

Portrait of the French-speaking Population in the Waterloo Wellington LHIN Area

Initial Report: Health Status

Entité²

de planification des services de santé en français pour les régions de
Waterloo • Wellington • Hamilton • Niagara • Haldimand • Brant

September 27, 2012

AUTHORS

Carole Lamoureux, Executive Director
Sika Eliev, Health planner, Analyst and Researcher
Jocelyne Blais-Breton, Health Planner

Special thanks to our Administrative Assistant, Alexia Lemoine for the layout and editing of the document.

CONTACT

Waterloo Wellington office:

1145 Concession Road, Suite 210
Cambridge, ON, N3H 4L5
Tel.: 519.653.1470 ext. 392

Hamilton Niagara Haldimand Brant office:

3 Cross Street, Suite 304
Welland, ON, L3B 5X6
Tel.: 905.734.1579

TABLE OF CONTENTS

LIST OF TABLES	2
INTRODUCTION	3
PURPOSE.....	4
BACKGROUND	5
METHODS	6
SOCIAL DETERMINANTS OF HEALTH	9
PORTRAIT.....	17
CONCLUSION	23
BIBLIOGRAPHY.....	24
SUPPORTING DOCUMENTS	27
DOCUMENT 1 : WW LHIN SYSTEM STRATEGIC PRIORITIES 2012/2013	28
DOCUMENT 2 : FRENCH LANGUAGE SERVICES ACT.....	29
DOCUMENT 3 : NEW INCLUSIVE DEFINITION OF FRANCOPHONE (IDF) IN ONTARIO.....	30
DOCUMENT 4 : AGREEMENT BETWEEN THE WWHNHB LHINS AND ENTITE DE PLANIFICATION POUR LES SERVICES DE SANTE EN FRANÇAIS POUR LES REGIONS DE WATERLOO, WELLINGTON, HAMILTON, NIAGARA MARCH 2011.....	31
DOCUMENT 5 : OFFICIAL LANGUAGES ACT AND SUPREME COURT OF CANADA RULINGS	32
DOCUMENT 6 : THE EXCELLENT CARE FOR ALL ACT, 2010	33
DOCUMENT 7 : ACRONYMS.....	34
DOCUMENT 8 : MYTHS.....	35
DOCUMENT 9 : EVIDENCE-BASES INFORMATION ON BARRIERS	37
DOCUMENT 10 : EDUCATION STATISTICS	39

LIST OF TABLES

- Table 1:** Francophones who do not have a high school diploma in WW region, 2011:
page 10.
- Table 2:** French-speaking population with very little or no access to health care services
in French, 2005:
page 37.

INTRODUCTION

This report aims to increase knowledge on the health status of the French-speaking (FS) population in the Waterloo Wellington (WW) LHIN area. It is a work in progress since most health organizations and health service providers in Ontario do not record patients' language during the utilization of services.

The report presents a *social determinant of health* approach to define the health status of the target population. This approach focuses on improving the health status of the French-speaking population in the geographic area of the Entité², the French Language Health Planning Entity (FLHPE). Recommendations for action aim to improve the health of the entire target population, rather than individuals.

Focusing on the health of the French-speaking population necessitates the reduction of inequalities in health status between the majority and minority population groups. An underlying assumption of a population health approach is that reductions in health inequities require reductions in material and social inequities. The outcomes or benefits of a population health approach, therefore, extend beyond improved population health outcomes to include a sustainable and integrated health system, increased provincial and national growth and productivity, and strengthened social cohesion and citizen engagement.¹

According to the document: *“The Waterloo Wellington Local Health Integration Network System Strategic Priorities 2012/2013, the priorities for the WW LHIN region are the same for all 14 LHINs in the province: Enhancing access to primary care; Enhancing coordination & transitions of care for targeted populations; Implementing evidence-based practice to drive quality and Access to care”* (Document A).

Relevant and accurate quantitative and qualitative data are necessary elements when defining the health status of any population. Auspiciously, there is a growing body of evidence on the health of minority populations. The environmental scan entitled: *Setting the Stage: Primary Health Care in French in Southern Ontario (2006)*, conducted by the *Réseau franco-santé du Sud de l'Ontario*, is an invaluable source of data.

The role of the FLHPE is to make recommendations to the WW LHIN on how to improve the French population's access to quality health services. Thus, the FLHPE supports the LHIN in its core value of acting in the best interest of the region's population health and well-being. We trust the WW LHIN will incorporate the necessary strategies in its Integrated Health Services Plan (IHSP).

¹ Public Health Agency of Canada. Retrieved from: www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php

PURPOSE

The official provincial mandate of the FLHPE for the Waterloo Wellington and Hamilton Niagara Haldimand Brant areas can be found in the *Signed Funding and Accountability Agreement*, March 15, 2011. The mandate is clear: to provide recommendations and advice to the two LHINs on “*strategies to improve access to, accessibility of and integration of French language health services in the local health system; and the planning for and integration of health services in the Areas*”.²

The goals and objectives of the Parties (FLHPE, WW LHIN and HNHB LHIN) “*believe that the health system should be guided by the requirements of the French Language Services Act in serving Ontario’s French-speaking community*”³ in accordance with Ontario Regulation 515/9 *Engagement with the Francophone Community* under the *Local Health System Act 2006* (LHSIA). As stipulated in the agreement, the FLHPE will provide advice to the LHINs on:

- methods of engaging the Francophone Community in each of the Areas;
- the health needs and priorities of the Francophone Community in each of the areas, including the needs and priorities of diverse groups within that Community;
- the health services available to the Francophone Community in the Areas;
- the identification and designation of health service providers for the provision of French language health services in the Areas;
- strategies to improve access to, accessibility of and integration of French language health services in the local health system; and
- the planning for and integration of health services in the area.

The above initiative will contribute to the overall strategy of the WW LHIN to:

- improve access to health services
- improve the health of the population
- enhance system effectiveness
- build community capacity to achieve a sustainable health system.⁴

It should be noted that the information contained in this document is based on the most recent yet limited available data.

² Signed Funding and Accountability Agreement, 2011:6.

³ Ibid., p.6.

⁴ WW LHIN website: <http://www.waterloowellingtonlhin.on.ca>. Consulted July 2012.

BACKGROUND

In 2012, the FLHPE prepared a *Demographic Profile of the Francophone Communities in the Regions of Waterloo Wellington Hamilton Niagara Haldimand Brant*. The Demographic Profile illustrates that the French-speaking population in Ontario is increasing due to the new and *Inclusive Definition of Francophone* (Document C). The French-speaking population in the WW area is also becoming more racially and ethnically diverse and the median age is older than the general population.

The WW LHIN area includes a French-speaking population of 15,300 residents. The overall French-speaking population across Southern Ontario totals approximately 175,000.⁵

⁵ Réseau franco-santé du Sud de l'Ontario [Franco Health Network of Southern Ontario]. 2006. *Setting the Stage – Primary Health Care in French in Ontario*. Regional Report. Note that the data specifically related to the Waterloo Wellington LHIN area was included in the overall data for the Wellington-Dufferin-Guelph, Brant, Haldimand-Norfolk, Hamilton, Niagara, Waterloo and Halton regions. P.1.

METHODS

Identification of Community of Interest (COI)

The community of interest (COI) depicts the French-speaking population of the WW LHIN region. The WW LHIN area covers a large territory (4,800 square kilometres) comprised of four urban centres: Waterloo, Kitchener, Cambridge and Guelph. The WW LHIN boundaries include Wellington County, the region of Waterloo and the city of Guelph.⁶ The Waterloo and Wellington region includes an important rural geographic area.

New Inclusive Definition of Francophones (IDF)

The French-speaking target population referred to in this report is in keeping with the new IDF adopted by the government of Ontario in June 2009. The IDF reflects the diversity of the Francophone community in the province. It includes an immigrant population whose first language is neither French nor English, but whose second language is the official French language. These immigrants have an excellent knowledge of French. They speak it in their home, at work and in social situations. Faced with a choice between health services in French or English, they would prefer speaking in French, as English is their third language. This reality is true for 6% of the French-speaking population (Document B).

A minority population in an area “non-designated” under the FLSA

In Canada, the French language is one of two official languages. The Francophone population is one of the three founding peoples of Canada. French-speaking citizens have guaranteed legal Constitutional rights in Canada.

In Ontario, the government recognizes the distinct status of the minority French-speaking population as entrenched in the French Language Services Act (Document B) in 25 designated regions. Although the French-speaking population lives in a minority situation, it has full access to publicly-funded French language schools and the right to govern their school boards. Many Ontario government ministries offer services in both French and English.

Education and health are two of the most important sectors affecting the vitality of the population. In Ontario, more than 500,000 French-speaking residents live in designated and non-designated areas. Although WW is a non-designated area, the law stipulates that the LHINs are nevertheless responsible for the well-being of the total population including the French-speaking minority.

⁶ The French Language Health Planning Entity for the WWHNHB Area. 2012. *Demographic Profile of Francophone Communities in the Regions of Waterloo Wellington Hamilton Niagara Haldimand Brant (WWHNB)* – Revised August. P.10

Knowledge gathering

To draw the portrait of the French-speaking population in the WW region, the health planners conducted a (a) literature search of evidence-based information, (b) analysed data from existing databases and (c) consulted with key community informants.

a. For the [literature search](#) in English and French, key words were entered such as “minority”, “French-speaking”, “Ontario”, “health”, “integration”, “determinants of health”, “access to care”, “cultural competency”, “linguistic barriers”, “health risk” and “equity”.

b. The [database search](#) included the following health search engines such as ABI/Inform Complete; OVID; CIHNNHAL; CMA Infobase; Medline; Cochrane Library; Pub Med; Sage; eHealth Online Lit; Combined Health Information Database and ProQuest. A list of databases was provided by the HNHB LHIN; however, some of those databases were not accessible to the FLHPE.

c. Finally we [consulted](#) with the community of practice (COP) such as faculty from academic institutions⁷, key informants, authors and other stakeholders to ensure that no important sources of information were omitted.

Definitions and interpretation

The definitions of key words appearing in this document are common definitions used by the Ministry of Health and Long-Term Care (MOHLTC) and Health Canada.

a. Access

In the literature research the most common definition of *access* used by health planners, health policy analysts and policy analysts for French language health services, is “...*gaining admittance to health services in French*”.

The official mandate of the six Entities in the Province is to increase “*access*” to services in French. The above wording reflects this common definition. Under Article 2- Purpose and Term of Agreement, 2.1 (e) in the *Signed Funding and Accountability Agreement*, it is stated that “*strategies to improve access to, accessibility of and integration of French language health services in the local health system; ...*”.⁸

According to certain LHINs in Ontario, the word “*access*” has a different connotation. In the Drummond Report, the LHINs are being asked to continue to provide excellence in the provision of health services during difficult economic times and ensure their sustainability. In the process of strategic planning, the focus of some LHINs has been to look closely at the 1% of the population which uses a high percentage of health resources. To diminish high usage cost, the preferred approach is to increase “*access*” to alternate services and resources.

A clear definition of “*access*” on the part of parties involved in the planning of health services is important.

⁷ Louise Bouchard, PhD. Ottawa University; Gratien Allaire, PhD. & Louise Picard, Laurentian University; Monique Benoit, Laurentian University; Anne Maryse Lavoie, PhD. Laurentian University; Sylvie Larocque, PhD. Laurentian University.

⁸ Signed Funding and Accountability Agreement. 2011. P.5.

b. Integration

Experts agree that *integration* is a necessary component for the provision of good quality health services. According to the World Health Organization (WHO) (2008), integrated service delivery is “*the management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system*”.⁹

Integration is the opposite of fragmentation and working in silos.

c. Inequality/Equity

Inequity in health care is unfair and unjust practices. The converse, *equity* in health care is described by the WHO Constitution (WHO, 1946) as the highest standards of health within reach of all without distinction of race, religion, political belief, economic or social condition.¹⁰

Equity in health care implies everyone attains full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstance.¹¹

Efforts to promote social equity in health care are aimed at creating opportunities and removing barriers for achievement of health and well-being for all. It involves a fair distribution of resources needed for health, fair access to opportunities available, and fairness in offer of services when ill.¹²

The Drummond Report¹³ has emphasized a “patient focus” approach in a new provincial health system. This patient focus approach is based on the real needs of the population rather than the preferences of institutions or professionals regardless how well intentioned.

⁹ World Health Organization (WHO). 2008. “Making health system work: Integrated health services – what and why?” *Technical Brief*, No.1.

¹⁰ Margaret Whitehead and Göran Dahlgren. 2006. *Concepts and principles of tackling social inequities in health: Leveling up Part 1*. World Health Organization, Europe. P. 5.

¹¹ *Ibid.*, p.5.

¹² *Ibid.*, p. 5.

¹³ The Drummond Commission Report. 2012. *Commission on the Reform of Ontario’s Public Services*. <http://www.fin.gov.on.ca/en/reformcommission/announcemet.html>. Chapter 5.

SOCIAL DETERMINANTS OF HEALTH

A “patient focus” approach necessarily takes into account the social determinants of health. The social determinants of health include such important variables as:

a. education; b. employment; c. income; d. early childhood development; e. social networks and support; f. gender; g. geographical environment; h. language; i. culture; j. age; k. access to health services; l. genetics and m. individual risk behaviours.

According to a recent demographic profile, Gagnon-Arpin et al. (2011)¹⁴, 25% of the total Francophone population living in the WW region rated their health as “Fair” or “Poor” in comparison with the residents of WW who are significantly more likely than Ontarians overall to rate their health as “Excellent” or “Very Good”.¹⁵

a. Education

The study of Juha and Raphael on *Social Determinants of Health: the Canadian Facts* (2010) reveals that about 50 percent of the population has some post-secondary education. The more troubling aspect of all, is that children whose parents do not have post-secondary education perform notably worse than children of more educated parents.¹⁶

In the WW region, the overall proportion of adults with a high school diploma or any other type of certification was slightly lower than the provincial average. Forty-seven percent of adults (age 20+) have attained post-secondary certificate or degree, and almost 27 % have not completed high school.¹⁷ The information included the general population and does not distinguish between linguistic groups.

Waterloo Region has 4 French language schools. In 2011, the number of students in the French language schools in the WW region totalled 1,638.

¹⁴ Isabelle Gagnon-Arpin, Golnaz Sedigh and Louise Bouchard. 2011. *Demographic and Health profiles of Ontario's francophone communities*. Report prepared for the *Alliance des réseaux ontariens de santé en français*. (Note: Statistics included in the health profile are from cycles of the Canadian Community Health Survey (CCHS) conducted in 2001 (cycle 1.1), 2002 (cycle 1.2), 2003 (cycle 2.1), 2004 (cycle 2.2), 2005 (cycle 3.1), 2008 and 2009).

¹⁵ Health System Intelligence Project (HSIP). (no date). *Population Health Profile: Waterloo Wellington LHIN*. Authors: Namrata Bains, Kristin Dall, Carley Hay, Michael Pacy, Jennifer Sarkella and Mary Ward. HSIP for the LHINs. P.2.

¹⁶ Mikkonen, Juha and Dennis Raphael. 2010. *Social Determinants of Health: The Canadian Facts*. Toronto: York University School of Health Policy and Management. P.15.

¹⁷ Health System Intelligence Project (HSIP). (no date). *Population Health Profile: Waterloo Wellington LHIN*. Authors: Namrata Bains, Kristin Dall, Carley Hay, Michael Pacy, Jennifer Sarkella and Mary Ward. HSIP for the LHINs. P.1.

Table 1: Francophones who do not have a high school diploma in the WW region, 2011

Geographic region	% of students with no diploma
Waterloo	24.9
Wellington	18.2

The above (Table 1) shows the % of French-speaking students who have not completed their high school diploma.¹⁸

There is notable difference in highest level of education achieved between generations within the French population. This gap is due in part to past government educational policies through the years. Most seniors did not have access to elementary and secondary French language schools in Ontario. Consequently, many French-speaking elderly are illiterate.

As a result of guaranteed access to elementary and secondary French language schools in Ontario, the younger generation has attained a higher level of schooling. The younger French-speaking generation is at par with the same age group in Ontario.¹⁹

b. Employment

In 2006, the average annual growth rate for employment in the WW LHIN area was 2.0%, significantly higher than the growth rate for the province (1.6%).²⁰ The unemployment percentage among men and women was 7.7%.²¹

Thirty four point one percent (34.1%) of French-speaking citizens in Waterloo were unemployed compared to 32.5% in Wellington.²²

c. Income

According to the Trillium Foundation (2008), the average income in the region of WW slightly exceeded that of the province.²³ The average income for men in the WW region was higher than the provincial average. The average income for women in the area was lower than the provincial average.

¹⁸ Isabelle Gagnon-Arpin, Golnaz Sedigh and Louise Bouchard. 2011. *Demographic and Health profiles of Ontario's francophone communities*. Report prepared for the *Alliance des réseaux ontariens de santé en français*. (Note: Statistics included in the health profile are from cycles of the Canadian Community Health Survey (CCHS) conducted in 2001 (cycle 1.1), 2002 (cycle 1.2), 2003 (cycle 2.1), 2004 (cycle 2.2), 2005 (cycle 3.1), 2008 and 2009).

¹⁹ Louise Picard and Gratien Allaire (dir.). 2005. *Second Report on the Health of Francophones in Ontario*. Sudbury and District Health Unit and the Institut Franco-ontarien, Laurentian University: Public Health Research, Education & Development (PHRED) program (Programme de recherche, d'éducation et de développement en santé publique (REDSP)), Sudbury, December.

²⁰ Ibid., p.20.

²¹ Statistics Canada. 2011. *Health Profile*. October.

²² Isabelle Gagnon-Arpin, Golnaz Sedigh and Louise Bouchard. 2011. *Demographic and Health profiles of Ontario's francophone communities*. Report prepared for the *Alliance des réseaux ontariens de santé en français*. (Note: Statistics included in the health profile are from cycles of the Canadian Community Health Survey (CCHS) conducted in 2001 (cycle 1.1), 2002 (cycle 1.2), 2003 (cycle 2.1), 2004 (cycle 2.2), 2005 (cycle 3.1), 2008 and 2009).

²³ The Ontario Trillium Foundation. 2008. *Your Community in Profile: Waterloo, Wellington, Dufferin: Building healthy and vibrant communities*. The Ontario Trillium Foundation is an agency of the Government of Ontario.

Forty-six point two percent (46.2%) of French-speaking workers in the region of Waterloo earned less than \$30,000 per year compared to the same population living in Wellington (45.5%).²⁴

Low income rates were higher among recent immigrants, aboriginal people, visible minorities and female lone parents. At that time, the data did not differentiate between linguistic groups.²⁵

Twenty-three percent of all foreign-born women lived in poverty compared with 20 % of immigrant men and just 16 % for Canadian born-women in the year 2000.²⁶ Thirty-five percent (35%) of females who immigrated before the year 2000 were living in poverty compared with 21% of women who immigrated earlier, between 1981 and 1990.²⁷

Thus, immigrants, especially women, are disproportionately poorer than the Canadian born population. In addition to poverty, this population suffers from marginalization, gender inequities, social processes that reinforce under-employment, discrimination and the loss of pre-existing support systems.²⁸

According to the Canadian Medical Association (CMA) Poll, conducted in August 2012, results found “particularly worrisome” that a widening gap in health status appears to be separating Canadians in different income brackets. The poll found that the recent economic downturn had a significant impact on lower income earners. Nearly 50% of survey respondents reporting household income of \$30,000 or less (46%) reported they were spending less time, energy and money sustaining their health, compared with 19% of those with incomes over \$60,000. “*We as Canadians tend to think we have a fair society and an equitable public health care system when in reality there are vast number of Canadians who are forced to do without when it comes to health care*”.²⁹

The poll did not take into account different languages and cultures. Therefore, there is still no research on the impact of the economic downturn and its effect on the French-speaking population.

²⁴ Isabelle Gagnon-Arpin, Golnaz Sedigh and Louise Bouchard. 2011. *Demographic and Health profiles of Ontario's francophone communities*. Report prepared for the *Alliance des réseaux ontariens de santé en français*. (Note: Statistics included in the health profile are from cycles of the Canadian Community Health Survey (CCHS) conducted in 2001 (cycle 1.1), 2002 (cycle 1.2), 2003 (cycle 2.1), 2004 (cycle 2.2), 2005 (cycle 3.1), 2008 and 2009).

²⁵ The French Language Health Planning Entity for the WWHNHB Area. 2012. *Demographic Profile of Francophone Communities in the Regions of Waterloo Wellington Hamilton Niagara Haldimand Brant (WWHNHB)* – Revised August. P.21

²⁶ Statistics Canada, 2006 documented in *The Healthcare Professional's Guide to Clinical Cultural Competence* by Rani Srivstava. (2006), p.267.

²⁷ Ibid., p.267.

²⁸ Oxman-Martinez, Abdool & Loiselle-Leonard, 2000; Vissandjée, Leduc, Gravel, Boudreau & Carignan, 1998 in *The Healthcare Professional's Guide to Clinical Cultural Competence* by Rani Srivstava. (2006), p. 267.

²⁹ Canadian Medical Association. 2012. *CMA poll finds “worrisome” gap in income-related health status* by Patrick Sullivan, August.

d. Early childhood development (ECD)

The Health System Intelligence Project (HSIP), states “*low birth weight is an important determinant of infant morbidity and mortality. In Waterloo Wellington 5.1% of infants born in 1999-2001 were of low birth weight [...]. The infant mortality rate in Waterloo Wellington of 5.1 per 1000 livebirths was slightly lower than the provincial average; however, the difference was statistically significant.*”³⁰

Fraser Mustard (2010) stated the importance of ECD on healthy adulthood.³¹

“*There is strong evidence that early childhood experiences influence coping skills, resistance to health problems and overall health and well-being for the rest of one’s life*”.³²

The recognition of ECD has generated numerous government initiatives such as: Better Future Better Beginnings, increase daycare spaces and a push for daycare centres in our elementary schools, including French language schools.

e. Social networks and support

Several existing organizations and networks support the vitality of the French-speaking population; for example, Churches and Church Parishes, Seniors’ Clubs, French language schools, Parent Councils, Association of Francophones of Kitchener-Waterloo (AFKW), Club Richelieu, Knights of Columbus, Women’s auxiliary, Federation of French-speaking Seniors of Ontario (*Fédération des aînés francophones de l’Ontario (FAFO)*).

Less is known about the sub-population of Francophone immigrants for WW. Studies (Mackinnon & Howard, 2000) found that the lack of social support has been described as a major impediment to personal healthcare for immigrant women. “*Many immigrant women prefer the support of family and friends to cope with psychological distress, depression, or other emotional illness rather than, or before, going to a doctor. Without a social connection and a feeling of belonging these options for self-care are greatly reduced.*”³³

f. Gender

Life expectancy among males and females in WW is similar to life expectancy for Ontarians. Female life expectancy was 82.0 years of age compared to male life expectancy of 77.8 years of age³⁴ in 2001.

The gender breakdown for French-speaking population for **Waterloo** was 47.3 % men and 52.7 % women. The French-speaking population of **Wellington** was 43.3 % men and 56.6 % women.³⁵

³⁰ Health System Intelligence Project (HSIP). (no date). *Population Health Profile: Waterloo Wellington LHIN*. Authors: Namrata Bains, Kristin Dall, Carley Hay, Michael Pacy, Jennifer Sarkella and Mary Ward. HSIP for the LHINs. P.2.

³¹ Mustard JF. Early brain development and human development. In: Tremblay RE, Barr RG, Peters RDeV, Boivin M, eds. *Encyclopedia on Early Childhood Development* [online]. Montreal, Quebec: Centre of Excellence for Early Childhood Development; 2010:1-5.

Available at: <http://www.child-encyclopedia.com/documents/MustardANGxp.pdf>.

³² Mikkonen, Juha and Dennis Raphael. 2010. *Social Determinants of Health: The Canadian Facts*. Toronto: York University School of Health Policy and Management. P.23.

³³ MacKinnon, M. & L.L. Howard. 2000. *Affirming immigrant women’s health: Building inclusive health policy. Final Report*. May. Halifax, NS: The Maritime Centre for Excellence for Women’s Health. P. 269.

³⁴ Ibid., p.2.

g. Geographical Environment

As stated above, the Waterloo Wellington LHIN covers a large territory (4,800 square kilometres) comprised of four urban centres: Waterloo, Kitchener, Cambridge, and Guelph. The WW LHIN boundaries include Wellington County, the region of Waterloo and the city of Guelph.³⁶ The Waterloo and Wellington region includes an important rural geographic area.

The Canadian Social Data Strategy³⁷, reports a segment of the **senior** population preferred to settle north of Cambridge (33.8 %), in the center of Waterloo (31.5 %), north-east of Kitchener (29.7 %) and north of Wilmot (29.3 %).

h. Language

According to 2011 data from the Ministry of Health and Long-Term Care (MOHLTC) which took into account the new inclusive definition of Francophone (IDF), the French-speaking (FS) population of the Waterloo Wellington region is 15,300. The FS population represents 5.2% of the total French-speaking population for the whole Central and Southwest Ontario region.

The majority of the French-speaking population lives in the region of Waterloo. The number of people having **knowledge of the French language numbered 30,255.**³⁸

Within the Aboriginal nation, many Métis identify French as their mother tongue. Statistical data on the French-speaking Métis population is not currently available.

The University of Ottawa's Research Institute on the Health of Populations determined language is a social determinant of health. The research showed that being from the French-speaking minority population significantly puts one at a social disadvantage affecting health.³⁹

French-speaking immigrants experience difficulty in communicating with professional health care workers or professionals such that it impacts on their own health: frustrations, stress and anxiety are apparent.⁴⁰

³⁵ Isabelle Gagnon-Arpin, Golnaz Sedigh and Louise Bouchard. 2011. *Demographic and Health profiles of Ontario's francophone communities*. Report prepared for the *Alliance des réseaux ontariens de santé en français*. (Note: Statistics included in the health profile are from cycles of the Canadian Community Health Survey (CCHS) conducted in 2001 (cycle 1.1), 2002 (cycle 1.2), 2003 (cycle 2.1), 2004 (cycle 2.2), 2005 (cycle 3.1), 2008 and 2009).

³⁶ The French Language Health Planning Entity for the WWHNHB Area. 2012. *Demographic Profile of Francophone Communities in the Regions of Waterloo Wellington Hamilton Niagara Haldimand Brant (WWHNB)* – Revised August. P.10

³⁷ Canadian Social Strategy. 2006. *Canadian Census Data*. Catalogue No. 97-557-XCB2006012_Ontario Custom. Retrieved from <http://www.cscs-sacass.ca/index.htm>

³⁸ Waterloo Wellington LHIN. 2006 Census. Language – 20 % sample.

³⁹ Isabelle Gagnon-Arpin, Golnaz Sedigh and Louise Bouchard. 2011. *Demographic and Health profiles of Ontario's francophone communities*. Report prepared for the *Alliance des réseaux ontariens de santé en français*. (Note: Statistics included in the health profile are from cycles of the Canadian Community Health Survey (CCHS) conducted in 2001 (cycle 1.1), 2002 (cycle 1.2), 2003 (cycle 2.1), 2004 (cycle 2.2), 2005 (cycle 3.1), 2008 and 2009).

⁴⁰ Hien, Amélie and Jean Lafontant. 2011. *Inéquités de santé en milieu minoritaire : diagnostic de la situation chez les immigrants francophones de Sudbury*. RISF. www.plrs-ottawa2011.com/.../HIEN_anne_C1.pdf

Bowen suggests that “*language barriers contribute to: higher utilization of specialist services; increased risk of hospitalization; less adequate management of chronic diseases such as asthma and diabetes; a greater number of adverse drug reactions; reduced adherence to treatment plans; and failure to protect patient confidentiality or to obtain informed consent.*”⁴¹ Even, when patients do use health services, the fact that they cannot communicate in their mother tongue has significant ramifications.

Betancourt and Green (2010) researched the impact of offering health services on a minority population. Their findings showed minorities:

- Seek medical attention later in the progression of disease – sometimes too late
- Are less compliant with medical advice
- Are at increased risk for medical errors and pharmaceutical errors
- Are more likely to experience prejudice on part of health care professionals
- Report less satisfaction with health care services
- Experience less trust towards their health care professionals and less confidence in the health system due to language barriers
- Are less compliant with prescribed medication (Green & Betancourt, 2010)⁴²

The authors’ widely published and cited articles demonstrate the importance of cultural and linguistic competency.

i. Culture

Among Canada’s urban areas, the region of Waterloo had the fifth largest immigrant population per capita. They represented 22.3 % of the population and were mainly senior.⁴³ In 2006, about 37% of the senior population aged 55 and over were immigrants living in the Waterloo region.⁴⁴

Ten point two percent (10.2%) of French-speaking immigrants lived in Waterloo compared to 7.6% in Wellington.

It is estimated that 6% of the overall French-speaking population of Ontario are immigrants⁴⁵ (Document B).

There is also an Aboriginal population present across the region. They represent less than 1% of the region’s overall population. We know that there is a sub-aboriginal population who identify with the French Métis culture but their numbers are unknown.

⁴¹ Sarah Bowen. 2011. *Language Barriers in Access to Health Care*. Health Canada. November, P.20-21.

⁴² Betancourt, Joseph R. and Alexander Green. 2010. *Commentary: linking cultural competence training to improved health outcomes: perspectives from the field*. Massachusetts General Hospital, Boston: The Disparities Solutions Center, The Morgan Institute for Health Policy, Boston, April.

⁴³ Region of Waterloo. 2007. *Region of Waterloo Strategic Plan: Strategic focus 2007-2010*. Waterloo, On. Author (not identified); Region of Waterloo. 2006. *Document two: Regional growth and our human services*. Waterloo, On. Author (not identified).

⁴⁴ Region of Waterloo Public Health. 2010. *A Series of Public Health Briefs on Low Income Status: Low income status in Waterloo Region in 1996, 2001 and 2006*. Waterloo, On. Author (not identified).

⁴⁵ Statistics Canada. 2006. *Statistical Portrait of the French-Speaking Immigrant Population Outside Quebec (1991 to 2006)*; <http://www.statcan.gc.ca/pub/89-641-x/89-641-x2010001-eng.htm>.

j. Age

In terms of age groups, the WW region accounted for a large number of youth (19.5%) under 14 years of age in comparison with the province (18.2%).

Waterloo recorded the youngest population in the region, with a median age of 37 years.

There was a lower number of seniors (aged 65 and over) (11.9%) compared with the province (13.6%).⁴⁶

The *Demographic and health profiles of Ontario's francophone communities*⁴⁷, revealed that the French-speaking population aged 65 and over in Waterloo represented 13.2% while Wellington was 13.3%.

k. Access to health care services

WW has numerous social and health services. There are 77 health service providers (HSPs) across the area:

- 1 Community Care Access Centre
- 4 Community Health Centres (with 4 satellites)
- 12 Community Mental Health and Addictions Agencies
- 18 Community support Service Agencies
- 8 Hospital Corporations (10 hospital sites)
- 34 Long Term Care Facilities.⁴⁸

The majority of residents in WW (77.5%)⁴⁹ report having access to a primary health care physician. We do not know the extent of access to a French-speaking family physician.

By all accounts, existing services are offered in the English language only. Anecdotal information shows some health care professionals speak French but it is unclear if the French-speaking population is aware of their location.

The HSP capacity to offer services in French is unknown. Information on the requests for French language services is unknown, since organizations do not track such data.

⁴⁶ The French Language Health Planning Entity for the WWHNHB Area. 2012. *Demographic Profile of Francophone Communities in the Regions of Waterloo Wellington Hamilton Niagara Haldimand Brant (WWHNHB)* – Revised August. P.13

⁴⁷ Isabelle Gagnon-Arpin, Golnaz Sedigh and Louise Bouchard. 2011. *Demographic and Health profiles of Ontario's francophone communities*. Report prepared for the *Alliance des réseaux ontariens de santé en français*. (Note: Statistics included in the health profile are from cycles of the Canadian Community Health Survey (CCHS) conducted in 2001 (cycle 1.1), 2002 (cycle 1.2), 2003 (cycle 2.1), 2004 (cycle 2.2), 2005 (cycle 3.1), 2008 and 2009).

⁴⁸ Better Health – Better Futures Strategic Direction for a Quality, Integrated Local Health system for our Residents. August 2012. P. 6.

⁴⁹ Health System Intelligence Project (HSIP). (no date). *Population Health Profile: Waterloo Wellington LHIN*. Authors: Namrata Bains, Kristin Dall, Carley Hay, Michael Pacy, Jennifer Sarkella and Mary Ward. HSIP for the LHINS. P.3.

I. Genetics

There is a slightly lower prevalence of chronic conditions (arthritis/rheumatism, asthma, diabetes, heart disease, high blood pressure)⁵⁰ in WW.

There is a significant higher prevalence of Cystic Fibrosis (CF) among French Canadians. The CF belongs to the haplotype group Ib.⁵¹ Other rare genetic disorders (Andermann syndrome (ACCPN); ARSACS; Leigh Syndrome, French Canadian Type; and Tyrosinemia Type I)^{52,53} affect French Canadians, all of them are found at relatively high rates in Quebec and especially in the Saguenay-Lac-Saint-Jean region. A significant number of Francophones in Ontario originate from the province of Québec.

m. Individual risk behaviours

Individual risk behaviours are associated with increased mortality and morbidity. The HSIP reveals that WW has rates of smoking, heavy drinking, exposure to smoke (ETS), physical inactivity and overweight/obesity that are similar to the province.⁵⁴

A leading report on the Health Status of French-speaking population of Ontario was published in 2000 by the Sudbury & District Health Unit.⁵⁵ Certain risk behaviours were identified in this report. There is a higher incidence of tobacco, explaining the higher level of chronic respiratory diseases. The report showed a higher prevalence of alcohol consumption.⁵⁶

Another important report revealed that 25% of Francophones in WW feel a lot of stress in their life and 50% feel a lot of stress at work.⁵⁷

Another report indicated that physical inactivity and obesity (17.0%) in WW is problematic. It was reported that residents of WW consumed 5 or more fruits and vegetables daily.⁵⁸

Language differences were not noted.

⁵⁰ Health System Intelligence Project (HSIP). (no date). *Population Health Profile: Waterloo Wellington LHIN*. Authors: Namrata Bains, Kristin Dall, Carley Hay, Michael Pacy, Jennifer Sarkella and Mary Ward. HSIP for the LHINs. P.3.

⁵¹ The Hospital for Sick Children Toronto, On. Kerem et al.. 1990.

⁵² *French Canadian Ancestry and Relevant Health Conditions*. 2012. "**Cystic Fibrosis** (a serious lung condition characterized by excess mucus in the lungs – 1 in 900 French-Canadian will have this condition);

ACCPN (a neurodevelopmental disorder characterized by progressive inability to move, feel, and think clearly – accounts for over 99 % of mutations in the French-Canadian population);

ARSACS (a neurodegenerative disorder characterized by muscle spasticity and lack of muscle coordination – mutation found in over 90 % of affected individuals with French-Canadian ancestry); **Leigh Syndrome** (a metabolic and neurodevelopmental disorder that has only been described in individuals with French-Canadian ancestry – mutation found in about 98 % of identified cases);

Tyrosinemia Type I (a severe liver and kidney disorder – which accounts for about 90 % of mutations in the French-Canadian population). <http://spittoon.23andme.com/news/announcements/french-canadian-ancestry-and-releva>.

⁵³ Scriver, Charles R. 2001. "Human Genetics: Lessons from Quebec Populations". *Annual Review of Genomics Human Genetics*. 2:69-101.

⁵⁴ Health System Intelligence Project (HSIP). (no date). *Population Health Profile: Waterloo Wellington LHIN*. Authors: Namrata Bains, Kristin Dall, Carley Hay, Michael Pacy, Jennifer Sarkella and Mary Ward. HSIP for the LHINs. P.3.

⁵⁵ Louise Picard, February 2000. *Report on the Health of Francophones in Ontario*. Sudbury and District Health Unit (translation into English from the full version produced in French),

⁵⁶ Louise Picard, February 2000. *Report on the Health of Francophones in Ontario*. Sudbury and District Health Unit (translation into English from the full version produced in French), p. 11-12.

⁵⁷ Isabelle Gagnon-Arpin, Golnaz Sedigh and Louise Bouchard. 2011. *Demographic and Health profiles of Ontario's francophone communities*. Report prepared for the *Alliance des réseaux ontariens de santé en français*. (Note: Statistics included in the health profile are from cycles of the Canadian Community Health Survey (CCHS) conducted in 2001 (cycle 1.1), 2002 (cycle 1.2), 2003 (cycle 2.1), 2004 (cycle 2.2), 2005 (cycle 3.1), 2008 and 2009).

⁵⁸ Health System Intelligence Project (HSIP). (no date). *Population Health Profile: Waterloo Wellington LHIN*. Authors: Namrata Bains, Kristin Dall, Carley Hay, Michael Pacy, Jennifer Sarkella and Mary Ward. HSIP for the LHINs. P.3.

PORTRAIT

The Ontario Public Health Standards acknowledge that language and culture are essential determinants of health, on par with income, education and other determinants.

At first glance, the health status of the minority French-speaking and the majority English-speaking populations “appear similar”; however, the aforementioned data and information does not illustrate the complete picture.

THE REAL PORTRAIT:

EIGHT-YEAR-OLD BOY UNNECESSARILY SEDATED

Tom is an eight-year-old Francophone living in Eastern Ontario. He has serious otitis media and periodically needs day surgery to have tubes put in his ears.

Tom was only 4 years old when he underwent this surgery in 2005. At the time, his mother made sure that the entire medical team knew that her son spoke French and might speak to them in French, even though he understood a bit of English. She also translated everything that the doctor said about the surgery into French for her son. She reassured him and told him what was going to happen.

When the surgery was over, Tom opened his eyes in the recovery room and, quite naturally, asked in French for his mother, who was in the waiting room. The nurse did not understand French and saw that he was becoming agitated, but was unable to understand what he was saying. Although Tom was perfectly fine, the nurse administered a sedative and Tom went back to sleep.

Time passed and Tom’s mother became worried. When she asked the nurse what was happening, she was told that her son had been babbling incoherently and that they had concluded that he was showing signs of post-operative confusion.

Tom’s mother was angry. Her son was not incoherent when he woke up; he was speaking French. In spite of her insistence before the surgery, no one recognized that Tom was speaking French and was simply asking for his mother. Surgery that took less than an hour turned into a day-long ordeal for this four-year-old.

Now, some years later, Tom’s parents reiterate that Francophone patients must remain vigilant where their health needs and health care are concerned. This experience undermined their confidence in the health care system and strengthened their resolve to ask for French services in the future. (*Special Report on French Language Health Services Planning in Ontario, 2009. Office of the French Language Services Commissioner, pp.7-8. www.flsc.gov.on.ca*).

GROSS NEGLIGENCE

In 1993, a mother faced the unthinkable: her 6-year-old son, Luc, would not be receiving treatment because the region did not have a psychologist who spoke French.

As a toddler, Luc had been in an accident causing severe trauma. The doctors recommended that he receive psychological treatment. But with no French-speaking specialist for their son and four children at home, his parents made the difficult decision to abandon their search for treatment. They decided that they would temporarily offer their son the support he needed at home. For them, this was the short-term solution until Luc learned English and could be taken to see an English-speaking psychologist. They resigned themselves to their predicament. In the end, however, it caught up with them. Luc is now 21 and finally getting the therapy he didn't get in French at age 6. (Special Report on French Language Health Services Planning in Ontario, 2009. Office of the French Language Services Commissioner, p.9. www.flsc.gov.on.ca).

MISUNDERSTANDING OF MEDICATION

An 80-year-old woman went to a walk-in clinic because she wasn't feeling well. She was given a prescription. She started taking the medication, even though she didn't understand it or the dosage, which was written in English. After one week, she did not feel well at all and came to our community health centre. Our staff explained the effects of her medication and the importance of taking it as prescribed. Our medical staff adjusted the dosage because there was a risk that it would make her situation worse. The medication could have harmed her instead of helped her. (Marc Bisson, Executive Director, Centre de santé communautaire de l'Estrie, Special Report on French Language Health Services Planning in Ontario, 2009. Office of the French Language Services Commissioner, p. 8. www.flsc.gov.on.ca).

DOUBLE JEOPARDY: LANGUAGE AND MENTAL HEALTH CHALLENGES

Phil Joachim was diagnosed with schizophrenia when he was 15 years old. As a Francophone in Ontario he was faced with significant challenges. Phil had always attended French school and after being admitted to a children's hospital he began attending a special school for children under hospital supervision, which was only available in English. "Attending this school was very difficult for me because I didn't speak English very well," he said. "I was also only able to receive treatment from a psychiatrist in English because there were no French-speaking specialists in my area."

He explained that he was forced to translate for his mother, who spoke French only, in their family sessions together. Admittedly, Phil said, he sometimes left details out of the discussion, facts he, like other young people going through a difficult time, might not want his mother to know. Lack of translation was particularly difficult for Phil's mother. At the meeting where hospital staff determined where Phil would be treated and resides, she was unable to understand the details about this important decision.

Thirteen years later, there have been no significant changes in the availability of services for the approximately 300 Francophone children and adolescents with serious mental health problems who require access to mental health services in French. (Toronto District Health Council. 2003. *Francophone Forum on Access to Mental Health and Addiction Services (Prevention, Promotion and Delivery)*. P.4. www.francohealthtoronto.ca)

NEAR MISS

A French-speaking patient was prescribed a “nitro pump” by his English-speaking cardiologist. When the patient returned to the follow-up visit the nurse practitioner realized that because of limited understanding of English, he had not grasped how to use the pump correctly. He thought he had been given a ventilator.

Thankfully, his quick return to the clinic prevented a very serious consequence. (Jocelyne Maxwell, Executive Director, Centre de santé communautaire du Témiskaming, *Special report on French Language Health Services Planning in Ontario, 2009*. Office of the French Language Services Commissioner, p.6. www.flsc.gov.on.ca)

MISUNDERSTANDING OF SIGNS AND SYMPTOMS

Ronald Bisson learns that his brother has been diagnosed with pancreas cancer. They have already lost a sister to the same disease. Ronald visits his brother in hospital and speaks to him in French. The patient’s wife and teenage daughters say that their husband and father has been very agitated and restless in the later stage of the disease. They are happy to see Ronald’s calming effect on their loved one. Prior to Ronald’s visit, the family had called the doctors to intervene as a result of delirium-like behaviour.

The dying patient can no longer communicate in English to his family. Ronald is aghast, he says “*he would never had believed it if he had not seen it with his own eyes*”. His brother who had been perfectly bilingual during his adult life could no longer converse with his wife and daughters in English. The family said that a French-speaking nephew has the same calming effect on the patient.

After his passing, involved RN staff decided to learn French not because they were obliged to, rather they wanted to make sure that in a similar future situation they would be able to provide better quality services. (CNFS, video 2010-2011, View testimonial of Ronald Bisson available on www.entitesante2.ca or CNFS national website).

PREJUDICE AND OPPRESSION

A middle-aged woman drove to the nearest hospital facility in her Northern Ontario community to seek medical attention. At the admission desk she requested services in French. She lived in a designated area and the hospital was a designated health service provider.

The English attendant indignantly replied “*do you want to see a doctor? Or do you want services in French*” (in a sarcastic tone).

The patient felt disrespected, publicly humiliated, uncomfortable, oppressed, felt inferior and that she had crossed a line. (Hospital in the Nipissing Area, Testimonial shared during a French Community Gathering “Dîner de la Francophonie” at the Centre de santé communautaire of Sudbury, 2007).

RIGHT TO DIE IN FRENCH

Hélène Tremblay Lavoie, an 82-year-old woman lived in Toronto for 40 years. She lost her autonomy and required long-term care. Her daughter Sylvie inquired about services. She was looking for the most comfortable environment for her mother who was diagnosed with Alzheimer and dementia. Mrs. Tremblay Lavoie was no longer proficient in English. Doctors recommended that she be placed in a hospital setting. The daughter was in for a shock as there is only one establishment where Francophones can access long-term care services in French in Toronto. Bendale Acres, situated in Scarborough, has a floor of 37 beds where services are offered in both languages. At that time, they were at full capacity. Only 15% of the 37 beds were occupied by Francophone patients. Bendale Acres had no room for Mrs. Tremblay Lavoie. The only place they could find was in Welland - 1 hour and 45 minutes from Toronto. Her daughter visited her mother as often as possible. The drive to and from Welland proves to be difficult and resulted in fewer visits. Her choices at the time were Ottawa, Welland or Penetanguishene or to accept being placed in an Anglophone establishment.

Mrs. Tremblay Lavoie wished to die with dignity surrounded by French-speaking caregivers.



(Hélène Tremblay Lavoie with her daughter.
Published February 21st, La Presse, Hugo de Grandpré)

FOUR WEEK LONG WAIT FOR DISCHARGE

In 2004, a senior was admitted to the Sudbury General Hospital. Thirty percent of the Sudbury population is French-speaking. Her healthcare providers determined she needed to be transferred to a long-term care facility for continuous care. She ended up waiting 4 weeks to be seen by a French-speaking professional. (*Services de santé pour la communauté franco-ontarienne: feuille de route pour une meilleure accessibilité et une plus grande responsabilité. Groupe de travail sur les services de santé en français, Octobre 2005, p.3*).

NEW IMMIGRANT AND CULTURAL BARRIERS

Annie K. Zawadi talked about her experience as a victim of domestic abuse and the need for a greater understanding of the diverse multi-cultural Francophone community. By its nature and depending on its length, violence can affect the mental health of its victims. The condition of abused women tests one's nerves and it can go on for many years. In the end, an abused woman can develop signs of depression or desperation. "I needed help but I did not want to be labelled as a crazy person," Annie said. In Annie's case, her husband was both her abuser and her sponsor when she immigrated to Canada, so she felt literally trapped in her abusive situation. Her situation became increasingly difficult because of cultural barriers; she did not want to receive mental health help out of fear of being institutionalized and therefore losing her children and her rights. She chose a path of spirituality and was able to overcome her mental health problems and come out of her abusive situation. Today she lives in a peaceful manner and hopes that with time we can humanize and show the positive side of good mental health. (Toronto District Health Council. 2003. *Francophone Forum on Access to Mental Health and Addiction Services (Prevention, Promotion and Delivery)*. P.4. www.francohealthtoronto.ca)

SEVEN YEARS OF ISOLATION DUE TO MEDIOCRE HEALTH SERVICES

In 2002, a patient from the psychiatric hospital of North Bay was transferred to the counseling services of Hearst-Kapuskasing-Smooth Rock Falls. He was being transported back home to live in his community. According to protocol, the North Bay team gave a report to their colleagues concerning their patient before transfer of care. They indicated that the patient was very withdrawn and hardly spoke. The chief counselor of Kapuskasing started to speak to the patient in French. The North Bay professional team was stunned to hear the patient speak and engage in a real conversation. Since then, the patient has adapted to his life in the community of Kapuskasing, predominantly French-speaking. He spent seven years of his life in a psychiatric hospital in North Bay. During these seven years, he had been treated by doctors and professional health care workers who had spoken to him exclusively in English. Some witnesses said that this situation is not far removed from comparing it to seven years of isolated incarceration. (*Services de santé pour la communauté franco-ontarienne: feuille de route pour une meilleure accessibilité et une plus grande responsabilisation*. Groupe de travail sur les services de santé en français, Octobre 2005, p.3).

HISTORY REPEATS ITSELF

In the 1960s' Edmond and Lumena (Lepage) Miron were transferred from Verner to a senior care facility in Blind River more than 2 hours away. The distance essentially cut them off from family.

Lumena fell and died from complications due to her injuries. Edmond followed six days later. Despite having many loving children and grand-children, none of them could be present to comfort them in their time of need. (Family Archives, Miron Family Reunion, 2000).



(Edmond and Lumena Miron, 50th wedding anniversary in 1949.
Published on <http://lucmiron.com/Page34.html>)

*“ La maladie soudaine de Lumena oblige le couple à quitter son logis du village...ils demeurent temporairement chez certains de leurs enfants d’abord, chez Orietta (épouse Laurier Rainville) et finalement chez Léa et Octave Beaudry. Mais à cause des responsabilités familiales de chacun et de l’état de santé précaire des grands-parents, à regret, il faut les placer dans un foyer à Blind River, **ce qui a pour effet de précipiter la fin de leurs jours**. Lumina décède le 21 février 1956 à l’âge de 78 ans. Comme il ne pouvait vivre sans sa tendre moitié, six jours plus tard, soit le 27 février 1956, Edmond décède à son tour à 82 ans. » (Livre de la famille Miron, à l’occasion de la réunion familiale de 2000 à Verner, Ontario)*

The lived experiences above demonstrate the reason why the French-speaking population is weary of consultation.

CONCLUSION

Success hinges on the willingness of those in power to consolidate resources in order to improve the health of all citizens across the province. An effective health care system is a critical factor in the quality of life for all families.

French-speaking and English-speaking populations alike need access to health services in their language. The French-speaking population needs quality services for their vitality and well-being. Research and evidence-based studies are unequivocal: language and culture are essential determinants of health for the minority population and *may be the most important determinant of health for this population*.

Researchers, French-speaking leaders, French-speaking health care professionals, Francophone Community Health Centre administrators, Government policy analysts, Francophone social workers councillors and advocates, French-speaking teachers and lawyers, the Association des médecins de langue française du Canada (Médecins francophones du Canada), Secrétariat international des infirmières et infirmiers francophones (SIDIIEF), etc. all recognize that there is a pressing need for linguistically and culturally sensitive health care services tailored to the French-speaking population in all its diversity.

The French-speaking population has been waiting a long time and each day that it doesn't happen, there is suffering. The French-speaking community has a right to expect broad social support. They refuse a minimalist approach. They count on a proactive humanistic approach.

The negative effects of the language barrier have been sufficiently documented. It now becomes crucially important to focus on practical solutions and integration of French language services in Ontario and the WW LHIN area. It's the ethical thing to do. It's the law. It's the right thing to do.

BIBLIOGRAPHY

Action ontarienne contre la violence faite aux femmes. 2008. *Facilitation Guide: Across the Chasm: A better understanding of French Language Services in Ontario*. Ontario.

Bélanger, Mathieu, Louise Bouchard, Isabelle Gaboury, Brigitte Sonier, Isabelle Gagnon-Arpin, Aurel Schofield and Paul-Émilie Bourque. 2011. "Perceived Health Status of Francophone and Anglophones in an Official Bilingual Canadian Province. In *Canadian Journal of Public Health*, vol. 102 (2): 122-26.

Betancourt, Joseph R. and Alexander Green. 2010. *Commentary: linking cultural competence training to improved health outcomes: perspectives from the field*. Massachusetts General Hospital, Boston: The Disparities Solutions Center, The Morgan Institute for Health Policy, Boston, April.

Better Health – Better Futures Strategic Direction for a Quality, Integrated Local Health system for our Residents. August 2012.

Boelen, Charles. 1992. Medical Education Reform: The Need for Global Action, Volume 67, Number 11, November.

Bouchard, Louise. 2009. *Les déterminants de la santé en situation linguistique minoritaire*. Présentation au Colloque sur la santé des CLOSM du Canada, 5-6 novembre (Presentation is only available in French).

Bowen, Sarah. 2011. *Language Barriers in Access to Health Care*. Health Canada. November.

Canadian Social Strategy. 2006. *Canadian Census Data*. Catalogue No. 97-557-XCB2006012_Ontario Custom. Retrieved from <http://www.csd-sacass.ca/index.htm>.

The Drummond Commission Report. 2012. *Commission on the Reform of Ontario's Public Services*. <http://www.fin.gov.on.ca/en/reformcommission/announcemet.html>. Chap.5.

The French Language Health Planning Entity for the WWHNHB Area. 2012. *Demographic Profile of Francophone Communities in the Regions of Waterloo Wellington Hamilton Niagara Haldimand Brant (WWHNHB)* – Revised August.

Gagnon-Arpin, Isabelle, Golnaz Sedigh and Louise Bouchard. 2011. *Demographic and Health profiles of Ontario's francophone communities*. Report prepared for the *Alliance des réseaux ontariens de santé en français*. (Note: Statistics included in the health profile are from cycles of the Canadian Community Health Survey (CCHS) conducted in 2001 (cycle 1.1), 2002 (cycle 1.2), 2003 (cycle 2.1), 2004 (cycle 2.2), 2005 (cycle 3.1), 2008 and 2009).

Health System Intelligence Project (HSIP). (no date). *Population Health Profile: Waterloo Wellington LHIN*. Authors: Namrata Bains, Kristin Dall, Carley Hay, Michael Pacy, Jennifer Sarkella and Mary Ward. HSIP for the LHINs.

Leatt, Peggy, George H. Pink and Michael Guerriere. 2000. "Towards a Canadian Model of Integrated Healthcare" in *Healthcare Papers*, 1(2):13-25.

MacKinnon, M. & L.L. Howard. 2000. *Affirming immigrant women's health: Building inclusive health policy. Final Report*. May. Halifax, NS: The Maritime Centre for Excellence for Women's Health

Mikkonen, Juha and Dennis Raphael. 2010. *Social Determinants of Health: The Canadian Facts*. Toronto: York University School of Health Policy and Management.

Nexus Santé. 2009. Collaborer avec les francophones en Ontario: de la compréhension du contexte à l'application des pratiques prometteuses: Guide.
www.nexussante.ca/.../francophones_guide_Frenc...

The Ontario Trillium Foundation. 2008. *Your Community in Profile: Waterloo, Wellington, Dufferin: Building healthy and vibrant communities*. The Ontario Trillium Foundation is an agency of the Government of Ontario.

Oxman-Martinez, J., S.N. Abdool, & M. Loiselle-Leonard. 2000. "Immigration, women and health in Canada". *Canadian Journal of Public Health*, 91 (5), 394-395.

Picard, Louise. 2000. *Report on the Health of Francophones in Ontario*. Sudbury and District Health Unit (translation into English from the full version produced in French), February.

Picard, Louise and Gratien Allaire (dir.). 2005. *Second Report on the Health of Francophones in Ontario*. Sudbury and District Health Unit and the Institut franco-ontarien, Laurentian University: Public Health Research, Education & Development (PHRED) program (Programme de recherche, d'éducation et de développement en santé publique (REDSP)), Sudbury, December.

Region of Waterloo. 2007. *Region of Waterloo Strategic Plan: Strategic focus 2007-2010*. Waterloo, On. Author (not identified);

Region of Waterloo. 2006. *Document two: Regional growth and our human services*. Waterloo, On. Author (not identified).

Region of Waterloo Public Health. 2010. *A Series of Public Health Briefs on Low Income Status: Low income status in Waterloo Region in 1996, 2001 and 2006*. Waterloo, On. Author (not identified).

Réseau franco-santé du Sud de l'Ontario [Franco Health Network of Southern Ontario]. 2006. *Setting the Stage – Primary Health Care in French in Ontario*. Regional Report.

Réseau franco-santé du Sud de l'Ontario [Franco Health Network of Southern Ontario]. 2006. *Setting the Stage – Primary Health Care in French in Ontario*. Provincial Report.

Scriver, Charles R. 2001. "Human Genetics: Lessons from Quebec Populations". *Annual Review of Genomics Human Genetics*. 2:69-101.

Srivstava, Rani. 2006. *Healthcare Professional's Guide to Clinical Cultural Competence*. Mosby Canada.

Shortell, Stephen M., Robin R. Gillies, D.A. Anderson, Erickson K. Morgan and J.B. Mitchell. 1996. *Remaking Health Care in America. Building Organized Delivery Systems*. San Francisco: Jossey-Bass Publishers.

Statistics Canada. 2006. *Statistical Portrait of the French-Speaking Immigrant Population Outside Quebec (1991 to 2006)*; <http://www.statcan.gc.ca/pub/89-641-x/89-641-x2010001-eng.htm>.

Vissandjée, B., N. Leduc, S. Gravel, M. Boudreau & P. Carignan. 1998. « Promotion de la santé en faveur des femmes immigrantes au Québec ». *Revue Épidémiologique et Santé Public*, 43 : 124-133.

Whitehead, Margaret and Göran Dahlgren. 2006. *Concepts and principles of tackling social inequities in health: Levelling up Part 1*. World Health Organization. Europe.

World Health Organization (WHO). 1946. *Constitution of the World Health Organization*. London, World Health Organization.
http://whqlibdoc.who.int/hist/official_records/constitution.pdf

World Health Organization (WHO). 2008. "Making health system work: Integrated health services – what and why?" *Technical Brief*, No.1.

SUPPORTING DOCUMENTS

DOCUMENT 1

WW LHIN SYSTEM STRATEGIC PRIORITIES 2012/2013

MISSION

To lead a high-quality, integrated health system for our residents.

VISION

Better Health – Better Futures

CORE VALUE

Acting in the best interest of our residents' health and well-being.

SYSTEM STRATEGIC PRIORITIES 2012/2013



Retrieved from: <http://www.waterloowellingtonlhin.on.ca/page.aspx?id=10706>.

DOCUMENT 2

FRENCH LANGUAGE SERVICES ACT

In Ontario, the *French Language Services Act* was adopted in 1986 and came into effect in 1989. Using a process of designation based on the French-speaking population in a given area, this Act guarantees Francophones the right to receive services in French. There are currently 25 designated areas in Ontario where Francophone residents are entitled to receive services in French, including provincially funded health services. Nevertheless, the Act has limited effect. For example, municipal agencies (including municipal long term care facilities) are exempt, as are family physicians in private practice as well as public health units. Only agencies designated under the Act are obligated to offer services in French. Furthermore, the Act makes no provision for recourse in the event of failure by a designated agency to fulfil its obligation to offer services in French.⁵⁹

More recently, the *Montfort* decision has had a major impact on the right of Ontario Francophones to receive health care in their own language. Rendered by the Ontario Court of Appeal on December 7, 2001, the *Montfort* decision gave considerable weight to the spirit and letter of the *French Language Services Act*, finding that the Act had “quasi-constitutional” status. The effect of this Appeal Court judgment has been to give the *French Language Services Act* precedence over any other legislation adopted by the Legislative Assembly.

In practice, the Ontario government and any agency or group mandated to advise the government or implement its policies must take into account the legal and constitutional rights of Francophones, and must respect these rights in designing and implementing all policies and programs.⁶⁰

French language services act, R.s.o 1990, Chapter F.32

<http://www.search.e-laws.gov.on.ca/en/isysquery/0d391e94-4c21-4a1c-85de-b2ee7c96a27c/2/doc/?search=browseStatutes&context=#hit1>

⁵⁹ Réseau franco-santé du Sud de l’Ontario [Franco Health Network of Southern Ontario]. 2006. *Setting the Stage – Primary Health Care in French in Ontario*. Provincial Report. Pp.20-21.

⁶⁰ Ibid., Pp.20-21.

DOCUMENT 3

NEW INCLUSIVE DEFINITION OF FRANCOPHONE (IDF) IN ONTARIO

In June 2009, the provincial government unveiled a new *Inclusive Definition of Francophone* (IDF) which reflects the evolution and diversity of the French-speaking (FS) population in Ontario. It is a broader definition which takes into account the large number of newcomers and the new realities of this minority population in Ontario.

The IDF is not yet being considered at the federal level by Statistics Canada. Approximately 50,000 FS Ontarians were added to the provincial total as a result of the new definition. More detailed information on this definition and its impact on the LHIN areas can be found in the demographic profile prepared by the Entité².

DEFINITION:

The variable is calculated based on three questions in the census concerning mother tongue, the language spoken at home and knowledge of the official languages.

The IDF estimates the number of persons whose mother tongue is French, plus those people whose mother tongue is neither French nor English (allophones) but who speak French.⁶¹

⁶¹ Ontario. Office of Francophone Affairs. The New Inclusive Definition of Francophone (IDF) Questions and Answers <http://www.ofa.gov.on.ca/en/news-090604-faq.html>. Consulted Sept. 2012.

DOCUMENT 4

AGREEMENT BETWEEN THE WWHNHB LHINS AND ENTITE DE PLANIFICATION POUR LES SERVICES DE SANTE EN FRANÇAIS POUR LES REGIONS DE WATERLOO, WELLINGTON, HAMILTON, NIAGARA

MARCH 2011

ARTICLE 2 – PURPOSE AND TERM OF AGREEMENT

- 2.1 This Agreement is the agreement required by s. 3(2) of the Regulation. It sets out the roles and responsibilities of each Party relating to the provision of advice by the Entity on:
- (a) Methods of engaging the Francophone Community in each of the Areas;
 - (b) The health needs and priorities of the Francophone Community in each of the Areas, including the needs and priorities of diverse groups within that Community;
 - (c) The Health services available to the Francophone Community in the Areas;
 - (d) The identification and designation of health service providers for the provision of French Language health services in the Areas;
 - (e) Strategies to improve access to, accessibility of and integration of French language health services in the local health system; and
 - (f) The planning for and integration of health services in the Areas.

DOCUMENT 5

OFFICIAL LANGUAGES ACT AND SUPREME COURT OF CANADA RULINGS

The language rights of French-speaking Ontarians were originally entrenched in the 1867 *Constitution Act* establishing Canada as a country. The governments of Canada and Ontario also have constitutional obligations to the French linguistic community under the *Canadian Charter of Rights and Freedoms* and the constitutional principle of respect for and protection of minorities.

The federal *Official Languages Act* (OLA), enacted in 1969, further protects minority rights. First, it confers equal status on the two official languages, for example, regarding their use in Parliament and the institutions of Parliament. It also commits the Government of Canada to fostering the full recognition and use of English and French in Canadian society and enhancing the vitality of the English and French minority communities and assisting in their development.

The courts have helped clarify legislation respecting Francophone rights. Certain decisions have shed light on the obligation to implement health services for Francophone minority communities. In 1999, the Supreme Court of Canada's ruling in *Beaulac* established new rules of interpretation for language rights. Since *Beaulac*, the courts are tending to apply a broader and more liberal interpretation of language rights, in the interests of the preservation and enhancement of official language minority communities.⁶²

Official language act, R.S.C.,1985, c.31 (4th Supp.)

<http://laws-lois.justice.gc.ca/eng/acts/O-3.01/>

⁶² Réseau franco-santé du Sud de l'Ontario [Franco Health Network of Southern Ontario]. 2006. *Setting the Stage – Primary Health Care in French in Ontario*. Provincial Report. Pp.20-21.

DOCUMENT 6

THE EXCELLENT CARE FOR ALL ACT, 2010

The *Excellent Care for All Act* puts patients first by improving the quality and value of the patient experience through the application of evidence-based health care. It will improve health care while ensuring that the system we rely on today is there for future generations. The hospital sector will implement these legislative changes first, and results from hospitals will be assessed before extending the requirements to other health sectors.

The legislation includes requirements for:

- Quality committees, which will report to health care organizations on quality-related issues
- Annual quality improvement plans, which each health care organization will be required to develop and make public
- Executive compensation which will be required to be linked to achieving improvement targets set out in the annual quality improvement plan
- Patient/client/caregiver surveys to assess satisfaction with services
- Staff surveys to assess satisfaction with employment experience and views about the quality of care provided by the health care organization
- Declarations of values that will be developed after public consultation by health care organizations that is currently without one.
- Patient relations process to address patient experience issues and reflect its declaration of values

The legislation also expands the mandate of the Ontario Health Quality Council to recommend evidence-based delivery of health care based on clinical practice guidelines. The council will also make recommendations on possible changes to the way health care is covered and paid for to ensure that it is consistent with the evidence.

DOCUMENT 7

ACRONYMS

COI – COMMUNITY OF INTEREST

COP – COMMUNITY OF PRACTICE

ECD – EARLY CHILDHOOD DEVELOPMENT

ETS – EXPOSURE TO SMOKE

FLS – FRENCH LANGUAGE SERVICES

FLSA – FRENCH LANGUAGE SERVICES ACT

FS – FRENCH-SPEAKING

FLHPE – FRENCH LANGUAGE HEALTH PLANNING ENTITY

HSP – HEALTH SERVICE PROVIDERS

IDF – INCLUSIVE DEFINITION OF FRANCOPHONE

IHSP – INTEGRATED HEALTH SERVICES PLAN

JAAP – JOINT ANNUAL ACTION PLAN

JLC – JOINT LIAISON COMMITTEE

LHIN – LOCAL HEALTH INTEGRATION NETWORK

LHSIA – LOCAL HEALTH SYSTEM INTEGRATION ACT

WW – WATERLOO WELLINGTON

WWHNB – WATERLOO WELLINGTON HAMILTON NIAGARA HALDIMAND BRANT

DOCUMENT 8

MYTHS

1. Why offer services to Francophones when they are a small % of the population? French language is protected by provincial and federal laws. Human rights, ethics, inclusion, equity and access to quality services should never be a matter of number.

2. All Francophones speak English, why do they refuse to speak English to get their services? Not all Francophones speak English fluently. It is simply false to say or believe that all Francophones in Ontario are bilingual.

3. Why should we treat French differently from other minority languages in Ontario? The French has equal status under the Constitution of Canada and distinct status in the province of Ontario.⁶³ Only French and English are official languages in Canada. Only French is recognized as evident in the existence of publicly funded schools in Ontario. The *French Language Services Act* ensures access to numerous government services in Ontario.

4. According to the Ontario Human Rights Code, language is an enumerated ground for discrimination

In the *Ontario Human Rights Code*, language is not specifically named as a basis for discrimination. On the other hand, ethnic origin, ancestry and place of origin are all listed as grounds. Hence, if a government employee responds in a rude or unacceptable way to a Francophone asking for services in French, this behaviour could qualify as discrimination based on ancestry or ethnic origin.

5. Interpreter services meet the government's obligation to provide services in French Interpreter services are one way to offer health services in French; however it is not the ideal method.

6. Longer wait times to access health services in French is a sufficient reason for an official complaint under the FLS Act

True.

7. We are not obliged to offer services in French in a non-designated region

The LHINs are responsible for the health of the total population in their area, including the French-speaking population. Despite negligible progress in non-designated areas, the French-speaking community is vigilant. They are ensuring that they do not lose what they have already gained.⁶⁴

⁶³ Nexus Santé. 2009. *Collaborer avec les francophones en Ontario: de la compréhension du contexte à l'application des pratiques prometteuses: Guide*. Pp.52-53. www.nexussante.ca/.../francophones_guide_Frenc...

⁶⁴ Office of the French Language Services Commissioner. 2009. *Special Report on French Language Health Services Planning in Ontario*. www.flsc.gov.on.ca

8. French and English languages are not equal in the province of Ontario

*“Equality between French and English in Ontario is one of the objectives of the French Language Services Act”.*⁶⁵

9. People do not request services in French

Very few, if any, health service providers ask the patient about his or her preferred language of service. Very few, if any, French-speaking patients ask for services in French knowing 1) they may wait longer, 2) they may be ostracized for asking, 3) don't believe such quality services exist, and feeling: 4) uncomfortable asking, and being 5) accustomed to inferior quality of care.

“Although it is important, active offer does not guarantee fair and equitable treatment. Nor does it necessarily have an impact on the demand for services. Even when French language services are offered at the window or the counter, we wonder whether we are really going to be taken first or whether we are going to be stuck on some waiting list until a French-speaking doctor becomes available. And there is a lingering fear that we will not receive equal service. Often, Francophones continue to ask for service in English in the belief that they will be served more quickly. This is a systemic problem. Patients must feel confident that they will receive services that are equivalent to those offered in English, in terms of quality and speed. In other words, by itself, active offer isn't enough.” –Marc Bédard, Executive Director Réseau francophone de santé du Nord de l'Ontario.⁶⁶

10. There is a lack of French-speaking health care professionals in Southwest Ontario

Numerous federal and provincial strategies and resources exist in the province to assist with recruitment and training of French-speaking health professionals (e.g. CNFS, SSF, RIFSSSO, Professional Colleges and Associations, the six Entities in Ontario, etc.).

⁶⁵ *French Language Services Act; Facilitation Guide: Across the Chasm: A better understanding of French Language Services in Ontario*. 2008. Produced by the Project Steering Committee. P.5.

⁶⁶ Office of the French Language Services Commissioner. 2009. *Special Report on French Language Health Services Planning in Ontario, 2009*. Queen's Printer for Ontario. P.11.

DOCUMENT 9

EVIDENCE-BASED INFORMATION ON BARRIERS

a. Access to Health Care Services

According to the report “*Health Care Services for Franco-Ontarians: A roadmap to better accessibility and accountability*” (2005) produced by the French Language Health Services Working Group,⁶⁷ health care services in French are in short supply or non-existent in Ontario. No recent research indicates any change in this reality.

Table 2: French-speaking population with very little or no access to health care services in French, 2005

Services	% of FS population with very little or no access to health care services in French
Hospital	74%
Emergency access center	47%
Seniors homes	59%
Alcohol treatment centers	77%
Drug Addiction centers	66%
Mental health services (excluding psychiatric hospitals)	53%

b. Access to Existing Services in Primary Care

In some areas of the province, the FS population has access to a Community Health Centre (CHC) where primary care services are available in French. In the WW LHIN area, there is no designated CHC intended for this target population. Very little is known about the number of primary care services currently available in French.

⁶⁷ The French Language Health Services Working Group (Conseil provincial Franco-Santé). 2005. *Health Care Services for Franco-Ontarians: A roadmap to better accessibility and accountability*. October, p. 23.

A widely consulted provincial report: *Setting the Stage* (2006) recommended “...the creation of **access points**, virtual or real, building on existing resources and partnerships, and equipped with a good base of information on all available French language services and resources regardless of where they are located. These access points must be fully integrated into the health system and other systems (education, social services, and early childhood education), and must be responsive to local needs, and able to deliver primary care to their clients and help them navigate through a highly complex health system. They must also be multidisciplinary and adopt a holistic approach to health”.⁶⁸

c. Lack of awareness on the behalf of the majority

d. Lack of utilization data on the number French-speaking citizens accessing services:

A possible solution is to establish protocols with health service providers (HSPs) to gather data.

e. Lack of cultural interpretation and medical accompaniment services - Necessity to rely on family members, or untrained interpreters for communication:

Lack of support for newcomers...“the lack of interpreters or bilingual providers is the greatest barrier to access reported by newcomers.”⁶⁹

f. Lack of French-speaking human resources:

FS health professionals are a key ingredient to improved access to services in French. All parts of Southern Ontario reported shortages of health care providers. Few incentives are offered to attract FS professionals. There is a need for a reliable and current inventory of existing French-speaking providers accessible to the general population aligned with the WW LHIN area. It is unknown at this time how many health care workers are bilingual in the various institutions and agencies. Recruitment and retention of French-speaking health professionals can be a challenge. There is an opportunity to link with the *Consortium national de formation en santé (CNFS)* (National Consortium for Health Training) which has access to thousands of new bilingual graduates. In Southern Ontario, very few professional development programs are available in French for the FS health professionals. In addition, young people who leave the region to pursue higher education in French never return because there are better opportunities elsewhere in agencies where they can practice their health profession in French and be appreciated for it. “Obviously, much work remains to be done to develop provincial and local recruitment strategies and offer improved working conditions and better remuneration to French-speaking health professionals”.⁷⁰

g. Working in silos

⁶⁸ Réseau franco-santé du Sud de l’Ontario [Franco Health Network of Southern Ontario]. 2006. *Setting the Stage – Primary Health Care in French in Ontario*. Provincial Report, p. 27.

⁶⁹ Charles Boelen. Medical Education Reform: The Need for Global Action, Volume 67, Number 11, November 1992, p. 745.

⁷⁰ Réseau franco-santé du Sud de l’Ontario [Franco Health Network of Southern Ontario]. 2006. *Setting the Stage – Primary Health Care in French in Ontario*. Provincial Report, p. 28.

DOCUMENT 10

EDUCATION STATISTICS

Waterloo Region is comprised of the three municipalities of Kitchener, Waterloo and Cambridge, plus the four townships of Woolwich, Wellesley, North Dumfries, and Wilmot. The population of Waterloo Region is over 500,000. The majority of schools are part of either the Waterloo Region District School Board (98 elementary schools, 15 secondary schools) or Waterloo Catholic District School Board (47 elementary school, 5 secondary schools). In addition, Waterloo Region has 4 French schools and 11 private schools. In total, there are over 90,000 elementary and secondary school students in Waterloo Region.

Guelph

The population of Guelph is over 100,000. The majority of schools are part of two District School Boards: Wellington Catholic District School Board and Upper Grand District School Board. In total, there are over 18,000 elementary and secondary school students. The city also has two private schools.

Active & Safe Routes to School is a joint project of the Wellington, Dufferin, Guelph Health Unit, the City of Guelph, Guelph Police Service, Upper Grand District School Board and Wellington Catholic District School Board. Also contact 1 800 265-7293 or 519.846.2715 ext 4660.

Kitchener/Waterloo

Waterloo Region is comprised of the three municipalities of Kitchener, Waterloo and Cambridge, plus the four townships of Woolwich, Wellesley, North Dumfries, and Wilmot. The population of Waterloo Region is over 500,000. The majority of schools are part of either the Waterloo Region District School Board (98 elementary schools, 15 secondary schools) or Waterloo Catholic District School Board (47 elementary school, 5 secondary schools). In addition, Waterloo Region has 4 French schools and 11 private schools. In total, there are over 90,000 elementary and secondary school students in Waterloo Region.

Active & Safe Routes to School in Waterloo Region is coordinated by the Active Transportation to School Workgroup of Together 4 Health and is funded by Together 4 Health through the Ontario Ministry of Health Promotion.

Together 4 Health is committed to creating a healthy community by promoting and supporting healthy lifestyle choices in Waterloo Region. As a partnership of agencies and individuals, we work collectively with the people of Waterloo Region to inspire, create and celebrate a culture of wellness in communities where we live, work and play.

The Active and Safe Routes to School Workgroup is comprised of representatives from representatives from Region of Waterloo Public Health, Waterloo Region District School Board, Waterloo Catholic District School Board, City of Cambridge, City of Kitchener, City of Waterloo, Ministry of Transportation, and Waterloo Region Police Service.

For more information about ASRTS in Waterloo Region, please go to www.together4health.ca

Hamilton

Hamilton has a population of approximately 503,000. The school districts are covered by two boards: Hamilton Wentworth District School Board and the Hamilton Wentworth Catholic District School Board for a total elementary and middle school student population of approximately 59,230. There are also 23 private schools in the city and 3 French Language Schools.

Active & Safe Routes to School is a joint project of Public Health Services Department, City of Hamilton - Bylaw Enforcement, Hamilton-Wentworth Catholic District School Board, Hamilton-Wentworth District School Board and Green Venture. Call (905) 546-3162.

Niagara Region

The Region of Niagara comprises 12 municipalities for a total population of 382,430. The school districts are the District School Board of Niagara, the Niagara Catholic District School Board, two French school boards and 24 private schools for a total of 186 elementary schools, with a combined student population of approximately 48,000. The Active & Safe Routes to School program is managed by the Niagara Region Public Health Department, Tel: (905) 688-3762 ext. 7298.

<http://www.saferoutestoschool.ca/fr/liste-des-collectivites-eas>, consulté en 2012.

<http://www.saferoutestoschool.ca/>, consulted 2012.