Healthy Child Manitoba
Putting children and families first

Manitoba

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September 2010

His Honour Philip S. Lee
Lieutenant-Governor
Province of Manitoba

I have the pleasure of presenting for the information of Your Honour the Annual Report of Manitoba's Healthy Child Manitoba Office for the year 2009/10.

Respectfully submitted,

Jim Rondeau
Chair, Healthy Child Committee of Cabinet,
Minister responsible for
The Healthy Child Manitoba Act, and
Minister of Healthy Living, Youth and Seniors

A partnership of:
Manitoba Healthy Living, Youth and Seniors · Manitoba Aboriginal and Northern Affairs · Manitoba Culture, Heritage, and Tourism · Manitoba Education · Manitoba Family Services and Consumer Affairs · Manitoba Health · Manitoba Housing and Community Development· Manitoba Justice · Manitoba Labour and Immigration / Status of Women

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September 2010

Jim Rondeau
Chair, Healthy Child Committee of Cabinet
310 Legislative Building

Sir:

We have the honour of presenting to you the 2009/10 Annual Report of the Healthy Child Manitoba Office.

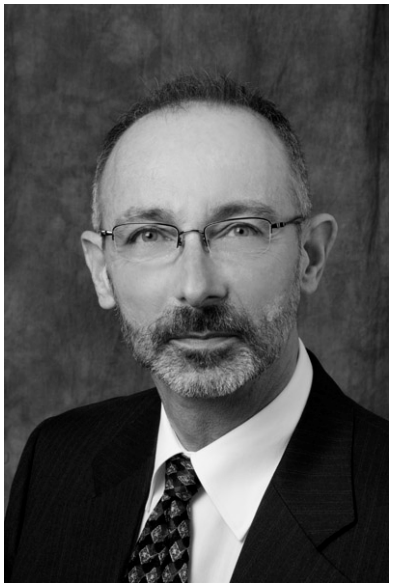
This report reflects the continued commitment of government and community partners in the Healthy Child Manitoba Strategy to facilitate child-centered public policy. In 2009/10, Healthy Child Manitoba Office (HCMO) activities and achievements included:

- continuing the province-wide implementation of the Triple P - Positive Parenting Program, wherein approximately 198 community agencies, school divisions, family resource centres, and child and family service agencies have now partnered with HCMO for training;
- working collaboratively with Healthy Child Committee of Cabinet partner departments on Manitoba's multi-year FASD strategy, with HCMO continuing its cross-sectoral coordination of the strategy;
- continuing the development of a provincial approach to Middle Childhood and Adolescent Development (MCAD), and piloting evidence-based model MCAD programs in the Manitoba context, including the Healthy Buddies program (in partnership with Manitoba Education; Manitoba Healthy Living, Youth and Seniors; and the Manitoba Institute of Child Health), the Life Skills Training (LST) program (in partnership with Manitoba Education and Manitoba Justice), and the Signs of Suicide (SOS) program (in partnership with Manitoba Family Services and Consumer Affairs, the *Changes for Children* initiative, and the Winnipeg Regional Health Authority), all in partnership with Manitoba school divisions and schools;
- supporting 26 parent child coalitions across the province, including an annual Provincial Forum, hosted by HCMO, to provide coalition members and community partners with the newest research, (in 2009 the first Pan-Canadian Early Development Instrument Conference) professional development and networking opportunities;
- working collaboratively with partner departments and community stakeholders to implement *Reclaiming Hope: Manitoba's Youth Suicide Prevention Strategy* (including the SOS program pilot noted above and planning for a pilot of the Communities That Care approach);
- implementing a partnership with the Manitoba First Nations Education Resource Centre (MFNERC) under the Indian and Northern Affairs Canada (Education Partnerships Program) for a three-year collaboration to review all existing early childhood initiatives and programs in Manitoba First Nations, develop a comprehensive early childhood model for effective and relevant early child development programs, and present to all First Nations for ratification and community-based implementation of this joint model, including the provincial launch of Seeds of Empathy in MFNERC communities as one of the first steps in this initiative; and
- continuing our working relationship with the Public Health Agency of Canada and First Nations Inuit Health Branch to develop and promote the goals and values of the Manitoba Children's Agenda.

The Healthy Child Manitoba Office continues to work toward the best possible outcomes for Manitoba's children and youth.

Respectfully submitted,

Jan Sanderson
Secretary to Healthy Child Committee of Cabinet,
Chief Executive Officer, Healthy Child Manitoba Office, and
Deputy Minister of Healthy Living, Youth and Seniors



Jeffrey Schnoor
Chair, Healthy Child Deputy Ministers' Committee, and
Deputy Attorney General and Deputy Minister of Justice

Table of Contents

HEALTHY CHILD MANITOBA
ORGANIZATION CHART
March 31, 2010

PREFACE

Report Structure

The Annual Report is organized in accordance with the appropriation structure of the Healthy Child Manitoba Office (HCMO), which reflects the authorized votes approved by the Legislative Assembly. The report includes information at the Main and Sub-appropriation levels relating to the office's objectives, actual results achieved, financial performance and variances, and provides a five-year historical table of expenditures and staffing. Expenditures and revenue variance explanations previously contained in the Public Accounts of Manitoba are now provided in the Annual Report.

Mandate

As legislated by *The Healthy Child Manitoba Act,* Healthy Child Manitoba (HCM) is the Government of Manitoba's long-term, cross-departmental prevention strategy for putting children and families first. Within Manitoba's child-centred public policy framework, founded on the integration of economic justice and social justice, and led by the Healthy Child Committee of Cabinet (HCCC), HCMO works across departments and sectors to facilitate a community development approach toward the best possible outcomes for Manitoba's children and youth (prenatal – 18 years).

Background

In March 2000, the Government of Manitoba established the HCM Strategy and the Premier created HCCC. In 2009/10, the HCCC Chair was Minister of Healthy Living, Youth and Seniors Jim Rondeau, appointed by the Premier in November 2009, succeeding Past Chairs Minister of Healthy Living Kerri Irvin-Ross (September 2006-November 2009), Minister of Healthy Living Theresa Oswald (October 2004-September 2006), Minister of Healthy Living Jim Rondeau (November 2003-October 2004), and Minister of Family Services and Housing/Minister of Energy, Science and Technology Tim Sale (March 2000-November 2003). HCCC develops and leads child-centred public policy across government and ensures interdepartmental cooperation and coordination with respect to programs and services for Manitoba's children and families. As a statutory committee of Cabinet, HCCC signals healthy child and adolescent development as a top-level policy priority of government. It is the only legislated Cabinet committee in Canada that is dedicated to children and youth. HCCC meets regularly during the year and is supported by the Healthy Child Deputy Minister's Committee and the Healthy Child Manitoba Office.

Healthy Child Committee of Cabinet (HCCC) 2009/10

Jim Rondeau, Minister of Healthy Living, Youth and Seniors (Chair)
Eric Robinson, Minister of Aboriginal and Northern Affairs
Flor Marcelino, Minister of Culture, Heritage, and Tourism
Nancy Allan, Minister of Education
Gord Mackintosh, Minister of Family Services and Consumer Affairs
Theresa Oswald, Minister of Health
Kerri Irvin-Ross, Minister of Housing and Community Development
Andrew Swan, Attorney General and Minister of Justice
Jennifer Howard, Minister of Labour and Immigration, Minister responsible for the Status of Women, and Minister responsible for Persons with Disabilities

Directed by HCCC, the Healthy Child Deputy Ministers' Committee (HCDMC), comprising the Deputy Ministers of the nine HCCC partner departments, share responsibility for implementing Manitoba's child-

centred public policy within and across departments, and ensuring the timely preparation of proposals, implementation plans and resulting delivery of all initiatives under the HCM Strategy. Chaired by the Deputy Attorney General/Deputy Minister of Justice, HCDMC meets on a bi-monthly basis.

Healthy Child Deputy Ministers' Committee (HCDMC) 2009/10

Jeff Schnoor, Deputy Attorney General and Deputy Minister of Justice (Chair)
Harvey Bostrom, Deputy Minister of Aboriginal and Northern Affairs
Sandra Hardy, Deputy Minister of Culture, Heritage, and Tourism
Gerald Farthing, Deputy Minister of Education
Grant Doak, Deputy Minister of Family Services and Consumer Affairs
Arlene Wilgosh, Deputy Minister of Health
Jan Sanderson, Deputy Minister of Healthy Living, Youth and Seniors
Joy Cramer, Deputy Minister of Housing and Community Development
Jeff Parr, Deputy Minister of Labour and Immigration

Provincial Healthy Child Advisory Committee 2009/10

The Healthy Child Manitoba Act also mandates the Provincial Healthy Child Advisory Committee. Its role is to contribute to the Healthy Child Manitoba vision by providing recommendations to the Chair of HCCC regarding the Healthy Child Manitoba Strategy. The Committee consists of ministerial appointees drawn from community, educational, academic and government backgrounds. The Committee is chaired by Strini Reddy, a retired educator, former president of the Manitoba Association of School Superintendents, and Member of the Order of Manitoba.

Healthy Child Manitoba Vision

The best possible outcomes for Manitoba's children and youth (prenatal to age 18 years).

Objectives

The major responsibilities of HCMO are to:

- research, develop, fund and evaluate innovative initiatives and long-term strategies to improve outcomes for Manitoba's children and youth;
- coordinate and integrate policy, programs and services across government for children, youth and families using early intervention and population health models;
- increase the involvement of families, neighbourhoods and communities in prevention and promoting healthy child development through community development; and
- facilitate child-centred public policy development, knowledge exchange and investment across departments and sectors through evaluation and research on key determinants and outcomes of child and youth well-being.

Major Activities and Accomplishments

HCMO coordinates the Manitoba government's long-term, cross-departmental strategy to support healthy child and adolescent development. During 2009/10, HCMO continued to improve and expand Manitoba's network of programs and supports for children, youth and families. Working across departments and with community partners, HCMO is committed to putting the interests of children and families first; and to building

the best possible future for Manitoba through two major activities: (I) program development and implementation, and (II) policy development, research and evaluation.

In 2009/10, Healthy Child Manitoba Office (HCMO) activities and achievements included:

- continuing the province wide implementation of the Triple P - Positive Parenting Program, through which approximately 198 community agencies, school divisions, family resource centres, and child and family service agencies have now partnered with HCMO for training;
- working collaboratively with Healthy Child Committee of Cabinet partner departments on Manitoba's multi-year FASD strategy, with HCMO continuing its cross-sectoral coordination of the strategy;
- continuing the development of a provincial approach to Middle Childhood and Adolescent Development (MCAD), and piloting evidence-based model MCAD programs in the Manitoba context, including the Healthy Buddies program (in partnership with Manitoba Education; Manitoba Healthy Living, Youth and Seniors; and the Manitoba Institute of Child Health), the Life Skills Training (LST) program (in partnership with Manitoba Education and Manitoba Justice), and the Signs of Suicide (SOS) program (in partnership with Manitoba Family Services and Consumer Affairs, the *Changes for Children* initiative, and the Winnipeg Regional Health Authority, all in partnership with Manitoba school divisions and schools;
- supporting 26 parent child coalitions across the province, including an annual Provincial Forum, hosted by HCMO, to provide coalition members and community partners with the newest research, (in 2009 the first Pan-Canadian Early Development Instrument Conference) professional development and networking opportunities;
- working collaboratively with partner departments and community stakeholders to implement *Reclaiming Hope: Manitoba's Youth Suicide Prevention Strategy* (including the SOS program pilot noted above and planning for a pilot of the Communities That Care approach);
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- continuing our working relationship with the Public Health Agency of Canada and First Nations Inuit Health Branch to develop and promote the goals and values of the Manitoba Children's Agenda.

Sustainable Development

The Sustainable Development Act sets out principles for HCMO to follow in integrating considerations for the environment, human health, and social well-being into daily operations. Guided by its mandate to work across departments and sectors to improve the well-being of Manitoba's children, youth, families and communities, HCMO activities and achievements related to sustainable development are represented throughout this report.

I. HCMO Program Development and Implementation

The well-being of Manitoba's children and youth is a government-wide priority. HCMO program development and implementation activities continued to focus on the five original HCCC core commitments (March 2000): parent-child centres, prenatal and early childhood nutrition, fetal alcohol syndrome (FAS) prevention, nurses in schools, and adolescent pregnancy prevention. Over time, these commitments have evolved and expanded respectively, as follows:

- Parent-Child Coalitions
- Healthy Baby

- Fetal Alcohol Spectrum Disorder (FASD) Prevention and Support
- Healthy Schools
- Middle Childhood and Adolescent Development

HCMO program development and implementation are supported by the Healthy Child Interdepartmental Program and Planning Committee, which includes officials from HCCC partner departments, as well as Manitoba Local Government (Neighbourhoods Alive! Program). Chaired by HCMO, the committee works to coordinate and improve programs for children and youth across departments.

HCMO program development and implementation includes initiatives for early childhood development (ECD), FASD prevention and support, middle childhood and adolescent development, and community capacity building.

A) Early Childhood Development (ECD)

A focus of the Early Childhood Development (ECD) portfolio is to raise the profile of the evidence and programs that support children aged 0-5 years, including the prenatal period. Research shows that investments in ECD, through universal and targeted early childhood programs and services, set a foundation for children's health, well-being, and lifelong success at learning. In 2009/10, work continued on the provincial ECD strategy, incorporating evidence-based principles and best practice models.

Parent Child Coalitions

The Parent Child Coalitions bring together community strengths and resources within a geographic boundary to promote and support community-based programs for young children and their families. This community development approach includes representation from parents, school divisions, early childhood educators, health professionals and other community organizations. Core priorities of Coalition activities include positive parenting, nutrition and physical health, literacy and learning, and community capacity building.

Parent Child Coalitions operate in every region of the province, organized within the 11 regional health authority (RHA) boundaries outside Winnipeg and the 12 Community Areas within Winnipeg. Two cultural organizations and eight family resource programs also receive parent child funding. Parent Child Coalitions plan community activities based on local needs and determined through community consultation. A wide variety of service delivery approaches are used and a wide range of activities are offered.

The Council of Coalitions includes representatives from each Parent Child Coalition and meets on a regular basis to promote community development, networking and sharing of resources. Also, the Provincial Healthy Child Advisory Committee includes representation from urban, inner city, rural and northern coalitions. Annually, HCMO hosts an annual Provincial Forum to provide Parent Child Coalition members and community partners with professional development and networking opportunities. In 2009/10, HCMO partnered with the Council for Early Child Development, the Human Early Learning Partnership, and the Offord Centre for Child Studies to host the first pan-Canadian conference on population based measurement of children's development for communities, i.e., the Early Development Instrument (EDI).

Triple P – Positive Parenting Program

On March 21, 2005, HCCC announced funding to implement the Triple P - Positive Parenting Program system in Manitoba. Triple P is founded on more than 30 years of rigourous international research conducted at the University of Queensland's Parenting and Family Support Centre in Australia and

internationally. Since the initial announcement in 2005, HCMO has been presenting to and consulting with community agencies, RHAs, child care centres, family resource centres, school divisions, and others to inform and seek partners on this new approach to supporting Manitoba's parents, with an initial focus on families with children under the age of 12 years and especially under age six years.

In order to reach all parents, the Triple P system is designed as a training initiative to broaden the skills of current service delivery systems (e.g. those working in health, early learning and child care, social services, education), at multiple levels of intensity, from brief consultations to intensive interventions. Parents have the opportunity to access evidence-based information and support, when they need it, from Triple P trained and accredited practitioners in their local community.

Agencies and organizations with trained staff are then able to offer Triple P to clients within their particular mandate. Thus, for some agencies this means providing Triple P services to the general public while for others it is provided to those clients within the mandate that they currently serve (e.g., mental health services of an RHA, clinical support services of a school division, or parents whose children attend a local child care facility).

To ensure successful implementation and delivery, Triple P has been phased in across the province. Based on an HCCC-approved, two-part selection process based on both need and capacity, five initial communities were selected from four geographic categories (inner-city, suburban, rural and northern) using RHA and Winnipeg Community Area (WCA) boundaries. This process included identifying communities with the highest need, as determined by results from the EDI, and community capacity and readiness.

For 2005/06, the five regions that were identified to receive training and implement Triple P based on the above criteria were: North End/Point Douglas, Elmwood and Seven Oaks in Winnipeg, as well as North Eastman and Burntwood.

Based on the same selection criteria, an expansion of training to the following regions and communities was announced in August 2006: NOR-MAN, Parkland, Interlake, South Eastman, Brandon, and in Winnipeg: Downtown and Inkster community areas.

In April 2008, training was opened to the remaining regions (i.e., Assiniboine, Central and Churchill) and Winnipeg community areas (i.e., Fort Garry, River East, Transcona, River Heights, St. Vital, St. Boniface, St. James, and Assiniboine South).

Triple P training and accreditation continues to be provided to staff from a wide range of organizations and agencies to enhance their skills in this population-level prevention and early intervention approach. HCMO continues to work with organizations and agencies to identify the most appropriate person(s) to be trained, at different levels of the Triple P system, using general guidelines established by Triple P International.

HCMO continues to be committed to allocating funding to support the costs of training service providers (including a subsidy for travel and accommodation) in the Triple P system and to provide, at no cost to agencies, the resource materials needed to deliver Triple P.

In partnering with HCMO and in participating in Triple P training and accreditation, agencies and organizations commit themselves to (a) deliver Triple P services to parents and families in their community; and (b) ensure strong managerial and supervisory support for their staff through the training, accreditation and implementation phases of Triple P, as well as its province wide evaluation (currently being developed).

In recent years, Triple P training and/or accreditation opportunities have been held in Winnipeg, The Pas, Thompson, Brandon, Swan River, Altona, Winkler, Dauphin, Portage la Prairie and Churchill. Feedback from practitioners who have taken training has been very positive regarding the quality of the training received. Practitioners have also expressed strong satisfaction and appreciation that training has been

offered in the various regions as well as in Winnipeg.

By the end of March 2010, 1150 practitioners from approximately 198 community agencies, RHAs, school divisions, child care centres, government departments, and other organizations, have participated in Triple P training and have successfully completed accreditation. A number of these practitioners have been accredited to deliver more than one level of Triple P intervention.

In February 2010, the first Triple P training in French for Francophone practitioners was held in Winnipeg. Approximately 30 service providers participated in training to be able to deliver Group Triple P in French. This training offered in French was the first such Triple P training held in Canada and honoured a commitment made to Francophone communities in Manitoba that Triple P training and services would be made available in French. In November 2009, HCMO also facilitated a memorandum of understanding between Triple P International, HCMO, and the Government of Manitoba Translation Services to facilitate the translation of Triple P resource materials for both service providers and parents. An increasing number of these Group Triple P resources will be available in French in the coming months, including the parent workbook, the parenting DVD, and the practitioner manual and guidebook.

There has also been a positive response from many First Nations communities (especially in northern Manitoba) in sending practitioners for training. Practitioners have included nurses, crisis counsellors, FASD mentors, Canada Prenatal Nutrition Program (CPNP) staff, school guidance counsellors, educational assistants, resource teachers, early learning and child care staff. To provide guidance in the delivery of Triple P to Aboriginal families, HCMO facilitated the establishment of the first Canadian Triple P Aboriginal Advisory Committee in fall 2009, with representation from Aboriginal practitioners in five provinces (British Columbia, Alberta, Saskatchewan, Manitoba, and Ontario) and the Northwest Territories. HCMO currently chairs this committee, which began its work in early 2010, reviewing Triple P resource materials.

In fall of 2008, Triple P officially launched its first media campaign with public messaging that included print ads in community newspapers throughout the Province as well as bus shelter and interior bus ads. Two radio spots were also developed that promoted the message that parenting is both rewarding and sometimes challenging and that all parents and all children can benefit from support and information. Messaging to the public concerning the importance of parenting and the availability of Triple P in Manitoba continues and constitutes and important universal component of Triple P.

On an ongoing basis as well, newsletters are sent to more than 5,000 practitioners, agencies, child care facilities, family doctors, and other community partners, in both official languages. The newsletter promotes Triple P and provides information about Triple P across the province.

A comprehensive Triple P Manitoba parent/practitioner website (www.manitoba.ca/triplep) was also launched in October 2008 to provide information and resources to the community and to service providers across the Province of Manitoba. The website features a directory of organizations and agencies with Triple P trained and accredited practitioners. Other components of the site include: the basic principles of Triple P, parenting tips and resources, practitioner information regarding training as well as articles and resources pertinent to Triple P, and links to relevant parenting sites. To date, there has been a very positive and encouraging response to the website from both the general public and from practitioners. The website remains one of the most frequently visited sites on the Government of Manitoba website and for much of the 2009/10 year was highlighted as a result of its popularity with a direct link on the Government of Manitoba home page. The Triple P website will be further developed in the coming months to include a more “user friendly” Directory of Services and additional information and supports for parents.

Healthy Baby

In July 2001, HCMO introduced Healthy Baby, a two-part program that includes Healthy Baby Community Support Programs and the Manitoba Prenatal Benefit. Healthy Baby supports women during pregnancy and the child’s infancy (up to the age of 12 months) with financial assistance, social support,

and nutrition and health education.

Healthy Baby Community Support Programs are designed to assist pregnant women and new parents in connecting with other parents, families and health professionals to ensure healthy outcomes for their babies. Community programs offer family support and informal learning opportunities via group sessions and outreach. Delivered by community-based partners, the programs provide pregnant women and new parents with practical information and resources on maternal/child health issues, prenatal/postnatal and infant nutrition, breastfeeding, healthy lifestyle choices, parenting ideas, infant development and strategies to support the healthy physical, cognitive and emotional development of children.

The Healthy Baby Community Support Program funded 29 agencies to provide programming in over 100 communities and neighborhoods province-wide in 2009/10. In Winnipeg, Healthy Baby Community Support Programs funded the Winnipeg Regional Health Authority (WRHA) to provide professional health support (public health nurses, nutritionists, registered dietitians) to Healthy Baby sites. In urban centres, community-based programs are delivered on a weekly basis by a team which includes a program coordinator and health professionals. In rural and northern centres, community-based programs are delivered primarily on a monthly basis by a program coordinator with additional support from health professionals, depending on regional resources.

In 2009/10, the new *Healthy Baby Community Program Guide* was completed with the support, input and feedback of community partners. The *Program Guide*, which will be introduced to service providers at the 2010 Healthy Baby Provincial Meetings, addresses the goals, objectives and standards of service for Healthy Baby programs with an emphasis on both administrative and service delivery priorities. The *Healthy Baby Resource Guide* is currently in development and will complement the *Program Guide* by providing program staff with evidence-based resources and programming ideas that they can use in group sessions. Two new resources were developed for Healthy Baby program participants in 2009. "Favorite Family Foods: Recipes from the Healthy Baby Program," a book of low cost, easy to make, nutritious recipes; and "Making Connections: Your First Two Years With Baby", a low literacy information and resource guide to support postpartum women and their families during the critical first two years of baby's life.

The Manitoba Prenatal Benefit (MPB) was modeled after the National Child Benefit. Manitoba was the first province in Canada to extend financial benefits into the prenatal period and to include residents of First Nations on-reserve communities. The MPB is intended to help women meet their extra nutritional needs during pregnancy and also acts as a mechanism to connect women to health and community resources in their area. Benefits can begin in the month a woman is 14 weeks pregnant and continue to the month of her estimated date of delivery. A woman qualifies for benefits if her net family income is less than $32,000.00. Benefits are provided on a sliding scale based on net family income. The maximum number of benefits is seven and the maximum benefit amount is $81.41. Information sheets on pregnancy, nutrition, baby's development and the benefits of going to a Healthy Baby Community Support Program are enclosed with monthly cheques.

In 2009/10, the benefit was provided to 4,213 women in Manitoba during their pregnancies, totaling $1,903,635.57. Since the program launch date of July 1, 2001, 39,675 women have received prenatal benefits totaling $17 million.

Through a consent provided on the MPB application form, HCMO is able to connect women to community health services and/or Healthy Baby community support programs as a further means of supporting healthy pregnancies. Referrals are made to both provincial and federal prenatal programs and health agencies (both on and off reserve). In 2009/10, the MPB office made 3,919 referrals.

Healthy Baby Community Programs	1,828 referrals
Public Health	1,341 referrals
First Nation Health Centres/Nursing Stations	750 referrals

Milk coupons are offered through the Healthy Baby Community Support Programs as an incentive to participate and as a nutritional investment. Milk coupons can be redeemed at participating stores across

Manitoba. Over 250 stores across Manitoba continue to partner with HCMO for the milk coupon redemption program. In 2009/10, $124,500.84 was expended for the redemption of milk coupons, representing an 11% increase from the previous fiscal year.

Families First

Home visiting programs have demonstrated value in supporting families to meet the early developmental needs of their children. Manitoba's home visiting program, Families First, employs paraprofessionals who receive in-depth training in strength-based approaches to family intervention. The program's goals are to ensure physical health and safety, support parenting and secure attachment, promote healthy growth, development and learning, and build connections to the community.

Families First is funded and coordinated through HCMO, and delivered through the Regional Health Authorities (RHAs) in Manitoba. The program provides a continuum of home visiting services for families with children, prenatal to school entry. Public Health Nurses (PHNs) complete the screening process with all new births in Manitoba (over 15,000 births annually). Families identified through the screening process are offered an in-home Parent Survey focusing on parent-child attachment, challenges facing the family, current connection to community resources, and personal and professional support. The Parent Survey process is used to guide public health staff in determining the level of support most complementary to each family's situation, including home visiting, as available. In 2009/10, HCMO provided funding to RHAs to employ 148.7 equivalent full-time home visitors province-wide.

Initial Families First (formerly BabyFirst and Early Start) program evaluation highlights were distributed in 2005/06. The evaluation suggested that the universal screening and in-depth assessment processes are successful in identifying families that are most in need of home visiting and other supports. After being in the program for one year, families had improved parenting skills and were more connected to their communities (for more information, see http://www.gov.mb.ca/healthychild/familiesfirst/evaluation.html). Work is proceeding on a comprehensive Families First Home Visiting Evaluation Report, and this report is expected to be released in summer 2010.

Support for Training and Professional Development

HCMO ensures that all Families First home visiters and the public health nurses who supervise them receive comprehensive training opportunities to continually improve program outcomes and ensure job satisfaction.

Staff are trained in the Growing Great Kids curriculum, a parenting and child development curriculum that focuses on the integration of the relationship between parents and their child, with comprehensive child development information, while incorporating the family culture, situations and values specific to each parent. The curriculum aims to foster empathic parent-child relationships while also guiding staff in their efforts to provide strength-based support to families.

All Families First Home Visitors and their supervisors participate in four days of core training to give staff the tools for delivering successful services to families. Starting with building the philosophical foundation for work with families and overall program goals, staff receive training related to building trusting relationships, promoting positive parent-child relationships and healthy child development, recognizing family progress and boundaries or limit setting.

Participants include Families First staff as well as other community partners. Supervisors participate in a fifth day of training, focusing on clinical supervision and program and quality management.

In 2006, HCMO began training for home visitors and supervisors working in the Maternal Child Health Program of First Nations Inuit Health Branch (FNIHB) and Assembly of Manitoba Chiefs (AMC). In 2009, 21 individuals from 11 First Nation communities received provincial core training. This included practitioners from the communities of Rolling River, Dakota Tipi, Brokenhead, Swan Lake, Opaskwayak Cree Nation, Norway House, Pine Creek, Keeseekoowenin, Sagkeeng, Nelson House and Cross Lake.

Additionally, Families First staff receive training in Bookmates Family Literacy Training. Bookmates enhances family literacy through raising parental and community awareness about the importance of reading to infants and young children. HCMO provides grant support to Bookmates Inc. to deliver training workshops in literacy development.

In 2009/10, 37 Public Health Nurses (PHNs) received Parent Survey training and 22 PHNs received Advanced Parent Survey training. Over 500 PHNs have been trained to date. PHNs have opportunities annually for advanced training related to the Parent Survey process.

Les Centres de la Petite Enfant et de la Famille - Francophone Early Childhood Development (ECD) – Hub Model

HCMO continues to support the further development of the Francophone ECD – Hub Model, les centres de la petite enfant et de la famille. This school-based model is designed to provide a comprehensive continuum of integrated services and resources for minority language parents of children from prenatal through to school entry, including universal resources for increasing support and education of parents, access to specialized early intervention services such as the provincial Healthy Baby program, as well as comprehensive speech/language and other specialized developmental/learning services. The overall goal is to ensure that ECD provincial programs are accessible to all Manitobans. This model supports both ECD and the early acquisition of French language and literacy skills critical to later school success.

The model of les centres de la petite enfance et de la famille was implemented in two demonstration sites in 2004/05, École Précieux-Sang in Winnipeg and École Gabrielle-Roy in Ile des Chênes. In 2006/07, the model was expanded to two additional school settings école Réal Bérard in St. Pierre Jolys and école St. Jean Baptiste. In 2007/08, école Roméo-Dallaire (Winnipeg) and école St-Jean-Baptiste Lagimodière (Lorette) were added. In 2008/09, école St-Georges and école St-Joachim (La Broquerie) were added. In 2009/10, école Notre Dame de Lourdes, and école Taché (satellite St-Boniface), and école Noël-Rtichot (satellite St-Norbert) were added. Funding continues to be matched under the Canada/Manitoba Agreement on the Promotion of Official Languages.

The centres de la petite enfant et de la famille Steering Committee directs formal committees of government and community partners to address seven key issues: literacy/numeracy, parent education and awareness, support for exogamous families, research, early identification and intervention/multi-disciplinary services, linguistic and cultural supports, and professional training.

Intersectoral Cooperation on Early Childhood Development (ECD)

HCMO is responsible for reporting on Manitoba's implementation of the commitments in the September 2000 First Ministers' Meeting Communiqué on Early Childhood Development (ECD). This endeavour is led by the Federal/Provincial/Territorial (F/P/T) ECD Working Group and includes public reporting in all jurisdictions across Canada (except Québec) regarding ECD investments, activities and outcomes of children's well-being, and the development of intersectoral partnerships for exchanging ECD knowledge, information and effective practices.

In November 2002, the Government of Manitoba released the first of a series of major progress reports on Early Childhood Development. *Investing in Early Childhood Development* and subsequent Progress Reports provide information to Manitobans on ECD investments, activities and outcomes of children's well-being, and the development of intersectoral partnerships for exchanging ECD knowledge, information and effective practices.

In the 2003 and subsequent *Investing in Early Childhood Development* Reports, reporting to Manitobans on Early Learning and Child Care is included.

The *Investing in Early Childhood Development* 2005 Progress Report to Manitobans provided us with a first look at trends in the early development of Manitoba's children, as well as trends in related family and community characteristics. Data on indicators of children's well-being are provided for three points in time, necessary to assess trends. For printed copies of these reports, see http://www.gov.mb.ca/healthychild/ecd/ecd_reports.html#progress

Seeds of Empathy

In collaboration with the Manitoba First Nations Educational Resource Centre (MFNERC), under a tripartite agreement (2009-2012) between Indian and Northern Affairs Canada, MFNERC, and HCMO, Manitoba launched Seeds of Empathy, an expansion of the popular Roots of Empathy program founded by Mary Gordon. Community orientation days were attended by several Northern First Nations communities.

Like Roots of Empathy, Seeds of Empathy is designed to reduce physical aggression and bullying by fostering children's empathy and emotional literacy. The long term goal is to improve emotional health and build parenting capacity of the next generation. While Roots of Empathy is provided in kindergarten to Grade 8 classrooms, Seeds of Empathy is aimed at the early childhood years to be implemented in child care facilities, nursery schools and Aboriginal Head Start programs.

In 2009/10, SOE training began for early childhood centres, Aboriginal HeadStart sites and nursery schools. Under a randomized control trial, communities across Manitoba, including First Nations communities are implementing the two year process of staff training, program delivery and evaluation. Seeds of Empathy is an important component of *Reclaiming Hope: Manitoba's Youth Suicide Prevention Strategy.*

B) FASD Prevention and Support

HCMO addresses FASD through public education and awareness, prevention and intervention programs, support services to caregivers and families, and evaluation and research. HCMO supports partnerships in the community with organizations such as the Manitoba Coalition on Alcohol and Pregnancy (CAP) to advance these goals. CAP provides a forum for service providers, families, and government representatives to share information and resources. It facilitates knowledge exchange through meetings, special events, a regularly published newsletter and a website (capmanitoba.ca).

In 2007/08, the Province of Manitoba announced a coordinated, multi-year strategy to address FASD in Manitoba. The funding for this strategy is allocated to a number of government departments including Family Services and Consumer Affairs; Health; Healthy Living, Youth and Seniors; Education; Housing and Community Development; and Justice. The Healthy Child Manitoba Office is tasked with leading the coordination of the FASD strategy. The strategy includes a number of specific initiatives: Spectrum Connections, a youth and adult resource; FASD Specialists to support child and family services agencies; increased diagnostic services for adolescents; funds to enhance public education initiatives; a training strategy to improve service delivery systems; expansion of the InSight Mentoring Program (formerly known as Stop FASD) to three rural communities; more support for women with addictions; more training supports for schools divisions; and increased FASD research.

InSight Mentoring Program (formerly Stop FASD)

InSight is a three-year mentoring program for women at risk of having a child with FASD. Based on a best practice model, the program uses paraprofessional home visitors to offer consistent support to help women address substance use problems, support women's recovery from trauma, reunite women with their children, engage in family planning, utilize community resources and enhance wellness overall. The goal is to support and build women's sense of empowerment in living and enhancing their health, stability

and independence. This program is founded on a philosophy of harm reduction and culturally grounded practice. It is woman-centered and trauma-informed and works to meet clients where they are at and support them in setting their own goals – no matter what they are. Following the success of the two original Winnipeg sites located at the Aboriginal Health and Wellness Centre and the Nor'West Co-op Community Health Centre, InSight was expanded to sites in Thompson and The Pas in 2001, where they are administered by Burntwood RHA and Nor-Man RHA, respectively.

In 2008/09, the InSight Mentoring Program was expanded again, this time to Dauphin, Flin Flon and Portage la Prairie. The program can now support the engagement of 240 women with 16 mentors working around the province.

Canada Northwest Fetal Alcohol Spectrum Disorder (FASD) Partnership

Canada Northwest FASD Partnership (CNFASDP) is a collaborative venture of Canada's four western provinces and three territories that maximizes efforts, expertise and resources to prevent and respond to the needs of FASD across jurisdictions. The Partnership hosts regular conferences and symposia to provide families, service providers and health professionals with opportunities for personal and professional development and networking. In 2007/08, a unique Brain Summit was held in Winnipeg, Manitoba. Approximately 100 FASD diagnostic clinicians and researchers (psychologists, occupational therapists, speech-language therapists and pediatricians) from across Canada attended this two-day event to reach further consensus as to the common methods to be used to quantify the degree of brain deficits in individuals with FASD. The Brain Summit sought to determine if there are further refinements that could be made to the brain scale to reflect the individual maladaptive severity of the disability.

In 2005, the Partnership established The Canada Northwest FASD Research Network (CanFASD Northwest) to build a common research agenda in western/ northern Canada. CanFASD Northwest has formed five Network Action Teams that are conducting research in a number of program areas which may have crosscutting themes. In 2007/08, a Research Network Website was launched (www.canfasd.ca). The Website provides: an explanation of the Canada Northwest FASD Partnership Research Network; access to the Research library; current information on each of the Research Action Teams; and news updates and information on upcoming events.

Effective April 1, 2010, the University of Manitoba will sign a contract with CanFASD Northwest to host the Prevention Network Action Team on Mentoring programs across the Partnership. Dr. Linda Burnside and Dr. John McDermott will co-lead the development and work of this National Action Team. They will begin by bringing all the mentoring programs across the partnership together to identify their research questions and themes of concern. They will then develop methodological strategies, identify potential barriers to be addressed and establish a timeframe for implementation.

FASD Information Manitoba

In 2009/10, HCMO and Health Canada continued to support this provincial toll-free telephone line for FASD information and support. The telephone line continues to be managed by Interagency FASD, which became a program of New Directions for Children, Youth, Families and Communities in fall 2009. FASD Information Manitoba (1-866-877-0050) was established in 2001/02 to disseminate information and to provide strategies and support to individuals, families and professionals dealing with alcohol-related disabilities, and to link them to community-based services.

Screening for Prenatal Alcohol Use

Since 2003/04, additional funding has been provided for a universal screening process for the collection of more relevant data on the prevalence of alcohol use during pregnancy. As part of the screening process, Public Health Nurses now ask all women who deliver a baby in a Manitoba hospital about their

use of alcohol during pregnancy including the frequency of alcohol use and the amount of alcohol consumed. Results from 2003 to 2006 indicate that approximately 13% of women in Manitoba drank alcohol during their pregnancy. The information collected will help Manitoba plan and target program resources and measure the impact of FASD prevention work.

Support in the Classroom for Students with FASD

The purpose of the Bridges program is to refine a model to enhance the school experience and outcomes for children with FASD and other alcohol-related disabilities in the Winnipeg School Division. A partnership involving HCMO, Manitoba Education and the Winnipeg School Division continued their efforts to identify, review and disseminate best academic and behavioural practices for students with FASD in grades four to six.

In 2009/10, David Livingstone School launched “Jilly’s Story,” a book written by the students in the Bridges FASD classroom to educate others about the strengths and needs of students with FASD, and to promote a more positive image of individuals living with FASD. The book received an extremely positive response and has been distributed world wide.

Project CHOICES

Developed in the late 1990s by a team of U.S. researchers in partnership with the U.S. Centres for Disease Control and Prevention (CDC), Project CHOICES uses a women-centred, harm reduction approach to providing information and a brief motivational intervention consisting of four counselling sessions and one contraception consultation visit. The intervention focuses on increasing the participants’ commitment to change through the use of motivational interviewing and content aimed at increasing motivation.

This program is intended to focus on non-pregnant women, aged 16 years of age to menopause, who are engaging in high-risk drinking behaviour (consuming more than two drinks on any one day or more than eight drinks per week on average) and who have had intercourse without effective/consistent contraception use. The specific goal of Project CHOICES is to encourage women at risk of an alcohol-exposed pregnancy to change either or both of these target behaviours, which are established risk factors for alcohol-exposed pregnancies.

Klinic Community Health Centre and Nor’west Community Health Centre have agreed to work collaboratively to help develop the program to fit the implementation and service delivery needs of Manitoba. Both sites are expected to start seeing clients in the fall of 2010.

C) Middle Childhood and Adolescent Development

The Middle Childhood and Adolescent Development (MCAD) portfolio focuses on raising the profile of the evidence and programs that support children and youth aged 6-18 years. Research shows that investments in MCAD maintain the investments and positive gains that are achieved in early childhood programs and services. In 2009/10, work continued on the development of a provincial approach to MCAD, incorporating harm reduction strategies for risk behaviours and principles of population health, based on scientific knowledge of best practice models.

Within the MCAD portfolio, Middle Childhood focuses on children aged 6 - 12 years and Adolescent Development focuses on youth aged 13 - 18 years.

Healthy Schools

In 2009/10, HCMO continued to partner with the education sector to facilitate and support progress towards positive health and education outcomes for all students.

Healthy Schools is Manitoba's comprehensive school health initiative to support and empower school communities to positively influence the interdependency between health and learning and to create school environments that enhance the healthy development of children and their families by working in partnership with community service providers and resources. Under the auspices of HCCC, Healthy Schools is a partnership between Manitoba Healthy Living, Youth and Seniors; Manitoba Education; and HCMO; with Healthy Living, Youth and Seniors serving the lead role.

Healthy Schools focuses on six priority health issues in the context of the school community: physical activity, healthy eating, safety and injury prevention, substance use and addictions, sexual and reproductive health, and mental health. The Healthy Schools initiative includes the following three components:

Targeted Provincial Campaigns

Annual funding was provided to schools through the Healthy Schools Targeted Provincial Campaigns to undertake projects that support and increase awareness of an important health and wellness issue. In 2009/10, schools were eligible to receive funding through the Healthy Schools Campaigns for activities that focused on physical activity (fall 2009) and healthy eating (spring 2010).

Community-based Activities

In 2009/10, annual funding was provided to school divisions and all independent and band operated schools through the Healthy Schools Community-Based funding to facilitate partnerships with regional health authorities and other local resources around developing and implementing Healthy Schools activities. Examples of Community-based activities include:

- wellness promotion (e.g. workshops, fairs, days) on various health topics;
- purchase of equipment and/or materials (e.g. sports equipment, books);
- implementation of programs and staff training;
- distribution of kits (successful learners, healthy living, medicine bags);
- presentations to students on various topics (e.g. bullying, Teen Talk); and,
- development and implementation of division wide healthy living (e.g. nutrition) policy.

Resources

The Healthy Schools website (www.manitoba.ca/healthyschools) provides information and educational materials to assist school communities in promoting health. The following resources are available online:

- a resource directory featuring a searchable listing of services, programs and organizations throughout Manitoba related to child health and education and other useful topics;
- an electronic subscription to Healthy Schools eNews, a service that provides the latest information about Manitoba Healthy Schools;
- a Healthy Schools newsletter is distributed to all schools three times a year;
- a Power Point presentation that stakeholders can use to promote the initiative;
- an opportunity to share Healthy School stories with others around Manitoba; and,
- an annotated index/list of existing resources focusing on the six key health topics featuring information for school staff, parents, youth, and children.

Roots of Empathy

In 2009/10, HCMO continued to support Roots of Empathy (ROE), a classroom-based parenting program that increases pro-social behaviour and reduces physical aggression and bullying by fostering children's empathy and emotional literacy. In the long term, the goal of ROE is to build the parenting capacity of the next generation of parents.

ROE involves children in classrooms from kindergarten to grade eight (K-8). Certified ROE instructors deliver the curriculum, approved by Curriculum Services Canada, in the same classroom, three times a month for the school year. The heart of the program is a neighbourhood infant and parent(s) who visit the classroom once a month.

By the end of the school year, students have become attached to "their baby" and have come to understand the complete dependence of the baby on others. They have also come to understand health and safety issues, such as proper sleep position, injury prevention, Shaken Baby Syndrome, FASD, the risks of second-hand smoke, the benefits of breastfeeding, and the stimulation and nurturance required for healthy child development. As the ROE instructor coaches children to observe and interpret the baby's feelings, students learn to identify and reflect on their own feelings, and to recognize and respond to the feelings of others (empathy), thereby strengthening emotional literacy.

Building on the success of the 2001/02 pilot of the ROE program, and the positive outcomes of improving prosocial behaviour and reducing aggression in students, as reported in the three year longitudinal randomized control trail (2008), ROE has continued to expand across Manitoba. In 2009/10, ROE was delivered by 191 ROE certified instructors in 208 classrooms across Manitoba. This includes 84 new ROE instructors who received training in 2009/10; 60 of these are scheduled to be certified in June 2010.

Mentoring Interventions

In 2009/10, HCMO continued to support mentoring programs both within and outside of Winnipeg, including Big Brothers and Big Sisters (BBBS) In School Mentoring programs in Winnipeg, Brandon, Portage la Prairie, and Morden/Winkler, as well as the New Friends Community Mentorship program in the Lac du Bonnet and Pinawa area. In addition, HCMO continued to support out of school programming at the Boys and Girls Club of Thompson.

On November 10, 2009, representatives from community organizations in Manitoba that provide mentoring for children and youth, as well as those interested in learning how mentoring could support existing programming in their organizations, attended a Mentoring in Manitoba workshop sponsored by HCMO. This conference was designed to provide our community partners with information on the value and best practices associated with mentoring and to provide a formal opportunity for networking among our partners. As a result of this conference, a Mentoring Network has been created.

COACH

In 2009/10, HCMO continued to support COACH, a 24-hour wrap around program for 5 to 11 year old children with extreme behavioural, emotional, social and academic issues. COACH is designed for children who have committed criminal offences for which they would be charged if they were age 12 and over; who have been in and out of care; and who reside within the Winnipeg School Division catchment. The program runs for 12 months of the year and provides both the appropriate school curriculum and family-based components as well as community socialization, aimed at returning students to an educational setting where they can function with specialized supports.

There is an ongoing program evaluation of COACH which focuses on pre and post measures in a case study format. Multiple informants including the parent/guardian, teacher, psychologist, COACH, COACH Manager, and the student provide responses on a standardized survey at the start of attendance at

COACH and close of each school year. Progress has been noted in academic, social, emotional, community and behavioural functioning as well as an increase in the parents' involvement with the school setting, and based on parent reports, an improved relationship with their child.

Healthy Buddies

In 2009/10, HCMO and Manitoba Education, launched a pilot Healthy Buddies project, a peer mentoring initiative that pairs younger students with older students who teach the younger students about nutrition, physical activity and positive self-image.

First implemented in British Columbia, Healthy Buddies was developed by physicians and educators as an early intervention resource beginning in kindergarten and continuing through grade 7. Older students spend half the program time learning the lesson and half the time teaching it to younger students. This process helps older students become role models and to better understand the lessons themselves.

Each participating classroom receives resources such as games, videos, and music to assist in the teaching and learning process. The aim of Healthy Buddies is to complement existing healthy schools programming such as expanding physical education and smoking reduction efforts.

The pilot project was launched in 20 schools, including First Nation band schools. These schools are participating in an evaluation to determine the effectiveness of Healthy Buddies in Manitoba. Results of the Healthy Buddies evaluation will be available in fall/winter 2010. For more information on Healthy Buddies, please see http://www.healthybuddies.ca

Life Skills Training

In 2009/10, HCMO, in partnership with Manitoba Justice and Manitoba Education, launched a pilot Life Skills Training (LST) project.

Developed by Dr. Gilbert J. Botvin (Cornell University), LST is an evidence-based prevention program targeting social and psychological factors that may cause youth to initiate high risk behaviours, including substance abuse and violence. LST focuses on teaching children how to make healthy choices throughout their lives by improving personal self-management skills, general social skills and self esteem, and drug resistance skills.

The pilot project was launched in 30 grade three classrooms across the province. These schools are participating in an evaluation to determine the effectiveness of LST in Manitoba. For more information on LST, please see http://www.lifeskillstraining.com

School/Community-Based Primary Health Care

HCMO's Teen Clinic model uses a community development approach to build partnerships among health providers, educators and community organizations to improve health outcomes for Manitoba teens. Since 2002/03, HCMO has funded the Elmwood Teen Clinic, an after-hours, school based primary health care facility located at Elmwood High School and managed by Access River East one day per week. The clinic addresses the general health and well-being of students and neighbourhood youth, including sexual and reproductive health issues. In 2009/10 there were over 586 visits to the Elmwood Teen Clinic.

Results from a 2003 client satisfaction survey were very strong with over 96% of respondents indicating satisfaction with service. A subsequent process evaluation indicated that key components of the model including an effective triage system, appropriately trained and qualified staff, and appropriate and committed community partnerships all contributed to the progress of the Elmwood Teen Clinic.

Based on the success and interest in the Elmwood Teen Clinic, in 2005/06, HCMO expanded the model to a second pilot at St. John's High School in Winnipeg. The St. John's Teen Clinic, managed by Mount Carmel Clinic, operates similarly to the Elmwood Teen Clinic. In 2009/10 there were over 600 visits to St. John's Teen Clinic.

In 2006/07, the Interdepartmental Teen Clinic Committee which included representatives from HCMO; Health and Healthy Living; Education, Citizenship and Youth; Family Services and Housing; and the Status of Women selected NOR-MAN RHA and Interlake RHA to receive new HCMO funding to establish teen health services in their regions. The main criteria for the selection of the teen clinics were the need for adolescent health services in the region, the capacity of the region to implement their plan, and the utilization of multidisciplinary partnerships.

NOR-MAN RHA has matched the HCMO funding to enhance teen primary care services in Flin Flon, The Pas and Cranberry Portage. The NOR-MAN model is a combination of school-based and community-based clinics that provide maximum access to services for NOR-MAN youth. There were over 500 visits to the NOR-MAN Teen Clinics in 2009/10.

Interlake RHA established a school-based teen clinic in École Selkirk Junior High in 2007. This clinic is an after hours clinic that is open to all youth living in the Interlake region. There were over 500 visits to Selkirk Teen Clinic in 2009/10. As well, an evaluation framework has been developed to evaluate all the HCMO-funded clinics.

Health and Wellness Promotion

HCMO extends support to community-based agencies to support the healthy development of adolescents including those that emphasize the direct involvement of youth in identifying their own issues and developing their own solutions. Klinic's Teen Talk program is a comprehensive health promotion program designed to empower youth to make healthier lifestyle choices. Program components include the use of community role models and elders, and an emphasis on peer mentoring to facilitate youth leadership, issue ownership and decision-making. In 2009/10, 15,410 youth received Teen Talk services.

Signs of Suicide

In 2009/10, HCMO partnered with Manitoba Family Services and Consumer Affairs (under the *Changes for Children* initiative) and the Winnipeg Regional Health Authority to pilot the Signs of Suicide (SOS) program, a new initiative within the Awareness and Understanding component of Reclaiming Hope - Manitoba's Youth Suicide Prevention Strategy. The purpose of SOS is to help develop the public's understanding that suicide is an important community health issue, that it can be prevented and that everyone can play a part in providing support to youth at risk.

SOS, developed in the United States, is an evidenced-based, school-based prevention program incorporating curricula to raise awareness of suicide and its related issues; and a brief screening for depression and other risk factors associated with suicidal behaviour. Youth are taught to recognize the signs of suicide and depression and they are taught the specific action steps necessary for responding to those signs. The program is designed to decrease suicide, suicide attempts and self-injury by increasing knowledge and adaptive attitudes about depression among students. An important component of the program is the anti-stigma approach which treats mental illness like a physical illness, that is, clarifying that both require treatment. The program encourages youth to seek help on an individual level, as well as for their peers. At the same time, the program encourages schools to develop community-based partnerships with Mental Health professionals and other stakeholders to address issues associated with student mental health and youth suicide.

In the 2009/10 school year, 13 schools, including four First Nation band schools, implemented the SOS program for their grade 9 students. These schools are participating in an evaluation to determine the effectiveness of SOS in Manitoba. Results of the SOS evaluation will be available in 2010/11. For more information on SOS, please see http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=53

D) Community Capacity Building

HCMO, in collaboration with Healthy Child partner departments, also assists communities in building local capacity to support children, youth, and families. The following are examples of organizations that received funding in 2009/10:

Mino Bimaadiziwin Inc., an educational program that incorporates a holistic and cultural approach to addressing substance-abuse issues for First Nations youth attending Southeast College in Winnipeg received support. Students completing the program participated in a trip that serves as a reward but also as an additional learning experience that helps reinforce the positive lifestyle choices they have made.

Support was provided to **Manitoba Theatre for Young People** for their Aboriginal Arts Training and Mentorship program which provides classes in theatre, film and related arts to more than 425 Aboriginal youth in Manitoba. This specialized program also helps youth develop an understanding, awareness and appreciation of themselves, their heritage, culture, and identity.

Canadian Centre for Child Protection was provided support for the 10th Missing and Exploited Children Conference, a training opportunity for participants from law enforcement, social work, community organizations and education to increase and share knowledge concerning issues of missing and exploited children.

HCMO supported the **Mauro Centre for Peace and Justice** to bring international performers to Winnipeg to participate in the Winnipeg International Storytelling Festival, an event that uses storytelling as an approach to build relationships and bring people together across cultural and economic divides.

HCMO provided a contribution to the **Fondation Charite Congo Canadaine (FCC-Canada**) to support their Camp D'Eté Pour Jeunes Congolais, a 'transition to school' summer camp for Congolese and other newly immigrated children. The Fondation Charite Congo Canadaine, established in 2008, is a community-based organization that assists Congolese families and other new Canadians to overcome cultural, economic and language barriers as they integrate into Canadian life.

Communities That Care

In 2009/10, HCMO partnered with Manitoba Family Services and Consumer Affairs (under the *Changes for Children* initiative) and the Winnipeg Regional Health Authority to pilot Communities that Care (CTC), a new evidence-based initiative that combines strategic consultation, technical assistance, training and research-based tools to help communities come together to promote the positive development of their youth and the prevention of adolescent problem behaviors - including underage drinking, substance abuse, delinquency, teen pregnancy, school drop-out and violence.

Developed by Dr. J. David Hawkins and Dr. Richard F. Catalano - professors of social work at the University of Washington, directors of the Social Development Research Group (SDRG), and internationally known researchers in crime, violence, substance abuse prevention and positive youth development - CTC is currently being used in more than 500 communities across the US and in Australia, Canada, Germany, the Netherlands, and the United Kingdom. The Social Development Research Group (SDRG) at the University of Washington will provide training and research support to the Province of Manitoba in its efforts to pilot the CTC prevention planning system in four diverse communities throughout the Province. These communities will be identified in cooperation with the Child and Family Services Authorities Standing Committee. Over time, local community people will be trained

as trainers for CTC. For more information on CTC, please see http://ncadi.samhsa.gov/features/ctc/resources.aspx

Equity- Focused Health Impact Assessment

In March of 2005, Manitoba launched the Triple P – Positive Parenting Program system to assist parents with evidence-based parenting information and supports. Currently Manitoba's Triple P initiative focuses on providing services to families with children below 12 years of age. Recognizing that families with teenage children are in need of similar supports, consideration is now being given to expanding the initiative to support parents of teenagers (12-16 years), available as Teen Triple P, a specific program variant from the Triple P system.

This stage of program planning for supports for parents of teens, coincided with a timely opportunity to pilot the use of a new planning tool, a health impact assessment (HIA), proposed by a research team from the University of Manitoba. Internationally, the use of health impact assessment has grown considerably over the past 20 years, with many jurisdictions now institutionalizing HIA to the extent of having legislation and regulations that support or require the use of HIAs. This impact assessment will focus on the potential for the proposed Teen Triple P to enable equitable access to the program and produce equitable outcomes and, as such, is called an equity- focused health impact assessment (EfHIA).

This pilot EfHIA of the proposed Teen Triple P in Manitoba, initiated in 2009/10, is supported by the Public Health Agency of Canada (PHAC), and is being carried out in partnership with HCMO and the University of Manitoba (Dr. Benita Cohen, Faculty of Nursing), with mentoring support from colleagues from the University of New South Wales (Australia) who bring extensive experience conducting EfHIAs. The purpose of this impact assessment pilot is to:

- assess the potential for the proposed Teen Triple P in Manitoba to achieve equity of access and outcomes for families of diverse backgrounds, including marginalized and socially disadvantaged populations, using an established EfHIA process;
- recommend alternative actions to decision makers at HCMO, for their consideration, that could promote greater equity of access and outcomes among diverse families participating in the proposed Teen Triple P, if required;
- evaluate the influence of the EfHIA process regarding the integration of equity-oriented recommendations related to the implementation of the proposed Teen Triple P; and
- identify key lessons from the pilot test process, tools and outcomes, in the Manitoba context, as well as recommendations for improvement that could be utilized to facilitate and inform the application of EfHIA in Canada.

II. HCMO Policy Development, Research and Evaluation

Overview of the HCM Provincial Evaluation Strategy

HCMO Policy Development, Research and Evaluation (PDRE) staff lead the HCM Provincial Evaluation Strategy, Manitoba's model for measuring child centred public policy. PDRE, with the HCMO Data Centre, works with cross-sectoral partners, as legislated under the HCM Act, to (a) inform and support HCCC policy accountability, (b) build capacity for research and evaluation, through all stages: consultation, evaluation framework development, evaluation/research implementation, and knowledge exchange and action planning.

There are five key areas of PDRE focus:

A) Community Data Development and Analysis

The purpose of HCMO Community Data Development and Analysis is to 1) lay the foundation necessary to do research and evaluation, 2) integrate child and youth data initiatives and evaluations, 3) inform HCCC policy planning, and 4) coordinate the Manitoba Child and Youth Status report every five years as stated in the HCM Act.

A long-term goal of CDDA is to provide longitudinal information which is one of the best tools to use in policy-planning, research and evaluation. Two sources of data are currently being prepared for the first pieces in the longitudinal file: The Families First Screen (FFS) is a post-natal screen on all off-reserve births in Manitoba, and the Early Development Instrument (EDI) is a questionnaire that Kindergarten teachers fill out in all public schools in Manitoba. The FFS and EDI data will be linked as new cohorts become available (e.g. when children from the FFS start school). Another source of information is the 2009 Youth Health Survey an inter-sectoral project where youth in grades 6-12 were surveyed. The YHS will be linked to the HCMO longitudinal database when the children from the FFS and EDI cohorts become youth. Privacy and confidentiality is maintained in accordance with FIPPA, PHIA and HCM Acts.

B) Provincial Program Evaluations

Provincial program evaluations provide information for cross-sectoral policy and program decision-making. Building on the findings from a small number of intensively studied research sites (Families First, InSight (formerly Stop FASD)), provincial programs are extensively evaluated in multiple sites with a large number of families, using quantitative data collection and analysis. Results of provincial program evaluations provide information on program effectiveness, key program components and program efficiency, toward program improvement. Provincial program evaluations assess and provide knowledge on cross-sectoral outcomes for the HCM goals for children (improved physical and emotional health, safety and security, learning success, and social engagement and responsibility). The new provincial evaluation report of the Families First program will be released in summer 2010 and will be made available on-line (http://www.gov.mb.ca/healthychild/familiesfirst/ff_eval2010.pdf). HCCC also commissioned the Manitoba Centre for Health Policy (MCHP) to work in partnership with HCMO to conduct an evaluation of the Healthy Baby program.

C) Population-Based Research

Population-based research explores questions regarding child, family and community development, and longitudinal and cohort effects of universal, targeted and clinical interventions. Research results provide new knowledge to support policy development and program planning and to determine the most effective cross-sectoral mechanisms for achieving the best possible outcomes for Manitoba's children, families and communities. An example of an ongoing population-based research initiative is the Manitoba Birth Cohort Study. Reports from this population-based research study are available on-line (http://www.gov.mb.ca/healthychild/ecd/ecd_reports.html#birthcohort).

In 2009/10, HCMO led and/or partnered in several population-based research initiatives including: Predictors and Outcomes of Prenatal Care: Vital Information for Future Service Planning (2009 - 2012); Centre for Gender, Mental Health and Violence Across the Lifespan (2009-2011); The Interplay Between Maternal Distress and Addiction on the Development of Childhood Asthma and Allergic Disease (2007-2012); Youth Suicide in the Justice System (2009-2011); and Health and Health Care of Francophone Children (2009-2011); and Towards Flourishing: Improving Mental Health Among New Mothers in the Manitoba Families First Home Visiting Program (funded by Public Health Agency of Canada).

D) Specialized Evaluations

Specialized evaluations provide information on a specific intersectoral area of focus or issue. Policy questions are intensively studied in selected sites. Specialized evaluations are time-limited and involve a single site and/or a promising program that is currently underway. Results of specialized evaluations provide outcome information on promising programs, toward establishing local best practice models in Manitoba communities. Examples of specialized evaluations conducted or launched by HCMO during 2009/10 include the Healthy Buddies pilot evaluation (see p. 21 above), the Life Skills Training (LST) pilot evaluation (see p. 21 above), and the Signs of Suicide pilot evaluation.

E) Knowledge Exchange and Action Planning

Knowledge exchange and action planning includes HCMO consultation, education, training, supervision and technical expertise to assist civic, academic and government communities to:

- plan, implement and evaluate programs and services for children and families;
- measure and monitor outcomes at the community level;
- develop local best practice models for the enhancement of family and community resilience;
- share knowledge on children's development with communities.

PDRE supervises students from Psychology, Social Work, and Nursing Faculties to complete Undergraduate and Masters practica and internships. In 2009/10, PDRE supervised a Master of Social Work practicum placement, and a Psychology Doctoral internship.

HCMO PDRE staff chair/participate in several local, provincial, and national committees**,** including the following:

- Canadian Council for Learning (CCL) Early Childhood Learning Knowledge Centre – Directing Committee and Health and Learning Knowledge Centre
- Canadian Institutes of Health Research (CIHR) – Institute for Human Development, Child and Youth Health (IHDCYH) – Institute Advisory Board
- Canadian Language and Literacy Research Network (CLLRNet) – National Literacy Strategy Planning Committee, Renewal Steering Committee, and Research Management Committee
- Centre of Excellence for Early Childhood Development (CEECD) – National Advisory Committee
- Community Data Network
- Council for Early Child Development – National Expert Advisory Committee
- Federal/Provincial/Territorial (F/P/T) Early Childhood Development (ECD) Working Group and F/P/T Committee for ECD Knowledge, Information, and Effective Practices
- F/P/T Early Learning and Child Care (ELCC) Working Group
- F/P/T Inter-sectoral Healthy Living Issues Group and its Committees
- Healthy Child Manitoba's Legislated 5-Year Report - Interdepartmental Report Content Development Working Group
- Healthy Child Manitoba's Legislated 5-Year Report - Interdepartmental Knowledge Exchange Strategy Working Group
- Human Resources and Skills Development Canada – Understanding the Early Years (UEY) – Provincial/Territorial Advisory Committee
- Invest in Kids Foundation – Board of Advisors
- Many Hands, One Voice (co-led by the Canadian Pediatric Society and the major national Aboriginal organizations) – Advisory Committee
- Mental Health Commission of Canada: Evergreen National Child Mental Health Strategy
- Pan-Canadian Early Development Instrument (EDI) Working Group
- Statistics Canada's Aboriginal Children's Survey – Technical Advisory Group
- Statistics Canada's National Longitudinal Survey of Children and Youth – Steering Committee
- Strategic Knowledge Cluster on Early Child Development – Steering Committee and Advisory Committee

HCMO PDRE staff is regularly invited to deliver presentations at local, provincial, national, and international conferences. In 2009/10, some examples included:

- Department of Family Social Sciences Research Symposium, University of Manitoba (Winnipeg, MB, April 2009)
- *Helping Families Change Conference 2009: Encourage, Empower, Engage* - 11th Annual International Helping Families Change Conference – University of Queensland and Triple P International (Toronto, ON, April 2009)
- *Successful Transitions: National Longitudinal Survey of Children and Youth* conference – Human Resources and Skills Development Canada (Ottawa, ON, April 2009)
- *Towards 2020 Conference: Canada's Commitment to Children and Youth* – Child and Youth Friendly Ottawa (Ottawa, ON, April 2009)
- *Lighting the Fire* - Manitoba First Nations Education Resource Centre (Winnipeg, MB, May 2009)
- *Putting Science Into Action: Equity from the Start Through Early Child Development* conference – Council for Early Child Development (Sackville, NB, May 2009)
- *Where the Rivers Meet: Raising the Level in Early Childhood Education* – 32nd Annual Early Childhood Education Conference – Manitoba Child Care Association (Winnipeg, MB, May 2009)
- Annual Meeting of the Canadian Psychological Association (Montreal, June 2009)
- Canadian Mental Health Association – Manitoba Division Annual Conference: Moving Forward Together: Facilitating Empowerment in Mental Health - (Winnipeg, MB, June 2009)
- *Public Health in Canada: Strengthening Connections* – Canadian Public Health Association 2009 Annual Conference (Winnipeg, MB, June 2009)
- *Awakening the Spirit: Moving Forward in Child Welfare* Conference of the Prairie Child Welfare Consortium (Winnipeg, October 2009)
- *Getting in the Right Door at the Right Time: 2nd National Invitational Symposium on Child and Youth Mental Health* – Mental Health Commission of Canada (Ottawa, ON, November 2009)
- *School Readiness and School Success: From Research to Policy and Practice* conference - Centre of Excellence for Early Childhood Development and Strategic Knowledge Cluster on Early Child Development (Québec City, QC, November 2009)
- *The Early Development Imperative: A Pan-Canadian Conference on Population Level Measurement of Children's Development* - Council for Early Child Development, Healthy Child Manitoba, and Offord Centre for Child Studies (Winnipeg, MB, November 2009)
- Community Pediatrics section meeting, Department of Pediatrics and Child Health, Faculty of Medicine, University of Manitoba (Winnipeg, MB, January 2010)
- Pediatric Grand Rounds, Department of Pediatrics and Child Health, University of Manitoba (Winnipeg, MB, January 2010)
- Public Health Agency of Canada (Ottawa, ON, January 2010)
- Provincial Healthy Child Advisory Committee (Winnipeg, MB, January 2010)
- *Today's Kids in Crisis: How Can We Change Their Future?* Workshop - Lord Selkirk School Division Early Years Committee and Understanding the Early Years Selkirk-Interlake (Selkirk, MB, January 2010)
- Ontario Ministry of Children and Youth Services conference (Toronto, ON, February 2010)
- Health-in-Common's Vibrant Communities Symposium (Winnipeg, March 2010)
- Faculty of Continuing Education, University of Winnipeg (Winnipeg, MB, March 2010)
- Manitoba Centre for Health Policy 20th Anniversary Conference (Winnipeg, March 2010)

HEALTHY CHILD MANITOBA

RECONCILIATION STATEMENT

DETAILS	2009/10 Estimates $000
2009/10 Main Estimates	28,393
2009/10 ESTIMATE	**28,393**

Appropriation 34: Healthy Child Manitoba
Expenditures by Sub-Appropriation
Fiscal Year ended March 31, 2010

Expenditure by Sub-Appropriation	Actual 2009/10 $000	Estimate 2009/10		Variance Over/(Under)	Expl. No.
		FTE	$000		
34-1A Salaries	2,304		2,318	(14)	
34-1B Other Expenditures	456		478	(22)	
34-1C Financial Assistance and Grants	24,788		25,597	(809)	1
Total Appropriations	**27,548**		**28,393**	**(845)**	

Explanation:

(1) Under expenditure is due primarily to in-year expenditure management exercise.

Expenditure Summary for
Fiscal Year ended March 31, 2010
with Comparative Figures for the Previous Fiscal Year

Estimate 2009/10 $000		Sub-Appropriation	Actual 2009/10 $000	Actual 2008/09 $000	Increase (Decrease)	Expl. No.
2,318	34-1A	Salaries	2,304	2,232	72	
478	34-1B	Other Expenditures	456	411	45	
25,597	34-1C	Financial Assistance and Grants	24,788	24,203	585	
	34-2	Amortization				
28,393	**Total Expenditures**		**27,548**	**26,846**	**702**	

Historical Expenditure and Staffing Summary by Appropriation ($000)
for Fiscal Years Ending March 31, 2006 - March 31, 2010

Sub-Appropriation	2005/06		2006/07		2007/08		2008/09		2009/10	
	SY		SY	$	SY	$	SY	$	SY	$
34-1A Salaries	29.00	1,397	32.00	1,939	33.00	2,040	34.00	2,232	35.00	2,304
34-1B Other Expenditures		335		334		339		411		456
34-1C Financial Assistance and Grants		22,435		22,780		22,939		24,203		24,788
34-2 Amortization (3)										
Total	**29.00**	**24,167**	**32.00**	**25,053**	**33.00**	**25,318**	**34.00**	**26,846**	**35.00**	**27,548**

Footnotes:

(1) Actuals for 2009/10 are based on year-end expenditure analysis report dated June 30, 2010.

(2) Prior years' comparative figures have been restated, where necessary to conform to the presentation adopted for the fiscal year ending March 31, 2010.

Indicators of Progress Against Priorities (Performance Reporting)

The following section provides information on key performance measures for the department for the 2009/10 reporting year. This is the fifth year in which all Government of Manitoba departments have included a Performance Measurement section, in a standardized format, in their Annual Reports.

Performance indicators in departmental Annual Reports are intended to complement financial results and provide Manitobans with meaningful and useful information about government activities, and their impact on the province and its citizens.

For more information on performance reporting and the Manitoba government, visit www.manitoba.ca/performance.

Your comments on performance measures are valuable to us. You can send comments or questions to mbperformance@gov.mb.ca.

What is being measured and using what indicator? (A)	Why is it important to measure this? (B)	What is the starting point? (baseline data and year) (C)	What is the 2009/10 result or most recent available data? (D)	What is the trend over time? (E)	Comments/Recent Actions/Report Links (F)
1. The progress of our Early Childhood Development (ECD) strategy, by measuring positive parent-child interaction in Manitoba, through the following three indicators from the National Longitudinal Survey of Child and Youth (NLSCY) for children aged 0-5 years: a) **Reading** (families with	We know that parents and families are the primary influences in the lives of children. Research shows that positive parent-child interaction including reading with children, positive parenting and positive family functioning are key determinants of successful early childhood development. Research has also established that the	We are using 1998/99 as the baseline measurement. **Reading** (% of parents who	Our most recent data is from 2004/05. **Reading** (% of MB parents that	<u>Stable:</u> Results suggest the	ECD (Early Childhood Development) Programs were a core commitment for 2009/10. In 2005, the Healthy Child Committee of Cabinet announced support of $1.4 million to implement the Triple P – Positive Parenting Program. Since 2008 training has been offered in all Manitoba regions and Winnipeg communities have

What is being measured and using what indicator? (A)	Why is it important to measure this? (B)	What is the starting point? (baseline data and year) (C)	What is the 2009/10 result or most recent available data? (D)	What is the trend over time? (E)	Comments/Recent Actions/Report Links (F)
daily parent-child reading)	best prevention investments occur during the early years. Healthy early childhood development sets the foundation for positive development by building resilience and by reducing the likelihood of negative outcomes later in life.	read to their child daily): 76.0% in MB 69.7% in Canada <u>Note:</u> Due to corrections and changes in the NLSCY since 1998, the number of parents who read to their children has been revised.	read to their child daily): 73.6%for Manitoba 66.0% for Canada	trend in reading in Manitoba is stable since 1998/99	received training in Triple P. Over the long term, this program is intended to positively impact these indicators. As of March 30, 2010, 1150 staff from 198 agencies, organizations, and government departments have completed training and accreditation in Triple P. In 2008/09, approximately 57 Aboriginal agencies have sent staff for training (163 practitioners in all). Response from agencies serving First Nation communities continues to be positive.
b) **Positive Parenting** (families with warm, positive, engaging interaction between parents and children including praising, playing, reading and doing special activities together)	It is important to know how families in Manitoba are doing so that the Government of Manitoba can make decisions about which investments will best support Manitoba's children and families, including those that will support positive parent-child interactions.	**Positive Parenting** (% of children living in families with positive parenting): 88.4% in Manitoba 88.0% in Canada	**Positive Parenting** (% of MB children living in families with positive parenting): 96.0% for Manitoba 93.7% for Canada	<u>Increasing:</u> Results suggest improvements in positive parent-child interaction since 1998/99	<u>Note:</u> Some practitioners are trained and accredited in more than one accredited course.
c) **Family Functioning** (how well family members relate to and communicate with one another, including the		**Family Functioning** (% of children living in families with positive family functioning): 88.3**%** for Manitoba 89.1% for Canada	**Family Functioning** (% of MB children living in families with positive family functioning): 92.9% for Manitoba 91.0% for Canada	<u>Increasing:</u> Results suggest improvements in family functioning since 1998/99	Positive parent-child interaction can also

What is being measured and using what indicator? (A)	Why is it important to measure this? (B)	What is the starting point? (baseline data and year) (C)	What is the 2009/10 result or most recent available data? (D)	What is the trend over time? (E)	Comments/Recent Actions/Report Links (F)
ability to solve problems together) Please see Note 1 below for more detailed information about this indicator.					be considered an intermediate outcome for children's school readiness (measured below). Limitation: While the information collected is fairly representative of the Canadian population, the NLSCY does not include Aboriginal children living on reserves or children living in institutions, and immigrant children are under-represented. For more detailed information, please see the ECD Progress Reports at: http://www.gov.mb.ca/healthychild/ecd/ecd_reports.html
2. The progress of our ECD strategy by measuring children's readiness for school, using results from the Early Development Instrument (EDI). The EDI is a questionnaire	Ensuring the best start for children when they begin school is important for successful lifelong health and learning, as well as for the province's future well-being and economic	This measure has been phased in, beginning in 2002/03. 2005/06 was the first year that all 37 Manitoba school divisions participated in the EDI; therefore, 2005/06 data will be	Our most recent data is from 2008/09 and marks the third year that 37 out of 37 Manitoba school divisions collected the EDI. In 2006/07, the EDI moved to a biennial collection,	Stable EDI trend analyses show that between 2005/06 and 2008/09, the proportion of children who are Very Ready in one or more domains and Not Ready in one or more	Note: 'Very Ready' includes the proportion of children whose scores fell in the top 30th percentile - based on Canadian norms - in one or more areas of child

What is being measured and using what indicator? (A)	Why is it important to measure this? (B)	What is the starting point? (baseline data and year) (C)	What is the 2009/10 result or most recent available data? (D)	What is the trend over time? (E)	Comments/Recent Actions/Report Links (F)
measuring Kindergarten children's readiness for school across several areas of child development including: • physical health and well-being • social competence • emotional maturity • language and thinking skills • communication skills and general knowledge For more about the EDI, please see Note 2 at the bottom of this table.	prosperity.	used as the baseline for future measurements. 2005/06 Results (based on 37 school divisions and 12,214 children) 62.4% of participating kindergarten students were 'Very Ready' in one or more areas of child development. 28.3% of participating kindergarten students were 'Not Ready' in one or more areas of child development.	therefore there is no data available for the 2007/080 school year. 2008/09 Results (based on 37 school divisions and 12,139 children) 63.0 % of participating kindergarten students were 'Very Ready' in one or more areas of child development. 29.1% of participating kindergarten students were 'Not Ready' in one or more areas of child development.	domains is stable. However, analyses that examine the provincial trends in the Language and Thinking Skills domain of development, show that between 2005/06 and 2008/09, the proportion of children who are Very Ready has increased, and the proportion of children who are Not Ready has decreased.	development. 'Not Ready' includes the proportion of children whose scores fell into the bottom 10th percentile - based on Canadian norms - in one or more areas of child development. Limitation: While the EDI is collected in all provincial school divisions, the EDI is not collected in band schools or independent schools (with the exception of First Nation/Frontier partnership schools,; and the one band school and one independent school that collected in 2008/09). EDI Reports can be viewed at: http://www.gov.mb.ca/healthychild/ecd/edi.html
3. The progress of the prevention strategy for FASD (Fetal Alcohol Spectrum	Research has established that alcohol can have multiple serious	In 2003, 13% of women in MB stated that they consumed some amount of	The most recent data are from 2008/09. In 2009, 13% of	Alcohol consumption during pregnancy has remained stable since 2003.	A prevention strategy for FASD in Manitoba was identified as an ongoing Healthy Child

What is being measured and using what indicator? (A)	Why is it important to measure this? (B)	What is the starting point? (baseline data and year) (C)	What is the 2009/10 result or most recent available data? (D)	What is the trend over time? (E)	Comments/Recent Actions/Report Links (F)
Disorder), by looking at maternal alcohol consumption during pregnancy. Public Health Nurses meet with mothers of newborns to conduct a provincial postnatal screen (approximately 12,000 births per year are screened, which is about 84% of all births in Manitoba each year). Standardized questions related to alcohol use during pregnancy are included in the screen.	consequences on fetal development. Fetal Alcohol Spectrum Disorder (FASD) is acknowledged as the most common preventable cause of birth defects and developmental disabilities that are permanent and irreversible. Alcohol consumption during pregnancy is the causal risk factor for FASD.	alcohol during their last pregnancy. The incidence of drinking during pregnancy varied by Regional Health Authority and ranged from 9% to 28 % of women indicating alcohol use at some time during pregnancy.	women in MB stated that they drank alcohol during pregnancy. 11, 943 women were screened in 2009, representing 78% of all births in Manitoba. New questions related to alcohol use were introduced in the 2007 screens. Women who used alcohol during pregnancy were asked if they continued to drink after discovering their pregnancy. In 2007, 35% of women who drank alcohol in pregnancy continued to drink after discovering their pregnancy. In 2009, 12.1% of women who drank alcohol in pregnancy continued to drink after discovering their pregnancy. In 2009, the prevalence of drinking during pregnancy varied between RHAs	The following shows the percentage of women who stated they drank alcohol during pregnancy from 2003 to 2009. 2003 – 13.3% 2004 – 12.3% 2005 – 13.1% 2006 – 12.7% 2007 – 16.1% 2008 – 13.7% 2009 – 13.0% <u>The proportion of women who continued to drink after discovering their pregnancy has decreased from 35% in 2007 to 12.1% in 2009.</u> Data from two national health surveys show that 17% to 25% of Canadian women indicated alcohol use at some time during pregnancy and 7% to 9% drank throughout pregnancy (National Longitudinal Survey on Children and Youth, 1994/95; National Population	Committee of Cabinet (HCCC) core commitment in 2005/06. Manitoba is the first jurisdiction in Canada to implement the collection of population-level information on the prevalence of maternal alcohol use during pregnancy. <u>Limitation:</u> The provincial screen represents data on approximately 84% of all births in Manitoba, it is not collected on new mothers living on reserves. Prevalence and incidence data for FASD is limited because diagnosis is complicated and difficult. Based on the best available data, Health Canada estimates the Canadian FASD incidence to be 9 in every 1,000 live births

What is being measured and using what indicator? (A)	Why is it important to measure this? (B)	What is the starting point? (baseline data and year) (C)	What is the 2009/10 result or most recent available data? (D)	What is the trend over time? (E)	Comments/Recent Actions/Report Links (F)
			ranging from 5.2% to 21.9%.	Health Survey, 1994).	(Health Canada, 2003). At least 200 children each year receive a diagnosis of FASD in Manitoba.
4. We are measuring the progress of our Healthy Adolescent Development (HAD) strategy, by looking at Manitoba's teen pregnancy rates, Sexually Transmitted Infection (STI) rates and usage of health and wellness services by teens.	It is important to know the rates of teen pregnancy, STI and service usage in Manitoba so the province can support Healthy Adolescent Development initiatives. These are activities that inform youth about sexual and reproductive health, using a harm reduction approach; to target youth who may be sexually active to reduce the potential harms associated with high risk sexual activity; improve outcomes for pregnant young women; increase teens' access to primary health care, including sexual and reproductive health; and increase teens' capacity for self-care.	The pregnancy and STI rates measurement began in 2001/02. Pregnancy Rates (number is per 1,000 youths aged 15-19): 2001/02 – 53.1	2008/09 Pregnancy Rate (number is per 1,000 youths aged 15-19): 47.0 This rate is for the whole province including First Nations women on reserves.	Pregnancy Rates (for youth aged 15-19) is stable: Manitoba has consistently had among the highest teen pregnancy rates across Canada. Since 2006/07, the rates of teen pregnancy have been stable. These rates are for all Manitoba youth including First Nation youth living on reserve. (number is per 1,000 youths aged 15-19): 2001/02 – 53.1 2002/03 – 50.2 2003/04 – 48.9 2004/05 – 45.2 2005/06 – 43.4 2006/07 – 47.3 2007/08 – 47.1 2008/09 – 47.0 This trend is consistent for most populations and regions across Manitoba.	Note: By increasing access to teen health services through prevention campaigns and programs and implementing teen health clinics in high needs communities in MB, it is expected that there will be an increase in youth accessing health and wellness services. If more youth access health services, there is the potential that reported STI rates for youth may increase in the short term due to increased testing and diagnosis (i.e., surveillance effect) Data for teen pregnancy rates (deliveries (live births), therapeutic abortions, and spontaneous abortions) is collected by Health Information Management ,

What is being measured and using what indicator? (A)	Why is it important to measure this? (B)	What is the starting point? (baseline data and year) (C)	What is the 2009/10 result or most recent available data? (D)	What is the trend over time? (E)	Comments/Recent Actions/Report Links (F)
	Comprehensive evaluation of the Healthy Adolescent Development (HAD) strategy is necessary to determine causal effects over time.				Manitoba Health.
		STI Rates (number is per 1,000 youths aged 15-19): 2001 – 17.1	2008 STI Rates (number is per 1,000 youths aged 15-19 for Chlamydia, gonorrhea and syphilis): 30.5	STI Rates Rates have increased since tracking began in 2001. (number is per 1,000 youths aged 15-19): 2001 – 17.1 2002 – 18.3 2003 – 20.5 2004 – 22.4 2005 – 18.8 2006 – 21.1 2007 – 25.9 2008 – 30.5	STI Rates include: Chlamydia, Gonorrhea and Syphilis. Data is collected by Communicable Disease Control (CDC) Branch, Manitoba Health.
			Teen Clinic Usage In 2009/10 HCMO funded teen clinics had the following number of visits: Elmwood Teen Clinic: 586 St. John's Teen Clinic: 667 Nor-Man teen clinics:	Teen Clinic Usage: These measures are new and there is not enough data to establish a trend.	Teen Clinics, Teen Talk and Teen Touch usage is collected through the Healthy Child Manitoba Office.

What is being measured and using what indicator? (A)	Why is it important to measure this? (B)	What is the starting point? (baseline data and year) (C)	What is the 2009/10 result or most recent available data? (D)	What is the trend over time? (E)	Comments/Recent Actions/Report Links (F)
			529 Selkirk Teen Clinic: 515 <u>Teen Talk</u> In 2009/10, Teen Talk engaged with 16,478 Manitoba youth. This includes 829 workshops delivered to 13,933 youth; 150 youth that participated in peer support training; and 2,395 youth that participated in peer support activities. Workshops include topics such as sexuality, birth control and STI, drug and alcohol use, and harm reduction.		<u>Teen Touch</u> Due to a dramatic drop in calls, Teen Touch closed its services in September 2009. Callers to this phone-line are redirected to the 24 hour crisis line operated by Klinic.

Notes:

***Note 1*: Measures of positive parent-child interaction:**

How are these data collected?
Data from the National Longitudinal Survey of Children and Youth (NLSCY) is used. The NLSCY was initiated in 1994 to find out about the well-being of children and their families, provincially and nationally.

Every two years, the NLSCY collects comprehensive data by surveying parents, teachers, principals, and children aged 10 and older. Information on positive parent-child interaction is collected. 2006/07 data will be available for analysis in fall 2010.

What do the most recent measures tell us?
Most children in Manitoba experience positive interactions with their parents during their first years of life. Specifically, most children in Manitoba are read to daily or several times a day. Most children in Manitoba live in families with positive parenting and positive family functioning.

Thousands of the 90,000 children under age six in Manitoba could benefit from improvements in positive parenting, reading with their parents, and family functioning. These children can be found in every community and every kind of family in Manitoba (e.g., across income groups)

Research shows that all parents can benefit from varying levels of support, information and resources to assist them in raising healthy children.

What is the trend information from previous surveys?

Reading (% of parents that read to their child daily)			**Positive Parenting** (% of children living in families with positive parenting)			**Family Functioning** (% of children living in families with positive family functioning)		
Year	**Manitoba**	**Canada**	**Year**	**Manitoba**	**Canada**	**Year**	**Manitoba**	**Canada**
1998/99	76.1%	69.7%	1998/99	88.4%	88.0%	1998/99	88.3%	89.1%
2000/01	69.5%	65.4%	2000/01	89.8%	90.0%	2000/01	89.1%	88.6%
2002/03	73.0%	67.3%	2002/03	92.7%	93.3%	2002/03	89.8%	90.2%
2004/05	71.1%	64.8%	2004/05	94.0%	92.4%	2004/05	91.9%	91.3%
2006/07	73.6%	66.0%	2006/07	96.0%	93.7%	2006/07	92.9%	91.0%

Note: ***Reading:*** *The 2000/01 and 2002/03 data included children between the ages of 0-5 while the 1998/99 data included children between the ages of 2-5. Due to the corrections and changes in the NLSCY, we are re-reporting the percentage of parents who read to their children.*

Note 2: **Readiness for School and the Early Development Instrument (EDI):**

How are these data collected and shared?
Kindergarten teachers complete the EDI questionnaire for all children in their classroom. EDI results can only be presented for groups of children; the EDI is never used to assess or report on the development of individual children.

Participation by schools in the collection of the EDI data has been building over time. Beginning in 2002/03, collection of EDI data by school divisions has been phased in, with full Manitoba school division participation as of 2005/06. Biennial collection of the EDI began in 2006/07, with 2007/08 being the first "off" year, and the most recent results from the 2008/09 school year.

Local level EDI results are shared with:

- Schools and School Divisions, including school boards, teachers, administrators, and resource workers
- Communities, including parent-child coalitions, early childhood educators, community residents, health professionals, community development and resource workers, policy makers, and parents.

Why is readiness for school so important and what are the measures used for?
'Readiness for school' is a baseline of Kindergarten children's readiness for beginning grade one. It is influenced by the factors that shape the early years, including family functioning, parenting styles, neighbourhood safety, community support, and socio-economic factors. EDI results are a reflection of the strengths and needs of children's communities.

The EDI was based on a need to measure the effectiveness of investment in ECD at a population level and based on a community need to plan and deliver effectively for ECD.

Specifically, the EDI tells us how we are doing as a province in getting Manitoba's children ready for school and this helps us to learn what is needed to support healthy child development. Furthermore, the EDI helps local communities improve programs and services for children and families.

What do these data tell us so far?
EDI results show that about two-thirds of children in Manitoba and Canada are very ready for school. However, significant numbers of children, about one in four, are not ready to learn at school entry.

Children who are not ready for school can be found in every community and every kind of family in Manitoba, (i.e., across all income levels and demographic groups).

More detailed information from the 2005/06, 2006/07 and 2008/09 EDI Reports are available at: http://www.gov.mb.ca/healthychild/ecd/edi.html

The Public Interest Disclosure (Whistleblower Protection) Act

The Public Interest Disclosure (Whistleblower Protection) Act came into effect in April 2007. This law gives employees a clear process for disclosing concerns about significant and serious matters (wrongdoing) in the Manitoba public service, and strengthens protection from reprisal. The Act builds on protections already in place under other statutes, as well as collective bargaining rights, policies, practices and processes in the Manitoba public service.

Wrongdoing under the Act may be: contravention of federal or provincial legislation; an act or omission that endangers public safety, public health or the environment; gross mismanagement; or, knowingly directing or counseling a person to commit a wrongdoing. The Act is not intended to deal with routine operational or administrative matters.

A disclosure made by an employee in good faith, in accordance with the Act, and with a reasonable belief that wrongdoing has been or is about to be committed is considered to be a disclosure under the Act, whether or not the subject matter constitutes wrongdoing. All disclosures receive careful and thorough review to determine if action is required under the Act, and must be reported in a department's annual report in accordance with Section 18 of the Act.

The following is a summary of disclosures received by HCMO for fiscal year 2009/10:

Information Required Annually (per Section 18 of The Act*)*	**Fiscal Year 2009/10**
The number of disclosures received, and the number acted on and not acted on. Subsection 18(2)(a)	NIL
The number of investigations commenced as a result of a disclosure. Subsection 18(2)(b)	NIL
In the case of an investigation that results in a finding of wrongdoing, a description of the wrongdoing and any recommendations or corrective actions taken in relation to the wrongdoing, or the reasons why no corrective action was taken. *Subsection 18(2)(c)*	NIL