

AN INSTITUTIONAL ETHNOGRAPHIC ANALYSIS OF THE ORGANIZATION OF
FRENCH HEALTHCARE AND DISABILITY SERVICES FOR FRANCOPHONES IN
CANADA

by

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Honours Bachelor of Arts in Second Language Teaching (French as a Second Language) (French
Immersion Stream), University of Ottawa, 2020

An MRP

presented to Ryerson University

in partial fulfillment of the
requirements for the degree of

Master of Arts

in the program of

Early Childhood Studies

Toronto, Ontario, Canada

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ABSTRACT

An Institutional Ethnographic Analysis of the Organization of French Healthcare and Disability Services for Francophones in Canada

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This Institutional Ethnographic study analyzes how the Canadian healthcare systems in the provinces of Manitoba, Ontario, and the Northwest Territories are organized around the French language. Eight Francophone parents of disabled children were interviewed from 2015 onwards as part of the Inclusive Early Childhood Service System Project. The participants' experiences describe how the healthcare systems force minority-language speakers to conform to the monolingual Anglophone systems by making them speak English and having limited availability of French services and health information. Additionally, the data detailed the work that French-speaking families do to use services in their chosen language, such as being advocates for their child, travelling to French services, and navigating the healthcare system with little help from healthcare professionals. The findings demonstrate that the Canadian provincial and territorial healthcare systems are organized in a monolingual way and more needs to be done to help all minority-language speakers in Canada.

ACKNOWLEDGEMENTS

I would like to acknowledge the continuous support, encouragement, and contributions from my supervisor and the principal investigator of the Inclusive Early Childhood Service System (IECSS) project, where my study originated from, Dr. Kathryn Underwood. The IECSS team also contributed to my work throughout this project. I would also like to acknowledge the assistance that I got from the students from the Graduate Student Writing Support Center at Ryerson, who helped me improve my writing throughout this academic year. Finally, I acknowledge my partner and family who have always encouraged my growth as a writer, researcher, and student.

TABLE OF CONTENTS

Abstract	iii
Acknowledgements	iv
List of Appendices	vi
Chapter 1, Introduction	1
Chapter 2, Literature Review	7
Chapter 3, Theoretical Framework	20
Chapter 4, Methods	23
Chapter 5, Findings	31
Chapter 6, Discussion	38
Chapter 7, Conclusion	46
Appendices	51
Appendices are listed in the LIST OF APPENDICES	
Reference List	52

LIST OF APPENDICES

Appendix A – Problematics Table

57

CHAPTER 1, INTRODUCTION

French and English are Canada's two official languages. A person is considered a minority-language speaker if their primary language is not the majority-language of the province or territory (Ricard, 2019). Therefore, Francophones outside of Quebec are considered a minority-language community. The Federal government has committed to maintaining equality between both languages, thus public services in Canada have an obligation to be offered in both official languages (Minister of Justice, 1969). Additionally, the *Canadian Charter of Rights and Freedoms* (1982) mandates that any person has a right to communicate and receive information in English or French when there is enough need. Yet, Francophones in Canada report avoiding speaking French in the public-service sector because their English counterparts are not fluent, leading to misunderstandings and miscommunication (Bergeron, 2012). Francophones in majority English-speaking provinces have expressed that when they seek healthcare services, they experience stress due to healthcare professionals' language barriers (Ngwakongnwi et al., 2012). Moreover, healthcare services which can be offered in French are either unavailable or weak (Moissac & Bowen, 2017).

This master's research paper is focused on understanding the organization of French healthcare and disability services for Francophone families in majority English-speaking areas. This Institutional Ethnography seeks to discern how healthcare services are organized around the French language and what can be learned about minority-language services in general. The analysis provides a description of the problems that French-speaking families with disabled children experience when navigating a mainly monolingual healthcare system which forces them to assimilate into Anglophone cultural concepts of disability, care, and childhood. This analysis

will present interconnected issues surrounding broader problems of how language organizes people in Canadian Society.

In this study, I analyzed data from the Inclusive Early Childhood System Service Project (IECSS), which included 20 interviews and institutional maps for nine self-identified French-speaking participants from 2015 to 2020. Participants were from Manitoba, Ontario, and the Northwest Territories. I examined the interviews to identify the role of institutions in governing minority-language childhoods and constructing disability. Then, I analyzed how mainly Anglophone services force minority-language families to do extra work to utilize services in their first language. Together, this description and analysis will be used to generate knowledge that identifies service-delivery gaps in the healthcare system for Francophone families with disabled children. Moreover, connections can be made between these current institutional processes and historical and sociological conditions to understand how the healthcare system has and continues to influence Francophone families with disabled children.

Personal Location

My family is Anglophone, but I was in the French immersion program throughout elementary and high school. I also took my undergraduate degree in French and graduated with the French Immersion certificate from the University of Ottawa and because of this, am bilingual. Throughout my studies, I immersed myself in the French language and culture. Additionally, I live in Ottawa, so I frequently work with French colleagues and children. Therefore, I think that I have sufficient insight and experience of French language, beliefs, values, and behaviours that allows me to understand the lived experiences that the participants and literature have described.

Research Problem

The healthcare system in Canada is still a mainly monolingual service, which places families who do not speak English at a disadvantage. Francophone Canadian families are then put in the position of assimilating into Anglophone Canadian beliefs regarding health, illness, disability, care, and childhood. Additionally, language is a social determinant of health. The World Health Organization (WHO) (2016) defines social determinants of health as the non-medical conditions an individual is born into, is raised with, and it is part of daily life that influences their health outcomes. The social determinants of health are an important factor that exacerbates health inequities between minority-language and majority-language populations (WHO, 2016). Additionally, the social determinants of health are a part of positive holistic healthcare, which is a complementary relationship between a healthcare provider and a patient that recognizes health as the balance of physical, spiritual, psychological, and social aspects of wellbeing (National Academies of Sciences, Engineering, and Medicine, 2016; Patterson, 1998). Moreover, holistic healthcare recognizes that health is not just physical, it is a spiritual and psychological experience as well, which shifts patient – healthcare provider relationships (de Vibe et al., 2009). Holistic healthcare is essential for helping a person interact within the healthcare institution because it allows them to act independently (Patterson, 1998). Thus, when an institution does not allow individuals to use their primary language, it will affect not only the health of the individual but the productivity and effectiveness of the institution (Patterson, 1998).

There are many communication issues individuals can experience when they do not or cannot receive healthcare or disability services in their own language. Minority Francophones have generally been linked to poorer health outcomes (Ngwakongnwi et al., 2012). When a

service is not offered in a primary language such as French, a patient is more likely to receive an improper diagnosis, or respond negatively to medications (Langille et al., 2012; Savard et al., 2013). Moreover, having healthcare provided in a person's first language is critical for patient education leading to better overall health (Langille et al., 2012). Additionally, not being able to communicate in the majority-language severely affects the quality of services a patient will receive (Mercure et al., 2018). Finally, being able to talk to a service provider in their primary language gives the patient and their caregiver more confidence (Turner, 2005). Therefore, Francophone families experience a multitude of issues that disadvantage them because of the monolingual-Anglophone organization of the Canadian healthcare system.

Purpose & Significance

The goals of the study are to better understand how children's healthcare and disability services are organized around the French language and the implications for Francophone and other minority-language citizens. The objective is to gain a better understanding of which processes and organizing practices hold power in our society and the implications for understanding systemic conditions through which disability and minority-language discrimination may be enacted. Specifically, this study will explore how healthcare and disability services in Canada are organized to favour majority-language (English) speakers, thus placing Francophones and other minority-language speakers at a disadvantage. Finally, the historical prioritization of English (Bergeron, 2012), and the discrimination against minority-language speakers have contributed to this imbalance of power between Anglophones and minority populations such as Francophones, Indigenous peoples, and other minority-language groups in Canada.

A potential benefit of this study is that more attention can be called to this issue concerning minority languages in the healthcare system and lead to new knowledge in this area of healthcare delivery. Interventions need to be created to help reduce language barriers and discrimination against minority-language speakers within the Canadian healthcare system (Hunter-Adams & Rother, 2017; Moissac & Bowen, 2017; Ngwakongnwi et al., 2012; Samkange-Zeeb et al., 2020). Conversely, the literature has mostly focused on the Canadian healthcare system as a whole, such as general practitioners, but this leaves out other health and disability services (e.g. speech and language pathologists, rehabilitation services) (Bélanger et al., 2018). Most of the literature associated with minority-language health services centres on adult patients, leaving out children who are not invited to advocate for themselves (Boudreau, 1999; de Moissac & Bowen, 2017; Drolet et al., 2015; Ngwakongnwi et al., 2012; Savard et al., 2020). This study will add to the existing literature by giving attention to the lived experiences of Francophone disabled children and their families. Additionally, studying bilingual policy frameworks on a provincial and territorial level will make contributions to knowledge of language policy that has not been fully explored. By making connections to past historical language discrimination, I will identify steps toward greater inclusivity, while identifying where language, geography and sociological issues related to accessing healthcare remain.

Research Questions

Three main research questions will be used to guide the analysis of data.

1. What do the experiences of Francophone families tell us about how health and disability services are organized for the purposes of delivering French language services to a disabled child?

2. How is access to Francophone healthcare and/or disability services in Canada organized and who is able to gain access to these services?
3. What historical and sociological conditions have produced the current institutional processes that influence Francophone families and their children's access to services?

CHAPTER 2, LITERATURE REVIEW

French Language Policy Context in Canada

Federal Level Policy

According to the 2016 census, there are 7,914,498 French-speaking Canadians, making up about 22% of the population (Official Languages Branch - Canadian Heritage, 2018). Since French is one of two official languages in Canada, there are several policies that outline the requirement of having public services in French (e.g., the *Canadian Charter of Rights and Freedoms*, the *Official Languages Act*). Conversely, researchers argue that these policies were instituted too late and do not adequately serve the Francophone community (Savard et al., 2020). Examining these policies will help to provide evidence of the historical and sociological contexts of regulations that should have helped Francophone Canadians but did not.

Since 1867, the English and French languages have been used in Federal courts and proceedings but the notion of two official languages was not introduced until 1967 (Heritage Canada, 2019). The *Official Languages Act* (1969) outlined several goals:

To ensure respect for English and French as the official languages of Canada and ensure equality of status and equal rights and privileges as to their use in all federal institutions, in particular with respect to their use in parliamentary proceedings, in legislative and other instruments, in the administration of justice, in communicating with or providing services to the public and in carrying out the work of federal institutions; support the development of English and French linguistic minority communities and generally advance the equality of status and use of the English and French languages within Canadian society; and set out the powers, duties and functions of federal institutions with respect to the official languages of Canada (Minister of Justice, 1969).

In 2019, the Federal government made a commitment to revitalize the *Official Languages Act*, which is yet to be released.

The *Canadian Charter of Rights and Freedoms* (1982) strengthened French language rights by outlining the necessary equality and respect for both official languages in the public sector (Department of Justice, 2019; Heritage Canada, 2019). The Charter clarified that there was no limit on the amount of power the government was given to improve the equality of status between both languages (Department of Justice, 2019). Additionally, the Charter gave the right to Federal employees to work in the language of their choosing (Department of Justice, 2019). There have been many critiques of these laws mainly being that they are far-sighted and do not actually outline a particular purpose for the use of official languages (Bélanger et al., 2018; Drolet et al., 2015). Since healthcare is the responsibility of Provincial and Territorial governments, the *Canadian Charter of Rights and Freedoms* and the *Official Languages Act* cannot be as influential on healthcare institutions as is needed to necessitate services in minority languages (de Moissac et al., 2012). This issue is demonstrated by the fact that the Commissioner of Official Languages still receives complaints about the ability to speak French in public sectors (Gagné & Cormier, 2019). Although there are Federal laws that support the use of French, there are still many challenges that Francophones face in having these rights implemented properly, such as not having quality French services and not having continuous care in French (Drolet et al., 2015; Savard et al., 2013).

Policy in Ontario

Francophones in Ontario make up approximately 4% of the population, with 550,595 people identified in the 2016 census (Official Languages Branch - Canadian Heritage, 2018). This is the highest number of Francophones outside of Quebec, but they are still considered to be

a minority-language population. For this reason, the government of Ontario in its *French Language Services Act* (1986) identified 22 designated areas in Ontario where the concentration of French-speaking individuals is high enough to make speaking French a necessity in government agencies (Ontario Ministry of Health and Long Term Care (OMHL), 1986). As of 2021, the number of designated French areas has expanded to 26 (OMHL, 2021). *The French Language Services Act* (1986) has considered the expressed needs of the Francophone community when creating and implementing programs aimed at improving the status of the French language in the province (OMHL, 1986). The Act requires that French services be offered at the same time and be of the same quality as English services (OMHL, 1986). Although this law necessitates at the very least the availability of French in many areas of Ontario, approximately 70% of Franco-Ontarians report not being able to find a family doctor that can communicate in French (Farmanova et al., 2018). Moreover, 80% of Francophones in Ontario cannot find a specialist that can speak in French (Farmanova et al., 2018). This demonstrates that the language policies in Ontario that have been and continue to be in place do not foster an environment where French is equally offered, therefore prioritizing English over French.

Policy in Manitoba

In Manitoba, there are 40,978 self-identified Francophones, which is about 3% of the province's population in the 2016 census (Official Languages Branch - Canadian Heritage, 2018). It was not until 1989 that an official *French Language Services Policy* was created in Manitoba. This policy provides a framework for including French services in the public sector (Manitoba Francophone Affairs Secretariat, 1989). Similar to Ontario, this policy states that in designated areas, different institutions must offer French services and consider the effects of this offer for Franco-Manitobans (Manitoba Francophone Affairs Secretariat, 1989). Furthermore, it

is important to highlight that this policy is not a legal requirement (Health Canada, 2006). Public services must consider the outlines of this policy, but it is not critical that they implement them (Health Canada, 2006). Not having a legal requirement makes it hard to enforce French services in Manitoba, creating a healthcare system that favours majority-language speakers over minority-language speakers.

Since 1990, the province has created many guidelines and reports to help improve the status and availability of French services (Government of Manitoba, 1998; Government of Manitoba, 2005; Government of Manitoba, 2012; Government of Manitoba, 2016). For example, The Gauthier Report and Chartier Report compared the Francophone healthcare experience in Manitoba to Ontario, and found that healthcare facilities were only providing French services out of goodwill because the policies did not make specific language requirements by law (Chartier, 1998; Gauthier, 1990). Furthermore, the policies in place at the time covered a broad range of services, meaning that there were no specific requirements for any service sector (Gauthier, 1990) and therefore made the requirements difficult to enforce. French services were unevenly available, there were few French-speaking healthcare professionals, and the quality of these services were not comparable to English services (Chartier, 1998; Gauthier, 1990). The most critical comment was that the *French Language Services Policy* (1989) was defective, incomplete, and needed to be modernized to reflect the growing Francophone population of the province (Chartier, 1998). Several recommendations resulted from these reports, such as requiring bilingual signs in all healthcare facilities, the need for training more French-speaking healthcare professionals, and having French translators available in healthcare facilities (Chartier, 1998; Gauthier, 1990). The recommendations, observations, and judgements made by

these reports demonstrate how the *French Language Services Policy* (1989) did not mandate enough requirements to adequately serve the franco-Manitoban community.

Policy in the Northwest Territories

There are 1,240 individuals in the Northwest Territories that identify as French-speaking, comprising approximately 3% of the territory's population in the 2016 census (Official Languages Branch - Canadian Heritage, 2018). French is an official language in the Northwest Territories and the government recognizes the cultural, economic, and social contributions of the Francophone population (Government of the Northwest Territories, 1988). The *Official Languages Act of the Northwest Territories* (1988) stated that any member of the public has a right to communicate and receive information in both official languages from community and regional service providers if there is enough demand. It also made a commitment to help achieve equality of status between the two languages (Government of the Northwest Territories, 1988). The Act did not specifically mention healthcare, and therefore, this could have contributed to issues in receiving healthcare services in French.

More recently, the government has published a Strategic Plan on French Language Communications and Services for 2018 to 2023 (Government of Northwest Territories, 2018). The plan described many guidelines to focus on accountability and engagement with the Francophone community to help improve French language services and communication (Government of Northwest Territories, 2018). The strategic plan did include many suggestions for improving French healthcare, such as having access to interpreters, hiring more Francophone staff, and having health forms available in both languages (Government of Northwest Territories, 2018). Additionally in 2021, a French Language Communication and Service Guide that stemmed from the strategic plan, noted a need for active offerings of French in public service

sectors (Northwest Territories Francophone Secretariat, 2021). The active offer is a communication strategy that allows an individual to know that they can communicate in either official language and helps to foster trust between a consumer and provider (Northwest Territories Francophone Secretariat, 2021). These plans and strategies demonstrate that there is still more work that needs to be done in this territory to help Francophone individuals such as incorporating more bilingual services, tools, and professionals into the healthcare system.

Monolingual English Healthcare Services

Monolingual English services refers to environments where Francophones are expected and subsequently forced to use English when seeking a healthcare or disability service because the healthcare workers only speak English (Vaish, 2020). This is an issue for Francophone Canadians because if they do not receive healthcare in French, they may receive incorrect treatments and are not able to fully participate in their care (Ngwakongnwi et al., 2012). Issues surrounding monolingual English services, specifically in Ontario, have been discussed since the early 1990s (Boudreau, 1999; Kérisit & Dubois, 1995; Martin, 1992). Shortages of Francophone healthcare professionals force French-speaking patients to seek services in English because they did not have any other option (Boudreau, 1999; Kérisit & Dubois, 1995; Martin, 1992). The monolingual English problem had also been discussed in Alberta, where French-speaking healthcare providers were very limited, which obliged Francophones to seek healthcare in English (Deroche et al., 1999). Thus, Francophones in Canada have been dealing with a monolingual healthcare system for decades, which creates a multilayered complication because many generations of Francophones may have had to conform to Anglophone services. This creates a cycle where Canadian Francophones, no matter their age, may experience issues with a

monolingual healthcare system, contributing to issues surrounding access and equality across age groups (Farmanova et al., 2018).

Monolingual healthcare services have also been identified as a concern on a national scale (Drolet et al., 2015). Canadian healthcare is organized as a monolingual English service, that favours the majority-language speaker over any minority-language speaker (de Moissac et al., 2012; Giguère & Conway, 2014; Ngwakongnwi et al., 2012). There is especially concern for the number of Francophone physicians who are specialists rather than general practitioners (Savard et al., 2020). Another issue is that monolingual services are not confined solely to general healthcare services, but also social and mental health services (Savard et al., 2013; Savard et al., 2018). These findings present not only an issue that has spanned over many years, but that is widespread across many different provinces and territories, and through different health and disability services. Even though these systems are different, they all seem to prioritize offering English services over French. This means that very few Canadian Francophones can access services in their chosen language, creating a monolingual healthcare system that is due to various issues within the healthcare institution that will now be discussed.

Low Importance for Bilingual or French Services

Canadian Francophones have consistently described that health services they use affords little to no importance for offering assistance in French. Using healthcare services in an individual's chosen language is not only a desire, but an important requirement (Société Santé en Français, 2014). When limited importance is placed on bilingual services, healthcare institutions diminish the needs of minority-language speakers, creating a monolingual healthcare system. Healthcare providers in contexts where French is a minority-language do not always recognize that Francophones experience issues in obtaining healthcare in their chosen language (de

Moissac & Bowen, 2017; Société Santé en Français, 2014). Even if a patient wants communication in French, healthcare providers who do not speak French cannot support this request (Ngwakongwi et al., 2012). Access is an issue because not being able to receive services in one's own language can make the patient or caregiver feel as if they are not as important as their majority-language counterparts and are not supported by the healthcare system (Drolet et al., 2015). Thus, only Francophones who are persistent in advocating for themselves and are willing to potentially wait for a French-speaking service provider will be able to access services in French (de Moissac & Bowen, 2017; Savard et al., 2020).

The lack of French services demonstrates that the healthcare system places little value on offering bilingual services (Savard et al., 2020). Employers do not encourage or do not support employees to continually offer services in French due to lack of perceived importance (Savard et al., 2018). For example, there is a low awareness and use of interpreter services by healthcare professionals (de Moissac & Bowen, 2017; Giguère & Conway, 2014; Ngwakongwi et al., 2012). This contributes to a cycle of low supply and demand when service providers reduce French offerings due to a perceived lack of need (Farmanova et al., 2018). Therefore, Francophones who are bilingual and can communicate in English are more likely to use health services frequently because Francophone patients conform to this monolingual system, even if they prefer to have services in French (de Moissac & Bowen, 2017; Farmanova et al., 2018; Ngwakongwi et al., 2012; Savard et al., 2020).

Limited Referrals and Continuity of Care Between French Services

The organization of a mainly monolingual healthcare system also contributes to o patients receiving limited referrals and continuity of care between French health services (Ngwakongwi et al., 2012). This means that Francophones receive very few referrals to Francophone healthcare

professionals, and they do not continuously receive care in French (Drolet et al., 2015; Société Santé en français, 2014). Navigation of the system is not easy and there is no mechanism in place that will actively pair bilingual or Francophone patients with French-speaking providers, so it is up to proactive professionals and patients to do so (Drolet et al., 2015; Savard et al., 2013; Savard et al., 2020; Société Santé en français, 2014). Health services that do not have Francophone professionals will rely on referring French-speaking patients to other bilingual service providers rather than solving the problem by hiring Francophone providers (Farmanova et al., 2018). Limited referrals and continuity of care also contribute to Francophones feeling uncomfortable using the healthcare system (Bélanger et al., 2018). For example, Canadian Francophones have stated that they experience stress and may avoid seeking healthcare due to professionals' language (Ngwakongnwi et al., 2012). Therefore, the limited referrals and continuity of care perpetuates a cycle where Francophone patients cannot find French-speaking healthcare professionals. Oftentimes, this means that only those who have a working knowledge of the healthcare system are able to navigate the system and to use services in French (Drolet et al., 2015). The Canadian healthcare system is organized in a way that minority-language speakers must find healthcare services in their chosen language, rather than having help from a healthcare provider to do so (Drolet et al., 2015; Savard et al., 2020).

Low Active Offerings of French

Canadian healthcare institutions often do not have procedures in place to actively offer their services in both French and English (Farmanova et al., 2018). An active offer is a clear visual or verbal representation that shows patients that they can receive information and communicate in both official languages when obtaining healthcare (Treasury Board of Canada, 2019). An active offer can include asking what language a patient wants to communicate in,

bilingual name tags and signage, bilingual telehealth care, and advertisements displaying how to utilize French services within the health institution (de Moissac & Bowen, 2017). If a healthcare institution does have an active offer in place, they are organized in a way that recognizes minority-language populations; if they do not, it can perpetuate a monolingual healthcare system (Bélanger et al., 2018).

Having an active offer of both official languages is important because this helps with continuity of care across services in French, and recognizing the needs of Francophone Canadians (Farmanova et al., 2018). It has been found that healthcare institutions in Canada tend to favour adopting models in which translators are available to patients, instead of finding bilingual staff who can actively offer French and English care (Benoit et al., 2012; Giguère & Conway, 2014; Savard et al., 2018). This does not solve the problem of adequately serving minority-language populations, and patients have expressed that they prefer dealing with a healthcare provider over a translator (Giguère & Conway, 2014; Ngwakongnwi et al., 2012). Conversely, many Canadian service providers are not aware of the possibility of an active offer of bilingual services (Savard et al., 2020). This demonstrates that healthcare institutions are still organized in a way that focuses solely on majority-language speakers and leads to healthcare professionals not being informed of how to adequately serve Francophone populations. The importance of actively offering bilingual services is demonstrated by active offers being identified as a tool to limit issues within Canadian French healthcare (de Moissac & Bowen, 2017). Therefore, when an institution does not clearly offer bilingual services, it will create communication barriers between patients and healthcare professionals, leading to health problems for the patient and an ineffective healthcare system. Only Francophones who are

willing and able to overlook not having an active offer of bilingual service can utilize French services (Bélanger et al., 2018; Farmanova et al., 2018; Giguère & Conway, 2014).

Professional Issues

Francophone professionals have consistently stated that they cannot speak their own language at their workplace even though the *Canadian Charter of Rights and Freedoms* (1982) gives employees the right to choose what language they use while working (Department of Justice, 2019; Savard et al., 2013). There is also less opportunity to collaborate with other service providers in their own language (Drolet et al., 2015). In addition, if the practitioner works mostly in their second language, it can lead to feelings of being incompetent in their first language because they do not use specific work-related language (Savard et al., 2018). These communication issues will isolate Francophone healthcare practitioners, affect how they care for patients, and limit the number of French-speaking patients they can reach, negatively influencing the health institution.

Language problems also create more work for Francophone healthcare professionals and students. Specifically, there is a demonstrated lack of French-speaking healthcare professionals and an inability to hire these workers throughout the healthcare institution (Bélanger et al., 2018; de Moissac & Bowen, 2017; Drolet et al., 2015). There is less availability of resources to explain diagnoses and treatments because minority languages such as French are more so used in social contexts (Drolet et al., 2015). Majority-language speakers will more frequently ask their minority-language colleagues to act as translators, which creates more caseloads and extra work for these professionals (Savard et al., 2018). The extra work that Francophone professionals endure compared to their majority-speaking counterparts points to a system that is organized to favour majority-speaking professionals.

A frequently cited issue across Manitoba, Ontario, and the Northwest Territories is that there is a lack of healthcare education programs that are offered in French, leading to a shortage of Francophone health professionals (Martin, 1992; Mercure et al., 2018; Ngwakongwi et al., 2012). This contributes to longer wait times for Francophones seeking healthcare in French and thus leads to the conclusion that only those who are willing to endure long wait times can access French health and disability services. Another issue that stems from this limited French health education is that it makes it more difficult for Francophones to find healthcare professionals who are comfortable speaking in French (de Moissac et al., 2012; Giguère & Conway, 2014). The learning opportunities for minority-language speakers who want to enter healthcare and disability service professions are more limited compared to their majority-language counterparts (Mercure et al., 2018). Moreover, minority-language students will more likely pursue their studies in the majority-language and will not learn specific vocabulary in their native language (Savard et al., 2018). Therefore, mainly monolingual health education has caused multifaceted issues across Canadian provinces and territories, such as additional work that French-speaking healthcare providers have, limiting their ability to help Francophone patients.

Positive Experiences with Canadian French Healthcare

The literature has few examples of minority Francophones having positive experiences with the healthcare system. Firstly, in highly populated bilingual areas, such as in Eastern Ontario, having bilingual healthcare is easier (Savard et al., 2020). Secondly, in the only officially bilingual province (New Brunswick) Francophone and Anglophone individuals report equal rates of self-perceived health, which is not seen anywhere else in the country (Bélanger et al., 2011). Francophones in New Brunswick also do not experience as many barriers to finding French-speaking healthcare professionals or services compared to other provinces or territories

(Belanger et al., 2011). Although Francophones do not experience issues with a monolingual healthcare system in every Canadian city, there is not enough evidence from these small areas to conclude that there is not an issue within the Canadian healthcare systems.

CHAPTER 3, THEORETICAL FRAMEWORK

Critical Disability Theory

Critical Disability Theory originated in response to the typical study of disability and to aid in the disability rights movement (Meekosha & Shuttleworth, 2009). There is not one single researcher that is associated with the origin of Critical Disability Theory, although Michel Foucault's approach to analyzing power relations is essential for Critical Disability Theory (Campbell, 2001). Additionally, the founding ideas of Critical Disability Theory stem from disability studies and Critical Race Theory and focus mainly on the lived experiences of physically and cognitively disabled individuals (Procknow et al., 2017). It does not focus on critiquing the characteristics of disabled people but scrutinizes the social, cultural, historical, and political conditions that frame these differences as disabilities (Schalk, 2017). Critical Disability theorists do not center solely in academia but move towards activism and social justice for all people, not only those that societies label as disabled (Meekosha & Shuttleworth, 2009; Schalk, 2017).

This analysis will use Critical Disability Theory as an underpinning because it focuses on how disability is intertwined with other forms of oppression within society (Goodley, 2013). Moreover, it transcends the boundaries of traditional academic disciplines, allowing for a deeper analysis of ableism, which is a set of ideologies and practices that perpetuate a certain body standard and therefore views disabled bodies as less (Campbell, 2001; Goodley, 2013; Meekosha & Shuttleworth, 2009). Critical Disability Theory positions disability as a socially constructed notion that places disabled children in a minority population (Myers, 2018; Procknow et al., 2017). The theory focuses on identifying the barriers to inclusion that disabled people face and analyzes the ways that policy frameworks and cultural views either promote or deny inclusion

(Goodley et al., 2018; Watson, 2012). By doing so, Critical Disability Theory identifies different power imbalances between institutions, disabled individuals, their caregivers, and families (Meekosha & Shuttleworth, 2009). Thus, Critical Disability Theory is essential when analyzing many interrelated societal norms and how different societal bodies, such as the healthcare system, control disabled individuals (Procknow et al., 2017).

Critical Disability Theory studies how ableist opinions, which favour a standard body, affect disabled individuals' wellbeing (Goodley et al., 2018). It challenges the belief that self-sufficiency, autonomy, and independence are only associated with able-bodies (Goodley et al., 2018; Procknow et al., 2017). The theory also questions the relationship between normalization, accessibility, identity, and privilege of having what is considered a 'typical' body or state of being (Saxton, 2018). The acceptance of a typical body creates a binary view of health and wellbeing, when it should really be viewed on a continuum, which further disadvantages disabled people (Meekosha & Shuttleworth, 2009; Procknow et al., 2017). This is important to consider when analyzing the role that institutions, such as healthcare, play in constructing beliefs regarding ability and disability. Critical Disability Theory favours a more diverse society that is accepting of all bodies, minds, and ways of being (Meekosha & Shuttleworth, 2009).

Critical Disability Theory has also been used in studies specifically involving the healthcare system, which relates directly to this paper and is therefore important to mention. To begin, Critical Disability Theory posits that the healthcare system views disabled individuals as commodities that are used to increase profit due to their heightened use of health and disability services (Procknow et al., 2017). The theory has been used to rethink how caring for disabled individuals is actually classifying, managing, and trying to normalize disabled people (Meekosha & Shuttleworth, 2009). It also deconstructs the medicalized views of disability in order to

combat ableist forms of social oppression against disabled children, such as restricting the social and physical activities disabled children can be involved in (Goodley, 2013). Critical Disability Theory can be used to help expand healthcare knowledge of the interactions of social structures, power relations, and individuals' lived experiences when seeking healthcare (Straus & Brown, 2019). Most importantly, Critical Disability Theory has been used to advocate for a more diverse healthcare system by rethinking cultural meanings of ability, social processes of interacting with disability, and a political system that leaves disabled individuals behind (Meekosha & Shuttleworth, 2009).

Critical Disability theorists have presented how the social and political constructions of disability are affected when they are translated between languages (Sati, & Prasad, 2020). This is important since the participants for this study did not operate in their chosen language. When factors associated with disability, such as beliefs surrounding disability are translated from different languages, the presented ideas are usually deconstructed and therefore changed between languages (Sati & Prasad, 2020). Different languages have different understandings of disabilities, this will affect a disabled person's identity as well as how their society perceives them (Halder & Asaaf, 2017). Thus, Critical Disability Theory can be used to study how a disabled person's identity changes depending on their interactions using various languages (Rudnicki, 2018). Specifically in monolingual healthcare systems, this is important to consider when dealing with minority populations, such as Francophones, because they may not share the same views of diagnoses and treatments as an Anglophone healthcare provider.

CHAPTER 4, METHODS

This Institutional Ethnography investigates how the English and French languages operate within the Manitoba, Northwest Territories, and Ontario healthcare systems are organized to aid these language speakers. This project is a part of the Inclusive Early Childhood Service System Project (IECSS), which is a longitudinal study that seeks to understand how families across Canada interact with different institutions to seek support for their disabled child (IECSS Project, 2019). These data were used to explore the following research questions:

1. What do the experiences of Francophone families tell us about how health and disability services are organized for the purposes of delivering French language services for disabled children and their families?
2. How is access to Francophone healthcare and/or disability services in Canada organized and who is able to gain access to these services?
3. What historical and sociological conditions have produced the current institutional processes that influence Francophone families and their children's access to services?

Research Design

Institutional Ethnography was presented by Dorothy Smith as a critical form of ethnography in the late 1990s (LaFrance, 2019). Institutional Ethnography generates knowledge to help people whose everyday activities are organized against their interests (Rankin, 2017a). A researcher who is using Institutional Ethnography begins with the standpoints of individuals (Kearney et al., 2019). By formulating a problem, the researcher can analyze relationships, interconnected issues, and raise questions about society's organization (Rankin, 2017a). It also allows the researcher to question how social phenomena work and are organized rather than just examining how and why they happen (Kearney et al., 2019). Thus, Institutional Ethnography is

suited to advocating for groups who are disadvantaged (Walby, 2007), such as Francophone Canadians.

Institutional Ethnography started off as a methodology used solely in the social sciences, but it is increasingly being utilized in health research to understand the power relations that influence health practices into conforming to follow policy mandates (Peacock, 2017). Since this project focuses on studying the healthcare systems, it is important to also describe various ways that Institutional Ethnography has been used in this domain. Rankin (2015) utilized Institutional Ethnography to identify the shortcomings of patient and family centered care within Canadian hospitals. Quinlan (2009) employed Institutional Ethnography as a method to study how the transfer of knowledge in multidisciplinary healthcare teams is facilitated through communication between professionals. Not only is Institutional Ethnography practical in health research inquiry, but it also contributes to the identification of positives and negatives of the healthcare experience. Since the description of the Canadian Francophone healthcare experience is the focus of this project, and since Institutional Ethnography has been used in various studies analyzing the healthcare system, Institutional Ethnography is an applicable method.

A researcher who uses Institutional Ethnography will view the world as a social place (McGibbon et al., 2010). Institutional Ethnography prioritizes individuals' lived experiences in exploring how a person's social involvement is governed by institutional control and coordination (LaFrance, 2019). This approach preserves people's presence as subjects in research, as it uses individual experiences to inform the ethnography (Kearney et al., 2018). Furthermore, Institutional Ethnography is not grounded in theory which can sometimes categorize and use social actions to exemplify theoretical frameworks (Kearney et al., 2019). Thus, Institutional Ethnography can be applied to the study of individual experiences to

understand how the healthcare systems organize the participants' experiences and interactions within the system (Rankin, 2015).

Underwood et al., (2019) designed the IECSS Institutional Ethnography to identify how power interactions and dominant ways of thinking of disability manage a family's transition from early childhood care to a kindergarten program. The IECSS project has a large research team including various graduate students, professors, and project partners from several Canadian universities. Several members from the research team conducted interviews beginning in 2015. Institutional Ethnography can be used in diverse settings, such as childcare and health centers, as well as on a large international scale, demonstrating its versatility and suitability for this project.

Data Collection

IECSS Interviews

From the IECSS participants (n= 136) n=8 self-identified French-speaking participants from Ontario, Manitoba, and the Northwest Territories were identified for this study. A total of 19 interviews and eight institutional maps spanning from 2015 to 2020, were included in the analysis, with between 1 and 6 interviews from each participant. Each of these participants were interviewed for approximately 40 minutes to 1.5 hours. The researchers would travel to the participants to ease the interview process for the participants (Creswell & Creswell, 2018).

Participants in the IECSS Project contacted the research team directly to volunteer to participate. The consent agreement was read to the participants before each interview and they were asked if they understood the agreement, if they had any questions, and whether they would like to continue with the project. After each interview was conducted, the researchers would ask the participants if they would like to be contacted again for another interview, as it is a longitudinal study (Girbich, 2012). In Cohort 1, there were initially three interviews per

participant; one interview was conducted each year over three years with a possibility of extending participation for another three years to a total of six years. In Cohort 2, there was one interview each year for six years.

Participants

Participants involved in the larger IECSS all had a preschool aged child with a disability or had concerns about their children's development. They had not necessarily used or accessed support for their child. The interviews were conducted with the parent(s) or guardian(s) of the child, and most of the time mothers were interviewed, although in one case, both parents were interviewed. Participants were also asked about their cultural and ethnic backgrounds. Based on their responses, participants were from diverse cultural and ethnic backgrounds. Five participants identified as white. Additionally, one participant identified as Aboriginal, as well as one participant identified as African. One participant chose not to disclose their cultural or ethnic background. These participant characteristics reinforce the notion that francophonie is not a singular race, ethnic, or cultural background (Ngwakongnwi et al., 2012). Especially in Canada, where Francophones immigrated from many different French-speaking countries, it is important to acknowledge and consider these differences (Ngwakongnwi et al., 2012).

The age range of the target children, or the disabled child who was the focus of the study, ranged from three to seven. The inclusion criteria for analysis in this MRP was that participants self-identified as Francophone, or indicated French as a language spoken at home. The IECSS project had 12 participants who identified as Francophone: However, four spoke French. These participants spouses or other family member spoke French fluently, but their primary language was English, and they were therefore excluded. A minority-language speaker must be someone whose chosen or primary language is not the dominant language of the area (Ricard, 2019).

Secondary Access to Data

In January 2021, an amendment was made to the original Research Ethics Board (REB) approval from the IECSS project to include me as a student researcher. Once this was approved, an encrypted Universal Serial Bus (USB) stick was sent to me by mail so that I could receive the data from the team. The data was sent via the website Hightail, an encrypted, secure file sharing website. When I downloaded the data from Hightail, I put it on the encrypted USB and then deleted the files from my computer and cleared my trash to ensure the only place the data was stored was on the USB stick. When I accessed and analyzed the data, I used the Ryerson Virtual Private Network (VPN) to guarantee that the private information was not at risk (Salkind, 2009).

Data Analysis

The Use of Critical Disability Theory in this MRP

Critical Disability Theory was used to analyze the literature and policies to find the various forms of oppression, exclusion and limitations disabled children and their families experience within the healthcare systems. It was used to explore how a power imbalance between the healthcare institution and families with disabled children helps to form monolingual healthcare systems within Canada. The theory was utilized when analyzing the policy frameworks to express how policy frames disability as a socially constructed notion, and how governments and decision-makers are not inclusive toward minority populations. Additionally, Critical Disability Theory was important to consider when examining the literature and policies because it discerns that institutions construct beliefs of disability that are then pushed onto families and children (Saxton, 2018). It was also used when examining how the healthcare systems classify families based on language and illness. Finally, Critical Disability Theory

helped to understand how power imbalances are created within the healthcare systems for a variety of reasons, such as disabilities and languages, which is the focus of this paper.

Critical Disability Theory was used during the analysis of the interviews and institutional maps to identify when disabled children were not included. It was also used to identify language-related barriers to utilizing healthcare that further marginalize Francophone children and their families. The theory was used to recognize issues that have been previously discussed in the literature related to minority-language barriers and accessibility that negatively affect a parent or child's wellbeing, such as low importance for bilingual services and limited amounts of Francophone healthcare providers (see: de Moissac & Bowen, 2017; Drolet et al., 2015; Savard et al., 2020). Critical Disability Theory was also used to identify new potential challenges that minority-language families experience when utilizing healthcare and disability services for their child. Finally, Critical Disability Theory helped to form conclusions, as it can be used to advocate for Francophone families and their disabled children (Meekosha & Shuttleworth, 2009).

Analyzing the Data

A research problematic is specifically used in Institutional Ethnography to describe everyday interactions between individuals and institutions in which the individuals' activities are coordinated by institutions and how the actions are connected to other individuals (Kearney et al., 2019; Rankin, 2017). These research problematics were initially determined during the literature review and were used to establish context for analyzing the Canadian healthcare institutions. This analysis included studies and policy frameworks around bilingualism and the public service to see if they promoted or denied inclusion. The provincial mandates of Ontario, Northwest Territories and Manitoba were the center of this analysis, as these are the provinces

where the participants live. The pre-established problematics included identifying whether participants could access French services at all, such as, the problematics questioned if the participants had to travel to access these services and if they had to pay more to access services in French. The pre-established problematics also included the issues related to limited availability of minority-language services, such as lack of stability in staffing, delays in receiving services, and a lack of French-speaking staff. Finally, the pre-established problematics was used to identify if the participants had to conform to the monolingual societal standards by learning English. These pre-established problematics were used to identify the barriers to inclusion that Francophone disabled children faced. See Appendix A for a problematic table.

Emerging problematics directly from the data that were not reflected within the literature (Linneberg & Korsgaard, 2019), but still present issues for Francophones were also found during the analysis. Analysis that utilizes multiple forms of data allows the researcher to describe a problem using participants' recounting of their interactions with organizing institutions, while also considering the literature. This allowed me to utilize multiple perspectives to form conclusions (Girbich, 2012; Rankin, 2017). Additionally, throughout this phase of analysis, I analyzed the data three separate times, which afforded me the opportunity to have prolonged engagement and persistent observation with the data (More, 2015). These techniques also helped in producing rich data by conducting a thorough analysis and because the participants were interviewed multiple times, allowed for more critical introspection. For example, this approach allowed me to use existing information to reinforce previous research about language issues within the healthcare systems and to make new contributions by presenting other issues that Francophones experience.

Organizing the Data

Microsoft Excel was used to organize and manage the data, as efficient handling of data is an important step in data analysis (Dey, 1993). Each problematic that was previously described was assigned a colour. A separate column was assigned for the phrases that the participants said in the interviews that correspond to each of the problematics. This was done to ease the readability of the document (Girbich 2012; Linneberg & Korsgaard, 2019).

CHAPTER 5, FINDINGS

Throughout my analysis, I found 11 different problematics and a total of 134 individual circumstances from participants that have aided in mapping and tracking the imbalance of power between the healthcare institution and minority-language families (Rankin, 2017). In this paper, I will be detailing five problematics that illustrate how institutions are organized and how actors work within these institutions (Kearney et al., 2019). Participants are considered to be expert informants who observe how the healthcare institution controls their everyday activities and interactions within the system (Rankin, 2017). Institutional Ethnography does not focus on analyzing the participants, and instead uses their lived experiences and the work that they do as a collective group to describe these ruling relations (Kearney et al., 2018). For this reason, the findings have been grouped according to the different problematics and the quotes from various participants will be used to help recount the work minority-language families do to obtain services in their chosen language. The eight participants that were included in the study will be referred to as F01 through F08.

Many of the participants speak French as their first language and use English as an additional language. They also use direct translations from French to English that may not make sense to native English speakers in specific contexts. I adjusted quotes in English for clarity.

Lack of French-Speaking Staff and/or Services

A lack of French-speaking staff and/or services refers to various situations where families did not interact with a service that was offered in French, or a service provider did not have a French staff available to interact with the family in their preferred language. A lack of Francophone staff and/or services points to a healthcare institution that is not organized to help French-speaking families. Many participants identified that there were few French-speaking

service providers across different allied health resources, such as speech and language pathologists and teaching aids. Participant F01 stated that, “You know, there aren’t very many French-speaking speech therapists.” The same participant elaborated:

That’s right. There’s a shortage of speech therapists. Maybe there are enough English-speaking speech therapists, but in French, there’s a shortage. You know, bilingual people there are never any who are just French. It’s very difficult to even get bilingual people.

Similarly, participant F05 said, “We didn’t get any therapy over the summer because there’s been a shortage of [French-speaking] speech language pathologists in the area.” Participant F03 described the number of French-speaking teaching aids in Toronto by saying, “Because the service in French— there is a lack of staff and they give [help to] maybe one or two [students]. They only work with the severe cases in the school.” Participant F04 described a similar situation in Manitoba, “The schools are saying, ‘Oh we’re so short of staff.’” These quotes all describe a shortage of French-speaking service providers across multiple Canadian cities and provinces.

This lack of Francophone staff and services results in many other language related issues that families have described, which demonstrate how the various provincial healthcare systems are not organized in a way that allows French-speaking individuals to benefit from its services. The first language related issue is that since there were so few Francophone service providers, the participants got very few sessions, or the appointments were very short. Participant F04 described this situation in a French preschool and claimed that, “So I thought [the French] preschool was four days a week, but it was actually only two because there’s so many kids. So I put him into the English preschool.” A related issue was also presented by participant F03 in which they described a time discrepancy between English and French programming for children. They said:

Yeah, I go [to both locations] and also I told you I go to the downtown [Francophone location]. As you know here [at the Francophone center] it is just two hours 11:30-1:30, but here at the downtown [English center] it is from 8:15-12:45 all morning.

The same participant says that, “There is a Francophone centre. There is this one [Francophone] lady who comes for one hour weekly.” Similarly, time spent with resource teachers in schools with French curriculum is short: participant F08 says, “It’s just that the amount of time they have to spend [at] all the schools with all those kids is just not enough.” The same participant also detailed how French-speaking speech therapists only offer services in French for specific age groups:

Speech does seem to be better. But the really bad thing about speech, and I don’t know if it’s [the same in] other places, you can only get it while you’re in kindergarten. Like up until kindergarten ... When you start Grade One, you’re done.

These experiences demonstrate that a lack of Francophone service providers creates issues related to the duration of appointments and how many patients service providers can see.

Monolingual Service

Monolingual services are a problematic that favours majority-language speakers over minority-language speakers, creating monolingual healthcare services within the institution. French-speaking families cannot find a service in French, or the French service is so time limited that they must resort to using English services. Participant F07 described this issue by saying, “I find that most programs are not special. They’re all in English. So, no. It’s not in French.”

Participants also reported problems related to monolingual services within the general healthcare system, describing utilizing lack of French-speaking doctors and the availability of healthcare information in French. Participant F05 detailed how they could not find health

research in French to help them understand their child's speech: "Yeah, all the research I'm finding, none of it's in French." Additionally, participant F01 said, "It's a pediatrician in New Liskeard [where they live]. It's in English".

Several participants described similar situations with monolingual play groups, daycares, or teaching aids. Participant F02 said that, "The childcare we're using right now is Anglophone, because daycare here [in French] is on and off, on and off, on and off." Additionally, when speaking about a social play group, participant F03 said, "This one is just English. There are no services in French here." Participant F05 noted, "They had an English-speaking aide not a therapist. I don't know how that works but she was only [speaking] English so we didn't work with her."

Finally, participants also had issues with monolingual disability services such as speech, applied behavioural analysis (ABA) therapy, and occupational therapy. When discussing the possibility of using speech therapy, participant F05 said that:

We were talking about maybe doing an intensive week therapy with him down there, I got all excited and then realized, oh right we're French. She [the speech therapist] doesn't speak French so she wouldn't have been able to do that.

Participant F03 described monolingual ABA therapy, stating that, "Also, he did his second language [English], before he did the first language [French] ABA program in [Ontario]." The same participant explained further that, "No the therapies, I did everything in English. ABA, everything in English. Just the support in the school in French." Participant F07 described their problems finding a French-speaking occupational therapist by stating that, "Yes, to help him with his development because he has many difficulties, so it was a bit hard for me with difficulties with the English language." Thus, the participants have discussed a widespread

monolingual issue across the varied disability services, therapies, and within many provincial and territorial healthcare systems.

Minority-Language Service Delay

An additional problematic occurs when the healthcare systems cause service delays, such as long waitlists or extensive wait times between appointments for minority-language families. Participant F08 detailed this issue across multiple services in: “I think either delay or inability to have services, whether it was OT, or physio, or speech, or Dietician. I mean in Yellowknife, it seems like they’re always leaving.” Participant F04 described the waitlist for French-speaking teaching aids at a Manitoban French: “There’s a huge waiting list and there’s one teacher who does it all.”

Service delays are also present when families are seeking a healthcare or disability assessment in French. Participant F04 described a delay for an assessment from a French-speaking speech and language pathologist, saying that, “It was well over a year before we even had our assessment and there was nothing all summer.” The same participant continued to face this issue when seeking a follow-up assessment for her child and said that, “Just the waitlist. Like just waiting because that might mean that he needs more [services].” Additionally, participant F07 also detailed a long wait time when trying to receive an assessment from a French-speaking occupational therapist by saying that, “Yes, they told me that they would send his file, I don’t know, in at most six months.”

There are also waitlists for French-speaking speech and language services. Participant F05 said that, “There’s a 6-month at least waiting period before you can get seen by a speech language pathologist.” The same participant also described a gap between appointments with speech and language pathologists stating, “They replaced her with this new one ... Yeah and

then this one's going off on maternity leave. Yeah so then we'll probably have another gap.”

Participants have identified issues with minority-language service delays across multiple therapies, and while waiting to access various services within healthcare systems across Canadian cities.

Proximity of Service

Every participant that mentioned travelling to services described having to commute long distances to access service in French. In Ontario, participant F01 was seeking a health evaluation in French and said:

We wanted to check for that [ADHD], but he has to be evaluated by a psychologist [and] an occupational therapist. But everything is not in French, it's all in English. So he can't be evaluated here. I have to go to Sudbury, all the time, to go see a pediatrician.

This participant had the same issue with speech services, “If I stay in Kirkland, I would have to go down to New Liskeard every week just to see the [French-speaking] speech pathologist. It doesn't make sense. It's one hour on the road. It's ridiculous!” Participant F05 discussed the possibility of additional travel if they were not bilingual and only spoke French and could only use French services for their child by saying, “It would have been difficult. I probably would have been looking at Quebec stuff or definitely concentrating more in Ottawa because Ottawa has a higher French population.” In Manitoba, participant F04 spoke about their travel problems when needing appointments with a French-speaking doctor, describing how they, “Used to be in Winnipeg like three times a month.” These quotes demonstrate that across different provinces, families must travel to access disability services in French.

Continuity of Staffing

Continuity of staffing can be described as a processing interchange problematic, a continuous cycle where one healthcare professional passes a family off to another professional. This problematic demonstrates the inability of the provincial healthcare systems to work with minority-language families across the provinces and territories in this study. Participant F07 described this professional interchange due to language issues when dealing with doctors, stating that, “Yes, I always had difficulties with English, so they passed me to [a French-speaking doctor].” Continuity of staffing is also an issue when dealing with French-speaking speech and language services. Participant F01 said, “It was constantly, oh he assesses him, he works on him super fast, then they change the speech pathologist.” Additionally, participant F07 said that:

It was the secretary that explained that, “We transferred you here because [child’s name] needs it because of his surgery, so you will start with me. If a spot opens up at the other [French] clinic you will be transferred there.”

Participant F05 described how they have worked with multiple speech and language pathologists saying that, “They replaced her with this new one ... Yeah and then this one’s going off on maternity leave.” Finally, participant F06 detailed a similar experience by saying, “Yeah. They change a lot. I’ve been probably through maybe ten already ... Maybe a little less than ten, but it’s been quite a bit.” These experiences illustrate issues relating to professional interchange occur across health and allied health services within the provincial and territorial healthcare institutions.

CHAPTER 6, DISCUSSION

The findings suggest that the healthcare systems across Canada are organized in a way that favours majority-language speakers over minority-language speakers. These monolingual healthcare systems create many issues for Francophone families. There are limited French-speaking staff or services, leading to short appointments if a family can access a service, as well as long wait times between appointments. Furthermore, there are long wait times to get assessments for services in French, or families have to travel long distances in order to find a service provider who can speak French. Francophone families also experience heightened handover between health professionals due to language barriers or a lack of specialist, negatively affecting the capacity for French disability services. These issues force many Francophone families to seek services in English so they can be seen more often or have access to disability services. Cumulatively, these findings demonstrate that even though Canada is a bilingual country, with English and French being its two official languages, its public services fail to adequately help those who do not speak English, in these provinces and territories (Moissac & Bowen, 2017; Ricard, 2019). An Institutional Ethnographer is interested in analyzing and identifying power dynamics between individuals and ruling organizations to describe how peoples' actions and interactions are organized for them rather than by them (Rankin, 2017b). These interactions are also analyzed to understand the work of individuals to carry out the actions of institutional organizations (Rankin, 2017b).

First, the findings will be presented to describe how Canadian healthcare systems are organized to maintain majority-language values. Second, the work that Francophone families do to receive disability services for their children will be discussed. The analysis highlights service

delivery weaknesses and will be used to formulate recommendations for addressing language barriers within the organization of Canadian healthcare systems.

Monolingual Canadian Healthcare Systems

The problematics that have been previously presented overwhelmingly indicate that Canadian healthcare systems are not organized in a way that adequately serves the needs of Francophone children and families. Although public services across Canada should be offered in both official languages, this analysis suggests they are primarily offered in English, which forces Francophone families to conform to monolingual healthcare services, Anglophone behavioural expectations, and understandings of disability and childhood (Minister of Justice, 1969; Vaish, 2020). French-speaking families in Canada are forced to conform to the beliefs and organization of the monolingual healthcare systems through processing interchanges and ruling relations enacted by the healthcare systems in Canada (Rankin, 2017b). These forms of organization and control will now be discussed.

Ruling Relations in the Monolingual Healthcare Systems The main ruling relation enacted upon French-speakers within the Canadian healthcare systems is when there is a lack of French services or service providers. Having limited availability of French services or French-speaking providers demonstrates that the Canadian healthcare systems are not organized in a way that helps Francophones (Ngwakongnwi et al., 2012). The monolingual organization of the Canadian healthcare systems made many participants feel as though they could not use health and disability services for many reasons. Since the Canadian provincial and territorial healthcare systems mainly prioritize offering majority-language health and disability services, Francophones do not feel comfortable using the healthcare systems. Moreover, not offering or having services in French marginalizes many Francophone Canadians because they may choose

to avoid or stop using health and disability services (Giguère & Conway, 2014). Francophones who cannot utilize services in their chosen language also do not feel as important as English-speaking Canadians within the healthcare systems, causing them to withdraw from utilizing health and disability services (Drolet et al., 2015). These findings help to understand disability is intertwined with other forms of oppression within society, such as minority-language marginalization within Canadian healthcare systems (Goodley, 2013). Francophone disabled children and their families are denied inclusion within the Canadian healthcare systems because they do not interact in ways that conform to the Anglophone behaviours and beliefs regarding health (Goodley et al., 2018; Watson, 2012). Therefore, the findings demonstrate that the Canadian healthcare systems pressures French-speakers to stop interacting with the systems because they do not fit in with the majority-language, able bodied population.

An interrelated ruling relation that Francophones choose to help their children is when participants use English to communicate with health and disability service providers. Instead of not using health and disability services at all, the monolingual organizations of the Canadian healthcare systems force French-speaking families to conform to the beliefs and behaviours of the monolingual Anglophone healthcare systems by speaking English. The experiences described by participants demonstrate how the monolingual organization of varying healthcare systems within Canada force minority-language families to be in a double minority group of disabled minority-language individuals. Many participants described how they had to resort to using English disability services because they could not find or wait for the service in French (Boudreau, 1999; Farmanova et al., 2018; Kérisit & Dubois, 1995; Martin, 1992). The participants also spoke in English or used health, disability, and childcare services that did not offer French programming because they had no other choice if they wanted consistent care for

their child (Bélanger et al., 2018). When participants conform to the systems that only operate in English, they are forced to follow the beliefs and values of the majority-language, further removing them from their community, language, and culture (Halder & Asaaf, 2017). This changes how you understand your own identity, such as what is considered to be a healthy person (Sati & Prasad, 2020). For example, the unconscious ableist biases that control and force individuals to use multiple disability and health services to get children to conform to the widely accepted view of ‘normal’ health, development, and behaviour that is socially constructed in North America (Campbell, 2001; Goodley, 2013; Meekosha & Shuttleworth, 2009).

Francophone disabled children in Canada are forced to conform not only to what is believed to be the only way to have a healthy life, but also to use the language that is most spoken within the healthcare systems. Thus, the data points to provincial and territorial healthcare systems that reinforce English beliefs, behaviours, values, and ways of operating within the systems, marginalizing any minority-language speaker.

Another important ruling relation is that provincial and territorial healthcare systems sometimes do not have available health information or research in French that helps parents understand their child’s diagnosis. By not having resources and information in French (e.g., pamphlets, videos, online websites, etc.), the systems force Francophones to consult health-related information in English (Drolet et al., 2015). English resources mainly list English service providers, so not having health information available in French can possibly lead Francophones to utilize services only in English because they may not know where to find French-speaking service providers and do not get help to do so (Drolet et al., 2015). The participants described instances where they could not find health information in French. A lack of information in French, and likely other languages, demonstrates a priority for English within Canadian

provincial and territorial healthcare systems that has been perpetuated for decades (de Moissac & Bowen, 2017; Deroche et al, 1999; Kérisit & Dubois; 1995; Martin, 1992). Even though there have been many changes to provincial legislation, the healthcare systems are not providing adequate or equal health information in French compared to English in Canada (Giguère & Conway, 2014). Moreover, this lack of French health information helps to identify a power imbalance where the Canadian healthcare systems are not adequately informing Francophone families about their children's disability, which further disadvantages them (Meekosha & Shuttleworth, 2009). Therefore, the findings demonstrate that the Canadian provincial and territorial healthcare systems force Francophones to conform to the monolingual majority-language system by not having health information always available in French.

Processing Interchanges in the Monolingual Healthcare Systems The final ruling relation that is enforced upon Francophone Canadians is when they are continuously passed from one healthcare professional to another because there is no French navigation system outside of Quebec that connects French-speaking providers to Francophone patients (French Language Health Services Network of Eastern Ontario, 2015). These processing interchanges control the interactions that Francophone Canadians have within the healthcare systems because there is no way that Francophones can easily and continuously access the services of a French-speaking healthcare professional (Drolet et al., 2015). The participants mentioned a few different ways that they experienced these processing interchanges within Canadian healthcare systems. The monolingual healthcare systems in Canada force Francophone Canadians to rely on the healthcare systems to find French-speaking service providers for them and they have no way of stopping the healthcare systems from switching them from one healthcare professional to another (Société Santé en français, 2014). The prioritization of hiring and having mainly Anglophone

healthcare professionals in Canada means that Francophone families must wait to receive referrals and continuously work with new healthcare professionals (Bélanger et al., 2018; de Moissac & Bowen, 2017). Moreover, Canadian healthcare systems are perpetuating this cycle of a low supply of French-speaking healthcare professionals paired with high demand for these services (Farmanova et al., 2018). For example, by referring Francophone families to the few known Francophone or bilingual service providers, rather than solving the issue by hiring more French-speaking service providers (Farmanova et al., 2018). The result of this processing interchange is that healthcare systems within Canada are not providing Francophones with the required resources or support in navigating the systems (Bélanger et al., 2018).

What Work Do Francophone Canadians Do?

The monolingual English organization of the Canadian healthcare systems can force Francophone families to put effort into using health and disability services in their chosen language. The first problematic that describes work that Francophones do is that they must travel to use health and disability services in French. Health and disability services limitedly support Francophones because even though participants expressed a desire to have services in French, the professionals do not have the resources and capacity to do so, making families travel to other places that do (Ngwakongnwi et al., 2012). Many participants described how they had to travel to French-speaking service providers because the health and disability services in their area only communicated in English. Thus, Canadian healthcare systems control the interactions of minority-language speakers by forcing them to travel to their French-speaking provider if they are willing and capable to do so, rather than having easy access to health and disability services.

A second form of control is that Canadian healthcare systems do not regularly actively offer services in French, so participants must navigate the systems by themselves to have their

language and continuity of care needs met by a French-speaking health professional (Farmanova et al., 2018). The monolingual organization of Canadian healthcare systems necessitate that Francophone families look for these services themselves (Drolet et al., 2015). The participants described many instances where they had to find a French-speaking service provider by themselves because there was no healthcare professional who could do it for them. This requirement demonstrates that the Canadian healthcare systems are organized in a way that does not support all Francophones and does not help them in finding services in French due to limited referral support (Société Santé en français, 2014).

A final way that the organization of the Canadian healthcare systems force Francophones to do their own work, rather than be helped by these systems, is that French-speaking service providers offer a small number of short appointments. Furthermore, French-speaking service providers may also only give appointments with long wait times in between them. These connected problematics force Francophone parents to continuously and forcefully act as advocates and be proactive in their health research to help their children (Savard et al., 2013; Savard et al., 2020). Additionally, since there are so few French-speaking providers in the monolingual Canadian healthcare systems, participants must fight for appointments with Francophone service providers (Bélanger et al., 2018; de Moissac & Bowen, 2017; Farmanova et al., 2018). The participants described how they must continually provide updated information and keep track of their child's progress, rather than having a trained health professional do so, because they do not get to utilize services as frequently as what is required (Ngwakongwi et al., 2012). Since there are so few Francophone service providers who are isolated from other practitioners and cannot accept more clients, participants also discussed how they must act as a mediator between different service providers to ensure that their children are receiving

appropriate care (Drolet et al., 2015). Thus, the monolingually organized Canadian healthcare systems necessitate that minority-language patients, families, and practitioners must work by advocating and doing research to use French health and disability services.

Cumulatively, these problematics that describe the work that Canadian Francophone families do to participate in the healthcare systems demonstrate how the Canadian healthcare systems view disabled children and their families as commodities (Procknow et al., 2017). By forcing Francophone families to travel to use French services, navigate the healthcare systems by themselves, and continually advocate for their child, the healthcare systems are prioritizing the patient experience of majority-language speakers over minority-language speakers. The Canadian healthcare systems that care for disabled children are classifying families based on language, managing their interactions within the systems, and trying to normalize disabled people (Meekosha & Shuttleworth, 2009). The monolingual Anglophone organization of the Canadian healthcare systems perpetuate power imbalances between the healthcare institutions and Francophone families by forcing them to work to interact with the system in their chosen language (Straus & Brown, 2019). Thus, the Canadian healthcare systems that have Francophone disabled children as patients must advocate for more inclusive and diverse healthcare systems by rethinking how to support minority-language families (Meekosha & Shuttleworth, 2009).

CHAPTER 7, CONCLUSION

Health and disability services in Canada are required to serve patients and families in both official languages, French and English. Yet, the findings demonstrate that there is a clear issue within Canadian healthcare systems where Francophone families outside of Quebec are not being treated the same as Anglophones because they do not speak the majority-language. The monolingual Anglophone organization of Canadian healthcare systems force French-speaking families to conform to Anglophone behaviors, beliefs, and values by not having enough health and disability services and health information available in French. Additionally, the organization of Canadian healthcare systems force Francophones to conform by requiring them to speak English to use health and disability services. Francophone Canadians also must advocate for themselves, know how to navigate the monolingual healthcare systems with no help from service providers, and travel long distances if they want to have services in French. Overall, these findings demonstrate that healthcare systems across Canada need to recognize that there are issues within the systems and address them to help all minority-language speakers.

Limitations

The scope of this paper is a limitation for several reasons. Firstly, there are more problematics that the participants discussed but could not be thoroughly analyzed due to the length of this paper. Examining these other problematics could have provided a more complete understanding of how Francophone families interact and are controlled by the healthcare systems. Secondly, although there are participants from Manitoba, Ontario, and the Northwest Territories, they do not represent every province or territory in Canada, so the results cannot be applied to the whole Canadian healthcare system. There are only eight participants that could be included in this study, so their experiences cannot be considered the only experience that

Francophones have when interacting with the healthcare systems. Additionally, it is hard to conclude that Francophones do 'more' work than Anglophone Canadians because of the limited amount of data that was being analyzed for this paper. If there were more participants from each province or territory, more generalizable conclusions that apply to the whole Canadian healthcare system could have been made.

The type of analysis has also presented some limitations. Performing secondary analysis of the interview transcripts and the institutional maps meant that I could not ask specific questions to the participants about their experience using the healthcare systems in their second language. Although the IECSS project researchers did ask questions about the participants' experiences with language barriers within the Canadian healthcare systems, the goal of the project was not to specifically understand this phenomenon. When analyzing the interview transcripts, sometimes the participants only answered one question specifically related to language issues, or little time was spent specifically detailing their issues related to not having healthcare or disability services in their chosen language. If I was able to interact with the participants and only discuss the language barriers they experienced within the healthcare systems, this might have resulted in more detailed descriptions of the problematics. Another issue related to the analysis is that I did not consider if the participants were originally born in Canada or if they immigrated here. Since some of the participants did mention that they were not from Canada, this could have contributed to an additional layer of problematics within the healthcare systems because those participants are navigating unfamiliar healthcare systems. One study compared the healthcare experiences of immigrants to non-immigrants in Canada and found separate issues (Ngwakongnwi et al., 2012). So, this distinction might be important to consider in future analysis of this data.

Implications for Future Research

The focus of this study was to learn more about how French-speaking families in Canada interact with the healthcare systems to help their disabled children. Although parents are the ones who must organize appointments, referrals, and interactions within the healthcare systems, it is also important to recognize the efforts of the children. A future research implication could be to interview the children to better understand their opinions and experiences receiving care in their second language rather than their chosen language. For example, many of the participants mentioned how their children had to interact with healthcare, education, or disability service providers in English because there was not a French-speaking professional to do so. Analyzing the children's' experiences can provide another layer of information to help understand how the healthcare systems are organizing minority-language families. According to the United Nations Convention on the Rights of the Child, including children in research would aid in respecting their rights as active, knowledgeable members of society by including their opinions in matters that affect them (UN General Assembly, 1989). Therefore, the inclusion of children in this research would respect the opinions, agency, and expertise of children in understanding their environments and the interactions that they participate in.

An additional implication for future research is that most of the cited literature is in French. There were very few studies written in English that discussed issues that the monolingual healthcare systems in Canada create for minority-language speakers. For example, if I could not read French articles, I would have had very limited pre-conceived problematics before analyzing the data and the conclusions I formed could have been very different. Thus, there is more research that needs to be done and written in English so that Anglophone service providers can understand the issues that Francophone Canadians experience.

This paper called attention to the issues that Francophone Canadians, who are a minority-language population outside of Quebec, experience. Future research can also begin to explore the issues that other minority-language populations face when interacting with the monolingual Anglophone healthcare systems across Canada. This problem of Canada being a multicultural, and therefore multilingual country, yet not being entirely inclusive, has been called to attention in the media recently. Specifically, scholars have criticized how Canadian policies, such as the *Official Languages Act*, are not consistent with the Canadian assertions of acceptance, multiculturalism, and multilingualism (Lewis, 2021). Since issues related to multiculturalism and multilingualism are being discussed in the Canadian political sphere, it should also be researched in healthcare systems across Canada. Therefore, future research should focus on how other minority languages that are not an official language in Canada, can be included more effectively within Canadian healthcare systems.

Future Practice Implications

Institutional Ethnography is a method that is especially useful for developing and informing policy because it gives insight into how systems, such as provincial and territorial healthcare systems, are working and organized (Kearney et al., 2018). The information that Institutional Ethnography provides to researchers and policy makers allows policies to reflect what is going on in the everyday activities of organizations, such as healthcare institutions (Kearney et al, 2018). The findings that have been presented throughout this paper can inform future healthcare policies specifically in Ontario, Northwest Territories, and Manitoba. First, language policies within these places must have more precise language so that no ambiguity can lead to misinterpretations of the regulations surrounding the need to offer services in French and English. Second, healthcare policies need to be created that reflect the demand for more French-

speaking health and disability services and service providers. Third, healthcare policies should include requirements that aid Francophones in navigating the provincial and territorial healthcare systems, so that they do not have to conform to Anglophone beliefs and values regarding language and disability. Overall, Anglophone healthcare providers and policy makers need to acknowledge that there are monolingual Anglophone healthcare systems in Canada, so that they can become informed of the issues and better help the children and families that they serve.

Significance of the Study

This study has concluded that there are clear issues within Canadian provincial and territorial healthcare systems that disadvantage, control, and organize Francophone families. The monolingual healthcare systems within Canada force Francophone families to conform to Anglophone beliefs regarding disabilities, ways of behaving, and interacting within the healthcare systems. Additionally, if these issues are happening to a population that speaks an official language, then it can be assumed that other minority-language speakers also experience similar issues. Therefore, these problems need to be researched and addressed within all Canadian healthcare systems so that linguistic oppression and control are not perpetuated. Canada is supposed to be a country that accepts all races, cultures, and languages, so its healthcare systems must be able to serve all the languages that patients speak.

APPENDIX A

Problematic	Description
Access to Interpreter?	Do the healthcare systems consider interpreters to be an essential role so that Francophones could communicate with English-speaking health and disability service providers?
Do the Services Offer Social Support?	Do the health and disability services offer social support in French for Francophone participants?
Extra Money to Access French Services OR French Services are Privately Rather than Publicly Funded?	Do the Canadian healthcare systems necessitate that French health and disability services be paid for? Or are French services only offered through private financing rather than publicly funded health and disability services?
Lack of French-Speaking Staff/Services?	Does the prioritization of English services and service providers within Canadian healthcare systems mean that there is a lack of French-speaking staff and health/disability services?
Limited Referral Support	Do the Canadian healthcare systems have a navigation system for Francophone participants?
Minority-Language Service Delay?	Does the prioritization of English services and service providers within Canadian healthcare systems mean that there are service delays for minority-language participants?
Monolingual Service	Are the Canadian healthcare systems organized in a way that only offers health and disability services in one language (English)?
Proximity of Service	Do the Canadian healthcare systems necessitate that Francophones travel to use services in French?
Services Used to Help with English Communication	Do the Canadian healthcare systems require that Francophones learn English to participate in health and disability services?
Stability/Continuity of Staffing?	Are the Canadian healthcare systems organized in a way that ensures continuity and stability of French-speaking health and disability professionals?

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