

Evaluation of the Public Health Agency of Canada's Maternal and Child Health Programs – 2019-2020 to 2024-2025

FINAL REPORT – MARCH 2026

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Table of contents

EXECUTIVE SUMMARY	1
PROGRAM DESCRIPTION AND CONTEXT	1
EVALUATION APPROACH AND SCOPE	2
OVERVIEW OF FINDINGS	2
RECOMMENDATIONS	5
MANAGEMENT RESPONSE AND ACTION PLAN	6
PROGRAM DESCRIPTION	8
EVALUATION SCOPE AND APPROACH	9
FINDINGS	10
1. EVOLVING NEEDS AND FEDERAL, PROVINCIAL, AND TERRITORIAL RESPONSES	10
2. HOW DID THE PROGRAMS RESPOND TO POPULATION NEEDS?	13
3. ACHIEVEMENT OF OBJECTIVES AND OUTCOMES	15
4. OPTIMIZATION OF THE PROGRAMS	21
CONCLUSIONS AND RECOMMENDATIONS	26
CONCLUSIONS	26
RECOMMENDATIONS	27
APPENDIX A: PROGRAM OBJECTIVES AND EXPECTED RESULTS	28
APPENDIX B: EVALUATION METHODOLOGY	29
SCOPE AND EVALUATION QUESTIONS	29
DATA COLLECTION METHODS	29
LIMITATIONS	31
EVALUATION LENSES AND GOVERNMENT PRIORITIES	32
EVALUATION GOVERNANCE	33
APPENDIX C: ADDITIONAL CAPC AND CPNP PERFORMANCE DATA TABLES	34
APPENDIX D: PROGRAM EXPENDITURES	36

List of acronyms

AHSUNC	Aboriginal Head Start in Urban and Northern Communities
CAPC	Community Action Program for Children
CAPCHP	Community Action for Prenatal and Child Health Program
CGC	Centre for Grants and Contributions
CPNP	Canada Prenatal Nutrition Program
DCY	Division of Children and Youth
EDI	Early Development Index
ELCC	Early Learning and Child Care
HEY	Healthy Early Years
HPCDPB	Health Promotion and Chronic Disease Prevention Branch
G&Cs	grants and contributions
MCH	maternal and child health
PHAC	Public Health Agency of Canada
PT	provincial and territorial
PTs	provinces and territories
RO	Regional Operations

Executive summary

Program description and context

The Public Health Agency of Canada (PHAC) provides national leadership on key maternal and child health promotion issues and conducts a range of activities, including providing funding for community-based programming, and fostering knowledge development and exchange. Maternal and Child Health (MCH) program activities are managed by the Division of Children and Youth (DCY) within the Health Promotion and Chronic Disease Prevention Branch (HPCDPB). DCY supports community-based programming through several initiatives. This evaluation is focused on the following two programs led by DCY and administered in collaboration with Regional Operations (RO) and the Centre for Grants and Contributions (CGC):

- The **Community Action Program for Children (CAPC)**, which promotes the health and development of children aged 0 to 6 years, who face challenges that may put their health at risk. Funding recipients develop and deliver a range of comprehensive and culturally appropriate early intervention and prevention activities aimed at improving health behaviours and overall general health and well-being. The program's grants and contributions (G&Cs) budget is about \$51.5 million per year.
- The **Canada Prenatal Nutrition Program (CPNP)**, which supports the health of pregnant women and people and their infants who face challenges that may put their health at risk. Funding recipients deliver a range of programs and activities aimed at increasing healthy birth weights, promoting and supporting healthy nutrition during pregnancy and postpartum, promoting and supporting breastfeeding, as well as positive health behaviours and well-being. The program's G&Cs budget is about \$27.2 million per year.

Together, these programs aim to reach participants who face challenges that may put their health at risk, in order to strengthen their knowledge and skills and support their overall health and well-being. The programs also aim to encourage funded organizations to collaborate with various sectors to support the needs of program participants.

CAPC is currently funding 415 recipients and CPNP is funding 241. Of these recipients, 121 have received funding from both programs. Up to 2025-2026, contribution agreements were amended on a regular basis, with a majority of funding recipients having received continuous funding for close to 30 years. In early 2025, as a step towards evolving the programs, CAPC and CPNP were merged into one program, the Community Action for Prenatal and Child Health Program (CAPCHP). This has created an administrative efficiency while maintaining the same total funding. Existing CAPC and CPNP funding

recipients were then invited to apply to a targeted solicitation process for the new CAPCHP, except for Quebec's funding recipients, who will continue to be funded under the CAPC and CPNP until the end of March 2028.

Evaluation approach and scope

The evaluation reviewed DCY activities from April 2020 to March 2025, specifically those supporting community-based programming through CAPC and CPNP. The overall intent of the evaluation was to assess how the design and administration of CAPC and CPNP could be optimized. The evaluation considered program achievements, changes to be implemented, as well as the high-priority needs and health inequalities of pregnant women and people, families, and children experiencing vulnerabilities.

The evaluation questions explored the following themes:

- Evolving needs and federal, provincial, and territorial responses;
- Responses to population needs;
- Achievement of program objectives and outcomes; and
- Optimization of program design, management, and administration.

Overview of findings

Evolving needs and federal, provincial, and territorial responses

Key indicators related to inequities in the social determinants of health have shown slow and steady improvement over the last 30 years in Canada. This period overlaps with the introduction of CAPC and CPNP in the mid-1990s. Statistics show that the proportion of children under 18 living in poverty decreased from 24.2% in 2000 to 18.3% in 2023. The proportion of teen pregnancies also dropped from 5.4% in 2000 to 1.3% in 2023. In addition, breastfeeding initiation and duration have shown sustained progress. Despite improvements, there remain pockets of social and economic need that vary across regions. Funding recipients reported that program participants experience distinct needs related to food insecurity, isolation, and limited access to care, particularly among demographic groups like newcomers. Moreover, data from the Early Development Index (EDI) indicates that over a quarter of young children across Canada continue to be vulnerable in at least one of five domains of early childhood development.

The federal government has made a number of investments since the mid-1990s to improve socio-economic conditions for children and families. These include the expansion of benefits and tax credits for families, temporary income support provided during the COVID-19 pandemic, as well as the introduction of provincial and territorial (PT) as well as

Indigenous Early Learning and Child Care (IELCC) agreements. PHAC itself, and Health Canada before PHAC's creation in 2004, launched other early childhood health and development programs like Aboriginal Head Start in Urban and Northern Communities (AHSUNC), the Healthy Early Years (HEY) program, and programs addressing family violence. Furthermore, many provinces and territories (PTs) expanded their supports for children and families over this period, often building on the work of existing CAPC and CPNP funding recipients by providing additional funding or complementary programming, such as newborn screening, home visiting, and family support programs, and co-located early childhood hubs or family resource centres.

Responses to population needs

Supported by stable CAPC and CPNP funding for around 30 years, recipient organizations have built expertise, trust and familiarity with their local communities and partners. To provide programs and activities that meet the needs of local populations, which often go beyond the intent of CAPC and CPNP, many have adapted by collaborating with a multitude of partners and leveraging funds from other sources. Such collaborations have allowed them to offer wrap-around services to families, sometimes incorporating Indigenous or newcomer languages and cultural resources. It is estimated that CAPC and CPNP funding recipients leveraged a value of \$44.6 million in 2022-2023 from other sources to support their activities, including \$37.9 million from PT, regional, and municipal governments. A majority of funding recipients reported delivering six or more service types, such as enabling access to health professionals, information and communication technologies, nutrition supports, transportation and accompaniment.

Due to the capacity and reach of the funded organizations, PHAC has been able to leverage CAPC and CPNP to support a variety of other public health objectives and priorities, such as the dissemination of information related to COVID-19 and measles vaccination, as well as congenital syphilis prevention. In addition, community-based CAPC and CPNP funding recipients continue to act as service hubs and facilitate local and regional collaborations with public health authorities. These connections at the individual and organizational levels enabled funding recipients to contribute to emergency responses within their communities, such as the COVID-19 pandemic and environmental events like floods and wildfires.

Achievement of objectives and outcomes

Stable CAPC and CPNP funding and project implementation has enabled the programs to meet their objectives of building capacity, partnerships, and collaboration, as well as knowledge development and exchange. Over time, a network of over 600 funding

recipients across Canada has been developed to support the health and well-being of pregnant women and people, infants, and children (0 to 6 years), as well as parents and caregivers. Eighty-one percent of these organizations have at least one partnership. Of those who reported any partnerships, many (68%) reported partnerships with four or more different types of organizations, such as those focused on public health, literacy, food security, and education. Networking among CAPC and CPNP funding recipients is supported by five nonservice delivery funding agreements that facilitate learning and sharing knowledge resources. The activities of CAPC and CPNP funding recipients have contributed towards building social cohesion, which is a factor in individual and community resilience. Participants reported that engagement in activities allow parents to connect with each other, reducing isolation and loneliness.

Performance data analysis showed that both programs continue to reach participants who face challenges like lone parenthood, low educational achievement, and poverty.

However, the data also showed that program participation has been slowly decreasing over time, from a combined total of 271,521 participants in 2019-2020 to 232,234 in 2022-2023. This was due in part to funding limitations and the COVID-19 pandemic leading to fewer activities being offered. That said, 2024-2025 data showed early signs of increased uptake as the total went up to 252,523 participants. Over the years, participant surveys have shown consistently high levels (75% to 85%) of knowledge gained and strengthened health behaviours among parents and children. This is linked to the development of skills that support healthy pregnancies, parenting, and family health and well-being.

Furthermore, in 2025, 88% of CAPC and 94% of CPNP respondents stated that they agreed or strongly agreed that their overall health and well-being had improved as a result of participating in the program. While there is no longitudinal data on how long these impacts have lasted, academic literature, including University of Toronto research on CPNP, highlights the value of ongoing investments in perinatal health and early childhood health and development to address vulnerabilities, promote well-being and reduce health and social costs throughout a lifetime.

Optimization of program design, management, and administration

CAPC and CPNP design and funding levels have remained unchanged for 30 years. This has led to a 45% decline in budget value due to inflation, significantly reducing purchasing power and straining the ability of funding recipients to meet the objectives of the programs. In addition, the emergence over the last 30 years of other federal, PT MCH initiatives to address needs has created instances of overlapping program objectives. In addition, there is an absence of coordination mechanisms among the various players. Moreover, access to CAPC and CPNP funding has historically been limited to the original recipient organizations, thus restricting broader participation and reducing PHAC flexibility to

respond to demographic shifts and emerging needs, especially among equity-deserving populations like urban Indigenous populations, official language minority communities, newcomers, and refugees.

Following the evaluation of CAPC and CPNP in 2021, PHAC explored alternative delivery models through stakeholder consultations. Efforts to shift toward an open and competitive funding solicitation raised concerns about funding loss, particularly for organizations serving small, rural, or remote communities. To date, incremental changes have been slowly implemented to streamline reporting requirements and lower administrative burden. At the same time, DCY continues to explore promising policy options to maximize the impact of investments. Finally, while the current shared management model for the CAPC and CPNP draws on the valuable expertise of DCY, RO, and CGC, many internal interviewees noted that the approach could benefit from further refinement. While there is a program charter in place that outlines respective roles and responsibilities, there is room for further clarification of roles for some internal partners, strengthening accountabilities and improving communication practices.

Recommendations

Recommendation 1: Use lessons from the 2026 CAPCHP renewal to develop a revised funding approach that better positions PHAC to address priorities and emerging child health needs.

The program delivery model has not been significantly updated in over 30 years, despite changing needs and the emergence of other federal, PT initiatives with similar goals. This presents a challenge to the sustainability of both CAPC and CPNP, particularly since inflation has diminished the value of the investment over the years.

Recommendation 2: As PHAC develops the revised funding approach, consider how CAPCHP's community capacity work can support PHAC's broader strategic priorities.

One of the key achievements of CAPC and CPNP is the stable community capacity built across Canada, with most funding recipients having developed partnerships that allow them to act as a hub for a broad range of services to families. Recipients have also built trust over time within their local communities, which allows them to act effectively as welcoming places for intended populations. This type of community capacity has enabled the Agency to reach a variety of populations with public health information on topics such as COVID-19 and measles vaccination as well as congenital syphilis prevention. Moving forward, as PHAC develops a revised funding approach there is an opportunity to explore ways to maintain and leverage these program strengths to further advance PHAC's broader strategic priorities.

Management Response and Action Plan

Recommendation 1

Use lessons from the 2026 CAPCHP renewal to develop a revised funding approach that better positions PHAC to address priorities and emerging child health needs.

Management response

Agree

Table 1: Action plan for recommendation 1

Action Plan	Deliverables	Expected Completion Date	Accountability
1. Develop a revised approach to funding based on PHAC's mandate and strategic direction, lessons learned from 2026 CAPCHP program renewal, and updated demographic data. This renewed approach will align with and inform PHAC's work on Grants and Contributions modernization.	1.1 Internal lessons learned document - Document (approved by Executive Director) describing lessons learned from CAPC/CPNP program and the CAPCHP invitation to submit a funding request process.	December 30, 2026	Director General - Centre for Health Promotion and Chronic Disease Prevention
	1.2 Internal report (approved by Executive Director) on PT demographic data from 2021 Census - Updated PT demographic data and/or data tables based on 2021 census (e.g., % of children in low income households, % of children living with immigrant parents, % of children living with a lone parent).	April 30, 2027	

Action Plan	Deliverables	Expected Completion Date	Accountability
	1.3 Internal document (approved by Director General) outlining a proposed revised CAPCHP funding approach which aligns with PHAC's work on Grants and Contributions modernization - Document proposing revisions to the CAPCHP funding approach based on an overview of findings from 1.1 and 1.2 and a review of PHAC's mandate and strategic direction.	April 30, 2027	

Recommendation 2

As PHAC develops the revised funding approach, consider how CAPCHP's community capacity work can support PHAC's broader strategic priorities.

Management response

Agree

Table 2: Management response and action plan for recommendation 2

Action Plan	Deliverables	Expected Completion Date	Accountability
2. Develop a plan for sharing information about the CAPCHP program across the Agency to promote knowledge exchange and identify opportunities to support PHAC's broader strategic priorities.	2.1 Internal knowledge exchange strategy - Document (approved by Director General) outlining potential senior management tables and relevant Knowledge Development and Exchange (KDE) products/information to share with them.	April 30, 2027	Director General - Centre for Health Promotion and Chronic Disease Prevention

Program description

PHAC provides national leadership on key maternal and child health promotion issues and conducts a range of activities, including providing funding for community-based programming, and knowledge development and exchange. Maternal and Child Health Program activities are managed by the Division of Children and Youth (DCY) within the Health Promotion and Chronic Disease Prevention Branch (HPCDPB). DCY supports community-based programming through several initiatives. This evaluation is focused on the following two long-standing programs:

- The **Community Action Program for Children (CAPC)**, which promotes the health and development of children aged 0 to 6 years, who face challenges that may put their health at risk. Funding recipients develop and deliver a range of comprehensive and culturally appropriate early intervention and prevention activities aimed at improving health behaviours and overall general health and well-being.
- The **Canada Prenatal Nutrition Program (CPNP)**, which supports the health of pregnant women and people and their infants who face challenges that may put their health at risk. Funding recipients develop and deliver a range of programs and activities aimed at increasing healthy birth weights, promoting and supporting healthy nutrition during pregnancy and postpartum, promoting and supporting breastfeeding, as well as positive health behaviours and well-being.

Together, these programs aim to reach participants who face challenges that may put their health at risk, in order to strengthen their knowledge and skills and support their overall health and well-being. The programs also aim to encourage funded organizations to collaborate with various sectors to support the needs of program participants. See Appendix A for a list of objectives and outcomes associated with these programs.

DCY administers the programs in collaboration with Regional Operations (RO) and the Centre for Grants and Contributions (CGC). RO serves as the PHAC's main contact point for funding recipients and provinces and territories (PTs), while CGC manages the Agency's overall approach and financial administration of G&Cs.

CAPC is currently funding 415 recipients and CPNP is funding 241. Within the total of 656 recipients, 121 have received funding from both programs. Until 2025-2026, contribution agreements were amended on a regular basis, with a majority of funding recipients having received continuous funding for close to 30 years. In early 2025, as a step towards evolving the programs, CAPC and CPNP were merged into one program, the Community Action for Prenatal and Child Health Program (CAPCHP), creating an administrative efficiency while maintaining the same total funding. CAPC and CPNP funding recipients

were then invited to apply to a targeted solicitation process for the new CAPCHP, expect for Quebec's funding recipients, who will continue to be funded under the CAPC and CPNP until the end of March 2028.

Financial profile

Total planned spending for these two programs was approximately \$81.9 million per year over the last five fiscal years. Just over \$80 million was dedicated for G&Cs transfers to funding recipients. To administer the programs, PHAC's planned spending on salary, benefits, and operations and maintenance (O&M) was approximately \$1.3 million per year, including nine full-time equivalent (FTE) employees. These figures do not include program support provided by RO and CGC staff, as both have responsibilities beyond CAPC and CPNP, and their planned budgets encompass all of their activities and are not recorded at the level of these two programs. Still, RO estimates that their annual expenditures for these two programs are about \$2.8 million on salary and O&M.

Of the \$80.6 million, \$53.4 million was slated for CAPC and \$27.2 million was for CPNP. It should be noted that in 2024-2025, annual planned contribution funding for CAPC decreased to \$51.5 million, following a permanent transfer of \$1.9 million to the Aboriginal Head Start in Urban and Northern Communities (AHSUNC) program. This transfer allowed recipients receiving both CAPC and AHSUNC funding to consolidate their funding under one AHSUNC contribution agreement, thus eliminating administrative duplication and reducing reporting burdens.

Evaluation Scope and Approach

This evaluation assesses how PHAC's Maternal and Child Health Programs could be optimized in terms of design and administration. The evaluation considered program achievements from April 2020 to March 2025, changes to be implemented, as well as the high priority needs and health inequalities of families and children experiencing vulnerabilities. This evaluation was required under the *Financial Administration Act*.

The evaluation questions explored the following themes:

1. Evolving needs and federal, provincial, and territorial responses;
2. Adaptations to population needs;
3. Achievement of objectives and outcomes; and
4. Program optimization.

Information was collected from documents, performance information, literature, and financial data, as well as from interviews with internal staff and external partners and stakeholders. See Appendix B for more details on the methodology.

Findings

1. Evolving needs and federal, provincial, and territorial responses

Key takeaways: Key indicators related to inequities in the social determinants of health have shown slow and steady improvement over the last 30 years in Canada, such as poverty rates, education rates, and teen pregnancy rates. Since the mid-1990s, when CAPC and CPNP were first introduced, the federal government has increased its support for children and families by investing more to improve their economic and health conditions. Many PTs also expanded their support for children and families over this period. Despite improvements, needs remain, as data has shown low birth weights are rising steadily, and many participants continue to face challenges that go beyond the original intent of the programs, such as food insecurity, isolation, and limited access to care.

Evolving population needs

From 2000 to 2023, the proportion of children in Canada under 18 and living in poverty decreased from 24.2% to 18.3%. Child low-income rates trended downwards through the 2000s and 2010s, hitting a historic low in 2020 of 13.5%, then rebounded in 2021 to 15.6%, and rose again in 2023 to 18.3%.¹ These overall declines coincide with expanded government transfers, including enhancements to the Canada Child Benefit, Employment Insurance benefit increases, and, in most recent years, to temporary COVID-19 pandemic income supports like the Canada Emergency Response Benefit (CERB), which was made available in 2020.

Nearly all interviewees reported that recent CAPC and CPNP participants have experienced challenges in meeting basic needs due to increased cost of living, housing, food, and transportation. In 2024, 32.9 % of children under 18 in ten provinces, roughly 2.5 million, faced household food insecurity, compared to 2.1 million reported in 2023. This increase illustrates deepening economic pressures on Canadian households, driven by inflation, increased housing costs, and insufficient income supports. According to the annual report on household food insecurity produced by Research to Identify Policy Options to Reduce Food Insecurity, also known as PROOF,² rising costs for food have outpaced income growth, leaving many low- and moderate-income families unable to meet basic nutritional needs.

Although the proportion of teen pregnancies in Canada dropped from 5.4% in 2000 to 1.3% in 2023,³ premature birth rates reached a 50-year high at 8.3% in 2023. Moreover, rates of low birth weight, which is the proportion of live births in Canada with a birth weight under 2,500g, have risen steadily, from 5.7% in 2002 to 7.0% in 2022.⁴ Overall, this represents a slow increase over a long period, with modest year-to-year variability.

While 91% of parents in Canada started out breastfeeding in 2022,⁵ up from 81.5% in 2000,⁶ many stopped within the first six months, especially due to barriers like difficulty with breastfeeding and not producing enough breast milk.⁷ Expert interviewees also cited lack of postpartum supports, a gap partially addressed by CPNP. Global breastfeeding targets have aimed to increase the rate of 6-month exclusive breastfeeding to at least 50% by 2025 and 60% by 2030;⁸ however, exclusive breastfeeding at 6 months in Canada is below this target. Still, exclusive breastfeeding to 6 months shows long term gains, increasing from about 17% in 2003 to about 26% in 2011-2012, then increasing from 35.6% in 2017-2018 to about 38% in 2022. Duration of any breastfeeding, including exclusive and non-exclusive breastfeeding, to at least 6 months strengthened during the COVID-19 pandemic period, increasing from about 62% in 2017-2018 to about 69% in 2022.⁹

Lastly, a recent analysis of the Early Development Index (EDI), led by the Offord Centre at McMaster University, estimates that the percentage of five-year-old children across Canada vulnerable in at least one of five developmental domains, including physical health and well-being, social competence, emotional maturity, language and cognitive development, communication skills, and general knowledge, rose from 27.3% to 28.5% over the course of the COVID-19 pandemic. Furthermore, EDI data shows that children living in low socioeconomic neighbourhoods are more likely to experience vulnerability compared to those living in neighbourhoods with the highest socioeconomic status.¹⁰

Evolving federal, provincial, and territorial responses

When the programs were established in 1993, CAPC and CPNP were among the only federal programs established for child development, along with the “Brighter Futures Initiative”, which was designed to improve the health and well-being of First Nations and Inuit communities. Only a few complementary supports were in place for child care at that time, such as the Child-care expense tax deduction for families and the Child Care Initiatives Fund to promote research into innovative child care approaches. Lower-income families could also receive tax benefits through the Child Tax Benefit and Working Income Supplement, or social organizations supporting children in care through the Children’s Special Allowance. The federal government has made investments since the mid-1990s to improve socio-economic conditions for children and families which, in turn, have helped to

address inequities related to social determinants of health. By 2024, federally-funded programs serving children aged 0 to 6 and their families had expanded and radically changed. For example:

- Through Employment and Social Development Canada (ESDC), the Indigenous Early Learning and Child Care (IELCC) and Early Learning and Child Care (ELCC) agreements provide child care funding supports in partnership with Indigenous organizations and PTs.^{11,12}
- There has also been changes in the number and type of individual benefits, grants, and tax credits available for families with children aged 0 to 17, such as the expansion of the Canada Child Benefit and the Employment Insurance Maternity and Parental Benefits, as well as the introduction of the Canada Child Disability Benefit and Disability Tax Credit (2016), the Canada Learning Bond (2004), and the Canada Dental Benefit (2022 to 2024).
- PHAC provides a variety of funding opportunities related to MCH like the Healthy Early Years program that is aimed at official language minority communities,¹³ and the Mental Health Promotion Innovation Fund that supports innovative services in mental health promotion.¹⁴
- The Canadian Institutes for Health Research's Mental Health in the Early Years Implementation Science Team Grants provide funding to support research and service delivery projects focused on promotion, prevention, and treatment of early childhood mental health issues for children aged 0 to 5 via community-based or clinical programs involving caregivers and children.¹⁵
- PHAC's AHSUNC program, introduced in 1995, funds community-based organizations to help them deliver healthy development programs for Indigenous children and their families.¹⁶ Indigenous Services Canada (ISC) funds the similar Aboriginal Head Start On-Reserve program.
- Additional short-term funding for mental health programming targeting children, among other population groups, was available through PHAC funding streams, including the "Supporting the Mental Health of those Most Affected by the COVID-19 Pandemic Fund",¹⁷ funding for Kids Help Phone, as well as an initiative to address family violence.¹⁸

Since the introduction of CAPC and CPNP funding in the mid-1990s, the provincial and territorial (PT) landscape has also changed significantly, with most PTs now investing in perinatal and early childhood health. Some PTs have built on CAPC and CPNP by adding their own funding to support initiatives, while others provide complementary programming,

often through the same community organizations. According to interviewees, a few PTs continue to view these activities as a federal responsibility, while, for example, Quebec integrates CPNP into its social service delivery. External funding for recipients most commonly comes from other levels of government. As reported in a summary of 2022-2023 funding recipient data, PT, or municipal governments funded CAPC funding recipients with \$26.2 million), as well as CPNP recipients with \$11.7 million.

All PTs now have ELCC agreements with the federal government, and most PTs have increased services for pediatric mental health. There are different approaches for their activities in this area. For example, most PTs conduct home visits and family support programs that leverage family resource centers or networks, including CAPC or CPNP recipients. Some have also developed early childhood service hubs or early years centres, co-locating early child care services with early child development and family supports.

Key informants, including PHAC staff and funding recipients, reported a lack of coordination between PHAC's funding programs and funding from other federal government organizations. Some interviewees note that eligible community organizations are piecing together funding from multiple federal sources, and that this fragmentation contributes to inefficiency from dealing with disparate funders, as well as an important reporting burden. While many interviewees did see the various funding streams as complementary, given the profound needs experienced by specific populations, there was a high level of agreement that there needs to be closer coordination between the federal organizations involved in funding these initiatives.

Lastly, coordination with PTs had been facilitated via Joint Management Committees; however, these were suspended in April 2025, pending the programs' redesign. This is discussed in more detail in Section 4 - Optimization of the programs.

2. How did the programs respond to population needs?

Key Takeaways: CAPC and CPNP funding recipients have relied on expertise, partnerships, and community trust to align their services with the needs of key populations. Most of them offer wrap-around services to families beyond CAPC and CPNP programming.

Wrap-around programs and activities for families

Population health needs are often more extensive than the scope of CAPC and CPNP or the capacity of a project in any given location. Therefore, many recipients have partnered with other health and social services organizations to offer wrap-around services to

families. These services sometimes incorporate Indigenous or newcomer languages and cultural resources. Funding recipients have adapted to evolving community needs by leveraging staff expertise, becoming a trusted local presence, and integrating with health and social systems while offering flexible programs. Some of these needs, like food security, often fall beyond the original intent of CAPC and CPNP, although these programs were established to allow for implementation tailored to regional maternal and child health needs. Interview data shows that funding recipients are still able to adapt their services to those needs, but limited funding makes this challenging for many.

Around 62% of funding recipients delivered six or more types of support services. The most common types were:

- access or referral to health professionals;
- access to phone, internet, fax, and photocopiers to support applying for social services;
- food and vitamin supplements or vouchers; and
- transportation and accompaniment.

Other PHAC programs have also used the CAPC and CPNP network to support other public health priorities, in line with population needs like providing COVID-19 vaccine information, responding to mis- and disinformation, and providing awareness of congenital syphilis.

Supporting emergency response

Although not funded by CAPC and CPNP investments, many interviewees, particularly those in regions or part of PT governments, highlighted the important role that the organizations funded by CAPC and CPNP have played in emergency preparedness and response within their communities. For example, some interviewees described how CAPC and CPNP funding recipients provided support to refugees fleeing the war in Ukraine and to children and families affected by natural disasters like hurricanes and wildfires, as well as a mass-casualty event. Supports included distributing necessary items like clothes and other supplies, and providing mental health support for families experiencing trauma. This role was highlighted as a benefit of supporting community-based organizations that are already well-connected to children and families in their regions. However, funding recipients also reported that emergency conditions had challenged their operations in 2022-2023 (n=47%). Of the forty-seven percent just over half (53%) of the funding recipients reported they had to cancel events due to bad weather causing conditions like poor roads and flooding in their facility.

3. Achievement of objectives and outcomes

Key Takeaways: The network of CAPC and CPNP funding recipients serves to increase participant knowledge and skills in support of perinatal, infant, child, and family health. Research shows that perinatal and early childhood programs deliver strong returns by boosting family well-being, reducing long-term societal costs, increasing productivity, and promoting equity. Although CAPC and CPNP have improved participant health and well-being in the short term, there is no longitudinal data on how long this impact lasts. Participation numbers have decreased in recent years, due to the pandemic and funding limitations, but there are early signs of post-pandemic improvement.

Progress on objectives

Since the 2021 evaluation, both CAPC and CPNP programs have made progress in achieving the stated objectives of building community capacity, partnerships, and intersectoral collaboration, as well as facilitating knowledge development and exchange.

Building community capacity

Over the years, CAPC and CPNP funding recipients have contributed towards building community capacity by strengthening social cohesion, which is a factor in community resilience.¹⁹

- CAPC and CPNP funding recipients have supported the facilitation of local and regional collaborations with public health authorities. They have built capacity among community public health organizations across the country and served as consistent and stable sources of funding for 30 years, which has also led to these organizations becoming essential services within communities.
- CAPC and CPNP have consistently produced a wide range of positive results in the adoption of positive health practices and behaviours for populations who face challenges that may put their health at risk. The 2025 CAPC and CPNP participant surveys showed that the programs benefit parents/caregivers and children in many different ways. Most parents learned parenting and wellness skills, promoted health behaviours, and expanded their social support networks.
- Many external interviewees reported that drop-in play groups and in-person or virtual group education sessions provide an opportunity for parents to connect with each other, reducing isolation and loneliness. Over the years, funding recipients have established strong and trusted relationships with program participants and families. Through CAPC and CPNP, children and families facing challenging

situations can access a range of basic public health supports that contribute to their overall well-being. Ninety-seven per cent of participants surveyed in 2025 agreed or strongly agreed that they were accepted and welcomed by CAPC and CPNP funding recipients.

These relationship-building efforts proved especially valuable during the COVID-19 pandemic. The programs and funding recipients demonstrated flexibility and innovation in continuing to support families and addressing isolation and disrupted services. PHAC staff provided information resources to funding recipients, as they were key liaisons and seen as front line responders during the pandemic. Funding recipient staff continued to contact participants in lockdown via online parenting classes or maintained some in-person services to support essential workers. As lockdowns were lifted, funding recipients remained a key support for participants facing challenges by, for example, providing vaccination clinics and education in a culturally safe and empathetic way. This resulted in positive outcomes for participants, including improved access to local resources, enhanced knowledge and skills, adoption of healthier practices, and better overall health and well-being.

Building partnerships and intersectoral collaboration

Most funding recipients have developed partnerships with other community organizations, funders from the public and private sectors, and public health authorities in order to better respond to participants' needs. More specifically, 81% of CAPC and CPNP funding recipients reported having a partnership with another community organization in 2022-2023. Of those with partners, 68% reported partnerships with four or more different types of organizations. Health sector organizations like public health units, community health centres, and clinics were the most frequently reported partner type.

In terms of funding partnerships, the figures for 2022-2023 show that:

- For every dollar invested by CAPC, funding recipients received 61¢ in funding from other sources, 11¢ in donations, and 11¢ in volunteer hours, for a total of \$0.83 in additional resources.
- For every dollar invested by CPNP, funding recipients receive 73¢ in funding from other sources, 29¢ in donations, and 8¢ in volunteer hours, for a total of \$1.10 in additional resources.

Stable and established recipients were able to leverage funds from more sources than less established ones. A one-year snapshot of program funding and funding leveraged from other sources is shown in Table 3.

Table 3: Funding amounts in fiscal year 2022-2023 by source and program

Funding source	CAPC	CPNP
PHAC Funding via contribution agreements	\$54.1 million	\$26.2 million
Provincial, territorial, regional, and municipal governments	\$26.2 million	\$11.7 million
Not-for profit/community organizations	\$1.5 million	\$1.2 million
Business and private sector	\$293 thousand	\$181 thousand
Estimated value of in-kind contributions	\$5.7 million	\$5.6 million
Total	\$87.8 million	\$45.2 million

Many internal and external interviewees highlighted that CAPC and CPNP funding provided an important structure that supported recipient organizations with consistent and reliable funding to seek partnerships and leverage additional funding from other sources, or to share space with other organizations to provide coalition programming. In 2022-2023, 56% of CAPC funding recipients and 41% of CPNP funding recipients were leveraging funds from other sources, with an estimated value was \$44.6 million compared to \$80.6 million in PHAC funding. However, some interviewees noted that forming partnerships and leveraging funds can be more difficult in rural areas where there are fewer organizations offering complementary services. Funding recipients in large population centres were able to leverage greater funding on average than recipients located in geographic areas with smaller populations. See Table 7 in Appendix C for more details.

Development and exchange of knowledge

Funding recipients have continued to develop and mobilize knowledge resources. In 2022-2023, 57% of CAPC and 79% of CPNP funding recipients reported using at least one PHAC-funded or supported knowledge resource for program delivery. These covered topics like breastfeeding, substance use during pregnancy, safe sleep for babies, and the Nobody's Perfect parenting program.²⁰ Funding recipients most commonly reported providing these resources directly to participants and colleagues, or using them as an educational resource within programming. CAPC and CPNP projects are also supported by five non-service delivery projects and informal CAPC and CPNP coalitions that support sharing knowledge resources and learning from one another. Interviewees reported that CAPC and CPNP funding recipients often participate in formal and informal networks to support knowledge translation and exchange across funding recipients and with external partners. In 2022-2023, 2,959 staff from 289 funding recipients participated in activities

supported by non-service delivery projects. Also in 2022-2023, non-service delivery projects produced a total of 360 knowledge products or capacity-building activities in support of CAPC and CPNP funding recipients.

Progress on outcomes

The CAPC and CPNP programs aim to increase participant knowledge and build skills to support perinatal, infant, child, and family health. The programs also aim to have funding recipients collaborate with organizations from various sectors to support participants' needs.

Participation

Over 600 CAPC and CPNP funding recipients continue to deliver programming from over 2,100 sites. They reported reaching 252,523 participants in 2024-2025. Prior to the COVID-19 pandemic, CAPC saw a modest but consistent increase in its reach over time, while CPNP's reach saw a consistent decrease. As shown in Table 4, both programs experienced a dramatic decline in participation during the pandemic. Several interviews indicate that social isolation increased while families were unable to access in-person services. Still, results for 2024-2025 show signs of improvement, as combined program participation increased by 8.7%, especially for CPNP. Interviewees indicated that this was most likely due to people slowly returning to in-person services due to limitations of activities delivered online.

Table 4: Total participants and percent change year-over-year for CAPC and CPNP

Program	2013-2014	2015-2016	2017-2018	2019-2020	2022-2023	2024-2025
CAPC	223,340	227,067 (+1.66%)	231,248 (+1.84%)	226,240 (-2.17%)	191,349 (-15.42%)	202,264 (+5.7%)
CPNP	51,228	48,045 (-6.21%)	47,117 (-1.93%)	45,281 (-3.90%)	40,885 (-9.71%)	20,259 (+50.5%)
CAPC and CPNP Combined	274,568	275,112 (+0.20%)	278,365 (+1.18%)	271,521 (-2.46%)	232,234 (-14.47%)	252,523 (+8.7%)

Note: These numbers are sourced from annual funding recipient reporting. Due to very few cases of reporting omissions, not all participants are represented by these figures.

The participants reached by CAPC and CPNP projects have been described as a population facing challenges that may raise risks to health. Table 5 shows data reported by participants through surveys in 2018 and 2025 on six demographic profile characteristics selected by PHAC. Survey results showed that the most prevalent of these characteristics were families with low income, meaning at or below the low-income measure; recent immigrants who came to Canada in the past 10 years; and lone-parent families. Less frequent were families with Indigenous identity; respondents with lower level of education, having not completed high school; and teenage parents aged 19 years or younger. The majority of 2018 survey respondents reported experiencing at least one of these characteristics. See Table 8 in Appendix C for more detail.

Table 5: Demographic profile of participants for 2018 and 2025^{Note 1}

Program and year	Lone parent or caregiver	Teen parent	Less than high school education	Indigenous identity	Not born in Canada	Below low-income measure
CAPC - 2018	24.8%	1.4%	13.5%	17.2%	27.4	58.2%
CAPC - 2025	25%	0.5%	9%	14.2%	34%	57% ^{Note 2}
CPNP - 2018	27.6%	6.8%	20.9%	23.8%	35%	73.7%
CPNP - 2025	22%	2%	8%	20%	41%	60% ^{Note 2}

Note 1: In 2018 a paper based demographic survey was completed by program participants. In 2025 PHAC conducted a pilot version of an online survey resulting in limited participation by those facing challenges in completing an online survey, e.g., lack of access to a device or internet service.

Note 2: Low-income measures for 2025 are based on the percentage of participants with \$60,800 or less in annual household income, while low-income measures for 2018 were calculated based on Low-income cutoff tables from Statistics Canada, which factor in the size of the household. Household size was not included in the 2025 survey. To place 2025 values in context, according to Statistics Canada, the Low-income measure threshold for a three-person household before taxes is \$60,282, and \$69,608 for a four-person household.

Multisectoral collaboration

About 90% of CAPC and CPNP funding recipients that delivered support services (n=630) reported facilitating access or referral to health professionals, such as a speech language therapist. Interviewees noted that CAPC and CPNP funding recipients are often leveraged

by other organizations to deliver needed programs to participants. In some cases, these organizations have become embedded into PT programming. Examples of initiatives from external organizations hosted by CAPC and CPNP funding recipients include specialists like public health nurses, psychologists, and speech-language pathologists, and partnering with food banks.

Knowledge, health and well-being improvements

The programs have continued to improve knowledge, skills, behaviour, and self-reported health for participants. Children and families facing conditions of vulnerability receive a range of public health supports:

- programming, knowledge and resources on positive health behaviours;
- access and referrals to essential health care and social support services; and
- supports in building resilience and protective factors.

Survey data indicates that knowledge gained and changes to behaviour have been consistently high, between 75 to 85%, over the years for pregnant women and people, parents, and their children attending programming. In 2025, 88% of CAPC and 94% of CPNP respondents stated that they agreed or strongly agreed that their overall health and well-being improved as a result of coming to the programs. See Table 10 in Appendix C for more details.

Over the years, the funding recipients have established strong and trusted relationships with participants and families. Through CAPC and CPNP, children and families who face challenges that may put their health at risk can access a range of basic public health supports that contribute to their overall well-being.

In addition, interviewees and funding recipient performance reports provided anecdotal evidence on a variety of positive impacts on the health and well-being of CAPC and CPNP participants. Commonly cited examples included:

- improved protective factors in the child's environment, including better parental knowledge on healthy behaviours like stress management, nutrition, and child development;
- improved social and emotional attachment like the parent-child bond;
- improved community trust and peer support;
- access to food and shelter; and
- improved health outcomes like breastfeeding initiation and physical activity.

A majority of interviewees noted connections to other services in their community and a caring community of peers as a key benefit of CAPC and CPNP programming.

Furthermore, several interviewees noted that long-term funding allows CAPC and CPNP funding recipients to provide a stable presence in the community, a place where parents know that they can access support if needed.

There is no longitudinal data on how long these impacts last, but a wide array of published literature has documented the value of ongoing investments like CAPC and CPNP in perinatal health and early childhood health and development to address vulnerabilities, promote well-being, and reduce health and social costs throughout a lifetime.²¹ These studies include the House of Commons Standing Committee on Health report on Fostering Healthy Childhoods,²² University of Toronto research on CPNP,^{23,24} the UNICEF report card on child well-being,²⁵ and the McMaster University Offord Centre study on the impact of COVID-19 on early childhood development.²⁶

A 2025 systematic review evaluated the impact of nutrition intervention programs in the first 1,000 days of life on long-term physical and mental health in children. While they found a gap in existing intervention research with long-term follow-up, some positive impacts on dietary behaviour and cardio-metabolic health were observed in the long term.²⁷

4. Optimization of the programs

Key Takeaways: For 30 years, the Community Action Program for Children (CAPC) and the Canada Prenatal Nutrition Program (CPNP) have not changed their design or funding, making it harder for the programs to stay effective and respond to new needs. To improve flexibility, the Division of Childhood and Youth (DCY) plans to move to an open application process, which will allow for a fresh look at how the programs are run and measured, while valuing the community networks built over time. A further challenge for the programs is a lack of coordination between PHAC and other federal, provincial, territorial, and municipal partners supporting prenatal and early childhood health and development.

Resource use

DCY demonstrated strong financial management of the programs over the evaluation period (2020-2021 to 2024-2025). Actual spending was very close to the planned amounts, with the programs spending on average 99% of the approximately \$82 million budgeted annually over the five fiscal years. See Table 11 in Appendix D for more details.

Actual spending on salaries tended to be on par with planned amounts, except for minor instances of pre-approved overspending related to monitoring and program renewal. Operations and maintenance (O&M) spending tended to fall short of planned spending levels due to savings on contracting and not backfilling positions. The exception was in 2024-2025, when a contract for resource printing was higher than anticipated.

Administration of CAPC and CPNP also involves resources from Regional Operations (RO) and the Centre for Grants and Contribution (CGC). CGC manages PHAC's overall approach and financial administration of G&Cs. RO is responsible for monitoring and supporting CAPC and CPNP projects, as well as working with regional partners and stakeholders to address gaps and to identify tools, resources, and opportunities to leverage support on shared priorities. Since RO and CGC staff have responsibilities beyond these programs, their financial data is not recorded at the level of specific programs. Still, RO was able to estimate that it spends about \$2.8 million per year on salary, and O&M for CAPC and CPNP activities. See Table 12 in Appendix D for more details.

CAPC and CPNP funding levels have remained unchanged since 1997 for CAPC and 1999 for CPNP.²⁸ Inflation has had a significant effect on the purchasing power of this amount, with most funding recipients experiencing a drop of approximately 45% in the purchasing power from this funding between the launch of the programs and 2025.²⁹ In other words, the combined contributions funding budget of \$80.6 million for CAPC and CPNP in 1997 was worth only \$44.32 million by 2025. As such, rising costs relative to funding have continued to pose a significant challenge to funding recipients, which hampers their capacity to deliver activities. Project reporting shows that, in 2022-2023, 48% of CAPC and 35% of CPNP recipients reported staffing challenges, and in 2023-2024, 66% of CAPC and 73% of CPNP recipients reported gaps in staff training and development. Such staffing issues are not limited to CAPC and CPNP, but have been identified as a broad challenge across child health, early learning, and child care sectors in Canada.^{30, 31}

Furthermore, access to CAPC and CPNP funding has been limited to the original recipients since the start of the two programs, with very few changes. Changes to the recipient list have been very infrequent, most commonly due to a recipient leaving the programs by choice or due to an organization closing. The closed nature of the funding model has limited the participation of other organizations that could benefit from program funding. Thus, PHAC has been limited in its ability to reallocate CAPC and CPNP funding in response to changing demographics and emerging needs of equity-deserving populations, such as urban Indigenous populations, official language minority communities, newcomers, and refugees.

Governance and collaboration

Various federal and PT-level programs and initiatives have been developed over the years to respond to a need for prenatal and early childhood health and development supports and services. There is an opportunity to improve coordination between other federal programs and PT partners to support alignment on common priorities, especially in light of the increased number of federal and PT program activities related to maternal and child health over the last 30 years.

In April 2024, PHAC formally discontinued the outdated Federal-Provincial-Territorial protocol agreements that established the terms and conditions for the joint management of CAPC and CPNP in each of the PTs when they were launched in the 1990s. Joint Management Committees (JMCs) were originally created to support this, including priority setting and funding recipient selection. Since then, the JMCs became less relevant³² and less active due to stable program funding and evolving PT contexts, to the point that engagement was observed to be uneven across PTs. With JMCs now inactive and PHAC taking steps to evolve its delivery of grants and contributions (G&Cs) programs, there appears to be an opportunity to reconsider how PHAC and PTs collaborate to advance shared priorities.

The evaluation found no evidence of a formal mechanism or sustained coordination at the federal level between PHAC and other departments who are active in delivering funding or benefit programs for similar populations, especially Employment and Social Development Canada (ESDC) and Indigenous Services Canada (ISC). PHAC could benefit from the introduction of better interdepartmental coordination in order to maximize effective use of its limited maternal and child health (MCH) resources in achieving the positive MCH impacts through synergies with other programs.

Program administration and performance measurement

While data shows strong financial stewardship, many internal interviewees noted that the current model of shared management between DCY, RO, and CGC creates inefficiency, including unclear roles, accountabilities, and communication processes, despite the creation of an internal program charter to guide respective roles and responsibilities. PHAC's internal review of the G&Cs administration model identified three key issues: misaligned accountabilities, inconsistent RO engagement, and the need to balance CGC's financial oversight with administrative efficiency. Overall, internal interviewees agreed that streamlining administration, while leveraging the complementary strengths of program areas, would help address these challenges.

Performance data has been collected consistently over time and data tools have been improved. However, the effort required by funding recipients to produce data appears to still outweigh its value for measuring CAPC and CPNP outcomes, especially considering the amount of funding per recipient. Additionally, data quality and inconsistency issues persist. Funding recipients often receive funding from various sources and are thus required to complete multiple reporting templates for PHAC and other funders. As funded organizations provide services in an integrated way, it is difficult for them to link specific results to individual sources of funding. This causes some organizations to either overreport or underreport on the full reach of their activities. With the programs' redesign, there is an opportunity to reconsider performance data needs and methods. The current targeted solicitation has already implemented a change by gathering more detailed information on community needs and streamlining reporting requirements.

Changes following the 2021 evaluation

There is broad consensus among interviewees that the programs continue to serve their intended populations. However, factors such as inflation-driven funding erosion, increased administrative burdens on both recipients and PHAC, and a need for greater agility in addressing emerging priorities as well as changing demographics have prompted consideration of future design changes. DCY consulted broadly on future design and made incremental changes to the programs, while providing additional time for current recipients to prepare for a future open solicitation funding process.

From May 2021 to July 2023, a series of internal and external engagements took place to discuss proposed changes to CAPC and CPNP with RO, CGC, researchers, practitioners, PT Joint Management Committee (or equivalent) partners, and current funding recipients. More than half of the feedback from currently funded recipients expressed uncertainty about the proposed changes to the long-standing program model. One of the main concerns was that introducing a competitive, or 'open', funding process with no budget increase would likely mean that many current funding recipients might not be successful under a new selection process, leading to programming closure for some communities. Despite significant opposition to changing the funding model, some funding recipients expressed appreciation for the current iterative approach to transitioning the programs.

As part of the 2025-2026 CAPCHP funding renewal process, recipients were asked to complete a community needs assessment to inform their funding request. The current CAPCHP solicitation process will enable DCY to obtain up-to-date information on community needs and priorities, as well as updated project workplans and budgets from the funding recipients to ensure project activities are aligned with the refreshed objectives. Following this process, CAPC and CPNP funding recipients did not change, though there

was some attrition due to a few previous funding recipients not completing the process. While this change has no impact on funding allocated to recipients, it will reduce the administrative burden and streamline project reporting. Furthermore, in 2024-2025, DCY transferred approximately \$1.9 million in contribution funding and consolidated agreements from CAPC to AHSUNC to reduce the reporting burden of funding recipients who were participating in both programs.

Alternative delivery models

Although DCY consulted broadly and developed options for potential program design changes, a clear policy direction for the future has yet to be decided. There continues to be an opportunity to build on the work done to date to rethink program design and maximize investments, while allowing for flexibility to address differing regional needs, aligning with PHAC's mandate and recognizing the limits of PHAC's financial resources.

Furthermore, future program design can leverage strengths and capacities of community-based programming built by CAPC and CPNP investments over time. Recipients have demonstrated capacity for supporting multiple PHAC objectives and priorities, such as engaging with groups experiencing vulnerabilities to provide vaccination information and congenital syphilis prevention. As service hubs, they have also facilitated local and regional collaborations with public health authorities.

Conclusions and Recommendations

Conclusions

Key indicators related to inequities in the social determinants of health have shown slow and steady improvement over the last 30 years in Canada. This period overlaps with the introduction of CAPC and CPNP in the mid 1990s. However, social and economic needs like food insecurity, isolation, and limited access to care were reported across regions, highlighting newcomers in particular. Early Development Index (EDI) data shows that over a quarter of young children across Canada continue to be vulnerable in at least one of the five domains of early childhood development. The federal government has made investments since the mid-1990s to improve socio-economic conditions for children and families, including expansion of benefits and tax credits, temporary COVID-19 pandemic income support, and the PT and Indigenous Early Learning and Child Care (IELCC) agreements. Provinces and territories also expanded their supports for children and families over this period, often building on CAPC and CPNP funding.

Stable CAPC and CPNP funding has enabled recipient organizations to build expertise, trust, and familiarity with their local communities and partners. Many funding recipients collaborate with a multitude of partners and leverage funds from other sources, allowing them to offer wrap-around services to families adapted to local needs. PHAC itself has been able to leverage the network of CAPC and CPNP funding recipients to support other priorities such as vaccine uptake and communicable disease prevention. More broadly, the funding recipients, acting as local service hubs, have been a resource for emergency responses, including for the COVID-19 pandemic, floods, and wildfires.

The programs continue to meet the objectives of building capacity, partnerships, and collaboration, as well as the development and exchange of knowledge. A network of over 600 funding recipients across Canada that supports the health and well-being of pregnant women and people, children aged 0 to 6 years, and parents and caregivers has been built. Furthermore, funding recipients have contributed towards building social cohesion, which is a factor in individual and community resilience. The programs continue to reach participants who face challenges such as lone parenthood, low educational achievement, and poverty. While data also showed that total participation has been slowly decreasing over time, there has been some recovery since the COVID-19 pandemic. Participant surveys have shown consistently high knowledge levels gained and behaviour changes linked to skills development that supports healthy pregnancies, parenting, and family well-being. Studies highlight the value of ongoing investments in perinatal health and early childhood health and development to address vulnerabilities, promote well-being, and reduce health and social costs throughout a lifetime.

The programs' funding levels have remained the same for over 30 years, leading to a 45% decline in their value due to inflation. This has significantly reduced purchasing power and strained the ability of funding recipients to meet the objectives. As well, the emergence of other federal, PT MCH initiatives to address profound needs has created instances of overlapping objectives, along with a lack of coordination. Access to CAPC and CPNP funding has historically been limited to the original recipient organizations, reducing PHAC's flexibility to respond to demographic shifts and emerging needs. Following the 2021 evaluation of CAPC and CPNP, PHAC explored alternative delivery models; however, efforts to shift toward a competitive funding process were met with resistance, especially due to concerns over funding loss in rural and remote regions. As PHAC brings in incremental changes like the introduction of the new Community Action for Prenatal and Child Health Program (CAPCHP), it also needs to continue its work to streamline reporting requirements and lower administrative burden.

Recommendations

Recommendation 1: Use lessons from the 2026 CAPCHP renewal to develop a revised funding approach that better positions PHAC to address priorities and emerging child health needs.

The program delivery model has not been significantly updated in over 30 years, despite changing needs and the emergence of other federal, PT initiatives with similar goals. This presents a challenge to the sustainability of both CAPC and CPNP, particularly since inflation has diminished the value of the investment over the years.

Recommendation 2: As PHAC develops the revised funding approach, consider how CAPCHP's community capacity work can support PHAC's broader strategic priorities.

One of the key achievements of CAPC and CPNP is the stable community capacity built across Canada, with most funding recipients having developed partnerships that allow them to act as a hub for a broad range of services to families. Recipients have also built trust over time within their local communities, which allows them to act effectively as welcoming places for intended populations. This type of community capacity has enabled the Agency to reach a variety of populations with public health information on topics such as COVID-19 and measles vaccination as well as congenital syphilis prevention. Moving forward, as PHAC develops a revised funding approach there is an opportunity to explore ways to maintain and leverage these program strengths to further advance PHAC's broader strategic priorities.

Appendix A: Program objectives and expected results

Objectives

- **To build community capacity** that encourages and supports the health and well-being of pregnant women and people, infants and children aged 0 to 6 years, and their parents and caregivers.
- **To build partnerships and intersectoral collaboration** that promote the health and well-being of pregnant women and people, infants and children aged 0 to 6 years, and their parents and caregivers.
- **To facilitate knowledge development and exchange** that promote the health and well-being of pregnant women and people, infants and children aged 0 to 6 years, and their parents and caregivers.

These three overarching program objectives are drawn from the new CAPCHP program that merges CAPC and CPNP.

Outcomes

The following CAPC and CPNP objectives are shown in the 2025-2026 PHAC Departmental Plan:³³

- Parents, caregivers, and their children who face challenges that may put their health at risk participate in CAPC projects. Pregnant and postpartum women and people and their families facing challenges that may put their health at risk participate in CPNP projects.
- CAPC and CPNP projects collaborate with organizations from various sectors to support participants' needs.
- Parents, caregivers, and their children participating in CAPC gain knowledge and build skills to support parental, child, and family health. CPNP participants gain knowledge and build skills to support their health and well-being through pregnancy, and to support the health and well-being of their infants and families.
- Improving the health and well-being of CAPC and CPNP participants and their families.

Appendix B: Evaluation Methodology

Scope and evaluation questions

This evaluation focused on the performance of PHAC's Maternal and Child Health Programs from April 2020 to March 2025.

The evaluation was guided by the following questions:

- What are the emerging challenges related to the health and well-being of pregnant women and people, infants and young children aged 0 to 6 years, and their parents and caregivers, and how has the federal, provincial, and territorial responses evolved?
- To what extent are the programs and funded projects effectively responding to these issues or challenges?
- How well are the programs' objectives and outcomes being achieved?
- How can program management and administration be optimized while supporting project sustainability at the community level?

Data collection methods

To address the evaluation questions, the evaluation team collected and analyzed multiple lines of evidence that were triangulated to improve the reliability and credibility of evaluation findings and conclusions. The following lines of evidence were used:

Document review

The evaluation team received and reviewed approximately 238 files, including both internal and public documents submitted by the Division of Child and Youth (DCY). Internal documents included strategic planning documents, annual reports, work plans, operational plans, governance documents, surveys, newsletters, consultation reports, meeting summaries, guiding policies, briefing materials, performance reports, and summary reports. Public documents included departmental reports, Canada.ca web pages, and external reviews. Data from documents was collated and analyzed by indicators and themes using evidence matrices.

Interviews

Interviews were conducted virtually based on a predetermined interview guide. Transcriptions were generated by Microsoft Teams for each interview. This information was validated by an analyst and used to supplement manual note taking. Interviewees were given the option to submit a written response using the interview guide as a template, and six interviewees chose to submit a written response. Thematic analysis of interview notes and written responses was conducted using NVivo software. In total, 57 internal and external interviewees from the following groups participated in interviews (34) or submitted written responses (6):

- 11 program staff members, senior management, and advisors from DCY and the Health Promotion and Chronic Disease Prevention Branch (HPCDPB);
- 9 PHAC Regional Operations (RO) staff members;
- 6 PHAC staff members from other organizations and branches;
- 16 funding recipients;
- 6 representatives of PT government ministries; and
- 9 experts in perinatal, infant, child, and family health.

Performance data review

Performance data from the following sources was reviewed:

- Performance Information Profile (PIP) data for fiscal years 2020-2021 to 2024-2025;
- Short-form annual reporting for fiscal years 2020-2021, 2021-2022, 2023-2024, and 2024-2025;
- Long-form annual for fiscal year 2022-2023;
- 2018 and 2025 Participant Outcome Survey data; and
- Other internal tracking and reporting dashboards.

Financial data review

Financial data provided by the Chief Financial Officer and Corporate Management Branch was reviewed, including budgeted versus actual expenditures.

Literature review

The evaluation identified two questions of interest to be addressed by a literature review, one of which was supplemented by generative AI.

The first review identified literature with a structured search strategy to answer the question: *“Over the last five years, in what ways have communities and populations changed, what are the main issues these populations are now facing, and how has COVID-19 influenced those changes?”* Fifteen relevant sources were identified and reviewed by an analyst and key indicators were identified for child poverty, low birth weight, and breastfeeding.

The second review used the generative artificial intelligence platform Microsoft Copilot to identify provincial funding sources for community organizations providing services to children aged 0 to 6 and their families, in 1997 and in 2025. The information identified by this scan was reviewed and validated by an analyst.

Limitations

The evaluation team used triangulation to analyze data collected by these various methods in order to increase the reliability and credibility of the evaluation findings and conclusions. Still, most evaluations face constraints that may affect the validity and reliability of findings. Table 6 outlines the limitations encountered during the evaluation, and the mitigation strategies that were put in place.

Table 6: Limitations, impacts, and approach for addressing them

Limitation	Impact on the evaluation	Approach for addressing the limitation
External key informant interviews and review of qualitative elements of annual reporting were only possible with a small number of funded recipients.	Findings from the interviews are not generalizable to the broader stakeholder groups or the Canadian public. Findings from qualitative elements of annual reporting may not be representative of all funding recipients.	Data from the key informant interviews was triangulated with other sources of data like documentation, annual reporting, program data, recipient consultations, where possible. A random sample of 16 funding recipients was created for qualitative elements of annual reporting.

Limitation	Impact on the evaluation	Approach for addressing the limitation
Not all of the funded projects provide the same performance data. For example, CPNP projects in Québec and CAPC and CPNP projects in the territories have very different reporting.	This limits the opportunity for a comprehensive and comparative understanding of CAPC and CPNP impacts across all provinces and territories.	Interviews were conducted with key informants located in Québec and the territories in an effort to understand the performance of funded projects. Annual project reporting data also used as a data source for the evaluation.
Performance measurement from the two programs was inconsistent. More specifically, participant survey's online pilot methodology had low response rates and coding errors, and there were occasional cases of annual funding recipient reports not submitted due to project closures, reporting omissions, or funding transfers to another program.	Program survey data is not representative of all CAPC and CPNP participants, and the low-income cut-off measure is not directly comparable to previous survey collection years. Program performance data shows trends but does not count all CAPC and CPNP participants.	Data from the participant survey was triangulated with other sources of data, including previous years of the survey and published literature, where possible. Added explanatory note to Table 4.

Evaluation lenses and government priorities

The evaluation applied several lenses and frameworks to assess the progress and impacts of PHAC's Maternal and Child Health Programs with respect to Government of Canada priorities.

In support of the United Nations' 2030 Agenda for Sustainable Development and the United Nations' Sustainable Development Goals, PHAC's maternal and child health

programs contribute to Goal 3: “Good Health and Well-Being.” In particular, the following indicators:

- 3.2 - By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.
- 3.4 - By 2030, reduce by one-third premature mortality from non-communicable diseases through prevention and treatment, and promote mental health and well-being.
- 3.7 - By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information, and education, and the integration of reproductive health into national strategies and programmes.

The evaluation applied an SGBA Plus lens to its assessment of the program. Although official languages were not specifically examined, they were not found to be an issue for the program’s activities.

Evaluation governance

The Office of Audit and Evaluation worked closely throughout the evaluation with a program contact in HPCDPB’s DCY to access documents and performance data, and to identify stakeholder groups. The scope for this evaluation was presented to PHAC’s Performance Measurement and Evaluation Committee (PMEC) in February 2025 to receive input and guidance on the evaluation questions. The preliminary findings were presented to PMEC in January 2026. The final report and Management Response and Action Plan developed by HPCDPB were presented to PMEC in March 2026, where committee members recommended the evaluation for the President’s approval.

Appendix C: Additional CAPC and CPNP performance data tables

The following tables provide data for various objectives and outcomes discussed in Section 3 - Achievement of objectives and outcomes.

Table 7: Average funding amount leveraged by CAPC and CPNP recipients, by geographic area

Large population centres (n=138)	Medium population centres (n=85)	Small population centres (n=183)	Rural (n=127)	Remote (n=12)	Isolated areas (n=14)	Reserves (n=24)	Self-governing First Nations communities (n=7)
\$232,285	\$117,032	\$82,332	\$109,002	\$111,000	\$89,241	\$193,371	\$131,027

Table 8: Percentage of participants who presented various risk factors in 2018

Program	0 risk factor presented	1 risk factor presented	2 risk factors presented	3 risk factors presented	4 risk factors presented	5 risk factors presented	6 risk factors presented
CAPC	33.6%	26.0%	24.9%	12.5%	2.8%	0.2%	0.0%
CPNP	19.1%	25.2%	31.2%	17.9%	5.8%	0.8%	0.0%

Note: Individuals were only included in the analysis if they provided valid responses for all measured risk factors. For example, if a respondent skipped the question about being a lone parent, they would not be included due to missing data. This method ensured that the analysis accurately reflected the risk level experienced by the respondents. As a result of this method, the sample size was reduced for the analysis of this index, but results were weighted to maintain representativeness of smaller sample.

Table 9: Indicators of partnerships and intersectoral collaboration

Indicator	2013-2014	2019-2020	2022-2023
% of projects that leverage multi-sectoral collaborations	88%	77%	81%
% of projects that leverage funds from other sources	69%	51%	49%
% of projects leveraging in-kind contributions	No data	No data	65%

Table 10: Changes in capacity among CAPC-CPNP participants.

Indicator	2013-2014	2018-2019	2024-2025
% of participants who gain knowledge and skills as a result of programming	86% (combined)	85% (combined)	CAPC (87%) CPNP (88%)
% of participants and parents who improve their behaviours	81% (combined)	81% (combined)	CAPC (84%) CPNP (87%)
% of participants and children who experience improved protective factors as a result of programming	81% (combined)	81% (combined)	CAPC (88%) CPNP (88%)
% of parents and caregivers who state their children's health and well-being has improved as a result of programming	89% (CAPC)	90% (CAPC)	84% (CAPC)
% of pregnant women and parents who state their health and well-being has improved as a result of programming	81% (combined)	90% (combined)	CAPC (88%) CPNP (94%)

Note that the data within the Table 10 is drawn from a participant survey conducted by DCY every five years. Due to challenges in the implementation of a new online data collection method in 2024-2025, this data cannot be generalized to all CAPC and CPNP participants and, as a result, is not directly comparable to participant survey data from 2018-2019 and 2013-2014.

Appendix D: Program expenditures

Table 11: DCY planned versus actual spending, 2019-2020 to 2024-2025

Year	Allocated Budget (\$)				Actuals (\$)				Variance (actuals minus budget) (\$)	% of budget spent
	Salary	O&M	G&Cs	Total	Salary	O&M	G&Cs	Total		
2020-2021	1,011,954	335,113	80,589,000	81,936,067	959,301	92,789	79,760,902	80,812,992	(1,123,074)	98.6
2021-2022	1,027,041	247,416	80,589,000	81,863,457	1,017,119	69,308	80,361,589	81,448,016	(415,442)	99.5
2022-2023	1,011,954	335,113	80,589,000	81,936,067	1,071,268	143,530	80,356,122	81,570,920	(365,147)	99.6
2023-2024	1,011,954	335,113	80,589,000	81,936,067	1,040,968	220,320	79,942,036	81,203,324	(732,743)	99.1
2024-2025	1,077,178	335,113	80,589,000	82,001,291	1,395,727	446,458	78,502,122	80,344,307	(1,656,985)	98.0
Total	5,140,081	1,587,868	402,945,000	409,672,949	5,484,383	972,405	398,922,771	405,379,559	(4,293,390)	99.0

Notes: 1) Salary figures include the employee benefit program (EPB). 2) Overspending on salaries were principally due to: Participant Survey contract in 2023-2024 and 2024-2025; addition of 1 more full-time equivalents (FTEs) in 2024-2025 to support program renewal activities; contract in 2024-2025 to develop capacity building supports to assist funding recipients to respond to the new CAPCHP solicitation process. 3) Underspending on O&M was related to contracting processes, as well as not hiring or backfilling positions when they came available. Overspending in 2024-2025 was due to contract for printing of more MCH resources than in previous years to meet elevated demand.

Table 12: Actual Spending of Regional Operations for CAPC and CPNP, 2020-2021 to 2024-2025

Year	FTE	Salary	O&M	Total
2020-2021	27.7	\$2,536,008	\$27,633	\$2,563,641
2021-2022	28.0	\$2,417,701	\$62,305	\$2,480,006
2022-2023	31.3	\$2,608,270	\$144,620	\$2,752,890
2023-2024	31.8	\$3,167,111	\$145,102	\$3,312,214
2024-2025	26.9	\$2,935,847	\$113,700	\$3,049,547
Total		\$13,664,938	\$493,360	\$14,158,298

Important Notes: 1) lower O&M spending in FYs 2020-2021 and 2021-2022 is due to travel restrictions during the COVID-19 period.
2) FTEs and salary expenditures below funding levels because of staffing limitation

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