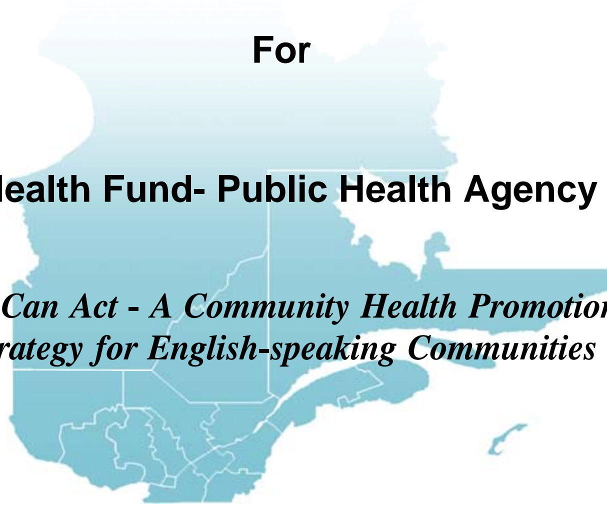
Community Health and Social Services (CHSSN)

Final Report on Results 2005-2007



For

Population Health Fund- Public Health Agency of Canada

We Can Act - A Community Health Promotion Strategy for English-speaking Communities

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I. Brief Summary

The We Can Act (WCA) project is *a community health promotion strategy for English-speaking communities* built on an initiative launched in 2003: "A Community Guide to the Population Health Approach". The purpose of this guide was to introduce community organizations to the population health approach towards defining needs, priorities and actions to improve the health determinants affecting minority English-speaking communities in the Province of Quebec, Canada. WCA enabled these communities, as the primary population group, to move to the next phase of implementation of a health promotion strategy in using approaches enunciated in the guide.

The project was originally designed within a two year timeframe (2005-2007), however a third year of funding was added (2007-2008) resulting in the extension of activities. Therefore, this report serves as an interim report capturing the results of activities undertaken in 2005-2007.

The purpose of the WCA 2005-2007 project was established according to five major health promotion goals. These goals included: 1) Increasing the capacity of communities to map their own health determinants, 2) Creating new knowledge with respect to social support networks, 3) Developing multiple strategies in the promotion of coordinated actions of the social economy and health sectors, 4) Implementing community mobilization strategies and 5) Disseminating new knowledge.

Primary activities accomplished included:

- Conducting a community vitality survey of the English-speaking communities in the province of Quebec and dissemination of its results
- Producing a report on the state of social support networks in minority English-speaking communities, including the delivery of training to community members
- Analyzing and interpreting statistical information for the development of a report on the linguistic minority English-speaking community in Quebec
- Supporting the development of two social economy projects in two administrative regions
- Developing and delivering a community animation and mobilization program, including training to map health determinants and create health determinant profiles in nine administrative regions
- Hosting a provincial health and social services forum

Project outcomes to date include: enhanced community capacity and resources to map health determinants leading to strengthened community action, development of strategic information on social support networks resulting in engaged efforts to create supportive environments; increased coordination and actions between the social economy sector and communities concerned in health and social services; increased participation of English-speaking communities in the identification of population needs and the development of service models; and bringing together key stakeholders to review results of population

health initiatives, resulting in a transfer of knowledge and promotion of best practices. A full description of project activities and outcomes can be viewed at www.chssn.org/En/Population_Health_Project.html

II. Background

The sponsoring agency, Community Health and Social Services Network (CHSSN), is a network of 62 community resources, associations, foundations, public institutions and other stakeholders dedicated to the development of health and social services for English-speaking communities in Quebec, through partnership. The network's primary objectives are to foster projects and initiatives through partnership and network-building, to promote access to English-language health and social services; to provide information about the English-speaking community and its needs; to evaluate and disseminate successful models of organization of services, to pursue community education based on key developments within the health and social services network and to support conferences and other forms of consultation on the provision of English-language health and social services.

The CHSSN promotes knowledge-based community development as a means for communities to enhance their vitality and improve the health and well being of their members. CHSSN projects and partnerships address health determinants affecting the health status of communities, as well as support strategies to attain a sustainable health and social services system. This is consistent with the population health approach, which focuses action on a whole population.

The WCA project evolved through the identification of the needs and strategies to address health disparities and unmet determinants of health. Identification of supporting data also served as a basis for validation. To achieve this, the CHSSN participated in numerous exchanges and consultations with both government and community organizations in the development of project objectives and activities.

The project was developed according to the following needs:

Need:
Strategies are required to build community capacity to address social and income inequalities and other health determinants that influence health outcomes. Learning to map health determinants is a key first step in strengthening community action aimed at developing health promotion and prevention skills, accessing resources, building effective infrastructure, developing strong social networks and evaluating results.

Evidence:
The 1998 Quebec Social and Health Survey showed that English-speaking people (by mother tongue) perceived their economic situation to be poor or very poor to the same degree as French-speakers. Inadequate income levels are linked to factors such as higher incidence of drug use, average-to-poor eating habits, food insecurity, including incapacity to offer balanced meals to children, lack of recreational physical activity, excessive weight, lack of breast examinations, long-term health problems, high level of

psychological distress, presence of suicidal ideas, and limitations on activity.[1] Many communities struggle to deal with the health and social consequences of deprivation or disadvantage while striving to maintain demographic vitality.

Need:
New knowledge on social support networks is required in English-speaking communities to support community organizations engaged in efforts to create supportive environments. An expanded knowledge base will help them address issues of youth retention in the regions, sustainable economic development, strengthening social networks and promoting community participation in the health and social services system.

Evidence:
In a context of demographic decline, many English-speaking communities are concerned with social support networks. English-speakers are much more likely than French-speakers to say that they would turn to family first in case of illness. However, they are far less likely than French speakers to have a family member living nearby.[2] In half of the administrative health regions, the proportion of caregivers (persons aged 35 to 64) to seniors in English-speaking communities was less than the provincial average. Social support networks are also important for particularly vulnerable groups. For example, women are more likely than men to suffer depression, stress overload (often due to efforts to balance work and family life), chronic conditions such as arthritis and allergies, and injuries and death resulting from family violence.[3]

Need:
Multiple strategies are required to engage different sectors in coordinated actions to improve health determinants. For example, English-speaking communities do not participate in Quebec's social economy to the extent that francophones do. The social economy provides communities opportunities to address employment issues and provide services to community members as well.

Evidence:
English-speaking communities in the majority of administrative health regions experience a greater rate of unemployment than francophone communities.[4] In certain communities unemployment rates are over 35% due to industry closures and long-term change causing economic and population decline. The 1998 Quebec Social and Health Survey determined that unemployment is linked to factors of health vulnerability such

[1] Institut de la statistique du Québec, *Enquête social et de santé 1998.*
[2] Missisquoi Institute, *Quebec's English-speaking communities in the year 2000: A preliminary report on the omnibus survey of the attitudes and experiences of English-speaking Quebecers*, 2000.
[3] Health Canada, *Toward a Health Future: Second Report on the Health of Canadians*, 1999.
[4] Health Canada Consultative Committee for English-speaking Minority Communities, *Report to the Federal Minister of Health*, July 2002.

as food insecurity, poor perception of health status, increased number and duration of health problems and high levels of psychological stress. The health of English-speaking communities is affected by factors that fall outside the health sector. Social, economic and environmental factors interplay and affect health outcomes.

Need:

Mobilization strategies are required to ensure that English-speaking communities participate in the development of new local services networks responsible for primary health care, first-level social services and long-term care. When local services networks are defining their population's needs, English-speaking communities must participate in this process to become stakeholders in the design of new population-based services.

Evidence:

Evidence from the 1998 Quebec Social and Health survey indicates differences in access to health professionals, including general physicians and specialists, between the central and distant regions, with those in distant regions experiencing more constraints. English-speaking communities in distant regions are more likely to represent a very small proportion of the regional population. They are also more likely to have difficulty obtaining the range of services in English.[5]

Need:

A provincial forum is required to bring together English-speaking communities involved in population health initiatives, service providers, government partners, research and policy communities in order to evaluate results, transfer knowledge and share best practices with respect to applying the population health approach.

Evidence:

Health promotion strategies are based on values that foster empowerment and community development, increase the capacity of individuals to develop prevention and coping skills, and promote the adaptation of health and social services systems to meet new needs. English-speaking communities and their organizations have engaged in a range of population health initiatives that are contributing to public policy development, creating supportive environments, strengthening community action, developing personal skills and reorienting health and social services.[6] Opportunities to share results are limited.

Need:

[5] Health Canada Consultative Committee for English-speaking Minority Communities, *Report to the Federal Minister of Health*, July 2002.

[6] Community Health and Social Services Network, *A Community Guide to the Population Health Approach,* March 2003.

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Evidence:
Evidence from the 1998 Quebec Social and Health Survey indicates differences in access to health professionals, including general physicians and specialists, between the central and distant regions, with those in distant regions experiencing more constraints. English-speaking communities in distant regions are more likely to represent a very small proportion of the regional population. They are also more likely to have difficulty obtaining the range of services in English.[7]

Need:
A provincial forum is required to bring together English-speaking communities involved in population health initiatives, service providers, government partners, and research and policy communities in order to evaluate results, transfer knowledge and share best practices with respect to applying the population health approach.

Evidence:
Health promotion strategies are based on values that foster empowerment and community development, increase the capacity of individuals to develop prevention and coping skills, and promote the adaptation of health and social services systems to meet new needs. English-speaking communities and their organizations have engaged in a range of population health initiatives that are contributing to public policy development, creating supportive environments, strengthening community action, developing personal skills and reorienting health and social services.[8] Opportunities to share results are limited.

[7] Health Canada Consultative Committee for English-speaking Minority Communities, *Report to the Federal Minister of Health*, July 2002.
[8] Community Health and Social Services Network, *A Community Guide to the Population Health Approach,* March 2003.

III. What did you intend to do in this project?

The five goals developed for the project in 2005-2007 remained the same throughout and are the following:

1. Increasing the capacity of communities to map their own health determinants is an empowerment strategy for English-speaking communities to gain recognition as stakeholders in the health and social services system. The ability to map the range of health determinants will better focus health promotion strategies and ensure health services are adapted to the realities of English-speaking communities.

2. Creating new knowledge with respect to social support networks in English-speaking communities will support communities in their efforts to address demographic decline and eroding community infrastructure. New knowledge will allow communities to develop actions to strengthen social support networks for vulnerable clientele such as seniors, women and youth in difficulty.

3. Development of multiple strategies promoting coordinated actions of the social economy and health sectors will address employment and income issues in selected disadvantaged English-speaking communities, as well as increase the capacity health services to respond to unmet needs.

4. Implementation of community mobilization strategies to ensure English-speaking communities participate in the development of new public local services networks will help to ensure that the organization of population-based health services is responsive to communities' needs.

5. Organization of a provincial forum will transfer knowledge and best practices stemming from population health initiatives carried out by English-speaking communities that are contributing to public policy development, creating supportive environments, strengthening community action, developing personal skills and reorienting the health and social services system.

Illustration I: Portrait of primary activities achieved to date

Details of results can be downloaded at:
www.chssn.org/En/Population_Health_Project.html

	Primary Activities Achieved
Strategic information	✓ Updated the Missisquoi Institute-CROP omnibus survey in 2000 of the attitudes and experiences of English-speaking Quebecers. 2005 *CHSSN-CROP Community Vitality Survey of the English-speaking communities in the Province of Quebec*. ✓ Production of a report on the state of social support networks in English-speaking communities. ✓ 2005 survey results analyzed into document presented by Jack Jedwab with the Canadian Institute for Research on Linguistic Minorities.
Multiple strategy	✓ Development of two pilot social economy case studies on the Lower North Shore and in the Gaspé to create new resources serving the health and social services needs of each community. ✓ Evaluation and dissemination of project results to other English-speaking communities.
Mobilization strategy including Community Capacity Building	✓ Development and implementation of a community animation program to promote participation of English-speaking communities in the development of new local services networks. ✓ Development and implementation of a “Mapping Health Determinant” training program for English-speaking communities. ✓ Production of health determinant profiles in nine selected ESC
Provincial forum	✓ Organization of a provincial forum to evaluate population health initiatives, transfer knowledge and promote best practices.

Describing unintended activities and difficulties encountered.

All major activities identified in the project were carried out as planned. A mid-term participatory evaluation retreat was held in May 2006, and its goals were to:

- Become more familiar with a participatory approach to project development and evaluation
- Inform, share and learn from others leading We Can Act (WCA) activities
- Collectively identify refinements to the project’s administration, major activities, evaluation methods, and project outcomes

- Identify long-term outcomes sought and project activities and scenarios beyond 2007

Retreat discussions identified the integration of community capacity building activities with those identified within the mobilization strategy activities. It was further identified that the training team of the mobilization strategies would be in the best position to deliver the training required for those activities identified within community capacity building. This change enabled enhanced integration of activities, maximization of time of community organizers and volunteers, cost sharing between activities, and it ensured the realization of intended project outcomes.

The most significant difficulty encountered in the project was realized in the delivery of mobilization activities. The CHSSN contracted services from a community partner in the delivery of a community animation program. The community partner suffered organizational staff changes at the senior level and this produced a delay in the development and delivery of the program. CHSSN provided additional support to new senior staff and participated to a greater extent in both the design and delivery of the program.

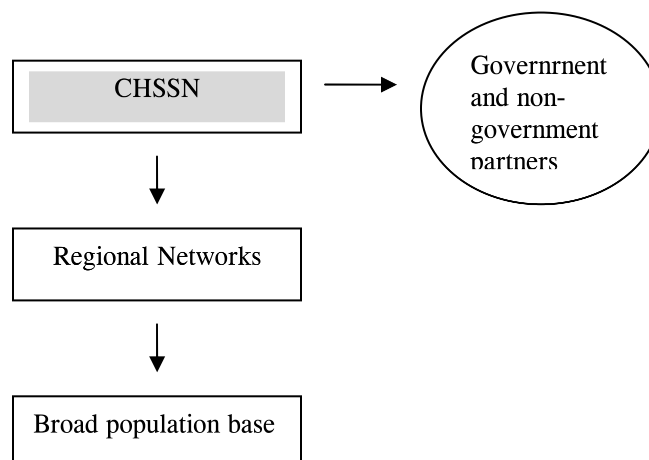
IV. Participation of the Population Group

To enhance sustainability of project results and to maximize the participatory involvement of the population group, the CHSSN worked in partnership with nine health and social services networks. These networks, consisting of paid staff and volunteers, are a representative body and voice for the community. Government and non-government organizations participate as network members acting as the link between community and the coordination and delivery of services to community. This network model served as the process through which the population group (community) was consulted and solicited to participate in project activities. Illustration II below highlights the CHSSN network model for community engagement and participation.

Supplementary efforts were made by certain regional health and social service networks to consult and implicate a broader population sample. Some examples included the involvement of community members in hosting community forums in the delivery of training and dissemination of information and the development of presentation material for a provincial forum. In addition, the success of previous and ongoing community engagement and community involvement processes by networks, as part of their regular activities, allowed for enhanced community involvement for WCA activities. For example, network volunteers were readily accessible and willing to participate.

Section V illustrates the various roles regional health and social service networks served as the representative population group and partner for the CHSSN throughout the project.

Illustration II: CHSSN network model for community engagement and participation



V. Partnership and Intersectoral Collaboration

The major partners consisted of nine health and social service networks in the province of Quebec. In order to achieve project results, various government departments and other organizations were also implicated.

The following chart (Illustration III) below demonstrates how the population group/partners participated with the CHSSN in the WCA 2005-2007 project:

Illustration III: Participation of population group/partners

Goal	Population Group/Partners Involved	Contribution
Strategic information	Department of Canadian Heritage, 9 NPI networks, CROP Polling Firm, Ministry of Education, Quebec Community Groups Network (QCGN) and CBC radio.	Support in updating of the Missisquoi Institute-CROP omnibus survey in 2000 of the attitudes and experiences of English-speaking Quebecers. This included survey design, implementation, promotion and dissemination.
Multiple strategy	2 NPI networks (Baie des Chaleures and the Lower North Shore).	Involved in project design and evaluation of social economy projects including consultation and involvement with local authorities and community members.
Mobilization strategy including Community Capacity Building	Centre des organismes communautaires and NPI networks. NPI networks	Design and delivery of training materials and evaluation design and delivery. Review and validation of regional statistical information for report on social support networks.
Provincial forum	NPI networks, Ministry of Education, McGill University Training and Human Resources Development Project.	Preparation and presentation of new health and social services initiatives.

VI. Results

Describe what you see as the major accomplishments or achievements of the project and what difference this project made in the community.

For the first time in the evolution of regional networks, members and community representatives participated in training and in defining and mapping their own communities' health determinants. This achievement, along with additional skills and resources acquired from participation in a community animation program, has inspired numerous networks to produce their own regional health portraits for continued health and social service planning, thereby leading to enhanced network sustainability.

The administering of a provincial-wide vitality survey of the English-speaking communities in the province of Quebec also served as a significant accomplishment within the WCA project. A study of this magnitude and depth provides new and rich information for community and government stakeholders participating in the health and social service reform. For example, many recently submitted health and social services access plans to the Ministry of Health, site data collected from the survey. This new information should have significant long-term impact on health and social services reform in the province of Quebec. Additionally, the involvement of major partners in the study, such as the Ministry of Education and QCGN (representing justice), serve as a first attempt for the English-speaking community to collect their own determinant of health data. This should lead to a significant change in the way both local government and communities collect data and take action on their health. In addition, the survey updated and compared results of the Missisquoi Institute-CROP omnibus survey conducted in 2000 of the attitudes and experiences of English-speaking Quebecers.

The English-speaking community has never formally participated in the social economy as a way to create new and sustainable health and social service resources. Two regions were successful in modelling the steps to a social economy enterprise with health and social service outcomes. In addition, community members participated in the documentation and dissemination of their learning's resulting in the transfer of knowledge on the social economy to seven other regional health and social service networks.

The organization of a provincial forum involved over sixty presenters disseminating innovative population health initiatives. Further, a record attendance of participants ranging from community to government organizations and individual community members, suggests greater interest and involvement in future collaborative population health planning efforts.

Describe your experiences and knowledge gained by applying a population health approach (including which determinants of health were affected or influenced and how they were influenced).

The following four insights were gained by applying a population health approach:

1. An integrated and collaborative approach to population health initiatives engages often forgotten partners in addressing health determinants. It further allows for enhanced opportunities for inter-sectoral exchanges, networking and partnership development. These insights were experienced when involving, for example, other sectors such as education, or when supporting regional networks to involve a broader population sample and implicate other local institutions.

2. Community capacity building techniques (i.e., empowerment; acquisition of new skills, information, resources and knowledge; and leadership opportunities) aids the population group take action on their health. The integration of these techniques within the WCA project has led to an increase in leadership and community involvement in planning and delivering population health initiatives.

3. A focused approach in addressing one underlying determinant of health produces enhanced results. For example, social environments served as the main underlying determinant in the WCA project. As a result, all energies were put towards the strengthening of social networks and enhanced participation (building of attachments) between institutions, organizations and the populations at large. Results identify both a strengthening of social networks and enhanced attachments between the constituencies in question.

4. The network and partnership model adopted by the CHSSN is effective in the delivery and sustainability of population health initiatives. Regional networks comprised of community members as well as government and non-government representatives served as an excellent social structure through which capacity, relationships and partnerships could be developed or enhanced. It further served as a social structure, which focused on the attachments with institutions as well as the population at large. As such, the networks were able to incorporate WCA activities into their existing work and sustainability plans thus ensuring ownership, integration and continuity of their population health initiatives.

If any activities will continue beyond the project-funding period, describe them and indicate how they will continue.

Strategic Information:
The CHSSN has identified within its strategic plan ongoing use and dissemination of statistical information produced from the provincial Vitality Survey beyond 2008. For example, regional networks require ongoing statistical analysis support as they prioritize health and social service needs on an annual basis and participate in health care reform. As such, the CHSSN has committed resources towards providing continued access and interpretation of the data.

Multiple Strategies:
Relationships have been established with the formal social economy sector and regional networks. It is intended that these relationships will lead to the future piloting of social economy enterprises. To ensure the continuation of this activity, the CHSSN, as part of its community support team functions, is providing ongoing support and guidance to regional networks concerning their interests in participation in the social economy sector.

Mobilization and Community Capacity Building Strategy:
The community animation program has resulted in formal links between a contracted community partner, COCo, and regional networks. Continued in-kind and fee-for-service arrangements have been established already between the two entities thus indicating a level of sustainability achieved. Furthermore, train-the-trainer workshops were held along with developed workbooks so that regional network coordinators can continue to carry out and sustain this activity at a local level.

As part of the CHSSN community support team, ongoing support for mapping health determinants is being provided. For example, the CHSSN held follow-up asset-based community development training to support regional networks in their mobilization efforts.

Provincial Forum:
Through partnerships and financial commitments from government departments, the CHSSN has been successful in hosting 2 mini forums since the provincial forum held in 2005. Knowledge development and the transfer of that knowledge is identified as a key strategic direction for the CHSSN, and thus all efforts are made to ensure that future exchanges of population health initiatives occur.

If any resources were produced during the project, describe the dissemination process (i.e., what material was disseminated to whom; was the material in hard format, electronic, web based CD, and how it was distributed).

Strategic Information:
The production of a report on the state of social support networks titled *Social Support Networks in Quebec's English Speaking Communities* was disseminated in electronic and in hard copy format to the nine regional networks participating in the project. In addition, the report was further introduced to regional networks as it served as the foundational resource for the mapping of health determinants training.

Results stemming from the 2005 Vitality Survey were presented at the provincial forum in 2006 and then posted on the CHSSN website for further dissemination. Moreover, the CHSSN contracted the Canadian Institute for Research on Linguistic Minorities to produce an additional report titled *Unpacking the Diversity of Quebec Anglophones*. This report is currently available on the CHSSN website and is being considered for presentation in a future community forum held by the Quebec Community Groups Network (QCGN).

Multiple Strategies:
Two social economy case studies were written, capturing the processes and learning's of two region's attempts at piloting a social economy project. These case studies were disseminated to regional networks through electronic format and then posted on the CHSSN website.

Mobilization and Community Capacity Building Strategy:
The community animation program produced a series of six workbooks, which were distributed during training sessions with regional networks. Additional resources, such as the mapping of health determinants workshop materials, were also posted on the CHSSN website along with a participatory results-based planning template.

Provincial Forum:
The conference program, conference report and closing address were posted on the website preceding the forum.

VII. Evaluation

Describe the evaluation process carried out during each activity or phase of your project.

The chart below describes the evaluation process carried out during each phase of the project.

Illustration IV: CHSSN WCA Evaluation Process

Steps	Actions
1. Defining the project work	Working session with CHSSN staff in development of draft work plan. Validation of work plan and proposed activities with regional networks according to their needs assessments and priorities developed. Solicitation and input from identified partners. Evidence-based research (statistics) to further validate need. Research and determination of innovative models, modes for delivery and management of project. Identification of contracted partners, resources and skills required. Confirmation of project administration team and delivery of participatory evaluation training and dissemination of information. Development of a results-based participatory evaluation template.
2. Developing success indicators and their measures	Working session to develop evaluation plan including indicators, their measures and outcomes expected.
3. Collecting the evaluation data	Identification of data collection methods. Strategic Information: Observation, monitoring and review of material and reports (records) measuring the use and application of data produced.

	Mobilization and Community Capacity Building: Community Animation Program: Post training questionnaire; Post program participant telephone survey; documentation of facilitator reflections and learning's (written). Mapping Health Determinants training: Post training questionnaire, facilitator team post reflection session. Multiple Strategies: Documentation of process and learning's through a case study format; post information session questionnaire. Provincial Forum: Tracking of quantitative information (sessions held, number of stakeholders and presenters implicated, attendance, etc.), observation and face-to-face informal interview technique re: participant satisfaction. Other: Documentation of a mid-term process evaluation retreat. Participatory evaluation activity: delivery of the mandatory project evaluation form. Observation re: increased capacity of networks leading to strengthened community action.
4. Analysing and interpreting the data	As evaluation data was collected, it was disseminated to the implicated population group and partners for key learning's to be identified. Data was then used in preparing final reports and the mandatory final report for PHAC.
5. Using the results	Evaluation findings were used throughout the project. Final evaluation report to be disseminated to partners and population group implicated in the project.

See the attached Project Evaluation Summaries (Appendices I-IV) at the end of this report.

VIII. Recommendations

Based on the knowledge gained from the WCA project to date, the CHSSN offers the following seven general recommendations:

1. A network model approach, which engages a subset of the population group and key institutions all within an organized social structure, can be an effective strategy in the delivery of population health initiatives.

2. Community mobilization and capacity building strategies have a greater chance to be strengthened and sustained when distance professional support (support team) is available to the population group.

3. The development and use of population health determinant statistical information can be a powerful strategy leading to joint population health planning between the population group and representatives of health and social services institutions.

4. The integration of key population health strategies (i.e., statistical information, community mobilization and capacity building, multiple strategies, etc.) can enhance community capacity, leading to increased action on determinants of health.

5. Sharing of population health models, approaches and initiatives between those in similar situations (i.e., minority linguistic populations) should be further encouraged and supported.

6. Formal engagement of local public health professionals should be promoted as a way to enhance sustainability of certain population health initiatives.

7. Additional training efforts should be taken to support community in understanding and applying population health determinant statistical information.

APPENDIX I: Framework Worksheet for the Five Key Evaluation Questions – CHSSN WCA Administration Team

Did we do what we said we would do? "What?"	What did we learn about what worked and what didn't work? "Why?"	What difference did it make that we did this work? "So what?"	What could we do differently?" "Now what?"	How do we plan to use evaluation findings for continuous learning? "Then what?"
All activities and goals were accomplished according to the project work plan.	The use of qualitative health determinant information works well when collaborating with public health professionals. Training on mapping health determinants and community animation works well when support is provided (i.e., CHSSN support team). Large regions (Gaspe) which involve more than one network must be approached separately as needs vary. The linking of initiatives with regional networks enhances the integration with existing initiatives and offers a greater chance for sustainability. A population health initiative works, however, collaboration with other linguistic minority communities could enhance networking, knowledge and resource development.	New statistical information collected is now being used in the development of formal health access plans. Skill acquisition, knowledge, leadership, and resources are leading to increased capacity and sustainability for networks resulting in increased efforts to create supportive environments. Increasing sustainability of regional networks enhances efforts to create supportive environments. Population health is essential to improving the health of minority English-speaking communities.	Provide more training on the interpretation and use of statistics. Also, focus on collection of community-driven data (i.e., Health asset inventories etc.) This will aid in community mobilization. Vary training according to needs of networks (i.e., Not all networks are at the same place thus requiring specialized and adapted training) Enhanced focus on public health and the relationship development between networks and public health professionals. Bridge links with francophone networks outside of Quebec.	Continue to promote the use of evidence and knowledge generation with regional networks. Integrate evaluation findings in the development of future training offerings. Continue to encourage regional networks to engage in participatory evaluation processes. Support the dissemination of evaluation findings and learning's from minority francophone population health initiatives.

II: Framework Worksheet for the Five Key Evaluation Questions - COCo

Did we do what we said we would do? "What?"	What did we learn about what worked and what didn't work? "Why?"	What difference did it make that we did this work? "So what?"	What could we do differently?" "Now what?"	How do we plan to use evaluation findings for continuous learning? "Then what?"
Implemented a mobilization program over a 2-year period beginning in 2005, to encourage participation of community resources in the development of the local health and social services networks to respond to the needs of Anglophone populations, involving: • Development and delivery of 8 training packages including a total of 12 sessions with participation from all regions. • Providing ongoing support, offering consultations and conference calls in the encouragement of community participation in Health and Social Services board elections. • Focussing on providing basic information and working with the groups to apply the training to their individual contexts.	Between the time of the needs assessment in 2005 and the completion of the set training modules in late 2006, NPI coordinators had done a lot work on their own to find the knowledge they lacked. The group may have responded better to immediate contact and dialogue. In the interest of capacity building and empowerment, another option could have been to work closer with the groups who were seeking the knowledge, rather than to prepare a training module to present to them at a later date. Having the coordinators participate fully in the creation of the material, based on their immediate needs may have lead to a more engaging format than	The greatest and most inspiring difference was that Coordinators felt supported because they: • Expressed more confidence in their skills and abilities; training confirmed they were heading in the right direction. • Acquired knowledge concerning grant writing, volunteer development, board roles and responsibilities, fundraising, project management, time management and on how to develop deeper ownership of initiatives with partners. • Developed skills that will enable them to make this knowledge work for them. The applied nature of the training helped support these changes. In many communities, training invited various community	In the future, it could be more useful to concentrate on contact with groups, using less formally structured training to focus on working with coordinators in flexible ways, through dialogue, facilitation and/or mentorship rather than training and presentations. COCo's presence in the regions earlier in the process would have been useful in the building of a helping relationship as well. More regular contact with CHSSN to share and learn about connected work would have been appreciated. Knowing more about other CHSSN initiatives would have helped the work COCo was doing with groups.	The positive feedback from participants highlights COCo's success at meeting needs present in communities in the regions. The work also served as an important 'intro to COCo' for many communities in the regions, and we will work to maintain these relationships. Our better understanding of the needs of communities will lead to a better response, more effective programming for the regions. All coordinators expressed the need for ongoing contact to continue their learning. Continued plan to support their work and their concerns (i.e., Lower North Shore, MINA, and Townshippers' Associations focus on funding development; Lower North Shore and MINA's focus on grant writing, and the priorities expressed by all

	binders and PowerPoint presentations. Other interesting learning points included: • Importance of being out in the regions early on so that relationships can be built and ongoing support can be offered. • Importance of having a wide-ranging 'tool kit' to be responsive to the specific needs of each region/ partners. • Value of having an 'intro' session with all the regions (Quebec City retreat workshop developed our knowledge of their realities and gave them a chance to get to know us). • The networking strategy was different and adapted to each region. (i.e., Lower North Shore, Townships, MINA - working with a lot of partners to strengthen their initiatives, Thetford Mines- supporting the 'host' organization, Montreal - working with partners to focus on the NPI initiative). It was important to adapt the	partners to participate. • Addressed challenges and learned and shared skills that will help them tackle the needs of their communities in healthy and sustainable ways. In addition, COCo, NPI coordinators and other community partners are now more familiar with each other, and will continue to act as resources to one another. These long-term connections are crucial to the ongoing health of smaller, often isolated communities.		regions of developing shared ownership of their networking partnership initiative and the importance of working at the political level.)

	training strategy to the regions' needs. • The importance of having 'outside' people provide training because it allows participants to raise difficult issues (i.e., potential nepotism, conflicting perspectives, power dynamics). • The timing of the training needs to be adapted to each community (i.e., timing not appropriate for the two Gaspé groups).			

* Community animation program, completed by contracted community partner

Appendix III: Framework Worksheet for the Five Key Evaluation Questions – Lower North Shore

Did we do what we said we would do? "What?"	What did we learn about what worked and what didn't work? "Why?"	What difference did it make that we did this work? "So what?"	What could we do differently?" "Now what?"	How do we plan to use evaluation findings for continuous learning? "Then what?"
For the LNS, the desired outcome was to set the groundwork for the establishment in 2007 of a group facility that would provide services within the region to the physically and intellectually challenged population. Most of the preparatory work was completed (needs assessment, types of services, facilities, potential locations, structure, etc.). However, start-up decisions regarding operational, structural and funding operations were delayed due to the addition, during the course of development activities, of other clients with loss of autonomy (i.e., seniors) in order to provide greater service and make the facility viable in the long-term. Consequently, a second needs assessment covering the additional clientele will by completed by June 2007.	This project identified a very important health and social services need that had not previously been addressed. The aspect that had the most positive outcome was the awareness raised around the lack of services and resources for the physically and intellectually challenged population of the Coast. Despite the fact that the establishment of a group facility for the physically and intellectually challenged was targeted by the LNS Coalition for Health, there was a disconnect between parallel efforts being made for seniors. This resulted in the delay (although a potentially positive one) due to the further assessment required. Wider communications to keep other sectors informed, even if they would not be actively involved with	The greatest and most inspiring difference this project made was that the rights of the challenged population were acknowledged and received greater recognition. The project raised awareness so that the general population on the Coast also became more attentive to the situation of the physically and intellectually challenged population. The second difference was that it brought together two sectors (physically and intellectually challenged, and seniors) to potentially work in partnership to establish a group facility that might not otherwise have remained viable in the long-term as individual units.	Approach differently the working dynamic of some of the partnerships, i.e., create and communicate more specific mandates with regard to expectations of certain partners, especially those on which are sources of funding and information.	One of the outputs of a project funded by Canadian Heritage will be the creation of a 'how to' guide for the establishment of a social economy project in the Health and Social Services sector. This guide will: • Depict the steps taken in this project to establish a group facility as a social economy enterprise • Describe the successes and obstacles that had to be overcome throughout the process. • Inform and educate other organizations about what is involved in such a comprehensive project. Other organizations will benefit from COASTERS' dissemination of this guide and from the learning to establish a group facility on the Lower North Shore for the physically and intellectually challenged and seniors.

	physically and intellectually challenged, would have been beneficial.			

* Multiple strategies completed by external consultant and population group

Appendix IV: Framework Worksheet for the Five Key Evaluation Questions - Gaspe

Did we do what we said we would do? "What?"	What did we learn about what worked and what didn't work? "Why?"	What difference did it make that we did this work? "So what?"	What could we do differently?" "Now what?"	How do we plan to use evaluation findings for continuous learning? "Then what?"
For the Gaspe, the desired outcome was to position the Family Ties organization for long-term sustainability as a social economy enterprise serving the health and social service needs of English-speaking families in the New Carlisle area. As part of a larger project through the CSSS-BDC to improve access to English language health and social services, Family Ties completed a five-year strategic plan within a results-based framework, as well as a partnership/funding assessment.	There was no identified social economy initiative at the beginning of this segment of the project and considerable time was spent making contact with various community stakeholders in order to assess the potential for working with one or more particular organizations. Even though an 'awareness' meeting was held with several regional organizations at the beginning, having a common table with established goals/programs related to health and social services would have made the determination of project partners more targeted and time efficient. There was an initial attempt to engage a seniors home in providing a wider range of services to the area seniors population residing outside of the facility (in New	While Family Ties had already been offering a successful program responding to community needs for a decade, there was a growing risk of either mission drift (due to intermittent project funding) or organizational implosion from staff burn out and lack of organizational depth due to insufficient resources available for the task at hand. The planning exercise helped Family Ties to establish an operational framework for its programs and services, as well as identify strengths and weaknesses in partnership arrangements and funding sources. The organization is now better positioned to deliver services and programs to the English-speaking community in the long-term and on a contract basis on behalf of other providers (i.e. CSSS-BDC)	Given that there was no one single entry point with which to engage the community of organizations working in the health and social services sector, there was not much else that could have been done differently other than to persist in attempts to engage a variety of organizations interested in supporting the start-up or expansion of services through a social economy enterprise. More effort to raise awareness of the opportunity and potential inherent in a social economy enterprise by community actors is evidently necessary. The senior's home in New Richmond set aside the notion without undertaking significant discovery processes as to the potential benefits, and Vision Gaspe chose not to pursue any kind of new social economy initiative.	There needs to be a greater level of awareness by English language organizations regarding the potential of social economy enterprises in the health and social services sector. This will require awareness programs; training as well as engagement with French language institutions to have them make available information materials and resources (i.e. support personnel) in English, either directly or via an intermediary such as CHSSN.

	Richmond.) The offer of planning support was not taken up as the non-profit organization chose not to examine a potential expansion of its service provision to seniors in the area.			

* Multiple strategies completed by external consultant and population group