Assessing the CAPC/CPNP Joint Management Infrastructure as a Model for FPT Collaboration: Looking Back and Moving Forward

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Assessing the CAPC/CPNP Joint Management Infrastructure as a Model for FPT Collaboration: Looking Back and Moving Forward

I. Introduction

Canadian Policy Research Networks (CPRN) conducted research to provide the Public Health Agency of Canada (PHAC) with a report that includes a retrospective review and forward-looking analysis of the federal/provincial/territorial joint management infrastructure (JMI) that oversees the Community Action Program for Children (CAPC) and the Canada Prenatal Nutrition Program (CPNP) in communities across the country.

The broad aims of the study were twofold, to:

1. Describe the CAPC/CPNP joint management infrastructure¹ and assess how well it has worked; and
2. Determine the broader potential of the JMI as a multi-level governance model for advancing PHAC priorities.

II. Background and Context

CAPC and CPNP are part of the Government of Canada’s larger commitment to invest in the well-being of vulnerable children. For more than ten years, each program has provided funding to community groups or coalitions, either to deliver programs that address the health and development of children aged 0-6 years who are living in conditions of risk (CAPC), or to enhance or develop programs for vulnerable pregnant women (CPNP). Together, the two programs have created a network of over 750 funded projects in communities across the country.

CAPC and CPNP are governed by federal/provincial/territorial administrative protocols signed in 1993 and adapted to accommodate the launch of CPNP in 1994. These protocols establish both the terms and conditions for managing the projects and create a network of Joint Management Committees (JMCs), or later derivatives, to govern the programs. At present, there are thirteen JMIs in Canada – one for each province and territory.² As well, some regions have other infrastructure to manage the programs such as the Atlantic JMC.

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¹ Joint management infrastructure is an inclusive term used to describe all of the structures, and sub-structures, used for the joint management of CAPC/CPNP programs within the provinces/territories. This includes Joint Management Committees and Councils, Program Advisory Committees, Working Groups, and so on, regardless of the actual names. It also includes all of the sub-structures such as executive committees and program management committees, etc.

² In the northern territories, programs are run through a Northern Secretariat.
Each JMC is comprised of representatives from the regionally-based PHAC office, the ministries of health or social services of the respective provincial or territorial government(s), local health authorities and community organizations. The mandate of these joint regional authorities is to allocate resources, respond to jurisdictional priorities, and develop strategies to address evolving issues related to program implementation. At the operational level, PHAC provides programmatic support to community-based projects through its regional and national offices.

Management authority for the CAPC and the CPNP has recently moved from Health Canada to the Public Health Agency of Canada (PHAC), an agency established by the Government of Canada to develop a new approach to federal leadership and collaboration with provinces and territories on efforts to renew the public health system in Canada and support a sustainable health care system. A review of the joint management infrastructure used to implement these programs may elicit more general lessons about federal/provincial/territorial co-operation in the field of public health. Specifically, is the CAPC/CPNP infrastructure a model that can be replicated to achieve other PHAC priorities?

III. Project Overview

Canadian Policy Research Networks (CPRN), a not-for-profit, policy research organization, was funded by the Public Health Agency of Canada (PHAC) through the CAPC/CPNP National Projects Fund to conduct this project. David Hay, Director of CPRN’s Family Network, and Brian Bell, a principal with The Alder Group, were the project’s senior researchers assisted by Judi Varga-Toth, Assistant Director, Family Network, and Tatyana Teplova, CPRN Researcher. Lynda Becker and Peter Puxley of CPRN provided project management and communications support, respectively. See Annex 1 for information on CPRN and the project team.

The study conducted four key pieces of research and analysis:

- A retrospective review of the CAPC/CPNP infrastructure as it was constituted under the original protocols, with a description of how it has evolved over the last ten years;

- A profile of the current federal/provincial/territorial infrastructure, with particular attention to the mechanisms that provinces and territories have instituted to respond to local needs;

- An analysis of the strengths, weaknesses, threats and opportunities (SWOT) affecting the current infrastructure for the CAPC and the CPNP; and

- A forward-looking assessment of the current CAPC/CPNP joint management infrastructure as a federal/provincial/territorial mechanism for influencing and responding to decisions, policy changes and program improvement at the national, provincial/territorial, regional, and community levels.
Project methods were qualitative, including document review, key informant interviews with individuals and groups, and a workshop to verify the analysis presented in the preliminary report. The final report has been disseminated by CPRN through its established communication mechanisms. The primary beneficiaries of the research are PHAC and its partners in the joint management infrastructure.

The study addresses the need of CACP/CPNP projects to describe the link between communities, provincial/territorial initiatives and federal priorities. By developing a comprehensive analysis of the CAPC/CPNP governance structures, it also supports the knowledge mobilization goals of the CAPC/CPNP National Projects Fund, which is to share the knowledge base generated through CAPC and CPNP learning among projects supported through the fund and with other communities such as service providers for children, researchers, educators and policy-makers.

The completed study supplies PHAC with a baseline understanding of the joint management infrastructure as it was originally designed and as it now exists; an analysis of what constitutes a “successful” federal/provincial/territorial infrastructure from different perspectives; and evidence-based inputs to help PHAC evaluate the wider potential of the CAPC/CPNP joint management infrastructure as a mechanism for realizing PHAC priorities related to FPT collaboration in the promotion of public health.

IV. Research Questions and Methods

1. Project Activities

The researchers used qualitative research methodologies for the project. These included: review and analysis of available documentation at the national, provincial/territorial, and regional levels; individual and/or group key informant interviews (face to face and by telephone) with past and present program partners individually and/or collectively (for example, members of the JMCs at all levels, advisory committee members, project coalition members, and children’s managers); and individual key informant interviews with selected external program stakeholders.

The research team was supported by an Advisory Committee comprised of PHAC representatives (primarily regional managers and program consultants) who provided assistance and advice on the design and implementation of the research.

Integral to the research and analysis, CPRN convened a workshop with key PHAC stakeholders using the preliminary report as the foundation for discussion. The objective of the workshop was to inform and strengthen the final research product, in particular the forward-looking assessment (the fourth research objective). See Annex 2 for the roundtable agenda and list of participants.
2. Summary of Research Objectives, Key Questions, Data Collection Activities and Timeline

The project was conducted from April through September 2005. Project planning, document review and the development of interview protocols were conducted in April and May. Key informant interviews were conducted in June, and the workshop was held in July. Drafts of the report were prepared in June, July and August. The report was finalized and translated in August and September.

<table>
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<tr>
<th>Research Objectives</th>
<th>Key Questions</th>
<th>How the Data Is to Be Collected</th>
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| 1. Complete a historical/retrospective profile of the JMI | • What kind of joint management infrastructure did the protocol establish?  
• What stakeholders did the protocol identify as being involved and what kinds of participation were called for? Did this participation occur; why/why not?  
• What are the key infrastructure changes that have occurred within the JMI? What triggered these changes and were they important?  
• Was the protocol ever revised to reflect these – or other – changes? Why; why not? | • Primary method: Document review  
• Secondary method: Key informant interviews |
| 2. Develop a profile of the current JMI | • What kind of joint management infrastructure is in place today?  
• Are there any plans to change the joint management infrastructure? What are they?  
• What stakeholders does the present protocol, or arrangement, identify as being involved and what kinds of participation are called for? Is this participation occurring; why/why not?  
• What constitutes a successful JMI? Do each of the partners define “success” in the same way? If not, why not? | • Primary method: Document review and input from regional contact  
• Secondary method: Key informant interviews |
| 3. Complete a SWOT analysis | • Has the joint management infrastructure worked? Why or why not?  
• What are its strengths; its weaknesses?  
• Is the original protocol still appropriate? What are the opportunities associated with its continued use; the drawbacks?  
• Are there plans to change the protocol? Why/why not? | • Primary: Key informant interviews  
• Secondary: Document review |
| 4. Conduct a forward-looking assessment | • Is the joint management infrastructure a model that the PHAC should replicate?  
• Is it an effective FPT mechanism for influencing and responding to decisions, or to policy changes and program improvement? | • Primary: Expert Workshop  
• Secondary: Key informant interviews |
3. Description of the Document Review Process

Documents were provided to the research team from the national office of PHAC and from PHAC regional offices. To complete the initial analysis of the JMC structure, function and evolution in each province and region, the research team made a written request to PHAC project contacts (program consultants and children’s managers) to provide:

i. Reference lists of documents in regional offices. Documents requested included the following types of materials:
   a. all the current information/material on the JMI in the region;
   b. notes/minutes from JMC meetings, including notes to the national office;
   c. any administrative reports, e.g. quarterly reports, annual reports;
   d. any regional evaluations of the program (not projects); and
   e. any meeting notes and/or other material regarding regular meetings of program consultants for CAPC/CPNP, including coalitions (e.g. British Columbia, Manitoba and Ontario).

ii. A note that chronologically describes significant events/milestones in the history of the program and the JMI and, in particular, events that produced change.

The findings from the document review, while contributing to the overall findings for the project, also served to set up the approach to the key informant interviews. A list of all the documents reviewed is provided in Annex 3.

4. Description of the Key Informant Interview Process

Selection of the Key Informants – Initial Round of Interviews

An initial sample of key informants was selected, with one informant drawn from each province/territory (13 plus 1 at the Atlantic level, plus 1 at the national level). These key informants were key program staff members with excellent knowledge of CAPC/CPNP and the joint management infrastructure (JMI). The list of key informants was built from consultations with the Advisory Committee, children’s managers and program consultants.

The purpose of the initial interview was to gather as much information as was possible about the current operations of the JMI (current profile) as well as to verify any historical data (historical/retrospective). The initial key informant was asked to nominate up to four key informants who are currently participating or who have participated in the JMI, or are people who have worked with and are knowledgeable about the JMI, e.g. researchers, academics, government officials, project participants (staff, volunteers, consumers) or community representatives.
Selection of the Key Informants – Second Round of Interviews

A second round of up to four interviews was conducted with people nominated either directly through the initial interview process (above) or by other key informants. These people included a combination of federal and provincial/territorial JMC members; other JMC members (e.g. non-government representatives); and other stakeholders, including former program staff, JMC members, former project participants, and community representatives.

A list of key informants for this study are attached in Annex 4.

Interview Procedures

A semi-structured interview guide was developed on the basis of the key questions identified above. Interviews were conducted primarily by telephone, with a few conducted face-to-face (both individually and with small groups). The project timeline and the limited number of opportunities to arrange meeting times with key informants meant that the majority of interviews were conducted by telephone.

All informants were contacted in advance of the interview by members of the CPRN project team to seek their agreement to participate and to schedule a time for the interview. The interview guide containing the key questions was sent to all informants prior to the interview. The guide included a preamble that provided an overview of the project, identified the interview objectives and addressed issues of anonymity and confidentiality. The Key Informant Interview Guide is attached as Annex 5.

V. Findings

The findings are based on the information collected from the document review and from the key informant interviews. The findings are provided in two main sections. The first section describes the JMI infrastructure from its implementation in each jurisdiction in 1993 through its evolution to its present form. The second section provides an overview of the SWOT analysis of the JMI.

1. A Retrospective Review of the CAPC/CPNP Infrastructure

1.1 The Protocols

The Protocols between Canada and the provinces/territories were signed in 1993, with the exception of Nunavut (which was signed in 2000, after becoming a separate territory). The Protocols defined program priorities and target groups, management or consultation and planning mechanisms, evaluation, communication and funding commitments. The Protocols applied first to the CAPC Program and were later amended to include CPNP.

A comparative summary of each of the Joint Management Infrastructures, highlighting key roles and responsibilities, structure, membership and the nature of community involvement called for in the programs’ implementation is included as Annex 6.
The governance structures established by the Protocols were similar in that they took the form of a joint committee, with most having essentially the same purposes. However, there was variation in the roles and responsibilities among the structures and in how they were set up to conduct their business. These variations were reflected in the different names given to the committees. For example, one Protocol established a two-tiered structure, consisting of an Executive Management Committee and a Program Management Committee. In two jurisdictions, the Protocols established Advisory Committees in line with the advisory (as opposed to management) nature of the work. And in one region, Atlantic Canada, the two levels of government established an Atlantic Joint Management Committee as an administrative body to promote the pan-Atlantic sharing of information and the collaboration of effort in implementing the two programs.

The membership of the Joint Management Infrastructures also varied according to jurisdiction. Most of the Protocols established that the JMCs were to be composed solely of representatives of the federal and provincial/territorial governments; all were co-chaired by the two levels of government (though the degree of leadership provided by each varied considerably). Several protocols provided for the inclusion of other stakeholders on the JMC, including representatives from community organizations.

The priorities and target groups identified within the Protocols reflected the specific needs of each jurisdiction. In most cases, the target group included children at risk aged 0-6 and their families; however, in several jurisdictions the Protocols stipulated that the target population was “not limited” to this age group while in another the age limit was extended to children of primary school age. A number of jurisdictions recognized the special needs of Aboriginal children. As well, some recognized the needs of official language minority groups. It should be noted that jurisdictional priorities were identified in appendices attached to the Protocols.

Evaluation was a mandatory component of all of the Protocols. What was different across the provinces/territories was the degree of participation of the JMIs in these activities. In some jurisdictions, the two levels of government agreed either to jointly develop an evaluation framework or to jointly carry out any evaluation of the programs. Other jurisdictions did not specify the responsibilities for evaluation or agreed to review an evaluation framework developed by other parties. In one jurisdiction, the full responsibility for evaluation was delegated to the Government of Canada. In the Atlantic region, four provincial jurisdictions (JMCs) agreed to collaborate with the federal government on a common evaluation framework.

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3 There was a greater degree of flexibility in allowing changes to the appendices as compared to the Protocol. This enabled each jurisdiction to be responsible to changing needs and priorities.
1.2 Program Implementation

Most of the Protocols (including the Terms of Reference) provided for consultation with community and the involvement of community organizations in the decision-making, planning, design and evaluation of the projects. This involvement was an integral part of implementation although it took many different forms in different jurisdictions.

In one jurisdiction, the Protocol called for community involvement through direct membership on the JMC and in another this involvement took the form largely of community representation on regional advisory committees. However, in many jurisdictions involvement was interpreted by the JMIs as supporting an approach that included activities such as engaging the community in reviewing priorities and target areas, in assessing and identifying needed programs and services, and in developing and sponsoring community-based projects. In many cases, this work was undertaken through a strong commitment on the part of the JMI to a “bottom up,” community-based model of development.

Perhaps one of the most important aspects of community involvement was the frequently strong JMI encouragement and support for the development of community-based coalitions to achieve a coordinated and collaborative approach to children’s issues at the regional and local levels. Many of these coalitions have become strong and effective project and program advocates and, in the later years of the program, have frequently had a place at the JMI table (though usually on an invitational basis). In addition, many of these coalitions appear to have played important roles in contributing to the development of more recently created provincial and territorial early childhood development (ECD) initiatives.

The JMIs also chose to implement the programs in very different ways, reflecting the particular capacities and needs of each province/territory. For example, project selection and development were approached through different combinations of needs assessment exercises and calls for proposals. In some cases, the JMIs were actively engaged in the processes, in some they largely provided oversight, and in others they managed the services of both staff and contracted development specialists. Projects were sponsored by a diverse spectrum of community-based organizations, ranging from umbrella organizations operating in multiple sites to separately funded projects. In areas where no infrastructure existed, community-based organizations were developed and then became project sponsors. Many of the projects were – and remain – multi-purpose organizations such as family and parent resource centres, often with CAPC and CPNP programming co-located within the same agency. In one jurisdiction, the Protocol determined that up to 50 percent of the CAPC budget could be accessed by community-based health and social services organizations administered by the province.

Particular efforts were also made, in some jurisdictions, to fund projects serving francophone minorities and Aboriginal populations: in several provinces, through the Protocol and/or through the deliberations of the JMI, a specified amount of each year’s funding was to be dedicated to Aboriginal children living off-reserve.
In most jurisdictions, in addition to the JMI, various kinds of working groups, committees and sub-committees were established. In most cases, the Protocol (and usually, the Terms of Reference) provided for establishing such structures but did not specify the purposes for which they should be created. The one exception may be for CPNP, where some of the Protocols were amended to create separate committees/sub-committees for the joint management of this program. In the other jurisdictions the CPNP was managed through the existing joint management infrastructure.

Additional committees, sub-committees and working groups were established by the JMIs to undertake a variety of tasks. These usually included committees and sub-committees on evaluation and communications; other structures have been created to advise on such matters as the eligibility of agencies for CAPC/CPNP funding, standards for the provision of employee benefits to agency staff, and the development of mechanisms to foster an integrated approach to federal/provincial/territorial child-centred programs. Several jurisdictions have also created structures to effectively manage program operations: in one case the operations committee was established within the JMI Terms of Reference but in the others these committees were created by the JMI itself.

Some of these structures appear to be particularly successful as joint management infrastructures in their own right, for example the Aboriginal Management Committee (Ontario) and the Atlantic Children’s Evaluation Sub-Committee (ACES)/ACES Working Group. In all cases they provide, among other things, strong opportunities for engagement by various experts, project sponsors, and others in the related policy and program decision-making processes.

1.3 Evolution of the JMI

There have been many changes to both the operations and structure of the JMIs since 1993. However, there have not been any amendments to the Protocols and there have been very few changes to the Appendices. Most of the latter were made to integrate CPNP into the Protocols in 1994-1995 (and later, in some jurisdictions). There have also been at least two amendments to the Appendices/Terms of Reference for the JMIs in one jurisdiction to reflect changes in the membership of the Joint Management Committee due to provincial restructuring. In most other jurisdictions, the JMIs have also contemplated changes to their Terms of Reference – sometimes through quite structured deliberations and other times less formally – to address changing memberships and/or changing roles and responsibilities. However, these exercises have usually been abandoned for reasons ranging from “more pressing priorities” to concerns that by re-opening the Terms of Reference the entire modus operandi of the Committee could be disrupted.

Some jurisdictions have experienced little change to the membership of the JMI. However, many have undergone significant changes, usually associated with government restructuring at the provincial/territorial levels (though to some extent within Health Canada/PHAC). These changes have been disruptive, particularly when they involve the co-chair (as has often been the case). As well, there has been some decline in the level of senior members of JMCs in some jurisdictions, and this has been seen to detract from the effectiveness of the Committee.
There has also been a significant evolution in the work of the JMIs since their establishment. At the outset, the focus was on program start-up, design and development with a lot of attention to operational requirements. Over time, attention shifted to program maintenance and renewal. Today, most JMIs continue to devote considerable attention to program evaluation and to creating ongoing opportunities for information-sharing, both relating to the programs directly and to some of the emerging and broader FPT children’s initiatives. Some Committees have also placed greater emphasis on planning and strategic issues but these efforts have met with mixed success thus far.

Perhaps one of the greatest challenges is that it is becoming increasingly difficult to bring the relevant FPT players together around CAPC/CPNP. This may in part be due to the fact that the profile of these programs has changed significantly since about 2000. For example, in 1993 Health Canada was seen by many to be a new player on children’s issues at the community level. Nevertheless, for many, the money associated with CAPC/CPNP was welcomed as “the only show in town.” (It must be noted, however, that many others also recognized CAPC as an innovative and highly promising way to improve the health status of children and families.) In contrast, there are a myriad of FPT agreements today on early childhood development, early learning, child care, and so on; these have significantly increased the levels of funding available for children’s issues and changed the landscape of players at the table. The time and commitment demanded of people to make the JMI a success may often no longer be available – or accessible.

2. SWOT Analysis

2.1 Definitions of Success

The Terms of Reference for the Joint Management Infrastructures (in most cases included as Appendices to the Protocols) set out the purpose of the Committees. As discussed above in the retrospective review of the JMI infrastructure, these statements of purpose are generally similar across all of the jurisdictions. The JMI’s purpose included providing:

- Direction to Health Canada on the implementation and delivery of the program(s);
- A process for priority-setting and its implementation;
- Recommendations on projects for approval to the Minister of Health;
- Participation in the evaluation and monitoring of the programs; and
- A forum for issue resolution.

A preliminary review of available program materials revealed very little by way of any discussion of what constitutes a successful JMI. Key informants, on the other hand, defined a successful JMI in relation to a variety of factors. Most of these can be associated with two themes, effective working relationships and successful program outcomes.
Effective Working Relationships in a Supportive Environment

This was the most popular theme. This was described as JMI members who have developed a sense of trust and respect for one another. The Committee environment is one that invites clear and honest communications, supports the open exchange of information, and contributes to collaboration and partnerships. The members are also able to contribute timely and consistent direction to program design and implementation.

Successful Program Outcomes

The second broad theme relates to defining success in relation to the outcomes of the JMI’s operations. This was characterized as the JMI enabling concrete things to happen at the community level through activities that are designed, delivered and evaluated in an integrated manner. This idea was expressed in a variety of ways but is perhaps best reflected in the suggestion that the JMIs have been instrumental in encouraging policy- and decision-makers to approach children’s issues and communities through a holistic and integrated program lens in order to address the needs of priority populations. In addition, the JMI facilitates progress in areas that are otherwise encumbered by jurisdictional issues.

Other Success Factors

Other factors ranged from the importance of senior management support for the JMI (i.e. senior managers are engaged in the JMI process and are committed to it, and to seeing it work) through to the importance of providing a vehicle for community engagement in the development and selection of projects at the community level.

A few “divides” in definitions of success within the same jurisdiction were identified; one distinguished between success as sharing and building on best practices as opposed to success being the avoidance of duplication. Another distinguished between defining success in terms of “process” as opposed to “outcomes.” These are illustrative in that they reflect some of the different orientations of different members of JMI. They also suggest a reason for some of the tensions that have existed within most JMIs at one or more points in their evolution. For example, on the “process-outcome” point, evaluation is an area where most JMIs have played a strong role (and there appears to have been considerable “value-added” by the Committees’ involvement). Nevertheless, there have still been some tensions between the two levels of government around where the emphasis on evaluation should be placed, the most appropriate methodology, what constitutes the best and most useful outcomes, and so on.

Small group discussion among CAPC/CPNP program consultants at the July CPRN Roundtable reflected some consensus that the JMIs have contributed to the successful program outcomes identified within the CAPC/CPNP Results-Based Management and Accountability Framework. However, many of the indicators or examples of this success take the form of “proxies” – for example, the creation of community infrastructures that are still in place and often now being used for other children’s program purposes. At the same time, there was general agreement that it is difficult to know the extent to which the outcomes are the result of the JMI’s activities.
In addition, it was noted that where positive outcomes can be demonstrated (e.g. projects reach priority populations, projects inform and contribute to other relevant policy and program development), these outcomes are more immediate. Some of the intermediate and the longer-term outcomes will take considerably longer to achieve, such as changes at the community and population levels (e.g. reduced disparities), and changes at the level of individual behaviours (e.g. healthy birth weights).

2.2 The JMI’s Strengths

When key informants were asked to identify the main factors contributing to the JMI’s success, the following themes emerged:

The Overall Design of the Program/Protocols

The Protocols provided a critical framework for the two levels of government to co-operate around mutually-agreed upon objectives and allowed for the relatively smooth “rolling out” of the CAPC/CPNP programs (including the identification of priorities and the development, implementation, evaluation and monitoring). The Protocols also defined the primary joint management infrastructures (and in cases, sub-structures), encouraging a rigorous approach to program development in a comparatively new program domain.

The Structure and Operations of the JMI Itself

The JMIs had a strong focus from the outset (though at later stages, some parties were of the view that this should be expanded to address broader children’s issues); there were generally clearly negotiated roles and responsibilities; there was some stability of membership (particularly over the critical first five to six years in most jurisdictions); representation was/is reasonably multi-sectoral (on the provincial/territorial side) involving portfolios such as health, family and children, community, education and training; and there was/is considerable flexibility built into both the Protocols and the JMIs themselves to manage and operate the programs in a manner that reflects the particularities of each jurisdiction.

In addition, there is a sense that the JMI, when conceived and implemented in 1993, was “the right kind of mechanism at the right time” for the CAPC/CPNP initiative. It allowed for and facilitated the moving forward on an initiative that might otherwise have been impeded by jurisdictional disagreements. On the other hand, there have also been many significant changes to the landscape and this very strength of the JMI in 1993 may preclude it from having continuing relevance today.

The Capacity for Collaboration and Information and Knowledge Sharing

The JMI affords an opportunity for the two levels of government to collaborate and share important information and knowledge, both formally and informally, about respective program interests. This has contributed to strengthened collaboration and enrichment of early childhood initiatives. In the absence of the JMI, there is a sense that this exchange and transfer would not have been accomplished to the extent that it has.
This sharing is recognized as a valuable investment in the development and implementation of child development, early learning and related programs. For example, the coalitions established under CAPC/CPNP have provided the basis for healthy child development initiatives; family and parent resource centres initiated within CAPC/CPNP have been expanded and enriched under later FPT arrangements in several jurisdictions; and the experience and expertise acquired through CAPC/CPNP has been integrated into provincial/territorial planning for new programs and services for families and children.

**Commitment**

The success of the JMI has been the result of a strong commitment of the two levels of government, the departments and ministries involved, and especially of the participating government officials to early childhood development initiatives and the goals and objectives of CAPC/CPNP. To many, this commitment has been the single most important factor contributing to the success of the JMI effort, “through good times and bad.” This commitment, among other factors, has been transposed into effective working relationships among Committee members.

**Effective Working Relationships**

The members of the JMIs have developed a sense of trust and respect that has supported the collaborative work of the Committees, including contributing to the capacity of members to negotiate compromise and continuously seek the “high road,” and usually consensus, to move the programs forward. This has been assisted by strong and co-operative (and, earlier on in the process, consistent) leadership from the co-chairs. It has also been made possible by the commitment, interests and skills of the individual members who have often played an effective advocacy role for children’s issues within and across their respective departments/agencies.

**2.3 The JMI’s Weaknesses**

When key informants were asked to identify the main factors contributing to the JMI’s weaknesses or shortcomings, the following themes emerged:

**Scope of Mandate**

The JMI has not been able to sufficiently expand its mandate to address additional issues arising from new FPT children’s initiatives, particularly the ECD initiatives. In at least one case, Nunavut, this limited mandate represents a constraint on the implementation of CAPC/CPNP Protocol as it fails to address the commitments within defining instruments of Nunavut governance and to support a “single window” approach to service delivery. In several other jurisdictions, this limited mandate – and a reluctance of all parties to “re-open” the Protocols – has contributed to the JMI’s failure to maintain its relevance with the passing of time. This perceived limitation in scope (by some), is regarded to have contributed to some of the above-noted decline in commitment, declining seniority of Committee membership, lack of ongoing collaboration on children’s issues, and so on.
Program Funding Uncertainty

Despite the commitment of long-term federal funding contained in the Protocols, the uncertainties around the levels of funding have, at times, eroded working relationships within the JMI (this includes the significant reductions in the 1997 Budget, the lack of any subsequent enrichment to program budgets, and the lack of clarity around contribution arrangements after 2007). At the same time, and more recently, there is some perception among federal members of the JMI's that more effective relationships may at times have been compromised by a lack of transparency on the part of the provinces/territories surrounding their intentions and use of the federal ECD funding.

Collaboration

There is some question about whether effective collaboration for CAPC/CPNP could have been established and maintained if there had not been significant levels of federal funding brought to the table at the outset. Some also questioned the quality of the collaboration when what is considered to be an effective partnership arrangement in one program area (i.e. CAPC/CPNP) does not appear to be able to be extended to other program areas supported within the ECD Agreements that contribute to similar goals and outcomes for children.

For example, even though the benefits of sharing best practices at the JMI level may be substantial and have probably contributed quite positively to more recent programming at the provincial/territorial level, there is little formal documentation of these instances. As a result, examples of such knowledge exchange and uptake are often simply identified as “unintended” consequences of the JMI experience and/or are seen (at best) as one jurisdiction’s copying – or even duplicating – another’s best practices. However, few, if any, have been openly acknowledged or credited. This has been identified by some as a lack of transparency that diminishes the JMI “partnership” and generates some cynicism about commitments to future collaborative programming for children.

Changing Organizational Structure

In some jurisdictions, the frequent reorganization of departments and agencies subsequent to 1993, particularly at the provincial/territorial level, has often had an adverse impact on support for the JMI and its operations. Similarly, changes within Health Canada involving regional roles and responsibilities and, most recently, the establishment of the PHAC, also present challenges for the effective operations of the JMI. For example, having a strong direct presence in a jurisdiction (including program capacity and human resources expertise) is important to developing and sustaining a credible and effective JMI that can work consistently, transparently and effectively with both provincial/territorial partners and communities.

The very different FPT environment of today presents a new set of challenges for the ongoing operation of the JMI: among these are the very significant increase in the levels of funding available for children’s issues and the arrangements under which the monies are transferred between jurisdictions; the regionalization of health services and the role of new regional health authorities in the planning and delivery of health services and determining the allocation of...
resources at the local level; and the demands of integrating services within the context of “horizontal” management structures while also engaging a variety of new and somewhat non-traditional players in the funding and delivery configuration.

Access to Resources

There is some perception that JMIs have not had sufficient access to resources to enable them to do their work well. JMIs would benefit from operational monies to support periodic meetings (e.g. travel and accommodation), to augment direct staff support (provided largely by Health Canada/PHAC), to undertake Committee work (e.g. research, policy and planning activities) and to facilitate and support important networking, training and professional development activities across regions and communities. In at least one jurisdiction there is also a perception that the workload associated with operating the JMI is excessive (and certainly in some other jurisdictions, some members suggested that the time required to even attend meetings is becoming burdensome, particularly in the absence of a clear, results-oriented agenda).

Changes in Membership

Changes in the membership of the JMI (particularly post-2000) have been disruptive and have contributed to tensions, abrupt changes in parties’ positions on issues, loss of momentum around work issues, and so on. As well, Committee effectiveness has been strengthened or hindered by imbalances in the seniority of members.

2.4 Opportunities

In addition to building on strengths and addressing weaknesses, key informants had a few additional suggestions when asked about the opportunities for the continued operation of the JMI for CAPC/CPNP:

JMI for All Programs (Federal/Provincial/Territorial) for Children

One of the challenges to the JMI noted in the retrospective review of the JMI was the increasing difficulty in bringing FPT players together around CAPC/CPNP. One suggestion, given the success of the JMI as a FPT management mechanism, was to bring all federal/provincial/territorial programs for children – currently managed by various accords, agreements, MOUs, etc., and delivered by various departments, ministries and organizations in numerous ways – under one JMI. The suggested outcome was a better vision and design of all of the goals and objectives for children and for children’s programming in Canada. This would also provide an opportunity to review where CAPC/CPNP fit within these other programs.

Some informants cautioned that a JMI might not be appropriate for all programs, although a rationale was not provided or developed regarding which programs would work and which ones would not. On the other hand, several others suggested that the JMI model might be suitable for other purposes – presumably extending beyond children to other populations and issues – on the strength of its capacity to operate at the level of program as opposed to intergovernmental
content and dynamics. In doing so, the structure may have important capacities and flexibilities that would otherwise not be available to officials.

*JMI*s for Policy and Program Development, and Operations

Another comment was that a JMI might not work at all times in the program’s lifespan. The suggestion was that a JMI was particularly successful at the beginning to ensure collaborative and effective program and policy development, but less successful (or at least, necessary) as an operational management mechanism.

**Information Sharing and Networking**

Informants suggested that more national, provincial/territorial, and regional opportunities to share information (e.g. best practices), as was supported by the national JMC meeting in 1999, would be of strategic benefit to JMI participants. Resources would be necessary to adequately prepare synthesis materials, conduct the meetings, and provide ongoing networking opportunities and supports.

There is also some belief that the JMI could be successful if its mandate were to go beyond this, and focus on related responsibilities more supportive of the Social Union Framework Agreement (and less of “an intrusion into the space of the provinces and territories”). Examples of such activities include policy development; research (including process and outcomes-based initiatives that support both individual and community level investigations); and knowledge exchange and uptake, including support of best practices.

**Joint Funding**

Some key informants suggested that the success of a JMI in the future could be strengthened through the provision of joint federal and provincial/territorial funding at the beginning of the program, to enhance the collaborative nature of the endeavour. This approach would be a significant departure from the present arrangement that could be characterized as a partnership (at least in some respects) at the level of knowledge exchange and policy discussion but not at the level of funding practice. As is discussed earlier, while there are certainly suggestions that the CAPC/CPNP experience has contributed to subsequent program developments at the provincial/territorial level, for CAPC/CPNP the jurisdictions have more often than not proceeded to develop and implement complementary programs on parallel rather than integrated funding tracks.
2.5 Threats

As to challenges to the continued operation of the JMI, key informants suggested that the weaknesses identified above are threats in the medium- to long-term if they are not addressed. Additional threats identified included:

Program Uncertainties

Informants generally lacked information on future program resource levels and on the overall future of the programs themselves. Informants expressed frustration over this lack of information, particularly as they indicated that they weren’t part of any substantive discussions about the programs’ future. Informants cited examples of unilateral federal decisions that were contrary to collaborative decisions made previously. Unilateral decisions and lack of discussion with all JMI participants moved some informants to suggest that their trust in the principles of the JMI was being compromised.

The FPT Environment

Again, the discussion in the retrospective review of the JMI noted the challenges with JMI participation and alluded to the changing nature of FPT relations regarding children’s programs. In particular, since the development of the National Children’s Agenda and the National Child Benefit, many different mechanisms have arisen for FPT collaboration (the PHAC’s formation of Pan-Canadian Public Health Networks and related working groups is a recent example). Areas of shared interest, for example child care, are now primarily funded through transfer payment mechanisms with a very different set of management and delivery requirements that are reflected in much less formal accords and agreements. The question raised by informants was, given a changed environment, would a JMI approach be one that would be possible to introduce, or even consider?

This question may become even more complex as the deliberations move progressively into the health domain. Consideration will need to be given to the vision, mandate and priorities of the PHAC, the interface with the vision, mandate and priorities of other relevant federal departments and agencies; and how these can be integrated to articulate a holistic health approach to children’s issues at the federal level (and here experience associated with the development and implementation of the federal councils may be instructive). Deliberations along these tracks would facilitate assessment of the most appropriate infrastructure for moving forward in a federal/provincial/territorial context, perhaps building on the SUFA mechanism as discussed above and/or on the emerging Public Health Networks.
VI. Looking Forward

Informants were asked, “Is the joint management infrastructure a model that the PHAC should replicate?” and, “Is the JMI an effective FPT mechanism?” These questions were considered in three ways, for the:

1. JMI and CAPC/CPNP;
2. JMI as a multi-level governance model for PHAC for existing or new FPT initiatives (for children’s and/or other programs); and
3. JMI as a multi-level governance model for other federal departments and agencies for existing or new FPT initiatives (for children’s and/or other programs).

Informants were unanimous in their positive response to these questions. The endorsement was conditional, however, as the discussion in the SWOT analysis suggests. First, the opportunity of introducing a JMI as a FPT mechanism in the current environment of FPT relations needs to be fully investigated and considered. For example, is federal leadership sufficient? Or, conversely, is full FPT collaboration and agreement a necessary pre-condition for the introduction of a new initiative in areas of provincial/territorial jurisdiction using a JMI mechanism?

Given that consideration, and again, as the preceding discussion in Section V makes clear, successful continuation and/or replication of the JMI depends on building upon the strengths and successfully addressing the weaknesses that were identified by informants. In particular, any JMI has to at best address the integration of FPT initiatives for children, or at least complement and not duplicate existing FPT initiatives and activities. As well, a clear commitment needs to be made to sufficient resources to fulfill obligations.

Given the methodological limitations of this study, the analysis has lead to the proposal of questions as conclusions. These questions do not have clear answers and require careful consideration by PHAC.

1. What kind of FPT intergovernmental relationships – overall – does the Agency want to create and work within (from the level of the new Pan-Canadian Public Health Networks through to the delivery of Grants and Contributions programming)?
2. How, if at all, does this relate to any requirements or opportunities that are presented by the Social Union Framework Agreement (SUFA)?
3. What kind of intergovernmental arrangements would the Public Health Agency of Canada want to realistically create for developing and delivering grants and contributions?
4. What are the essential learnings from the JMI experience – building on the findings from the analysis from this project on the strengths, weaknesses, opportunities, and threats/challenges – that can contribute to shaping this arrangement?
1. Additional Questions and Next Steps

Following on the questions posed above, there are five major limitations to the findings of this research project that suggest next steps.

First, it will be helpful to have a better understanding of the expected outcomes of the current PHAC grants and contributions alignment exercise to appreciate the role that the joint infrastructure model might play in future PHAC leadership. For example, how will PHAC use grants and contributions as a policy tool to advance its vision, mission and mandate; how might it use the grants and contributions to contribute to and strengthen the new and emerging public health network throughout the country; and, how might the aligned grants and contributions contribute to addressing priority population health issues?

Second, the participants in the workshop to discuss the project’s preliminary findings of this study were from PHAC and HC and hence one level of government only. To fully process the findings from this project, all, or at least a broader range of JMI stakeholders, should participate. This includes provincial/territorial people who may be involved in future arrangements. It would also be important to talk with community representatives who have been engaged in the program (e.g. parents, project coordinators, coalition leaders, etc). Many of the key informants expressed the desire to remain engaged with the subject of this project as they were committed to strengthening the JMI as an FPT mechanism. Some informants expressed regret that they would not have this opportunity, and some others suggested that this was not reflective of the collaborative spirit of the JMI.

Third, to properly look at the infrastructure of CAPC/CPNP at least three components need review: one is the JMI, but the other two include, first, province/territory-wide coalitions that have been created over the course of the program; and second is the coalitions that have been created at the community level itself. Through the leadership of the JMI, there has been strong vertical integration among these three components and it is this combined infrastructure that has contributed to the positive outcomes achieved.

Fourth, what outcomes are examined is also critical. Community-level outcomes and child-specific outcomes should be examined as an explicit program goal is to build community capacity. Community capacity outcomes are not simply “unanticipated” outcomes. In CAPC sites, communities are actively engaged in making decisions so this is an important model to inform and to be incorporated into new programming. The community setting also provides a rich base for further research and support of demonstration projects.

Fifth, if PHAC wants a more fulsome answer to the question of the JMI as an effective FPT mechanism, additional research is required. There are two considerations here: one, that it is difficult to assess “success” in isolation from the overall program, the numerous communities and projects, and program and project outcomes. The findings currently reflect that operationally, the JMI is “successful” and “effective,” and there are some particular elements of success and effectiveness that have been revealed. What we don’t know is if the JMI contributed in any way to the broader goals of the CAPC and CPNP programs, i.e. supporting families and children at risk.
The second consideration for additional research is that the JMI has been examined in isolation from other existing FPT mechanisms. We know that other FPT initiatives used the JMI model (e.g. National Crime Prevention Strategy). And there are many other FPT mechanisms in existence. It would be beneficial to conduct a comparative research project on these different mechanisms, to better and more broadly understand the elements of success.
Annex 1. Project Team and CPRN Profile

Project Team Profile

David Hay, Family Network Director, CPRN – Prior to joining CPRN, David was Manager of Reports and Analysis for the Canadian Population Health Initiative at the Canadian Institute for Health Information, where he was responsible for coordinating knowledge exchange and public engagement strategies for CPHI. David led the research, writing and production of CPHI’s national population health report, Improving the Health of Canadians 2004. David has many years of experience researching and writing in the areas of population health, well-being, and social development in the private, public and non-profit sectors. Particular areas of expertise include child and family policy, poverty and inequality, and measurement and evaluation. David has conducted many projects in the health area, including projects for Health Canada. Two projects for Health Canada were an assessment of school food programs, and an evaluation and support project for 23 British Columbia community tobacco projects funded through Health Canada’s Community Action Initiatives Program of the Tobacco Reduction Strategy. He has had affiliations with a number of social policy organizations and projects in a voluntary capacity, including: as a director of the Canadian Council on Social Development; a founding member of Campaign 2000 to End Child Poverty in Canada; and as president of the Greater Victoria Child and Youth Advocacy Society.

Judi Varga-Toth, Assistant Director, Family Network: Judi Varga-Toth, M.A., joined CPRN in February 2005 to work with the Director to develop the Family Network’s research programs and projects and its outreach activities. Previously, Judi was the National Programs Manager for Family Service Canada. Judi has many years of experience managing projects related to family well-being in Canada as well as researching and writing in the area of children’s issues. Her particular areas of interest and expertise include social capital and family well-being, social policy affecting the most vulnerable segments of the Canadian population, the impact of violence on children and the interface between families and municipalities. Judi holds an M.A. in European Studies from the Institut des hautes études européennes, Université Robert Schuman, Strasbourg, France, focusing on the social, political and legal impacts of the European Union, and a B.A. in Political Studies from Queen’s University, Kingston, Ontario.

Brian Bell, Principal, The Alder Group – Brian is a health and social policy analyst with experience in government and the non-government and private sectors. He has worked extensively in the areas of health promotion, population health and social development on a diversity of issues. He has advised government departments and agencies and non-government organizations on policy and program development matters in relation to initiatives such as public engagement, advocacy and capacity building, strategic and operational funding, social inclusion, health promotion and the determinants of health and crime prevention through social development. Brian is a former senior civil servant with federal experience in the Ministry of State for Social Development, the Privy Council Office, Human Resources Development Canada and Health Canada. He also served as a national program director with the YMCA Canada and is a founding member of The Alder Group.
Tatyana Teplova, Researcher, Family Network: Tatyana Teplova, M.A., started working with CPRN in January 2005. Previously, she was with the Centre for Voluntary Sector Research and Development, a joint unit between Carleton University and the University of Ottawa. Her areas of interest and expertise include social and child care policies, evaluation, work-life balance and welfare state sustainability. Tatyana is working on her doctoral dissertation in public policy at the School of Public Policy and Administration, Carleton University with a focus on social and family policies.

Canadian Policy Research Networks (CPRN)

CPRN’s mission is to create knowledge and lead public debate on social and economic issues important to the well-being of Canadians. Our goal is to help make Canada a more just, prosperous and caring society. CPRN’s trademark is its ability to help policy makers and citizens debate the beliefs, values, frameworks, policies, programs and “ways of doing” that will help the country to cope with social and economic transformations. By working in this way, Canadian Policy Research Networks has created a unique voice in the policy research community in Canada.

CPRN fosters integration. In a world that is increasingly fragmented by discipline, jurisdiction, language and culture, CPRN has unique process skills for shared learning that shape the way research is designed, carried out, and communicated. It is a neutral space, where diverse groups of people can reflect, collaborate and struggle with their differences in order to arrive at new understandings and to identify common ground.

CPRN is independent. CPRN is a non-profit organization with charitable status that began operating in December 1994. It acquires its funding from federal and provincial governments, foundations and corporations. This diversity ensures that no single voice dominates the research. The Board of Directors ensures good stewardship of these resources.

CPRN is cost effective. Projects are ambitious in their scope, but costs and risks are spread across a number of funders. Research costs are reduced by attracting expert collaborators from universities, think tanks and other organizations. Overhead costs are minimized to ensure that CPRN has a sustainable future.

CPRN is networked. Internally, CPRN has four research networks – on Family, Health, Work, and Public Involvement – and conducts special corporate projects on cross-network issues.Externally, nearly 1,000 people participated in CPRN research events during its first four years of operation. Research funding was contributed from 61 government departments or organizations, and research was completed with the help of 59 researchers from 16 universities, as well as with numerous self-employed researchers.

CPRN has a unique research process. CPRN has extensive experience in the use of shared learning techniques to test hypotheses and inform policy debates. In most major CPRN projects (generally, those with budgets exceeding $100,000), brainstorming sessions and roundtables are part of the research design. This iterative process captures input from researchers, policy makers, and stakeholders at each stage, making the findings relevant to stakeholder needs.
**CPRN maintains high research standards.** CPRN requires internal and external peer review of all research papers prior to publication.

**CPRN invests in communication as a key component of its mandate.** Documents are produced through CPRN’s publication facilities, posted on its Web site (www.cprn.org), and published in traditional paper form. Planning for the release of research publications, some of which are translated, is only a first step. Presenting at conferences and policy forums, conducting briefings for officials, experts and interest groups, preparing spin-off articles, and writing newsletter reports and “op. ed.” pieces are also the norm. In addition, CPRN publishes: *Network News* – a quarterly newsletter aimed at a wide audience; *Policy Direct* – a subscription service for governments; and *e-network*, a weekly e-mail news service. These provide subscribers with short updates on research projects, corporate activities, new publications, commentaries, Roundtables and upcoming events.

**About CPRN’s Financial Structure**

CPRN is funded through a combination of federal, provincial, foundation, and corporate sources. In March 1999, following an independent evaluation, the federal government provided a one-time grant that serves as risk capital, solely to support strategic investments in research capacity and the preliminary development of research before project funding is secured.

As a non-profit organization, CPRN does not aim to accumulate a surplus, but it must finance all costs to ensure the sustainability of the organization over the longer term. Accordingly, each project is required to cover both the direct and indirect costs of the research that is undertaken (see below). Invoicing for financial contributions to CPRN projects is based on project deliverables, as described in the funding contract. Initial contributions to launch research projects are generally requested.

Direct research costs include:

- Compensation for researchers within and outside of CPRN
- Compensation for project-specific administrative time
- The purchase of research data and reports
- Research-related travel, when required to collect data or present findings
- Research events such as brainstorming sessions, roundtables, workshops and Advisory Committee meetings, and
- The publication of each project’s research findings.

Direct research costs for data collection, travel, research events, and publications are incorporated into each project budget based on historical knowledge of the actual costs of these activities.
Indirect costs include personnel costs as well as supplies and services related to:

- **Communications**: Communicating research findings to the print and electronic media and to stakeholder groups, repackaging research findings to reach broader audiences once projects have been completed, and ongoing outreach to current and potential stakeholders in the public, private and non-profit sectors (through, for example, the CPRN Web site, the quarterly magazine *Network News*, CPRN’s weekly list-server *e-network*, and CPRN’s contact database)

- **Management**: Management of quality control processes (peer review, formal editing), management of contracts with funders and researchers, human resource management and development, as well as legal and financial services, and

- **Administration**: This includes the costs associated with the physical premises, office furniture and equipment, CPRN’s information technology and document management systems (hardware and software), office supplies, postage, and supportive services (telephones, fax systems, couriers).

Indirect costs for communications, management and administration are charged to projects based on the historical relationship between direct and indirect research costs.
Annex 2. Roundtable Agenda and List of Participants

Assessing the CAPC/CPNP Joint Management Infrastructure as a Model for FPT Collaboration: Looking Back and Moving Forward

CPRN Roundtable – July 12, 2005
10:00 a.m. to 4:30 p.m.

250 Albert Street, 14th Floor
Ottawa, Ontario

AGENDA

9:30 – 10:00 Coffee and Muffins
Note: Refreshments will be available all day.

10:00 – 10:30 Welcoming Remarks by David Hay and Anne Stenhouse
• Introductions

10:30 – 11:15 Plenary Presentation: Overview of the Project Report

11:15 – 11:30 Refreshment Break

11:30 – 12:30 Small Group Discussion: Findings

Group 1: In considering the strengths and weaknesses that are presented in the report:
• What findings are consistent with your experience; inconsistent?
• What other points would you have expected to see included; liked to see included?

Group 2: In considering the opportunities and threats that are presented in the report:
• What findings are consistent with your experience; inconsistent?
• What other points would you have expected to see included; like to see included?

12:30 – 1:00 Report Back from Small Groups

1:00 – 2:00 Lunch
2:00 – 3:00  **Small Group Discussion: Looking Forward**

**Group 1:**  *On the basis of the synopsis of the findings and your own experience:*

- Has the JMI contributed to successful CAPC/CPNP Program outcomes? Which outcomes; how?
- What additional research do you believe needs to be undertaken to fully answer this question?

**Group 2:**  *On the basis of the synopsis of the findings and your own experience:*

- Is the JMI an effective FPT mechanism: in what circumstances can it be particularly effective and where is it less effective?
- What additional research do you believe needs to be undertaken to fully answer this question?

3:00 – 3:30  **Report Back from Small Groups**

3:30 – 4:00  **Plenary Feedback on Small Group Reports**

4:00 – 4:30  **Closing Remarks, Next Steps**

4:30  **Adjourn**
## List of Participants

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<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Organization/Region</th>
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Annex 3. List of Documents Reviewed

Alberta


Minutes of the Joint Management Committee Meeting. February 20, 2002.


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1 This review of documents is not exhaustive and was completed in a very limited timeframe by CACP/CPNP program consultants. In the course of the process, there were considerable difficulties in identifying and accessing historic documents, many of which were available in hard copy only and could not be transmitted to the researchers.


**British Columbia**


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Minutes BC JMC

**Manitoba**


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1. CPNP Advisory Committee Minutes. Meeting December 7, 1999.

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Newfoundland and Labrador

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Nova Scotia

Memorandum of Understanding respecting the Community Action Program for Children,

Protocol between Canada and the Province of Nova Scotia on the Community Action Program


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Northwest Territories


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Nunavut


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**Quebec**


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CAPC SK Renewal Request Review Form.

Lix, Lisa. “A Needs Assessment for the Canada Prenatal Nutrition Program in Saskatchewan.”

Executive Summary: Renewal of CPNP in Saskatchewan.

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1. CPNP Sub-Committee Meeting. April 26, 1995.

Yukon


Memorandum to Kay Stanley, ADM Health Programs and Services Branch from Heather Fraser, A/Regional Director, BC/Yukon. Re: CAPC Joint Management Committee and Protocol, Yukon. October 10, 1995.
Atlantic JMC

Memorandum to Kay Stanley, Assistant Deputy Minister, Health Promotion Services Branch, from A/RD Health Promotion and Social Services, Atlantic Region. Re: Terms of Reference for Pan-Atlantic Joint Management. November 9, 1994.


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Communication Working Group. Terms of Reference.


Briefing Note to Atlantic Deputies. February 14 and 21, 2002.


PHAC Atlantic Regional Office Evaluation Report. March 2005


Atlantic Children’s Evaluation Sub-Committee (ACES)/Working Group Contact List.
Minutes

National Documents


Annex 4. List of Key Informants

Alberta
Karen Radke, Manager, Healthy Children and Youth Section, AB, PHAC
Dianne Daly, Project Manager, Alberta Mentoring Partnership
Tim Moorhouse, Director, Alberta Children’s Services
Barb Hansen, Senior Policy Lead, Provincial Health Office Branch, Population Health Division, Alberta Health and Wellness.

British Columbia
Mary Elizabeth Fry
Lisa Forster-Coull, Consultant, Population of Health and Wellness, Ministry of Health Services
Deb Leach
Barb Oleschuk

Manitoba
Kimberley Resch, A/Regional Manager, Children’s Health Section
Mark Robertson, Manitoba Education and Youth, Program and Student Services, Department of Education
Darlene Girard, Department of Family Services and Housing, Healthy Child Manitoba
Diane Roussin, c/o Centennial Project

New Brunswick
Edith Doucet, Assistant Deputy Minister, Department of Family and Community Services
Susan LeBlanc, CAPC Program Consultant, PHAC

Newfoundland and Labrador
Rosalind Smyth, Project Manager, National Child Benefit Provincial Reinvestment, Department of Health and Community Services
Frances Ennis, CAPC/CPNP Program Consultant, PHAC

Nova Scotia
Shulamith Medjuck, Coordinator, Federal/Provincial Initiatives, Department of Community Services
Sophie Pitre-Arseneault, CAPC/CPNP Program Consultant, PHAC

Northwest Territories
Gillian Moir, Education, Culture and Employment, GNWT
Kathleen Laskoski, Program Consultant, Health Canada
Ross Leaders, Regional Director, Northern Secretariat, Health Canada
Catherine Praamsma, Assistant Deputy Minister, Health and Social Services, GNWT
**Nunavut**

Maureen Connors, Manager of Programs, Northern Secretariat/Nunavut

**Ontario**

Pegeen M. Walsh, Regional Director, PHAC  
Marilyn Tate, Program Consultant, Healthy Child Development, PHAC  
Mary Sehl, Senior Evaluation Analyst, National Crime Prevention Centre, Public Safety and Emergency Preparedness Canada  
Carol Crill-Russell, Vice-President, Research, Invest in Kids  
Charleen Gorbet (Retired) Manager, Healthy Child Development, PHAC  
Marilyn Pettie-Junnila, Executive Director, Ka:nen Our Children Our Future

**Prince Edward Island**

Kathleen Flanagan Rochon, Department of Health and Social Services (Retired)

**Quebec**

Michel Gaussiran, CAPC Team Leader  
Sylvain Tremblay (Retired, Former Program Manager)  
Lise Pelletier, Program Manager  
Aline Bérubé, CPNP Team Leader  
Jean-Louis Caya, Regional Director (Quebec), PHAC  
Sonia Poulin, Provincial Representative  
Alexandre Leblond, Provincial Representative  
Jacinthe Bonneau, Provincial Representative

**Saskatchewan**

Lorie Brennand, Program Consultant, PHAC  
Larry Flynn, MB/SK Regional Manager, Population Health, PHAC  
Cathy Ryan, Community Developer Coordinator, Saskatchewan Prevention Institute

**Yukon**

Pat Martin, Program Consultant, Northern Secretariat/Yukon  
Debbie Mauch, Healthy Families, Government of Yukon  
Patricia Dickson, CPNP Program Consultant, Yukon

**Atlantic JMC**

Beth Sherwood, A/Regional Director, PHAC  
Kathy Coffin (Retired Regional Director)  
Michelle Rivard, A/Manager, Children’s Programs, PHAC  
Yolande Samson, Atlantic Evaluation Consultant, PHAC
Annex 5. Key Informant Interview Guide

Assessing the CAPC/CPNP Joint Management Infrastructure as a Model for FPT Collaboration: Looking Back and Moving Forward

Project Overview and Key Informant Interview Guide
Organizations and Partners

Canadian Policy Research Networks (CPRN), a not-for-profit, policy research organization, has been contracted by the Public Health Agency of Canada (PHAC) to implement this project. David Hay, Director of CPRN’s Family Network, and Brian Bell, a principal with The Alder Group, will serve as the project’s senior researchers assisted by other CPRN research, project management and communication staff.

Goals and Objectives

CPRN is undertaking research to provide PHAC with a report that includes a retrospective review and forward-looking analysis of the federal/provincial/territorial joint management infrastructure (JMI) that oversees the Community Action Program for Children (CAPC) and the Canada Prenatal Nutrition Program (CPNP) in communities across the country. The broad aims of the study are twofold: first, to describe the CAPC/CPNP joint management infrastructure and assess how well it has worked; and, second, to determine the broader potential of the JMI as a multi-level governance model for advancing PHAC priorities.

Activities

The project will use qualitative research methods to secure the needed information. These will include document review, key informant interviews with individuals and groups and a workshop to verify the analysis presented in the preliminary report. The final report will be disseminated by CPRN through its established communication mechanisms.

What the Project Can Do and Who It Will Benefit

The proposed study will deliver four key pieces of research and analysis:

- A retrospective review of the CAPC/CPNP infrastructure as it was constituted under the original protocols, with a description of how it has evolved over the last ten years;
- A profile of the current federal/provincial/territorial infrastructure, with particular attention to the mechanisms that provinces and territories have instituted to respond to local needs;
- An analysis of the strengths, weaknesses, threats and opportunities affecting the current infrastructure for the CAPC and the CPNP; and
- A forward-looking assessment of the current CAPC/CPNP joint management infrastructure as a federal/provincial/territorial mechanism for influencing and responding to decisions, policy changes and program improvement at the national, provincial/territorial, regional, and community levels.

The beneficiaries of the study are PHAC and its partners in the joint management infrastructure.

Intended Outcomes

The completed study will supply PHAC with a baseline understanding of the joint management infrastructure as it was originally designed and as it now exists; an analysis of what constitutes a “successful” federal/provincial/territorial infrastructure from different perspectives; and evidence-based inputs to help PHAC evaluate the wider potential of the CAPC/CPNP joint management infrastructure as a mechanism for realizing PHAC priorities related to FPT collaboration in the promotion of public health.
Key Informant Interview Guide

Thank you for agreeing to be a key informant for this project. Your insights are extremely valuable to us and are essential in meeting the project objectives. The objectives of this interview are:

- Exploring issues related to the history and evolution of the JMI
- Obtaining information on the key elements of the current JMI
- Identifying strengths, weaknesses, threats and opportunities affecting the current JMI
- Obtaining information for a forward-looking analysis of the JMI
- Identifying other key informants

For any particular question, please feel free to indicate that you don’t know or have no opinion. You can decline to answer any question or withdraw from the interview completely at any time. Your responses will be kept strictly confidential: the information you give us will not be associated with you by name or position, and the interview data will not be shared with anyone outside of the Research Team. You may be quoted or paraphrased, however the report will not refer to or identify you by name or position.

1. Historical/Retrospective

1.1. What kind of joint management infrastructure did the protocol establish?\(^4\)

1.2. What stakeholders did the protocol identify as being involved and what kinds of participation were called for? Did this participation occur; why/why not?

1.3. What are the key infrastructure changes that have occurred within the JMI? What triggered these changes and why were they important?

1.4. Was the protocol and/or the appendices ever revised to reflect these – or other – changes? Why; why not?

2. A Profile of the Current Infrastructure

2.1. What kind of joint management infrastructure is in place today?

2.2. Are there any plans to change the joint management infrastructure? What are they?

2.3. What is your present mechanism for engaging stakeholders?

\(^4\) Joint management infrastructure is an inclusive term used to describe all of the structures, and sub-structures, used for the joint management of CAPC/CPNP programs within the provinces/territories. This includes Joint Management Committees and Councils, Program Advisory Committees, and so on regardless of the actual names. It also includes all of the sub-structures such as executive committees and program management committees, etc. Therefore, key informant interviews will normally focus on a single JMI per jurisdiction. However, where appropriate, questions may also address specific issues particular to a sub-structure. Further, and in exceptional cases, it may be necessary to direct the questions to two structures altogether, for example, the Aboriginal Management Committee and the JMC in Ontario.
3. **SWOT Analysis**

3.1. What constitutes a successful JMI? Do each of the partners define “success” in the same way? If not, why not?

3.2. What are its strengths; its weaknesses?

3.3. Is the original JMI still appropriate? What are the opportunities associated with its continuing operation; the drawbacks?

4. **A Forward-Looking Analysis**

4.1. Is the joint management infrastructure a model that the PHAC should replicate?

4.2. Is it an effective FPT mechanism for influencing and responding to decisions, or to policy changes and program improvement?

5. **About You**

5.1 How long have you been involved with the JMI for CAPC and/or CPNP?

5.2 What is your current level of involvement with the JMI for CAPC and/or CPNP?

6. **Other Key Informants**

6.1 Can you identify any other key informants that you think should be interviewed for this project?

If you have any questions or comments, or for more information on the project, please contact either Anne Stenhouse at PHAC, or David Hay at CPRN.

Anne Stenhouse
613 957 8502
Anne_Stenhouse@phac-aspc.gc.ca

David Hay
613 567 7500 x2007
DHay@cprn.org
Annex 6. Comparative JMI Table

Explanation of Comparative Table

The information presented in the table has been prepared on the basis of input from the documents reviewed and key informant interviews, including current JMI participants. To the best of our knowledge, the information is accurate. However, there may be some gaps and inaccuracies remaining.

The following outlines the approach utilized for creating a comparative table:

1. The first comparative column (historical) is based on the information contained in the Protocols/Appendixes/Amendments (CPNP). If a working group/sub-committee/other piece of infrastructure was formed later, this would not be reflected in this column.

2. The second comparative column reflects the current infrastructure, supported by documentary or other evidence. Current means operating in 2004-2005. Therefore, JMI structures created between 1993 and the present are not reflected in this column. For example, a Working Group that was created and operated over 2000-2003 but is now disbanded will not be identified.

3. The row titled Community Involvement is intended solely to identify the kind(s) of community engagement called for in the Protocol/Appendices. It does not describe the kinds of community involvement subsequently invited or supported by JMIs to initiate, implement and/or support program activity (e.g. community needs assessment, community development processes, participatory community evaluations, etc.).

4. “N/A” is used in cases when the particular infrastructure was not provided for by the protocol; when the Protocols/Appendices/Amendments do not contain any information relevant to that specific section/committee (e.g. regarding community involvement); and in several other instances where appropriate.
# CAPC/CPNP Joint Management Infrastructure

<table>
<thead>
<tr>
<th>Alberta</th>
<th>Historical (as established by the Protocols/Appendices/Amendments to the Protocol)</th>
<th>Current (2004-2005)</th>
</tr>
</thead>
</table>
| **Structure** | • The Protocol provides for the establishment of a Management Committee.  
• The Management Committee may establish any working committees it deemed appropriate | The current infrastructure consists of:  
• Joint Management Committee  
• Program Management Committee (formed from the JMC Working Group)¹ |
| **Membership** | | |
| Joint Management Committee | The JMC will consist of representatives from each of the following departments and agencies:  
• Government of Canada, Department of National Health and Welfare  
• Alberta:  
  • Family and Social Services  
  • Health  
  • Education  
  • Premier’s Council in Support of Alberta Families Canada and Alberta may also jointly name up to three additional representatives to the Management Committee. | The JMC will consist of representatives from each of the following departments and agencies:  
• Government of Canada, Public Health Agency of Canada, Regional Director  
• Province of Alberta:  
  • Ministry of Children’s Services, Director  
  • Alberta Health and Wellness, Team Leader  
  • Alberta Learning, Project Leader  
  • Alberta Aboriginal Affairs, Director  
Broad Based Community Representation. Include up to three "non-program" community representatives. Potential names will be recommended by the Co-Chairs to the Committee for approval.² |

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| Program Management Committee | N/A | The Program Management Committee will consist of one representative from each of the following departments and agencies:
- Government of Canada, Public Health Agency of Canada, Regional Manager
- Province of Alberta
  - Ministry of Children’s Services, Senior Manager
  - Alberta Health and Wellness, Team Leader
  - Alberta Learning Ministries, Team Leader
  - Aboriginal Affairs, Team Leader
  - Children’s Mental Health, Team Leader
  - Rural Population Representative
  - Urban Population Representative
- Non-project participants to be recommended by the Co-Chairs to the Committee for approval[^3] |

| Roles and Responsibilities | The role of the Management Committee is:
- to promote the development of stronger links between federal programs, provincial programs, municipal programs and community based, non-government programs and services;
- to provide overall direction for the program in Alberta; and,
- to make recommendations to the Minister regarding the funding of community programs
Its functions include:
- identify the criteria for program funding in Alberta, in order to ensure that the program is responsive to local principles, objectives and needs;
- promote links between federal, provincial, municipal and community-based programs and services; | The role of the Joint Management Committee is:
- to proactively communicate about and champion CAPC and CPNP in Alberta;
- to promote and support achievement of the overall objectives of CPNP and CAPC through the development of stronger linkages between federal and provincial initiatives related to early childhood development;
- to provide overall strategic direction setting and decision making for CAPC and CPNP in relation to other government and agency initiatives;
- to develop processes for implementing new programs, money and/or closing off program areas. The impetus for these changes may be announcement of new initiatives by the Federal Government to be managed through CAPC and CPNP or recommendations from the PMC through the critical incident report(s); |

[^3]: ibid.
• review the application process and the process for allocating funds across the province, with special reference to geographical communities and high risk communities without a geographical base;
• review a summary of all proposals submitted to the program;
• review the applications recommended by the Government of Canada to ensure that they are consistent with provincial priorities and principles;
• request status reports if desired, and review annual progress reports prepared by community programs and by the Government of Canada;
• review information on the effectiveness of community programs funded by the program and, if appropriate, identify community programs to be improved or terminated;
• review plans for communications and public consultations prepared by the Government of Canada to ensure consistency with the conditions outlined in the Protocol;
• review and approve the evaluation frameworks for the program which set out criteria for the evaluation of community programs in Alberta;
• assess the operation and effectiveness of this Protocol and, if necessary, make appropriate recommendations for amendment. The Management Committee may also commission research, analysis or other activities that may be necessary in order to establish or review new directions for the program in Alberta. An example of such an activity is research to identify high risk communities (Protocol, 1993).

• the JMC “table” will act as a forum for the discussion of strategic communication including federal/provincial/local announcements, communication of sensitive decisions, etc., rather than individual processes with separate partners.
  Its functions include:
  • facilitate recruitment and ensure full membership of the Joint Management Committee;
  • proactively promote links between relevant federal and provincial ministries and initiatives to ensure the alignment of CAPC and CPNP with other strategic directions;
  • engage in research, strategic analysis and direction setting for CAPC and CPNP based on the finding of the Critical Issues Reports and linkages with other federal/provincial/regional initiatives.
  • create and sustain policy environments that enable joint actions in support of children and families in Alberta;
  • receive and review critical issues reports related to CAPC and CPNP projects;
  • host symposia designed to highlight the successes, positive impacts and future developments of CAPC and CPNP across the province including annual strategic direction setting processes.¹

¹ ibid.
<table>
<thead>
<tr>
<th>Community Involvement</th>
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</table>
| Joint Management Committee | N/A | Membership of the JMC includes “broad-based community representation.”
| Program Management Committee | N/A | Membership of the OMC includes “one rural and one urban representative.”
| British Columbia | Historical (as established by the Protocols/Appendices/Amendments to the Protocol) | Current (2004-2005)

| Structure | |
|-----------------------|--|------------------|
| The Protocol provides for an establishment of a Management Committee | JMC |
| An Amendment to the Protocol established a CPNP Sub-Committee | CPNP Advisory Committee (with community representatives) |
| | CAPC Advisory Committee (with community representatives) |
| | CAPC and CPNP Advisory Committees make recommendations to JMC. These committees have facilitated communication and sharing of information at the community level and identification of issues and priorities for the JMC |

| Membership | |
|-----------------------|--|------------------|
| Joint Management Committee | The Protocol specified the establishment of a management committee consisting of representatives of: | No confirmed changes |
| | • Canada | |
| | • British Columbia | |
| | • “and as may be agreed by both parties, community organizations, and off-reserve Aboriginal and Métis representatives” | |

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5 ibid.
6 ibid.
<table>
<thead>
<tr>
<th>Roles and Responsibilities</th>
<th>The functions of the JMC are to:</th>
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<tbody>
<tr>
<td>Joint Management Committee</td>
<td>• review the information provided to it relating to data and activities pertinent to the CAPC, solicit applications and recommend which programs will receive funding;</td>
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<td>• review the priorities of the CAPC to ensure they are, to the fullest extent possible, responsive to local, regional and provincial objectives and principles;</td>
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<td></td>
<td>• facilitate the development of stronger links between federal programs and services, provincial programs and services and community-based programs and services;</td>
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<td>• monitor and review the effectiveness of the programs and services funded under this agreement and, where appropriate, make recommendations for improvement;</td>
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<td>• review and coordinate communication on and the promotion of the CAPC in the Province of British Columbia; share and review public information and direct public information activities which do not require Ministerial approval;</td>
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<td>• review the proposed and actual expenditures of funds to each program funded under this Protocol and the process of allocation of funds across the provinces, which includes the recognition of both geographic communities and communities of interest;</td>
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<td></td>
<td>• develop an evaluation framework for the Community Action Program for Children which sets out criteria for the funded program's self-evaluation, and for any external evaluations of funded programs;</td>
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<td></td>
<td>• assess the operation and effectiveness of this Protocol and, if necessary, make appropriate recommendations for amendment;</td>
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<tr>
<td></td>
<td>• consult with community, off-reserve Aboriginal and Métis organizations in the design of the program.</td>
</tr>
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</table>

No confirmed changes
**Community Involvement**

| Joint Management Committee | The Protocol provides for community involvement through the function of the JMC to “consult with community, off-reserve Aboriginal and Métis organizations in the design of the program” as well as potential involvement of community, and off-reserve Aboriginal and Métis organizations as JMC members as deemed necessary by parties to the Protocol. | No confirmed changes |

| Manitoba | Historical (as established by the Protocols/Appendices/Amendments to the Protocol) | Current (2004-2005) |

| **Structure** | • The Protocol specified that a Management Committee would be established.  
• An Amendment to the Protocol established a CPNP Sub-Committee | • JMC  
• CAPC Advisory Committee  
• CPNP Advisory Committee |

| **Membership** | | |

| Joint Management Committee | The Management Committee will consist of representatives of:  
• Government of Canada  
• Manitoba | No confirmed changes |

| CAPC Advisory Committee | N/A | The CAPC Advisory Committee consists of:  
• two representatives from PHAC;  
• four from provincial government;  
• five community representatives from CAPC priority groups⁸ |

| CPNP Advisory Committee | N/A | The CPNP Advisory Committee consists of:  
• three representatives from federal government  
• two from provincial government;  
• one academic/medical expert;  
• up to six experts in community-based delivery with a minimum one person to be Aboriginal.⁹ |

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⁸ CAPC Advisory Committee Terms of Reference – November 2004.

⁹
| Roles and Responsibilities | The Management Committee:  
• shall in accordance with the objectives and priorities of the program and the Protocol, and subject to Manitoba’s priorities identified in Annex A to this Protocol, ensure that the proposals shall identify at a minimum:  
  • the applicant as a non-profit, incorporated community organization;  
  • the recognized experience of the applicant in the area proposed;  
  • the need for the intervention described in the proposal;  
  • evidence of consultation and collaboration with other organizations; and  
  • evidence that no other organizations currently provide services identified in the proposed community program.  
• shall identify other basic information requirements which proposals must fulfil in order to facilitate the assessment of such proposals as are solicited or received and for the purposes of ongoing reporting of progress, results and outcomes achieved by community programs to facilitate the evaluation of the program;  
• shall review and assess proposals submitted in accordance with the objectives and priorities of the program and Manitoba priorities identified in Annex A to this Protocol, and recommend to the Minister for funding those proposals which best meet the objectives and priorities;  
• shall provide advice and consultation to the Government of Canada concerning proposals recommended, funded and implemented pursuant to | No confirmed changes |

9 CPNP Advisory Committee Terms of Reference – October 2003.
this Protocol;

- shall seek advice and consultation from the public or community organizations concerning priority areas, target groups, and programs, services, or interventions to address the priority areas identified, through outreach activities such as workshops, community forums, or advisory committees; their composition at least once annually, to ensure representativeness;
- shall meet as often as is required or directed by the parties to this Protocol to perform the responsibilities outlined herein;
- shall monitor and review the priorities identified in Annex A to this Protocol and the operation of this Protocol and make recommendations to the parties for changes to the priorities or the Protocol;
- shall facilitate co-operation and collaboration between the two levels of government and community organizations;
- shall receive information from the federal representatives on the Management Committee with respect to relevant developments in Manitoba under the Brighter Futures "Indian and Inuit Initiative"; and
- may share, where appropriate, developments under the program in Manitoba with the Brighter Futures "Indian/Inuit Initiative" for the purposes of planning and co-operation.
| CAPC Advisory Committee | N/A | Roles and responsibilities of the CAPC Advisory Committee:  
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<td>• to work in accordance with the conditions of the CPAC Protocol for Manitoba;</td>
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<td>• to review project responsiveness to local, regional and provincial principles and objectives while maintaining the</td>
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<td>integrity of the national program;</td>
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<td>• to recommend new project funding by:</td>
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<td></td>
<td>• reviewing project proposals which meet CAPC criteria to ensure they are consistent with Manitoba priorities and</td>
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<td>the terms and conditions of CAPC,</td>
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<td>• selecting project proposals for recommendation to the Minister for funding approval, and</td>
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<td>• notifying the Manitoba Children’s Agenda Coordinating Working Groups and the Associate Deputy Minister (ADM)</td>
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<td>of Family Services and Housing of funding recommendations.</td>
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<td>• to review and assess project renewal applications and make recommendations on renewal;</td>
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<td>• to recommend funding increases greater than $25,000 for existing projects;</td>
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<td>• to review and make recommendations to the evaluation framework for CAPC;</td>
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<td>• to ensure project’s participation in the national, provincial and project level evaluation, review the results</td>
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<td>and, monitor project’s effectiveness;</td>
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<td>• to review provincial information on children at risk to determine where and how CAPC can be most effective.</td>
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</tbody>
</table>

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10 CAPC Advisory Committee Terms of Reference – November 2004.
| CPNP Advisory Committee | N/A | Roles and responsibilities of the CPNP Advisory Committee:  
• to work in accordance with the conditions of the CPAC Protocol for Manitoba and the CPNP Addendum to the Protocol;  
• to refine the funding priorities and eligibility criteria of the program to ensure they are responsive to local, regional and provincial principles and objectives while maintaining the integrity of the national program;  
• to review project proposals to identify those which are:  
  • consistent with the national program objectives, design principles, and eligibility criteria,  
  • include elements of comprehensive prenatal nutrition programs in Manitoba,  
  • address Manitoba priorities, and  
  • are supportive and/or complimentary to other federal and provincial children’s programs.  
• to select project proposals for recommendation to the Minister for funding approval and renewal;  
• to recommend funding increases greater than $25,000 for existing projects;  
• to advise on the expenditure of the yearly provincial program allocation for Grants and Contributions;  
• to review and assess project renewal applications and make recommendations for ongoing funding or termination;  
• to facilitate participation of project staff and sponsors in the national, provincial and project level evaluation, review the results and, where appropriate, make recommendations for project improvement;  
• to share and review provincial perinatal health information for use in strategic planning;  
• to review communication plans for CPNP to ensure they respect the conditions set out in the Protocol; and  
• to assist with the dissemination of the relevant program outcomes to the agencies/organizations whom they represent.\textsuperscript{11} |

\textsuperscript{11} CPNP Advisory Committee Terms of Reference – October 2003
### Community Involvement

| Joint Management Committee | The Protocol provides for community involvement through the JMC function of seeking advice and consultation “from the public or community organizations concerning priority areas, target groups, and programs, services, or interventions to address the priority areas identified, through outreach activities such as workshops, community fora, or advisory committees.” | No confirmed changes |

| CAPC Advisory Committee | N/A | Community involvement is provided for through membership of CAPC stakeholders in the CAPC Advisory Committee¹² |

| CPNP Advisory Committee | N/A | Community involvement is provided for through membership of community representatives in the CPNP Advisory Committee¹³ |

### New Brunswick

| Historical (as established by the Protocols/Appendices/Amendments to the Protocol) | Current (2004-2005) |

### Structure

- The Protocol (Appendix B) provides for the establishment of a “Management Committee.”

### Membership

<table>
<thead>
<tr>
<th>Joint Management Committee</th>
<th>The Management Committee will consist of:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>• Department of Health and Welfare</td>
</tr>
<tr>
<td></td>
<td>• Province of New Brunswick represented by</td>
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<td></td>
<td>• Department of Health and Community Services</td>
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<td></td>
<td>• NB Mental Health Commission</td>
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<td></td>
<td>• Department of Income Assistance</td>
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<td>• Department of Municipalities, Culture and Housing</td>
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<td>• Any other agencies as determined by the Committee from time to time</td>
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<th>Current members include:</th>
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<tbody>
<tr>
<td>• Regional Manager, Children’s Programs, Atlantic Regional Office</td>
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<tr>
<td>• Program Consultants (2) NB-PHAC</td>
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<tr>
<td>• Department of Family and Community Services (2)</td>
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<tr>
<td>• Department of Health and Wellness, (incl. Provincial Coordinator, Early Childhood and School-Based Services)</td>
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<tr>
<td>• Department of Education</td>
</tr>
</tbody>
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¹² CAPC Advisory Committee Terms of Reference – November 2004.

¹³ CPNP Advisory Committee Terms of Reference – October 2003.
<table>
<thead>
<tr>
<th>Roles and Responsibilities</th>
<th>Joint Management Committee</th>
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<tr>
<td></td>
<td>The role of the Management Committee is to:</td>
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<tr>
<td></td>
<td>• facilitate the development of stronger and complementary links between federal programs and services, provincial programs and services and community-based programs and services;</td>
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<td>• make recommendations on program policy and direction;</td>
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<td>• review information provided to it regarding the collection of data and activities pertinent to the program, solicit proposals, recommend initiatives which should receive approval and recommend which should be terminated;</td>
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<td>• review the priorities of the program to ensure they are complementary and responsive to NB’s objectives and principles;</td>
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<td>• prepare an annual budget for the program detailing the proposed expenditure of funds;</td>
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<tr>
<td></td>
<td>• develop a process for the allocation of funds, financial reporting, audit, and forecasting of expenditures;</td>
</tr>
<tr>
<td></td>
<td>• review the expenditure of funds to initiatives;</td>
</tr>
<tr>
<td></td>
<td>• conduct an overall evaluation of the program to ensure its conformity with the principles, goals and priorities of the program;</td>
</tr>
<tr>
<td></td>
<td>• monitor and evaluate the effectiveness of the initiatives (in accordance with Appendix C) and make recommendations for their improvement;</td>
</tr>
<tr>
<td></td>
<td>• make recommendations regarding the operation and effectiveness of the Protocol and, where necessary, make recommendations for amendment;</td>
</tr>
<tr>
<td></td>
<td>• review evaluation reports and renewal applications for both programs to be approved … every 3 to 5 years.</td>
</tr>
</tbody>
</table>

No confirmed changes
<table>
<thead>
<tr>
<th>Community Involvement</th>
<th>Newfoundlan and Labrador</th>
<th>Structure</th>
<th>Membership</th>
</tr>
</thead>
</table>
| Joint Management Committee | The Protocol provided that “the Management Committee may, from time to time, consult with community organizations as needed.” | The Protocol (Appendix 1) provided for the establishment of a two-tiered structure, consisting of:  
- Executive Management Committee (EMC)  
- Program Management Committee. | Members include:  
- RDG National Health and Welfare  
- ADM Department of Health  
- ADM Department of Social Services |
| Newfoundland and Labrador | Historical (as established by the Protocols/Appendices/Amendments to the Protocol) | Current infrastructure consists of:  
- Executive Management Committee (EMC)  
- Joint/Program Management Committee. | Members include:  
- Parent-Child Consultant; Director Health Promotion; Policy Analyst, Department of Health and Community Services  
- Director, Student Support Services, Department of Education  
- Children’s Manager, Atlantic Region; CAPC/CPNP Program Consultants, NL; PHAC |
| Structure | | | Members include representatives of:  
- Canada, and  
- Newfoundland, as approved by the Executive Management Committee |
| Membership | | | Current members include:  
- Department of Health and Community Services  
- Department of Education  
- PHAC – Children’s Manager and Program Consultants (2) |
<table>
<thead>
<tr>
<th>Roles and Responsibilities</th>
<th>The EMC’s roles and responsibilities include:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• decision-making regarding the program policy direction and priorities;</td>
</tr>
<tr>
<td></td>
<td>• assess the operational effectiveness of the protocol and recommend any necessary amendments;</td>
</tr>
<tr>
<td></td>
<td>• approve the composition of the PMC;</td>
</tr>
<tr>
<td></td>
<td>• manage the program budget and the process for allocating funds;</td>
</tr>
<tr>
<td></td>
<td>• recommend which programs should receive funding and which should be terminated;</td>
</tr>
<tr>
<td></td>
<td>• determine the nature, content and process for dissemination of all public information on the program.</td>
</tr>
<tr>
<td></td>
<td>No confirmed changes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program Management Committee</th>
<th>The Committee will consult with community agencies and organizations.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The PMC’s roles include:</td>
</tr>
<tr>
<td></td>
<td>• identify priority health and development issues, high risk communities and target groups; facilitate the development of stronger and complementary links between federal programs and services, provincial programs and services and community-based programs and services;</td>
</tr>
<tr>
<td></td>
<td>• facilitate the development of partnerships among community-based organizations targeting identified priority issues and risk communities; participate in consultations; recommend to the EMC programs and budget allocations which will receive funding through the program;</td>
</tr>
<tr>
<td></td>
<td>• prepare an annual budget for the program detailing the proposed expenditure of funds; oversee the development, implementation and monitoring of programs funded and, where appropriate, make recommendations for improvements;</td>
</tr>
<tr>
<td></td>
<td>No confirmed changes</td>
</tr>
</tbody>
</table>
- ensure evaluation is a component of all projects and participate in the development and implementation of a comprehensive evaluation strategy;
- monitor and evaluate the effectiveness of the funded programs;
- review and coordinate the communication and promotion of the program;
- assess the operation and effectiveness of the protocol and, if necessary, make recommendations for amendment.
- review evaluation reports and renewal applications for both programs to be approved…every 3 to 5 years.

<table>
<thead>
<tr>
<th>Community Involvement</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The Executive Management Committee</td>
<td>N/A</td>
</tr>
<tr>
<td>Program Management Committee</td>
<td>The protocol provides for community engagement through the responsibility of the Committee to “consult with community agencies and organizations.”</td>
</tr>
<tr>
<td>Northwest Territories</td>
<td>Historical (as established by the Protocols/Appendices/Amendments to the Protocol)</td>
</tr>
<tr>
<td>Structure</td>
<td>The Protocol provides for the establishment of a management committee.</td>
</tr>
</tbody>
</table>
| Membership | The members include:  
  - representatives of the federal government  
  - representatives from the Northwest Territories | The members include:  
  - representatives of the Federal government  
  - representatives from the NWT Government Departments of Health and Social Services and Education, Culture and Employment. |

14 The JMC in NWT is currently non-operational.
<table>
<thead>
<tr>
<th>Roles and Responsibilities</th>
<th>The JMC’s functions include:</th>
<th>Although the JMC is currently non-operational, the Northern Secretariat has an active Joint Management Committee Working Group (JMCWG) and CAPC CPNP NWT Coalition (CCNC) which actively oversees and guides the CAPC and CPNP programs within the NWT. These two groups have provided and currently provide funding recommendations. By this means the community needs are identified through ongoing communications with project coordinators, the Government of NWT, Community Health and Social Services Boards, and other community NGOs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Management Committee</td>
<td>• review the priorities and establish eligibility criteria, within the Community Action Program for Children, to ensure they are to the fullest extent possible, responsive to local and regional objectives and principles; • solicit applications from eligible organizations and advise the Minister of Health and Social Services of these applications; • review and recommend to the Minister the applications to receive funding; • facilitate the development of stronger links between federal programs and services, territorial programs and services and community-based programs and services; • monitor and review the effectiveness of the programs and services funded under this Protocol and, where appropriate, make recommendations for improvement or termination; • review and coordinate communication on and the promotion of the Community Action Program for Children in the Northwest Territories; share and review public information and direct public information activities which do not require Ministerial approval; • review the proposed and actual expenditures of funds to each program funded under this Protocol and the process of allocation of funds across the province, which includes the recognition of both geographic communities and communities of interest; • develop an evaluation framework for the Community Action Program for Children which sets out the criteria for programs’ self-evaluation, and for any external evaluations of programs; • assess the operation and effectiveness of this Protocol and, if necessary, make appropriate recommendations for amendment; and,</td>
<td></td>
</tr>
<tr>
<td>Community Involvement</td>
<td>The JMC has received CAPC and CPNP project recommendations from two sources: Joint Management Committee Working Group (JMCWG) since 2001 and CAPC CPNP NWT Coalition (CCNC) since 2003.</td>
<td></td>
</tr>
<tr>
<td>Joint Management Committee</td>
<td>The Protocol provided for community involvement through the JMC’s function to “consult with community organizations in the design of the program.”</td>
<td>N/A</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>Historical (as established by the Protocols/Appendices/Amendments to the Protocol)</td>
<td>Current (2004-2005)</td>
</tr>
<tr>
<td>Structure</td>
<td>The Protocol provides for the establishment of a Program Advisory Committee • The Protocol allows establishing working groups through the statement that “the expenses of the Committee and any required working groups will be assumed by the Government of Canada”</td>
<td>Current infrastructure include: • Program Advisory Committee</td>
</tr>
<tr>
<td>Membership</td>
<td>Members of the Committee include: • The Government of Canada • Nova Scotia departments, having an interest in the program</td>
<td>Current members include: • Department of Community Services • Department of Health • Department of Education • PHAC – Children’s Manager Atlantic Region and CAPC/CPNP Program Consultant</td>
</tr>
<tr>
<td>Roles and Responsibilities</td>
<td>Program Advisory Committee</td>
<td>Community Involvement</td>
</tr>
<tr>
<td>---------------------------</td>
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<td>-----------------------</td>
</tr>
<tr>
<td></td>
<td>The Program Advisory Committee will:</td>
<td>Appendix B stipulates that in participating on the PAC, Nova Scotia officials are to review applications to ensure that they are “community initiated, community-based, and community supported.” To this end, the Protocol identifies seven “indicators of community orientation” (e.g. programs are based and coordinated as much as possible on the basis of provincially recognized regions of service; program consumers should participate in the management; programs should provide social support to consumers … and strengthen existing family and community support).</td>
</tr>
<tr>
<td></td>
<td>• review applications to be recommended for approval to ensure that they are consistent with provincial priorities and the terms and conditions of the programs;</td>
<td>Note: A 1990 background document identifies additional roles and responsibilities for the PAC but it is not clear whether these are current today, e.g.</td>
</tr>
<tr>
<td></td>
<td>• review communication plans to ensure they respect the conditions set out in the Protocol;</td>
<td>• provide regular updates on provincial initiatives and other federal initiatives</td>
</tr>
<tr>
<td></td>
<td>• and participate at Atlantic JMC meetings and sub-committees.</td>
<td>• review priorities for both programs and make appropriate changes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• facilitate access to information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• review evaluation reports and renewal applications</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No confirmed changes</td>
</tr>
</tbody>
</table>

Note: A 1990 background document identifies additional roles and responsibilities for the PAC but it is not clear whether these are current today, e.g.

- provide regular updates on provincial initiatives and other federal initiatives
- review priorities for both programs and make appropriate changes
- facilitate access to information
- review evaluation reports and renewal applications
<table>
<thead>
<tr>
<th>Nunavut</th>
<th>Historical (as established by the Protocols/Appendices/Amendments to the Protocol)</th>
<th>Current (2004-2005)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Structure</strong></td>
<td>Prior to its creation in 1999, Nunavut followed the JMC Protocols signed in agreement with the Alberta/NWT and the Ontario/Nunavut regions. Subsequently, the Northern Secretariat was given the mandate to support an integrated, single window approach for the delivery of health programs supported by three funding streams (FNIHB, PHAC and HECSB) in the Northern Territories. Keeping in mind the Secretariat’s mandate to provide an integrated approach to delivery, the JMC Protocol for the sole management of CAPC and CPNP programs was never formalized in Nunavut.</td>
<td>The Northern Secretariat (FNIHB, Health Canada), through a Memorandum of Understanding with PHAC, manages the delivery of health programs in the Northern Territories, including Nunavut. Although there is no formal JMI in place in Nunavut, community needs are identified through ongoing communications with project coordinators, the Government of Nunavut, the Nunavut Tunngavik Inc., the Nunavut Federal Council and the Virtual Circle of Officials (VCO).</td>
</tr>
</tbody>
</table>
| **Membership** | The informal JMC include representatives of:  
• Federal government  
• Nunavut | N/A |
<table>
<thead>
<tr>
<th>Roles and Responsibilities</th>
<th>The Management Committee will:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Management Committee</td>
<td>• review the information provided to it relating to data and activities pertinent to the Community Action Program for Children, solicit applications, and recommend to the Minister which programs will receive funding;</td>
</tr>
<tr>
<td></td>
<td>• review the priorities and establish eligibility criteria, within the Community Action Program for Children, to ensure they are, to the fullest extent possible, responsive to the local and regional objectives and principles;</td>
</tr>
<tr>
<td></td>
<td>• facilitate the development of stronger links between federal programs and services, territorial programs and services and community-based programs and services;</td>
</tr>
<tr>
<td></td>
<td>• monitor and review the effectiveness of the programs and services funded under this agreement and, where appropriate, make recommendations for improvement or termination;</td>
</tr>
<tr>
<td></td>
<td>• review and coordinate communication on the promotion of the Community Action Program for Children in Nunavut, share and review public information, and direct public information activities which do not require ministerial approval;</td>
</tr>
<tr>
<td></td>
<td>• review the proposed and actual expenditures of each program funded under this Protocol and the process of allocation of funds across the territory, which includes the recognition of both geographic communities and communities of interest;</td>
</tr>
<tr>
<td></td>
<td>• develop an evaluation framework for the Community Action Program for Children which sets out criteria for programs’ self-evaluation and for the external evaluations of programs;</td>
</tr>
<tr>
<td></td>
<td>• assess the operation and effectiveness of this Protocol and, if necessary, make appropriate recommendations for amendment; and,</td>
</tr>
<tr>
<td></td>
<td>• consult with community organizations in the design of the program (Protocol, 2000).</td>
</tr>
</tbody>
</table>

N/A
<table>
<thead>
<tr>
<th>Community Involvement</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Management Committee</td>
<td>The Protocol provided for community involvement through the JMC’s function to “consult with community organizations in the design of the program.” Community involvement is ensured through a number of mechanisms, including site visits, etc.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ontario</th>
<th>Historical (as established by the Protocols/Appendices/Amendments to the Protocol)</th>
<th>Current (2004-2005)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Structure</strong></td>
<td>• The Protocol provided for the establishment of a Joint Management Committee. • Appendix B of the Protocol allowed for establishing “working groups including program staff and other stakeholders as necessary”</td>
<td>The current infrastructure consists of: • Joint management committee • Aboriginal management committee</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Membership</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Management Committee</td>
<td>The Committee will be composed of: • Department of National Health and Welfare: • the Ontario Regional Health Promotion and Social Development Office, • the Regional Director’s General Office • the Indian and Inuit Health Services Division • Ontario representatives: • the Ministry of Community and Social Services, • the Ministry of Health • the Ministry of Education and Training</td>
</tr>
<tr>
<td>Aboriginal Management Committee</td>
<td>Note: The AMC was created in 1993 under a separate set of Terms of Reference to manage CAPC and (later) CPNP for aboriginal projects off-reserve. The Committee was made up of federal, provincial and Aboriginal representatives from off-reserve Aboriginal organizations within Ontario. However, the Terms of Reference were never formally incorporated into the Protocol. The AMC continues to operate today as a “parallel organization” to the JMC. CAPC/CPNP programs are delivered through an incorporated body, Ka:nen Our Children Our Future, which reports to the AMC.</td>
</tr>
</tbody>
</table>

| Roles and Responsibilities | Joint Management Committee | The Joint Management Committee will: • confirm program priority areas • review submissions screened by federal regional staff • recommend submissions for funding to the Minister • review allocation flow with respect to committed funding levels The Protocol also speaks to evaluation and communications (which are to be shared with the JMC prior to release). | Currently, the JMC recommends projects consistent with provincial priorities and overall program direction. |

<p>| Community Involvement | Joint Management Committee | N/A | N/A |</p>
<table>
<thead>
<tr>
<th>Prince Edward Island</th>
<th>Historical (as established by the Protocols/Appendices/Amendments to the Protocol)</th>
<th>Current (2004-2005)</th>
</tr>
</thead>
</table>
| **Structure**        | The Protocol (Appendix A) allowed for establishment of a Joint Management Committee. | The current infrastructure includes:  
• Joint Management Committee  
• CPNP Advisory Committee |
| **Membership**       | The members included representatives of:  
• National Health and Welfare  
• Government of Prince Edward Island | The current members include:  
• Director of Children’s Secretariat  
• Department of Education  
Children’s Manager, Atlantic Region; CAPC/CPNP Program Consultant, PEI-PHAC |
| Joint Management Committee | N/A | Members include representatives of:  
• PHAC  
• Government of PEI  
• CPNP project coordinators |
| **Roles and Responsibilities** | 1. Manage the overall PEI process (including recommending successful “business plans/projects” for approval by the Minister of Health)  
• Through a community development process, the JMC will establish and announce provincial priorities and invite community participation in the development of coalitions  
• Coalitions will collaborate with the JMC in the design of program features/projects that will address the priorities  
• Funding will be directed to these coalitions  
2. Facilitate the development of Atlantic initiatives and stronger links between federal programs and services, provincial programs and services to communities;  
3. Facilitate co-operation and collaboration between the two levels of government and community agencies; | No confirmed changes |
<table>
<thead>
<tr>
<th><strong>CPNP Advisory Committee</strong></th>
<th>N/A</th>
<th>The current mandate of the Committee is to act as an advisory body to the JMC and provide expertise in the area of prenatal nutrition, child development (infancy) and/or community development.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community Involvement</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Joint Management Committee</strong></td>
<td>The Protocol provided for the Committee to invite community participation in the development of coalitions with the purpose of further collaboration with the JMC.</td>
<td>No confirmed changes</td>
</tr>
<tr>
<td><strong>CPNP Advisory Committee</strong></td>
<td>N/A</td>
<td>Membership includes CPNP Project Coordinators.</td>
</tr>
<tr>
<td><strong>Quebec</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Historical (as established by the Protocols/Appendices/Amendments to the Protocol)</strong></td>
<td><strong>Current (2004-2005)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Structure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Protocol provided for establishing</td>
<td>The current structure includes:</td>
<td></td>
</tr>
<tr>
<td>• a Joint Management Committee (comité de gestion mixte/CGM);</td>
<td>• a Joint Management Committee (comité de gestion mixte/CGM);</td>
<td></td>
</tr>
<tr>
<td>• an Operational Committee which reports to the CGM;</td>
<td>• Operational Committee, which reports to the CGM;</td>
<td></td>
</tr>
<tr>
<td>• Working Groups can be formed as needed.</td>
<td>• Working Groups can be formed as needed (at least two operated with time limited mandates at some point).</td>
<td></td>
</tr>
<tr>
<td><strong>Membership</strong></td>
<td></td>
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</tr>
</tbody>
</table>
| **Joint Management Committee** | Provincial Members:  
- Quebec Ministry of Health and Social Services represented by three directors (Inter-provincial Relations, Social Adaptation, Health Promotion) and one member of the Operational Committee  
Federal Members:  
- Health and Welfare Canada represented by RDG, Director of Health Promotion and Social Development, Program Manager for Community Action within the “Grandir ensemble” program  |
| (amendment of March 2005) | Provincial Members:  
- Quebec Ministry of Health and Social Services represented by Managers from the Directorate for Social Services and Public Health and the individual assigned to this file  
Federal Members:  
- Public Health Agency of Canada represented by RDG and the Children’s Manager |
| **The Operational Committee** | Members:  
- Quebec Members: Regional Coordination Directorate, Department of Community Organizations, Services for Youth and their Families, Health Promotion Directorate, Conference of Regional Health Authorities  
- Health Canada Members: the Manager responsible for the program and regional program consultants as needed |
| (amendment of March 2005) | Members:  
- Quebec Members: Youth and Substance Abuse Department, Department for Community Action, Public Health Directorate and two members from the Regional Health and Social Service Development Agencies (Public Health Department and Regional Youth Service Organizations);  
- Public Health Agency Members: the Children’s Manager, CAPC and CPNP Team Leaders, Children’s Programs Evaluation Manager;  
- Additional members may be invited by either party upon mutual agreement. |
Roles and Responsibilities | The roles and responsibilities of the JMC are:
---|---
Joint Management Committee | • oversee the application of the agreement and to propose, if needed, modifications;
| | • ensure communication between relevant federal and provincial counterparts concerned with CAPC/CPNP;
| | • approve a communication plan aimed at the general population and interested stakeholders of the program, excluding press releases announcing approved projects;
| | • determine the funding envelope to go towards the régies régionales and that towards community organizations with province-wide mandates;
| | • recommend projects proposed by the Operational Committee and determine their level of funding, in accordance with the signed agreement;
| | • approve the tools and documents prepared by the Operational Committee and, if needed, oversee the work of the committee;
| | • define, as needed, the mandates of other committees and working groups necessary for the operationalization of the program;
| | • determine the need for and hire outside consultants to undertake certain activities.

(19 amendment of March 2005)
The roles and responsibilities of the JMC are:
• oversee the application of the agreement and to propose, if needed, modifications;
• ensure communication between relevant federal and provincial counterparts concerned with CAPC/CPNP;
• approve a communication plan aimed at the general population and interested stakeholders of the program, excluding press releases announcing approved projects;
• determine the funding envelope to go towards the Agences de développement des réseaux des services de santé et de services sociaux and that towards community organizations with province-wide mandates;
• recommend projects proposed by the Operational Committee and determine their level of funding, in accordance with the signed agreement;
• determine the need for and hire outside consultants to undertake certain activities.
The Operational Committee

The functions of the Operational Committee are:
• propose the tools and documents necessary to operationalize the program;
• propose the evaluation framework for the program;
• analyze the proposals submitted by the régies régionales by determining the eligibility of projects, the level of funding and assigning a priority level to each based on the quality of the proposal and regional equity;
• analyze the proposals submitted by the regional authorities;
• analyze the proposals submitted by community organizations with a province-wide mandate;
• propose the list of approved projects to the JMC, in priority order, by region and provincially;
• complete all other tasks mandated by the JMC.

(remark of March 2005)

The functions of the Operational Committee are:
• approve the tools and documents necessary for the evolution of the program;
• propose the evaluation framework for the program;
• analyze the proposals submitted by the Agences de développement des réseaux des services de santé et de services sociaux by determining the eligibility of projects, the level of funding and assigning a priority level to each based on the quality of the proposal and regional equity;
• analyze the proposals submitted by community organizations with a province-wide mandate;
• propose the list of approved projects to the JMC, in priority order, by region and provincially;
• complete all other tasks mandated by the JMC;
• authorize the mandates of other committees and working groups necessary for the operationalization of the program.

<table>
<thead>
<tr>
<th>Community Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Management Committee</td>
</tr>
<tr>
<td>The Operational Committee</td>
</tr>
</tbody>
</table>
### Saskatchewan

<table>
<thead>
<tr>
<th>Historical (as established by the Protocols/Appendices/Amendments to the Protocol)</th>
<th>Current (2004-2005)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Structure</strong></td>
<td>The current infrastructure consists of:</td>
</tr>
</tbody>
</table>
| • According to the Protocol “the Parties agree to establish an advisory committee” A CPNP Sub-Committee was established by an addendum to the Protocol. | • CAPC Advisory Committee  
• CPNP Sub-Committee |
| **Membership** | The current members include: |
| **CAPC Advisory Committee** | • three representatives from the Government of Canada  
• one representative from each provincial ministry signatory of the Protocol  
• one representative from the Federation of Saskatchewan Indian Nations  
• one representative from a First Nations Tribal Council  
• two representatives from the Métis Nation of Saskatchewan  
• Prevention of Handicaps  
• Saskatchewan Child Care Association\(^{15}\) |
| The Advisory Committee will consist of:  
• representatives of the Government of Canada;  
• at least one representative from each provincial ministry signatory to this Protocol;  
• representatives from various community organizations, designated by mutual agreement of Canada and Saskatchewan. | |
| **CPNP Sub-Committee** | Current members:  
• membership has not changed from the original. |
| CPNP Sub-Committee members include:  
• up to three representatives of the Government of Canada;  
• one representative from each provincial ministry signatory of the Protocol;  
• one representative from a First Nations Tribal Council;  
• one representative from the Métis Nation of Saskatchewan;  
• two representatives from various community organizations designated by mutual agreement of Canada and Saskatchewan; and  
• additional nutritional/dietician representation as deemed appropriate. | |

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\(^{15}\) CAPC Advisory Committee Terms of Reference – 1996 (current).
<table>
<thead>
<tr>
<th>Roles and Responsibilities</th>
<th>The functions of the Advisory Committee are to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAPC Advisory Committee</td>
<td>• refine the priorities and criteria of the program to ensure they are responsive to local and regional principles and objectives;</td>
</tr>
<tr>
<td></td>
<td>• facilitate the links among federal programs and services, provincial programs and services, and community-based programs and services;</td>
</tr>
<tr>
<td></td>
<td>• review summary of all proposals to the program;</td>
</tr>
<tr>
<td></td>
<td>• review program applications to be recommended by Canada for approval by the Minister to ensure they are consistent with provincial priorities and the terms and conditions of the program;</td>
</tr>
<tr>
<td></td>
<td>• review proposed and actual expenditures on programs, and the process of allocation of funds across the province as it relates to both geographic communities and communities of interest;</td>
</tr>
<tr>
<td></td>
<td>• review implementation and progress reports on program activities;</td>
</tr>
<tr>
<td></td>
<td>• review information on the effectiveness of programs funded by the program and, where appropriate, make recommendations for improvement or termination;</td>
</tr>
<tr>
<td></td>
<td>• review program and provincial information on children at risk, and within communities served by programs, to determine effects and outcomes;</td>
</tr>
<tr>
<td></td>
<td>• review communication plans for the program to ensure they respect the conditions set out in the Protocol;</td>
</tr>
<tr>
<td></td>
<td>• review an evaluation framework for the program which sets out criteria for the programs’ self-evaluation; and,</td>
</tr>
<tr>
<td></td>
<td>• assess the operation and effectiveness of this Protocol and, if necessary, make appropriate recommendations for amendment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The Advisory Committee’s roles and responsibilities are:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• to work in accordance with the guiding principles and the conditions of the CAPC Protocol</td>
</tr>
<tr>
<td>• to recommend long- and short-term program strategies;</td>
</tr>
<tr>
<td>• to refine the priorities and criteria of the program to ensure they are responsive to local, regional and provincial principles and objectives;</td>
</tr>
<tr>
<td>• to strengthen the links among federal, provincial, and community-based agencies, programs and services;</td>
</tr>
<tr>
<td>• to review program proposals which meet CAPC criteria, to ensure they are consistent with SK priorities and the terms and conditions of CAPC and to make recommendations to Canada for approval by the Minister;</td>
</tr>
<tr>
<td>• to review program expenditures and the process for allocation of funds across the province;</td>
</tr>
<tr>
<td>• to review information on the effectiveness of programs funded by CAPC and, where appropriate, make recommendations for improvement or termination;</td>
</tr>
<tr>
<td>• to review provincial information on children to determine where and how CAPC can be most effective;</td>
</tr>
<tr>
<td>• to review communication plans for CAPC to ensure they respect the conditions set out in the Protocol;</td>
</tr>
<tr>
<td>• to advocate as appropriate with respect to activities which enhance the health and well-being of children and their families;</td>
</tr>
<tr>
<td>• to review an evaluation framework for CAPC;</td>
</tr>
<tr>
<td>• to review the delivery of community development resources which are provided to assist communities;</td>
</tr>
<tr>
<td>• to assess the operation and effectiveness of the Protocol, and, if necessary, make appropriate recommendations for amendment.</td>
</tr>
</tbody>
</table>

16 CAPC Advisory Committee Terms of Reference – 1996 (current).
CPNP Sub-Committee’s roles and responsibilities are:

- to work in accordance with the guiding principles and the conditions of the CAPC Protocol and the CPNP addendum to the Protocol;
- to recommend long- and short-term program strategies;
- to refine the priorities and criteria of the program to ensure they are responsive to local, regional and provincial principles and objectives;
- to strengthen the links among federal, provincial, and community-based agencies, programs and services;
- to review program proposals which meet CPNP criteria, to ensure they are consistent with SK priorities and the CPNP terms and conditions and make recommendations to Canada for approval by the Minister;
- to review program expenditures and the process for allocation of funds across the province;
- to review information on the effectiveness of programs funded by CPNP and, where appropriate, make recommendations for improvement or termination;
- to review CPNP and provincial information on mothers and babies at risk, and within communities served by programs to determine effects and outcomes;
- to review communication plans for CPNP to ensure they respect the conditions set out in the Protocol;
- to advocate as appropriate with respect to activities which enhance the health and well-being of children and their families;
- to review an evaluation framework for CPNP;
- to review the delivery of community development resources which are provided to assist communities; and
- to assess the operation and effectiveness of the Protocol, and, if necessary, make appropriate recommendations for amendment.\(^\text{17}\)

17 Addendum to the Protocol, August 1996.
<table>
<thead>
<tr>
<th>Community Involvement</th>
<th>The Protocol provided for community involvement through membership in the Advisory Committee (representatives of community organizations).</th>
<th>The current structure provides for community representation through membership in the Advisory Committee.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAPC Advisory Committee</td>
<td>The CPNP amendment to the Protocol allowed for community involvement through membership in the Committee (two representatives of community organizations).</td>
<td>The current structure provides for community participation through membership in the CPNP Sub-Committee.</td>
</tr>
<tr>
<td>CPNP Sub-Committee</td>
<td><strong>Yukon</strong></td>
<td>Current (2004-2005)</td>
</tr>
</tbody>
</table>
| Structure | • The Protocol provides for establishment of a Joint Management Committee  
• The CPNP Amendment to the Protocol provides for establishment of a CPNP Management Committee.  
The purpose of the Joint Management Committee is to develop, implement, and monitor the Canada Prenatal Nutrition Program (CPNP) and Community Action Program for Children (CAPC) in the Yukon in alignment with the Memorandum of March 16, 1999, between Health Canada (CAPC and CPNP) and Healthy Families Yukon and Health and Social Services. | The current infrastructure includes:  
• CAPC Joint Management Committee  
• CPNP Regional Management Committee |
| Membership | The Protocol provides that members will include representatives of:  
• Canada  
• Yukon | The Joint Management Committee is composed of a minimum of one primary and one consistent alternate representative from each of the Federal/Territorial Ministries which have officially entered into a partnership for the development and delivery of the Program:  
• Yukon Health and Social Services (a minimum of one representative is required as part of quorum);  
• Health Canada and one primary and one consistent alternate representative from the following organizations:  
  • Council for Yukon First Nations  
  • Yukon Education  
  • Other organizations as the committee sees fit to invite. |
### Regional Management Committee CPNP

The members will include:
- Yukon Health and Social services
- Health Promotion and Social Development Office, HWC
- Council for Yukon Indians
- Yukon Advisory Council on Indian Child Welfare
- First Nations Health Commission
- Yukon Education

The Regional Management Committee CPNP is composed of a minimum of one primary and one consistent alternate representative from each of the Federal/Territorial Ministries which have officially entered into a partnership for the development and delivery of the Program:
- Yukon Health and Social Services (a minimum of one representative is required as part of quorum)
- Health Canada and one primary and one consistent alternate representative from the following organizations:
  - Council for Yukon First Nations
  - Maternity Nurse
  - Other organizations as the committee sees fit to invite, i.e. Dietician, Child Development.

### Roles and Responsibilities

<table>
<thead>
<tr>
<th>JMC roles and responsibilities are:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• review the information provided to it relating to data and activities pertinent to the Community Action Program for Children, solicit applications and recommend to the Minister which programs will receive funding;</td>
</tr>
<tr>
<td>• review the priorities and establish eligibility criteria, within the Community Action Program for Children, to ensure they are, to the fullest extent possible, responsive to local and regional objectives and principles;</td>
</tr>
<tr>
<td>• facilitate the development of stronger links between federal programs and services, territorial programs and services and community-based programs and services;</td>
</tr>
<tr>
<td>• monitor and review the effectiveness of the programs and services funded under this agreement and, where appropriate, make recommendations for improvement or termination;</td>
</tr>
<tr>
<td>• review and coordinate communication on and the promotion of the Community Action Program for Children in the Yukon, share and review public information, and direct public information activities which do not require Ministerial approval;</td>
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</tbody>
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<table>
<thead>
<tr>
<th>The JMC functions include:</th>
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<tr>
<td>• review the information provided to it relating to data and activities pertinent to the Community Action Program for Children, solicit applications, and recommend to the Minister which programs will receive funding; build on data and information already available from recent relevant studies completed in the YT in order to determine community priorities for at risk children 0-6 years and their families;</td>
</tr>
<tr>
<td>• review the priorities to ensure they align with the Yukon Government’s priorities and establish eligibility criteria for possible funding under the Community Action Program for Children; the criteria are, to the fullest extent possible to be responsive to local and regional objectives and principles; any contractors required to facilitate the development, implementation and monitoring of CAPC in YT will be hired from the Yukon by HPPB and provide information and act as a resource to the Management Committee;</td>
</tr>
<tr>
<td>• facilitate the development of stronger links between federal programs and services, territorial programs and services, and community-based programs and services;</td>
</tr>
<tr>
<td>Review the proposed and actual expenditures of funds of each program funded under this Protocol and the process of allocation of funds across the territory, which includes the recognition of both geographic communities and communities of interest;</td>
</tr>
<tr>
<td>Develop an evaluation framework for the Community Action Program for Children which sets out criteria for programs' self-evaluation, and for any external evaluations of programs;</td>
</tr>
<tr>
<td>Assess the operation and effectiveness of this Protocol and, if necessary, make appropriate recommendations for amendment; and,</td>
</tr>
<tr>
<td>Consult with community organizations in the design of the program.</td>
</tr>
</tbody>
</table>

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22 CAPC JMC Terms of Reference – 2000 (current).
| Regional Management Committee CPNP | The CPNP RMC roles and responsibilities are:  
• review the information provided to it relating to data and activities pertinent to the Canada Prenatal Nutrition Program (CPNP), solicit applications, and recommend to the Minister which programs will receive funding;  
build on data and information already available from recent relevant studies completed in the YT in order to determine community priorities for at-risk pregnant women and their families;  
• review the priorities to ensure they align with the YT Government’s priorities and establish eligibility criteria for possible funding; the criteria are, to the fullest extent possible, to be responsive to local and regional objectives and principles; any contractors required to facilitate the development, implementation and monitoring of CPNP in YT will be hired from the YT by HPSDO and provide information and act as a resource to the Management Committee.  
• facilitate the development of stronger links between federal programs and services, territorial programs and services, and community-based programs and services;  
• monitor and review the effectiveness of the programs and services funded under this agreement and, where appropriate, make recommendations for improvement or termination;  
• review and coordinate communications on and the promotion of CPNP in the Yukon, share and review public information, and direct public information activities which do not require Ministerial approval;  
• review the proposed and actual expenditures of each program funded under the CAPC Protocol and the process of allocation of funds across the territory, recognizing both demographic and geographic communities and accountability for allocation contribution funds and prevent lapsing of unspent monies;  
No confirmed changes |
- develop an evaluation framework for the CPNP which sets out criteria for programs' self-evaluation, and for any external evaluations of programs;
- arrange for consultation with community organizations in the implementation of the program; identify ways of involving the communities and families with children at risk in the development and implementation of programs and services funded under CAPC; and,
- assess the operation and effectiveness of the Protocol and, if necessary, make appropriate recommendations for amendment.

### Community Involvement

<table>
<thead>
<tr>
<th>Joint Management Committee</th>
<th>The Protocol provides for community involvement through a JMC function “to consult with community organizations in the design of the program.”</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The current Terms of Reference provide for community involvement through the JMC function to “arrange for consultation with community organizations in the implementation of the program; identify ways of involving the communities and families with children at risk in the development and implementation or programs and services funded under CAPC.”</td>
</tr>
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<table>
<thead>
<tr>
<th>Regional Management Committee CPNP</th>
<th>The CPNP amendment to the Protocol provides for community involvement through the function of the CPNP Committee to “arrange for consultation with community organizations in the implementation of the program; identify ways of involving the communities and families with children at risk in the development and implementation of programs and services funded under CAPC”</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>No confirmed changes</td>
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<tr>
<td>Atlantic Region</td>
<td>Historical (as established by the Protocols/Appendices/Amendments to the Protocol)</td>
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<tr>
<td>-----------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Structure</strong></td>
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<tr>
<td></td>
<td>N/A</td>
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<tr>
<td><strong>Membership</strong></td>
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<td>N/A</td>
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<td><strong>Evaluation Working Group</strong></td>
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<thead>
<tr>
<th>Roles and Responsibilities</th>
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</thead>
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<td>Atlantic Joint Management Committee</td>
<td>N/A</td>
</tr>
<tr>
<td>Evaluation Working Group</td>
<td>N/A</td>
</tr>
<tr>
<td>Community Involvement</td>
<td></td>
</tr>
<tr>
<td>Atlantic Joint Management Committee</td>
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<tr>
<td>Evaluation Working Group</td>
<td>N/A</td>
</tr>
</tbody>
</table>

\(^{24}\) ibid.
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COGECO Inc.                                   Scotiabank
Maclab Enterprises                            
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Many e-network subscribers and friends of CPRN

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Ekos Research Associates Inc.                  TD Bank Financial Group
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Canadian Heritage                              Law Commission of Canada
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Health Canada                                  Privy Council Office
Human Resources Development Canada              Social Development Canada
Human Resources and Skills Development Canada   Statistics Canada
Indian and Northern Affairs Canada             Treasury Board of Canada, Secretariat
Industry Canada                                

Provincial Governments:
Alberta
- Human Resources and Employment

British Columbia
- Ministries of Health
- Ministry of Children and Family Development
- Office of the Deputy Minister to the Premier

Manitoba
- Department of Family Services and Housing
Ontario
- Association of Colleges of Applied Arts and Technology of Ontario (ACAATO)
- Ministry of Community and Social Services
- Ministry of Finance Pre-budget Consultation
- Ministry of Health
- Ministry of Training, College and Universities (MCTU)

Saskatchewan
- Department of Community Resources and Employment

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City of Toronto

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| Canadian Health Services Research Foundation | The Neptis Foundation |
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| Association of Fundraising Professionals (AFP) | The Learning Partnership |
| Canadian Institute of Planners     | National Voluntary Organizations |
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| Canadian Labour Congress           | United Way of Canada |
| Canadian Medical Association       | Université de Montréal |
| Canadian Population Health Initiative | University of Toronto (Faculty of Law) |

**Other:**

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