ACCESS TO HEALTH AND INTERPRETER-COMPANION SERVICES

# The experience of sparsely populated Francophone minority communities in Canada

**Research report – INTACC Project**

**Filed with the *Société Santé en français***


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# Highlights

## FINDINGS

- Access to services in French is important to Francophones, regardless of how comfortable they are with the majority language.

- Language concordance is necessary for being able to correctly describe one's symptoms and receive appropriate care, correctly understand instructions and benefit from the care provider's emotional support.

- A significant proportion of Francophones do not have access to health services due to language discordance.

- In addition to non-consultation, language discordance affects health and the quality of service received. In this type of situation, the patient suffers longer due to the additional tests that he must undergo, inappropriate treatment, extended waits for follow-up or inaccurate understanding of the health care provider's instructions. Additional consultation for the same health problem is often necessary due to inappropriate care.

- Social and health services offered in French in Francophone minority communities are seen as being limited; health systems seem somewhat insensitive to Francophones' needs and response is poor to the challenges associated with access to services in the minority official language.

- The main obstacles to access to services in French are a shortage of bilingual health professionals, unawareness of the services available in French, and an insufficient active offer.

- The basic practices of active offer best meet Francophones' needs: the fact of being consulted regarding preferred language, access to bilingual health professionals as well as access to health forms and telephone services in French mainly define active offer. These practices are essential in the hospital and emergency room setting, as well as with a family doctor and mental health counsellors.

- Francophone community associations play an important role in the promotion of French health services, and companion services. These services are not, however, funded but offered by volunteers, which poses significant challenges.

## RECOMMENDATIONS

- Increase the number of bilingual professionals and do more to promote the practice of active offer in the minority language setting.
- Set up and support interpretation services with support for 1) training and language evaluation of interpreters in both official languages, 2) the development of organizational practices and policies in health settings, and 3) the evaluation of these services for meeting minimum practice standards.
- Develop interpreter training in French, including distance education, accessible in every Francophone minority region of Canada.
- Explore combined interpreter and support service models.
- Explore the use of technology in promoting services in French and support tools as well as offering distance interpretation service, making this service available to a greater number of Francophones in minority settings.
- Conduct a study on the opinions of non-Francophone managers and health professionals, who have a Francophone clientele and who have used interpreter-companion service services, to obtain an overview of the issues associated with offering services in French.

## Summary

There have been a number of recent studies on the impact of language barriers on health and access to social and health services. In Canada, offering services in the patient's official language of choice is increasingly recognized as an essential component in health systems for purposes of reducing inequities in health and to better fulfill the needs of vulnerable populations. At this time, two strategies are put forward for meeting the needs of patients whose preferred official language is not the majority language in their province: 1) offering direct services through a bilingual provider and 2) interpretation or translation services. In Francophone minority communities outside Quebec, the offer of direct services is limited due to a shortage of bilingual health professionals. In order to fill this gap, some health regions have developed policies for services in French and provide interpretation services. Other regions rely on support and interpretation services available in the community. Minimum standards of practice for interpretation have been identified for providing reliable, safe and complete communication.

In contexts where there are few requests for interpretation services, as may occur in rural and remote communities, or in communities with a sparse Francophone population, the interpreter's role is often combined with that of companion service or health navigator. However, the multiple roles in a job that includes interpreting, support and navigation are often poorly defined. It is essential that the skills and characteristics of the interpreter-companion service be clearly defined, not only for the interpreter involved but also for the employer and the public, who need to understand the responsibilities and professional limitations of interpreter-companion services. Certain skills are associated with these roles, particularly with regard to language and interpreting skills and interpersonal relations. Training in interpretation is highly recommended; the use of casual, untrained interpreters, whether family members, friends or even health professionals poses significant risks for the patient and the care provider as the illusion of appropriate communication may hide errors such as omissions, additions or substitutions of words, concepts or ideas, not to mention the clinical ethical issues inherent to this duty. Screening and appropriate training as well as an evaluation process for the interpretation service have been identified as being key components of best practices for ensuring ethical decision-making, compliance with legal obligations and delivering quality care.

In Canada, an officially bilingual country, little research has been done on the impacts of language barriers on access to care and quality of care for official language minority populations in rural or remote settings, as well as for communities with sparse Francophone populations. This study therefore seeks to fill this knowledge gap. Its objectives are a better understanding of the experience of Francophones and interpreter-companion services who work in these settings with regard to social and health services in French, and more specifically, regarding active offer and interpretation, support and navigation services. The findings of a survey make it possible to identify facilitators and barriers to this access and to evaluate the importance of language concordance in the health field. Individual interviews with Francophones who have used interpreter-companion service services deepen our knowledge of these individuals' experiences when there is linguistic support. Finally, interviews with interpreter-companion services make it possible to offer an original perspective on the supply of services to Francophone patients and to describe the role played by interpreter-companion services in a health context, in improving access to services in French in minority settings. It is hoped that these findings support the communities, government decision-makers, institutions and health professionals in planning services offered in minority official languages, and that they provide research-based evidence sufficiently convincing to lead to future research in this field.

Nearly 300 Francophones from six regions of Canada participated in the study. The socio-demographic profile of the respondents shows that they are primarily Francophones of Canadian origin with university education and higher-than-average income. Moreover, most of the participants report having good language skills in both official languages.

Access to health services in French is perceived as being poor to non-existent for most of the respondents, who also state that the health systems seem to have little awareness of Francophones' needs and do not meet the challenges brought about by language. Although nearly 40% of the respondents are in favour of seeking services in French, more than half of the participants have access to services in English without language support. One-fifth does not access health services due to language discordance.

Few get a relative or friend to accompany them to act as an interpreter or request professional interpretation, support or navigation services. Access to a bilingual health professional and consulting a directory for services in French improve access to services in this language. However, the predominant barriers to this access, as identified by the respondents, are the shortage of bilingual professionals, lack of knowledge of health services in French and interpretation, and lack of active offer.

Language concordance is essential in the field of health and social services, particularly for the more vulnerable such as unilingual children, Francophones who have recently settled in an English-speaking province, individuals in physical or emotional distress, dementia sufferers, or those under the effects of medication. Some circumstances are priorities, i.e. visits to a family doctor, emergencies, hospitalization or mental health-related situations. Moreover, the participants confirm the importance of receiving services in French, regardless of their level of bilingualism. Language concordance enables them to communicate their needs properly and understand the instructions to be followed, but also allows them to receive emotional support from the care provider.

The participants emphasized that language barriers have a direct impact on access to quality care and services. The lack of access manifests itself in failure to consult, extended suffering or stress, additional tests, inappropriate treatment, improperly followed instructions and multiple medical appointments for an unresolved health problem. The patient's state of health remains precarious until the care provider clearly understands the patient's needs and the patient has thoroughly understood the care provider's instructions.

In the minority Francophone setting, Francophones seem to have little knowledge of professional interpretation services and make little use of them. Nonetheless, community associations play an important role in promoting health services in French and in providing support, either through an online directory of services in French or through the coordination of volunteers to offer interpretation and support for clients. Although the beneficiaries of this support appreciate it, particularly regarding emotional support, support by a non-professional poses significant challenges with regard to availability constraints and concerns related to confidentiality and professionalism. Moreover, the volunteers generally receive little training in interpreting and do not have the benefit of organizational support in the health systems. Interpreting-companion services also seem to be very much appreciated by health professionals according to interpreter-companion services. The latter further state that certain health institutions encourage and fund this service as they observe a reduction of risk and a better quality service.

### Four main observations appear from the findings of this study:

1. Promote the hiring of bilingual health professionals and the practice of active offer in communities where Francophones live;
2. In the absence of bilingual health professionals, a combined interpretation and support service could meet the needs created by complex social or health problems and those related to lack of knowledge of the health system on the part of vulnerable Francophones or those in a situation of vulnerability;
3. To provide a quality, safe and complete service, interpreter-companion services must receive adequate training, have their language skills in both languages evaluated, and be supported through organizational policies and practices;
4. Setting up interpreter training that is offered in French and through distance education would benefit all Francophone minority communities;
5. Use of technology to promote services in French and the tools available, as well as to offer a centralized health-focused interpretation service for Francophones living in rural and remote regions of Canada should be explored;
6. A study dealing with the perspective of non-Francophone health professionals who have a Francophone clientele and who have used interpreter-companion service services, as well as the opinion of health institution managers where these professionals work, would make it possible to have an overview of all affected stakeholders.

### Some recommendations follow arising from these observations:

1. Promote the hiring of bilingual health professionals and the practice of active offer in communities where Francophones live;
2. In the absence of bilingual health professionals, a combined interpretation and support service could meet the needs created by complex social or health problems and those related to lack of knowledge of the health system on the part of vulnerable Francophones or those in a situation of vulnerability;
3. To provide a quality, safe and complete service, interpreter-companion services must receive adequate training, have their language skills in both languages evaluated, and be supported through organizational policies and practices;
4. Setting up interpreter training that is offered in French and through distance education would benefit all Francophone minority communities;
5. Use of technology to promote services in French and the tools available, as well as to offer a centralized health-focused interpretation service for Francophones living in rural and remote regions of Canada should be explored;
6. A study dealing with the perspective of non-Francophone health professionals who have a Francophone clientele and who have used interpreter-companion service services, as well as the opinion of health institution managers where these professionals work, would make it possible to have an overview of all affected stakeholders.

## Introduction

The purpose of this research, which was conducted in six regions of Canada where Francophones are living in minority settings, is to provide a better understanding of the experience of Francophones regarding access to care in their language in communities with sparse Francophone populations. The findings of a survey make it possible to quantitatively show the perspective of a large number of individuals with regard to access to health services, facilitators of this access and barriers created by language discordance between the patient and care provider. The presence of active offer is also described as well as the use of the services of health interpreters, companion services or navigators. Individual interviews with Francophones who have used interpretation-companion services are used to qualify and deepen our understanding of what one experiences with the assistance of language support. Finally, interviews with interpreter-companion services provide a different perspective on the services offered to Francophone patients and describe the role played in the health system by these stakeholders for improving the offer of services in French in minority settings.

This report first explains the broader context of access to social and health services for Francophones in minority settings in Canada, language barriers and interpretation service models. The objectives of the study are then explained as well as the data collection methods and tools developed. The findings are addressed on the basis of the themes emerging from the users' and interpreter-companion services' perspectives. The discussion makes it possible to explain the trends observed with regard to access to social and health services in communities with sparse Francophone minority populations and to the interpretation, support and navigation services available in these communities.

## Background

A number of recent reviews of research testify to the impact of language barriers on health and access to social and health services (Bowen, 2015; Ohtani et al., 2015; Schwei et al., 2016). The negative effects of language discordance include poor comprehension and adherence to prescribed treatments (Wilson et al., 2005; Traylor et al., 2010), an undermining of patient safety (Divi et al., 2007; Fryer et al., 2012; Wasserman et al., 2014), reduced quality of care (Cohen et al., 2005; Ayanian et al., 2005) and patient and care provider dissatisfaction (Arthur et al., 2014; Jacobs et al., 2006). Negative effects are also reported with regard to the outcomes of care given (Eneriz et al., 2014; Shah et al., 2015) and additional costs caused by readmission or extended stay in hospital (Karliner et al., 2010; Lindholm et al., 2012). The offer of services in the patient's preferred language is increasingly recognized as a critical component in health systems for reducing risks, improving the quality and performance of services, as well as better consideration of the inequality in health and the needs of the vulnerable populations supported by these systems (Bowen, 2004; Schwei et al., 2015). At this time, two strategies are put forward for meeting the needs of patients whose preferred language is not the majority language of the country, which in this case is English: 1) direct offer of services by a bilingual health care provider and 2) interpretation or translation services.

In official language minority Canadian communities living outside Quebec, a shortage of bilingual health professionals is the main obstacle to access to social and health services in French (de Moissac, Giasson & Roch-Gagné, 2015; Drolet et al., 2014). Directs services in the minority language are therefore often not available. In order to increase the number of bilingual health professionals, professional training, continuing education and resources are available in French for a number of professions (Consortium national de formation en santé, 2015; Médecins francophones du Canada, 2010). In addition, care providers are encouraged to implement active offer (Consortium national de formation en santé, 2015), defined as follows:

> [tr.] Active offer is defined as the set of measures taken so that French language services are readily available, accessible and known, and of comparable quality to that of services provided in English. (RIFSSSO. 2012)

When access to direct services in one's language proves to be impossible, the second-best option is to provide professional health interpretation service (Bowen, 2004; Flores, 2005; Ngo-Metzger, 2007). Some health regions in Canada have developed policies to this effect and provide these services, such as Winnipeg (Winnipeg Regional Health Authority) and the Toronto Central Local Health Integration Network (Silversides & Laupacis, 2013). These services also exist in some regions of Quebec where the density of the Anglophone population is sufficient to justify them (Santé et services sociaux Québec, 2015). Other regions rely on community support and interpretation services set up by organizations such as Accueil francophone de Thunder Bay and volunteer organizations like Canadian Volunteers United in Action (CANAVUA) in Alberta. Although there are several health interpretation models based on regional settings, some minimum practice standards have been identified: 1) coordination of organizational policies and practices; 2) use of trained interpreters only; 3) screening and linguistic evaluation of interpreters; 4) availability of information on interpretation services for patients and care providers and 5) a data collection method making it possible to evaluate the services (Bowen, 2004; Healthcare Interpretation Network (HIN), 2010; Winnipeg Regional Health Authority, 2013). Whether the services are offered through community or regional organizations, these minimum standards are essential for ensuring that the interpretation service is accurate, safe and complete.

In settings where requests for interpretation services are low, as may occur in rural and remote communities or in communities with a sparse Francophone population, the interpreter's role is often combined with that of a companion service or health navigator.

Companion services generally provide emotional support or transportation, while navigators provide personalized support to vulnerable individuals to help them overcome the obstacles in the health system and access services without undue delay (Hedlund et al., 2014). The navigator is particularly assigned to assisting individuals with complex needs like cancer patients (Freeman, 2006; Freund et al., 2008) and immigrants with little knowledge of their adopted country's health system (Nguyen et al., 2011; Pimentel and Eckart, 2014). In addition, navigation services together with the offer of service in the patient's language are used to improve access to care for patients in minority populations (Charlot et al., 2015).

The multiple roles in a single job including interpretation, support and navigation, are often poorly defined. Moreover, this type of job may be called by various titles: cultural broker, patient advocate or mediator (Sleptsova et al., 2014). It is critical, however, that the skills and characteristics specific to the role of interpreter be clearly defined, not only for the interpreter involved, but also for the employer and the public, who must understand the responsibilities and limits of the interpreter's role in the health field (HIN, 2010). Community interpreters, i.e. individuals who do two-way health interpreting or with government agencies, social services agencies and community centres, must have the specific skills for this role (HIN, 2010). These skills include language and interpreting skills as well as interpersonal skills (HIN, 2010). It is, moreover, highly recommended that language testing confirm the interpreter's bilingualism and such evaluation also includes the level of comprehension of the source language (language from which the interpretation must be rendered) and his or her ability to transmit the message as accurately as possible into the target language (language into which the interpretation is done) (HIN, 2010). Interpreter training, whether obtained from a recognized academic institution or from quality continuing education, should include modules dealing with medical terminology in both languages as well as standard practices in interpreting, which include accuracy, confidentiality, impartiality, respect of the individual, maintaining professional boundaries, responsibility, professionalism and continuing education (HIN, 2010). In addition, a good understanding of clinical practices and procedures, such as obtaining informed consent, as well as a practical knowledge of the health system are required (HIN, 2010). Training is therefore essential: the use of casual, untrained interpreters, whether they are family members, friends or even health professionals, poses risks for the patient and the care provider as the illusion of appropriate communication may mask errors such as omissions, additions or substitutions of words, concepts or ideas (Flores et al., 2012; Kilian et al., 2014). Screening and appropriate training, as well as an evaluation process for the interpretation service have been identified as being key components of best practices for ensuring ethical decision-making, compliance with legal obligations and the delivery of quality care (Bowen, 2004; HIN, 2010).

The risks resulting from language barriers and the absence of professional interpretation services during consultations where the care provider and patient are language discordant have been raised in a number of countries (Bowen, 2015). These risks include reduced access to services, dissatisfaction on the part of the patient and care provider, less relevant or lower quality of care, as well as impaired patient safety (Bowen, 2015).

We note that in Canada, an officially bilingual country, little research has been done on the effects of language barriers on access to care as well as the quality and safety of care for official language minority populations. A recent review of scientific literature revealed almost no Canadian evidence with regard to official language minorities, and even less in communities with sparse Francophone populations living outside Quebec (Bowen, 2015). Systematic studies describing the patient's experience, as well as the perspective of health professionals and their experience in providing services to official language minorities are also few in number. This study therefore seeks to remedy this shortage of information and evidence on access to social and health services in the minority official language for Francophones living in rural or remote settings, as well as communities in Canada with sparse Francophone populations. It is hoped that the data emerging from this study support the communities, government decision-makers, the health institutions and professionals in planning services offered in minority official languages. In addition, this data will provide scientifically-supported evidence for future research on this topic.

Mixed methodology was used for this study: quantitative and qualitative methods were used to better meet the research objectives. The quantitative method is based on a survey used to facilitate data collection from a random sample of the Francophone population in rural or remote or low-density settings for finding statistical data. The qualitative method, which included interviews with Francophone health service users and escort-interpreters, made possible a more detailed exploration and a finer understanding of the themes that emerge on access to health and interpretation services, based on experiences in the communities.

Data was collected in six different regions of Canada, facilitating transferability and generalization of data to similar populations. These regions have in common: 1) implementation of interpreter, navigator or companion services or 2) the exploration of facilitating mechanisms for improving access to social and health services in the minority official language. These six regions are located in the following provinces and territories: Newfoundland and Labrador, Ontario (North Simcoe Muskoka and Thunder Bay), Saskatchewan, Alberta and Yukon. The table in Appendix 1 describes these six regions with regard to the Francophone population, the minority official language legal framework at the provincial or territorial level, coordination of French-language services by the health authority and the availability of interpretation, navigation or companion services offered either by the health authority or a community organization. When interpretation, navigation or companion services are available, a brief summary is added.

## Research objective

In order to address the lack of knowledge on the topic of access to social and health services in French in low-density Francophone communities in Canada, the research objective is:

To better understand the experience of Francophones living in low-density Francophone minority communities in Canada and the experience of the interpreters, companion services and navigators who support these French-speaking patients with regard to:

1. French-language services in the area of social and health services;
2. The practice of active offer;
3. Interpretation, navigation and companion services.

### The research questions developed to meet this objective are the following:

1) What are the perspectives of Francophone users and the interpreters, navigators and companion services regarding the importance and need for services in French in the field of social and health services? What is the impact of not receiving these services? Is the health system aware of the needs of Francophones and the challenges associated with French-language services and does it fulfill these needs?

2) What is the experience of Francophone users and interpreters, navigators and companion services with regard to the offer of services to Francophone users living in communities with a sparse Francophone population? Does active offer exist? What are the facilitating factors and obstacles to obtaining services in one's language?

3) What is the experience of Francophone users and the interpreters, navigators and companion services with regard to interpretation, navigation or companion services? Which services are available and used? Are they suitable? What are the conditions for success and the improvements proposed to the services and programs currently offered?

## Methodology

The methods used for this study are a Web and paper-based survey, and semi-directed individual interviews. First, a survey aimed at Francophones living in sparsely populated Francophone minority communities in Canada was distributed. This survey was made up of open and closed questions. Certain survey respondents then had the opportunity to participate in an interview to express their opinion on the interpretation, navigation or companion services received, or quite simply on the access to social and health services in French in their region.
A second series of semi-directed interviews was carried out, this time with the interpreters, navigators or companion services who provide services to minority Francophones in these same regions.

### POPULATION, SAMPLING AND RECRUITMENT

The participants come from two distinct populations:

1) Francophones who are members of sparse francophone minority communities living in one of the six regions defined by the Canada wide INTACC project. i.e. Newfoundland and Labrador, Ontario (North Simcoe Muskoka and Thunder Bay), Saskatchewan, Alberta and Yukon.

Some adult members of these communities were invited to participate in a Web or paper-based survey about access to social and health services in French in their region. Participation as an assisting family member (on behalf of a child or senior) was encouraged. The invitations to participate were sent by e-mail in the communities of each region (with the exception of Yukon) through Francophone community organizations. These organizations then forwarded this invitation by e-mail to their membership list or distributed hard copies during community events bringing together Francophones. These organizations include but are not limited to schools and nursery schools, religious groups, cultural and sports organizations, local newspapers, Francophone institutions and immigrant reception organizations.
In the survey, a question on the use of interpretation, navigation or companion services made it possible to identify respondents having experience with this service. These respondents were invited to participate in an individual telephone interview to expand on certain themes concerning their experience. Of the thirty respondents contacted, twenty were available for an interview.

2) Interpreters, navigators or companion services

The interpreters, navigators and companion services who work in one of the six regions in the INTACC project were invited to participate in a telephone interview in order to describe their experience. The invitation to participate was directly forwarded to the participants by INTACC project managers in each region. These participants then contacted the researcher to set up a telephone appointment.

### ETHICS

This study received the ethical approval of the Université de Saint-Boniface research ethics committee. Permission to interview the interpreters, navigators or companion services was received from the senior managers of the organizations providing these services.

### METHODOLOGY AND TOOLS

**Survey**: The survey used to canvas the opinions of the members of low-density Francophone minority communities is a tool developed in-house by the research team in consultation with the community partners in the six regions where the survey was conducted. The survey included twenty-one questions in various formats: multiple choice, multiple answers, Likert scale questions and written answers. The survey was available online from the end of October 2015 until the end of February 2016. The advertising for the survey was not done in a simultaneous fashion through all regions, thus leading to its prolonged online access. A reminder was sent out three weeks after the initial invitation to participate in the survey. Hard copies were also distributed through INTACC project partners and Francophone community organizations to promote the participation of seniors or people with limited access to the Internet. These surveys were accompanied by a postage-paid envelope addressed to the lead researcher, thus facilitating their return.

**Interviews**: The telephone interviews with Francophones who had used interpretation, navigation or companion services, as well as with interpreters, companion services or navigators, were conducted by the lead researcher. These semi-directed interviews varied in length from twenty to forty-five minutes. Through open questions and items on a 5-point Likert scale, the participants were able to describe and evaluate the services. The interviews were recorded and partially transcribed for analysis purposes. The researcher also took notes during the interviews. The tools used are found in Appendix 2.

### ANALYSIS

#### Quantitative analysis

Descriptive statistics including frequency and percentages were used to describe the survey and interview participants as well as the quantitative data from the survey. The analysis was performed with the SPSS software version 21.0 (IBM Corporation). The chi-squared test or Fisher's exact test was used in the comparison study of data for the various regions. Statistical significance was set at 5%. A comparison of data coming from the regions as a group and data including the participants for whom the place of residence is not known suggests that the data from the latter group is very similar to the regional data as a whole. Total data (n=297) is presented in the report and regional data is available in Appendices 3 and 4. Moreover, comparisons by sex, age group, education and income were performed using the chi-squared test and Fisher's exact test. Only significant data is mentioned.

#### Qualitative analysis

Analysis of qualitative questions was performed using NVivo v. 11 software (QRS International, 2012) using the inductive approach as described by Thomas (2006). This approach causes dominant themes to appear based on raw data. The audio recordings and notes taken during the interviews were reviewed by the researcher to identify emerging themes (Neal et al., 2015). A partial transcription was then made of the segments relevant to the categories or themes, thus facilitating a more in-depth analysis. By proceeding inductively, it was possible to identify nodes and then combine them into categories and themes (Patton, 2002). More categories were then developed following a rigorous and repeated review of the transcribed data. The analysis was performed one question at a time, with a focus on the individual participants first in order to facilitate comparison of the answers. The triangulation of sources (surveys with Francophones, interviews with Francophones and interviews with interpreters, companion services and navigators) ensure the quality and validity of the data (Thomas. 2006).

## Findings

### PARTICIPANT PROFILES[1]

CThis section presents the socio-demographic profile of the survey and interview participants. In total, 344 individuals participated in the survey, 260 of which online and 84 on paper. From this total, 18 participants did not live in one of the regions where the study was conducted, two participants were not yet of age, and 27 participants answered only the first question of the survey. The total number of participants who met the participation criteria (adult Francophone living in one of the six regions of the study) is 297. Twenty participants in the survey also agreed to speak at greater length about their experiences with interpretation, support or navigation services. Six interpreter/navigator/companion services from three regions also participated in individual telephone interviews.

#### Survey participant profile

The socio-demographic profile of the survey participants shows a higher proportion of women (78.9%) than men (21.1%). Participants ranged in age from 19 to 84 years with an average of 42.1 years and a median of 40 years. The distribution of participants by age group is illustrated in Figure 1 on the following page. Moreover, the majority of the respondents is married or in a common-law relationship (73.0%), while 27% are single, separated, divorced or widowed.

[1] The masculine gender was used in preparing this report for ease of reading and is not intended as discriminatory.

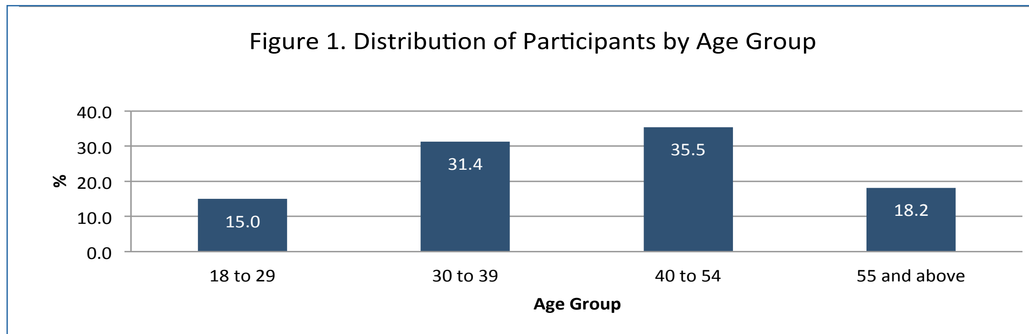


Figure 1. Distribution of Participants by Age Group

Figure 2 illustrates the distribution of participants by region. Remember that the survey was not distributed in Yukon. The distribution is therefore: Newfoundland-and-Labrador (n-16; 5.4%); North Simcoe Muskoka and Thunder Bay, Ontario (n=24; 8.0%); Saskatchewan (n=108; 36.4%); and, Alberta (n=53; 17.8%). We note that 32.3% of the participants did not indicate their place of residence.

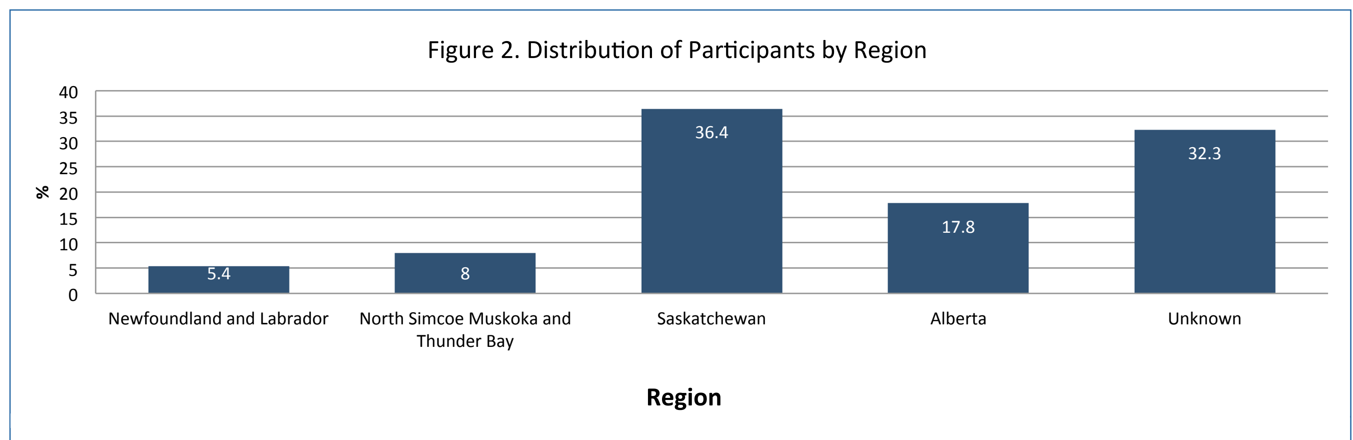


Figure 2. Distribution of Participants by Region

For most of the participants, the highest level of education completed is university, i.e. 36.2% had completed a bachelor's degree and 26.8% had completed graduate degrees. We note that 30.1% of participants had completed college studies while 6.9% had completed elementary school or high school (Figure 3).

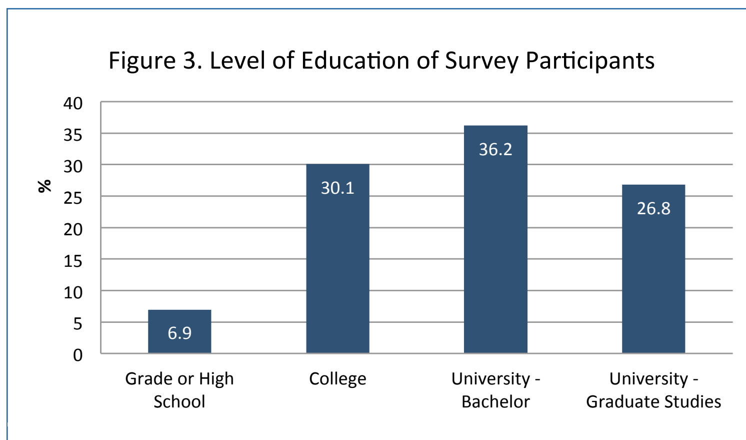
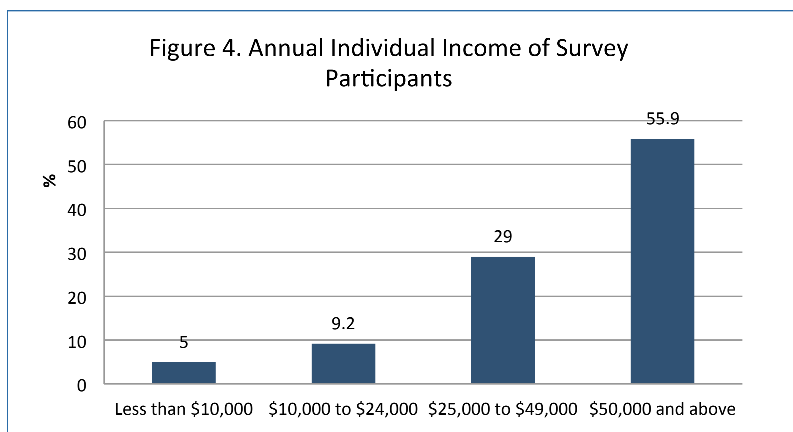
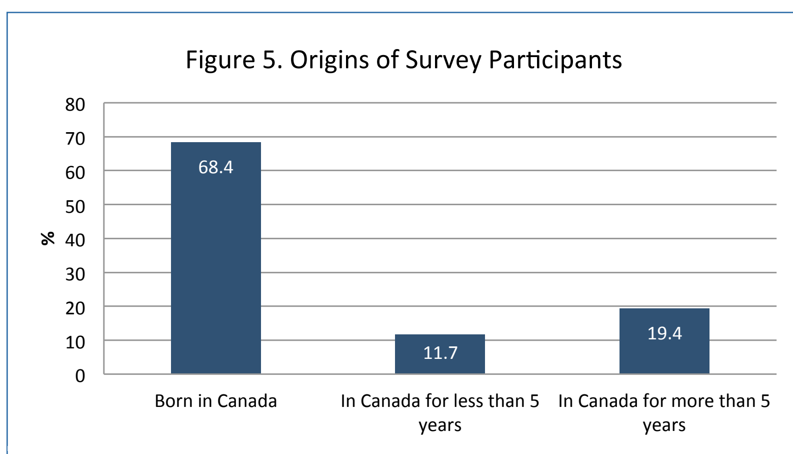


Figure 3. Level of Education of Survey Participants

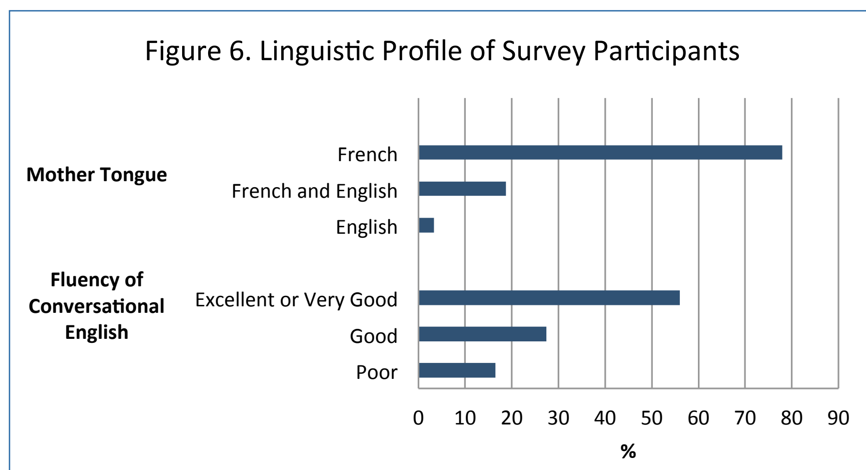
Over half of the respondents have a personal annual income of $50,000 or more (55.9%) and 29% have a personal annual income between $25,000 and $49,000. A small percentage of the participants have an annual income between $10,000 and $24,000 (9.2%) or less than $10,000 (5.0%) (Figure 4).




The background of the survey participants is illustrated in Figure 5. Most of the respondents were born in Canada (68.4%), while 11.7% have lived in Canada for less than 5 years and 19.4% for more than 5 years.

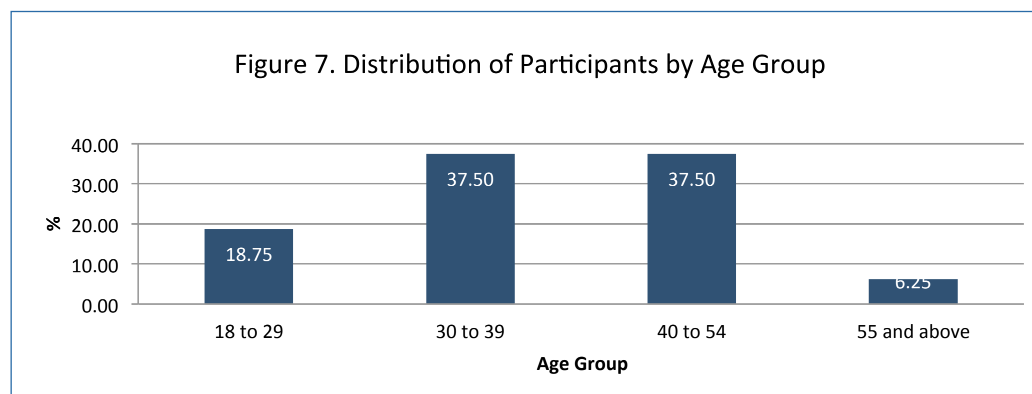



The survey participants' linguistic profile is illustrated in Figure 6 (next page). The first language learned, still understood and most often used at home is mainly French (78.0%), while 18.7% of the respondents chose the option French and English combined and 3.3% specified that this first language is English only. With regard to the ease of conversing in English during a medical consultation, more than half described their level of fluency as excellent or very good (56.0%). Approximately one-quarter (27.4%) say they have a conversational fluency in English in this type of situation while 16.5% say they have a weak proficiency level.  comprise et la plus souvent utilisée à la maison est majoritairement le français (78,0 %), tandis que 18,7 % des répondants ont choisi l'option du français et de l'anglais combinés et 3,3 % précisent que cette première langue est l'anglais uniquement. Pour ce qui est de la facilité de converser en anglais lors d'une consultation médicale, plus de la moitié qualifient leur compétence linguistique comme étant excellente ou très bien (56,0 %). Environ le quart (27,4 %) dit pouvoir bien converser en anglais dans une telle situation tandis que 16,5 % disent avoir une faible compétence.




## Profile of the participants in the semi-directed interviews

The profile of the twenty interview participants shows that nearly two-thirds (65%) of the respondents are women. The average age is 39.4 years and the mean age is 37 years. The distribution of participants by age is illustrated in Figure 7 (note that 4 participants did not indicate their age). Three-quarters of the participants were between 30 and 54 years of age. Sixty percent of the respondents are married or in common-law relationships, while 40% are single or divorced. Slightly more than half (60%) live in an urban area. The best represented province is Saskatchewan, with 14 respondents. The other regions are represented by one or two participants each.




Regarding education, 70% of the respondents have an undergraduate or graduate university degree and 25% have completed college studies. As for income, 45% report a personal annual income of $50,000 or more, 30% earn between $25,000 and $49,000 and 25% earn less than $25,000. More than half, or 63.2%, were born in Canada while 26.3% have been living in Canada for less than 5 years and 10.5% for more than 5 years. Most of the participants (85%) speak French as their mother tongue while 10% of the respondents list both English and French as their mother tongue. Finally, 42.1% of the respondents state that they have an excellent or very good level of conversational fluency in English during a medical consultation, compared to those who state their proficiency level to be good (15.8%) or weak (42.1%).

### Profile of the interpreter-companion services participating in the study

Six interpreter-companion services participated in semi-structured telephone interviews. Of these six participants, two-thirds were women. The participants ranged in age from 29 to 72 years, with an average age of 44 years and a mean age of 37.5 years. Given the limited number of participants, and to protect their anonymity, the regions from which they come will not be disclosed. However, all work in urban areas with a sparse Francophone population in three regions of Canada. One of the individuals works full time as an interpreter-companion service, two others work part time in a broader coordination position and three are volunteers. Years of experience as an interpreter-companion service range from 8 months to 19 years. Half of the participants were born in Canada, one-third has lived in Canada for less than 5 years and one individual has lived in Canada for more than 5 years.

## ACCESS TO SOCIAL AND HEALTH SERVICES IN FRENCH

Access to social and health services by the Francophones participating in the survey is overall perceived as being excellent or very good for most of them (54.8%), and weak or non-existent for 16.4% of the sample. With regard to services in this same field, but in French, the trend is somewhat opposite; 6.8% of respondents selected the option “excellent” or “very good” while 76.8% perceived these services in French as being “weak” or “non-existent” in their community (Figure 8). As one interview participant explained: “There are services in French? I never had anything in French here and I’ve never seen anything indicating that there are services in French”. Individuals without post-secondary education (23.5%) are more inclined to report better access to services in French. Regarding raising awareness of the health system about the needs of Francophones and the difficulties related to their access to social and health services, the majority of participants deem that the system has poor or no awareness (87.4%) of these needs and the challenges they create. Moreover, 79.6% of participants perceive that the health system meets these challenges of access to such services in French, in their region, poorly or not at all. This percentage goes up to 92.5% for individuals aged 55 years and over.

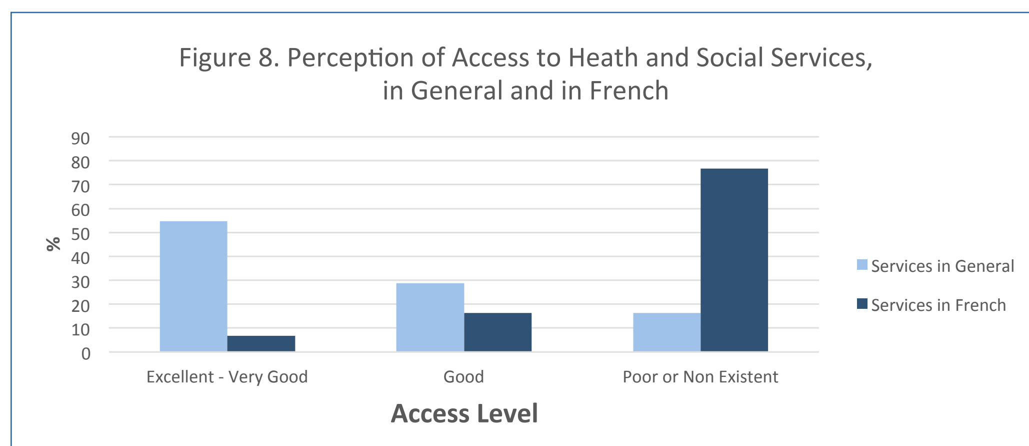
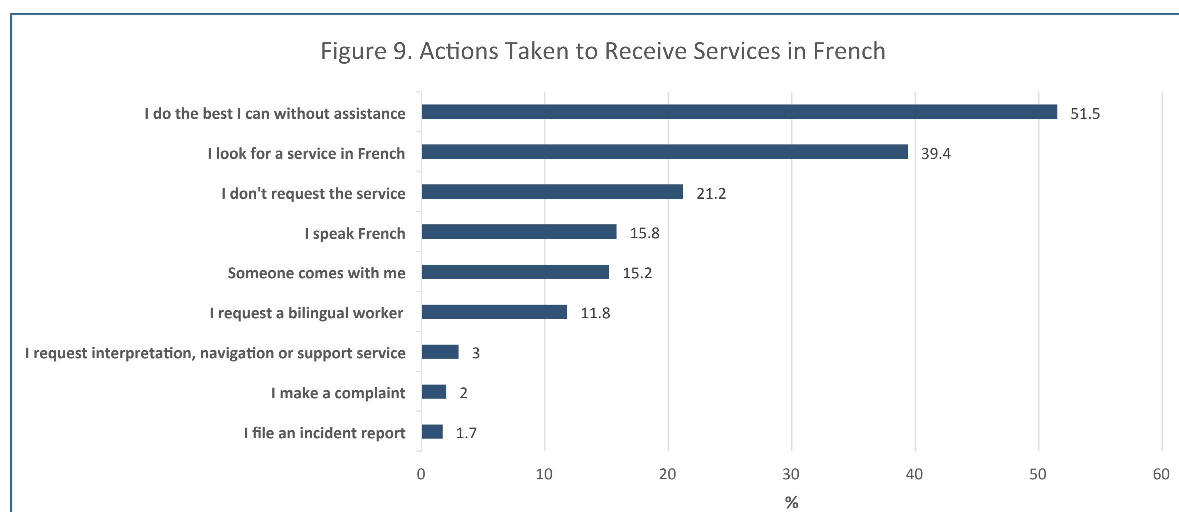



Figure 9 illustrates the actions taken by the respondents when they need social or health services. First of all, over half of the respondents (51.5%) report doing the best they can without assistance, as one of the interview participants stated: “*You manage in English. You get by somehow.*” It must be specified that for some, despite a certain fluency in English, communication can be difficult, as this participant described it: “*I would really like service in French much more than in English because I can’t manage 100% in English. If I hurt somewhere and don’t know how to express it in English, it’s going to be hard for the doctor.*”

Moreover, the interpreter-companion services stress that certain patients feel confident in their ability to manage suitably with their doctor during a medical consultation that occurs in English only. However, as described on the next page, it isn’t until they’re going through the experience that the patient realizes he needs support:

> There are also patients who will say "*I am capable but I would prefer it if you could be there just in case, should I not understand*". We arrive, go into the doctor's office, the doctor speaks and the patient indicates that yes, she understands everything going on…and most of the time when these people tell me: "*Yes, yes, I understood*", they did not understand... Most of the time, they tell me: "*Next time, come and I will let you speak.*" There are many who try, they want to be self-sufficient and do things on their own, but when it comes to health, they see that it doesn't take a lot to change the diagnosis or recommended treatment. It's easy to make a mistake.

The interpreter-companion services recognize therefore that despite a certain confidence on the part of Francophones, the need is nonetheless there for some of them when it is a matter of medical consultation.




One strategy used for accessing services in French is doing some research to find these services, as reported by nearly 40% of the respondents. The interview participants describe this research as often being done online: "*Good thing I can browse on the computer. I can find information in French*". A number of participants also use the Internet to find out more about medical terminology in English in order to be able to explain their unwellness to the doctor. Some will prepare in advance and make a list of medical terms in English, while others will have Google Translate handy on their mobile device at the time of their consultation. Others find out from colleagues at work or from their network of friends: "*I ask a colleague if she knows a dentist. I work in a Francophone setting so I can ask…You ask questions until you find something*". One's social network is therefore a source of information for accessing services in French.

A significant proportion of the respondents, i.e. more than one-fifth (21.2%) have not used health services due to limited access to services in their mother tongue. One of the reasons given for not using these services is discomfort at the idea of having to communicate in English, as described by this participant: "*Language stops me from going to these appointments…If things were happening in my language, I definitely wouldn't be embarrassed to go see [the doctor]".*

Not being able to express oneself correctly adds to the level of stress, like for the friend of this respondent: "*This raises his stress level to the point that he does not want to go to the hospital…he hesitates to put himself in a situation where he knows he really can't express his needs properly*". Finally, non-consultation is also explained by the additional challenge of finding a companion service. By way of example, a mother with two children having health problems said: "*I am not going yet because I have to find someone to come with me*".

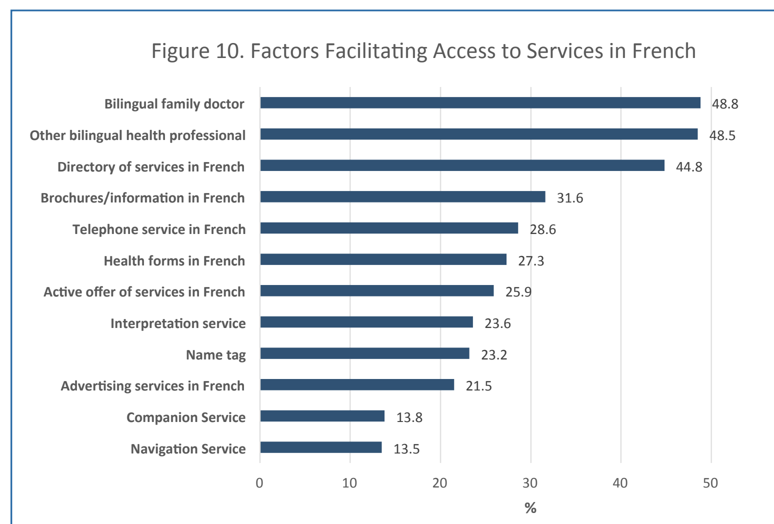
Some participants prefer to travel for the benefit of services in French. For example, one participant uses services in French in the neighbouring Francophone province. Another continues to consult a bilingual professional whom she used to see before she moved. A few survey participants specify that being bilingual, they prefer to use the services in their community even if they're offered in English as the services are close by and easily accessible. Others state: "*I have to settle for what's available, often in English only*" or "*I do some research in advance but I don't dare request services in French if I have not found any. Unfortunately, I am used to there not being any*". These comments suggest that the limited access to services in French discourages more than one individual from requesting them or even to look for them: "*There are not any, there are not any so I no longer seek any*". However, some participants (15.8%) will speak to their care provider in French, whether in person or on the telephone when it is a matter of accessing health services. This practice is more current among participants 40 years of age and over (22.0%). Moreover, 11.8% of the respondents request a bilingual worker; this percentage goes up to 33.3% for low-income participants. Finally, very few of the participants file a complaint when service is not available in French (2.0%) or report a problem when the care received was inadequate due to language (1.7%).

Being accompanied by a family member or friend who acts as an interpreter is reported as being a more current practice (15.2%) than using the services of a professional interpreter, navigator or companion service (companion service) (3%). Women (19.1%) and those with low income (41.7%) are most likely to ask a relative or friend to accompany them. Regarding professional services, some interview participants specified that, in their opinion, these services included those provided by a family member, an acquaintance or bilingual health professional who had been called upon to act as an interpreter. Other participants considered the translation service available online through "Google Translate" as an interpretation service, given the ability to find English terminology through this application. Moreover, the "Google" navigator was also considered support for self-navigation, assisting participants to find services available in French in their region.

Based on the experience of interpreter-companion services surveyed in this study, access is limited to social and health services in French in their community. Apart from a Francophone clinic in certain cities and a few bilingual health professionals, few services are available in French. Although signage occasionally appears in both languages, the service, even reception, is often unilingual English. So, the participants in this study agree that based on their experience, access to health services in French is limited.

## Facilitation factors improving access

Certain factors promote access to health services in French. The survey respondents had the option of choosing from a list of items available to them for improving their access to these services. Figure 10 illustrates these options in descending order, as selected by the survey participants.



## BILINGUAL HEALTH PROFESSIONALS

According to the respondents, the predominant two options available and which improve access to services in French are a bilingual family physician (48.8%) or other health bilingual health professionals (48.5%). We note, however, that significant statistical differences are observed according to the region of residence of the respondent with regard to the family doctor. A higher percentage of respondents in Alberta and the Ontario regions (North Simcoe Muskoka and Thunder Bay) (67.9% and 66.7% respectively) chose this option compared to a lower percentage among participants from Newfoundland and Labrador (31.2%). Moreover, the university-educated respondents are those who most often report a bilingual family doctor as a solution (66.7 %), compared to individuals having an elementary school or high school education (41.2%). One interview participant pointed out however "I am delighted to have a Francophone doctor but it is not enough". In addition, five interview participants specified that the services of a bilingual physician were available at a certain time in the past, elsewhere in Canada. The presence of other bilingual health professionals, such as dentists and dental hygienists, optometrists and ophthalmologists, mental health councillors (psychologists or social workers) and nurses, is recognized by the participants. Also reported, but in lesser numbers, are therapists (physio or massage therapists), gynaecologists, laboratory technicians, paediatricians, chiropractors and osteopaths.

## DIRECTORY OF SERVICES IN FRENCH AND COMMUNITY ASSOCIATIONS

A directory or list of social and health services in the community is another factor that improves access to services in French for a large proportion of the participants (44.8%). We note however that the less education the participants have, the less they mention the directory as a facilitating factor; for example, 29.4% of participants without post-secondary education identify the directory as a facilitating factor compared to 68.2% of participants with graduate university degrees. A number of participants mention an online directory on the sites of some Francophone organizations or community associations. For example, in Saskatchewan reference is made to the Réseau Santé en français de la Saskatchewan, which seems to be familiar to many and which distributes an online directory of services in French.

According to the interview participants, the Francophone community associations seem to play an important role in access to services in French, particularly in western Canada. Besides the example cited above, we also note the Association canadienne-française de Regina, the Fédération des aînés fransaskois and the Centres francophones communautaires, and the Centre d'accueil des nouveaux arrivants francophones and the Association canadienne des volontaires unis dans l'action (CANAVUA) [Canadian Association of Volunteers United in Action] in Alberta. These community organizations offer, from time to time, a referral service for bilingual family doctors, particularly for new arrivals, or a companion service. These services are provided by volunteers but some organizations, like those in Saskatchewan, take care of coordination and receive funds from the Department of Canadian Heritage. Services available include transportation, support during doctor's appointments or at the hospital, and occasionally a follow-up with the family who does not live near the person in need. These services are especially intended for seniors who need transportation and emotional support, but also for cancer patients who are too ill to travel alone. Those who have benefited from companion services testify to the respect and personal skills of the companions who quickly put the patients at ease and gain their trust. Volunteering is an important community value for these companion services, who do it out of the goodness of their hearts. Many participants stated that the Francophone community organizations play a major role as factors facilitating access to services in French as they are an easily accessible source of information and support.

## ACTIVE OFFER

The active offer of services in French, and more specifically, the fact of being asked in which language one wishes to receive service, is reported by approximately one-quarter of the survey participants (25.9%). Participants with the lowest and the highest level of education are the ones declaring that they were consulted on their language of preference for service (41.2% and 39.4% respectively), compared to participants with a college diploma or undergraduate university degree (22.1%).

Moreover, participants less often mention a badge identifying a bilingual employee and advertising about social and health services in French, i.e. 23.2% and 21.5% respectively. Certain participants say that professionals are aware of their Francophone patients' needs and acknowledge the importance of active offer, as "*it is easier for them to communicate in their language*". One participant tells of the following occurrence: "*When I have to be admitted or go to the emergency room, the doctor asks to be accompanied by a bilingual nurse so he can really understand the details*". This participant specifies that this doctor had been recruited by a rural Francophone community and had been informed in advance about the needs of the community's Francophone clientele. Thus, the participants said that the care providers who understand the importance of language concordance practice active offer.

Other factors which improve access to services in French are health literature (31.6%), a social and health services telephone service (28.6%) and forms in French (27.3%). As an example, the interview participants identified the health information telephone line which is occasionally offered in French thanks to an agreement with a neighbouring province where services in French are more easily accessible, like in New Brunswick and Manitoba. Another example: forms in French for applying for a health card, although telephone services related to this application are not available in French.

### SERVICE OF AN INTERPRETER-COMPANION SERVICE

Finally, professional interpretation and navigation and companion services also facilitate access to services in French. The Interpretation service is reported by a greater number of participants (23.6%) than are companion services (13.8%) or navigation services (13.5%). A greater proportion (66.7%) of low-income respondents state that they need interpretation services. Among all the survey participants, 9.4% had previously used the services of an interpreter. We also note that 10.4% of respondents used a navigation service and 4.0% a companion service. This latter percentage rises to 12.5% however, in Newfoundland and Labrador and to 8.7% in North Simcoe Muskoka and Thunder Bay, and is very low in Saskatchewan (1.9%) and Alberta (0%).

According to the interpreter-companion services participating in this study, the Francophones who most often require the services of an interpreter or companion service are individuals without support, whether it be language, transportation or emotional support. The main reason for requesting service is concern about being understood. Patients can generally communicate in English in other circumstances but less easily in the health field: "*Where it is technical, a bit stressful, where there are consequences for giving the wrong answer, stress increases and that is where they need someone like me*". The patients are most often seniors and pregnant women, often of immigrant status. A number of patients come from Quebec or have lived for a long time in a small, French-speaking village and their children do not live in the same region or are not available at the required time. Others have mobility problems or live in rural or remote areas where mass transit is not available. Finally, some are French-speaking visitors or tourists from other regions of Canada.

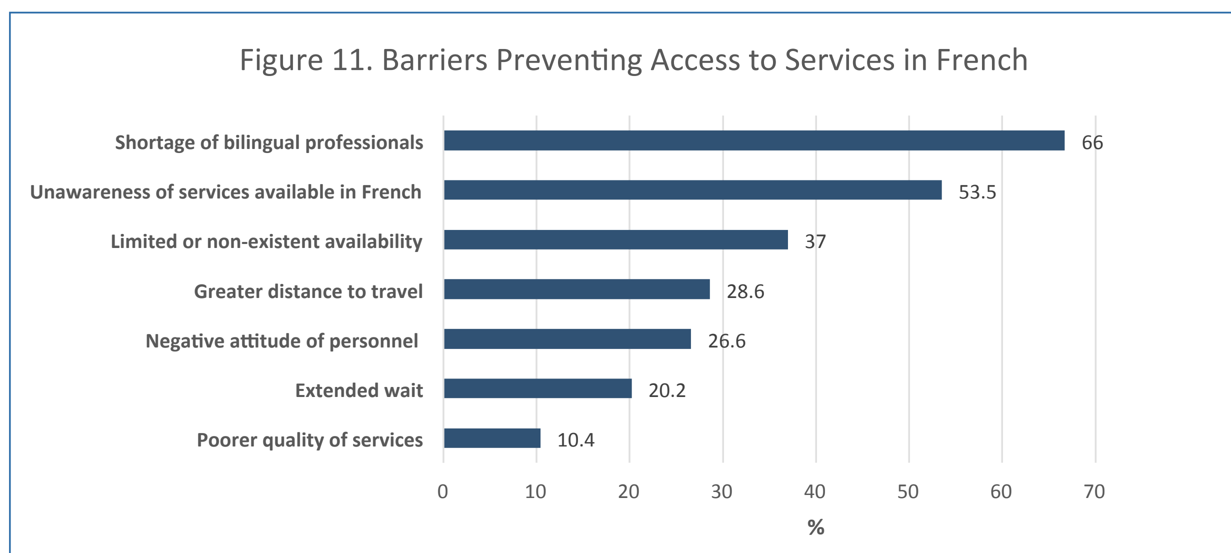
According to the interpreter-companion services, the organizations offering these services are generally known to Francophones by word of mouth. The organizations also advertise, particularly with other institutions dispensing health services, so that professionals are aware that the service is available. As well, professionals who have dealt with an interpreter-companion service are informed about the availability of the service and are invited to use is as needed. Advertising is also done with Francophone organizations and immigrant assistant organizations so that the clients themselves are able to request support. The interpreter-companion services travel in various settings and work with many professionals: specialists, doctors in clinics and hospitals, including intensive care and day surgery, physiotherapists and other types of therapists, oncology service providers, dentists and optometrists. So, the service is available to all health professionals and all Francophone clients from the region.

Opinions are divided regarding satisfaction related to the available factors improving access to health services in French. Approximately half of the survey respondents (47.9%) deem that the facilitators chosen appropriately or very appropriately meet their language needs while the other half (47.2%) state that they somewhat inadequately or inadequately meet their needs.

A much greater number of low income participants (90.0%) in terms of percentage, report that the available options meet their needs, compared to higher income participants (41.1%). Those who state that the options selected met their needs most often chose French health forms; the fact that they were asked in which language the service is required; a bilingual family doctor; a telephone information and referral line for health and social services in French.

## Barriers to access

The survey participants were also invited to select barriers to access to services in French from among a number of choices as presented in Figure 11.




### SHORTAGE OF BILINGUAL PROFESSIONALS

The barrier chosen by the greatest proportion of participants is the shortage of bilingual professionals (66.7%). According to the interview participants, services in French in their community are poor or inexistent as most of the personnel is unilingual English-speaking. As explained by some participants, being treated by a bilingual professional, particularly in a hospital setting and in specialized fields, is pure chance. It is also reported that although some personnel members are bilingual, they are not always present: "*The woman who spoke French did not work every day…She is not there on Mondays, Wednesdays and occasionally on Fridays she is not there*". Furthermore, some respondents state that bilingual health professionals do not identify themselves: "*The bilingual professionals rarely identify themselves as such*" and "*Occasionally, there are staff who speak French but use English only, even when they see that the person has a problem expressing his or her needs in English*". All these components contribute to the participants' perception that there is a shortage of bilingual professionals.

### LACK OF AWARENESS OF HEALTH SERVICES AND INTERPRETATION SERVICES IN FRENCH

A second significant barrier is the fact of being unaware of the services available in French, as reported by 53.5% of the survey participants. This percentage rises to 65% or more for participants between 18 and 39 years of age and those 55 and older. Because there are few services in French, a specific search to find them must be carried out. For some individuals, this requires additional effort, while others admit that finding the information sought is "*not easy*".

This research is often done on the Internet, which as one participant says, is a source of information that is not always accessible to everyone, particularly seniors and the poor. Since there are few services in French available, they are all the more difficult to find: "*What discourages me is when it is not obvious, and the time it takes. If I am in a hurry, I do it in English*". Others lose the motivation required for the search and the request for services in French: "*Quite simply, there are none*". For all these reasons, the participants will use a service in English.

The participants also indicate limited or inexistent availability of interpretation service (37.0%), which is reported more often by men (51.9%) and participants aged 55 and over (60.0%). One participant explained that interpretation service may be available but "*If you are sick in the afternoon or evening, you are out of luck, as the service is just available in the morning. It is a matter of availability of the interpretation service*". Another participant from Saskatchewan shared his experience: "*The hospital did not use an interpretation service: it was a nurse who had studied at the Alliance Française and they managed with the interpretation. I do not think that is very professional for a hospital as such; they had not thought ahead*". In another case, a respondent pointed out that on one occasion, a written notice for a medical follow-up specified that in situations of language difficulties, the patient should be accompanied by an interpreter: "*It is up to you to come with someone who will try to be a stand-in interpreter*". In this case, the patient was not informed about the availability of a professional interpretation service.

## DISTANCE AND EXTENDED WAIT TIME

A further distance to travel for service in French (28.6%) and extended wait times for an appointment with a bilingual professional (20.2%) are also considered barriers to access to services. In the North Simcoe Muskoka and Thunder Bay regions of Ontario, a higher percentage of respondents state that it is necessary to travel a significant distance to access a service in French (58.3%). The distance to be travelled is also problematic in rural regions, as specialists are most often in urban centres. As one participant described the situation: "Those who are marginalized, they do not have means of transportation" and "there no longer is a bus system between the small villages in southern Saskatchewan…if you have to go to Swift Current or Moose Jaw for an appointment, you have to plan your ride to come back". Another observes: "We try to stay closer to home, in our neighbourhood, so that will often just be in English". According to some participants, the fact that services in French are offered in a mixed setting, i.e. that the bilingual physicians also see English-speaking patients, contributes to unduly lengthening the amount of time it takes to get an appointment. "[this health centre] is for Francophones and Aboriginals, Inuit and Anglophones…Not a lot is Francophone in there". It is recommended that a "full-service French-language clinic" be established. Some examples are cited like the Centre de Santé Communautaire Saint-Thomas in Edmonton, pointing out that, as this is the only bilingual clinic in this region, waiting times for getting in are excessive. Services in French are therefore available, but remain inadequate to appropriately meet the demand.

The additional expenses that patients must cover for using experts outside their region are added to the difficulty of having to travel a great distance to receive care in French. For example, this participant had to invest a considerable amount to have her child assessed in French for an autism spectrum problem outside her province: "We had to go elsewhere; this cost 3 weeks' pay. The travel costs will probably not be reimbursed because we went outside the province". Additional costs are also reported for consulting private services available in French. One non-immigrant participant, who after having requested services, observed that: "I cannot access interpretation services from Immigration Canada, I have no service, no assistance, apart from paying $3,000 to $4,000". These additional costs required for obtaining health service in French strongly suggest inequality in access to care for members of the official language minority.

## NEGATIVE ATTITUDE AND POORER QUALITY SERVICE

Some survey participants also reported a negative attitude on the part of personnel with regard to language (26.6%), particularly from participants aged 55 years and over (47.5%). "*Ignorance or incomprehension regarding the situation and reality of Francophones in a minority setting on the part of personnel and professionals*" was felt.

Some health professionals do not seem concerned about language-related issues and do nothing to resolve the problems encountered. Often, “they do not think to ask if the patient needs services in a language other than English” because they do not think that is their responsibility or they have no interest in speaking French. So, it is up to the patient to request service in French or the services of an interpreter. Others also mention a poorer quality service (10.4%). Some interview participants shared their fear of a lack of confidentiality in a small Francophone community: “Everyone knows one another. I am not certain that doctor-patient confidentiality is always respected with a Francophone doctor who treats many of the people I know”. Compared to other regions, a greater percentage of respondents from North Simcoe Muskoka and Thunder Bay in Ontario commented on a negative attitude toward language (54.2%) on the part of personnel and a poorer quality service (16.7%). Bear in mind, however, that the number of respondents in these regions is low (n-24) and that these data must be considered cautiously.

The negative attitude concerning the offer of services in French is also felt at other levels of responsibility, such as among health institution and health network managers and political decision-makers. In some regions, it is reported that although jobs and services are designated as bilingual, the managers are not genuinely concerned about the needs of Francophones with regard to social and health services. It is also clear that there is an obvious lack of willingness to designate positions as bilingual:

> [tr.] There is tremendous friction around the idea of designating positions bilingual as there is no will to designate positions bilingual…The truth is that many more are able to speak French. But management does not acknowledge this. The red-tape for designating a position bilingual intimidates managers and it is not a priority.

Others observe a systematic failure to comply with laws on services in French: “*They do not take it seriously because all the Francophones speak English…The policies have been developed but not put into effect with regard to Francophones. Services are not accessible to the francophone population*”.

So, participants feel that in general, little importance is placed on the minority official language.

### ACTIVE OFFER DOES NOT EXIST

Regarding active offer, the majority of interview respondents are in complete agreement: active offer is not routinely practiced in the services they have used: “*No, never, absolutely not. Everything happens in English*” and “*Too often we are given no choice. The service is automatically given in English, so we are not even asked if we need it, if we understand English or not*”. There is no sign indicating that a service is available in French, no name tags identifying bilingual personnel. To obtain service in French, you have to look for it, request it and find out about the option of receiving care in French from a bilingual professional. Another obstacle identified by participants is coming up against a service that claims to be bilingual but is not.

Interpreter-companion services participating in the study also observed that there is very little active offer. One interpreter-companion service stated: “*It can be said that even those [professionals] who speak French in the hospitals and clinics don’t say so. [The patient] is not even asked “To which language are you most accustomed?*”, and another said: “*No mention of language when I went to a hospital for tests*”. So, it is not always easy to identify the professional able to offer a service in French, nor the services that are available in French. Moreover, the interpreters stress that bilingual professionals are not always able to discuss health problems in French; their French language skills are inadequate and they are unfamiliar with the appropriate medical terminology to properly explain a diagnosis, treatment, and the necessary follow-ups in French. Active offer therefore remains very limited.

## THE IMPORTANCE OF LANGUAGE CONCORDANCE

The majority of the survey participants (86.0%) state that it is important or very important for them to receive health services in French. All the individuals with poor English skills, as well as the majority of individuals with an excellent or very good proficiency in English (74.8%) state that services in French are important to them.

The frequency with which these services are required is always or often, for more than half of participants (52.1%), and occasionally for approximately one-third (35.8%). Considering the ease of conversing in English during a medical visit, more participants with poor English skills say that the services are always or often necessary (78.0%), while this percentage is lower among individuals with excellent or very good proficiency in the majority language (37.7%).

### Vulnerable populations

According to the participants, some sub-populations are more vulnerable with regard to language concordance during a medical consultation. Children with a poor knowledge of English are among these groups: "*Children cannot speak English at the doctor's or the dentist's and will not understand, so I always have to be there to explain and translate*". It is stressed that: "*especially for children who have to personally explain challenges they are experiencing, if they are unable to express it, it does not progress or progresses much more slowly than if there were an intermediary*". Among these children, some have learning disabilities, like autism spectrum disorder, or chronic illnesses like diabetes. These children need more frequent follow-ups and with a number of professionals, according to one participant. Another participant testifies that if the child has previously received care elsewhere, in Quebec for example, the medical file is in French, which complicates the transition to English-speaking workers.

Canadians' mobility is an element that was raised by a number of interview participants. Nearly half of the participants revealed that they are from a French-speaking region of Canada and that their mother tongue is French. A number have found it difficult to adjust when moving to a province where the majority speaks English. The obstacles related to understanding a new health system, applying for a provincial health card and looking for a family doctor and health services are made more complicated by the fact that nearly all the services are offered in the majority official language of the adopted province. Although Canada is recognized as a bilingual country and "*French is an official language and so logically that should be done*", the participants bemoan bilingualism not always being apparent, particularly in settings where the Francophone population is sparse: "*Just because there are fewer of us does not mean we should not have access to services in French*", or "*people who only know French are too limited and do not have the same assets as Anglophones and will not get far.*" So, the problems related to language discordance affect French-speaking Canadians who move to a majority English-speaking province.

### Situations of vulnerability

There are many circumstances where it is considered essential to receive services in French, according to the participants. Here is the list in descending order by number of participants in the survey who identified them through the comments: with my family doctor (n=21), in emergency situations (n=21), during a mental health or social services consultation, either in therapy with a psychologist or for an appointment with a social worker (n=20), with specialists (dentists, speech and language pathologists, pharmacists, and others) (n=15), as well as before, during and after a stay in hospital for a serious illness or surgery (n=11).

Using hospital services, particularly the emergency room, is problematic for individuals for whom English is a second language, as in these situations, it is difficult to plan for someone to accompany you or the English terms for describing the symptoms and the pain felt. Traumatic experiences for family members are related here: "*At some time last year, I was travelling. My wife was rushed to hospital. She had to have surgery and there was no one there who understood what she was saying for the doctor to understand her*". Another person, who suffers from asthma, gave this testimonial:

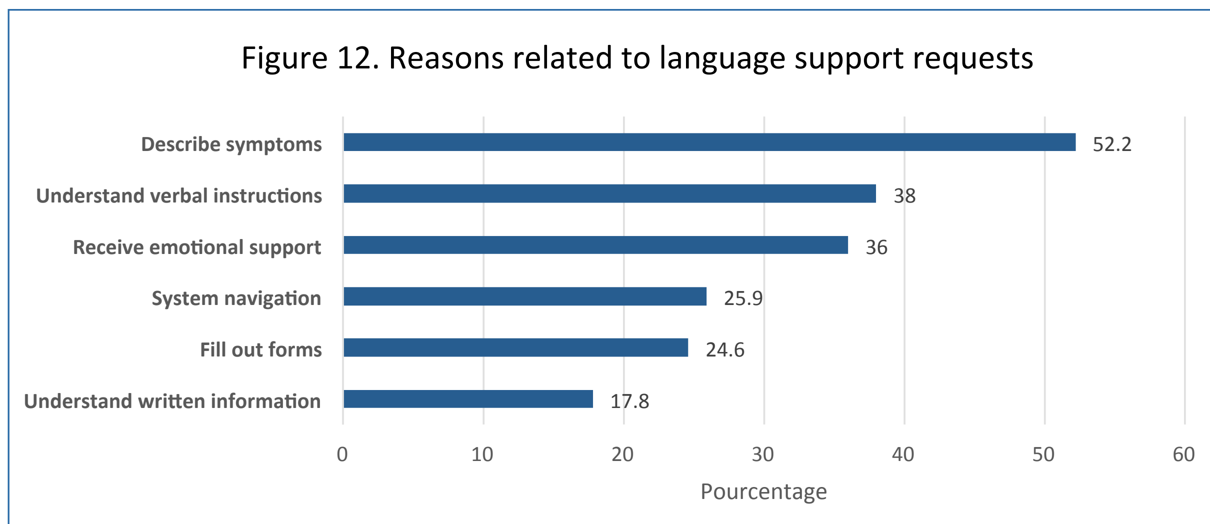
> *Once I had an attack. I called 911 but the 911 made me sicker than my illness… I am sick, my language proficiency is not at all acceptable, and they nonetheless want to ask me questions…before they sent me someone. For a life and death emergency like asthma, I do not understand.*

Another participant who is a nurse, tells of an experience where a patient was unable to correctly describe her symptoms and as a result, did not receive the appropriate care: "*The symptoms she described were a heart attack with a pulmonary embolism, and what the individuals treating her understood was abdominal pains…after 8 hours, she went into intensive care, she nearly died*". These experiences illustrate the potential severity of the repercussions of language discordance on access to services.

Though less dramatic, other situations nonetheless demonstrate the fundamental importance of receiving services in one's own language. We mention here some conditions that entail great vulnerability: for example, when the patient presents with weakened cognitive faculties, such as an elderly person suffering from dementia, someone in excruciating pain or under the effects of strong medication, such as when waking up from surgery. In situations like these, it can be difficult to express oneself in the majority language: "*I am completely bilingual, but not when I am in pain*". Or: "*My father had a heart attack. He was very ill during the winter and was taking a great deal of medication, so he was not himself. He did not understand because he was drugged*". Another situation is that of a woman facing violence; following an attack by her partner, she was directed to psychiatric services and medicated to reduce her state of hysteria. Having no access to service in French, the patient was unable to express her distress to a nurse, a doctor or the social worker assigned to her case: "*All these nuances caused this woman to be over medicated, she was like Jello, she could not lift her head from the table to be able to tell it like it is and to really understand the questions*". For other participants, the essential need for service in their language is also seen in cases of psychological distress: "*It is hard to explain something, especially emotions, if it is not in your language and you do not have the vocabulary for it*". Patients who experience a chronic or one-off state of vulnerability are more at risk to suffer very serious negative impacts on their health directly related to their inability to communicate their needs in a second language.

## Why language concordance matters

The main reasons language support is required are illustrated in Figure 12. Among a choice of possible responses, participants chose "*being able to properly describe my symptoms*" (52.2%) as the main reason. A number of interview participants do not feel comfortable expressing themselves in English in the area of health: "*If you have to get care and have to speak English, and English is not my first language, I am not confident*". For another, "*It is difficult to convey and share your problem when their language is not yours*", in speaking about a worker who does not understand French. One participant stressed that language is important for communicating relevant information to the care provider: "*Regarding health, it is very important to be understood by the doctor to prevent false diagnoses*" and furthermore "*It has a great deal of influence because if I explain better, I am better directed or the doctor knows what tests have to be done*". One respondent described an experience that a colleague had, demonstrating precisely how major an issue language is: "*Her mother had an odor coming from the lower part of her body and the doctor was saying that it was just an infection of some sort. In the meantime, because she could not express herself in English properly, they discovered when she died that she had had untreated uterine cancer*". The use of hard to translate French expressions such as "*d'avoir mal au cœur*" which does not refer to heart problems but nausea. Moreover, misunderstanding of medical terms in English also seems problematic: "*I have an intermediate to advanced level of English. I do not have all the technical words. I do not have the terminology. I am missing words*". According to the participants, language concordance is essential to be able to correctly describe one's symptoms and thus receive the right care.




The second reason given for requesting assistance for language problems is to make sure that the instructions given verbally by the care provider are correctly understood (38%): "*to correctly understand the service given and follow the doctor's recommendations*". These instructions are related to treatment, prescriptions, and prescribed diagnostic tests.

Equally important is the need to receive emotional support (36%). One participant shared, with disbelief, an experience with a psychologist: "*I was writing in French on Google translation and the psychologist was reading the translation…*". As stated by another individual: "*When my health is not good and I need to confide or speak about my pain to a doctor who understands and enables me to understand what I have to do, at that moment, I need assurance and confidence and attentive listening.*" The importance of language is recognized in "*linguistic spontaneity during sensitive discussions*". A parent said: "*When parents have young children, there is a lot of questioning. There is already concern about what is going on, the fact of having another obstacle, i.e. a language barrier, adds considerably to the stress already there*". Finally, a request for support with language-related challenges is also common when it involves the ability to better navigate the health system (25.9%), i.e. knowing where to go to get the appropriate service, filling out health forms in English (24.6%) and understanding written information in English (17.8%).

## IMPACT OF LANGUAGE DISCORDANCE ON ACCESS TO CARE AND QUALITY OF SERVICE

The life experiences described above arose from circumstances that placed the patients at risk, and for some, in extreme life and death situations. Remember the woman who was describing cardiovascular problems that were falsely interpreted as being related to a digestion problem, the woman suffering from an acute respiratory problem and having to answer questions in English before an ambulance was sent to her assistance, the over-medicated woman, or the one who died from undiagnosed and untreated cancer. We also stress that a significant proportion of respondents say that they do not have access to health services due to language discordance. Other examples testify eloquently to the impact that language has on access to the right care and the quality of the service received.

Thus, misunderstanding the patient's symptoms could cause the patient not to get the necessary care: "*If I were able to make them understand what I am feeling, they could react more quickly*". The diagnosis is thus more difficult to establish as the care provider does not understand the symptoms the patient described and must request additional tests: "*I think that by explaining it better, the doctor will understand the actual problem and be able to skip this or that test*".

In this type of situation, the treatment and tests prescribed may not be appropriate and not help resolve the health problem. In another case, one participant said she was waiting for surgery for an unfairly extended amount of time because "*my family doctor, who does not speak French, is very nice but it is more difficult for him to understand my needs and I also have a hard time understanding what he can offer me. I wait, I wait, I wait [for my surgery]*". This situation leads to a certain amount of frustration for this patient, as her health problems persist due to undue delays for her surgery. Another participant confides that poor communication caused her to not correctly follow the instructions given to her: "*I had not understood correctly. I took the medication incorrectly, that is what he told me today…It is frustrating because you are not sure if you are following the instructions correctly, understanding the directions and you are dissatisfied*". Another testimonial reveals that language incomprehension on the part of the care provider was the reason why the patient had to consult more than once before obtaining appropriate service: "*Had I had an interpreter, they would have quickly understood the seriousness of the situation. She had to return home and come back the next day for people to understand her condition*". Finally, another participant reports that an unsuitable medication was prescribed for her health problem: "*Occasionally, one will receive drugs that are not appropriate for the illness and so the illness is not going to get better.*" The consequences of a language discordance therefore have an impact on access to care and the quality thereof; the patient's discomfort and concern may be aggravated due to additional tests he must undergo, inappropriate treatment, extended waits for follow-up or incorrectly followed instructions. Similarly, one or more consultations for the same health problem that was not resolved may also occur.

Interpreter-companion services are in a position to observe the interactions between French-speaking patients and care providers during consultations. All were able to share incidents demonstrating the negative impacts of language discordance. Here are some examples:

> *Two weeks ago, I was called by a doctor who asked me to come for a patient. She had been there before because she had been diagnosed. She had understood that she had an infection in her brain, and in her mind, it was really that; it was more or less cancer, and that is what she told everyone around her, her family and friends, and ultimately, when I went with her, it was totally different. She had had an infection between two layers of skin on her skull but it was not in the brain. However, in her mind, it was the brain that was affected. She had misunderstood the diagnosis. This is a very big difference. Her family was worried, she was worried and they saw things as much worse than they were.*
>
> *I had an experience with another woman, who was pregnant, who couldn't manage to speak the language at all, so she went by herself (to her doctor) and tried to explain but could not be understood…the doctor was unable to understand the problem. Fortunately, it was not too late because when I went back with them and explained, you see how the doctor was very surpised to understand and know what their problem was. This was not just one or two people, this has happened to many [patients].*

The interview participants nonetheless appreciated the services received and many spoke highly of the quality despite the difficulties posed by misunderstanding due to language barriers: "Everyone does their best with what they have" says one participant, or "Once the problem is understood. I think that the services are good quality". However, there is the perception of not being respected as a full citizen and member of a minority official language group. Some feel like "second-class citizens" because they are not able to be understood when they express themselves in their mother tongue. This feeling of inferiority is at times felt more sharply by study participants as they have the impression of knowing less about their health status and thus being deprived of significant information.

As this young pregnant woman described it: "*It definitely would not be the same if I were being cared for by a Francophone doctor. I think I would be better informed*". Further research and additional investment in time are often necessary to this end, as described by a respondent who attended the same health information session twice to be better prepared to undergo surgery in an English-speaking hospital setting: "*I prepared a great deal, a lot of English hospital vocabulary to make myself understood*". The embarrassment associated with inadequate understanding of the doctor's instructions was also mentioned by a number of patients. Some even emphasized that the fact of not properly grasping the doctor's remarks and to have the doctor repeat them is likely to be met with impatience; so, as a result, to avoid creating tension, "*you pretend you understand when you do not*". These examples are all evidence of compromising the quality of service due to the language discordance between the patient and care provider, as the service the patient may expect is not rendered or is incompletely rendered.

## ROUTINE PRACTICES IN INTERPRETATION-COMPANION SERVICES IN THE MINORITY SETTING

Interpreters, navigators and companion services who participated in this study described their roles very similarly, regardless of where they work. However, their professional titles differ considerably. For some, the role of *health navigator* suggests a referral role for Francophones and care providers with regard to services available in French. As we will see in the following section, these navigators primarily support and interpret. Others are recognized as being interpreters but also support and, if need be, navigate. In order to simplify the reading of this section, the term interpreter-companion service will be used generically.

### The interpreter-companion services roles and responsibilities

The role of the interpreter-companion service is usually documented in a job description, at least when it is a paid position. The job consists of an assortment of tasks and, in addition to interpreting for health professionals and patients, includes accompanying patients and navigation duties related to services in French. As a general rule, the tasks associated with interpretation are general and loosely defined, such as "*accurately interpreting the information to provide effective communication between clients and professionals*" and to "*protect confidentiality and objectivity at all times*". The companion service's tasks are more detailed, and include intake, orientation and patient's transport to appointments, support for the patient and his/her family and post-appointment follow-up, if necessary. The duties associated with navigation vary and may include the compilation and updating of a list of services and resources available in French in the community organizations, liaising between health organizations used by Francophones, and providing information, referrals and recommendations to patients and care providers alike regarding services available in French. The description of volunteer interpreter-companion services' tasks is generally communicated verbally during a meeting with the service coordinator or at a more formal presentation, or through documents sent by e-mail. Details of the various tasks, as described by the participants, are found in Appendix 5.

Although a number of participants see their role as being "*the voice of the patient who is unable to comfortably express himself in English*", most also recognize the importance of emotional or moral support, as this clientele needs to be reassured about the medical situation at hand:

> *When I accompany these people, my work is 80% moral support and support to the individual. The language comprehension aspect is paramount because if the individual does not always understand the important word everything can fall apart, but the fact that there is someone with him gives the individual more confidence, he asks more questions and understands better.*

Here is another example: "*Often, when I go to the Cancer Centre, there is bad news given. It can be hard, at times, for a patient to be sitting there all alone and be told that there is nothing more that can be done. Just having someone there with them makes them feel less alone*". According to most of the participants, emotional support is an important part of their work with the patients.

Generally, interpreter-companion services feel confident in their role as interpreters and say they have adequate proficiency in both official languages to be in a position to provide interpretation. The elements that help are experience in the health field and training received in medical terminology as well as regarding the responsibilities related to interpretation or support. Previous experience in the health field is also beneficial: "*I always worked with the elderly, so I have the experience, the hospitals, nothing bothers me*". Confidence also comes with experience: "*Life experience teaches us to do many things*".

## Interpreter training

The training the interpreter-companion services participating in this study received varies. One participant had 3 years of part-time distance training in English encompassing 6 modules, including one on medical interpretation. Another had 3 weeks of training as a court interpreter. Some volunteers completed training in medical terminology through an online program in English that lasted approximately 4 months and encompassed 8 modules. Others had a few hours of training offered by a professional interpreter on interpreters' rights and responsibilities. All have a basic understanding of confidentiality and professionalism, while some also have an in-depth mastery of topics like integrity, impartiality, accuracy, and the interpretation and patient representation boundaries. Regarding linguistic evaluation, half of the participants were formally evaluated for writing and speaking in both languages, by a department who specializes in that area.

No training in companion services, however, was provided to participants. One participant pointed out, however, that support services for First Nations populations and cancer patients are exemplary practices that are used as models for providing companion services to Francophones in minority settings. According to most of the participants, the skills required to be a companion service are compassion, generosity and empathy: "*I like helping people and I benefit as well. I am very glad to do it; I give what I receive; life is about paying it forward. You have to be generous and empathetic*". The interpreter-companion services who participated in this study are universally perceived in the interviews as compassionate, patient individuals with a profound desire to help people in need. According to one participant, you have to be sensitive and demonstrate know-how in order not to offend either the care provider or the patient. Frequently, delicate situations arise such as during the diagnosis of a serious illness. For a patient who lives alone, the interpreter-companion service must be vigilant: "*It is no small matter…you have to be there*". These individuals recognize the need for these services in their community and are happy to be able to contribute to the well-being of its members. "*It is very important because at least the person is satisfied, cured, gets the care that is needed. Because it is about health somewhat…If the doctor has a better understanding of what is wrong with the patient, it reduces the risk of death. For me, it is very, very important*".

## Challenges associated with interpretation-support

The interview participants were able to explain their experiences with interpreters and companion services whether it be a relative or close friend, a volunteer or a professional service. Those who were accompanied by a relative or close friend revealed certain difficulties associated with this practice. First of all, some individuals do not have a family or community support network and therefore cannot ask anyone to accompany them. Those who are socially isolated, live in rural areas or those who have recently moved to the area make up the majority of these individuals. Others still have a support network but not nearby. Finally, even those who have the advantage of active support in the community face coordination problems in relation to making appointments and the companion service's availability: "*Making appointments with specialists is hard enough as it is. In addition, I have to tell my husband to book a specific day off and come with me at a set time. This is not pleasant for either one of us*". The discomfort related to having to frequently ask for support is expressed by other participants in this way: "*Always asking people is not always pleasant*".

Challenges were also identified by participants who acted as companion services for a family member or colleague. They indicate that certain individuals need a great deal of support. Whether for access to services and making appointments or accompanying them during consultations, the companion service must take on additional responsibility.

In the case of long-term treatments, like for an autistic child, for example, support is obviously over a long period. Others observe hesitation on the part of the individual being accompanied, particularly if it is not a family member, as "*indeed, there are no more secrets*". This participant, who does not feel trained as an interpreter, says that "*with a qualified interpreter, there is a component of professionalism and confidentiality, while with me, it was informal, she did not want to reveal all her problems, all her secrets. With an interpretation service, it is clear, it is official, there is a code of conduct.*" It also happens that English is the companion service's second language: "*I am mainly Francophone so I do not necessarily know all the words in English*" and another says "*I have no one here except my husband…but I speak English better than he does*". Having a family member or friend to accompany a person is appreciated but presents some challenges.

Other pitfalls were also identified regarding community volunteer companion services. Although one respondent stated that doctors are generally comfortable with a volunteer companion service present, in a hospital setting it may occur that because the companion service is not a family member, the companion service is not as well received. Other obstacles can also impede the effectiveness of a volunteer service: elderly companion services and the varying availability of volunteers who are poorly suited to the flexibility required by this work because there is a great variety of health care access scenarios. Additional tasks for the companion service were also mentioned, such as making connections with family members who do not live near the individual in need and having to notify the hospital in advance of the fact that the patient will be accompanied by a volunteer. Finally, prior negative experiences with a companion service and the matter of confidentiality in small communities occasionally result in the services of a companion service not being requested.

Interpreter-companion services also shared substantial challenges regarding the matter of volunteerism. First of all, it is difficult to recruit volunteer interpreter-companion services. These individuals must have a good knowledge of both official languages, have a car for providing transportation and be available during the day. Moreover, one cannot expect them to travel great distances for medical appointments or to keep their schedule flexible. Therefore, in the health environment, an appointment or health assessment may frequently be postponed at the last minute, thus changing with minimal advance notice, the schedule set with the volunteer and that the time planned for a medical proves to be completely inaccurate: "*The other time with Ms. X, I spent the day. It was supposed to be an appointment or tests for her blood vessels and it was supposed to be for 1.5 to 2 hours. It was rescheduled and in the end, it was 10 hours in total...*". Coordination of follow-ups, tests and prescriptions, if required, may also be problematic: "*If I had not been available in the afternoon, it would have been a real problem for Ms. X to find someone else qualified to interpret, if there has to be a replacement because the appointment is extended… the problem is doubled for coordination*". An experienced interpreter-companion service, whose demonstrated knowledge of the services offered by certain health professionals is such that she is able to anticipate these situations, no doubt has an advantage over volunteers with limited experience. Occasionally an interpreter-companion service requests to be replaced by another interpreter. This process is always made easier with interpreter-companion services holding paid and full time positions. The many challenges associated with volunteers make it difficult to guarantee volunteer interpreter-companion service services during health professionals' office hours. The same holds true for interpreter-companion services who only work a few hours per day. The solution to this set of issues lies in the availability, at the desired time, of bilingual health professionals, which is also a significant issue. According to participating interpreter-companion service providers, there are not many such employees and they are not necessarily present at the institution when their language skills are required.

According to participants who are interpreters-companions, there are also some problems associated with professional interpretation-companion services. These challenges are mainly related to the multiple roles and voluntary nature of interpreter-companion services in some communities. First of all, interpreter-companion services perform a number of duties during a medical consultation. Interpretation is done for both the care provider and the patient so that they are able to properly understand each other's comments. Generally, accompanying is done before and after the consultation.

. The interpreter-companion service therefore feels called upon to resume a support role to allow the patient to pull himself together before continuing the consultation.

It is therefore occasionally difficult to respect the boundaries of interpretation when the patient needs support. Another challenge associated with the multiple roles of the interpreter-companion service is to have a proper understanding of the health system in order to be able to get the information and contacts necessary for following-up on the patient's behalf. Identifying the individual authorized to provide the required information can be demanding: "I feel less confident with regard to the flow of the process and medical follow-up", one interpreter-companion service confides.

### Perception of the quality of the interpretation-companion services

Of the twenty interview participants, nearly half indicated that professional interpretation, health navigation or companion services are not available in their region. Four participants used telephone interpretation services and four participants reported the existence of companion services offered by community organizations, particularly in western Canada. With regard to professional interpretation services by telephone, three of the four participants who used this service said they were disappointed in the quality of the service at times, as described by this participant: "*The last time, the interpreter I had was not good. I do not think he understood what I was saying and he did not translate well. He did not translate the fact that I was pregnant, just that I had cramps….I thought 'forget about interpretation, go yourself [to the hospital]*". One person, who is also a health professional, said that the interpretation service is slow, that a person has to wait from 10 to 30 minutes before gaining access to the interpreter. In an emergency situation, this is an unrealistic waiting period: "*When life depends on it, there is no time to lose*". Others nonetheless state that they have had positive experiences.

The interview participants were also questioned about their openness to using an interpretation service if it was available. For seven participants, the service would be used without reservation, as its added value is recognized: "*If this service were available, I would definitely use it*".

For another participant: "*When you are newly arrived in an English-speaking region, you certainly need someone to know what is being said. You have to learn the language*". Some pointed out that the professionalism of the interpreter's role is the key factor in patient confidence: "*With an interpreter's service, it is clear. It is official. There is a code of conduct*". Others remain somewhat cautious for various reasons. Some do not want to share personal information with a stranger. Others do not want to be a bother or prefer to be accompanied by a family member or an acquaintance. Others prefer to go alone as they say they understand English well enough to get by, particularly if the medical situation is neither urgent nor serious. One participant also states that in complicated care situations, it is more difficult to rely on an interpretation service, especially concerning the patient's medical and family history.

Interpreter-companion services participating in this study are unanimous in saying that the patients are very pleased with the service provided by interpreter-companion service: "*The patient is very happy to be able to speak his or her language…to see that communication is working well*". Sometimes a patient goes to a medical appointment alone and then has to book a new appointment, this time with the assistance of an interpreter-companion service, because the health problem still exists. When the patient is accompanied, he receives the service needed, and is satisfied:

> You can see that even the woman was quite happy because she had been prescribed a medication that she was not supposed to be prescribed…The woman was really frustrated because since her [initial appointment], the pain had not stopped, she still had the same problem. And when we went together, the doctor gained a better understanding of what had happened to her, which made her very happy.

The role of the interpreter-companion service is also well accepted by the health professional consulted, according to the interpreter-companion services.

They state that non-French speaking professionals express some measure of relief when seeing their Francophone patient accompanied by an interpreter because "*they know they need them*". This openness is made most obvious if the interpreter-companion service is already known or has come with the same patient a number of times. The care provider therefore recognizes the added value of the interpreter's presence for understanding the patient's needs and, in return, a good comprehension of the diagnosis, treatment and follow-up by the patient. Moreover, in some regions of Canada, health professionals develop an increasing awareness of their clientele's cultural differences and admit that it is important to "*culturally connect with the person*" through an interpreter. This applies not only to First Nations peoples but also to Francophones in minority situations, one participant explained.

Interpreter-companion services explain, however, that the health professional may be reticent if unfamiliar with the service of an interpreter-companion service or is not expecting an interpreter-companion service to attend the medical appointment. He may be impatient at times as the consultation takes a bit longer when held with an interpreter. When the interpreter-companion service informs the health professional of where they are from and their role supporting the patient, the reaction is generally positive:

> *"As soon as you arrive, the way they act, for example, from reception, you would see that they are quite happy that someone is there to help the patient understand better…some will say so openly". "They are appreciative because they want to help the patient and in order to do so, they have to understand him."*

At times, some doctors actively facilitate access to interpretation services for their Francophone patients as they are fully aware of the obstacles and risks associated with language discordance. Others are surprised that this type of service exists but are appreciative. So, in general, interpreter-companion services are very favourably received and their support is appreciated.

The role of the interpreter-companion service also seems to be accepted by the health system, as according to some interpreter-companion service participants, this represents savings and reduces risks associated with poor patient-care provider communication: "*When a patient comes back with the same infection two weeks later because he had misunderstood, this is costly for the system*" and "*We are doing them a favour and reduce costs and risks somewhere along the way…they know exactly what they have to do because if people are not comfortable or do not understand exactly what the problem is with the patient, it can lead to problems*". According to one interpreter-companion service, the telephone interpretation service available in his province attests to an acknowledgement of the health system's need for it. Although he deems this interpretation service less effective than face-to-face, "*it is already a valuable resource because it helps*". Another participant stresses the fact that being able to offer services to Francophones in their language is beneficial for everyone, as healthy Francophones "*feel better about themselves, work more, pay more taxes which leads to better schools and better roads. It is that simple. A country that respects its minorities makes for happier people…and a better country*". This same participant states that services in French are of substantial importance in the institution where he works, as managers maintain funding for this service despite budget reductions.

### Suggested improvements

Some suggestions were made by participants for improving interpreter-companion service services. These suggestions focus on two areas in particular: the training and hiring of interpreter-companion services in French-speaking communities.

With regard to training, interpreter-companion services put forward the following ideas, in no particular order: training in 1) first aid, 2) advanced medical terminology for those who do not have previous training in the health field, 3) interpersonal relations, 4) navigating the health system, especially in the hospital setting, 5) standard practices and ethics in interpretation, and lastly, 6) cultural adaptation to better support Francophones of all origins. Ongoing training was also mentioned with regard to medical terminology as new ways of treating health problems regularly emerge and interpreter-companion services must keep up to date with recent terminology. Interpreter-companion services also wish to have French language upgrading.

Given the growing demand for interpreter-companion service services in most of the regions surveyed, participating interpreter-companion services are in favour of hiring interpreter-companion services in health and community organizations. One participant suggests that this service be managed by a community organization, thus allowing services to be offered in all health institutions, whether public or private. This means that the Francophone community organization, which already maintains ties with Francophones in the community, will see to the service's visibility growing and be a bridge between the clientele and the social and health services institutions in the region. It is strongly stressed that the service be provided by a full-time staff member specifically assigned to this task rather than volunteers. This would greatly facilitate access to the service during the regular business hours of care providers. The participants increasingly observe that demands exceed available resources: "*The more visible you are, the higher the demand*". They stress that visibility of the interpreter-companion service is essential as it allows patients and health care providers to be informed about the availability of this service and the importance of language in the assistance relationship. Yet, above all, the participants wish to see the normalization of the use of French and active offer in English-speaking settings.

In one region, a pilot project on offering an interpretation service through telemedicine seems to have reaped benefits as this technology facilitates access to interpretation services for Francophone residents in remote and rural settings, fostering patient consultations with professionals in other cities, such as specialists practicing in other major urban centres. An evaluation of this interpretation service model could enlighten us on the benefits and challenges related to this practice.

## Discussion

LThe objective of this study was to better understand the experience of Francophones living is sparsely populated communities and rural/remote regions with regard to social and health services in French, active offer and interpretation, navigation and companion services. The importance placed on language by the users of these services and by the health systems was explored as well as the impact of language discordance on the quality of the service received. A number of facilitating factors and barriers to access to services in French, which often highlight the practice of active offer, were identified. The data collected in this study demonstrate that Francophones, particularly those belonging to sparsely populated Francophone communities and those in rural/remote settings, perceive inequality in access to social and health services in French in their region. Inequality in access to services in French and English persists despite laws and policies on French-language services enacted in a number of provinces and territories. This situation is similar to that of Francophones living in other minority communities in Canada where the density of Francophones is higher (de Moissac, Giasson & Roch-Gagné, 2015; Drolet et al., 2014).

Language concordance, which is increasingly recognized as a core component in the offer of services intended to reduce health inequalities (Bowen, 2004; Schwei et al., 2015), matters for French-speaking minorities, regardless of their bilingualism level. Significant participation in the survey by individuals born in Canada enabled us to observe that the problem is not limited to Francophone immigrants but also affects Canadians whose mother tongue is French. Canadians' high mobility, particularly toward the territories and Alberta (Statistics Canada, 2015), contributes to this phenomenon. In a bilingual country, Canadians expect to receive health services in the official language of their choice. The participants say that they make out as best as they can and are sufficiently bilingual to be able to properly communicate with the care provider. However, in situations of distress, some participants and the interpreter-companion services observe that language barriers definitely exist.

The situations of language discordance between the Francophone patient and non-French speaking care provider, as described by the users of interpretation services-companion services, show the negative impact of the language barrier on access to appropriate care. Lack of comprehension during the assessment of the medical problem at the outset of a consultation can lead to treatments that do not target the patient's actual condition and put him at risk. The consequences are serious whether it is a cardiovascular or acute respiratory attack, or a chronic health condition that can be fatal without treatment. During these types of experiences, there is deep dissatisfaction with the service received, as well as a feeling of injustice and inferiority. These data corroborate earlier studies of other minority language groups which demonstrate the impact of language barriers on health and access to care (Eneriz et al., 2014; Shah et al., 2015) as well as on the quality of the care received (Cohen et al., 2005; Ayanian et al., 2005). The situation is similar for the Francophone official language minority population in Canada.

Inequalities in access to services in French, according to the participants, seems to be related to a shortage of bilingual professionals. Yet, access to bilingual family doctors and other health professionals is reported by nearly half of the survey respondents as a factor that improves access to services in French and which meets the needs of the users of these services. This proportion of professionals seems high compared to that of a Manitoba study which estimates that the proportion of individuals having access to bilingual providers is one-quarter (de Moissac et al., 2011). This discrepancy may be explained in part by the over-representation of participants from Saskatchewan, where there is an online directory of services in French that seems to be well-known to the participants. This may also be explained in part by the fact that the survey sample represents a significant number of individuals with a high socio-economic profile, i.e. university education and higher than average Canadian income (Statistics Canada, 2016). Individuals with this type of profile are themselves, generally more likely to participate in surveys pertaining to health (Demarest, 2013). This bias may affect the results, given that individuals with less education and low income, as a rule, have poorer access to health services (Sudore et al., 2006). Finally, some interview participants specified that they had had care provided by bilingual workers in the past and elsewhere in Canada. It may be then that, over the course of their lives, the survey respondents had access to a bilingual health professional but that said professional is not available now. Taking these elements into account encourages one to carefully consider the findings related to access to bilingual health professionals.

Users of services participating in this study state that they routinely use the Internet, whether for finding a service or learning the vocabulary necessary for a medical consultation in English. The use of this technology, suited to the needs of Francophones in minority settings, may turn out to be a winning strategy for improving access to services in French. Some tools already exist: an online directory of social and health services in French in the region; an application for mobile devices entitled MediLexico (Collège Éducacentre, no date), a lexicon of medical terms in both official languages; a help site for preparing users before a medical visit, entitled DiscutonsSanté.ca (Capsana, 2015), available on the web. Promotion of these tools, which are readily available and which meet users' needs or their adaptation to the minority context, should be considered. We note, however, that everyone is not in a position to take advantage of these technologies and that they are less likely to meet the needs of more vulnerable Francophones, i.e. low income and limited education. A broader range of strategies that make use of personal contacts and video service still seems necessary.

Access to bilingual providers is not the only factor in services being considered adequate. The findings also suggest other components of active offer: initiative, which consists of asking in which language one would like to receive service, telephone services and health forms in French are examples of facilitating factors pointed out by participants. Sensitivity to the patient's standard language and the opportunity provided to express himself verbally and in writing in French seem to be of utmost importance, particularly at reception and during the initial consultation. This is when patients most feel the need to express themselves in the best way possible, as they realize that the ability to describe their symptoms correctly will enable the care provider to recommend the appropriate tests, make a correct diagnosis and prescribe the right treatment. The practice of active offer is therefore essential to first identify the Francophone patient and then direct him to a bilingual care provider or an interpretation service.

The data suggest that there is little evidence of active offer in the settings studied, which is a significant barrier to access to services in French. The practice of active offer, particularly in minority settings where Francophone populations are sparse, must be encouraged and supported through innovative strategies that specifically target non-Francophone workers who have limited awareness of the issues related to language discordance. Active offer should be promoted to all health professionals who work in minority communities, regardless of their language proficiency (de Moissac et Drolet, forthcoming). Raising the awareness of professionals and management of health institutions about Francophones' needs and about the means for facilitating their access to the appropriate services in their language is necessary because they are in a position to develop policies on active offer, recruitment of bilingual health professionals and their retention in institutions serving Francophones (Savard et al., forthcoming).

In most of the regions involved in this study, non-Francophones professionals and the health systems seem to be dismissing the needs of Francophones and paying little attention to the challenges related to offering services in the minority official language. However, when an interpreter-companion service comes along with a Francophone patient, the reception the interpreter-companion service receives, in most cases, shows that the health professional is relieved and appreciative of the support received to better communicate with his or her French-speaking patient. When non-francophone speaking health professionals are aware of the availability of an interpretation service and personally observe the benefits to the helping relationship with their patient, they seem more inclined to acknowledge the undeniable benefits of language concordance and to adapting to the changes this practice requires for future consultations. The same holds true in the institutions funding interpreter-companion service services as, according to some interpreter-companion services, the reduction in risks and costs related to language incomprehension is valued. So, interpretation-companion services are deemed beneficial and likely to respond to the challenges of active offer of services in French in communities with a sparse Francophone population. Additional studies on the opinion of non-Francophone health professionals and managers of health institutions who have accessed interpretation-companion services could certainly improve our understanding of the issues related to care for Francophones and cooperation with interpreter-companion services.

This study enables us to observe that there is little awareness of interpretation, navigation and companion services and as a result, they are under-utilized. Among the survey respondents, less than one-quarter were aware of the existence of these services in their region and only one-tenth had used them. It is possible that the users perceive access to this service as being restricted to extreme need, such as cases when patients have a total lack of knowledge of the care provider's language, for example. Others primarily perceive that the service has a limited availability or is non-existent. Those who have used interpretation and companion services are mainly the elderly, immigrants and Francophones who have moved to a majority English-speaking province. These individuals generally have complex needs, not only with regard to health but also related to a poor understanding of the health system or a significant lack of social support. The interpretation and support service, whether physical or emotional, is shown to be very appropriate for this vulnerable clientele. Considering the importance placed on the social and emotional support of these individuals, a combined service model that includes navigation, interpretation and support, could be ideal for fulfilling their needs. However, the roles must be well defined as much for the individual performing the task, as for the employer and the public who must have a clear understanding of the responsibilities and limits of the interpreter-companion service's job.

Close cooperation with Francophone community organizations seems obvious as a strategy for promoting services in French, as these organizations are well-known by their clientele, particularly in the minority setting. In fact, the interpretation, navigation and companion services observed in the study settings are often managed by a community organization thanks to the support of volunteers which poses significant challenges, as the findings have shown. Whether in the case of a family member or volunteer, their concerns are similar: the insistence on confidentiality and professionalism, the availability of volunteers and the language skills in both official languages.

Previous research has clearly reported the dangers related to the work of a casual untrained interpreter, as interpretation can create the illusion of adequate communication between the patient and caregiver (Flores et al., 2012; Kilian et al., 2014) when it is clearly not the case. Minimum practice standards, such as those developed by Healthcare Interpretation Network (2010) cannot be guaranteed unless the service is provided by personnel who have been trained and evaluated in both official languages and supported by proven organizational policies and practices. Support for the organizations that coordinate and provide interpretation and companion services is necessary to guarantee that the service is appropriate, safe and high quality.

Finally, certain improvements suggested are worth exploring. First of all, an interpretation training program, offered in French, through distance learning could provide some basic foundations for introducing interpretation services in minority Francophone communities. This training could also address the challenges of multiple roles as played by the interpreter-companion service, and guidelines with regard to tasks and standards to be respected. Continuing education would also be appreciated so that interpreter-companion service remain aware of new developments in the health field, particularly of recent terminology related to medical conditions and the their treatment. Finally, a telemedicine interpretation pilot project seems to have been successful and should be explored further, as this technology could prove very useful for Francophones living in rural and remote communities.

## Findings and recommendations

This study has enabled us to better understand access to social and health services in French, active offer and interpretation, companion services and navigation services in a number of communities with sparse Francophone populations in Canada. One of the main issues associated with access to health services and quality of service is language concordance between the care provider and the patient. The following observations stand out from the comments made by the interpreter-companion services and Francophones living in these communities:

1) Language concordance matters for Francophones, regardless of their level of bilingualism:

a. Language concordance noticeably improves communication between the care provider and the French-speaking patient; the patient is able to make himself understood, receive the necessary services and emotional support, and then understand instructions and follow them;

b. Language concordance is that more critical in situations of vulnerability, such as emergencies, times of severe physical or psychological distress and hospitalization;

c. Language concordance is essential for certain more at risk populations, such as unilingual Francophone children, the elderly, pregnant women and Francophones who move to a majority English-speaking province.

2) Language discordance has a negative impact on Francophones' access to health care and on the quality of the services they receive:

a. One-fifth of participants, who are for the most part educated and financially well-off, do not access social and health services due to language discordance;

b. The impact on health includes prolonged suffering or stress, an unresolved health problem, additional tests, inappropriate treatment, improperly followed instructions and multiple consultations for a health problem that is ongoing due to inadequate communication between the treating physician and the patient;

c. A lesser quality of service is observed; the care provider may grow impatient with a patient who has problems expressing himself in English. Moreover, misunderstanding during the assessment of a medical problem leads to treatments that do not target the patient's actual condition and put the patient at risk; this leads to dissatisfaction with the service.

3) Francophones in minority settings feel that they are subjected to unequal access to social and health services, with limited services, a shortage of bilingual professionals and little active offer. Awareness of interpretation and companion services is minimal and as a result, they are under-utilized.

4) Interpreter-companion services fulfill a genuine need:

a. Individuals with complex health and social support needs most often access interpretation and companion services;

b. Combined interpretation- companion services are more relevant, due to the importance of emotional and social support of Francophone patients in times of need;

c. The offer of an interpretation-companion service through volunteers presents many challenges and may result in interpretation having a negative impact on the quality of care received and put the patient's safety at risk.

Given these observations, and in order to reduce the risks and additional costs associated with inadequate care, these recommendations seem relevant:

1) Promoting the hiring of bilingual health professionals and the practice of active offer remain priorities in communities where Francophones live, as language concordance is of the utmost importance;

2) In the absence of bilingual health professionals, a combined interpretation and companion services could fulfill the needs created by complex social or health problems and those related to a lack of understanding of the health system on the part of Francophones who are vulnerable or in situations of vulnerability;

3) To ensure quality, safe and complete services, interpreters-companion services must receive adequate training, assessment in both languages and ongoing support through organizational policies and practices;

4) Setting up interpretation training, provided in French through distance learning, would be beneficial for all minority Francophone communities;

5) The use of technology could be explored for the purpose of promoting services in French and the tools available, as well as for offering a centralized interpretation service for Francophones living in rural and remote regions of Canada. To this end, an evaluation of the telemedicine interpretation service, that is currently a pilot project in Ontario, could provide information on the success of this initiative;

6) Community organizations which already play a fundamental role in the promotion of services in French and are central to minority Francophone communities, are key stakeholders who must be supported;

7) A study on the opinion of non-Francophone health professionals who have a Francophone clientele and who have used interpretation-companion services, as well as managers of health institutions where these professionals work, would provide us with an overview of all relevant stakeholders.

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# Appendix 1. Profile of the Francophone population and French language services in the six regions in the study

| | Francophone population | Provincial law or policy on French-language services | Health authority French-language services | Interpreter, navigator or companion service services offered by a Health authority | Community Interpreter, navigator or companion service services |
|---|---|---|---|---|---|
| **Newfoundland-and- Labrador (St. Johns)** | 0.6% mainly in the Avalon Peninsula and Labrador | None | Bilingual Services Office, Eastern Health Region (Avalon Peninsula) | 3 interpreters during weekday office hours and on call | None |
| **Northern Ontario (Thunder Bay)** | 2.8% in Thunder Bay; 4.8 % in northern Ontario; mainly elderly | French Language Services Act in 25 designated regions in Ontario, including the Thunder Bay District | Réseau du mieux-être francophone du Nord de l'Ontario, which funds Accueil francophone | Accueil francophone (1986)<br>2 navigators/ interpreters; face-to-face or remote through Ontario telemedicine | Accueil francophone began as a community organization |
| **Central Ontario**<br><br>**(North Simcoe Muskoka)** | 5% in Midland and the surrounding regions (North Simcoe Muskoka LHIN) | French Language Services Act in 25 designated regions in Ontario, including the Simcoe District | Réseau franco-santé du Sud de l'Ontario and the CHIGAMIK Community Health Centre | Health navigator pilot project | None |
| **Saskatchewan (Saskatoon)** | 2%, mainly elderly and immigrants | Provincial policy on French-language services Saskatoon Health Authority's policy on interpretation | None | NoneReferral to the Multicultural Community Interpretation Services in Ontario<br>(by telephone; $) | None |
| **Alberta (Edmonton)** | 2.2% | None | Multicultural Program - University of Alberta Hospital à Edmonton | Interpretation services available during the week; face-to-face service, requested by care provider | Navigation/ interpretation service offered by CANAVUA (2011) (volunteer organization) |
| **Yukon (Whitehorse)** | 15% à Whitehorse | The Languages Act recognizes French and English as the official languages | Service at the Whitehorse General Hospital; 120 bilingual professionals with high turnover | Interpretation service 3 hours per day on weekdays | Informal (family members and friends) |

# Appendix 2. Data collection tools

## COMMUNITY SURVEY OF FRANCOPHONES

**If you are Francophone, living in a minority community in Canada and have received social or health services, we are interested in your experience regarding services in French.** This short survey (6-8 minutes) is administered by a research team at the Université de Saint-Boniface in Manitoba which has received the approval of its research ethics committee. We would appreciate it if you would answer all the questions. There are no wrong answers. Your answers will remain confidential and anonymous. By answering the questions, you consent to participating in this study. The information collected will be used to inform decision makers in the health field regarding access to care in French for Francophone minority populations in Canada.

**Je réponds pour** : ❏ Myself ❏ A child ❏ An elderly parent ❏ A friend

### A- The first section pertains to your experience regarding access to social and health services

1) In general, access to social and health services in your community is:

❏ Excellent
❏ Very good
❏ Good
❏ Poor
❏ Non-Non-existent

2) Access to social and health services in French in your community is:

❏ Excellent
❏ Very good
❏ Good
❏ Poor
❏ Non-Non-existent

3) How important is it to you to receive services in French?

❏ Very aware
❏ Aware
❏ Not very aware
❏ Not aware
❏ I do not know

4) In your opinion, is the health system aware of Francophones' needs and their difficulties related to access to social and health services?

❏ Very aware
❏ Aware
❏ Not very aware
❏ Not aware
❏ I do not know

5) 5) In your opinion, how is the health system's response to the difficulties related to access to social and health services in French?

❏ Excellent
❏ Very Good
❏ Good
❏ Poor
❏ Non-existent

6) a. Based on your experience, which of the following options are available and improve your access to services in French: (you may select all the options that apply to you)

❏ a family doctor able to provide service in French
❏ other bilingual health professionals
- if applicable, which professions:

______________________________

❏ a name tag identifying a bilingual employee
❏ an interpreter's service in the health and social services field
❏ a navigator's service in the health and social services field
❏ a support service in the health and social services field
❏ a list or directory of social and health services in French in your community
❏ a brochure or written information in French on the topic of health
❏ a health form in French
❏ being asked in which language service is required
❏ advertising on the topic of social and health services in French
❏ a telephone service in French in the health and social services field
❏ other: (please specify) _______

______________________________

## Appendix 2. Data collection tools (continued)

### COMMUNITY SURVEY OF FRANCOPHONES

6) How well do the options selected above meet your language-related needs?

- ❑ Very adequately
- ❑ Adequately
- ❑ Not very adequately
- ❑ Inadequately
- ❑ I do not know

7) Which barriers prevent you from accessing services in French: (you may select all the options that apply to you)

- ❑ a shortage of bilingual social and health services professionals
- ❑ a greater distance to travel to access service in French
- ❑ a negative attitude among personnel regarding language
- ❑ limited or non-existent availability of interpretation service
- ❑ an extended wait for an appointment with a bilingual professional
- ❑ not being aware of the services available in French
- ❑ inferior quality of service
- ❑ other: (please specify) _______

________________________________

8) When you need social or health services, how often do you feel you need to have them in French?

- ❑ Always
- ❑ Often
- ❑ Occasionally
- ❑ Never
- ❑ I do not know

9) In which circumstances is it essential for you to receive services in French? __________

________________________________

10) When you need social or health services, what do you do: (you may select all the options that apply to you)

- ❑ I speak French, whether it is in person or by telephone
- ❑ I look for a service in French
- ❑ a family member or friend accompanies me as interpreter
- ❑ I request a bilingual worker
- ❑ I ask for interpretation, navigation or companion services
- ❑ I do the best that I can without assistance
- ❑ I do not request service
- ❑ I make a complaint when the service is not available in French
- ❑ I make an incident report when care received was inadequate due to language
- ❑ other: (please specify) _______

________________________________

11) What are the reasons why you would request assistance for language-related problems: (you may select all the options that apply to you)

- ❑ describing my symptoms in English
- ❑ understanding verbal instructions given by the care provider
- ❑ understanding written information in English
- ❑ completing forms in English
- ❑ navigating the health system, i.e. knowing where to go to get the right service
- ❑ receiving emotional support
- ❑ other: (please specify) _______

________________________________

________________________________

12) a. In order to receive social or health services in French, have you previously used:

- ❑ an interpretation service
  - if so, how?
  - ❑ in person
  - ❑ by telephone
  - ❑ remotely via the Internet or telemedicine
- ❑ a navigation service
- ❑ a support service
- ❑ CANAVUA services
  - if so, with which health professionnal?

________________________________

- where does he work? ________

________________________________

12) b. If you would be able to participate in a telephone interview lasting approximately 30 minutes to further discuss your experience with interpretation, navigation or companion services, please provide the following information:

Name: ______________________

Telephone number:

________________________________

E-mail address: : ______________

________________________________

# Appendix 2. Data collection tools (continued)

## COMMUNITY SURVEY OF FRANCOPHONES

**B- This second part enables us to better describe the survey participants. Your answers will be confidential and used for research purposes only.**

13) Sex

❑ Male
❑ Female

14) Age _______

15) Marital status

❑ Single
❑ Married
❑ Separated
❑ Divorced
❑ Widowed
❑ Comman law

16) Place of residence

❑ Rural region
❑ Urban region
VCity or town:

_______________________________

Postal code:

_______________________________

17) Highest level of education completed

❑ Elementary school
❑ High school
❑ College
❑ University - Bachelor's degree
❑ University - Graduate studies
❑ Other (please specify):

_______________________________

18) Personal annual income

❑ Less than $10,000
❑ $10,000 to $24,000
❑ $25,000 to $49,000
❑ $50,000 and over

19) Background

❑ Born in Canada
❑ In Canada for less than 5 years
❑ In Canada for over  5 years

20) First language learned, still understood and most often used in the home
❑ French
❑ English
❑ French and English
Other :

_______________________________

21) Fluency of conversational English during a medical consultation

❑ Excellent
❑ Very good
❑ Good
❑ Poor

Additional information:

_______________________________
_______________________________
_______________________________
_______________________________
_______________________________
_______________________________
_______________________________
_______________________________
_______________________________
_______________________________

**Thank you for participating in this study!**

# Appendix 2. Data collection tools (continued)

## INTERVIEW GRID FOR USERS

Thank you for agreeing to speak with us about your opinion and experience with the social and health services available in your community. I assure you that your remarks will be confidential and anonymous throughout this study. If you wish to end your participation along the way, you may do so at any time without consequences. Before we begin, do you consent to this interview being recorded for transcription purposes?

**Let's begin with some general questions on your opinion and experiences with social and health services in French.**

### A- Opinions on access to social and health services in French

According to your survey, you report that (*according to a summary of the participant's survey answers*).

1) Have you previously had an experience in the health sector where the working language was problematic, either for yourself or a member of your family? Can you describe this experience for me?

Probing further: Was there active offer?

Were you accompanied by a family member or friend who acted as an interpreter, or did you request assistance? Why or why not?

Are there situations in which you would not want to use the services of an interpreter?

Would you say that the language-related difficulty had an impact on your health in this case? Was there a difference in the quality of service received?

2) Generally, how do you go about getting services in French?

Probing further: What motivates you to seek services in French? What discourages you from doing so?

### B- Opinions on the services of an interpreter/navigator/companion service

You mentioned in your survey that you have used the following service:

______________________________________________ (specific name of the service in question)

1) Prior to your first experience with an interpreter/navigator/companion service, how did you feel about using this service?

2) What made you request this service?

Probing further: How did you hear about the service?

Did you request the service or was it offered to you?

Was it for yourself or for a family member?

Why did you decide to use this service?

## Appendix 2. Data collection tools (continued)

### INTERVIEW GRID FOR USERS

3) Could you describe, for us, your experience with this service based on the following aspects?

   a. Could you describe, for us, your experience with this service based on the following aspects?

   b. What did the interpreter/navigator/companion service do before, during and after the consultation?

   Probing further: If the worker had more than one role, which service was the most helpful and how could each be improved?

   c. How does this experience compare with a similar consultation with the same health professional without the assistance of the interpreter/navigator/companion service? (Please specify whether you were alone or accompanied.)

4) Could you evaluate the interpretation/navigation/companion services according to the following criteria:

   a. How trusting were you in the interpreter/navigator/companion services keeping your information confidential: in other words, that he would not discuss it with anyone else?

   ❏ Very confident ❏ Confident ❏ Not very confident ❏ Not confident ❏ I do not know

   b. b. How confident did you feel that the interpreter/navigator/companion service was accurately translating what the health professional was saying?

   ❏ Very confident ❏ Confident ❏ Not very confident ❏ Not confident ❏ I do not know

   c. How confident did you feel that the health professional had correctly understood your concerns with the help of the interpreter/navigator/companion service?

   ❏ Very confident ❏ Confident ❏ Not very confident ❏ Not confident ❏ I do not know

   d. How would you describe the ease and comfort of the health worker in working alongside the interpreter/navigator/companion service?

   ❏ Very comfortable ❏ Comfortable ❏ Not very comfortable ❏ Uncomfortable ❏ I do not know

   e. In your view, how good was your understanding of your condition and the prescribed treatment at the end of the consultation?

   ❏ Excellent ❏ Very good ❏ Good ❏ Poor ❏ I do not know

   f. Did you have any concerns or worries about the role of the interpreter/navigator/companion service?

   g. Did the health professional question you about your relationship with the interpreter/navigator/companion service?

   h. Did the health professional question the interpreter/navigator/companion service regarding his or her training or level of experience in this role?

   i. Would you use the same service? If so, why? If not, why not?

5) Would you like to add anything else about the interpretation/navigation/companion service or about social and health services in French in your community?

## Appendix 2. Data collection tools (continued)

### INTERVIEW GRID FOR INTERPRETERS/NAVIGATORS/COMPANION SERVICES

Thank you for agreeing to speak with us about your practice as an interpreter/navigator/companion service in the area of health in your community. I assure you that your remarks will be confidential and anonymous throughout the study. If you wish to end your participation along the way, you may do so at any time without consequences. Before we begin, do you consent to this interview being recorded for transcription purposes?

**Let's begin with some general questions about the accessibility of social and health services in French.**

1) Based on your experience, are health professionals aware of their Francophone patients' needs and these patients' challenges associated with access to social and health services?

- Are health professionals aware of the barriers and risks associated with language? What specific events lead you to believe this?
- How actively do health professionals facilitate access to language services for their Francophone patients? How do they do this (recommending interpretation services, requesting the assistance of a bilingual professional, practicing active offer)?

  – If this is not done, why, in your opinion?

2) You are in a position to observe services to Francophones in your community on a daily basis. Are you aware of any incidents or problems that have occurred between a patient and a health professional due to language? Could you expand on this, provide me with an example?

(What happened, what was the setting, how was the problem discovered, what risk was apparent to you, what did you do in response to this risk, how aware were the patient and health professional of the language challenge; what follow-up was done?)

**My next questions are aimed at better understanding your experience in the role of interpreter/navigator/ companion at ______________________________(name of the specific service).**

3) What is your main role in the health services offered for Francophones in your community?

– What are the specific roles and responsibilities related to your position as interpreter/navigator/companion service (specify individually for each role)?

- Can you give me details of what you do prior to a consultation with a health professional and a patient?
- Can you give me details of what you do during a consultation with a health professional and a patient?
- Can you give me details of what you do after a consultation with a health professional and a patient?

– Do you have a written job description for your position that you could share with me? What are the standard practices or ethics that you are supposed to follow and that you could share with me?

– In your role, are you requested or expected to do other tasks (like tasks related to interpretation, navigation or support, for example, that are not in your job description)? How do you feel about these additional tasks?

4) For whom and in what context do you offer your services?

- Why do patients request your services? (Ask about difficulties related to communicating in English, being a newcomer, needing emotional support, etc.)

## Appendix 2. Data collection tools (continued)

### INTERVIEW GRID FOR INTERPRETERS/NAVIGATORS/COMPANION SERVICES

5) How are your patients informed about the availability of your services?

6) How are health professionals informed about the availability of your services?

7) Why do you think your role is necessary? Could you tell me about an action on your part which seems to have had a positive effect?

8) How much is your role embraced by :

a. The patient?
b. The health professional consulted?
c. Other health professionals?
d. The health system in general?

- What events lead you to believe that your role is/is not well accepted by the above-mentioned groups (individually)?

9) How confident do you feel in your role as interpreter/navigator/companion service and why (helpful components may be training, experience, integration in the health system and being accepted by it, etc.)?

10) What training have you received for your role (each role individually, if more than one)?

- Ask for the details on training: where was it received, how long, when language testing was done and by whom, components of the training (ethics, standards medical terminology, interpretation, etc.)
- Earlier, you mentioned that your employer has/has not provided guidelines regarding ethics and practice standards for the roles of interpreter/navigator/companion service. Do you know of other guides on ethics or standards? That you use? What are they? (If you have received formal training, were these principles presented to you during training?)

**Finally, I would like your suggestions on interpretation/navigation/companion services in general and how these services could best be supported and improved on an ongoing basis.**

11) Which aspects of the service work well?

12) Where are there gaps in the service or where is service missing?

13) What suggestions would you have for improving the interpretation/navigation/companion services? (Definition of roles, making the role more visible in the health system or to health professionals, etc.)

14) Which additional support, resources or training would help you in your role/roles?

15) Is there anything else you would like to add on the topic of interpretation/navigation/companion services or health services in French in your community?

## Appendix 2. Data collection tools (continued)

### INTERVIEW GRID FOR INTERPRETERS/NAVIGATORS/COMPANION SERVICES

16) Sex

- ❏ Male
- ❏ Female

17) Age _______

18) Employer

______________________________

______________________________

19) Job

- ❏ Full-time
- ❏ Part-time

__________(hours/week)

Combined with another job: (Specify)

______________________________

______________________________

20) Previous experience in the health field

______________________________

______________________________

______________________________

______________________________

______________________________

21) Number of years in this or a similar role

______________________________

______________________________

22) Work location

City or town:

______________________________

Postal code:

______________________________

23) Background

- ❏ Born in Canada
- ❏ In Canada for less than 5 years
- ❏ In Canada for over 5 years

Additional comments:

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

**Thank you for participating in this study!**

# Appendix 3. Tables of socio-demographic profiles of the Francophone survey and interview participants

### TABLE 1: SOCIO-DEMOGRAPHIC PROFILES OF SURVEY PARTICIPANTS

| CHARACTERISTICS | Number of participants | Percentage |
|---|---|---|
| **SEX** | | |
| Female | 194 | 78.9 |
| Male | 52 | 21.1 |
| **AGE** | | |
| Average | 42.5 years | |
| Mean | 40 years | |
| **MARITAL STATUS** | | |
| Married or common-law relationship | 181 | 72.4 |
| Single, separated, divorced or widowed | 69 | 27.6 |
| **PLACE OF RESIDENCE** | | |
| Terre-Neuve-et-Labrador | 16 | 5.4 |
| North Simcoe Muskoka and Thunder Bay | 24 | 8.0 |
| Saskatchewan | 108 | 36.4 |
| Alberta | 53 | 17.8 |
| Region not specified by the participant | 96 | 32.3 |
| **HIGHEST LEVEL OF EDUCATION** | | |
| High school | 17 | 6.9 |
| College | 74 | 30.1 |
| University – bachelor's degree | 89 | 36.2 |
| University – graduate studies | 66 | 26.8 |
| **ANNUAL PERSONAL INCOME** | | |
| Less than $10,000 | 12 | 5.0 |
| $10,000 to $24,000 | 22 | 9.2 |
| $25,000 $ to $49,000 | 69 | 29.0 |
| $50 000 or more | 133 | 55.9 |
| **BACKGROUND** | | |
| Born in Canada | 169 | 68.4 |
| In Canada for less than 5 years | 29 | 11.7 |
| In Canada for over 5 years | 48 | 19.4 |
| **FIRST LANGUAGE LEARNED, STILL UNDERSTOOD AND MOST OFTEN USED IN THE HOME** | | |
| French | 188 | 78.0 |
| English | 8 | 3.3 |
| French and English | 45 | 18.7 |
| **FLUENCY OF CONVERSATIONAL ENGLISH DURING A MEDICAL CONSULTATION** | | |
| Excellent – Very good | 139 | 56.0 |
| Good | 68 | 27.4 |
| Poor | 41 | 16.5 |

## Appendix 3. Tables of socio-demographic profiles of the Francophone survey and interview participants (continued)

### TABLE 2: SOCIO-DEMOGRAPHIC PROFILES OF INTERVIEW PARTICIPANTS

| CHARACTERISTICS | Number of participants | Percentage |
|---|---|---|
| **SEX** | | |
| Female | 13 | 65 |
| Male | 7 | 35 |
| **AGE** | | |
| Average | 39.4 years | |
| Mean | 37 years | |
| **MARITAL STATUS** | | |
| Married or common-law relationship | 12 | 60 |
| Single or divorced | 8 | 40 |
| **PLACE OF RESIDENCE** | | |
| Rural | 8 | 40 |
| Urban | 12 | 60 |
| **HIGHEST LEVEL OF EDUCATION** | | |
| Elementary school – High school | 1 | 5 |
| College | 5 | 25 |
| University – bachelor's degree | 7 | 35 |
| University – graduate studies | 7 | 35 |
| **ANNUAL PERSONAL INCOME** | | |
| Less than $24,000 | 5 | 25 |
| $25,000 to $49,000 | 6 | 30 |
| $50,000 or more | 9 | 45 |
| **BACKGROUND** | | |
| Born in Canada | 12 | 63.5 |
| In Canada for less than 5 years | 5 | 26.3 |
| In Canada for over 5 years | 2 | 10.5 |
| **FIRST LANGUAGE LEARNED, STILL UNDERSTOOD AND MOST OFTEN USED IN THE HOME** | | |
| French | 17 | 85 |
| English | 1 | 5 |
| French and English | 2 | 10 |
| **FLUENCY OF CONVERSATIONAL ENGLISH DURING A MEDICAL CONSULTATION** | | |
| Excellent – Very good | 8 | 42.1 |
| Good | 3 | 15.8 |
| Poor | 8 | 42.1 |

# Appendix 4. Tables of survey findings by region

### 1. As a general rule, access to social and health services in your community is*:

| | | Newfoundland-and-Labrador | Muskoka and Thunder Bay | Saskatchewan | Alberta | Total[a] |
|---|---|---|---|---|---|---|
| Excellent - Very good | Participants | 9 | 14 | 62 | 31 | 160 |
| | % | 56.2 | 60.9 | 57.4 | 59.6 | 54.8 |
| Good | Participants | 5 | 6 | 34 | 8 | 84 |
| | % | 31.2 | 26.1 | 31.5 | 15.4 | 28.8 |
| Poor or non existent | Participants | 2 | 3 | 12 | 13 | 48 |
| | % | 12.5 | 13.0 | 11.1 | 25.0 | 16.4 |
| TOTAL | Participants | 16 | 23 | 108 | 52 | 292 |
| | % | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

[a] The total includes data for all participants of the regions indicated and the participants whose place of residence is unknown.
*Statistically significant difference at 5% between the four regions based on the chi-squared test or the Fisher exact test; p = 0.217.

### 2. Access to social and health services in French in your community is*:

| | | Newfoundland-and-Labrador | Muskoka and Thunder Bay | Saskatchewan | Alberta | Total |
|---|---|---|---|---|---|---|
| Excellent - Very good | Participants | 0 | 1 | 6 | 7 | 20 |
| | % | 0.0 | 4.2 | 5.6 | 13.5 | 6.8 |
| Good | Participants | 0 | 4 | 11 | 10 | 48 |
| | % | 0.0 | 16.7 | 10.3 | 19.2 | 16.4 |
| Poor or non existant | Participants | 16 | 19 | 90 | 35 | 225 |
| | % | 100.0 | 79.2 | 84.1 | 67.3 | 76.8 |
| TOTAL | Participants | 16 | 24 | 107 | 52 | 293 |
| | % | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

[a] Statistically significant difference at 5% between the four regions based on the chi-squared test or the Fisher exact test; p = 0.090.

# Appendix 4. Tables of survey findings by region (continued)

### 3. How important is it for you to receive services in French?*

| | | Newfoundland-and-Labrador | Muskoka and Thunder Bay | Saskatchewan | Alberta | Total |
|---|---|---|---|---|---|---|
| Very important - important | Participants | 14 | 24 | 86 | 48 | 253 |
| | % | 87.5 | 100.0 | 80.4 | 90.6 | 86.0 |
| Not very or not important | Participants | 2 | 0 | 21 | 5 | 43 |
| | % | 12.5 | 0,0 | 19.6 | 9.4 | 14.0 |
| TOTAL | Participants | 16 | 24 | 107 | 53 | 296 |
| | % | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

[a]Statistically significant difference at 5% between the four regions based on the chi-squared test or the Fisher exact test; p = 0.079.

### 4. In your opinion, is the health system aware of the needs of Francophones and the difficulties associated with access to social and health services for them?*

| | | Newfoundland-and-Labrador | Muskoka and Thunder Bay | Saskatchewan | Alberta | Total |
|---|---|---|---|---|---|---|
| Very aware - aware | Participants | 1 | 5 | 11 | 7 | 43 |
| | % | 6.2 | 20.8 | 10.8 | 14.6 | 15.7 |
| Not very aware | Participants | 12 | 15 | 51 | 27 | 146 |
| | % | 75.0 | 62.5 | 50.0 | 56.2 | 53.3 |
| Unaware | Participants | 3 | 4 | 40 | 14 | 85 |
| | % | 18.8 | 16.7 | 39.2 | 29.2 | 31.0 |
| TOTAL | Participants | 16 | 24 | 102 | 48 | 274 |
| | % | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

[a]Statistically significant difference at 5% between the four regions based on the chi-squared test or the Fisher exact test; p = 0.233.

# Appendix 4. Tables of survey findings by region (continued)

## 5. In your opinion, how well does the health system respond to the difficulties associated with access to social and health services in French?*

| | | Newfoundland-and-Labrador | Muskoka and Thunder Bay | Saskatchewan | Alberta | Total |
|---|---|---|---|---|---|---|
| Excellent - very well | Participants | 0 | 1 | 5 | 2 | 13 |
| | % | 0.0 | 4.2 | 4.7 | 3.8 | 4.6 |
| Well | Participants | 0 | 4 | 8 | 13 | 45 |
| | % | 0.0 | 16.7 | 7.5 | 25.0 | 15.8 |
| Poorly | Participants | 12 | 16 | 75 | 32 | 185 |
| | % | 75.0 | 66.7 | 70.1 | 61.5 | 64.9 |
| Not at all | Participants | 4 | 3 | 19 | 5 | 42 |
| | % | 25.0 | 12.5 | 17.8 | 9.6 | 14.7 |
| TOTAL | Participants | 16 | 24 | 107 | 52 | 285 |
| | % | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

[a]Statistically significant difference at 5% between the four regions based on the chi-squared test or the Fisher exact test; p = 0.099.

## Appendix 4. Tables of survey findings by region (continued)

### 6a. Based on your experience, which of the following options are available and improve your access to services in French: (You may select all the options that apply to you)

| | | Newfoundland-and-Labrador | Muskoka and Thunder Bay | Saskatchewan | Alberta | Total | p* |
|---|---|---|---|---|---|---|---|
| Bilingual family doctor | Participants | 5 | 16 | 53 | 36 | 145 | 0.017 |
| | % | 31.2 | 66.7 | 49.1 | 67.9 | 48.8 | |
| Other bilingual health professional | Participants | 4 | 11 | 60 | 30 | 144 | 0.114 |
| | % | 25.0 | 45.8 | 55.6 | 56.6 | 48.5 | |
| Name tag | Participants | 4 | 7 | 24 | 10 | 69 | 0.749 |
| | % | 25.0 | 29.2 | 22.2 | 18.9 | 23.2 | |
| Interpretation service | Participants | 8 | 7 | 25 | 14 | 70 | 0.171 |
| | % | 50.0 | 29.2 | 23.1 | 26.4 | 23.6 | |
| Navigation service | Participants | 2 | 5 | 12 | 10 | 40 | 0.411 |
| | % | 12.5 | 20.8 | 11.1 | 18.9 | 13.5 | |
| Companion service | Participants | 1 | 4 | 16 | 13 | 41 | 0.328 |
| | % | 6.2 | 16.7 | 14.8 | 24.5 | 13.8 | |
| Directory of services in FR | Participants | 7 | 14 | 58 | 28 | 133 | 0.839 |
| | % | 43.8 | 58.3 | 53.7 | 52.8 | 44.8 | |
| Brochures/ information in FR | Participants | 4 | 12 | 35 | 17 | 94 | 0.325 |
| | % | 25.0 | 50.0 | 32.4 | 32.1 | 31.6 | |
| Health forms in FR | Participants | 3 | 10 | 28 | 19 | 81 | 0.241 |
| | % | 18.8 | 41.7 | 25.9 | 35.8 | 27.3 | |
| Being asked in which language service is required | Participants | 5 | 9 | 24 | 19 | 77 | 0.190 |
| | % | 31.2 | 37.5 | 22.2 | 35.8 | 25.9 | |
| Advertising of services in FR | Participants | 3 | 8 | 24 | 14 | 64 | 0.630 |
| | % | 18.8 | 33.3 | 22.2 | 26.4 | 21.5 | |
| FR telephone service | Participants | 3 | 10 | 35 | 17 | 85 | 0.527 |
| | % | 18.8 | 41.7 | 32.4 | 32.1 | 28.6 | |

[a] Statistically significant difference at 5% between the four regions based on the chi-squared test or the Fisher exact test.

# Appendix 4. Tables of survey findings by region (continued)

## 6b. How well do the above selected options fulfill your language needs?*

| | | Newfoundland-and-Labrador | Muskoka and Thunder Bay | Saskatchewan | Alberta | Total |
|---|---|---|---|---|---|---|
| Very adequately - adequately | Participants | 7 | 12 | 42 | 31 | 127 |
| | % | 46.7 | 50.0 | 40.0 | 63.3 | 47.9 |
| Not very adequately - inadequately | Participants | 8 | 11 | 55 | 16 | 125 |
| | % | 53.3 | 45.8 | 52.4 | 32.7 | 47.2 |
| I do not know | Participants | 0 | 1 | 8 | 2 | 13 |
| | % | 0.0 | 4.2 | 7.6 | 4.1 | 4.95 |
| TOTAL | Participants | 15 | 24 | 105 | 49 | 265 |
| | % | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

[a] Statistically significant difference at 5% between the four regions based on the chi-squared test or the Fisher exact test; p = 0.214.

## 7. Which barriers prevent you from accessing services in French: (You may select all the options that apply to you)

| | | Newfoundland-and-Labrador | Muskoka and Thunder Bay | Saskatchewan | Alberta | Total | p* |
|---|---|---|---|---|---|---|---|
| Shortage of bilingual professionals | Participants | 11 | 21 | 82 | 38 | 198 | 0.419 |
| | % | 68.8 | 87.5 | 75.9 | 71.7 | 66.7 | |
| Greater distance to travel | Participants | 4 | 14 | 24 | 21 | 85 | 0.002 |
| | % | 25.0 | 58.3 | 22.2 | 39.6 | 28.6 | |
| Negative attitude of personnel | Participants | 4 | 13 | 29 | 14 | 79 | 0.066 |
| | % | 25.0 | 54,2 | 26,9 | 26,4 | 26,6 | |
| Limited or non-existent availability | Participants | 8 | 13 | 46 | 17 | 110 | 0.260 |
| | % | 50.0 | 54.2 | 42.6 | 32.1 | 37.0 | |
| Extended wait | Participants | 1 | 6 | 18 | 14 | 60 | 0.231 |
| | % | 6.2 | 25.0 | 16.7 | 26.4 | 20.2 | |
| Unawareness of the existence of services available in FR | Participants | 11 | 13 | 62 | 33 | 159 | 0.742 |
| | % | 68.8 | 54.2 | 57.4 | 62.3 | 53.5 | |
| Poorer quality of service | Participants | 0 | 4 | 18 | 2 | 31 | 0.030 |
| | % | 0.0 | 16.7 | 16.7 | 3.8 | 10.4 | |

[a] Statistically significant difference at 5% between the four regions based on the chi-squared test or the Fisher exact test.

## Appendix 4. Tables of survey findings by region (continued)

### 8. When you need social or health services, how often do you feel you need them in French?*

| | | Newfoundland-and-Labrador | Muskoka and Thunder Bay | Saskatchewan | Alberta | Total |
|---|---|---|---|---|---|---|
| Always - often | Participants | 8 | 19 | 46 | 28 | 138 |
| | % | 50.0 | 79.2 | 45.1 | 52.8 | 52.1 |
| Sometimes | Participants | 6 | 4 | 41 | 21 | 95 |
| | % | 37.5 | 16.7 | 40.2 | 39.6 | 35.8 |
| Never | Participants | 1 | 0 | 13 | 4 | 27 |
| | % | 6.2 | 0.0 | 12.7 | 7.5 | 10.2 |
| I do not know | Participants | 1 | 1 | 2 | 0 | 5 |
| | % | 6.2 | 4.2 | 2.0 | 0.0 | 1.9 |
| TOTAL | Participants | 16 | 24 | 102 | 53 | 265 |
| | % | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

[a] Statistically significant difference at 5% between the four regions based on the chi-squared test or the Fisher exact test; p = 0.067.

## Appendix 4. Tables of survey findings by region (continued)

### 9. When you need social or health services, what do you do: (You may select all the options that apply to you)

| | | Newfoundland-and-Labrador | Muskoka and Thunder Bay | Saskatchewan | Alberta | Total | p* |
|---|---|---|---|---|---|---|---|
| I speak in French | Participants | 0 | 12 | 16 | 6 | 47 | 0.000 |
| | % | 0.0 | 50.0 | 14.8 | 11.3 | 15.8 | |
| I look for a service in French | Participants | 3 | 19 | 37 | 26 | 117 | 0.000 |
| | % | 18.8 | 79.2 | 34.3 | 49.1 | 39.4 | |
| Someone comes with me | Participants | 2 | 7 | 17 | 8 | 45 | 0.417 |
| | % | 12.5 | 29.2 | 15.7 | 15.1 | 15.2 | |
| I request a bilingual worker | Participants | 1 | 6 | 15 | 7 | 35 | 0.428 |
| | % | 6.2 | 25.0 | 13.9 | 13.2 | 11.8 | |
| I request interpretation, navigation or support service | Participants | 0 | 1 | 1 | 4 | 9 | 0.100 |
| | % | 0.0 | 4.2 | 0.9 | 7.5 | 3.0 | |
| I do the best that I can without assistance | Participants | 10 | 11 | 62 | 34 | 153 | 0.493 |
| | % | 62.5 | 45.8 | 57.4 | 64.2 | 51.5 | |
| I don't request service | Participants | 5 | 2 | 26 | 11 | 63 | 0.272 |
| | % | 31.2 | 8.3 | 24.1 | 20.8 | 21.2 | |
| I make a complaint when the service is not available | Participants | 0 | 1 | 3 | 1 | 6 | 0.783 |
| | % | 0.0 | 4.2 | 2.8 | 1.9 | 2.0 | |
| I file an incident report | Participants | 0 | 3 | 0 | 1 | 5 | 0.004 |
| | % | 0.0 | 12.5 | 0.0 | 1.9 | 1.7 | |

[a] Statistically significant difference at 5% between the four regions based on the chi-squared test or the Fisher exact test.

## Appendix 4. Tables of survey findings by region (continued)

### 10. For which reasons would you request assistance for language-related difficulties: (You may select all the options that apply to you)

| | | Newfoundland-and-Labrador | Muskoka and Thunder Bay | Saskatchewan | Alberta | Total | p* |
|---|---|---|---|---|---|---|---|
| Describing my symptoms in English | Participants | 10 | 17 | 62 | 37 | 155 | 0.384 |
| | % | 62.5 | 70.8 | 57.4 | 69.8 | 52.2 | |
| Understanding verbal instructions from the worker | Participants | 7 | 13 | 42 | 22 | 113 | 0.603 |
| | % | 43.8 | 54.2 | 38.9 | 41.5 | 38.0 | |
| Understanding written information | Participants | 5 | 7 | 17 | 10 | 53 | 0.249 |
| | % | 31.2 | 29.2 | 15.7 | 18.9 | 17.8 | |
| Completing forms in English | Participants | 4 | 7 | 32 | 13 | 73 | 0.931 |
| | % | 25.0 | 29.2 | 29.6 | 24.5 | 24.6 | |
| Navigating the health system | Participants | 5 | 8 | 24 | 13 | 77 | 0.599 |
| | % | 31.2 | 33.3 | 22.2 | 24.5 | 25.9 | |
| Receiving emotional support | Participants | 9 | 14 | 44 | 22 | 107 | 0.313 |
| | % | 56.2 | 58.3 | 40.7 | 41.5 | 36.0 | |

[a] Statistically significant difference at 5% between the four regions based on the chi-squared test or the Fisher exact test.

### 11. In order to receive social or health services in French, have you previously used:

| | | Newfoundland-and-Labrador | Muskoka and Thunder Bay | Saskatchewan | Alberta | Total | p* |
|---|---|---|---|---|---|---|---|
| An interpretation service | Participants | 1 | 1 | 10 | 7 | 24 | 0.748 |
| | % | 6.2 | 4.5 | 9.3 | 13.2 | 9.4 | |
| A navigation service | Participants | 1 | 0 | 14 | 7 | 26 | 0.290 |
| | % | 6.2 | 0.0 | 13.1 | 13.2 | 10.4 | |
| A companion service | Participants | 2 | 2 | 2 | 0 | 10 | 0.024 |
| | % | 12.5 | 8.7 | 1.9 | 0.0 | 4.0 | |

[a] Statistically significant difference at 5% between the four regions based on the chi-squared test or the Fisher exact test.

# Appendix 4. Tables of survey findings by region (continued)

## 12. Sex*

| | | Newfoundland-and-Labrador | Muskoka and Thunder Bay | Saskatchewan | Alberta | Total |
|---|---|---|---|---|---|---|
| Male | Participants | 4 | 1 | 26 | 15 | 52 |
| | % | 25.0 | 4.2 | 25.0 | 28.3 | 21.1 |
| Female | Participants | 12 | 23 | 78 | 38 | 194 |
| | % | 75.0 | 95.8 | 75.0 | 71.7 | 78.9 |
| TOTAL | Participants | 16 | 24 | 104 | 53 | 246 |
| | % | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

[a]Statistically significant difference at 5% between the four regions based on the chi-squared test or the Fisher exact test; p = 0.080.

## 13. Marital status*

| | | Newfoundland-and-Labrador | Muskoka and Thunder Bay | Saskatchewan | Alberta | Total |
|---|---|---|---|---|---|---|
| Married or common-law relationship | Participants | 8 | 19 | 79 | 40 | 181 |
| | % | 50.0 | 79.2 | 75.2 | 75.5 | 73.0 |
| Single, separated or divorced | Participants | 8 | 5 | 26 | 13 | 67 |
| | % | 50.0 | 20.8 | 24.8 | 24.5 | 27.0 |
| TOTAL | Participants | 16 | 24 | 105 | 53 | 248 |
| | % | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

[a]Statistically significant difference at 5% between the four regions based on the chi-squared test or the Fisher exact test; p = 0.155.

## Appendix 4. Tables of survey findings by region (continued)

### 14. Highest level of education completed*

| | | Newfoundland-and-Labrador | Muskoka and Thunder Bay | Saskatchewan | Alberta | Total |
|---|---|---|---|---|---|---|
| Elementary – High school | Participants | 0 | 1 | 8 | 7 | 17 |
| | % | 0.0 | 4.2 | 7.6 | 13.7 | 6.9 |
| College | Participants | 7 | 6 | 23 | 18 | 74 |
| | % | 43.8 | 25.0 | 21.9 | 35.3 | 30.1 |
| University – Bachelor's degree | Participants | 3 | 12 | 42 | 16 | 89 |
| | % | 18.8 | 50.0 | 40.0 | 31.4 | 36.2 |
| University – Graduate studies | Participants | 6 | 5 | 32 | 10 | 66 |
| | % | 37.5 | 20.8 | 30.5 | 19.6 | 26.8 |
| TOTAL | Participants | 16 | 24 | 105 | 51 | 246 |
| | % | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

[a]Statistically significant difference at 5% between the four regions based on the chi-squared test or the Fisher exact test; p = 0.171.

### 15. Annual personal income*

| | | Newfoundland-and-Labrador | Muskoka and Thunder Bay | Saskatchewan | Alberta | Total |
|---|---|---|---|---|---|---|
| Less than $10,000 | Participants | 0 | 0 | 6 | 5 | 12 |
| | % | 0.0 | 0.0 | 5.9 | 9.8 | 5.0 |
| $10,000 to $24,000 | Participants | 2 | 1 | 8 | 6 | 22 |
| | % | 13.3 | 4.2 | 7.9 | 11.8 | 9.2 |
| $25,000 to $49,000 | Participants | 6 | 10 | 28 | 11 | 69 |
| | % | 40.0 | 41.7 | 27.7 | 21.6 | 29.0 |
| $50,000 and more | Participants | 7 | 13 | 58 | 28 | 133 |
| | % | 46.7 | 54.2 | 57.4 | 54.9 | 55.9 |
| TOTAL | Participants | 15 | 24 | 100 | 50 | 238 |
| | % | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

[a]Statistically significant difference at 5% between the four regions based on the chi-squared test or the Fisher exact test; p = 0.675.

# Appendix 4. Tables of survey findings by region (continued)

## 16. Background*

| | | Newfoundland-and-Labrador | Muskoka and Thunder Bay | Saskatchewan | Alberta | Total |
|---|---|---|---|---|---|---|
| Born in Canada | Participants | 14 | 18 | 66 | 35 | 169 |
| | % | 87.5 | 75.0 | 62.3 | 66.0 | 68.4 |
| In Canada for less than 5 years | Participants | 1 | 3 | 13 | 8 | 29 |
| | % | 6.2 | 12.5 | 12.3 | 15.1 | 11.7 |
| In Canada for over 5 years | Participants | 1 | 3 | 27 | 10 | 48 |
| | % | 6.2 | 12.5 | 25.5 | 18.9 | 19.4 |
| TOTAL | Participants | 16 | 24 | 106 | 53 | 247 |
| | % | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

[a]Statistically significant difference at 5% between the four regions based on the chi-squared test or the Fisher exact test; p = 0.489.

## 17. First language learned, still understood and most often used at home*

| | | Newfoundland-and-Labrador | Muskoka and Thunder Bay | Saskatchewan | Alberta | Total |
|---|---|---|---|---|---|---|
| French | Participants | 10 | 21 | 80 | 40 | 188 |
| | % | 66.7 | 87.5 | 79.2 | 78.4 | 78.0 |
| English | Participants | 1 | 0 | 3 | 1 | 8 |
| | % | 6.7 | 0.0 | 3.0 | 2,0 | 3.3 |
| French and English | Participants | 4 | 3 | 18 | 10 | 45 |
| | % | 26.7 | 12.5 | 17.8 | 19.6 | 18.7 |
| TOTAL | Participants | 15 | 24 | 101 | 51 | 241 |
| | % | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

[a]Statistically significant difference at 5% between the four regions based on the chi-squared test or the Fisher exact test; p = 0.729.

# Appendix 4. Tables of survey findings by region (continued)

## 18. Fluency of conversational English during a medical consultation*

| | | Newfoundland-and-Labrador | Muskoka and Thunder Bay | Saskatchewan | Alberta | Total |
|---|---|---|---|---|---|---|
| Excellent – very good | Participants | 7 | 11 | 59 | 33 | 139 |
| | % | 43.8 | 47.8 | 56.2 | 62.3 | 56.0 |
| Good | Participants | 6 | 7 | 30 | 13 | 68 |
| | % | 37.5 | 30.4 | 28.6 | 24.5 | 27.4 |
| Good | Participants | 3 | 5 | 16 | 7 | 41 |
| | % | 18.8 | 21.7 | 15.2 | 13.2 | 16.5 |
| TOTAL | Participants | 16 | 23 | 105 | 53 | 248 |
| | % | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

[a]Statistically significant difference at 5% between the four regions based on the chi-squared test or the Fisher exact test; p = 0.809.

## Appendix 5. Interpreter-companion service's tasks

The request for interpretation or support service is generally made by the patient who contacts the coordinating organization. The patient speaks directly to the interpreter-companion service if he is an employee or to the service coordinator who then contacts the volunteer interpreter-companion service. If the need to be physically accompanied is expressed by the patient, transportation is provided by the interpreter-companion service. At the doctor's office or where the care is given, the interpreter-companion service meets with the patient prior to going into the care provider's office. For some patients, particularly the elderly, the interpreter-companion service introduces himself with the patient at reception in order to give notice that the patient has arrived. If the patient is able, he is invited to take over the situation or to observe how to do so, as one participant describes: "*If it is someone who just has a language problem, to help the person learn what to do, I take the person with me to reception, I speak and the person is there hearing everything I say. For me, this is valuing the person*". In the patient's presence, the interpreter-companion service introduces himself to the health professional and briefly explains his role. In some cases, the health professional will verify the patient's consent to the presence of a third party during the consultation. This consent is provided verbally. The medical appointment then continues with the health professional starting the conversation and the interpreter-companion service interpreting in the patient's language. The patient may then ask questions which the interpreter-companion service translates for the care provider. So, this is consecutive interpretation.

During the consultation, an interpreter-companion service reports that he writes down what is discussed and after the consultation, takes up certain items with the patient. Without asking directly, the interpreter asks the patient some questions to make sure that the patient has correctly understood. After the consultation, the interpreter-companion service finds out about expected follow-ups, like making future appointments, support for diagnostic tests, or getting new prescriptions filled: "*I also accompany them for mammography or ultrasounds during pregnancies, for example. I interpret even while that is going on*". Some will also translate instructions to be followed into French to make sure that the patient understands what he needs to do. Only when the patient has finished his tests and received a prescription, as the case may be, will the interpreter-companion service bring the patient back home, thereby ending his or her involvement. Occasionally, however, the interpreter-companion service will contact a particularly vulnerable patient a few days later, mainly to reassure the patient that no news is generally a sign that everything is fine, or to remind the patient that there is a follow-up coming. Others will contact the doctor's office to find out the next steps or be updated as to next steps or of the progression of the patient's file.

Coordinating the service is a bit different regarding volunteer interpreter-companion services. From the time the volunteer agrees to support a patient, there is communication between the interpreter-companion service coordinator and the volunteer to check that the latter is familiar with the patient's profile and ensure he understands the specifics of his role with the patient. Similarly, follow-up is done with the service coordinator for reporting and sharing, where appropriate, whether further medical monitoring is needed in the coming days.

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