

**FRANCOPHONE AND ACADIAN EXPERIENCES IN THE PRIMARY HEALTH
CARE SYSTEM IN HALIFAX, NOVA SCOTIA**

by

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Abstract

Objectives:

This research explored the experiences of francophones and Acadians who received primary healthcare in Halifax, Nova Scotia.

Approach:

Semi-structured interviews were completed with 15 self-identified francophones or Acadians. Participants provided feedback on the preliminary phenomenological analysis and final results were determined based on the analysis and participant feedback.

Results:

Language, culture and community were central in participants' experiences but despite the high importance placed on receiving French language health care services, participants often had to compromise and access services in English. Other influences included the strategies they developed to utilise English services and their perception of health care professionals' sensitivity for their linguistic barriers and needs.

Conclusion:

Though it was not always easy or straightforward participants in the study were able to utilise health services but not always in French. Creating situations that may require them to relinquish their language and, to some extent, their cultural identity.

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Chapter 1: Introduction

Background

The primary language of over 34,000 Nova Scotia residents is French (Bouchard-Coulombe, Lepage & Chavez, 2011). Most of these French speaking individuals identify as either francophone or Acadian. Francophone may represent a variety of French-speaking individuals and communities within Nova Scotia including immigrant and native populations. Acadians are descendants of a group of French immigrants who established specific colonies in the 17th century primarily in the eastern Maritime provinces. Despite their unique histories and cultures, both groups speak French and are linguistic minorities within Nova Scotia.

The majority of francophones and Acadians state that it is important to receive health services in French, but they experience difficulty accessing French language services (Bouchard-Coulombe et al., 2011; RéseauSanté, 2010). More than 75% of francophones and Acadians in Nova Scotia use English when communicating with their family doctors (Bouchard-Coulombe et al., 2011). The literature recognizes that the ability to understand and be understood is essential for proper primary health care services and that the best communication is achieved when health care providers and patients speak the same language (Bowen, 2001). Further, beyond the role language plays in effectively communicating information about illness, disease and disability concerns, linguistically appropriate services are also an important way to show respect for the service user's culture (Samson & Spector, 2011).

Linguistic minorities, including francophones and Acadians, experience inequities in several aspects of the health care system when compared to English-speaking Canadians (Bouchard, Gaboury, Chomienne, Dubois & Gilbert, 2009; Fédération des communautés francophones et Acadiennes (FCFA), 2002). The negative effects of linguistic barriers on health with respect to access, comprehension, quality and satisfaction of health services have been highlighted in the literature (Woloshin, Schwartz, Katz & Welch, 1997; Bouchard et al. 2009; Picard, Carriere & Hebert, 1999; Bowen 2001; Jacobs, Shepard, Suaya & Stone, 2006).

Specifically, within Nova Scotia, 34,000 francophones and Acadians constitute slightly less than 4% of the population. One third of them reside in Halifax while the remainder are scattered in communities throughout the province (Bouchard-Coulombe et al., 2011). Despite their relatively small population, francophones and Acadians are quite visible in Halifax with festivals, schools, community radio, and organisations (FCFA, 2002). Within the Halifax community, over 60% of francophones and Acadians reported that it was very important to them to receive health care in French, but less than 25% regularly receive services in French (RéseauSanté, 2010; Statistics Canada, 2011).

Despite the important role language plays in health care service, little is known about the lived experience of francophones and Acadians with the local health care services in Halifax, the provincial capital. This research sought to explore this gap and by providing insights into these experiences, the research yields a better understanding of and recommendations to improve the francophone and Acadian experience with the primary health care system.

Research Questions

The research question was: How do francophones and Acadians experience primary health care services in Halifax Nova Scotia? This question sought to: 1) understand the experiences and challenges of being a francophone and Acadian within the predominantly anglophone health care system of Halifax; and 2) explore the importance that the population places on receiving French language services.

Terminology

“Francophone and Acadian” is used throughout this document to describe residents of Nova Scotia who report French as their first official language. This group includes French-Canadians, Acadians, francophone immigrants and francophones from other provinces currently residing in Nova Scotia. Furthermore, “Official Language Minority” is used in this report to describe individuals who speak French or English and who reside outside a province with the same official language as that person (i.e. French speakers living outside of Quebec and English speakers living inside of Quebec).

Study Design

This qualitative research study was framed by a phenomenological theoretical underpinning. Data was collected using one-on-one, semi-structured, qualitative interviews with members of the francophone and Acadian community in Halifax Nova Scotia in French. The analysis was guided by Smith and Osborn’s (2003) process of phenomenological analysis. The results and discussion highlight major themes, their implication in the experiences of the population, areas for future study and

recommendations for the health care environment and the francophone and Acadian community.

Position of the Researcher

I have always been a part of a francophone community through my education, employment and social environments despite French being my second language. This connection to the official language minority group provides sensitivity for their reality.

My interest for research in this area stems from the two years I spent at the Montfort Hospital, a national symbol of *la francophonie*¹, working with pioneers in the field of francophone minority health research. While employed at the hospital I received numerous opportunities to participate in research, policy initiatives and advocacy with experts in several areas of francophone health.

I have approached the issues of francophone health from both a professional and a personal perspective. Both dimensions of my experience were utilised to build rapport with participants, analyse and interpret the data, and report the findings in a manner that fairly represents the personal experiences, and the relevant scientific and theoretical literature.

Conclusion

With few exceptions, the health of the francophone and Acadian minority population in Nova Scotia is largely unexplored in the empirical literature. Being part of a

¹ *La francophonie* refers to the heritage, value and pride of belonging to a community of French speaking people (Organisation internationale de la Francophonie, 2013).

minority language population has been linked to communication barriers that negatively influence access, comprehension, quality and satisfaction with the health care system. This research sought to fill a gap in the literature by exploring how francophones and Acadians experience the primary health care system in Halifax Nova Scotia. The research design used qualitative methods and invited members of the francophone and Acadian population to share their experiences through semi-structured interviews. A phenomenological analysis highlighted the major themes of the interviews and their influence and implication on participants' experiences. As I have been part of a francophone community for the majority of my life, I was able to build rapport with participants and approach the analysis and reporting process from diverse vantage points in order to draw a nuanced picture of the francophone and Acadian experience.

Chapter 2: Literature Review

Introduction

The ability to understand and be understood is important for proper primary healthcare services. The best communication is achieved when healthcare providers and patients speak the same language (Bowen, 2001). Research has shown that when an individual's language does not correspond with the language of the provider, the patient may experience approximately three times the likelihood of poor comprehension when compared with patients who shared the same language as the provider (Wilson, Chen, Grumback, Wang & Fernandez, 2005). Thus, linguistic disconnect between patient and provider creates inequities and linguistic barriers that influence the experience of using health care services.

In Canada there are several minority language groups but only two official languages, French and English. English is the majority language with over 24.8 million individuals, or 75.0% of the population reporting it as their first language and French is the official minority language representing 7.7 million Canadians, or 23.2% of the population (Bouchard-Coulombe et al., 2011). Other than in the province of Quebec, francophones and Acadians represent a minority of the population and face challenges related to their ability to receive health care services in their first language (Bowen 2001; Picard et al., 1999). The Federal Official Language Act (OLA) stipulates that people have the right to access government services in French if they prefer, but the OLA does not apply to health care. The issue of health care was only highlighted in 2003 by the Canadian Federal Action Plan that was created to support the OLA. In response to the

Federal Action Plan, Health Canada revised their dual language initiative to support the official language minority communities in accessing linguistically appropriate care (Health Canada, 2004). Despite revisions, francophones and Acadians still rarely have access to French language health services creating difficulties, barriers, and a unique experience for the official language group.

This literature review is divided into three parts. The first part examines the Official Language Minority (OLM) national and Nova Scotia provincial health policies and programs. Second, literature on linguistic barriers for users of the primary health care system is explored. Finally, information about Nova Scotia's francophones and Acadians is presented to provide context for understanding the experiences shared in this study.

OLM Health Policy and Programs

As previously stated within Canada there are two official languages; English and French. Excluding Quebec, 4.4 % of the population speaks French as a mother tongue (Statistic Canada, 2011). This small OLM population has language rights that are enshrined in the federal constitution.

The right to use English or French in public contexts was highlighted as early as 1867 in the Constitution Act. The 1969 Official Languages Act solidified the legal rights of the French and English languages. The goal of the Official Languages Act is to protect and ensure respect and equality for language status, rights and privileges of the official languages populations in Canada. However, until recently language rights have not been central in the development and implementation of programs or policies at any level. The failure of policy and programs to ensure language rights may have contributed to the rise

of the Separatist movement in Quebec and their refusal to sign the 1982 Canadian Charter of Rights (Official Language Community Development Bureau (OLCDB), 2007). After the refusal in 1982, Canada began developing several mechanisms to better promote and protect the language rights of members of official language groups.

The primary mechanism was updating the Federal Language Act in 1988. The principal change was in part VII of the Act, which now states that the government is required to foster the development and vitality of OLM communities. The intention of this section was to enable these communities to thrive and enjoy the same benefits as the rest of the population (Health Canada, 2004; Officer of the Commissioner for Official Language, 2011). Specifically section 41 of part VII states:

- (1) Government of Canada is committed to
 - a. Enhancing the vitality of the English and French linguistic minority communities in Canada and supporting and assisting their development; and
 - b. Fostering the full recognition and use of both English and French in Canadian society (Officer of the Commissioner for Official Language, 2012)

In 1994, the federal government created an accountability framework and designated 30 federal institutions as partners in the development of OLM communities, including Health Canada (Canadian Heritage, 2012). This was the first time OLM language and health intersected in the federal documents.

In 2002 a Federal Government Action Plan for official languages for the years 2003 to 2008 was announced. The Plan defined federal assistance for key departments that were highlighted in the accountability framework of 1994. A second part of the Action Plan called *A Road Map to Linguistic Duality* was implemented in 2008-2013. The total investment for the two phases of the plan was \$226 million (2003-2008: \$119 million; 2008-2013: \$107 million). The priorities for health between 2003 and 2008 included community networking, training and retention of health professionals, and improved access to health care services. During the second phase for the years of 2008 to 2013 new priorities for health were established and included awareness, consultation, communication, coordination and liaison, funding and program delivery, and accountability (Officer of the Commissioner for Official Language, 2011).

What complicates matters in Canada is that these policies and programs guarantee Canadians access to federal services in the official language of their choice but for the most part Canadian health provision falls under provincial jurisdiction. The primary mechanisms available to federal government for protecting and promoting official language rights in health are the transfer payments from the federal to the provincial governments. Transfer payments are processed on the conditions that provinces apply for funds based on provisions in the Canada Health Act (Department of Finance Canada, 2011). One of those provisions relates to accessibility, and though this would seem to be the ideal setting to protect linguistic barriers stemming from poor accessibility, in the Canadian Health Act access is defined only as “reasonable access” and has not been linked to the Official Languages Act (Canadian Heritage, 2012). The challenges for Health Canada’s implementation of the OLA due to the disconnection between federal

and provincial legislation contribute to the variability in access to French health services and the vulnerability of Canada's official language minority communities.

Linguistic Barriers for Users of the Primary Health Care System

The lack of inclusion of OLM guidelines in health policy and programs may have limited the ability of French speaking minorities to properly access and utilise health care services. Within the literature, these limitations are referred to as linguistic barriers. Furthermore, over half the literature written on linguistic barriers focuses on primary health care (Jacobs, Chen, Karliner, Agger-gupta & Mutha, 2006). Primary health care is a crucial part of the health care system and is the patient's first point of contact with that system. Therefore, experiences with primary health care impact a person's experience with the rest of the health care system. This part of the literature review first describes the importance of primary health care. Second, it focuses on describing what is known about the linguistic barriers that influence experiences with primary health care.

Primary health care. Primary health care (PHC) services have a vital influence on the health status of individuals in every language group. They are an instrumental determinant of health "and a key resource in improving health in an equitable manner" (Baum 2009, pg. 1967). Over a six-year period (2000-2006), the Primary Health Care Transition Fund supported provinces and territories in their efforts to improve the primary health care system (Health Canada, 2007). Since the Canadian health care reform in 2006, supported by the Transition Fund, primary health care has become the foundation of the health care system (Health Canada, 2006).

Thousands of Canadians receive PHC services offered by health professionals such as: family doctors, pharmacists, nurses, nurse practitioners, dieticians, physiotherapists and social workers. It typically involves routine care, care for urgent but minor or common health problems, mental health care, maternity and child care, psychosocial services, liaison with home care, health promotion, chronic disease prevention and management, nutrition counselling and end-of-life care (Canadian Institute for Health Information (CIHI), 2006).

The National Population Health Survey found that almost 80% of Canadians made use of primary health services in the 12 months prior to the survey, particularly family physicians, and almost 50% indicated multiple uses (46.7% in Quebec to 67.8% in Newfoundland and Labrador) (Statistics Canada, 2000). Despite high use, there are still inequities, most notably 12.3% of Canadians are without a regular family physician and 4.3 million Canadians report experiencing difficulties accessing PHC services (Sanmartin, Gendron, Berthelot & Murphy, 2004). A survey sampling 5,500 Canadian adults reporting a need for routine or ongoing care showed 13% experienced difficulty accessing care. Of the sample 21% of the adults that required immediate or emergency care from PHC services faced barriers accessing the care (CIHI, 2009). Thus, despite high utilisation of PHC services, many Canadians experience difficulties receiving the service.

Health outcomes of francophone official language minorities. Difficulties with PHC services are prominent among linguistic minority populations due to the linguistic barriers they experience (Bowen, 2001). The francophone OLM communities experience

issues of inequities and barriers in health services however there is limited information about their health outcomes in order to create a clear understanding of its impact. Of the research that is available it has typically shown francophones to be in poorer overall health than non-francophones (Picard et al., 2006; Réseau des services de santé en français de l'Est de l'Ontario (RSSFEO), 1999). However, not all studies have replicated these findings. Research on health outcomes for this population is highlighted below and organised by province.

In Manitoba, only one study has examined and compared the health outcomes of francophones and non-francophones. They found franco-Manitobans' self-rated health is increasing with each new generation. Adults and seniors were less healthy than their non-francophone counterparts, while young francophones were healthier than young non-francophones. The authors suggest that the health of the OLM population is increasing with the evolution of French language laws and policies in the province (Chartier et al., 2012).

In Ontario there has been significant movement in the field of francophone health research. Research groups in the east as well as researchers from northern and central Ontario have released a number of studies in the past decade. The prevalence of certain illnesses including respiratory disease, hypertension and musculo-skeletal problems were found to be higher for francophones than those of the combined provincial population (RSSFEO, 1999). Additionally, a secondary analysis of the Canadian Community Health Survey by Statistics Canada found that the proportion of francophones in minority situations who described their state of health as "excellent" was lower than their Anglophone counterparts (Picard et al., 2006). A secondary analysis on a more recent

version of the questionnaire found similar results on self-rated health status; a difference between number of chronic illness as well as mental health issues were also highlighted (Chomienne et al., 2010). Franco-Ontarian men were less likely than all other sex and language groups to rate their health as excellent (Bouchard et al 2009).

New Brunswick's examination into the health of francophones and Acadians began with the seminal large-scale study undertaken in the 1980s by Robichaud concluding that language was a determining factor in the health status of the province's populations. Specifically in Northern New Brunswick, francophones had a higher rate of institutionalization and hospitalization than non-francophones (Robichaud, 1986). More recently, a secondary analysis on the Canadian Community Health Survey by Statistics Canada found that the proportion of francophones and Acadians in minority situations who described their state of health as "excellent" was lower than of their anglophone counterparts (Bélanger et al., 2011).

In Nova Scotia, the first study on francophone health compared a francophone rural community to several anglophone rural communities. The study examined treatment rates of cancers, circulatory diseases, diabetes and psychiatric disorders. There were no differences found between the francophone and anglophone communities, but, compared with the overall provincial average, the rural communities had higher treatment incidence rates (Langille, Rainham & Kisely, 2012). Community consultations have also been done through community organisations. Though these consultations have not addressed health status, the importance and the interest this population places on their health and receiving health care in their own language has been highlighted (RéseauSanté, 2010).

Two recent studies examined the importance and utilisation of health care services qualitatively. Samson & Spector (2012) found that HIV positive francophones from Ontario felt that receiving care in their own language not only acted as a tool for proper and effective communication but offered respect for their culture and language. In Calgary Alberta, non-immigrant francophones and immigrant francophones expressed a preference for health services in French and little interest in using interpreters. This population often delayed seeking care and experienced emotional distress and discontentment with care received (Ngwakongnwi, Hemmelgarn, Musto, Quan & King-Shier, 2012).

Differences in health status between the majority and minority official language populations in Canada have been highlighted. However, based on the lack of uniformity between research across and within provinces, a conclusive representation of this population's health status in comparison to non-francophones is difficult to determine. Some investigation into the importance and the experience of using health care services have shown that francophones and Acadians experience difficulties because of language incompatibilities; however this research is limited and the Nova Scotian francophone and Acadian perspective is still largely unknown.

Linguistic Barriers

Linguistic barriers to health care refer to the difficulties associated with language incompatibilities between patients and providers. The literature on these linguistic barriers highlights four key areas of concern: access to health services, comprehension, quality of health services, and satisfaction with health services (Jacobs et al., 2006).

Barriers for access to health care services. There are considerable gaps between the availability of services in French and services in English. *Fédération des communautés francophones et acadienne du Canada* (FCFA) have investigated this phenomenon and found evidence that francophones living in minority situations experience significant access barriers to health care. In 2001, they collected data from all provinces and territories and found that 50 to 55% of francophones did not or rarely had access to French health services. When compared to the proportion of English services in the same region there was 3 to 7 times less availability of French health services (FCFA, 2002). Furthermore, priority services and services for which language and communication were most important, such as primary care and psychological care, were not distinguished by a higher level of accessibility. There were large regional differences and some gaps were expected because of low density of francophones in a region; however, higher density of francophones did not assure higher accessibility (FCFA, 2002).

A Canadian literature review by Sarah Bowen completed for Health Canada in 2001 found that there was overwhelming evidence of poor access to services in minority languages resulting in high utilisation of English language services for these linguistic populations. Further, the effects of accessing service in a language the user was not comfortable in resulted in issues with quality of services, proper and effective communication between patient and physician, and negative health outcomes (Bowen, 2001). This review did not focus specifically on francophones and Acadians. Nevertheless, Bowen (2001) acknowledges that French language minorities may also experience barriers to accessing health care when living outside of Quebec

Barrier for comprehension of health services. When patient and provider do not speak the same language there is an increased risk of miscommunication and poor comprehension. Patients who have a poorer understanding of the care they receive are less likely to actively participate in their health care (Fraenkel & McGraw, 2007). Furthermore, they are less likely to follow recommendations for treatment and follow-up visits when compared with patients whose understanding of English is better.

Even when a patient and her/his physician speak the same language, there is a risk of miscommunication between the two parties. A study by Crane found that overall patients correctly identified 59% of the instructions given by her/his physician after an appointment. Non-English speakers identified significantly less instructions than English speaking patients (Crane, 1997). Evidence suggests that optimal communication and the fewest interpretation errors occur when non-English speaking patients have access to trained professional interpreters or bilingual providers (Flores et al., 2003). Bonacruz & Cooper (2003) suggest that use of interpreters is generally low due to poor identification of the need for and provision of an interpreter by the health care institution. Furthermore, patients express a preference for friends or family members over unfamiliar professional interpreters (Ngwakongnwi et al., 2012). Unfortunately, untrained interpreters can lead to medical errors with potentially serious consequences (Flores et al., 2003). Due to the inconsistencies, poor utilisation and undesirability of interpreters by patients and providers, interpreters are not an ideal solution for issues of comprehension.

One of the major complications of poor comprehension is poor adherence to treatment, including medication and follow-up appointments. Communication ability between patient and her/his provider significantly influences whether instructions about

medical prescriptions were understood by the patient (Shapiro & Saltzer, 1981). Wisnivesky et al., (2012) and Karter, Ferrara, Darbinian, Ackerson, and Selby (2000) also found significant associations between limited English proficiency and poor medication adherence in different populations. Additionally, medication adherence was improved with the availability of bilingual staff and multilingual labels (Compton, Haack & Phillips, 2010). Follow-up appointments are less likely to be scheduled and attended by non-English speaking patients. A cohort study in Ohio, US showed that 83% of patients without language barriers received a follow-up appointment, whereas only a quarter of the patients who communicated through an interpreter or should have utilised an interpreter were scheduled for second appointments (Sarver & Baker, 2000). Thus, comprehension in a medical situation is important for treatment and adherence after the original appointment.

Comprehension and adherence to treatment are negatively impacted by fragmented language between patient and provider. Though not an ideal solution, methods such as interpreters can create better communication between patient and provider.

Barriers for quality of health care services. Communication is essential for proper delivery of health services. Often in order to use the available health care services linguistic minority patients must try to communicate in a language they are not fully comfortable in, or they may be required to rely on family, friends or other health care professionals to describe symptoms, transmit emotions and uncertainties, ask questions, and receive instructions (Carrasquillo, Orav, Brennan, & Burstin, 1999; Morales, Cunningham, Brown, Honghu & Hays, 1999). This is not an ideal situation. The patient

or the translator may misinterpret meaning, not fully understand instructions or be shy or embarrassed about sharing personal health information in an unfamiliar language or to the third party. These issues may contribute to the quality of health care received by linguistic minorities.

A study examining the delivery of health care services to linguistic minorities reported heightened risk of diagnostic error, exposure to increased unnecessary medical tests as well as longer consultation times with professionals (Perkins, 1999). Furthermore, minority language patients had higher rates of hospitalisation and iatrogenic complications (Hamper, Cha, Gutglass, Binns, & Krug, 1999). Increased use of emergency services, higher rates of diagnostic tests and lengthier hospitalization were also found within linguistically marginalized population (Carrasquillo et al., 1999; John-Baptiste et al., 2004). There was no literature that examined these realities in a francophone and Acadian population however; scholars hypothesise that the results would be similar (Bowen, 2001; Bouchard et al., 2009).

Barriers for satisfaction with health care services. The relationship between patient and provider is important for creating a medical environment that fosters trust and confidence. A study of linguistic minorities accessing emergency room services found that the patient-physician relationship suffers when language incompatibilities are present (Flores, 2006). Patients who did not speak the same language as the provider tend to rate their experience with health care services more poorly than patients who share the providers language because of increased difficulty connecting with the provider. Furthermore, these patients are less likely to return or want to return for further

consultation or follow up care (Flores, 2006). These results support the hypothesis that minority language status is an important contributor to patient-physician relationship, patient's perception of care, and their overall patient experience. Therefore, francophone and Acadian minorities in Canada, who experience difficulty communicating in English, are faced with several barriers that may influence their experience and perception of the health care services they are trying to access.

Nova Scotia OLM Population and Health Policy and Programs

Culture and language influence perceptions and experiences of health and illness including how patients express and manifest their symptoms, their style of coping, their family and community supports, and their willingness to seek treatment (Department of Health and Human Services, 2001; Kirmayer, Brass, & Tait, 2000; National Collaborating Centre for Aboriginal Health, 2009). Therefore, in order to explore the experiences of the francophone and Acadian population it is essential to consider language barriers but also how those barriers are influenced by the cultural and social realities of having membership in a francophone and Acadian community. The following section explores the francophone and Acadian population in Nova Scotia, including history, culture and social realities. The second part of this section describes the French health programs and policies in Nova Scotia affecting francophones and Acadians.

Nova Scotia's OLM Population

Demographics of the population. The francophone and Acadian population in Nova Scotia constitutes approximately 3.7% of the overall population in the province. One third of the francophone and Acadian population resides in Halifax (approximately 10,240 individuals). One third of the population is located between the towns of

Yarmouth and Digby. Finally, 7% of francophones are in Richmond County and 9% in Inverness County, with the remaining population scattered throughout the province (Bouchard-Coulombe et al., 2011).

Within Nova Scotia, francophones and Acadians are a minority and face challenges to maintain their language and culture. Dependence on anglophone infrastructure as well as high levels of bilingualism and cross-linguistic marriages contribute to the challenge (Bouchard-Coulombe et al., 2011). Longitudinally, the French language has seen a slow but steady decrease in the province since 1951 (Bouchard-Coulombe et al., 2011). Nearly all francophones and Acadians, particularly within Halifax, are bilingual (92%). Generally, due to minority status, bilingualism is essential for their survival in the community, which includes for access to health services (Webber, 1994; Bouchard-Coulombe et al., 2011). Historically, the maintenance of the minority francophone culture has fallen to its members but there is also indication in the literature that the education system was central to the preservation and continuation of the social networks and culture within a francophone minority community. Schools were expected to create an ideal environment where language and culture had a place of honour and instilled a strong feeling of pride in the cultural identity of youth, thus combating assimilation (Cormier, 2005). In the Halifax region, actions for the preservation of their culture and language has been shown in the growth of community infrastructure highlighted by the growth of the Acadian school board to 5 schools.

Nova Scotia's francophones and Acadians are an aging population, with children and youth (0-14) accounting for only 10% of the population. Unlike other populations of

francophones in Canada, they have similar education levels and income as their anglophone counterparts (FCFA, 2004). Members of the francophone and Acadian population of Nova Scotia were born primarily in the province. Only 30% are from away. Of the 30%, 3% were born outside of Canada. These immigrants are primarily from France, accounting for approximately 30% of francophone immigration to Nova Scotia. Other origin countries include Lebanon (12%), the United States (11.7%) and Egypt (6.9%). francophones who were born in another province and moved to Nova Scotia represent the remaining portion of the “from away” population. Nearly half of this population originated from Quebec and one third from New Brunswick. Of the francophones and Acadians born in Nova Scotia, in 2006 they numbered 22, 615 individuals (67.1%) (Bouchard-Coulombe et al., 2011).

Two communities: francophones and Acadians. French speakers in Nova Scotia predominantly identify as either francophone or Acadian. These are two distinct groups of people with separate histories that have shaped many of their current realities. Historically, Acadians were 17th century French settlers in the Maritimes. Acadia was a colony of New France, and was geographically and administratively separate from the French colony of Canada which led to Acadians and French-Canadians developing two distinct histories and cultures (Centre d'études Acadiennes, 2007)

Acadians have a history of domination and oppression. In 1755, they were exiled from the province; some were deported to France, New England, and many eventually relocated in Louisiana. This period was named the “grand-derangement”. Some Acadians avoided deportation and later after permission was granted some returned (Rivard, 2008).

It was not until the 19th century that Acadians gained new rights, assumed positions of power, and founded educational institutions (Centre d'études acadiennes, 2007). During the 1881 Acadian convention, August 15th was chosen as National Acadian Day. During the following convention in 1884, an Acadian flag and a national anthem, Ave Maris Stella, were adopted. The National Acadian Day was recognised under federal law in 2003 and under Nova Scotia law in 2004 (Centre d'études acadiennes, 2007). Nevertheless, it is also important to note that this population is resilient, visible and vocal within Halifax, and proud of their heritage.

French-Canadians in Nova Scotia include both francophones born in the province who are not decedents of the original French settlers and immigrants from other provinces and countries. Immigrants from other countries are a diverse group, identifying with a wide range of religious, ethnic and traditional cultural practices. French-Canadians from other provinces may self-identify in terms of their own regional history. The cultural map of Nova Scotia thus includes Franco-Ontarians, Franco-Manitobans, the Franco-Yukonais, the Franco-Ténois, the Fransaskois, and the Franco-Columbians (Frenette, n.d). Despite the heterogeneity of the francophones and Acadians, they experience similar current realities stemming from their membership in a minority community –including difficulties with accessibility and utilisation of health services in their own language.

Community values and commitments. Despite cultural differences within the province, francophones and Acadians value and respect their cultural and linguistic heritage. Seventy eight percent of francophones and Acadians report that it is very

important to be able to use French in their daily lives and 86% believe it is important for organisations to participate in developing the French communities within the province (Bouchard-Coulombe et al., 2011). The language practices of francophones and Acadians are strongly influenced by the dynamics of living in a primarily anglophone environment. To thrive, they report a high rate of bilingualism that decreases their use of the French language in their daily lives. Despite the influence of the majority environment, 77% of francophones and Acadians believe that government services should be provided in French and that their linguistic rights need to be respected in their province. Furthermore, they report being confident in their linguistic presence in Nova Scotia and 67% believe that this presence will be maintained or increased in the future (Bouchard-Coulombe et al., 2011).

In regards to health, 42 % of francophone and Acadian Nova Scotians and 60% within Halifax report it is very important to obtain health services in French (Bouchard-Coulombe et al., 2011; RéseauSanté, 2010). However, 82% of their contact with nurses, 75% of contact with family doctors and 81% of contact with other professionals and specialist is in English (Bouchard-Coulombe et al., 2011). Contrary to the utilisation of the English health services by francophones and Acadians a 2006 census showed that 20% of doctors working in Nova Scotia reported being able to conduct a conversation in French but only 5.4% of them report using French regularly in practice (Bouchard-Coulombe et al., 2011). Ideally, the presence of professionals able to conduct a conversation in French should increase the accessibility of French health care services. However, the gap between available French speaking professionals and francophones and Acadians using French language to obtain health services is still large.

Health policy and programs. Despite the barriers experienced by this population many health-related initiatives have been made possible through Health Canada's support for improving access to health services for Official Language minority communities. In 2004 the province developed a French language policy and action plan to improve French health care (OLCDB, 2007). The French Language Service Act outlined the provision of French services in Nova Scotia, but, like the Official Languages Act, it does not address health care. Also in 2004, the network for French language health services in Nova Scotia (Réseau Santé Nouvelle-Écosse) was established to promote the accessibility of health and wellbeing services. The network includes health care professionals, health care institutions, community organisations, department of Health, Consortium National de Formation en Santé (CNFS) and the Conseil scolaire acadien provincial. The Nova Scotia Department of Health hired a French-language health services coordinator, also in 2004, to work with the Acadian and francophone communities and district health authorities to encourage the system to be more responsive to the health needs of the French-speaking population. Since all this movement in 2004, there has been some visible progress in Nova Scotia; one hospital in Chéticamp provides services in French and policy within the Cape Breton District Health Authority stipulates that all patient care positions posted in the facility must include a French language requirement. RéseauSanté launched a program to develop a plan for primary health care services in 2006. The plan presented a series of action areas and since its implementation an online directory of health care professionals who offer services in French has been established. French language advanced paramedic programs are now being offered at Université St. Anne.

Lastly, a bilingual primary health care walk-in clinic and family doctor was opened to serve Halifax, Dartmouth and Bedford in 2013.

Overall, the province has made some advancement in regards to French language health services. The progress by the province in regards to French language health initiatives demonstrates a strong dedication to improvement, however difficulty accessing and using primary health services is still an issue for many francophones and Acadians creating a unique experience for individuals in the middle of this improvement.

Chapter 3: Methodology, Research Design and Research Methods

Objective

This research question, how do francophones and Acadians experience the primary health care system, examined how francophones and Acadians experience primary health care services in Halifax Nova Scotia. The objective was to develop an in-depth understanding of the role of language and culture in the lived experiences of this particular population as they utilised the primary health care system. The following section describes the paradigmatic approach, method of inquiry, analysis and dissemination as well as ethical considerations and quality of research.

Theoretical Approach

A theoretical approach or paradigm is a worldview or belief that guides the research process. Based on the research paradigm the limits of what is considered legitimate inquiry are established in order to develop a framework and determine the methods of the research through ontology, epistemology and methodology (Guba & Lincoln, 1994). Furthermore, the paradigmatic strategy provides direction for decision making and the role of the researcher (Patton, 2002). As this research sought to examine individual's lived experiences that have been molded by interactions with the natural, social and physical environment, the approach that best fit the purpose of this research was phenomenology.

The ontological, epistemological and methodological commitments were shaped by the purpose of the research ,the research question and the paradigm chosen to define the study and are explored in the following sections.

Ontology. The ontological question describes the nature and form of reality and therefore determines what can accurately be known about it (Guba & Lincoln 1994). This theoretical approach assumed the main characteristic of reality are subjective and multiple and that multiple realities and knowledge are constructed based on social and personal experiences (Crotty 1998, Labonte & Robertson 1996, Mackey 2005). This research included individuals from a similar linguistic minority group. These individuals shared some of the same social, cultural and environmental experiences. However, to respect the ontology, the researcher recognised these individuals may interpret phenomena in a unique way, thus, variations in interpretations were not considered more or less true but simply the product of differences in experience, understandings and personal characteristic (Guba & Lincoln 1994).

Epistemology. The question of epistemology seeks to denote the relationship between the researcher and the research participants in order to frame what can be known about the world. Specifically, it is concerned with the nature, scope and basis of knowledge and provides a foundation for deciding whether the knowledge collected during the research process is adequate and legitimate (Crotty, 1998; Guba & Lincoln 1994). Based on Crotty's work in the late 1990s phenomenology, as it is predominantly used in North American, is influenced by a constructivist epistemology (Crotty, 1998). The constructivist viewpoint emphasises that knowledge, or human understanding, is a construction in a transactional and subjectivist manner (Guba & Lincoln, 1994; Barkway, 2001). This research reflected that viewpoint by utilising a qualitative and interactive method of inquiry between the researcher and the subject.

Methodology. The methodology question depicts how the researcher determines what he or she believes to be known by establishing the manner by which the researcher operates as a research instrument and the approach to data analysis (Guba & Lincoln 1994). Phenomenology complimented the research question and purpose by offering a lens to comprehend individual lived experience of a phenomenon in an uncontrolled natural environment by using knowledge embedded in common life experiences (Mackey, 2005). Primarily established through work by Heidegger, phenomenology has four basic principles; being-in-the-world, fore-structure, time, and space (Mackey, 2005).

Individuals cannot exist without being part of the framework of their surrounding environment. Being-in-the-world refers to this inseparability of the object and the individual. Based on this principle the researcher must examine the subject in the world and cannot attempt to understand their experiences separate from the world. The perspective of the research was that individuals are influenced by their environment. Therefore, in the inquiry process an emphasis was placed on understanding the social and cultural environment of francophones and Acadians in Halifax. This emphasis provided insights into the meaning and background of the lived experiences shared by participants during the inquiry process.

Fore-structures are what is known in advance and make up the background knowledge about the situation before the inquiry and analysis process. The researcher established fore-structure through an extensive literature review of health care and francophone minorities as well as other linguistic minorities. Knowledge was also acquired through personal experiences which included living in a francophone

environment, working in health care and experience with several research and interest groups promoting French language health care. This knowledge was used while developing interview questions, facilitating a rich discussion using probes during the interview as well as during the analysis process to add depth to the understanding of the experiences that were shared by the subject.

The principle of time grounded the experiences of the subject. The interpretation of human experience should be sensitive to temporal flow because past, present and future may be experienced as one or influence each other (Heidegger, 1962). Critical events disrupted the regular flow of time such as an illness or difficult situation that was suddenly triggered part way through a separate narrative (Mackey, 2005). Furthermore, past experiences may have also directly influenced recent and current experiences with the services (i.e. a negative experience in the past may lead an individual to expect or prepare for a negative experience in the present). Due to the presence of time in the inquiry and analysis process, the researcher was mindful of the experience of time through reflection on why the individual recalled and shared certain experiences.

The last principal is space (Heidegger, 1965). Space refers to what is more important to a person's experience and what is less important (Mackey, 2005). Individuals have less emotional space between themselves and important experiences. During the inquiry and analysis process the researcher observed that some of the experiences shared by the participants were more emotionally charged, were allocated more description, or were repeated a number of times. These experiences were considered to have less space between the subject and the phenomenon and were

therefore considered of particular importance. By understanding this principal, it allowed the researcher the ability to bring depth into the analysis of the phenomena by reflecting on the importance of each experience.

Overall, the research, supported by the phenomenological paradigm, sought to develop an understanding of how francophones and Acadians experience primary health care services. The research was sensitive to the principles of phenomenology of being in the world, fore-structure, time and space. This sensitivity was reflected in the inquiry and analysis.

The role of the researcher in phenomenology. Phenomenology emphasizes that research is a dynamic process that requires an active role for the researcher (Smith & Osborn, 2003). The research objective was to understand the personal world of the individual being studied. Since that world was private to the individual, the researcher had to be an active member in the discussion about their understanding of that world. While participants described their experiences, the researcher facilitated the interview by asking questions and probing for more details to develop the most complete understanding possible. The role taken on by the researcher during the semi-structured interview was a facilitator and guide, rather than to dictate exactly what would happen during the encounter (Smith & Osborn, 2003). Thus, the researcher sought to build rapport, ask questions and encourage sharing by engaging participants openly and using personal and professional experiences.

Furthermore, the researcher sought to understand the experience of the participant through a process of cyclical interpretation (Smith & Osborn 2003, Thompson 1990). As

the researcher, my experiences, understanding of the literature and professional learning all contributed to the analysis process in order to develop the most knowledgeable, informative and accurate portrayal of the individuals' experiences possible.

Study Design

After receiving approval from Dalhousie Research Ethics Board (Appendix A) members of the francophone and Acadian community in Halifax were recruited to participate in 45-90 minute in-depth one-on-one semi-structured qualitative interviews about their experiences with primary health care services. Interviews were analysed using multi-level thematic and cyclical analysis to determine themes and relationships from the experiences shared during the interviews. This design was developed to effectively blend background knowledge and individuals' experiences to understand primary health care services through the perspective of the official language minority population of Halifax Nova Scotia.

Sample and recruitment. Phenomenological studies are often conducted with small samples due to the detailed case-by-case analysis. Further, the aim of the studies is to comment on the perceptions and understandings of the particular group rather than make general claims. Ideally in such a study design the researcher seeks to achieve saturation in the experiences collected from the participants. In this study the data collection achieved saturation when the experiences being described in the interviews developed patterns, trends and repetition. Based on the recommendation for achieving saturation in a phenomenology study this research sought approximately 10 individuals to participate in the interview process (Mackey, 2005). However, because of the high level

of interest in the study and the rapid rate at which individuals came forward to participate, 15 individuals participated in interviews over an eight week recruitment period.

The individuals who participated in the study comprised of self-identified francophones and Acadians living in Halifax who wanted to share their experience with primary health care services. Criteria that the individuals needed to meet to be included in the research project were: 1) individuals must personally identify as either francophone or Acadian; 2) French was to be the primary language of all contact between the researcher and individuals participating in the study - the individuals had to be comfortable expressing themselves in French; 3) 10 years of residency in Halifax or surrounding areas; and 5) the minimum age of participation was 18 as the research was interested in the experiences of adults who are most likely accessing their health services independently.

Criterion number three was changed from 10 years to 5 a few weeks into recruitment. Originally the reasoning for the 10 year minimum was to assure that individuals participating in the study had a solid understanding of the local health care system to create a strong basis from which to explore and share their experiences. Due to the mobile characteristic of the francophones and Acadians population in Halifax, the new 5 year criterion opened up the research to more francophones and Acadians as well as young families who had experiences valuable to the research purpose. The supervising committee determined that 5 years was an adequate amount of time to develop a strong understanding of the local health care system and to create experiences to draw upon for

the purpose of the research. This amendment was approved by Dalhousie's ethics review board on September 26th 2012 (Appendix B- Ethics Approval).

The study used purposive and snowball sampling in order to recruit participants adhering to the inclusion criteria. The recruitment process relied heavily on word of mouth and poster/flyer advertisement in businesses and public press. Word of mouth was primarily achieved during community presentations and events the researcher attended as well as participants' involvement in recruiting friends or colleagues. News of the study spread quickly in the community and was announced on radio and in community newspapers. Posters were displayed in consenting organizations and businesses that served the desired population (Appendix C- poster, Appendix D-list of organisations). The community responded very positively to the study resulting in a sample size that exceeded what was originally anticipated.

Procedure. Participants took part in one 45-90 minute semi-structured interview. A safe, private and comfortable location for the interview was determined through consultation with the participant. This included locations such as the participant's house, a private room in a library, public coffee shop or a reserved location on the Dalhousie campus.

After all elements of the consent form were explained verbally, the individuals had a chance to review and read the consent form themselves. They provided written consent to participate in the research by signing the form. On the same form individuals were asked if they would like to be part of a group that would review the preliminary results in order to provide comments, suggestions and insights to further the analysis

process. If they were interested in this opportunity they provided an email address on the consent form (Appendix E- Consent Form).

A question guide consisting of several open-ended questions and probes were used to provide some structure to the interviews. The interview questions attempted to gain in-depth understanding of the role language had in the participant's experiences with primary health care services. Each question focused on a different topic or idea but was open-ended to elicit a broad range of responses based on individual's experiences (Rabiee, 2004) (Appendix F- Question Guide). The semi-structured nature of the interview was ideal for generating rich data with a conversation style engagement between the researcher and the participant. The conversation style may have made the participant feel comfortable with the interview setting which could have produced advantages such as in-depth reflection and exploration of the participants' interests, concerns and experiences (Giorgi & Giorgi 2003, Smith & Osborn, 2007).

Data collection and management. All interviews were audio-recorded with a digital recorder. A series of field notes was kept to record dimensions of the interview that were observed but are not easily picked up by the audio device (e.g. breaks in speaking, visual responses, body language and interruptions). After the interview the recordings were transcribed in their entirety and included elisions, slang, and nonverbal sounds (e.g., laughs, sighs). This level of detail was important because the analysis focused on the description of the knowledge, attitudes, values, beliefs, and experiences of an individual and a group of individuals (Fontana & Frey, 1994). All identifying

information that could have linked the participants to the interview was removed during the transcription process.

Recorded interviews as well as transcriptions were inputted into ATLAS.ti, a qualitative data analysis software program, to help with the organisation and management of the data. However, the majority of the analysis was done by hand because of researcher preference. Everything stored on the computer was password protected. All consent forms, print copies of the data and digital recordings were kept locked in the researcher's office on campus. The print copies used by the researcher during data analysis were cleaned of any identifying information and only used in a private location so that other people did not have access to them.

Analysis and interpretation. Phenomenology framed the analysis in order to learn about the lived experiences of the participants. Since meaning is central to phenomenology the aim was to understand the content and complexity of those meanings and not to measure their frequency (Smith & Osborn, 2003). The analysis was guided by Smith and Osborn's (2003) and Giorgi and Giorgi's (2003) frameworks for phenomenological analysis.

The transcripts were reviewed individually in the initial analysis stage in order to fully appreciate the meaning behind individual experiences (Smith & Osborn, 2003). The first step in the interpretation process was to become as familiar as possible with the accounts from the interviews. The researcher recorded comments and made note of significant or interesting text during an initial read (Smith & Osborn, 2003). Comments were made on use of language, sense of the person coming across, similarities and

differences, repetition, amplifications, time and contradictions in the transcript (Giorgi & Giorgi, 2003).

During the second reading of the transcript emerging theme titles, which are phrases or words that aim to capture the essential quality of what was found in the text, were recorded (Smith & Osborn, 2003). The theme titles linked back to the initial comments as well as what was actually being said by the individual. After the entire transcript had been reviewed, the emergent theme titles were listed and clustered in an analytical or theoretical ordering in order to highlight the connections between themes. During this process, review of transcripts and quotations assured the clustered themes were appropriately linked together (Giorgi & Giorgi, 2003). The process was cyclical as the researcher was constantly checking the transcripts, drawing on her interpretations that were based in background knowledge, and finally rechecking the themes and clusters.

Once the theme titles were clustered they were given a title that represented a superordinate theme. Giorgi and Giorgi (2003) suggest including an identifier (i.e. key word and page number) to each superordinate theme in order to indicate where in the transcript instances of each theme can be found. This was accomplished when the themes were inputted into ALTA8i as the program generated that information.

The rest of the interviews were analysed in the same fashion. The superordinate themes from previous transcripts were used to orientate new transcript analysis, however as more interviews were reviewed the themes evolved and changed. Initial interviews were revisited with the new themes in mind to see if new knowledge generated from the additional transcripts influenced the initial interpretation. The researcher also respected

that there were convergences and divergences in the data and several of the final subordinate themes recognized that accounts from individuals were similar but also different (Giorgi & Giorgi, 2003; Smith & Osborn, 2003).

Once all interview transcripts were analysed a final table was developed depicting the superordinate themes. Originally 10 superordinate themes emerged and through a final process of reduction and inclusion the final analysis resulted in 5 superordinate themes (Giorgi & Giorgi, 2003; Smith & Osborn, 2003). Factors upon which the reduction process was based included prevalence, richness of passages, inclusion of sub-themes (Giorgi & Giorgi 2003; Smith & Osborn, 2003). For example, “quality of services received” and “language and communication” were originally separate themes. After recognising that participants’ perceived quality of service to be very dependent on their ability to communicate, the themes were merged to create a richer account of the role of language.

To promote a cyclical analysis design, the 5 preliminary themes were summarized in a 1.5 page document and emailed to the 11 participants who indicated they would participate in reviewing the preliminary results. After, providing an update on the research at a RéseauSanté steering committee meeting, two individuals replied via email. They offered comments, thoughts and further ideas about the themes. After receiving this feedback the researcher reviewed each transcript and followed the original analysis path with the feedback in mind. The final findings are presented in the results section.

Language

Due to the requirements of the Master's degree program the research was analysed and written in English. However, based on the characteristics of the population of interest communication including recruitment, information letters and interviews were in French. In order to facilitate an Anglophone analysis the French audio recordings were transcribed directly into English by the researcher. The researcher is fluent in French and English and has the ability to translate and explain phrases and expressions that were used by participants. As the Acadian French dialect potentially had some deviations from the researcher's dialect, French to Acadian translation resources including dictionaries and bilingual Acadian individuals were used to explain any areas of confusion. Any consultation on translation was limited to specific phrases or sections. Included in the transcripts were comments about the French audio. Further, quotes, expressions and slang that the research believed would not hold the same meaning when translated. The French audio recordings of the interviews were available for re-examination throughout the analysis process and were revised as needed.

Dissemination

Based on the nature of the research and the requirements for completion of the current degree program the research was documented in the form of a master's thesis and presented to a committee of supervisors and to peers. The original direction of the research was guided by members of the RéseauSanté, a community based organisation that lobbies for francophone health services, and a presentation of the research will be offered to them. Further, an executive summary of the thesis document will be created in

French to be distributed to the community through the RéseauSanté. Preliminary findings were presented at Crossroads Interdisciplinary Health Conference at Dalhousie University in April 2013. The research was presented during the summer of 2013 at one national conference: Canadian Applied Health Policy and Research conference in Vancouver, and one international conference: Pathways Interdisciplinary Social Work conference in Los Angeles.

Ethical Considerations

Approval of an application to the Dalhousie Research Ethics Board was granted. Ethical considerations included informed consent, storage of data, privacy and confidentiality, and vulnerability of individuals.

Informed consent. The participants had the option to receive the consent form in advance via email, mail (if time allowed) or pick up. Providing a copy of the consent form prior to the interview allowed individuals a chance to consider their participation prior to arrival at the research venue. However, few participants utilised this option and most were provided with a consent form on the day of the interview prior to commencing any study activities.

Written consent was obtained from each individual prior to beginning the research activities. The researcher reviewed the consent form with participants by outlining the research design, purpose, risks and benefits, and making sure each individual knew they did not have to answer questions if they did not want to, and could withdraw from the study at any time. The researcher also asked the participants why they volunteered, to ensure that consent was freely given (Canadian Institutes of Health Research, Natural

Sciences and Engineering ... Research Involving Humans, 1998). Although it was mentioned on the consent form that the sessions would be audio recorded, the researcher verbally asked permission to record the interview. Once these steps were completed, the consent form was signed and the participant verbally consented to the audio recording, the interview process began.

Storage of data. Consent forms were stored separately from the data in a locked filing cabinet on the Dalhousie campus. The transcripts and audio recordings were in electronic format and saved on a password protected computer in a locked room. Identifying factors such as name, work place, etc. were removed from transcripts and not included in the written report. The researcher and supervisors had sole access to the transcripts and audio recordings.

Confidentiality. Protecting the privacy of the individuals participating in the research was important to the study. Every effort to protect privacy was made. However, it could not be guaranteed. For example, it could have been required by law to allow access to research records. The interviewer had a duty to report suspected child abuse or neglect, or the abuse or neglect of an adult in need of protection to the Department of Child, Youth and Family Services. These were explained in the consent form. These situations did not occur during this research.

At the end of the interview, participants were asked if there was anything that they would like to remove from the interview and that information would not have been included as data. Participants also had up to three weeks to remove themselves and their

data from the study without providing a reason. None of the participants opted to remove themselves from the study.

When the interviews were transcribed, all identifying information such as names, providers and other personal information were removed. Only the consent form contained participants' name and was kept separate from all interview files. All participants were assigned a number with the prefix SF and suffix M or F indicating sex and then a pseudo name for use within the thesis. This identifier was the only means of identifying them in the transcripts, data analysis and quotations. All study paper documents have been kept in a locked filing cabinet at Dalhousie University and will be destroyed after the completion of the project. Electronic documents will be destroyed after the completion of the project. The supervisor and committee members had access to the print copies of the transcripts but did not review them and instead provided feedback on the researcher's verbal and written accounts of the data.

Participants were not identified in any reports, publications or presentations of this study. Only major themes were reported and direct quotes from individuals were used in order to best illustrate these themes but quotes were only identified by an assigned participant number.

Vulnerability of participants. The participants may have felt vulnerable while discussing themes in the interview. Feelings or experiences of inequity, injustice, personal trauma or negative experiences may have been uprooted. Effort was made to create a comfortable environment for the participant and the participant was offered contact information of resources within the community should they feel the need to

discuss emotions or experiences further (List of available resources can be found in Appendix D).

Risk and Benefit Analysis

Risk analysis. There was relatively low risk for participants in this study. They may have felt discomfort as the interviews addressed personal and perhaps sensitive matters. The time range for the interview varied depending on the participant but it was anticipated that interviews would reach a minimum of 45 minutes. The length of the interview could have caused the participant to be fatigued. These risks were mitigated by explicitly informing the participant that they had the right to leave the study, stop the interview at any time, pause, or skip questions should they wish. A list of French social supports, such as RéseauSanté, social workers and psychologists, was offered to the participant after the interview should they wish to discuss emotions or experiences further.

Benefit analysis. Participants may have felt empowered by sharing their stories and expressing their ideals about their health care services. The community benefited by providing information about primary health care for francophone and Acadian to the RéseauSanté Nouvelle-Écosse. This study was one of the first studies exploring the experiences of francophones and Acadians population in Halifax Nova Scotia and therefore generated new knowledge into a little explored realm of the literature.

Trustworthiness

The trustworthiness of the research design and data analysis process was concerned with evaluating the results put forward to determine whether or not they had

any merit to them, and whether the claims were useful for research purpose (Marshall & Rossman, 2010; Seale, 1999). There are four components of trustworthiness: credibility, transferability, dependability and confirmability (Patton, 2002).

Credibility. Strong credibility of the research establishes confidence in a high value of truth for the participants and the context of the research (Lincoln & Guba, 1985). In order to establish strong credibility the research must be self-aware, transparent and expose potential bias through rich descriptions of the research and analysis steps (Koch, 2006). This was established through field notes and memos which helped to expose any biases about the results and reduce their impact on the researcher's interpretation of the data (Patton, 2002). The research used neutral language in the interview guide and choice of words was critically assessed by the research and advisory committee prior to data collection. Despite precautions, it was assumed that language would have an influence on responses. The researcher noted this but recognized that the data collection process was interactive therefore the language as well as the researcher contributed to the results.

The research also employed member checking and negative case analysis during the data analysis process in order to uphold credibility (Lincoln & Guba 1985; Mays & Pope 2000). During the interviews the researcher performed verbal member checking in order to clarify meaning and intention during the interview. Additionally, individuals were given the option to review the results section of the final report in order to provide comments, suggestions and insights about the researcher's interpretation of the interviews.

Negative case analysis is the process of looking for elements in the data that seem to contradict the developing explanations and constructions (Mays & Pope 2000). By doing this the analysis was refined until the majority of the cases could be explained within the major themes that were developed over analysis process. This process ensured that the researcher was critical throughout the analysis and interpretation and did not simply see what she expected to see.

Transferability. The researcher described and explained every step taken in the entire research process in order to create transparency. Since qualitative research aims to provide thick and detailed description of the specific participants, context and research process it is not concerned with the transferability of the research findings (Koch, 2006). However, by providing a rich illustration of the study others can decide whether or not the findings apply to their own context.

Dependability. This research sought to establish dependability by having highly auditable data analysis findings. Auditable refers to the ability of another investigator to clearly follow all the decisions made by the researcher in the study as well as if another researcher could arrive at similar conclusions given the data, perspective and context of the research (Koch, 2006; Lincoln & Guba 1985). The notes that recorded all decisions and interpretations of the researcher increased the auditability of the findings. Furthermore, the guidance and advice from the advisory committee increased the dependability of the decisions made by the researcher.

Confirmability. Confirmability is concerned with how much the results include the bias, motivation or perspective of the researcher (Lincoln & Guba 1985). Despite the

interactive nature of knowledge development in this study, the researcher still worked to ensure her own biases were omitted as much as possible (Crotty, 1998). This was accomplished through a process of reflexivity. The memos taken by the research allowed the researcher to remain conscious of biases and avoided making interpretations based on them. Additionally, direct quotations were used to support interpretations therefore the researcher was continuously aware of the data and ensured their personal biases do not counter the realities described in the data.

Chapter 4: Results

Introduction

This chapter describes the results from interviews with the francophones and Acadians who participated in the study. The results describe the major themes that emerged from the data, and associated subthemes. The major themes presented are: the importance of language; strategies for utilising health services; the role of health care professionals; the influence of the francophone and Acadian community; and the need to compromise on personal priorities to receive health care.

Theme 1. *I Cannot Explain my Illness in English: The Central Role of Language for Receiving Health Care Services*

English is the primary language of the health care system in Nova Scotia. Some participants had access to French speaking health care providers, most often a family doctor, but primarily participants used English services. Each participant had a different level of confidence speaking and understanding the English language and this affected their ability to communicate symptoms, feelings and concerns with their health care professional. The ability or inability to communicate strongly influenced the emotional experience of accessing and using health care. Some participants felt the quality of the care they received was diminished by the lack of language proficiency between patient and provider. Overall, participants agreed that it was preferable for conversations about important health issues to be conducted in a language that they were comfortable in.

The experience of understanding and being understood. The participants explained that there were linguistic differences between French and English that increased their difficulties expressing concerns to their health care provider. Sylvie

explained how easy it would be to be misunderstood by her health practitioners if her concerns had to be translated. For example, she explained that language has embedded emotions and subtleties that are important in the medical environment and could be lost when language had to be translated.

“I cannot explain my illnesses in English. When I have an illness I’m “mal au coeur” I’m not about to have a heart attack I’m just “mal au coeur” and when I’m “mal dans le coeur” that is something else. And it is difficult to explain and there are complexities.” (Sylvie)

These subtleties could be complicated when mixed with specialised medical vocabulary. Participants explained that the vocabulary used when conversing in a social situation was different from the vocabulary needed for communication in a medical situation. Vocabulary needed for a medical situation included terminology for medical tests, illnesses, and medication. These terminologies may be difficult for any non-health professional even if they speak English as their first language. However, francophones and Acadians in the study often struggled to describe symptoms, body parts and organs, ask questions and explain medical history. Additionally, the emotions that were tied to the medical experiences were also difficult to express accurately in a second language. The participants who were confident speaking English in social situations admitted that they were less confident communicating with vocabulary for a medical situation and had concerns about understanding instructions and advice from health care professionals. For example, Christophe has been seeing the same Anglophone family doctor for 30 years. Over this time he developed a good relationship with her and grew to have confidence in

her as his physician. However, he explained that his limited knowledge of the English language had interfered with his ability to comprehend parts of his past medical treatments. For example, he was anxious about asking for clarification after being prescribed a series of medical tests. Due to the specialised terminology used by his doctor he did not feel confident he would understand her explanations. Thus, he completed the tests with the assumption that they were good for him and did not ask for clarification about why the tests were prescribed.

“But in the end, it wouldn’t do anything for me to start a discussion about it [medical testing]. It would have been a discussion that was a little too specialised and I didn’t have the skills to understand the little details.”

(Christophe)

Another participant explained that she had difficulty understanding her health professional’s answers to her questions. She admitted that because of her difficulty with English and because of the medical terminology used by the physician she was not always able to explain or understand details. She also suggested that just as she cannot provide her doctors with all the details, her doctors may adjust their communication to suit her and withhold some of the details she would not understand.

“...she probably tried to express that to me but with words that I don’t really understand so if I had a doctor who was francophone I wouldn’t have that problem. So if I was ever in a situation where I had lots of questions on how and why and how to protect myself [...] no answers.

Maybe it would be the same in French but at least I would understand the

details more. [...] I think that as well sometimes when they see the accent and I'm looking for words well they aren't giving all the details that they would give to an Anglophone [...] So you find yourself that the doctor isn't going to give you all the details because he doesn't know what you understand as vocabulary and you aren't giving all the details because you don't understand the vocabulary either.” (René)

Some participants, such as Pascal, do not have a language barrier with their Anglophone health care professionals. Pascal grew up in an Acadian area and learned the specialised medical vocabulary in English from the beginning. He even jokingly admitted that he cannot tell you what a CAT scan is in French. Even with his high level of bilingualism, in certain situations Pascal felt more comfortable communicating in French, namely mental health services.

“And it was completely by chance and I came in and we started talking in English and at one point she asked me if I was francophone and if I would prefer to talk in French and I said yes. [...] When it comes to that, things that are more emotional that is really important to have someone who speaks your language. Even people who are bilingual and as bilingual as me they will be better able to express themselves with mental health problems in French than in English.” (Pascal)

Many participants spoke about mental health and emotional situations that reduced their ability to understand and be understood by their health care provider. One participant shared an experience about her daughter who was having mental health issues

and needed emergency care. Due to her daughter's distress she was unable to communicate with the nurses in English and the language barrier resulted in conflicts between the mother, the patient, and the care providers. The inability to communicate escalated the issue.

“An example would be when my daughter had problems with anxiety. We went to the IWK and the nurses did not speak French. My daughter was in a state of anxiety that made her, if you were speaking in another language, well she barely understood French so she was definitely not able to communicate in English either. And it was really a horrible experience for her and for us because the nurses instead of treating her with respect they were treating her with aggressiveness. [...] I'd say they weren't taking her serious. She was trying to explain things to them, and we were trying to explain to them... it was really not a good experience. I know they are trying really hard to have French services at IWK but at that moment it was an emergency. It was really not a good experience at all at all at all. And when we are talking about mental health that is not in our language I think it is one of the worst experiences a person can have.” (Stéphanie)

Additionally, participants expressed that in emergency situations it was very important to have access to services in their own language. In these situations heightened anxiety reduced their ability to communicate in English with health care professionals,

creating situations that increased the likelihood of not understanding information and not being able to convey accurate accounts of the problem.

In the first quote, Christophe explained that in an emergency situation he would be uncomfortable using English and would not be able to relay as much information in English as in French. The second quote reiterates the consequences that may result when a person who is not fluent in English attempts to access emergency services through the 911 phone system.

“[in an emergency] and one of my kids or my wife was hurt, well certainly it would be more agreeable for me to get a hold of someone with French services so I could better explain what happened and what is happening. With the English person I would tell them about 75% of what I would tell someone in French.” (Christophe)

“The 911, the person that answers is Anglophone all the time, but it shouldn't be like that. Not in Canada. In no situation... if I call it is essential that the person understands, you know. And it is an emergency, it isn't because I have a small question about something little, it is critical. Like the lady whose son stopped breathing she was telling me that the person on the other side of the line had no idea what she was saying and her son wasn't breathing in front of her.” (Stéphanie)

Participants who required high doses of medication or general anaesthesia may also experience difficulties. One participant shared a story about his wisdom teeth

extraction. Prior to surgery he felt very confident communicating with the nurses and doctors in English. However, after he awoke from the surgery he couldn't understand the instructions he was given in English and could have done damage to the incision.

“It was fine in the beginning, they asked me questions and it was fine I understood everything.... I was put to sleep well not really sleep but drugged to the max and when I work up I completely forgot English. All I remember was the nurses freaking out because I was taking all the stuff out of my mouth and they were telling me to put it back but I was just speaking to them in French. All I remember was them yelling “go find so and so and so on the third floor I’m pretty sure he speaks French”. So I was in a chair, taking things out of my mouth, trying to get up and pushing people and I was only speaking in French and I didn’t understand when they were talking to me in English. Finally they found my uncle in the reception and my uncle was able to talk to me in French to tell me to stop and to sit down. So now I always think if I have to go for an operation when I wake up I will probably forget the English language.” (Pascal)

Overall, the ability to understand and be understood was difficult for participants experiencing a language barrier. Participants explained that during situations that involved mental health, emergency and state altering medication their experiences were more difficult. These situations of heightened difficulty may further influence the perception of the care received.

Quality of services and safety. The participants expressed concerns about the quality of service they received when they experienced a language barrier and had poorer communication with their health care professional. The participants' quotations illustrate that difficulty with English reduced their perception of the quality of medical care, their ability to follow treatment protocols, and their understanding of the medical advice they received.

Specialised vocabulary can cause misunderstandings in a treatment plan which may hinder the patient's ability to follow directions. This was the experience of Sylvie during one of her first blood tests in Nova Scotia. She misunderstood some of the words in the instructions for preparing for the test. "[When I first arrived in Nova Scotia and was referred for a] blood test, I didn't know what "to fast" meant. I didn't know that, so it was really a process to learn all that [language associated with treatments]". She explained that over the years she learned the terminology related to her medical needs, however if she required care for something new, she believed she would not understand the new terminology.

Some treatments and medical tests required active participation by patients in order for the tests to be completed. Martine shared her experience of having to use a cardiac monitor. The monitor was worn for a number of days and when she felt her symptoms coming on she had to record her symptoms and environmental characteristics in writing. This was difficult for her to do in English and she felt she may not have provided the best descriptions of her situation to her doctor.

“So I have to see a cardiologist sometimes because I have problems with my heart and I’m not really sure I’m receiving the best services because it is very difficult for me to explain what is going on. I have to wear a machine for a certain amount of time and write what was happening. I have to write it in English because if I wrote in French no one would understand so I had to get out the dictionary to try to find the terminology to try to explain something that was already hard to explain in French. So it wasn’t simple.” (Martine)

A physician’s ability to properly treat a patient may be hindered when the patient has difficulty communicating their symptoms, anxiety and health concerns. The following quote explains one participant’s experience of trying to seek help from her family doctor about a pain she was feeling and being unable to communicate the severity of the pain or her emotional anxiety. She believes the difficulty communicating increased the time necessary to reach a diagnosis.

“We [family doctor and I] were not able to understand each other because of the language. So I asked to see a specialist and the specialist was able to explain what it was and that it was preferable to remove it [cyst causing her pain], we removed them but it took maybe four appointments with my doctor before she would give me an appointment with the specialist [...] if I would have had a doctor in my own language we wouldn’t have had that issue.” (Sylvie)

Good communication between a patient and health provider was considered by the research participants to be essential in order to ensure proper health services. The experiences shared by participants showed that language fluency was a factor influencing the quality of care they received. Furthermore, misunderstandings on the part of the patient influenced their ability to comply with treatment plans.

Language influences the emotional experience. Language and comprehension also had an impact on the emotional experience of having an issue with one's health. When participants were not confident in the language spoken by their health care provider the process of seeking and receiving care often evoked distress, embarrassment and feelings of uncertainty.

“Sometimes with the doctors they have other people to see and they may not have the time. Maybe I didn't take the time, maybe I wasn't comfortable, when it isn't your first language it is difficult to feel comfortable with the person, you are embarrassed to make a mistake. You are asking yourself will he understand me. And sometimes when you are a young adult as well sometimes you don't try either. However with someone that you are comfortable with it helps, it is easier, you are less embarrassed to make mistakes” (Charlotte)

This participant's experience illustrated her sense of insecurity and embarrassment during interactions with an Anglophone health professional because of her lack of English proficiency. The difficulties associated with communicating to a health care professional further caused distress for patients who felt they were not being

understood. Claire described a situation when she left her appointment in distress because of the frustration of trying to express herself to an anglophone health professional.

“I felt like I wasn’t able to get my feelings and emotions across and it was when I really needed it. There were things I wanted to talk about and I wasn’t able to and I was told my accent made it difficult. I went for 5-6 sessions and each time I was like why am I going why. I would leave in tears.” (Claire)

The participants who had access to French health care services were more confident about the care they received. They were more satisfied with the care provided to them, and the emotional experience of dealing with a francophone health service provider was considered to be a tremendous benefit. Sylvie who was referred to a bilingual specialist after trying to convince her family doctor to look deeper into a health concern, explained: “I was lucky because the specialist was bilingual and he was able to tell me [about the medical problem] and it was then that I was able to let it go... I left and I was reassured”. She was also lucky to have a French nurse available to explain the process of her daughter’s miscarriage. She reflected that:

“there are a lot of things, lots of details that you have to do right now, not tomorrow, right there, [after the miscarriage]. I didn’t have any other questions [the nurse] really answered [all my questions] very well. Oh my God as soon as they explained me everything (exhales: relief) and then the center of my attention could be my daughter. I could stop thinking she was in danger.” (Sylvie)

The language used to communicate health information strongly influenced the emotional experience of many of the participants. When participants felt confident expressing themselves in the language used by the health professional, they were reassured and had more confidence in the care they received.

Conclusion. Overall language and comprehension played an essential role in the experience of using health care services. From the participants' perspective language was a tool to explain symptoms and express emotions, both of which were difficult in a second language. When the participants were not confident in the language of the provider they felt less reassured by their provider and lacked confidence in the quality of the health care treatment.

Theme 2. *So We Can Understand Each Other: Strategies for Engaging with Health Care Services*

Participants used many of the same adaptive strategies in order to function in the Anglophone health care system. These strategies required considerable effort in order to access and receive health services. Their strategies included: interpretation, special preparation prior to health care visits, and translation tools.

Interpretation. Few participants knew about the interpretation services offered at local hospitals. They explained that the service was never offered to them when they visited the health care location. Participants who had knowledge of the service had not made use of it. They explained that when they needed medical care, asking for a translation service was not on their mind. One participant described what she hopes to be a more standardized method of offering French translation service in the future.

“I think that services at the hospital are most important. [They] have translators but they [need to] offer that service. Not everyone knows about it, so they should tell you that the service is available and ask if we want it or not. When we are filling out the paper work to just have: if you need help with language. Then when you get there [to see a doctor] they will know. So you can check that you need a translator. I think that would reassure francophones.” (Claire)

The majority of the participants explained that the interpreters they used were family members or friends, not a member of a professional interpretation group or a volunteer provided by the health care provider. Sylvie brought her daughter to her appointment with a specialist after having difficulty explaining herself to her doctor.

“He [the specialist] was Anglophone and I brought my daughter to do the translation. To be sure that everyone understood each other because ... [my family doctor] didn't understand so I really wanted him to understand the pain I was feeling. So my daughter was able to explain. He was very patient, and he saw that my daughter could do some translation [...] and with drawings we were able to understand each other.” (Sylvie)

However, not everyone felt comfortable inviting a third person to attend their medical appointments. “No, I would prefer to go by myself and make myself understood with words, gestures or drawings.” (Claire)

Some participants had acted as translators in the past for their family and did not feel comfortable filling that role. Stéphanie shared her experience of translating for her mother-in-law who came to Halifax to see a specialist. She did not feel confident about her ability to translate medical terminology accurately and she felt additional pressure being responsible for the comprehension during the medical service. Additionally, the subject of the appointment was very personal and she believes it was uncomfortable for her mother-in-law to share some of the details with a third party:

“I was accompanying my mother in law for health care services here, she is unilingual francophone, other than “barley” that she put in her soup that was probably the only vocabulary she had in English. She was coming here to see a specialist and it was me who had to interpret for my mother in law about the test they were doing. I’m not a doctor, I have no medical training, and they were asking me to do that translation. It was very difficult. And it was a test that required a certain level and intimacy for my mother in law and I was there. I’m not even her daughter.” (Stéphanie)

Preparation. Participants invested time and effort to prepare themselves for their appointments to ensure they had the ability to understand the discussion and to be understood by health practitioners. Participants reported checking vocabulary with family, friends or on the Internet to ensure they could communicate with the health care professional. Josiane explained that in order to properly ask questions during an appointment for an Intrauterine Device (IUD) she used the Internet to learn the correct vocabulary before the appointment.

“Yes yes like for my appointment with the obstetrician for my IUD I wanted to talk about the options, like can I have an operation for example or will the IUD have an impact on pre-menopause and what not. So I have to go and do research so I will have the vocabulary to receive the service.” (René)

To book an appointment with her family doctor Martine explained that she verified words with family members and prepared the dialogue before calling the receptionist.

“In the beginning it was often my husband who called to schedule appointments. Or it has happened that I’ve asked my kids to call for me. Or would prepare and write everything down to be sure. It isn’t always easy because my accent is strong and people don’t always understand me.” (Martine)

When participants were unable to understand instructions, explanations or comments made by their health care professional during an appointment, afterwards they often verified meaning with family, friends or on the Internet.

Use of tools. Participants also described tools that improved their ability to communicate with their health care providers. One participant laughed while she explained a tool that seemed childish but that she thought would have improved her experience of trying to explain the word “gallbladder” to a nurse before an appointment for an echocardiogram.

“At one point there was an organisation that was talking about having a pictogram and images that would make it easier and sometimes I would laugh saying [for] me that yes that would help in certain cases or we could go with our great big visual dictionary to show everything! We are laughing but the differences between two words... just to have a little bit of paper or a flash card or something... to have a tool that will help us communicate easier.” (Josiane)

Claire explained a situation she encountered when looking for specific medication at a pharmacy. When she did not know the terms in English she was able to use her smartphone dictionary to communicate with the pharmacist. “I think it more difficult for me to explain symptoms. So I will have my translator on my iPhone. The other day I was looking for “wart” I didn’t know what that was in English so I took my translator and I showed her” (Claire)

Conclusion. The participants used resourceful methods to improve communication with their health care provider. Often their methods required extra engagement and time to prepare questions and vocabulary, balance schedules to ensure a friend or family member was available to act as translators or to organize the tools that were helpful to have on hand.

Theme 3. *It Matters How They Think: The Role of Health Care Professional When Receiving Health Services*

This theme describes how the perceived sensitivity of health care professionals to linguistic diversity affected the participants’ experience of the health care service. The

word sensitivity was used to describe situations in which health care providers showed respect for the patient and acted in a way that improved the patients' emotional experiences. Participants explained three ways in which professionals showed sensitivity for the patients' language: understanding the importance of offering French services, taking the time to work with the patient to reach a good level of understanding, and having a little understanding of the French language. It is important to acknowledge that providers' interactions with patients were not only constructed by their individual sensitivity level but by structural and workplace environments as well. The medical environment places expectations on health care professionals to meet with a large volume of people in a timely manner creating stress on the quantity and quality of their encounters with each individual. Furthermore, an environment that does not highlight the importance of linguistic diversity may have an influence on the perspective of the health care provider. Though participants focused primarily on the actions of the health care professional the structural environment in which the interaction took place may also be an important factor for sensitivity.

Offering French services if available. Several participants explained that they were not offered French services or translation services when they sought medical care even if the option was available. When they did receive their health care service in French it was often by chance and unplanned. Two participants shared their thoughts on how health care services could be more sensitive to the importance of their French language. The first suggests equipping each clinic with a list of locations offering French language services. The second believes that a question around language preference should be on intake paper work.

“If I go to a clinic it would be nice if they could say, ‘sorry we don’t have a bilingual service but you could have one on Spring Garden or Sackville or wherever’. I would go there it wouldn’t bother me. I don’t expect them to give me French services just for me.” (Sylvie)

“At least if the hospitals had on their forms or their files a little box that said francophone patient, Anglophone [...] or another language [...]. Even then it is a question of safety. There is a lot of work that has to get done at that level to create awareness of information [...if the health care professional does not speak French, to be sensitive and] to be able to say that I don’t speak French but there is someone here that can help you in French... do that active offer.” (Stéphanie)

Other participants had the experience of being offered information in French. Josiane received her medication instructions from the pharmacy in French. This was offered to her without her asking. “The pharmacy that I go to offered it to me one day. They had the francophone pharmacist in the beginning but they stayed very sensitive that they will go themselves to get the French information on the website.” (Josiane)

Health care professionals making an effort to use French. All participants explained that they preferred their health care professionals to speak French. Many of them felt if a health care professional could not communicate entirely in French, using a little French demonstrated sensitivity. It made the participant feel more comfortable, they

were less stressed about being misunderstood, and the patients felt respected and valued as a francophone and Acadian. Stéphanie explained:

“I think that we have tried to say that to the health professional. That often it is just a question of having that comfort and that reassurance that if I say “J’ai mal” “J’ai inquiète” the person will understand what I’m talking about. It isn’t the diagnostic... yes it is true that if you can get that in French that is great... but to be able to create that relationship with them... oouufff (relief)... if they understand a little or a lot you know like it is reassuring. I don’t think that the community here expects all or nothing I think that they really expect if we can have it, 100% excellent but a little is also really good. I think that has a lot to do with our culture too, with the Acadian culture, if we can have a little that is just fine. We will take what we can because we had nothing and now we have this and we are happy about it.”
(Stéphanie)

Another participant explained that when an effort was made by health care providers to accommodate the francophone and Acadian population that frequented her doctor’s office she felt important and respected.

“[The receptionist] she has started taking French classes because everyone from Quebec has the same doctor. From the daycare we all have the same doctor so now she is taking French classes. I find that really great. And she is trying to say little words. And it makes you feel that you are important and that it isn’t because we are francophone that we can’t be understood and she is trying to understand our accent. I’ve

always been well received.” (Claire)

Being sensitive about vocabulary and communication style. The participants experienced professionals who demonstrated a range of behaviours that were either sensitive to the challenges they experienced or insensitive to those challenges. For example, one participant described her experience with an insensitive health care professional. She was contacted by her doctor’s office by phone. The receptionist spoke quickly and used abbreviations that made it very difficult for the participant to understand.

“There was a woman who called me and was talking really fast [...]. Some people don’t have the delicacies to say I’m going to talk a little slower and I’m paying attention to the words and terms I’m going to use. She was using a few terms, like sometimes there are acronyms that people use like for your information FYI well she was saying blah blah blah FUT something and I’m like what is that and then she answers you like you are stupid. So it is important but it really depends on the openness [of the health care professional]” (Charlotte)

Not all experiences with English speaking health care providers were negative. Sylvie described the professionalism and patience that a nurse showed her when her daughter was unable to come to an appointment to help translate for her. Despite the language barrier she felt comfortable with this health care professional.

“There was a long form about three pages or two and a half to fill out. I asked a lot of questions and the nurse was very patient. After they re-asked me questions verbally when I walked in without looking at the form so ok

that was good. It went very well the service with them was excellent. They weren't bilingual, they are very very professional.” (Sylvie)

Conclusion. When health care professionals acted in a way that the patients perceived as being sensitive to their linguistic needs, those actions increased their confidence and reduced their anxiety. A sensitive health care professional would offer French services if they were available, try to speak a little French if they could or if French services were not available the professional would be conscious about their manner of speaking so the francophone patient could follow the discussion.

Theme 4. *Being Part of the Community: The Influence of the Francophone and Acadian Community*

The francophone and Acadian community played two primary roles that influenced participants' experience with health services. Participants' connection with the francophone community provided knowledge and networks to formal and informal French language services and increased participants' perception of the importance of having French language services for the community.

Knowledge and networks. Most participants said that they found their family doctor by being connected to other francophones and Acadians in the community. Word of mouth was the primary means of knowledge sharing. Charlotte and Stéphanie explained that it was through word of mouth that they found their French speaking family doctors.

“I love my doctor here... it was word of mouth. That is how you find things in the community, and the moment you know that there is a French doctor

and you know we try to jump on it and then there isn't any place left. But yes I heard someone talking about her from someone around here [work].”

(Charlotte)

“We bought our house, and through word of mouth from being part of the community, we learned that there were doctors who were French at that clinic, or who spoke French or who understood French so it just worked out well.” (Stéphanie)

The importance of having French language services for the community.

Participants also perceived French health care services as an important asset that helps to reinforce the collective community. This belief acted as motivation for francophones and Acadians to actively promote French health services. Even if an individual felt they did not need French language services they still believed those services were important for other members of the francophone and Acadian community and felt responsible for promoting the development of the service. Members of the community for whom French language services were perceived as more important were individuals who did not have a high level of bilingualism and for vulnerable populations such as children. The development of French health services was also perceived to be associated with the growth and continuation of the francophone and Acadian community in Halifax.

Participants explained that promoting French health care services was important for others in the community whom they knew needed French health service. Pascal was comfortable with the English language services he has been receiving since he moved to Halifax. However, despite not needing French services for himself he knew many people in the community who did. He highlighted that the responsibility for promoting French

services was taught to him throughout his upbringing and has become part of this cultural identity.

“It is more something cultural. To me it [having French health services] is more important not for me but because I work with a lot with other francophones and I know that they can’t express themselves in English and normally they aren’t from Nova Scotia or they are older so they don’t have the education to know things in both languages. So it is more for them and less for me. Because for me I don’t have any difficulty, and if I had the choice, do I want services in French instead of English? Yes, because that is programmed in my mind to push for French services and if we don’t push for the service we will not have the service. It isn’t to be... I’m not sure how to say it... but it isn’t a necessity for me to have the service but for the people that can’t express themselves at all. And I see that all the time I have a lot of clients that only speak French.” (Pascal)

Other participants also felt responsibility for other members of the community who they believed needed French language services. Christophe has been a patient with the same Anglophone family doctor since moving to Halifax 30 years ago. He would prefer to receive his services in French because he is not 100% confident communicating in English and he is aware of French-speaking family doctors in the area. However, in his opinion there are many young families who need access to French services more than he does. Therefore, to allow the space for others in French speaking physicians’ bookings he chooses to stay with his current provider. Furthermore, Nathalie has been accessing

English services since she moved to Halifax without any difficulty but still considers it to be important to have French services for others who are “from away” and do not have the same level of bilingualism.

“I can see, I could think of a few uncles and aunts who still live in Cape Breton and if they had to come here to Halifax there would be many of them that it would be really hard from them to do everything in English. [...] I think it would be important for emergency or specialist you know for like cancer or something. Because they can’t get that in Cape Breton and they may have to come here to Halifax. It would be hard for them to speak English. Even if they understand and they could speak a little English it would be much better if there was someone who could help them in French.” (Nathalie)

Children in the francophone and Acadian community were given specific considerations when they required health services. This was especially important for young children who may be unilingual and for those who are not overly exposed to anglophone culture. Frédérique shared an experience she had with an optometrist when she was a child and the difficulties that francophone children may encounter because they are growing up in the francophone community.

“If I have kids I think it is more important to have services in French. (why?) For evaluating them, I can speak both languages but with kids they are little maybe it will take them some time before they speak English and I don’t want to always have to translate. So when I was a kid our eye doctor

was Anglophone and they had little characters for the kids to say what they were and they were all Sesame Street characters well we didn't watch Sesame Street and we didn't know what they were. So my sister wasn't able to say big bird or anyone else so it would be hard to evaluate whether the child sees or not so for things like that. It is a question of language and culture too where you have to have both. I'm able to say that is a bird.

(Laughter) I think it is [important] for that as well and because I have the impression that seeing my friends who have kids it becomes so intense and worried that you really want to be able to be understood for real. [...] I think that when I have kids I will want to have access to French services.”

(Frédérique)

Furthermore, having French services available for children would teach the importance of their French language and their French culture. Émilie explained that she wanted her children to believe being francophone and bilingual gave them an advantage and seeing professionals speaking French would encourage her children to be proud of their language.

“I have been trying for a long time to have services for my children in French and there is no way. [...] For me it is important for my girls because they can communicate better in French than in English and there are many more families like mine. They are bilingual they can speak in English but it would be preferable to have services in French. But for my girls since they are growing up in an Anglophone environment I want them to see that it is

possible to work in a professional manner, in other settings than a daycare, in French. They will see and hear that you can be French because there are francophone doctors, francophone services and there are all sorts of people that work in jobs that are francophones. That there is an advantage to be bilingual in this world and they are lucky to be bilingual from the very start because they didn't have a choice. So they are bilingual but I don't want them... it is very easy to lose your identity in a minority situation so it is important to seek out as many opportunities to assure that it is valued by my girls as well as by the world around them.” (Émilie)

Community growth was also mentioned by many participants. They expressed that health care services would contribute to the growth of the francophone community and to the continuation of their culture and language in Halifax. Claire explained that to grow as a community, francophones have to ask for and promote French services.

“I like to encourage French services, that is in my values, so if I had the choice to encourage French services I like to do that because I think we are a little community and if we want to grow I think it is important. It is hard because there isn't really francophone [services] here and I'm not going to go to another province to be served because I think we have a good system here.” (Claire)

Continuing francophone culture and language for future generations was valued by the participants. Christophe compared the evolution of the education system in Halifax with possibilities for a health care system that would benefit future generations.

“I think more of my grandchildren. I would like that we could have a French health care center where we can have all the services. [...] Like in the evolution of the school system, it would be nice to see the same development in health and the youngest generation they could profit from that [...] in my opinion... for them it will be easier to live in their language and to valorise their language.” (Christophe)

Conclusion. Community had two roles in the francophone and Acadian experience in the health care system. First, it served as a source of information. Individuals who were connected in the community learned about French health care services by word of mouth. The second role was instilling the importance and values to in promoting and building the strength of the community the francophone people. Participants considered the community as a whole when explaining how French health services would benefit others in the community and contribute to the growth of the francophone and Acadian culture.

Theme 5. *Making the Choice: The Compromise between French Language and Receiving Health Care Services*

This theme highlights the contradictory experience of participants’ desire for French language health services and utilisation of English language health services. Every participant agreed that it was important to have French language health services and most stated they were less comfortable when their health care was not in their own language. However, participants also explained that their highest priority was to receive the health service even if the service was delivered in English. The compromise on participants’ desire for French services for use of English service, whether a choice or a

necessity, was highlighted in experiences with emergency health services, primary health care professionals and health services for their families.

Compromise for emergency health care services. As previously highlighted, in an emergency situation it is more difficult to communicate in a second language because of high levels of anxiety. Due to this reduced ability to communicate, participants stated it was important to have emergency health services in French. Nevertheless, in an emergency situation every participant's highest priority was to receive care, regardless of language. Josiane explains that in an emergency situation she valued receiving the necessary treatment and health services over which language the treatment and health services were delivered.

“Another example is a few months ago I had an allergy reaction in a restaurant and I had to go to the hospital. The paramedics didn't speak French but I was with a friend and she was bilingual so it wasn't that bad. So she asked: “do I want French services at the hospital.” I mean I can't breathe. All I wanted was for you to help me. I'm not going to start to complain about the language. I want to breathe I don't care about language but at the same time I know that isn't the right decision to promote French services but, you know, you are sick you just want to live.” (Josiane)

Other participants felt they did not have a choice but to receive emergency health care in English. Sylvie stated that it is “imperative [for her] to have French health services” because she has had several issues with linguistic barriers in the past. She explained that in many emergency situations francophones and Acadians do not have the

option to ask for French services and must use the English service even if there is a risk for negative consequences due to miscommunication.

“If you don’t have a choice you don’t have a choice. If I cut my finger off [it doesn’t matter if] the person that operates speaks English or Chinese. If I go and I’m bleeding a lot [...] when you get to that point you don’t have a choice and if it isn’t done right well that is too bad because you weren’t able to understand, then it is your fault [that the] other wasn’t able to understand.” (Sylvie)

Compromise with primary health care professionals. Within the previous themes, participants’ statements have highlighted that receiving French language services is important and they appreciated when a provider would work with them and try to communicate, if only partially, in French. However, participants also wanted the highest quality of care from their family doctor which included professionals being very comfortable in the language of delivery and in some of the participants’ experiences, their perceived professionals being very confident in English. Josiane explained that she appreciates that her health care provider made the effort to communicate in French, specifically in non-emergency medical situations. However, when receiving a health service was of high importance she preferred that it was the doctor, over herself, who was comfortable delivering the services.

“The doctor that came to see me and said I speak a little French; that isn’t enough. I would have just said “no talk to me in English”. And then it starts to be almost rude to say please just speak in English, you don’t want

to do that because they are making the effort but it isn't when you are sick that you want to be the person they practice their French on.” (Josiane)

Stéphanie shared her thoughts about choosing her family doctor. It was very important to her to have French services for her children; however, quality services for herself and her family was most important.

“Language was also a factor but if I wasn't satisfied with how he offered services I would have found another doctor. [...] For me, the ultimate line is to get high quality services. If it is in my language super, if not I will accept it. But I won't refuse... I won't go with a mediocre doctor because they speak French. No.” (Stéphanie)

Even if French speaking family doctors were to become available some of the participants stated they would not leave their Anglophone provider. Generally, they would prefer to have their health services in French but when they first sought a family doctor in Halifax a francophone doctor was not available so they accessed English care despite it being more difficult. Consequently, after the time and energy they invested in finding and building a relationship with their anglophone doctor, the effort to develop a new relationship with a new family doctor was unappealing.

“My language of preference, if I were to have people that were the same quality as I have right now it would be French. [...] If I was just coming here I would try to get all my services in French but presently at the point where I am, I'm already established.” (Christophe)

Compromise for health services for their families. Mothers also expressed contradicting sentiments about services for their children. Both Émilie and Claire

admitted that French services were very important for them and especially for their children but they would not sacrifice quality or timely service to have a French service over an English service.

“For me it would be very important to have French services for my child in French for a general case to see a general physician or a dentist umm but if we needed a specialist and the choice was to see the English specialist in one month and the French specialist in one year well the choice would obviously be to see the English one” (Émilie)

“Like for my daughter I wouldn’t have waited to find a French doctor for her operation for her ears. Same thing for my son when he had gastroenteritis and he had to do all those test for his stomach. That wasn’t French or English that was I want him to have the test. The priority was that he had those tests.” (Claire)

Conclusion. Many of the francophone and Acadian participants wanted to receive their health care services in French because they felt more confident and comfortable communicating in their own language. However, often to receive proper services their only option was to accept them in English. Thus receiving services that were of timely and of high quality took priority over linguistic preference. When French services were not available, they invested time and energy to find English language services that met their needs. Due to this investment they were not willing to sacrifice their current anglophone health care provider should a French service become available. Furthermore, in an emergency health situation, especially if it concerned their children, they would not compromise their well-being by demanding French health services and had no other

choice than to use the health services in English.

Chapter 5: Discussion

This study explored the lived experiences of the francophones and Acadians using the health care system in Halifax, Nova Scotia. The interviews focused on participants' experiences in the health care system, as well as their perceptions of the importance of French language services. Phenomenology was used as a lens for the study and the principle of "in-the-world" informed the discussion. This principle emphasizes that an individual's experiences are linked to their social and physical environments. This chapter discusses the importance of the themes influencing participants' experiences and the cultural, social and environmental context in which we understand them. Specifically, participants experienced conflict between their cultural identity and the identity they needed to assume when using the health care system, issues with privacy when it was necessary to invite interpreters into their health care environment, and difficulties related to being active participants in their health care decisions. To conclude, this chapter discusses implications for health promotion and suggests ideas for future research.

Themes Influencing Participants' Experiences and the Environmental Context

Overall, the findings demonstrated that many factors co-existed to shape participants experiences in the health care system. A significant dimension that must be acknowledged, in order to shape our understanding of these experiences, is that francophones and Acadians are accessing and utilising health care for the same reasons and with similar methods as the general population. Therefore, difficulties highlighted in the francophone and Acadian experience may also parallel a non-francophone's experience. Difficulties with comprehension when health care providers use technical

medical terminology (Wilson et al., 2005), difficulties communicating in emotional situations or experiencing feelings of discomfort stemming from perceived insensitivity from health care professionals may be experienced across language populations. However, embedded within this perspective, we need to acknowledge that the population of this study is unique and that their experiences are contextualised and therefore must be understood through their social and physical environments (Mackey, 2005). The participants in this study functioned as an official language minority group in an environment where francophones and Acadians have historical roots and their rights to language are protected by legislation (OLCDB, 2007). Few participants explicitly made reference to their official language status but their narratives reflected their minority environment and spoke to their struggles to navigate within the majority anglophone culture of the health care system in Halifax.

Language ability and the language in which service was received were the main factors influencing participants' experiences. This coincided with other francophone and Acadian realities in the literature (Picard, 2006; Bowen, 2001; Wilson et al., 2005; Jacobs et al., 2006). The most common language of service delivery was English. To manage in English, patients who were not fluent in that language developed strategies to improve their experience. Similar to the findings of other research, support was often provided informally, by family members or friends (Shapiro & Saltzer, 1981; Ngwakongnwi et al., 2012; Bonacruz & Cooper, 2003; Flores 2006; Hudelson & Vilpert, 2009).

The linkage between community and navigating health care was less conspicuous in the literature. The research participants in this study expressed strong connections with

the francophone and Acadian community. These strong connections functioned as a facilitator for accessing and using services. This level of connectedness was not found in other studies examining francophone health in other provinces (Zanchetta et al., 2013). For the participants in this study, the francophone and Acadian community was an important contributor to their experiences and a crucial support influencing access and utilisation. This community framework that supported the minority population was external to the health care system and the participants in this study still struggled with a certain measure of insecurity when accessing care and rarely sought support within the health care system itself.

My Culture or My Health: Cultural Identity in the Health Care Experience

Participants expressed strong ties to their cultural heritage, a desire to live as francophone or Acadian, and many had made efforts to actively support the local francophone or Acadian cultural groups to promote sustainability and availability of French services. However, due to limited French resources they felt disadvantaged when required to acculturate with the anglophone environment because they relied on the majority culture's health services and resources to ensure their basic needs were met. In this situation, participants experienced strain between their role as patient and their role as francophone or Acadian.

The cultural and linguistic community that francophones and Acadians identified with functioned as a source of connectedness and support for its members. However, the community also faced difficulties preserving their language, and research participants felt it was necessary and part of their responsibilities and values as francophones and

Acadians to actively contribute to the community as a means of language preservation. Their role as members of the community included promoting health care in French in order to support the community and to contribute to institutional completeness (Breton, 1991; Bouchard, Gilbert, Landry & Deveau, 2006; Jedwab, 2008). Participants' vision included developing stability, social networks and resources for future generations. A francophone health care system is therefore a contributor to the strengthening of the overall francophone and Acadian community.

Despite the important and supportive environment the community created for participants in this study, the majority of participants were unable to succeed as promoters of French health care. This was largely due to the predominant English language health care environment and the limited availability of French language health services. Understandably, when people faced the choice of receiving health care or insisting on a situation where they can live their francophone and Acadian identity, participants chose to receive necessary health care. Some were torn between their desire to fulfill their role as francophone and Acadian community builders and supporters, and people in need of health care that is offered in English. This tension set the tone for their continuing encounters in the health care system and ultimately did not allow participants' to be a francophone and Acadian and a patient while utilising the health care system.

A Public Solution for a Private Matter

When language difficulties were experienced, access and utilisation of translation strategies increased communication ability and confidence during the appointment. However, maintaining privacy during health care services was difficult when these

strategies were rooted primarily in community support. Thus, while the utilisation of strategies positively influenced participants' experience with the health care system it also inhibited their right to privacy.

Consistent with the literature, the participants in this study rarely used formal interpretation services (Ngwakongnwiki et al., 2012). They explained that these services were not offered to them, and they often invited family and friends from the community into their private health care appointments as language interpreters. This support was a key factor in the participants' experiences with the health care system and created a unique framework to manage language difficulties, facilitate treatment and access health services. With interpreters present addressing intimate health care issues they preferred to not share with family and friends in a confidential manner was almost impossible.

Some participants in this study preferred not to use formal and informal interpreters because they preferred to conduct their health care matters privately. Unfortunately, for those who had difficulty with the English language, they experienced problems that negatively influenced and sometimes impeded the reception of care; including poor communication and difficulty comprehending medical advice. Health care professionals who did not use interpreters during medical appointments with linguistic minorities experienced similar problems (Diamond, Schenker, Curry, Bradley & Fernandez, 2009). The situation was complicated for many participants as they weighed the harms and benefits between the two options. Thus, the choice between utilising interpretation services and confidentiality was another source of tension encountered by this population in the health care environment.

My Health, Your Decision: Participating in Health Care Decisions

The increase in linguistic diversity in Canada should promote a healthcare system that no longer ignores language barriers (Zanchetta et al., 2013). Serving diverse language groups places additional burdens on the health care system and the health care providers. Unwanted additional burden coupled with limited cultural and linguistic sensitivity training contributes to a health care environment that is insensitive to the needs of linguistic minorities. In this study, insensitivity and language difficulties negatively impacted the development of partnerships with health care professionals and reduced participants' confidence to engage in discussions that would allow them to understand, actively participate and make decisions in their health care.

The literature shows that language can have a significant impact on the way health care professionals relate and provide clinical services to the patient. Language fluency also affects how the patient conceptualises their role and responsibility for their health care (Marshall, Medves, Docherty & Paterson, 2011). The benefits of active participation by the patient in health care treatments have been documented in the literature and would be ideal to promote within a minority population facing linguistic barriers (Street et al. 2005; Fraenkel & McGraw, 2007). However, several needs have to be met for patients to take an active role in decisions related to their health care, one of which included the opportunity to discuss options with their physician to arrive at a decision concordant with their values (Fraenkel & McGraw, 2007). When the professional and the patient do not share the same language, it is more difficult to have a discussion about the patient's health care needs. This was true for the participants in this study.

The participants stated that both their own language ability and the level of sensitivity of the provider interacted to create a positive or negative experience during their health care appointments. Both participants with low and high levels of English-language proficiency were more comfortable speaking to their health care needs, symptoms, inquiries and concerns if they felt the provider was sensitive to their needs. Participants who felt comfortable having those conversations with their health care provider were able to actively participate in their health care. Alternatively, participants who expressed low levels of active participation did not feel they could ask questions with their health care provider and stated that they would not understand if they did ask. These participants expressed receiving treatment, medication or diagnostic testing without fully understanding why they were doing so.

Patient participation in their health care service results in increased patient knowledge, adherence to with medical advice, improved outcomes and quality of care (Street et al. 2005; Fraenkel & McGraw, 2007). These benefits may be increasingly important for linguistic minority populations who experience difficulty in these areas (Bouchard 2006, Picard et al., 1999). Based on the experience of the participants in this study, creating an environment that makes the patient feel comfortable is important for increasing active participation. Furthermore, research shows that the majority of active participation behaviours were patient-initiated rather than prompted by the physician (Street et al., 2005). Therefore, empowering the linguistic minority patients within the health care environment would be an important step for improving their experience through increased participation in their health care.

Limitations

The study had several limitations. One of the limitations came from the characteristics of the researcher. I had limited experience conducting qualitative interviews prior to this study, which may have hindered the depth of the responses given by participants. The interview questions were designed with the help of my supervising committee to promote thoughtful responses from participants. Additionally, my age, education level, urban residency and other characteristics likely shaped the framing of the questions I used and the responses given by participants if they were not completely comfortable sharing information with an anglophone, Caucasian, and 24 year old female. Moreover, I came to this study with experiences of my own related to my use of English and French language health care systems, but tried to remain reflexive throughout the entire process to ensure that I understood the participants' perspectives.

Secondly, using multiple languages in the research process may have been a limitation for the qualitative method used in the study. Qualitative methodology is rooted in language and sensitive to vocabulary and meaning. In this study the interviews were translated into English for logistical reasons and there was concern that the interpretive act of translation may lose some of the complexities of participants' language. The literature suggested that the best way to preserve language meaning in cross-linguistic studies was for the interpreter and researcher to partner for the translation process, offering the pair an opportunity to discuss meaning of passages and consider vocabulary (Larkin, 2007; van Nes 2010). In this study I also acted as translator which placed me in the best position to preserve vocabulary and meaning during the translation process. To produce additional assurance that participants' meaning was not lost during this process, I

had the option to not translate passages that had meaning that spoke truer in the original language as well as frequently inserting comments in the transcription to further explain the significance of the passage from the francophone perspective. Additionally, an Acadian and a francophone individual were available to discuss short passages with me. Finally, the transcripts were reviewed in totality and compared with my field notes and the audio recording before beginning the analysis process.

Recommendations and Implications

This research adds to current literature on francophone health by qualitatively exploring health services from the perspectives of francophone and Acadian patients in Halifax, NS. The use of qualitative methods was one of the study's strengths because it facilitated the gathering of data on a variety of perspectives and experiences which at times were inconsistent or contradictory. Further, qualitative methods provided a powerful lens with which to understand and consider the struggles participants had in describing and reflecting on their experiences with the primary health care system. This section of the thesis highlights several recommendations for addressing the difficulties in the experiences shared by participants.

The difficulties experienced by the study population stemmed primarily from not receiving services in their own language. This study indicates that ideally French language health care services should be available for all individuals who want them. Unfortunately, a fully equitable delivery of bilingual health care is unlikely in the province, as Nova Scotia is primarily a unilingual province and there are difficulties associated with cost, priorities as well as with recruitment of bilingual health care professionals.

In light of this, a recommendation stemming from this research is to develop a standardized delivery of health care services in both official languages. This does not necessarily mean that all services need to be delivered in French. Rather, I recommend the provision of a standardized delivery of official languages health services across the province that meets the needs of the francophone and Acadian populations through a mix of translation tools and services, cultural and linguistic sensitivity, and bilingual providers.

A first step to be considered for a standardization of official languages health care services is at the policy and legislation level. The disjunction between Federal and Provincial legislation in regards to the Official Language Act and health care should be rectified. Bilingual health care is addressed at a Federal level but responsibility for the delivery of health care is a provincial matter and in Nova Scotia health care delivery in both official languages is not tied to provincial law, policies or standards. This obstacle creates large variability in access and delivery to health services for official language minorities throughout the province. The development and implementation of standardized legislation would support official language minority communities by increasing accountability for the delivery of health care services, and by unifying the expectations of the health care professionals and the patients in regards to accessing and utilising official languages health care services.

At the provincial and municipal level, francophones and Acadians should be provided with inclusive health care environments. Failure to address the linguistic needs of patients is a form of discrimination. Participants in this study were forgiving and polite

while describing experiences when their language and culture were not respected and when they struggled to deal with health care services provided in English. Francophones and Acadians who are patients in the health care system should not have to assume responsibility for lobbying for respect and accommodation from the institutions and professionals that are in place to care for and support them.

Health care professionals' level of sensitivity was an important part of participants' experiences and is essential for reducing discrimination towards the francophone and Acadian population. Research supports the benefits and effectiveness of cultural sensitivity and cultural sensitivity training within the health care system (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003; Nogaard, Kofoed, Kyvik & Ammentorp, 2012). These benefits were also supported by the results of this study. It is recommended that those who train health care providers must include strategies on how service providers can meet the needs of francophone and Acadian minorities along with training for meeting the needs of other minority groups. Several simple approaches were highlighted by study participants and these should be incorporated into the training of health care professionals and in the delivery of health care services.

First, when French language services are available they should be offered to francophone and Acadian patients. Examples of services that are often available are: on-site formal interpretation, a health care professional who speaks French or a copy of French instructions, particularly medication instructions or instructions for preparation for medical tests. It is also important to highlight that even without the availability of a French language service a positive and patient environment of care, that would help mitigate some of the linguistic issues, can be created when health care providers

demonstrate respect for and value the language and culture of the patient. Methods suggested for accomplishing this includes the use of some French language even if the professional does not consider themselves a fluent French speakers or by being considerate when communicating (speaking slowly, repetition when necessary, use of appropriate vocabulary, avoiding culture specific references etc.). Each of these methods for engaging with francophone and Acadian patients should be highlighted in cultural sensitivity training for professionals and entrenched in the delivery of primary health care.

Changes in the health care system to support francophone and Acadian minorities should also focus on a physical and structural environment that increases multi-lingual inclusivity in order to develop a climate of respect and acceptance between the health care provider and patient. Some suggestions for this included bilingual signage, and alerting staff to resources underlining the availability of language supports so they are knowledgeable when directing linguistic minority patients. Further, interactions between health care services and patients should be respectful and sensitive by centering the interaction on how the service can best serve the patient. A suggestion made by several participants is to include a question about language preference during patient in-take interviews to allow an opportunity for the patient to discuss language with their health care provider.

A final recommendation stemming from the results is to support and formalize strategies developed from the connection between participants and their community. Despite the issues of privacy, informal supports and strategies that stemmed from their community were important factors in participants' health care experiences. Formalizing

strategies, such as interpreters or communication tools, may increase access and utilization by members of the community and address issues of privacy. Suggestions by participants include publically available translation or communication tools, such as lists of common word used in health care situations with translations and pictograms, in health care locations. Another suggestion is for health care settings to use and advertise a paid or volunteer based interpretation service that can be accessed by patients or health care professionals. For example, a method used in other areas of the health care system is volunteer based navigation teams that connect patients' with an individual who can support them through their health care process. These teams have had success in the past and help patients and their families navigate the fragmented maze of doctors' offices, clinics, hospitals, out-patient centers, payment systems, support organizations and other components of the healthcare system (Freeman 2004, 2006). These services may replace the need to involve a family member for translation purposes as well as play a role in advocacy to ensure that people from francophone and Acadian communities are able to have their healthcare needs met appropriately (Ansari, Newbigging, Roth, & Malik, 2009). Therefore, creating formal social infrastructure for these types of strategies will make the resource available to more members of the community and address some issues around privacy.

Future Research

This research focused on the perspectives of francophone and Acadian patients utilising the health care system. It found that their perceptions, the health care environment and individual characteristic greatly influenced their experiences. To further develop an understanding of the francophone and Acadian reality within the health care

environment it would be beneficial to review the perspectives of health care providers and policy maker working in the health care environment.

An issue that also merits future exploration is the ethical practices of gaining informed consent in the health care system from individuals experiencing language barriers. As highlighted by participants, understanding medical terminology and context was often a struggle. Thus ethical considerations and methods of consenting for medical procedures is an important piece in the reality experienced by linguistic minority populations that should be explored at greater lengths.

There was indication in the literature review that francophones were primarily located in rural regions throughout Canada. Although the highest proportion of Nova Scotian francophones and Acadian lived in Halifax, there is a significant proportion that inhabits rural regions in Nova Scotia. Individuals from rural regions experience unique issues related to their experience with health care services. A study by Langille et al. (2012) demonstrated that the Acadian population in rural Nova Scotia did not have significant health differences from their English counterparts. However, both rurality and OLM status have been shown to represent a risk for access to health care therefore it would be important to examine the interaction between these factors as they relate to individuals' experience.

Last, there may be a difference between the experience of the Acadian and francophone people. Future studies should explore the possible differences in their experience in the health care system that may be influenced by the differences in the proximal and distant histories of the two groups. It would be important to explore this

difference in order to assure every official language group is receiving the best health care service.

Conclusion

The experience of Acadians and francophones in the health care system is dependent on many factors that vary from individual to individual. Though not all francophones and Acadians have an issue with the English language, they all agree about the importance of having French services. Their experiences in a health care system that are characterised by the language, culture and values of the majority population are not simple and are influenced by the competing reality of minority culture and individual needs.

Participants' level of connectedness to the community increased their sense of membership and responsibility to the community which included promoting health care in French. From the first point of contact with the health care system participants experienced tension between promoting French-services and utilisation of English-language services. While receiving health services language, sensitivity and strategies for engaging during their appointments interacted to create difficulties for confidentiality and privacy. Utilising ties with their community and informal interpreters reduced patients' ability to choose to receive their health care services in private. The strain between privacy and receiving the best care was a struggle for participants who viewed their health as an intimate experience. Additionally, language ability and sensitivity from health care professionals had a varying impact on patient's ability to participate in their health care treatment. Encouraging active participation was possible when patients felt

comfortable and valued in their health care experience. These tensions and contradictions in patient experiences could be improved via increased sensitivity from the health care system to support and empower francophones and Acadians as well as supporting infrastructure in their community to increase utilisation and knowledge of supports that are available.

Overall, this research has contributed to the literature on francophone health by exploring the issue from the patients' perspective. The results and recommendations are unique to the population that was involved in the research. Other linguistic minority groups, however, may experience similar realities and may also benefit from the recommendations proposed.

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Appendix A: Ethics Approval

4/23/13

Gmail - RE:Ethics Approval # 2012-2746



Caila Aube <caila.aube@gmail.com>

RE:Ethics Approval # 2012-2746

1 message

sharon.gomes@dal.ca <sharon.gomes@dal.ca>

Tue, Jul 24, 2012 at 9:13 AM

To: caila.aube@dal.ca

Cc: Susan.tirone@dal.ca, sharon.gomes@dal.ca

2012-2746

The Francophone / Acadian Experience: Primary Health Care in Halifax, Nova Scotia

Dear Ms Caila Aube,

Please be advised that your project entitled The Francophone / Acadian Experience: Primary Health Care in Halifax, Nova Scotia has been approved by the Dalhousie Research Ethics Board effective July 24, 2012

An official approval letter stating the terms and duration of the approval will be forwarded to your attention in due course. Please read this letter carefully as it stipulates your ongoing responsibilities with respect to the ethical conduct of the study.

NOTE: For future correspondence concerning this project, we would ask that the assigned file number 2012-2746 is referenced.

Funding: N/A

Award:

Sharon Gomes
Civic Address
Research Ethics
Henry Hicks Academic Administration Building
6299 South Street, 2nd Floor, Suite 231
PO Box 15000
Halifax, NS
B3H 4R2

Mailing Address
1459 Oxford Street
Halifax, N.S.
B3H 4R2
T - 494-3423
Fax - 494-1595

Sharon.Gomes@dal.ca

Appendix B : Ethics Amendment

4/23/13

Gmail - RE: Amendment approval # 2012-2746



Caila Aube <caila.aube@gmail.com>

RE: Amendment approval # 2012-2746

1 message

sharon.gomes@dal.ca <sharon.gomes@dal.ca>
To: caila.aube@dal.ca
Cc: susan.tirone@dal.ca, sharon.gomes@dal.ca

Wed, Sep 26, 2012 at 4:12 PM

2012-2746
1011607

Dear Ms Caila Aube,

Please be advised your amendment dated September 20,2012 for project entitled The Francophone / Acadian Experience: Primary Health Care Services in Halifax, Nova Scotia has been approved by the Research Ethics Board effective September 26, 2012 .

Your amendment may commence as of todays date. September 26, 2012

Please retain this email on file as confirmation of your approval.

Trusting this information is satisfactory.

Sharon Gomes
Research Ethics
902-494-3423
Sharon.Gomes@dal.ca

<https://mail.google.com/mail/u/0/?ui=2&ik=0004c6f957&view=pt&q=ethics&qs=true&search=query&th=13a04014362494ff>

1/1

Appendix C : Poster



INTERESTED IN PARTICIPATING IN A RESEARCH STUDY?

The francophone and Acadian experience: primary health care system in Halifax Nova Scotia.

- ✓ **Are you currently over 18 years of ages?**
- ✓ **Do you identify as a francophone or Acadian individual?**
- ✓ **Have you lived in Halifax or surrounding area for at least 10 year?**
- ✓ **Do you speak French and feel comfortable sharing your experiences in French?**

If you answered “**YES**” to **ALL** of these questions, you are invited to participate in a research study that hopes to learn about the experiences of francophones and Acadians in the primary health care system in Halifax, Nova Scotia.

We want to hear YOUR VOICE!

You will participate in one 45 minute to 90 minute one-on-one interview discussion.

If you are interested in participating in this university research study, or simply wish to learn more about it, please contact Caila Aubé at X-XXX-XXXX.

ÊTES-VOUS INTÉRESSÉ(E) À PARTICIPER À UNE RECHERCHE?

L'expérience francophone et Acadienne avec le système de santé primaire à Halifax, Nouvelle-Écosse.

- ✓ **Est-ce que vous avez 18ans ou plus?**
- ✓ **Est-ce que vous vous identifiez comme francophone ou Acadien(ne)?**
- ✓ **Est-ce que vous vivez à Halifax ou ses alentours depuis 10 ans ou plus?**
- ✓ **Est-ce que vous vous sentez confortable à partager vos expériences et à vous exprimer en Français?**

Si vous avez répondu “OUI” à **TOUTES** les questions, vous êtes invité(e) à participer à l'étude de recherche qui cherche à en savoir plus sur les expériences des francophones et Acadiens avec le système de santé primaire à Halifax, Nouvelle-Écosse.

VOTRE EXPÉRIENCE EST IMPORTANTE!

Vous participerez à un entretien en face-à-face d'environ 45 à 90 minutes.

Si vous êtes intéressé(e) à participer à cette recherche universitaire ou si vous voulez plus d'information s'il vous plaît contactez Caila Aubé au X-XXX-XXXX.

Appendix D : List of francophone Organisations

Francophone community organizations in Halifax

Seniors and Women

Fédération des femmes acadiennes de la Nouvelle-Écosse

Arts and culture

Conseil culturel acadien de la Nouvelle-Écosse

Les voix d'Acadie Choir

Councils, commissions and economic development committees

Association métropolitaine pour l'établissement des immigrants

Education

Alliance française d'Halifax-Dartmouth

Canadian Parents for French – Nova Scotia

Fédération des parents acadiens de la Nouvelle-Écosse

Communications and technology organizations

Radio-Halifax-Métro

Community development organizations

Association des juristes d'expression française de la Nouvelle-Écosse

Fédération acadienne de la Nouvelle-Écosse

Health organization

Réseau Santé Nouvelle-Écosse

Parish councils and social clubs

Mission Sainte-Famille

Appendix E: Consent Form

Consent to Take Part in Research

Study title	How do francophones and Acadians experience primary health care services in Halifax, Nova Scotia?
Degree Program	Master of Art, Health Promotion School of Health and Human Performance Dalhousie University
Research Supervisor	Dr. Debbie Martin School of Health and Human Performance Dalhousie University 6230 South Street Halifax, Nova Scotia B3H 3J5 Email: debbie.martin@dal.ca Phone: X-XXX-XXXX
Principal Investigator	Caila Aube, BA, GradCert, MA (candidate) School of Health and Human Performance Dalhousie University 6230 South Street Halifax, Nova Scotia B3H 3J5 Email: caila.aube@dal.ca Phone: X-XXX-XXXX
Contact Person	Caila Aube, BA, GradCert, MA (candidate) School of Health and Human Performance Email: caila.aube@dal.ca Phone: X-XXX-XXXX

Introduction

You are invited to take part in a research study being conducted by Caila Aube, a graduate student at Dalhousie University, as part of her Master of Arts in Health Promotion. Participation in this study is completely **voluntary**. Even after you have provided consent to participate you may withdraw from the study at any time. You **do not** have to answer any question you do not want to answer.

The study is described below. This description will tell you about the risks, inconveniences or discomforts that you might experience. Participation in the study might not benefit you directly, but we might learn things that will benefit others in the future. If you have any questions concerning the study, consent form and your participation please contact Caila Aube by phone X-XXX-XXXX or by email caila.aube@dal.ca.

Purpose of the Study

Research has shown that language can play an important role in health care services however, little is known about the perspective of francophones and Acadians in Nova Scotia. This research study seeks to explore the experience of francophones and Acadians who receive primary health care in Halifax Nova Scotia. We would like to understand the experience of being a francophone and Acadian within the predominantly Anglophone health care system of Halifax. This includes learning about the processes, behaviours, challenges and expectations faced by francophones and Acadians within the social and professional environment of health care. By providing insights on this phenomenon the findings of this research may serve to recommend improvements to primary health care services for the francophone and Acadian community.

Study Design

If you chose to participant Caila Aube, the primary researcher, will conduct a one-on-one face-to-face interview with you. The interview is expected to take approximately 45 minutes to 1 hour. The interview will ask you questions about your past experiences and future expectations with the primary health care services, as well as your cultural and linguistic identity. With your permission the interview will be audio taped and transcribed and translated into English. Your interview as well as the interviews from the other participants of the study will be reviewed and analysed. All of the information collected during the interview will be kept confidential. The interview will be available only to researchers who are part of this project and for the purpose of this project. If you agree to participate in this study, you will need to provide the interviewer with your consent. If you wish a summary of the findings will be provided to you for your comments prior to completing the final report. If you wish to review the findings you will have to provide an email or mailing address to the researchers.

Who can participate in the Study?

Any individual 18 years of age or old who identifies as francophone or Acadian residing in Halifax proper may participate. The research will be conducted in French and is about the primary health care services in Halifax, Nova Scotia therefore individuals should feel comfortable expressing themselves in French and have an interest in the primary health care services for francophones and Acadians in Halifax, Nova Scotia.

Who will be conducting the research?

Caila Aube, a graduate student at Dalhousie University and principal investigator, will be primarily responsible for the research. Caila Aube's Master of Arts thesis supervisors Dr. Debbie Martin and Dr. Susan Tirone will be assisting with all aspects of the research process.

Possible Risks and Discomforts

There are minimal risks to partaking in this research study. Nevertheless, talking about your personal experiences, health and health care system may cause some feeling of distress or make you uncomfortable. You are only asked to share information you are comfortable with therefore you do not have to answer any questions that makes you feel uncomfortable. This study is not meant to judge or evaluated your health or your actions but is interested in your experiences and how they may inform health services for francophones and Acadians. If at any point you wish to cease participation in the study you may simply ask to end the interview. If after the interview you decide you no longer wish to participate in the research and you wish that your interview is not included in the study, simply call or email Caila Aube and your interview will be removed from the study. Due to the timeline of this project I ask that you inform Caila Aube of your wish to withdraw within 3 weeks of your interview date.

Possible Benefits

There may be no direct benefit to you for participating in this study. Through this study we hope to create a better understanding of the reality of francophones and Acadians in regards to primary health care services, which may help to inform future health promotion initiatives, services and policies.

Compensation

Your participation in the study is greatly appreciated, we would like to thank you for your interest and hope that you enjoyed your experience but no physical compensation will be provided.

Confidentiality and Anonymity

Protecting your privacy is an important part of this study. Every effort to protect your privacy will be made. However, it cannot be guaranteed. For example we may be required by law to allow access to research records. The interviewer has a duty to report suspected child abuse or neglect, or the abuse or neglect of an adult in need of protection to the nearest social worker or Department of Child, Youth and Family Services Office.

When you sign this consent form you give Caila Aube permission to :

- Collect information from you
- Share information with the people conducting the study

At the end of the interview, you will be asked if there is anything that you would like to remove from the interview and this information will NOT be included as data.

When the interviews are transcribed all identifying information such as names and other personal information will be removed. Only this consent will have your name on it and it will be kept separate from all other interview files. Everything that has to do with this study will be kept in a locked filing cabinet at Dalhousie University for a minimum of 5 years, after which the information will be destroyed. Only Caila Aube and her thesis advisors, Dr. Debbie Martin, Dr. Susan Tirone, Dr. Don Langille will have access to the audio-tapes and transcription of the interview.

You will not be identified in any reports, publications or presentations of this study. Major themes identified from all the interviews will be reported and direct quotes from individuals may be used in order to best illustrate these themes but quotes will only be described by an assigned participant number not their names.

Questions

If you have any questions about the study, consent form, or your participation in the study you may call Caila Aube at X-XXX-XXXX or email her at caila.aube@dal.ca.

Problems and Concerns

If you have any difficulties with or wish to voice a concern about any aspect of your participation in this study you may contact Dalhousie Ethics

Research Ethics, Dalhousie Research Services

Henry Hicks Academic Administration Building

6299 South Street, Suite 231, Dalhousie University

Halifax, Nova Scotia B3H 4R2

Phone: (902) 494-3423

Fax: (902) 494-1595

E-mail: ethics@dal.ca

Please check as appropriate:

I have read the consent { }	Yes { }	No
I have had the opportunity to ask questions/to discuss this study { }	Yes { }	No
I have received satisfactory answers to all of my questions { }	Yes { }	No
I have received enough information about the study { }	Yes { }	No
I have spoken to _____ and (s)he has answered my questions { }	Yes { }	No
I understand that I am free to withdraw from the study { }	Yes { }	No
• at any time during the interview or up to three weeks after you have reviewed your transcripts		
• without having to give a reason		
I agree to have my responses audio recorded { }	Yes { }	No
I understand that it is my choice to be in the study and that I may not benefit { }	Yes { }	No
I agree to take part in this study { }	Yes { }	No

Signature of participant

Date

To be signed by the Interviewer:

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

Signature of Interviewer

Date

Research Contributor's Agreement for Interviews

The following agreement should be filled out by the research participant, or by the interviewer on behalf of the research participant. The research participant may sign at the bottom, or he/she may also have their consent recorded using the digital recorder.

I, _____, hereby acknowledge that I have participated in the research study entitled, "The francophone and Acadian experience: primary health care in Halifax, Nova Scotia". As a participant in this research project, I agree to:

- Have my direct quotes from the interview used for the research report research publications or presentations. Yes { }
No { }
- I would like to have the opportunity to review my transcript to ensure that I am comfortable sharing all of the information I have provided. Yes { }
No { }
 - If yes, please provide contact information (mailing address or email address) to which to the transcripts may be sent for your review:

Participant's Signature

Date

Interviewer's Signature

Date

Formulaire de consentement

Titre de l'étude	L'expérience francophone et Acadienne avec le système de santé primaire à Halifax, Nouvelle-Écosse.
Programme d'étude	Master of Art, Health Promotion School of Health and Human Performance Dalhousie University
Superviseure	Dr. Susan Tirone School of Health and Human Performance Dalhousie University 6230 South Street Halifax, Nova Scotia B3H 3J5 Email: susan.tirone@dal.ca Phone: X-XXX-XXXX
Enquêtrice Principale	Caila Aube, BA, GradCert, MA (candidate) School of Health and Human Performance Dalhousie University 6230 South Street Halifax, Nova Scotia B3H 3J5 Email: caila.aube@dal.ca Phone: X-XXX-XXXX
Personne à contacter	Caila Aube, BA, GradCert, MA (candidate) School of Health and Human Performance Email: caila.aube@dal.ca Phone: X-XXX-XXXX

Introduction

Nous vous invitons à participer à une étude effectuée par Caila Aubé, une élève de deuxième cycle pour compléter sa maîtrise en promotion de la santé à l'université de Dalhousie. Votre participation à cette étude n'est pas obligatoire et vous pouvez vous en retirer à tout moment. Que vous participiez ou non à l'étude, la qualité de vos services de santé ne sera pas affectée.

Nous fournissons ci-dessous une description de l'étude. Cette description vous indiquera les risques ou les inconvénients que vous pourriez ressentir lors de votre participation. Il est peu probable que la participation à l'étude ait le moindre avantage pour vous personnellement, mais nous espérons apprendre des choses qui pourront être bénéfiques pour la communauté dans l'avenir.

Toutes questions ou préoccupations que vous pourriez avoir peut être adressées à la responsable principale de l'enquête, Caila Aubé, avec qui vous pouvez communiquer en appelant le X-XXX-XXXX ou par courriel caila.aube@dal.ca.

Description de l'étude

La littérature sur les barrières linguistiques dans le domaine de la santé confirme que la langue peut jouer un rôle important dans les services de santé. Par contre on connaît peu de chose au sujet de la réalité des francophones en situation minoritaire en Nouvelle Ecosse. Ce projet de recherche cherche à remplir ce trou et à découvrir l'expérience des francophones et Acadiens qui reçoivent des services de santé primaire à Halifax. Nous aimerons comprendre l'expérience d'être francophone et Acadien dans un système de santé principalement anglophone. Ça inclut d'explorer les processus, comportements, défis et attentes auxquels les francophones et Acadiens font face dans les environnements social et professionnel de la santé. Les résultats de l'étude pourront servir comme recommandations pour améliorer le système de santé pour la communauté francophone et Acadienne d'Halifax.

Que demandera-t-on?

Si vous choisissez de faire partie de l'étude, vous participerez à un entretien en face à face avec l'enquêtrice primaire, Caila Aubé. L'entretien sera d'une durée de 45 minutes à 90 minutes. Les questions de l'entretien vous demanderont de raconter vos expériences avec le système de santé primaire, votre culture et votre identité linguistique. Avec votre permission, l'entretien sera enregistré et transcrit en anglais pour permettre l'analyse des données. Vos données et celles des autres participants seront révisées et analysées ensemble. Toute information recueillie durant les entretiens sera gardée confidentielle. Seuls l'enquêtrice primaire et les chercheurs qui supervisent le projet auront accès aux entretiens. Pour participer à l'étude vous devez consentir en complétant la page de signature à la fin de ce document.

Qui peut participer à l'étude?

Toute personne âgée de 18 ans ou plus qui s'identifie comme francophone ou Acadienne et habite à Halifax, Bedford ou Dartmouth. L'individu doit s'intéresser au système de santé primaire pour les francophones et acadiens à Halifax, Nouvelle Écosse.

Qui va faire le travail de recherche?

Caila Aubé est une étudiante en maîtrise en promotion de la santé à l'université de Dalhousie. La superviseure de la maîtrise Dr. Susan Tirone offrira son expertise sur tous les aspects du processus de la recherche.

Risques et gêne éventuels

Il y a peu de risque associé à votre participation dans la recherche. Il peut être difficile de parler de vos expériences personnelles de votre santé et des services de santé. Certains individus trouveront que certaines des questions les mettent mal à l'aise. Vous n'êtes pas obligé de répondre aux questions auxquelles vous ne souhaitez pas répondre. Le but de cette étude n'est pas de juger ou évaluer votre santé ni vos actions mais, de s'intéresser à vos expériences et comment ces expériences peuvent être utiles au système de santé primaire pour les francophones et Acadiens. À n'importe quel moment vous pouvez arrêter l'entretien. Si vous voulez retirer votre information de l'étude SVP contactez Caila Aubé par courriel ou téléphone jusqu'à trois semaines après l'entretien.

Avantages éventuels

La participation à l'étude n'aura pas d'avantage direct pour vous, mais cette étude nous permettra peut-être d'apprendre des choses qui pourront contribuer à améliorer les services de santé offerts à l'avenir aux francophones et Acadiens.

Indemnisation/remboursement

On vous remercie pour votre participation. Aucune indemnisation n'est offerte.

Confidentialité et anonymat

Une partie importante de l'étude est de garder votre confidentialité et toute action sera faite pour protéger votre vie privée. Par contre on ne peut pas la garantir. Il y a des situations où la loi nous oblige à partager l'information. S'il y a un soupçon d'abus ou de négligence d'un enfant ou d'abus ou de négligence d'un adulte qui a besoin de protection, l'intervieweur a le devoir de partager son soupçon avec la ministère des services communautaires.

Avec votre signature vous donnez la permission à Caila Aubé de:

- Recueillir votre information
- Partager cette information avec les individus qui supervisent l'étude

À la fin de l'entretien on vous demandera s'il y a quelque chose que vous voulez retirer et cette information sera retirée des données recueillies lors de votre entretien. Quand l'entretien est transcrite toute information qui pourra vous identifier sera retirée. Seul ce formulaire de consentement aura votre nom et sera entreposé dans un endroit sécurisé et séparé des fichiers des entretiens. Seuls Caila Aubé, et son comité de supervision Dr. Debbie Martin, Dr. Susan Tirone et Dr. Don Langille auront accès à la transcription des entretiens. Tout aspect physique de cette recherche sera gardé dans un classeur fermé à clé à l'université de Dalhousie pour un minimum de 5 années. Après la période de 5 ans l'information sera détruite.

Vous ne serez pas identifié dans les rapports, publications ou présentations reliés à cette étude. Les thèmes principaux de tous les entretiens seront identifiés et des citations directes pourront être utilisées pour mieux illustrer les thèmes. Les citations seront identifiées par un numéro de participant qui sera assigné par hasard à chaque entretien.

Questions

Si vous avez la moindre question sur l'étude en général, veuillez communiquer avec Caila Aubé au numéro indiqué à la première page de cette lettre.

Problèmes et préoccupations

Si vous avez des difficultés concernant la participation à cette étude ou souhaitez exprimer la moindre préoccupation au sujet de cette étude, vous pouvez communiquer avec la directrice du comité d'éthique à l'Université Dalhousie, au (902) 494-3423 ou à ethics@dal.ca.

Page de réponse :

SVP cocher:

J'ai lu le formulaire de consentement { }	Oui { }	Non
J'ai eu la possibilité de poser des questions { }	Oui { }	Non
J'ai reçu des réponses satisfaisantes à toutes mes questions { }	Oui { }	Non
Je comprends que je peux me retirer de l'étude à n'importe quel moment sans pénalité		
<ul style="list-style-type: none">• Durant l'entretien et jusqu'à trois semaines après l'entretien• Je n'ai pas besoin de donner une raison { }	Oui { }	Non
J'accepte que l'entretien soit enregistré { }	Oui { }	Non
Je comprends que c'est mon choix de faire partie de l'étude et qu'il n'y aura peut-être pas d'avantage direct pour moi.	Oui { }	Non
{ }		
J'accepte de participer à l'étude { }	Oui { }	Non

Signature du participant

Date

Signé par l'intervieweur:

Je certifie par la présente que j'ai expliquée l'étude au meilleur de mes capacités. J'ai invité à poser des questions et j'y ai répondu. Je crois que le participant comprend les attentes de l'étude et les risques et qu'il ou elle a choisi de sa propre volonté de participer à de l'étude.

Signature de l'enquêtrice

Date

Déclaration de consentement par le participant

Je, _____, reconnait que j'accepte de participer à l'étude de recherche intitulée « L'expérience francophone et Acadienne avec le système de santé primaire à Halifax, Nouvelle-Écosse ». Comme participant à l'étude:

- J'accepte que mes propos soient cités directement dans le rapport de recherche, publications ou présentations de cette étude. Oui { }
Non{ }
- J'aimerais avoir l'opportunité de réviser une copie des résultats pour donner des commentaires, suggestions et idées pour enrichir le processus d'analyse et d'interprétation Oui { }
Non{ }
- J'aimerais recevoir un résumé des résultats de l'étude Oui { }
Non{ }
 - Si oui, SVP indiquez vos coordonnées ci-dessous (adresse postale ou courriel)

Signature du participant

Date

Signature de l'enquêtrice

Date

Appendix F: Question Guide

Question Guide

Before the interview:

- Thank the individual for agreeing to participate in the research study
- Provide a copy of the consent form
- Verbally highlight the key information in the consent form
 - o Everything the participant say will be kept completely confidential, which means their name or identifying information will not be connected to anything they say.
 - o Participation is completely voluntary. The individual may stop the interview, skip or refuse to answer any questions at any point during the interview.
- Verbally check whether the participants consent to the interview being audio-taped
- Assure the consent form has been signed
- Ask the individual if they have any questions before the interview begins
- Check the recorder
- Begin the interview.

Script.

Hello, thank you for taking the time to talk to me today. As we've discussed previously I'd like to talk a little bit about your experiences with the primary health care system in Halifax Nova Scotia and how language has influenced that experience. Today when I ask about primary health care service I am referring to first access services like the emergency room, family doctor, dentist, and pharmacist basically any health services that you can access without being referred. There are no right or wrong answers so please just answer the questions as best you can and include any experiences and examples you feel are important. Only answer the questions you feel comfortable with. You are welcome to change names and omit specific information if you feel it is necessary. Do you have any questions before we begin?

A) Demographics participants/health services

1. What language(s) do you speak. In what situation(s) do you usually speak them?
 - a. Which language is the one that is most comfortable for you to use with primary health care providers?
2. How does your cultural or linguistic identity influence your daily life?
3. How important is it for you to live your cultural or linguistic identity in your daily life?
4. What primary health services are you currently using? [provide examples stated in the introduction]
5. In which language are you receiving your primary health care services?

B) Can you walk me through a time when you needed to use primary health care services in the Halifax area

a. Specifically, how language influenced your experience?

**The ideal format for this interview question would be the individual recounting an experience they have had with primary health care. The story would follow chronological order and touch on many aspects of accessing, interacting and using the services. The following bolded sections consist of probe questions in the case that interviewer wishes more information on an important topic however as each individual experience and manner of storytelling is different therefore these probes will serve only as a guide.

b. Seeking out services

i. Can you tell me about a time you had to use primary health care?

1. How did you go about finding the service?

2. What are some factors that you considered about the provider when you accessed this care?

3. Were you able to have access to French language services from this provider?

a. Was getting/not getting services in French important to you?

i. Why?/Why not?

- b. If you absolutely felt you needed or wanted care in French how would you go about finding a French speaking health professional?
4. Did you face any challenges in having access to this provider? How did you overcome these challenges?

c. In the waiting room

- i. When booking an appointment or arriving at the service how does the language in which you are greeted influence how you feel about the situation?
- ii. Once you have arrived at your chosen primary health care service how does language influence your experience in the waiting room?
- iii. How would sharing a common language with the receptionist/greeter/ patients in the waiting room influence your experience with your primary health care services?

d. During the appointment

- i. When you are meeting with the health care professional does language influence your experience? How? In what ways?
- ii. (If services not provided in French) Would sharing a common language with the health care professional influence your experience with your primary health care services provider? How? In what ways?

(If services provided in French) Tell me about how how getting the service in your own language may have influenced your experience with the provider?

e. After the appointment/ understanding instructions/ booking a follow up

- i. Did language influence your ability to ask questions, receive instructions, or book follow up appointments?
- ii. If you were given instructions or information packages how you did feel about the language you received them in? Were you satisfied that you understood this information fully. If you experienced any difficulties, can you tell me how you overcame these?
- iii. Thinking about your experience during this visit, how would (or did) sharing your preferred language with the receptionist, provider, and other patients have influenced (influence) your experience?

C) Importance of French Script: *you may have indicated that it was or was not important to you to receive your health care services in French. I would just like to get more of an understanding about your feelings...*

1. What are some services that are most important to have in your preferred language? Can you tell me about an experience that has influenced this feeling of importance to you?
2. Which [primary] health care professionals do you consider most important to have the ability to speak to you in French? Can you tell me about an experience that has influenced this feeling of importance?
3. Are there situations related to receiving care that make it more or less important to receive services in French? Can you tell me about an experience that has influenced this feeling of importance?

D) Expectations

1. How have your experiences with primary health care in Halifax shaped how you feel about the services in Halifax?
 - a. Will it influence how you approach services in the future?
2. Can you tell me about what your expectations about language when receiving health care?
 - a. When you access PHC do you expect to speak in French or English?
Can you tell me why?
 - b. In your opinion what is an acceptable level of access/availability of French services? Can you tell me why?

E) Community insight

1. What would you suggest to health planners in order to create a better primary health care system for francophones and Acadians in Halifax?
 - a. What do you think is actually possible in Halifax?

Question Guide

Before the interview:

- Thank the individual for agreeing to participate in the research study
- Provide a copy of the consent form
- Verbally highlight the key information in the consent form
 - o Everything the participant say will be kept completely confidential, which means their name or identifying information will not be connected to anything they say.
 - o Participation is completely voluntary. The individual may stop the interview, skip or refuse to answer any questions at any point during the interview.
- Verbally check whether the participants consent to the interview being audio-taped
- Assure the consent form has been signed
- Ask the individual if they have any questions before the interview begins
- Check the recorder
- Begin the interview.

Script.

Bonjour, premièrement j'aimerais vous remercier pour votre participation aujourd'hui.

Comme nous avons déjà discuté aujourd'hui j'aimerai parler de vos expériences avec le système de santé primaire ici à Halifax et comment votre identité linguistique et culturelle influence ces expériences. Quand nous parlons du système de santé primaire on veut dire les services de premier accès comme votre médecine de famille, l'urgence,

un dentiste ou un pharmacien. Alors en général tous services que vous pouvez accéder sans être adressé à un spécialiste. SVP répondre aux questions le mieux que vous pouvez et inclure toutes expériences et exemples que vous pensez important. Il n'y a pas de bonnes ou mauvaises réponses aux questions. Si une question vous faites sentir mal à l'aise vous ne devez pas répondre. Si vous le croyez nécessaire vous pouvez changer les noms ou omettre des détails spécifiques. Avez-vous des questions avant qu'on commence?

Démographiques

1. Variable Linguistique

- a. Quelle langue parlez-vous? En quelle situation est-ce que vous les parlez (au travail? A la maison? Etc.) ?
- b. Quelle est votre langue de préférence avec vos professionnelles de la santé primaire?

2. Variable d'identité/culturelle

- a. Comment est-ce que votre identité linguistique ou culturelle influence votre vie quotidienne?
- b. Est-ce que c'est important de pouvoir vivre votre identité culturelle et linguistique dans votre vie quotidienne?
- c. Quel rôle est-ce que vous aimeriez que votre identité joue dans votre vie quotidienne?

3. Variable de service de santé primaire

- a. Quel sont les services de santé primaire que vous utilisez? [*provide examples stated in the introduction*]
- b. En quelle langue est-ce que vous recevez ses services?

Exploration des expériences avec les services de santé

Pouvez-vous me guider à travers d'un temps quand vous avez utilisé des services de santé ici en Halifax? Spécifiquement comment est-ce que la langue à influencer l'expérience?

1. Le processus de trouver les services

- a. Pouvez-vous me parler de votre expérience quand vous étiez en recherche des services de santé ici en Halifax?
 - i. Comment est-ce que vous avez trouvez ce service?
 - ii. Quelle factor avez-vous considérez quand vous avez choisi ce service?
 - iii. Est-ce que vous étiez capable d'accéder ce service en français?
 - iv. Est-ce que c'était important de recevoir ce service en français? Pourquoi?
 - v. Quelles étaient des défis que vous avez surmonté pour accéder ce service? Comment avez-vous surmonté ses défis?
- b. Si vous avez besoin ou voulu ce service en français comment est-ce que vous trouveriez le service en français ou un professionnel qui parle en français pour offrir le service?

2. Faire la réservation, enregistrement et la salle d'attente

- a. Pouvez-vous me parler de votre expérience quand vous été au bureau et vous attendez votre rendez-vous ?

- i. Quand vous faites la réservation pour le rendez-vous ou quand vous arrivez au rendez-vous comment est-ce que la langue dans laquelle vous êtes accueilli influence vos sentiments de la situation?
 - ii. Quand vous avez arrivé au service que vous avez choisi comment est-ce que la langue influence votre expérience dans la salle d'attente?
 - 1. Matériel de lecteur
 - 2. Autre patient
 - iii. Si vous avez partagé une langue en commun avec la réceptionniste ou les autres patients dans la salle d'attente est-ce que cela aurait eu une influence sur votre expérience?
3. Pendant le rendez-vous
- a. Pouvez-vous me parler de votre expérience durant votre rendez-vous ?
 - i. Pendant votre rendez-vous, quand vous êtes avec le professionnel de santé comment est-ce que votre langue et la langue de la professionnelle influence votre expérience?
 - ii. (Si le service n'est pas en français) Si vous avez partagé une langue en commun avec la professionnelle de santé est-ce que cela aurait eu une influence sur votre expérience? Comment?

4. Après le rendez-vous, compréhension des instructions, réservé un suivi
- a. Pouvez-vous me parler de votre expérience après votre rendez-vous avec le professionnel de santé?
 - i. Est-ce que votre capacité de demander des questions, comprendre des instructions ou réserver un suivi est influencés par votre langue et celle des autres?
 - ii. Si vous avez reçu des instructions comment est-ce que vous ressentez avec la langue des instructions? Est-ce que vous étiez satisfait que vous avez compris l'information complètement?
 - iii. Est-ce qu'il y avait des défis qui ont posé des problèmes?
Comment avez-vous surmonté ses défis?
 - b. En pensant de votre expérience durant cette visite au complète, comment est-ce que avoir une langue en commun avec la réceptionniste, professionnelle de santé et d'autre patients influencerai (à influencer) votre expérience?

L'importance de recevoir des services en Français

5. Même si vous parlez bien en anglais, pourquoi est-c'est important d'avoir accès et de recevoir des services de santé en français?

6. Est-ce qu'il y a des certains types de services de santé qui sont plus importants de recevoir en français que d'autre? Le ou les quelles?
 - a. Pouvez-vous me parler d'une expérience qui a influencé ses sentiments d'importance?
7. Est-ce que c'est plus important qu'un certain type de professionnel de santé parle en français qu'une autre?
 - a. Pouvez-vous me parler d'une expérience qui a influencé ses sentiments d'importance?
8. Est-ce qu'il y a des situations où recevoir vos services en français sont plus ou moins important?
 - a. Pouvez-vous me parler d'une expérience qui a influencé ses sentiments d'importance?
9. Est-ce que c'est plus important que votre professionnel de santé communique dans la langue qui est plus confortable pour lui ou en français même s'il n'est pas aussi confortable qu'avec l'autre?
 - a. Pour vous quels seront les avantages et désavantages dans les deux situations?
10. Quel aspect de la culture francophone/Acadien est important pour vous et important que la professionnelle de santé connait et respect?
 - a. Exemple: Est-ce que c'est important de comprendre vos values et convictions etc.

Vos attentes

11. Pouvez-vous me parler de vos attentes en ce qui concerne la langue quand vous recevez des services ici en Halifax?
 - c. Quand vous accédez les services de santé primaire est-ce que vous attendez de parler en français ou en anglais? Pourquoi?
12. Dans votre opinion quel est un niveau d'accessibilité acceptable pour les services de santé en français?
 - d. Pourquoi est-ce que cela est un niveau acceptable?
 - e. Est-ce que vous attendez à cela quand vous approchez le système de santé?
13. Comment est-ce que vos expériences ont influencées vos sentiments au sujet des services ici en Halifax?
 - f. Est-ce que cela va influencer comment vous approchez les services dans l'avenir?

Les idées de la communauté

14. Est-ce que vous avez des suggestions pour les planificateurs du système de santé pour crée un meilleur système pour les personnes francophones/Acadiens d'Halifax?
 - b. Qu'est-ce que pensez-vous est vraiment possible en Halifax?