



CENTRE DE RECHERCHE ET D'EXPERTISE EN ÉVALUATION

Final Evaluation Report

Final Version

Health and Social Services
Networking and Partnerships Initiative

Presented to
the QCGN

By

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Final Evaluation Report of the
Health and Social Services Networking and
Partnerships Initiative

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CREXE would like to thank the more than 140 people who participated in the different phases of the evaluation of the HSSNPI program by agreeing to be interviewed, taking the time to complete the questionnaires that were sent out, or participating in different focus groups. Respondents included the coordinators of projects funded by the program, network partners, members of English-speaking communities across Quebec, project developers who submitted projects under the HSSNPI and potential network partners. Without their cooperation, the evaluation initiated in winter 2006 would have been impossible.

We also wish to thank the HSSNPI project coordinators in all the regions visited for their outstanding cooperation in helping to coordinate every phase of the evaluation process. We also wish to thank the members of the Volunteer Committee and the ad-hoc Evaluation Committee for their interest and support throughout the process.

FOREWORD

In March 2003, the Government of Canada adopted a new action plan on official languages, part of which dealt with improving access to health services for official language minority communities. The latter fell under the responsibility of Health Canada, and comprised three initiatives, including the Contribution Program to Improve Access to Health Services for Official Languages Minority Communities. The Health and Social Services Networking and Partnership Initiative (HSSNPI) was launched in March 2004 as part of the Contribution Program to Improve Access to Health Services for Official Languages Minority Communities. The Quebec Community Groups Network (QCGN) received approximately \$4.3 million in funding over five years (2003-2008) from Health Canada to implement HSSNPI. The goal of HSSNPI was to build the networking and partnership capacities of English-speaking minority communities in Quebec so as to improve access to health and social services in English.

In February 2005, the QCGN mandated Centre de recherche et d'expertise en évaluation (CREXE) at École Nationale d'Administration Publique (ENAP) to present a proposal to evaluate the HSSNPI. The CREXE team proposed an evaluation process to assess the program in April 2005. At the same time, a draft HSSNPI evaluation framework was submitted and accepted by QCGN and the HSSNPI Volunteer Committee. The CREXE team was subsequently mandated to undertake the evaluation of the a) implementation and b) impacts (results) of the HSSNPI program.

SUMMARY

Introduction

In February 2005, the Quebec Community Group Network (QCGN) mandated the Centre de recherche et d'expertise en évaluation (CREXE) at L'École nationale d'administration publique (ENAP) to evaluate the Health and Social Services Networking and Partnership Initiative (HSSNPI). Specifically, the mandate was to evaluate the a) implementation and b) the impacts (results) of the program. The evaluation process consisted of three phases.

- In Phase 1 information was collected on the program issue and its various facets in order to document the *raison d'être* for the intervention and plan the subsequent implementation and effects studies. It concluded with the submission of an evaluation framework in April 2005.
- In Phase 2 (carried out in fall 2005 and winter 2006) the implementation and preliminary impacts of the program were assessed. A report on Phase 2 of the evaluation process was provided by CREXE to the QCGN in October 2006.
- In Phase 3, CREXE completed its assessment of the impacts (results) of the HSSNPI with regard to the English-speaking population. Phase 3, was undertaken in the fall 2007 and a final evaluation report was submitted in March 2008.

Under Health Canada's Contribution Program to Improve Access to Health Services for Official Language Minority Communities, the QCGN received approximately \$4.3 million in funding over five years (2003-2008) to implement the HSSNPI. The main objective of the program was to build provincial, regional, local, and sector health and social service networks in Quebec. These networks were intended to help to establish durable links between specific English-speaking communities and their health and social services systems with a view to improving access to a wider range of English-language services in the specific communities identified.

The accepted HSSNPI evaluation framework proposed to study the following questions with regard to implementation:

- 1) What is the *raison d'être* for the program and is it still relevant?
- 2) Was the program implemented as originally planned?
- 3) What factors facilitated or challenged program implementation?
- 4) Has the program yielded the expected outputs?

The accepted HSSNPI evaluation framework proposed to study the following questions with regard to generating impacts (results):

- 5) Did the HSSNPI lead to the generation, integration, and sharing of information and knowledge?

- 6) Did the HSSNPI lead to the creation of networks and partnerships that mobilized and engaged community resources and institutions, fostered the participation of decision-makers and organizations in the public health and social services system, and encouraged them all to work together?
- 7) Did the HSSNPI lead to the design and implementation of evidence-based plans and strategies at the provincial, regional, and local level to improve access to health and social services in English?
- 8) Did the HSSNPI facilitate dialogue among networks, institutions, planners, and English-speaking communities?
- 9) Did the HSSNPI lead to improved access to health and social services in English?

The accepted HSSNPI evaluation framework proposed to study the following question in terms of the final evaluation:

- 10) Overall, what is the value of the HSSNPI?

Methodology and methodological constraints

Three data sources were used to collect information about program implementation:

- A documentary analysis
- Semi-structured interviews
- An online survey

Individuals contacted to participate in the evaluation included project coordinators (interviews and online survey); network partners (interviews and online survey); and developers of non-funded projects and their potential partners (online survey). Data gathered from these different sources was then triangulated to obtain a more precise overview of the program.

As for the impacts (results) of the program on the English-speaking population, a single data source was used:

- Focus groups with members from five different English-speaking communities

Despite the CREXE evaluation team's constant efforts to ensure the validity, reliability, and rigor of the research method, the evaluation process presented certain limitations.

- The first of these is the low response rate with regard to the on-line survey. Only 17% of network partners, 3% of project developers who did not receive funding, and 8% of potential partners responded to the survey. Certain findings, therefore, need to be qualified.
- The second of these is related to the representivity of the respondents from certain groups (partners interviewed and focus group participants). It is impossible to determine whether all characteristics of the population under study are represented in the sample groups. Therefore, there is a degree of error. Biases may have been in-

roduced by subjects whose characteristics do not match those of the target population.

At the same time, however, a large number of respondents (over 140) participated in the evaluation. We also heard a range of views (respondents having planned and implemented the program, project coordinators, network partners, potential partners, members of five English-language minority communities).

We are, therefore, confident that the resulting portrait is reliable and valid.

Responses to evaluation questions

Responses to the first four questions related to implementation are addressed first. They are followed by the five questions related to the impacts (results) of the HSSNPI. The final question is related to the program's overall value and is addressed at the end of this section.

◆ HSSNPI implementation

1) What is the *raison d'être* for the program and is it still relevant?

The implementation study demonstrated that the main problem at the conceptual stage of the program was the limited capacity of communities and community organizations to participate fully in the health and social services system. Building capacity within the English-speaking communities appeared necessary if they were to play a meaningful and effective role in the public health and social services system. To achieve this goal, community organizations needed to have access to more resources and better organization. These findings were based on research on Quebec's English-speaking communities, as well as on the experience of key people who have been working on this issue for a number of years.

Networking was paramount among the three priorities set forth in the Government of Canada's 2003 official languages action plan. The CHSSN was tasked by the Health Canada Consultative Committee to design an approach that could leverage networking into building capacity for English-speaking communities. The idea was to develop an integrated strategy to accessibility that included coordinating activities related to primary care (via Primary Health Care Transition Fund - PHCTF), human resource development (via the McGill Project), and community capacity building (via the HSSNPI).

With regard to community capacity building, two dimensions underlay the developed approach: first, allocating resources to community organizations that agree to establish a roundtable whose role is to build and consolidate links among a variety of community and public-sector stakeholders; and second, identifying community needs and understanding how the health system works so that the community has access to services that are adapted to its needs and circumstances. Therefore, the assessment of the *raison d'être* of the program had to ensure that the types of projects funded by the HSSNPI promoted capacity building in vulnerable English-speaking communities and that the allocated funds were invested in network development and the creation of knowledge on community member needs.

Project selection was entrusted to an independent committee of volunteers who were responsible for the overall management of the HSSNPI, including the selection and funding of specific proposals. The Volunteer Committee¹ ensured that selected projects met established program criteria. At minimum, project promoters had to represent a non-profit organization, present a project to develop a health and social service network at the local, regional, or provincial level, and demonstrate sufficient knowledge of the community the project was meant to serve. Each proposal's potential to increase access to health and social services in English and generate sustainable results was also assessed.

Our assessment of Volunteer Committee choices showed that all of the projects selected respected the basic program requirements, even though some proposals had to be improved before qualifying for funding. All of the funded projects were submitted by not-for-profit organizations and contained a network development component. Funding was also allocated to projects that initially ranked poorly in terms of certain program criteria (such as the quality of the information provided about population needs, the action plan suggested, the sustainability strategy, etc.). In these cases, projects with evident potential were requested to improve certain parts of their proposals and/or submit a sustainability strategy in order to qualify for funding. Selected projects were, therefore, consistent with the idea of building community capacity.

Since the HSSNPI aims to build capacity in vulnerable communities, CREXE also looked at the proportion of the funds allocated by the Volunteer Committee to regions with access problems. The review of documents showed that the Volunteer Committee awarded 81% of the funding to regions with an index access under the provincial average. In addition, the ratio of awarded funds to English-speaking organizations is greater in regions with an index under the provincial average, i.e. the HSSNPI spent \$5,42 for each English speaker living in regions with an index below 1 (the provincial average), compared to \$0,71 in regions with an index superior to the provincial average. We can therefore conclude that more funding went to needier and isolated regions.

Finally, the evaluation of HSSNPI's *raison d'être* concluded with an assessment of the ongoing relevance of the program's main issue i.e. the limited capacity of English-speaking communities and community organizations. Indeed, there are illustrations that capacity levels vary among English-speaking communities across Quebec. As a result, the issue at the origin of HSSNPI is still relevant. First, even though the program was well publicized throughout the province, some regions did not present any proposal. This situation could be attributed to the English-speaking communities in these regions which are simply not organized enough to build a project. Secondly, the assessment of the proposals received at the beginning of the program showed that the proposals were of varying quality. Apart from irrelevant proposals, some potentially interesting projects ranked poorly with regards to the quality of information provided about population needs and the action plans proposed. This is another illustration of the limited capacities of these communities. For these reasons, there are still needs for a program like the HSSNPI. This also brings to light the need to find ways to encourage and support the creation of projects in regions with the lowest levels of access so that they can take advantage of a program like HSSNPI.

¹ The names of the individuals who served on the volunteer committee during the 2003-2008 project period are presented in annex I.

2) Was the program implemented as originally planned?

The study of the *raison d'être* showed that the initial intention of the HSSNPI was to make money available to specific communities to help them build their capacity to partner and develop relationships with the public health and social services sector so that the public sector would in turn adapt its services to their needs and circumstances. At another level, the program was intended to help each funded community develop its own capacity to adjust, interact and support itself in order to come up with more creative ways of addressing issues related to accessibility to health and social services. According to the data consulted during the evaluation, the nature of HSSNPI plans and activities match these initial intentions.

The HSSNPI was designed to offer conditional, multi-year funding to participants so that they could plan and implement projects until the end of the program in March 2008. A critical condition for granting and continuing to receive multi-year funding was the requirement to reapply for funding on an annual basis. This method was adopted to respect Health Canada's program management standards and to ensure that program participants generated ongoing results as contained in their approved project proposals.

In 2004–2005 (the first year of the public call for proposals), the Volunteer Committee selected 10 projects. Some participants were surprised to see a public call for proposals issued for the year 2005–2006. In the end, however, all initially funded groups performed well and continued to receive funding. Over the course of the program, only one new community group joined the HSSNPI. All initial participants received funding until the end of the program.

Lastly, prior to the program launch, it was also planned to fund a pilot project. The project chosen was put forward by the Townshippers' Association in the Estrie region. Since the association already had a relationship with the program designers, its work was used as a case study and the processes it used to develop and manage its project were shared with other HSSNPI participants.

3) What factors facilitated or challenged program implementation?

Health Canada's Contribution Program to Improve Access to Health Services for Official Language Minority Communities is a grants and contribution program with specific requirements regarding the development of results-based plans and initiatives. The program contains prescriptive reporting requirements with regard to program and financial activities. Continued funding by Health Canada requires the submission of satisfactory quarterly narrative and financial reports which demonstrate the generation of agreed upon results and due diligence and probity in terms of program management. The HSSNPI was subject to the provisions of Health Canada's funding program.

The HSSNPI's competitive selection process required that general information be provided to all applicants without giving any applicant an undue advantage in the presentation of their project proposals.

Initially (in the 2004-2005 and 2005-2006), program participants experienced difficulties in the planning and preparation of the funding applications. Problems included the complexity of the documents and the results-based language and requirements. In addition, some par-

ticipants felt that there was duplication in the submission of year to year information. Some indicated that there were difficulties in reaching the program managers at the start-up of the program and that there was a lack of feedback on past applications. In the first two years of the program, there was some confusion with respect to the management of the HSSNPI and the CHSSN community support role.

The implementation evaluation revealed that most project coordinators interviewed found that the program reporting requirements were heavy. The time required to produce reports was perceived by some to be unrealistic. Coordinators also mentioned that the lack of feedback on documents was a source of irritation.

There was an evident effort on the part of participants, program managers, the Volunteer Committee and the community support program of the CHSSN to address start-up issues on a regular basis and those that could be resolved by administrative means were corrected.

The online survey showed that for 50% of the coordinators, the main difficulty encountered during project preparation was estimating project costs in line with the HSSNPI funding envelope. Most HSSNPI participants thought their project would receive more funding. The projects that were impacted upon the most were those in regions where much travel was necessary.

As for factors that facilitated or complicated program implementation in the field, project coordinators mentioned a number of elements that may have had an effect, including geography; the history (or lack thereof) of partnerships in the region; the presence (or absence) of an Anglophone regional association in the region; the presence (or absence) of health and social services representatives in the initial conception of the project; the level of cooperation from certain public establishments; and the skills of project coordinators.

4) Has the program yielded the expected outputs?

At the program level, ten groups received HSSNPI funding. 7/10 regional/local groups received funding which was consistent with the program's objectives and selection guidelines. By the end of 2007–2008, HSSNPI had distributed \$3,082,834 to the funded groups. Not considering the CHSSN grant, each participating group received an average of \$246,604 (or \$49,321/year). Furthermore, 83% of the funded proposals met the Volunteer Committee's criterion of serving isolated English-speaking communities in Quebec. This is superior to the HSSNPI guidelines requiring that 50% of funded organizations be located in more isolated communities with small English-speaking populations.

The program monitored participant performance via regular quarterly reports, on-site visits and ongoing telephone and email communications with program participants.

At the participants' level, the online survey found that 85% of the project coordinators more or less agreed that despite some difficulties, notably with respect to the financial resources available, their organizations received sufficient funding to effectively execute their project activities. Despite less than expected funding allocations for some of them, the allocated financial resources allowed participants to deliver the anticipated program goods and services. It must also be noted that the Volunteer Committee was able to increase funding to program participants over the life of the program.

As a conclusion for the first four questions, the Preliminary Evaluation Report prepared by CREXE and deposited with the QCGN in October 2006 concluded that all things considered, the HSSNPI implementation, both at QCGN and program participants' levels, was excellent. Specifically:

- All expected outputs were successfully delivered and the HSSNPI was successful in spending the available funds as originally planned;
- The program was well publicized and information about the program, application procedures and related documentation were easily accessible;
- The largest level of funding went to isolated regions;
- The coordinators were satisfied with the support activities provided by the QCGN for the preparation of projects;
- Administrative issues were identified and resolved.

◆ **HSSNPI impacts (results)**

Before carrying on with the following questions, here is a summary of the main conclusions of the Preliminary Evaluation Report prepared by CREXE and deposited with the QCGN in October 2006 concerning HSSNPI impacts at that moment:

- Every funded organization developed at least one network;
- Participants' participation and commitment to the networking units were very satisfactory;
- The developed networks seemed also to have good sustainability potential;
- All HSSNPI participants generated knowledge concerning the health and social services needs and priorities of their respective communities;
- The CHSSN project was also successful in producing useful knowledge for the participants;
- English-speaking community members were effectively building relationships with health and social services representatives;
- Access priorities were also identified and actions were initiated in the funded communities;
- An increased understanding by public sector officials of the determinants of health and well-being for English-speaking individuals and their specific access needs and priorities was also reported by project participants and networks' members;
- New collaboration between community and public sector groups was nurturing a more informed dialogue which was creating a shared understanding of access issues;
- Access to English-speaking volunteers to assist in service delivery was increasing;

Here are the main findings pertaining to HSSNPI impacts.

5) Did the HSSNPI lead to the generation, integration, and sharing of information and knowledge?

All HSSNPI participants generated knowledge concerning the health and social services needs and priorities of their respective communities and were active in community outreach by developing a variety of communication tools. Every project included research activities (surveys, focus groups, regional forum, etc.). Both project coordinators and network partners agreed that the work accomplished had been successful in identifying the determinants of health and well-being for their English-speaking communities.

An analysis of quarterly narrative reports found that over half of the participants had reported that research activities had fuelled databases on the English speaking community in each region.

More than half of the participants also mentioned that the information gathered was disseminated to network unit partners, thereby increasing their own knowledge base. Knowledge and best practices were also successfully shared by the CHSSN with English-speaking community organizations and groups.

In sum, the HSSNPI achieved excellent results in terms of generating, integrating and sharing information and knowledge.

6) Did the HSSNPI lead to the creation of networks and partnerships that mobilized and engaged community resources and institutions, fostered the participation of decision-makers and organizations in the public health and social services system, and encouraged them all to work together?

This evaluation question covers three of the program targets (or outcomes): network creation, coordination, and community participation.

Every funded organization developed at least one network. During the first two years of the program, each participant created around 2 networking units. In each community, project coordinators were able to recruit from 5 to 150 partners. Still during the first two years of the program, on average, project coordinators and network partners met with their partners 26 times. Since then, all networking unit have remained active. Meetings are held between partners. Networking units seem to operate in a structured manner (based on the development of internal structures, practices, policies, mission statement, objectives, results-based strategic plan and evaluation procedures). Even though it is impossible at present to determine whether these networking units will sustain themselves, steps have been taken in that direction (drafting of a sustainability plan, approval of the plan by partners, grant applications, steps to be recognized as a charitable organization). CHSSN has also created a provincial network to link all funded communities.

For results concerning the coordination of actors involved, the online survey administered for the implementation evaluation showed that 82% of network partners and project coordinators agreed or strongly agreed that their participation in a networking unit allowed their organization to increase its capacity for developing future projects in collaboration with

unit members. Furthermore, 83% of network partners were open to the idea of sharing some of their organization's resources with other network partners in order to implement projects related to health and social services. Interviews with network partners revealed that since joining a networking unit, almost all of them had discovered new community groups that shared their interests. Partners that had never worked together in the past now had the opportunity to participate in network activities and start working together on different types of projects. Participation in networking activities has also allowed them to discover resources and services available in their community.

Finally, for results with respect to community participation, an assessment of quarterly narrative reports produced since the implementation evaluation showed that at least five projects have managed to secure a place for an English-speaking community representative on a board of directors of a public establishment. Some project participants mentioned that they had attended board meetings on various occasions since the beginning of their project in order to access decision-makers in their region. Some were also representing the English-speaking community on clinical project consultations, special issue consultations, advisory committees, and roundtables. Activities in which program participants had participated included: meetings with various partners and public representatives; sharing of information; developing new services for the community; providing input for decisions about required services; preparing joint applications for funding; etc. Representation for the English-speaking community at the provincial level has also been provided by CHSSN.

In terms of network creation, coordination, and community participation the results assessed via the evaluation process are excellent.

7) Did the HSSNPI lead to the design and implementation of evidence-based plans and strategies at the provincial, regional, and local level to improve access to health and social services in English?

At the time of the implementation evaluation, some projects had already begun developing and implementing formal action plans (in a few cases approved by health and social services representatives) which were informed and shaped by the knowledge that had been developed and disseminated. The online survey revealed that almost three-quarters of project coordinators strongly agreed or agreed that their project had led to the development and implementation of an action plan containing service-delivery models, strategies and initiatives adapted to the needs and priorities of English-speaking communities in their region. Most of these action plans were endorsed by network steering committees and network participants and partner organizations. In some cases, action plans were even endorsed at the CSSS administrative and director-general levels. Since the final evaluation focused on the Program's impacts (results), as perceived by the English-speaking population, it is not possible to formulate an opinion on the level of success reached with regard to the implementation of these plans. However, by consulting participants' narrative reports, it is possible to acknowledge that actions and initiatives aiming at improving access to health and social services in English were undertaken by every networking unit.

8) Did the HSSNPI facilitate dialogue among networks, institutions, planners, and English-speaking communities?

Project participants and partners reported an increased understanding by public sector officials of the determinants of health and well-being for English-speaking individuals and their specific access needs and priorities. Also, HSSNPI project coordinators and network partners were statistically more likely than respondents in regions not exposed to the program² to agree that community leaders and public system decision-makers have an adequate understanding of the determinants of health and well-being for English-speaking individuals.

Several public partners mentioned that the HSSNPI projects were an eye-opener for them. Their new relationships with the English-speaking community have provided their organizations with valuable information on the community's needs. This collaboration has nurtured a more informed dialogue and helped create a shared understanding of access issues among networking unit partners.

Regarding dialogue with the English-speaking communities, the implementation evaluation found that most HSSNPI participants already had developed communication tools (guides, newsletters, websites, telephone directory, etc.). Focus groups with community members showed that during the past three years, respondents had generally been exposed to promotional tools developed under the HSSNPI. Furthermore, a majority of respondents felt that their knowledge of health and social services had improved over the past three years. The respondents attributed this improvement to the communication tools received and to the greater efforts on behalf of staff and health authorities to communicate with them in English.

9) Did the HSSNPI lead to improved access to health and social services in English?

In terms of the supply of services, the HSSNPI evaluation of impacts (results) looked at volunteer recruitment and training, reorganization, and newly introduced services.

Since not all projects had a volunteer component, only some participants reported results in this area. In these cases, the initiatives reported on appear to have been successful in recruiting and training a number of volunteers. Links were also established between certain project developers and volunteer bank coordinators. An assessment of the quarterly narrative reports showed that recruited volunteers helped with interpreting, English conversation sessions at CSSS and community events. Volunteer training activities included sessions on how to act as an interpreter in emergency situations, providing assistance to seniors with mobility problems, and assisting at an income tax clinic for low income earners.

² These respondents were developers of non-funded projects and potential partners (people working at Quebec's Agence de santé et services sociaux who were in charge of access issues, access committee members and members of Anglophone regional associations).

Program outcomes with respect to reorganization and the introduction of new services were more encouraging than those observed during the implementation study. Since the implementation evaluation phase, various initiatives have resulted in public service reorganizations and the introduction of new public services, even though the available data does not allow us to determine whether these results were solely due to HSSNPI. Often, the combined effect of other initiatives like PHCTF and the McGill Project may also have contributed to the impacts (results) observed. This observation is reinforced by the consensus among English-speaking focus group participants that health and social services network personnel are more open than before to providing services in English. The McGill Project included measures to increase the number of public-sector staff members capable of providing services in English. The difficulty in attributing credit for the impacts (results) may point to the desirability and effectiveness of an integrated approach. The HSSNPI was seen as a vehicle to ensure that the communities had a voice in the decisions made under the other two programs. In this respect, the results have been excellent.

In terms of demand for services, the evaluation of HSSNPI impacts (results) looked at knowledge of the specific basket of services, the quality of services, and decisions about use of services.

With regard to knowledge about a basket of available services, the main finding to emerge from the focus groups is that participants' knowledge of available services has improved over the previous three years thanks to the information made available to them. **In our view, this has been the main contribution of HSSNPI.** A number of participants also noticed greater willingness on the part of public service providers to use English with unilingual English-speaking patients. This was not the case before, and has led to greater knowledge of available services.

The majority of participants felt that service quality had improved in the past three years, although there was a lack of consensus as to whether it was the services themselves that had improved or simply the quality of English in providing specific services. Participants from the different focus groups repeated that they witnessed significant improvement in the quality of English spoken by public-sector staff when they were being treated. It was also noted that public-sector staff members were making significant efforts to improve their ability to speak to patients in English, efforts that were not being made a few years ago. As mentioned earlier, this effect could be attributable to McGill Project as much as to HSSNPI. Still, this result constitutes an improvement with respect to one barrier to access.

As for decisions about service consumption, most focus group participants mentioned that their level of comfort with using health and social services had increased in the past three years. Although some of the factors they identified as influencing their comfort level had little to do with language (nature of illness, waiting time, distance to travel), several others did (knowledge of French, knowledge of services available in English, being accompanied by a French speaker, the attitude of staff toward English-speaking patients). As mentioned earlier, HSSNPI had a direct effect on one of these factors (knowledge of services available in English). In contrast, available data did not allow us to establish a direct link between HSSNPI and improvements in staff attitudes toward English-speaking patients. However, the program undoubtedly contributed in an indirect way to this outcome (notably through

the involvement of several project coordinators with health and social service network partners as part of the McGill Project).

◆ **HSSNPI value**

The final question is related to the program's overall value.

10) Overall, what is the value of the HSSNPI?

For each question asked throughout the evaluation, it appears that the answers provided were aligned with the Program's objectives. It seems that the Program fostered the participation of English-speaking community representatives on public-sector boards of directors, access committee and agencies. These representatives can now advocate more effectively for English-speaking community members' interests and assist health and social services officials in designing service intervention plans that are more adapted to the needs and circumstances of this population.

HSSNPI was also effective in raising the awareness of English speaking community members via advertising and service referral tools. These results could be legitimately attributed to the HSSNPI.

Other results observed during the focus groups could be attributed to the combined effects of the three different program interventions (PHCTF, McGill Project and HSSNPI) referred to in this evaluation. In these particular cases, it seems to make sense that the HSSNPI was a principal and decisive contribution to the actual results on accessibility, i.e. by getting involved with health and social services institutions. Finally, even though plans of actions and strategies were developed by the Program's participants, the evaluation was confronted with the challenge of finding English-speaking community members who had been exposed to the initiative. Consequently, it is difficult to conclude on the actual results of these interventions on the population.

In spite of these drawbacks and for all the reasons listed above; and within the limits of the evaluation mandate and in light of the instruments used and the information gathered, the HSSNPI is assessed as being effective overall.

Finally, it is not possible to conclude on the Program's efficiency. Even though we have a good idea of how much the HSSNPI cost, we have little information to quantify the effects observed. Because results tend to be more diffuse as the project moves along in time, especially at the population level, information gathered is more qualitative than quantitative. Regarding this situation, the choice to use focus groups appeared to be the best solution to enable an evaluation of the Program's impact on its targeted population. This choice, however, limited the evaluation to an assessment based upon qualitative data. This is a clear limitation on the assessment of the results of the program. On the other hand, the evaluation benefited from detailed field data from a variety of different sources, which we are confident would have identified any important issues related to the evaluation's findings and final assessment.

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LIST OF INITIALS AND ACRONYMS

CA: Coasters Association

CAMI: Council for Anglophone Magdalen Islanders

CASA: Committee for Anglophone Social Action

CCS: Catholic Community Services

CHSSN: Community Health and Social Services Network

CLSC: Centre Local de Services Communautaires

CREXE: Centre de Recherche et d'Expertise en Évaluation

CSSS: Centre de Santé et de Services Sociaux

ENAP: École Nationale d'Administration Publique

FRP: Fraser Recovery Program

HSSNPI: Health and Social Services Networking and Partnership Initiative

MCDC: Megantic English-Speaking Community Development Health and Community

PHCTF: Primary Health Care Transition Fund

QCGN: Quebec Community Group Network

RAWQ: Regional Association of West Quebecers

TA: Townshippers Association

INTRODUCTION

Under the Contribution program to improve access to health services for official language minority communities, the Quebec Community Group Network (QCGN) received approximately \$4.3 million in funding over five years (2003-2008) to implement the Health and Social Services Networking and Partnership Initiative (HSSNPI). This program is intended to build provincial, regional, local and sector health and social service networks in Quebec. These networks should help establish durable links between English-speaking communities and the health and social services system with a view to improving access to a wider range of English-language services in these communities. QCGN mandated the Centre de recherche et d'expertise en évaluation (CREXE) at the École Nationale d'Administration Publique ENAP to evaluate the HSSNPI.

The evaluation process

In its April 2005 proposal, the CREXE presented an evaluation approach based upon a 12 sequential step evaluation process (see Table 1).

- The first four steps concern program planning, specifically 1) the program's *raison-d'être* (issue); 2) the situations the program is supposed to address (program theory or targets); 3) the scope of the desired corrections (objectives); and 4) the logic of the intervention.
- The following three steps relate to implementation, i.e., 5) the human, financial and material resources available for the program (inputs); 6) the production activities (process); and 7) the elements produced (outputs).
- Finally, the remaining steps concern the evaluation's summative dimensions: 8) measurement of outcomes; 9) attainment of objectives (effectiveness); 10) absolute performance of resources (efficiency); 11) relative performance of resources (alternatives) and, finally; 12) the value of the program.

The first phase concluded with the submission of an evaluation framework (CREXE, 2005). It consisted of collecting information on the program's *raison-d'être*/issue and its various facets in order to document the rationale for a publicly supported intervention. It also served to plan the subsequent implementation and impact (results) evaluation phases.

The second phase, i.e. the evaluation of the program's implementation, was the subject of an interim report (CREXE, 2006a). It incorporates information from the evaluation framework and presents an assessment of the program's overall implementation, as well as a preliminary assessment of the program's impacts (results). It is an interim working document that explores possible avenues for program improvement following the implementation phase.

This current report summarizes the first two and concentrates on the third phase of the evaluation process. It updates previously presented information wherever possible. It pro-

vides an assessment of HSSNPI impacts (results), as well as conclusions on the program's overall value.

Table 1: CREXE sequential process of evaluation

Steps	Evaluation framework	Preliminary evaluation	Final evaluation
1. Raison d'être 2. Program theory 3. Objectives 4. Logic of intervention	Analysis of the program's raison d'être, theoretical foundation, objectives and logic of intervention.	Presentation of the program's raison d'être, theoretical foundation, objectives and logic of intervention.	Presentation of the program's raison d'être, theoretical foundation, objectives and logic of intervention.
5. Inputs 6. Process 7. Outputs	Analysis of reporting and implementation evaluation strategies.	Evaluation of the reporting and implementation of the program.	
8. Outcomes	Elaboration of different outcomes measurement strategies.	Measurement of the preliminary outcomes of the program.	Evaluation of outcomes, effectiveness, efficiency, alternatives and value of the
9. Effectiveness 10. Efficiency 11. Alternatives 12. Value	Elaboration of different effectiveness, efficiency, alternatives and value evaluation strategies.		program (taking into account the results of the preliminary evaluation).

The three following sections briefly describe the approach adopted for the three studies.

◆ Phase 1 of the evaluation process

The evaluation framework covers the first four steps of the evaluation process: 1) the raison d'être for the program (issue), 2) the situations it is meant to correct (targets); 3) the scope of the desired corrections (objectives); and 4) the logic of intervention. It resulted in the development of a causal and a logic model for the HSSNPI.

The evaluation questions related to the implementation phase include:

- What is the raison d'être for the program and is it still relevant?
- Was the program implemented as originally planned?
- What factors facilitated or challenged program implementation?
- Has the program yielded the expected outputs?

◆ Phase 2 of the evaluation process

The evaluation questions related to the impacts (results) phase include:

- Did HSSNPI lead to the generation, integration and sharing of information and knowledge?
- Did HSSNPI lead to the creation of networks and partnerships that mobilize and engage community resources and institutions foster the participation of decision-makers and organizations in the public health and social services system, and encourage them all to work together?
- Did HSSNPI lead to the design and implementation of evidence-based plans and strategies at the provincial, regional and local level to improve access to health and social services in English?
- Did HSSNPI help facilitate dialogue among networks, institutions, planners, and English-speaking communities?
- Did HSSNPI lead to improved access to health and social services in English?

◆ Phase 3 of the evaluation process

The evaluation question related to the overall value of the program was:

- Overall, what is the value of the HSSNPI?

Evaluation timeline & methodology

The evaluation framework also presents the methodology for the preliminary evaluation and the final evaluation, as well as a timetable.

◆ Preliminary Evaluation

The preliminary evaluation documents the inputs available to the program including coordinators, production activities, and the outputs. The conclusions of this evaluation phase helped to structure the program implementation phase.

◆ The Second Phase of the Evaluation

The second phase of the evaluation ran from December 2005 to May 2006. It focussed on implementation and provided for a survey of program coordinators, project developers who received funding to develop partnership networks and projects, and network partners. It provided suggestions on adjusting the program.

◆ Final Evaluation

The final evaluation pays special attention to the impacts (results) of the HSSNPI as perceived by the English-speaking community. It looks specifically at the issue of access to English-language health and social services for this population, i.e., improvements in the supply of English-language services and use of these services.

▪ Methodology

- The methodology used to identify program impacts (results) was planned during the drafting of the evaluation framework and revised after the implementation study.
- As agreed with the QCGN and the HSSNPI Volunteer Committee following the presentation of the implementation evaluation report, the focus group method was retained to collect information from the English-speaking population.
- This choice was made in light of anticipated difficulties in reaching a sufficient number of English-speaking health and social service users who had been exposed to network initiatives.
- Thirty-eight English-speaking community members from five regions (Magog, Montreal, Thetford Mines, Gaspé, and Chandler) took part in the discussions.

◆ An evaluation in keeping with Health Canada requirements

The evaluation is designed to comply with Treasury Board criteria. It takes Health Canada directives into account, including those set forth in the Health Canada Evaluation Policy of June 20, 2002.

◆ Contents of the report

The report contains four chapters and a conclusion:

- The first chapter examines the *raison d'être* for the program, i.e., the issue of access to a full range of health and social services for English-speaking people in Quebec
- Chapter Two presents the program and its intent (targets and objectives) and tools (type of intervention), and reviews its various components using a logic model that summarizes the main evaluation challenges.
- Chapter Three presents the methodology that guided the implementation and impacts (results) evaluation.
- Chapter Four summarizes the main results of the implementation and impacts (results) studies.
- The conclusion provides an overview of the findings based on the methodology employed.

1 The issue of language access

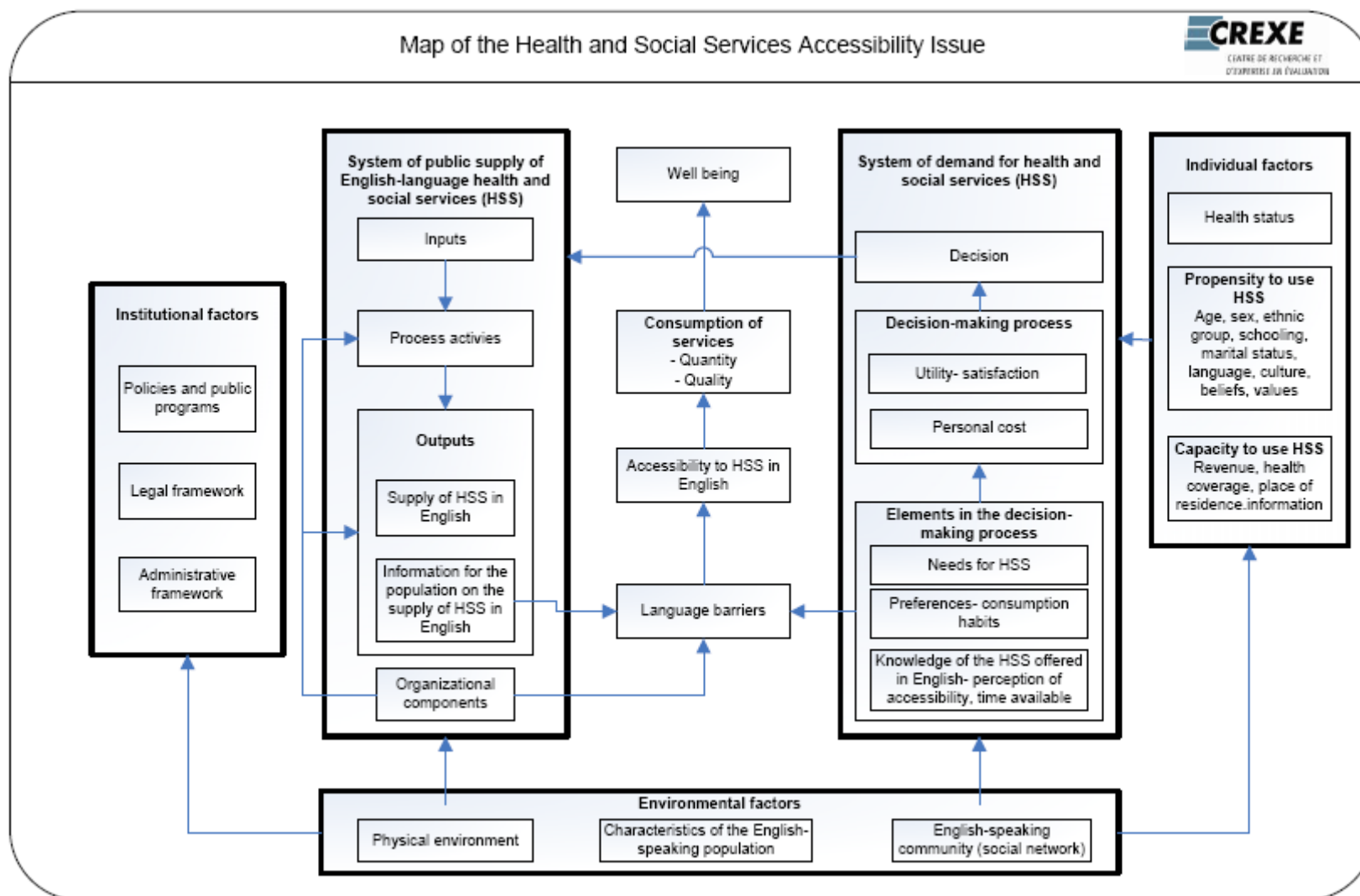
The evaluation of a publicly funded initiative like HSSNPI must be based on the problems it is intended to address i.e. access to health and social services by English-speaking Quebecers. Together, these problems are known as the program issue. The study of the program issue is the first step in the evaluation process. It involves identifying undesirable situations and analyzing them in order to determine the program issue's main characteristics. The results of this analysis are used to develop an issue model, i.e., a simplified visual representation, in causal form, of the main aspects of the program issue.

For the members of a community, lack of access to health and social services in their own language translates into higher health risks (Wehbi, 2005). Language access can be understood as the fact that a service is available to an entire population, despite language differences (Government of Quebec, 1994). In Quebec, various studies have shown that members of the English-speaking community have problems accessing health and social services (Jedwab, 2001). Indeed, linguistic accessibility is at the heart of the debate over access to health and social services for the English-speaking community (Bowen, 2001). According to Wehbi (2005), English speakers are less inclined to use services if they consider that language constitutes too significant a barrier.

Figure 1 (Map of the Health and Social Services Accessibility Issue) schematically presents the issues of language barriers, access to services, consumption of services, and user well-being. These four key elements occupy the centre of the diagram, surrounded by five blocks representing 1) the system of public supply of services, 2) the system of demand for services, 3) individual factors, 4) environmental factors, and 5) institutional factors. These blocks and the four previous elements are causally linked and evoke the complexity of the problem of linguistic minority access to services.

Each block of variables is dealt with in a separate section of this report to help clarify the program context.

Figure 1: Map of the Health and Social Services Accessibility Issue



1.1 The supply of English-language services

The hypothesis postulating a link between provision of services, access, and use is solidly supported by various studies (Piché and Côté, 1998). Provision of services can be divided into two main aspects: service delivery and organizational components.

Service delivery corresponds to the quantity of resources invested and the means put in place to deliver the services to English-speaking Quebecers. Human, material, and financial resources are the inputs required to provide health and social services to the English-speaking clientele. The resources invested help improve service providers' ability to communicate in English with the users of the system. They also allow the English-speaking community to participate in various network activities such as advisory committees, volunteer groups, and boards of directors (Morency, 1996). Outputs are the products and services made available to the population and can be grouped into three categories: prevention and promotion activities, clinical services, and nonclinical services (job transfers, recruitment, training, translation, administrative products, etc.). According to Morency (1996), attainment of the language access objective depends on these three outputs. Among other things, regular dissemination of administrative information notifying the public about services available in English facilitates the use of health and social services.

The organizational component refers to the entity responsible for health and social service delivery and to its culture, organizational structure, and leadership (Hafsi and Demers, 1997). When program intentions, implementation strategies, and intervention resources are compatible with the culture of an organization, implementation is easier. Within the framework of the program, awareness of the needs of the English-speaking population on the part of the health network is vital for interpreting and explaining the services available. Certain organizational behaviours show sensitivity to the right of English speakers to receive services in their language, including the adoption of language access measures, invitations to the English-speaking community to attend public information sessions, and the translation of information documents (Morency, 1996). The supply of services presented in the issue map corresponds to all public initiatives to improve access to services for English-speaking Quebecers.

1.2 Demand for English-language services

For Rodwin (2000), demand for services is a decision process comprised of three sequential elements: 1) the elements of decision making, 2) the decision-making process, and 3) the decision itself.

The elements of decision making are the first component of demand. They include knowledge of the basket of available services, conditions and costs of access and use, consumer preferences and habits, and health service needs. The more information individuals have about the services available in their region, the more likely they are to use those services (Wehbi, 2005). The level of knowledge of available services also depends on the information transmitted by the English-speaking community, personal knowledge, and community involvement. Personal preferences and resources are other factors affecting demand (Grin, 2000). In a health system where French is the main language, English-speaking Quebecers

have acquired use habits that directly influence their demand for services: among other things, they often turn to family networks rather than the public healthcare system (CHSSN, 2006). For its part, CREXE (2006b) found that in the event of an emergency, English speakers generally prefer to visit an English-language institution, even if it is located outside their area of residence. The adoption of such behaviours can influence estimates of demand for English-language services because the resulting demand does not correspond to the real needs of the population. Accurate estimates are difficult because of 1) partial expression of needs; 2) ignorance of and unfamiliarity with services provided by the public system; and 3) personal choices guided by preference.

On the basis of these elements, individuals will then undertake the decision-making process, which consists of evaluating the benefits of formulating a request in light of their needs and the costs they will have to assume. This analysis takes into account their satisfaction with health and social services used previously. Although difficult to evaluate, demand for services is very important in the study of access to health and social services. For a minority community, the demand variable is crucial because the provision of services depends primarily on demand from the community (Grin, 2000). In other words, demand for services is first and foremost the result of collective community involvement (Grin, 2000), but is expressed to the health and social services system as the outcome of decisions made by individuals, who assess service usefulness and the satisfaction they will gain from using that service. In short, even though demand remains difficult to evaluate, its characteristics must be taken into account if we wish to understand service access problems.

1.3 Individual, environmental, and institutional factors

In addition to demand and the service provision system, a number of other factors influence access. Let us look at the three main ones: individual, environmental, and institutional factors.

◆ Individual factors

The behaviour of health and social service consumers can be viewed as the outcome of a rational calculation whose purpose is to maximize satisfaction in relation to available resources and their alternative uses. From this viewpoint, various external factors may influence the decision to use a service. Davidson et al. (2004) mention that health status (Piché and Côté, 1998), the propensity to use health services (according to language, culture, and ethnicity), and the ability to use services (primarily on the basis of place of residence and the level of information (CHSSN, 2006) should be taken into consideration.

◆ Environmental factors

Environmental factors include the physical environment, the characteristics of the English-speaking population, and the vitality of the English-speaking community (social network). Each conditions the supply of and demand for services. The physical environment corresponds to the natural environment in which community activities take place. Major socio-economic characteristics (level of bilingualism, education levels, unemployment rate, median individual income, median age, demographic weight) are good indicators of the vitality of the English-speaking community.

◆ Institutional factors

Lastly, institutional factors refer to the legislative and administrative framework and to public policies and programs in health and social services. Given their importance, these factors largely determine the structure and values of the system; agency missions, resources, and forms of organization; and the content and conditions of use of the services provided.

HSSNPI is a component of federal and provincial government public policies and programs in the health field. These policies and programs set government directions, objectives, and priorities for health and social services. They also represent the means of intervention for achieving these objectives, as well as the resources mobilized for this purpose.

Differences have been observed in the level of knowledge and use of health and social services by French- and English-speaking Quebecers (CHSSN, 2006; Office of the Commissioner of Official Languages, 2004; Consultative Committee for English-Speaking Minority Communities, 2002). The socioeconomic and demographic analysis of the English-speaking minority also suggests the presence of language barriers limiting use of and access to English-language health and social services (Jedwab, 2001, 2004; Office of the Commissioner of Official Languages, 2004; CHSSN, 2006). We are now in a position to better define the *raison d'être* for HSSNPI.

1.4 The *raison d'être* for the program

Several problems explain the barriers English-speaking Quebecers face in accessing health and social services: the scarcity of human resources capable of providing English-language services; insufficient demand for English-language services due to the low density of the English-speaking populations in some areas, and its implications for service costs; consumption habits consisting of only requesting services in emergency situations, and ideally at English-language institutions; and the ambiguity of the legal framework governing the language of service in the health network (CREXE, 2006b). However, two elements sum up the problems that led to the creation of HSSNPI: the challenges of planning services for English speakers in the face of inadequate information on their needs and insufficient consultation between the health network and representatives of the English-speaking community; and the limited capacity for action on the part of English speakers in certain regions due to geographically dispersed populations and the absence of community organizations to defend and promote their interests.

Now that we have defined the program's *raison d'être*, let us take a closer look at its intentions.

2 The program and its intentions

Part VII of the Official Languages Act [(R.S. 1985, c. 31, 4th Supp.) s. 41–45] relates to the advancement of English and French in Canada. Section 41 of the Act requires the federal government to enhance the vitality of the English and French official language minority communities of Canada and to foster the full recognition and use of both English and French in Canadian society. Section 42 gives the Minister of Canadian Heritage the mandate to promote a coordinated approach to the implementation of this commitment.

In 1994, the Government of Canada approved the creation of an accountability framework to facilitate the implementation of sections 41 and 42 of the Official Languages Act. The Government of Canada also designated thirty key federal institutions—including Health Canada—because of their importance to the development of official language minority communities. Like all other designated federal institutions, Health Canada must proceed to outline an annual or multi-year action plan relating to the implementation the Official Languages Act. The action plan must take into account the particular needs of the official language minority communities. As a result, they are required to pay special attention to development priorities of the official language minority communities of Canada.

In this context, Health Canada created two consultative committees in 2000: the Consultative Committee for English-Speaking Minority Communities and the Consultative Committee for French-Speaking Minority Communities. The mandate of both committees is to advise the Minister of Health on the priorities of Canada's English and French minority communities with regard to health and social services. The French and the English consultative committees each submitted, in September 2001 and July 2002, a report on the needs of their respective minority communities. The reports illustrate the primary needs of official language minority communities regarding health services and their accessibility. For example, the report of the Consultative Committee for English-Speaking Minority Communities indicates that the level of access to health and social services in English varies from one administrative region to another. To reduce these variations, the reports of the consultative committees presented to the federal Minister of Health included recommendations and alternatives to improve access to health services in official language minority communities.

In addition to the efforts of both consultative committees, the 2002 Speech from the Throne included the formal engagement, on the part of the Government of Canada, to promote linguistic duality in Canada. The Government also pledged to present an action plan to revitalize its Official Language Policy. Stéphane Dion, President of the Privy Council Office and Minister of Intergovernmental Affairs, was given a mandate by the Prime Minister to coordinate the Government of Canada's Official Language Policy. His mandate also included chairing a group of cabinet ministers whose mandate was to facilitate the implementation of coordinated measures in different sectors of government activity.

During a consultative exercise, Minister Dion received dozens of reports from leading official language minority communities, such as the Quebec Community Groups Network (QCGN) and the Federation of Francophone and Acadian Communities of Canada. As a result of this consultative exercise, a five-year action plan (2003–2004 to 2007–2008) was developed and adopted. On March 12, 2003, Prime Minister Jean Chrétien and Ministers Stéphane Dion and Lucienne Robillard released *The Next Act: New Momentum for Can-*

ada's Linguistic Duality, Government of Canada's new Action Plan for Official Languages. The plan, also known as the Official languages Action Plan contains, among other things, accountability and coordination frameworks as well as financial commitments relating to the implementation of the plan.

A total budget of \$751.3 million over five years was granted to the Action Plan. Health Canada obtained \$119 million to put in place specific programs to support official language minority communities. Three programs were created to support:

- The development of initiatives aimed at the improvement of health and social services access in both official languages (\$30 million)
- The creation of networks (\$14 million)
- The training and putting in place of qualified personnel (\$75 million)

In response to the reports of the consultative committees and aligned with the Action Plan, Health Canada created the Contribution Program to Improve Access to Health Services for Official Language Minority Communities. This program, spread over a five year period, offered financial support for the development of networks. It aims at improving access to health and social services in official language minority communities by helping the communities respond to their specific needs while improving their health and the general performance of the Canadian health care system.

Under the Contribution Program, the Quebec Community Groups Network (QCGN) received approximately \$4.3 million in funding for five years (2003-2008) to implement the Health and Social Services Networking and Partnership Initiative (HSSNPI). The program was designed to build provincial, regional, local, and sector health and social service networks in Quebec. These networks focused upon establishing long-term relationships between English-speaking communities and the public health and social services system with a view towards improving access in these communities to a wider range of services offered in English.

2.1 Objectives, results, and targets

The goal of HSSNPI is to build the networking and partnership capacities of English-speaking minority communities in Quebec so as to enable them to improve access to health and social services in English. Its specific objectives are to:

- Generate, integrate, and share information and knowledge
- Design and implement evidence-based plans and strategies at the provincial, regional, and local level to improve access to health and social services in English
- Create networks and partnerships that mobilize and engage community resources and institutions, foster the participation of decision-makers and organizations in the public health and social services system, and encourage them all to work together
- Facilitate exchanges among networks, institutions, planners, and English-speaking communities

The HSSNPI program has been designed to generate five specific results at the end of four years:

- Effective operation of networks;
- Availability of knowledge and expertise;
- Participation of English-speaking communities;
- Reduced isolation for English-speaking communities;
- Improved access to services in English in Quebec.

These non-quantified objectives provide an overview of the intentions of the program designers. They do not provide a means of measuring their attainment. Nonetheless, from an evaluation perspective, they enable the definition of the situations the program seeks to improve. They correspond to the targets for which impacts (results) are measured.

The evaluation framework prepared by CREXE provided a model of the causal theory for the program (see Figure 2). It also enabled the evaluation team to identify short, medium, and long term targets.

◆ **Short term targets**

In theory, the HSSNPI program has two short term outcomes (targets).

- The first short term target of the program is to build networking and partnership capacities in the English-speaking communities across Quebec. The goal of this target is to act on one of the three environmental factors of the access issue: to build up English-speaking community social networks.
- The second short term target of HSSNPI is to produce and share knowledge regarding the health and social service needs and priorities of English-speaking Quebecers. The information is produced to influence public service system provider inputs.

◆ **Medium term targets**

The medium term outcomes (targets) of the HSSNPI can be divided into four levels:

- Level 1
 - Community participation in the public health and social services system
- Level 2
 - Identification of English-speaking community needs and priorities vis-à-vis health and social services provided by local or regional health and social services organizations
 - Coordination of service delivery for English-speaking populations
 - Development and training of volunteers

- Level 3
 - Accessibility to health and social services through action at the supply level. There are three targets here: reorganize existing services, create new services, and advertise existing services and refer community members to them.
 - Accessibility to health and social services through action at the demand level. There are three targets here: Increase awareness of new and reorganized services, increase satisfaction with the user experience, and assist with decisions to use services.

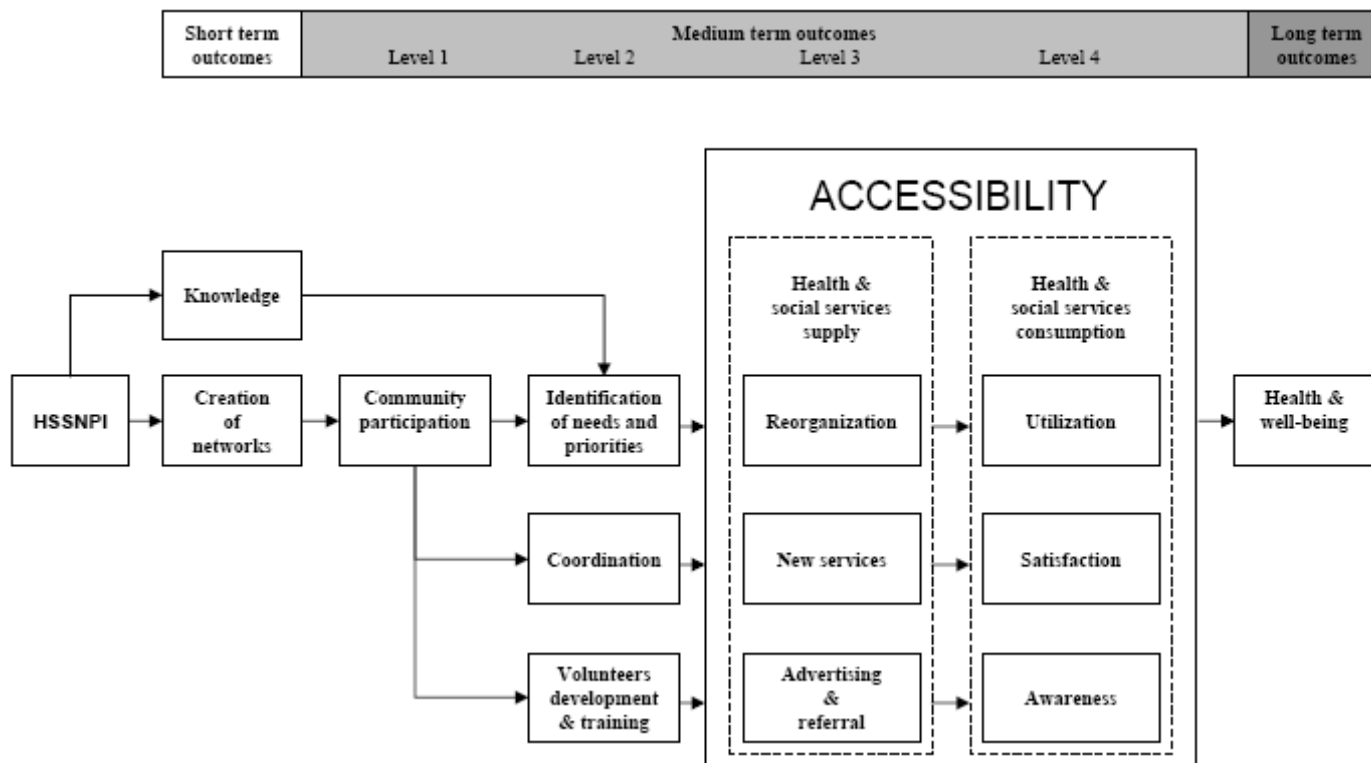
◆ **Long term target**

In the long term, the program seeks to have an impact on the health and wellness of English-speaking Quebecers.

2.2 The logic of intervention

The logic of intervention refers to the instruments selected by the project designers to improve access to services. HSSNPI has a five-year funding commitment from Health Canada's Contribution Program. Financial support was provided for one month in 2003–2004 and was available on an annual basis until the end of the 2007–2008 fiscal year. Funding is available for projects focussed on building the networking and partnership capacities of English-speaking communities so that they can improve access to health and social services in English. Multi-year funding is a fundamental characteristic of the program.

Figure 2: HSSNPI causal model



2.3 The implementation plan

The implementation plan essentially corresponds to 1) the inputs made available to the various program partners; 2) the activities intended to produce goods and services for the population; and 3) the anticipated outputs, i.e., the goods and services in question.

The inputs are the human, financial, material, and information resources made available for the program. The commitment from Health Canada's Contribution Program is worth \$4.3 million over five years (2003-2008). Financial support was provided for one month in 2003-2004 and was made available on an annual basis until the end of the 2007-2008 fiscal year. According to the HSSNPI Quarterly Cash flow and Record of Expenditures, the program has a closed budget of approximately \$1 million per year until the end of the program.

Concerning human resources, two groups can be distinguished: 1) human resources at the program level (program managers, volunteer committee, QCGN staff); and 2) human resources at the participants' level (project developers, project coordinators, English community regional association staff and volunteers).

Process activities at the program level include providing information regarding the program and the procedure for preparing and presenting proposals, reviewing the applications received and selecting the projects to fund; delivering the funding to the selected organizations; supporting the participants, performing monitoring and reporting activities for each project, and evaluating the HSSNPI. At the participants' level, activities include project planning and preparation of applications; carrying out planned project activities; and completion of reporting and evaluation activities.

Outputs correspond to the goods, services, and products arising from the program, as well as the people it reach. At the program level, the outputs are the funds allocated to program participants. At the participants' level, the main outputs are 1) the networks created and 2) the information and knowledge acquired about the local English-speaking community.

2.4 Anticipated impacts (results)

The creation of networks is expected to promote community participation in the public health and social services system to ensure that communities take an active part in the process of creating public health and social services in English.

Community participation should, in turn, help English-speaking communities identify their members' needs and priorities vis-à-vis the health and social services provided by local or regional health and social services organizations. Identification of needs and priorities by local and regional networks should be facilitated by research findings and by information and analyses on health determinants provided by the provincial network (CHSSN). The creation of networks should also have an impact on the coordination of service delivery for English-speaking populations as it is expected to foster volunteer development and training.

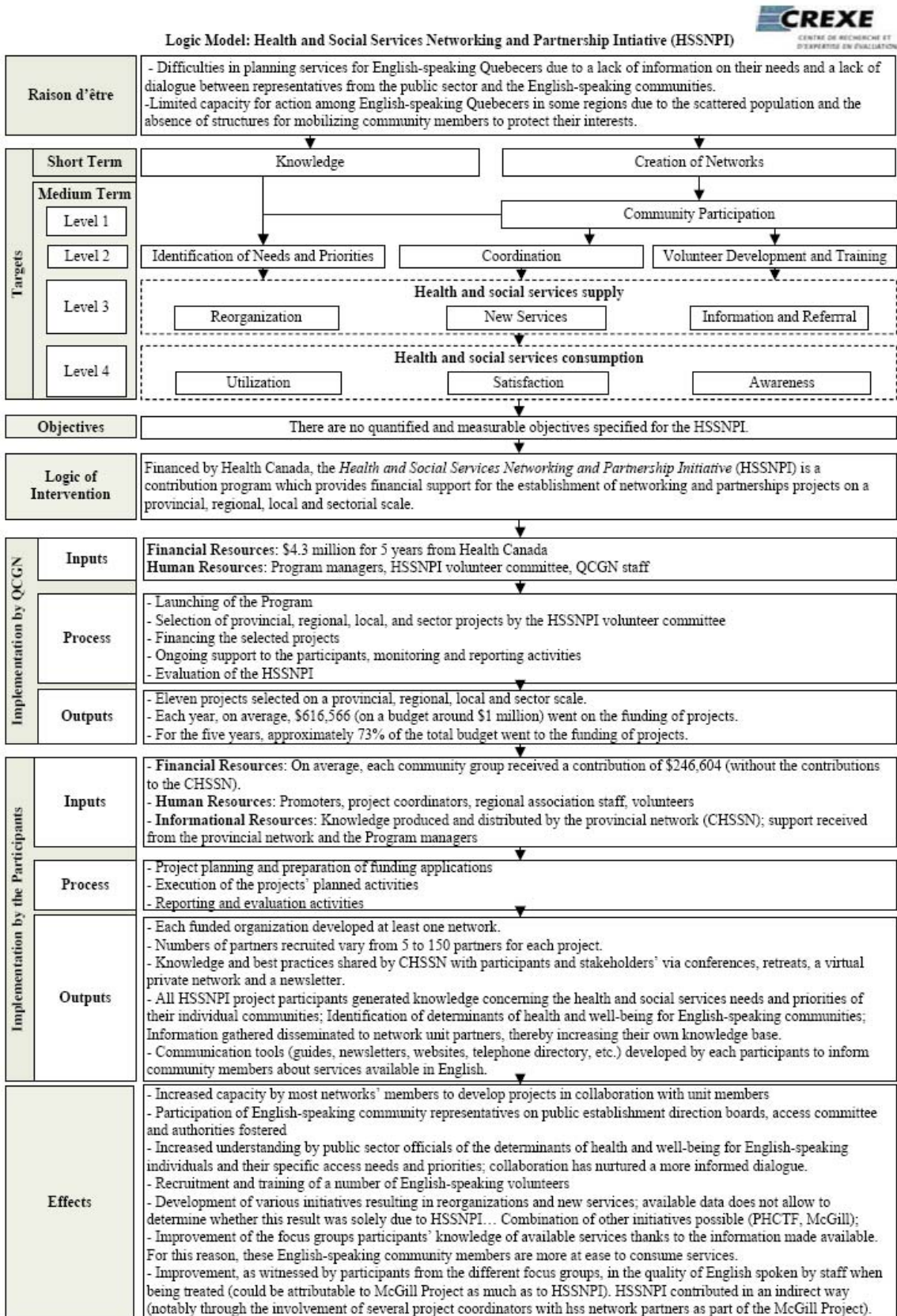
Together, Level 2 targets should influence the supply of health and social services to English-speaking Quebecers. This can be achieved in three ways: by reorganizing existing services, by creating new services adapted to the specific needs of the English-speaking com-

munities, and by advertising existing services and referring members of the community to these services. As a result, the consumption of adapted health and social services by English-speaking communities of Quebec should increase. To use a service, one must first be aware of it, have a reason to use it (e.g., a satisfactory previous experience), and then actually decide to use it.

Finally, the consumption of services by members of English-speaking communities should, in the long term, improve the health and wellness of English-speaking Quebecers.

Figure 3 (HSSNPI Logic Model) presents a complete outlook on the program.

Figure 3: HSSNPI Logic Model



3 Methodology

This chapter presents the variables studied, followed by the methodologies used in the various phases of the evaluation. Evaluation limitations are discussed in the last section of the chapter.

3.1 The variables

The variables studied were derived from the program issue and the logic model (see Figure 3: HSSNPI Logic Model). The variables used in the phase II and III studies are presented in Table 2 below.

Table 2: Variables for the study

Variables		
Program raison d'être	HSSNPI pertinence	
QCGN level (macro implementation)		
Inputs	Funding from Health Canada; human resources	
Process activities	Information regarding the program; preparation and presentation of the proposals; review and selection of the applications received; funding of the selected projects; monitoring and reporting of the projects	
Outputs	Funded groups; monitoring and reporting activities	
HSSNPI participants' level (micro implementation)		
Inputs	Funding from the QCGN; human resources	
Process activities	Document preparation and presentation; project activities	
Outputs	Information and knowledge development; creation of networks	
Effects	Level 1	Community participation
	Level 2	Identification of needs and priorities; coordination; volunteer development and training
	Level 3	Supply (reorganization of services; new services; information and referral)
	Level 4	Consumption (awareness of services; satisfaction with services; use of services)

3.2 The three phases of the evaluation process

The chosen methodology uses a number of data sources and a variety of data collection techniques: analysis of theoretical and administrative texts, one-on-one in-person and telephone interviews, self-administered online questionnaires, and focus groups. The methodology is described on the basis of the three evaluation phases discussed above, i.e., the evaluation framework, the interim report on implementation and preliminary impacts, and this report on impacts (results) and overall value of the program.

Phase 1 - Evaluation framework

The evaluation framework presents the process selected for program evaluation. It documents the issue the program is intended to address, particularly with respect to the program's raison d'être, targets, and objectives. It indicates the methodology that will be used for the program implementation and effects study.

The data sources consulted at this phase were scientific documentation regarding the issue of access to services; project managers, particularly coordination team members; and administrative and legal documents regarding the program. The collection tools are summarized in the exploratory interview guide.

Phase 2 – The preliminary evaluation

Three data sources were used to collect information about program implementation: a documentary analysis, semi-structured interviews, and an online survey. Data gathered from these different sources was then triangulated to obtain a more precise overview of the program.

- Documentary analysis

In order to perform the documentary analysis, all HSSNPI-related documents (HSSNPI policy and program framework documents, application forms submitted, contribution agreements, quarterly narrative reports, quarterly cash-flow reports, etc.) were gathered and studied.

- Semi-structured interviews

After the documentary analysis, semi-structured interviews were conducted. Respondents involved at the macro implementation level were targeted first, using names suggested by the Volunteer Committee and the program manager. Questions dealt with the intentions behind the program, the available resources (financial and human), the activities carried out in the course of implementation at the QCGN level, and the outputs (projects funded, support provided).

Respondents involved at the micro implementation level were also targeted. Because of the small number of projects, each main project coordinator was interviewed. Furthermore, at least three additional persons were interviewed for each project. The names of these persons were proposed by the project coordinators. Interviewees were selected according to the availability of the persons selected. However, whenever possible, interviewees from different sectors (community organizations, health and social sector representatives, education sector, etc.) were selected. Questions dealt with the initial design of their projects, the resources obtained through the program, the available resources (financial and human), the outputs produced, the first effects observed at their level, and the difficulties encountered.

In all, 52 people were contacted and interviewed during this phase of the evaluation: 9 of them were involved at the macro program planning and implementation level, 16 worked with organizations that had projects funded by the HSSNPI (micro implementation), and 27 were partners within the various networks. Interviews lasted from 30 to 60 minutes. All comments were noted and recorded with a tape recorder. Notes from the discussions were

then subjected to a thematic analysis in order to identify similar ideas that had emerged in response to each question.

- Online survey

Lastly, an online survey was performed. The survey targeted two groups: HSSNPI project coordinators and network partners (respondents involved in HSSNPI), and developers of non-funded projects and their potential partners (respondents not involved in HSSNPI). A different version of the questionnaire was sent to each group. Identified respondents who did not have access to the Internet received a paper version of the questionnaire. Of the targeted respondents in the first group, 14 were project coordinators and 175 were network partners. The group of respondents not involved with the program was composed of 29 developers of non-funded projects and 119 potential partners. Names and email addresses of potential partners were obtained from people working at Quebec's Agence de santé et services sociaux who were in charge of access issues in regions without any HSSNPI projects. English-speaking community groups also helped in the process by providing names and email addresses.

The questionnaires were first sent on April 17, 2006. A follow-up mailing took place on May 1, 2006. Of the 337 persons contacted, 54 answered their questionnaire: 13 project coordinators, 30 network partners, one developer who did not receive program funding, and 10 potential partners.

Questions dealt with the creation of the networks, acquisition of knowledge about the English-speaking communities, community participation in public health and social service institutions, identification of English-speaking community health and social services needs and priorities, coordination between community health and social services and public health and social services, development and training of volunteers, the reorganization of existing services, the addition of new health and social services, and advertising and referral services. In addition, there were questions on unexpected outcomes that might have occurred, as well as external factors that were identified during interviews and the documentary review. Project coordinators also answered queries on program implementation. Descriptive statistics were produced for each question. Then, when possible, answers to questions were compared between each group (respondents involved with the program and those who are not).

Phase 3 – The final evaluation

The evaluation framework proposed to evaluate the program's impacts (results) on the English-speaking population by using a telephone survey. However, in light of anticipated difficulties in reaching a sufficient number of users of English-language health and social services who had been exposed to HSSNPI, the choice was made to use the focus group method. It was agreed that this technique would be a more effective way to collect information on the impacts (results) program, as observed by members of the English-speaking population.

Four focus group interviews were conducted in five Quebec regions (one session was held simultaneously in two regions by teleconference) for the purpose of exploring the experiences, perceptions, and attitudes of members of Quebec's English-speaking communities

toward access to health and social services in their region. Participants were asked to discuss the delivery of English-language services in their region and the quality of the services received. They were also questioned on their knowledge of existing English language health and social services as well as on their current level of comfort in using health and social services in order to identify factors facilitating or hindering the use of available services.

Five regions were selected to provide geographical diversity to the groups. To ensure a diversity of opinions, each group was composed of eight to ten individuals who were either unilingual English speakers or individuals whose mother tongue was English. Selected participants either resided in Montreal or in one of the three regions that hosted the focus groups and had used at least one health or social service within the past year. For practical reasons, local HSSNPI project coordinators recruited the participants. It was agreed that a person residing locally would be more effective in recruiting participants. No financial incentive was offered, but travel expenses were covered for participants who had to travel a significant distance to attend the session. All group interviews lasted approximately one hour. All comments were noted and recorded with a tape recorder. Notes from the discussions were then subjected to a thematic analysis in order to identify similar ideas that had emerged in response to each question. The analysis assessed the networks' contribution to enhancing the level of access.

3.3 Limitations of the study

Despite CREXE's constant efforts to ensure the validity, reliability, and rigor of the re-search procedure, the evaluation presented a certain number of limitations. The first of these is the low response rate (17% of network partners, 3% of project developers who did not receive funding, and 8% of potential partners). Certain findings therefore need to be qualified.

Another limitation is the representivity of the respondents from certain groups (partners interviewed and focus group participants). As it is impossible to determine whether all characteristics of the population under study are represented in the sample group, there is a degree of error. Biases may have been introduced by subjects whose characteristics do not match those of the target population. In our sample, for example, the weight of respondents who are most enthusiastic about HSSNPI may be higher than it is among the partners and the English-speaking population in general.

At the same time, however, a large number of respondents (over 140) participated in the evaluation. We also heard a range of views (respondents having planned and implemented the Program, project coordinators, network partners, potential partners, members of five English-language minority communities). We are therefore confident that the resulting portrait is reliable and valid.

4 Results

Chapter 4 presents the results of the study as they relate to the program's raison d'être, implementation, and impacts (results).

4.1 Raison d'être for the program

We explored the program's raison d'être through interviews with stakeholders involved in program implementation. Even though the topic was discussed previously in Section 1.4, and the evaluation mandate did not require an in-depth analysis, the issue of raison d'être was presented to a number of respondents for their opinions regarding (1) the program designers' original intentions and the logic of intervention they developed; (2) and the extent to which funded projects addressed the problems identified.

Program designers' original intentions and the logic of intervention they developed

Respondents involved with implementation concurred that the main problem at the origin of the program was the limited capacity of communities and community organizations to participate fully in the health and social services system. This weakness is attributable to weak community infrastructures and the fact that community members are not very well organized or not highly mobilized. In order to play a role within the system (and adopt a participative strategy), community organizations need to have access to more resources and to be better organized. In light of this finding, the idea of building capacity within English-speaking communities was introduced into Health Canada's funding programs.

At the same time, three priorities were chosen within the health component of the Government of Canada's official languages action plan: networking, primary care, and human resource training and development. These three priorities were intended to be components of an integrated strategy. In fact, the CHSSN plays an important role in PHCTF, the McGill project and the HSSNPI. With respect to networking, CHSSN was tasked by the Health Canada Advisory Committee to design a program approach which went on to become the HSSNPI. The three initiatives were designed to complement each other. The role of HSSNPI is to help build community capacity to interact with partners in the public system, who in turn are motivated to develop contacts with the communities because they have been given the resources to do so (through PHCTF and the McGill project).

Two dimensions underlay the idea of capacity building with the English-speaking community: first, allocating resources to a community organization that agrees, by means of a very specific results-based program, to establish a roundtable whose role is to develop and consolidate links between stakeholders; and second, identifying community needs and understanding how the health system works in order to ensure the community has access to services that are adapted to its needs and circumstances. These are essential steps for explaining the needs of the community and the best ways to meet them via public sector service providers.

Extent to which funded projects address identified needs

As we have just seen, a choice was made to build capacity within English-speaking community by funding the creation of a network and learning more about the needs of its mem-

bers. The evaluation of the program's raison d'être should ensure that projects funded under HSSNPI were not at cross-purposes with this goal.

To be eligible for HSSNPI funding, project developers had to meet a number of minimum criteria: represent a non-profit organization, present a project to develop a health and social service network at the local, regional, or provincial level, and show sufficient knowledge of the community the project was meant to serve. Interviews with program designers also revealed that the projects funded had to increase access to health and social services in English. This is an important part of the rationale of the selection criteria. So is the idea of the sustainability of the initiatives and of the results achieved.

All of the projects selected respected the basic program requirements. All of the funded projects were submitted by not-for-profit organizations and had a network development component. Funding was also allocated to projects that initially ranked poorly in terms of certain program criteria (such as the quality of the information provided about population needs, the action plan suggested, the sustainability strategy, etc.). In these cases, projects with evident potential were requested to improve certain parts of their proposals and/or submit a sustainability strategy in order to qualify for funding. Selected projects were, therefore, consistent with the idea of building community capacity.

4.2 Program implementation

We will present implementation using documentary data and results from the surveys conducted during Phase 2 of the evaluation (the implementation evaluation). When possible, data has been updated in light of documents that postdate the implementation evaluation. Inputs, production activities, outputs will be assessed for each level of implementation (program management and program participants). The difficulties encountered will also be addressed.

Macro implementation (QCGN)

◆ Resources (inputs)

According to the Canadian Comprehensive Auditing Foundation³, inputs are the resources and authorities given to an organization to carry out activities, produce outputs, and achieve results. In the case of the HSSNPI, inputs included the funding received from Health Canada and the human resources used.

▪ Funding from Health Canada

The program has a closed budget of approximately \$1 million per year until the end of the program (see Table 3). According to the HSSNPI Quarterly Cash flow and Record of Expenditures, HSSNPI staff was successful in spending the available funds as originally planned. Since 2003–2004, the overall difference between the budgets projected by the program and actual program expenses has been very close to 0 (-0.21%).

³ Canadian Comprehensive Auditing Foundation (Page consulted June 22nd 2006). Canadian Comprehensive Auditing Foundation web page, [on line], <http://www.ccaf-fcvi.com>

By the end of fiscal year 2007–2008, \$4,231,371 (99,8% of the total allocated for the program) had been spent. As far as implementation by the program is concerned, since 2003–2004, 73% (\$3,082,834) of the HSSNPI budget went to funding projects and 27% (\$1,148,537) to coordination (staffing, travel/accommodations, materials/supplies, rent/utilities), evaluation and dissemination activities and others. Table 3 shows that the proportion of funding going to HSSNPI participants went in increasing. From 59% in 2003-2004, it reached 79% in 2007-2008.

Table 3: Budget distribution since the beginning of the program

	2003– 2004	2004– 2005	2005– 2006	2006– 2007	2007– 2008	Total
Staffing	\$42,819,	\$216,411	\$94,921	\$91,093	\$94,463	\$539,707
Travel/accommodations	\$1,801	\$8,507	\$9,195	\$1,715	\$841	\$22,059
Materials/supplies	\$28,125	\$8,406	\$3,403	\$2,640	\$3,767	\$46,341
Rent/utilities	\$4,531	\$3,329	\$648	\$1,305	\$2,908	\$12,721
Cost of ser- vices/equipment rental	\$1,775	\$77,507	-	-	-	\$79,282
Evalua- tion/dissemination of results	\$1,926	\$58,332	\$108,888	\$110,573	\$52,589	\$332,308
Secondary contribu- tions to HSSNPI par- ticipants	\$136,366 (59%)	\$619,850 (62%)	\$760,000 (76%)	\$780,000 (78%)	\$786,618 (79%)	\$3,082,834 (73%)
Others	\$12,214	\$4,474	\$22,945	\$17,672	\$58,814	\$116,119
Total	\$229,557	\$996,816	\$1,000,000	\$1,004,998	\$1,000,000	\$4,231,371

■ Human resources

The human resources used to manage HSSNPI are divided into two components. First, a Volunteer Committee was assigned the responsibility to manage the HSSNPI under the supervision of the QCGN. A program management consultant was hired by the QCGN to support the work of the Volunteer Committee. The selection of the projects that would receive funding under the program was undertaken by the Volunteer Committee. A public call for candidates was held to recruit community leaders and health and social service experts to participate in the HSSNPI Volunteer Committee.

According to the HSSNPI Quarterly Cash flow and Record of Expenditures, 13% (or \$539,707 on \$4,231,371) of the budget has been spent under the item “Staffing” since the beginning of the Program. This includes program management and QCGN staff support. The start up of the program required a heavy investment of time and energy to get the HSSNPI up and running. After this initial period, program management costs decreased substantially as illustrated in the table above.

◆ **Process activities**

The second step in assessing the quality of implementation at the QCGN level was to look at program activities. The Canadian Comprehensive Auditing Foundation defines activities as the procedures involved in, or steps taken, to carry out a program or to deliver a good or service. The following activities were identified and assessed at the QCGN level: information about the program; preparation and presentation of project proposals; review and selection of the applications received; funding of the selected projects; project monitoring and reporting.

▪ **Information about the program**

The program provided general information about the HSSNPI. A communications plan to guide the public launch of HSSNPI was drafted and implemented. The main objective of this communication strategy was to inform English-speaking Quebecers about the HSSNPI, its objectives, the availability of funds, the application process, and the program's progress and results. The examination undertaken at the implementation evaluation revealed that the intended communication strategy was executed as planned. The program was well publicized. Information about the program and application procedures was easily accessible, as was related documentation.

One way to judge the effectiveness of the communication plan was to study the project proposals that had been submitted to HSSNPI since the beginning of the program. That way, it would be possible to know if the selected communication channels and the activities carried out reached the intended audiences and had the expected effects. Organizations from 11 different regions presented proposals in the first two years of the program. Of these proposals, 64% came from organizations that are not members of QCGN and/or CHSSN, which is an indication that the program was well publicized outside these two organizations' networks. However, some regions did not present any proposals (Abitibi-Témiscamingue, Capitale-Nationale, Mauricie-Centre du Québec, Lanaudière, and Nord-du-Québec). The lack of community capacity would be a plausible explanation for this situation.

▪ **Preparation and presentation of proposals**

Health Canada's Contribution Program to Improve Access to Health Services for Official Language Minority Communities is a grants and contribution program with prescriptive reporting requirements with regard to program and financial activities. Continued funding throughout any fiscal year by Health Canada requires the submission of satisfactory quarterly narrative and financial reports which demonstrate that the program is generating the results it committed to and that it is managing the program's activities and finances with due diligence and probity. .

The HSSNPI program, funded under the Contribution Program to Improve Access to Health Services for Official Language Minority Communities was subject to the provisions of Health Canada's program standards.

In its call for proposals, the HSSNPI program defined the general framework of the projects it wanted and outlined certain obligatory requirements. It also left project developers

sufficient latitude to shape the content of their projects according to local, regional and sector considerations while aligning them with the requirements of the program. The rationale for such an approach was based upon pre-established program success criteria which determined that all projects would have to be evidence and results-based, generate knowledge on the health and social service needs and determinants of health of specific English-speaking populations, create a network of community and public-sector partners and focus their activities on enhancing access to health and social services within the communities being served by the project's promoters. The program also established a multi-year funding approach and set as a condition that multi-year funding would require annual applications in order to ensure that program participants generated the results committed to in their applications on an ongoing basis.

The program structure and requirements of Health Canada's Contribution Program to Improve Access to Health Services for Official Language Minority Communities, the predetermined success criteria of the HSSNPI and the need to adapt the above to the circumstances of specific English-speaking populations implied that strong skills were needed in results-based planning.

At the start-up of the program, HSSNPI program staff and the CHSSN provided information and support to potential applicants. The HSSNPI's competitive selection process required, however, that information to potential applicants be supplied without providing any applicant with an undue advantage in the competitive selection process. Overall, the implementation and first effects evaluation showed that 92% of the coordinators agreed or strongly agreed that they were satisfied with the support provided by the program for the preparation of their project. However, as will be outlined in the micro-implementation section, participants encountered some difficulties in preparing their proposals.

▪ **Review and selection of applications received**

The members of the Volunteer Committee assessed and approved program applications and determined funding levels.

The implementation evaluation showed that only a limited number of quality proposals were received. More than half of the proposals were rejected because they failed to meet essential program criteria such as aiming to build a network. Despite the fact that the great majority of the rejected proposals were simply looking for money, some potentially interesting projects ranked poorly with regards to the quality of information provided about population needs and the action plans proposed. In our opinion, this illustrates that different capacity levels exist among the English-speaking communities across Quebec. It also brought to light the need to find ways to encourage the creation of projects in regions with the lowest level of access so that they could take advantage of a program like HSSNPI.

Despite the variable quality of the proposals, the Volunteer Committee judged the merits of all proposals submitted according to the selection criteria and their assessment of the potential of the proposed projects. Only projects that met the selection criteria received funding. Proposals were assessed on merit and not on geographical region, although, as required by the program, more isolated regions were given priority consideration.

- Funding of selected projects

Once the projects were selected and funding levels determined, the ongoing allocation of contribution funds to program participants and the development and management of the program became the main focus of HSSNPI activities. During the implementation and first results evaluation it was observed that project funding had generally been disbursed on a normal monthly basis. However, during the HSSNPI's first and second years (2004-2005 and 2005-2006) some participants were late in producing their quarterly narrative and financial reports. This resulted in delays in the ongoing distribution of funds by Health Canada to the program because the program was not able to produce required reports on time. Consequently, funding was withheld by Health Canada until the reporting requirements were fulfilled. Overall, however, the ongoing financing of the projects went well.

- **Project monitoring and reporting**

Project developers were required to submit a narrative report every three months. They also had to submit a cash flow forecast and record of expenditures every quarter (usually seven to ten days after the end of the quarter). Furthermore, one on-site visit was made to each participating group by a program representative. The CHSSN also monitored particular project progress via its support services. When required, the program would also seek the CHSSN's advice regarding the progress of certain projects.

The implementation evaluation showed that overall, the monitoring and reporting mechanisms that were developed and used seemed effective in providing information on project status and in ensuring that network developers respected their program activity and financial commitments.

- ◆ **Outputs**

According to the Canadian Comprehensive Auditing Foundation, outputs are the goods and services delivered in order to achieve desired outcomes. The following elements constituted expected HSSNPI outputs at the QCGN level: the groups funded; the amount of money distributed; and the monitoring and reporting activities.

- **Funded groups and amount of money transferred**

Ten groups received HSSNPI funding (see Table 6), a level which met the program performance criteria of funding "7 to 10 regional-local groups". By the end of 2007-2008, HSSNPI had distributed \$3,082,834 to the funded groups. Not considering CHSSN's grant, each participant received an average of \$246,604 (or \$49,321/year).

Table 4 presents the funding awarded to each region since the beginning of HSSNPI. After the provincial network (CHSSN), the two regions that benefited the most from HSSNPI were Gaspésie-Îles-de-la-Madeleine (23%) and Estrie-Montérégie (20%). Outaouais received 8%, Côte-Nord and Chaudière-Appalaches 7% and Montreal 6%.

Table 4: Allocation of funding by region since the beginning of the program

	Provin- cial net- work	Gaspésie- Îles-de-la- Madeleine	Estrie- Montréal- gic	Ou- taouais	Côte- Nord	Montreal	Chaudières- Appalaches
HSSNPI participants	CHSSN	CASA CAMI FRP VISION	TA	RAWQ	CA	CCS	MCDC
\$	\$863,401	\$723,600	\$618,816	\$249,000	\$225,000	\$190,417	\$212,600
%	29%	23%	20%	8%	7%	6%	7%

The report from the Consultative committee for English-Speaking Minority Communities (2002) presented the results of a survey documenting the proportion, for each Quebec region, of English-speakers receiving services in English. Based on these results, the authors of the report presented an index which was obtained by comparing each regional result with the provincial average. As presented in Table 5, the Volunteer Committee awarded 81% of the funding to regions with an index under the provincial average⁴. Even though no funding was allocated to English-speaking individuals, the ratio of awarded funds per English-speaking individuals in each region is greater in regions with an index under the provincial average. Indeed, HSSNPI spent \$5,42 for each English speaker living in regions with an index below the provincial average, compared to \$0,71 in regions with an index superior to the provincial average⁵. Thus, even though not so many acceptable proposals emerged from regions with level of access under the provincial average (as it has been outlined by the documentary analysis) (CREXE, 2006a), more funding went to isolated regions.

Table 5: Funding since the beginning of HSSNPI according to the level of access

	Funding	% of funds awarded	Funding per Eng- lish speaker
Regions with level of access < 1	\$1,804,016	81%	\$5,42
Regions with level of access > 1	\$415,417	19%	\$0,71

⁴ According to this document, regions with an index over the provincial average are Montreal, Côte-Nord, and Nord-du-Québec.

⁵ Data on English-speaking populations in each region are from the Baseline Data Report 2003–2004.

Micro implementation (HSSNPI participants)

◆ Resources (inputs)

At the program participants' level, inputs included three elements: the funding received from QCGN, the human resources used, and the information received from HSSNPI staff and CHSSN.

▪ Funding from QCGN

Table 6 shows the funding transferred to each community group, as mentioned in their Quarterly Cashflow and Record of Expenditures.

Table 6: Organizations that received HSSNPI funding

	2003– 2004	2004– 2005	2005– 2006	2006– 2007	2007– 2008
Council for Anglophone Magdalen Islands (CAMI)	-	\$38,000	\$56,000	\$56,000	\$61,000
Committee for Anglophone Social Action (CASA)	-	-	\$20,000	\$40,000	\$45,000
Catholic Community Services (CCS)	-	\$40,000	\$50,000	\$50,000	\$50,417
Community Health and Social Services Network (CHSSN)	\$57,200	\$200,000	\$200,000	\$200,000	\$206,201
Coasters' Association	-	\$40,000	\$60,000	\$60,000	\$65,000
Fraser Recovery Program (FRP)	-	\$40,000	\$60,000	\$60,000	\$65,000
Megantic English-Speaking Community (MCDC)	-	\$42,600	\$55,000	\$55,000	\$60,000
Regional Association of West Quebecers (RAWQ)	-	\$40,000	\$68,000	\$68,000	\$73,000
Townshippers' Association (Estrie)	\$79,166	\$114,650	\$70,000		
Townshippers' Association (Montérégie)	-	\$40,000	\$70,000	\$140,000	\$105,000
Vision Gaspé-Percé Now	-	\$24,600	\$51,000	\$51,000	\$56,000
Total	\$136,366	\$619,850	\$760,000	\$780,000	\$786,618

Even if some project coordinators interviewed for the implementation evaluation did not see a significant difference between the budgets they requested and the contributions awarded by the Volunteer Committee, most project coordinators met were expecting more funding from the program. Indeed, questionnaires showed that for 50% of the coordinators, the main difficulty encountered during project preparation was to operate with the funding

available. The developers of funded projects had to modify their budgets and activity planning in order to function with grants awarded. The projects which appear to have been impacted the most from this situation were those in regions where geographically dispersed English-speaking communities required greater travel.

On the other hand, the online survey found that 85% of project coordinators at least more or less agreed that their organizations were funded at levels that allowed for effective execution of their project activities. In some cases, once salaries were accounted for, there was limited funding left to cover additional expenses. Evidently, the allocation of resources did not compromise the viability of the approved projects. Indeed, at the moment of the implementation and first impacts (results) evaluation, it was observed that the contributions allocated by the program had allowed participants to deliver the anticipated goods and services. This finding is consistent with the philosophy of the program to use its funding allocations to enable the start up of projects and assist them in leveraging resources to acquire additional support.

- **Human resources**

The contributions received from HSSNPI allowed the community groups to fund the salary of at least one project coordinator. In projects with many components, the funding received financed the salary of more than one coordinator. The budget's staffing component also included fees for administrative support, outside resources such as consultants, and benefits. Most HSSNPI project coordinators were supported by their regional association's staff and, in some cases, volunteers.

The implementation evaluation demonstrated that some project coordinators were concerned about their workload, which was heavier than what they had initially projected. In some cases, extensive traveling or the search for alternative sources of funding to cover travel costs increased the workload. Other coordinators had no particular problem with the workload, but mentioned that their salaries did not match the responsibilities and skills required for the position.

- **Information resources**

When the HSSNPI was conceived it included in its design the development of a provincial network. The latter was to interface with provincial entities in the health and social services field, generate information and knowledge on a provincial, regional, sub-regional, local and sector basis and provide ongoing professional support to individual projects. Therefore, in addition to the information and support provided by the HSSNPI program to help participants develop and manage their projects, the CHSSN also provided ongoing assistance to individual projects through its Community Support Team. Support was provided on site or by phone and dealt with the formalization of networks, participation in other projects, organizational and board development and assistance to organizations with staff changes. The CHSSN also kept the participants abreast of new funding opportunities in order to help them sustain their newly created initiatives.

As indicated above, another one of CHSSN's responsibilities with respect to the HSSNPI was to produce and share knowledge regarding the health and social services access issue. This mandate was fulfilled through the development and execution of research projects, the

organization of stakeholder conferences, participants' retreats, a research symposium, training sessions, and other activities. CHSSN also used its website to provide participants with a great deal of information on Quebec's English-speaking communities and the initiatives underway. A newsletter (Netlink) and four baseline data reports (including a case study of the 11 networks created) were also developed and made available online. All of this information was intended to help participants document their community's situation regarding access to healthcare and support them in shaping their initiative.

CHSSN conducted an evaluation of its support services and reported that the findings indicated that everything was "overwhelmingly positive." The quality and relevance of CHSSN support were confirmed during the implementation evaluation by interviews and the online survey of project coordinators. The coordinators appreciated the support provided, the availability of staff, the fast answers to their queries, the extensive experience of CHSSN staff in the health sector, their willingness to travel, their help finding alternative sources of funding and their work organizing retreats.

◆ **Process activities**

At the level of the funded groups, three main areas of activity were observed: the preparation and presentation of program funding applications, reporting and evaluation activities, and execution of project activities.

▪ **Project planning and preparation of funding applications**

As indicated above, the HSSNPI required that participants apply for funding each year to ensure that they were meeting their program and financial obligations. The purpose of this approach was to reinforce program monitoring and make sure that the program responded to standards of due diligence and probity.

Consequently, each participant had to fill out a funding application on an annual basis describing their individual projects and their progress over the preceding year, the anticipated results and related activities for the upcoming year, the performance indicators that would be used to assess the achievement of their results and planned expenditures.

Some difficulties were encountered by some participants in meeting these requirements. CHSSN activities sometimes overlapped with program reporting periods even though reporting deadlines were agreed to at the beginning of each fiscal year and were contained in the contribution agreement signed by each participant. Other difficulties and challenges identified included the complexity of documents, especially a lack of familiarity with results-based management approaches and language, the quantity of information required, the duplication of requested information from one year to the next, difficulties in securing adequate information from the program at the start-up and lack of feedback on past applications. There was initially some confusion about the program management role and the CHSSN community support role.

Each of these issues was addressed as it was raised. Ongoing training and information and additional professional support was provided to participants regarding the requirements of a results-based management approach. An ad-hoc committee was established by the Volunteer Committee which included program participants. The committee identified how ad-

ministrative requirements could be streamlined and duplication avoided. This work resulted in a change in year to year program information requirements and application packages were adjusted accordingly. Program information requirements and application support became more accessible when the QCGN agreed to switch the program from a competitive application processes to a cohort approach in 2006-2007. Overall, issues were resolved by appropriate corrective measures. All of these adaptations seem to have been well received by the participants, with a number of respondents describing an improvement during the 2006–2007 application process.

- **Reporting and evaluation activities**

As indicated above, project developers were required to submit narrative progress reports every three months, as well as a cash flow forecast and record of expenditures seven to ten days after the end of each quarter. These reporting requirements were dictated by the standards of the Health Canada contribution program.

The implementation evaluation revealed that most project coordinators interviewed found the program reporting requirements to be heavy. The time required to produce reports was perceived by some to be unrealistic. Coordinators also mentioned that lack of feedback on reporting documents was a source of irritation. While no changes could be made to Health Canada's reporting requirements, administrative changes were made, as indicated above, to address specific concerns.

- **Project activities**

In terms of project implementation and management, project coordinators were responsible for developing their project components; recruiting members for the network, animating the network, organizing meetings with people involved in the public health sector, coordinating project activities, seeking alternate funding for their initiatives, etc.

Each project has its own particularities. As observed during the implementation evaluation, there was no one best way for communities to proceed. The idea was to let them develop the activities best suited to their particular circumstances while respecting the overall requirements of the program. As indicated above, three components were common to all of the projects: network development, knowledge development, and communication activities. In addition, various initiatives were undertaken to enhance access to services in English. Some projects had a special emphasis such as developing the volunteer sector in their specific region.

Given that the Fraser Recovery Program (FRP) was a sector activity in support of two regions and the CHSSN project was designed to develop and manage a provincial network, each of these projects had their own particularities. The FRP project provided assistance and support for regarding youth alcohol and drug abuse in Gaspésie and Îles-de-la-Madeleine. As outlined in the Information Resources section, CHSSN responsibilities were to support participants and produce and share knowledge regarding the issue of access to health and social services.

◆ **Outputs (or HSSNPI short term outcomes)**

The following elements constitute anticipated HSSNPI outputs at the participants' level: information and knowledge developed, and the creation of networks. These elements could also be considered as the HSSNPI short term outcomes.

▪ **Information and knowledge development**

The conclusions of the implementation and first impacts (results) evaluation regarding information and knowledge was that all HSSNPI participants generated knowledge concerning the health and social services needs and priorities of their respective communities and all were active in community outreach by developing communication tools. Indeed, an assessment of the participants' quarterly narrative reports found that every project included research activities (surveys, focus groups, regional forums, etc.).

Interviews demonstrated that project coordinators and network partners had similar perceptions as to the success of knowledge development activities. Indeed, both agreed that their projects had been successful in identifying the determinants of health and well-being for their respective English-speaking communities. Analysis of quarterly narrative reports found that over half of participants had reported that research activities had fuelled databases on the English speaking community in the specific region identified. More than half of the participants also mentioned that the information gathered was disseminated to network unit partners, thereby increasing their own knowledge base.

Project coordinators and network partners interviewed also agreed that knowledge development activities helped with the identification of English-speaking community health and social service needs. Some program participants also mentioned in their quarterly narrative reports that research efforts helped to understand the specific needs and priorities of the English-speaking population in each region.

Lastly, the implementation study demonstrated that knowledge and best practices were successfully shared by CHSSN with English-speaking community organizations and groups via a stakeholders' conference, a retreat, a virtual private network, and a newsletter.

▪ **Creation of networks**

The implementation evaluation found that every funded organization had developed at least one network. Program participants created around 2 networking units. CHSSN also created a provincial network to link all funded communities. In each community, project coordinators were able to recruit from 5 to 150 partners. These partners included volunteers, as well as community, municipal, and health and social services workers. On average, project coordinators and network partners met with other partners 26 times during the first two years of the program.

The new networking units seemed to have good sustainability potential according to observations made on the following variables: the development of network mission and vision statements; levels of partner adherence and commitment to these statements; partner perceptions on the relevancy of the network; partner satisfaction regarding participation in the

network; the number of partners that left the network; concrete actions taken to ensure network sustainability; partner organization interest in providing long-term financial support and in monitoring the network; the strength of ties between network members.

The assessment of quarterly narrative reports produced by participants since the implementation evaluation found that all networking units remain active. Meetings are held between partners. Networking units seem to operate in a structured manner (identified name, mission, mandates, vision, values, logo, evaluation procedures, and articles of incorporation, membership guidelines, member roles, agendas and minutes of every meeting).

All project coordinators were also busy with other partners. As one participant mentioned:

“The network continues to be solidified as the coordinator attends meetings with other partners and sits on tables where information is shared.”

Some participants mentioned that sustainability plans have been drafted and approved by their partners. Another participant mentioned that its partners had confirmed their interest in maintaining the networking unit beyond 2008. Many participants were also active in applying for funding or charitable status.

Factors facilitating or challenging implementation

Based on a review of participant narrative reports, activities for the various projects all appeared to be going as planned. No signs of major project failure were detected. The interviews during the implementation evaluation tended to support this finding. Participants were taking on activities and tasks relevant to the overall program goal. However, some participants had experienced unexpected difficulties in implementing their initiatives, while in other situations, certain factors had facilitated implementation.

◆ Geography

The principal difficulty observed during the implementation evaluation was region size because it affected the extent to which certain project coordinators could travel. In some regions, English-speaking communities are scattered over a vast area. In these situations, it was difficult for the project coordinator to reach every community.

◆ A history of partnerships

A second factor observed during the implementation evaluation had to do with the history of partnerships in the region. In areas where English-speaking communities and the public health and social services sector had worked together prior to HSSNPI, this history of past cooperation was often found to be a facilitating factor. This was also true in regions where contacts between English-speaking communities and health and social services representatives were well-established, and where project coordinators and network partners were already in contact with the members of the actual networking units before networking activity actually began.

◆ The presence of an English-speaking regional association

The presence of a well-established regional association representing the English-speaking community was also mentioned as a factor that could influence the quality of implementation of certain projects. For example, a regional association with a ten-year track record would provide a more solid project foundation than a newly created organization.

◆ The presence or absence of health and social services representatives during initial project design

The involvement of health and social services representatives during the project design phase may have facilitated partner recruitment. Because these representatives were involved right from the start, project coordinators did not have to convince them to join the network. Furthermore, they may have lent credibility to the initiative, helping convince other potential partners to get involved and bringing their own expertise to bear in project development.

◆ Lack of cooperation from certain public institutions

Some project coordinators mentioned that in the course of carrying out their project activities, certain persons representing local authorities (health and social services representatives, municipalities, etc.) showed a negative attitude toward the formation of a health and social services networking unit.

◆ Project coordinator skills

HSSNPI required knowledge and skills on the part of project coordinators (in results-based management, reporting, network development, data analysis, strategic planning, and issues related to the health and social services sector). Because these skills were not mastered at the same level by all project coordinators, some HSSNPI participants may have performed at different levels in the early phases of program implementation.

Summary of Implementation and first impacts Review

In summary, CREXE initially concluded in 2006 that the implementation phase of the program had been excellent. The evaluators' assessment of this phase of the program has not changed since presenting that report. As indicated, in the report deposited with the QCGN in 2006, all expected outputs were successfully delivered;

- ◆ HSSNPI was successful in spending the available funds as originally planned;
- ◆ The program was well publicized and information about the program, application procedures and related documentation were easily accessible;
 - Unfortunately, some regions with identified access issues presented no project proposals. The lack of community capacity would be a plausible explanation for this situation.

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- ◆ The largest level of funding went to isolated regions;
 - ◆ The coordinators were satisfied with the support activities provided by the QCGN for the preparation of projects;
 - Administrative issues were identified and resolved.
 - ◆ The execution of every project's activities seemed to go well;
 - ◆ The level of outcomes reached for the program's short-term outcomes was excellent;
 - Every funded organization developed at least one network;
 - Participants' participation and commitment to the networking units were very satisfactory;
 - The developed networks seemed also to have good sustainability potential;
 - All HSSNPI participants generated knowledge concerning the health and social services needs and priorities of their respective communities;
 - The CHSSN project was also successful in producing useful knowledge for the participants;
 - English-speaking community members were effectively building relationships with health and social services representatives;
 - Access priorities were also identified and actions were initiated in the funded communities;
 - An increased understanding by public sector officials of the determinants of health and well-being for English-speaking individuals and their specific access needs and priorities was also reported by project participants and networks' members;
 - New collaboration between the two groups was nurturing a more informed dialogue which was creating a shared understanding of access issues;
 - Emerging partnerships were observed, which may lead to improved coordination in the delivery of health and social services;
 - Since most of the projects were in the early stages of implementation, more coordination was likely as the projects mature, but the elements were presents.
 - Access to English-speaking volunteers to assist in service delivery was increasing;
 - There was evidence that certain funded groups had already recruited a noticeable number of volunteers to assist in service delivery and have developed data bases of volunteers;
 - Volunteer training activities were also established in some projects;
 - With regard to reorganization and new services offered, the program was not yet very successful;
 - Examples of service reorganizations and new services offered in communities exposed to the HSSNPI program were observed but not many of these represent concrete service reorganization;

- Concerning the new services made available, it might sometimes be difficult to attribute entirely these results to the HSSNPI;
- Finally, it was possible to illustrate that the program had net effects at many levels (knowledge development, community participation, identification of needs and priorities, coordination, volunteer development and training).

4.3 Impacts (results)

As mentioned earlier, we examined the medium term Level 1 effects of HSSNPI on the participation of the English-speaking community. We then looked at medium term Level 2 effects on the identification of community needs and priorities, and on the coordination, recruitment and training of volunteers. After that, we explored the medium term Level 3 effects, this time on health and social services delivery. At this level, we could see HSSNPI's impacts (results) on the reorganization and introduction of new services and the information made available about these services. Lastly, we examined the effects of HSSNPI on members of the English-speaking community by looking at service consumption, knowledge of available services, satisfaction with services used, and decisions on whether to use services or not. The limitations of this exercise have already been mentioned. However, the observations drawn from the various surveys provide very useful information on the potential scope of the HSSNPI in the medium and long term.

Level 1

- **Community participation**

One of our conclusions in the implementation study was that through the networking units created, members of the English-speaking community were effectively building relationships with health and social services' representatives. In many cases, these interactions have led to the involvement of HSSNPI coordinators in various public sector committees, projects, and activities. These efforts appear to have strengthened English-speaking community representation in health and social services decision-making bodies, boosted the community's sense of ownership and participation in the planning and development of services for the English-speaking community and helped to promote participation by members of the English-speaking community in health and social services structures at the provincial, regional, and local level.

The HSSNPI was expected to generate active participation by members of the English-speaking communities in the consultative and decision-making bodies of the public health and social services system. One key to ensuring this result is the presence of English-speaking representatives within these bodies. An assessment of participants' quarterly narrative reports produced since the implementation evaluation shows that all program participants have been active at the local and regional level. Furthermore, at least five projects indicated that they had secured a place for a member of the English-speaking community member on a public sector board of directors (public agencies, CSSS, access committee, regional development council, community groups).

HSSNPI participants have also represented the English-speaking communities on consultative and decision-making bodies in the public health and social services system. Indeed, some project participants mentioned in their narrative reports that they had attended on

various occasions since the beginning of their project to access committee meetings in their region. Some were also representing the English-speaking community on clinical project consultations, special issue consultations, advisory committees, and roundtables. Project coordinators had access to CSSS directors, CSSS human resources directors, health professionals, school board representatives, school representatives, police representatives, mayors, municipal councillors, community group representatives, and others.

Activities in which program participants had participated included: meetings with various partners and representatives from healthcare and community organizations; sharing of information between partners and public sector representatives; developing new services for the community; providing input for decisions about required services; preparing and presenting joint applications for funding; taking an active part in the organization of community forums, community events, and partnership development; participating in lobbying for specific services.

The CHSSN has also been active at the provincial level, providing representation for the English-speaking community on the Provincial Advisory Committee of Ministère de la santé et des services sociaux, the Health Canada Consultative Committee, and the Statistics Canada Advisory Committee, as well as with the National Institute for Health Research. The CHSSN was also involved in the McGill Training and Human Resources Development Project and the Primary Health Care Project. At least four participants mentioned having taken an active part in these two initiatives by providing insights to public partners on how these projects should be developed.

Level 2

▪ Identification of needs and priorities

The implementation evaluation concluded that all the projects generated data on the local English-speaking communities and that this information helped clarify community needs and set community priorities.

Project participants and partners reported an increased understanding by public sector officials of the determinants of health and well-being for English-speaking individuals and their specific access needs and priorities. Indeed, our online survey revealed that 64% of project coordinators and network partners agreed or somewhat agreed that community leaders and health and social services decision-makers and administrators in their respective regions have an adequate understanding of the determinants of health and well-being for English-speaking individuals. Also, HSSNPI project coordinators and network partners were statistically more likely than respondents in regions not exposed to the program to agree with that statement⁶. This seems to be an indication that HSSNPI has been successful in this area.

At the time of the implementation evaluation, some projects had already begun developing and implementing a formal action plan (in a few cases approved by health and social services representatives) informed and shaped by the knowledge that had been developed and

⁶ These respondents were developers of non-funded projects and potential partners (people working at Quebec's Agence de santé et services sociaux who were in charge of access issues, access committee members and members of Anglophone regional associations).

disseminated. The online survey revealed that almost three-quarters of project coordinators (73%) strongly agreed or agreed that their project had led to the development and implementation of an action plan containing service-delivery models, strategies and initiatives adapted to the needs and priorities of English-speaking communities in their region. Most of these action plans were endorsed by network steering committees (N=5) and network participants and partner organizations (N=5). In some cases (N=3), action plans were even endorsed at the CSSS administrative and director-general levels.

Moreover, there were many indications that public sector awareness of the needs of the English-speaking community had never been so great. Several public partners mentioned that the HSSNPI projects were an eye-opener for them. Their new relationships with the English-speaking community of their region/locality provided their organizations with valuable information on the community's needs. This collaboration has nurtured a more informed dialogue and helped create a shared understanding of access issues among networking unit partners.

▪ **Coordination**

The identification of partnerships (service models, strategies, and initiatives) should result in better coordination among the partners involved. At the time of the implementation evaluation, the HSSNPI was already showing promising results at this level, with emerging partnerships observed in all projects. The online survey revealed that most projects generated from one to four partnerships involving representatives from the community and/or the public health and social services sector. One coordinator even mentioned a project that had generated 75 partnerships.

Fully 82% of network partners and project coordinators agreed or strongly agreed that their participation in a networking unit allowed their organization to increase its capacity for developing future projects in collaboration with unit members. Furthermore, 83% of network partners were open to the idea of sharing some of their organization's resources with other network partners in order to implement health and social services-related projects.

In yet another finding from the online survey, HSSNPI project coordinators and network partners were statistically more likely than respondents in regions not exposed to the program to agree that there is considerably more coordination between community health and social services and public health and social services in their respective regions. This could be an indication that HSSNPI has been successful in this respect. Numerous network partners mentioned during interviews that, since joining a networking unit, they have discovered new community groups that share their interests. Many interviewees confirmed that partners that had never worked together in the past now had the opportunity to participate in network activities, and consequently had started working together on ad hoc projects. Numerous partners also mentioned discovering resources and services available in their community when they started participating in networking activities.

Most examples of coordination given in participants' quarterly narrative reports were at a local and regional level. They included cooperation between project coordinators, network partners, community groups, and public health and social services representatives. Coordination was also observed at the provincial level, notably on the part of CHSSN (via its pro-

vincial network) and program participants. Service delivery models were shared among the participants. Examples of improved coordination included:

- Co-organization of activities between partners
- Assistance in facilitating activities
- Information sharing
- Co presentation of funding requests
- Sharing of financial resources (to hire a health professional)
- Sharing of services
- Translation of existing French documents into English
- Consultations during recruitment of bilingual professionals
- Volunteer development and training

The implementation evaluation found that certain funded groups had already recruited a noticeable number of volunteers to assist in service delivery and were developing volunteer databases. The online survey revealed that 140 English-speaking volunteers had been integrated into volunteer and community organizations and health and social services institutions in order to provide services in English. The number of volunteers recruited ranged from 10 to 50 volunteers. Volunteers have been recruited to help with translations, English conversation sessions at CSSS and community events.

As one project coordinator mentioned in a quarterly narrative report:

“The number of people calling for information about volunteering has increased since [2005-2006] (85 vs. 55). Fifteen were referred to local resources. Twenty-three Volunteer Bank columns were published in [the newspaper]. The coordinator received 30 inquiries concerning the Volunteer Bank column; [...] 13 requests for a volunteer to translate documents; [...] and two requests from individuals seeking a volunteer to help develop computer skills. A health and social services professional called the Coordinator looking for a volunteer for a client.”

Certain volunteer development partnerships were also concluded. As one quarterly narrative report notes:

“The Volunteer Coordinator has maintained regular contact with volunteer and community organizations that provide volunteer services in the region, has expanded the network of partners, and has established working partnerships where possible.”

In another report, a coordinator mentioned that the list of the recruited volunteers have been displayed at all the nursing stations at the hospital and the local CLSC.

Volunteer training activities have also been arranged for new volunteers. For example, volunteers were trained by hospital staff on how to act as interpreters in emergency situations. Other volunteers were trained on how to provide assistance to seniors with mobility problems. Volunteers also received training on how to assist at an income tax clinic for low income earners. Another coordinator developed a volunteer handbook for all volunteers working with the community group.

Lastly, a project coordinator reported in a quarterly narrative report that in his region:

“The volunteer presence is strengthened, expanded and more engaged [...] The volunteer network activities strengthen local resources and permit sharing of info and practices.”

Level 3

◆ Accessibility (supply of health and social services)

The implementation evaluation concluded that the program had produced good results in the first two years concerning anticipated, short term level 1 and level 2 outcomes. However, in 2006, CREXE observed few examples of increased supply of services, a situation likely attributable to the fact that most projects were in the early phases of development. Unlike short term Level 1 and Level 2 outcomes, Level 3 outcomes require greater involvement on the part of other public sector partners as well as structural changes. It will probably take more time before we see greater impact on access to services.

▪ Reorganization and new services available

Reorganization refers to the optimal and innovative use and organization of existing resources. Cases of service reorganization in communities exposed to the HSSNPI program were observed during the implementation evaluation, but few of them were very concrete. Since then, more concrete initiatives have been put into place. Here are some examples drawn from quarterly narrative reports:

- CSSS has implemented an employee identification badge with a “mellow yellow” band indicating which people are able to provide service in English.
- Partners dealing with shared issues are now in a position to serve the English-speaking community through joint recruitment of bilingual interveners.
- Activities for seniors are held on a partnership basis to help alleviate the feeling of isolation and loneliness of many retired persons.
- Maps of villages showing the services provided in each community are being created for new employees of the CSSS.
- A buddy system has been created for CSSS employees.

One project coordinator said in a quarterly narrative report:

“It was brought to our attention by community members that an increasing number of notices in both languages have appeared throughout the hospital regarding, for example, closure of facilities because of inclement weather and holidays (...). We were most pleased that the director general of the CSSS offered to post signs indicating that services in English are available for the asking.”

As for new services, the implementation evaluation concluded that some services have already been made available to English-speaking communities. However, it was sometimes difficult to attribute these results entirely to the HSSNPI. As was the case for the reorganizations, other initiatives, like PHCTF or the McGill Project, may also have contributed to the creation of these new services.

In the online survey, project coordinators and network members reported that the number of health and social services previously unavailable in English that now were available in English ranged from zero to eight. According to these respondents, the number of people who had benefited from these new services ranged from approximately 0 to 700, with an average of 136.

An assessment of the quarterly narrative reports produced since the implementation evaluation shows that quite a few services have been made available. For example:

- With regard to the McGill project, the organization and presentation of tele-health sessions (videoconferences offered at local hospitals) were reported by many project coordinators. These sessions provided information to educate the English speaking communities on various health issues. Access was also improved by second language training for CSSS employees. Some partnerships have also resulted in the hiring of bilingual staff.
- FRP resulted in the creation of a community resource intervention team that started working with at-risk youth. The team conducted workshops and community forums to educate the community on the issue of substance abuse and provided support and suggestions to school staff for the implementation of an anti drug policy and protocol. FRP also helped bring in a theology student with training in youth substance abuse treatment who had worked extensively with local at-risk and addicted youth. FRP, via the ADAPT initiative, secured necessary funding to send four at-risk youth to a one-week summer recovery camp.

Here are examples of other new services reported:

- The opening of a youth clinic at a local CLSC
- A transportation service for people with reduced mobility
- Recruitment of a youth addiction worker using program funding
- A diabetes education program in English to be offered by a local CLSC
- Provision of a space for seniors and youth activities at a CLSC
- A summer camp for kids from an isolated region
- A three-day free English youth camp for children aged 11 to 13
- An initiative for younger members of the 60 and over cohort aimed at reaching people who are often sandwiched between caring for younger and older generations
- A youth forum bringing together service providers, community organizations, and the school board to examine problems, solutions, and services, and to find ways to cooperate in order to maximize services for English-speaking youth
- A youth center that provides basic needs (shelter, meals), help and someone to talk to, structure, family mediation, simulations of real-life situations, homework and study help, information, and referrals and accompaniment.

The final evaluation was an opportunity to question members of the English-speaking communities on their perceptions of the new services available to them. In general, participants from all focus groups were able to identify examples of new health and social ser-

vices available in English in their region. However, perceptions about the change in the number of services differed significantly from place to place. A few participants reported noticing a significant increase in the number of services available in English during the past three years, but the majority felt that the number had not changed much. However, most participants acknowledged that attitudes toward providing services in English had changed, leading to the addition of more bilingual services within the past year.

- **Advertising and referral**

Interviews and documentary reviews showed that at the time of the implementation evaluation, most HSSNPI participants had already developed communication tools to refer members of the English-speaking community to existing resources or services. These communication tools included radio advertisements on available healthcare services, interviews in the local media, guides to available English services, articles, press releases, newsletters, websites, meetings, flyers, promotional materials, stickers, in-house information and referral services, and a telephone directory.

The online survey showed that English speakers in various communities were receiving this information. Project coordinators and network partners were asked approximately how many English-speaking individuals seeking information on health and social services in their respective regions had received information during that particular year. Answers ranged from 50 to 4,000 individuals, with an average of 641. Likewise, the same respondents were asked approximately how many individuals requesting health and social services in English this year had been directed to the appropriate public or community resources by information and referral services. Answers ranged from 15 to 3,000 individuals, with the average being 360.

As in the case of reorganization and of services observed, the final evaluation was an opportunity to question members of the English-speaking communities on their perceptions of advertising and referral services. Although only a handful of participants could specifically recall what they had received, when they had received it, and what the source of the information was, their answers showed they had generally been exposed to promotional tools aiming at raising awareness of services available in English. Indeed, during the past three years, participants in all focus group session had received flyers and pamphlets regarding health and social services. Certain promotional tools such as specific letters were identified by some of the participants. It was also mentioned that community groups receiving HSSNPI funding were involved in the development and/or distribution of some of these communication tools.

Level 4

- ◆ **Accessibility (consumption of health and social services)**

The final evaluation was an opportunity to find out whether newly developed partnerships and services and the information provided about available services had led English-speaking Quebecers to view services as being more accessible. To measure accessibility, three variables must be observed: knowledge of available services, the quality of the experience, and the decision to make use of the services.

- **Awareness**

The majority of participants from all focus groups felt that their knowledge of health and social services had improved over the past three years. They mentioned that the information sent to them had definitely increased their awareness of the services available in English. Apart from communication tools, many participants attributed this improvement to the greater efforts on behalf of staff and health authorities to communicate in English with English-speaking patients, despite their own limitations with the language. On a few occasions, focus group participants said that caregivers who could neither speak nor understand English would seek out a bilingual colleague for assistance. Three years ago, staff was not making such efforts to accommodate patients. With their increased awareness of the services offered, a majority of participants felt that the availability of services had increased. Nonetheless, most participants also believed that there was still considerable room for improvement.

- **Quality of the services**

Most of the participants in the focus group sessions believed that the quality of health and social services in their region had improved over the past three years. For others, the quality ranged from “very poor” to “very good.” However, many participants mentioned being unsure whether it was the services that had improved or whether it was the quality of English that had gotten better. Participants from the different focus groups repeated that they witnessed significant improvements in the quality of English spoken by staff when they were being treated. It was also noted that staff members were making significant efforts to improve their ability to speak to the patients in English, efforts that were not being made a few years ago. Still, some participants reported no change in the quality of the services offered, while a minority (mostly in Gaspé) believed that the quality of the health and social services had actually regressed over the past three years. However, this problem does not seem limited to the English-speaking communities since it is also true for all services users in Gaspé (as expressed by some participants of the Gaspé session).

- **Utilization of services**

When ill or injured, participants from all focus groups chose among a variety of options. These included visiting local hospital emergency room, CLSCs or walk-in clinics, making appointments to see family doctors and even calling friends and family. Their choice often depended upon such criteria as the severity of their condition; the estimated waiting time for consulting a doctor at a local clinic, CLSC or hospital; their access to friends or family who could assist them due to their involvement with health and social services; and even the distance separating them from the different health care institutions.

Generally speaking, most of the participants from all of the focus groups felt that their level of comfort in using health and social services had improved over the past three years. They believed that the comfort level varied according to several factors, including the nature of the injury or illness suffered, the corresponding waiting time for seeing a doctor, their knowledge of the French language, their knowledge of what services were available in English, the fact that they were accompanied by a friend or a family member if their knowledge of French was limited, the efforts made by staff to accommodate them in English, and staff attitudes toward English-speaking patients.

CONCLUSION

The process used to evaluate the Health and Social Services Networking and Partnership Initiative sought to answer various questions about the implementation of the program and its effects. The final report has provided answers to many of these questions through documentary research and surveys of the partners and participants involved in the project.

◆ Review

Answers to the first four questions on implementation posed in the introduction to this report are reviewed here. They are followed by the five questions on program effects and the question on the Program's overall value.

1) What is the *raison d'être* for the program and is it still relevant?

The implementation study demonstrated that the main problem at the origin of the program was the limited capacity of communities and community organizations to participate fully in the health and social services system. Building capacity within the English-speaking communities appeared necessary if they were to play a role in the system. To achieve this goal, community organizations needed to have access to more resources and be better organized. These findings were based on research in Quebec's English-speaking communities as well as on the experience of key people who have been working on this issue for a number of years.

Networking was paramount among the three priorities set forth in the health component of the Government of Canada's 2003 official languages action plan. The CHSSN was tasked by the Health Canada Consultative Committee to design an approach that would leverage networking to build capacity in English-speaking communities. The idea was to develop an integrated approach to the accessibility issue by acting simultaneously at the level of primary care (via PHCTF), human resource development (via the McGill Project), and community capacity (via HSSNPI).

Two dimensions underlay the idea of capacity building with the English-speaking community: first, allocating resources to community organizations that agree to establish a round-table whose role is to standardize the links between stakeholders; and second, identifying community needs and understanding how the health system works in order to ensure the community has access to services that are truly adapted to its needs and circumstances. The study of the *raison d'être* had to ensure that the types of projects funded promoted capacity building in vulnerable English-speaking communities and that the funds allocated were put toward network creation and the development of knowledge on community member needs.

Project selection was entrusted to the Volunteer Committee described in this report. At minimum, project promoters had to represent a non-profit organization, present a project to develop a health and social service network at the local, regional, sector, or provincial level, and show sufficient knowledge of the community the project was meant to serve. Project potential to increase access to health and social services in English and generate sustainable results was also assessed.

Our assessment of Volunteer Committee choices showed that all projects selected respected the basic program requirements. All of the funded projects were submitted by not-for profit organizations and had a network development component. Funding was also allocated to projects that initially ranked poorly in terms of certain program criteria (such as the quality of the information provided about population needs, the action plan suggested, the sustainability strategy, etc.). In these cases, projects with evident potential were requested to improve certain parts of their proposals and/or submit a sustainability strategy in order to qualify for funding. Selected projects were, therefore, consistent with the idea of building community capacity.

Since the HSSNPI aims to build capacity in vulnerable communities, CREXE also looked at the proportion of the funds allocated by the Volunteer Committee to regions with access problems. The review of documents showed that the Volunteer Committee awarded 81% of the funding to regions with an index access under the provincial average. In addition, the ratio of awarded funds to English-speaking organizations is greater in regions with an index under the provincial average, i.e. the HSSNPI spent \$5,42 for each English speaker living in regions with an index below 1 (the provincial average), compared to \$0,71 in regions with an index superior to the provincial average. We can therefore conclude that more funding went to needier and isolated regions.

Finally, the evaluation of HSSNPI's *raison d'être* concluded with an assessment of the ongoing relevance of the program's main issue i.e. the limited capacity of English-speaking communities and community organizations. Indeed, there are illustrations that capacity levels vary among English-speaking communities across Quebec and that the issue at the origin of HSSNPI is still relevant. First, even though the program was well publicized throughout the province, some regions did not present any proposal. This situation could be attributed to the English-speaking communities in these regions which are simply not organized enough to build a project. Secondly, the assessment of the proposals received at the beginning of the program showed that the proposals were of varying quality. Apart from irrelevant proposals, some potentially interesting projects ranked poorly with regards to the quality of information provided about population needs and the action plans proposed. This is another illustration of the limited capacities of these communities. For these reasons, there are still needs for a program like the HSSNPI. This also brings to light the need to find ways to encourage and support the creation of projects in regions with the lowest levels of access so that they can take advantage of a program like HSSNPI.

2) Was the program implemented as originally planned?

The study of the *raison d'être* showed that the initial intention was to make funding available to the communities to help them build their capacity to partner and develop relationships with the public sector so that the public sector would in turn adapt its services to respond more adequately to the need and priorities of English-speaking communities. At another level, the program had to help each funded community develop its own capacity to adjust, interact and support itself in order to come up with more creative ways of addressing issues related to accessibility to services. According to the data consulted during the study, the nature of HSSNPI and its activities is aligned with these initial intentions.

One of the initial ideas behind HSSNPI was to ensure that all communities across Quebec had a reasonable opportunity to participate in the program. The program also provided for

the possibility of multi-year funding to participants so that they could plan and run projects until the end of the program in March 2008, as long as each project demonstrated that it had achieved its program activity and financial commitments. In 2004–2005 (the first year of the public call for proposals), the Volunteer Committee selected 10 projects. The QCGN decided that it was necessary to undertake a second public call for proposals to ensure that communities across Quebec, not selected in 2004–2005 application process, had a reasonable opportunity to join the program. The selected participants in 2004–2005 were surprised to see a public call for proposals issued for the year 2005–2006, because they felt that the possibility for receiving multi-year funding could be comprised. In the end, however, only one additional group integrated the program in 2005–2006 and all of the initially funded groups continued to receive funding. All of these participants received funding until the end the program and many saw their allocation grow over the life of the program.

Lastly, prior to the program launch, it was also planned to fund a pilot project. The project chosen was put forward by the Townshippers' Association in Estrie. Since the association already had a relationship with the program designers, its work was used as a case study and the process it went through was also shared with other groups.

3) What factors facilitated or challenged program implementation?

Health Canada's Contribution Program to Improve Access to Health Services for Official Language Minority Communities is a grants and contribution program with prescriptive reporting and accountability requirements with regard to program and financial activities. Continued funding throughout any fiscal year by Health Canada requires the submission of satisfactory quarterly narrative and financial reports which demonstrate that the program is generating the results it committed to and that the program is being managed with due diligence and probity.

The HSSNPI is a results-based program that supports evidence-based projects which are funded on an ongoing basis if they demonstrate regular performance. The reporting requirements of the HSSNPI enabled the program to meet the reporting requirements of Health Canada and ensure that project participants' performance was maintained at acceptable levels according to their specific contribution agreements.

As a competitive funding program, especially in the first two years before switching to a cohort management model in 2006–2007, program managers and the community support program of the CHSSN sought to strike an appropriate balance between providing information to current and potential applicants while not providing any applicant with an undue advantage in the competitive application process.

Some program participants experienced difficulties in the planning and preparation of their funding applications, especially at the outset of the program. Problems included the complexity of the documents, the language used in the documents, the quantity of information required and the duplication of requested information from year to year, difficulties in reaching the management team at the start of the program and lack of feedback on past applications. Some communication challenges also arose with respect to HSSNPI's program management role and the CHSSN community support role. Problems were resolved by appropriate corrective measures.

The implementation evaluation revealed that most project coordinators interviewed found that the program reporting requirements were heavy. The time required to produce reports was perceived by some to be unrealistic. Coordinators also mentioned that the lack of feedback on reporting documents was a source of irritation. A committee was formed to address these difficulties and issues that could be addressed administratively were resolved.

Overall, the implementation and first effects evaluation showed that 92% of the coordinators agreed or strongly agreed that they were satisfied with the support provided by the program for the preparation of their projects.

The online survey indicated that for 50% of the coordinators, the main difficulty encountered during project preparation was to operate with the funding made available. Most HSSNPI participants thought their project would receive more funding. The projects that were impacted the most from not receiving the funding requested were those in regions where much travel was necessary.

As for factors that facilitated or complicated program implementation in the field, project coordinators mentioned a number of elements that may have had an effect, including geography; the history (or lack thereof) of partnerships in the region; the presence (or absence) of an Anglophone regional association in the region; the presence (or absence) of health and social services representatives in the initial conception of the project; the level of cooperation from certain public establishments; and the skills of project coordinators.

4) Has the program yielded the expected outputs?

At the program level, ten groups received HSSNPI funding, a level which met the program performance criterion of funding for “7 to 10 regional/local groups.” By the end of 2007–2008, HSSNPI had distributed \$3,082,834 to the funded groups. Not considering the CHSSN grant, each participating group received an average of \$246,604 (or \$49,321/year). Furthermore, 83% of the funded proposals met the Volunteer Committee’s criterion of serving isolated English-speaking communities in Quebec. This is superior to the HSSNPI guidelines which required 50% of selected organizations to come from more isolated communities with small English-speaking populations. The program also performed regular monitoring and accountability activities including reviewing quarterly reports, communicating by email and telephone with participants and completing on-site visits.

At the participants’ level, the online survey found that 85% of the project coordinators more or less agreed that despite certain difficulties, notably with respect to the financial resources made available, their organizations received sufficient funding to effectively execute their project activities. Despite receiving less than requested financial resources, the allocated funding allowed participants to deliver the anticipated program goods and services, as is outlined in the next two sections.

As indicated earlier on in this report, the implementation phase of the program was excellent.

5) Did the HSSNPI lead to the generation, integration, and sharing of information and knowledge?

HSSNPI achieved excellent results on this question. All HSSNPI participants generated knowledge concerning the health and social services needs and priorities of their respective communities and were active in community outreach by developing communication tools. Every project included research activities (surveys, focus groups, regional forum, etc.). Both project coordinators and network partners agreed that the work accomplished had been successful in identifying the determinants of health and well-being for their English-speaking communities.

An analysis of quarterly narrative reports found that over half of the participants had reported that research activities had fuelled databases on the English speaking community in each region.

More than half of the participants also mentioned that the information gathered was disseminated to network unit partners, thereby increasing their own knowledge base. Knowledge and best practices were also successfully shared by the CHSSN with English-speaking community organizations and groups.

6) Did the HSSNPI lead to the creation of networks and partnerships that mobilized and engaged community resources and institutions, fostered the participation of decision-makers and organizations in the public health and social services system, and encouraged them all to work together?

This evaluation question covers three of the program targets (or outcomes): network creation, coordination, and community participation.

Regarding network development, results achieved by HSSNPI in the area of network creation were excellent. Every funded organization developed at least one network. During the first two years of the program, each participant created an average of 2.2 networking units. In each community, project coordinators were able to recruit from 5 to 150 partners. On average, project coordinators and network partners met with other partners 26 times. Since then, all networking unit have remained active. Meetings are held between partners. Networking units seem to operate in a structured manner. Even though it is impossible at present to determine whether these networking units will sustain themselves, steps have been taken in that direction (drafting of a sustainability plan, approval of the plan by partners, grant applications, steps to be recognized as a charitable organization). CHSSN has also created a provincial network to link all funded communities.

Results are also excellent for the coordination of actors involved. The online survey administered for the implementation evaluation showed that 82% of network partners and project coordinators agreed or strongly agreed that their participation in a networking unit allowed their organization to increase its capacity for developing future projects in collaboration with unit members. Furthermore, 83% of network partners were open to the idea of sharing some of their organization's resources with other network partners in order to implement projects related to health and social services. Interviews with network partners revealed that since joining a networking unit, almost all of them had discovered new community

groups that shared their interests. Partners that had never worked together in the past now had the opportunity to participate in network activities and start working together on ad hoc projects. Participation in networking activities has also allowed them to discover resources and services available in their community.

Finally, results achieved with respect to community participation are excellent as well. An assessment of quarterly narrative reports produced since the implementation evaluation showed that at least five projects have managed to secure a place for an English-speaking community representative on a board of directors of a public sector establishment. Some project participants mentioned that they had attended board meetings on various occasions since the beginning of their project in order to access committee meetings in their region. Some were also representing the English-speaking community on clinical project consultations, special issue consultations, advisory committees, and roundtables. Activities in which program participants had participated included: meetings with various partners and public representatives; sharing of information; developing new services for the community; providing input for decisions about required services; preparing joint applications for funding; etc. Representation for the English-speaking community at the provincial level has also been provided by CHSSN.

7) Did the HSSNPI lead to the design and implementation of evidence-based plans and strategies at the provincial, regional, and local level to improve access to health and social services in English?

At the time of the implementation evaluation, some projects had already begun developing and implementing formal action plans (in a few cases approved by health and social services representatives) informed and shaped by the knowledge that had been developed and disseminated. The online survey revealed that almost three-quarters of project coordinators strongly agreed or agreed that their project had led to the development and implementation of an action plan containing service-delivery models, strategies and initiatives adapted to the needs and priorities of English-speaking communities in their region. Most of these action plans were endorsed by network steering committees and network participants and partner organizations. In some cases, action plans were even endorsed at the CSSS administrative and director-general levels. Since the final evaluation focused on the Program's effects, as perceived by the English-speaking population, it is not possible to formulate an opinion on the level of success reached in the implementation of these plans. However, by consulting participants' narrative reports, it is possible to acknowledge that actions and initiatives aimed at improving access to health and social services in English were undertaken by every networking unit.

8) Did the HSSNPI facilitate dialogue among networks, institutions, planners, and English-speaking communities?

Project participants and partners reported an increased understanding by public sector officials of the determinants of health and well-being for English-speaking individuals and their specific access needs and priorities. Also, project coordinators and network partners were statistically more likely than respondents in regions not exposed to the program to agree that community leaders and public system decision-makers have an adequate understanding of the determinants of health and well-being for English-speaking individuals.

Several public partners mentioned that the HSSNPI projects were an eye-opener for them. Their new relationships with the English-speaking community have provided their organizations with valuable information on the community's needs. This collaboration has nurtured a more informed dialogue and helped create a shared understanding of access issues among networking unit partners.

Regarding dialogue with the English-speaking communities, the implementation evaluation found that most HSSNPI participants already had developed communication tools (guides, newsletters, websites, telephone directory, etc.). Focus groups with community members showed that during the past three years, respondents had generally been exposed to promotional tools developed under the HSSNPI. Furthermore, a majority felt that their knowledge of health and social services had improved over the past three years. The participants attributed this improvement to the communication tools received and to the greater efforts on behalf of public sector staff and health authorities to communicate with them in English.

9) Did the HSSNPI lead to improved access to health and social services in English?

In terms of the supply of services, the HSSNPI effects study looked at volunteer recruitment and training, reorganization, and newly introduced services.

Since not all projects had a volunteer component, only some participants reported results in this area. In these cases, the initiatives reported appear to have been successful in recruiting and training a number of volunteers. Links were also established between certain project developers and volunteer bank coordinators. An assessment of the quarterly narrative reports showed that the volunteers recruited helped with translation, English conversation sessions at CSSS, and community events. Volunteer training activities included sessions on how to act as a translator in emergency situations, providing assistance to seniors with mobility problems, and assisting at an income tax clinic for low income earners.

Program outcomes with respect to reorganization and the introduction of new services were more encouraging than those observed during the implementation study. Since the study, various initiatives have resulted in reorganizations and the introduction of new services, even though the available data does not allow us to determine whether these results were solely due to the HSSNPI. Often, the combined effect of other initiatives like PHCTF and the McGill Project may also have contributed to the results observed. This observation is reinforced by the consensus among English-speaking focus group participants that health and social services network personnel are more open than before. The McGill Project included measures to increase the number of staff members capable of providing services in English. The difficulty in attributing credit for the results is not a bad thing, however, since the three programs were originally meant to be part of an integrated approach. The HSSNPI was seen as a vehicle to ensure that the communities had a voice in the decisions made under the two other programs. In this respect, the results have been excellent.

In terms of demand for services, the HSSNPI evaluation of results looked at knowledge of the basket of services, the quality of services, and decisions about use of services.

With regard to knowledge of the basket of available services, the main finding to emerge from the focus groups is that the participants' knowledge of available services has improved over the previous three years thanks to the information made available to them. In our view, this has been the main contribution of the HSSNPI. A number of participants also noticed greater willingness of public service provider staff to use English with unilingual English-speaking patients. This was not the case before, and has led to greater knowledge of available services.

The majority of participants felt that service quality had improved in the past three years, although there was a lack of consensus as to whether it was the services themselves that had improved or simply the quality of English. Participants from the different focus groups repeated that they witnessed significant improvements in the quality of English spoken by staff when they were being treated. It was also noted that staff members were making significant efforts to improve their ability to speak to patients in English, efforts that were not being made a few years ago. As mentioned earlier, this effect could be attributable to McGill Project as much as to the HSSNPI. Still, this result constitutes an improvement with respect to one barrier to access.

As for decisions about service consumption, most focus group participants mentioned that their level of comfort with using health and social services had increased in the past three years. Although some of the factors they identified as influencing their comfort level had little to do with language (nature of illness, waiting time, distance to travel), several others did (knowledge of French, knowledge of services available in English, being accompanied by a French speaker, the attitude of staff toward English-speaking patients). As mentioned earlier, the HSSNPI had a direct effect on one of these factors (knowledge of services available in English). In contrast, available data did not allow us to establish a direct link between HSSNPI and improvements in staff attitudes toward English-speaking patients. However, the program undoubtedly contributed in an indirect way to this outcome (notably through the involvement of several project coordinators with health and social service network partners as part of the McGill Project).

10) Overall, what is the value of the HSSNPI?

For each question asked throughout the study, it is the judgement of CREXE that the answers provided align with the program's objectives. More notably, it seems to make sense that the program fostered, in most cases, the participation of English-speaking community representatives on the boards of directors of public establishments, access committees and authorities where they can now advocate and promote English-speaking community members' interests and assist health and social services representatives in their interventions with regard to this population. The HSSNPI was also effective in raising awareness of English speaking community members about accessibility through advertising and referral tools. These results can be legitimately attributed to the HSSNPI.

Other results observed during the focus groups could be a result of the combined impacts of the three interventions (PHCTF, McGill Project and the HSSNPI). In these particular cases, it seems to make sense that the HSSNPI was a principal and decisive contributor prior to the generation of actual results on accessibility (by getting involved with health and social services institutions).

Even though plans of actions and strategies were developed by the program's participants, the evaluation of program results was rendered more difficult in terms of identifying English-speaking community members exposed to these initiatives. Accordingly, it is difficult to offer a conclusion on the actual impact of these strategies on the targeted population. In spite of these drawbacks, for all the reasons listed above, in light of the instruments used and considering the limits of our mandate and the information gathered, it is the opinion of CREXE that the HSSNPI was effective overall.

Finally, it is not possible to conclude on the program's efficiency. Even though we have a good idea of how much the HSSNPI cost, limited information is available to quantify the results observed. Because results tend to be more diffuse as the program moves along in time, especially at the population level, information gathered is more qualitative than quantitative. To address this situation, the choice to use focus groups appeared the best solution to enable an evaluation the program's result on its targeted population. This choice provided the evaluators with almost entirely qualitative information. This fact is a clear limitation with regard to assessing the effectiveness and efficiency of the project. . However, the study benefited from detailed field data from different perspectives, which we are confident, would have identified any important program problems.

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ANNEX

ANNEX I

HSSNPI Volunteer Committee

Here are the individuals who served on the volunteer committee during the 2003-2008 project period.

- ◆ **Sheilagh Murphy, Chair**
- ◆ **Sally Chislett**
- ◆ **Patricia Lemieux**
- ◆ **Anne Macwhirter**
- ◆ **Robert Pincott**
- ◆ **Anne Usher**

ANNEX II



Evaluation Framework (Preliminary version)

**Evaluation Framework of the Health and Social
Services Networking and Partnership Initiative**

Presented to

**Evaluation committee
Quebec Community Groups Network**

April 31st 2005

Introduction

The Quebec Community Groups Network (QCGN) has received a contribution of approximately \$4.3 million for five years from Health Canada to implement the Health and Social Services Networking and Partnership Initiative (HSSNPI). Among other objectives, this initiative intends to build provincial, regional, local and sector health and social service networks in Quebec in order to improve the accessibility to health and social services in English for the English-speaking Quebecers. Since the HSSNPI is a strategic, results-based program that required from the QCGN an assessment of the performance and progress of its partners to ensure ongoing success, the QCGN mandated CREXE's services to produce an evaluation framework for this program.

The core of this document contains the program theory and the evaluation scenarios of the HSSNPI. The program theory includes a causal model of the program. A causal model is an illustration of how the initiative ultimately affects the identified long term outcomes. It focuses on the most important outcomes of the program and organizes them into systematic causal relationships. It also includes a logic model. A logic model illustrates the logic of intervention of the program and is used to summarize the program in order to get a quick insight into it. This document also presents the evaluation scenarios proposed for the preliminary and final evaluation. The first phase, the preliminary evaluation, concentrates on the implementation of the program. The second phase, the final evaluation, focuses on the measurement of the program's outcomes and overall efficiency. Finally, this document also contains an evaluation timeline, a presentation of the research team, a budget and mandate's terms and conditions.

1 Context

Part VII of the *Official Languages Act* [(R.S. 1985, c. 31 (4th Supp.)) s. 41-45]⁷ relates to the advancement of English and French in Canada. Section 41 of the *Act* requires the federal government to enhance the vitality of the English and French official language minority communities of Canada and to foster the full recognition and use of both English and French in Canadian society. Section 42 gives the Minister of Canadian Heritage the mandate to promote a coordinated approach to the implementation of this commitment.

In 1994, the Government of Canada approved the creation of an accountability framework to facilitate the implementation of sections 41 and 42 of the *Official Languages Act*. The Government of Canada also designated thirty key federal institutions – including Health Canada – because of their importance to the development of official language minority communities. Like all other selected federal institutions, Health Canada must proceed to outline an annual or multi-year action plan relating to the implementation of the *Official Languages Act*. The action plan must take into account the particular needs of the official language minority communities. As a result, they are required to pay special attention to development priorities of the official language minority communities of Canada⁸.

In this context, Health Canada created, in 2000, two consultative committees: the English Official Language Community Consultative Committee and the French Official Language Community Consultative Committee. The mandate of both committees is to provide advice to the Minister of Health on the priorities of English and French minority communities of Canada with regard to health and social services. The French and the English consultative committees each submitted, in September 2001 and July 2002, a report on the needs of their respective minority communities. The reports illustrate the primary needs of official language minority communities regarding health services and their accessibility. For example, the report of the English Official Language Minority Consultative Committee indicates that the level of access to health and social services in English varies from one Administrative Region to another. To reduce these fluctuations, the reports of the consultative committees presented to the federal Minister of Health included recommendations and alternatives to improve access to health services in official language minority communities⁹.

In addition to the efforts of both consultative committees, the 2002 Speech from the Throne includes the formal engagement, on the part of the Canadian government, to promote linguistic duality in Canada. The Government of Canada also pledges to present an action plan to revitalize its Official Language Policy. Stéphane Dion, President of the Privy Council Office and Minister of Intergovernmental Affairs, was given a mandate, by the Prime Min-

⁷ Department of Justice (page consulted February 7th, 2005). *Consolidated Statutes and Regulations: Official Language Act*, R.S. (1985), c. 31 (4th Supp.), [available online], <http://laws.justice.gc.ca/en/O-3.01/90080.html#rid-90172>.

⁸ Canadian Heritage (consulted February 7th 2005). *Official Languages: Interdepartmental Coordination*, [available online], http://www.pch.gc.ca/progs/lo-ol/ci-ic/ci-ic_e.cfm.

⁹ The report of the English official-language community Consultative Committee has been submitted in July 2002 (http://www.hc-sc.gc.ca/english/media/releases/2002/2002_83.htm). The integral version of the report can be found on the Web site of the *Community Health and Social Services Network* (CHSSN) at http://www.chssn.org/sante_canada/CCESMC%20report%20LR.pdf.

ister, to coordinate the Canadian Government's Official Language Policy. His mandate also included the direction of a group of Cabinet Ministers to facilitate the implementation of concerted measures in different sectors of activity.

During a consultative exercise, Stéphane Dion received dozens of reports from leading official language minority communities, such as the Quebec Community Groups Network (QCGN) and the Federation of Francophone and Acadian Communities of Canada. As a result of this consultative exercise, a five-year action plan (2003-2004 to 2007-2008) was adopted. On March 12, 2003, Prime Minister Jean Chrétien and Ministers Stéphane Dion and Lucienne Robillard released *The Next Act: New Momentum for Canada's Linguistic Duality*, Government of Canada's new Action Plan for Official Languages¹⁰. The plan, also known as the Action Plan contains, among other things, accountability and coordination frameworks as well as financial commitments relating to the implementation of the Action Plan for Official Languages.

A total budget of \$751.3 million over five years was granted to the Action Plan for Official Languages. Health Canada obtained \$119 million to put in place intervention programs to support official language minority communities. The programs were created to support:

- The development of initiatives aimed at the improvement of health and social services access in both official languages (\$30 million);
- The creation of networks (\$14 million);
- The training and putting in place of qualified personnel (\$75 million).

Thus, in response to the reports of the consultative committees and in continuity with the Action Plan, Health Canada created the *Contribution Program to Improve Access to Health Services for Official Language Minority Communities*. This program, spread over a five year period, offers support for the establishment of networks and aims at improving access to health and social services in official language minority communities, answering their specific needs, and improving their health and the general performance of the Canadian health care system¹¹.

Under the *Contribution Program to Improve Access to Health Services for Official Language Minority Communities*, the Quebec Community Groups Network (QCGN) has received a contribution of approximately \$4.3 million for five years to implement the Health and Social Services Networking and Partnership Initiative (HSSNPI). Among other objectives, this initiative intends to build provincial, regional, local and sector health and social service networks in Quebec. These networks should help establish durable links between English-speaking communities and the health and social services system with a view to-

¹⁰ Privy Council Office (2003). *The Next Act: New Momentum for Canada's Linguistic Duality – Action Plan for Official Languages*, (consulted February 10th, 2005), [available online], http://www.pco-bcp.gc.ca/aia/docs/ActionPlan/ActionPlan_e.pdf.

¹¹ Health Canada (consulted February 4th 2005). News Release: *Contribution Program to Improve Access to Health Services for Official Languages Minority Communities*, [available online], http://www.hc-sc.gc.ca/english/media/releases/2004/2004_21bk1.htm.

ward improving access in these communities to a wider range of services offered in English.

2 Program Theory

The analysis of the program theory is the central task of the elaboration of the evaluation framework. Causal and logic models are at the heart of the evaluation process. On the one hand, the causal model illustrates the problem that led to the creation of the program. It focuses on the most important outcomes of the program and organizes them into systematic causal relationships. The causal model is also used to develop appropriate measurement strategies. On the other hand, the logic model emphasizes the logic of intervention of the program. It is often used to summarize the program, its implementation, its outcomes and efficiency and can be used by different stakeholders to get a quick insight into the program.

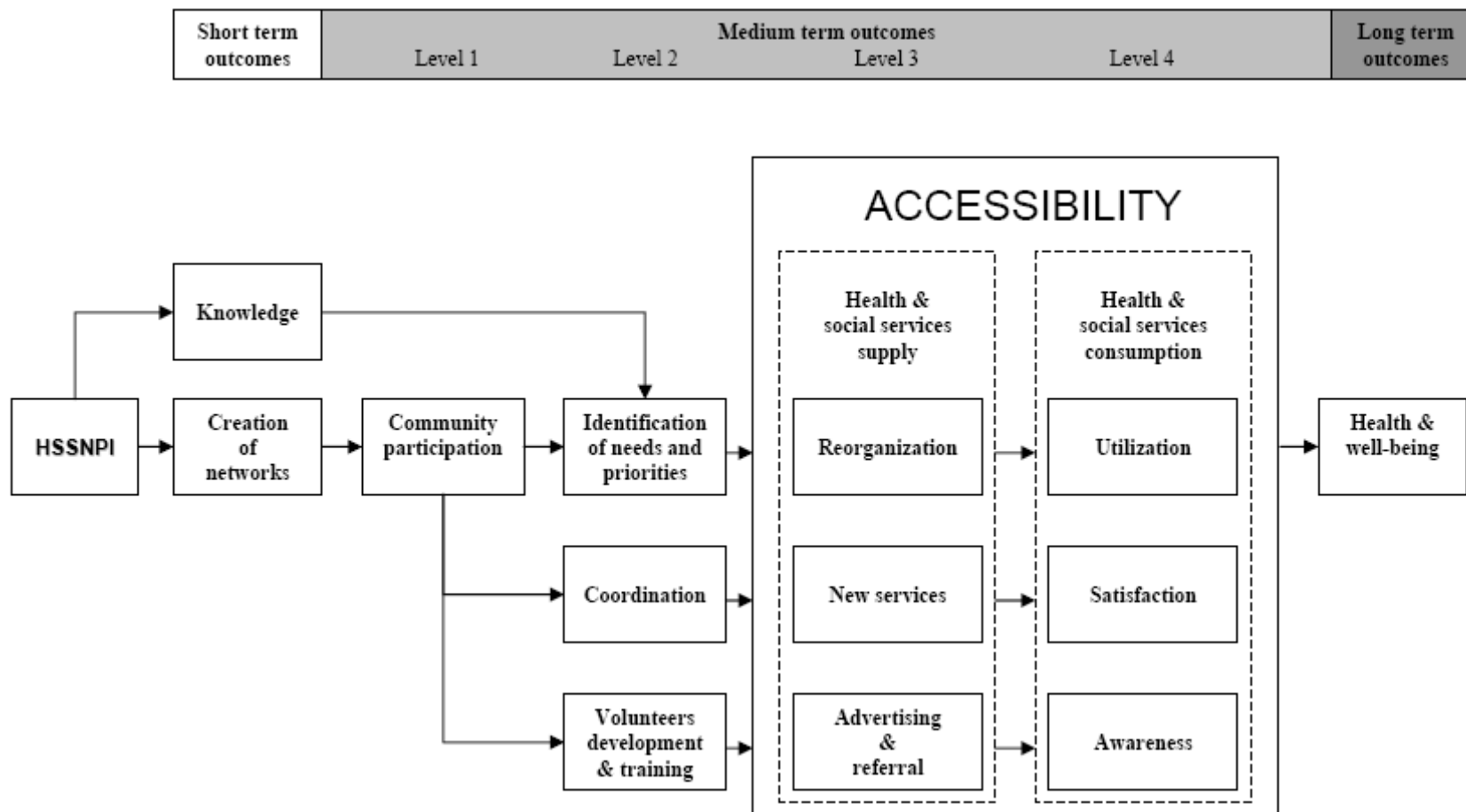
2.1 Causal Model

The causal model of the HSSNPI illustrates how this initiative ultimately affects the health and well-being of members of English-speaking communities. The expected outcomes of the HSSNPI can be divided into three categories: short, medium, and long term outcomes.

In theory, the HSSNPI has two short term outcomes. The first short term outcome of the program is the building of networking and partnership capacities of English-speaking communities across Quebec. In the causal model, the creation of networks is presented as a short term outcome of the program. Nine of the ten projects financed by QCGN in 2004 have the creation of networks as their main objective. The second short term outcome of HSSNPI is the production and sharing of information and knowledge regarding the health and social service needs and priorities of English-speaking Quebecers. More specifically, the Community Health and Social Services Network (CHSSN) was selected by QCGN to act as the HSSNPI's provincial network. CHSSN's mandate is to provide research findings, information and analyses on health determinants and trends within English-speaking communities to the HSSNPI local and regional networks and other interested parties.

Medium term outcomes of the HSSNPI are expected to follow from short term outcomes and can be divided into four levels. The creation of networks is hypothesized to promote community participation in the public health and social services system (*Level 1*). Community participation should, in turn, help English-speaking communities identify their members' needs and priorities vis-à-vis the health and social services provided by the local or regional health and social services organizations (*Level 2*). Needs and priorities identification by local and regional networks should be facilitated by research findings, information and analyses on health determinants provided by the provincial network. The creation of networks should also have an effect on the coordination of service delivery for English-speaking populations (*Level 2*) and is expected to foster volunteer development and training (*Level 2*).

Figure 1. HSSNPI’s causal model



Together, *Level 2* outcomes should influence the **accessibility** to health and social services in English for the English-speaking Quebecers (*Level 3* and *Level 4*). In the model, we define accessibility as the junction of health and social services supply and health and social services consumption. According to the model, the supply of health and social services can be adapted in three ways: 1) by reorganizing existing services, 2) by creating new services tailored to the specific needs of the English-speaking communities, and 3) by advertising existing services and referring members of the community to these services (*Level 3*). All together, the supply of health and social services influence the consumption of health and social services. In the model, consumption is defined as: 1) the utilization of adapted health and social services by Quebec's English-speaking communities; (2) the satisfaction of the beneficiaries; (3) the awareness of services availability among members of the communities (*Level 4*).

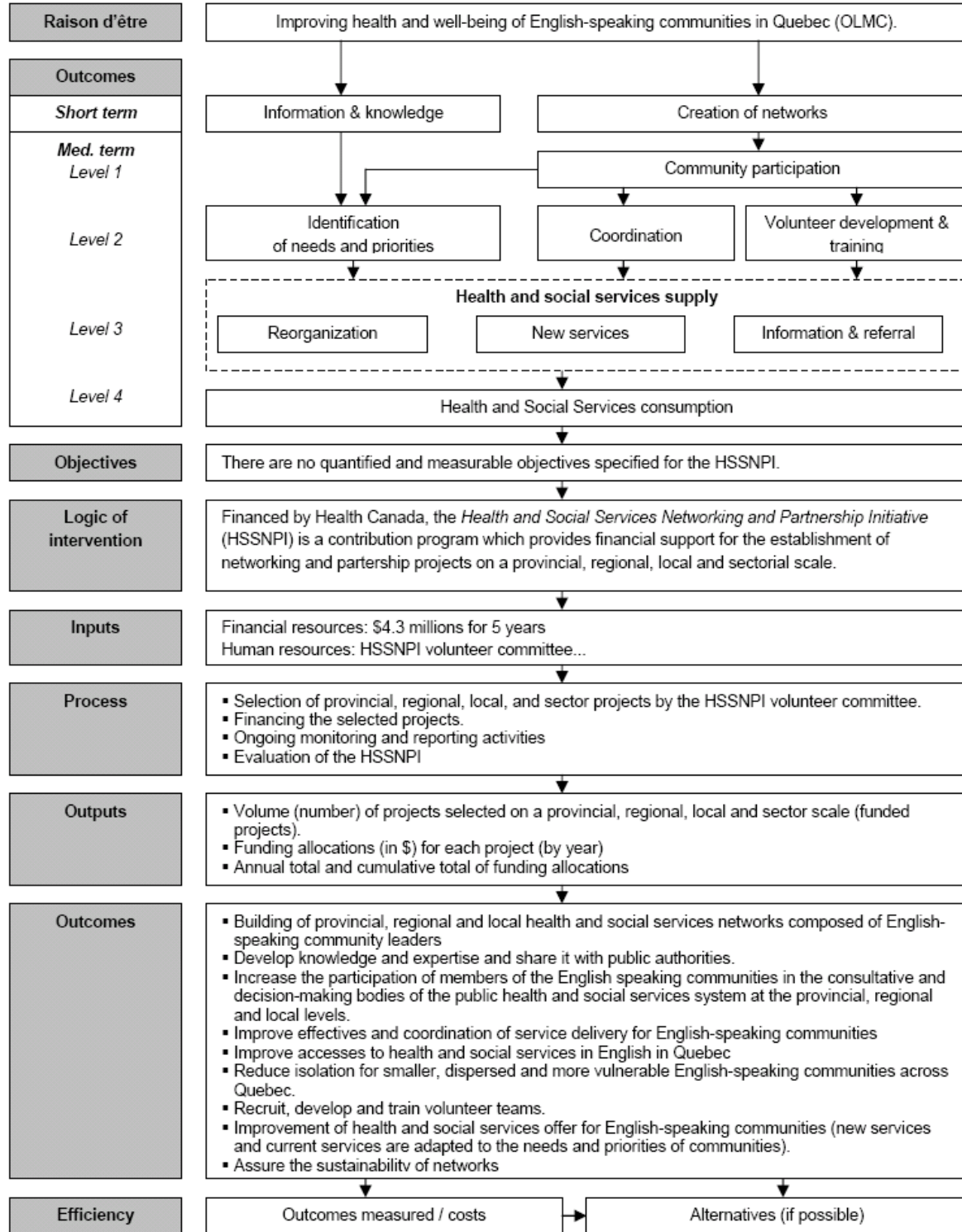
Finally, the access to services provided in English to members of English-speaking communities should, in the long term, influence the health and well-being of English-speaking Quebecers (*Long term outcomes*).

As mentioned in the service proposal, key stakeholders were consulted during the preparation of the evaluation framework. Our research group met with program participants to present and discuss the causal model. We paid special attention to the external factors that could possibly affect the short, medium and long term effects of the HSSNPI. The stakeholders identified many external factors (age distribution, socio-economic status, size of the community, collaboration of local public officials, etc...). The identification of these external factors helped us adapt our measurement strategy and contextualize the measured effects of the initiative in different communities. These meetings also facilitated the definition and the shared comprehension of the evaluation mandate.

2.2 Logic Model

HSSNPI's logic model illustrates the logic of intervention of the program. The first parts of the logic model (*raison d'être* and program theory) are derived from the causal model, the remaining sections of the model correspond to the production process of the program (logic of intervention, inputs, process and outputs) and its hypothesized effects on English-speaking communities (objectives, outcomes, and efficiency). These sections of the model will evolve in parallel to the evaluation process. At the end of the final evaluation, the logic model will summarize the entire evaluation on a single page.

Figure 2. HSSNPI’s logic model



3 Evaluation Scenarios

The evaluation of the HSSNPI will be divided in two phases. The first phase, the preliminary evaluation, concentrates on the implementation of the program. The second phase, the final evaluation, focuses on the measurement of the program's outcomes and overall efficiency. Figure 3 presents a twelve step sequential evaluation process developed by members of the CREXE. This process covers the preparation of the evaluation framework, the preliminary, and the final evaluation of the HSSNPI.

The evaluation process proposed is well matched for the evaluation needs of the QCGN, consistent with the results based management approach of the Government of Canada, and can easily be adapted to fit the guidelines of the Treasury Board of Canada Secretariat concerning the preparation of annual accountability reports¹².

¹² Treasury Board of Canada Secretariat (2003). *Guidance: Departmental Performance Reports 2003-2004* (consulted February 7th 2005), [available online], http://www.tbs-sct.gc.ca/rma/dpr/03-04/guidance/table-of-contents_e.asp.

FIGURE 3. Sequential process of evaluation

Steps	Evaluation framework	Preliminary evaluation	Final evaluation
1. Raison d'être 2. Program theory 3. Objectives 4. Logic of intervention	Analysis of the program's raison d'être, theoretical foundation, objectives and logic of intervention.	Presentation of the program's raison d'être, theoretical foundation, objectives and logic of intervention.	Presentation of the program's raison d'être, theoretical foundation, objectives and logic of intervention.
5. Inputs 6. Process 7. Outputs	Analysis of reporting and implementation evaluation strategies.	Evaluation of the reporting and implementation of the program.	
8. Outcomes	Elaboration of different outcomes measurement strategies.	Measurement of the preliminary outcomes of the program.	Evaluation of outcomes, effectiveness, efficiency, alternatives and value of the
9. Effectiveness 10. Efficiency 11. Alternatives 12. Value	Elaboration of different effectiveness, efficiency, alternatives and value evaluation strategies.		program (taking into account the results of the preliminary evaluation).

3.1 Preliminary Evaluation

As shown in Figure 3, the preliminary evaluation serves two complementary purposes. First, the preliminary evaluation studies the reporting and implementation of the program. Documenting these two aspects of a program allows clients of the evaluation to know precisely how the program is being implemented, and focus specifically on projects or parts of the program that do not meet expectations. In this case, the preliminary evaluation will allow QCGN to know how each initiative is being implemented by its local partners. The preliminary evaluation should also allow QCGN to focus on projects for which implementation is behind schedule and advance the implementation of the program between the moment of the preliminary and the final evaluation.

Second, the preliminary evaluation helps contextualize the evaluation of outcomes, effectiveness, efficiency, alternatives and value of the program conducted during the last phase

of the evaluation process. In this case, the causal model shows that the creation of networks and the production and sharing of information and knowledge is at the heart of the HSSNPI. Medium term outcomes and long term outcomes all depend on the realization of these short term outcomes. In theory, if the implementation of the program is not completed, the expected outcomes will not take place. Documenting the implementation of the program will allow us to contextualize the findings of the final evaluation and distinguish the unique outcomes of the program.

Outcomes of Interest

The preliminary evaluation should be directed at evaluating the implementation and reporting of the program. However, the implementation of the HSSNPI does not end with the allocation of funding to local partners. QCGN is also partly responsible for the short term outcomes of the program since it is actively involved in the monitoring of its partners' activities. The HSSNPI is a strategic, results-based program designed to allow QCGN to constantly assess the performance and progress of its partners to ensure ongoing success. Consequently, the evaluation of implementation and reporting of the program should cover the short term outcomes of the causal model. Table 1 presents, for each of the three evaluation scenarios proposed, the outcomes of interest, the indicators, data sources, and respondents.

Table 1. Preliminary evaluation scenarios

OUTCOMES (SCENARIOS)	INDICATORS	DATA SOURCES (SCENARIOS)	RESPONDENTS (SCENARIOS)
Creation of networks (A, B, and C)	<p>Size of the network</p> <ul style="list-style-type: none"> • Number of people involved <p>Composition of the network</p> <ul style="list-style-type: none"> • Network administrators • Community leaders • H&SS representatives (local, regional, and provincial level) • Volunteers <p>Activities of the network</p> <ul style="list-style-type: none"> • Frequency of meetings • Duration of meetings • Number of members attending the meetings • Discussions' objects <p>Sustainability of networks</p>	<p>Documents analysis (A, B, and C)</p> <p>Online inquiry (A, B, and C)</p> <p>Interviews (B and C)</p>	<p>Project administrators (A, B, and C)</p> <p>Project administrators (B and C)</p> <p>Public H&SS representatives (C only)</p>
Information & knowledge (A, B, and C)	<p>Completion of the studies</p> <ul style="list-style-type: none"> • Number of studies completed • Determinants of health identified • Relative importance of determinants <p>Needs and priorities identification</p> <ul style="list-style-type: none"> • Inventory of existing services • Identification and relative importance of needs • Setting of priorities 	<p>Documents analysis (A, B, and C)</p> <p>Online inquiry (A, B, and C)</p> <p>Interviews (B and C)</p>	<p>Project administrators (A, B, and C)</p> <p>Project administrators (B and C)</p> <p>Public H&SS representatives (C only)</p>

In all evaluation scenarios, we propose the use of a comparative change design with equivalent groups to assess the net impact of the program on the identified medium terms outcomes. This design requires a pretest measure that will be conducted in September 2005 and a posttest measure in September 2007. By doing so, we will be able to measure the difference between posttest outcomes and pretest outcomes. The difference between these two measures will be presented, analyzed and discussed in the final evaluation. However, since the first measure of the outcomes of the final evaluation is conducted before the submission of the preliminary evaluation, the results of the pretest measure will be presented, analyzed and discussed in the preliminary evaluation. The measure will cover the same outcomes of interest described in Table 2. Thus, the preliminary evaluation will be a formative evaluation since the results of the pretest measures will allow the QCGN to see if the program is heading in the right direction. If necessary, corrective actions could be brought by the QCGN before the posttest measures are conducted in September 2007 for the final evaluation of the HSSNPI.

Measurement Strategies

Short term outcomes of the HSSNPI will be measured in September 2005. These measures will be used to evaluate the short term outcomes of the HSSNPI during its implementation. These results will be presented in the preliminary evaluation report. In addition, measures will also be taken in September 2007 to evaluate short term outcomes of the HSSNPI once the implementation of the program is completed. These results will be presented in the final evaluation report. The difference between the measures of 2005 and 2007 should allow us to identify a tendency in the measured outcomes and provide valuable information on the state of the implementation at the end of the process.

Data

To obtain the data necessary to accurately assess the outcomes of the HSSNPI, we will use documentary analysis, online inquiries and interviews. Depending on which evaluation scenario is chosen by QCGN, two or three of these methods will be used. Yet, in each evaluation scenario, both quantitative and qualitative data are used to measure the outcomes of interest.

A documentary analysis is included in all three evaluation scenarios. Recipient organizations of HSSNPI actively participate in ongoing monitoring and reporting activities. Recipients of funding are required to report on the status of their projects as required by the QCGN, especially with regard to implementation of approved activities and progress toward the generation of specific results. Reporting requirements consist of providing QCGN with information relevant to the assessment, evaluation, monitoring, management and good governance of the HSSNPI. Information such as, but not limited to, status of implementation of activities and potential adjustments, identification and assessment of results and performance indicators, work plans, and activity description are requested from recipients. This information is valuable for the evaluation. The first step of our inquiry strategy consists of analysing these documents. The relevant information will give us a general appreciation of the outcomes of each individual project. This information will also guide us in the planning and development of the online inquiries, and for the preparation of interviews.

An online inquiry is also included in all three evaluation scenarios. Online questionnaires will be used to gather both quantitative and qualitative data. Project administrators and health and social services representatives will be contacted by e-mail and by mail. The Website address, identification number and passwords required to access the questionnaire will be given to the respondents and they will have to complete the questionnaire online. The data will automatically be stored in a secure consolidated data bank. The data bank will then be used to evaluate the implementation of the HSSNPI. The triangulation of multiple data sources, in this case project administrators and health and social services representatives, confers greater validity to the results of the evaluation.

Finally, semi-structured interviews are proposed in evaluation scenario B and C only. In scenario B, an interview with each project administrator is planned, for a total of 10 interviews. In scenario C, in addition to the interviews with the project administrators, interviews with one representative of a local or regional health and social services organizations are proposed, for a total of 20 interviews. The interviewer will discuss, among other things, the preliminary results of the implementation evaluation and the factors that could explain the measured outcomes.

3.2 Final Evaluation

The main objective of the HSSNPI's final evaluation is to evaluate the impact of the HSSNPI on the medium term outcomes. The final evaluation also takes into account the outcomes measures, effectiveness, and efficiency of the program and judge the overall value of the program. The results of the final evaluation will be interpreted in the light of the results of the preliminary evaluation.

Outcomes of Interest

The final evaluation should be directed at evaluating the outcomes, effectiveness, and efficiency of the program. While short term outcomes are considered in the final evaluation, the primary interest of the final evaluation rests in the evaluation of medium term outcomes of the program. In the three evaluation scenarios proposed, medium term outcomes are always measured. However, none of the scenarios proposes to evaluate the long term outcomes of the HSSNPI. The final evaluation of the program must be completed by January 2008. Therefore, the program will not be in place long enough to allow us to measure its effects on long-term outcomes, the health and well-being of members of the English-speaking minority communities.

Table 2. Final evaluation scenarios

OUTCOMES (SCENARIOS)	INDICATORS	DATA (SCENARIOS)	RESPONDENTS (SCENARIOS)
Medium term Effects			
<i>Level 1</i>			
Community participation (A, B, and C)	<p>Members</p> <ul style="list-style-type: none"> Number of people involved <p>Type</p> <ul style="list-style-type: none"> Community leaders H&SS representatives (local, regional, and provincial level) Volunteers <p>Involvement</p> <ul style="list-style-type: none"> Level of involvement (local, regional, provincial) Time allocated to network related activities Type(s) of activities <p>Importance of English-speaking representatives in decision-making bodies</p>	<p>Documents analysis (A, B, and C)</p> <p>Online inquiry (A, B, and C)</p> <p>Interviews (B and C)</p>	<p>Project administrators (A, B, and C)</p> <p>H&SS representatives (A, B, and C)</p> <p>Project administrators (B and C)</p> <p>H&SS representatives (C only)</p>
<i>Level 2</i>			
Identification of needs and priorities (A, B, and C)	<p>Determinants of health and well-being identification</p> <ul style="list-style-type: none"> Identified determinants Relative importance <p>Needs and priorities identification</p> <ul style="list-style-type: none"> Inventory of available services 	<p>Documents analysis (A, B, and C)</p> <p>Online inquiry (A, B, and C)</p>	<p>Project administrators (A, B, and C)</p> <p>H&SS representatives (A, B, and C)</p>

OUTCOMES (SCENARIOS)	INDICATORS	DATA (SCENARIOS)	RESPONDENTS (SCENARIOS)
	<ul style="list-style-type: none"> Service priorities identification <p>Evidenced-based service delivery models</p>	Interviews (B and C)	<p>Project administrators (B and C)</p> <p>H&SS representatives (C only)</p>
Coordination (A, B, and C)	<p>Coordination between community representatives and public officials</p> <ul style="list-style-type: none"> Level of coordination (local, regional or provincial) Time allocated to network related activities Example(s) of improved coordination 	<p>Documents analysis (A, B, and C)</p> <p>Online inquiry (A, B, and C)</p> <p>Interviews (B and C)</p>	<p>Project administrators (A, B, and C)</p> <p>H&SS representatives (A, B, and C)</p> <p>Project administrators (B and C)</p> <p>H&SS representatives (C only)</p>
Volunteers development & training (A, B, and C)	<p>Quantity</p> <ul style="list-style-type: none"> Total number of volunteers Number new volunteers <p>Level of participation</p> <ul style="list-style-type: none"> Time devoted to community services <p>Training</p> <ul style="list-style-type: none"> Number of people trained Hours of training Type of training <p>Complementariness</p>	<p>Documents analysis (A, B, and C)</p> <p>Online inquiry (A, B, and C)</p> <p>Interviews (B and C)</p>	<p>Project administrators (A, B, and C)</p> <p>H&SS representatives (A, B, and C)</p> <p>Project administrators (B and C)</p> <p>H&SS representatives (C only)</p>
<i>Level 3</i>			

OUTCOMES (SCENARIOS)	INDICATORS	DATA (SCENARIOS)	RESPONDENTS (SCENARIOS)
<p>Health & social services supply (A, B, and C)</p> <ul style="list-style-type: none"> • Reorganization • New services • Information & referral 	<p>Optimal and innovative use and organization of existing resources</p> <p>Quantity of services Quality of services Evidenced-based Complementariness</p> <p>Number of individuals informed</p> <p>Number of individuals referred to existing and new services</p>	<p>Documents analysis (A, B, and C)</p> <p>Online inquiry (A, B, and C)</p> <p>Interviews (B and C)</p> <p>Postal inquiry (C only)</p>	<p>Project administrators (A, B, and C)</p> <p>H&SS representatives (A, B, and C)</p> <p>Project administrators (B and C)</p> <p>H&SS representatives (C only)</p> <p>Members of the English-speaking communities (C only)</p>
<i>Level 4</i>			
<p>Health & social services consumption (A, B, and C)</p>	<p>Awareness</p> <ul style="list-style-type: none"> • Awareness of the availability of services among members of the community <p>Access</p> <ul style="list-style-type: none"> • Access to services offered in their community <p>Quantity</p> <ul style="list-style-type: none"> • Information and referral services are directing more individuals to appropriate 	<p>Documents analysis (A, B, and C)</p> <p>Online inquiry (A, B, and C)</p> <p>Interviews (B and C)</p> <p>Postal inquiry (C only)</p>	<p>Project administrators (A, B, and C)</p> <p>H&SS representatives (A, B, and C)</p> <p>Project administrators (B and C)</p> <p>H&SS representatives (C only)</p> <p>Members of the English-speaking</p>

OUTCOMES (SCENARIOS)	INDICATORS	DATA (SCENARIOS)	RESPONDENTS (SCENARIOS)
	services. Satisfaction <ul style="list-style-type: none"> • Levels of satisfaction regarding access to and quality of services 		communities (C only)

Measurement Strategies

In 2004-2005, 28 organizations applied for funding under the HSSNPI and 10 were selected for funding by QCGN's Volunteer Committee. The Volunteer Committee also determined the allocation of the funding envelope. For 2004-2005, QCGN financed one provincial project, seven regional projects, one local project, and one sector project. The study of the HSSNPI leads to the conclusion that two different research methodologies should be used for the final evaluation: case studies and quasi-experiments.

Table 3. Projects financed by QCGN in 2004-2005

Provincial Network
<ul style="list-style-type: none"> • Community Health and Social Services Network (CHSSN)
Regional Networks
<ul style="list-style-type: none"> • Townshippers Association <ul style="list-style-type: none"> A) Estrie Project B) Montérégie Project
<ul style="list-style-type: none"> • Council for Anglophones Magdalen Islanders (CAMI)
<ul style="list-style-type: none"> • Coasters Association
<ul style="list-style-type: none"> • Association of West Quebecers
<ul style="list-style-type: none"> • Mégantic English-Speaking Community Development Corporation of Chaudière-Appalaches and L'Érable (MCDC)
<ul style="list-style-type: none"> • Catholic Community Services
Local Networks
<ul style="list-style-type: none"> • Vision Gaspé-Percé Now
Sector Network
<ul style="list-style-type: none"> • Fraser Recovery Program

Because of the nature and specific objectives of the provincial project submitted by the Community Health and Social Services Network (CHSSN) and the sector project of the Fraser Recovery Program, the case report method should be used to evaluate these projects. The method used to gather data will be the same as the one used for the remaining eight projects, but no control group will be used to assess the net impact of the program. Nonetheless, the case report method and type of data used will allow us to make before after comparisons to estimate the impact of these projects.

The kind of design that authorities in the field of evaluation tend to agree is the best is the randomized experimental design. However, such a design is often extremely difficult to arrange and implement. Nevertheless, other rigorous research designs are available for use by evaluators. Quasi-experimental designs are easier to arrange and implement and possess intrinsic advantages and disadvantages over the ideal randomized experimental design. In the case of the HSSNPI, a quasi-experimental comparative change design with equivalent groups will be used for the evaluation of the remaining eight projects (five regional projects and three local projects). The exposed group will be composed of the English-speaking communities affected by the eight projects financed by QCGN in 2004-2005, and the control group by English-speaking communities that have not been affected by the HSSNPI. Priority will be given to the eighteen communities which submitted a project to QCGN, but did not benefit from QCGN's financial support.

Figure 4. Comparative change design with equivalent groups

	Pretest (2005)	Treatment	Posttest (2007)
Exposed groups	O ₁	X	O ₂
Control groups	O ₃		O ₄

When using a comparative change design with equivalent groups, the net impact of the program is obtained by measuring the difference between posttest outcomes (O₂) and pretest outcomes (O₁) of the exposed groups and the difference between posttest outcomes (O₄) and pretest outcomes (O₃) of the control groups (net impact = (O₂-O₁) - (O₄-O₃)). In this case, the same indicators will be measured by asking project administrators and health and social services representatives the same questions on two different occasions. The first inquiry will be completed by the respondents in September 2005 (pretest outcomes) and the second inquiry in September 2007 (posttest outcomes). Therefore, the net impact of the program will be the difference between posttest outcomes (O₂) and pretest outcomes (O₁) of the exposed group minus the difference between posttest outcomes (O₄) and pretest outcomes (O₃) of the control group for all measures we will be taking.

Data

To obtain the data necessary to accurately assess the outcomes of the HSSNPI at the final evaluation, we will use documentary analysis, online inquiries, interviews, and a postal inquiry. The type of data gathering method used depends on the evaluation scenario chosen by QCGN. Again, in each evaluation scenario, both quantitative and qualitative data are used to measure the outcomes of interest.

A documentary analysis is included in all three evaluation scenarios. The information included in the reports of project administrators to QCGN will also be used for the final evaluation. Again, this information will give us a general appreciation of the outcomes of each individual project and help us develop online questionnaires and prepare interviews.

An online inquiry is also included in all three evaluation scenarios. Online questionnaires will be used to gather both quantitative and qualitative data. Project administrators and health and social services representatives of the exposed and control groups will be contacted by e-mail and by mail. The Website address, identification number and passwords required to access the questionnaire will be given to the respondents and they will have to complete the questionnaire online. The data will automatically be stored in a secure consolidated data bank, which will then be used to evaluate the impact of the HSSNPI on the different outcomes of interest. The triangulation of multiple data sources, in this case project administrators and health and social services representatives, confers greater validity to the results of the evaluation.

Semi-structured interviews are proposed in evaluation scenario B and C only. In scenario B, a total of 10 interviews is proposed; one with each project administrator. In scenario C, interviews with one representative of a local or regional health and social services organizations are also proposed in addition to the interviews with the project administrators, for a total of 20 interviews. The interviewer will discuss, among other things, the impact of the program on the outcomes of interest, the situation since the preliminary evaluation, and the factors that could explain the measured outcomes.

Finally, in addition to the online inquiry, the scenario C includes a postal inquiry. Members of the English-speaking communities affected by the program and members of the English-speaking communities not affected by the program will be asked to answer questions concerning the supply and consumption of health and social services. Again, the triangulation of multiple data sources confers greater validity to the results of the evaluation, especially with respect to the *Level 3* and *Level 4* medium term outcomes since the members of the community are directly involved at these stages in the causal model.

4 Evaluation timeline

The research process leading to the preliminary evaluation report should begin in July 2005 and is expected to be completed by January 2008.

Table 4. Evaluation timeline

PRELIMINARY EVALUATION		
ACTIVITY BLOCKS	ACTIVITIES	SCHEDULE
Documentary Analysis	Analysis of the monitoring reports	July 2005
Online inquiry	Preparation of the questionnaire	August 2005
	Completion of the questionnaires by the identified respondents	September 2005
Interviews	Preparation of the questionnaires	September 2005
	Interviews with the identified respondents	October 2005
Data analysis	Analysis of data and evaluation of implementation	November 2005
Preparation of the preliminary version of the preliminary evaluation report	Drafting of the preliminary report	December 2005
	Presentation of the preliminary report to the Evaluation Committee.	January 2006
	Meeting with the Evaluation Committee and validation of the report.	January 2006
Preparation of the preliminary evaluation report	Adjustments to the report	January 2006
Presentation of the preliminary evaluation report		January 2006

The research process leading to the preliminary evaluation report should begin in July 2005 and is expected to be completed by January 2008.

FINAL EVALUATION		
ACTIVITY BLOCKS	ACTIVITIES	SCHEDULE
Documentary Analysis	Analysis of the monitoring reports	May 2006
Online inquiry (pretest)	Preparation of the questionnaire	August 2005
	Completion of the questionnaires by the identified respondents	September 2005
Online inquiry (posttest)	Preparation of the questionnaire	August 2007
	Completion of the questionnaires by the identified respondents	September 2007
Interviews	Preparation of the questionnaires	September 2007
	Interviews with the identified respondents	October 2007
Data analysis	Analysis of data and evaluation of implementation	November 2007
Preparation of the preliminary version of the final evaluation report	Drafting of the preliminary report	December 2007
	Presentation of the preliminary report to the Evaluation Committee.	January 2008
	Meeting with the Evaluation Committee and validation of the report.	January 2008
Preparation of the final evaluation report	Adjustments to the report	January 2008
Presentation of the preliminary evaluation report		January 2008

5 Presentation of the research team

École nationale d'administration publique (ENAP) offers graduate programs (master and doctorate) in Public Administration. Among other things, an expertise in policy analysis and program evaluation is offered at ENAP. During their stay, students are invited to put their experience, competences and knowledge to work by engaging in practical work in real world situations.

Besides its fundamental educational mission, ENAP also developed a diversified consulting expertise in various field of intervention, including policy analysis and program evaluation. This expertise is offered to governmental and non-governmental organizations in Quebec, Canada and worldwide.

5.1 Members of the team

Sylvain Bernier, Principal Researcher, is in charge of the project. He is doctoral candidate and Lecturer at École nationale d'administration publique (ENAP). He is also Vice-President of the Société québécoise d'évaluation de programme (SQEP) and editor of the society's newsletter. He obtained his Bachelor's degree in Political Science and Economics from Bishop's University in 2000 and his Master's degree in Program Evaluation from ENAP in 2001. His research interests relate mainly to Public Choice theory, education policy and the application of statistical methods to program evaluation.

Richard Marceau, Scientific Adviser, is Professor at École nationale d'administration publique (ENAP). He is also President of the Société québécoise d'évaluation de programme (SQEP). Richard Marceau obtained his Bachelor's degree in Physics from Laval University, his Master's degree in Water Sciences at the National Institute of Scientific Research (NISR), a Ph.D. in Political Science from Laval University and Postdoc in Policy Analysis from NISR. His teaching at ENAP relates mainly to program evaluation and public policy analysis. Richard Marceau's publications include program evaluation studies in wastewater management, university studies programs, and regional economic development.

Pierre Beaudry, Academic Coordinator at ENAP-Gatineau, has a Master's degree in Public Administration from ENAP and a Bachelor's degree in Teaching from the University of Montreal. Pierre Beaudry worked 33 years for the Government of Canada and occupied administrative functions for many years. He has been Principal consultant and director, consulting, at Consulting and Audit Canada and he has conducted numerous program evaluations for the Government of Canada and other foreign governments and organizations. He has also been Vice-President of Aylmer's Health Cooperative board of directors.

Johann Jacob, Research Agent, just completed a Master's degree in Organizational Analysis and Development at ENAP. His academic background, strong in organizational development, performance assessment, and strategic management confers him an expertise in production processes evaluation, among other things. Johann Jacob is perfectly bilingual and is an experienced researcher. He also worked as Research Assistant at ENAP'S Observatoire de l'administration publique.

6 Budget

	Scenario A	Scenario B	Scenario C
Preliminary Evaluation			
Short term outcomes & Medium term outcomes (Level 1, 2, 3, 4)			
Documentary analysis	\$ 11 500	\$ 11 500	\$ 11 500
Online inquiry	\$ 17 500	\$ 17 500	\$ 17 500
Interviews		\$ 19 000	\$ 23 500
Direct Research Fees (DRF)	\$ 29 000	\$ 48 000	\$ 52 500
Indirect Research Fees (IRF)	\$ 11 600	\$ 19 200	\$ 21 000
<i>Sub-total</i>	\$ 40 600	\$ 67 200	\$ 73 500
Final Evaluation			
Short term outcomes & Medium term outcomes (Level 1, 2, 3, 4)			
Documentary analysis	\$ 11 500	\$ 11 500	\$ 11 500
Online inquiry	\$ 31 500	\$ 31 500	\$ 31 500
Interviews		\$ 19 000	\$ 23 500
Postal inquiry			\$ 46 000
Direct Research Fees (DRF)	\$ 43 000	\$ 62 000	\$ 112 500
Indirect Research Fees (IRF)	\$ 17 200	\$ 24 800	\$ 45 000
<i>Sub-total</i>	\$ 60 200	\$ 86 800	\$ 157 500
Total DRF	\$ 72 000	\$ 110 000	\$ 165 000
Total IRF	\$ 28 800	\$ 44 000	\$ 66 000
Total	\$ 100 800	\$ 154 000	\$ 231 000

7 Terms and conditions of the mandate

The mandate will be between July 2005 and January 2008. Any delay in the transmission of the decision at the time of the signature of the contract or at any other moment during the preparation of the preliminary or the final evaluation will necessitate an equal extension of the delay provided for the realization of this mandate.

7.1 Ethics and confidentiality

Our research team adheres to the ethical research standards in force in Quebec's universities and we commit ourselves to preserve the right to anonymity and confidentiality of those who will participate to the preparation of the preliminary and final evaluation of the HSSNPI.

7.2 Publication of the results

The QCGN remains the sole proprietor of the preliminary evaluation and the final evaluation. However, the principal agrees that the results of the research can eventually be used for the purpose of academic publications or communications in collaboration with members of the QCGN who contributed to the realization of the study, if any.

The QCGN allows École nationale d'administration publique (ENAP) to use the whole study or any parts of the preliminary evaluation and the final evaluation for educational purposes.

7.3 Payment conditions

The total amount of the agreement is payable in four payments. The first payment, equivalent to 75% of the cost of the preliminary evaluation is due at the signature of the agreement. The second payment, equivalent to 25% of the cost of the preliminary evaluation is due at the presentation of the final version of the preliminary evaluation report to the Evaluation Committee in January, 2006. The third payment, equivalent to 75% of the cost of the final evaluation also is due at the signature of the agreement. The fourth payment, equivalent to 25% of the cost of the final evaluation is due at the presentation of the final version of the final evaluation report to the Evaluation Committee on January, 2008.