CULTURAL DIMENSIONS OF LINGUISTIC BARRIERS IN HEALTH CARE

Hospitable Networks: Quebec's Community Development Approach to the Linguistic and Cultural Dimensions of Health Care

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Introduction

This paper uses the case of Quebec's English-speaking minority communities to examine the role of community sector organizations in the provision of culturally appropriate health care. It is argued that the community development approach is distinguished from prevailing strategies by its multidimensional and structurally embedded impact upon a locally relevant continuum of care.

Approaches to Linguistic and Culturally Appropriate Care

Much of the discussion around culturally appropriate health care in the context of globalizing populations is focused upon the issue of the linguistic and cultural competence of care providers. Prevailing strategies seek to develop the linguistic competence and cultural sensitivity of care providers as an important feature of their medical expertise and to improve the "receptivity" of public health institutions as "hosts" of the ethno- culturally diverse groups they serve (Kirmayer, 2012; Allen, 2008). The promotion of "cultural safety" generally refers to reducing barriers to open, reciprocal and safe places in clinical services (Brown et al., 2009; Brascoupe & Waters, 2009) and is considered to be a means to improve the rapport of health practitioner and patient and thus improve treatment outcomes. Within this framework, community organizations and networks are acknowledged but largely as potentially useful resources for health and social service practitioners seeking to identify and mobilize extra-institutional support for their patients (Kirmayer, 2011).

In contrast, the community development approach addresses linguistic and cultural barriers but assigns different roles to the actors within the health care scenario .The focus shifts from the cultural competence of health professionals and cultural safety within clinical settings to the inclusion of patients, through their community advocates, in the decision-making and planning of the bureaucratic and complex structures that characterize modern medicine. In this model, the linguistic and cultural competence of the care provider is but one indicator of culturally appropriate care alongside the equally important measure of networking among minority community organizations and their partnerships with public health authorities (Nowell & Hanson, 2011). The exchange between care provider and patient is not restricted to the medical setting and the associated power structure implied in even the most receptive clinical services but extends to the patients' local community network and the hospitable space they create within their territory for this encounter. One telltale marker of this approach, for example, is the emergence of health professionals who are "boundary crossers", in that they move freely between domains like that of public institutions and community level organizations and have the trust of both domains (Kilpatrick, Cheers, Gilles & Taylor, 2009).

It cannot be argued that the community development approach *replaces* efforts to enhance the cultural competence of health professionals and receptivity of public health institutions and agencies. However, the case of Quebec does recommend that in redefining the role of minority community organizations the impact of promoting culturally appropriate care is enhanced. Cultural dimensions are considered not only in terms of the efficacy of individual treatment but also as incorporated and sustained at the level of system structure. Whether long-standing citizens or newcomers, community organizations assist patients in identifying social support networks and trajectories to services at the community level and also ensure their ongoing representation in the policy and planning of "their" public institutions.

The Case of Quebec's English-speaking Communities and their Networking and Partnership Initiative in the Health and Social Service Sector

Profile of Quebec's English-speaking Minority Communities

Today, Quebec is the only Canadian province that has a predominantly French-speaking population and French as the sole official language at the provincial level**.** Quebec's English-speaking communities form a numerical, linguistic and cultural minority within the province and are noted for their diverse ethno-cultural composition. According to the 2006 Census of Canada, nearly one third (32.6%) of English-speakers in Quebec are immigrants which is a rate more than four times that found in the Quebec Francophone population (OCOL, forthcoming). There are 240,295 English speakers in Quebec who are also members of the visible minority population representing 24.2% of the provincial English-speaking population. (CHSSN, 2012, p.3)Quebec's English-speaking community tends to be composed of a large percentage of newcomers from outside of the province of Quebec and outside of Canada. Across Quebec, there are 101,175 English speakers who arrived from outside of Quebec between 2001 and 2006. In 2006, this in-migrant group represented 10.6% of the English-speaking population (OCOL, forthcoming). In 2011, there were 20,638 English-speakers living in the Nord-du-Quebec region most of whom are members of Canada's aboriginal peoples (QCGN, 2013, p.10).

According to the 2011 census, 65.5% of Quebec's English-speakers are able to communicate in both of Canada's official languages although this varies widely across the regions of the province from 17.5% in Nord-du-Quebec to 90.8% in the Mauricie region (QCGN, 2013, p.22). Knowledge of French is notably low among English-speakers 65 years and over and among newcomers to the province. Language barriers in health prevention and treatment services – particularly in mental health – are evident even among those with knowledge of French due to the distress of illness and the lack of familiarity with the lexicon of medical procedure.

Community Health and Social Services Network (CHSSN) and the Networking and Partnership Initiative (NPI) 2003-2013

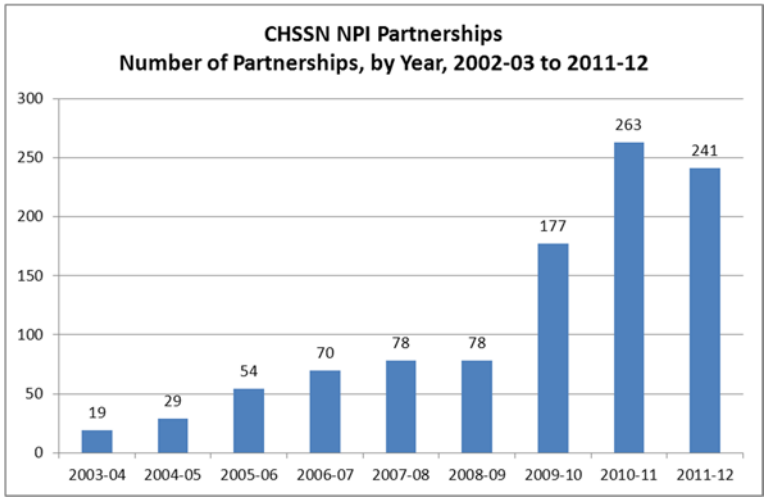
Through the Community Health and Social Services Network (CHSSN)[1] and Health Canada's official language strategy[2], 19 community networks have been established across Quebec's territory as focal points for addressing the priorities of English speakers with respect to the health

[1] For further description of the CHSSN and its Networking and Partnership Initiative see the CHSSN *Baseline Data Report* http://www.chssn.org/En/pdf/2013_Baseline_Data_Report_final_En.pdf, p.1-8.

[2] For further description of Health Canada's strategy go to http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/rapb-dgrp/pd-dp/olcdb-baclo-eng.php

and social service system. Many of these are housed within regional community organizations that have a long tradition in the lives of English speakers and reflect the dedication to the community sector that is a distinguishing characteristic of Quebec's minority language group[3].

NPI networks are trained in community consultation and in the use of an evidence-base that profiles the situation of their local English-speaking communities in terms of key health determinants[4], socio-demographic features and health and social service access. Information that is tailored to the level of CSSS[5] (health clinic) territory and captures the diverse ethnocultural background and social environment of the patient population lays the foundation for establishing partnerships with public health authorities and influencing policy promoting linguistic and culturally appropriate care. These include partnering with health and social service centers delivering primary level care as well as regional planning authorities who, in turn, integrate this knowledge within their action plans .The figure below demonstrates the rate of growth of NPI partnerships with public health agencies between 2003 and 2012.[6]



[3] Indicators of community sector participation such as high levels of volunteerism (CHSSN, 2006) as well as tendency to rely on community organizations for health and social service information and as a source of support in the event of illness (CHSSN, 2006 and 2011) point to a pattern of conduct and pathway to care which distinguishes Quebec's minority language group from the majority.

[4] Health Canada lists some twelve health determinants that have been shown to have a strong influence on the health status of a population among which access to health services is included. For further discussion see Raphael, D. (Ed.) (2008). *Social Determinants of Health: Canadian Perspectives.* Toronto: Canadian Scholar's Press. See also, Mikkoven, J and Raphael, D. (2010) *Social Determinants of Health: The Canadian Facts.* http://www.thecanadianfacts.org/ and WHO, Social Determinants of Health website http://www.who.int/social_determinants/en/.

[5] CSSS is the French acronym for *Centre de santé et des services sociaux*. This is translated into English as *Health and Social Service Center.*

[6] This figure was first produced by the author for the CHSSN *Baseline Data Report* 2012-2013 http://www.chssn.org/En/pdf/2013_Baseline_Data_Report_final_En.pdf , p.6.

Minority Language Community Networks as Host

Quebec's NPI partnerships with public agencies have given rise to a myriad of innovative practices designed to increase timely and culturally appropriate engagement between health care agencies and Quebec's minority language population. Both the community development approach and the model promoting the cultural competence of health experts hold the overall objectives of increased institutional engagement and improved treatment success but their different tactics lend the former the advantage of an impact that reaches a wider range of implicated players. An example that underscores this difference is the emergence of health professionals who move beyond the medical domain to engage patients in a setting provided by their community network. In the words of NPI leaders themselves[7],

> *We have wonderful feedback from our workshops where we have professionals come in to speak with our communities in English…Workshops with different topics, like anxiety prevention, also take place in the schools to reach out to English-speaking families and youth. (NPI Coordinator, 2013)*
>
> *… we use teleconferencing to bring medical expertise and network communities together… Or, we find a free room and invite a professional from the CSSS to attend the session and lead discussion about a health problem and local services. These sessions have led to the development of peer support groups – a Parkinson's group, a prostate cancer group, a caregiving support group, and bereavement group. There has been incredible support from doctors and it is not easy to liberate a professional for such an event.* (NPI Coordinator, 2013)

The impact of these visiting experts or "boundary crossers" touches many dimensions along the continuum of care. For the doctors and nurses, entering the "turf" of the patients' community and speaking their language is, in itself, training in their culture. For the patient community, knowledge of health services, treatment procedures and health conditions is transferred in a familiar, small-scale setting and in the company of supportive others. The stigma of lacking language skills is reduced as well as the pressure to process information in the limited time allotted in a doctor's office or clinical setting. Whether newcomer to a disease, or to Canada, social support within the patients' culturally safe milieu is mobilized and isolation is reduced. Successful knowledge transfer and improved trust ultimately leads to improved patient engagement of public health services. For community organizations, the sessions allow them to monitor the needs of the patient community and astutely advise the health and social service authorities with whom they partner.

Conclusion

The profile of Quebec's culturally diverse English speaking minority communities indicates that they play an important role as hosts to newcomers to the province. Through the community development approach in the health sector, their hospitable networks impact a range of players located in this minority and at different levels of the public health system with whom they partner. In this way, they lay the ground for a local and collaboratively formed trajectory to improved treatment success.

[7] These are the words from interviews with NPI coordinators reported by the author with their permission.

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