

Informing a Monitoring Framework for British Columbia's Universal Prenatal and Early Childhood Public Health Prevention and Promotion Services

July 2026



Nicole Catherine
Jen Barican
Jessica Tang
Oliver White
Kimberly Thomson

At the Children's Health Policy Centre, we acknowledge that we live and work on First Peoples' ancestral lands. We understand and commit to the ongoing work of reconciliation that is required to honour all Indigenous Peoples.

Citing this report

Catherine N, Barican J, Tang J, White O, & Thomson K. (2026). *Informing a Monitoring Framework for British Columbia's Universal Prenatal and Early Childhood Public Health Prevention and Promotion Services*. Vancouver, British Columbia: Children's Health Policy Centre, Faculty of Health Sciences, Simon Fraser University.

Acknowledgements

The British Columbia (BC) Ministry of Health funded this report.

Children's Health Policy Centre

Faculty of Health Sciences, Simon Fraser University
2435 – 515 West Hastings Street, Vancouver, BC V6B 5K3
childhealthpolicy.ca

Contents

Executive Summary	4
1. Overview	5
2. Background.....	5
3. Goals and Objectives.....	5
4. Methods.....	5
5. Findings.....	6
5.1 Lessons from comparator jurisdictions.....	6
5.1.1 Scotland	6
5.1.2 Australia.....	7
5.1.3 Manitoba.....	8
5.2 System requirements for population-level monitoring in BC	8
5.2.1 Standardized service contact pathway	8
5.2.2 Standardized data collection systems	9
5.2.3 Routine data linkage capacity.....	9
5.2.4 A feasible indicator strategy	9
5.2.5 Governance, purpose and equity foundations.....	10
5.3 A roadmap for establishing a monitoring system in BC.....	10
5.3.1 Priority monitoring domains and illustrative indicators	11
6. Conclusion	12
7. Appendix.....	13
8. References.....	17

Executive Summary

This report informs the development of a monitoring framework for BC's universal prenatal and early childhood public health prevention and promotion services. Drawing on lessons from comparable jurisdictions, we identified priority domains and indicators for monitoring universal services from pregnancy to age six as well as corresponding system requirements needed to support population-level monitoring in BC.

We found that BC already has many of the foundational elements needed for population-level monitoring, including existing indicator work, data systems, and public health infrastructure. Building on these strengths, the next step is to better align and standardize service pathways, data collection, data linkage, indicators, and governance into a coordinated provincial monitoring system. Doing so would strengthen BC's ability to monitor service reach, service quality, outcomes, and equity across universal prenatal and early childhood public health prevention and promotion services and support ongoing system improvement.

1. Overview

This report informs the development of a monitoring and evaluation (M&E) framework for British Columbia's (BC) universal public health prevention and promotion services. Led by the Children's Health Policy Centre at Simon Fraser University (CHPC-SFU), this report draws on existing provincial work (i.e., on indicators and data sources) and identifies system design requirements to support population-level monitoring. Commissioned by the BC Ministry of Health, the report is intended to inform the maternal and child health program by outlining the system-level requirements needed to align routine service delivery with population level monitoring.¹ The focus is on the design of the monitoring component of the M&E framework to support consistent, population-level tracking of universal services and outcomes. (Evaluation of program impacts requires complementary study designs and is outside the scope of this framework.)

2. Background

A robust M&E framework defines its purpose, scope, governance structure, priority populations and intended outcomes.²⁻⁴ It also establishes how data will be generated and used for monitoring, including defining key questions and identifying feasible approaches to capturing information through routine service delivery.⁵⁻⁶ In 2013, the Child and Youth Health and Well-Being Indicators Project identified a core set of population-level indicators and data sources designed to track the health and wellbeing of BC children and youth.⁷ Led by Child Health BC, this project identified five core dimensions of child health and well-being and 51 health indicators, including 17 indicators with a lack of data availability (see Appendix Figure A1 for the complete indicators).⁸ BC's Child and Youth Health and Well-Being Indicators Project was refreshed starting in 2023 with findings anticipated for release in 2027. These updated dimensions and indicators should be considered as part of a strong provincial foundation for monitoring social determinants of health and outcomes in the early years (i.e., birth to age six).

3. Objectives

Our objective was to review comparative universal child health monitoring frameworks to inform a potential provincial monitoring framework for BC's universal prenatal and early childhood public health prevention and promotion service delivery.

4. Methods

We conducted a focused scan of the literature to identify established frameworks and models used to support monitoring of universal prenatal and early childhood public health services in comparable jurisdictions with publicly-funded health systems. The search focused on selected government reports from high-income settings, as well as selected academic literature describing approaches relevant to BC. We

reviewed these frameworks to identify key features, including how service delivery, data collection and indicators are structured, with a focus on elements that were transferable to the BC context.

5. Findings

5.1 Lessons from comparator jurisdictions

We identified three comparator examples illustrating different levels of system integration between universal service delivery, routine administrative data, and indicator frameworks for monitoring. These examples were used to examine how different jurisdictions link service delivery, data collection and indicators to support population-level monitoring:

1. Scotland Universal Health Visiting Monitoring Model: provides an example of a coordinated national system linking standardized service contacts, routine data collection, and national indicators to support continuous monitoring.
2. Australia's national early childhood monitoring and reporting approaches: include routine service delivery and administrative data collection, but indicators and data systems are not consistently aligned with service delivery across jurisdictions.
3. Manitoba is included as a complementary example illustrating how population-based administrative data linkage and governance can support system-level monitoring. It is not a fully integrated model, highlighting that strong data infrastructure alone is insufficient, and that effective monitoring systems also require linkage to standardized universal service delivery pathways with defined contact points.

5.1.1 Scotland

Scotland has established a practical M&E approach that integrates universal health visiting services with routinely collected administrative data to derive indicators to support child health (see Appendix Figure A2).⁹ The approach is grounded in a defined set of national indicators, multiple administrative data sources, and a logic model. It was developed alongside the roll out of the Universal Health Visiting Pathway (2015–2016) and refined through program evaluation and routine data analyses.^{10–11} Scotland's Universal Health Visiting Pathway provides a structured schedule of 11 contacts from pregnancy to school entry, delivered primarily as home visits by health visitors (with flexibility for clinic or community settings as required).¹⁰ The Child Health Surveillance Programme (CHSP), captures standardized child health and developmental data used to derive indicators through these contacts, linking routine service delivery to national monitoring indicators.¹² Following evaluation of the pathway, an outcome indicator framework was developed to support ongoing monitoring using routinely collected data.^{10, 12} Data collection is embedded within routine universal service delivery rather than separate research or evaluation systems, enabling key indicators to be captured systematically as part of care with minimal reporting burden.¹¹ CHSP data are linked with other routinely-collected sources, including immunization records and hospital admissions, at the individual level using a unique Community Health Index number, enabling cross-system

linkage within Scottish health data infrastructure.¹² Indicators captured through CHSP and related sources (e.g., breastfeeding, prenatal exposure to smoking, and developmental concerns) are routinely reported in aggregate to monitor service reach, continuity, and variation in outcomes across population groups and geography, supporting system-level monitoring, equity analysis, and performance tracking.¹¹⁻¹²

Scotland's integrated service-data model provides a relevant example for BC, illustrating how standardized service contacts can be used to embed routine data collection and generate linked, population-level data for ongoing system planning and improvement. In contrast, BC delivers early childhood prevention and promotion services through multiple programs and health authorities, without a single standardized contact schedule that links routine service contacts to a consistent provincial indicator framework. Overall, Scotland provides an example of an integrated system in which standardized service contacts, routine data collection, and indicators are explicitly linked, supporting routine population-level monitoring.

5.1.2 Australia

Australia operates a National Framework for Universal Child and Family Health Services that aims to support prevention and promotion of child health and development prenatally through early childhood (up to eight years of age). A program logic model identifies core inputs and performance measures (see Appendix Figure A3).¹³ Service intensity is highest in the prenatal and early postnatal period, and timing and frequency vary across state and territories.¹³ The framework defines core service components (e.g., developmental monitoring, parenting support, and preventive care) delivered through state and territory maternal and child health systems, which underpin routine data collection.¹³ Service delivery models typically combine home visiting and clinic-based contacts during infancy and early childhood; however, the absence of a standardized contact schedule limits the consistency of data collection for indicator generation across jurisdictions.¹³ National indicator frameworks exist to support monitoring—defining structured indicator domains—but these are not consistently aligned with how services are delivered.¹⁴ In addition, the Australian Government published a more recent framework to monitor the health and wellbeing of children and their families over time.¹⁵ The framework identifies eight interconnected outcomes across children, families, and communities that support the wellbeing of children aged 0–5.¹⁵ Although the monitoring and evaluation framework is still under development and has not yet been fully implemented,¹⁶ the strategy identifies national indicators, data measures, and key data gaps, particularly in areas such as child socio-emotional wellbeing and cultural connection.

Australia contains many core components of a monitoring system, including universal service delivery, routine administrative data collection, and national indicator frameworks. However, in contrast to Scotland, these elements operate largely in parallel rather than as a coordinated system.¹⁴ While some jurisdictions (e.g., Victoria) have relatively well-developed perinatal and child health datasets and established data linkage capacity, these approaches are not consistently aligned with how services generate and capture data across Australia.¹⁷ Recent national policy developments indicate a shift toward greater alignment of outcomes and indicators; however, integration with service delivery remains incomplete.^{14, 17} As in BC, key

elements of an M&E system are in place, but Australia cannot consistently connect service delivery, data collection, and indicators into a single system that supports routine, population-level monitoring.

5.1.3 Manitoba

Manitoba provides an example of a population-level data infrastructure approach to monitoring early childhood health and development. The Manitoba Centre for Health Policy maintains linked administrative data across health, education, and social services, supported by established governance and data linkage processes.¹⁸ These data enable longitudinal analyses of child and family outcomes over time and support system-level monitoring through integrated administrative datasets. Manitoba also collects standardized information through public health screening and enhanced early intervention programs including previously implemented BabyFirst and the current Families First program.^{19–20} Manitoba demonstrates strong capacity for population-level data linkage and analysis, providing a complementary example of how linked administrative and public health data can support monitoring across the early life course.

In BC, the biggest gap is not the availability of indicators, but the lack of a structured mechanism to generate data through routine service contacts for population-level monitoring.

5.2 System requirements for population-level monitoring in BC

The comparator examples from Scotland and Australia demonstrate that effective monitoring systems depend on the integration of service delivery, data collection, and indicators within a single, coherent system. In BC, the biggest gap is not the availability of indicators, but the lack of a structured mechanism to generate data through routine service contacts for population-level monitoring. The priority is therefore to establish this integration through defined service contact pathways and aligned data systems. This is time-sensitive. A refreshed provincial child health indicator set is expected in 2027. Without provincial capacity to generate and link indicators through routine service delivery, the utility of these indicators for population-level monitoring will remain limited.

5.2.1 Standardized service contact pathway

A first step is to define a standardized service contact pathway for universal services, including key stages during pregnancy and early childhood, and the minimum information to be routinely collected at each contact, while maintaining flexibility in how services are delivered across regional health authorities. Without this, service delivery and data collection vary across regions, limiting comparability and the ability

to generate a province-wide view of service use and outcomes. In BC, services are delivered across five regional health authorities with variation in workflows and information systems. BC's First Nations Health Authority operates under distinct governance and service delivery structures. A more consistent service pathway within the publicly delivered system would support comparable data collection and integration across regional health authorities. Enhanced family visiting programs such as BC's Family Health Visiting Program, demonstrate the feasibility of structured service contacts with embedded data collection for families with higher needs. While program eligibility is defined by specific criteria, this model shows how service delivery and data capture can be integrated in practice. Extending this approach to universal services would establish defined service contacts for consistent data generation, forming the basis for population-level monitoring.

5.2.2 Standardized data collection systems

A common approach to how information is collected and recorded is needed across BC's health authorities. Currently, service data are captured across multiple information systems (e.g., PARIS, Panorama, and other program-specific systems) that use different formats, definitions, and processes—limiting the ability to combine information across regions or generate consistent population-level data to support monitoring. A provincial approach would build on existing data collection practices by identifying information to be collected at each service contact, and standardizing how it is defined and recorded across systems. For example, consistently capturing whether a service contact occurred, when it occurred, and key information at defined points would enable comparable indicators and support consistent reporting across regional health authorities.

5.2.3 Routine data linkage capacity

Linkage between service-level data and administrative datasets is essential for longitudinal monitoring across the early life course. While BC has strong data assets and established mechanisms for linking administrative data (e.g., hospital, perinatal, and immunization datasets), these operate separately from routine service delivery and are not designed for routine system monitoring. In BC, data linkage is typically conducted through specialized provincial services (e.g., historically through Population Data BC [PopData BC]) for approved research and analytic purposes, rather than as part of routine service delivery. Linkage should be embedded as a core system function to enable tracking of service reach, continuity, and outcomes over time.

5.2.4 A feasible indicator strategy

Indicator selection should be focused and manageable in scope. BC already has access to substantial indicator work through the Child Health and Well-Being Indicators Project (2013),⁸ which is currently being refreshed. Building on this work, Table A1 in Appendix illustrates a set of potential indicators relevant to monitoring maternal and child health services from pregnancy to age six, alongside illustrative examples from comparator jurisdictions. The main challenge may then be determining which indicators can be generated consistently through routine services. Expanding the number of indicators without aligning

them with how data are actually collected can increase reporting burden without strengthening monitoring. Priority should be given to data that can be reliably captured during routine service contacts, such as whether a visit occurred, when it occurred, and key maternal and child health information collected at that time. As the system becomes more integrated, indicators can be derived from routinely collected data across regional health authorities for monitoring and decision-making. Not all domains of interest can be measured consistently through routine service data (e.g., parent-child relationships).

5.2.5 Governance, purpose and equity foundations

Monitoring maternal and early childhood health services delivered by public health in BC requires provincial leadership to set common standards, support data sharing and linkage, and ensure that information is collected consistently across regional health authorities. A next step is to establish a minimum set of expectations for how and when data are recorded through service delivery. Health authorities then apply these standards within local service delivery. Without this structure, differences in how services are delivered and how data are recorded will continue to limit system-level monitoring. Equity must be embedded within system design by routinely collecting information that allows differences across groups and settings to be identified. Embedding equity at the point of data collection (e.g., who is reached, who is included/excluded, in which settings) ensures that these differences can be identified consistently across health authorities and province-wide. BC has an opportunity to move toward a more integrated system, in which service delivery determines when data are collected, and those data are used to monitor services at the population level. This will support better coordination, a clearer understanding of who is being reached, and ongoing system improvement.

**For BC, this process requires identifying key service contacts,
determining what information can be collected consistently at those contacts,
and ensuring that data can be recorded and reported across health
authorities for regular reporting.**

5.3 A roadmap for establishing a monitoring system in BC

The comparator examples from Scotland, Australia and Manitoba demonstrate that population-level monitoring systems are developed over time through alignment of service pathways, data collection, and indicators. For BC, this process requires identifying key service contacts, determining what information can be collected consistently at those contacts, and ensuring that data can be recorded and reported across health authorities for regular reporting. Table 1 below outlines a proposed process for establishing a monitoring system in BC.

Table 1. Process for Establishing a Service-Based Monitoring System in BC

Stage	What Needs to be Defined	Current BC Context	Insight from Comparator Systems
1. Define service contact pathway	Identify a minimum set of universal service contacts across pregnancy and early childhood	No standardized provincial pathway across health authorities	Scotland: defined national contact schedule enables consistent data generation
2. Align data collection to contacts	Specify what information is collected at each contact (e.g., visit occurred, timing, key health information)	Data collected inconsistently across PARIS, Panorama, and program systems	Scotland: structured forms embedded in contacts; Australia: indicators defined but not tied to contacts
3. Standardize core data elements	Agree on common definitions and formats for a minimum set of data elements	Variation in data fields and definitions across systems	Australia: strong indicator frameworks highlight domains but lack consistent data capture
4. Enable data linkage	Establish processes to link service data with administrative datasets	Linkage is program- and research-based, not embedded in routine service delivery	Manitoba: strong linkage capacity
5. Generate indicators	Derive indicators from consistently collected and linked data	Indicators exist but cannot be generated consistently	Scotland: indicators derived directly from service data and linkage
6. Use data for monitoring and reporting	Report on service reach, continuity, and outcomes across populations	Limited provincial view due to system fragmentation	All systems demonstrate components, but only integrated systems enable routine monitoring

5.3.1 Priority monitoring domains and illustrative indicators

Once the system—service pathway, data, and linkage—is established, BC can begin measuring and reporting on key aspects of maternal and early childhood health and services delivered by public health. Monitoring can be organized across key domains:

Service Reach and Access: Monitoring uptake of universal prenatal and early childhood public health services. Examples: prenatal registration and early prenatal care contact; nature, timing, and number of contacts prenatally to early childhood and beyond; immunization coverage at key milestones; completion of early developmental screening (e.g., 18-month assessments).

Service Quality and Continuity: Monitoring how consistently services are delivered and whether children and families receive intended levels of care.

Examples: number of contacts relative to expected schedule; timing of visits; continuity of provider or program; number, type and completion of referrals.

Population Maternal and Child Outcomes: Tracking broader outcomes that may be influenced by universal services and can be measured using linked data.

Examples: low birth weight and preterm birth; breastfeeding initiation and duration; referral to maternal mental health and substance use-related service use (e.g., physician or hospital contacts) can be linked to examine child injury-related healthcare encounters and early child development outcomes (e.g., population-level measures such as developmental vulnerability at school entry).

Equity: Examining differences across population groups and settings to identify gaps in access, service use, and outcomes.

Examples: neighbourhood income; urban-rural-remote communities; maternal age; newcomer status; and racial, ethnic identity where data collection and use support the identification and reduction of inequities.

6. Conclusion

A universal public health monitoring system in BC must align service delivery with standardized data collection to generate information on who is reached, how services are delivered, and where gaps remain. This information can then be used to strengthen service delivery and reduce child health inequities.

7. Appendix

Figure A1. Dimensions and Indicators of Child and Youth Health & Well-being in British Columbia (2013)⁸

PHYSICAL HEALTH & WELL-BEING	MENTAL & EMOTIONAL HEALTH & WELL-BEING	SOCIAL RELATIONSHIPS	ECONOMIC & MATERIAL WELL-BEING	COGNITIVE DEVELOPMENT
#1 Low Birth Weight	#22 Incidence & Prevalence of the Most Common Mental Health Disorders	#29 Positive Parent Relationship	#40 Children & Youth Living in Low-income Households	#45 Communication Skills
#2 Smoking during Pregnancy	#23 Positive Self-esteem	#30 Trusting Adult Relationship	#41 Parental Unemployment Rate	#46 Pro-social Behaviour Skills
#3 Alcohol Use during Pregnancy	#24 Positive Self-rated Mental Health	#31 School Connectedness Rate	#42 Children Living in Families with Poor Housing Conditions	#47 Child Literacy
#4 Breastfeeding	#25 Positive Life Satisfaction	#32 Community Connectedness Rate	#43 Unmet Food Needs	#48 Child Numeracy
#5 Fruit & Vegetable Consumption	#26 Considered Suicide	#33 Incidence of Abuse/Neglect	#44 Youth Not in Education, Employment, or Training	#49 Grade 10 Literacy
#6 Vision Screening	#27 Suicide Rate	#34 Incidence of Sexual Abuse		#50 Grade 10 Math
#7 Hearing Screening	#28 Most Common Prescription Mental Health Drugs	#35 Rate of Children in Care		#51 High School Completion
#8 Dental Caries Prevalence		#36 Discrimination Rate		
#9 Percentage of Children with Healthy Weight		#37 Bullying Rate		
#10 Positive Self-rated Health		#38 Youth Conviction Rate		
#11 Youth Physical Activity Levels		#39 After-school Activities		
#12 Frequency of Tobacco Use				
#13 Binge Drinking				
#14 Marijuana Use				
#15 Immunization Rates				
#16 Asthma Prevalence				
#17 Serious Injury among Children and Youth				
#18 Chlamydia Incidence				
#19 Teenage Birth Rate				
#20 Physical Health and Well-being Skills				
#21 Infant Mortality Rate				

Figure A2. Universal Health Visiting Pathway Contact Diagram — Scotland²¹

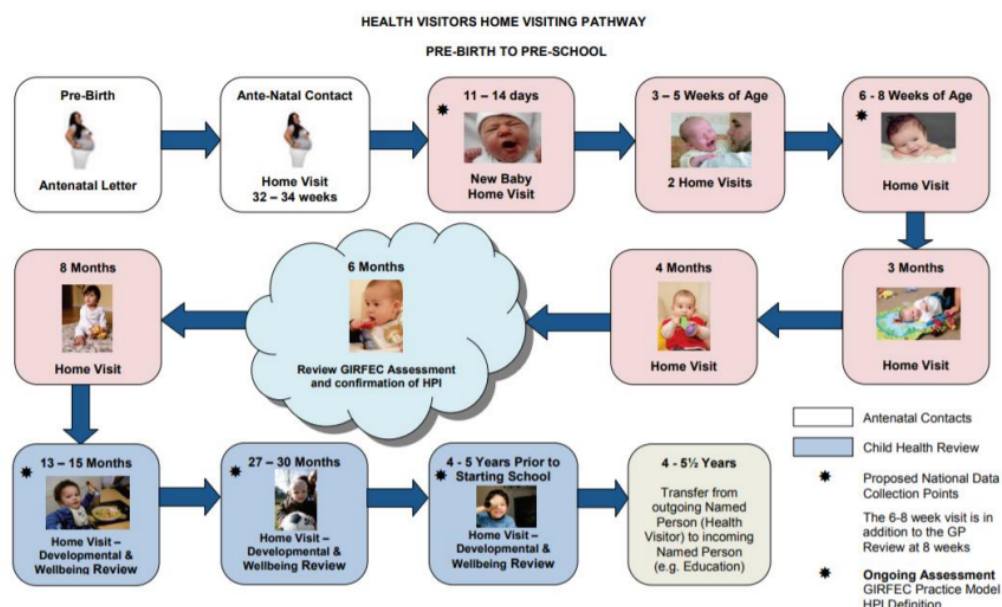
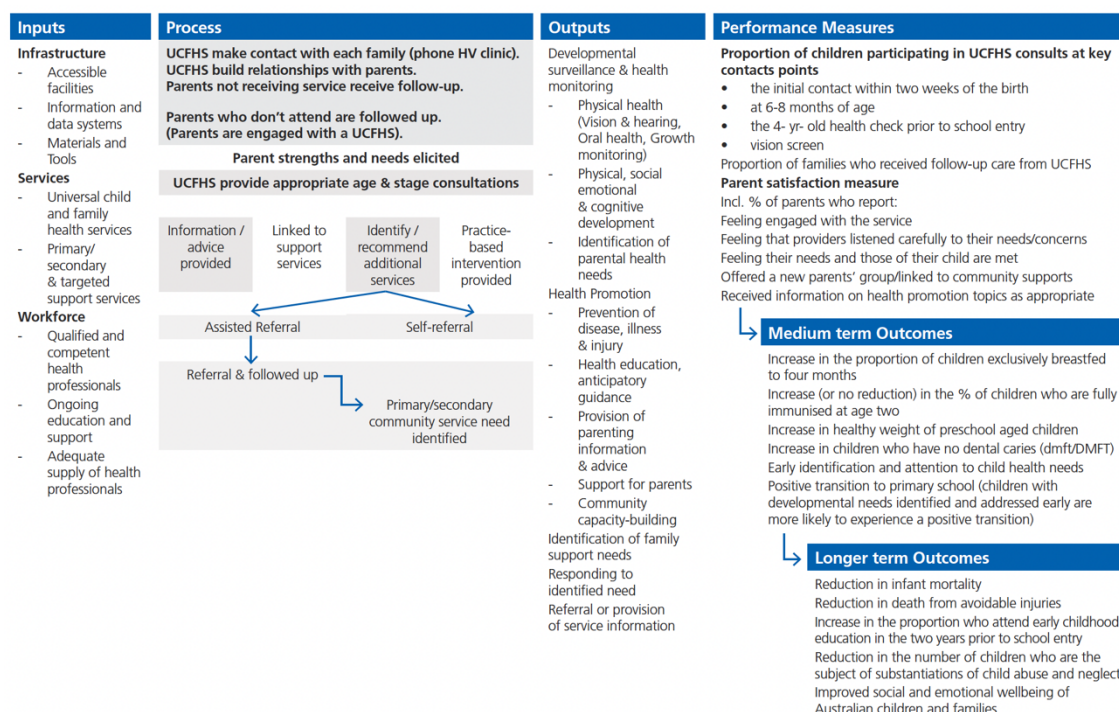


Figure A3. National Framework for Universal Child and Family Health Services Program Logic — Australia¹³



Illustrative BC maternal and child health indicators (prenatal to age six)

Existing indicator work in BC has identified a broad range of child health indicators through BC's Child and Youth Health and Well-Being Indicators Project (2013).⁸ For the purposes of this report, we identified a smaller set of potential indicators relevant to monitoring maternal and child health and social determinants of health from pregnancy to age six.

Table A1. Example Indicators for Monitoring Maternal and Child Health Services in British Columbia, With Illustrative Examples from Comparator Jurisdictions

Monitoring Domain	Illustrative BC Indicators (Prenatal to Age Six) ^{8, 22–25}	Example Indicators from Comparator Jurisdictions ^{12–15}
Healthy beginnings	Prenatal care initiation	Not available (N/A)
	Prenatal substance exposure	Parental smoking — Scotland Prenatal tobacco exposure — Australia
	Birth outcomes: preterm, low birth weight	Birth outcome indicators — Australia
	Breastfeeding initiation/duration	Exclusive/any breast feeding at six to eight weeks — Scotland Exclusively breastfed at four months — Australia
	Immunization coverage at key milestones	Complete immunization coverage by age two years — Scotland Immunization coverage rate of children at ages one to two and age five — Australia
Maternal wellbeing	Maternal mental health	N/A
	Exposure to intimate partner violence	N/A
Social determinants of health	Household income/limited income	N/A
	Housing instability	Adequate housing between birth to age five — Australia
Learning and development	Developmental screening completion	N/A
	Developmental concerns identified through screening	Any developmental concern at 27 to 30 months — Scotland
	Developmental vulnerability at school entry (Early Development Instrument for a subsample)	Developmentally “on track”— Australia
Child physical health	Healthy weight/obesity	Child at risk/clinically obese at 27 to 30 months — Scotland BMI above cut-off — Australia Children long-term health condition ages two to five— Australia

	Early childhood dental health	Any attendance at dentist by age two — Scotland
Healthy and safe environments	Child maltreatment/child protection involvement	Placed on child protection register/ “looked after child” status between birth to age three — Scotland Child protection/not — Australia
	Child injury-related healthcare encounters	Hospitalizations for injuries and ingestions by age three — Scotland Death due to injuries — Australia
Equity	Reporting all indicators by neighbourhood income, geography, maternal age, and other relevant population characteristics	Geographic and population-group variation — Scotland; Australia

8. References

1. British Columbia. Ministry of Health. (2024). *British Columbia's Population and Public Health Framework: Strengthening Public Health*. Victoria, BC. https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/public-health/pph-framework/bc_population_and_public_health_framework.pdf
2. de Laat J, Radner J, Holding P, et al. (2023). *Measurement for Change: Reflections from innovators' experiences with monitoring, evaluation, and learning systems for Early Childhood Development*. *Frontiers in Public Health*, 11, e1021790.
3. The Organisation for Economic Co-operation and Development (OECD). (2024). *Monitoring and evaluation of child and youth policies and outcomes in Ireland*. Paris, France: OECD. https://www.oecd.org/content/dam/oecd/en/publications/reports/2024/07/monitoring-and-evaluation-of-child-and-youth-policies-and-outcomes-in-ireland_79ebe07a/2bd86a9d-en.pdf
4. Spinosa CZ, Burrell L, Bower KM, et al. (2023). Moving toward precision in prenatal evidence-based home visiting to achieve good birth outcomes: Assessing the alignment of local programs with their national models. *BMC Health Services Research*, 23, 812–815.
5. UN Women. (2010). *Monitoring and evaluation frameworks (3 parts)*. <https://www.endvawnow.org/en/articles/335-monitoring-and-evaluation-frameworks-3-parts.html>
6. Simister N. (2009). *Developing M&E systems for complex organisations: A methodology*. Oxford, England: INTRAC. <https://www.intrac.org/resources/developing-systems-complex-organisations-methodology/>
7. Canadian Institute for Health Information (CIHI), Office of the Provincial Health Officer (PHO). (2013). *Child and Youth Health and Well-Being Indicators project: CIHI and B.C. PHO joint summary report*. Ottawa, ON, Victoria, BC: CIHI, PHO. <https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/special-reports/child-health-2013.pdf>
8. Office of the Provincial Health Officer (PHO). (2016). *Is “good”, good enough? The health & well-being of children & youth in BC*. Victoria, BC: PHO. <https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/annual-reports/pho-annual-report-2016.pdf>
9. Scottish Government. (2015). *Universal health visiting service*. <https://www.gov.scot/policies/maternal-and-child-health/universal-health-visiting-service/>
10. Horne M, Marryat L, Corby DH et al. (2022a). *Evaluation of the Universal Health Visiting Pathway in Scotland phase 1 report – routine data analysis – implementation and delivery*. Edinburgh, Scotland: Scottish Government. <https://www.gov.scot/publications/universal-health-visiting-pathway-evaluation-phase-1-report-routine-data-analysis-implementation-delivery/>

11. Horne M, Marryat L, Wood R. (2022b). *Evaluation of the Universal Health Visiting Pathway in Scotland phase 1 report – routine data analysis – baseline outcomes*. Edinburgh, Scotland: Scottish Government. <https://www.gov.scot/binaries/content/documents/govscot/publications/research-and-analysis/2022/06/universal-health-visiting-pathway-evaluation-phase-1-report-routine-data-analysis-baseline-outcomes/documents/evaluation-universal-health-visiting-pathway-scotland-phase-1-report-routine-data-analysis-baseline-outcomes/evaluation-universal-health-visiting-pathway-scotland-phase-1-report-routine-data-analysis-baseline-outcomes/govscot%3Adocument/evaluation-universal-health-visiting-pathway-scotland-phase-1-report-routine-data-analysis-baseline-outcomes.pdf>
12. Horne M, Marryat L, Corby DH, et al. (2024). Development of an outcome indicator framework for a universal health visiting programme using routinely collected data. *BMC Health Services Research*, 24, 728.
13. Australian Government. Department of Health and Aged Care. (2011). *National Framework for Universal Child and Family Health Services*. Canberra: Australia. <https://www.health.gov.au/resources/publications/national-framework-for-universal-child-and-family-health-services>
14. Australian Institute of Health and Welfare (AIHW). (2025). *National Core Maternity Indicators*. Canberra: Australia. <https://www.aihw.gov.au/reports/mothers-babies/national-core-maternity-indicators>
15. Australian Government. Department of Social Services. (2024a). *Early Years Strategy 2024–2034 – Outcomes Framework*. Canberra: Australia. <https://www.dss.gov.au/system/files/documents/2024-12/ey-s-outcomes-framework.pdf>
16. Australian Government. Department of Social Services. (2024b). *Early Years Strategy 2024–2034 – First Action Plan 2024–2027*. Canberra: Australia. <https://www.dss.gov.au/system/files/documents/2024-12/ey-s-first-action-plan.pdf>
17. State Government of Victoria. Department of Health. (2026). *Victorian Perinatal Data Collection*. <https://www.health.vic.gov.au/quality-safety-service/victorian-perinatal-data-collection>
18. Katz A, Enns J, Smith M, et al. (2020). Population data centre profile: The Manitoba Centre for Health Policy. *International Journal of Population Data Science*, 4, 1131.
19. University of Manitoba. (2023a). *Manitoba Population Research Data Repository – Data Description – BabyFirst Screening (BFS)*. <https://umanitoba.ca/manitoba-centre-for-health-policy/data-repository>
20. University of Manitoba. (2023b). *Manitoba Population Research Data Repository – Data Description – Families First Screening (FFS)*. [http://mchp-appserv.cpe.umanitoba.ca/datadescription/?dataset=Families%20First%20Screening%20\(FFS\)](http://mchp-appserv.cpe.umanitoba.ca/datadescription/?dataset=Families%20First%20Screening%20(FFS))
21. Doi L, Eunson J, Ormston R, et al. (2021). *Evaluation of the Universal Health Visiting Pathway in Scotland phase 1 main report – primary research with health visitors and parents and case note review*. Edinburgh, Scotland: Scottish Government. <https://www.gov.scot/publications/evaluation-universal-health-visiting-pathway-scotland-phase-1-main-report-primary-research-health-visitors-parents-case-note-review/>
22. Catherine N, Barican J, Tang J, White O, & Thomson K. (2026). Early indicators, early evidence. Rapid framework for monitoring and evaluating maternal-child outcomes. Vancouver, British Columbia: Children's Health Policy Centre, Faculty of Health Sciences, Simon Fraser University.

23. British Columbia. Ministry of Health. (2013). Healthy Start Initiative: Provincial Perinatal, Child and Family Public Health Services. Victoria, BC.
<https://www.health.gov.bc.ca/library/publications/year/2013/healthy-start-initiative-phs.pdf>
24. British Columbia. HealthLink BC. (2025). *Healthy start: Public health services*.
<https://www.healthlinkbc.ca/living-well/family-planning-pregnancy-and-childbirth/pregnancy/health-care-providers-during-4>
25. Fraser Health. (2026). *Public Health Services*. <https://www.fraserhealth.ca/Service-Directory/Services/Public-Health-Services>

Cover photo is from Bigstock.