

DRAFT

**Demographic Profile
for the English Speaking population
of the Outaouais**

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1. Introduction

Health care continues to rank as the number one priority and concern of Canadians no matter where they reside in this country. Moreover, minority populations contend with added challenges in accessing appropriate health and social services in a timely manner. A number of studies have confirmed that language is a key determinant of health. Inability to function in the official language of the majority population creates large inequalities in health status. Research has found that language barriers cause problems in communication and understanding. They are responsible for reduced usage of preventative services and increased amount of time spent in consultations and diagnostic tests. These barriers influence the quality of care in areas where language is an essential tool, such as mental health services, social services, physiotherapy and occupational therapy. Language barriers also reduce the probability of compliance with treatment and diminish the level of satisfaction with the care and services received.

This report adopts a population health approach in seeking ways to improve the health of the Outaouais population by taking into account key factors which influence health such as income, family status, education, employment, availability of health services and culture. Its objectives are to identify the distinctive characteristics of the English-speaking population of the Outaouais using the latest census data, and to define needs and priorities within each of the five sectors of the region.

In 2006, a subsequent report will follow, which will integrate qualitative findings from consumer and provider interviews and focus groups on the topic of Outaouais health and social services. This final report will provide essential information that will enable English-speaking communities and all stakeholders to take positive and concerted action towards improving the well being of the population.

1.1 Provincial and Regional Context of Health and Social Services Networking and Partnership Initiative

The health and social services system is a complex structure for both the population and health and community workers to understand and navigate. A population health approach promotes the establishment of partnerships with all stakeholders in order to effect and sustain positive change. Recent changes to the Health and Social Services system are significant and will directly impact on the organization of services. Therefore a clear understanding of this system is vital to ensure effective communication and participation.

In April 2003, the newly elected Liberal government set out to maintain their election pledge to revamp the health and social services system. Their priorities focus on providing citizens with access to a uniform range of services, as close to their home as possible and to respond to the needs of vulnerable persons. These priorities require significant changes to the health and social services system in order to adopt a more integrated approach.

The previous Régie Régionale de la Santé et Services Sociaux de l'Outaouais (Outaouais Regional Health and Social Services Board) was replaced by the Agence de développement de réseaux locaux de santé et de services sociaux de l'Outaouais (Outaouais Health and Social Services Agency) in December 2003 with the adoption of Bill 25. The Agency is responsible for proceeding with the restructuring of the Health and Social Services system and for establishing the Centres de santé et services sociaux (Health and social services centers). A series of consultations were conducted by the Agency from February 2004 to April 2004 within the health

and social services system as well as with the public in order to define the territories and retain the most efficient structure. A final proposal was adopted by the Agency's Board of Directors on April 29th, 2004 and forwarded to Health and Social Services Minister Couillard for his approval.

As a result, five Health and Social Services Centres were established. Each Health Centre groups the previous CLSC, long-term care and hospital missions under one umbrella. Service agreements have been concluded with regional institutions (such as drug/alcohol treatment centres, rehabilitation centres, etc.) to ensure that the appropriate services are available to their communities. The five Health and Social Services Centres are: Gatineau (Hull, Aylmer, Gatineau), Pontiac, Papineau (Vallée de la Lièvre, Petite-Nation), Vallée de la Gatineau (Maniwaki) and des Collines.

Each Health Centre is responsible for providing their population with a uniform access to services, as close to their residence as possible with a specific focus on vulnerable populations in their sector, such as seniors with loss of autonomy, high-risk youth, people with mental health problems, chronic disease and terminal cancer. Each Centre is governed by a Board of Directors and accountable to the Agency. Their mandate includes the organization of services (a role previously held by the Agency) and the establishment of formal links with all stakeholders in the Health and Social Services (HSS) system.

The role of the Agency is to oversee the restructuring process, support the Health Centres, define regional health and social services priorities and allocate funding to the institutions and community organizations.

These ongoing changes are significant and will require the cooperation from all stakeholders to ensure a smooth transition towards an improved health and social services system.

A number of relevant studies on health and social service issues in the Outaouais, Quebec and Canada have been conducted which have informed this report. These include: the CROP-Missisquoi Survey, *Language Barriers in Access to Health Care* (Health Canada, 2001); *The Consultative Committee for English-Speaking Minority Communities* (Health Canada, 2002); *Styles de vie des jeunes du secondaire en Outaouais, 1991-1996-2002* (Direction de Santé publique, RRSSS de l'Outaouais); and *Le portrait de santé : La région de l'Outaouais et ses districts de CLSC* (Direction de santé publique, RRSSS de l'Outaouais, 2002). The CROP-Missisquoi survey is briefly described below.

The CROP-Missisquoi Survey:

In spring 2000, the Department of Canadian Heritage provided funding to the Missisquoi Institute to undertake an omnibus survey on the attitudes and experiences of English-speaking Quebecers. CROP Inc. was commissioned by the Institute to conduct the survey. The Institute was founded in 1991 in order to develop a social research capacity within the Anglophone population in Quebec. The survey provides a good overview of the experiences of Anglophones in the province. Differences in attitudes and experiences of this community across all sixteen administrative regions were explored because of fears that the experiences of Montreal area residents would be generalized as being representative of all other Anglophones in the province. In order to make valid comparisons between the English and French-speaking populations, control groups of Francophones were surveyed in each of the administrative regions.

Another important gap in knowledge which the survey filled was the ethnic and linguistic diversity within the English-speaking community in Quebec. A healthy minority of residents

who identify English as their first official language in fact speak another language at home and report this third language as their mother tongue.

Although the survey is not directly comparable to Census data, it provided an important opportunity to investigate French language literacy, education, health and social services, employability and manpower development, media and internet consumption, community leadership, geographic stability and mobility.

1.2 Determinants of Health Approach

A public health approach is a “practical, goal-oriented, and community-based approach to promoting and sustaining health. This approach seeks to identify risk and protective factors, determine when in the life course they typically occur and how they operate, and enable researchers to design preventive programs that are effective in reducing risk and promoting protection.”¹ Income and social status, social environments and support networks (parenting, peer groups, community resources, etc.), education and literacy, employment and working conditions, health services, gender, culture, and individual factors (individual capacity and coping skills, biology and genetic endowment) all determine the health of Canadian children and youth (in other words, they are *health determinants*).² Health determinants are a broad range of individual and collective factors that have been shown to exert a determining influence on health status. However, certain populations have inequitable access to these determinants of healthy child and youth development. These include females, racial and ethnic minorities, First Nations people, disabled people, and low-income individuals.³

Key Determinants of Health

Income and social status:

Income and social status is the most important determinant of health. A large body of research proves that health status improves significantly at each level of income and social hierarchy. Countries which are in general wealthy and do not have large gaps between the rich and poor have the least amount of health problems. It makes no difference how much these countries spend on health care.⁴

Poverty, broadly speaking, is measured through an individual’s level of education, income, and occupational status. Access to power, prestige and wealth is unequal in Canada. Low-income children and youth tend to be more vulnerable compared to more affluent individuals. They do less well at school, are not as likely to complete high school, and experience less labour market success. However, the negative effects of poverty can be overcome with a positive family environment (good parenting skills, stable family unit, and good mental health). In fact, roughly two-thirds of children from low income families have average or above average cognitive and behavioural outcomes.⁵ The adverse consequences of poverty for the remaining one-third of children are compounded by parents who use coercive styles, low bonding, and mental health problems. The depth of poverty (how far families fall below the low income cut-off, and for how long) is an important determinant of vulnerability: children who are very poor, for long periods of time, have poor cognitive and behavioural outcomes.⁶

Social environments and support networks:

When an individual has *social support* from his or her family, community and friends, s/he is more likely to be in better health. In fact, there is a growing body of research which suggests that social relationships are equally significant as other known health risk factors (e.g., smoking, obesity, sedentary lifestyle, high blood pressure).⁷ Broadly speaking, *social environments* (societal values and rules which impact on the well-being of people) are also important health determinants. Social stability, respect for diversity, safety, positive social relationships, and community cohesiveness provide a strong social environment which buffers against health risks.⁸

The *family* is a critical point for prevention of health problems. An overwhelming number of studies show that low-cost prevention and early intervention programs for families at

risk are proven to improve people's health. In Canada, these include the Child Development Initiative; Child Care Visions; Canada Prenatal Nutrition Program; Community Action Program for Children; Quebec's CLSCs; New Brunswick's Early Childhood Initiatives; Ontario's Better Beginnings, Better Futures; Saskatchewan's Action Plan for Children, etc.); the First Nations-Inuit Child Care Initiative and Aboriginal Head Start; and no-cost recreational programs.⁹

Prenatal and early childhood experiences are arguably the most critical determinants of a child's health later on in life. During this period of time, an infant's brain can be exposed to risks and/or protection which will determine his or her life course. For example, smoking during pregnancy or being a teenage parent can result in low birth weight, a condition which has been positively linked with health and social difficulties throughout a person's lifetime. Alcohol and/or drug use can result in fetal alcohol spectrum disorder (FASD), wherein damage occurs to an infant's brain. Mothers at each step up the income scale have babies with higher birth weights compared to those infants on the income step below.¹⁰ For these reasons, it is crucial for Outaouais health and social services professionals to be able to identify high-risk neighbourhoods where vulnerable young parents live. Cost-efficient programs such as in-home visitation by public health nurses during the pre-natal and infancy years are proven to work.

Parent training is another low-cost method to promote healthy child and adolescent development in high-risk families. Children with strong bonds to their parents have better mental and physical health.¹¹ *Family stress* (unemployment, poverty, being young parent) can contribute to parent child relations which are hostile and punishment practices which are inconsistent and harsh. These demographic factors can heighten parents' antisocial tendencies, resulting in harsh and inconsistent discipline practices. Child maltreatment is a significant risk factor for poor intellectual and academic outcomes. These outcomes include reduced academic ability and attainment, neurological impairment, and language development. Victims of child abuse and neglect are more likely than non-victims to have personality disorders, impaired psycho-social development and impaired empathic responses. Child maltreatment is also a significant predictor of IQ and reading ability scores through kindergarten – grade twelve.

Peer group problems can interact and feed off individual and family risk factors. Evidence suggests that most student peer networks are organized around hobbies, interests, and other activities shared by friends. Positive peer relations are strong protective factors for many students. Positive social support is related to lower rates of depression and anxiety.¹²

The *physical environment* is also a key health determinant. Natural environmental factors including the air, water, and soil quality are very important. Housing, workplace safety, community and road design are examples of the human-built environment which also determine the health of residents in any particular community.¹³

Finally, *community factors* can interact with the other risk factors to heighten the risk of poor health. Neighbourhoods characterized by high-density housing, disorganization, high population turnover, high crime rates and unemployment tend to have weak social support. Local infrastructures to promote inclusion and participation in community activities are scarce. There are usually few social networks and ties, with a disproportionate number of single-parent families and individuals experiencing mental or physical health problems. Immigrants, ethnic and visible minorities, and First Nations people make up a disproportionate share of many social housing communities.

Education and literacy:

An individual's health status is associated with his/her level of education and literacy.¹⁴ People with high literacy skills and post-secondary education are more likely to report that they feel healthy and less likely to have activity limitations or lost work days. These individuals are highly likely to have well-paying jobs and to report high levels of social support in their communities, and to report that they have a strong sense of personal control over their life circumstances.¹⁵ Individuals with higher levels of literacy are much more likely to enjoy a better quality of life, have healthy lifestyles, and experience lower rates of disease. People with low levels of literacy are likely to live in poverty and experience unemployment. These factors are known to predict good health.¹⁶

One of the best predictors of children's cognitive and behavioural outcomes for the early and elementary school years is the mother's level of education. This is because of two primary reasons: almost all single-parent families are headed by mothers; and women still shoulder the vast proportion of child care responsibilities in Canada, even in nuclear families (i.e., fathers spend a small minority of time with children compared to mothers). In turn, key predictors of high school completion are cognitive ability and prior academic achievement.¹⁷ Children with a higher level of school readiness in kindergarten and grade one score higher on reading and math tests in the early grades. Parental literacy skills are highly correlated with a child's motivation to succeed. Caregivers with minimal skills have difficulty modelling positive literacy values and behaviours to children. An intergenerational transmission of illiteracy can result when parents pass on to their children attitudes and skills which keep them in this cycle.

Canada's *high school dropout rate* is considerably higher compared to other countries.¹⁸ The overall high school completion rate for nineteen – twenty year-old Canadians was 81 percent during 1995 – 1998. Male youth were less likely to complete high school (78 percent); 84 percent of female youth did not drop out.¹⁹ Rates varied by province, from a low of 79 percent (Quebec) to a high of 85 percent (PEI) during this same period of time. Aboriginals are twice as likely to drop out of high school or not have a post-secondary diploma compared to non-Aboriginals.²⁰ When the educational attainment of Aboriginals is compared to Canada's non-Aboriginal population, figures are startling. In 1996, 45 percent of Aboriginals aged 20 – 29 years had less than high school; for non-Aboriginals, the rate was 17 percent. For the same age group, only 32 percent of Aboriginals had completed high school, whereas 36 percent of non-Aboriginals had completed.

Employment and working conditions:

Health status improves with the level of control over work circumstances and the level of work-related stress. Individuals who are exposed to workplace hazards and injuries can have serious health problems. People employed in lower status and lower paying jobs are most likely to experience these problems. Unemployment is highly correlated with poorer health.²¹

Health services:

An individual's easy access to health services which are designed to maintain and promote health, prevent disease and injury, and restore health will result in improved health. Easy access means neighbourhood-based, services in the person's language spoken at home, no cost for those with the least ability to pay, and without lengthy wait times.

Gender and culture:

Gender and culture are key social factors that influence all other health determinants. *Gender* means the many different roles, personality traits, attitudes, behaviours, relative powers and influences which society assigns to being male and female. Whereas ‘sex’ refers to biology, ‘gender’ refers to the socially constructed meaning related to an individual’s sex. Gender does not just refer to being male or female. It also relates to a person’s sexual orientation and identity (gay, lesbian, bisexual, heterosexual, two-spirited [when a First Nations person identifies as being a sexual minority], transgender, or questioning [when an individual has questions about their sexual orientation]). A growing body of research demonstrates that GLBTQ people (gay, lesbian, bisexual, two-spirited, transgender, questioning) are at elevated risk for experiencing mental and physical health difficulties related to homophobic harassment and attacks, social isolation, and rejection by family.

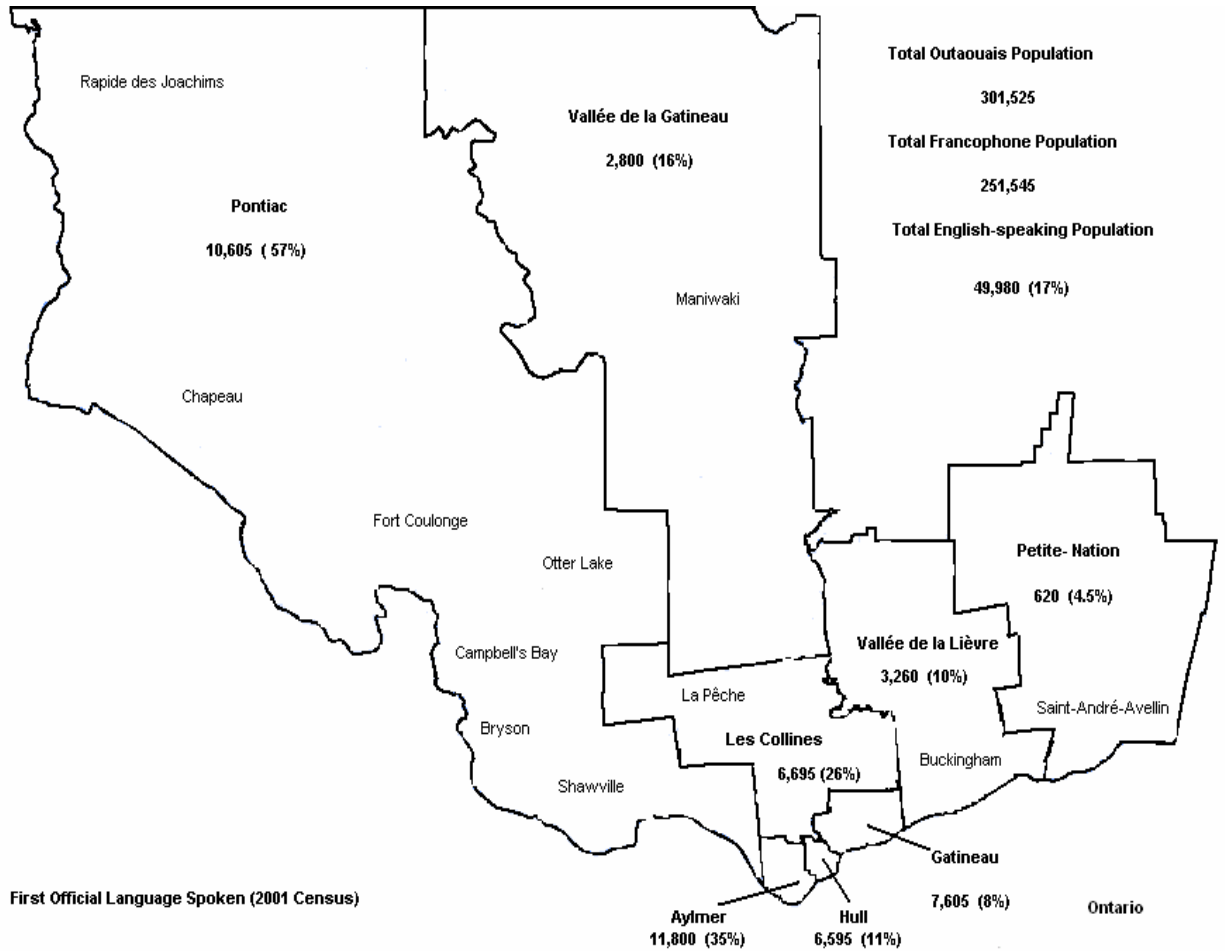
Culture means an individual’s ethnic and/or racial (hereafter referred to as ‘ethno-racial’) origins and broader social, political, geographic and economic factors. Research demonstrates that language barriers have significant negative effects on access to health care, quality of care, rights of patients, patient and provider satisfaction, and patient health outcomes. In Canada, patients who do not have command over one of the official languages do not have access to the same quality of care as do Canadians who are fluent in English or French. Thus, official language proficiency is an important determinant of health, and most likely interacts with ethnicity, race and income level to produce an important risk to the health of many Canadians. Linguistic minorities (such as the Anglophone population in Quebec, First Nations peoples, new Canadians [immigrants and refugees], deaf persons) have difficulties in accessing health and social services in their mother tongue. These services are poorly advertised, are often simply not available, and print and electronic information is rarely translated. Consumer feedback consistently rates the health and social services delivered by the majority population as poor.²²

Individual factors (individual capacity and coping skills, biology and genetic endowment):

Individual capacity and coping skills refer to social environments that support and enable healthy choices and lifestyles, as well as an individual’s knowledge, intentions, behaviours and coping skills for dealing with life in healthy ways. This factor is a key determinant of health.²³ *Biology and genetic endowment*, another significant health determinant, refer to the basic biology and organic makeup of a person’s body. Inherited predispositions impact on how people are influenced by particular diseases or health challenges.²⁴ Children are born with different sets of abilities and potential as a result of bio-physiological factors. In the preschool years, children with difficult temperaments, early onset aggression, anti-social behaviour and social difficulties are at high risk for serious and violent offending trajectories. Without comprehensive early intervention to address risk and protective factors, these children will likely grow into the five percent of all adolescents who are responsible for committing over half of all serious youth crime.²⁵

Personal health practices refer to behaviours such as smoking, use of alcohol and drugs, healthy eating, physical activity, and other practices that impact on health and well being. Many of Canada’s most prevalent health problems are related to these behaviours.²⁶

Map 1: English-Speaking Population of the Outaouais, by Sector



2. Socio-demographic Portrait of the English-speaking Population

2.1 Statistics Canada Census Data Overview

Statistics Canada 2001 census data have been produced for the Outaouais region as a whole and cross-tabulated by each key determinant of health against the English-speaking population, the French-speaking population, and both populations combined, for each of the five sectors within the Outaouais. Data runs are also available to compare the Outaouais with the province of Quebec as a whole. It is therefore possible to identify key health risks and assets in each of the distinct sectors and for the English-speaking population in general.

Overall, there are large differences between the rural (Pontiac, Vallée de la Gatineau, Vallée de la Lièvre, Petite-Nation) and urban areas (Aylmer, Gatineau, Hull). Les Collines de L'Outaouais is the only notable exception to this rural/urban split, with residents in this sector being the most affluent, educated, and having the lowest unemployment rate. In general, the rural areas have much higher rates of poverty, unemployment and high school non-completion.

In the general Anglophone population, there is a low rate of aging and population growth, and substantial health and social services. However, compared to the Francophones, the Anglophone unemployment rate is high (11.8%), the rate of bilingualism is low (50.3%), and the high school drop-out rate is among the highest (40.8%) in the Province. Although the English-speaking community is better educated overall, they are no more likely compared to the French-speaking community to have higher incomes. Anglophones are more likely to have an extremely low income. While the English-speaking minority population has a slightly higher proportion of very affluent individuals compared to their French counterparts, as a whole these groups closely resemble each other in terms of income, age and gender. Overall, however, Outaouais English speakers are more disadvantaged compared to the Francophones: they are poorer, older, much more likely to be out of work, and have many more First Nations and ethno-racial minorities in their community. These latter groups are most likely to experience persistent poverty, joblessness and a myriad of serious health problems in Quebec and Canada.

Table 1: Total English-speaking Population by Province, Region and CLSC District.

	Total age and sex	0-4	5-9	10-14	15-19	20-29	30-39	40-49	50-64	65 +
Québec	651,890	37,310	44,800	44,195	43,515	85,065	97,160	96,425	10,7345	96,075
Outaouais	49,980	2,715	3,510	3,710	3,410	5,905	8,015	8,540	8,450	5,725
Hull	6,595	335	320	295	385	1,550	1,250	1,015	825	620
Aylmer	11,800	755	1,055	1,105	980	1,295	1,885	2,105	1,660	990
Gatineau	7,605	385	490	490	500	1,020	1,455	1,345	1,250	670
Pontiac	10,605	545	715	800	730	945	1,350	1,585	2,160	1,775
Des Collines	6,695	375	525	545	415	505	1,100	1,410	1,245	575
Vallée de la Gatineau	2,800	170	205	240	200	250	370	430	520	415
Vallée de la Lièvre	3,260	135	175	205	165	285	555	560	620	560
Petite-Nation	620	15	25	30	35	55	80	90	170	120

Census Canada 2001

2.2 Income and Social Status:

There is a higher proportion of English-speaking low income residents compared to low-income Francophone residents. The average income rate of the Anglophone population is comparable to that of the French majority and also to the Quebec English-speaking population. However, there is tremendous variation between the five sectors in the Outaouais. For example, whereas Des Collines has 96% of its population at or above the low-income cut-off, Vallée de la Gatineau has 45% of its population *below* the cut-off (see Table 2). Slightly more Anglophones receive government transfers compared to Francophones in the region (roughly 12% for both), but no more than the whole of English speaking Quebec.

Table 2: Income for English-speaking Population

Income	Québec	Outaouais	Hull	Aylmer	Gatineau	Pontiac	Des Collines	Vallée de la Gatineau	Vallée de la Lièvre	Petite Nation
10-19 K	18 %	16 %	18%	11 %	15 %	20 %	13 %	19 %	17 %	18 %
20-29 K	13%	11 %	14%	10%	11%	11%	10%	15%	11%	17%
30-39K	9 %	10%	13%	10%	11%	8%	10%	8%	12%	7%
40-49 K	6 %	7%	7%	8%	9%	5%	7%	4%	7%	6%
50-59 K	4 %	5%	5%	5%	5%	3%	6%	1%	6%	3%
60-74 K	3 %	4%	4%	5%	6%	3%	8%	2%	2%	4%
75 K +	5 %	4%	4%	5%	4%	1%	7%	1%	4%	3%
* At or above low-income cut-off	75%	82%	72%	87%	80%	81%	96%	55%	81%	69%

Census Canada 2001

Table 3: Income for Francophone Population

Income	Québec	Outaouais	Hull	Aylmer	Gatineau	Pontiac	Des Collines	Vallée de la Gatineau	Vallée de la Lièvre	Petite Nation
10-19 K	18%	16%	17%	11%	14%	18%	12%	23%	15%	27%
20-29 K	13%	12%	13%	10%	12%	11%	11%	14%	11%	13%
30-39K	10%	11%	11%	11%	11%	9%	12%	10%	12%	9%
40-49 K	7%	8%	8%	8%	8%	6%	8%	5%	8%	4%
50-59 K	4%	5%	6%	6%	6%	4%	6%	3%	5%	2%
60-74 K	3%	5%	5%	7%	5%	3%	6%	2%	3%	2%
75 K +	3%	3%	4%	5%	3%	2%	4%	1%	2%	1%
* At or above low-income cut-off	81%	83%	77%	90%	84%	80%	92%	79%	85%	82%

Census Canada 2001

* At or above low-income cut-off: Income levels at which families or unattached individuals spend 20% more than average on food, shelter and clothing. Definition Census Canada Dictionary 2001

2.3 Social Environment and Support Networks

The English speaking population has a low rate of aging (10.3%) and their Minority-Majority Index (mmi)²⁷ ranks twelfth out of the sixteen Quebec regions. This community experienced growth between 1996 and 2001. The Anglophone and Francophone Outaouais residents have a comparable age structure and although it is difficult to verify, their respective social support networks seem to be strong. The widowhood rates are similar amongst both groups.

There is a strong overlap between poverty, single-parent families, and high school drop out (Tables 14, 15) in the most high-risk areas of the Outaouais. Table 4 shows that Vallée de la Gatineau has the highest proportion of lone parents of all age groups and of those aged 15-24 (Table 6). It also has the youngest population in the region, primarily due to the large First Nations community. As discussed previously, First Nations peoples in Canada have an increasing birthrate, contrary to the trend of the mainstream majority.

The Anglophone rate of bilingualism in the Outaouais is low compared to the broader English speaking population in Quebec (only 50.3% are bilingual).

The *caregiver ratio* places the number of elderly (aged 65 years and older) in a community in a ratio with the number of those in the care-giving age cohort (aged 35 – 54 years), and allows a relative rank to be created. This method is useful in the comparison of caregivers in the French-speaking and English-speaking populations in the Outaouais. The ratio for the English-speaking community is 3.25:1, where ten percent of the community is aged 65 years or older. The provincial average for the English-speaking population is 2.3:1.²⁸ Thus, *the caregiver ratio is a significant asset for the Anglophone community*, much higher than that for the broader English speaking community in Quebec.

Table 4: English-speaking Population, Lone Parents All age groups

Living Arrangements	Québec	Outaouais	Hull	Aylmer	Gatineau	Pontiac	Des Collines	Vallée de la Gatineau	Vallée de la Lièvre	Petite Nation
Male	4.75%	4.85%	4.95%	5.81%	4.45%	3.40%	3.87%	7.81%	6.22%	2.78%
Female	6.91%	7.03%	7.21%	8.21%	7.33%	5.35%	5.37%	11.63%	6.53%	4.63%
Total Sex	11.67%	11.86%	12.16%	13.98%	11.78%	8.70%	9.24%	19.44%	12.75%	7.41%

Census Canada 2001

Table 5: Francophone Population, Lone Parents All age groups

Living Arrangements	Québec	Outaouais	Hull	Aylmer	Gatineau	Pontiac	Des Collines	Vallée de la Gatineau	Vallée de la Lièvre	Petite Nation
Male	4.75%	5.12%	5.68%	4.56%	5.37%	4.01%	3.96%	5.17%	4.76%	5.02%
Female	6.88%	7.49%	8.81%	6.47%	8.40%	4.19%	4.30%	6.73%	6.62%	6.43%
Total Sex	11.63%	12.61%	14.48%	11.05%	13.76%	8.29%	8.21%	11.89%	11.38%	11.45%

Census Canada 2001

Table 6: English-speaking Population, Lone Parents 15-24 years old

Living Arrangements	Québec	Outaouais	Hull	Aylmer	Gatineau	Pontiac	Des Collines	Vallée de la Gatineau	Vallée de la Lièvre	Petite Nation
Male	1.24%	1.23%	1.53%	1.94%	1.19%	0.51%	1.02%	1.00%	0.93%	1.85%
Female	1.18%	1.21%	0.92%	1.43%	1.13%	0.93%	1.09%	2.66%	0.93%	1.85%
Total Sex	2.41%	2.44%	2.44%	3.33%	2.32%	1.44%	2.11%	3.65%	1.71%	2.78%

Census Canada 2001

Table 7: Francophone Population, Lone Parents 15-24 years old

Living Arrangements	Québec	Outaouais	Hull	Aylmer	Gatineau	Pontiac	Des Collines	Vallée de la Gatineau	Vallée de la Lièvre	Petite Nation
Male	1.25%	1.18%	1.38%	1.17%	1.40%	0.61%	0.73%	0.90%	0.91%	0.74%
Female	1.21%	1.18%	1.30%	1.27%	1.40%	0.49%	0.65%	0.80%	1.09%	0.88%
Total Sex	2.46%	2.36%	2.66%	2.43%	2.79%	0.97%	1.36%	1.77%	1.98%	1.62%

Census Canada 2001

Table 8: Mobility 1 year, English-speaking population

	Internal Migrants	Intraprovincial Migrants	Interprovincial Migrants	External Migrants
Québec	4.73 %	3.44 %	1.29 %	1.73 %
Outaouais	8.25 %	3.66 %	4.59 %	0.81 %
Hull	17.14 %	8.66 %	8.48 %	3.22 %
Aylmer	7.57 %	2.27 %	5.29 %	0.39 %
Gatineau	7.21 %	2.85 %	4.36 %	0.95 %
Pontiac	5.16 %	2.30 %	2.86 %	0.00 %
Des Collines	6.82 %	2.69 %	4.13 %	0.34 %
Vallée de la Gatineau	6.03 %	3.85 %	2.01 %	0.00 %
Vallée de la Lièvre	5.67 %	3.15 %	2.68 %	0.31 %
Petite-Nation	14.81 %	14.81 %	0.00 %	0.00 %

Census Canada 2001

Table 9: Mobility 1 year, Francophone Population

	Internal Migrants	Intraprovincial Migrants	Interprovincial Migrants	External Migrants
Québec	5.77 %	5.58 %	0.20 %	0.39 %
Outaouais	6.42 %	5.35 %	1.07 %	0.35 %
Hull	8.38 %	6.70 %	1.68 %	0.59 %
Aylmer	6.62 %	4.83 %	1.77 %	0.56 %
Gatineau	5.39 %	4.37 %	1.02 %	0.37 %
Pontiac	5.08 %	4.72 %	0.37 %	0.00 %
Des Collines	6.06 %	5.34 %	0.71 %	0.30 %
Vallée de la Gatineau	5.18 %	4.76 %	0.45 %	0.00 %
Vallée de la Lièvre	7.21 %	6.44 %	0.78 %	0.09 %
Petite-Nation	6.33 %	6.25 %	0.11 %	0.07 %

Census Canada 2001

Table 10: Mobility 5 years, English-speaking population

	Internal Migrants	Intraprovincial Migrants	Interprovincial Migrants	External Migrants
Québec	14.19 %	10.77 %	3.42 %	5.74 %
Outaouais	20.61 %	8.92 %	11.67 %	2.57 %
Hull	37.30 %	16.78 %	20.51 %	9.00 %
Aylmer	18.81 %	6.45 %	12.36 %	2.36 %
Gatineau	18.29 %	6.99 %	11.37 %	2.35 %
Pontiac	12.80 %	5.84 %	6.96 %	0.34 %
Des Collines	20.49 %	7.84 %	12.72 %	1.29 %
Vallée de la Gatineau	13.79 %	8.73 %	5.06 %	0.35 %
Vallée de la Lièvre	21.02 %	12.81 %	8.21 %	0.00 %
Petite-Nation	34.62 %	29.81 %	3.85 %	2.88 %

Census Canada 2001

Table 11: Mobility 5 years, Francophone Population

	Internal Migrants	Intraprovincial Migrants	Interprovincial Migrants	External Migrants
Québec	17.61 %	17.05 %	0.56 %	1.33 %
Outaouais	19.19 %	16.29 %	2.90 %	1.01 %
Hull	23.69 %	19.40 %	4.31 %	2.53 %
Aylmer	19.42 %	14.60 %	4.84 %	1.00 %
Gatineau	15.00 %	12.27 %	2.73 %	0.76 %
Pontiac	14.40 %	12.18 %	2.25 %	0.32 %
Des Collines	22.61 %	20.33 %	2.27 %	0.67 %
Vallée de la Gatineau	16.64 %	15.73 %	0.91 %	0.17 %
Vallée de la Lièvre	23.86 %	21.96 %	1.91 %	0.08 %
Petite-Nation	20.64 %	19.90 %	0.73 %	0.18 %

Census Canada 2001

2.4 Education and literacy

Outaouais Anglophones are more likely than Outaouais Francophones and Quebec Anglophones as a whole to have not completed high school. For example, Table 18 shows that *the Western Quebec School Board (WQSB) high school drop out rate in 2001 – 2002 was just under 41%*, compared to an overall (both English and French) provincial rate of 25% and Outaouais general rate of 36%.²⁹ In 2001, Outaouais Anglophones aged 15 – 24 years were six percent more likely to drop out of high school compared to Francophones of the same age in this community (Tables 12, 13). Even in the age ranges of 25 – 44 years, 45 – 64 years and over 65 years, Anglophones were roughly thirteen percent less likely to not have a high school diploma compared to Francophones of the same age groups (Tables 14, 15). English speaking residents were four percent more likely than their French speaking counterparts in the region to have post-secondary qualifications, but thirteen percent less likely than their Anglophone neighbours across the province to have this (Tables 16, 17). Again, there is tremendous variation within each of the regional sectors in the Outaouais.

Overall, many more boys compared to girls leave high school without their graduate certificate. For example, the drop out rate for boys in WQSB schools was 45.8% compared to 35.8% for girls. These provincial, regional and language rates did not significantly change for the period 1999 – 2002.

Despite the startling rates of high school drop out, more Anglophones than Francophones have completed university degrees in the Outaouais, although the Outaouais English speaking residents are less likely than their provincial counterparts to have completed university degrees. Anglophone women are seventeen percent less likely compared to Anglophone men to complete university degrees in the region. This is likely to do with the disproportionate share of child care responsibilities which women still bear in Canada.³⁰

Literacy rates are not measured in the Statistics Canada census, but instead are measured through World Health Organization (WHO) and the Programme for International Student Assessment (PISA surveys) every couple of years. However, the evidence around the world is clear on the link between poverty, early high school leaving and literacy: no matter what country one lives in, the rate of literacy is extremely low amongst individuals who live in poverty and do not complete high school. As a result, it is extremely difficult for these individuals to find and keep work. Also, illiteracy tends to be intergenerational, meaning that illiterate parents find it difficult to read to their children, and therefore these young people tend to have very low levels of literacy as well. There is no reason to believe that those areas of the Outaouais characterized by chronic poverty would be any different.

Table 12: English-speaking Population (15-24 year olds) with Less than High School Leaving Certificate

	Québec	Outaouais	Hull	Aylmer	Gatineau	Pontiac	Des Collines	Vallée de la Gatineau	Vallée de la Lièvre	Petite Nation
Male	2.86%	3.77%	3.15%	4.46%	3.12%	4.61%	3.57%	3.43%	2.26%	2.11%
Female	2.33%	3.10%	2.58%	3.14%	3.19%	3.73%	2.72%	3.64%	2.26%	3.16%
Total	5.18%	6.86%	5.72%	7.59%	6.38%	8.40%	6.29%	7.07%	4.51%	5.26%

Census Canada 2001

Table 13: Francophone Population (15-24 year olds) with Less than High School Leaving Certificate

	Québec	Outaouais	Hull	Aylmer	Gatineau	Pontiac	Des Collines	Vallée de la Gatineau	Vallée de la Lièvre	Petite Nation
Male	3.16%	3.71%	2.86%	3.61%	4.13%	3.68%	3.73%	3.79%	3.95%	3.75%
Female	2.44%	2.80%	2.21%	2.87%	3.21%	2.93%	2.32%	2.40%	3.03%	2.95%
Total	5.60%	6.51%	5.07%	6.48%	7.33%	6.71%	6.14%	6.27%	7.03%	6.74%

Census Canada 2001

Table 14: English-speaking Population (Total age group) with Less than High School Leaving Certificates

	Québec	Outaouais	Hull	Aylmer	Gatineau	Pontiac	Des Collines	Vallée de la Gatineau	Vallée De la Lièvre	Petite Nation
Male	13.00%	16.23%	10.87%	12.66%	13.98%	26.47%	11.05%	25.27%	19.74%	15.79%
Female	13.35%	14.38%	9.66%	11.29%	15.05%	19.88%	9.01%	21.63%	23.12%	21.05%
Total	26.34%	30.60%	20.46%	23.95%	29.18%	46.30%	19.97%	47.11%	42.86%	36.84%

Census Canada 2001

Table 15: Francophone Population (Total age group) with Less than High School Leaving Certificates

	Québec	Outaouais	Hull	Aylmer	Gatineau	Pontiac	Des Collines	Vallée de la Gatineau	Vallée de la Lièvre	Petite Nation
Male	15.74%	16.86%	12.87%	11.55%	15.56%	25.88%	18.23%	26.82%	19.63%	26.09%
Female	16.38%	16.21%	14.99%	11.27%	15.33%	20.67%	13.50%	22.88%	17.97%	24.15%
Total	32.12%	33.07%	27.87%	22.84%	30.90%	46.62%	31.75%	49.66%	37.66%	50.23%

Census Canada 2001

Table 16: English-speaking Population (Total age group) with University Degree

	Québec	Outaouais	Hull	Aylmer	Gatineau	Pontiac	Des Collines	Vallée de la Gatineau	Vallée De la Lièvre	Petite Nation
Male	12.64%	9.80%	15.31%	12.05%	8.05%	2.57%	17.33%	3.21%	3.95%	7.37%
Female	11.79%	9.05%	13.73%	9.82%	7.83%	4.14%	15.21%	3.64%	4.32%	7.37%
Total	24.43%	18.84%	29.04%	21.82%	15.81%	6.71%	32.54%	7.07%	8.08%	14.74%

Census Canada 2001

Table 17: Francophone Population (Total age group) with University Degree

	Québec	Outaouais	Hull	Aylmer	Gatineau	Pontiac	Des Collines	Vallée de la Gatineau	Vallée De la Lièvre	Petite Nation
Male	7.82%	8.33%	12.49%	12.71%	7.55%	3.83%	9.12%	3.52%	4.46%	3.92%
Female	8.38%	9.47%	14.22%	14.25%	8.36%	5.10%	10.49%	4.26%	5.43%	4.51%
Total	16.20%	17.80%	26.72%	27.00%	15.91%	9.00%	19.61%	7.78%	9.88%	8.43%

Census Canada 2001

Table 18: 2001-2002 High School Drop-Out Rate in the Outaouais

School Year 2001-2002	*Western Quebec School Board	CS des Draveurs	CS des Portages-de- l'Outaouais	CS au Coeur- des-Vallées	CS des Hauts- bois-de- l'Outaouais
Total # of students Sec. V	650	1,092	731	378	190
% students without a high school diploma	40.9 %	28.5 %	32 %	46.80%	34.20 %

Ministry of Education Website: meq.gouv.qc.ca/stats/Portraits_regionaux/pdf/7_reussite.pdf

Banque de cheminement scolaire

*Statistics from the Western Quebec School Board include the administrative regions 07 and 08.

2.5 Employment

Public administration (16.3%), retail trade (8.6%), manufacturing (7.7%) and professional/scientific/technical services (7.2%) are the largest employers of Anglophones in the Outaouais. Large gender differences are evident in the types of occupations held by the English speaking population in the region. These differences are just as large in the Francophone population and the rest of the Anglophone population in Quebec. Women are more than four times as likely compared to English-speaking men to be working in health care and social assistance than in any other industrial sector. Women are twice as likely to be employed in finance, insurance and educational services.

The general unemployment rate in the Outaouais is 11.8%. There is a large difference between the Francophone and Anglophone unemployment rates, however. This is surprising, given the higher proportion of Anglophones who have achieved university degrees compared to Francophones. *The English speaking population's unemployment rate is 32% higher than that of the French speaking population.* However, compared to the broader Anglophone population of Quebec, the Outaouais population has proportionately fewer unemployed, fewer out of the labour market, and a much higher proportion who are self-employed (22% higher). Compared to the French speaking community in the region, Anglophones are 57% more likely to be self-employed.

Again, there is significant variation between the five sectors in levels of unemployment and average income. Des Collines is by far the most affluent sector, with a very low unemployment rate across age groups and a very high proportion of the employed who made over \$75K in 2001. Pontiac and Vallée de la Gatineau have the highest levels of unemployment across age groups and the highest proportion of the population whose income was under \$20,000 in 2001.

2.6 Health Services

The Outaouais Anglophone population has a high proportion of residents who use out-of-province medical facilities and services, primarily in Ontario. In its two designated institutions for health and social services, the English-speaking population is underrepresented as employees in the health care and social assistance industrial sector. Compared to the rest of Quebec, the use of English in health situations is average, with the Outaouais placing fourth out of sixteen regions, and fifth in terms of entitled services. Table 19 shows that Aylmer and Pontiac sectors have rates of out-of-province hospital services which are over double the Outaouais rate, whereas

Gatineau and Vallée de la Gatineau have rates which are significantly less than the regional average.

Table 19: Hospital Services Received by the Outaouais Population Outside the Region.

	Outaouais	Hull	Aylmer	Gatineau	Pontiac	Des Collines	Vallée de la Gatineau	Vallée de la Lièvre	Petite-Nation
Ontario	5.10%	5.00%	11.50%	3.80%	11.00%	5.40%	0.80%	2.10%	6.00%
Elsewhere in Québec	3.20%	1.70%	2.10%	1.70%	0.80%	1.30%	9.90%	1.00%	10.60%

Une vision intégrée du réseau Outaouais Agence de développement de réseaux locaux de services de santé et de services sociaux Avril 29, 2004.

Statistics for Ontario are from 2001-2002. Statistics for elsewhere in Québec are from 2002-2003.

2.7 Gender

Not unlike the rest of Canada, sexist practices persist in the Anglophone community vis à vis unpaid care for seniors. Compared to their male counterparts, English-speaking women do twice the amount of work (defined as ten hours+/week of unpaid care for seniors) in this area compared to men, and the Anglophone population as a whole does more unpaid work than the French-speaking community. Of those who are in the labour force, Anglophone men are more likely to be unemployed compared to their female counterparts. There are three and one-half times more English-speaking widowed women compared to widowed men in the Outaouais.

2.8 Culture

Three and one-half times more Anglophones in the Outaouais identify as Aboriginal compared to the Francophone community and a greater proportion of the English-speaking community report multiple ethnic origins. Like the rest of Canada, the ethnic and racial makeup of the Quebec population is undergoing dramatic change; for the period of 1986 - 1996, the number of visible minorities has roughly doubled (jumping from approximately 6.5% to 13%). Although the majority of new Canadians who settle in Quebec live in Montreal, increasingly they are moving to other regions in Quebec.

The Vallée de la Gatineau sector is home to two First Nations peoples. The average age of First Nations Peoples in Canada is approximately 25 ½ years, a full ten years younger than the average age of all Canadians. Census data from 1996 indicate that whereas approximately 40% of the 800,000 Aboriginal people in Canada were younger than eighteen years, only 24% of non-Aboriginal people were under eighteen years of age. Birth rates in the First Nation population are much higher than that for non-Aboriginals. Whereas there were approximately 144,000 First Nation youth aged 15 – 24 in Canada in 1996, by 2006 this number will increase by more than one-quarter, to approximately 181,000. The First Nations youth population is experiencing tremendous growth. The Vallée de la Gatineau sector seems to be part of this national trend.

Based upon the body of research used for this report, English-speaking Outaouais residents most likely do not have access to the same quality of health and social services care as French-speaking Outaouais residents. The minority population most certainly does not have

equitable access to health care due to the fact that they do not speak the majority language. Reliance on family members or untrained interpreters recruited on an ad hoc basis poses too many risks to patient access and quality of care.³¹ Many anecdotal reports from English-speaking residents suggest that quality of care and access to care for those who are not fluent in French is a pressing issue. In particular, the following issues have come to light: delays in seeking care; reduced compliance and comprehension; lower satisfaction; reduced access to mental health and counseling services. These issues will be explored further in the upcoming focus groups with consumers and service providers.

5. Sources

Bowen, S. (2001). *Language Barriers in Access to Health Care*. Prepared for the Health Systems Division, Health Policy and Communications Branch, Health Canada.

Carter, J. (2003). *Population Health Initiative: A Guide to the Population Health Approach*. Ottawa: Community Health and Social Services Network, Health Canada.

Courteau, J., L. Émond, et P. Garvie (2002). *Le portrait de santé. La région de l'Outaouais et ses districts de CLSC*. Gatineau : Direction de santé publique, RRSSS de l'Outaouais.

CROP and Missisquoi Institute (2000). *Attitudes, Experiences and Issues for Québec's Anglophone Communities*. (link to CHSSN website – online Power Point presentation.

Deschesnes, M., S. Demers, et P. Finès (2003). *Styles de vie des jeunes du secondaire en Outaouais, 1991-1996-2002*. Hull: Direction de Santé publique, RRSSS de l'Outaouais.

Deschesnes, M., S. Demers, et P. Finès (2003). *Trends in Adolescent Lifestyles in the Outaouais 1991-1996-2002: Results for the Anglophone Students of the Western Quebec School Board*. Hull: Direction de Santé publique, RRSSS de l'Outaouais.

Deschesnes, M., et P. Finès (2003). *Évolution de la consommation de tabac, d'alcool et autres drogues chez les élèves du secondaire dans la région de l'Outaouais, 1985-1991-1996-2002*. Hull: Direction de Santé publique, RRSSS de l'Outaouais.

Direction de la Santé Publique, Régie régionale de la Santé et des Services sociaux de Montreal-Centre (1998). *Social Inequalities in Health: The 1998 Report on the Health of the Population*.

Dubeau, J. and S. Smythe (2001). *Partners against Crime Team Final Report*. Aylmer: ENRICH.

Éducation Québec (2003). *Indices de défavorisation par école. Commission scolaire Western Québec*

Éducation Québec (2004). *Évolution du taux de décrochage (ou sortie sans diplôme des élèves du secteur des jeunes, en formation générale, pour les commissions scolaires de la région de L'Outaouais, selon le sexe, de 1999-2000 à 2001-2002*.

Floch, W. (2004). *Demographic Data from the Department of Canadian Heritage based on the 1996 and 2001 Canadian Census*. Ottawa: Patrimoine Canadian Heritage.

Gravel, S. and A. Battaglini (2000). *Culture, Santé et ethnicité: Vers une santé publique pluraliste*. Montréal : Régie régionale de la santé et des services sociaux de Montréal-Centre.

Groupe Recherche Focus inc. (2004). *A Time for Change : The English-Speaking Community of the Estrie Region at a Crossroads. Health and Social Services Needs Assessment*. Quebec City, QC: GRF.

Health Canada Consultative Committee for English-Speaking Minority Communities (CCESC) (2002). *Report to the Federal Minister of Health*. Ottawa: Health Canada.

Health Canada Population and Public Health Branch Strategic Policy Directorate (2001). *The Population Health Template: Key Elements and Actions that Define a Population Health Approach*. Ottawa: Health Canada.

Pitre, E., P. Tomlinson and C. Twardawa (2005). *Listening to Our People: The VEQ Youth Report 2005*. Québec, QC: VEQ.

Pocock, J. (2004). *Baseline Data Report 2003-2004. Regional Profile of Outaouais*. CHSSN for NPI (Health Canada and QCGN)

Saber-Freedman, S. (2001). *Consolider nos acquis: Plan d'action pour améliorer l'accès aux services de santé et aux services sociaux en langue anglaise au Québec et favoriser l'épanouissement des communautés anglophones minoritaires.*

The Holland Centre in partnership with the Committee for Anglophone Social Action (Gaspé) and the Régie régional de la Santé et des services sociaux de Montréal-Centre. *Patient and Community Support Network. A Project to Improve the Health and Well-being of English-speaking Communities in Quebec.*

Walling, R., L. Hanrahan and J. Johnson (2001). *The Holland Centre Experience: A Community Development Model for Minorities.* Holland Resources Development Corporation.

6. End Notes

- ¹ US Department of Health and Human Services, 2001: glossary.
- ² Federal, Provincial and Territorial Advisory Committee on Population Health, 1999.
- ³ Canadian Institute of Child Health, 2000.
- ⁴ Health Canada, 2001.
- ⁵ Willms, 2002c.
- ⁶ Duncan et al., 1998; McLeod and Nonnemaker, 2000.
- ⁷ Health Canada, 2001.
- ⁸ Ibid.
- ⁹ Jenson and Stroick, 2000.
- ¹⁰ Health Canada, 2001.
- ¹¹ McCreary Center Society, 1999.
- ¹² Cohen and Wills, 1985.
- ¹³ Health Canada, 2001.
- ¹⁴ Literacy refers to the ability to read and understand written materials (books, mathematical charts, reports), to apply this knowledge (for solving problems, assessing situations and making decisions), and to communicate this information by speaking and writing.¹⁴ Two major international studies provide data on the performance of Canadians in this area: the 1995 International Adult Literacy Survey (IALS) and the 2000 Programme for International Student Assessment (PISA) study. Roughly ten percent of Canadian youth have serious literacy problems.
- ¹⁵ Willms, 2002c.
- ¹⁶ Health Canada, 2001.
- ¹⁷ Willms, 2002c.
- ¹⁸ OECD, 2000.
- ¹⁹ Statistics Canada and Council of Ministers of Education, 1999.
- ²⁰ 1996 Census.
- ²¹ Health Canada, 2001.
- ²² Bowen, 2001.
- ²³ Health Canada, 2001.
- ²⁴ Ibid.
- ²⁵ Shaw, 2002; Spratt et al., 2001.
- ²⁶ Health Canada, 2001.
- ²⁷ MMI (Minority-Majority Index) “compares the characteristic of the regional minority Anglophone population relative to the majority Francophone population which shared the same region. An mmi greater than 1.00 indicates that the characteristic is more commonly found in the minority Anglophone population. An mmi less than 1.00 indicates that it is less present in the minority population.” (Pocock, 2004: 160)
- ²⁸ Floch, Dept. of Canadian Heritage
- ²⁹ Éducation Québec, 2004.
- ³⁰ **Statistics Canada study on parenting and who does the work at home**
- ³¹ Bowen, 2001.