resource capacity through skills development of workers and volunteers is also a priority.

Aboriginal Head Start On Reserve child educators are licensed according to provincial legislation and are provided with ongoing cultural development training. First Nations are in the process of developing their own standards. SF-MCH may wish to coordinate a workshop in order to share developments of this standardization work with the work of developing an early childhood curriculum for the SF-MCH program.

LINKING SF-MCH WITH THE OTHER COMMUNITY PROGRAMS FOR CHILDREN AND YOUTH

In keeping with the long-term goal of the MCH National Program to support pregnant First Nation women and their families with infants and young children living on reserve, to reach their fullest developmental potential over the lifespan, a priority that is essential for linkage includes; access to local, integrated and effective programming grounded in First Nation regional and community specific cultures and responding to individual, family and community needs.

The pilot phase of SF-MCH has seen several initiatives aimed at defining such linkages with the programs. There is much work to be done in terms of developing and implementing a "comprehensive" approach to MCH services; however, a great many successes have been realized in terms of identifying commonalities between the programs, enhancing referral protocols, sharing information and working within a shared case-management approach, sharing educational support groups, focus groups, workshops and training sessions, and the design and implementation of special research topics (e.g., Breastfeeding research program of the Canadian Prenatal Nutrition Program First Nation Inuit Component and SF-MCH and the Birthing Options Research Project of the Midwifery Program and SF-MCH in Manitoba; both of which are described in detail further in the report).

It is within the MCH mandate that the long-term goal of the program is to build the foundation for current investments to develop a more comprehensive and integrated approach towards maternal and child services on reserve. The activities carried out over the period of the pilot phase should show a building of comprehensive integration. It is evident that the pilot project

has laid substantial ground-work for such an approach trough a combination of the peer support program (i.e., in clarifying the parameters of the program, roles, responsibilities, protocols and precise linkage requirements) and other activities done between the programs (i.e., including the referral protocols, shared group, workshop and training opportunities, shared dissemination of knowledge and research studies implemented).

SF-MCH quality assurance and peer support framework was conducted in partnership with the provincial program counter-part: Healthy Child Manitoba's Families First Program. Although it is not known whether the provincial program has implemented their quality assurance piece, the ground for an intensive and ongoing collaboration is established. The collaboration work shows a creative use of resources and time management and is indicating positive impacts for the SF-MCH. Through ongoing collaboration, the needs of Aboriginal families moving to and residing off reserve can be better understood, which can be an important indirect benefit of the collaboration. Another long-term goal of the national MCH program is the development of programs and services for residents of First Nation communities that are comparable to those provided by provinces for other Canadian families and their children. With the standardization and overall quality assurance work, SF-MCH is already working towards meeting this goal.

A goal set out in the national guidelines is to identify opportunities to bring safe birthing options closer to First Nation communities. One pilot project is underway in partnership with the community health program in Opaskwayak Cree Nation. Another birthing program was conducted comparing birthing options and the impacts of each model on women in two First Nation communities: one an MCH site with access to midwifery and another a non-MCH site without access to midwifery. As indicated above, both research projects are reported on later in the report.

The quality assurance program has helped to shape the realization of the short-term goals as indicated in the national MCH guidelines. These are:

1. Standardization of regular, ongoing education and training opportunities for professional and paraprofessional staff and for women and families throughout the Manitoba region.
2. A review of the program participation data over the time period 2006-2010 indicates increased participation of community members in program development, utilization and advocacy.
3. As noted above, coordination of services for pregnant women and families with children 0-6 years is an ongoing and successful endeavour. Over and above the requirement of community, regional and national integration, SF-MCH has reached out and established international indigenous collaborations with partner programs in New Zealand, Australia, the US and Israel. These program developments are described later in the report.
4. With the support of Function Four Ltd., a technology and development agency, the MCH program, research and evaluation team, has engaged in ongoing development of the Health and Socio-economic information system, coined the SF-IMS. Since 2006, the pilot project has redesigned and improved the system repeatedly for greater efficiency in the delivery of an accessible system of home visiting, screening, assessment and case management program for pregnant women and families with young children. At

this point in the pilot project, we have exceeded our expectations in this area of work and now look towards analysis of data at community and regional levels, capacity building potential of the database and linkages with other data systems.

5. Several evaluation tools have been developed to measure progress in meeting short-term objectives. These include: the development of the health and socio-economic information system, community surveys, focus groups, interviews, on-line and telephone questionnaires. Short-term impacts are reported on in several sections of this report.

AN EVALUATION OF SF-MCH STANDARDS OF CARE (PROGRAM AND PRACTICE STANDARDS)

The regional management team at AMC in collaboration with community-based program staff and the research and evaluation team in 2007 developed the initial standards of care for SF-MCH. The standards of care have since been revised over time and through experiences in program implementation. The quality assurance document is a "living document" in that it is constantly updated based upon lessons delivering the program "on-the-ground." The document is utilized by all of the partners from local to regional geographies. SF-MCH, in only a few years of piloting the project, has succeeding in developing regional standardization without compromise or risk to the integrity of community unique expression. Such regional standardization of a community-based health program promotes excellence in healthcare delivery to women and families in remote geographies and is an essential determinant of health. The standards are described and evaluated below:

HEALTH PROMOTION

SF-MCH is designed and implemented as a health promotion program. Health promotion activities are provided at the community level for all eligible families and are linked with other community health, social services, education and recreation programs. Linkage options are based on identified priorities and program mandates to suit the needs and interests of participating families.

Families participating in the health promotion sessions are ideally enrolled in SF-MCH and are considered to be program participants. For reasons of quality assurance, program participants following each group session complete an evaluation form.

Standard #1 – implementation and assessment in health promotion activities geared towards the needs and interests of families in the communities. Activities focus on pre-natal, post-natal women, caregivers of children birth to age six years, and early years' child development. Activities focus on individual and family-centered health and development. Theoretical perspectives are based in developmental, human ecological and indigenous approaches.

HOME VISITATION

Pregnancy and the early childhood development years offer a prime opportunity for family engagement in health promotion programming. Many families are eager for support, networking and are happy to learn new ways to promote the healthy development of children. Further, participation in the program may assist families in learning more effective communication techniques and may enhance more trusting relationships within the family and community.

Standard #2 – determination and extent of involvement in SF-MCH is totally voluntary. Families who do decide that they would like to participate in the program may do so to whatever extent they feel comfortable. Raising levels of comfort of community families towards the program may involve the delivery of group cultural, educational and recreational programs, program involvement in other community activities and celebrations, linkage with other trusted programs and services. To increase participation of families, SF-MCH responsibility includes working towards gaining community trust and respect through engagement in activities that are valued by the communities.

Standard #3 – Culture Appropriateness incorporates two distinct but related concepts. These are: cultural respect and cultural competency. Cultural respect is given to participants and to all families within a community regardless of one's background or comprehension of community values, traditions or way of life. To be culturally respectful means that one is paying attention to the community within which one is living and working and honouring that way of life in everything one does. When we are culturally respectful we become more and more understanding of the culture with time. All staff working within SF-MCH is culturally respectful at all times. Cultural competency involves a deep understanding of community values, traditions and way of life. Culturally competent staff is able to teach traditions, engage participants in ceremonies, and recommend healers and other cultural advisors in support of families health and development interests. SF-MCH staff is not necessarily adept at culturally competency, however, are able to form linkages that bring such competency into all aspects of programming. With this type of cultural appropriateness, SF-MCH allows opportunities for families to become teachers as well as learners within the program.

Standard #4 – screening will be provided to program participants consistent with cultural and community-based norms to assist with understanding individual prenatal or postpartum developmental health requirements. When referral is received prenatally, the SF-MCH screen will be completed in the first or second prenatal contact. **Postnatal screens will be completed as soon as possible and not more than fourteen (14) days following maternal discharge from the hospital; similarly for midwife-assisted births, the SF-MCH screen will be completed within 14 days of the birth of the child.** The SF-MCH intake form can be completed prior to or at the same time as the initial screening visit. Factors of interest to the program at this point are reflected in the screens, including: overall pregnancy health, nutrition, exercise and addiction information, home environment, relationship, social and economic supports, program linkage requirements, and related life opportunities for caregivers (e.g., childcare, community safety and recreational, training, education, employment).

Standard #5 – family assessment is completed for all positive prenatal and postpartum screens as well as for all late referral entries. When family assessments are not completed, reasons are noted in provider program journals. Assessments are initiated within seven (7) days and completed within thirty (30) days of a positive prenatal, postpartum or developmental screen for families. A positive screen is one that receives a score of thirteen (13) or higher on the prenatal screen, nine (9) or higher on the postpartum screen. Families with children who score two (2) or more "no's" on the Nipissing Developmental Screen or "at risk" by other screening methods employed are also offered further assessment. The assessment process is employed for referral families as well in order to determine eligibility. Assessment allows for greater specific understanding of individual and family needs and for a prioritizing of families since

programming at this point in time is not resourced to an extent that allows for engagement with all of the families in the communities.

Standard #6 – Program enrolment is offered to families depending upon assessment results within three days following the assessment process. Families are offered services in accordance with their risk-factor results and depending upon availability of resources based on the following guidelines:

1. High risk – family is offered home visitation and/or case management services depending on parental agreement.
2. Low risk – family is offered some level of service within SF-MCH and is offered referral to other agencies for health education and health promotion services.
3. Complex needs – warrants more in-depth case management in order to gain a better understanding of the family's requirements.

Standard #7 – the first home visit is implemented within seven (7) days of initial contact with the family. It is within this first face-to-face visit where the nurse and/or home visitor begins to develop a trusting bond with the family. Several factors are present in setting the environment for this visit, SF-MCH takes into consideration environmental, relationship, preparedness, parenting and early childhood development knowledge of the parents to ensure as comfortable a visit as possible. The visit is non-judgmental, culturally respectful and informative as both families and the program begin to learn more about one another. Intensity and length of visitation are negotiated through ongoing engagement with families. Agreement to initiate home visitation is expected to occur ninety percent (90%) of the time.

Prenatal Visits: SF-MCH provides families with a minimum of monthly visits to prenatal participants depending on the severity and complexity of issues requiring attention at this developmental time and on parental interest.

Postpartum and Family Home Visits: SF-MCH provides weekly home visits to all families enrolled in the home visitation component of the program with decreasing intensity based upon accepted criteria. Home visitation scheduling is based upon program leveling (described in the Guidelines for Determining Intensity of Home Visiting Services Document). It is recommended that families remain on level one (1) for a minimum of nine (9) months to give families and home visitors ample opportunities for relationship building and for familiarity with specific program requirements. The frequency of future visitation is determined on family progress towards meeting personal and program goals. Programming is offered to families for children up to age six (6) years.

Standard #8 – comprehensive case management is a critical component of SF-MCH. Nurse supervisors provide these services to families with complex needs or in communities where another service or program is already offering such service. SF-MCH staff will join that team.

Standard #9 - the SF-MCH program incorporate checks and balances in order to ensure that staff is provided with realistic workloads that assure that home visitors have adequate time to spend with each family to meet their needs as determined in the assessment process, family service level and computed on the Caseload Management Worksheet. Home visitors strive to complete eighty percent (80%) of the required caseload home visits. For those home visitors

that have full caseloads, this equates to a target of 15 home visits per week or an average of 3 visits per day. Ensuring that the program is realistic in scheduling workload is important to ensure effectiveness of the visit but also to decrease the chances of staff burnout.

Standard #10 – nurse supervisors provide consistent and comprehensive supervision, consultation and direction to the home visitors on all aspects of their work. Supervision is reflective, strength-based, relationship-based, process-oriented, and solution focused. Opportunities for information sharing/debriefing following family interactions are made available to all SF-MCH staff. Such supervision is encouraged as it raises the quality of programming and indirectly supports family progress.

Standard #11 – reflective supervision is provided to home visitors by the nurse supervisor at a regularly scheduled weekly time for a minimum of two (2) hours for each full-time home visitor. One-third (1/3) to one-half (1/2) of each home visitors caseload is reviewed each week. The nurse supervisor selects the families for review at each case review session. Separate times may be required to review families currently experiencing crises or families in need of special attention. Additional time is scheduled on a quarterly basis to review Learning Plans. Reflective supervision offers staff opportunities for skill development and increased self-awareness, both of which contribute to quality programming. As well, reflective supervision enhances congruency between nurse supervisor and home visitor expectations of programming.

Standard #12 – Nurse supervisor-accompanied home visits occur on at least two (2) visits per quarter term to allow for documentation and feedback. On accompanied home visits, nurse supervisors:

Evaluate and support the use of approved curriculums

Complete developmental reviews and performance appraisals

Assess on-the-job skills, areas for growth and training needs

Standard #13 – Nurse supervisor skills are also assessed regularly within the program. Nurse supervisors engage with the peer resource specialist and/or nurse program advisor to discuss the family assessment process and other program aspects on a monthly basis for the first six (6) months of training and on an annual basis thereafter. Just as home visitors benefit from regular reflective supervision, the nurse supervisors also benefit from regular feedback. This part of the assessment allows for increased program quality at the community-level as well as enhanced community-uniqueness and regional standardization and understanding of the overall program direction, goals and objectives.

Standard #14 – regional quality assurance requirements include consistent documentation in programming. The peer resource specialist, and later including the peer network specialists as well, provides bi-annual quality assurance visits to each of the community programs. The regional nurse program advisor performs at least one annual review for each program site to ensure compliance with the standards. These regional quality assurance methods will enhance the level of regional standardization, optimal service delivery and consistency throughout the region.

TRAINING AND EDUCATION

Professionals and peer/paraprofessionals hired within SF-MCH come into the program with various degrees of education and training. Regardless of educational level or related experiences of the staff hired, SF-MCH achieves better outcomes when providing staff with comprehensive and ongoing education and training. The type of training offered is specific to developing the necessary competencies for engagement, motivation and overall work with the participant and community families.

Orientation and core training provide the foundation for engagement while curriculum training supports the development of competencies in areas pertaining to comprehensive parenting and child development.

Standard #15 – SF-MCH nurse supervisors provide newly hired program staff with an orientation during the first two (2) weeks of employment. All newly hired nurse supervisors are provided with orientation training by regional staff within the first four (4) weeks of hiring. Orientation allows for familiarization with the overall program structure and functioning and with other staff members. Training includes materials on:

Program vision, goals, services, policies and operating procedures

Program linkage requirements and environmental scan of community and regional services, programs and resources

Provincial child abuse and neglect indicators and reporting requirements

History, philosophy and methods of home visitation

Confidentiality protocol

Training manuals and curriculums

Standard #16 – Core training is completed within ninety (90) days of hiring. Standardized training assures that all staff has the necessary knowledge and skills for working effectively with families. Six (6) major training areas are: history, philosophy and methods of home visiting; program specific knowledge and techniques, knowledge of families and children; parenting and child development education specific to the community culture and geography.

Standard #17 – nurse supervisors and home visitors are encouraged to complete the approved curriculum training within six (6) weeks of receiving the core training. Curriculum training must be completed within one hundred and fifty (150) days of hiring. Continuing competency development (including but not limited to Tier 2 and 3 Training) must also be implemented and ongoing. Ongoing training assures advanced expertise of the staff and ensures ongoing relevance and quality of the overall program. Horizontal education (i.e., knowledge exchange within levels of SF-MCH between communities and including the regional and national offices) is also recommended.

Standard #18 – wrap around training be provided to community staff is also required as part of programming overall education. This provides staff with ongoing competency development for mandated program elements. Recommended training opportunities include but are not limited to:

Case management

Working with high-risk families

Parenting programs

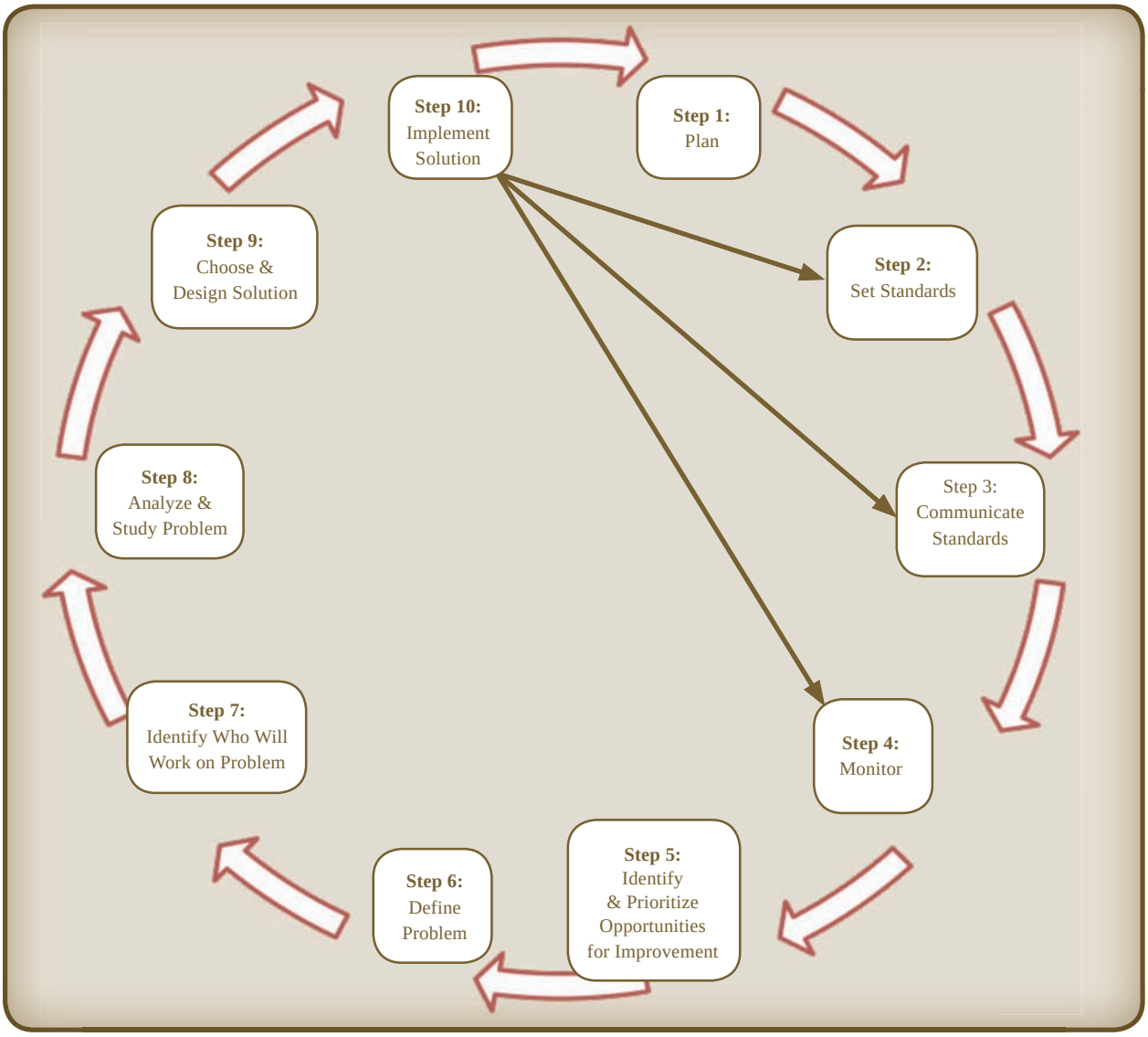
The current wrap around training is intended to support home visitors in integrating the skills learned in the core training. Wrap around training is offered through a series of fifteen (15) assignments. Consistent application of newly acquired skills during family interactions increases the confidence and competence of home visitors in supporting families in areas of parenting, healthy child development and family functioning.

THE QUALITY ASSURANCE ASSESSMENT PROCESS

This process of quality assurance assessment is adapted from the model created by the Joint Commission on Accreditation of Health Care Organizations. The process is reflective of the work already being implemented in SF-MCH by the regional office, peer support specialist and nurse program advisor. The process is replicable, measurable, and can be easily integrated into ongoing program management. The process is circular allowing for inter-community variations. Time may be spent on any of the steps as required. Steps should not be skipped although the process may require moving forward and background depending upon particular need sets. As such, the quality assurance assessment process allows for informed recommendations and measurable improvements. The process is development in such a way as to allow for revision, expansion of components or the entire strategy. It is recommended that the standards listed above be continued as they allow for program comprehensiveness and measurable assessment. The standards consider all aspects of SF-MCH programming and health impacts. In future evaluations of SF-MCH, a more formal framework can be developed in order to evaluate the process and impacts of implementation of each of the program standards.

THE QUALITY ASSURANCE ASSESSMENT PROCESS

1. Plan for quality assurance
2. Develop guidelines and set standards
3. Communicate standards and specifications
4. Monitor quality
5. Identify problems and select opportunities for improvement
6. Define the problem operationally
7. Choose a team
8. Analyze and study the problem to identify its root causes
9. Develop solutions and actions for improvement
10. Implement and evaluate quality improvement efforts



EXPLICATING THE 10-STEP PROCESS: A REVIEW OF SF-MCH ACCOMPLISHMENTS AND RECOMMENDATIONS FOR IMPROVEMENT

STEP ONE – PLAN FOR QUALITY ASSURANCE

Planning began with a review of the program's scope of care in order to determine which services and activities should be addressed. Questions considered at this point included the following: can all aspects of programming be addressed at once or should critical areas be identified, i.e., high priority vs. problem prone services? Once staff agreed upon focal points, meaning that they determined where exactly to begin, they needed to select a quality assurance approach; for example, an approach that focused on both processes and desired outcomes. Planning topics included a study of the home visitation approach and details of the home visit process to determine strengths and areas in need of improvement, roles, responsibilities and staff relationship dynamics. Planning also included assigning responsibilities for quality assurance implementation and assessment.

(Planning was comprehensive. It began with defining the regional program mission and tailoring it for meaningfulness within particular communities. The next step was to implement environment and program scans in order to assess opportunities and constraints in the internal and external (supportive) environments (community, regional and national levels). Strategic planning produced a clear and shared vision of what the program must do to achieve its mission in the light of particular environment considering community adaptability, acceptance and understanding. Once these steps were achieved, the program was able to determine quality assurance priorities based on the clearly developed mission, objectives and standards.

STEP TWO – DEVELOP GUIDELINES AND SET STANDARDS

In order to provide consistent and high-quality services, activities and supports, SF-MCH had to translate its programmatic objectives into operational procedures. In its widest sense, a 'standard' is a statement of the quality that is expected within the program. Standards included in the planning were:

Practice guidelines – these are protocols or practice parameters. They define how the processes (for example, prenatal care) are to be carried out. Guidelines are defined as, "systematically developed statements to assist practitioner and participant decisions about appropriate programming for specific circumstances." More specifically for the prenatal care example, staff considered their responsibilities in relation to the care provided by nurses and physicians at community health centers and in the regions? What were the details of their screening, assessment, and intervention programming that connects to, support, or overlap with supports offered elsewhere? Practice guidelines concern both clinical and administrative processes.

Performance Standards – these are specific criteria that are used to measure the outcome of service delivery activities. They are also used to measure compliance with the guidelines. Performance standards are designed to evaluate practice. They include authoritative statements of a) minimum levels of acceptable performance or results, b) excellent levels of performance or results, and c) the range of acceptable performance or results. They can be related to programming processes through measurement of health outcomes or compliance with the guidelines. While health outcomes are often difficult to measure, it is often possible to monitor intermediate level outcomes such as participation in areas of programming or follow through with recommended activities and referrals. Performance standards form the core of the monitoring system (discussed in step 4 below). These have been identified and information pertaining to performance standards is collected formally at the community level and inputted onto the SF-MCH Health and Socio-economic Information System. This data is utilized by the community programs and within the region. A more formal evaluation strategy should be developed utilizing this information on future SF-MCH evaluations.

Guidelines, standard operating procedures and performance standards were developed by program and evaluation teams of SF-MCH for all of clinical, management, and assessment areas. They are reflective of the perspectives of the families in the communities and of the program staff. Both perspectives are essential to ensure effectiveness of planned activities and their accessibility and acceptability within the community. Staff works together to periodically review and revise guidelines and standard procedures. The program standards are reviewed and updated regularly. Staff at all levels of SF-MCH programming participates in the development of guidelines and setting standards. Community-level staff involvement is integral to the process because they are often most understanding of health issues and local conditions, more so than the higher-level

managers, and resulting guidelines are likely to be more appropriate and effective. As well, staff participation generates greater commitment to quality because health workers are more likely to implement and support an effort they have developed.

STEP THREE – COMMUNICATE GUIDELINES AND SPECIFICATIONS

Communication is a straightforward, simple and necessary step for successful quality assurance implementation. Back and forth communication between levels of staff inside the communities, between communities, and between community, region and national offices is essential in order to continually shape and work through a quality assurance strategy that works, is effective and workable. SF-MCH communication includes ongoing supervision, training, conferences, informal discussions and presentations. Meetings, particularly in our region where communities are separated by a vast geography and time and resources are sparse, can be assisted by modern technologies. The Internet (e.g., WEBX, emails, electronic newsletters, online discussion groups and program websites) is an essential communication medium. SF-MCH has developed protocols for communication at the onset. Communications now occur via face-to-face meetings, telephone and Internet (i.e., emails, administrative reports and newsletters). Communication bases should be further developed, e.g., WEBX technologies, which have been discussed in the region should be up and running by 2011.

STEP FOUR – MONITORING QUALITY

Monitoring refers to the routine collection and review of data that helps to assess whether program standards are being followed and whether outcomes are improved. By monitoring key indicators, managers and nurse supervisors were able to determine whether the services delivered followed the prescribed practices and achieved the desired results. Quality assurance involved a creative process orientation that had profound implications for monitoring and the collection of new data. Detailed assessment of processes through special comprehensive studies or routine assessments provided useful information about specific service delivery problems. The SF-MCH health database was developed with the inception of the program in Manitoba. Monitoring through quality assurance programming helped to generate a more in-depth understanding of the types of data, relationships between and uses for the data that we are seeking. Through data utilization and familiarity we were able to develop a better understanding of the mechanisms by which outcomes were generated. The quality assurance program directly affected a higher quality of data. Staff at all levels of the program has been involved in the design of the data system, and in the collection and organization of the data. Such involvement helped to raise the quality and workability of the data. Our intension was to further develop the data system so as to link our data with other population health databases.

Database development and monitoring has included the following activities:

A. Indicator selection – an indicator is a measurable characteristic of an actual system performance and determines the extent to which desired outcomes are achieved or the degree to which guidelines or standard operating procedures are adhered. Indicators are used to monitor the quality or appropriateness of important clinical and management activities. The number of indicators was minimized after assessment of key processes and identification of potential focus areas.

B. Setting of thresholds – thresholds define the program's acceptable level of performance as measured by indicators at a given point in time. They allow program staff to detect potential problems or areas for improvement. Performance thresholds are based on clinical or medical knowledge of risks or on what is operationally feasible, for example, determining the appropriate number of home visits necessary per home visitor. Acceptable levels are relative and are revised as conditions and priorities change. The role of thresholds is to trigger action when the monitored indicators suggest inadequate program performance. They are not needed in all cases and are set only after consultation with the program staff.

C. Selection and uses of information sources – existing information sources were used first so as to minimize bother to program participants (e.g., the SF-MCH health information system contains an abundance of information on the program and its participants). The goal of the quality assurance assessment program is to rely on accessible data and to keep further data collection activities to a minimum as this activity can get in the way of staff roles and responsibilities to implement the program. The SF-MCH research and evaluation team and regional nurse advisor have developed assessment forms (data collected as part of the health information system), quantitative surveys and qualitative research that inform on elements of programming and family health. All of this information is accessible to the quality assurance assessment program. It is especially important to minimize the burden of data collection on the staff – generally, program staff should NOT be asked to collect data that they cannot use in their day-to-day work. Data collected at the local level and then compiled for higher-level program managers is more likely to provide a basis for a constructive dialogue between staff and management about problems and priorities.. SF-MCH staff has been successful at minimizing disturbance of participants and the amount of paper generated through data collection techniques. Other data sources that double in terms of support through programming have been direct observation and assessment of home visiting, reflective supervision and the assessment process and feedback provided to individual practitioners and communities during individual staff and community program debriefings by the peer support specialist.

D. Data system design - SF-MCH has specified who will collect what data and how the data is to be collected. Frequency of data collection and compilation was also discussed. A schedule for the ongoing dissemination of results was shared with staff in the communities. Over time, staff should become adept at self-monitoring, relying less on regional level supervision. Ongoing discussions about data specifics are suggested.

E. Implementation of the monitoring activities – Once the system was designed and responsibilities assigned, data collection and compilation was begun. Since we have already begun the process of data collection, compilation, management and assessment, it is important that the processes are reviewed with staff so that checks, balances and monitoring activities can continually be updated. Ongoing monitoring focuses on different issues at different times with rotating focal points. Further evaluation is required to collect information on community response to the system.

STEP FIVE – IDENTIFY PROBLEMS AND SELECT OPPORTUNITIES FOR IMPROVEMENT

SF-MCH has employed a mechanism of constant checking of the health information system with verification of the data recorded in the system to ensure that the data is reflective of what is actually going on in the program. The program has employed the participatory approach to problem identification, identifying opportunities and problem solving offers several advantages. Practices and policies have been developed through actual community experiences, so the program reflects actual health and social circumstances and programming interests of the families in the communities. Problems and opportunities have been identified within teams and then explicated. Transparency/clarity will raise the potential of SF-MCH to impact health changes. Once problems and opportunities were identified, plans are laid out (strategies), the peer support specialist/team and community were then able to strategize about how to manage issues, discuss options and measure effectiveness of each of the strategies imposed. These discussions take place within the peer support meetings and debriefings. They are effectively carried out as is evident in the peer support specialist field notes and letters to the communities and AMC. It is suggested, however, that the evaluation team collects feedback regarding the perspectives of the community staff on the effectiveness, benefits and challenges of these meetings.

STEP SIX – DEFINE PROBLEMS

Once problems are identified, the challenge is to define them operationally, pointing to the relationship between actual performance and performance as prescribed in the program's guidelines and standards. Throughout the pilot project phase, communities were often engaged in dialogue about programming and asked to come up with their own solutions. Often difficulties arose in following through with the solutions, due to competing priorities in communities that often lay beyond the scope of the program. An example of a competing priority in the communities was raised in our work on teen pregnancy: community members said that options in the communities were not available to pregnant teens and, at the same time, grandmothers and younger women in the same study said that abortion was not culturally acceptable (i.e., it was a destruction of a life given to parents and a community by the Creator, therefore, was not any individual's right to decide to destroy that life). Further, it was discovered that communities with clearly defined leadership support were able to accomplish follow-through much more readily than those without such support. In the supported communities, the appropriate tasks and steps were taken leading to enhancements in programming. Sometimes, program staff was given contradictory directions by chief and health directors or managers of other community health programs. In some situations, the SF-MCH nurse program advisor at AMC and her team were able to mediate between the different vantage points to come to consensus. It is suggested that education seminars are held focusing on assisting community leaders in their role as supporters of community-based health programs. It is essential that leadership be educated on the purpose of maternal child health programming, linkage requirements, and peer support. The links between practice and improved services and how these translate to family and community outcomes should be made very clear. Communication to leaders and to community should clearly state where problems begin and end and how to recognize when problem are solved.

STEP SEVEN – CHOSE TEAMS

The SF-MCH peer support specialist assists communities in identifying problems, examining where they exists and involving the people that will help to bring about resolution, their exact duties and responsibilities. Community staff is involved in analyzing problems, implementing and assessing quality improvement efforts. The teams are composed of only those who are directly involved with, contribute inputs, resources to and/or benefit from the activity or activities in which problems occurs. Involvement includes those most knowledgeable about specific issues and processes. Learning to work together as a team is a challenging and continuous process. Teams may need basic skills pertaining to planning, facilitating meetings, communicating effectively, making group decisions and/or resolving conflict. This process is in effect throughout the region. Subsequent evaluations will focus on assessments of the implementation of this strategy.

STEP EIGHT – ANALYZE AND STUDY PROBLEMS TO IDENTIFY ROOT CAUSES

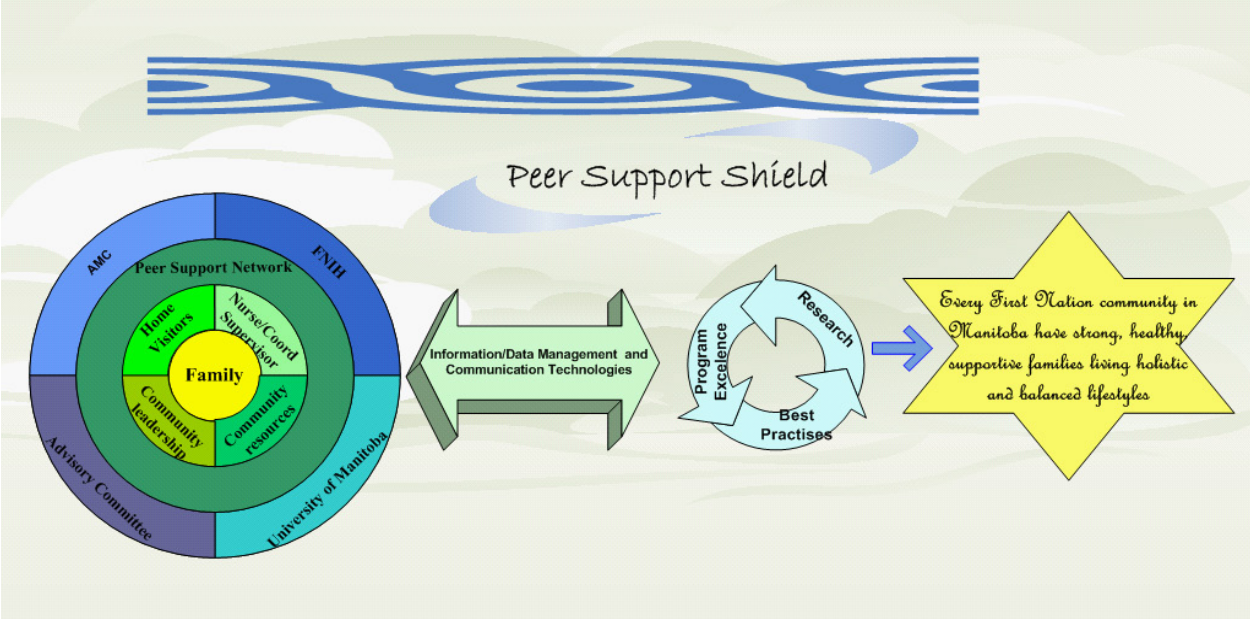
In coming to understand programming, staff needed to uncover problems and their root cause(s). Given the complexity of SF-MCH programming, we needed clear identification of root causes via systematic and in-depth analysis. Analytic tools like system modeling flow-charting and/or cause-and-effect diagrams have been used. Once several causes are suggested, the teams worked to identify the ones most damaging or key in instilling most of the change. By addressing critical causes the SF-MCH team begins to realize significant improvement with minimal effort. After identifying the causes with the use of tools, teams are ready to begin to conduct in-depth examinations, through review of the data, interviews, service delivery observations, and employment of basic statistics; and will soon be ready to graph changes, effects, and report on trends. All of this work has been put into effect in order to assist communities in taking lead roles in developing and implementing community-level programming, research and evaluation. Focus of the work to the present has been on creating the tools to make this work possible and to train the communities to manage the system. Technically, the communities are ready to use their own data to plan and implement all levels of programming, etc. However, there is a learning curve that must be given time to develop. It is anticipated that in the next year, there will be substantial improvements in this area of work. Development of the information system and other evaluation methodologies has occurred within a process of participatory and community-driven research. Such processes ensure continual feedback on cultural appropriateness and effectiveness.

STEP NINE – DEVELOP SOLUTIONS AND ACTIONS FOR QUALITY MPROVEMENT

The problem-solving team should now be ready to develop and assess potential solutions. Solutions to quality issues can take several forms, e.g., educating staff about guidelines and standards through supervision or focused in-service training. Solutions may also include job aids (i.e., wall charts or checklists). Often solutions and improvements are touted in management systems related to supervision, training and logistics. Some more difficult issues may require procedural redesign. Problem-solving teams are encouraged to think creatively and to generate a variety of solution options. Choices should include potential costs and effectiveness. The current evaluation does not include a review of problem solving techniques implemented. However, such activities will be included in the next evaluation.

STEP TEN – IMPLEMENT AND EVALUATE QUALITY IMPROVEMENT EFFORTS

Implementing quality improvement requires careful planning therefore time has been allotted to planning, piloting, redesigning, implementing, assessing and again redesigning as necessary. Time was allotted for flexibility, creativity and trial-and-error in working towards the best possible solutions. The team selected indicators to evaluate whether solutions were implemented correctly and whether they resolved the problems they were designed to address. Quality assurance and in-depth assessment work came hand-in-hand. Once solutions are proven to be effective, program managers codify and disseminate the new process so that others can learn from the experience. Teams then move to solving other problems and improving other programming areas. Although it is understood that this work is quickly developing in the communities, particularly with the support of the SF-MCH nurse program and practice advisor and peer support specialist, more formal evaluation strategy to assess these activities is required.



The following diagram utilized by the pear support team depicts the following relationship between research best practices, and the necessary support in achieving program excellence

Developed by Wanda Philips-Beck, RN.,MSc. and Michele Tully RN.

Opaskwayak Cree Nation Family Fun Day
MCH Program Child

Opaskwayak Cree Nation Community Pow-wow

CHAPTER 5

IDENTIFICATION OF KEY HEALTH ISSUES IN THE REGION

Key health issues in the Manitoba region were identified over the time of the pilot project. Health issues were identified in the process of local service delivery and in reviews of program data. Discussions of health issues and priorities in focus were regularly held in community and regional meetings and workshops. Between 2006 and 2010, the following health issues were selected for more in-depth analysis:

Childbirth Options in Northern and Remote First Nation communities

Infant Feeding & Breastfeeding

Fetal Alcohol Spectrum Disorder

Infant Mortality

Teen Pregnancy and Parenting

International Indigenous Health research collaborations

Mapping community collectives for Health and Social programming

The evaluation of SF-MCH 2010-11 will be published at a later date in 2011.

Long Plain MCH Program Activity

Opaskwayak Cree Nation MCH Program Child J'Lyn

CHAPTER 6

EVALUATION OF PROGRAM PROCESS; OUTCOMES & IMPACT (COMMUNITY-BASED PROGRAMMER AND PARTICIPANT SURVEY RESULTS)

This chapter describes two surveys implemented in 2009-10 to each of the SF-MCH community programs. One survey was distributed to program staff; the other was distributed to community members (including program participants and non-participants). The survey findings are discussed.

The SF-MCH 2010 Program Staff Survey was distributed to current supervisors, nurses, and home visitors working within the SF-MCH Program in January, 2010 to be completed electronically. In order to evaluate program processes, outcomes and impact this survey addressed the following broad areas;

Involvement

Communications

Program linkage

Daily tasks

Satisfaction and benefits of and in the SF-MCH program

The survey design provided the evaluation team with information pertaining to staff's experiences implementing the program as well as recommendations in order to increase and support the program's ability to meet the needs of each of the communities and the staff providing the program. As of January 2010 in the 16 SF-MCH program sites there were 48 nurses, supervisors, and home visitors. In total 43 surveys were completed (89.6%) and 5 surveys were started but not completed.

A second survey was developed in order to capture the impacts of the program within community by reaching participants and non-participants. The SF-MCH 2010 Community Survey was designed with the intention of determining not only community reach and awareness but also the attribution of impact to the implementation of the SF-MCH program in each of the sites. The survey conveyed responses in the following broad areas with the overall objective of determining the impact of the program in each of the 16 community sites;

community

support systems, and

family and interconnections

The intended sample size within each of the 16 sites included 10 participants and 5 non-participants of the SF-MCH program with a possible 240 SF-MCH Community Surveys distributed. A total of 14 SF-MCH Programs provided feedback, limiting the total number of possible surveys to be collected at 210. Overall at the end of the survey timeline there were 189 SF-MCH Community Surveys started and 177 (93.7%) of these surveys were completed with a range of sample sizes from each of the program sites. Some sites were able to obtain more surveys while others were only able to obtain approximately 10 in total. In general the ratio of program participants to non-participants completing the survey remained 2:1.

DEMOGRAPHICS OF SURVEY PARTICIPANTS

Within the SF-MCH 2010 Program Staff Survey responses indicate that as of January 2010 the majority of nurses, supervisors and home visitors have been involved in the implementation of the Strengthening Families program between 7 and 23 months (48%) with 41% holding their current position for 24+ months. An additional 28% of staff had been working in the program for 6 months or less. These numbers reflect feedback that has been received regarding the

consistency of staffing of the SF-MCH Program. Consistency has been a realization in many of the program sites, while others continually struggle with retaining staff. The implementation of Quality Assurance and Peer Support Program, described in this document has been a response at the realization of this potentially threatening program issue.

Program staff indicated previously held health and social service positions which are valuable as knowledge gained in similar work experiences can result in a higher level of understanding and competence in user engagement, resource availability and social history of the specific community. Forty-seven per cent (47%) indicated employment in education services/school with 39% having been employed in the Head Start and Canadian Prenatal Nutrition Programs, and 33% holding previous employment with Child and Family Services and Homecare.

As is typical in many front line social service positions, 100% indicated that they are women, with 33% between the ages of 26-34 and 29% between the ages of 35-42. For education levels, 26% indicated that they have graduated college with 24% stating that they graduated high school. In regard to the type of education received, Registered Nurses and Early Childhood Educators were indicated most often. Women in a First Nation are most likely to hold positions of care and nurturing but also are more likely to hold multiple roles of caregiver and provider, 86% of program staff indicated that they have dependants with 61% being the primary income earner in the household.

The SF-MCH Program staff has proven to be a passionate and dedicated group of women who are driven by the need to improve the health of the families in their communities. This can be illustrated through the personal and professional commitment to their communities, as 71% of survey respondents in January 2010 indicated that they are from the community in which they work. The additional 29% while not from the First Nation in which they are staffing the SF-MCH Program provided responses that indicated high levels of community involvement, commitment and passion for the program that they are central in delivering. The level of importance of not only the ability and training of staff but also the dedication, commitment, pride and involvement cannot be taken lightly These factors are critical to the success of a program as well as for positive community buy-in.

Within The SF-MCH 2010 Community Survey, 93% of the respondents were women (63% participants, 30% non participants) with 4% men (2% participants, 2% non-participants) there was no indication of gender for 3% of the surveys. The age range of the respondents is broken down as follows; 50% 18-25 years of age; 32% are 26-34 years of age; 10% 35-42 years of age; and 1% 58-65 years of age.

Education levels indicated by survey respondents include; 55% obtaining “some high school” (42% participants, 13% non-participants), with 23% having “graduated high school” (16% participants, 7% non-participants); 9% have “attended some college” with 6% having graduated college, 6% hold some university with 1% having an undergraduate degree and 1% having some graduate studies.

In order to create a picture of housing, survey respondents were asked to indicate which statements were true about their current housing situation 56% stated that they live in their own home with 42 % “sharing a home with immediate family”. Overall 43% indicating that the “home that I live in is safe” with 32% sharing that their home “is in need of repairs”.

When asked about their current employment situation 64% indicate that they are a stay at home parent with 23% responding that they are "unemployed" and 16% stating that they have paid full time work.

Current family structures of survey respondents include 47% stating that they are "common-law", 42% stating that they are "single" and 8% indicating that they are married.

Both of the surveys were analyzed according to the following 5 key evaluation areas with analysis of elements of both the program staff and community surveys incorporated within each of the following key questions.

KEY QUESTION # 1: WAS THE PROGRAM EFFICIENT?

Measuring the efficiency of a program entails the evaluation team asking several questions including; did the program work as intended; and what tangible results were accomplished in the implementation of the SF-MCH program? Variables examined in order to understand the efficiency of the SF-MCH program include:

1. Work hours
2. Picture of Home visits
3. Contributions to the SF-MCH program
4. Staff capacity to implement program (including training and level of ability)

SF-MCH program staff members were asked a series of questions which enabled the evaluators to create a picture of the typical work week in the program including number of hours spent on home visitation, group activities, office administration and community interactions. Each of these activities is pivotal in the implementation of the program itself. The survey relied on self-assessment and self-reported time allotments and evaluations.

WORK HOURS

Typically SF-MCH program staff work 40 hours per week (59%) with 18% working 35 hours, and 9% working 45+ hours per work week on average. Over and above regular paid work hours 25% of staff members are contributing an extra 2 hours per week on average to the program with 17% contributing 1 extra hour per week and 14% indicating 4 hours per week. This question was not intended to measure overtime hours but rather perceived extra contribution to the program above regular work days.

TYPICAL ACTIVITIES

1. HOME VISITATION

On average each SF-MCH program staff spends 6.4 hours per week **completing** home visits, with 36% indicating that 2 hours per week are spent **scheduling** home visits and an average of 4.8 hours per week spent on **preparing** for home visits.

Individually, time spent **travelling** to home visits on average per week is 4 hours. Time spent travelling to a home visits which subsequently gets **cancelled** takes up on average 3 hours per week.

The average time per week spent on the **completion of forms** during and after a home visits breaks down as follows:

Completing intake forms: 2 hours per week

Completing postpartum/prenatal screen: 2.1 hours per week

Completing developmental screen: 1.9 hours per week

Nurses work to complete the family assessments for their program families with the following report;

Completing family assessment : 1.9 hours per week

Program staff spends on average 3.8 hours per week **providing updates** and in communication with program staff. Supervisors and Nurses indicated that on average they spent 2.2 hours per week **shadowing home visitors** as part of the supervision and feedback process of the program.

2. GROUP ACTIVITIES

Planning and obtaining supplies for group activities run by the SF-MCH program takes on average 5 hours per month with the actual **group activities** themselves also taking an average of 5 hours per month.

3. PROGRAM LINKAGE

The SF-MCH program **links with other programs and services** on average 2.5 hours per week. There were 12 responses received from nurses in the program with 22 responses from home visitors. 58% of the nurses spend 1 hour per week linking with other programs while 64% of the home visitors spend 1 hour per week.

4. COMMUNITY INTERACTIONS

Community interactions, as a part of the work that the SF-MCH program staff engages in include; **informal discussions with non-program community members**, with an average of 2.4 hours per week.

An average of 2.9 hours per week is spent **advertising and promoting program activities.**

SF-MCH program staff spends on average 2.6 hours per week in their office working with program participants.

Providing reporting and updates at community meetings takes on average 1.7 hours per week. An average of 2.9 hours per week is spent on **supporting other community activities** through linkages with other programs and connecting with community members.

Additionally 2.6 hours per week are spent assisting with **community/family critical incidences/emergencies.**

5. OFFICE ADMINISTRATION

Office administration is a necessary component of the work that they SF-MCH program staff complete and staff on average spent 6 hours per week **filling out paper work and forms** related to work with the program families with an additional average of 5 hours per week is spent **inputting data** into SF-MCH information system . There are a number of factors which have contributed to the variance in time spent on paperwork and on the SF-MCH information

management system most common being the training of staff on the new electronic information management system as well as training of new hires within the program on such tasks. As the system becomes more familiar it is expected that the amount of time spent on the inputting of data for example will decrease.

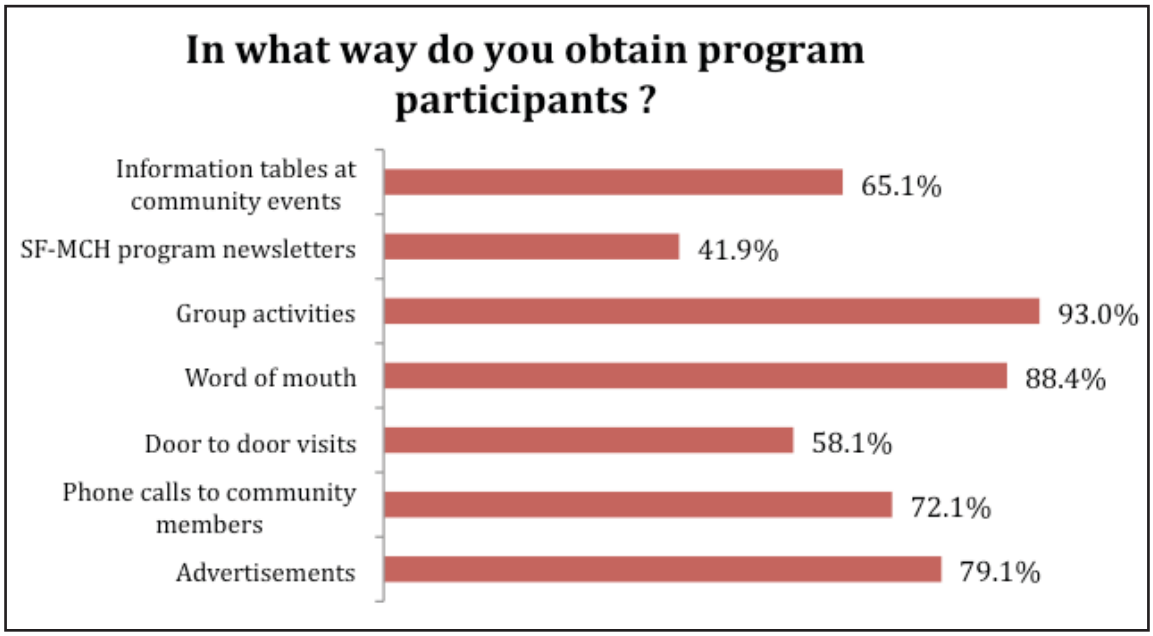
28 Home visitors and 13 Nurses responded to the questions regarding hours per week spent filling out paperwork with the 23% of nurses spending 3, 4 and 16+ hours respectively filling out paperwork while 18% of home visitors spend 5 per week.

Staff and supervisor meetings attended by staff take on average 2.6 hours per week. Of note, assisting in **non SF-MCH related office administration** takes up an average of 4.6 hours per week from the SF-MCH program. This has been noted as an area of concern for programmers as it removes program staff from the ability to complete work with families. However it does also potentially speak to the underfunding of health and social services program offices in that in reality administration needs to be covered off creatively.

6. PICTURE OF HOME VISITS

The evaluation team asked the SF-MCH Program nurses and home visitors to create a picture of home visits by responding to a series of questions concerning the typical home visits including how participants are obtained, scheduling visits, driving to visits and the length of visits.

The following chart depicts responses by SF-MCH program staff on how new participants for the program are obtained:



Previously in community visits and through discussions at Quarterly meetings it has been revealed that there can be difficulty when scheduling and completing appointments. We were interested in learning how this process is being dealt with, the actual time it takes with these challenges, and the success in completions of visits.

In order to schedule a home visit, 49% contact and set up a home visit through phone calls, 45% schedule when visiting a home and 6% use email.

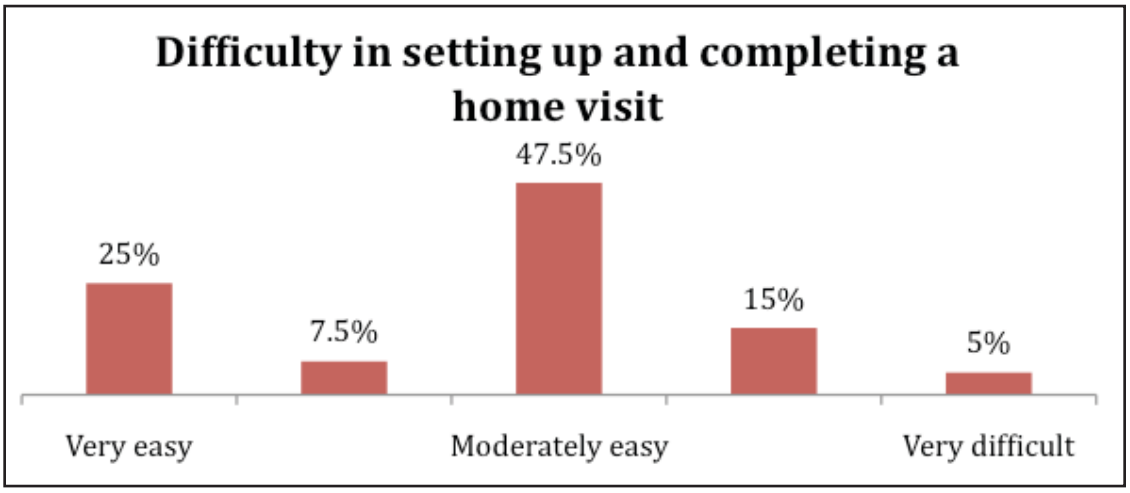
Program staff shared that the majority of the time it took 1 to 2 phone calls or visits (28% respectively) to schedule a home visit with the average number being 3.9.

Regionally the staff of the programs reported through the survey that the weekly average for home visits is 12.7. With each individual home visitor completing on average 7 home visits per week.

Per week on average 3.7 visits are cancelled and 4.6 visits are rescheduled when the home visitor travels to the home and finds the family not home or too busy. The average length of home visits is 62 minutes.

Part of a home visitation program is taking into consideration the amount of kilometres driven. The longest drive on average to a home visit is 25km with the average drive being 15km, the average amount of driving that is done each day by program staff is 30km.

On a scale of 1 to 5 with 1 being very easy and 5 being very difficult, program staff was asked the level of difficulty in setting up and completing a home visit. The rating average is 2.68 (moderately easy).

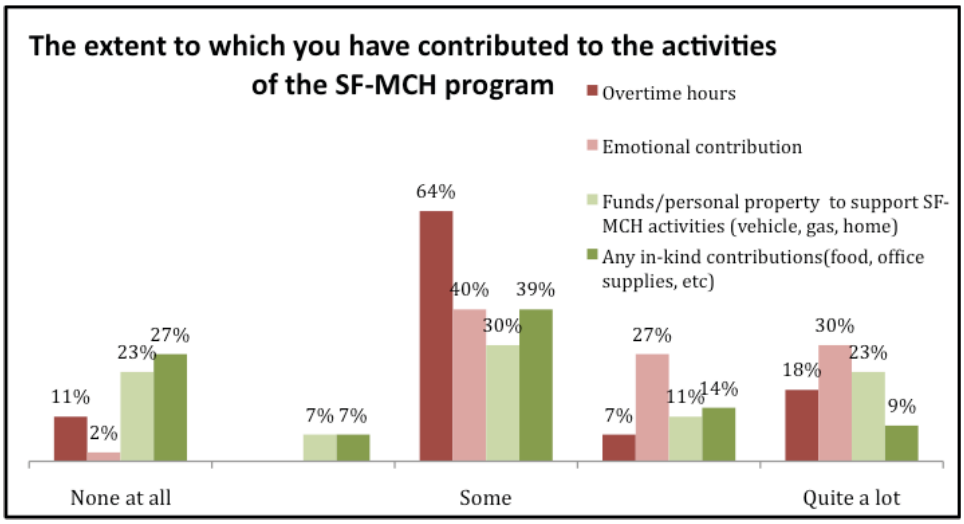


CONTRIBUTIONS TO THE SF-MCH PROGRAM

Program staff was asked to share their personal contributions to the program. On a scale of 1 to 5 where 1 is none and 5 is quite a lot the majority (64%) indicated that they contribute "some" (rating level of 3) overtime hours. The majority (40%) of program staff shared that they provide "some" emotional contribution (rating level of 3) as well as "some" funds/personal property to support SF-MCH activities (30%). In regards to in-kind contributions 39% indicated "some" (rating level of 3).

> "I would like to see a loving/ caring up-bringing for each child and given every opportunity to achieve the child's potential"
>
> - SF-MCH Program staff

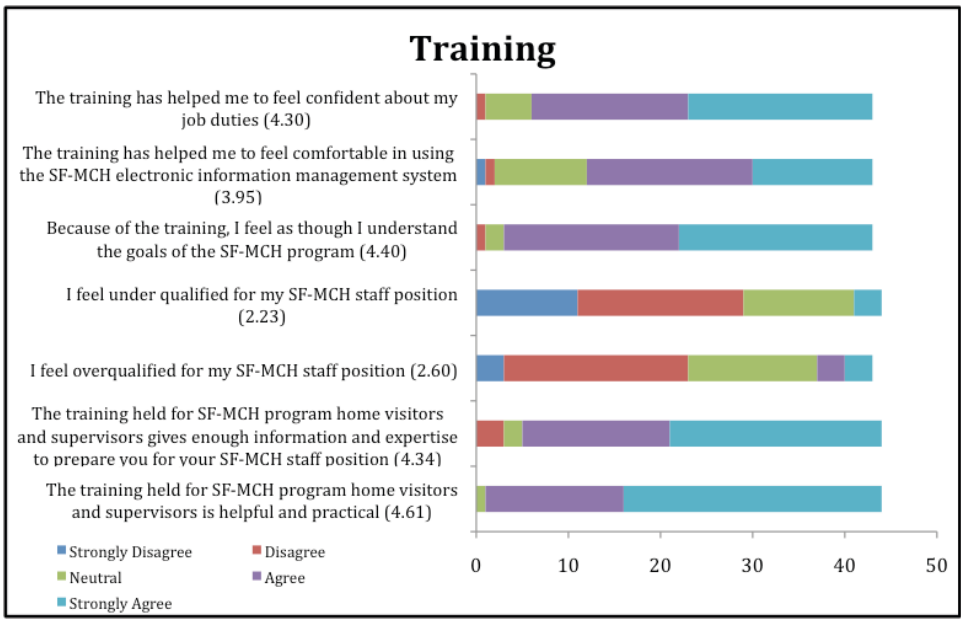
** It is important to note that when asked about the level of emotional contribution 97% of staff indicated 3 or higher (some to quite a lot) with an average rating of 3.84.



STAFF CAPACITY TO IMPLEMENT PROGRAM

TRAINING

SF-MCH Program staff have been asked about to rate the training received as part of the program on a scale of 1 to 5 where 1 is strongly disagree and 5 is strongly agree. The numbers indicated in the brackets are the average ratings for each of the statements.



> "The program is driven by the staff and also by the families in the program. Given all of the above issues which are all challenging to families in the program, the work we do is challenging and exciting and provides workers with so much reward. We realize families really need all the assistance that is provided. You can also see their appreciation of what the program offers"
>
> - SF-MCH Program staff

LEVEL OF ABILITY

In order to understand the perception of ability and skill level of the SF-MCH staff to deliver multiple aspects of the program staff was asked to rate the general level of expertise/ability of the SF-MCH staff in their program community from 1 to 5 where 1 is low ability and 5 is high ability.

The numbers in brackets are the average ratings for each of the statements

KEY QUESTION # 2: WAS THE PROGRAM EFFECTIVE?

Evaluating the effectiveness of the SF-MCH program is done through the following questions:

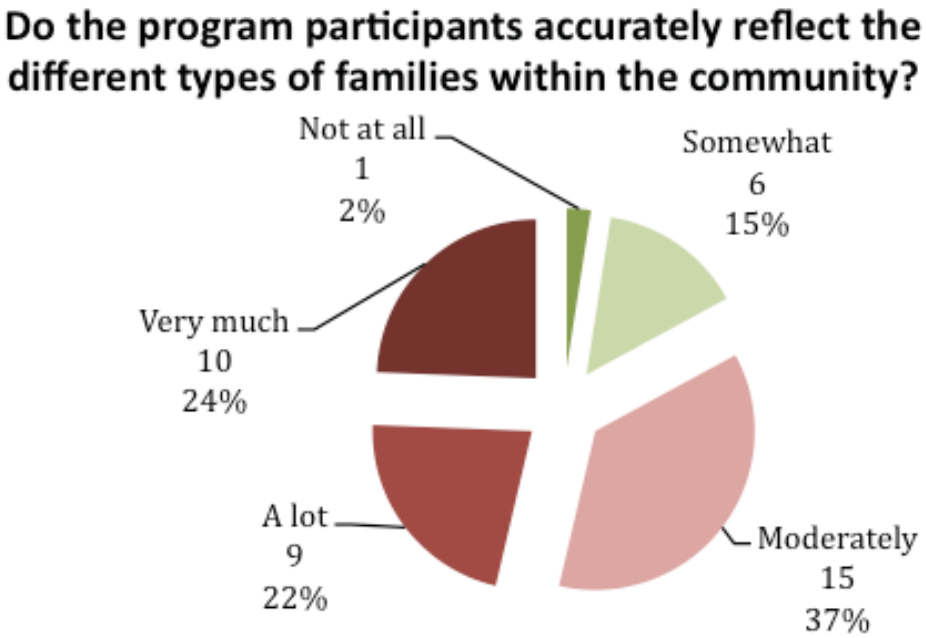
- To what extent is the program being implemented as intended? (Service definitions, service tasks, standards, other service delivery requirements?)
- To what extent is the program producing - a) products and services; b) quality products and services; c) service completions?

In order to understand the effectiveness of the SF-MCH program the evaluation team examined the following areas:

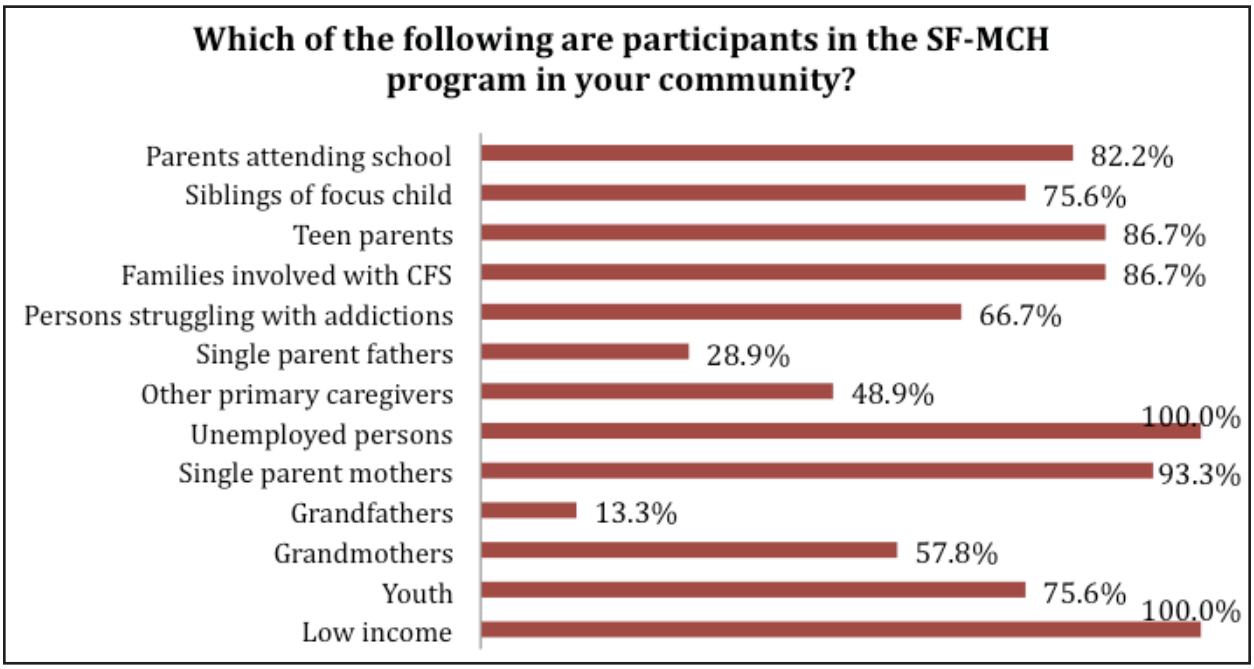
1. Community/participant representation
2. Linkages
3. Social, economic and cultural issues
4. Strengths of the community
5. Strengths of the family
6. Program participation (including motivation)
7. Home visitation activities and usefulness for participants

COMMUNITY/PARTICIPANT REPRESENTATION

When asked "Do the program participants accurately reflect the different types of families within the community" the SF-MCH staff responses were split fairly evenly across moderately (27%); very much (24%); and a lot (22%).



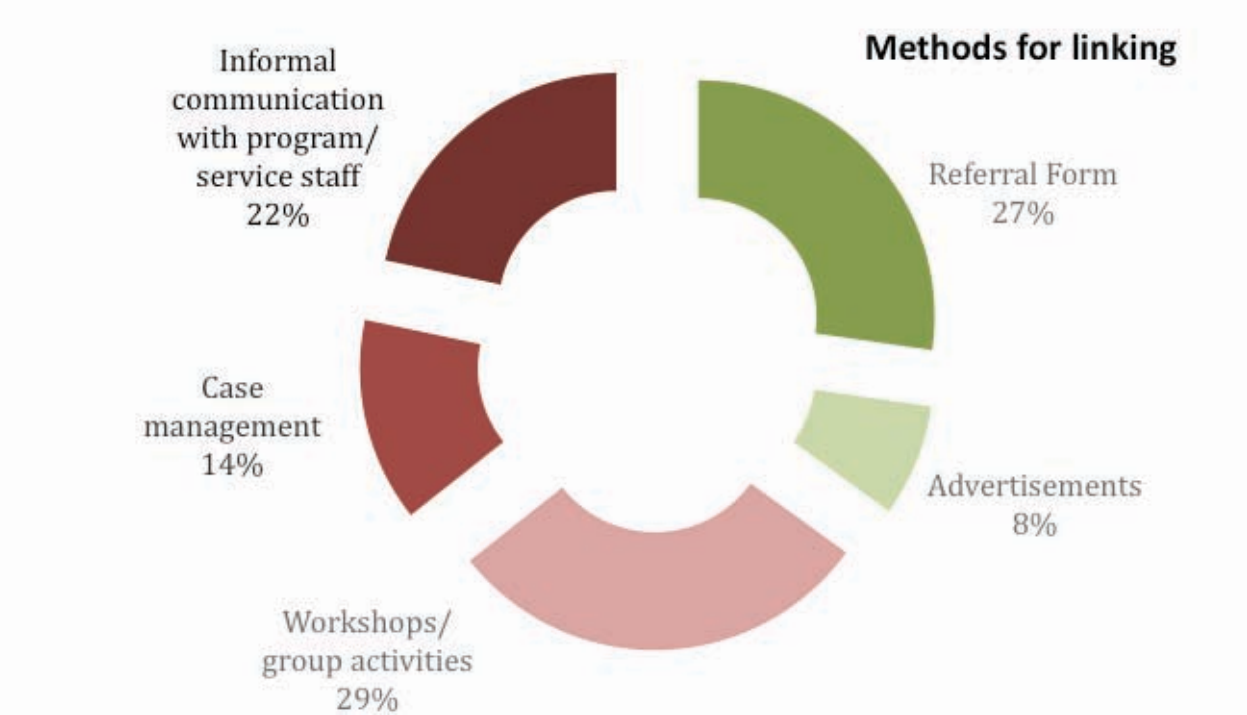
SF-MCH Program staff were asked which types of participants are represented in the programs the following responses rated above 50%: 100% of the programs have unemployed persons within their participants, low income (100%); single parent mothers (93%); teen parents (87%); families involved with CFS (87%); siblings of focus child (76%); youth (76%); and persons struggling with addictions are represented in 67% of the programs.



LINKAGES

One of the intended outcomes of the SF-MCH program is to create linkages between the health and social service programs in each of their communities. SF-MCH staff asked "are you connected with any of the following programs?" Of the possible choices 98% indicated connection with the Canadian Prenatal Nutrition Program (CPNP), 75% stated connection with Head Start, 73% said that their program was connected with Stop FASD Program, 61% had a connection with medical transportation in their communities, 55% created a connection with their local Child and Family Services, and 50% connected with mental health services in their communities.

When asked to indicate methods of linkage between the programs 29% of program staff indicated workshops & group activities, 27% stated that they use a referral form, 22% link through informal communication with program & service staff, and 14% participate in case management.



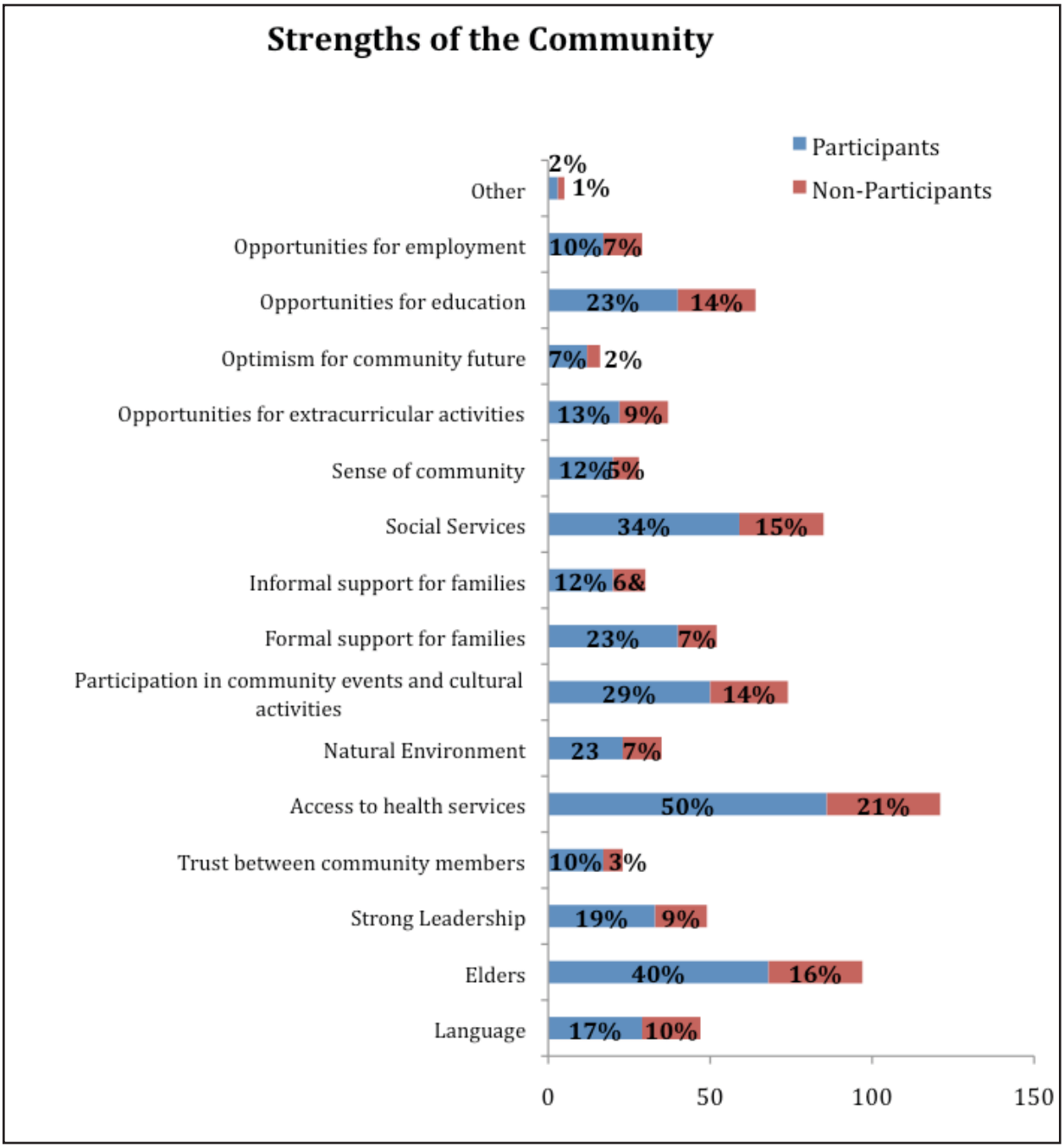
SOCIAL, ECONOMIC & CULTURAL ISSUES

Community members were asked in the surveys to indicate from their perception the social, economic and cultural issues faced in their communities. In total there were 180 respondents with 1414 responses indicated overall and broken down as follows;

1. Unemployment; 84%;
2. Alcohol/drug abuse; 81%;
3. Poor Housing Conditions; 74%;
4. Shortage of housing; 73%;
5. Teen families/pregnancy; 65%;
6. Overcrowded housing; 61%; and
7. Financial difficulties; 57%.

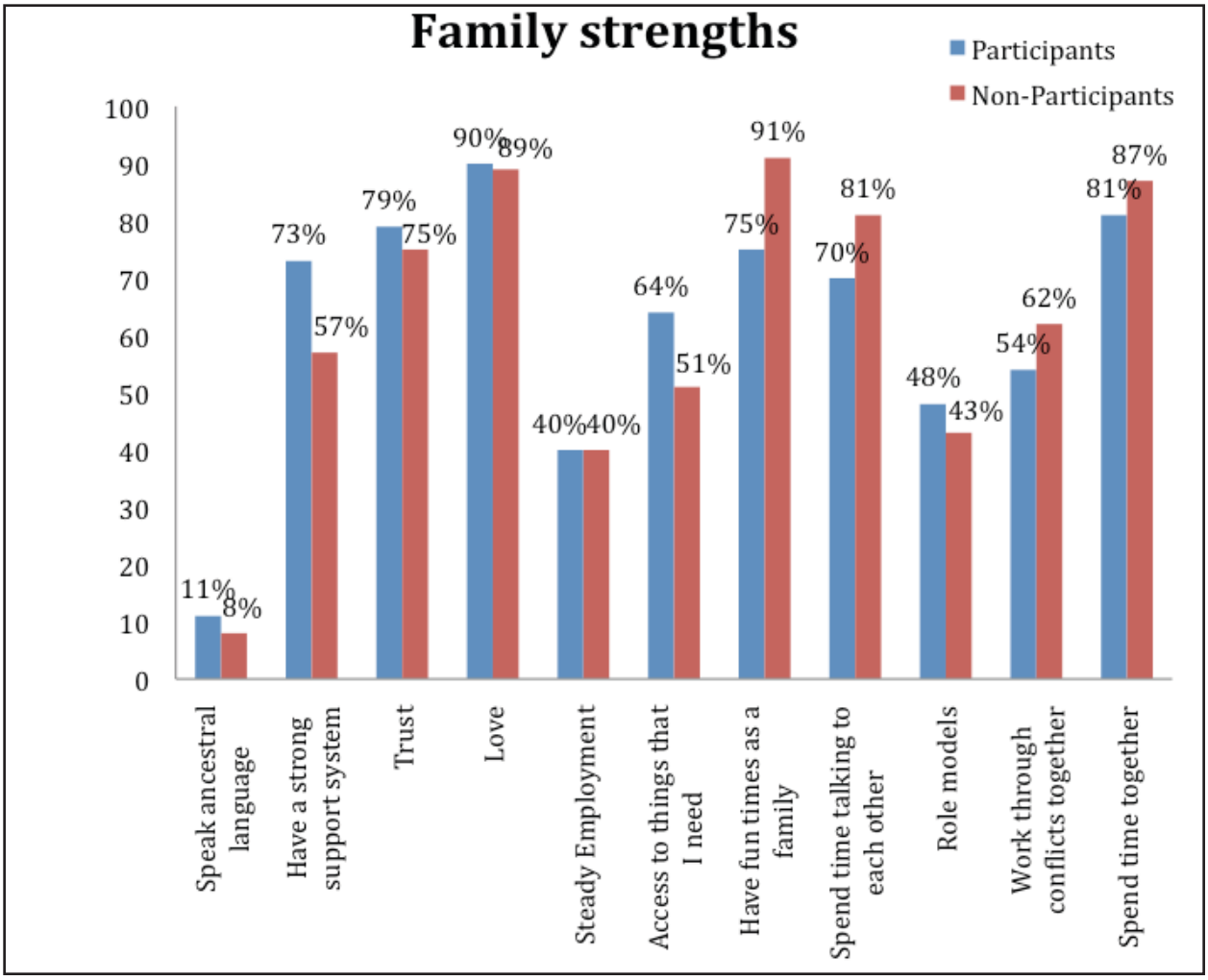
STRENGTHS OF THE COMMUNITY

Community members were asked to indicate the strengths of their communities, there were 172 respondents with 787 responses overall. The following chart depicts the responses for each category broken into SF-MCH program participants and non-participants responses; The top three responses for strengths of the community are as follows; Access to health services; 71%; Elders; 56%; Social Services 49%; and Opportunities for Education; 37%.



STRENGTHS OF FAMILY

Community members were asked to share perceptions of strengths in their families. Results are broken down into SF-MCH program participant and non-participant responses. Overall the most indicated responses from both participant and non-participant are Love (89%) and Spend time together (83%).

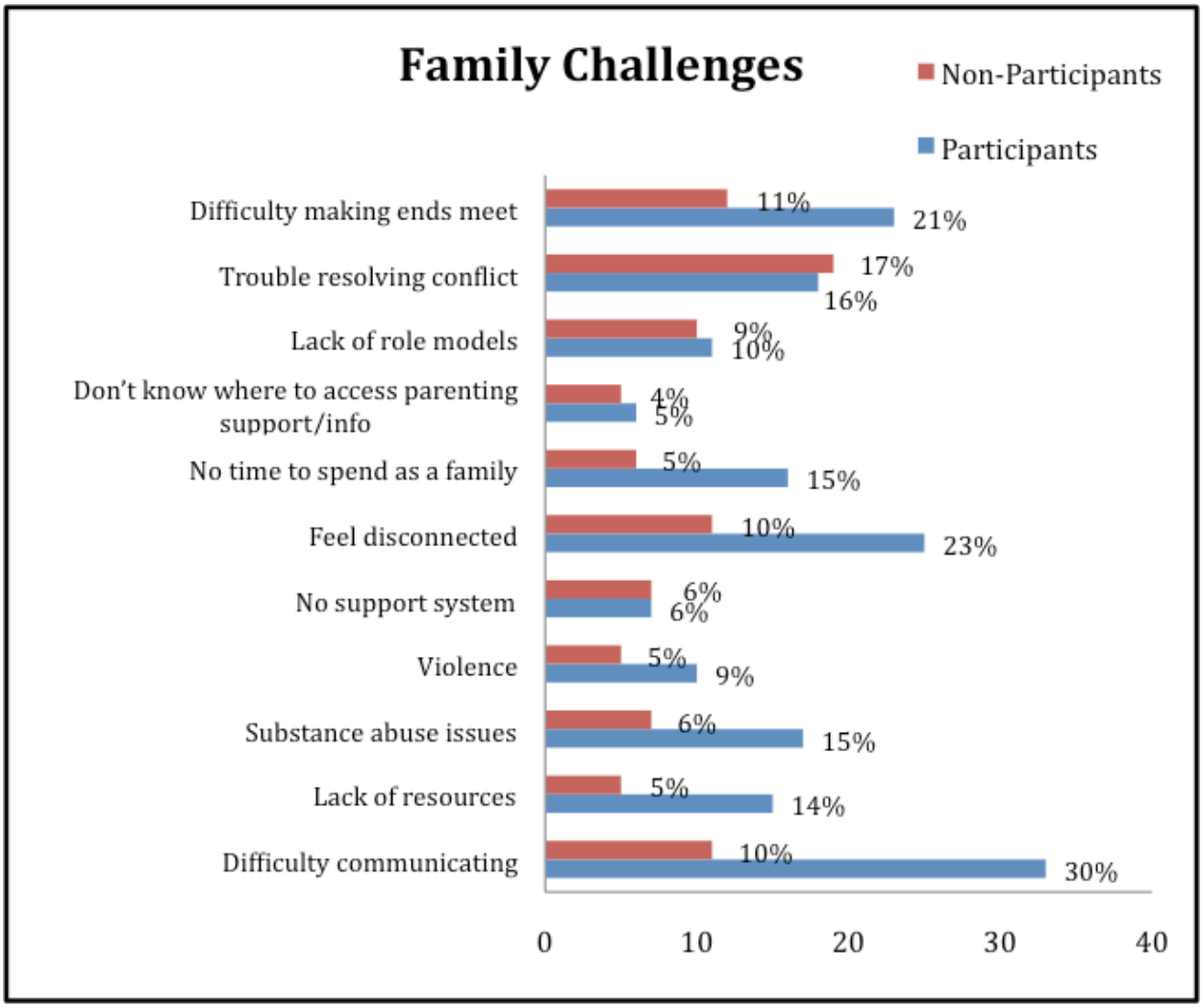


When the responses are examined for program participants the top indications for strengths of the family are: Love 90%, Spend time together 81%, Trust 79%, Have fun times as a family 75%, Have a strong support system 73%, Spend time talking to each other 70%, and Access to things that I need 64%

Top ranked responses for Non-Participants when asked to share family strengths include: Have fun times as a family 91%, Love 89%,Sspend time together 87%, Spend time talking to each other 81%, trust 75%,and Work through conflicts together 62%.

FAMILY CHALLENGES

Community members were asked in the survey to share what they thought were challenges faced in their family. SF-MCH program participant's top responses are: difficulty communicating 43%, and feeling disconnected 33% while non participants top responses were: trouble solving conflict 56%, and difficulty making ends meet 35%.



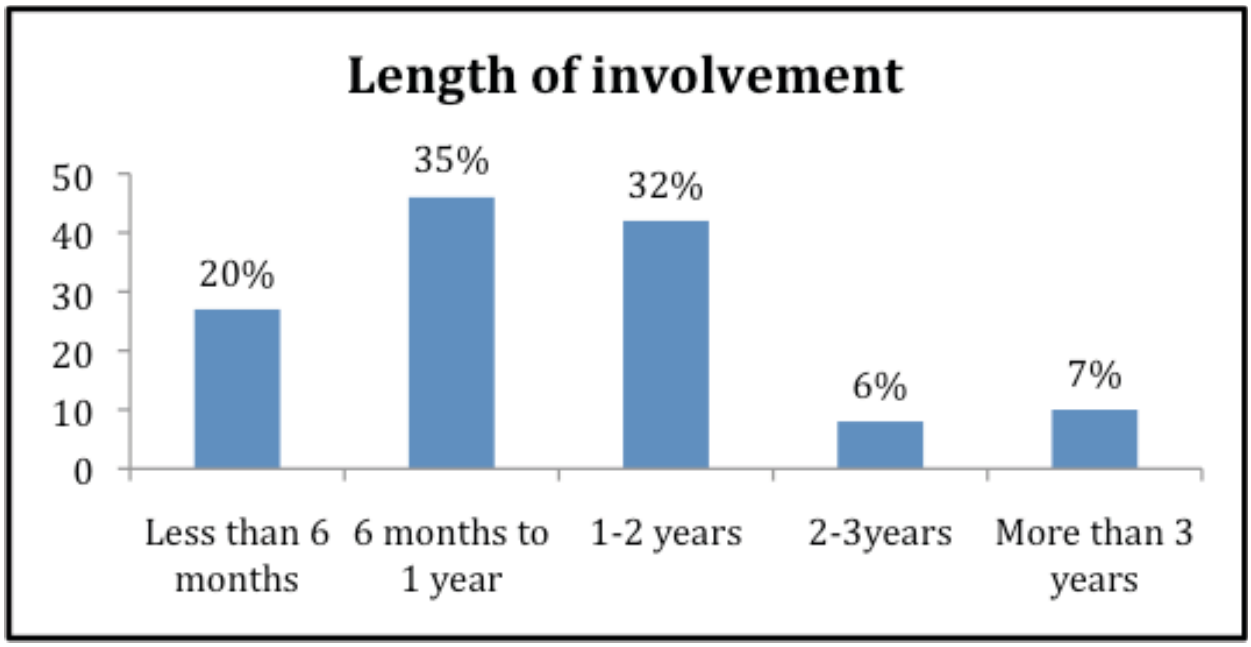
PROGRAM PARTICIPATION

Survey respondents were asked during what time period were they contacted about the SF-MCH program; 68% of those who responded were contacted while they were pregnant (61% participants, 7% non-participants); 30% were contacted after their child was born (24% participants, 6% non) with 2% stating that they were never contacted.

Of the survey participants 67% indicated they were involved in the SF-MCH program with 21% stating no involvement and 12% not indicating. This sample for the survey was intentional in order to provide a comparison group and to begin to determine impact. For the purpose of comparison those who did not indicate were included in the non-participant sample.

Of the SF-MCH Program participants 35% have been involved for 6 months to 1 year, 32% 1-2 years, and 20% less than 6 months.

When SF-MCH program participants were asked to share why they became involved in the program there were several areas including: to get involved, for education and learning parenting skills, to receive support, to gain information on prenatal and support during prenatal, because they were invited or referred to the program, and because they felt it was a positive program. A sample of responses is shown below:



I like the staff, lots activities to do with children, make family stronger

I just felt that it was a good opportunity to get involved in something that would benefit families in the community. It is a good program. I have no complaints.

Something to do, learn more about parenting, and have extra support

To help my parenting skills, to strengthen my family bond

Because it gets me and my baby out, and gets my baby to interact with other babies.

For a support system for me and my family

My friends recommended to me. Plus I enjoy participating in activities.

For program information also for home visits; For education for prenatal bonding and for the new information in the curriculum

Because it is a valuable resource to have in the community. It is one of the positive programs available to community members, helping them to grow as well as their children.

Participants were then asked to share their reasons for continuing to participate in the SF-MCH Program; responses included good staff, home visits, helpful information, for the family & kids, support, and activities. Some of the responses are shared below:

We finally have good staff on board the inconsistency in the past has turned me away but I am willing to participate fully until my son is no longer within the age range

Good workers who come and see me

(Home Visitor), I enjoy her coming and we do our activities together

The staff, the programs, well planned out and happy

My home visitor is a person who wants you to feel a part of something and that is what keeps me involved

I like the home visits and information

The visits and things we talk about

Weekly visits from home visitor, coupons, which helps me out in time of need, and just being able to socialize with one other person other than immediate family

I like learning about how to be the parent I want to be for my children

The activities and subjects they talk about

The information in modules

The information they give me, helps a lot

The support and information to help ensure I am heard since I am ignored

Benefits and support

The support and fun

Family visitor, meeting new people, trust, bonding and caring

I enjoy the program; it is good for me and my child

Meeting and getting to know my members and the community, feel accepted

Good support

Of the survey respondents who indicated that they were not a part of the SF-MCH program the following feedback was received; inconsistent unapproachable staff or conflicts with the home visitors, too shy to ask for help, already receive enough support from family, no transportation, child now over the age limit, already have the information that they need to raise their children. There were a total of 68 responses including 21 participants who indicated that there were no reasons for lack of participation, 6 individuals who had not heard of the program to participate, 5 participants indicated that lack of time was a barrier, 4 people who shared that work schedule kept them from participating, 3 people cited lack of childcare as a barrier to participation, 3 people due to school and another 3 suggested that the only reason they would not participate is if they were not expecting a child.

When survey respondents were asked to share whether the program would be able to encourage

participation in other ways, 22 people stated that nothing more could be done while the following feedback was also provided:

Raise awareness of the program and what it offers

More group activities, the addition of different activities including more incentives

Engaging children that are slightly older than 6

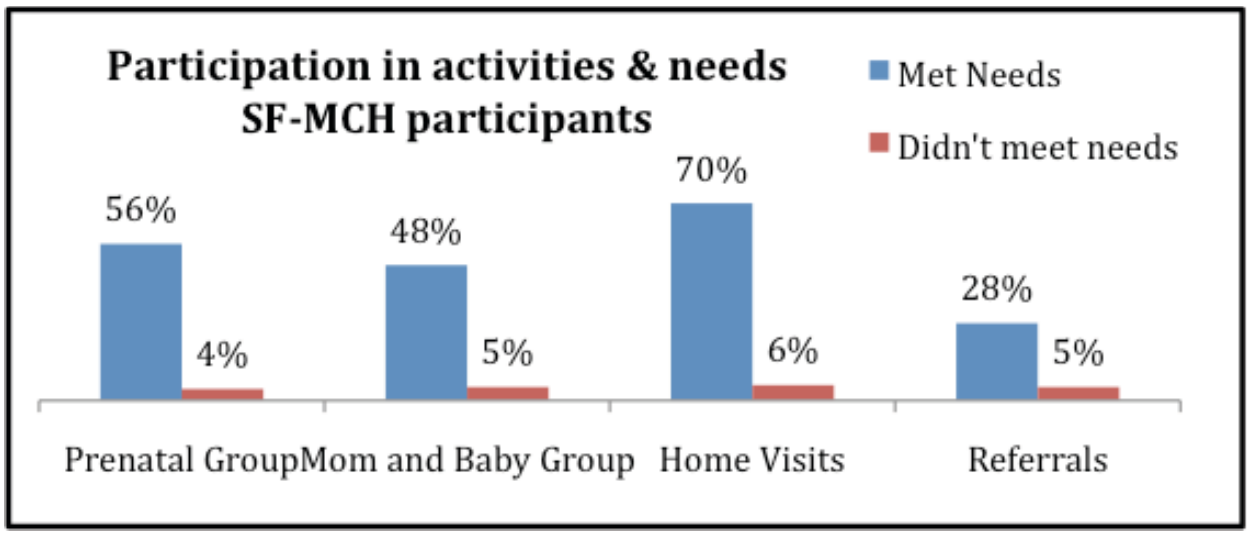
Targeting young mothers, more workers in the program

Information on large families and stress management techniques

PARTICIPATION IN ACTIVITIES

Survey respondents were asked to share which activities they have participated in and if these activities met or did not meet their needs. Of the SF-MCH program participants (responses shown in chart below) 70% stated that the home visits were participated in and met their needs.

In regards to satisfaction levels with each of the 4 choices (prenatal group, mom and baby group, home visits and referrals) SF-MCH program participants were overall satisfied with the activities;

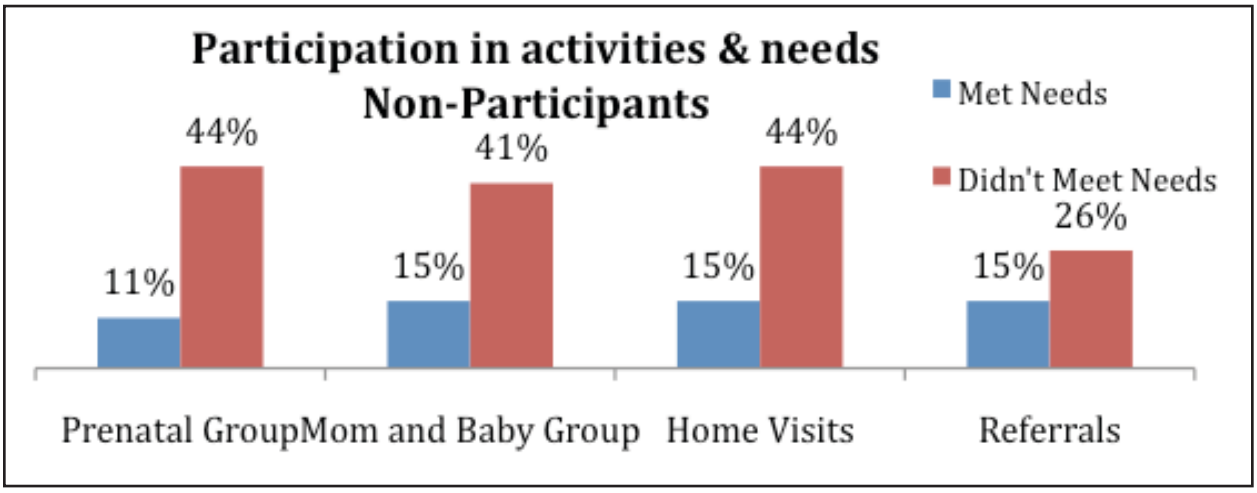


Prenatal group (65% satisfied, 8% neutral, 2% unsatisfied)

Mom and baby group (58% satisfied, 5% neutral, 2% unsatisfied)

Home visits) (86% satisfied, 5% neutral, 3% unsatisfied)

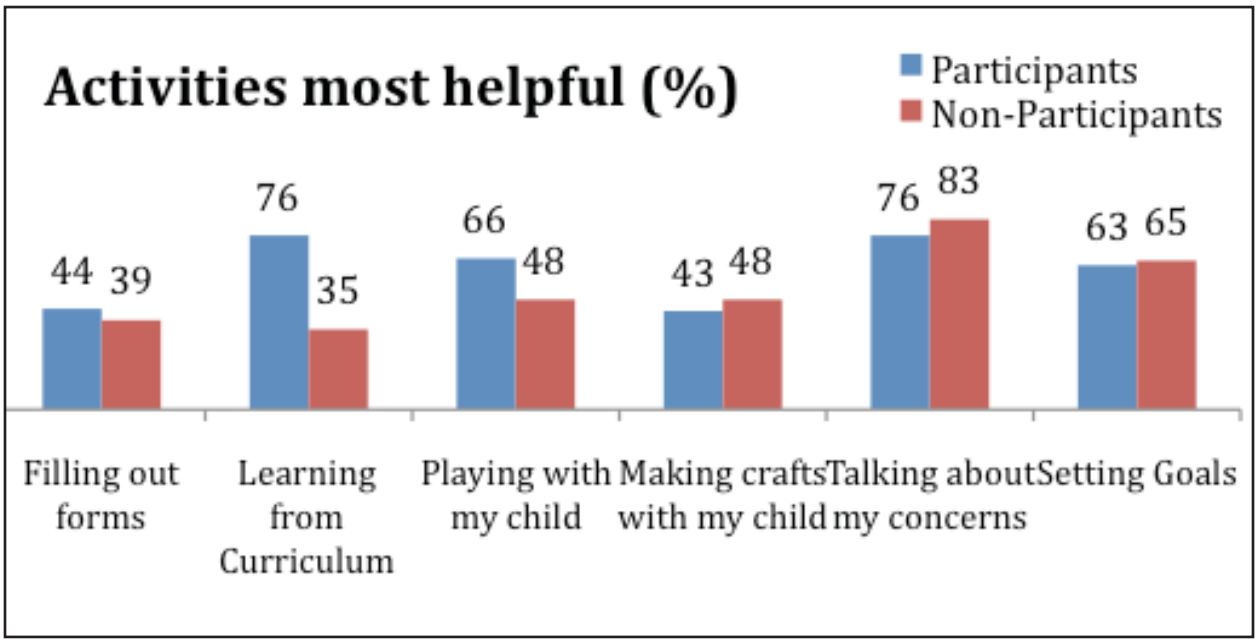
Referrals (26% satisfied, 5% neutral, 2% unsatisfied)



Overall non-participants who completed the survey stated that the activities did not meet their needs.

HOME VISITS: ACTIVITIES MOST HELPFUL

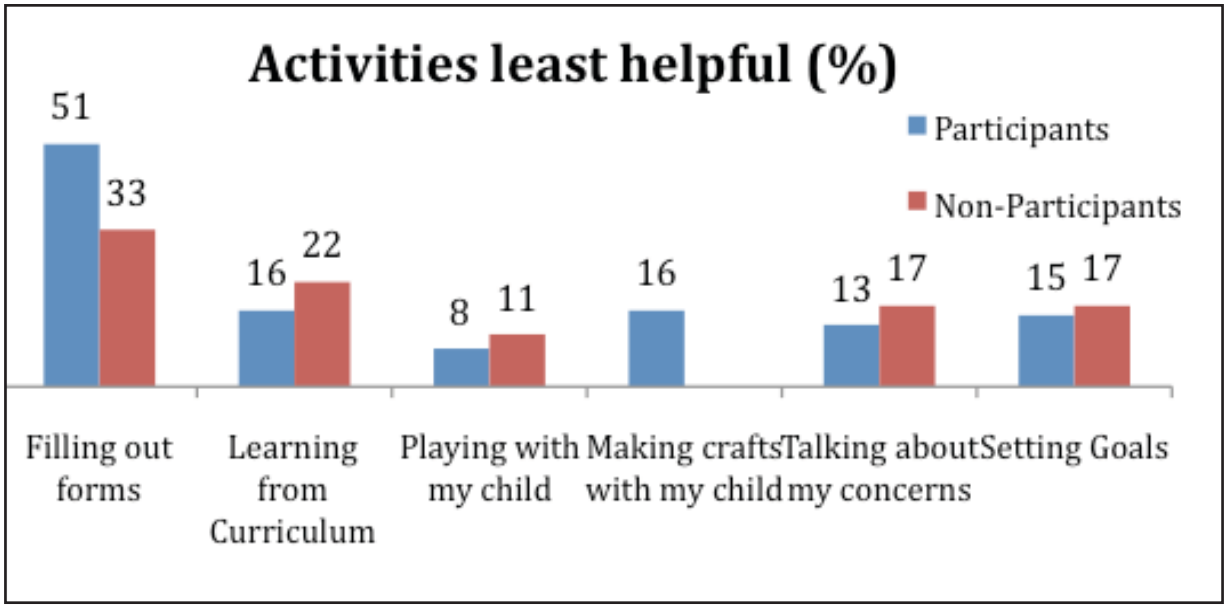
Survey respondents were asked to share which activities completed in a home visit they perceived as the most helpful. The majority of program participants (76%) indicated "Learning from the curriculum" and "Talking about my concerns" as most helpful while non-participants indicated "Taking about my concerns" (83%) as most helpful.



HOME VISITS: ACTIVITIES LEAST HELPFUL

Respondents indicated which activities were least helpful for them in the home visit. The majority of participants (51%) and non-participants (33%) indicated filling out forms as the least helpful from their perspective.

KEY QUESTION # 3: HOW HAS THE PROGRAM IMPACTED THE COMMUNITY?



Understanding the outcomes of the SF-MCH Program in each of the funded First Nations requires an examination of the following questions:

What measureable impacts did the program achieve?

To what extent is the program meeting the community need?

In order to measure the impact of the SF-MCH program in the community the following areas have been examined:

1. Types of social, economic and cultural issues faced by families in the program site communities
2. Social, economic and cultural strengths
3. Program/community cohesion
4. Community perspectives of impact
5. Staff perception of impact
6. Level of program involvement
7. Program ability to meet perceived needs
8. Satisfaction with health and social programs
9. Level of resources
10. Sense of community
11. Program effect on family connections

"We like to try get to the families as soon as we find out they are having a baby, so we can get them early in the pregnancy to start helping them with preparing for a family, like if this is their first child. We want to show the families what is all in the community that could help them in any way, and if we don't have it in our community we let them know where they can go to get it, and we also help them in that area as well. We want our families to know that there are other sources out there not only what they see in the community, we want them to do their best in everything they do. And to accomplish as much as they can"

- SF-MCH Program staff

"I think we have a pretty supportive group, we help each other the best we can. If there is a family I'm working with I can't help, I ask one of my coworkers to give me a hand, it's all for the betterment of our community"

- SF-MCH Program staff

"The program is very much strength based and building on that in every way. It is about helping people to feel hope for their future, individually and as a family and as a community"

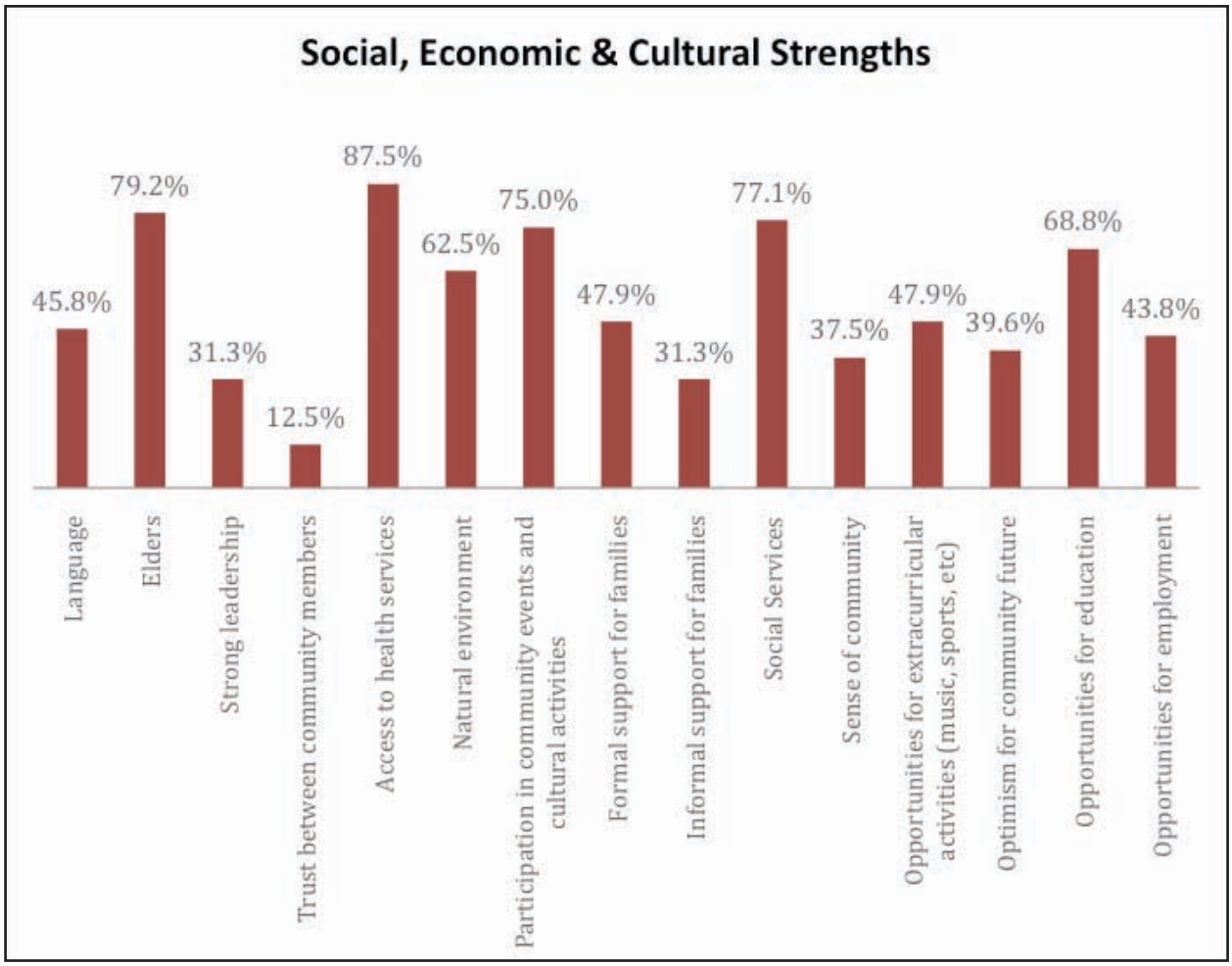
- SF-MCH Program staff

"The program looks at strengths not problems. It encourages strong family bonds"

- SF-MCH Program staff

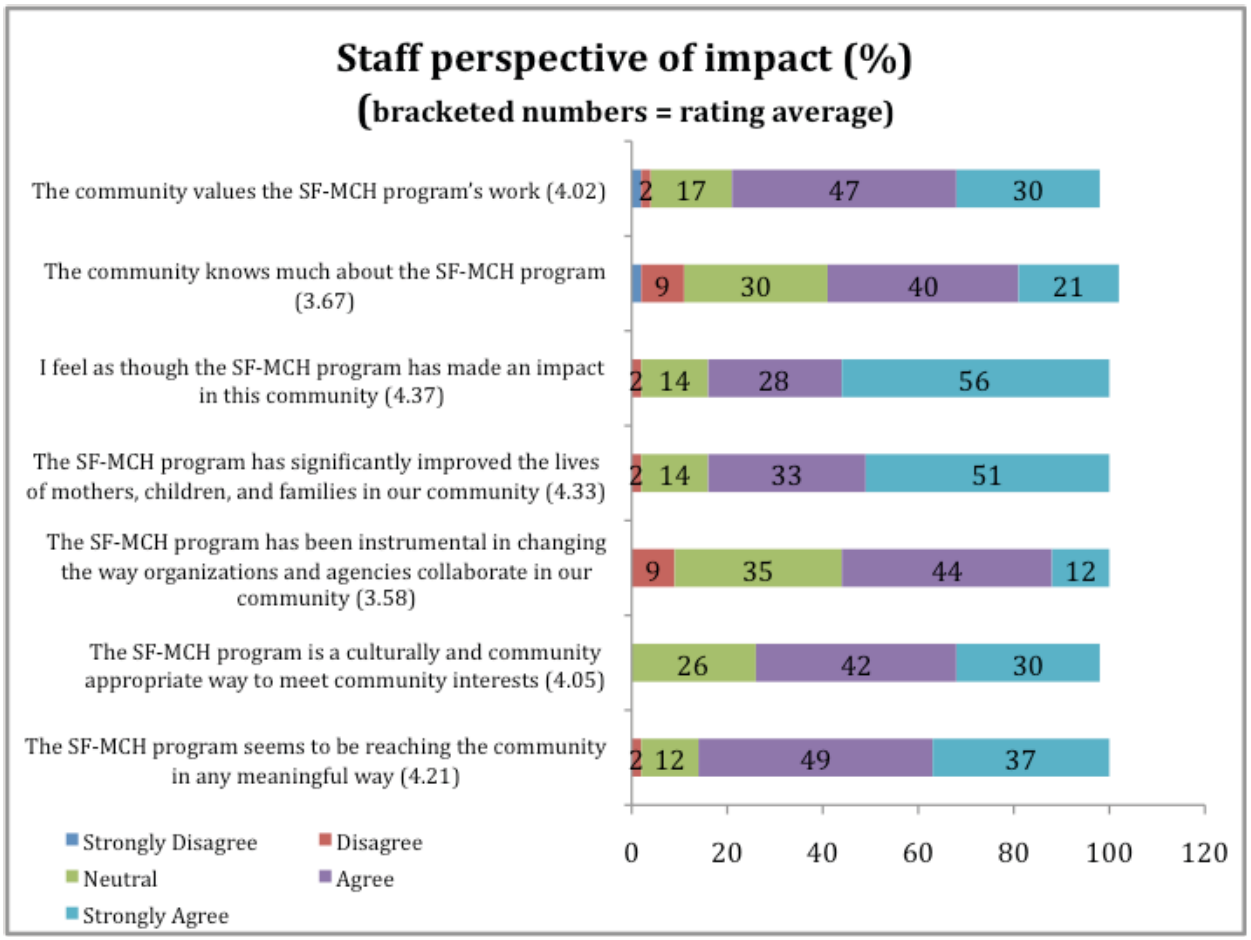
SOCIAL, ECONOMIC & CULTURAL STRENGTHS

When asked to share strengths of the communities program staff providing the responses shown in the chart below. The majority (87.5%) chose access to health services, 79.1% indicating Elders and 77.1% sharing that social services were strengths of their community.



PERSPECTIVES OF PROGRAM IMPACT

SF-MCH Program staff was asked to share their perspectives of whether the community has been impacted in any way through the implementation of the SF-MCH program in each of the 16 sites.



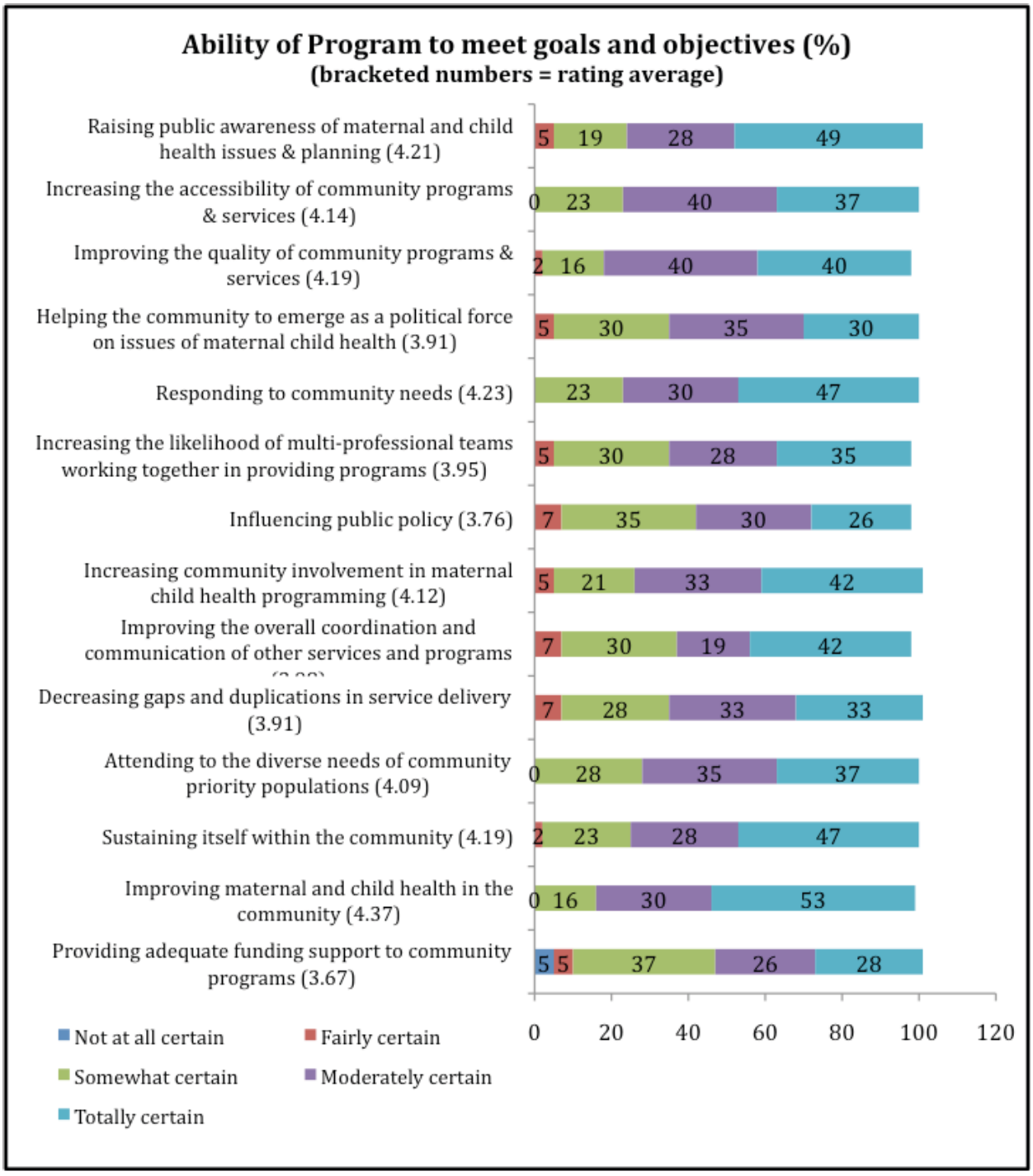
PROGRAM STAFF PERCEPTION OF INFLUENCE ON MATERNAL CHILD HEALTH

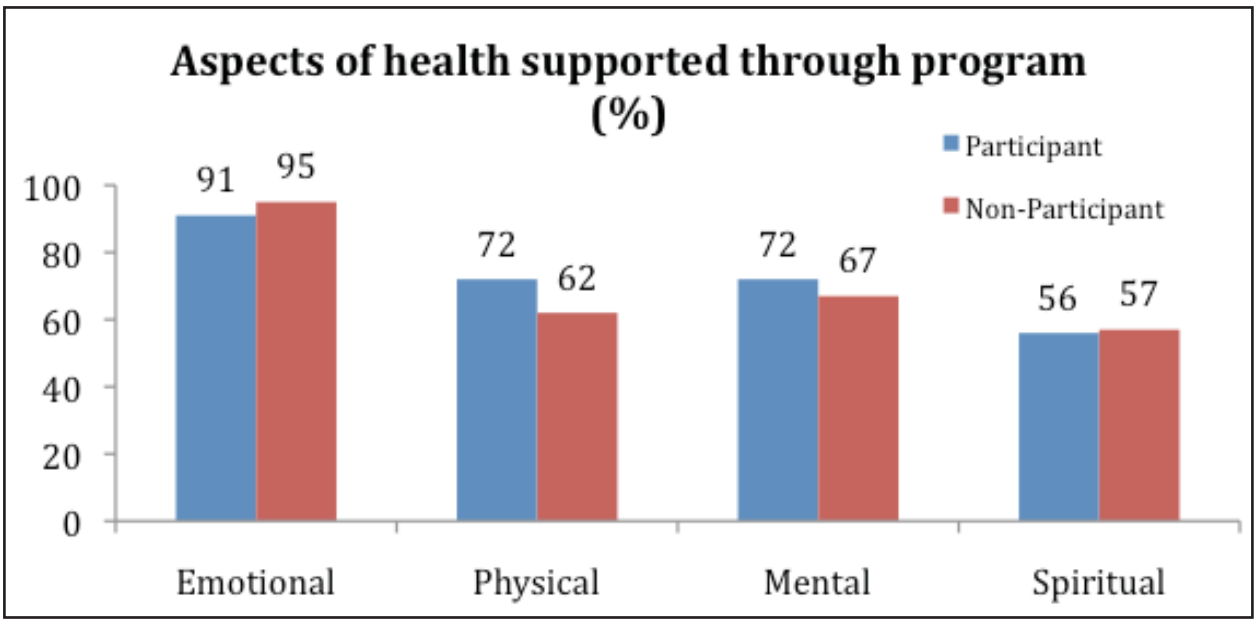
On a scale of 1-5 where 5 is very important; "Thinking about the work that has been accomplished in influencing maternal and child health in your community over the past few years, how important was the SF-MCH program in getting this work accomplished"? Eighty-one percent of staff indicated that the program has been a **very important** factor with 12% stating that the program was an **important** factor.

Staff shared their perspectives of the ability of the SF-MCH program to meet goals and objectives listed below; whether they were not at all certain, fairly certain, somewhat certain, moderately certain, or totally certain. Overall responses to the statements were favourable with the majority of indications being that they were totally certain that the program was meeting each of these statements in their program sites. The bracketed numbers is the rating average out of 5 where 5 is totally certain.

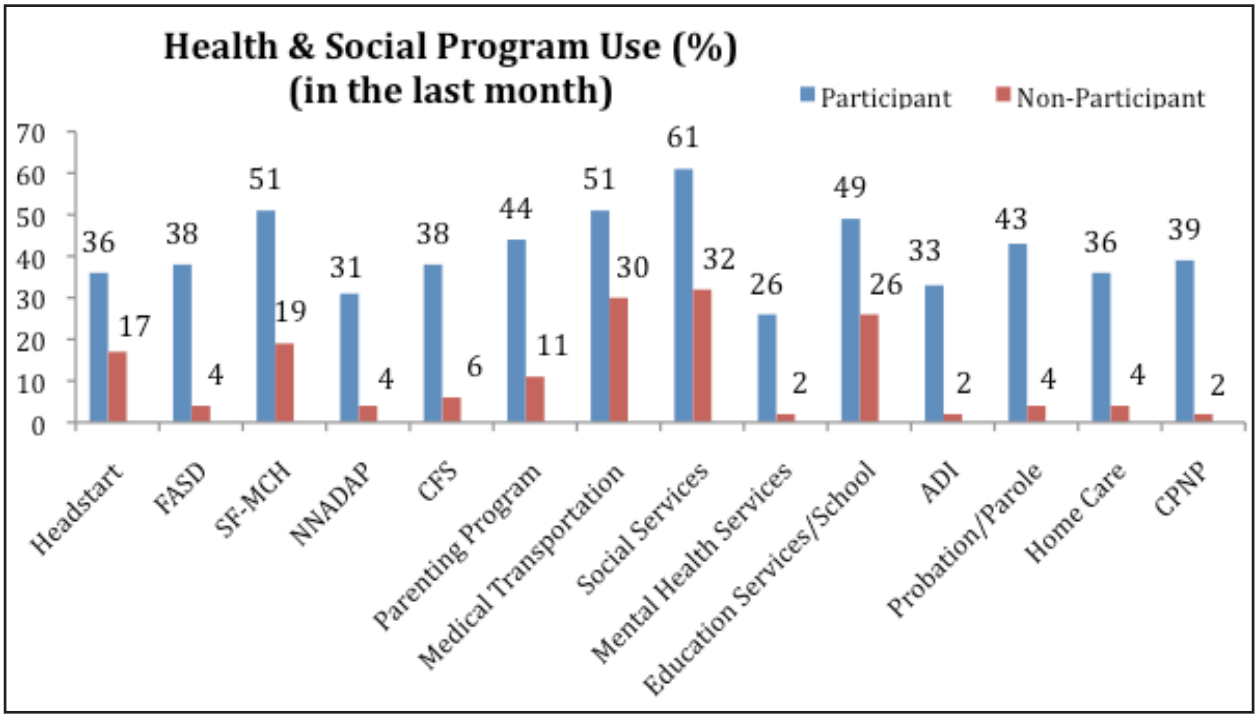
SF-MCH Participants and non-participants shared their perspective on the aspects of health that are supported through the implementation of the program. Emotional health support

captured the majority of responses with physical and mental health indicated about two-thirds of the time. Slightly more than half of the respondents suggested that spiritual health was supported through the SF-MCH program indicating a possible area for growth; as a holistic and interdependent view of health is most relevant in many of the program sites





Respondents to the community survey were asked to indicate which additional programming had been accessed in the last month. Overall SF-MCH program participants are more likely to access health and social services, perhaps indicating a division between accessibility and harder to reach families.



PROGRAM/COMMUNITY/PARTICIPANT COMPATIBILITY

Respondents to the community survey indicated whether the health and social service programs available meet the needs of their community. The majority of SF-MCH program participants indicated that they met their needs either completely (36%) or most of the time (35%) with

non-participants most often selecting some of the time (33%).

When asked whether the resources available met their needs again the majority of SF-MCH participants indicated their needs were met completely (40%) and most of the time (35%). Non participants most often indicated their needs were met with the resources available some of the time (35%) and completely (29%).

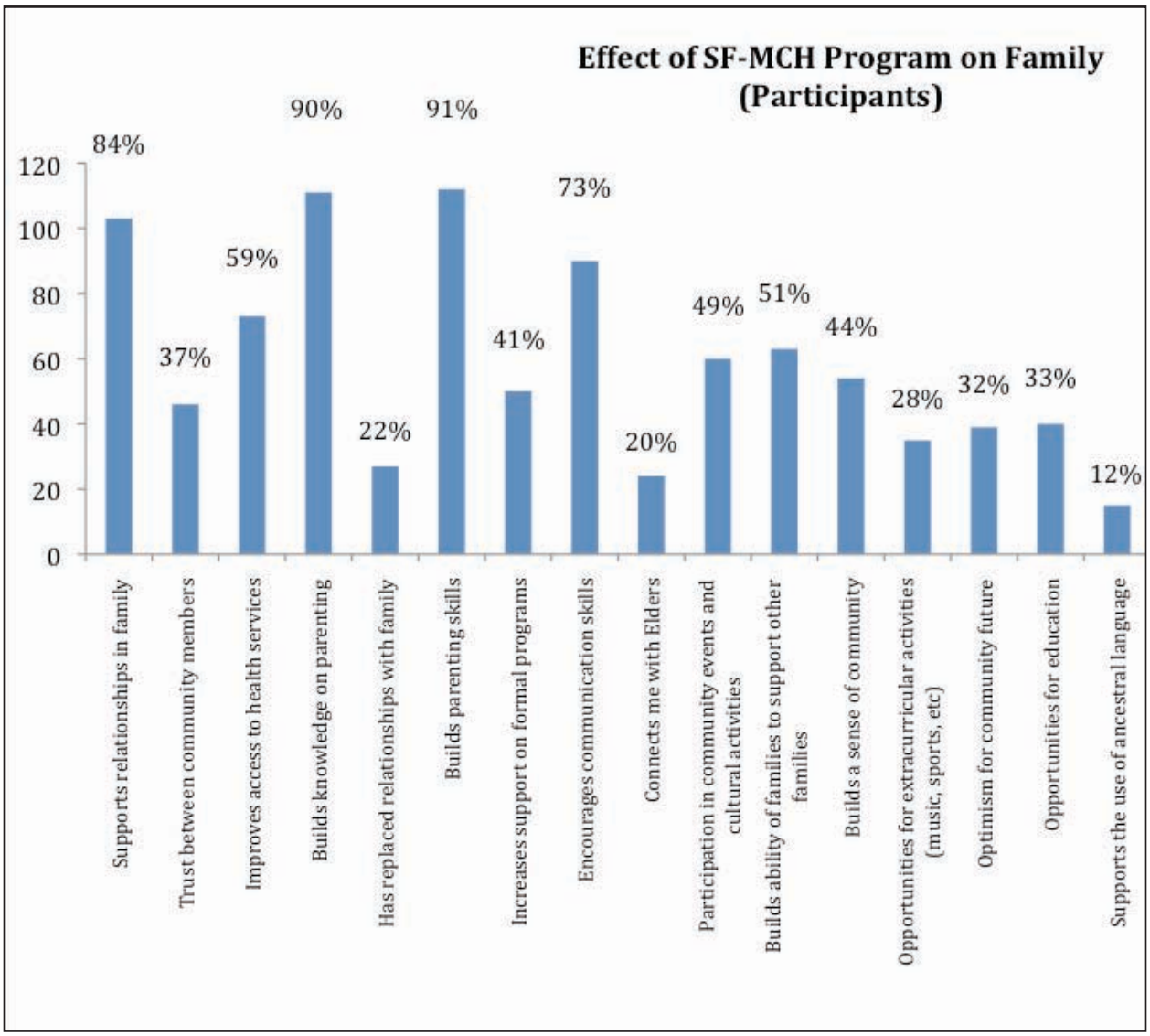
Finally community survey respondents were asked to indicate whether the resources available addressed the needs of the community. The majority of SF-MCH participants indicate that available resources meet community needs most of the time (36%) and completely (33%). Non-participants share that these resources meet community needs some of the time (32%) and completely (26%).

SF-MCH PROGRAM ABILITY TO SUPPORT

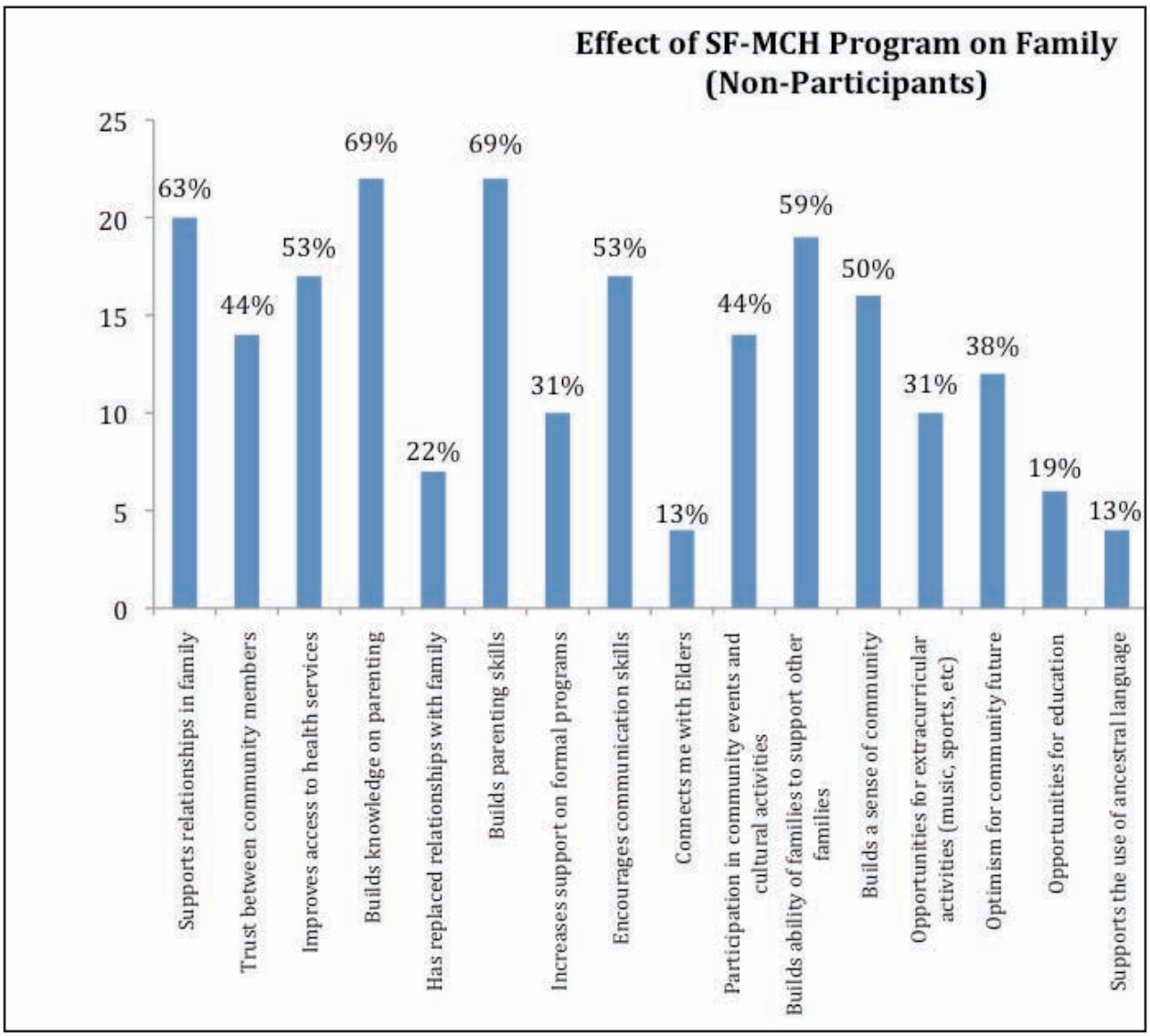
Community survey respondents were asked whether the SF-MCH program supported them as individuals with the following options; none at all, a little, some, moderate, and quite a lot. Overwhelmingly SF-MCH participants indicate that the program supports them individually quite a lot (64%) as well as a family quite a lot (71%). The majority of SF-MCH participants also indicated that the program in their community included both mothers and fathers quite a lot (50%). The program itself met the individual needs of the SF-MCH participants quite a lot (56%) and their family's needs quite a lot (58%).

EFFECTS OF SF-MCH PROGRAM

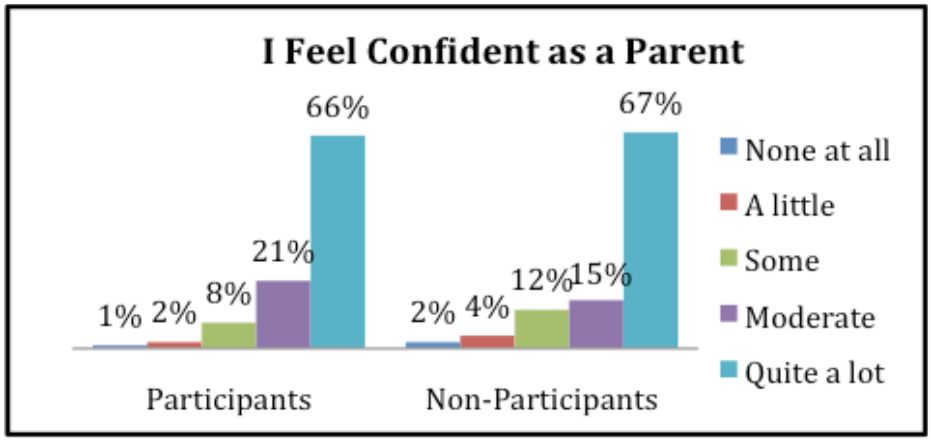
Community survey respondents were asked to indicate the overall effect of the SF-MCH program on family. Effects indicated most often by program participants include; Builds parenting skills (91%); Builds knowledge on parenting (90%); Supports relationships in family (84%); and Encourages communication skills (73%). As indicated below the SF-MCH program is supporting positive effects and growth in many areas according to participants. This is a significant finding for this evaluation, as these indicators of parenting and relationships are precisely areas of intergenerational impact from colonial impositions such as residential schooling and assimilistic policies which have torn at the fabric of First Nation families and communities for generations. It is evident that the SF-MCH program is working to repair these impacts and the effects are overwhelmingly positive.



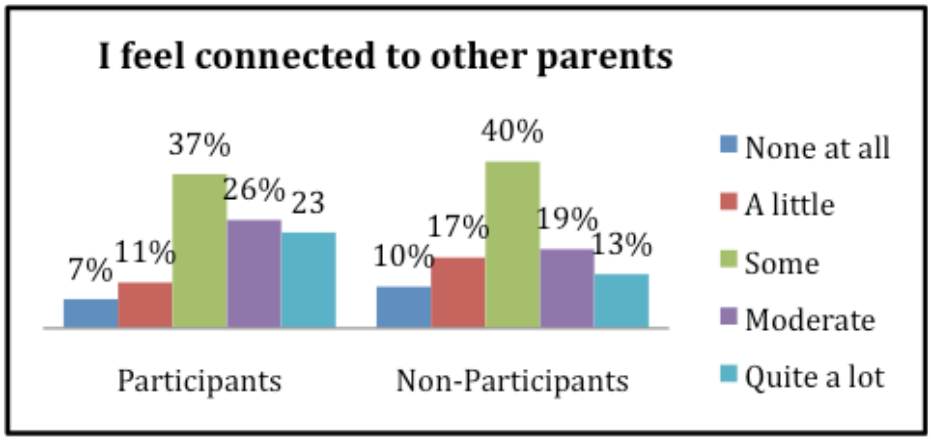
In comparison with the effects of the SF-MCH program on participants (above) non-participants were also asked to share the effects of the program on family. The top three indications are identical to above with lower indicated percentages; Builds parenting skills (69%); Builds knowledge on parenting (69%); Supports relationships in family (63%). This can indicate a couple of scenarios. Firstly that other community members are becoming aware of the impacts of the program on participant families, vicariously or indirectly experiencing the supports, potential and impacts of the program; Second that non-participants who indicated so may have been previous program families as this was not captured within the survey. This is an area that will be further explored in the subsequent year's evaluation: what are the indirect impacts of the SF-MCH program on community health?



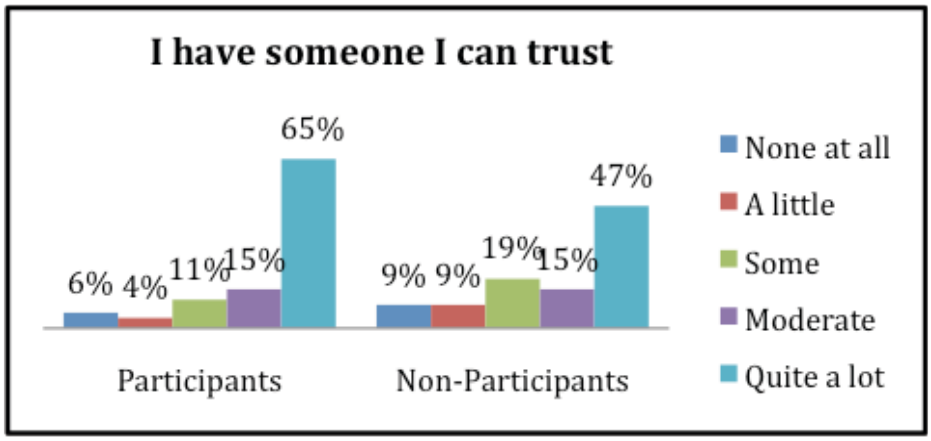
The next series of questions asked community survey respondents about their feelings as parents. In response to I feel confident as a parent the majority of both SF-MCH participants (66%) and non participants (67%) indicated that this was true quite a lot.



To the statement I feel connected to other parents both SF-MCH participants (37%) and non participants (40%) indicated some.



The majority of SF-MCH participants (65%) and non-participants (47%) indicated I have someone I can trust quite a lot.



These areas will be considered in other ways in the next phase of the evaluation as with these responses it appears that the SF-MCH program itself may not be affecting these areas or that there are other external to the program factors that support the development of parental confidence, connection and trust. The evaluation team will consider alternate ways in which to probe deeper into what respondents consider to be characteristics of parenting, connection and trust.

Program participants had the following statements to make concerning the SF-MCH program's impact and effect on individuals, families and community.

KEY QUESTION # 4: WHAT ARE THE STRENGTHS OF THE PILOT RUN?

"I noticed I am happier and I can talk to my kids and not yell, communication is better,"

"Yes, there have been some changes. My family is all together,"

"There are very positive changes,"

"Way more interaction and play,"

"Family support to me and my partner,"

"I just learned new ways on helping my child grow, to play and connect with her,"

"We learned new parenting skills,"

"I find that I understand my child's cues better,"

"Yes, I enjoy singing to my baby and reading. That's what they taught me to do. The brain is like a sponge,"

"I have come really close with my daughter's father. We do the activities with her,"

"Yeah, it has helped me to reconnect with my two older children,"

"Actually yes, me and husband communicate a lot differently and are more open with one another,"

"Yes, I have more patience with the kids now that I know about their development,"

"Have more respect for my family and partner,"

"Yes, there have been changes between my partner and I because when he participates he is learning as well, so my spouse helps more now than ever thanks to the MCH program,"

"Father is more involved with family,"

The strength of the pilot run of SF-MCH is determined by the evaluation team through critical inquiry into the extent that the program is achieving a measureable impact, what this what happened to the clients as a result of their participation in the program that would not have happened in the programs absence? Understanding the strengths of the pilot run brings together perceptions of both staff and community on the following areas:

1. Capacity building for communities and families to support families
2. Level of ownership and participation of staff
3. Communication strategies
4. Staff satisfaction with the program

> "I work for the SF-MCH program because I strongly believe in prevention and being proactive, to teach before there is a problem, to address issues before they grow in to bigger ones. To also be able to genuinely let people know we believe in them and the positive possibilities for their future, in total"
>
> - SF-MCH Program staff

> "There has been a big change with the families and you see it from being in the program for a couple of years and it sometimes takes this long to see the changes that families make and it is wonderful to see"
>
> - SF-MCH Program staff

CAPACITY BUILDING FOR COMMUNITIES & FAMILIES TO SUPPORT FAMILIES

Most staff in the SF-MCH program are community members with a high passion and commitment to the program and the families involved. They want the program to succeed in positively affecting the lives of the participants and are invested in the development and implementation of the SF-MCH program as they know the strength and capacity of the workers and families and the community is increasing and with it, the community health overall.

Comprehension of the program itself and the work that is to be completed is a factor in the successful implementation of programming. Program staff indicates unwaveringly that they are committed to the SF-MCH program (96% strongly agree). Eighty-five percent strongly agree that they understand the mission of the SF-MCH program with 91% indicating that they strongly agree with the statement I am committed to the mission of the SF-MCH program. To the statement I understand my job description/job duties and tasks the majority (80%) strongly agree.

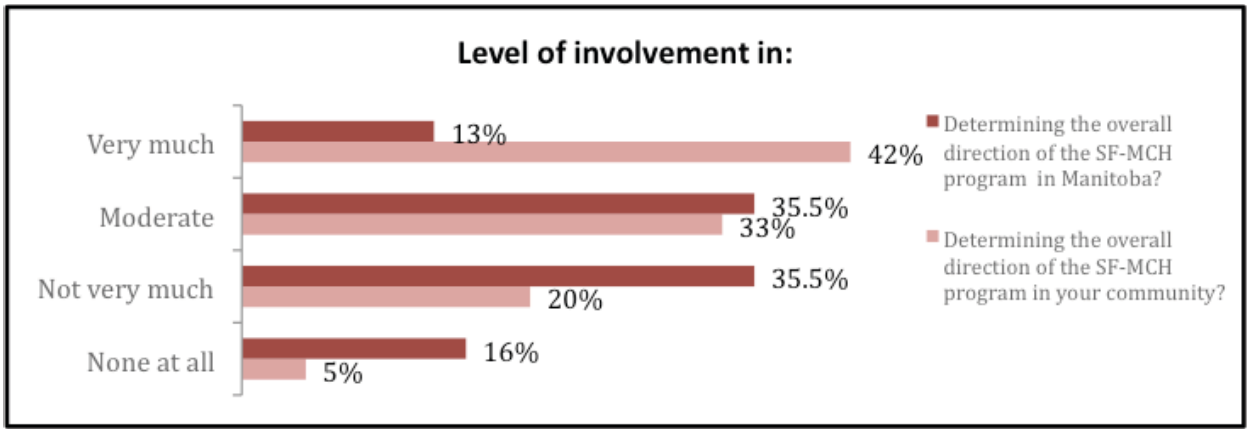
The SF-MCH program has been built on a foundation of collaboration and partnership that values the direction and voice of community members and staff. As such the survey sought responses to the statement I have a voice in the decisions made by the SF-MCH program in my community to which 56% strongly agreed and 33% agree somewhat. It is this community control over the direction of the program that allows for the adaptation to meet the needs of program families.

The majority of staff, 84% strongly agrees that they feel pride in the accomplishments of the SF-MCH program in their community with 76% strongly agreeing they feel pride in the accomplishment of the program overall. This is critical to the successful perpetuation of health and social service programming, committed staff who are proud of accomplishments of which they are directly a part of builds strength and capacity for community to support its members. In addition this provides a case study from which to found successive positively received and implemented programming. Ninety-eight percent of the staff indicate that the strongly agree with the statement I really care about the future of the SF-MCH program.

In regards to ownership over the program, 47% strongly agree and 35% agree somewhat that the community feels ownership of the SF-MCH program. To that statement I believe my community is positively impacted by the SF-MCH program 58% of staff strongly agree with 29% stating that they agree somewhat. It is this positive feedback that provides a solid foundation to positively impact the health of families in First Nation program sites.

LEVEL OF INVOLVEMENT (OWNERSHIP & PARTICIPATION)

SF-MCH Staff were asked to indicate the level in which they felt that that had influence over determining the overall direction of the program in their community as well as regionally within Manitoba. Overall the majority of the staff felt more influence in their communities than at the provincial level. This is indicative of the participation and partnership model that has been developed at the outset of the development of the SF-MCH program. It is important that this ownership and involvement continue to be nurtured. While responses for regional involvement were significantly lower, this is due to the fact that more often than not, Nurses and Supervisors are the representatives regionally through quarterly meetings with all staff gathering bi-annually. This however does not mean that the participation of Home Visitors cannot be taken into account and considered, but rather, requires an efficient communication mechanism in order to allow all staff to feel involvement at all levels.



COMMUNICATION STRATEGIES

Key to successful implementation and continuation of programming is the ability for communication between all levels of staff and community in order to maintain fluid awareness of expectations and standards of service required. This is important particularly with the underlying philosophy of participation and partnership within the SF-MCH program. SF-MCH Program staff was asked to share the level of success in communication between; program and families, non-participant families; program to program; and region to program. The ability of the program to communicate successfully across all levels is one of the indicators of the strength of the program overall. Each of the areas measured within the survey shows that overall communication between all levels within the program is good to very good with some areas for potential growth for example between the communities in order to build collaborative supports.

Communication between SF-MCH home visitors within community was indicated by staff as very good (51%) and good (42%). Between home visitors and supervisors in community was shared as very good (62%) and good (36%) indicating that there are open avenues for communication to occur and growth to be sustained.

Between program sites there is potential for support and learning through success, and communication between program communities would strengthen this resource. Overall this was indicated as good (51%) and very good (20%) with 22% indicating this avenue of communication as fair. It is apparent within these responses that there are opportunities for support and facilitation of communication between community program sites.

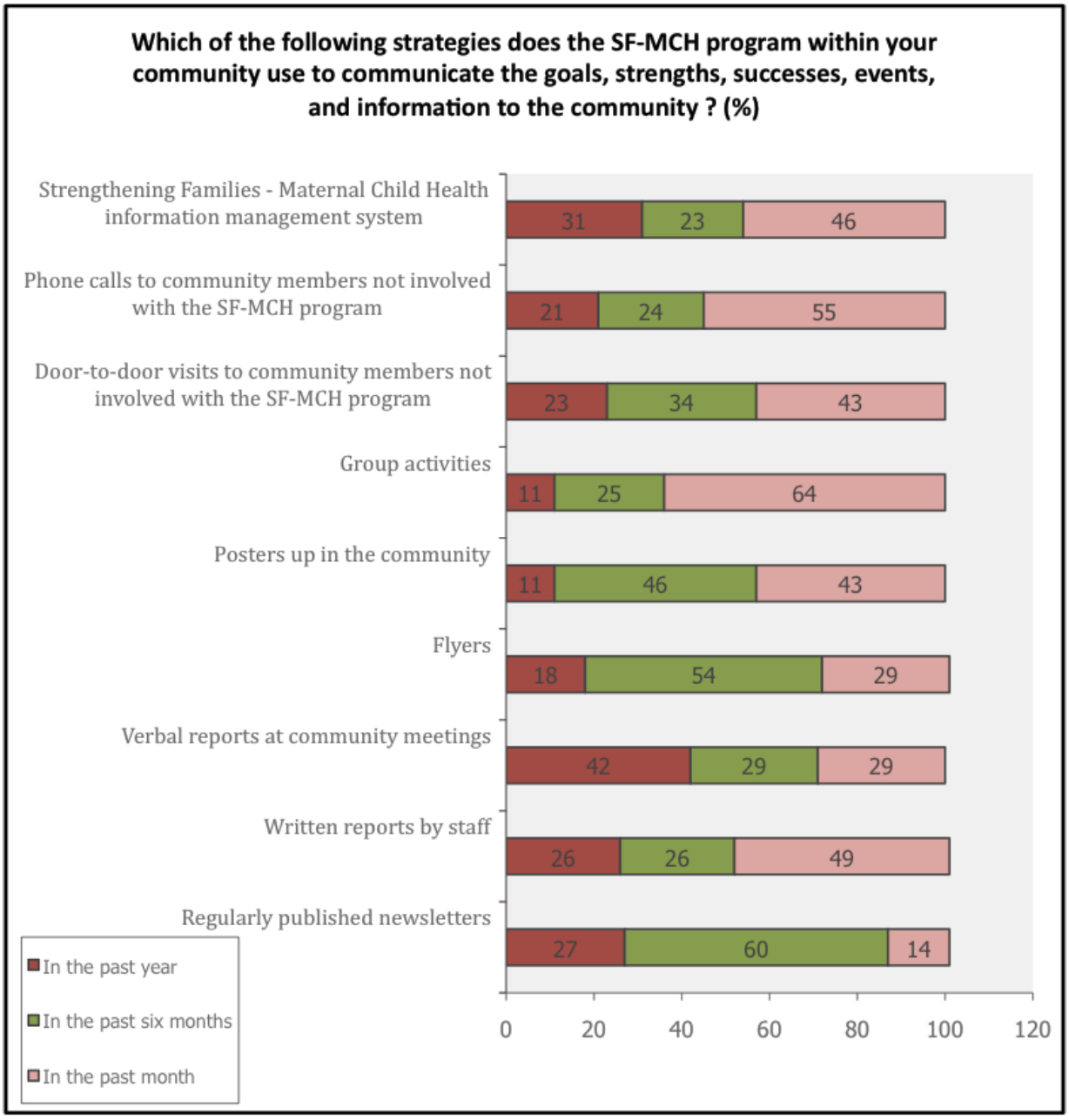
The partnership model and quality assurance developed for the SF-MCH program allows for a support system and training opportunities housed at AMC which would indicate a need for open communication mechanisms between program sites and regional staff. Staff indicated in the survey that this communication is good (54%) and very good (31%).

As a core element of the SF-MCH program is linking with other health and social programming in their community sites it is also essential that communication between these programs is fluid. Overall this was indicated as good (53%) and very good (38%) providing evidence that communication is positive and provides an opportunity rather than a barrier to promoting linkages.

Communication between SF-MCH staff within their community and community members was indicated as for the majority, good (67%) and very good (22%). This is important as community buy in of programming allows for the reach of the program to expand and to impact community health.

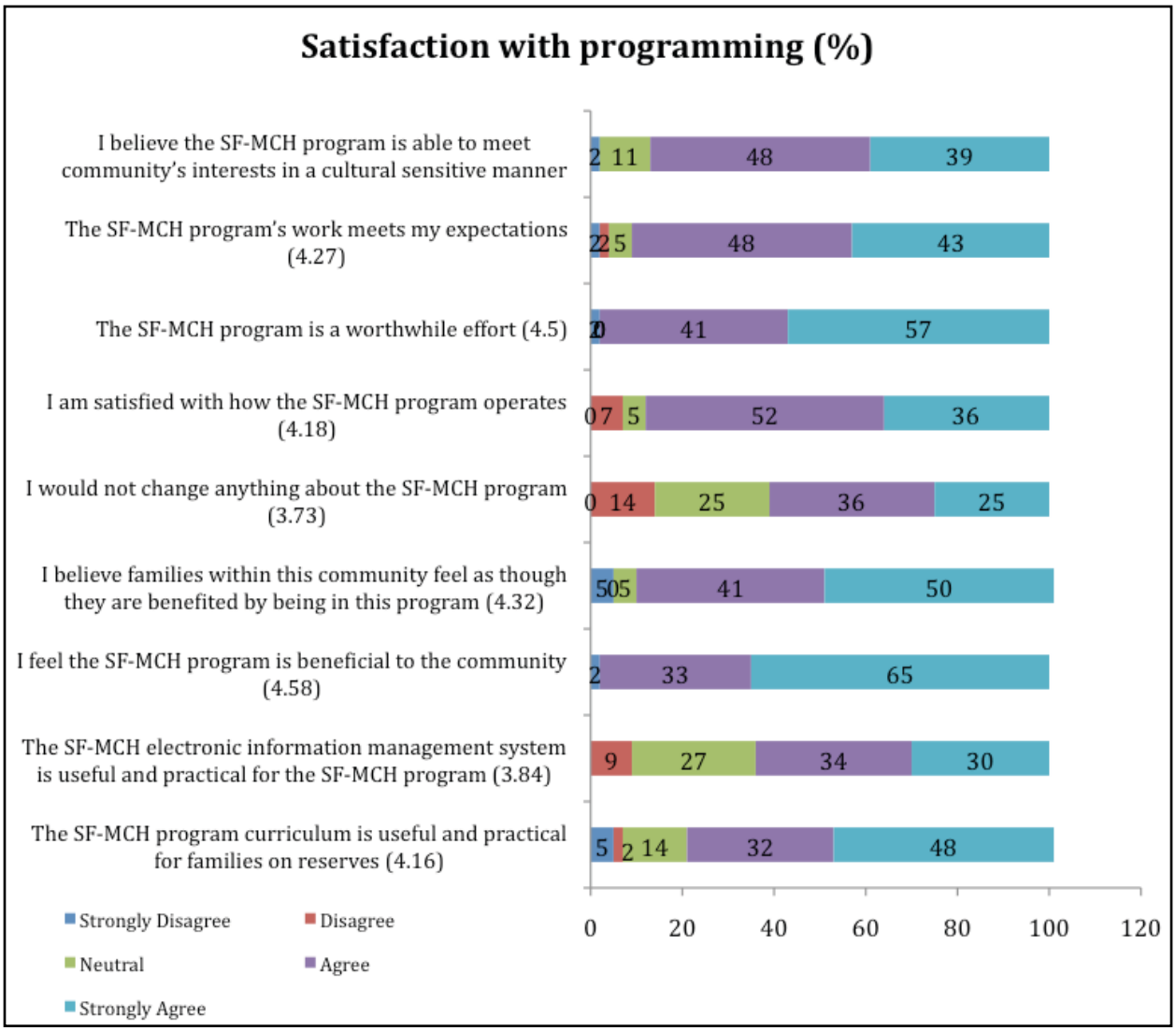
METHODS OF COMMUNICATION BETWEEN PROGRAM AND COMMUNITY

SF-MCH Program staff was asked to share methods of communication between the program and the community. The following chart depicts methods used in the last month, 6 months and one year. This depicts a wide communication strategy with the potential to reach many community members regarding the SF-MCH program.



SATISFACTION WITH SF-MCH PROGRAM

SF-MCH Staff was asked to share their perspectives on how the program is doing in the communities. The bracketed numbers beside the statements is the rating average for that statement. Overall each of the statements received the majority of responses that agreed or strongly agreed indicating that a strength is the ability of the SF-MCH program to meet the needs of their program communities and that the tools that are available to the staff to utilize as resources (e.g. training supports the regional team, visits and meetings, curriculum and information management system) are helpful.



KEY QUESTION 5: WHAT NEEDS TO BE DONE TO IMPROVE PROGRAMMING?

The input of community and SF-MCH staff input into the development and implementation of the program is priceless. The ability of these critical key informants in the evaluation of the program allows for the SF-MCH program to remain grounded within the reality of each of the program sites. When asked to identify areas requiring improvement for the future of the SF-MCH program staff and community members identified the following areas:

1. Difficult to reach families
2. Additional training for program staff

DIFFICULT TO REACH FAMILIES

SF-MCH Program staff was asked to share specific family types which they found were difficult to reach and/or engage. The following table indicates a sample of responses. Overall highly indicated responses include: high risk families with addictions, those with no phones, families who move often, and families with working parents.

> Pregnant mothers who are already involved with CFS and have previous children in foster care.
>
> Yes it was hard for me to reach the parents at the beginning when I first started here because I'm not from here and a lot of people didn't know me, or where I came from. But once I got into the homes and started getting to know the families, they started opening up to me and felt more comfortable with me, and even still today some families will try and avoid me as much as possible. Also some families think we work with CFS, but we explain to them that we do not work with or for them.
>
> Yes. Sometimes we've had a few that were just in our program for the food bank. Once the food bank was cancelled due to out-dated food we were receiving, the families were hard to reach and eventually discontinued contact.
>
> I feel that yes there are families that are harder to reach in the community such as families with disabilities.
>
> Families who do not have their own home and especially those who move frequently.
>
> Many families can be hard to reach, especially younger families such as teen parents.
>
> For families that I work with yes, due to home conditions/cleanliness of home, no access to telephone services and also addictions.
>
> The families in any kind of abusive relationships, Family with gang ties. Families who do not have a place to live so they move around house to house.
>
> Families with addiction issues
>
> High risk families dealing family violence and drug and alcohol addictions
>
> Most are hard to reach as they don't understand the program or the need first. What they are doing is "good enough". Many have no cars, phones
>
> Parents that are attending school.
>
> Those that have trust building and confidentiality issues
>
> Employed parents that want to stay in the program (they started into the program as unemployed)
>
> Single fathers and working families

Survey participants were asked to provide feedback on the question "Is there anything the program could provide in order to encourage participation"? In general responses centered on raising awareness, group activities, transportation, and other types of activities. In total there were 83 responses received with 22 respondents stating that there is nothing more or they did not know what more could be done. A summary of the comments received are as follows:

AWARENESS

More program awareness. Let the community members know what the program offers.

Yes, the program could advertise more information of what they do for families and what kind of activities they do to help our children grow and understand what they're going through.

News letters

Spread the word, get others involved, and keep encouraging others. Door prizes, games, and guest speakers.

Everyone has their own beliefs on how to live. Keep advertising maybe they will bite.

GROUP ACTIVITIES

Make it Interesting and Fun!

More activities somewhere elsewhere.

To have more fun sessions, interact with others.

More activities

More group events.

More group activities, maybe once a week.

More functions, drop in centre, moms and kids to connect and visit.

More program promotions for family outings.

OTHER ACTIVITIES/SUGGESTIONS

Engage children a few years older, ex. 6-9yrs because they or we as parents still need advice and keep up the home visits

Home visits even to grandparents because that's where the grandchild goes a lot of times.

They should have a family trip for everyone involved in the program.

more programs for young mothers

More info on toddler care and topics about large families/stress management. More traditional topics.

It needs other workers because the number of clients has increased. This will help in providing more quality time with each client and allowing more time for reporting and recording activities into the computer.

TRANSPORTATION

Transportation

Transportation to groups

Transportation and daycare

"I feel that the SF-MCH program is a great program for families. MCH staff has been receiving a lot of positive feedback from extended family of MCH participants about how the program has made a difference in their actions, behaviours and life. There is some difficulty reaching some families but the longer the program has been in the community the more interest we have noticed within the families."

- SF-MCH Program staff

"I started to work in this position because it was a new opportunity that the community really needed. It's been very effective in giving families advocacy and much needed support. I would like to see this program evolve into a higher level of service and revise the structure so that it works more effectively for all involved. I would like to see it be a permanently funded program"

- SF-MCH Program staff

ADDITIONAL TRAINING IDENTIFIED

SF-MCH Program staff has identified areas in which there are opportunities for skill buildings and development in order to benefit their program families. Some of these areas include more information on programs in the community and specifically how these programs can work with the SF-MCH program within the linkages framework (i.e. CFS mandate, FASD, ADI, and Family Violence) as well as case management skills and processes. Other areas include dealing with high risk families, abuse recognition training and reporting procedures, further training on breastfeeding support

Engaging hard to reach families was also identified by staff as an area in which more development could occur. An integration of Aboriginal teachings and cultural aspects including cultural competency were all identified by program staff. Identified by staff is also a need for staff conflict and retention workshops which has also been identified in earlier aspects of the survey as an area requiring work for the upcoming implementation years.

Community members who completed the survey were asked to share suggestions for improvement for example which activities, learning experiences or supports that would be useful in the home visits. Twenty-one people stated that they had no suggestions with the remaining responses summarized the following areas: be consistent, more activities including group activities, budgeting, support group with other moms, family outings, First Aid/CPR, Better transportation, more reading clubs, longer home visits, do a whole class together like swimming, exercises, or even talking (sharing) circles, more info on premature babies and their development.

Additional pertinent comments received throughout the community survey from SF-MCH Program participants and non-participants are included in the following list:

> You guys only talk about baby and mom you don't talk about boyfriends and family members; you need to talk about that stuff

Have support to couples who have not had a child

Maybe more visits or activities for children. Spelling bees or adult outings

More elder and youth interaction

To visit in evenings as well

More group activities with babies and families are always a plus

Make summer activities for the mothers and babies

Especially with all the young mothers, they can use this program for help. It really helps me. I am a young mother. For the community it is great to keep people together and something for people to do in the community

We need more community interaction with each other

Ask them what their needs are as a family and phone them to encourage them to come to activities

I think MCH should have a teen awareness program. With teen sexuality on the rise we need someone to help teens understand that parenthood, although fulfilling is also a difficult task

I like the one on one visitation. I would like to see more group activities to bring mothers/ families together. To try helping each other with parenting. To be able to talk about each experience as a new parent/or just a parent in general

Be consistent. A lot of programs have come and gone

If more people were involved

Baby Mikela focus child OCN MCH Program

Parent and focus child for OCN MCH Program
Mom: Michell, Daughter: J'Lyn

CHAPTER 7

CONCLUSION AND RECOMMENDATIONS: THE WAY FORWARD

In the time period of the SF-MCH pilot project 2006-2010, the partnership, which includes collaboration of community-based programmers, has indicated an absolute necessity for government's continued support in the provision of ongoing maternal child health programs in Manitoba First Nation communities. It is highly recommended that support not only be continued, but expanded to all First Nation communities throughout the province. It is also apparent, that central management through the Assembly of Manitoba Chiefs has been invaluable to raising SF-MCH programming standards to a level of excellence. Although, to date, a cost-benefit analysis has not been performed, a review of the work accomplished in the communities and regionally reveals positive preventative and intervention effects on community health and wellness.

The SF-MCH pilot project has been supported at various levels and has benefitted from engagement of First Nation community members, program providers and community leaders. In the communities, there is great support for SF-MCH. Initial implementation of the program has succeeded in building local capacities to deliver health programming and to develop health expertise to a level wherein community-based programmers can link with health professional inside and outside of communities to deliver health care. For example, rather than to rely on external prenatal care service provision by physicians in the larger cities, SF-MCH is building the capacity and resource potentials of nurses and home-visitors in the communities to deliver equal care. It is recommended that such capacity building efforts be continuously supported in the program. For this type of work, engagement of the Regional Maternal Child Health Advisory Committee, with expertise in health service delivery, programming and parenting in First Nation communities, has been invaluable.

Families are taking an active role in program engagement. The evaluation survey shows that trust is established between programmers of SF-MCH and community members. Among non-participants, the surveys reveals an interest in participation in the program in some capacity, however, barriers may be evident, while in other cases, community members are aware of the program and wait to see if the program will offer a service or activity that will be of better interest to them. Whether or not families are participating in SF-MCH, community members say that the SF-MCH is important and a valuable health promotion, education and intervention program that should receive ongoing support to stay in the communities. Families are noticing SF-MCH programming effects on reducing interpersonal violence, building trust in families and communities, health education, lifestyle changes, and improvements to maternal and child health and development. The development of trust between community members and health programs is essential to community wellness.

The Report of the Royal Commission on Aboriginal Peoples, through 'Gathering Strength,' made it clear that previous policies and practices of the Canadian government, like residential schools, maternal evaluations for childbirth, and child welfare programs, have negatively impacted on the health and wellness of families. Programs and policies that have excluded their interests and participation have devastated First Nation families. Prime Minister Martin promised at the outset of Maternal Child Health Program development for Canada that "never again" would policies and programs be planned without First Nations at the negotiating and planning tables. SF-MCH has succeeded in the design and implementation of a strategy that changes history. This is Manitoba's solution to the devastation. Evidence is being collected to record long-term health improvements. It is recommended that the program and research/evaluation process be continued in order to continue collection and recording of such evidence of health improvements in the communities.

Intercommunity collaboration and dialoguing has increased, particularly with the development of the regional peer support program. Community unique interests are supported and regional standardization has enhanced program excellence. In Manitoba, SF-MCH community programs have succeeded in increasing the likelihood that women will access prenatal care and that they will do so earlier and more regularly. Early and regular prenatal care is a primary determinant of maternal and infant health. As such, SF-MCH is succeeding in the implementation of a priority health goal for Canada and internationally. The recommendation is to continue in support of SF-MCH to focus on the delivery and support of prenatal care assessment and intervention to women and families. As well, in order to continue to improve on the kinds and quality of support provided to women and families through the program, it is recommended that regular training and education to the staff be continued to encourage state-of-the-art health care.

SF-MCH has encouraged active engagement of families in decision-making regarding individual health care needs, interests and goals. This type of programming introduces an important element to Canadian health care that is not as readily available through tertiary care settings. Family active participation in health matters is a way to get families to think about what they want for themselves, for the family as a whole, and to work towards prevention where necessary, as well as towards taking the steps to realize aspirations. As such, SF-MCH is a vital tool for empowerment and overall family and community wellness. An example of a community putting into practice its aspirations to improve health care delivery and to enhance its cultural relevance is that Opaskwayak Cree Nation Midwifery Project. It is recommended that the program be supported to enhance this component of its work.

SF-MCH is breaking new ground. Previous research studies on health programs, including Aboriginal Head Start and the Canadian Prenatal Nutrition Program, have raised the point that First Nation community programs are programs that are designed in Canadian and American cities for mainstream populations and then brought into First Nation communities for delivery. The problem with this trend is that programs are not created to the specific needs, interests and aspirations of the communities, nor are communities included in the development of programs. Bringing First Nations into program development efforts is critical to ensuring program relevance to culture, language and other aspects of community living.

Culture and language development is promoted through SF-MCH. This is the first of its kind program in Manitoba where communities and the region have been given the opportunity to create programming for families as per First Nation interests and priorities. The process of program development is an essential determinant of health wherein First Nations engage in the thinking about how to develop supports in the communities for health improvement. Culture is revised and created in programming according to local and regional expressions. It is recommended that this kind of development be further supported to allow for youth as well as Elder engagement in all aspects of culture education – expansion of cultural expression in terms of artistic development (i.e., art, literature, tradition) would greatly improve what is being done in the community programs.

The Regional Maternal Child Health Advisory Committee is an essential committee for program support at both local and regional levels. This committee includes Elder representation as well as representation from specialists of family health and development. The committee has been effective in communications between the communities and the region. As well, the Committee

represents maternal and child health issues in all of the Manitoba First Nation communities so that health is fostered through raised awareness regardless of whether communities are funded specifically to deliver SF-MCH. It is recommended that this committee receive ongoing support for engagement. More formal protocols for engagement should be established as well.

A fundamental element of the regional evaluation is the inclusion of community-based participatory protocol and an increased local capacity for engagement in research and evaluation activities. This has been largely accomplished in the pilot term. Community programmers also have access to their own health, social and economic data and are now able to develop strategies for health improvement based on locally derived information. The University of Manitoba Research and Evaluation team has played an important part in capacity development and education in the communities. Support for further capacity development of this kind must be encouraged. The University of Manitoba has a great capacity to engage communities in health education, and such activity is a priority for the University. SF-MCH should strive to utilize this opportunity to a greater extent.

Several research studies have been completed and many more are being developed to more thoroughly understand issues of maternal and child health in Manitoba First Nation communities. Each of the studies, submitted to the Regional Maternal Child Health Advisory Committee, listed recommendations that are pulled directly from interactions with the communities. Some of these are highlighted here. For example:

Presently, SF-MCH targets pregnant, new mothers, and their children. Through them, the program attends to the interests of extended families. Since grandparents are often involved with childcare, tangible supports to these caregivers ought to be available directly. Grandparents should be eligible for programs and services related to parenting young children, as well as having respite services and housework support. Some of the grandparents clearly needed respite and/or assistance getting to medical appointments. Some had many people for whom they were responsible, and caring for one grandchild meant help was needed for others (e.g., the child's parents and those intimately connected to the parents).

The grandmothers interviewed in the SF-MCH grandparenting study spoke about wanting to have recreational opportunities for their grandchildren, things that are accessible on foot and are safe for children. Expanded opportunities for children, youth, and respite care would alleviate some of the burdens carried by grandmothers.

Employment opportunities for older teenage children are limited and having something meaningful to do would lessen grandparent worry about the younger children in their care. For instance, grandparents believed that teens are interested in helping out, contributing to their own career development and to family care and community development – the problem is that the resources for them to do so are not available. It is recommended that SF-MCH partner with appropriate supports to encourage such opportunities for youth. Youth involvement directly translates into support for caregivers, particularly to the Elder caregivers. Implementing strategies in this nature will require the development of partnerships beyond the maternal and child health programs and across jurisdictional boundaries and funding envelopes.

The SF-MCH research studies on parenting revealed a need to focus on the social determinants of health in First Nation communities as a strategy to health improvement. Health, social and recreational supports must be equitably provided to First Nation caregivers as they are to caregivers elsewhere in Canada. On reserves, there is a need for improved sanitation and water. Housing issues

are of central concern. Houses are either not accessible to families or are of inadequate quality to many young families. Housing issues are the reason for many illnesses in children including respiratory disease and death. It is recommended that through SF-MCH programming, funds are provided to conduct relevant research on community health issues. Studies should focus on health education and promotion but also on social level improvements to decrease incidences of infant mortality and morbidity.

The SF-MCH partnership model and the quality assurance/peer support program have been described at length in the evaluation report. Both of these programs are impacting significant successes in SF-MCH delivery. It is recommended that the programs be continued and that each be more fully evaluated in the next program evaluation.

Regional programming has allowed for a kind of support that would otherwise not have been available. The rest of this chapter details the accomplishments of regional implementation, particularly through the position of the regional nurse program and practice advisor.

The Nurse Program and Practice Advisor primarily provided direct support to the **Strengthening Families community sites** in four broad areas: 1) Coordination of training, education and professional development; 2) Guidance in program development, and technical assistance in establishing quality assurance and operational procedures involving one to three visits to each community depending on the community need, 3) Dissemination of current relevant research, information, and "best practice" models 4) Coordination of activity for quarterly meetings, networking, subcommittee and working group meetings.

In addition, the Nurse Program and Practice Advisor with the Assembly of Manitoba Chiefs supports all 64 First Nations in policy committees and forums where Maternal Child Health issues that impacted First Nations were the focus. The NPPA was invited by Provincial Minister of Health in 2007 to participate on the Provincial **Maternal and Child Healthcare Services Task Force (MACHS)**. A briefing note was submitted by the NPPA to the task force in regard to the lack of services and support (Service Gap) for prenatal women relocating temporarily to urban locations. On September 9, 2008 the province confirmed that it will implement all of the recommendations from the Maternal and Child Health Services (MACHS) Task Force, established by the Minister of Health in March 2007. The task force made 20 recommendations and suggested 25 initiatives to build on the maternal and child health-care services available in Manitoba. As a result, a MACHS "Relocation Subcommittee" was established to examine the issue specific to recommendations

> A referral system will be developed to help expectant women who have to relocate from First Nations, Inuit and Métis communities or rural/remote communities for extended periods of time to access coordinated prenatal and social supports.
>
> A working group will be established to engage the community and develop community-based resources to support women who have to relocate from First Nations, Inuit and Métis communities or rural/remote communities for extended periods of time to give birth.
>
> Regional health authorities will hire new staff to support women who have temporarily relocated to access birth services outside their home communities. (MACHS Task Force Report, 2008).

The NPPA has been invited as well to begin discussions with the Winnipeg Regional Health Authority on how these recommendations are to be put into operation in the City of Winnipeg. The NPPA also sat on the National Wait times Guarantee Evaluation Sub-committee. The federal PWTG initiative examined Prenatal Wait times as well as access to diabetes screening in First Nation communities. In 2006 the federal government announced a Health Canada Initiative of projects in First Nation communities to test Patient Wait Time Guarantees (PWTG) for prenatal care and diabetes screening. The Initiative was implemented between 2007 and 2010 in 19 First Nation Communities across Canada. Those outcomes include the development of a set of tools for data capture and management and most importantly for the communities - the identification of service gaps, changes to clinical practices, increased integration of federal and provincial services, and better understanding of the use of data in health care management. The conclusions focus on the learning from the projects that can be utilized within other FNIHB programs and within Health Canada in general.

A number of important and significant partnerships were formed between the years 2006-2010. The Assembly of Manitoba Chiefs partnership with **Healthy Child Manitoba** that began in initially 2007 in activities to meet common training needs evolved to a joint working group called "Striving for Program Excellence" with members from both MCH and **Families First programs**. The working group is lead by the AMC Nurse Program & Practice Advisor and the provincial Families First Coordinator. This working group consisting of managers, regional and community level coordinators had been established to develop a common framework in establishing quality assurance processes that are common to both provincial and federal programs. The partnership has evolved to include the **Supporting Manitoba Families Joint Training Initiative** that supports both programs in the planning and delivering the mandatory Core and Curriculum training for Family Home Visitors. The SF-MCH community coordinators/ supervisors meet quarterly with the Families First coordinators to discuss common issues and participate in workshops to strengthen supervisory skills and community programs.

The Assembly of Manitoba Chiefs NPPA and Administrative Assistant was also integral in planning two large Children and Youth Division community programs "Gatherings" that brought children and youth programs from all 64 Manitoba First Nations together in October of 2007 and March 2009. The primary objective of these gatherings was to foster integration and building relationships to continue or begin working collaboratively between programs at the community level to support families (See Little Black Bear and Associates 'reports). In 2009, the Assembly of Manitoba Chiefs also purchased a large volume of education resources to support the CPNP and Maternal Child Health programs in all 64 communities. First Nations and Inuit Health funded all of these initiatives.

The NPPA of the Assembly of Manitoba Chiefs has also participated either directly in research or collaborative research that promote the health and wellbeing of First Nations women, children and families. The NPPA has reviewed or co-authored a number of papers on the subject matter. The NPPA also researches, informs and/or advises the Health and Social Wellness Unit of the AMC in matters as it pertains to maternal and child health. An example of this occurred when the local media published a story on the practice of evacuating women to give birth. The NPPA was able to assist the AMC in gathering information on the subject, briefing and informing the Director of Health who assists Grand Chief's Office to respond to the media in matters that are relevant.

The ties/linkages that the nurse program and practice advisor position has been able to establish with national, regional, and community programs, agencies, and so forth, is a central contribution to the success of SF-MCH and must be further supported. The nurse program and practice advisor has a unique mix of community experience, through her work and personal life as well as education and involvement with regional institutions (e.g., university and Health Canada), this mix of experience and training is invaluable to the development of SF-MCH. Such positions should be encouraged in future programming.

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