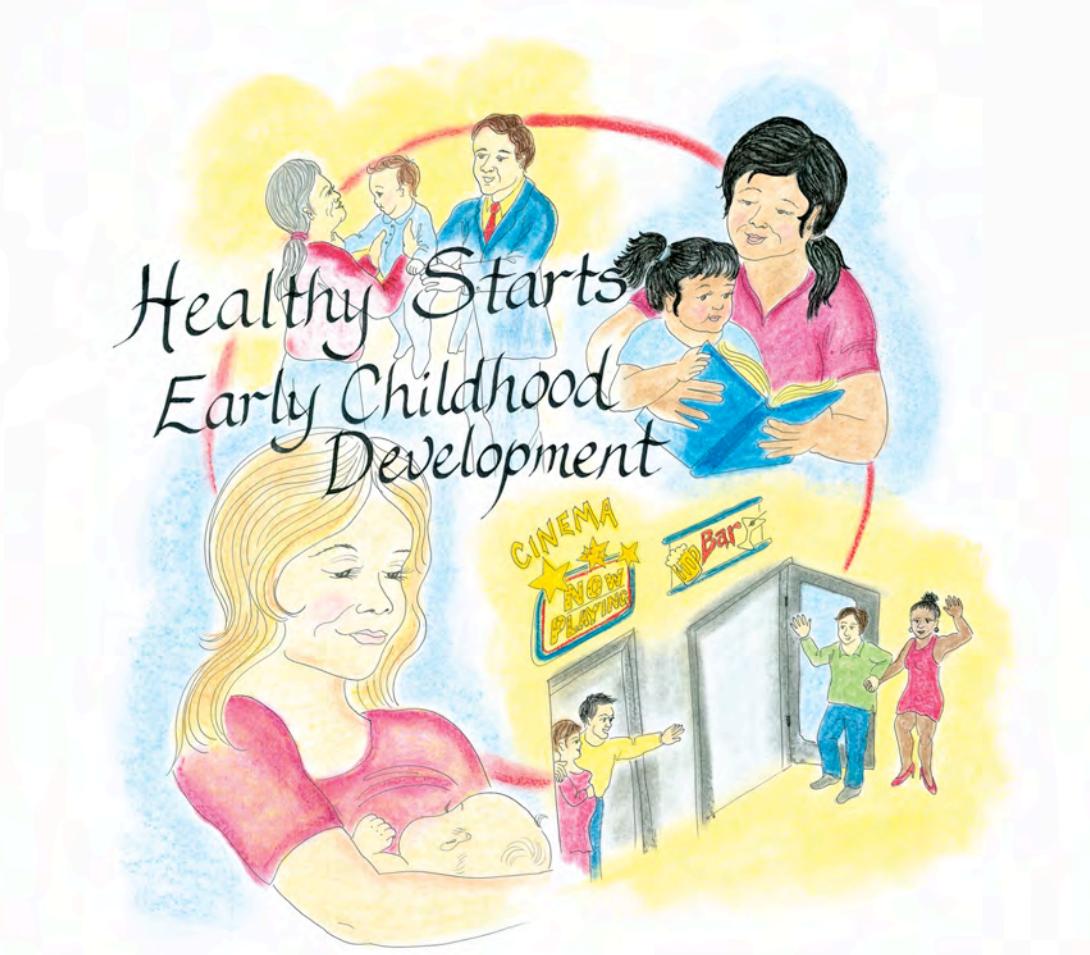

Guiding Document on Early Childhood Development:

An Integrated Population Health Approach

FOR DISCUSSION PURPOSES

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northern health
the northern way of caring

"… Sometimes it feels like this. There I am standing by the shore of a swiftly flowing river, and I hear the cry of a drowning man. So I jump into the river, put my arms around him, pull him to shore and apply artificial respiration. Just when he begins to breathe, there is another cry for help. So I jump into the river, reach him, pull him to shore, apply artificial respiration, and then just as he begins to breathe, another cry for help. So back in the river again, reaching, pulling, applying, breathing and then another yell. Again and again, without end, goes the sequence. You know, I am so busy jumping in, pulling them to shore, applying artificial respiration, that I have no time to see who is upstream pushing them all in."

McKinlay, J.; 1979

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1.0 Introduction

This report outlines current evidence and best practices regarding early childhood development (ECD); it outlines guiding principles for future work in this area by Norhtern Health. A healthy start for children may be the most influential factor on health, social and economic outcomes later in life for the individual and society. Using a population health approach, we will engage with communities and individuals to move towards increased health and wellness. This may be accomplished by promoting and supporting ECD initiatives, including policies, programs and services. This work should involve community partners to improve the health, wellbeing and quality of life of those who live, work, learn and play in Northern BC – now and in the future.

2.0 Background

> *Children are our future.*
>
> -- Shuswap Elder, Mary Thomas.

Child development is a foundation for community and economic development.[i] Healthy early growth and development builds a strong foundation for success into the adult years and is required for responsible citizenship and economic productivity.[ii] The early years of development establish the foundation for competence and coping skills that affect learning, behaviour and health. Evidence suggests that many health problems experienced later in life are influenced by the conditions of early life (e.g., high blood pressure, Type 2 diabetes and some mental health problems).[iii] Moreover, chronic conditions may be prevented or mitigated as early as preconception, prenatal and early childhood (e.g., obesity, anxiety and depression).

Child development begins before birth and the first years of life are a time of critical change as a child attains the skills they will use for the rest of their life.[iv] The early years of development are from conception to age six. In this time, the foundation for competence and coping skills are developed that affect learning, behaviour and health throughout life. Within this period, birth to age three is a particularly important period for development. The following section reviews some of the different areas of growth and development.

2.1 Growth and Development Areas

Multiple areas of growth and development occur through infancy and early childhood.[v] These include:[1]

- **Physical health and well-being**: physical development and refinement of coordination and motor skills.
- **Social competence:** development of social skills to get along with others and explore new things.
- **Emotional maturity**: emotional growth, including the expression of a range of emotions.

[1] While these factors are listed independently, it is acknowledged that they are not mutually exclusive. Development in one area can support development in other areas; all areas of growth and development are connected.

- **Language and cognitive development**: brain development and the capacity for learning (e.g., literacy, numeracy and memory use).
- **Communication skills and general knowledge**: development of skills to communicate one's own needs and understand others.

A healthy pregnancy and positive early childhood environment are crucial for optimal infant growth and development. Brain cells develop in utero, but the connections that allow a child to use knowledge do not occur until after birth. These synapses control every aspect of life, including motor function, emotion, social interaction, speech and learning. While the brain continues to develop these connections through life, the development period (conception to age six) is the most important. [vi]

A baby's physical growth occurs fastest in the first year. [vii] The average baby's physical growth doubles by age six months and triples by one year. Starting at about 18 months, motor skills develop rapidly and this is when most children learn to walk unaided. Language and cognitive development accelerates around age two. The most important time for language acquisition is between the ages of two and six. Developing healthy starts is a process that involves many factors. The following section highlights some of the key factors which affect ECD.

2.2 Factors Affecting Growth and Development

As mentioned above, developing a healthy start is a complex process that involves many interconnected factors. These factors must work together to support each other in order to successfully develop a healthy start. Further, factors will look different in different contexts and different communities (e.g., Aboriginal[2] or non-Aboriginal communities).

A complete review of all factors that contribute to a healthy start is beyond the scope of this paper. However, the following sections explore some factors in greater depth. This list is not exhaustive; it highlights some of the more well-known connections in a healthy start – starting very broadly with the determinants of health and narrowing in on some more specific factors, such as caregiving and nutrition.

2.2.1 Determinants of Health

Most broadly, ECD and the determinants of health are reflexive[3] to each other; that is: ECD is a determinant of health and the determinants of health impact ECD. Some determinants of health may not be modifiable (e.g., age, sex, ethnicity); other determinants of health may be modifiable (e.g., education, income, socioeconomic status [SES]).[4] There is uneven impact of health determinants across populations in the North, resulting in disparities and inequities. As an example of modifiable determinants of health, the following paragraph discusses SES.

Income and education are closely tied to SES. Higher SES is generally correlated with improved health outcomes and lower SES is generally correlated with poorer health

[2] Aboriginal is inclusive of First Nations, Métis and Inuit peoples. In the Northern Health region, Aboriginal peoples account for nearly 18% of the total population.

[3] Reflexive indicates that that there is a circular cause and effect relationship.

[4] Determinants of health are not easily delineated to assess their impact; as they are commonly interconnected and recursive to one another, so any delineation is somewhat artificial.

outcomes, including prevalence of chronic disease (e.g., coronary or respiratory disease).[viii] It has been documented that those with lower SES can be up to four times more likely to result in mortality from chronic disease than those with higher SES, even after normalizing for other risk factors (e.g., tobacco use, cholesterol levels, high blood pressure).[ix] Similar correlations cut across a wide range of disease processes, including heart disease, cancers and behavioural conditions.[5,x] However, connections between bio-medicine/biology/pathology and health outcomes (rather than connections between determinants of health and health outcomes) continue to be more entrenched and are more commonly addressed in health planning agendas (more discussion on determinants of health, ECD and health outcomes are in Section 4.0).

2.2.2 Positive Caregiving[6]

Families are usually the best place for children to be raised.[xi] Healthy relationships between infants and caregivers are the cornerstone of human development. Positive caregiving focuses on strong, nurturing relationships, good communication and positive attention to fuel a healthy start. Attachment theory research guides the evidence for developing a trusting relationship between a caregiver and child.[xii]

The Center for Development and Learning – a Louisiana-based Children's research centre – suggests that *Seven Essentials* support a child's healthy development. The *Seven Essentials* are:

- **Encourage** exploration with all the senses, in familiar and new places, with others and alone, safely and with joy.
- **Mentor** in basic skills, showing the whats and whens, the ins and outs, of how things and people work.
- **Celebrate** development advances, for learning new skills little and big, and for becoming a unique individual.
- **Rehearse** and extend new skills, showing your child how to practice again and again, in the same and different ways with new people and new things.
- **Protect** from neglect and inappropriate disapproval teasing, or punishment.
- **Communicate** richly and responsibly with sounds, songs gestures, and words; bring your child into the wonderful world of language and its many uses.
- **Guide** and limit behavior to keep your child safe and to teach what's acceptable and what's not - the rules of being a cooperative, responsive, and caring person.

While the *Seven Essentials* are important guidelines for any person involved in a child's life, they are particularly relevant to positive caregiving. These guidelines reinforce communications and relationships between caregiver and child. The Center for Development and Learning suggests that, like vitamins, the *Seven Essentials* should all be provided every day for every child to support positive development across multiple growth and development areas in the early years. However, the *Seven Essentials* may not reflect the needs of diverse populations, such as Aboriginal peoples. For diverse populations, the principles may differ or be expanded upon.

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[5] However, there are a few exceptions (e.g., malignant conditions, gynecological conditions and lung cancer).

[6] The term *caregiving* is used here instead of *parenting* because it is not uncommon for children to be raised by grandparents or extended families, including adoptive and foster families.

2.2.3 Interactions Between Caregiver(s) and Child

While some aspects of growth are intrinsic, a child's social environment plays a critical role in all areas of development.[xiii] Synaptic connections that control every aspect of life are influenced by a baby's experiences with their environment. Parents and caregivers can create a stimulating environment for infants and toddlers to increase cognitive functioning. Speaking and reading to children improves language and literacy acquisition.[xiv] Interactive toys and activities promote physical health and improve motor skills. Learning opportunities occur every day in a child's environment. Further, environments that support the prevention of injuries are important for growth and development.[xv]

Early attachment relationships are strongly associated with brain structures responsible for emotion regulation, attachment behaviour and stress-related coping mechanisms.[xvi] Children exposed to toxic stress can disrupt the architecture of the developing brain and lead to lifelong difficulties in learning, memory, self-regulation and behaviour problems. Toxic stress can be short-term or long-term, including: negative family dynamics and emotional deprivation, including chronic stressful conditions such as extreme poverty, abuse or severe maternal depressions.[xvii] Children who are exposed to serious stress early in life can develop an exaggerated response that, over time, weakens defense systems against diseases, including heart disease, diabetes and depression.[xviii]

2.2.4 Nutrition

Health and well-being at every stage of the life course is influenced by nutrition, beginning with the mother's pre-conception nutritional status, continuing through pregnancy to early infancy and beyond. Research shows that a child's tastes and eating habits are formed early in life with consequences for later obesity and also academic achievement.[xix] The macronutrients (proteins, carbohydrates and fats) are particularly important during prenatal and early development, when brain development and body growth is rapid. The World Health Organization and others emphasise the importance of breastfeeding in the first six months for lifelong health.[xx] A recent study indicates a strong relationship between breastfeeding and cognitive outcomes.[xxi] Breastfeeding for as little as four weeks showed a positive and significant effect on academic test scores.[xxii]

Breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants; it is an integral part of the reproductive process with important implications for the health of mothers. As a global public health recommendation, infants should be exclusively breastfed[7] for the first six months of life to achieve optimal growth, development and health. Thereafter, to meet their evolving nutritional requirements, infants should receive nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years of age or beyond. Exclusive breastfeeding from birth is possible except for a few medical conditions, and unrestricted exclusive breastfeeding results in ample milk production.[xxiii] Beyond breastfeeding, the development of supportive feeding relationships and competent eating are important for healthy nutrition for life (see Northern Health's Position on Healthy Eating and Position on Health, Weight and Obesity).

[7] With vitamin D supplements.

2.3 Unique Populations

Some groups within the general population may face unique challenges across or within some of the above listed factors. Beyond the determinants of health, if a child was faced with challenges in any of the factors, they could be faced with unique circumstances in life (e.g., parents with difficulties parenting, family dynamic concerns, unsupportive or unsafe environments, poor nutrition, English as a second language). In a population health approach, special considerations must be given for these unique populations due to the barriers they may face. Specifically, enhanced services could help to overcome barriers of access (see Section 5.1).

2.3.1 Aboriginal Peoples

Accounting for nearly 18% of the population in Northern BC, Aboriginal people are an important and ethnically unique cohort.[8] The health and social well-being of Aboriginal families is compromised by a multi-generational loss of culture, traditions, language and homelands. The experience of colonization and the compounding negative impacts of residential school policies and ongoing racism and discrimination play into the current health disparities experienced by many Aboriginal people.[xxiv] This is particularly important when considering ECD because Aboriginal people are the fastest growing segment of the population; nearly half of all Aboriginal peoples in Northern BC are under the age of 18. Cultural and spiritual values are identified as protective factors for Aboriginal peoples and must be considered to improve health equity and ECD for Aboriginal peoples.[xxv]

2.4 Measuring Early Childhood Development

As children experience their greatest development before they reach school age, home environments lay the foundation for their school experiences. Each child arrives with varying levels of readiness to learn. Readiness to learn is measured by the Early Development Instrument (EDI), a population health measurement tool.[9] It is important to note that the EDI does not test the school itself; it is a tool that gives a backward look at a child's development. In this, it speaks to the quality of the environment and experience those children had up to the time they entered Kindergarten.

The EDI is a population approach to measurement that provides vulnerability rates for groups of children; that is, the proportion of 'developmentally vulnerable' children in a given area – region, city, community or neighbourhood. **Vulnerable children are those whose EDI results suggest that they are behind where we would like them to be in one or more developmental areas**. Using sub-scales, the EDI development areas are:

- **Physical health and well being**: does the child come to school tired, hungry or have poor small and large muscle coordination?
- **Communication skills**: does the child have difficulty understanding and effectively being understood in the language of instruction of the classroom? (not about ESL)

[8] Aboriginal peoples include First Nations, Inuit and Métis peoples, despite tremendous ethnic distinctions among First Nations, Inuit and Métis peoples.

[9] The EDI is currently under review to determine if it is culturally appropriate for Aboriginal peoples.

- **Language and cognitive skills**: does the child demonstrate traditional readiness for school? (e.g., know their way around a picture book, know some numbers and letter facts appropriate to Kindergarten level)
- **Emotional maturity**: is the child able to have appropriate physical and relational behaviour towards others? (e.g., aggression, clique forming, empathy and helpfulness)
- **Social competence**: how does the child function in the semi-formal environment of the Kindergarten class? (e.g., able to pay attention, cooperate, disruptive)

3.0 EDI Outcomes

EDI data collection and mapping has been occurring for 10 years in BC and has recently completed its fourth wave of province-wide data collection.[xxvi] The following section highlights those results for the Northern Health region.

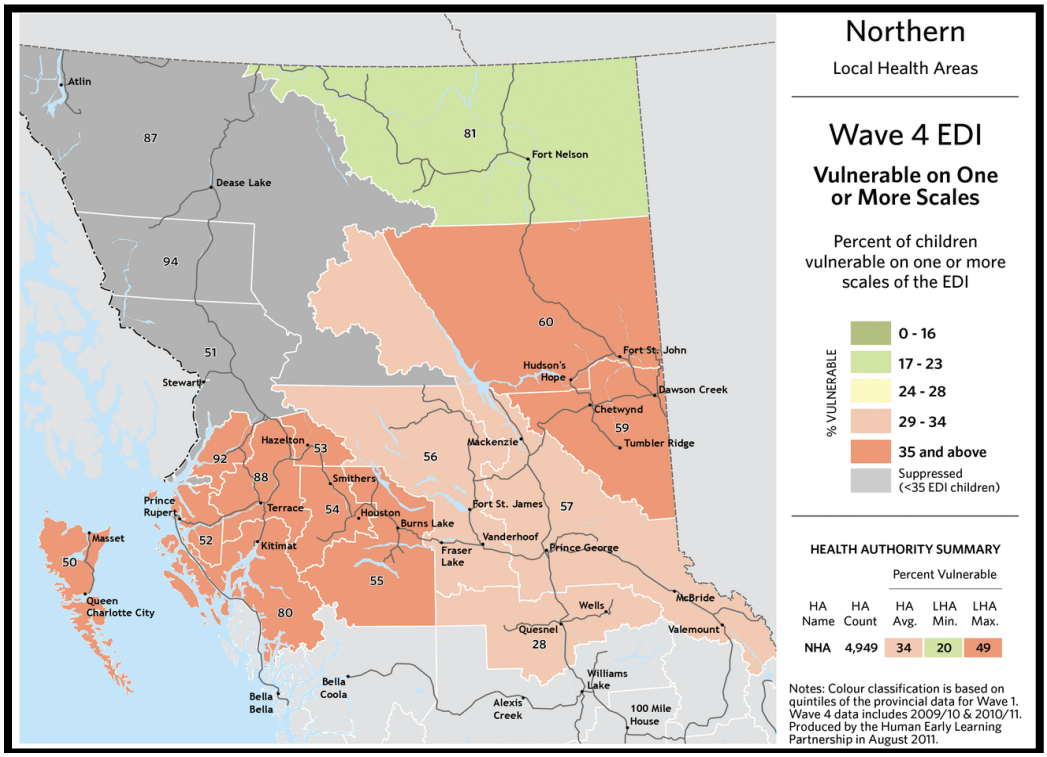
3.1 Northern Health

The Northern Health region has large variety of the vulnerability scores from one area to another (Map 1).[10] Regionally, there is a lack of overall net progress in EDI scores since the first wave of data collection; vulnerability rates[11] are remaining relatively unchanged over time or are increasing.[xxvii] These data suggest that not all children in the North are experiencing a solid start in life; this can limit future education and earning potential. However, when the numbers are considered for communities (Appendix A), Fort Nelson is an exception. In this community, vulnerability has decreased over time (from a red colour in W2 to a green colour in W4); indicating that progress is being made in ECD.

[10] While this map shows the region, community maps for each school district are available. The community-scale maps show EDI and SES data for custom geographic neighbourhoods. They are available online at: *http://earlylearning.ubc.ca*/media/uploads/mapsets/wave4/bc/wave_4_edi_by_sd_-_provincal_map_package_-_13sep11.pdf

[11] Lower vulnerability rates are favoured; they indicate improved outcomes.

Map 1: Wave 4 EDI Vulnerability Scores for Northern Local Health Areas



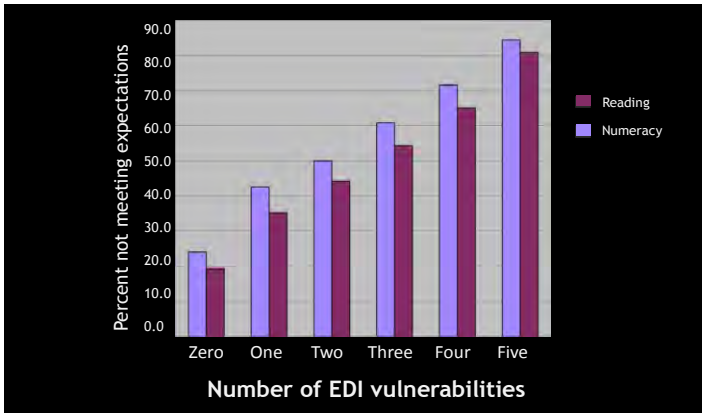
Source: Human Early Learning Partnership, 2011.
Note: Red shades indicate a higher vulnerability rate (poorer outcomes); green shades indicate a lower vulnerability rate (improved outcomes).

With respect to the continuum of SES in society, it is commonly thought that children from families of lower SES are the most vulnerable. The following section makes some connections between EDI vulnerability scores (as a proxy for ECD), health outcomes and the determinants of health.

4.0 Linking EDI Scores, ECD and Determinants of Health

When taken into consideration from a lifecourse perspective, EDI vulnerability scores are a very good indicator for future potential of individuals in a given area/community, particularly with respect to reading and numeracy later in life (Figure 1). The fewer vulnerabilities that a popualtion demonstrates on the EDI in Kindergarten is correlated with being more likely to meet expectations in Grade 4.[xxviii] As such, children's environments before they reach school can influence learning outcomes in Grade 4 and potentially their education – or learning – potential later in life.

Figure 1: EDI Vulnerabilities and Success in Grade 4



Source: Hertzman, nd.

Similar observations were seen when correlating EDI vulnerabilities in Kindergarten with university-eligible grades at school completion.[xxix] Knowing this, and given that 70% of new jobs require university-eligible grades,[xxx] it may be deduced that a child's environment before they reach school may then influence their economic — or earning — potential later after school completion, thus also impacting their determinants of health.

If a child's pre-schooling environment influences their learning and earning potential later in life, and knowing that education and economic status are determinants of health, ECD then underpins determinants of health later in life.[xxxi] As such, long-term health begins with developmental health.

Finally, children with parents of lower incomes tend to demonstrate more vulnerability on the EDI.[xxxii] This demonstrates a cycle of vulnerability: one of lower SES and poorer determinants of health. However, while families of lower SES are more statistically likely to be vulnerable, most vulnerable children in BC are from moderate SES, or "middle class families" (Figure 2).[xxxiii]

Figure 2: Vulnerable Children Across SES Scale

Source: Adapted from Hertzman, nd.
Note: In this figure, vulnerable children are indicated by a shade of red/brown.

As such, to capture vulnerable children across the population, programming and interventions that support ECD must be strategically planned. The following section addresses some strategic components of planning for a healthy start.

5.0 Planning for a Healthy Start

There are a number of interventions for ECD and this can help us plan for a healthy start. The overall goal of such planning is to reduce risk factors and increase protective factors to improve short- and long-term health outcomes.[xxxiv] The following sections outline universal and enhanced programming and discuss some elements of effective ECD programming.

5.1 Universal and Enhanced Programming

Literature from around the world supports the parallel implementation of universal and enhanced programming.[xxxv] The practice of targeted programming to certain segments of the population will not access vulnerable children across the population. Universal programs are more likely to capture vulnerable children across the SES gradient.[12] However, to be fully effective, universal programming must be high quality, inclusive of effective ECD programming components (see section below) and available for all of the early years.

In addition to universal programming, enhanced programming consists of smaller-scale programs that specifically target a group within the population (e.g., lower SES or orphaned children).[xxxvi] Enhanced programs aim to help overcome specific barriers and are designed for the needs and capabilities of that specific group.[xxxvii]

Evidence suggests that some combination that draws from the strengths of universal and enhanced programming may be the most effective method to capture those children who are vulnerable across the SES gradients. To be most effective, programming is appropriated to those groups in the population where specific needs are required (e.g., Aboriginal groups require culturally appropriate programming). This concept of ***proportionate universality***[13] supports the provision of "programs, services and policies that are universal, but with a scale and intensity that is proportionate to the level of disadvantage."[xxxviii] In this regard, universal programming is created and maintained in a way that eliminates barriers to access that are faced by the groups with the highest need; a universal approach that addresses barriers to access.

5.2 Characteristics of Effective ECD Programming

Some common characteristics are continuously proven to be effective in successful ECD programming. Drawing specifically from examples in Scandinavian countries and the province of Quebec, some of these characteristics include:

- Addressing the full span of child development, from prenatal to age six (the beginning of full public schooling).
- Be supported by legislation.
- Provide child health benefits to families.
- Support a family-centred approach.
- Extended parental leaves.
- High quality, educational child care at low-cost.
- Link the ECD system to the health care system and the education system.

[12] Some examples of universal programming for ECD would include child care and preschool.
[13] Also known as the continuum of universality.

5.2.1 A Canadian Success: *Un Québec fou de ses enfants*

In 1992, a report entitled *Un Québec fou de ses enfants [A Quebec Crazy for its Children]* outlined that the Government of Quebec and Quebecers needed to do more to meet the needs of young children and youth with equity, generosity and compassion.

The Quebec government adopted legislation and set a schedule for poverty reduction. This included: supplementary child health benefits, holistic family policy with extended parental leaves to 18 months, expanded high quality educational child care to preschoolers and extended child care for children up to 12 years of age at low cost to parents. Since this report and the fundamental changes, Quebec has gone from the bottom to the top on many important social indicators. From having Canada's lowest female labour participation, it now has the highest. Where Quebec women were once less likely to attend post-secondary education than their counterparts in the rest of Canada, today they dominate. Further, student scores on standardized test have gone from below Canadian average to above.

Despite working more, Quebec women are having more babies and dads are more involved in child rearing; 82% of Quebec dads take paid leave while 12% of dads take leave in the rest of Canada. Quebec's combined initiatives have resulted in a 50% reduction in child poverty since 1998. Economists revealed that the tax revenues from mothers who are able to work because of low cost children's programming pay for the entire cost of Quebec' system.

6.0 Current State of ECD Initiatives

National, provincial and regional initiatives are already underway to support ECD. Specific initiatives relevant to Northern Health are outlined in this section. For more comprehensive understanding of national and provincial initiatives, please see An Overview of Initiatives Affecting Early Childhood Development in BC.

6.1 Canada

In 1991, Canada ratified the United Nations treaty on the Convention of the Rights of the Child. In this, Canada is to provide environments that allow capacity for a child to evolve to their full potential.[xxxix] Included in this treaty is a call for the development and implementation of national ECD policies and programs to improve children's development and provide supports and services to parents to help achieve this. As a follow-up to this ratification, Canada released *A Canada Fit for Children* in 2004.[xl] This report is an action plan of the federal commitment to a focus on children.

In 2004, the Organization for Economic Co-operation and Development issued a report on Canada's state of ECD efforts. It notes that further overall effort and funding is required to create a universal system. [xli] Canada is the lowest investor in the western world in early years policies and regulations that are analogous to supporting initiatives in the development of children. Currently, Canada invests 0.3% of the gross domestic product (GDP) in ECD. In contrast, countries in the European Union invest 1.0% of the GDP, with Scandinavian countries investing 1.5% of the GDP.[xlii]

Of important note, the Federal/Provincial/Territorial Agreement on ECD was originally signed in 2000; funding was renewed in 2007. In this, provinces and territories receive funding to expand and improve ECD programs and services in four priority areas:[xliii]

- Promote healthy pregnancy, birth and infancy.
- Improve parenting and family supports.
- Strengthen ECD, learning and care.
- Strengthen community supports.

Regarding physical growth and development, Canada has developed guidelines for physical activity for children to age four to support developing physical literacy in the early years.[xliv] The physical activity guidelines for this group suggest activities appropriate to age categories with minimum suggested times. The sedentary behaviour guidelines suggest activities to limit to maximum suggested times. Both sets of guidelines are available on the Canadian Society of Exercise Physiology website.

6.2 British Columbia

In the province of BC, the Ministry of Children and Families, the Ministry of Education and the Ministry of Health collaborate to positively impact services and programs that promote the healthy growth and development of young children.[xlv] With increasing involvement by communities, business and non-traditional partners, public awareness of the importance of the early years has been raised.

In BC, various ministries are involved in different capacities to support ECD. Within each ministry, various programs are delivered to support early development. Some of these include:

- Ministry of Children and Family Development (MCFD) – Early Childhood Development programs and services
  - This ministry works to promote and develop the capacity of families and communities to care for and protect vulnerable children and youth and support healthy child and family development.
- Ministry of Health (MoH) – Healthy Families BC, Healthy Start programs
  - These programs seek to support women in pregnancy and children in the early years of development.
- Ministry of Education (MoEd)
  - While MCFD and MoH partner with MoEd for some programs (e.g., Strong Start; Ready, Set, Learn and full-day Kindergarten), the focus of MoEd is largely once children enter the school system (Kindergarten) and the focus of ECD is prior to this.

In 2009/2010, through the Federal/Provincial/Territorial Agreement on ECD, BC received approximately $66 million in federal funding to support a wide range of community-based early years programming and services for young children and their families province-wide. These programs and initiatives include:

- Children First
- Success By 6
- Success by 6 Aboriginal Engagement

- Full Day Kindergarten
- Seeds of Empathy
- Ready, Set, Learn
- StrongStart BC Early Learning Programs
- LEAP BC – Literacy Education Activity and Play

Recognizing the importance of early human capital investments, the Government of British Columbia's Strategic Plan is to lower the provincial rate of early childhood vulnerability (as measured by EDI scores) to 15% by fiscal year 2015/16.

Finally, the Medical Health Officer's Council of BC has a working group on Child and Family Poverty. They are developing a poverty reduction proposal and are connecting with other provincial groups, including: Health Inequities Coalition, Union of BC Municipalities, provincial government social policy committees, the Representative for Children and Youth, The Poverty Reduction Coalition, Canadian Centre for Policy Alternatives, BC Healthy Child Development Alliance and First Call BC Child and Youth Advocacy Coalition. Part of this work is informed by the 2009 BC Child Poverty Report Card.[xlvi]

6.3 Northern Health

Within Northern Health, a number of different programs are in place to support various areas of healthy growth and development of infants and children. Organized to align with provincial priority areas, programs include:[xlvii]

- **Promote healthy pregnancy, birth and infancy**
  - Northern Health's Healthy Start program
    - Prenatal Services (Prenatal Registry & Nurse Family Partnership Program)
    - Postpartum Services (Maternal & Newborn)
    - Child & Family Health Services
  - Northern Health's Perinatal Program and Council
  - Prenatal Registry Program
    - Universal prenatal registration, education and referral for pregnant women and their families
    - Enhanced public health nurse services (e.g., family support/visiting, perinatal depression prevention intervention, brief intervention counselling for tobacco cessation/reduction)
  - Midwifery
  - FASD Prevention

- **Improve parenting and family supports**
  - Public health nurse enhanced family support/visiting
  - Postpartum Services
  - Child and Family Services
  - Breastfeeding Support
  - Infant Mental Health Services
  - Period of PURPLE Crying
  - Expanded childhood immunizations
  - A Million Messages campaign

- **Strengthen ECD, learning and care**
  - Community collaboration, coordination and referral
  - Early Intervention Services (Speech and Language, Audiology, Dental)
  - Screening Services (Developmental/Ages and Stages Questionnaire), Vision, Dental, Early Hearing)
  - Northern Health Assessment Network – autism assessments, FASD & Complex Developmental Behavioural Conditions Assessments
  - WHO Growth Charts for Canada[14]

- **Strengthen community supports**
  - Regional ECD Coalition for Children and Youth (with Special Needs)

7.0 Northern Health Guiding Principles

Northern Health wants to increase health and wellness and improve quality of life by supporting families to raise healthy children and promote ECD. The importance of ECD should be recognized in a population health perspective. This may be achieved by working with individuals and community partners to promote the following guiding principles in ECD:

- Support healthy policy, programs and services aimed at improving ECD.
- Support expectant mothers to be healthy before and during pregnancy for positive birth outcomes.
- Raise awareness of the importance of attachment relationships developed between parent(s)/caregiver(s) and children in the early years of life.
- Support parent(s)/caregiver(s) with effective postnatal care.
- Support readiness for school.
- Support families beyond parental leave through to the beginning of schooling.

8.0 Sample Strategies

The Ottawa Charter for Health Promotion is an international resolution of the World Health Organization. Signed in Ottawa, Canada in 1986, this global agreement calls for action towards health promotion through five areas of strategic action. In concert, these strategies can create a comprehensive approach to promoting ECD.

This section presents examples that support the five strategic action areas of the Ottawa Charter; used together, they are actions that would the guiding principles presented in this paper. Examples are evidence-based and come from a scan of strategies proven effective in other places.

8.1 Build Healthy Public Policy

A broad range of local, regional, provincial, and federal organizations have a role in building healthy public policies that promote ECD. Some examples include:

- Adopt provincial legislation and set a schedule to support ECD (e.g., Quebec policies on family and children; supplement child health benefits, holistic family policy, extended parental leaves, expanded and high quality educational child

[14] For more information on this, please see the Northern Health Position on Health, Weight and Obesity.

care, extended child care for children up to 12 years of age at low cost for parents)

- Engage high level northern and provincial intersectoral leadership with the Ministry of Children and Families and the Ministry of Education.

8.2 Create Supportive Environments

Parents have the privilege and responsibility to nuture and care for their children, but no parent can do it all on their own. As a community, we must have the vision to ensure children and their parents and caregivers have the right types of support and services in place to help them succeed. A collective commitment is required to ensure parents and families have the supports and services necessary to achieve success.

Children and adults interact in a variety of settings – settings where they live, work, learn, and play. Within each of these environments, there is opportunity to support ECD using examples such as:

8.2.1 Home

- Promote and emphasize the importance of breastfeeding (see Northern Health's Position on Healthy Eating).
- Provide positive parenting that ensures children are well cared for, well nourished, rested, happy, engaged and allowed to play and learn with all the delight and energy of each stage of their development.[xlviii]

8.2.2 Work

- Support parents (men and women) to synchronize caring and earning.
- Build on maternity and parental leave to enrich the benefit value, and to extend the total duration from 12 to 18 months, reserving additional months for fathers (e.g., *15 by 15* Policy Framework for Optimal Early Human Development).
- Build on existing employment standards to support mothers and fathers with children over 18 months to work full-time for pay, but redefine full-time to accommodate shorter annual working hour norms without exacerbating gender inequalities in the labour market (e.g., *15 by 15* Policy Framework for Optimal Early Human Development).

8.2.3 School

- Support school-based programs (e.g., Strong Start). Schools have a local mandate and are often taken seriously by the community. When we build programming around the school, it brings a perception of universal access (as opposed to social-based services; see Northern Health's Position on Healthy Schools).
- Co-locate early child development services in schools. Co-location within schools destigmatizes services associated with ECD work and brings in users that may not traditionally attend programs.

8.2.4 Leisure/Community

- Align community processes with the school system to support school-based programs.
- Support play as a key developmental task in structured, educational and recreational activities.

- Promote breastfeeding-supportive spaces.
- Reduce barriers to families for children to access activities that may improve ECD outcomes (e.g., time, language, culture, or cost; see Northern Health's Position on Healthy Communities); hosting programs in schools can overcome some of the barriers.
- Support quality, accessible child care.
- Collaboration and/or co-location of family/child early intervention programs and service providers.
- Promote Canadian Physical Activity Guidelines and the Canadian Sedentary Behaviour Guidelines for optimal physical growth and development.

8.3 Strengthen Community Action

Successful actions to promote ECD are planned and implemented through partnerships and collaborations. Often public, private, and non-governmental organizations may be involved at local, regional, provincial, and federal levels. Examples of partnerships that foster community capacity and support ECD include:

- Engage with a broad range of partners to build coalitions for ECD (e.g., municipal planners, child care providers, recreational planners, interministerial, economic sector; Ontario's With Our Best Future in Mind).
- Promote primary health care leadership representation at Northern ECD community tables.
- Support broad participation by many sectors at higher levels may weather hostile political and economic times.
- Engage with community partners to focus on EDI outcomes and how they can focus efforts to influence outcomes and/or work to reduce barriers to high quality programming.
- Promote vertical coordination within the community. As the partners work together, they can learn how to better organize and mobilize at the local level. In turn, this can attract more funding (e.g., Bruce/WoodGreen Early Learning Centre).

8.4 Develop Personal Skills

A variety of resources and systems are available to support individuals and families to improve health outcomes through promoting ECD. Stakeholders should focus on the various levels of behaviour change and construct programs accordingly. Examples of programs and campaigns that may encourage the development of personal skills towards promoting ECD use include:

- Support vulnerable young pregnant women with intensive services throughout the pregnancy (e.g., Nurse Family Partnership)
- Develop pathways for universal and enhanced services that begin shortly after discharge (e.g., 6-8 weeks postpartum) for those who may not qualify for programs for vulnerable women. Programs can focus on breastfeeding, postpartum depression, tobacco cessation, and areas of social and economic vulnerabilities. Programs should also align with the BC Healthy Start initiatives.
- Invest in expectant mothers and their young children.

- Integrate early childhood programs into community schools (e.g., Toronto First Duty).
- Support self-management support skills training to promote client behaviour changes and goal setting.
- Promote Indigenous Cultural Competency training.

8.5 Reorient Health Services

Northern Health is already undertaking action to reorient health services and embed them in healthy communities. This work seeks to make services and programs more multi-disciplinary (e.g., Primary Care Homes); these changes reflect the need to be responsive to changing societal, cultural and economic influences in Norhtern BC.

A broad range of people are available to assist with reorienting health services. For example, health professionals, local government, community planners, sport and recreation professionals, general practitioners, allied health professionals and volunteer groups can influence ECD. Some examples of where this could be effective include:

- Expedite the establishment of a Northern Health Regional Pediatric Council with an integrated structure to the Northern Regional ECD Coalition
- Engage strong, stable, intersectoral leadership working together at the highest levels will make the greatest progress.
- Focus on skills/behaviours/factors affecting development and EDI outcomes.When leaders focus on EDI outcomes, they will change their orientation to focus their efforts on improving these outcomes (e.g., Early Years Study).
- Support multi-partner programs such as Single Plan of Care, pioneered by the Children's Treatment Network of Simcoe York.
- Create a Primary Care Clinic dedicated to children and families.

9.0 Conclusion

In conclusion, Northern Health adopts these guiding principles in its approaches to ECD. It is recognized that ECD is a modifiable risk factor for the development and progression of long-term socioeconomic status and social determinant of health. Messages in this paper are supported by current evidence and best practices from international examples. This paper presents evidence-based strategies that have been implemented and proven to support ECD initiatives in other places. These strategies support the comprehensive framework presented by the Ottawa Charter and support Northern Health's guiding principles.

10.0 Other Resources

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