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Quebec's English-Speaking Community and the Partnership Approach of Its Networks in Health

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Public Policy and Citizen-Based Practices That Support Social and Health Services for Official and Co-Official Language Minority Communities. An International Perspective: What Has Really Been Achieved and Where Are the Gaps?

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Article abstract

This article discusses the networking and partnership approach of improving access to public health and social services, with an interest in informing best practices for official language populations in a minority context. The case of Canada's official language minority residing in the province of Quebec and its Community Health and Social Services Network (CHSSN) is explored. Elements that support or inhibit partnership functioning, including innovative community-based participatory evaluation (CBPE) techniques, are explored. The contribution of the approach in improving the situation of Quebec's minority language communities with respect to their health care access is highlighted.



Quebec's English-Speaking Community and the Partnership Approach of Its Networks in Health

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Abstract

This article discusses the networking and partnership approach of improving access to public health and social services, with an interest in informing best practices for official language populations in a minority context. The case of Canada's official language minority residing in the province of Quebec and its Community Health and Social Services Network (CHSSN) is explored. Elements that support or inhibit partnership functioning, including innovative community-based participatory evaluation (CBPE) techniques, are explored. The contribution of the approach in improving the situation of Quebec's minority language communities with respect to their health care access is highlighted.

Résumé

Cet article traite de la formation de réseaux et de partenariats comme approche pour améliorer l'accès aux services publics de santé et aux services sociaux, dans l'intérêt d'informer les pratiques exemplaires pour les populations de langue officielle en situation minoritaire. Il examine le cas de la minorité de langue officielle du Canada résidant au Québec et de son Réseau communautaire de santé et de services sociaux (CHSSN). Il décrit les éléments qui appuient ou entravent le fonctionnement des partenariats, y compris les techniques innovantes d'évaluation participative axée sur la communauté (CBPE). Il met en évidence la contribution de cette approche à l'amélioration de la situation des communautés linguistiques minoritaires du Québec en ce qui concerne leur accès aux soins de santé.

Access to health care is listed among the social determinants cited by health organizations around the world as essential to the health of individuals and their communities (Mikkoven & Raphael, 2010). For Canada's official language minority communities, and for language communities in a minority context around the world, access to public health and social services is shaped by the extent to which policy and practice adequately address the linguistic and sociocultural factors proven to be key to health promotion (Bowen, 2001 & 2015; Bouchard & Desmeules, 2013; Kirmayer, 2012).

The Canadian literature scanning different approaches to improved and sustainable access to health care for official language minority communities (OLMC) gives much attention to initiatives working towards improving the quality of health professional-patient communication and securing minority language institutional settings to serve minority population users. The increase in bilingual and culturally-sensitive professionals, improved offer of service and, outside of Quebec, actions directed towards the establishment and maintenance of minority language institutions are among the trajectories frequently explored (de Moissac *et al.*, 2017; Vezina, 2017; van Kemenade & Forest, 2015). Less attention has been given to the role of networking and intersectoral partnerships in improving access to services in the health sector—and ultimately improving the health—of Canada's OLMCs (Pocock, 2013, 2016; Pocock, 2007; Vogel, Burt, & Church, 2010). The definition of the Public Health Agency of Canada (PHAC) of intersectoral collaboration is “the joint action taken by health and other government sectors, as well as representatives from private, voluntary and non-profit groups, to improve the health of populations” (PHAC, 2016).

Formed in 2000, the Community Health and Social Services Network (CHSSN)¹ is a non-profit provincial organization that responds to the health access challenges of English-speaking minority communities located in officially Francophone Quebec, by networking and the use of intersectoral partnerships. Through a series of projects linking community and public partners, the CHSSN works to strengthen networks at the local, regional and provincial level to reduce health inequalities, address health determinants, influence public policy and develop services.

This article analyzes the case of the CHSSN, with emphasis placed on describing the processes that can inform best practices in developing a sustainable culture of partnership between Quebec ministries, public health authorities, universities and research institutions, and non-profit community organizations. Community-Based Participatory Evaluation (CBPE) techniques for measuring their progress and outcomes are included among these processes. The contribution and limitations of the partnership approach of CHSSN networks in 1) the linguistic adaptation and growth of services; 2) increasing awareness of legislative

1. To learn more about CHSSN go to <https://chssn.org/about-us/>

guarantees and of the situation of Quebec's official language minority communities in the health sector; 3) increasing the representation of marginalized citizens in the decision-making and planning of public institutions; and 4) fostering trust among actors at all levels of the health care continuum are highlighted.

In terms of methodology, the article draws on data generated by CHSSN member networks, as the outcome of the monitoring and assessment they regularly undertake regarding their network and its partnering activities. The database provides information generated by 22 CHSSN member networks located throughout the territorial service network of Quebec. The recorded observations cover the period from 2003 to 2015, with intermittent tracking until 2019, and include monitoring the number of partnerships, rate of growth, partnership type (intersectoral, bridging and linking), and stage of partnership development using the CHSSN adapted 8-stage scale. The scale is a synthesis of findings derived from an analysis of 1) research concerned with conceptual models for partnership assessment, a review of 2) instruments used by organizations addressing health disparities through a partnership approach, and 3) consultations with Quebec's CHSSN networks regarding their experience with partnership growth and development in a minority language context. In keeping with CBPE approaches, CHSSN networks have been active participants in the production and validation of the 8-stage scale that guides their ongoing partnership development. The scale is discussed in detail later in this article. In addition, findings from semi-structured telephone interviews conducted by the author with CHSSN network coordinators (Pocock, 2007) are mentioned.²

Sociodemographic and policy context

Quebec's English-Speaking communities

There are more than one million English speakers³ living in Canada's province of Quebec, in communities dispersed over a large geographic territory (three times the size of France), where they form 13.8% of the total Quebec population (Pocock, 2018, Table 1). They live in diverse demographic circumstances, ranging from a population of 622,165 English speakers in the urban region of Montreal, to some 1,080 living in the more isolated area of the Lower Saint Lawrence (Pocock, 2018). Their level of French-English bilingualism, their vulnerable subgroups, their access to institutions, their service access issues, even their level of awareness of their status as an official language minority community varies, sometimes dramatically, from region to region.

2. The interview guide is included in the 2007 report as Appendix A, https://chssn.org/pdf/En/Baseline_Data_Report_06-07_v18.pdf

3. The language concept used throughout this article is First Official Language Spoken (FOLS), which is derived from three census questions: knowledge of official languages, mother tongue, and home language. The terms *English speakers* and *Anglophones* are used interchangeably as are *French speakers* and *Francophones*.

In terms of socioeconomic status (SES), also an important social determinant of health, it is important to note that Quebec's English-speaking communities experience higher rates of low income, unemployment and greater income inequalities within their population, compared to the Francophone majority, with whom they share the provincial territory (Pocock, 2018; Institut national de santé publique du Québec, 2012). Poverty is generally a predictor of higher rates of health problems within a population and a tendency to be more reliant on access to public institutions for care, rather than private, costly options. However, within Quebec's public health agencies, the number of Anglophone health professionals is low, as is the representation of English speakers within governance structures. While the recruitment and retention of bilingual health professionals is a challenge for OLMCs throughout Canada (Savard *et al.*, 2017; de Moissac *et al.*, 2017), in Quebec, the right of health professionals to work in French makes the challenge virtually insurmountable.

Lastly, Quebec's OLMC is notably distinct from the majority language population in terms of its heterogeneous composition (religious affiliation, ethnicity, visible minority status), and this adds complexity to meeting the need for culturally and linguistically sensitive access (Pocock, 2016). For example, one-third (33.6%) of Quebec's English speakers are immigrants. These levels are much higher than those found among Quebec's French-speaking majority, where immigrants represent 8.8% of the population (Pocock, 2016, p. 79). In English-speaking communities, this group tends to be less bilingual (English and French) than their non-immigrant counterparts (54% compared to 73.9%) (Pocock, 2016, p. 84). More than one quarter of the English-speaking population (27.9% compared to 7.8% of Francophones) are also members of a visible minority (Pocock, 2016, p. 88-90).⁴ One-third (33.2%) of this subgroup live below the low-income cut-off (LICO), compared to 17% of the English-speaking non-visible minority population and 13.8% of the French-speaking non-visible minority group (Pocock, 2016, p. 88-90).

Language policy and Quebec's public health system

Quebec's English-speaking communities find themselves in a complex legislative and policy context.

Canada, along with other nations around the world, has established language policy and legislation recognizing its official language minority communities and endorsing a commitment to supporting their vitality. The *Canadian Charter of Rights and Freedoms*⁵ and the *Official Languages Act*⁶, confer certain rights on English speakers in Quebec and

4. A visible minority is defined by the Government of Canada as "persons, other than aboriginal peoples, who are non-Caucasian in race or non-white in colour", <https://www23.statcan.gc.ca/imdb/p3Var.pl?Function=DEC&Id=45152>

5. Part 1 of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*Canadian Charter*].

6. RSC 1985, c 31 (4th Supp).

on French speakers outside of Quebec, in recognition of their status as Canada's official language communities in a minority context.⁷

In the health sector, this commitment is delivered through the Health Canada Official Languages Health Contribution Program, which features a three-pronged strategy aimed at integrating health professionals from OLMCs, strengthening local health networking capacity and promoting health services access and retention programs. The Official Languages Program of the Department of Canadian Heritage offers generalized support to community-based organizations working to support the vitality of official language minority communities (OLMCs).⁸

At the provincial level, Quebec's OLMC may be described as "a minority within a minority". As set out in the *Charter of the French Language*, French is recognized as the sole official language in the province, and the government has the legislative and policy objective of making it "the normal and everyday language of work, instruction, communication, commerce and business" in Quebec.⁹ In recognition of the historical presence of English-speaking communities, the preamble to the *Charter of the French Language* refers to a commitment to pursue the objective "in a spirit of fairness and open-mindedness, respectful of the institutions of the English-speaking community of Québec, and respectful of the ethnic minorities, whose valuable contribution to the development of Québec it readily acknowledges"¹⁰.

Access to educational services in English is described in detail in the *Charter of the French Language*, as are certain legal rights that are enshrined in the *Canadian Charter of Rights and Freedoms*.¹¹ However, the Charter is largely silent on the right to receive health and social services in English, which perhaps explains the English-speaking community's campaign in the 1980s to see legislative recognition of their rights. This culminated in the adoption of Bill 142 in 1986, which amended Quebec's *Act respecting health services and social services*, to provide a qualified right for English speakers to receive services in English.¹² Key elements of the revised legislation included the requirement for regional planning authorities to develop access programs for services in English, subject to the resources of the institutions in each region and for the designation of certain institutions¹³ that would be permitted to offer their range of services in English (Carter, 2012; Silver, 2000).

7. For further reading, see Bourhis, 2017 and 2019.

8. For a description of their support programs: <https://www.canada.ca/en/canadian-heritage/services/funding/official-languages.html>, consulted July 27, 2020.

9. *Charter of the French Language*, CQLR c C-11, Preamble, para 2.

10. *Ibid*, Preamble, para 3.

11. *Supra* note 5, s 23.

12. *An Act to again amend the Act respecting health services and social services*, SQ 1986, c 106.

13. A designated institution is an institution that is acknowledged by the Government of Quebec as required to make its health and social services accessible in the English language to the English-speaking population.

In the years since the adoption of Bill 142, English-speaking communities have worked with the government of the day to implement the commitments set out in the legislation, but have been buffeted by political, administrative and fiscal conditions which have seen successive governments place great emphasis on the promotion of French, invoking the right of health system employees to work in French as taking primacy over the client's right to receive services in English, while others have forced the merger of institutions which has led to the disappearance of many of the designated institutions.

CHSSN model

What is the Networking and Partnership Initiative (NPI)?

Through the Community Health and Social Services Network (CHSSN)¹⁴ and Health Canada's official language strategy¹⁵, 22 community networks (NPI) or *network nodes* are supported across Quebec's large territory, as focal points for innovative strategies in addressing the priorities of English-speaking communities with respect to the health and social service system. Three new community networks will be established by 2020. Many of these are housed within regional community organizations¹⁶ that have a long tradition in the lives of English speakers reflecting the dedication to the community sector that is a distinguishing characteristic of Quebec's minority language group, others are successfully established in territories without the regional organizations mentioned and often benefit from a long-standing network, generally a volunteer core, working out of church basements, schools, foodbanks and in neighbourhoods with a concentration of English speakers. Findings from network coordinator interviews align with an extensive review of the literature that shows that inclusive social connections with a history in the lives of a client population are a positive factor in network success (Nelson *et al.*, 2013). This is attributed to trust—an element that takes time and the test of joint action to procure—among network participants (Jones & Barry, 2016).

Considering the context of Quebec's English-speaking communities, the network approach is particularly fitting, since it offers what network coordinators describe as the “flexibility” and “space for innovation” deemed essential to connect demographically diverse communities and empower each to strategically mobilize according to their unique profile of

14. For a further description of the CHSSN's Networking and Partnership Initiative, see the CHSSN Baseline Data Report, http://chssn.org/pdf/En/2013_Baseline_Data_Report_final_En.pdf, p. 1-8 consulted July 27, 2020. For description and map indicating NPI network locations, go to <https://chssn.org/chssn-programs-and-projects/networking-and-partnership-initiative/>, consulted July 27, 2020.

15. For a further description of Health Canada's strategy: <http://www.hc-sc.gc.ca/ahc-asc/branch-dirigen/rapb-dgrp/pd-dp/olcldb-baclo-eng.php>. The views expressed herein do not necessarily reflect the official policies of Health Canada.

16. Some of these are funding recipients of the Canadian Heritage official language support program.

health needs and resources. For example, through the REISA network,¹⁷ an NPI located in the historic English-speaking Italian neighbourhood of urban Montreal has found common ground with the Coasters Association NPI Initiative, located on the more isolated Lower North Shore. They have exchanged models for initiatives to improve access to health and social services for their very different populations. The AGAPE NPI,¹⁸ located in ethnoculturally diverse Laval, and the CASA NPI,¹⁹ serving the widely dispersed and more ethnically-homogeneous English-speaking communities of the Gaspé coast, have both embarked on establishing wellness centres for their seniors who, despite different backgrounds, share a similar profile in terms of their health and social service access challenges. Today, there are 37 wellness centre sites in 11 regions, serving hundreds of English-speaking seniors throughout the province.

The CHSSN hub and its 22 NPI networks gather regularly for formal training and knowledge sharing (exchange of best practices in improving access to services, new research in health and health policy, updating the profile of English-speaking communities, changes in partners and partnerships, leadership coaching, funding sources) and are recognized experts in the skills that promote communication among and consultation with minority language communities in multiple geographic locations and diverse sociocultural contexts, with distinct health care access needs and issues (Pocock, 2016). In other words, they are an example of what can be described as bonding relations that, on the one hand, are equipped to be both highly local in their focus and action while, on the other, broadly inclusive in their reach and representation with respect to Quebec's English speakers.

Who are the network partners and what sort of partnerships do they form?

In their efforts to reduce barriers and improve access to health care for Quebec's English-speaking communities, CHSSN NPI organizations forge sustainable, typically multi-organizational, partnerships between non-profit community organizations serving this population and public institutions and agencies primarily in the domain of health. Some aspects of how they are established and develop are described below.

Growth and momentum:

The accompanying figure presents the annual count of NPI partnerships with public agencies monitored over a twelve-year period, demonstrating an increase from 25 in 2003-2004 to 514 in 2014-2015. As can be observed, the rate of growth varies when comparing the early phase of partnership formation (2003-2008) to that of the later phase (2009-2015).

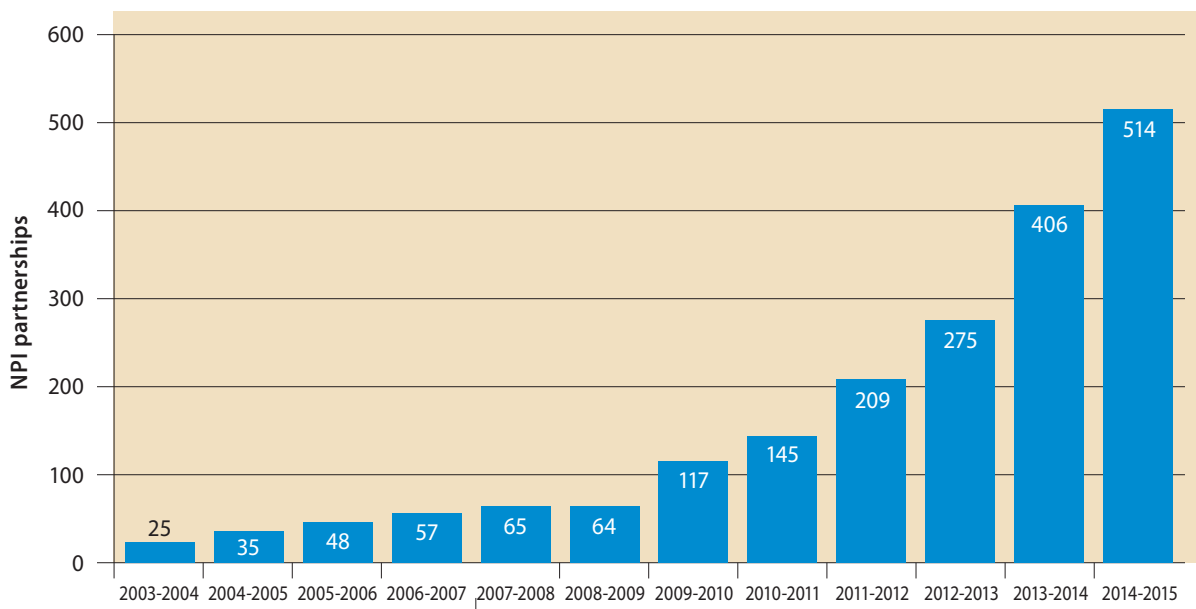
17. REISA is the French acronym for Réseau de L'Est de l'Île pour les services en anglais.

18. AGAPE is the name of the NPI serving the English-speaking citizens of Laval.

19. CASA is the acronym for Community for Anglophone Social Action.

Initially, NPI networks tended to start out with two or five partners and experienced steady growth over time. Among networks established latterly, they tended to start out with a larger number of partnerships that were maintained over time. They also grew more rapidly over a two- to three-year timespan compared to the early partnerships.

Figure 1
CHSSNN NPI Partnerships, Annual Count, 2002-03 to 2014-15



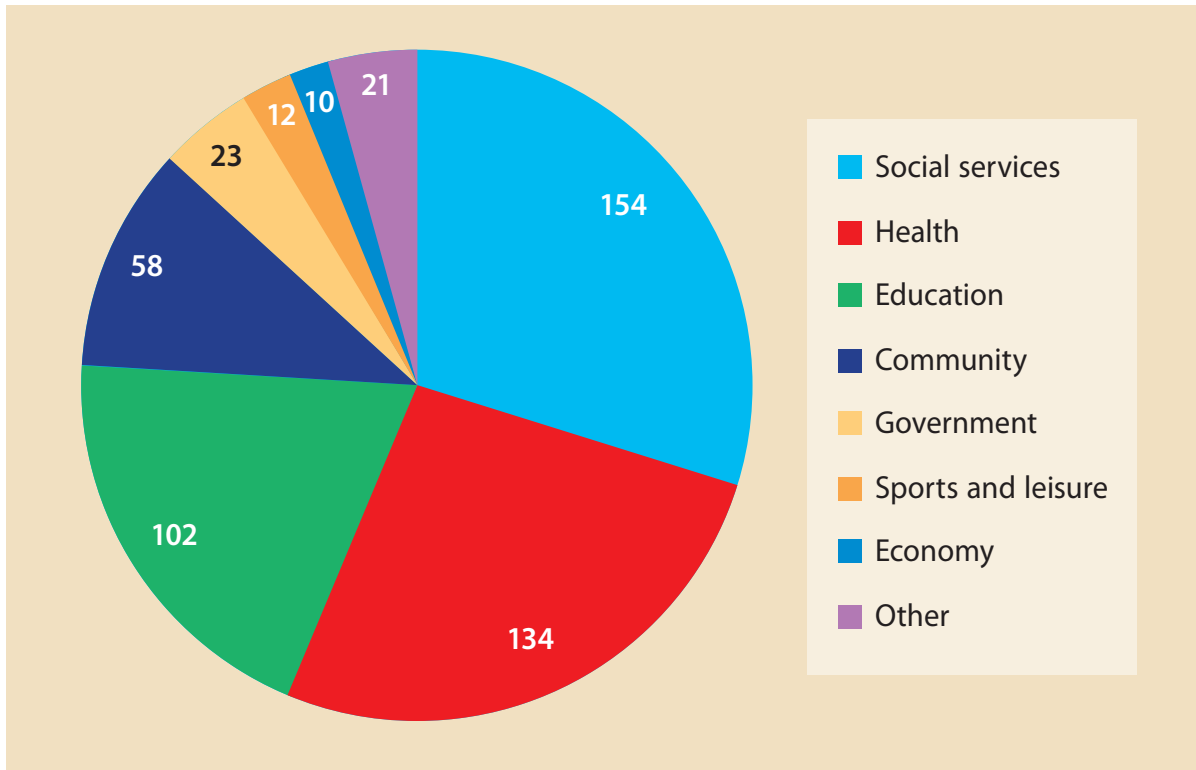
Source: JPocock Research Consulting, 2016, based on data collected from the NPI Groups.

This pattern of progress suggests successful knowledge transfer from the early ground-breaking years of partnering to the more recent implementation of this approach. Newcomers to the provincial network benefit from the increased awareness, expertise and proven track record of both the community organizations and their public partners, with respect to the partnership approach. While there are ups and downs in the evolution of any network, the accelerating momentum we observe in this case over time suggests an improved baseline of community readiness that remains intact in the face of change.

Intersectoral partnerships

Research concerned with the population health model has found that intersectoral partnerships are a proven core element of promoting health and health equity (Corbin, Jones, & Barry, 2018; World Health Organization [WHO], 2013).

Figure 2
CHSSN NPI Partnerships Overview, by Partner's Sector, 2014-15



Source: JPocock Research Consulting, 2016, based on data collected from the NPI Groups.

In the case of CHSSN partners, most partnerships are in the health and social service sector, but there are also partners from school boards and all levels of educational institutions; departments of both federal and provincial government, in areas such as sports and leisure and economic development; as well as provincial community organizations with health-related mandates such as Youth Employment Services (YES), AMI-Quebec Action on Mental Illness, and Seniors Action Quebec (SAQ).

Aside from recognizing the interrelatedness of the social determinants of health, CHSSN networks teach us that an important outcome of intersectoral partnerships is the enhanced opportunity to use health care access opportunities that lie beyond formal medical settings (Pocock, 2016). Vulnerable subgroups facing linguistic and cultural barriers at service points offered by public agencies, such as their local hospital or CLSC (health centre), may be more effectively and efficiently reached when services are offered in the comfort zone of their own *turf*. Some examples of these include, health related programs for children and youth in English language schools and colleges; health promotion activities for seniors in English, through local community learning service centres (CLSC); English language

mental health services in an employment services agency; church halls as sites for a series of health professional visits in English (or with translation), all operating under jurisdictions other than health, but allowing for alternative pathways to improved health information and increased contact with medical practitioners. According to NPI interviews, these pathways tend to increase the likelihood of early detection, diagnosis and treatment of disease; training in health prevention practices; improved health literacy; enrollment in programs and support for managing chronic conditions; in addition to fostering trust in medical experts. Ultimately, it is a means to increasing the use of formal, often complex, settings of public health and social services by the community, since 1) users gain an improved understanding of how to navigate the system and 2) medical professionals who are “boundary crossers” (Kilpatrick, Cheers, Gilles and Taylor, 2009) improve their “cultural competence”²⁰ and develop greater sensitivity to the situation of the minority population through hands-on encounters. Improved engagement of English speakers with the public system and the enhanced position of English speakers with respect to access to health services as a key determinant of health is a win-win for both the public system and the NPI community networks—a win that neither could achieve alone.

Bridging and linking

While bonding relations are an important part of networks, bridging and linking connections are considered necessary for their sustainability (Dale & Onyx, 2005; see Figure 3). This is highlighted in research on the predicament of Canada's OLMCs outside of Quebec, which argues that solutions need to be found to remedy communication barriers between health professionals and minority language patients, by bringing about change at the organizational culture level (Vezina, 2017). The case of the CHSSN demonstrates the strategy of a network that improves access to health and social services, by empowering marginalized citizens to influence the decision-making and planning of public health authorities. CHSSN networks not only partner with health and social service centres delivering primary care, but also with regional planning authorities who, in turn, integrate their knowledge of the health needs and access issues of the local English-speaking community into their long-term action plans. Networks have mobilized to ensure that, not only network coordinators, but also members of their local English-speaking community, are sitting on regional concertation tables and boards of directors of agencies that influence health and social service policy.

20. Considerable literature is devoted to the development of cultural competence among health professionals located within diverse (ethnically, religiously, linguistically) populations. See Kirmayer, 2012.

Figure 3
Social Capital Dimensions of Networks

Bonding	This refers to networks between people who share a “common bond” and are cohesive in their interests (<i>i.e.</i> a tight-knit rural community, or a family).
Bridging	These relations bring different groups together. They are outward looking and encompass people across social divides. They generate broader identities and links to assets more than bonding.
Linking	These are connections which tend to work vertically along a social hierarchy. This kind of network forges relations between groups who are unequal in terms of access to power such as a marginalized group and the decision-makers responsible for social policy.

Dale and Onyx, 2005

Where the partnership of CHSSN networks with the regional access committees²¹ of their *Agence*²² has been successful is by demonstrating the capacity of the partnering approach not only to nurture local leadership²³ and community voice, but to produce policy reflecting the influence of all those subject to it. In the words of some NPI coordinators: “At our first access plan committee meetings, the *Agence* staff person was very cautious. Today she is our best champion, working internally all the time on our behalf”, also “For us, the community and public partners are interdependent. We have an integrated vision. We share public policy.” (Pocock, 2013, p. 14).

How do CHSSN network partnerships impact access to public health and social services for Quebec's English-Speaking communities?

Based on indicators used by the Quebec Survey of Child Development in Kindergarten (Institut de la statistique du Québec, 2017), research reveals that the proportion of children (aged 0-5) exhibiting developmental delay in the areas of physical health and well-being, as well as communication skills and general knowledge, is greater among English-speaking children in the Outaouais region than French-speaking children. In light of this new evidence base, Connexions,²⁴ an NPI network located in the Outaouais, has used the partnership

21. As mentioned, legislation in Quebec includes the requirement for regional planning authorities to develop access programs for services in English, subject to the resources of the institutions in each region and for the designation of certain institutions that are permitted to offer their range of services in English.

22. Agence is an abbreviation of *L'Agence de santé et des services sociaux*, which translates into English as Health and Social Services Agency.

23. For further discussion of leadership in collaborative partnerships, see Nowell & Macon-Harrison, 2011.

24. See their website: <https://centreconnexions.org/>

approach to address the needs of English-speaking children and their families (Dault, 2019). Connexions offers a playgroup, Itsy-Bitsy Tots, at nearby Heritage College in partnership with its early childhood care education program. It offers a space for parents to socialize, participate in activities with their children and acquire important information about childhood development in English. For the College, it has allowed students to gain practical experience with children and parents and for teachers to supervise in real time. Young families living in the Outaouais do not have access to such programs and services in English through the public health and social services offerings in the area. This win-win situation has acted as a catalyst for another early childhood service that uses the same strategy to target new English-speaking parents called Baby Chat, which hosts a guest speaker with relevant expertise at each session. On the one hand, services in English that are not otherwise available to this vulnerable group are offered and, on the other, early childhood educators acquire an awareness of the situation of minority language children and families in their local region and improve their competence in family culture.

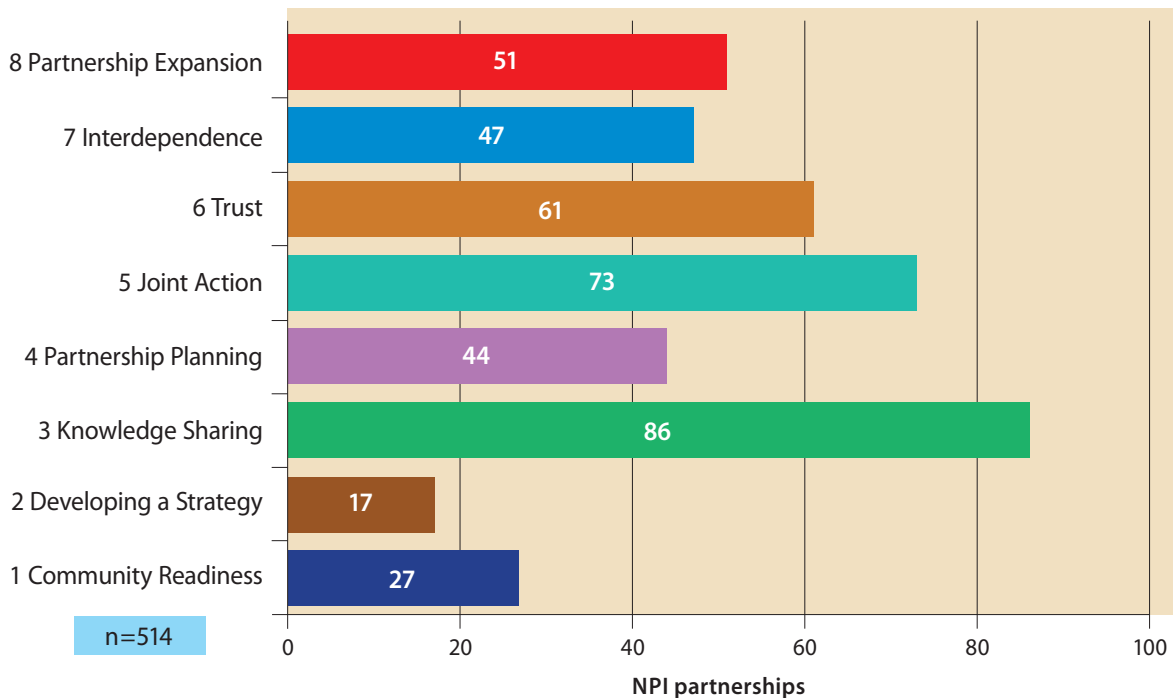
Given the current mobilization of CHSSN networks in the area of early childhood development, this partnership success offers a model with potential to be adopted by 22 network nodes throughout the province, to improve much needed service access in English.

How is partnership performance monitored and assessed?

CHSSN NPI partnerships are monitored and assessed using a Community-Based Participatory Evaluation (CBPE) approach, which invites involvement and co-leadership from those most directly involved with and affected by the activities of a network and its partnerships (Krannias, 2018; Gujit, 2014; Baker & Bruner, 2010). The input of the 22 community networks in the design and execution of their partnership evaluation ensures the identification of locally relevant questions and analyses, which can serve as a sustainable resource for co-learning and partnership maturity. At the time of the writing of this article, data collection for the most up-to-date partnership assessment by both NPI network coordinators and their public partners was underway and will be delivered to the provincial Health and Social Services Priorities Committee (HSSPC) that oversees the community-established priorities for English speakers in the health sector.

To demonstrate, the CHSSN tool for assessing the stages of partnership is a good example of a network produced and owned resource found in the toolkit of every NPI. Input from academic and government research, from the best practices of organizations working within the partnership approach, as well as CHSSN NPI networks has resulted in a measurement strategy, which is scientifically based, while also customized to fit the unique partnering situation of Quebec's geographically-dispersed language minority communities. The accompanying graph (Figure 4) depicts the state of NPI network partnerships by stage.

Figure 4
CHSSN NPI Partnerships, by Stage of Partnership, 2002-03 to 2014-15



Source: JPocock Research Consulting, 2016, based on data collected from the NPI Groups.

While there is no hard and fast formula to be found, all network interviewees agree that there are stages to partnership development, and it is advantageous to try to gauge where one is on the continuum at any given time. Every stage has its challenges and rewards, and inappropriate expectations at any given stage can be a recipe for failure. Trust and interdependence, for example, cannot be rushed and NPI coordinators unanimously advise that “baby steps” be taken (Pocock, 2013).

As illustrated by the accompanying bar chart, stages are generally described as unfolding from community readiness through to the state of interdependence. Partnership development is not a linear process, since certain stages, like knowledge sharing, will reoccur at different points even in the most mature partnerships. Some networks, especially those joining at a later phase, begin with a more mature relation to the public health and social service system at the outset and, therefore, advance more quickly through certain phases than those starting from scratch. Not all partnerships will move from stage 1 to stage 8, in its maturation. Some NPI partnerships may set knowledge-sharing as their goal, as in the case of a public agency or department without a mandate or funding for program creation or implementation. This partnership can be considered a strong connection, in spite of never reaching stages 4 through 8, in the larger development scheme. According to the

literature, a mix of both strong and weak ties, or a mix of partnerships at various stages, is desirable (Provan, Veazie, Staten, & Teufel-Shone, 2005, p. 608).

What elements, qualities and practices support or inhibit positive partnership functioning?

At the heart of the partnership approach are collaborative working relationships, where organizations achieve more by working together than they would working alone, in other words, synergistic relationships (Corbin, Jones, & Barry, 2018; Corwin, Corbin, & Mittelmark, 2012). In short, without synergy, there is no partnership. Network coordinators stress the importance of arrangements that are mutually beneficial to the parties and the risk posed by any imbalance in the give and take that leads to improved access to health and social services for the English-speaking community. For example, an organization may view the networks as an efficient one-stop-shopping opportunity to make contact with the dispersed English-speaking population, but fall short in contributing to the network's ongoing vitality or joint action that furthers the specific mission of improved health care. As supported by the literature, too much demand by public partners in the way of bureaucratic hoops typical of modern complex institutions, such as imposed evaluation indicators, or any sense of the networks as essentially underpaid extensions performing what should be government responsibility, or access points to an available volunteer workforce, can easily undermine partnership functioning (Walker & Gilson, 2005; Mackian, 2002). Public partners are also constrained by their mandate and the policy context, even as they try to embrace the all-important flexibility and innovation needed to effectively bridge the divide between majority and minority health and health access realities. The most commonly cited element-inhibiting partnership functioning among CHSSN networks is system restructuring and turnover in the workforce of their public partners.

In the case of the CHSSN, use of the stages of partnership measure among its monitoring tools guarantees that the elements and practices listed by researchers (Corbin, Jones, & Barry, 2018) supporting positive partnership functioning become targets or benchmarks for community organizations and their public partners. These include knowledge sharing; clarity and coherence in a shared mission, roles and responsibilities; participatory evaluation; inclusive and transparent leadership; trust building between partners; adequate human and financial resources; and adequate time (Pocock, 2013). Of utmost importance as the outcome of the CHSSN community-based participatory approach in its monitoring is what NPI coordinators refer to as a "strategic mindset" (Pocock, 2013, p. 15), or what the literature often refers to as a culture of evaluative thinking or critical thinking (Buckley, Archibald, Hargraves, & Trochim, 2015).

The partnership approach, as modelled by CHSSN and its NPI networks across Quebec, is an evidence-based approach. Successful knowledge transfer is frequently mentioned by

NPIs as an essential part of partnership functioning, as well as a partnership outcome with lasting impact on access to health and social services for Quebec's minority language community. It is important to bear in mind, particularly in the initial phase of partnership formation, that NPI community networks are often knocking on the doors of public health and social service institutions whose day-to-day operations are not informed by research that singles out the local English-speaking community as a particular constituency within their general clientele. The design and analysis of provincial health surveys that inform the public system, for example, are often not organized to yield results that distinguish language use among other regularly reported respondent characteristics like gender or age. For the most part, public partners, especially those located in designated institutions, are reliant on the evidence base that NPI networks bring to the partnership to meet their English language access obligations. The CHSSN knowledge-to-action cycle trains partners in current and locally-relevant knowledge of an otherwise invisible target population (provincial, regional and sub-regional), with respect to key social determinants of health and health status and supports the identification of the barriers and facilitators observed in the population's use of a wide range of public health and social services, including access to health information. Knowledge sharing lays a foundation for collaborative and effective intervention.²⁵ It also ensures partners—including public health policymakers and program managers, government and academic researchers, as well as English-speaking community leaders, advocates and volunteers from various sectors—who are aware of inequities in health and of the legislative guarantees that set the linguistic parameters of access for Quebec citizens to public health care provisions.

Conclusion

Access to health and social services is a recognized social determinant of health, and considerable literature draws attention to the linguistic and cultural barriers reducing the access of minority language communities to health care. Among Canada's official language minority communities, the challenges and benefits of the networking and partnership approach in health promotion and, specifically, improved access to health and social services, warrants closer attention by researchers.

Located in a province whose sole official language is French and subject to legislation designed to curtail the use of English, Quebec's English speakers face unique challenges in overcoming barriers in their access to health and social services. Strategies designed to increase the number of bilingual health professionals and staff, or establish health and social service institutions, whose priority is to serve the minority language population, are simply not feasible. Within this social and policy context, the case of the CHSSN offers

25. For discussion, see Graham, Stone, & Tetroe, 2015.

the partnership approach as a promising strategy, not only for Canada, but also for other globalizing nations that increasingly assume responsibility for a citizenry living in a minority language context that is often an invisible population within their boundaries.

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