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Résumé de l'article

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ARTICLE THÉMATIQUE

Construction of Francophone families' health literacy in a linguistic minority situation

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Abstract / Résumé*

With the increase in international mobility, healthcare systems should no longer be ignoring language barriers. In addition to the benefit of reducing long-term costs, immigrant-friendly organizations should be concerned with mitigating the way language barriers increase individuals' social vulnerabilities and inequities in health care and health status. This paper reports the findings of a qualitative, exploratory study of the health literacy of 28 Francophone families living in a linguistic-minority situation in Canada. Analysis of interviews revealed that participants' social vulnerability, mainly due to their limited social and informational networks, influenced the construction of family health literacy. Disparities in access to healthcare services could be decreased by having health professionals' work in alliance with Francophone community groups and by hiring bilingual health professionals. Linguistic isolation and lack of knowledge about local cultural organizations among Francophone immigrants were two important findings of this study.

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Introduction

In a world marked by globalization and the mobility of labour, the effects of language barriers on the health literacy (HL) of immigrants is important, especially as few Canadian health and social services agencies acknowledge the effect of limited HL on health status (Canadian Council on Learning, 2007; Rootman, Kaszap & Frankish, 2006). This is particularly so in the case of Francophone minorities (Bâ, Rivard & Leveque, 2005; Bouchard, Gilbert, Landry & Deveau, 2006). The Canadian province of Ontario has the largest concentration of immigrant and Canadian-born Francophones living outside the Francophone province of Quebec (Corbeil & Lafrenière, 2010; Houle & Corbeil, 2010). A substantial proportion of Ontario's Francophone immigrant population is both a linguistic and cultural minority, with 41.2% born in Africa, 23.2% in Asia, 12.9% in the Caribbean, and 12.2% in Middle Eastern countries (Government of Ontario, 2011; Roy, Belkhdja & Gallant, 2011).

Language, culture, and literacy interact in the development of HL: mastering a language expands clients' ability to understand health messages in different contexts, while language and culture frame their interpretation of the messages (Singleton & Krause, 2010; Institute of Medicine of the National Academies, 2004). In turn, HL involves personal life stories, cumulative experience, social learning, autonomy, and social interactions. HL incorporates the values, beliefs, fears, and behaviours of individuals as a result of their background in terms of (a) health culture and health knowledge, (b) the type of health education to which they were exposed, (c) practices in searching for health information—reading it, decoding it, and communicating it (orally or in writing), and (d) using numerical and health information to solve health problems in everyday life (Kaszap & Zanchetta, 2009; Kaszap & Clerc, 2008, as cited in Kaszap & Zanchetta, 2009). In short, HL is the accumulation of family, school, social, cultural, and professional assets gathered over time through exposure to information about health, attitudes toward health, health behaviours (Kaszap & Zanchetta, 2009), other forms of literacy applied to interpret the world (Masny & Dufresne, 2007), and access to contextualized knowledge (Barton & Hamilton, 2000). The cultural resources, goods and capital that visible cultural minorities possess play a significant role in accessing health care (Abel, 2008).

This study aims to describe the process of constructing family HL within a new linguistic context. Our study participants are immigrant and Canadian-born Francophone families living in a linguistic-minority situation. Three research questions guided this study: a) What dynamics exist between the previous experiences and current health practices developed by the families to ensure their well-being while learning about health? b) What strategies do immigrant and Canadian-born Francophone families use to widen their health knowledge to provide care for family members? and c) How do family health practices change to deal with structural and linguistic constraints with health-related experiences?

Study background: Implications of the historical relationship between main linguistic groups in Canada

Canada's 1969 Official Languages Act stipulates that English and French, the two official languages, are equally used in federal institutions. However, this is not the case in provincial or municipal governments or in private businesses (Denis, 1999). Healthcare services such as hospitals are under the jurisdiction of provincial and territorial governments, and most physicians practice as small businesses where provision of services in French is at their own discretion.

French is spoken by over 80% of those who recently moved from Quebec to other parts of Canada and by 3.7% of all immigrants to Canada (Government of Canada, 2009; Citizenship and Immigration Canada, 2010). The complex historical relationship between Canada's two main linguistic groups, Anglophones and Francophones, along with a high level of immigration accounts for the reason why some Canadians, and especially immigrants, live in a linguistic-minority situation within diverse groups of cultural minorities. Due to language barriers, cultural-minority immigrants are at a high risk of unequal access to health care (Volandes & Paasche-Orlow, 2007; Kreps & Sparks, 2008; Yang & Kagawa-Singer, 2007), which can amplify the negative consequences of low HL for health outcomes.

A systemic scarcity of skilled French-speaking health professionals outside of Quebec presents a crucial barrier to accessing health care services and programs for Francophones living in linguistic-minority situations in Canada. About 55% of Francophones living outside Quebec have either no or very limited access to services in French, particularly preventative interventions, and report lower health status than do Anglophones, leading to higher rates of emergency care (Bouchard et al., 2009). Because cultural and language discordance impact how people learn and whether they participate in their care (Bass, 2005; Stewart, Riecken, Scott, Tanaka & Riecken, 2008), measures are needed to address inadequate HL among Francophones, both immigrant and Canadian-born, living in linguistic-minority situations.

Partnerships among social organizations, Francophone communities, family members, and professionals (Andrulis & Brach, 2007; Rootman & Gordon-El-Bihbety, 2008; Zanchetta & Poureslami, 2006) are needed to develop communication strategies that reach all individuals with limited proficiency in English. In addition to reducing long-term costs, immigrant-friendly organizations should mitigate the way language barriers increase social vulnerabilities and inequities in health care (Bischoff & Denhaerynck, 2010). To improve people's access to health care, we need innovative health-teaching approaches that promote autonomy and use of technology to create meaningful communication strategies (The Joint Commission, 2010). In-service education about HL is crucial (Shlichting et al., 2007) for sensitizing professionals to the need for health education tailored to linguistic-minority populations (Rootman & Gordon-El-Bihbety, 2008; Zanchetta & Poureslami, 2006). Such programs positively influence clients' health knowledge and self-efficacy (Clement, Ibrahim, Crichton, Wolf & Rowlands, 2009).

Theoretical and conceptual framework

We drew on Multiple Literacies Theory (Masny's 2010) and Freire's (1973) critical pedagogy to guide this study. Multiple Literacies Theory considers literacies to be constructs with intertwining social, cultural, historical, and physical features as well as transformative processes embedded in time and space. Literacies consist of "words, gestures, attitudes, ways of speaking, writing, valuing: ways of becoming with the world" (Masny, 2010; p. 338). Literacies allow individuals to move in a dynamic process of becoming in the world. In the becoming process, critical attitudes are the core assumption of MLT, which views literacy as a way of speaking, writing, valuing, and thinking about the world. They are multimodal and fuse with religion, gender, race, culture, and power in communities. Literacies allow individuals to move in a dynamic process of "becoming in / with the world." In the "becoming" process, critical attitudes are key. Multiple Literacies Theory redefines "reading" as a broad act of "reading the world" and its relations with individual and collective experiences.

Freire's critical, liberatory pedagogy (Freire, 1973) places HL in a critical, political perspective within the process of becoming literate. For Freire (1973), education must stimulate a desire for action that addresses inequity and oppression. Since traditional forms of education are thought to contribute to the status quo in social structure, it is essential that education be reoriented towards promoting social change. Learners are encouraged to reflect on their own experiences in life and determine the individual and collective injustices encountered, and then to identify prominent ideas that would foster a change in their social reality.

Thus, we do not view HL as resulting from memorization or interpretation. Rather, we understand HL to be self-satisfying, efficient practices that are able to respond to individuals' health interests and goals. Becoming health literate goes beyond the ability to read and understand words; it involves critical awareness of one's condition within social, cultural, physical, and political environments. We also used these theoretical ideas to link Francophone linguistic identity and HL through the transfer of intergenerational knowledge and incorporation of values, beliefs, and health practices that are mediated by all forms of language and reading the world. We used the following conceptual definitions (within a Canadian perspective): (a) Francophones in a linguistic-minority situation are people whose ethno-linguistic identity, social identity, and identity engagement—and the personal meaning of these identities (Deveau, Landry & Allard, 2005)—relate to French culture, but who live where they are demographically and/or institutionally in a minority, and (b) Francophone identity is inferred when French is the parent language or the language most often spoken at home (Forgues & Landry, 2006).

Method

This qualitative, exploratory study was conducted with a convenience sample of 28 participant families, both Canadian-born and immigrants from 13 different countries, who reported on the experiences of their Francophone families (and thus describing the experience of 95 people). Of these families, 25 lived in Ontario (ON), Alberta (AB), and Saskatchewan (SK); three Francophone families living in Quebec (QC) were included as a comparison. Inclusion criteria for all families were speaking French at home; being either foreign- or Canadian-born; living in a linguistic-minority situation (for families outside Quebec); and being clients of a literacy program or receiving medical care or social services (where possible, in French). The most successful recruitment strategies were face-to-face contact, snowball referrals, and leads from students from Toronto's African communities.

Data were collected from 2007 to 2009 in the cities of Toronto and Ottawa (ON), Edmonton (AB), Regina (SK), and Québec (QC). Data collection involved individual interviews (one man and 23 women) and two interviews with couples. The theoretical and conceptual framework inspired the development of a semi-structured interview guide (available upon request) that was designed to capture interviewees' self-appraisals of their HL and explore their health experiences. We applied the problem-determined system approach, described by Wright and Leahey (2005). Based on this, a family revealed their systematic ideas about a given problem when reporting how they shared ideas and searched for solutions. We documented the interviewees' accounts of how their family members dealt with specific health-related issues and their relational dynamics throughout these experiences. Since we did not speak to all family members, we did not explore intergenerational or gender issues. Interviewers produced three sets of data: observations of participants' reactions to the interview, socio-demographic profiles of families, and families' health experiences and HL (see Table 1). We did not attempt to associate French linguistic competence and HL.

Table 1. Interview guide: Francophone family health literacy in linguistic-minority situations

Interviewee's identification	Health-related experiences
Part I. Socio-demographic data (self-reported) • Identity as a Francophone • Languages spoken at home • Source of family income • Access to biomedical and complementary health care • Self-assessed capacity to understand and use health information in French • Family health history • Sources of health information in French	Part II. Family health experiences and practices in the past 6 months and health literacy (self-reported) • Family composition • Practices to stay healthy • Traditional knowledge and beliefs about health and illness that are still used/valued • Adult health role models • Recent illnesses and the health care received for these • Access to health information in French • Ability to talk to others in French about health issues • Knowledge of and ability to access health resources in French • Factors facilitating learning about health and illness & Existence of health resources in French and their use • School system as a source of information on health and illness • Recreational and sports organizations as sources of information on health and illness • Difficulties in obtaining health information and quality health care in French; successful endeavours to obtain adequate French health care

The semi-structured interview sessions were digitally audio-recorded and transcribed. The qualitative software ATLAS.ti 6.0 (ATLAS.ti Scientific Software Development GmbH, Berlin, DE) was used to code the transcripts and create a guide for thematic analysis (Paillé & Mucchielli, 2008) by following these procedures: (a) developing a preliminary list of codes; (b) intensive, repeated readings of the texts to identify themes; (c) creating a thematic log with reflections about interview contents and attempts to group themes; (d) coding the transcribed texts; (e) refining the theme labels; and (f) tentatively answering our research questions, using the themes with their final labels.

After compiling 46 codes and extracting 732 quotations from the 28 transcribed interviews, two authors (MSZ, NL) critically read the coded texts, identified their meaning, grouped quotations to produce a high level of abstraction, and then defined six conceptual categories that were reduced to their core epistemological meaning. Five themes were refined as possible routes to empirically grounded answers to our research questions. These themes were: (a) using traditional practices to maintain health; (b) exploring the social environment; (c) interacting with formal and informal social networks; (d) awareness of inequities in accessing health care; and (e) acceptance or indignation about the lack of health care in French.

After the data were analyzed, a summary of the themes was given to a Francophone professional with more than 17 years of experience living in a Francophone-minority context, and who was knowledgeable about health/social services. As an insider in the target population (Sandelowski, 1998), she confirmed the final interpretation of the findings, attesting to the validity and reliability of our interpretation.

Ethics

Authorization to contact participants was formally requested and given by the Board of Directors of a community agency. Once the research project was approved by the Research Ethics Board of each researcher's institution, we actively recruited participants for the study. Everyone we contacted agreed to participate. Meetings were then arranged to further discuss the study. Signed informed-consent forms were obtained from all interviewees. Most interviews were conducted at participants' homes on evenings or weekends. Only adults were interviewed, either individually or as couples, according to each participant's preference.

Results

The findings are based on data from 28 interviewees reporting on the experiences of 95 individuals in their families. Study participants were born in Canada (QC, SK), several African countries (Algeria, Burundi, Democratic Republic of Congo, Djibouti, Egypt, Ethiopia, Madagascar, Mauritius, Morocco, Somalia, and Tunisia), Haiti, and France. Interviewees were living in Toronto, ON (n=9), Ottawa, ON (n=5), Edmonton, AB (n=5), Regina, SK (n=6), and Québec City, QC (n=3). We conducted interviews with two couples and 24 individuals (one man and 23 women). Most of the recent immigrants to Canada lived in Edmonton (AB). The families who had migrated from Quebec to Ontario reported French as the first, or home, language; the families in Regina also reported French as their first language. The other families reported French as the second language spoken at home, after another (non-English) language, or were bilingual (French and English) (see Table 2). Most of the immigrant participants spoke at least three languages. Overall, 60% of the participants in each city described English as their third language. Most were middle-aged (age range: 30-50 years old), married, heterosexual couples with at least one child. Most of the interviewees (n=23) were women, who reported on their own, their husbands', and their children's health experiences.

The findings presented here focus on major issues regarding the interviewees' family health experiences and practices in the past six months, as well as their HL-related experiences. The findings describe how previous family health experiences influenced Francophone immigrants' current health practices; their strategies for enhancing their health knowledge; their way of dealing with social-environmental constraints; and their suggestions for improving access to health care for Francophones in Canada.

Table 2. Socio-demographic profile of participant families (N=28)

Socio-demographic data	Edmonton (n=5)	Ottawa (n=5)	Québec City* (n=3)	Regina (n=6)	Toronto (n=9)
Language spoken					
French as first language	0	0	3	6	3
French as second language	5	5	0	0	6
Bilingual(French/English)	Missing data	2	3	Missing data	0
Years in school	11–15	16–21	16–21	16–21	16–21
Employed	2	3	3	6	7
Self-appraised understanding of health information as “very good”	3	2	2	3	7
Self-reported health problems	2	2	1	3	3

*Reference cases (see Table 3).

How previous health experiences influenced current health practices

The participants reported that their health experiences, before immigrating to Canada, were influenced by notions of health as a way of life. Their parents taught them to eat well, get regular medical check-ups, exercise frequently, not drink alcohol or smoke, and maintain proper hygiene. In the words of a Regina participant: “My parents told me that we must respect hygiene. We were also told to get regularly vaccinated and listen to the advice of doctors.” Since immigrating, the participants said they avoid “Canadian junk food,” adopt regular mealtimes, eat fruit and vegetables, avoid using microwave ovens, usually cook with little oil, use fresh ingredients, and substitute fish for red meat.

Although the participants generally believed that maintaining health is an individual responsibility, they also mentioned the roles of fate and divine intervention. A Toronto participant talked about the balance between these: “My parents taught me that health and sickness are in the hands of God, but that doesn’t stop me from seeking medical help when I am sick.” Many reported a preference for natural remedies, including herbs and spices (e.g., cumin, garlic, eucalyptus), to prevent and treat minor ailments. When they could not buy these remedies locally, they ordered them from their home countries and even consulted with physicians there by telephone. Practicing preventative care by maintaining a healthy diet and relying on natural remedies might account for the participants’ overall perception that their health was very good; they tended to use sources of health information only to deal with emerging problems. These sources of health information were usually physicians (only two participants cited other health professionals), television documentaries, the Internet, books on health, friends, and spouses. Families with children received information from elementary schools about vaccinations, prevention of contagious disease, food allergies, and Canada’s Food Guide.

Strategies for enhancing health knowledge

Participants’ strategies ranged from one extreme, for example, gathering all available information and then seeking clarification from friends, to the other, for example, not searching for any information or abandoning their search. In the latter case, either they abandoned their search resulting of frustration for not being able to find any information in French or they had no health problems to investigate, as exemplified by the following quotes:

“No, not at all Honestly, I do not bother looking for information, either in English or French.” (Ottawa participant)

Participants reported not finding French-language resources in their cities and not knowing where to find them, as reported by participants from Edmonton:

"I started researching about an illness, but it was difficult because there was no information in French."

"Our problem is that we do not have any information in French. Even if there is a vaccine against the flu, we receive information about it in English and never in French."

Those participants who did find French-language resources complained that they were difficult to understand, as they were written in highly technical language.

The participants' support and information networks were primarily made up of family and friends (often from different cultures), and, less often, organized groups, such as welcoming centres and church, or school parents' groups. Services occasionally used interpreters, some of whom, however, tended to include unfamiliar English phrases and jargon in a variety of unfamiliar accents. In addition, some participants reported difficulty communicating in specific situations, including those that required informed consent. In other cases, getting signed consent seemed to be the primary focus of communication, as a participant in Regina reported: "When it comes to the health professional, all that happens is they [keep asking] if you are able to sign or not."

Some participants preferred relying on friends and family, often their children, for translation. A high rate of bilingualism among immigrants' children may allow them to better liaise with healthcare services, as a participant in Regina suggested: "The kids today are 80% in favour of becoming bilingual. The young today are more open to learn languages compared to before."

Dealing with social-environmental constraints

The participants reported numerous negative experiences in trying to access health care where the key issue related to the language of service delivery. They were well aware that health care offered in French would enable them to understand, express, and use the information they gathered. One participant in Regina expressed a strong preference for widespread adoption of official-language bilingualism: "In general I do not think just about health. I believe that the two [official] languages should be spoken all the time." As a result of language barriers, they reported receiving incorrect treatment, signing consent forms without being fully informed, and feeling ignored by health professionals. They also complained of long wait times for services in French and of not being able to communicate with Anglophone healthcare staff. The most vulnerable were children in emergency department situations, adults living with a mental disability, and seniors.

Participants reported that when they attempted to communicate in English to health professionals, they were unable to quickly and appropriately phrase questions or understand the responses. This impaired communication caused stress, disorientation, and feelings of powerlessness. Overall, participants reported a severe shortage of French-speaking healthcare providers:

"I cannot go to hospitals because they all speak English and I am unable to express my need." (Edmonton participant)

"I was ready to bring [my autistic son] downtown to find French services ... It's really a problem when a child or someone in the family has a big need ... it is a big problem to [find] French[-speaking] professionals." (Toronto participant)

To deal with these constraints, participants used non-verbal communication, carefully considered what they needed to say before speaking, brought friends and family to appointments to help translate, learned to locate French services where these were available, and learned English. Some even occasionally exaggerated their symptoms to get health professionals' attention.

Despite their complaints of unmet needs, a combination of factors revealed that the participants' limited social networks made it difficult to develop family HL. Table 3 compares participants' experiences according to their geographical location.

Table 3. Accessing healthcare services by a Francophone living in Canada

Linguistic minority Ontario, Alberta, Saskatchewan	Linguistic majority Quebec
Access to healthcare services	
• Restricted accessibility to information • Hindrances due to language disparity and unprotected rights to bilingual services	• Non-restricted accessibility to information and services
Networking to strengthen health literacy	
• No perceived need to form a network or join cultural organizations to defend access to care • No perceived need or attempt to join local cultural organizations to have access to care or health information	• No perceived need to form a network or join cultural organizations to defend access to care

Thematic analysis and discussion

Our analysis of the construction of family HL took into consideration Francophones' desire to use French to preserve their cultural values and protect their identity and rights, as well as the participants' awareness of the inequities. Thematic analysis revealed a new understanding of living in minority-language situations and the dialectic between constructing family HL and counteracting restrictions imposed by unfavourable social environments. Five analytical themes clarified the participants' construction of family HL in linguistic-minority situations: (a) using traditional practices to maintain health; (b) exploring the social environment; (c) interacting with formal and informal social networks; (d) awareness of inequities in accessing health care; and (e) acceptance, or indignation of the lack of health care services in French.

Using traditional practices to maintain health

Being Francophone, having a strong self-identity and biological identity (i.e., being healthy, strong, and well-nourished), and being aware of their linguistic-minority status were all factors that contributed to participants' decisions to use traditional health knowledge within their families or use knowledge they gathered from their new social environments. These decisions depended on their perceived good health and their difficulties in finding French-language health resources after immigrating to Canada. It also depended on their practice of preparing and consuming healthy food, their awareness of current debates concerning Canadian health care and access to services in French, and their general education. As independent health consumers, the participants felt able to implement preventative measures and adopt health promotion strategies to protect themselves against the deficiencies in the healthcare services. Their behaviours illustrate the critical role of HL in personal and collective empowerment (Nutbeam, 2000), mobilization of cultural background (Kaszap & Zanchetta, 2009), and their understanding of their place in the social environment (Masny, 2010).

These results bring an alternative understanding of the so-called healthy immigrant effect, suggesting, in fact, that Francophones in linguistic-minority situations may be invisible in healthcare records. Given their self-perceived good health, they may underestimate the severity of their symptoms and may not even seek health care, either because they have no idea where to go or know that the health care is unavailable in French. New immigrants tend to use family doctors and emergency departments less often than long-settled ones (Uiters, Devillé, Foets, Spreeuwenberg & Groenewegen, 2009) because they are not as familiar with the local services and because of language and cultural differences (Rué et al., 2008; Szczepura, 2005). Immigrants who do not face language barriers tend to use community centres to access healthcare services (Dias, Severo, & Barros, 2008).

Exploring the social environment

The ability to explore the social environment depended on gender and employment status. Whereas men were connected to the community by their jobs and were predominantly bilingual, it was the women who investigated health care for their families and most often had to confront language barriers. Other forms of formal interaction with Francophones in their new social environments were very limited for all respondents. In fact, being employed or having school-age children determined the extent of their interactions, which translated into social support and awareness of local challenges.

Exploring one's social environment reflects the communicative/interactive dimension of HL: developing personal skills in a supportive environment (Nutbeam, 2000) and health information-seeking practices (Kaszap & Zanchetta, 2009) that develop literacy (Masny, 2010). Such exploration also means accessing Francophone organizations that can promote family HL. Exploring that environment helps Francophones translate social capital (social ties, resources, support, networks) into access to health care (Derose & Varda, 2009), breaking down their linguistic isolation. Our findings confirm that the linguistic isolation of Francophones is not merely a geographical issue; it is important in building family HL. Caring for the family is linked with linguistic-minority status and gender (Racine, 2008). We found low HL even among bilingual Francophone immigrants who felt unable to communicate in English during health crises. Multiple factors come into play to explain why the participants did not explore local health resources: lack of knowledge about existing services, social and geographical isolation, and perceived good health. Motivations to explore social environments and learn about health appeared to be personal. Lack of computer access or poor computer literacy also hindered learning. Only bilingual and computer-literate participants were aware of the paucity of French health information on the Internet.

Interacting with formal and informal social networks

Since the participants' interactions with formal social networks and formal communication with other local Francophones were very limited, few new ways of communicating were created. Participants, both those inside and outside Quebec, tended not to consult their cultural community on health issues but rather addressed their immediate family members, friends, and co-workers. This restricted their involvement with other linguistic-minority members as a source of social support.

Development of HL offered neither personal nor social benefits for socially isolated Francophones, who mostly looked to their physicians for information. Their perception of their own good health curtailed their search for information, development of critical HL, and awareness of disenfranchisement (Freire, 1973), as expressed by their position in social, cultural, physical, and political environments (Masny, 2010). Living in linguistic isolation inhibited the participants' mobilization of their relational, human, and cultural capital and contributed to their undervaluing their own social capital and that of others who live in social vulnerability. Limited participation in social networks reduced their opportunities to create bonds of solidarity, which may have, in turn, also undermined the development of their potential to overcome social vulnerability (Soulet, 2008) or improve their HL. The participants demonstrated one important aspect of critical HL — skill in navigating the healthcare service (Raphael, 2010; Kaszap & Zanchetta, 2009). The findings confirmed that, in a linguistic-minority situation, linguistic vulnerability intertwines with other social determinants of health (Ronson, & Rootman, 2009) in creating Francophone family HL, and evidence of these dynamic interactions abound in the participants' accounts.

The community expert who verified our interpretation of the findings stated that immigrant Francophones' lack of knowledge about existing French-language resources is crucial. In addition, Francophones' lack of sensitivity to and education about their rights to receive services in French aggravated the problem of access to care in French. The problem seem to be exacerbated by (1) health and social services professionals' acknowledgement of linguistic barriers but perceived inability to remove them due to limited budgets; (2) institutions not identifying French-speaking staff; and (3) Francophones not requesting health care in French because they had learned English.

Awareness of inequity in access to health care

Lack of French-language health care led some participants to consult with physicians in their home countries by telephone and order medication and herbs from overseas. The participants did not question the safety or efficacy of traditional health practices. Some mistrusted the Canadian healthcare service and undervalued the information given them by health professionals. Awareness of healthcare inequities did not promote collective learning and exchanges about health (Kaszap & Zanchetta, 2009). Instead, it delayed development of communicational/interactive aspects of a critical dimension of HL (Nutbeam, 2000). The participants' limited awareness of the healthcare inequities they faced resulted in a linguistic vulnerability that grew over time. This growth was propelled by four factors: (a) minimal access to French-language health care and information from physicians; (2) lack of motivation to learn about health unless actually ill, and a lack of awareness of their limited knowledge about health as a result; (3) minimal criticism of the quality of any information sought and thus the risk of making poorly informed decisions; and (4) possible attenuation of vulnerability through learning English.

Resignation or indignation about the lack of health care in French

Awareness of the inequity in health care impacted participants in two ways: some insisted on their right to service in French, while others resigned to the status quo. This second group realized that the shortage of French-speaking health professionals demanded that immigrants accept services in English, and they conformed by learning English. In short, their awareness of the lack of health care in French, their lack of awareness of available local resources, and their minimal ability to use computers worked against their interest in learning about health in French. Nonetheless, participants emphasized that Canada is officially bilingual and expressed indignation about the situation. "French is an official language. It is a law, not a privilege," as one participant in Toronto put it.

Few studies have explored how language differences between health professionals and patients affect patient safety (Johnstone & Kanitsaki, 2006). However, studies have shown that professionals provide inadequate information about medical procedures to immigrants and often do not understand patient-provided information (Suurmond, Uiters, de Bruijne, Stronks & Essink-Bot, 2011). Some immigrants rely on doctors in their home countries when their needs are not met in their host country (Marshall, Wong, Haggerty & Levesque, 2010) or find health professionals who speak their language in their host country (Stone, Pound, Pancholi, Farooqi & Khuntia, 2005). Older male immigrants who become proficient in English may still require information brokers to access health information and services due to their limited computer literacy or reluctance to gain the skill (Goodall, Ward & Newman, 2010).

The literature corroborates the strategies our participants reported using to deal with constraints in the healthcare service and supports their suggestions for addressing language barriers and health care-access inequities. For example, American hospitals collect data on patients' race, ethnicity, and language and use this information to improve interpretation services, hire staff with language skills, and translate educational resources (Jorgensen, Thorlby, Weinick, & Ayanian, 2010). In a Swiss hospital, patients with limited French proficiency preferred to have family, friends or staff interpret for them because they are more immediately available than professional interpreters (Hudelson & Vilpert, 2009).

Study contributions and implications

By understanding how Francophone immigrants to Canada handle the challenges of accessing health care in linguistic-minority situations, we can contribute to understanding the challenges faced by other linguistic minorities. More specifically, we found that Francophones outside Quebec, both Canadian-born and immigrant, are "othered" by provincial health care systems, where bilingualism is not mandatory. This study adds to the literature on exclusionary othering, the process of marginalizing that places minority groups into subordinate roles (Canales, 2010; Bannerji, 2000; Eisenberg & Spinner-Halev, 2005). Othering "often uses power within relationships for domination and subordination with the potential consequences being alienation, marginalization, decreased opportunities, internalized oppression, and exclusion" (Canales, 2010, p. 5). However, the extent of othering and its impact on Francophones' health needs is to be explored further. In addition, the differences between

marginalization of Francophones living in Anglophone provinces for more than three generations and that of newly arrived immigrants and refugees would benefit from more subtle analysis.

This study also contributes to the literature on the “healthy immigrant effect” (Hyman, 2007; Dean & Wilson, 2010), which suggests that the health of immigrants deteriorates as their length of stay in Canada increases. The language barriers that the study participants reported challenges the healthy immigrant effect, given their invisibility within provincial healthcare services because of poor access. Another contribution relates to studies on gender-specific trends in HL (Vissandjée, Thurston, Apale & Nahar, 2007), since our mostly female participants were a counterbalance to the trend of male participants being more likely to learn English and be better connected to their host societies.

Our findings have implications for educators, health and social services professionals, and health managers. Suggestions would include to (a) teach professional health-related French to health and social work students, (b) increase the visibility of French-speaking professionals, (c) partner with French-speaking community groups, (d) advocate policies to hire bilingual professionals, and (e) evaluate the organizational impact of initiatives to serve French-speaking minorities. The goal of social justice must guide professionals' efforts to promote HL among underserved populations.

Conclusion

Our findings reveal the unique language-related health inequities experienced by Francophone immigrants and migrants to a country that mandates official bilingualism; this context differs from other studies of linguistic minorities in host countries that are not officially bilingual. Our study advances knowledge about the experiential, interactional, and critical aspects of Francophones' construction of HL within linguistic-minority environments. Linguistic isolation and lack of knowledge about local cultural organizations among Francophone immigrants were two important findings of our study. Both illustrate the importance of health promoters and social workers combining efforts to help newcomers overcome challenges to accessing health care. Francophone women, in particular, appear at risk of isolation; their specific needs should be investigated. We recommend that this study be replicated with youth and men of all ages, and that comparative studies investigate countries with more than two official languages and other linguistic minorities.

However, this study's limitations include partial representation of the major barriers (e.g., lack of information about existing resources, lack of familiarity with professionals other than physicians, lack of social connections) faced by Francophones in accessing health care in French. In addition, the heterogeneous nature and small size of our sample precluded between-group analysis. Despite its limitations, our study can inform settlement policy for Francophones by focusing attention on the construction of Francophone immigrants' HL and their access to health information in French. Cultural brokering may be necessary to facilitate family HL among immigrants, bridge traditional and Western medicine, and increase immigrants' social networking with other Francophones for health information.

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