Health Canada   Santé Canada

Contribution Program to Improve Access to Health Services for Official Language Minority Communities

Formative Evaluation

Approved by

Departmental Executive Committee -
Finance, Evaluation and Accountability (DEC-FEA)
Health Canada

December 20, 2007

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Contribution Program to Improve Access to Health Services for Official language Minority Communities
Management Action Plan

Recommendations	*Program Responses*	*Time Frame*
1* It is recommended that a plan be developed to consolidate and disseminate, on an ongoing basis, objective, rigorous and neutral (as much as possible) research that has been published. The targeted research should contribute to better documenting the aspects relevant to the OLMCs with respect to their health services access and their health. *Consolidation of research should be considered a component of the program's performance measurement plan. Consequently, the performance measurement plan should be revised to reflect this recommendation.* * For more details on Recommendation 1, please see the "Summary and Recommendations" section at the end of the evaluation report..	Health Canada's Official Language Community Development Bureau (OLCDB) will develop a plan to consolidate and disseminate research relating to OLMCs and health.	December 2007
	Then the OLCDB will prepare a plan for development of an integrated knowledge base providing up-to-date knowledge in connection with OLMCs and health-related issues, comparing the OLMCs to the language majority associated with them. This database could include: • an analysis of OLMC-related legislation and policies; • a demographic analysis; • an analysis of health-related practices, as well as of access to health services and other social services; and • an analysis of the institutions and networks offering services to OLMCs in the health sector. This knowledge base will be used to ensure that the program model and implementation are evidence-based.	March 2008
	The OLCDB will continue to participate actively in the interdepartmental and interagency forums designed to promote, structure, consolidate and disseminate OLMC- and health-related research. Those forums include: • the Interdepartmental Coordinating Committee on Official Languages Research; • the Canadian Institutes of Health Research Consultative Committee on Official Languages Research; • the CNFS Joint Research Committee; and • the Survey on the Vitality of Official Language Minorities Working Group and Steering Committee.	Ongoing

Recommendations	Program Responses	Time Frame
2 Health Canada should do an in-depth review of the program model before renewing the program terms and conditions, and that review should be based on: 1) the advice of a larger number of neutral individuals who have pertinent experience and are sufficiently representative of the OLMCs at the local level; 2) the evaluation outcomes; and 3) the research outcomes collected (see Recommendation 1).	The mandate of nearly all the representatives on the consultative committees for French-speaking and English-speaking minority communities will end in March 2008. Appointments to these committees are at the discretion of the Minister of Health. The Minister will take into consideration the experience, representativeness and independence of the current and potential members in his recommendations for appointments by the Minister to these committees in 2008.	Ongoing
	Health Canada will continue to be advised and guided with regard to program planning and implementation by the consultative committees for the French-speaking and English-speaking minority communities.	Ongoing
	Several tools will be used to ensure that a large number of individuals/organizations and perspectives are considered in the program model review, including: • the research outcomes (Recommendation 1) and the evaluation outcomes (including the results of the 2006 Census and those of the 2006 Survey on the Vitality of Official Languages Minorities); and • the results of consultations with the health departments of the federal, provincial and territorial governments, as well as other pertinent departments.	March 2008
3 When the program is being renewed, Health Canada should review its selection process to ensure that it is open, transparent and based on specific criteria that make it possible to assess the recipients' ability to achieve the program objectives. Health Canada should also ensure that all the primary recipients agree to implement a similar process for selection of the secondary recipients.	The four primary recipients who would be able to present proposals under the Contribution Program to Improve Access to Health Services for OLMCs were identified by the consultative committees. These organizations were not subject to a selection process. Even though primary program recipients were preselected, a consistent and iterative assessment of recipients' proposals was conducted by Health Canada prior to approval of funding agreements concluded under the Contribution Program in 2003. When reviewing the Contribution Program to Improve Access to Health Services for OLMCs, Health Canada will work with its departmental Grants and Contribution Centre of Expertise to ensure that the program requirements are consistent with the recommendations of the Blue Ribbon Panel.	May 2008

Recommendations	Program Responses	Time Frame
	Within the renewed Contribution Program, Health Canada will ensure that the review and approval processes continue to be conducted in an environment of openness, transparency and rigour: 1. best practices in the review and approval processes will be shared with all current and potential primary and secondary recipients; 2. program review and approval processes will be posted on the Health Canada Web site; 3. primary recipients will be required to post on their Web sites their selection, review and approval processes for the selection and approval of secondary recipients; and 4. primary recipients will be required to use transparent and rigorous approaches—documented in project proposals—in the selection and approval of secondary recipients.	
4 In anticipation of program renewal, Health Canada should consider including in its submission to Treasury Board a request for salaries and operating funds to strengthen program monitoring and ensure that the research and performance measurement data reflecting the Treasury Board Evaluation Policy are available to inform decision makers in relation to the program.	In tandem with the response to Recommendation 1, resource requirements for program monitoring, research and performance measurement will be estimated and submitted to Treasury Board as part of the five-year renewal of the program for 2008-2009 to 2012-2013.	October 2008
5 Health Canada should identify the common outcome indicators (as well as the related definitions and targets) required for management and evaluation of the program. More specifically, data should be collected and reviewed periodically to identify and correct data gaps. Then appropriate comparison with the identified targets should contribute to the informing of program management.	For the remainder of the Contribution Program, the OLCDB will review activity and evaluation reports produced by recipients to ensure they are consistent with the program's Results-based Management and Accountability Framework (RMAF), are relevant to program management, and provide the data necessary for the summative evaluation. The OLCDB will identify the outcome indicators required for the summative evaluation of the program, the final evaluation of the Interdepartmental Action Plan for Official Languages, and the departmental reporting requirements under the Treasury Board Management, Resources and Results Structure that are reviewed and approved by the DPMED.	December 2007
	For the five-year renewal of the program (2008-2009 to 2012-2013), the OLCDB will develop a strategy to ensure that activity and evaluation reports produced by program recipients set out periodic outcome indicators that are consistent with the renewed program's RMAF, and are used to manage and evaluate the program.	October 2008

Recommendations	*Program Responses*	*Time Frame*
6 In partnership with key stakeholders (federal decision makers, program recipients and OLMC representatives), Health Canada should ensure that evaluation practices are: • consistent with the program's RMAF (including the additions to the performance measurement strategy referred to in Recommendation 5); and, • accepted as a program management aid.	Health Canada's DPMED will lead the program summative evaluation on the basis of outcome data collected in collaboration with the OLCDB, as well as primary and secondary recipients.	June 2008

Contribution Program to Improve Access to Health Services for Official Language Minority Communities

Formative Evaluation

Prepared by:

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EXECUTIVE SUMMARY

Background

This report presents the results of a formative evaluation of Health Canada's ***Contribution Program to Improve Access to Health Services for Official Language Minority Communities.*** The Official Language Community Development Bureau (OLCDB) is mandated to foster equitable access to health services by official language minority communities (OLMCs) in the language of their choice, by providing leadership in the coordination and implementation of activities pursuant to Part VII, Section 41 of the *Official Languages Act*.

In June 2003, the federal government announced the ***Contribution Program to Improve Access to Health Services for Official Language Minority Communities*** as a contribution *The Action Plan for Official Languages* announced in March of the same year. The ***Contribution Program to Improve Access to Health Services for Official Language Minority Communities*** represents a $89 million investment in health services to OLMCs addressing two inter-related priorities: networking and training and retention of health professionals.

The Program, managed by the OLCDB, is based on two components: (1) ***Networking Support*** and (2) ***Support for Training and Retention of Health Professionals.***

The ***Networking Support*** component of the Program has two beneficiaries: *Société Santé en français* (SSF) and Quebec Community Groups Network (QCGN). This component provides funds of $14 million over five years for the establishment and sustainability of networks that will mobilize the capacities of institutions, health professionals and communities to encourage health stakeholders to deliver services in the official language of their choice; foster the development of solid, durable links between health sector stakeholders; mitigate the geographic dispersal of communities; and promote greater community engagement.

The ***Support for Training and Retention of Health Professionals*** component provides funds of $75 million over five years — $63 million directed to the Francophone minority communities and $12 million to Anglophone minorities. McGill University is the beneficiary for the English-speaking official language minority community and for the Francophone official language minority communities there are 11 beneficiaries under the coordination of the *Consortium national de formation en santé* (CNFS).

The main objectives of the Contribution Program are to:

a) improve access to health services for official language minority communities;

b) meet the needs and improve health services in official language minority communities, thereby enhancing the health of these communities; and

c) improve the efficiency of the health system as a whole by improving health services for official language minority communities.

The Formative Evaluation

The **objectives** of the evaluation are to:

- look at Program relevance with an emphasis on retrospectively collecting data documenting the original context for the Program;
- assess relevance of the Program model as well as its implementation and administration;
- assess the extent of Program progress against Program objectives; and
- provide the evidence supporting any recommended mid-course adjustments to Program design, delivery and administration.

The evaluation study addressed six questions to assess the relevance, design, delivery, management, and progress of the program. The six questions are:

1. Is the Program relevant to the federal government priorities?
2. Does the Program complement or duplicate other governmental Programs / Initiatives?
3. Are Program objectives relevant to OLMC needs?
4. Is the design and delivery of the Program appropriate?
5. To what extent is the management of the Program appropriate?
6. What Program effects may be identified for training and networking at this mid-point of the Program?

Data have been collected through the use of the following methods:

- A literature review was conducted to describe the context that prevailed when the Program was originally designed and to uncover approaches used by other countries to provide health services to linguistic minorities.

- A document review collected information on program operations, strengths and weaknesses. It captured information related to all of the evaluation issues and was conducted by the OLCDB.
- The Antima Group conducted 13 interviews from four different sub-groups to inform evaluation questions related to program relevance and design. Interviewees were selected based on their knowledge of health services in OLMCs and their absence of direct involvement with the Program.
- An internet-based survey also conducted by The Antima Group gathered views on program progress as well as on program management and operations.
- The OLCDB developed a statistical profile to describe the situation of OLMCs, which was used to inform evaluation questions pertaining to program relevance. Descriptions of OLMCs were assembled from an analysis conducted by the Official Languages Support Programs Branch at Canadian Heritage based on 1996 and 2001 Census data.
- Data integration and analysis was conducted by the OLCDB.

Key Conclusions

Please find below the key conclusions stemming from the evaluation of the *Contribution Program to Improve Access to Health Services for Official Language Minority Communities* .

Relevance – The contribution Program is among the Government of Canada programs that are designated to support official language minority communities. The Program's objectives are consistent with government-wide priorities under the Official Languages Act to protect Canadian linguistic duality. The program rationale is based on the hypothesis that language is a barrier to accessing health services for OLMCs and by improving accessibility, health status will subsequently improve. Recent data may suggest that language is not a significant barrier to access due to the high bilingualism in the OLMCs. However, a further examination of needs of OLMCs is required because data was collected using a different definition of "access" than the one used by the program.

Design & Delivery – Based on the data made available through the evaluation, the design of the networking component of the Program may require adjustments in order to maximize its potential to contribute to the improvement of access to health services for the OLMCs. Nonetheless the Program is based on the results of consultation with stakeholders who appeared well positioned to provide advice. Overall primary beneficiaries were positive about the selection and approval process. The only area of concern was the time required for application processing due to the delays in project implementation.

Program Management – While Primary Beneficiaries are satisfied of their interaction with Program, the evaluation revealed that the heaviness of Program Officers' workload might have influenced their capacity to appropriately monitor the Program's projects. In addition, although a

monitoring system was in place, it was not possible to assess its appropriateness/usefulness given the lack of data, nor was it possible to determine the extent to which monitoring practices informed program management.

Program Progress – At this point in time, the Program appears to be close in reaching the level of ‘Immediate Outcomes’ of their logic model:

- networks have been implemented in all provinces and territories and the key partnerships necessary to empower communities are emerging;
- outside of Quebec, students enrolment appears to be on the rise as well as graduation rates in a variety of health and social service programs funded by the Program;
- McGill implemented English language training in all of the 16 regions of Quebec as well as french language training programs, although they do not appear to have generated the same level of interest.

Key Recommendations

There are valuable lessons to be learned from the formative evaluation of the Contribution Program for Improving Access to Health Service for Official Language Minority Communities, which have allowed for the identification of gaps in two core areas: knowledge base and program monitoring and reporting. Please find below the recommendations stemming from the evaluation, which are aimed at addressing these gaps.

Recommendation #1:
A plan for the ongoing consolidation and dissemination of objective, rigorous and independent (whenever possible) research documenting aspects relevant to OLMCs as it pertains to their access to health services and their health status should be developed within the Health Portfolio.

Research documenting aspects relevant to OLMCs should be considered as a component of the Program performance measurement strategy. As a result, the performance measurement strategy should be reviewed accordingly.

Recommendation #2:
Health Canada should complete a comprehensive review of the Program model is conducted in anticipation of the renewal of Program Terms and Conditions building on: 1) a broader set of relevant and independent stakeholders that closely represent OLMCs at the local level, 2) on evaluation findings and, 3) on the research evidence collected under Recommendation #1.

Recommendation #3:

Upon renewal of the Contribution Program, Health Canada should review its selection process to ensure it is open, transparent and based on specific criteria allowing for the assessment of recipients' capacity to deliver on Program objectives. Health Canada should also have all primary recipients engage in similar processes for the selection of secondary recipients.

Recommendation #4:

In anticipation of Program renewal, Health Canada should consider including in its submission to Treasury Board a request for salaries and operating funds to strengthen program monitoring and assure the research and performance measurement data responding to the Treasury Board Evaluation Policy are available to inform decision-makers on the Program.

Recommendation #5:

Health Canada should identify the common outcome indicators (as well as the related definitions and targets) required for the management and evaluation of the Program. More specifically, data should be collected and reviewed periodically to identify and correct data gaps. Then appropriate comparison with the identified targets should contribute to inform Program management.

Recommendation #6:

In partnership with key stakeholders – i.e. Federal level decision makers, Program beneficiaries and OLMCs representatives – Health Canada should ensure that evaluation practices are:

- *consistent with the Program's RMAF (including the additions to the performance measurement strategy referred at in Recommendation 5); and,*
- *accepted as a program management aid.*

INTRODUCTION

This report presents the results of a formative evaluation of Health Canada's Contribution Program to Improve Access to Health Services for Official Language Minority Communities (OLMCs) conducted by the Policy and Analysis Unit of the Official Language Community Development Bureau (OLCDB). The Departmental Performance Measurement and Evaluation Directorate's (DPMED) role in the evaluation pertained to providing advice at the workplanning stage; having some involvement in data analysis; and to ensure basic departmental criteria for quality and rigour were met. The requirement for this evaluation was set out in the program's Results-based Management and Accountability Framework (RMAF) as follows:

"This evaluation, scheduled to take place during fiscal year 2005-06 and due at the end of the third year of program operations, will focus on program delivery issues to assess the extent to which the Program is being delivered as planned and consistent with its terms and conditions. It will be a snapshot in time, focussing mainly on developing lessons learned and "best practices". Combined with the ongoing program monitoring, this evaluation will allow program managers to make any necessary adjustments or corrections to program delivery. Moreover, it will address all key evaluation issues, providing a preliminary assessment of the extent to which the Program is likely to achieve its objectives. [...]"

GENESIS OF THE CONTRIBUTION PROGRAM FOR IMPROVED ACCESS FOR OFFICIAL LANGUAGE MINORITY COMMUNITIES

The Official Languages Act

The first Official Languages Act came into effect in 1969. Its objective was to protect the language rights of Canadians in their relations with federal institutions and to define the institutions' obligations. The Act was amended in 1988 to include, under section 41, the federal government commitment to enhancing the vitality of Anglophone and Francophone minorities in Canada, to supporting and assisting their development, and to fostering full recognition and use of both English and French in Canadian society. This commitment now includes not only access to services for OLMCs, but also ensures that federal institutions will actively contribute to the development and growth of these communities.

For the advancement of English and French, the Official Languages Act commits the federal government to the following:

- "to enhancing the vitality of the English and French linguistic minority communities in Canada and supporting and assisting their development; and fostering the full recognition and use of both English and French in Canadian society" (section 41);
- "the Minister of Canadian Heritage, in consultation with other ministers of the Crown, shall encourage and promote a coordinated approach to the implementation by federal institutions of the commitments set out in section 41" (section 42);
- "the Minister of Canadian Heritage shall take such measures as that Minister considers appropriate to advance the equality of status and use of English and French in Canadian society." (section 43)
- and each year the Minister of Canadian Heritage is required to submit an annual report to Parliament on the matters relating to official languages for which he/she is responsible. (section 44).

On November 24, 2005, Bill S-3, An Act to Amend the Official Languages Act (promotion of English and French), received Royal Assent. Under this legislation, all federal institutions have the duty to ensure that positive measures are taken for the implementation of the government's commitment to enhance the vitality of the English and French language minority communities in Canada, while respecting the jurisdiction and powers of the provinces and territories. These modifications:

- reinforce the federal government's commitment under Part VII by adding, in Section 41(2), the obligation of federal institutions to take "positive measures" to implement this commitment;
- provide an opportunity to strengthen accountability and provide additional tools by giving the Governor in Council, in Section 41(3), the ability to make regulations with respect to how federal institutions carry out their duties under Part VII; and
- make Part VII of the Act enforceable by adding, in Section 77, the power for persons to make complaints to the Commissioner of Official Languages and to seek judicial recourse from the Federal Court.

Program Requirement

Health Canada's mission is to help the people of Canada maintain and improve their health. The Health Policy Branch undertakes policy activities to support the Minister in making decisions to protect and improve the health of Canadians and program activities to support the delivery of programs and services to Canadians.

In May 1999, Health Canada launched the Official Language Community Development Bureau which became part of the Health Policy Branch in June 2005.

The Official Language Community Development Bureau (OLCDB) is mandated to foster equitable access to health services by official language minority communities in the language of their choice, by providing leadership in the coordination and implementation of activities pursuant to Part VII, Section 41 of the *Official Languages Act* and by providing relevant policy, program, research and evaluation support to these activities. In fulfilling its mandate, the OLCDB conducts operational program activities and policy-related activities.

In 2000, Health Canada created two consultative committees to advise the Minister of Health on ways to enhance the vitality of the French-speaking and English-speaking minority communities in the health sector and to honour Health Canada's obligations under section 41 of the *Official Languages Act.* Community representatives on these committees were chosen from official language minority communities for their health sector expertise or their knowledge of official language minorities.

In 2001, the two Consultative Committees each coordinated the production of a baseline data report on health status and access to health services in their communities. The Consultative Committee for French-Speaking Minority Communities (CCFSMC) published its report in June 2001, establishing the need for French-Speaking Minority Community support vis-à-vis health services. The Consultative Committee for English-Speaking Minority Communities (CCESMC) published its study in October of 2001, confirming similar needs within the English-Speaking Minority Community.

Following from these baseline reports, both Consultative Committees presented advocacy reports to the Minister of Health in 2001 and 2002 that recommended:

- a five-year funded strategy in support of official language minority communities;
- five integrated areas of intervention;
  - networking and cooperation;
  - training and human resource development;
  - development of primary care infrastructure and intake facilities that bring together health professionals and that direct official language minority community persons to facilities where their language is spoken;
  - strategic information (research); and
  - technology.

These reports shaped Health Canada's approach to supporting OLMCs.

Program Description

On March 12, 2003, the Federal Government announced *The Action Plan for Official Languages* (APOL)*,* which included a $119 million investment over five years in health services to official language minority communities (OLMCs) for three inter-related priorities: community networking ($14 millions); training and retention of health professionals ($75 millions); and improved access to health care services ($30 millions)[1].

The first two priorities of the Action Plan (i.e., community networking, and training and retention of health professionals) are key enablers for the ultimate outcome of improved access to health care services. Better access to care requires both the development of community networks that foster collaborative relationships and coordination amongst key partners, and greater availability of trained health care professionals to offer their services in both official languages.[2]

The ***Contribution Program to Improve Access to Health Services for Official Language Minority Communities*** was launched in June 2003, following from the 2003 federal budget and *The Action Plan for Official Languages.* The Program is managed by the Official Language Community Development Bureau, and provides funding for two program components: (1) ***Networking Support*** and (2) ***Support for Training and Retention of Health Professionals.***

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[1] The $30 million OLMC Envelope of the Primary Health Care Transition Fund will be evaluated as part of the Fund's summative evaluation and will also be assessed in the Contribution Program's summative evaluation due in March 2008.

[2] See for example David et al., Chen.

The main objectives of the Contribution Program are to:

a) improve access to health services for official language minority communities;

b) meet the needs and improve health services in official language minority communities, thereby enhancing the health of these communities; and

c) improve the efficiency of the health system as a whole by improving health services for official language minority communities.

Program Components

The Contribution Program is designed to achieve its objectives through the implementation of two main components. The ***Networking Support*** component promotes the establishment of networks that facilitate and improve the circulation of health information and communication among health sector stakeholders. The intent is to mobilize the capacities of the five principal partners identified in the World Health Organization's "Towards Unity for Health" approach [Boelen 2000] — policy makers, health managers, health professionals, academic institutions, and communities — to encourage health stakeholders to deliver services in the official language of their choice; foster the development of solid, durable links between health sector stakeholders; mitigate the geographic dispersal of communities; and promote greater community engagement. Primary beneficiaries of the networking component, Société Santé en français (SSF) and Quebec Community Groups Network (QCGN), bring together secondary beneficiaries they have selected on the basis of proposals for projects which meet the objectives of the Program.

The ***Networking Support*** component provides funds of $14 million over five years for the establishment and sustainability of networks that will mobilize the capacities of institutions, health professionals and communities to encourage health stakeholders to deliver services in the official language of their choice; foster the development of solid, durable links between health sector stakeholders; mitigate the geographic dispersal of communities; and promote greater community engagement. Networks are to facilitate information sharing and resource development which will lead to new ways of improving access to health services for official language minority communities.

The $14 million is divided between the two official language minority communities at a two-for-one ratio, giving the Francophone communities $9.3M and the Anglophone communities $4.7M. This allocation is based on the fact that Francophones are dispersed much more widely than Anglophones; their communities therefore require more networks and resources.

The ***Support for Training and Retention of Health Professionals*** component ($75 millions) is designed to increase the number of health care professionals who are able to provide services in the language of the minority communities (English in Quebec, French outside of Quebec) and to promote the retention of health professionals in OLMCs. This is achieved through language training offered to health care workers and professionals, the promotion of health training for OLMC members as well as long distance support to professionals in more isolated regions.

The training and retention aspect of the Program are implemented through partnerships with Canadian educational institutions. Beneficiaries of this component for Francophone minority communities are recognized Canadian post-secondary institutions working to increase the supply of French-speaking health care Professionals in French language minority communities, and the Consortium national de formation en santé who acts as a secretariat coordinating these institutions ($63 millions). For Anglophone minority communities, the primary beneficiary is McGill University ($12 millions).

The purpose of the $63 million directed to the Francophone minority communities is to increase the number of practising Francophone health professionals in minority communities through improved access to available programs and the extension of such training across the country via participating educational institutions, as well as through media-based and distance training, and capacity-building within institutions that offer training to health professionals within Francophone minority communities.

The actual distribution of resources is based on the increase in new admissions and disciplines as well as expected results. In addition, up to 3% of resources ($1.89 million) were to be directed to the creation of a *Fonds de concertation de recherche* [research consensus fund] for facilitation, consensus-building and support for researchers and to raise awareness among subsidized organizations.[3]

The purpose of the $12 million in funds directed to ***Support for Training and Retention of Health Professionals*** for the Anglophone minority communities is to promote professional training and language training in the official language of minority communities, particularly in the regions of Quebec, as well as regional incentive measures for the recruitment and retention of health professionals, to encourage them to move to the regions or remain there.

The distribution of the funds for ***Support for Training and Retention of Health Professionals*** between the two official language minority communities was based on the needs of the two communities as understood by both consultative committees. Table 1 describes the distribution of original funding commitments by program component for each language community.

[3] The actual budget for the research consensus fund is $1.6 million.

Table 1 – Original Program Commitments by Component and by Year
(in millions of dollars)

Program Component		2003-2004	2004-2005	2005-2006	2006-2007	2007-2008	Total
Networking Support	Francophones	1.3	2.0	2.0	2.0	2.0	9.3
	Anglophones	0.7	1.0	1.0	1.0	1.0	4.7
Support for Training and Retention of Health Professionals	Francophones	9.5	9.5	12.0	16.0	16.0	63.0
	Anglophones	0.5	0.5	3.0	4.0	4.0	12.0
Total		12.0	13.0	18.0	23.0	23.0	89.0

PRIMARY AND SECONDARY PROGRAM BENEFICIARIES

The terms Primary Beneficiary and Secondary Beneficiary will be frequently used in this report. There are 14 primary beneficiaries of the Contribution Program as shown in Table 2. These organizations have entered into contribution agreements with Health Canada to receive and administer program funds.

- The ***Networking Support*** component of the Program has two primary beneficiaries, one for each official language group.
- The ***Support for Training and Retention of Health Professionals*** component has 12 primary beneficiaries. For the Francophone official language minority communities there are 11 contribution agreements with primary beneficiaries — 10 of these agreements are with academic institutions and the eleventh is with the *Consortium national de formation en santé* (CNFS) to ensure coordination of all institutional activities under a National Secretariat.

Table 2 – Primary Beneficiaries under the Contribution Program

Networking Support:

1 – Société Santé en français (SSF) . . . . http://www.forumsante.ca/
2 – Quebec Community Groups Network (QCGN) . . . . http://www.qcgn.ca/

Support for Training and Retention of Health Professionals:

3 – Consortium national de formation en santé, Secrétariat national . . . . . . http://www.cnfs.ca/
4 – Université Sainte-Anne, Collège de l'Acadie (Nova Scotia)
5 – Collège communautaire du Nouveau Brunswick, campus Campbellton
6 – Université de Moncton (New Brunswick)
7 – Government of New Brunswick
8 – La Cité collégiale (Ontario)
9 – Université d'Ottawa (Ontario)
10 – Université Laurentienne (Ontario)
11 – Collège Boréal (Ontario)
12 – Collège universitaire de Saint-Boniface (Manitoba)
13 – Campus Saint-Jean, Université de l'Alberta (Alberta)
14 – McGill University (Quebec) . . . . http://www.mcgill.ca/hssaccess/

The ***Networking Support*** component of the program involves secondary beneficiaries who receive program funding directly through the two primary beneficiary organizations for this component. Contribution agreements are signed between primary and secondary beneficiaries and funding is managed by the primary beneficiaries. There are 17 secondary beneficiaries for the Francophone portion of the ***Networking Support*** Program component and 10 secondary beneficiaries for the English-speaking official language minority community. Table 3 lists all secondary beneficiaries.

Table 3 – Secondary Beneficiaries (Networking Support Component)

	Organization	Region Served
Anglophone Network Beneficiaries		
1	Community Health and Social Services Network (CHSSN)	Province of Quebec
2	Catholic Community Services	Montreal East
3	Coasters Association	Lower North Shore
4	Committee for Anglophone Social Action (CASA)	Gaspé Peninsula
5	Council for Anglophone Magdalen Islanders (CAMI)	Magdalen Islands
6	Fraser Recovery Program	Mauricie and Central Quebec
7	Megantic English-Speaking Community Development Corporation (MCDC)	Chaudière-Appalaches and l'Érable
8	Regional Association of West Quebecers	Outaouais
9	Townshippers Association	Estrie and Montéregie
10	Vision Gaspé Percé Now	Gaspé Peninsula
Francophone Network Beneficiaries		
1	Réseau de santé en français de Terre-Neuve et Labrador	Newfoundland and Labrador
2	Réseau des services de santé en français de l'Île-du-Prince-Édouard	Prince Edward Island
3	Réseau pour les services de santé en français, Nouvelle-Écosse	Nova Scotia
4	Société Sante et Mieux-être en français du Nouveau-Brunswick	New Brunswick
5	Réseau-action formation et recherche	New Brunswick
6	Réseau-action organisation des services	New Brunswick
7	Réseau des services de santé en français de l'Est de l'Ontario	Eastern Ontario
8	Réseau franco-santé du Sud de l'Ontario	Southern Ontario
9	Réseau francophone de Santé du Nord de l'Ontario	Northern Ontario
10	Réseau santé en français du Moyen-Nord de l'Ontario	North-Central Ontario
11	Conseil communauté en santé du Manitoba	Manitoba
12	Réseau Santé en français de la Saskatchewan	Saskatchewan
13	Réseau santé albertain	Alberta
14	RésoSanté Colombie-Britannique	British Columbia
15	Partenariat communauté en santé (PCS)	Yukon
16	Réseau TNO Santé en français	Northwest Territories
17	Santé en français au Nunavut (Safran)	Nunavut

THE FORMATIVE EVALUATION OF THE PROGRAM

The formative evaluation of the *Contribution Program to Improve Access to Health Services for Official Language Minority Communities* was conducted mid-way through the Program (year 3 of 5) and covers the period from Program inception in June 2003 to July 2006. The evaluation work plan was developed from the RMAF by the evaluation team of the OLCDB with the support of the DPMED. Evaluation planning began in 2003 with the evaluation work plan approved in August 2006. Regular monitoring and reporting practices were put into place from program inception in view of collecting information for evaluation purposes. Data was collected from June 2006 to October 2006.

Program Logic Model

Table 4 is the Logic Model for the Contribution Program and it details the Program's activities and outcomes.

Table 4 – Program Logic Model

Rationale	According to a 2001 Health Canada study, language barriers impede access to health care and have a negative impact on the care that is delivered. The Program came into existence following an extensive consultation among stakeholders (communities, non-profit organizations, training institutions and governments) with the objective of improving access to health services for official language minority communities.	
Ultimate Target	Access to health care without language-related barriers for all Canadians in official language minority communities.	
Ultimate Objective	Improved access to health services for official language minority communities.	
Intermediate Objectives	Component 1: Networking Support • To establish and sustain networks to facilitate information sharing and resource development and lead to new ways of improving access to health services for official language minority communities.	Component 2: Support for Training and Retention of Health Professionals • To promote the training and retention of health care professionals for official language minority communities (OLMCs).
Resources (Inputs)	$14 Million over 5 years (2003-2004 to 2007-2008) • $9.3 million for Francophone minority communities • $4.7 million for Anglophone minority communities	$75 Million over 5 years (2003-2004 to 2007-2008) • $63 million for Francophone minority communities • $12 million for Anglophone minority communities
Production Activities	• Foster partnerships, collaboration and networks among health sector stakeholders (health professionals, communities, policy makers, health care institutions, training institutions). • Provide technical and financial support to networks. • Facilitate information-sharing among networks through seminars, working groups and newsletters.	• Facilitate recruitment, training and retention of health professionals for OLMCs through partnerships, collaborations, strategies and networks. • Facilitate and support research and increase awareness among Francophone training organizations.

Products	• Established Francophone and Anglophone networks (17 & 10 respectively).	• Programs to address the health needs of OLMCs. • Health professionals to meet the needs of Francophone and Anglophone minority communities.
Immediate Outcomes (1 year)	• Increased interaction and engagement between health partners and community members within OLMCs. • Improved use of existing resources and sharing of best practices.	• Increased capacity for training of health professionals within OLMCs. • Increased number of Francophone students enrolled in health professional training programs outside Quebec.
Intermediate Outcomes (2-3 years)	• Implementation of information-exchange mechanisms between health partners and OLMC members. • Increased commitment by health partners to improve health care services.	• Increased number of health professionals to meet the needs of OLMCs. • Improved quality and quantity of information on health care needs. • Improved quality and quantity of health care services available to OLMCs.
Ultimate Outcomes (4+ years)	• Increased satisfaction of Canadians in official language minority communities. • Improved access to health services in the language of choice. • Improved health of Canadians in official language minority communities.	

Objectives and Scope of the Formative Evaluation

It should be noted that the Contribution Program was launched in 2003 as a budget commitment and pursuant to the Action Plan for Official Languages (APOL) under the former Liberal Government. The Program's main objective is to increase health services to OLMCs, which in turn is expected to contribute to OLMCs vitality. The objective to increase OLMCs vitality is not a direct objective of the Contribution Program but rather of the APOL. Consequently, the focus of this evaluation is on the objectives that are specific to the Contribution Program.

The objectives of the formative evaluation are to:

- look at the program's relevance with an emphasis on retrospectively collecting data documenting the original context for the Program,
- assess relevance of the program's model as well as its implementation and administration,
- assess the extent of Program progress against Program objectives, and
- provide the evidence supporting any recommended mid-course adjustments to Program design, delivery and administration.

Evaluation Approach

In order to answer the evaluation questions, data were collected from a literature review, a document review, interviews, a survey and a statistical profile. The questions examined (see Table 5) are issues traditionally explored in formative evaluations (i.e., design, delivery and program management). Questions were also developed to examine program progress and relevance, in an effort to inform the early stages of the development of a future Treasury Board submission.

Table 5 – Evaluation Questions

Issue Area	Questions	Method
Relevance	Is the Program relevant to the federal government priorities?	Document Review Interviews
	Does the Program complement or duplicate other governmental Programs / Initiatives?	
	Are Program objectives relevant to OLMC needs[4]?	Statistical Profile Document Review
Design & Delivery	Is the design and delivery of the program appropriate? - Involvement of stakeholders - Selection of Program beneficiaries - Appropriateness of the Networking component - Appropriateness of the Training and Retention component - Contribution agreement as a funding vehicle - Appropriateness of funding distribution	Literature Review Document Review Interviews Survey
Management	To what extent is the management of the program appropriate? - Role of Program Officer - Program Monitoring and Reporting Systems	Survey Document Review
Progress	What Program effects may be identified for training and networking at this mid-point of the program?	Document Review Literature Review

4 The Program has three objectives: 1) to improve access to health services for OLMCs, 2) to meet their needs and improve health services in OLMCs, thereby enhancing the health of these communities, and 3) to improve the efficiency of the health system as a whole by improving health services for OLMCs. Since these objectives are extremely difficult to measure, this evaluation covers only the first one and partially the second one (meet the need and improve services). Impacts on the health status of OLMCs and on the overall health system are considered beyond the scope of this evaluation.

Methodology

Several methods were used to collect data for the evaluation and they are described below.

i) Literature Review

The purpose of the literature review was to inform the evaluation question pertaining to program design by:

- describing the theoretical, historical, and social contexts in which the Contribution Program was designed, in order to assess the reach and limitations of the planning activities that preceded the launch of the Contribution Program;
- providing an overview of the literature related to the impact of linguistic barriers on access to health services in order to assess the relevance of the Contribution Program activities;
- assessing the usefulness of alternative Canadian approaches; and,
- examining international literature to determine how other countries provide health services to linguistic minorities.

It should be noted that the second and third objectives have been covered in an exploratory manner.

The literature review was conducted by a researcher selected by the OLMCDB, who was working at the Canadian Institute for Research on Language Minorities at Moncton University.

ii) Document Review

The purpose of the document review was to collect information on program operations and the strengths and weaknesses of the Program. The document review captures information related to all of the evaluation issues.

The document review included the following documents:

- correspondence between Health Canada and primary beneficiaries from the beginning of the selection process, including project proposals, progress reports and evaluation reports;
- administrative documents such as Financial Reports, Contribution Agreements, Annual Reports and Action Plans;
- policy documents including the Treasury Board submission, the Action Plan for Official Languages, and the Official Languages Act (including amendments);
- documents commissioned by the program Consultative Committees;

- IPOLC program documents; and
- project documents.

Data stemming from the document review were collected and categorized using a grid, which organized the content by the indicators related to each evaluation question. A summary of the data was developed based on the information available for each indicator. The data were subsequently grouped according to themes serving as the basis for conclusions regarding the Contribution Program as a whole.

The document review was conducted internally by two Policy/Evaluation analysts of the OLCDB. The documentation was divided between the two analysts. To ensure consistency between the analysts, inter-rater reliability checks were performed at regular intervals.

iii) Interviews with Key Informants

The purpose of the interviews was to inform evaluation questions related to program relevance and design, particularly regarding the level of overlap with other programs.

The OLCDB supplied a public opinion firm with a list of 34 potential interviewees who were selected based on criteria that were informally applied. The criteria were: (1) some knowledge of health and/or social services in OLMCs , and (2) no direct involvement with Health Canada's Contribution Program. Thirteen telephone interviews were conducted with academics/researchers (n=2), international experts (n=1), provincial government representatives (n=7), and health service providers (n=3).

iv) Internet-Based Survey

The survey was implemented to gather views on program progress as well as on program management and operations.

The OLCDB provided a sampling frame, which listed all the individuals who should participate in the survey. This population included Program/Project administrators, current and former Program Officers and Project Participants who had an internet address. The sampling frame had a total of 383 contacts, of which 53 were not useable because the email address was invalid or the person had left the organization. The final number of useable records was 330.

v) Statistical Profile

The OLCDB developed a statistical profile to describe the situation of OLMCs, which was used to inform evaluation questions pertaining to program relevance. Descriptions of OLMCs were assembled from an analysis conducted by the Official Languages Support Programs Branch at

Canadian Heritage based on 1996 and 2001 Census data and data from the Canadian Community Health Survey both conducted by Statistics Canada. The statistical profile contains information regarding age structure, level of income, education, unemployment, population growth and mobility, rural/urban distribution, households below Statistics Canada's low-income cut-offs, and health status. Statistical data on patterns of behaviour regarding use of health services, language of service, satisfaction with health services and level of knowledge of health programs and services were also gathered.

Data Analysis

A grid was developed to map the data collected from the methods against evaluation questions and to assist with integrating and analysing the data.

Limitations of Methods

The following section sets out limitations for each source of evidence.

i) Literature Review

Originally the literature review was planned to be a systematic review based on an exhaustive list of key words but given the project tight timelines, the scope of the literature review had to be narrowed leaving aspects of the literature review not being covered in the same depth (objectives 2 and 3). The literature review report does not provide specific information on the search criteria or the data collection and analysis methods and tools used by the researcher. Consequently, it is not possible to validate adherence to a systematic approach or to determine the reliability of the data stemming from the review.

ii) Document Review

The review was limited by the availability and quality of the information included in the documentation. More specifically, it was found that some of the documents were incomplete or inconsistent. This quality issue had an impact on the amount of data available for triangulation with the other lines of evidence and on the extent to which conclusions can be validated. In addition, the document review is based on documents developed by funding recipients and consultative committees, both having a vested interest in the program continuity. Despite the fact this information could only be collected with this method, it should be noted that the information generated from the document review, which informs program progress, may be biassed.

iii) Interviews

The interviews were designed to gather opinions from individuals knowledgeable about the issue of official languages while not being involved in the program. Representatives from provinces and territories represented one category of interviewees. The most important limitation for this section seems to be linked to the confusion of a few interviewees between the Health Canada Contribution Program for Official Languages and the Primary Health Care Transition Fund, which is another program funded by Health Canada having an official languages component.

iv) Internet-Based Survey

The overall response rate for the survey was 32.1%. Participation among Program Officers and beneficiaries from the networking component was high with a response rate of 86%, while participation from beneficiaries of the training component including teachers was low with a response rate of less than 20%. Given the low response rate for the training component, the data generated from this survey could be seen as not representative of the training component – which may be problematic since this component accounts for 80% of program funding. Furthermore, the survey was administered to program beneficiaries or individuals involved in the program management and / or operations. Despite the fact this information could only be collected with this method, it should be noted that the information generated from the survey, which informs program progress, may be biassed.

v) Statistical Profile

For both the Census and the Canadian Community Health Survey, only aggregated data have been made available which means that two factors may influence the findings:

- The definition used for the term “language” is based on the first language spoken by an individual. Use of this definition means that the results may not be representative for OLMCs given that the proportion of the population that is still more comfortable to use the first language spoken in daily activities is unknown.
- In general, OLMCs tend to be located in rural areas. In the report, the statistics quoted compare the minorities to their respective majority regardless of the size of the communities. As a result, rural populations are often compared to entities capturing both rural and urban areas where the level of services is likely higher. This grouping of populations (rural and urban) suggests that the statistics pertaining to the majorities may not be the ideal comparison, but it is the best currently available.

PRESENTATION AND DISCUSSION OF FINDINGS

Program Relevance

The intent of this section is to assess the relevance of Program objectives with respect to government priorities and the needs of OLMCs it terms of access to health services.

QUESTION 1 IS THE PROGRAM RELEVANT TO THE FEDERAL GOVERNMENT PRIORITIES?

The purpose of this question is to assess whether the program remains a current priority. The answer to this question is based on the document review as well as the interviews.

Health Canada considers access to health care as a key determinant of the health status of a population.[5] National governments and health organizations around the world seek to address health inequalities among populations by improving the situation of those who are disadvantaged by barriers which reduce their access to health resources. Health Canada's mission to help the people of Canada to maintain and improve their health is realized, in part, through measures that ensure a wide spectrum of health services are equally accessible to all Canadian citizens.

The three objectives of the Program are consistent with this mission identified for Health Canada. The first departmental objective set out in the Report on Plans and Priorities (RPP) for 2006-2007 (RPP) is to "enhance the sustainability, innovation and integration of the health system." Under this objective, Health Canada aims to "work closely with provincial and territorial governments, as well as health organizations and other stakeholder groups to examine new and innovative ways to strengthen the efficiency and effectiveness of a universally accessible and equitable publicly funded health care system."

Furthermore, the RPP commits the department to working towards implementing administrative practices and policies to ensure that the enhanced accountability provisions of the *Official Languages Act,* which were introduced in November 2005, will be reflected in the provision of health services to official language minority communities across Canada.

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[5] Health Canada lists some twelve health determinants that have been shown to have a strong influence on the health status of a population among which access to health services is included. For further discussion see Raphael Dennis, ed. (2004). *Social Determinants of Health: Canadian Perspectives*. Toronto: Canadian Scholar's Press, p.5.

The **Support for Training and Retention of Health Professionals** component of the Contribution Program is consistent with commitments in Health Canada's RPP to build upon health human resource activities to support the two recent First Ministers accords on health care:

- the January 2003 Accord on Sustaining and Renewing Health care for Canadians; and
- the September 2004 Ten-Year Plan to Strengthen Health Care.

The second of these accords commits the federal government specifically to "targeted efforts in support of Official Languages Minority Communities to increase the supply of health care professionals for these communities."

Health Canada is committed to ensuring the long-term integrity of our publicly funded health care system and to upholding the principles of the *Canada Health Act.* In exercising its responsibilities under both the *Canada Health Act* and the *Official Languages Act,* the Department is mindful of provincial and territorial jurisdiction in matters relating to the delivery of health services and does not intervene in areas that fall within the purview of the provincial and territorial governments. However, Health Canada does work in partnership with provinces, territories and others to improve timely access to quality health care.

Finding 1 **The Contribution Program is among the Government of Canada programs that are designated to support official language minority communities. The Program's objectives appears consistent with government-wide priorities under the *Official Languages Act* and with Health Canada's mission, corporate objectives and priorities.**

QUESTION 2 DOES THE PROGRAM COMPLEMENT OR DUPLICATE OTHER GOVERNMENTAL PROGRAM/INITIATIVES?

The purpose of this question is to find out whether other programs or initiatives have objectives and / or activities that can contribute to the achievement of Health Canada Program for OLMCs. Oppositely, a second purpose for this question is to find out whether objectives of the Health Canada Program for OLMCs are not already pursued by another Program either at the federal or provincial level. This evaluation question is informed by the document review exclusively.

Initiatives funded under the APOL

The Contribution Program supports two of the three Health Canada community support initiatives which were launched pursuant to *The Action Plan for Official Languages.* These two initiatives are expected to be key enablers to improving access to health services for official language minority communities. The third initiative is administered through the Primary Health Care Transition Fund as mentioned previously (see footnote on p. 11).

In addition to supporting Health Canada initiatives, *The Action Plan for Official Languages* also provided support of $147.3 million to communities through initiatives in five other federal departments as shown in Table 6. These investments respond to communities' expectations through concrete measures in the key development areas of early childhood, health care, justice, immigration and economic development.

- Support to early childhood development in minority communities follows on a 2000 federal-provincial-territorial agreement by helping parents in minority language communities pass on their language to their young children and by encouraging provinces and territories to take into account the specific needs of these families.

- Improvements in access to the justice system in both official languages include funding for projects involving government and non-government partners, French-speaking lawyers' associations and their national federation, consultations with minority official language communities, and tools for training legal counsels on language rights.

- Pilot projects have been undertaken by Citizenship and Immigration Canada to promote immigration to francophone communities outside Quebec.

- Economic Development initiatives by Human Resources Skills Development Canada and by Industry Canada have been developed to increase communities' capacity to participate in the knowledge-based economy by sharing information over the Internet, and to enable communities to take advantage of existing economic development projects.

Table 6 – Distribution of Action Plan Community Development Funds by Federal Department
(in millions of dollars)

Canadian Heritage:		*Justice Canada:*	
• Support to minority communities	$19.0	• Legal Obligations	$27.0
• Intergovernmental cooperation	$14.5	• Access to Justice	$18.5
Health Canada:		*Citizenship and Immigration Canada*	
• Networking	$14.0	• Recruitment and Integration of Immigrants	$9.0
• Training and Retention	$75.0		
• Primary Health Care Transition Fund	$30.0		
Human Resources and Social Development Canada:		*Industry Canada:*	
• Literacy	$7.4	• Outreach and Counselling	$8.0
• Pilot Projects for Child Care	$10.8	• Internships	$2.0
• Development of Non-Governmental Organization Capacity	$3.8	• Pilot Projects (Tele-Training and Tele-learning)	$10.0
• Internships	$4.3	• *Francommunautés virtuelles*	$13.0
Total Support to Communities			**$266.3**

These program initiatives are coordinated across departments under the Minister responsible for Official Languages — who is responsible for general coordination of all activities under Parts IV, V, VI and VII of the *Official Languages Act* — and the Minister of Canadian Heritage who is entrusted specifically with coordination and reporting for Part VII of the Act.

Official Language activities by federal departments are coordinated through a committee of senior executives, a support committee of officials, an official languages secretariat, and a program branch at Canadian Heritage. These governance structures ensure the coordination and non-duplication of the Government of Canada's approach for the application of the *Official Languages Act* and the implementation of the Action Plan.

The data suggests that the rationale for the contribution Program is closely tied up to the Official Languages Act (OLA) and its underlying purpose to protect Canadian linguistic duality. More specifically, one of the four objective of the OLA is to commit the federal government to:

> "enhancing the vitality of the English and French linguistic minority communities in Canada and supporting and assisting their development; and fostering the full recognition and use of both English and French in Canadian society" (section 41)

This aspect seems to explain the close relationship between the Contribution Program and the Action Plan on Official Languages (APOL) which focus on the concept of community vitality. From this perspective, the objective of the Contribution Program and those of the APOL appear different but complementary.

Finding 2 **Following the launch of the Action Plan for Official Languages, initiatives have been undertaken in six federal government departments to provide support to official language minority communities. Taken together, these initiatives appear relevant to meet the objectives of the APOL and little overlap or duplication was identified.**

The Health Human Resource Strategy

Canada's First Ministers have repeatedly stressed the need for appropriate planning and management of health human resources through recent health accords in order to ensure that Canadians have access to the health care providers they need. In response, the 2003 Budget provided $85M to address pan-Canadian HHR needs. These funds have formed the basis for Health Canada's Pan-Canadian Health Human Resource Strategy, which was approved by the Treasury Board in 2004 with ongoing funding of $20M annually.

Under the Strategy, Health Canada is working with the provinces, territories and other key health-related organizations to improve health human resources planning and coordination. The Health Human Strategy will guide these efforts in three critical areas:

- **Health Human Resource Planning** – The objective of this component is to strengthen the evidence base and capacity for coordinated HHR planning. It focusses on the development of a national data set to guide HHR data collection as well as a supply-based database and reporting system for different health professions and education indicators which necessary to monitor the supply of health professionals. A framework also been developed, describing an innovative approach to plan HHR based on population health needs and health system design and provides the flexibility to deploy HHR differently in response to new delivery models;

- **Recruitment and Retention** – This component strives to increase interest in health careers and increase the supply of health care providers. The Strategy is also attempting to reduce the entry barriers for internationally educated health care professionals and to improve utilisation and distribution of existing providers; and,

- **Interprofessional Education for Collaborative Patient Centred Practice** – changing the way we educate health providers so Canadians will have better and faster access to the health care provider they need when they need it, ultimately boosting the satisfaction of both patients and health care providers.

According to the document review, officials from the Official Language Community Development Bureau consult regularly with the Health Human Resources Strategies Division of Health Canada to ensure coordination of specific initiatives with official language stakeholders, however the nature and impacts of these exchanges on the outcomes of Official Languages contribution program have not been documented.

Other Initiatives

In 2004, the Health Network at Canadian Policy Research Networks (CPRN) released an overview of *Health Human Resources Policy Initiatives for Physicians, Nurses and Pharmacists.* Data collection across Canada revealed a proliferation of government funded activities revolving around education and training initiatives, recruitment and retention and work place initiatives as well as national level health human resource planning. The government role has become more central in formulating policy on these issues and health human resources needs are seen to be part of an overall care renewal agenda. Most provinces are working on:

- updating or redesigning their health professions legislation,
- funding new undergraduate and training positions,
- increasing the number of organized recruitment campaigns by governments .

The interviews suggest that various stakeholders work together effectively. However, some concerns were expressed that there is not enough collaboration among the various organizations and levels of government that offer services to linguistic minority communities.

One interviewee stated that the key to better collaboration is “mutual respect and increased communications.” An example given was in regard to federal funding of an OLMC project whereby the province was not consulted. According to the interviewee, this particular province already had initiatives underway in the same realm but was told that the federally funded program would be withdrawn unless a letter of support was provided by the province. The province would have appreciated being informed ahead of time, and having the opportunity to integrate its own program with the federal program to avoid duplication and gain efficiency.

Finding 3 **The evaluation suggests that the Health Human Resource Strategy as well as a number of provincial or territorial initiatives can potentially contribute to the attainment of the Official Languages Contribution Program’s objectives. This through the sharing of infrastructures aimed at providing information or at amending legislation helping the Program to focus the efforts of the Training and Retention component. However, it is not possible to conclude on the extent to which the Contribution Program is taking an active role in relating to these other initiatives.**

QUESTION 3 ARE PROGRAM OBJECTIVES RELEVANT TO OLMC NEEDS?

The purpose of this question is to assess whether Program objectives remain relevant in light of recent data describing OLMCs linguistic profile and their use of health services. Data informing this evaluation question stems from the document review, the literature review as well as from the statistic profile developed from the Canadian community Health Survey [2005] and Census data collected in 1996 and 2001.

The development of the Program model which resulted in the Treasury Board submission of June 2003 relied on two main sources of information regarding Canada's official language minority communities. One source, dealing with Francophones outside of Quebec, was based on a research report conducted by an independent firm, SECOR, under the supervision of the *Fédération des communautés francophones et acadienne du Canada* (FCFA)[6] on behalf of the Health Canada Consultative Committee for French-Speaking Minority Communities (CCFSMC). This report, published in June 2001, is entitled *French-Language Healthcare: Improving Access to French-Language Health Services.* The second source, dealing with Anglophones in Quebec, was a report based on research supported by the Missisquoi Institute published in October 2001 entitled *Building on our Strengths.*

When the two research reports emerged in 2001, there was a notable paucity of consolidated research on Canadian OLMCs in the area of health. In this sense, they may have marked a turning point in the state of research and may have catalysed research activities in this field in subsequent years.

The two research reports identified the health-related needs of official language minority communities as follows:

- between 50% and 55% of Francophones in minority communities often had little or no access to health services in their mother tongue;
- there were important regional and local differences and significant disparities in health service delivery in Francophone minority communities;
- structures or mechanisms for greater empowerment or ownership of health by the French-speaking minority communities that would fit within the framework of existing health care systems needed to be implemented;
- four regions in Quebec had limited, extremely limited or non-existent access to entitled services in English provided by CLSC-delivered primary care programs;

[6] The Fédération des communautés francophones et acadiennes (FCFA) du Canada is the national and international representative of Francophone minority communities in Canada and comprises twelve provincial and territorial Francophone community associations as well as eight national sector-specific associations. Its mission is to defend and promote the rights and interests of Francophones living in the twelve provinces and territories where English is the first official language.

- seven regions in Quebec had limited, extremely limited or non-existent access to entitled English-speaking general and specialized medical services delivered by hospitals;
- eight regions of Quebec were in deficit with respect to having moderate to substantial access to entitled services in English from long-term care centres;
- four regions of Quebec were assessed as having limited, extremely limited or non-existent access to entitled English language services provided by youth protection centres;
- access to Quebec rehabilitation programs in English was generally weak for all categories of clientele; and
- almost half the administrative regions of Quebec had no designated English-speaking public health institutions to service the health care needs of minority communities.

While important points of reference, these reports are not without their limitations. The survey conducted as an investigation of Francophones outside of Quebec is limited to stakeholders in each region. While the survey designed to investigate the Anglophone minority includes a broader population base, it lacks a literature review to supply the findings with an international context. Both of these reports are quantitative in approach.

It is also important to keep in mind that access to health and social services in either official minority language depends on the availability of information regarding these services. Use of services rests upon knowing what programs are offered and through what health agencies. When surveyed in 2005, 73.1% of Quebec English-speakers reported that they had not received any information provided by public health and social services agencies about access to English services in the previous two years [CHSSN, 2005].

Findings of FCFA and the Missisquoi Institute reports are in line with the literature pertaining to the importance of language in effective care delivery which is confirmed by studies suggesting that language barriers:

- reduce the probability of using health services for preventative reasons;
- increase consultation time and probability of error in diagnosis and treatment;
- reduce the quality of service where communication is key (primary care, mental health services, senior home care); and
- reduce overall satisfaction with care and services by service users.[7]

[7] "There is compelling evidence that language barriers have an adverse effect on access to health services", Sarah Bowen, 2001. *Language Barriers in Access to Health Care,* Health Canada, p.v1. See also Ngo-Metzger et al.,"Linguistic and Cultural Barriers to Care". *Journal of general Medicine* 18 (2003):pp.44-52, Fernandez, D.Schillinger, K.Grumbach, A.Rosenthal et.al "Physician Language Ability and Cultural Competence", *Journal of General and Internal Medicine 19 (2004):pp.175-183,* Brach ,Fraser and Paez. "Crossing the Language Chasm". *Health Affairs* 24 (2005): 424-435 and Stewart M.A. "Effective Pysician-Patient Communication and Health Outcomes: A Review". *Canadian Medical Association Journal* 152,no.9(1995): 1423-1433.

However, the 1996 and 2001 Census data [Statistics Canada], which can be found in Appendix A, suggests that language may not be a barrier to access to health services in the case of OLMCs given their high rate of bilingualism. According to Census data, bilingualism rate is over 90% for OLMCs in 11 provinces and territories. OLMCs in the two other provinces (i.e. Quebec and New-Brunswick), have lower bilingualism rates of 61.2% and 69.5% respectively. These two provinces, where bilingualism rate is lower, capture 83.7% of the OLMC population. When Ontario is included, these are the three provinces where the minority population appears to constitute a 'critical mass' which seems necessary for the organization of centralized and /or specialized services.

Additionally, the Canadian Community Health Survey (CCHS) [Statistics Canada, 2005] – which does not consider the language variable in its definition of access – suggests that there is no significant differences between OLMCs and their respective majority for most indicators pertaining to health practices, care and access[8]. A summary description of the health services access for each minority in comparison with its associated majority based on the data of the CCHS (2005) is provided below. Additional detail can be found on the survey in Appendix B.

Francophone minority – Similar to Anglophones outside Quebec (majority), Francophones have a regular doctor, have received home care services, had a flu shot in the last year, a PAP smear within the last three years and a mammogram in the last two years. Their perceived unmet health care needs are in the same proportion as the majority. Francophone from OLMCs seem to receive less health care services (92.8% vs 96.7%), less physician care (61.3% vs 67.1%) and less community care (16.6% vs 19.9%). They also tend to have more difficulties in getting non-emergency surgery and health information. However, satisfaction indicators suggest that overall, Francophones from OLMCs are more satisfied with the care received than the associated majority.

Anglophone minority – As it pertains to this community, not as many Anglophones have a regular doctor (72.4% vs 75.3% for the majority). However, it appears that similar to Francophones (majority), Anglophones have received home care services and have perceived unmet health care needs in similar proportions (13.4% for Anglophones and 12.3% for Francophones). Anglophones from OLMCs appear more likely to get a flu shot annually (30.3% vs 24.4%) and a PAP smear (67.4% vs 64.5%) in comparison to the majority. Anglophones from OLMCs seem to receive a similar level of health care services according to the data (91.2% vs 93.4%), of physician care (59.5% vs 61.6%) and much more community-based services in comparison to the majority (22.3% vs 13.8%). However, they tend to have more difficulties in

[8] The reader should be reminded that the Canadian Community Health Survey compares the minorities to their respective majority regardless of the size of the communities. As a result, the OLMCs – which are largely rural – are compared to entities capturing both rural and urban areas where the level of services is likely higher. This suggests that statistics pertaining to the majorities are not a perfect basis for comparison but still the best currently available.

getting specialist care, tests, health information and immediate care. Satisfaction indicators suggest that overall, Anglophones from OLMCs are less satisfied with the care received than the associated majority.

Finding 4 **At the origin of the program, the need the program was to fulfill was based on studies commissioned by FCFA and the Missisquoi Institute, which suggested that about half of Francophones in minority communities had little or no access to health services in their mother tongue. Since that time, CCHS data (2005),which does not define[9] access in terms of the language in which the services are being delivered, suggest that differences between the majority and minority groups are not significant regarding health practices, care and access. In this context, it becomes difficult to determine whether access to health services and information is more restricted for official language minority communities versus majority communities, and thus whether the program is responding to a documented need.**

Program Design & Delivery

QUESTION 4 IS THE PROGRAM DESIGN AND DELIVERY APPROPRIATE?

The purpose of this question is to assess whether program design and delivery are appropriate to increase access to health services for OLMCs. These aspects will be evaluated with a focus on the key early steps of the program implementation (i.e., involvement of stakeholders in program design and delivery, the appropriateness of the processes used to select program beneficiaries, the appropriateness of the Networking and Support for Training and Retention components, and the appropriateness of contribution agreement as a funding mechanism and of the program funding distribution).

It should be noted that activities covered as part of the delivery aspect are assumed by Health Canada, while those implemented by funding recipients will be examined in the section pertaining to program progress. Findings from the literature review, the interviews, the survey and, to a lesser extent, the document review will be used to answer this question.

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[9] The appropriateness of the different definitions and what should be done in light of more recent data is not something to be discussed as part of an evaluation. The role of evaluation regarding definitions is rather focussed on making program administrators aware of the recent development in this respect for further consideration as part of a broader policy analysis aimed at making decision on the future of the program.

Involvement of Stakeholders

According to the Health Council of Canada (2005), public involvement contributes to improving the quality of information concerning the population's values, needs, and preferences; ensures public accountability for the processes and outcomes of the system; and protects the public interest.

The literature review further suggests that seven conditions are key to successful consultation processes: (1) representativeness, (2) independence, (3) early involvement, (4) influencing the policy decisions, (5) providing information, (6) resource accessibility, and (7) structured decision-making (Rowe and Frewer, 2000 and 2004; Forest et al., 2000 and 2003).

As it pertains to the Official Languages Contribution Program, the two Health Canada Consultative Committees presented reports to the Minister of Health (2001 and 2002) with their respective supporting research studies (2001). These studies were an initial effort to understand OLMC health needs and provided recommendations to improve access to health services for OLMCs. Also, these documents, generated by Consultative Committees, were instrumental in shaping the design of the Program and resulted in the implementation of three priorities identified in the Consultative Committees' reports (i.e., networking, training and primary health care services).

Finding 5 **The Health Canada Consultative Committees had early involvement in the planning process of the Official Language Contribution Program (influence on a policy decision) through the provision of information.**

According to the document review, members of the Consultative Committees were nominated based on their interest and expertise on the issues of access to health care for minority linguistic communities. They were chosen with the intent that they represent the OLMC to which they belong, rather than particular stakeholder organizations. As a result, Consultative Committees were expected to be the relevant mechanism to appropriately advise the department on the most promising initiatives to meet the needs of OLMCs.

Finding 6 **Given that limited information was collected on the background of Consultative Committees' members, it is difficult to assess whether the Consultative Committees satisfy the conditions of representativeness and independence. Additionally, no data was available to assess whether the conditions of resource accessibility and structured decision-making were satisfied.**

In addition to having used the Consultative Committees as a venue for stakeholder involvement in the development of the Official Languages Contribution Program, Health Canada continued to consult with OLMC stakeholders[10] in a number of ways since the launch of the Program in 2003. For example:

- In 2005, the mandate of both Consultative Committees was revised to include the provision of advice on proposed initiatives in various stages of development and implementation, contributing to the shaping of current and future program development through the provision of strategic directions as to the types of projects that are the most appropriate to meet the needs of OLMCs. According to the document review, Committees' mandates are broad which has allowed for a certain variance in activities and operational modes between the two Committees.

- Health Canada officials and stakeholders representing OLMC health care issues are also regularly active at the Government-wide stakeholder consultations coordinated by the Official Languages Secretariat.

- Senior Health Canada officials are generally present or invited to departmental meetings with stakeholder organizations to present on the activities and progress of Health Canada's OLMC programming and to hear firsthand OLMCs' concerns and answer questions.

- Health Canada officers in regional offices are also directly involved in consultations at the regional level. An official languages coordinator has been designated for each regional Health Canada office to provide onsite regular consultations with OLMC stakeholder organizations, to provide information on Health Canada programs and services available to OLMCs, and to gather information on their health-specific needs. These regional consultations are reported in the annual *Health Canada Status Report in support of Part VII of the Official Languages Act.*

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[10] The difference between members of Consultative Committees and OLMC stakeholders had not been documented as part of this evaluation.

- Finally, stakeholders can also provide input to Health Canada officials through an annual government-wide stakeholder consultation process organized by federal institutions

As well, the Minister and senior department officials also correspond directly with stakeholders on a regular basis. In 2005, there were 30 official letters to / replies from the Minister for OLMC-related issues and 180 letters to / replies from senior departmental officials. These letters included financing requests and confirmations, requests for senior officials to appear or speak at OLMC stakeholder conferences and events.

Despite all the different consultation venues, interviewees appeared to be concerned that local OLMCs were not sufficiently engaged in the development of the Program or present at "the table," and that there should be greater linkages between organizations at the local level and the various levels of government.

Finding 7 **OLMCs stakeholders are consulted in a number of ways and Consultative Committees contributed to the identification of program directions.**

Selection of Program Beneficiaries

Primary Beneficiaries

At the outset of the Program, primary beneficiaries identified by Health Canada based on the recommendations of the Consultative Committees (TBC by the OLMCDB) were asked to submit project proposals to a Review Committee, which was responsible for assessing the quality of proposals and making recommendations to enhance proposals. It was not possible to determine through the document review what the recommendations and selection of primary beneficiaries were based on.

According to the document review, the Review Committee created within Health Canada was composed of members with an in-depth knowledge of the goals, objectives and expected results of the program. The purpose of the review was to introduce the proposed projects to the Selection Committee and to determine whether they were in compliance with the program requirements. To this end, an assessment tool was developed and applied by committee members. However, the review did not reveal any details regarding the strengths and weaknesses of the criteria used through this assessment. Proposals could not be rejected but were submitted to a process of repeated revisions until the criteria were met. The number of committee members

evaluating any given proposal varied from 6 to 8. The evaluation did not reveal the membership of the Selection Committee and whether it overlaps with the Review Committee and / or the Consultative Committees

Finding 8 **Data collected as part of the evaluation suggests that a particular process, building on an assessment tool, was used to select primary beneficiaries.**

Secondary Beneficiaries

The *Networking Support* component of the Program involves secondary beneficiary organizations that receive Program funding. The Quebec Community Groups Network (QCGN) administers the Health and Social Service Networking and Partnership Initiative (HSSNPI), which is the Anglophone portion of the component. The HSSNPI has a transparent process, based on specific criteria, for the application, selection and approval of organizations wishing to apply for program funding under the Health and Social Service Networking and Partnership Initiative (HSSNPI). The eligibility criteria include:

- demonstrated experience, expertise and capacity to generate results in the area of health and social services;
- funding should not be a duplication of funding already being received or used to fund existing and ongoing operations;
- funds provided through the initiatives should be entirely used for the initiative; and
- demonstrated the sustainability of the project (i.e., the project is providing enduring benefits, long-term viability of the networks, financial support beyond the end of the project).

Regarding Société Santé en Français, it was not clear, based on the document review, that the process was implemented to select secondary beneficiaries. This may be due to the fact that the 17 Francophone networks were launched by the SSF through a separate contribution agreement under the OLMC Envelope of the Primary Health Care Transition Fund.

McGill University is the only training and retention project that coordinates the activities of secondary beneficiaries. According to the document review, McGill University used a transparent selection and approval processes however, the review revealed limited information on the broad eligibility criteria used to select secondary beneficiaries. These criteria can be found at http://www.mcgill.ca/hssaccess/.

Finding 9 **Two out of the three primary beneficiaries that are required to select secondary beneficiaries applied a selection process based on broad eligibility criteria.**

Beneficiaries' Satisfaction

The *internet-based survey* asked primary beneficiaries (both networking and training) to evaluate their experience with the Contribution Program's approval process. Overall, both networking and training primary beneficiaries appear to be relatively positive about the process. On a rating scale from strongly disagree to strongly agree, a high percentage of respondents/interviewees agreed that:

- their application was evaluated fairly (83%);
- the objectives were clear during the approval process (83%);
- the information required was relevant for assessment purposes (76%);
- the application process was clear and easy to understand (76%);
- the amount of information required was adequate (75%); and
- that the application process was conducted in an open and transparent fashion (71%).

The one area where many primary beneficiaries indicated some level of frustration with the approval process was in relation to processing time. Only one out of ten (10%) strongly agreed that the processing time was fair, while one-third (34%) felt it was not fair. One survey respondent stated that "The best way to improve the relationship (between network units and coordinating agency) would be to simplify the application process. There is too much detail required." Participants in the *informant interviews* recommended that the application processes. for contribution programs be simplified and streamlined. This is in keeping with the general agreement among those interviewed that an overall weakness of contribution agreements relates to heavy administrative burdens. Several interviewees pointed out that by the time all the approvals for a contribution program had been obtained and the funding began to flow, several months out of a two, three or four year program had already lapsed. This made it difficult to complete all the program objectives. Also, small organizations may have been discouraged from applying for funding as many do not have the resources to respond to complex requests for proposals.

The *document review* found that two successive audits of first year funding to *Société Santé en français* for *Networking Support* in 2003 caused significant delays for the development of networking activities among French-speaking communities.

Finding 10 **Overall, primary beneficiaries appeared to be relatively positive about the selection and approval process. The only area of concern was the application processing time and it was suggested that the application process be simplified and streamlined.**

Appropriateness of the Networking component

The Networking component of the Contribution Program promotes the establishment of networks that are expected to facilitate and improve the circulation of health information and communication among health sector stakeholders. The key goal of this component is the empowerment of local OLMCs in the area of health through greater community engagement, information sharing, and resource development as well as the formation of durable links with partners who have the ability to influence the planning and delivery of services.

Results of interviews underlined the importance for the network to operate at the community level in order to gain a true understanding of the communities issues. In this respect, it was also suggested as part of the interview that more community-level data should be collected to help local networks appropriately inform and influence regional health managers or provincial decision makers in the design, planning and delivery of services to OLMC populations.

The notion of greater collaboration among all levels of government and other key stakeholders was also raised by interviewees who believed that improved collaboration would result in more consistent and effective services being delivered, as well as efficiencies in terms of resource deployment. This finding is supported by the literature review which suggested establishing partnership agreements with provinces and territories in order to increase access to health services provided in french outside Quebec. These partnership agreements address geographical and political exclusion of OLMCs.

The literature review indicated however, that networks may only have a limited capacity to develop resources in the health domain. “At this point, objectives do not specifically target the implementation or delivery of linguistically appropriate health services. The American example could inspire a more structured approach in this respect, notably for the regions where the small numbers of francophones does not justify the creation of new services or of community health centres”(p. 13).

More specifically, the model implemented in United States is aimed at guaranteeing an optimal service for each individual (individualist approach), often through appropriate communication between the patient and the care provider. This type of approach is different from the approach

the Health Canada Contribution Program is attempting to implement, which aims to guarantee a collective right to a service in the language of the community when its language is different from the one of the majority or when the language spoken in the minority community has been awarded an official status (communautarist approach).

Based on the literature review, it is not clear whether it would be appropriate to implement one of these approaches from coast to coast. According to the review, approaches guaranteeing a collective right to OLMCs are more likely to increase community vitality through the development of policies giving control over health institutions to OLMCs. However, it is unclear whether the potential to increase access to health services is equivalent. As it pertains to objectives of the Health Canada Contribution Program, the literature review suggests that individualist approaches might be more appropriate, particularly for regions where the size of the minority does not justify the creation of new health institutions.

Overall, the literature review seems relatively sceptical about the appropriateness of networking, suggesting that "...the selected [networking] approach does not aim to develop or implement services to be delivered in french[11]. The partnerships can lead to the development of services, however nothing guarantees such an objective will be reached building only on the creation of partnerships. In communities where resources are limited, the development of networks does not guarantee the development of new health resources..."

Finding 11 **Data suggests that the design of the networking component may require adjustments in order to maximize its potential to contribute to the improvement of access to health services for OLMCs.**

Appropriateness of the Training and Retention Component

The Training and Retention component is designed to increase the number of health care professionals who can provide services in the language of the minority communities (English in Quebec, French outside of Quebec) and to promote the retention of health professionals in OLMCs. It is expected that these objectives can be achieved through language training offered to health care workers and professionals, the promotion of health training for OLMC members as well as long distance support to professionals in more isolated regions.

[11] The sentence is quoted from the literature review. Based on data stemming from the other lines of evidence, it appears reasonable to consider this statement as being applicable to English networks as well.

It should be noted that overall the evaluation produced little information on the Training and Retention component of the Program, particularly related to professional training and retention. Most of the information collected was related to the language training aspect of this component. Among individuals interviewed for this evaluation, it was widely felt that there is a shortage of health care professionals who are able to speak the minority language at a technical level. Also while interviewees appeared relatively confident in the networking component, some of them questioned the relevance or potential of the Training and Recruitment component.

It appeared difficult for interviewees to provide clear resolution to the problem of the shortage. Nonetheless, they emphasized that more needs to be done to provide health care professionals with language training, even if they still questioned the potential for training initiatives to contribute to improving access to health services. Interviewees specified that training medical professional to be truly bilingual is a long-term undertaking and that professionals receiving second language training may not develop the language skills necessary to handle the nuances of health care. Furthermore, according to the survey, most respondents who deliver language training think the curriculum and design of their program do not allow the students to understand and communicate complex or highly technical concepts. However, most believe that the program allows students to understand and communicate non-technical concepts in their second official language.

The interviews also suggested that individuals leaving the communities to learn a language tend not to return. One ambiguity with interview data is whether individuals leaving OLMC communities for post-secondary education tend to return. In this respect, the literature review suggests that the location where students train may affect where they settle and how they practice after they graduate [Chan and Barer, 2000]. According to the survey, bilingualism is one requirement to enter professional training in universities and colleges targeting OLMCs. Given the high rate of bilingualism in OLMCs, this may be an indication that colleges and universities are targeting individuals who are most likely to return to OLMCs.

Findings from the interviews and the literature review that support the notion of greater collaboration among all levels of government may also be relevant in the context of the Training and Retention component. Greater collaboration may be required to improve the delivery of health care services and the deployment of resources, primarily of provincial jurisdiction.

Finding 12 **Based on the data made available through the evaluation, there seems to be a concern about the ability of the Training and Retention component, more particularly the language training aspect of this component of the program, to deliver on program objective of increasing access to health services for OLMCs.**

Contribution Agreements as a funding vehicle

The use of Contribution Programs to assist communities in their development has been used in Canada for a long time. Notably, this funding strategy has been used in the establishment of programs whose missions are, in part, to involve and empower a disadvantaged or minority group.

For example, the Official Languages in Education Program at Canadian Heritage has been in existence since 1970 to support provincial and territorial governments in the delivery of minority-language education and second language instruction programs. This program likely contributed to enabling the development of minority language education systems for Francophone minority communities across Canada and for guaranteeing minority language education and French immersion programs.

As it pertains to the strengths and weaknesses of contribution agreements, clarity of the terms and conditions and of the accountability provisions were raised as strengths by interviewees. Interviewees also reported that contribution agreements tend to encourage community participation as funding directly impacts community organizations. However, the main concern with the funding structure of the Contribution Program is its short duration (5 years). Both networking and training programs have short- and long-term impacts that they are expected to achieve. Though renewed funding arrangements are expected post-2008, the conditions of these funding arrangements are still unknown. Consequently, it is difficult for organizations and communities to make future plans (i.e., passed the five year mark of the program) when funding is guaranteed for only a short period of time (i.e., five years).

Other concerns raised by interviewees related to the administrative burden, noting that reporting requirements should be streamlined to be more efficient and less time consuming. Interviewees also suggested that the burden associated with reporting requirements may discourage small organizations from applying for funding. Interviewees also suggested that clarity of the terms and conditions, which was identified as a strength, could in some cases constrain the funding recipient's ability to tailor the program to community needs.

Finding 13 **Overall, the contribution agreement appears to be a satisfactory mechanism to fund the Health Canada contribution program. Given the lack of information collected to do a comparison with other funding mechanisms, it cannot be concluded that this mechanism is the most appropriate.**

Appropriateness of Funding Distribution

The 2003 federal budget provided Health Canada with $89 million over five years (2003-2004 to 2007-2008) for Program funding. Under the approved Program conditions, all funds were directed entirely to Program contributions. Funds for management and administration of the Program were to be provided from existing Health Canada reference levels.

Table 7 presents the distribution of estimated program funding according to province and territory on both nominal and per capita basis. Expenditure estimates from the document review of project files include actual outlays up to July 2006 plus expenditure projections to March 2008[12]. The presentation compares funding distributions to population. It should be noted that such comparisons should be interpreted with care since networking funds are combined with training funds. As a result, provinces or territories where no training institutions exist may show amounts looking relatively low due to the fact that training funds have been accounted for in the province or territory where the teaching institution is located.

Table 7 – Distribution of Program Funds by Province and Territory

		OLMC Population, 2001			Program Funding		
	Total Population	Number of Persons	Share of Total Population	Distribution by Province and Territory	Amount	Distribution by Province and Territory	Amount Per OLMC Person
Provincial/Territorial Funds:							
Newfoundland and Labrador	508,075	2,098	0.4%	0.1%	$246,160	0.28%	$117
Prince Edward Island	133,385	5,275	4.0%	0.3%	$258,004	0.29%	$49
Nova Scotia	897,565	33,768	3.8%	1.8%	$1,844,632	2.08%	$55
New Brunswick	719,710	238,452	33.1%	12.5%	$21,030,592	23.76%	$88
Quebec	7,125,580	918,955	12.9%	48.2%	$15,693,294	17.73%	$17
Ontario	11,285,545	527,708	4.7%	27.7%	$30,896,407	34.91%	$59
Manitoba	1,103,700	43,382	3.9%	2.3%	$3,276,024	3.70%	$76
Saskatchewan	963,150	16,552	1.7%	0.9%	$378,368	0.43%	$23
Alberta	2,941,150	58,822	2.0%	3.1%	$3,021,121	3.41%	$51
British Columbia	3,868,875	59,372	1.5%	3.1%	$513,400	0.58%	$9
Yukon	28,520	882	3.1%	0.0%	$230,332	0.26%	$261
Northwest Territories	37,105	915	2.5%	0.0%	$219,436	0.25%	$240
Nunavut	26,665	415	1.6%	0.0%	$228,504	0.26%	$551
Total/Average	**29,639,025**	**1,906,596**	**6.4%**	**100.0%**	**$77,836,274**	**87.94%**	**$41**
National Funds:							
SSF (coordination)	22,513,445	987,641	4.4%	51.8%	$1,440,000	1.63%	$1
CNFS (coordination & research)	22,513,445	987,641	4.4%	51.8%	$9,230,383	10.43%	$9
Total/Average					**$88,506,657**	**100.00%**	**$46**

[12] Actual funding amounts vary from original commitments presented in Table III.2 because adjustments have been made throughout the course of a project. These variations are small. CNFS Secretariat reflects a larger variation since transfers can be made between CNFS member institutions through CNFS Secretariat. Larger than expected figures for CNFS Secretariat are, then, reflective of transfer amounts and not necessarily funds used within CNFS Secretariat.

On a per capita basis, program expenditures average $46 per OLMC person across Canada — ranging from a low of $9 per OLMC person in British Columbia to a high of $551 per OLMC person in Nunavut. These per capita estimates can be misleading, as the *Support for Training and Retention of Health Professionals* component of the Program targets post-secondary institutions with a capacity to provide educational support to OLMC members from across Canada and not only from their immediate regions.

On a nominal basis, Ontario receives the largest share of funding at 34.9% followed by New Brunswick (23.8%) then Quebec (17.7%). These three provinces also encompass the most OLMC persons — both as a share of population in the province (4.7%, 33.1% and 12.9% respectively) and as a share of OLMC persons across Canada (88.4% in total). Consequently, additional data on the relative needs of the provinces and on the origin of the students filling the spots funded by the Program by institution would be necessary to discuss in more detail the appropriateness of the funding provided to provinces.

Apart from the population distribution, the funding distributions are influenced by three factors in particular:

(1) The decision made to distribute *Networking Support* funds on a two-for-one basis to Francophone and Anglophone minority communities respectively, as recommended by the two consultative committees based on their understanding of the relative need of both groups.

More specifically, the $14 million of the networking component was divided between the two groups of OLMCs at a two-for-one ratio, giving the Francophone communities $9.3M and the Anglophone communities $4.7M. According to the document review, this allocation was based on the fact that Francophones are dispersed more widely than Anglophones. From this perspective, the Consultative Committees assumed that Francophone communities require more networks and resources and both Committees approved the ratio by mutual, informal agreement.

(2) The decision to distribute $63 million of funds for the *Support for Training and Retention of Health Professionals* to the French-speaking communities and $12 million to the English-speaking communities as recommended by the consultative committees based again on their understanding of the relative need of both groups.

(3) the relative availability of post-secondary training facilities for OLMC health care providers across Canada.

The extent and nature of the training supports required by the Francophone communities — who received $63 million of the $75 million devoted to *Support for Training and Retention of Health Professionals* — was substantial given the need to develop entire post-secondary programs and

train Francophones in institutions across Canada. On the other hand, the focus for English-speaking communities was to improve language skills and accessibility for health care providers engaged in the health care and educational systems. This focus did not necessitate significant funds.

As it pertains to English minorities, the following table (Table 8) shows the proportion of First Official Language English-speakers, the proportion of OLMC population for each region, and the percentage of program funds estimated for each region.[13] The share of program funds designated for language training was adapted from the original budget to account for varying needs and capacity.

Table 8 – Regional Distribution of McGill University Funding

Administrative Region	First Official Language Spoken (FOL) (# of speakers)	Proportion of the English-speaking population	% of Program funds designated for language training
Abitibi-Témiscamingue	5,315	1.16%	3.97%
Côte Nord	5,740	1.25%	3.97%
Gaspésie-Îles-de-la-Madeleine	9,740	2.12%	5.95%
Bas-Saint-Laurent	820	0.18%	1.98%
Saguenay-Lac-Saint-Jean	1,765	0.38%	1.98%
Mauricie et Centre-du-Québec	4,885	1.06%	1.98%
Estrie	23,390	5.09%	7.94%
Outaouais	53,945	11.74%	9.92%
Chaudière-Appalaches	2,685	0.58%	1.98%
Lanaudière	8,215	1.79%	3.97%
Laurentides	30,565	6.65%	7.94%
Montérégie	129,125	28.10%	15.87%
Capitale nationale	11,065	2.41%	5.95%
Montréal (eastern sector)	118,500	25.79%	15.87%
Laval	53,385	11.62%	9.92%
Nord-du-Québec	310	0.07%	0.79%
Total	**459,450**	**100.00%**	**100.00%**

Finding 14 **The evaluation suggests that the Program had put funding where the population was most important, however it is not clear whether the notion of "need" was appropriately considered to refine the distribution of funds.**

[13] This table is a summary of data from a McGill University Report (May 2005). These figures represent an estimate of distribution of funds. The allocation schedule may be changed to suit regional needs.

Program Management

QUESTION 5 TO WHAT EXTENT IS THE MANAGEMENT OF THE PROGRAM APPROPRIATE?

The intent of this section is to assess program management with a focus on the appropriateness of the performance information provided by beneficiaries and on the capacity of Program Officers to carry out their role. Findings from the survey and the document review will be used to assess this evaluation question.

Role of Program Officers

Program Officers represent the principal contact point to Health Canada for primary beneficiaries. According to the document review, Program Officers at the Official Language Community Development Bureau divided their time between two Programs: the Contribution Program and the Primary Health Care Transition Fund (PHCTF). The PHCTF had 71 projects under review for its Francophone component, whereas the Contribution Program had 14 files. According to the Program Manager, an acceptable numbers of files per Program Officer is between 5 and 10.

When the Program was launched, there were four Program Officers and one Program Manager working full-time at the OLCDB and one full-time Financial Administrator working primarily with processes linked to payments. In the following years, the turnover of Program officers increased so that most of the time, the OLCDB could not rely on more than two Program officers as it was the case at the summer of 2006 when data were collected for this evaluation.

While Program Officers are expected to represent the principal contact point to Health Canada for primary beneficiaries, the survey suggests that Program Officers do not tend to have frequent contact with program recipients with six Program Officers out of nine having one contact per week or less with program recipients (from the survey report p.15). Also according to the survey, Program Officers (n=9) activities include:

- assisting in the release of funds (n=7),
- communicating Health Canada policy or procedure changes to program recipients when they occur (n=4),
- assisting in amendments to contribution agreements (n=6),
- representing Health Canada and Health Canada interests (n=4), and
- ensuring timely and responsible monitoring of Project funds and activities (n=4).

As it pertains to the monitoring of project activities, the document review suggests that Program Officers verify narrative reports to follow progress. There is evidence that they are requesting additional information for incomplete or poorly completed reports. However, it was difficult to track the integrated changes or to observe any real progress or change made from report to report.

Finding 15 **Based on the data available, Program Officers appear to have a considerable workload; infrequent communications with recipients; and activities that seem more focussed on the processing of payments. Additionally, about half of Program Officers have been monitoring project files.**

The document review highlighted a number of additional issues related to human resources that may have had an influence on Program Officers capacity to carry out their role:

- the there was no acting Program Manager at OLCDB from 2002 until September 2005,
- the turnover rate among Program Officers was high,
- Société santé en français was audited which may have contributed to limit their ability to meet reporting requirements for a period of time, and
- the OLCDB office was relocated complicating file management by Program Officers.

According to the survey, the level of satisfaction among primary beneficiaries concerning their interactions with Program Officers was good, with 10 out of 14 respondents (primary beneficiaries) indicated a "5 or higher" on a 7-point scale for level of satisfaction. No respondents were completely dissatisfied. Of those respondents who were "less than satisfied," administrative burden, level of knowledge of the Program Officers and difficulty reaching the Program Officer were among the explanations.

Finding 16 **Despite Primary Beneficiaries are overall satisfied of their interaction with Program, the heaviness of Program Officers workload and contextual factors (turnover, vacancy) may have influenced their capacity to ensure close monitoring of contribution projects.**

Program Monitoring and Reporting Systems

The document review suggests that a monitoring system is in place covering all projects as outlined in their Contribution Agreement. The monitoring system builds on the work conducted in 2004 in conjunction with Government Consulting Services (formerly Consulting and Audit Canada) to produce a new format for reporting procedures. As a result, projects now have to submit a Narrative Report and a Financial Report quarterly, while Action Plans and Status Reports are required annually. Additionally, primary beneficiaries[14] agreed to provide a formative evaluation report.

The review revealed however that there was considerable variation in project files. In some cases data reported by beneficiaries were either insufficient or inconsistently and filing procedures were not standardized. However, files pertaining to other projects were detailed and project information was well documented including Program Officer input.

According to the document review:

- Financial Reports were most often completed on time and did not necessitate any change.
- Annual (or status) reports were most often of good quality. One project reported the use of an additional reporting and monitoring tool.
- Narrative reports provide a summary of short-term results with respect to yearly projected activities and planned results. There is a wide variety of quality in narrative reports and the quality of some of the reports seemed to indicate that projects lacked understanding of basic reporting.

Finding 17 **There is evidence of the existence of a monitoring system however, there is not enough data on the nature of the information collected through the different types of reports to assess its pertinence or usefulness. The varying level of completeness and quality of project files may also impact on the usefulness of the monitoring system.**

By October 2006, three evaluation reports had been received by the Official Language Community Development Bureau, representing 13 of the 14 Program projects under the Contribution Program. The CNFS Secretariat and member institutions were covered under a single evaluation report. The evaluation report for Quebec Community Groups Network was not

[14] McGill was not required to submit an evaluation until the end of a 4 year period but did submit a brief report.

received in the data collection time frame; however, the evaluators for QCGN did provide a PowerPoint presentation of preliminary evaluation results to the Official Language Community Development Bureau.

Some evaluations corresponded to the Official Language Community Development Bureau evaluation needs, whereas others were sparse and reflected a poor understanding of evaluation practice. It seems that Health Canada did not sufficiently follow-up with program beneficiaries regarding their evaluations.

In the formative evaluation survey, Program Officers and beneficiaries strongly endorsed all five reporting and monitoring tools (i.e., financial report, narrative reports, action plans, status reports and evaluations) and procedures. Concerns were expressed by Primary and Secondary beneficiaries regarding reporting requirements that they felt were sometimes excessive.

While respondents reported that the individual reporting and monitoring tools were useful, precise, and contained accurate information when completed, it was not clear to beneficiaries, Program Officers, and to the evaluation team how reporting and monitoring tools should work together to inform decision makers and Program administrators. There is a lack of a systematic integration of reporting and monitoring tools.

Finding 18 **While reporting / monitoring tools are supported, these tools are sometimes considered excessive which may be exacerbated by the apparent lack of understanding regarding the purpose and expected use of these tools as part of program management activities.**

Program Progress

The intent of this section is to assess the extent of program progress after three years of operation through the examination of activities carried out by the program primary and secondary beneficiaries. This exercise will document program results, which may then be quoted in a forthcoming Treasury Board submission as deemed appropriate.

Question 6 What Program effects may be identified for training and networking at this mid-point of the Program?

The purpose of this question is to assess the extent of program progress at the mid-point of the program as it pertains to its key activity area: Networking Support and Support for Training and Retention. Findings from the document review will be used primarily to answer the evaluation question as well as the literature review, to a much lesser extent.

Networking Component

The networking component of the Contribution Program promotes the establishment of networks that facilitate and improve the circulation of health information and communication among health sector stakeholders as well as the empowerment of local OLMCs in the health sector. Primary beneficiaries of the networking component are Société Santé en français and Quebec Community Groups Network. They bring together secondary beneficiaries they have selected on the basis of proposals for projects which meet the objectives of the Program.

Networks are in place in all provinces and territories. In Quebec, 10 groups receive funding to coordinate local or regional networking activities. Ontario has four regional network units (one of which precedes Health Canada Program for Official Languages) covering activities across all areas of the province, while in New Brunswick there are three networking units responsible for sector-specific collaborative activities. All other provinces and territories have one Francophone network operating in the province.

A large part of the network activity is in communicating and establishing links between players (Appendix C). The ten Anglophone network partners have reported participating in, establishing or organizing forums, work groups, network meetings, and retreats with either each other or with health partners. Seven of these network units have functional websites through which they share information with each other and the public. All of the 17 Francophone networks have participated, established or organized forums, and network meetings. Eight of the 17 Francophone network units have functional websites. The Anglophone networks are coordinated by a central network unit — the Community Health and Social Services Network — that serves as a strategic pivot for the other network units.

Most interviewees were familiar with the networking component of the Program and viewed it as “a very good thing.” Awareness of existing services as well as general health information with local level relevance has increased among community members, community organizations, health providers, health managers and policy-makers. There is evidence of a greater presence by OLMCs at “the table” where decisions are made with respect to planning and delivery of services, particularly in the regions where networking projects are active.

The internet-based survey revealed that 55% of individuals participating in network meetings found them very useful for increasing contact with health sector professionals. In addition, 42% of individuals found the network meetings were very useful for increasing their knowledge of activities and resources of the network as well as increasing knowledge of OLMC needs in their region. Conversely, under half of individuals found that these meetings were not useful in providing administrative assistance on the proposal process nor were they useful for acquiring technological capacity and skills.

Networks strive to engage the five principal health partners identified in the World Health Organization's "Towards Unity for Health" approach [Boelen 2000] which aims to foster unity in providing health services based on people's needs. According to the survey conducted as part of the evaluation, it seems that health service providers (65%), health system managers (60%) and educational institutes (60%) are more likely to be represented in networks than government officials and policy makers (27%).

Table 9 presents the extent to which networks involve these five key partners.

Table 9 – Extent to which Networks Involve Key Health Partners

Partner	Connecting[15]	Coordinating[16]	Cooperating[17]	Collaborating[18]
Health service providers (N=24)	100%	79%	67%	54%
Health system managers (N=22)	100%	77%	73%	64%
Government officials or policy makers (N=10)	100%	80%	50%	50%
Educational institutions (N=22)	100%	86%	73%	68%
Community level organizations (N=19)	100%	84%	74%	60%

The level of development of the network and its impact on health system access for OLMCs varies from network unit to network unit. However, given the strong level of involvement with health partners, networks may potentially be well positioned to affect change or impact OLMC access to health services.

Survey results also indicate that secondary beneficiaries feel they have influence (81%) and are empowered (81%) by their network with respect to decision-making as an OLMC. The working relationship between secondary beneficiaries and their coordinating agency can generally be described as good. This was noted by beneficiaries of their coordinating agency especially in the

[15] Involves the exchange of information for mutual benefit.

[16] Involves exchanging information and altering activities for a common purpose.

[17] Involves exchanging information, altering activities and sharing resources.

[18] Involves exchanging information, altering activities, sharing resources and enhancing the capacity of the other partner for mutual benefit and a common purpose.

areas of sustained support for the initiative; confidence in the network members to take a leadership role; and, in understanding administrative requirements and human resource capacity of the beneficiary group.

While some of the benefits from networking activities are immediate such as community engagement and increased awareness at all levels with respect to OLMCs and health related concerns, the key partnerships that hold the promise of authentic empowerment and sustainability are still in the early stages of development and durable bridging from the local to the regional and provincial levels are expected to be more tangible in the long-term. The fact that Francophone official language minority communities are so geographically widespread means the engagement and collaboration of these networks is an ongoing challenge, while for the population in Quebec acknowledgment of the contemporary OLMC profile by regional and provincial decision-makers is still a goal. Additional details on short terms results of the Contribution Program projects are presented in Appendix D.

Finding 19 **At this point in the Program, the Program has contributed to the implementation of at least one network in each province and territory however, the key partnerships necessary to empower communities and to foster the networks' sustainability are still at an early stage of development.**

Support for Training and Retention of Health Professionals Component

The training and retention component of the Program is implemented through partnerships with Canadian educational universities and colleges. Beneficiaries of this component for Francophone minority communities are recognized post-secondary institutions working to increase the supply of French-speaking health care professionals in French language minority communities, and the Consortium national de formation en santé secretariat (CNFS) that coordinates the projects within these institutions. For Anglophone minority communities, the beneficiary is McGill University.

Consortium national de formation en santé

The *Consortium national de formation en santé* is expected to use Program funding to bring about the extension of health professional training in French across the country via participating educational institutions as well as media-based and distance training. Since Program inception, CNFS member institutions have supported and extended training in the fields of: audiology, ergotherapy, gerontology, nursing and male nursing expert, kinesiology, medicine, nutrition, speech therapy, pharmacy, physiotherapy, psychology, clinical psychology, midwifery, medical laboratory sciences, health sciences,

sports therapy, nursing science, social service, radiological technology, medicine and social work. Various levels of programming are offered. Table 10 lists the university-level programs that have been offered in CNFS institutions from 2003 to 2006.

Table 10 – University-Level Programs Offered in CNFS Institutions, 2003 to 2006

	Program							Total
	Certificate	Minor	Bachelor	Graduate Certificate	Medicine	Masters	Ph.D	
Université Sainte-Anne, Collège de l'Acadie (Nova Scotia)			1					1
Université de Moncton (New Brunswick)	1	1	7			4	1	14
Québec / New Brunswick Agreement (New Brunswick)			1		1			2
Université d'Ottawa (Ontario)	1	1	10	1	6	1	1	21
Université Laurentienne (Ontario)	1		11	1		1		14
Collège universitaire de Saint-Boniface (Manitoba)			1					1
Campus Saint-Jean, Université de l'Alberta			1					1
Total	**3**	**2**	**32**	**2**	**7**	**6**	**2**	**54**

Since Program inception, CNFS colleges have supported and extended training programs in the following fields: health care aides, ergo therapy and physiotherapy assistant, dental hygienist, auxiliary nurse, massage therapy, personal support work, health sciences, continuous care health services, nursing, paramedic, ancillary medical, dental care, palliative care, medical laboratory technician, specialized education (technician), pharmacy technician, radiology technician, medical radiation technician, respiratory therapy, social-gerontology work technician, medical electrophysiology technician, etc.

Table 11 shows the total number of training programs for CNFS colleges.

Table 11 – Number of Programs Created in CNFS Colleges, 2003 to 2006

Université Sainte-Anne, Collège de l'Acadie (Nova Scotia)	4
Collège communautaire du Nouveau Brunswick – Campus Campbellton	8
La Cité collégiale (Ontario)	18
Collège Boréal (Ontario)	14
Collège universitaire de Saint-Boniface (Manitoba)	2
Total	**46**

In addition to offering courses in a traditional setting, many institutions have long-distance training programs. For example, the Collège Boréal has credited web-based courses; the Collège universitaire de Saint-Boniface has developed a series of video-conferences; and the Collège communautaire du Nouveau Brunswick, campus Campbellton has developed and is offering a certificate program entirely through long-distance training.

In the course of interviews conducted for the formative evaluation, interviewees underlined the need for additional resources and health professionals, which are in part addressed by the training and retention component. Some interviewees also highlighted current challenges facing OLMCs, out of which two appeared to be addressed in part by the training and retention component (i.e., the shortage of health care professionals who can speak the minority language with fluency in medical terminology and the inconsistency in services offered). The difficulty in obtaining specialized services such as mental health programs is noted as well as the general lack of knowledge of existing services among OLMC members. Some suggestions were made which have already been considered in the design of the training module such as investing in local level language training for health care professionals (as with McGill University). Another suggestion was to create a virtual learning centre for those professionals who are unable to take conventional training courses using the internet and videoconferencing (CNFS has established many long distance training programs). And another recommendation was to have interpreters at the point of service, which has been a successful practice in countries other than Canada. It was proposed this would ensure a focus on language and improve fluency in French or English.

Data collected for the formative evaluation of the Health Care Training and Research Project of the CNFS reveal an increasing number of candidates undertake health studies in french.

Under this project, the primary objective set forth by the ten member institutions of the Consortium was to accept 2500 new students over a five-year period, 2003-2008. As of the project's fourth year, 2135 candidates were registered in member institutions' health programs, which exceeds by 34% the goal set by the CNFS for 2006-2007. According to the Consortium, this finding suggests that the Consortium and its partners could achieve or surpass their original objective of 2500 new students.

In its third year of operation, the ten member institutions of the CNFS project have generated 574 graduates, which constitutes a 55% advance over the project's objective for 2005-2006. At the outset of the project, it was projected that 1200 students would graduate with health diplomas over the five-year period, 2003-2008. According to the CNFS evaluation, the number of graduates provides an encouraging marker that the five-year target of 1200 graduates will be achieved."

Finding 20 **Through CNFS, Program funds are being used to deliver a variety of health and social service training programs at many levels. However, the criteria applied / used to prioritize these programs have not been documented as part of this evaluation. Student enrolment appears to be on the rise as well as graduation rates.**

McGill Training and Retention Programs

The Training and Retention Program component within Quebec for English-speaking OLMCs is delivered exclusively by McGill University.

McGill University has opted to implement its training and retention strategy over a period of three years (2005-2006 to 2007-2008). Table 12 outlines the various measures McGill University has undertaken that fall within the program, the general activities of these measures, proposed timelines and budget allocations for each measure.

Table 12 – McGill University Training and Retention Strategy

	Activities	Timeline	Estimated Budget (as of 2005)
Measure 1	Implementation and teaching of English second language courses for French-speaking personnel in the 16 health and social services regions covered by the program;	2005-2006 to 2007-2008	$4,284,000
	Implementation and teaching of French second language courses for English-speaking personnel, in particular those persons working in a French-speaking environment;		$476,000
	Creation and support of exchanges and a network for trainers aimed at fostering communication and the sharing of best practices.		$990,000
Measure 2	Creation and support of incentives with respect to retention to encourage English-speaking professionals and students to work in the regions; Offer of distance professional and community support.	2006-2007 to 2007-2008	$3,000,000
Measure 3	Organization and support for symposia and conferences.	2005-2006 to 2007-2008	$750,000
Measure 4	Creation of an innovation fund that will finance projects related to the recruitment and retention of staff (supporting local or regional initiatives).	2006-2007 to 2007-2008	$2,000,000
Total			**$2,750,000**

It is important to highlight that measures 1 and 3 commenced in 2005-2006 while measures 2 and 4 were launched in 2006-2007. Data from these programs, therefore, is limited in most cases to only one year and to measures 1 and 3.

The document review revealed that there are high enrolment rates in English language courses which suggest that the McGill Initiative may be successful. In its first year, the following personnel categories have received training: intake personnel including health and social service intake (56%), social service workers (24%) and health care workers (20%). A total of 2460 of 5858 students requesting services received language training during 2005-2006. There is an immediate outcome from these enrolment rates in that they indicate an increased offer of health care workers with the ability and willingness to communicate in their second language. More specific data on the type of health professionals and on the area where Program trainees end up working would be necessary to draw stronger conclusions on program effects on access to services provided in English.

There is some question as to why the expectation regarding the training of English-speakers in French has not been met with the same success given the low rates of enrolment. Professional support and recruitment through telehealth and internships all appear to be on track towards meeting the outcome of increasing and retaining professionals in the regions outside of Montreal. This is difficult to assess in the short-term as the professional program has not yet produced graduates. More conclusions may be reached concerning outcomes in the summative evaluation.

In addition to the linguistic training program, McGill University has set aside a portion of funds to support the organization of symposia and conferences. In this regard, McGill organized a conference of 250 participants in the health and social services in Quebec that regrouped key players from provincial government, health service providers and institutions. Measure 3 represents a small (6.5%) portion of total spending. Though other activities are planned in this measure, activity will be limited as this measure acts only as a tool for the support of the training measures.

McGill University has successfully established linguistic training programs in all of the 16 regions of Quebec. The demand for linguistic training is large and McGill has targeted front-line health and social service personal responding to immediate Program objectives and concerns. McGill University has a global strategy aimed at both linguistic training and retaining Anglophone health care professionals in low-English and rural regions. Retention strategies will be delivered in 2006-2007 and 2007-2008.

Finding 21 **In the first few years of the Program, McGill implemented language training in all of the 16 regions of Quebec which appears successful. Language training programs developed by McGill also include french language training programs which have not created the same interest.**

Finding 22 **Given that no evidence had been collected on activities related to 'Retention' it is not possible to discuss the progress relatively to this aspect.**

Summary and Recommendations

There are valuable lessons to be learned from the formative evaluation of the Contribution Program for Improving Access to Health Service for Official Language Minority Communities. Please find below the conclusions stemming from the formative evaluation.

Key Conclusions

Relevance – Program objectives are relevant based on the assumption that accessing health services in its mother tongue is considered a right. Otherwise, recent data suggests that the hypothesis to the effect that language is a barrier to access to health services for OLMCs can be questioned. Should the Program be renewed, activities of initiatives such as the Health Human Resource Strategy and other provincial or territorial initiatives appear to be complementary to its success. This conclusion is based on the following key findings:

1. The Contribution Program is among the Government of Canada programs that are designated to support official language minority communities under the *Official Languages Act*.

2. Infrastructures – from the Health Human Resource Strategy as well as a number of provincial or territorial initiatives – aimed at providing information or at amending legislation may help the Program focussing the efforts of the Training and Retention component.

3. Data of the Canadian Community Health Survey released in 2005 suggest that differences between the majority and minority groups are not significant regarding health practices, care and access.

Design & Delivery – Based on the data made available through the evaluation, there seems to be concerns about the potential for the Networking and Support for Training and Retention of health professionals, as designed, to deliver on the program objective to increase access to health services for OLMCs. This nonetheless the Program is based on the results of consultation with stakeholders who appeared well positioned to provide advice on such initiatives. This conclusion is based on the following key findings:

4. The Health Canada Consultative Committees have been instrumental in defining program design and in identifying directions of the Official Language Contribution Program.

5. The design of the networking component may necessitate significant adjustments in order to improve access to health services for OLMCs. Similarly, there seems to be concerns about the potential for the Support for Training and Retention of health professionals to deliver on program objectives.

6. Consultative Committees appear to be perceived as bodies with unclear roles as it pertains to the transmission of communities concerns to governments.

Program Management – While Primary Beneficiaries are overall satisfied of their interaction with Program, the evaluation revealed that the heaviness of Program Officers' workload might have influenced their capacity to appropriately monitor the Program's projects. In additiona, although it was not possible to assess the appropriateness / usefulness of reporting and monitoring practices given the lack of data, nor was it possible to determine the extent to which they inform program management. This conclusion is based on the following key findings:

7. Program Officers appear to have a considerable workload; infrequent communications with recipients; activities that seem more focussed on the processing of payments; and about half of Program Officers have been monitoring project files.

8. Not enough data on the nature of the information collected through the different types of reports – which vary in terms of completeness and quality – were collected to assess their usefulness.

9. Reporting / monitoring tools are overall supported while sometimes considered excessive.

Program Progress – At this point in time, the Program appears to be close in reaching the level of 'Immediate Outcomes' of their logic model:

10. networks have been implemented in all provinces and territories and the key partnerships necessary to empower communities are emerging;

11. outside of Quebec, students enrolment appears to be on the rise – as well as graduation rates – in a variety of health and social service programs funded by the Program;

12. McGill implemented english language training in all of the 16 regions of Quebec as well as french language training programs, although they do not seem to generate the same level of interest.

Evaluation Recommendations

The conclusions of the evaluation have allowed for the identification of gaps in two key areas: knowledge base; and, Program monitoring and reporting. These gaps, if left unchecked, may limit Program's capacity to assess the extent of Program results and to meet its objectives. In order to address these gaps and maximize Program's potential to improve access to health services for OLMCs, the following recommendations have been formulated, stemming from the conclusion of the evaluation.

Recommendation #1 – *A plan for the ongoing consolidation and dissemination of objective, rigorous and independent (whenever possible) research documenting aspects relevant to OLMCs as it pertains to their access to health services and their health status should be developed within the Health Portfolio.*

Research documenting aspects relevant to OLMCs should be considered as a component of the Program performance measurement strategy. As a result, the performance measurement strategy should be reviewed accordingly.

The aspects covered by this data consolidation exercise should minimally include:

13. sufficiently precise data on the type and intensity of health services available to OLMCs compared to comparable communities of the associated majority;

14. sufficiently precise data, tracking the evolution of the use of the mother tongue as the main language spoken;

15. a gap analysis comparing the offer of services at the community level with evidence-based description of OLMCs needs (health status) and services available at reasonable distance from the communities, this in order to define the best (appropriateness and economy of input) program design or mix of interventions, to prioritize them and to identify research gaps.

Such information would prove to be useful as it pertains to:

- providing evidence to support the development of networks aimed at influencing planning and delivery of health services by integrating all the needed players: local organizations, provincial governments, public partners in the health sector and service providers;
- providing a baseline for collaboration between research communities situated at different levels (i.e. national, provincial, and regional), between Health Canada and other government departments, and between Francophone and Anglophone OLMCs;

- define an evidence-based funding distribution for the different Program component and OLMCs; and
- prepare the OLCDB for Program evaluations.

Recommendation #2 – *Health Canada should complete a comprehensive review of the Program model is conducted in anticipation of the renewal of Program Terms and Conditions building on: 1) a broader set of relevant and independent stakeholders that closely represent OLMCs at the local level, 2) on evaluation findings and, 3) on the research evidence collected under Recommendation #1.*

Recommendation #3 – *Upon renewal of the Contribution Program, Health Canada should review its selection process to ensure it is open, transparent and based on specific criteria allowing for the assessment of recipients' capacity to deliver on Program objectives. Health Canada should also have all primary recipients engage in similar processes for the selection of secondary recipients.*

Recommendation #4 – *In anticipation of Program renewal, Health Canada should consider including in its submission to Treasury Board a request for salaries and operating funds to strengthen program monitoring and assure the research and performance measurement data responding to the Treasury Board Evaluation Policy are available to inform decision-makers on the Program.*

Recommendation #5 – *Health Canada should identify the common outcome indicators (as well as the related definitions and targets) required for the management and evaluation of the Program. More specifically, data should be collected and reviewed periodically to identify and correct data gaps. Then appropriate comparison with the identified targets should contribute to inform Program management.*

Recommendation #6 – *In partnership with key stakeholders – i.e. Federal level decision makers, Program beneficiaries and OLMCs representatives – Health Canada should ensure that evaluation practices are:*

16. *consistent with the Program's RMAF (including the additions to the performance measurement strategy referred at in Recommendation 5); and,*

17. *accepted as a program management aid.*

Appendix A – Canada's Official-Language Minority Communities – Key Demographic Characteristics from the Perspective of Health

	Demographic Situation					**English-French Bilingualism**			**Socio-economic Characteristics (minority-majority index)**			**Aging (minority-majority index)**		**Health-related Professionals, Education and Industry (minority-majority index)**		
Region	Total population	OLMC (number)	OLMC (pct of population)	Population change, 1996-2001	Relative population growth	English-French bilingualism, general population	English-French bilingualism, official language minority	English-French bilingualism, official language majority	Lacking high school certification (relative to the majority)	Unemployment rate (relative to majority)	Low income (less than $20K) compared to majority	Proportion of seniors (relative to the majority)	High levels of unpaid care to seniors (relative to the majority)	Employed in health care and social services industry (relative to the majority)	Working in health occupations	Postsecondary training in health sciences
Newfoundland and Labrador	508,075	2098	0.4%	(173)	1	3.9%	93.0%	3.5%	0.81	0.76	0.97	1.29	0.81	0.58	0.65	0.66
Prince Edward Island	133,385	5275	4.0%	(60)	0.98	11.0%	96.8%	7.4%	1.2	0.99	1.06	1.76	1.08	0.68	0.54	0.54
Nova Scotia	897,565	33768	3.8%	(843)	0.98	9.3%	96.0%	5.9%	1.07	0.93	0.99	1.46	0.89	0.8	0.75	0.83
New Brunswick	719,710	238453	33.1%	(2,585)	1.00	32.6%	69.5%	14.4%	1.33	1.25	1.08	1.01	0.97	1.15	1.13	1.04
Quebec	7,125,580	918955	12.9%	(6,875)	0.98	37.8%	61.2%	34.6%	0.82	1.17	1.02	1.1	1.42	0.78	0.76	0.86
Ontario	11,285,545	527708	4.7%	15,908	0.97	11.6%	90.8%	7.8%	1.12	1.04	1	1.19	1.02	1.01	0.94	0.92
Manitoba	1,103,700	43383	3.9%	(3,188)	0.93	9.4%	96.8%	5.6%	1.01	0.74	0.94	1.56	0.79	0.98	0.99	0.91
Saskatchewan	963,150	16553	1.7%	(1,168)	0.95	5.2%	98.0%	3.5%	1.03	0.67	0.94	2.06	0.79	1	0.91	0.79
Alberta	2,941,150	58823	2.0%	6,323	1.02	6.7%	96.9%	4.9%	0.97	0.83	0.95	1.44	1.02	0.84	0.82	0.88
British Columbia	3,868,875	59373	1.5%	3,065	1.01	6.7%	96.8%	5.5%	0.96	1.09	1	1.34	0.82	0.9	0.93	0.77
Yukon	28,520	883	3.1%	(233)	0.85	10.5%	95.7%	7.3%	0.58	0.89	0.94	0.69	0.98	0.57	0.74	1.11
Northwest Territories	37,105	915	2.5%	(35)	1.01	7.7%	97.1%	5.6%	0.64	0.39	0.66	1.76	0.27	0.79	0.79	0.93
Nunavut	26,665	415	1.6%	(18)	0.90	4.0%	97.7%	2.9%	0.32	0.26	0.42	2.9	0.14	0.98	1.13	0.76
Canadians living as OL minorities	29,639,025	1906598	6.4%	10,120	0.97	17.0%	74.3%	13.1%	1.01	1.21	1.04	1.18	1.06	0.92	0.89	0.84
Francophone minorities	22,513,445	987,643	4.4%	16,995	0.97				1.16	1.17	1.03	1.24	0.97	1.02	0.96	0.91
Anglophone minorities	7,125,580	918955	12.9%	(6,875)	0.98				0.82	1.17	1.02	1.10	1.42	0.78	0.76	0.86

Source: Official Languages Support Programs Branch, Canadian Heritage, 2004, based on 1996 and 2001 Census of Canada, Statistics Canada, 1996, 2001.
Notes: Language definition is First Official Language Spoken, with dual responses distributed equally.
The minority-majority index compares the value for the OL minority group in a given region with the value for the majority for that region.

Appendix B – Health Practices, Care and Access for Official-Language Groups in Canada, 2005

	Francophones Outside Quebec	Anglophones Outside Quebec	Quebec Anglophones	Quebec Francophones
Do you have a regular doctor?	89.1%	89.0%	72.4%	75.3%
Self-perceived unmet health care needs	11.0%	11.1%	13.4%	12.3%
Self-perceived health (% of excellent, very good and good)	86.7%	88.7%	89.9%	90.0%
Do you have chronic conditions?	72.4%	69.4%	67.3%	68.1%
Have you received home care services by Government?	2.6%	2.8%	2.9%	3.1%
Have you received home care services not covered by Government?	2.9%	3.2%	2.5%	3.2%
Self-perceived unmet home care needs?	2.4%	1.7%	*1.7%	1.7%
Did you have a flu shot within last year?	37.6%	36.3%	30.3%	24.4%
Did you have a Pap Smear test within last 3 years?	72.3%	70.5%	67.4%	64.5%
Did you have a mammogram within last 2 years?	53.2%	48.0%	43.7%	46.4%
Received health care services?	92.8%	96.1%	91.2%	93.4%
Rating of quality of health care received	88.1%	85.9%	80.1%	86.9%
Satisfaction with way health care provided	88.8%	85.0%	81.9%	89.4%
Received health care services at hospital?	31.0%	28.2%	26.4%	32.4%
Rating of quality of health care at hospital received	82.4%	82.9%	76.7%	82.3%
Satisfaction with way health care at hospital provided	84.8%	80.3%	82.2%	84.7%
Received physician care?	61.3%	67.1%	59.5%	61.6%
Rating of quality of physician care received	92.8%	91.1%	87.7%	92.9%
Satisfaction with way physician care provided	91.1%	91.5%	89.0%	92.6%
Received community-based care?	16.6%	19.9%	22.3%	13.8%
Rating of quality of community-based care received	89.6%	77.4%	62.5%	88.7%
Satisfaction with way community-based care provided	90.7%	80.9%	67.9%	89.4%
Experienced difficulties getting specialist care	24.3%	22.5%	28.7%	19.4%
Experienced difficulties getting non-emergency surgery	*28.4%	16.4%	**19.6%	21.1%
Experienced difficulties getting test	*14.6%	21.0%	*31.3%	18.5%
Experienced difficulties getting health information	19.7%	14.9%	*21.7%	16.6%
Experienced difficulties getting on-going care	15.5%	14.1%	*20.8%	20.7%
Experienced difficulties getting immediate care	16.3%	21.6%	*26.7%	21.0%

Source: Canadian Community Health Survey (2005) and Health Services Access Survey [Tipenko 2006].
* Warning: high sampling variability associated with this estimate (16.5% < CV < 33.3%)
** Sampling variability associated with this estimate is in unacceptable range (CV > 33.3%)

Appendix C –Overview of Secondary Networking Beneficiary Activities

	Network Name [website]	Mission / Area of Activity	Network Information Exchange Practices					Region Served
			PF	WG	Web	M	RT	
Quebec Community Groups Network [www.qcgn.ca]								
1	Community Health and Social Services Network [chssn.org]	Provincial network coordinator / health and social services	X	X	X	X	X	Quebec
2	Catholic Community Services [www.ccs-montreal.org]	Support services / youth / mental health	X	X	X	X	X	Montreal East
3	Coasters Association [lns.htmlweb.com]	Networks / youth / health and social services	X	X	X	X	X	Lower North Shore
4	Committee for Anglophone Social Action [www.casa-gaspe.com]	Advocacy / health and social services	X	X	X	X	X	Gaspé Peninsula
5	Council for Anglophone Magdalen Islanders	Rights / health and social services	X	X	X	X	X	Magdalen Islands
6	Fraser Recovery Program	Youth addiction	X	X		X	X	Gaspé and Magdalen Islands
7	Megantic English-Speaking Community Development Corporation [www.mcdc.info]	Support services / partnerships / translation	X	X	X	X	X	Chaudière-Appalaches and l'Érable
8	Regional Association of West Quebecers [www.westquebecers.com]	Advocacy / liaison / health information	X	X	X	X	X	Outaouais
9	Townshippers Association (2 projects) [www.townshippers.qc.ca]	Cultural identity / engagement / support services	X	X	X	X	X	Estrie and Montérigie
10	Vision Gaspé-Percé Now	Elders / youth / health and social services	X	X		X	X	Gaspé Peninsula
Société Santé en français [www.forumsante.ca]								
1	Réseau de santé en français de Terre-Neuve et Labrador	Health and social services			X	X	X	Newfoundland and Labrador
2	Réseau des services de santé en français de l'Île-du-Prince-Édouard [santeipe.ca]	Health and social services	X			X	X	Prince Edward Island
3	Réseau pour les services de santé en français, Nouvelle-Écosse [www.federationacadienne.ca/fane/index.cfm?id=2917]	Health and social services / advocacy	X		X	X	X	Nova Scotia
4	Société Santé et Mieux-être en français du Nouveau-Brunswick	Health and well-being / advocacy	X			X	X	New Brunswick
5	Réseau-action formation et recherche	Health and social services	X			X	X	New Brunswick
6	Réseau-action organisation des services	Health and social services	X			X	X	New Brunswick
7	Réseau des services de santé en français de l'Est de l'Ontario [www.rssfe.on.ca]	Health services	X		X	X	X	Eastern Ontario
8	Réseau franco-santé du Sud de l'Ontario [www.francosantesud.ca]	Health services	X			X	X	Southern Ontario

	Network Name [website]	Mission / Area of Activity	Network Information Exchange Practices					Region Served
			PF	WG	Web	M	RT	
9	Réseau francophone de Santé du Nord de l'Ontario [santenordontario.ca]	Health and social services	X		X	X	X	Northern Ontario
10	Réseau santé en français du Moyen-Nord de l'Ontario	Health and social services	X			X	X	North-Central Ontario
11	Conseil communauté en santé du Manitoba	Health and social services / advocacy	X			X	X	Manitoba
12	Réseau Santé en français de la Saskatchewan [www.rsfs.ca/site]	Primary health services / advocacy	X		X	X	X	Saskatchewan
13	Réseau santé albertain [www.reseausantealbertain.ca]	Health services and health promotion	X			X	X	Alberta
14	RésoSanté Colombie-Britannique [www.resosante.ca]	Health and social services	X		X	X	X	British Columbia
15	Partenariat communauté en santé [www.francosante.org]	Health and social services	X		X	X	X	Yukon
16	Réseau TNO Santé en français [reseautnosante.ca]	Health and social services	X		X	X	X	Northwest Territories
17	Santé en français au Nunavut (Safran) [www.franco-nunavut.ca/safran]	Health and social services	X		X	X	X	Nunavut

Legend

PF	Provincial Forums
WG	Working Groups
Web	Websites/Newsletters
M	Meetings
RT	Retreats

Source: Official Languages Community Development Bureau, 2006

Appendix D – Short-Term Results of Contribution Program projects

Organization/ Project Component	Expectations	Outcomes
McGill – Language Training	McGill was expected (1) to offer French-language course to English-speaking health care and social service professionals and students working in Quebec. Through McGill, English-language courses are offered to French-speaking health care professionals across Quebec (47.9% of funding).	• Language courses have been designed and tailored to health care professionals. 15 of 16 regions are included in training in English as a second language course. • 18 establishments were involved: 39 centres de santé et de services sociaux, 14 centres de réadapation, 8 centres hospitaliers, 6 centres de protection de l'enfance et de la jeunesse et 6 centres d'hébergement et de soins de longue durée. • A total of 1,427 workers were trained in 2005-2006. This was 42% of those who expressed an interest in training. 3,398 are on the waiting list. • Language trainees were beginner and intermediate level. • Students included personnel de l'accueil, incluant l'accueil sante et l'accueil social (56%), le personnel des services sociaux (24%) et le personnel de la santé (20%). • French as a second language course is being offered to 30 health service providers in 2006-2007 in two regions, Montéregie and Outaouais.
McGill – Professional training/ support	McGill was also expected (2) to promote Professional training in the official language minority communities, particularly in the regions, as well as introduce regional incentive measures for recruitment and retention of Health professionals (25% of funding).	• English-speaking graduate retention programs: 20 projects in 10 regions. Primarily internships for English-speaking health and social service students with online supervision and support. • Long-distance support and professional development activities for English-speaking professionals outside of Montreal. • Long-distance community support: 5 programs developed aimed at public health education and prevention delivered to 28 sites through Tele-health.
Consortium national de formation en santé	• To improve access to health care and social service courses/programs for individuals from Francophone minority communities • Funding will be used to bring about an extension of such training across the country via participating educational institutions as well as media-based and distance training	Health Canada funds are used in CNFS universities and colleges to support a wide variety of programs (nursing, gerontology, medicine, social service, physiotherapy, paramedics, palliative care, etc.) • Ten universities and colleges distributed across Canada are members of CNFS. • Many institutions have long-distance training programs and to date, 133 courses were developed and available on-line.(For example, College Boreal has credited web-based courses, Université Saint-Boniface has developed a series of video-conferences, College Nouveau Brunswick is offering long-distance training) • 16 new programs have been launched and it is expected that 12 others will be in place by the end of March 2008 for an overall increase of 40% from the expected outcome.

Organization/ Project Component	Expectations	Outcomes
	• Build capacity within institutions that offer training to Francophone minority communities • No more than 3% of resources used for facilitation and to support for researchers	• 198 new clinical training settings have been developed representing a critical element in the success of CNFS. • Enrolment rates are exceeding expectations. Globally, CNFS generated 1,428 new inscriptions which is 33% greater than expected at Program mid-term. 296 training diplomas were granted which is 32% greater than predicted. • There is considerable activity in research. CNFS organized the first national forum on research concerning the health of Francophone minority communities in December 2004.
Quebec Community Groups Network	• Promotion of greater community engagement. • Development of durable links between stakeholders. • Mitigate geographic dispersal of communities and bridging for smaller isolated groups. • Facilitate information sharing and resource development. • Better position OLMCs to influence decisions surrounding the planning and delivery of health services in their region.	• Greater community engagement has been promoted through forums, working groups, meetings, publications among network units and open to the community at large • Links have been established among OLMC organizations and between community organizations, health professionals and health managers. The basis for links with government officials and policy makers is at hand but contact is less frequent and solid partnership is more of a long-term goal • Bridging networks with more isolated communities have been established. Each year over 50% of selected program participants are from vulnerable and isolated English-speaking communities across Quebec. Each of these communities are provided with ongoing access to professional development services through the network's community support program • The first stage of network building which entails establishing units, developing a shared knowledge base, collective visioning and the clarification of a strategic plan has been accomplished. There is evidence of resource sharing and cooperation which should lead to mutually beneficial exchanges in the future • There has been an emphasis in the Anglophone network on a knowledge-based approach to building networks. The focus on developing a locally relevant knowledge base (by province, health region and CSSS) concerning access to services and health determinants has empowered beneficiaries to press their case with appropriate partners in various regions. • The increased presence of Anglophone OLMCs in the health sector is illustrated by their representation in a number of areas such as Quebec's Provincial Committee on the Dispensing of Health and Social Services in the English Language, Advisory Committee of the Canadian Institute of Health Research, Vision Gaspe's presence on the Board of the local CSSS, Coaster's presence on the Board of the CSSS and the Regional Advisory Committee on English Language Services, etc.

Organization/ Project Component	Expectations	Outcomes
Société Santé en français	• establish strong, durable links among health sector stakeholders (health professionals, communities, policy makers, health care institutions, training institutions); • mitigate the geographic dispersal of Francophone and Anglophone minority communities and the isolation experienced by professionals; • promote community ownership (in terms of the planning, development, strengthening or pursuit and promotion of improved access to health care in French); • maximize the use of existing resources and share best practices; • make health sector stakeholders more aware of the importance of language in health service delivery; • improve services to French-speaking minority communities by delivering high-quality health care and increasing their use; and • build capacity to provide health services in French through professional networking, and promote research capacity in French.	• There are 17 networks among 12 provinces and territories with at least one network per province or territory (including 3 in New Brunswick and 4 in Ontario). Networks have undertaken activities that extend province-wide such as developing province wide repertoires of French-speaking health service providers. • Greater community engagement has been promoted through forums, colloquiums, meetings, websites and reports. • There is evidence of engagement with the five key partners – community organizations, ,health managers, health service providers, health policy makers, government officials. 8-10 networks have been formally recognized by provincial government authorities. • There is a strong partnership between the networks and projects funded under the Primary Health Care Transition Fund. • There is evidence of intra-provincial information sharing and resource development in Ontario and New Brunswick. Provincial joint participation is accomplished primarily through SSF meetings. • The strong partnership with local health units and government policy makers places SSF networks in a favourable position to have impact on the planning and delivery of services. Some SSF networks have also become a point of contact or regional "experts" on the health of OLMCs.

Source: Official Languages Community Development Bureau, 2006