Canada

IMMIGRATION AND HEALTH
HOW ARE FRANCOPHONES DOING?

A STUDY OF THE HEALTH STATUS OF FRANCOPHONE IMMIGRANTS IN BRITISH COLUMBIA

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Disclaimer

The opinions expressed herein do not necessarily reflect those of Health Canada or the Société Santé en français, nor those of Public Health Agency of Canada.

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LIST OF ACRONYMS

CCHS – Canadian Community Health Survey
CSF – Conseil Scolaire Francophone
FMC – Francophone Minority Community
FOLS – First Official Language Spoken
MSP – Provincial Medical Services Plan
LISC – Longitudinal Survey of Immigrants to Canada
PHAC – Public Health Agency of Canada
PHSA – Provincial Health Services Authority

A NOTE ON DEFINITIONS

The definitions of "francophone" and "immigrant" often vary depending on the organisations and authors that are using them. Often, these definitions are used restrictively and do not reflect the reality of the composition of francophone communities. For the purposes of this report, we generally use the following broad definitions when discussing Francophones and immigrants:

Francophone: A person who chooses to live a significant part of their life in French, including participating in activities in French and requesting services in French.

Immigrant: A person who is not born in Canada, but who is living here either temporarily or permanently.

We are using this definition of "immigrant" because temporary immigrants can become permanent ones. Positive experiences with services in French could influence their decision to remain in Canada and to integrate into the Francophone community. We are using this definition of "francophone" because the results of our survey suggest that immigrants with English as their FOLS may also wish to be part of the Francophone community.
It will be noted when these are not the definitions used.

EXECUTIVE SUMMARY

Since the 1990s, Francophone Minority Communities have increasingly looked to immigration as a means to reduce demographic decline by welcoming, integrating, and retaining Francophone immigrants. This strategy is supported by the federal government, which has allocated funding to aid FMCs in this objective. However, successful retention of immigrants requires FMCs to offer a continuum of services across different sectors that go beyond settlement services alone. Research on Francophone immigrants' experiences and needs in these sectors remains limited.

Health is one such sector where research on Francophone immigrants has not been fully developed. Literature on immigrants' health in Canada indicates that newcomers generally arrive in Canada in better health than their Canadian-born counterparts, but that this health advantage is at risk of disappearing the longer an immigrant remains in Canada. This decline is due to a range of sociodemographic and socioeconomic variables, including but not limited to gender, income, employment, language, and discrimination.

This study examines the relationship between these variables and the health of Francophone immigrants in BC. It combines several methods of collecting data: i) a literature review of research on immigrant health in Canada and the health of Francophones living outside of Quebec; ii) the processing and analysis of general statistical data on Francophone immigration in BC; iii) an online survey of Francophone immigrants; iv) semi-directed interviews with Francophone community stakeholders; and v) a focus group with front-line stakeholders who directly serve Francophone immigrants.

The results of this study indicate that Francophone immigrants mostly consider their general health and mental health to be good. However, fewer Francophone immigrants consider their mental health as good compared to their general health. There are also more Francophone immigrants that perceive their health as poor compared to immigrants living in BC in general, and they tend to feel that their health is worse now than when they arrived in Canada.

Variables related to language, gender, employment, income, stress, and social interactions were found to be significantly associated with health. For mental health, variables related to language, age, gender, stress, social isolation, cultural sensitivity, and discrimination were found to have the greatest effects. There was also a significant association between general health and mental health. That is, Francophone immigrants who felt their general health was poor were more likely to also consider their mental health as poor.

Interview and focus group data provided insight into the mechanisms behind these associations. It was suggested that Francophone immigrants are often lacking in knowledge about the healthcare system in BC, and thus are unable to effectively navigate it. Furthermore, immigrants often arrive with different understandings of both healthcare and health practices in Canada. The gap between what they expect out of healthcare and what they receive can create a mistrust of the system and keep them from re-engaging.
Health is also not always seen as a priority for newcomers. The cost of living in BC, and especially in the Greater Vancouver area means that employment and income are usually the top concerns of Francophone immigrants. However, the stress of having to deal with these factors can create a downward spiral whereby health affects employment and income, which in turn affect health.

Beyond direct effects on health, Francophone immigrants were generally found to have weak feelings of connection to the Francophone community. Given the significant association between health and social connection variables, this suggests that the Francophone community could do a better job of meeting the social connection needs of Francophone immigrants by encouraging them to be more involved with community activities. Fostering these connections is especially important should the Francophone community wish to maintain its vitality through the integration of French-speaking immigrants.

To meet the health needs of Francophone immigrants, this report presents 9 high-level recommendations for RésoSanté Colombie-Britannique, the Francophone community at-large, and non-Francophone and government partners.

Recommendation 1
Place more emphasis on population-health-based interventions rather than interventions which focus on accessing health services and individual health behaviors.

Recommendation 2
Make gender and sexual orientation a centrepiece of programs and interventions. In particular, ensure that community members are knowledgeable about and sensitive to the particular health challenges that women and members of the LGBTQ+ community face.

Recommendation 3
Increase the number of programs which consider cultural views, attitudes, and expectations on health and health care. Encourage cultural sensitivity training amongst Francophone organisations and French-speaking health professionals. Develop print and web resources to help Francophone immigrants navigate healthcare in BC as a start.

Recommendation 4
Increase initiatives supporting elderly Francophone immigrants and Francophone immigrant youth.

Recommendation 5
Invest more resources in mental health programs, particularly in stigma reduction.

Recommendation 6
Continue to look for better methods of engaging with Francophone immigrants. Try to reach Francophone immigrants that are not already connected to the community through partnerships with Anglophone organisations and advertising in locations such as community centres, public pools, and places of worship.

Recommendation 7
Rethink health programs as community-building activities rather than activities that are purely focused on health and implement programs oriented around this principle. Ensure that activities are accessible and not located too far away from where Francophone immigrants are living.

Recommendation 8
Continue and enhance partnerships with non-Francophone community stakeholders as well as government to support increased and improved service provision in French.

Recommendation 9
Increase health advocacy on service accessibility and other issues impact immigrants' health

BACKGROUND

Since the 1990s, Francophone Minority Communities have viewed immigration as a means to reverse demographic decline. Consequently, stakeholders within FMCs have been increasingly involved in the immigration continuum, with the end goal of retaining francophone immigrants as community members. In other words, Francophone communities want francophone immigrants to live part of their lives in French, participating in community activities and raising their children to speak the language (Fourot, 2016).

The federal government has also acknowledged the benefits of immigration for FMCs. In 2003, the federal government released the *Strategic Framework to Foster Immigration to Francophone Minority Communities* which listed five objectives:

1. **Increase the number of French-speaking immigrants to give more demographic weight to FMCs.**
2. **Improve the capacity of FMCs to receive Francophone newcomers and to strengthen their reception and settlement infrastructures.**
3. **Ensure the economic integration of French speaking immigrants into Canadian society and into FMCs in particular.**
4. **Ensure the social and cultural integration of French-speaking immigrants into Canadian society and into FMCs.**
5. **Foster the regionalization of Francophone immigration outside Toronto and Vancouver.**

These objectives were reaffirmed in the *Strategic Plan to Foster Immigration to Francophone Minority Communities* (Citizenship and Immigration Canada—Francophone Minority Communities Steering Committee, 2006), in addition to informing funding set aside for immigration in each of the Official Languages Action Plans since the first Plan in 2003. Most recently, in March 2018, the federal government announced the *Plan d'action fédéral/provincial/territorial visant à accroitre l'immigration francophone à l'extérieur du Québec* (Immigration, réfugiés et citoyenneté Canada, 2018) to better promote francophone immigration outside of Quebec and to ensure French-language services are available and accessible to francophone immigrants. Similarly, the *Plan d'action pour les langues officielles 2018-2023* (Gouvernement du Canada, 2018) promises over $40 million in funding to attract and retain francophone immigrants in FMCs.

The integration of immigrants into FMCs, however, has not proven to be without challenges. On the one hand, community organisations often struggle to balance funding needs and relationships with other stakeholders (Belkhodja & Beaudry, 2008). Indeed, it was noted in a 2014 report that the nature of funding agreements for immigration can negatively impact relationships between community stakeholders by reshaping organisational networks and creating competition between organisation for funds. It was recommended that initiatives be put in place to bring together stakeholders for the betterment of services to francophone immigrants (Fourot, 2014). On the other hand, francophone immigrants may also struggle when integrating into FMCs. Faced with a double minority status – triple in the case of racialized minorities – francophone immigrants often lack representation within community organisations and find services ill-adapted to their needs in sectors such as education (Laghzaoui, 2018; Fourot, 2016) and language support (Maddibo, 2016). Racialized francophone immigrants in particular often feel excluded from the francophone space owing to the perception that French-Canadians conceive of this space as reserved for white, Canadian-born individuals with French as their mother tongue (Maddibo, 2016; 2009-2010).

To overcome these challenges and achieve the goal of increasing FMC vitality through immigration, it is imperative that FMCs are able to provide a sufficient level of services to francophone immigrants across different sectors to respond to their needs (Magassa, 2008). Settlement services must not be thought of restrictively as those services offered by settlement agencies and their employees, but rather holistically. Successful integration encompasses a range of sectors including but not limited to: education, work, housing, language training, health, religion, and sports and recreation (Fourot, 2016).

This is particularly important in the case of British Columbia for a number of reasons. First, immigrants make up over 25% of the Francophone community, and the number of Francophone immigrants is increasing (Fourot, 2014). Second, the most recent data from Immigration, Refugees, and Citizenship Canada (2018) show the number of immigrants to BC with language abilities in French only increasing, while those with both French and English language abilities decreasing. Third, Francophones in BC, unlike other parts of the country, have a very low geographic concentration (Chavez & Bouchard-Coulombe, 2011). Thus, the BC FMC must welcome a large number of potentially unilingual newcomers while serving them across a large geographic area. However, research on the roles of sectors other than settlement in FMCs remains limited (Fourot, 2016).

In British Columbia, health is one such sector where research on francophone immigrants is lacking. To date, little information exists on the health of francophone immigrants in this province. In total, there are four reports of note. Between 2010 and 2013, the *Provincial Health Services Authority* conducted a qualitative community consultation on the subject and produced two reports highlighting the results of meetings with community stakeholders and francophone immigrants themselves. In 2016, RésoSanté Colombie-Britannique conducted two community surveys: one on francophone health and another on access to healthcare in French. While neither of these studies specifically targeted immigrants, data were sorted on the basis of immigration status. The results of these initial studies will be discussed in further detail below. Suffice it to say, very little research has been done on the health of francophone immigrants specifically, and virtually no quantitative data exist. In this context, RésoSanté Colombie-Britannique, in partnership with the PHAC, has undertaken this study to investigate the health needs of francophone immigrants to British Columbia. This study attempts to address the gaps mentioned above to paint a more complete picture of francophone immigrants' health experience in BC and provide recommendations for RésoSanté and the Francophone community to meet the health needs of this population.

LITERATURE REVIEW

Much of the research on immigrant health is informed by what is known in the literature as the "healthy immigrant effect". Immigrants tend to arrive in better health than their native-born counterparts but decreases as they spend more time in the host country. This effect is observed not only in Canada but in the United States, Australia, and several Western European countries (Subedi & Rosenberg, 2014). In Canada, it is often hypothesized that immigrants arrive in better health than Canadians themselves because of Canada's immigration policy, which selects immigrants who are more likely to be economically active and healthy based on their education, job skills, youth, and language ability (Beiser, 2005; Subedi & Rosenberg, 2014). However, health decline both physical and mental is predicted by a range of different factors.

A variety of factors causing immigrant health decline are identified in the Canadian literature on immigrant health, such as lifestyle choices (Subedi & Rosenberg, 2014), urban centre size (Chadwick & Collins, 2015), participation in non-religious organisations (Fuller-Thomson, Noack, & George, 2011), participation in groups or organisations in general, problems accessing health care, region of residence (Robert & Gilkinson, 2012), and ability to make new friends (Zhao, Xue, & Gilkinson, 2010). However, the two most important categories of factors are sociodemographic and socioeconomic.

First, several sociodemographic indicators seem to predict immigrant health decline in Canada, including gender, age, country of origin, ethnicity, and language. In multiple studies, gender frequently emerges as a significant predictor of mental and physical health (Subedi & Rosenberg, 2014; Kim et al., 2013; Robert & Gilkinson, 2012; Salami, 2017; Fuller-Thomson et al., 2011). For example, Fuller-Thomson et al. found that women were 27% more likely to report a decline in their health after 4 years in Canada (2011). Similarly, Robert and Gilkensen found that women were more likely to report emotional problems a few years post-migration (Robert & Gilkinson, 2012). Immigrants are also likely to report poor health depending on their country of origin (Fuller-Thomson, Noack, & George, 2011). Specifically, immigrants from Central and South America, Africa, and the Middle East have been found to be more likely to report more stress and emotional problems (Robert & Gilkinson, 2012) and immigrants arriving from underdeveloped countries are at more of a risk to lose their health advantage (Setia et al., 2011).

Being a member of a visible minority and facing discrimination is also a significant predictor of health outcomes. Kim and their collaborators found that experiencing discrimination was a significant risk factor for poor health (Kim et al., 2013). Being a visible minority has been found to increase reporting of emotional problems (Robert & Gilkinson, 2012) and to work in tandem with discrimination as a strong predictor for both physical and mental health decline (De Maio & Kemp, 2010). Hyman also identified racism as a determinate of health, with a range of direct and indirect effects (2009).

Socioeconomic indicators have been linked to health outcomes in a variety of studies. Subedi and Rosenburg (2014), Kim et al. (2013), and Zhao et al. (2010) all found income to be a significant predictor of general self-reported health. Similarly, Robert and Gilkinson (2012) and De Maio and Kemp (2010) found associations between income and mental health. Education levels have also been found to affect health. Kim et al. (2013) found that men with lower levels of education were more likely to consider themselves in poor health. Omariba and Ng (2011) also found that education was a more significant predictor of self-reported health than health literacy. Education also seems to have an impact on mental health, with higher levels of stress compared to more educated immigrants as reported by Robert and Gilkinson (2012). Finally, unemployment has also been found to negatively affect self-reported health (Kim et al., 2013; Setia et al., 2011; Robert & Gilkinson, 2012).

Language proficiency is also identified as an important factor affecting immigrant health. Pottie et al. (2008) found poor proficiency in English or French was significantly related to self-reported poor health for women, while Zhao et al. (2010) found an association only between knowledge of English. Many other quantitative studies, however, have found an association across sex and language (Kim et al., 2013; Fuller-Thomson et al., 2011; Omariba & Ng, 2011). Qualitative studies also highlight the barriers language can create when accessing healthcare (Lum et al., 2016; Chadwick & Collins, 2015; Khandor & Koch, 2011).

Despite language often being found to influence the health of immigrants, far less work has examined the influence of language of the health of Francophones living in a minority context. One quantitative study based on data from the CCHS found that francophones outside Quebec report poor health more frequently than anglophones. This difference disappears for francophone women when controlling for other determinants of health but remains significant for men (Bouchard et al., 2006). Another study on francophones in New Brunswick found that francophones tend to report poorer health but not at statistically significant rates (Bélanger et al., 2011). However, as New Brunswick is an officially bilingual province, it is expected that the availability of health services would be superior to that in other provinces. Qualitative studies have confirmed the linguistic struggles of francophones living in a minority context. General difficulties for French-speakers identified by these studies include difficulties expressing oneself (Hien & Lafontant, 2013; Ngwakongnwi et al., 2012), dissatisfaction with interpretation services, and disappointment in lack of services (Ngwakongnwi et al., 2012). These studies also identify specific issues for francophone immigrants, including lack of knowledge of the system, the cost of services not covered by provincial health plans (Ngwakongnwi et al., 2012), the lack of information about available services, higher risks of depression and inactivity due to winter, and cultural differences (Hien & Lafontant, 2013).

Data on Francophone immigrants in specific provinces is very limited. In British Columbia, there are only preliminary community studies. Between 2010 and 2013, the *Provincial Health Services Authority* undertook a community consultation on Francophone immigrant health with the goal of obtaining qualitative data on their experience in the provincial healthcare system. Two reports were written based on this project – one following a consultation with only immigrants, and another after a consultation with both immigrants and service providers. The main themes resulting from these consultations align with the indicators mentioned above, like communication barriers, cultural differences, and socioeconomic factors. Similarly, RésoSanté Colombie-Britannique undertook two studies in 2016 to draw a portrait of francophones' health status and determine their needs regarding access to health services in French. The first found that francophone immigrants tend to consider themselves in worse mental and physical health than non-immigrants (RésoSanté Colombie-Britannique, 2016). The second found that immigrants are generally less at ease in English. Thus, they attempt to consult professionals that speak French more often than non-immigrants. However, they do not always find family doctors that can communicate in their preferred language (RésoSanté Colombie-Britannique, 2016). It is, however, important to note that these two studies were not targeting immigrants specifically. As a result, the data do not concentrate specifically on immigrant needs.

The present study is thus part of a field of research that is beginning to develop. However, given the pan-Canadian nature of the majority of studies, there is still a gap to be filled with regard to sub-national data. This study thus targets only the francophone immigrant population of BC.

METHODOLOGY

This study uses the determinants of health framework to identify key variables affecting francophone immigrant health. The determinants of health framework moves away from the older, more traditional view of health as the absence of disease. In this outdated framework, people get sick for unspecified reasons. Sickness causes health needs, which are responded to by the health care system. Determinants of health, on the other hand, emphasize an ecological model, whereby a variety of social, physical, and genetic factors combine with individual behavioral and biological responses to influence not only health, but general well-being and prosperity (Evans & Stoddart, 1990). As a result, both quantitative and qualitative data focused on the 12 determinants of health as identified by the Public Health Agency of Canada (Gouvernement du Canada, n.d.):

1. *Income and Social Status*
2. *Social Support Networks*
3. *Education and Literacy*
4. *Employment and Working Conditions*
5. *Social Environments*
6. *Physical Environments*
7. *Personal Health Practices and Coping Skills*
8. *Healthy Child Development*
9. *Biology and Genetic Endowment*
10. *Health Services*
11. *Gender*
12. *Culture*

Of these 12 determinants of health, only healthy child development was not considered. This is because, for ethical reasons, participants in this study were limited to those 18 years of age and older. Furthermore, questions about adults' early childhood experience are deeply personal and may have triggering effects. Therefore, to remain as non-intrusive as possible, these types of questions were excluded.

This study used a mixed-methods approach to data collection. To collect quantitative data, a 51-question online survey was developed, drawing inspiration from other public health surveys in Canada such as the CCHS and the LISC. In addition, francophone community stakeholder input was sought to ensure questions reflected the reality of francophone immigrants and were worded to be comprehensible for immigrants from a variety of backgrounds. Questions were grouped into sociodemographic, linguistic, socioeconomic, mental health, social connection, health service, lifestyle habit, physical health, and information needs categories. Dependent variables were self-reported general health and mental health. Independent variables were drawn from the other categories. Several questions also asked participants for qualitative explanations of responses to previous quantitative questions.

An additional qualitative survey was sent to community stakeholders. This survey asked questions on stakeholders' perceptions of health issues facing Francophone immigrants and on RésoSanté's role in supporting their work. It was also used as a recruitment method for stakeholder interviews, whereby stakeholders were asked to provide their email address if they were interested in participating in a one-on-one interview.

As the size of the population of interest for this study was relatively small[1] and our resources were limited, participants were recruited through a variety of methods designed to maximize sample size. Facebook posts on RésoSanté's page were made on a semi-regular, biweekly basis to solicit responses from Francophone immigrants. Stakeholders were identified through RésoSanté's partnerships and through web searches and were contacted asking them to complete the stakeholder survey as well as distribute the immigrant survey through their networks. Stakeholder Facebook pages were also sent messages asking them to share RésoSanté's Facebook post. Participants were offered an incentive of a chance to win one of 3 $50.00 gift cards to Canadian Tire in exchange for their time to complete the survey.

1 Statistics Canada indicates that the Official Language Minority number of immigrants in BC was 15,860 in the 2016 Census (2017b). This is calculated based on the total number of French FOLS immigrants and half of French and English First Official Language Spoken immigrants. The total number of French and French and English FOLS immigrants is 21,470. Their definition of "immigrant" does not include non-permanent residents. According to their data, there are an additional 2,230 non-permanent residents living in BC with either French or French and English as their FOLS (2017b).

Quantitative data were analyzed in Stata 13 and Microsoft Excel. Due to the small sample size and sampling method, running models on the quantitative data would have been methodologically problematic. As such, dependent variables were cross-tabulated with different independent variables of interest, and then results were tested for significance using Fisher's exact test. For most analyses, the dependent variables were recoded into binary "Poor/Good" categories. To increase cell count, certain independent variables were also grouped into binary categories. For those variables which were found to be significant, odds ratios were calculated to highlight the effects of the independent variables on the dependent variables.

Qualitative data was collected from a focus group with front-line workers and one-on-one interviews with a variety of community stakeholders. The focus group focused on the role healthcare and health services play in the settlement process. Participants were asked to discuss in what capacity they discuss health with their clients, the types of questions they are asked about healthcare, and how they connect their clients with the health services they need. One-on-one interviews focused on how service providers perceived the role of different determinants of health on the health status of their clients. They were also asked questions as to how the community might tackle the health issues that francophone immigrants face.

Interview and focus group transcripts were analyzed in NVivo 12. Transcripts were read once to establish a thematic coding framework, and then coded into nodes based on this framework. After the initial coding, excerpts from each node were read again to establish sub-nodes to better reflect specific themes.

All qualitative data was translated from French to English by the author.

Firsthand accounts of Francophone immigrants' experiences were not sought for this study for two reasons. First, the two PHSA studies mentioned above already collected similar data, and certain stakeholders indicated that the on-the-ground reality for Francophone immigrants has not changed substantially since then. Second, we had ethical concerns about asking Francophone immigrants about their health experience. In particular, we were concerned that asking Francophone immigrants to discuss the difficulties they had faced with health in Canada would bring up traumatic memories that they would not be comfortable experiencing in the setting of a focus group.

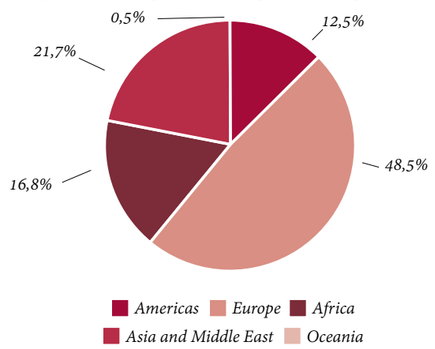
DEMOGRAPHIC PORTRAIT OF FRANCOPHONE IMMIGRANTS IN BRITISH COLUMBIA[2]

2 This section uses a more restrictive definition of "Francophone" as it deals with census data. Statistics Canada's definition of "Francophone" is based on first official language spoken.

According to 2016 Census data, there are 73,325 people with French as a first official language spoken in BC, or 1.6% of the total population of the province. Of these 73,325 individuals, 21,470 are immigrants who are permanent residents or naturalized citizens, and an additional 2,230 are temporary immigrants. Thus, approximately 32.3% of Francophones in BC were not born in Canada.

As presented in Figure 1, most Francophone immigrants are from Europe. Asia and the Middle East is the next biggest contributor, followed by Africa, then the Americas. Only Oceania is not a significant contributor to Francophone immigration in British Columbia.

Figure 1
Francophone Immigrants by Region of Origin



Source: Statistics Canada, 2017b

When breaking down these regions into subregions, Western Europe emerges as the largest contributor as seen in Table 1, with more than triple the number of immigrants as the next largest region – West Central Asia and the Middle East. Other significant regions are Eastern Europe, Eastern Asia, Northern Africa, Eastern Africa, and South America.

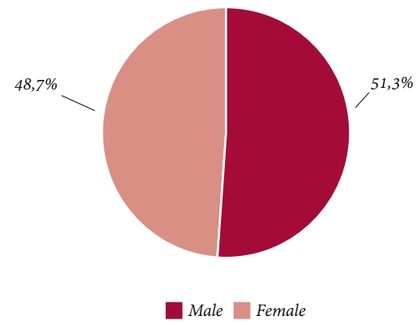
Table 1
Francophone Immigrants by Subregion

Subregion	Percentage
Western Europe	34.8%
West Central Asia and the Middle East	8.5%
Eastern Europe	8.4%
Eastern Asia	8.0%
Northern Africa	6.3%
Eastern Africa	6.2%
South America	5.7%
Southern Europe	4.4%
Central America	4.3%
Southeast Asia	3.0%
Central Africa	2.7%
Southern Asia	2.2%
Western Africa	1.5%
North America	1.2%
Carribean and Bermuda	1.2%
Northern Europe	1.1%
Oceania	0.5%
Southern Africa	0.2%

Source: Statistics Canada, 2017b

As per Figures 2 and 3, the francophone immigrant population is divided almost equally along gender lines, with approximately 49% men and 51% women. This is close the non-immigrant population, which is slightly more evenly divided.

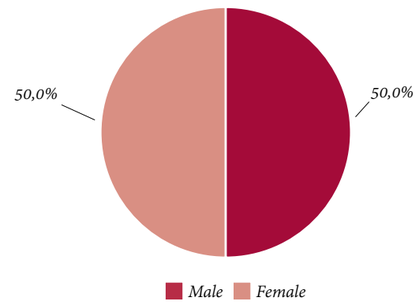
Figure 2
Francophone Immigrants by Gender



Source: Statistics Canada, 2017a

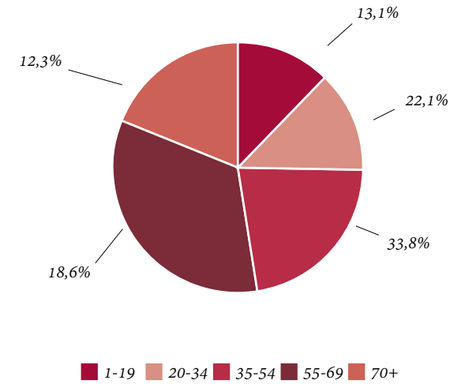
Figure 3
Francophone Non-Immigrants by Gender

Source: Statistics Canada, 2017a



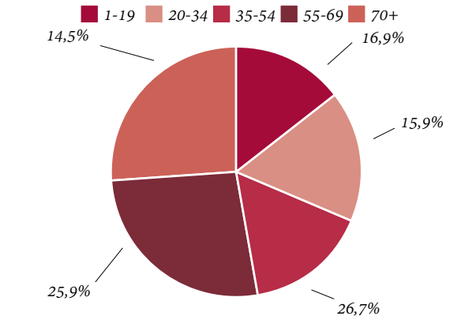
Figures 4 and 5 show the age split among Francophone immigrants and non-immigrants. In general, non-immigrants tend to be older than immigrants. However, there are more non-immigrant children (under 19) than immigrant children.

Figure 4
Francophone Immigrants by Age



Source: Statistics Canada, 2017a

Figure 5
Francophone Non-Immigrants by Age



Source: Statistics Canada, 2017a

These data suggest that Francophone immigrants are likely to have different health needs than the non-immigrant population. While the older, non-immigrant population is more likely to need direct care, the younger distribution of immigrants means that prevention and promotion are likely to have a greater impact as they age. Furthermore, while most francophone immigrants arrive from Europe, over 50% do not. These immigrants may hold different understandings of the healthcare system, and therefore may require different interventions than those arriving from Europe, where conceptions of healthcare tend to be similar to Canada's.

SURVEY RESULTS

DEMOGRAPHIC STATISTICS

Our sample consisted of 118 participants, with 94 having completed the full survey. As shown in Figure 6 respondents were predominantly female, at a rate of approximately five women for every one man. One respondent identified as a gender identity other than male or female.

Figure 6
Survey Respondents by Gender

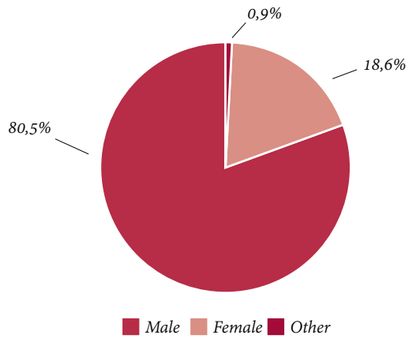


Figure 7 shows the distribution by age. Respondents were mostly between the ages of 20 and 35, with the next largest grouping being "middle aged" respondents between 35 and 54. Limited responses were received from those over 55 or under 20. This is likely because the survey was limited to those over the age of 18, and those over 55 are less likely to use the internet.

Francophone immigrants in our sample mostly came from Europe. As show in Figure 8, nearly three quarters of respondents indicated they came from a European country. Approximately 20% of respondents arrived from Africa. The remainder of respondents arrived from North and South America.

Figure 8
Survey Respondents by Country of Origin

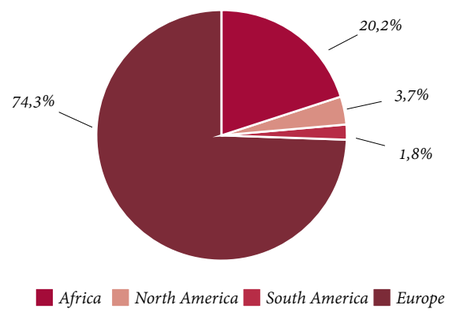


Figure 7
Survey Respondents by Age

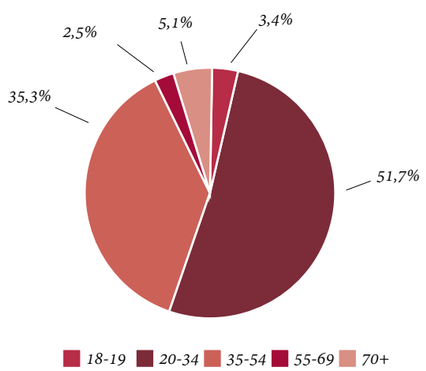
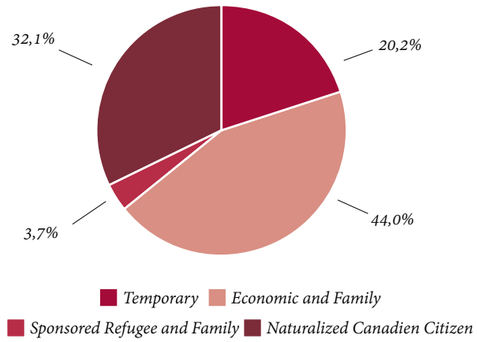


Figure 9
Survey Respondents by Immigration Status



Figures 9 shows that most respondents are in Canada as economic immigrants. A significant proportion, over 30%, are naturalized citizens, while 20% are temporary migrants. A very small proportion are refugees. While this may be due to refugees having potentially less access to information technology, this sample is consistent with other reports that show that BC has a much smaller proportion of francophone refugees as compared to other provinces (Fourot, 2014).

As per Figure 10 and 11, the majority of Francophone immigrants have French as their FOLS, followed by approximately 21% with both French and English. Almost 12% of respondents indicated English as their FOLS.

Figure 10
Survey Respondents by First Official Language Spoken

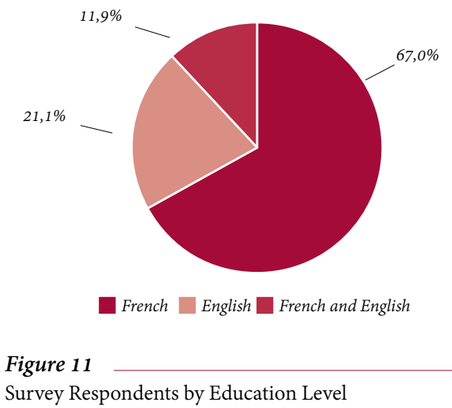
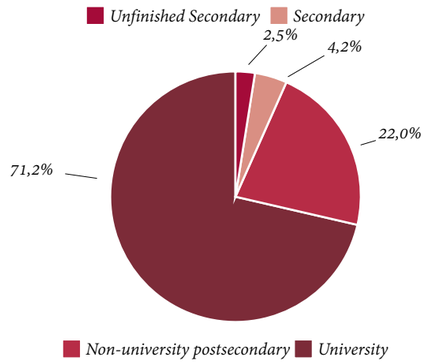


Figure 11
Survey Respondents by Education Level



Respondents are very well educated. As shown in Figure 11 only approximately 7% did not have some form of postsecondary education. Of those with postsecondary education, over 70% of respondents went to university, while 22% had a form of postsecondary education other than university.

Figure 12
Survey Respondents by Years Spent in BC

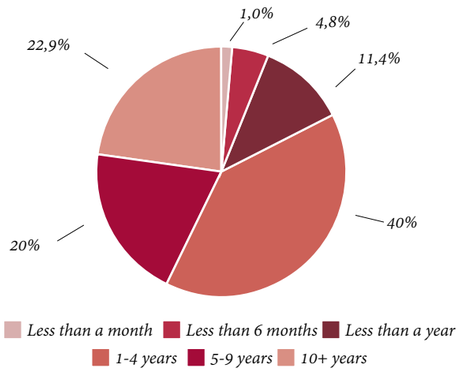
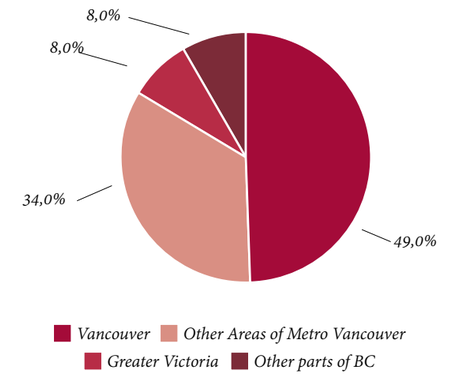


Figure 13
Survey Respondents by Region of Residence

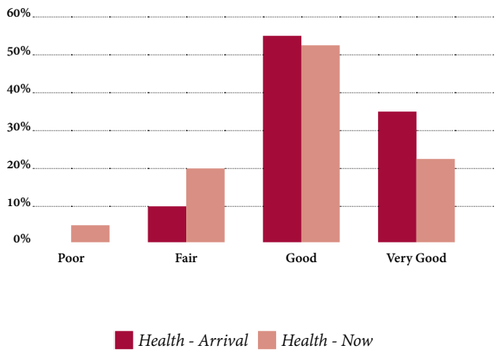


Most respondents have spent over a year in BC, as shown in Figure 12. A plurality of 40% have been in the province for between 1 and 4 years, with 20% between 5 and 9 years and nearly 23% for more than 10 years. 11% of respondents have been in the province for less than a year, while less than 5% have lived in BC for less than 6 months. 1% have lived in the province for less than a month. As indicated in Figure 13, a plurality of respondents, 49%, live in the City of Vancouver. 34% live elsewhere in Greater Vancouver, while 9% and 8% live in Greater Victoria and other parts of the province respectively.

HEALTH STATUS OF FRANCOPHONE IMMIGRANTS

Most Francophone immigrants reported that they currently are in good or very good general and mental health – approximately 75%. However, fewer immigrants felt they were currently in good or very good health as compared to when they arrived in Canada. For general health, no respondents felt their health was poor upon arrival in Canada, and approximately 10% felt their health was fair.

Figure 14
General Health Status



However, the number of respondents indicating their current health as fair or poor was much higher. Nearly 20% of respondents felt their current health was fair, and 5 % felt their health was poor. These results are displayed in Figures 14. These trends are similar for mental health status, although respondents' mental health is lower overall compared to their general health. Approximately 75% of respondents considered their mental health to be good or very good when they arrive in Canada. While the percentage of immigrants considering their mental health good now was slightly higher, the percentage of respondents who consider their mental health as very good dropped from approximately 28% to approximately 20%. Similarly, the percentage of respondents who consider their current mental health as poor or fair is higher at approximately 10% and 20% respectively. These results are presented in Figure 15.

Figure 15
Mental Health Status

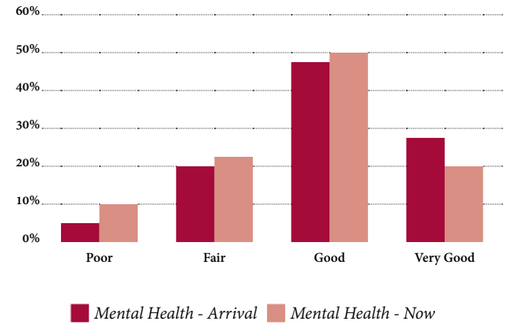


Table 2 presents summary statistics for the health status variables examined in this study. Each of these variables was measured on a 4-point scale (Poor, Fair, Good, Very Good). For general health status upon arrival in Canada, Francophone immigrants reported a mean status of 2.24. This suggests that Francophone immigrants generally perceived their health upon arrival in Canada as "good" or "very good". The standard deviation of 0.63 indicates that most respondents do not fall outside this category. Francophone immigrants tend to perceive their health status as less good now. The mean of 1.93 indicates that more immigrants feel their health is either "fair" or "poor". A standard deviation of 0.72 indicates that responses are more spread out: Many respondents still perceive their health status as good, but there are more respondents indicating it is not.

Like general health, francophone immigrants generally perceived their mental health status as "good", although the mean of 2.01 indicates that fewer respondents felt this way. A higher standard deviation indicates that responses to this question were also more spread out than general health status. Like general health status, respondents also felt that their mental health is worse now than it was when they arrived. While the mean of 1.8 indicates that most immigrants still saw their mental health as "good", more immigrants felt their mental health was poor or fair as compared to when they arrived.

Table 2
Self-Reported General Health and Mental Health Status – Difference of Means

VARIABLE	Arrival		Now		Difference of means (t-test)
	Mean	*Standard Deviation*	*Mean*	*Standard Deviation*	
Self-Perceived Health Status	2,24	0,63	1,93	0,72	0,30**
Self-Perceived Mental Health Status	2,01	0,79	1,80	0,87	0,20*
Observations	96		94		94

*** p < 0,01, * p < 0,05*

For analyses of significance, we have chosen to use the 0.1 level due to the small sample size and sampling methods in order to include as many contributors to health as possible. Table 2 also presents the results of two two-tailed difference of means t-tests on both the general health status and mental health status variables. In both cases, statistically significant differences are present between self-perceived health status on arrival and current health status at the 0.1 level. In general, immigrants tend to perceive their health as less good compared to when they arrived.
To investigate which factors are more closely associated with poor or fair health, we cross-tabulated a series of variables with health status and mental health status and conducted significance tests on the results. For these tests, we sorted the health status variables into binary "Poor/Good" variables to simplify the analysis. Data tables used for this analysis can be found in Appendix A.

Several variables emerged from these analyses as statistically significant for general health status at the 0.1 level. First, we found a relationship between satisfaction with health services in English and general health. Specifically, satisfaction with services in English was positively associated with general health status. Approximately 37% of respondents who were not satisfied with English health services were in poor health, but this proportion dropped to 24% among those who were satisfied with English health services. Transforming these rates into odds ratios shows that immigrants who were "not at all satisfied" or "not satisfied" with English health services are 2.3 times more likely to report being in poor health than those who were "satisfied" or "completely satisfied".

Second, smoking was found to be associated with general health. Those who smoke at least daily were more frequently in poor health than those whose smoke occasionally or who do not smoke at all. Due to small cell sizes, however, these results must be interpreted with caution. Weight also emerged as a statistically significant factor, with greater proportions of those identifying as having poor health being overweight or underweight. Respondents who reported being overweight were 2.2 times more likely to also report being in poor health, while those who reported being underweight were 10.5 times more likely to report being in poor health.

Feeling socially isolated was also identified as a statistically significant factor affecting general health status. In general, those who felt socially isolated often or always were more likely to report being in poor health that those who never or rarely felt isolated. Finally, mental health was closely associated with general health. Those reporting poor mental health were 3.5 times more likely to report poor general health than those who reported good mental health.

Mental health status was associated with a number of different variables. Demographically, most instances of poor mental health are concentrated between the ages of 30 and 50. Respondents between the ages of 40 and 49 had the highest proportion of people with poor mental health, with only 35% of respondents describing their mental health as good. Women are also 3.6 times more likely to report poor mental health than men. The single respondent that identified as a gender other than male or female also reported poor mental health.

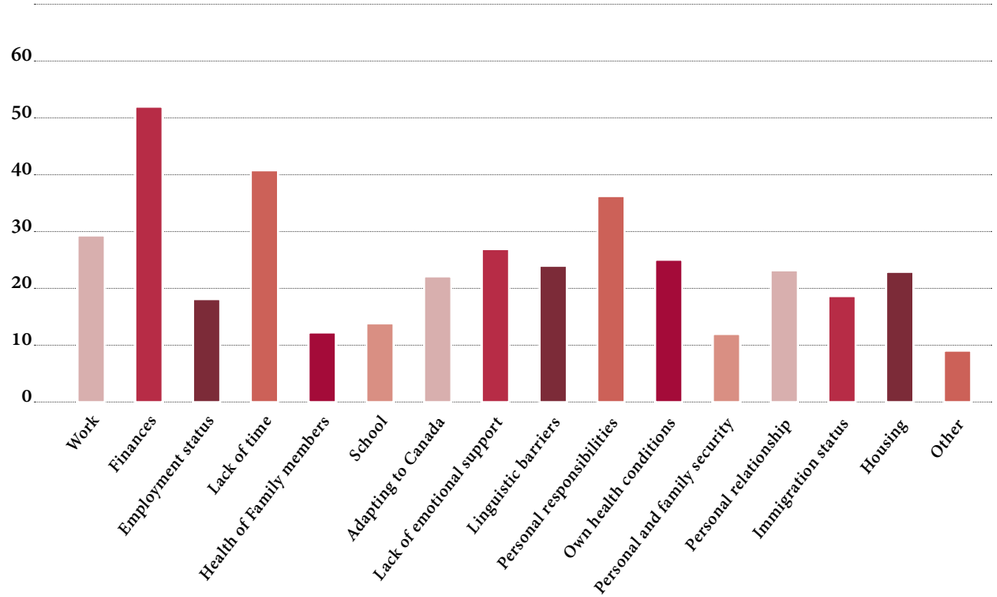
Factors related to work and finances were also found to be statistically significant. Respondents who were not at all satisfied or not satisfied with their jobs were 3.7 times

more likely to have reported being in poor health, and respondents who feel stressed at work often or always were 4.5 times more likely to report having poor mental health. Similarly, respondents who have not enough, or just enough money were 2.9 times more likely to report poor mental health.

Other stressful situations appeared to have significant impacts on mental health. Being stressed at home often or always made respondents 5.8 times more likely to report being in poor mental health, while those reporting those levels of general stress were 7 times more likely to report poor mental health. Likewise, those who found the healthcare system to be insensitive to their cultural origins were twice as likely to report poor health, while those who experienced discrimination in the healthcare system were 8 times more likely to report poor mental health.

Respondents identified a number of factors contributing to their overall stress as shown in Figure 16. Finances were the most frequently identified stressor, followed by a lack of time, personal responsibilities, and work. Own health conditions and lack of emotional support were the next most frequent. Surprisingly, immigration status, adapting to life in Canada, and linguistic barriers were some of the least frequently identified, ahead of only health of family members, school, and personal and family security. Some other factors identified by respondents included hidden and latent racism, romantic relationships, personal development, and a lack of contact with anglophones.

Figure 16
Stress Factors Identified by Respondents



Difficulty communicating with health professionals is also a predictor of poor mental health. 53% of respondents who reported having difficulties communicating with health professionals reported being in poor health, compared with only 26% of those who infrequently had issues with communications. Thus, those with difficulties communicating were 3.2 times more likely to have poor mental health.

Many social connection variables had statistically significant relationships with mental health. Only 21% of respondents who saw friends at least once a month and no respondents who saw close family at least once a month reported poor mental health. However, 59% of respondents who saw friends less than once a month and all respondents who saw close family less than once a month reported poor mental health. Social isolation is an even stronger predictor of poor mental health. 68% of respondents who reported feeling socially isolated often or always also reported poor mental health, compared to only 13% of those who never or rarely experienced social isolation. Respondents were therefore 14.4 times more likely to report poor mental health if they frequently felt socially isolated.

Since social connections are a determinant of health, respondents were asked whether they felt connected to the Francophone community on a 4-point scale. Respondents were then asked to describe their answer to this question. Table 3 presents the distribution of responses for respondents who explained their answers.

Table 3
Level of Connection to the Francophone Community

Do you feel connected to the Francophone community of BC?	Count	Percentage
No connection	2	3.1%
A weak connection	29	44.6%
A strong connection	19	29.2%
A very strong connection	15	23.1%
Total	**65**	**100%**

Of those who indicated no connection or a weak connection to the francophone community, the most cited reason for the lack of connection was simply not knowing any francophones or not having information on the community. For two respondents, their only connection to the community is through school, and they know few francophones outside of that context.

Of those with strong or very strong connections to the community, the most frequently cited reason was working in the community or being a member of a community organisation, followed by volunteering in the community or participating in community events. A smaller number of respondents cited having francophone friends as a reason they feel connected to the community. A few respondents mentioned either having children in the CSF or being in the CSF. The final two respondents who indicated strong connections mentioned their lack of English language skills and the strong presence of the community in newsletters and on social media as factors.

OPINIONS ON HEALTHCARE IN FRENCH

Respondents were asked three questions related to their satisfaction with heath services in BC. The first asked whether they were satisfied with services in English, followed by services in French, then access to services in French. These questions were measured on a 4-point scale (Not at all satisfied, Not satisfied, Satisfied, Completely satisfied).

Table 4
Satisfaction with Health Services – N/A Included

	Satisfaction with services **in English**	Satisfaction with services **in French**	Satisfaction with **access to services in French**
Not at all satisfied	5 (5.2%)	12 (12.5%)	10 (10.6%)
Not satisfied	10 (10.4%)	10 (10.4%)	22 (23.4%)
Satisfied	52 (51.2%)	22 (22.9%)	30 (31.9%)
Completely satisfied	17 (17.7%)	15 (15.6%)	7 (7.4%)
N/A	12 (12.5%)	37 (38.5%)	25 (26.6%)
Total	**96**	**96**	**94**

Table 5
Satisfaction with Health Services – N/A Excluded

	Satisfaction with services in English	Satisfaction with services in French	Satisfaction with access to services in French
Not at all satisfied	5 (6.0%)	12 (20.3%)	10 (14.5%)
Not satisfied	10 (11.9%)	10 (16.9%)	22 (31.2%)
Satisfied	52 (61.9%)	22 (37.3%)	30 (43.5%)
Completely satisfied	17 (20.2%)	15 (25.4%)	7 (10.1%)
Total	**84**	**59**	**69**

Table 6
Satisfaction with Health Services – Difference of Means

Satisfaction with English-language services		Satisfaction with French-language services		**Difference of means (t-test)**
Mean	Standard Deviation	Mean	Standard Deviation	
2.02	0.77	1.63	1.07	0.39*

Observations: 56

*** p<0.01, * p<0.05*

Table 6 presents summary statistics for respondents who answered both the English and the French satisfaction questions. The mean satisfaction with English-language health services was 2.02, which means that, on average, respondents were "Satisfied" with the services they used that were English. The mean satisfaction with French-language health services, on the other hand, was 1.63, which means that respondents were generally between "Not satisfied" and "Satisfied" with the services they had accessed in French.

A difference of means t-test was conducted to determine whether the difference between satisfaction with healthcare services was statistically significant. The difference between the means of the two variables was statistically significant at the 0.1 level, which means that it is unlikely that we would have obtained these results if there was truly no difference. Thus, Francophone immigrants are generally more satisfied with English-language services than they are with French.

Respondents were then asked to explain their answers to these questions. There was a high proportion of immigrants that did not rate their satisfaction with French-language services or with access to French-language services. This is unsurprising, as most respondents who answered the open-ended question noted the difficulty in finding French professionals. In total, 64 respondents wrote something for the question, and 20 out of 64 mentioned how hard it is to find a health professional that speaks French. One respondent noted: "It's not easy to find Francophone specialists even with the [RésoSanté] directory, they're often over-booked" (Respondent 8).

Many respondents had also never sought out French-speaking professionals, sometimes because they had never felt the need to, but also due to general difficulties with the health system: "I'm not searching specifically for services in French, because I don't need them, but also because often the most accessible is the closest walk-in clinic, and given the level of service, it's often a miracle that I can be seen in English" (Respondent 58).

Some respondents noted that it is much easier to communicate with a doctor in French than in English. This led some respondents to express their relief at finding a French-speaking professional either through RésoSanté's directory or accidentally. However, other respondents reported having bad experiences with French-speaking professionals: "I had a very bad experience with a doctor that I found using RésoSanté's directory. I left that doctor's office and asked for a transfer to another doctor. This took 2 years. At my new doctor's office I found (without really looking) a francophone doctor. The Mamans Francophones [Facebook Group] give daily advice so if I'm looking for a Francophone specialist I would be more likely to ask the mamans who will give me advice in which I would have more confidence" (Respondent 36).

Regardless of language, some expressed dissatisfaction with the health system in general: "Relatively satisfied, but disappointed by the short appointment and much worse level of service than in my country of origin." (Respondent 86).

Respondents were also asked whether they had a family doctor. Respondents who answered "no" to having a family doctor were asked to explain the reason why. Table 7 presents a count of responses to the family doctor question.

Table 7
Percentage of Respondents with a Family Doctor

Do you currently have a family doctor?	**Count**	**Percentage**
No	40	41.7 %
Yes	56	58.3%
Total	96	100%

Out of the 41.7% of respondents who do not have a family doctor, most indicated that they could not find one due to them not taking new patients. An equal number expressed that they were simply unable to find one or that they did not need one. A few respondents expressed that they did not have the time to spend looking for one. In the words of one of these respondents: "Searching for a francophone family doctor who is accepting new parents takes a lot of time which could be spent searching for a job" (Respondent 64).

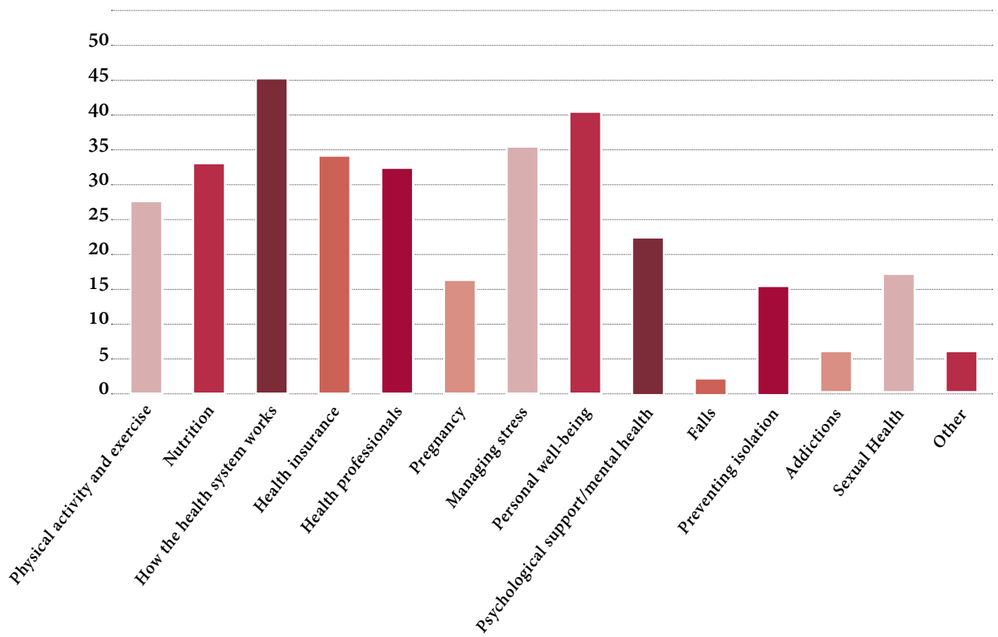
Another respondent indicated that this is relatively common among people they know: "It's basically an impossible task… I could look for someone, but it would take an enormous amount of time. I'm far from being an isolated case among my friends. The few friends of mine that have a family doctor are locals, who have always lived in Vancouver" (Respondent 12).

The remaining respondents did not have one either because they had not looked, they were paying for service at a private clinic, they didn't know how to find one, and they wanted naturalistic alternatives to traditional medicine.

NEED FOR INFORMATION

Finally, Respondents were asked which health subjects they would like to be more informed on. Figure 17 presents these results. The most frequently identified desire for information was on how the health system works. The next most frequently requested information was on personal well-being. Physical activity and exercise, nutrition, and health professionals received similar numbers of requests. The next most frequent was for information on psychological support and mental health, followed by pregnancy, preventing isolation, and sexual health, all with similar number of requests. Falls, addictions, and other topics were the least requested. Other topics included early childhood health, the impacts of health status on requests for citizenship, when to get screened for certain illnesses, and post-partum health.

Figure 17
Desire for Information on Health Topics



INTERVIEW AND FOCUS GROUP RESULTS

STAKEHOLDER INTERVIEWS

Stakeholder interviews were conducted with a variety of individuals, ranging from employees of general francophone associations to employees working in French-language health and social services. Interviewees were asked a variety of questions pertaining to the role language plays in health, access to health services in French, and challenges faced by francophone immigrants with regard to their health.

Unsurprisingly, all interviewees had something to say about the role of language in maintaining good health amongst francophone immigrants, whether it be due to communication problems that can result from miscommunication, discrimination one can face for not speaking English, or disappointment and confusion at not finding French services in a bilingual country. Francophone immigrants *"want to communicate in French. That's the first thing"* (Interview 5). The role of langue *"is primordial."* Ensuring that French language services are available is one of the main reasons Francophone organizations exist in the first place (Interview 4).

When Francophone immigrants are able to be served in their language, their first reaction is *"Surprise! "I didn't know it was possible!""* They feel that it *"makes a big difference and that it's much easier to feel comfortable in French"* (Interview 3). However, some immigrants are disappointed in the level of access to French-language health services because *"it's hard to know that we're in a Francophone country, that I could say is bilingual, where La Francophonie is there, but that we can't access those services here right away, like fast"* (Participant 5). Furthermore, the reality of the status of French in the province can be disappointing. Professionals that speak French may not know enough technical language to be able to help Francophone patients. When an interviewee accompanied a client to a doctor's appointment, he noticed that *"all the technical, medical jargon, [the doctor] didn't know it. He knew it in English but not French. But, [the directory of French-speaking health professionals] said he was a doctor who spoke French"* (Interview 1).

These difficulties with communication can cause problems and negatively impact Francophone immigrants' well-being. *"It's often a question of both emotional and physical security. For someone who is not a perfectly bilingual francophone trying to interact with a unilingual health professional, it's not a given that they'll always understand everything they were asked to do and not do"* (Interview 2). For those immigrants who are unilingual French-speakers, translation services can substitute for French-speaking health professionals. However, some immigrants do not take advantage of these services, preferring instead to use family members to translate. This needs to be discouraged, because they do not always properly translate what the patient is saying properly (Interview 3). That being said, interpreters also need to have cultural sensitivity training, as the variety of French used by patients may not correspond to that used by the interpreter which can also result in communication problems (Interview 1).

As language is so important for Francophone immigrants, most interviewees identified access to French-language health services as a primary concern. For one interviewee, *"access to francophone health professionals for people who haven't perfectly mastered English"* is the main issue francophone immigrants encounter with regard to their health. Even though this interviewee considered himself bilingual, *"sometimes there are health terms that don't immediately come to my mind because we use them once every ten years"* (Interview 2).

Another interviewee identified health services as a base service, alongside others. However, connecting to those services in French is not easy. For them, *"on every call that I receive from an immigrant, there are three basic subjects"*: housing, finding a family doctor, and employment. However, *"we always have trouble responding to the urgency of the needs of people, since we know that housing is really difficult; a francophone family doctor isn't a given either. It's possible, but we know that it's not easy. Then, work, when we can… I think out of those three things work is the easiest to make happen"* (Interview 5).

The feeling that access to French-language services is difficult was shared by another interviewee. For them, access to health services in French is *"mostly difficult"*. To find them, *"you have to meet or discuss with the right person. Really you have to have access to services like RésoSanté or [the organization where the interviewee works]."* After initial contact with an organization, employees of these organizations can *"look [for services for them] because we know where to call, we know who to ask for services in a given city."* Despite this, *"it's not something that's obvious for people. I still think that the internet has made accessing those resources easier. But, as a general rule, it's not easy. You can find them, but it's not easy"* (Interview 3). There is also a disparity between ease of access between French-Canadians that move to British Columbia and immigrants. French-language health services are *"more easily found and identified by Canadians that immigrate here. So, a Quebecois that comes to Vancouver will instinctually look for public services in French more so than an immigrant, who will not think to look"* (Interview 3).

This is particularly concerning when francophones can also face linguistic discrimination in English-language clinics. To begin with, the simple *"fact that these basic services are not delivered in their language is really harmful to their health. That's clear."* However, this interviewee also has had *"lots of clients that are refused access to care because they speak French"* (Interview 4).

Elderly francophones may be particularly vulnerable to difficulties with access to services in their language. This is increasingly problematic *"because our communities are aging and because there isn't an association for elderly people that does social work in Greater Vancouver."* Many Francophones *"are starting to be over 60 and so we accompany them to their appointments, as much to interpret as to ensure that there are follow-ups"* (Interview 4).

Interviewees also identified a number of challenges that francophone immigrants face when trying to maintain their health. The most frequently cited challenge was access to information. Interviewees 1, 3, 4, and 5 all reported that francophone immigrants often do not have enough information to navigate the healthcare system in BC or to adapt their health habits to life here. According to one interviewee, *"there are two big problems. The first is to understand how [the system] works. How to know who to talk to in order to get good care. […] And the second is how you make sure you don't pay, to make sure you're properly covered and have insurance"* (Interview 3).

For non-European, and especially African, immigrants, this need for information can extend to cultural health norms. For one interviewee, not understanding the Western definition of health is a *"really serious"* problem. For example, *"there are many people that don't know you have to bring your card to do physical activities [at community centres]. There are a lot of people that come here that don't even know that there are family doctors."* Cultural differences can also affect perceptions of medical appointments. In Africa, *"when you're sick, they prescribe you something every time. But here, they don't necessarily prescribe you something"* (Interview 1).

Need for information can also vary depending on immigration category. One interview noted that the need for information is even higher for refugees because *"the reality [is that] refugee families unfortunately don't have – and I don't mean to say that it's always like this, okay? But in general, they don't come from the same context, the same level of education, as other families that arrive here […] with advanced training, that really had a long process to get here, a process linked to a specific job sector."* Often, refugees *"need [to] always be led. […] They're people who we have to take aside for longer to explain our rules, how things work"* (Interview 5). Need for information also extends to different health topics. Another interviewee, for example, noted the particular need for information on sexual health, because in Greater Vancouver it's a topic *"that no one talks about"* and that the Francophone community *"doesn't talk about very much"* (Interview 4).

Employment, housing, and cost of living were also identified by several interviewees as having a significant impact on francophone immigrant health. For one interviewee, employment and health are the foundations of immigrant integration, because integration *"comes back to how to get a job, how to find work, how to get a home. Health is really important, because if you're not healthy, you can't work"* (Interview 1). However, even the process of looking for a job can have a negative impact on immigrants' health *"with regard to depression, stress, and then everything related to anxiety, self-esteem."* For many, *"it's a really stressful period"* because *"when you're looking for a job, you have to be the top of your game all the time and be actively looking, but at the same time you're lacking financial resources. So, stress chisels away at physical health, with sleep problems, nutrition problems."* When you're an immigrant, the impact is *"worse because you don't have access to certain services, so your savings, or the little nest egg you have diminishes every day, and every day you have this growing pressure"* (Interview 4).

These effects may be *"linked to what life demands of us here"* in Greater Vancouver. *"When you arrive, the cost of living is so high that the first thing you think of doing is working, and you don't really pay attention to the rest."* For many immigrants, *"if you don't need to [use health services], if you feel okay and you don't have a massive headache or an emergency, you keep working and you let it go. You say "no, I'll do that after, I have to work, I don't have time to leave work."* The cost of living in Greater Vancouver leads francophone immigrants to *"ignore the little signs that start to accumulate, and suddenly it becomes serious. And maybe when you go to get help, it's a bit late"* (Interview 5).

Culture also has a range of impacts on francophone immigrants' health according to the interviewees. It can affect their lifestyle habits, their nutrition, and their expectations of the healthcare system. Furthermore, it can also lead them to experience discrimination within both the healthcare system and the Francophone community. Francophone immigrants, from Europe or elsewhere, both experience a degree of culture shock when confronted with the healthcare system in BC. *"In both cases, there's a lack of confidence in the Canadian system, but a European [immigrant] will still turn towards Western medicine"* (Interview 3).

One interviewee discussed the differences between the role doctors play in France compared to Canada. For French people, *"if you're not very satisfied with the treatment […] you can ask for a second opinion."* But, *"in some countries, you're not necessarily used to contradicting the doctor, you see. That's their opinion and you, as a member of the family, as a patient, et cetera, you don't contradict them. While in other countries, you are used to saying "okay, I don't agree with that, is there another option, an option B?"* (Interview 4).

However, as noted in the above two quotes, interviewees felt that European immigrants still have an easier time with health in BC than immigrants from non-European countries. For instance, *"many Europeans, immigrants from Europe who arrive here, they're from educated, privileged social classes. For many people that arrive here, they already have university degrees, or already have knowledge and even a base level of English. Or even if they don't speak English very well, they're capable of understanding or expressing ideas."* In addition, European immigrants often have *"a knowledge of health services and of certain kinds of services you can find in Norther America. […] People coming from other countries also have similar experiences, have multiple, varied levels of education. But, […] the North American system is still relatively similar to the European system"* (Interview 4).

Immigrants from non-European countries, on the other hand, often face greater lifestyle differences in addition to having to learn how a new healthcare system works. According to one interviewee, *"what causes an immigrant to be in poor health is, first, not adapting. […] For example, an immigrant, he could see driving around in a car as a luxury. So, every time he goes [out], he drives. He doesn't see that he can really walk."* Differences in lifestyle can also affect immigrant children. For example, *"lots of parents don't know where to go to put their kids in sports,"* which can deprive children of opportunities for physical exercise (Interview 1).

They also face challenges adapting to new diets. One interviewee takes his clients "to Superstore to tell them these are calories, what do calories mean? And then what it means, for example, to have a lot of sugar." Often, their clients think that "putting lots of sugar, that's good. Putting lots of oil, that's good. But it's not good. Sugar isn't good." As a result, this interviewee tries to teach them (Interview 1). Technological barriers can also create problems for non-European immigrants. Often, new technologies are *"stranger for them. They'll ask, "How do I do this?""* when trying to access automated services by telephone or online (Interview 1).

Beyond difficulties understanding healthcare in BC and adapting to a new lifestyle, interviewees discussed the discrimination non-European immigrants can face within the healthcare system. One interview said they see discrimination *"Very… Very… Very…"* often. According to them, discrimination can cause serious problems *"if, for example, you're not well known, you're not well known, and you go [to health services] alone. […] If you go to the hospital alone, you'll die."* They tell their clients: *"when you go to the hospital and you're alone, in the case of an emergency, if you're sick, take someone, go with them."* Otherwise, the client risks not being treated quickly enough. For example, one of their clients came *"straight from the airport. Once he got to the airport, he did his medical history. They put him in the hospital here. They didn't treat him for 5 and a half hours. And then, he died. […] Because there wasn't anyone that could accompany him"* (Interview 1).

Non-European immigrants also sometimes face discrimination from within the Francophone community. One interviewee expressed that many African immigrants do not feel welcome within the Francophone community. Instead, they feel as though they are used to bring up the demographic weight of Francophones within the province without providing them with enough support services to thrive. According to them, *"there's the Global Francophonie and the Canadian Francophonie. We say we're part of La Francophonie. But they say, "No you're not, you're not part of La Francophonie." […] Because they define it by race, not by language. There are [African] people who are born in Belgium, who are born in France, on the Francophone side. But when they come here they become Francophiles"* (Interview 1).

According to this interviewee, this feeling of being left out leads African immigrants to *"pull back amongst themselves. They've pulled back."* The fact that African immigrants pull back from the community causes *"many stories of isolation. There are a lot of isolated people."* This is particularly significant amongst African children and youth. *"Lots of kids, when they get to 8th, 9th grade, they leave [the francophone community]. Because they start to isolate themselves. So, in 10th, 11th, 12th grade, they start to become lonely."* According to this interviewee, African immigrants start to believe that *"when we're small, we're together. But when we're big, now people are lonely"* (Interview 1).

Another interviewee suggested that discrimination can take other forms. There is also an *"evident discrimination […] if you look at the boards in our Francophone communities. There's not a lot of diversity. It's pretty white."* Nevertheless, for them, *"there's maybe not […] an institutional discrimination that's everywhere."* Generally, *"there isn't communication on the needs of immigrants"* and *"there's a total lack of knowledge."* This is even more problematic for *"those that aren't French or Belgian that come here. Because the activities that are planned in the community are targeted to those immigrants"* (Interview 4).

Finally, participants were asked to propose solutions and points of action for the problems they had discussed during their interviews. The most common solutions involved on-the-ground presence and advocacy.

Interviewees envisioned a variety of on-the-ground work. Two interviewees noted that a support worker that can help guide immigrants through the healthcare system in BC would be an asset to Francophone immigrants. Having *"a representative for someone, who is able to guide that person through their whole experience in the healthcare system would be of great value"* (Interview 3). One interviewee noted that a social worker with a specialization in health for African immigrants *"could really help us to do lots of things. It would be a really good thing to have an African social worker focused on health"* (Interview 1).

Two other interviewees identified the need for more work to be done to reach out to people where they are, and plan activities close to them. *"Often immigrants will more likely go to things that are close to their homes. […] There are all sorts of organisations that offer services to kids, through which we could reach families and I find that we maybe haven't done enough work in that direction."* For example, *"in the summer, there are so many families that go to the pool, outdoor and indoor. […] Sometimes it's easier to go see directly, to bring in more people when we're where they are"* (Interview 4). Another interviewee noted that the people who engage with Francophone organizations are those *"who have researched the francophone system. But if it we want to grow, […] we have to reach out to those people who aren't already a part of us. Those who speak French and that can help us make us stronger, but that are… I don't know where. So, the challenge is to maybe find them with those clinics [mobile clinics] and everything, but not just with advertising between us [francophone organisations]"* (Interview 5). These interviewees identified community centres, pools, libraries, and places of worship as locations the Francophone community could better target to inform people about services available.

Many interviewees felt it was necessary to do more activism to improve services in French. One interviewee noted the role that RésoSanté must be *"to continue to do lobbying, like what's being done right now, continue to network, continue to connect points in the community. So, working with Francophones Services which connects the points in the system"* (Interview 3). Another interviewee identified the need to make the needs of Francophone immigrants known to different levels of government. The Francophone community should undertake *"basic political action. Especially with the health ministries, with the provincial and federal ministries. People need to be aware of what's happening."* And, with regard to *"health, given our aging populations, given new immigrants, refugees arriving with multiple health needs, it's imperative that RésoSanté takes up its mantle of leader in that domain"* (Interview 4). Another interviewee insisted that effective action requires the Francophone organizations to reach more people and convince them to ask for French-language services on an individual basis. For example, *"Surrey has, at present, around 5-6 thousand Francophones. It's a lot."* But only around ten percent are members of a francophone association. The community must ask: *"Where are those 5,000? […] What would we be able to do if we could connect with the other 4,500?"* This interviewee suggests that political mobilization of these francophones could have a positive impact on service provision in French. If 5,000 francophones asked for service in their language, *"even just the act of asking will create a problem, a confusion, and that will result in other services and more services. Just the act of disturbing the norm."* But, to achieve this impact, *"we have to find those Francophones and motivate them to use their language in their everyday life, either with health or in other aspects of their life"* (Interview 5).

Other solutions mentioned by interviewees include:

- Initiatives to inform Francophones about when to get regular check-ups (Interview 1).
- More inclusion of ethnocultural diversity within the Francophone community (Interview 1).
- Some print resources for immigrants who are not as comfortable using the internet (Interviews 1 and 4).
- More information about having a healthy lifestyle in Greater Vancouver (Interview 3).
- Inform anglophone service providers about French-language services (Interview 3).
- Increased collaboration with anglophone service providers (Interview 4).
- Information sessions for newcomers that show them exactly how to navigate the health system (Interview 4).
- Infographics showing how to navigate the health system (Interview 4).
- More information for Francophones about free health services (Interview 4).
- More online resources (Interview 4).
- More funding for research to increase available information (Interview 4).
- Lobbying about problems with MSP, with the end goal of getting rid of it (Interview 4).
- Increased media presence in English-language media outlets (Interview 5).
- Have advertising in English as well as in French (Interview 5).
- Health components in other Francophone community events (Interview 5).

FOCUS GROUP WITH FRONT-LINE STAKEHOLDERS

A focus group was also conducted with front-line stakeholders who interact with Francophone immigrants as part of their daily jobs. Discussions revolved around the difficulties immigrants encounter due to the differences in healthcare in Canada, culture, and language. These difficulties, according to the participants, often cause a sense of fatigue and mistrust amongst immigrants, which can lead to or exacerbate mental health problems and cause a decline in physical health. Participants also identified solutions to these problems.

Francophone immigrants often have trouble understanding how the health system in BC works. The difference of speed at which the system operates can be quite jarring for many immigrants. Even the idea of having to make an appointment to see a doctor can be a big adjustment for immigrants. In British Columbia, *"when we say that you have to call the doctor, that you have to make an appointment, that you have to schedule it, you have to find an interpreter, that whole process is difficult to explain to them."* This complexity means that *"some understand, and other people don't"* (Participant 5).

The lack of understanding can affect not only adults' health, but children's health as well. For some immigrant parents, health services for children with special needs were not available through schools in their country of origin. The result is that some parents do not know to ask for help if their child is having difficulties. *"When they arrive from a completely different system where everything with regard to special needs isn't integrated at the school level, we have lots of families that have trouble understanding and accepting that their child has challenges, that you need to refer them, go see a pediatrician, go see a specialist"* (Participant 1)

Frequently, this lack of understanding stems from cultural differences. In some cases, immigrants come from a country where can go to the doctor whenever they want and get a quick answer. In other cases, they have internalized stigma about their medical conditions, and worry that a doctor with whom they are unfamiliar will divulge confidential information. For African immigrants especially, many of the health norms in Canada do not resonate. For example, jogging is considered *"a waste of time for many cultures. Seriously, it's a waste of time because they don't make the connection between exercise and health"* (Participant 8).

The same participant also mentioned that African immigrants often carry superstitions about the causes of health issues. For example, *"among many African people, when they're sick, when they're not physically well, they'll go to the hospital. And still, they'll think that it's not an illness. They'll simply think that if they aren't well, it's maybe that person yesterday that gave me a mean look, things like that"* (Participant 8).

Participants also identified language as a primarily challenge to the health of francophone newcomers throughout their interactions with the healthcare system. According to one participant, finding good French-language services in Vancouver, especially for immigrants who have serious illnesses, is always a struggle. Effectively, *"when someone arrives with fairly serious health problems, you really have to find good services, services in French for Francophones obviously. That's always a challenge in Vancouver"* (Participant 1).

When those services are not available, it often falls to an interpreter to help immigrants who have trouble with English. However, interpreters are not a perfect solution. When one participant accompanied one of their clients and her child to a doctor's appointment and *"she was asked a question about her child's history, [and] we hit a roadblock. Because she wanted to be able to explain, but she was blocked with regard to language."* Beyond language issues, their clients are often hesitant to share their medical history with an interpreter *"because there are stories that are purely… that a person feels are confidential and can't be confided to anyone. But when you're confronted with an interpretation, you feel, the person starts to close off"* (Participant 5).

Participants also highlighted the difficulties immigrants face when booking appointments, because medical office staff are often not French speakers even when the doctor is. As a result, settlement workers often must accompany their client through the whole process. *"It's important to go right to the end with the client because, if you just give them phone numbers, they'll call once, and it will end there"* because the secretaries do not speak French. It is equally important to *"make sure they went back, because they were happy with there appointment. Did it go well? Because […] even if there aren't a lot of Francophone doctors, if it didn't go well […] they don't have to stay with the doctor"* (Participant 1).

Other participants talked about the need for front-line workers to have information about French-language services at their disposal. RésoSanté's directory was identified as one of the primary resources for these workers, as well as the PHSA Francophone Services department and the French option on the MSP help line. However, another participant emphasized the need for community workers to direct as many people as possible to these resources to ensure that the need for them is acknowledged. For them, *"the issue is that it's used"* by immigrants, because *"if [community workers] are the ones calling them, it won't necessarily count"* (Participant 2).

These factors can often lead to feelings of mistrust towards the health system and a feeling of fatigue with the processes. Often, *"simply due to a misunderstanding of the system here in Canada, because of cultural difference, all of the sudden you're hit with discrepancies, disappointments, rejections, and probably also a degradation of levels of health over time just by simply misunderstanding the local system"* (Participant 3).

Another participant mentioned that misunderstandings might be exacerbated by not having a dedicated day where the healthcare system is explained to immigrants. *"That's what emerges when people live with that discrepancy and where there isn't an educational day, an awareness day, to really understand. What we've seen is mistrust that grows, and grows, and it's very concerning. Because then, especially when there's a big cultural difference, I would say the bigger the difference the more mistrust."* If Immigrants do not have enough information, they are more likely to say to themselves *"well, I don't go anymore. I don't trust them anymore. I don't go. If my doctor gives me a referral, I don't go. This system is worthless, and I'm not interested anymore"* (Participant 9).

In addition to losing trust, refugees in particular can begin to feel very fatigued by the system. The numerous appointments, tests, vaccinations, and the like take a toll on their mental health. One interviewee had a case where their client did not understand why he had to do more medical exams, saying *"Why do I have to go again when I get here?"* The participant told their client *"it's because it's the procedure."* But, the interviewee also mentioned that their clients *"are tired. They want to, as you say in English, "move on with their life [stated in English during the focus group]""* (Participant 4).

Participants identified several actions to take to try to meet the health needs of Francophone immigrants. First, many participants identified workshops as a way to provide immigrants with information on health and wellbeing. For these types of events, partnering with other organisations is key, because front-line workers *"don't have the expertise. [But we do have] notions."* If they notice a need on a particular topic, like nutrition, *"we organise a workshop on nutrition, and not only will we look for the expertise, we work with RésoSanté to bring in the person that will do the presentation, and we bring the newcomers"* (Participant 2). Some participants did note, however, that it can be difficult to recruit people for workshops. One participant expressed skepticism that workshops are effective. Other participants, in response, suggested that health related information sessions be incorporated into other events. Rather than have an event that specifically revolves around health, integrating health into other activities could encourage more people to participate. *"You really need to be creative, create activities maybe for youth, a health day maybe. And create other things and insert those themes in them. […] Now we try to insert all information sessions in more community-oriented activities, so we create that ambiance of connection, of coming together, that social ambiance"* (Participant 7).

These types of activities, in a less formal setting, can balance giving information about health in Canada with valuing the knowledge immigrants bring with them from their own countries. For example, community kitchens create the possibility of finding a *"balance between the idea that we're there to educate them, to give them missing information, and the idea of recognising their practices and their knowledge."* During one of their community kitchens, a participant noticed that *"all these women came with lots of knowledge about cooking in general, so it was valued. Then there was an informal exchange about their perceptions and knowledge of health like."* These types of activities create *"an ambiance, an aura of trust when we went to suggest new information or practices. That we're not just here to diminish their knowledge"* (Participant 9).

The other main idea participants expressed was the need for communication and collaboration between stakeholders. According to one participant, improving French-language services *"is a long-term project."* Their organization *"effectively need[s] [the feedback of Francophone organizations], whether it's RésoSanté, whether it's PHSA, to know where the gaps are, to see what tools are missing, the areas where there's actually a gap in service in French"* (Participant 3).

Finally, another discussed the need to be aware of what other stakeholders are doing, and to find points where collaboration is possible. Francophone organizations need to *"come ask us questions. What are you doing? And to come together and think: Are there other things we can do together? And to inform us as well, come to us."* This participant highlighted the need for a roundtable *"where we have a frequent exchange and where at least there's a continuity"* and *"moments of updating each other: Where are we now? What have we been doing?"* (Participant 7).

DISCUSSION

The results of this study indicate that Francophone immigrants are, generally speaking, in good health. On both general and mental health status questions, most Francophone immigrants (around 70% and 60% respectively) reported to be in either good or very good health. Therefore, Francophone immigrants mostly view their general health and mental health as good.

Despite a majority of Francophone immigrants considering themselves in good health, there are two main concerns with these results. First, rates of good general and mental health are much lower than those for immigrants to BC who participated in the 2014 annual component of the CCHS, which sit at 86% and 92% respectively (Statistics Canada, 2014). This suggests Francophone immigrants may be in poorer health than immigrants to BC in general. Second, a statistically significant number of francophone immigrants feel their general and mental health is worse now than it was when they arrived in Canada. Evidence for the "Healthy Immigrant Effect" is thus present in the Francophone immigrant population of BC. Francophone immigrants therefore need more resources to help them maintain their health after migrating to BC.

French-language health services also do not appear to be fully meeting the needs of Francophone immigrants. While most respondents were satisfied with French-language health services, fewer respondents were satisfied with those services compared to English-language services. Qualitative data from the survey suggests that this may be due to bad experiences with French-speaking doctors. However, many respondents indicated general frustration in accessing healthcare in BC, which may compound the effects of not being fully satisfied with services in French while having had to look harder to find them. Levels of satisfaction with access to French-language services were even lower, with only 54% of respondents satisfied. The qualitative survey data indicates that this is likely due to the difficulty finding French-speaking professionals, coupled with the fact that many French-speaking family doctors are not taking any patients. Furthermore, relatively large numbers of respondents indicated that they had nothing to say with regard to either satisfaction with or access to French-language health services. This may indicate that many respondents do not access French-language services at all. For some respondents, this appears to be due to a lack of interest in finding professionals that speak French. For others, this is likely due to the difficulty in finding professionals, or not being aware of resources available. Conversely, Francophone immigrants who do manage to access services in their language tend to have positive experiences. Both survey and interview data indicated that Francophone immigrants who do manage to find services in French, either on purpose or by accident, tend to be much happier being served in their language of choice.

There are several factors at play that make accessing services in French difficult for Francophone immigrants. First, Francophone immigrants tend to lack information. Both interview and focus group data suggest that Francophone immigrants often do not fully understand how the healthcare system works in BC. Problems can range from not understanding how to obtain coverage under MSP, to not knowing what to expect from physicians during doctor's appointments. The lack of information can, in turn, result in negative experiences for Francophone immigrants who find the medical culture clash jarring.

Furthermore, Francophone immigrants – especially non-European immigrants – have different cultural norms that further impact their understanding of health in Canada. Data indicate that francophone immigrants may have different understandings of nutrition, physical activity, privacy in medicine, and types of healthcare that do not apply in the same way to life in BC. Thus, many immigrants require information on how to adapt their lifestyles to life here in order to maintain their health.

Systemic barriers can also have an impact on Francophone immigrants' health. The survey data indicated that Francophone immigrants who feel the health system has not been sensitive to their culture are much more likely to report being in poor mental health than those who felt it has. Francophone immigrants who experienced discrimination within the health system, while few, were even more likely to report poor mental health. Interview and focus group data suggest the effect may be partly due to the lack of information mentioned above, which can create a sense mistrust in the healthcare system due to the gap between an immigrant's expectations of the kind of care they will receive and the reality of doctor-patient relationships in Canada. Immigrants thus become less likely to re-engage with BC healthcare because they no longer trust it.

Interview and focus group data also indicate that part of the reason Francophone immigrants have negative experiences with healthcare in the province is due to expectations of what services are like here. In other words, they do not realize how short doctor's appointments here are, how long wait times can be to see a doctor, or how long it can take to be seen by a specialist. When they come in with unrealistic expectations of how the system works, they sometimes decide to disengage.

However, Francophone immigrants are also affected by the shortage of physicians across the province. Reliance on walk-in clinic physicians mean that most Francophone immigrants will be unable to develop a relationship with a single physician who understands their health history, especially one who speaks their language. Interview and focus group data indicated that Francophone immigrants are often used to longer appointments, where they can go over their health concerns with their doctor in detail. This type of appointment is often easier with family physicians. These problems may be exacerbated by language. Survey data indicates that having problems communicating with health professionals strains respondents' mental health. Data from the interviews and focus groups supports this hypothesis. Participants indicated that miscommunications and misunderstandings are far more common when not communicating in your first official language, and immigrants often feel far less at ease when having to converse with health professionals in English. Furthermore, interview data also indicated that Francophone immigrants may also face linguistic discrimination from health practitioners and clinic staff due to latent prejudices towards French speakers in Western Canada.

These barriers are not exclusive to francophones living in BC. A report from Danielle de Moissac (2016) studied the difficulties faced by francophones in other provinces when trying to access healthcare. Even though language is an important factor in determining the experience of francophones in different healthcare systems, those systems are not sensitive to francophones' needs and respond to them poorly. Often, the difference between the patient's language and the language used by the health professional causes francophones to either not seek health services or to receive poor quality services. Other provinces also face a lack of health professionals that speak French (De Moissac, 2016). Briefly, access problems affect francophones across the country.

Barriers to accessing care are problematic, as data suggest that Francophone immigrants are negatively impacted by the pressures of life in BC, especially those related to employment and salary. Both salary and employment variables were associated with poor general and mental health. Those who reported being unsatisfied with their employment or having less than enough or just enough money were much more likely to report poor health. Interview data suggests that this may be due to the priority employment and salary take when immigrating to BC. The pressures to find a job that can account for your expenses are more immediate, which leads immigrants to pay less attention to health and could lead to health decline. Other survey data also supports this hypothesis. Finances, work, lack of time, and personal responsibilities were the most frequently cited causes of stress amongst survey respondents. Therefore, when faced with linguistic barriers, Francophone immigrants may decide that the stress of dealing with healthcare is simply not worth the time when it could be spent on dealing with more pressing needs.

In addition to these factors, many Francophone immigrants' health is impacted by a lack of contact with close family and friends, and by feelings of social isolation more generally. On its own, this would suggest that more mental health resources need to be made available to Francophone immigrants. However, mental health is also closely associated with general health. Francophone immigrants who have poor mental health also tend to consider their general health as poor and vice versa. Efforts to improve immigrants' mental health may therefore also help with their overall health.

Certain groups appear to be more vulnerable to poor health than others. Interview data suggest that non-European immigrants, refugees, the elderly, and youth face greater obstacles to good health. Non-European immigrants may face greater challenges adapting to life in Canada due to different cultural norms and expectations around health. While this was not something that was found in the survey data, multiple interviewees and focus group participants indicated that this may be the case. Refugees were also identified in qualitative data as an especially vulnerable group. They often arrive in Canada with greater health problems, having experienced violence and trauma before arriving. Refugees were not a major demographic in the survey results, and all reported good health. It is possible that our sampling methods were ineffective at finding refugees at greater risk of poor health. Elderly immigrants were identified as being vulnerable due to their distance from francophone services, the lack of availability of services in their language, and poverty. Francophone immigrant youth, especially non-European youth, were also identified as being vulnerable by certain interviewees. Because many of them are not located close to Francophone community services, after they leave the CSF they often lose their connection to the community and the resources it can provide.

The survey data suggests that some other groups may be more vulnerable to poor mental health. Women are far more likely to be in poor mental health than men and have higher rates of stress and social isolation than men. This may be due to the extra duties that women are expected to perform, on top of the efforts they must already make to adapt to life in Canada. Therefore, women may require more mental health support than men. Although

individuals outside the gender binary are not significantly represented in the survey, they may also be vulnerable due to the stigma and discrimination non-gender-conforming individuals face.

Temporary migrants and naturalized citizens face slightly higher rates of poor mental health as well. For temporary migrants, this could be due to the more precarious nature of their residency, coupled with a lack of access to many of the services that are provided to permanent residents. The Francophone community could place increased effort into supporting these individuals' mental health. Naturalized citizens may have higher rates of poor mental health for somewhat similar reasons: citizens also lose access to the support services that are provided to permanent residents. Naturalized citizens will also have been in Canada for longer, making them more vulnerable to the healthy immigrant effect.

Finally, people between the ages of 40 and 59 tended to have much higher rates of poor mental health. This is likely due to the increased life pressures placed on individuals in this age range, as they must take care of children, earn enough money to pay their expenses, and have less opportunities to live social lives.

Two other groups may also be vulnerable to poor health. People who are over- or under-weight tended to have higher rates of poor general health. This may be due to these individuals associating unhealthy weights with poor health and thus considering themselves not to be healthy. Or, it may be that those who do not consider themselves at a healthy body weight simply do not feel as healthy as those who are. These individuals may require more support in maintaining healthy lifestyles and being physically active.
Men may also be more vulnerable to poor health for different reasons than women. This is not based on the survey results themselves, but the fact that most survey respondents were women and that men were less likely to reply. Despite this, men perceived themselves as overweight more often, smoked more, and drank more than women. Thus, men may be at an increased risk for poor health in the future. Furthermore, in a study of health in FMCs, being a member of an FMC was found to have a statistically significant, negative impact on men's health but not women's (Bouchard et al., 2009). Taken together with the results for women, these results suggest that Francophone immigrant men and women face different health challenges, and thus may require different interventions.

Results also suggest that there are certain health issues that require more attention than others. First, it is very clear that more attention needs to be paid to the mental health of Francophone immigrants – not only because mental health is poorer in general, but because it is associated with general health as well. Thus, providing increased mental health support for Francophone immigrants may have the side effect of improving other aspects of their health that are less reachable by community interventions. Second, it is clear that Francophone immigrants want to be better informed as to how to stay in good health. The survey indicated high demand for information on how the healthcare system works, including health insurance. However, there were also many requests for information on lifestyle elements such as exercise, nutrition, managing stress, and general well-being. Third, although requests were less frequent, interview data suggests that sexual health may be an underexplored topic in the Francophone community. It is simply a topic that is not being discussed very much through French-language resources. Finally, there were far more requests for information about managing stress than about mental health and psychological support. Despite this, stress was strongly associated with poor mental health in the survey. It is possible that these results are due to a reluctance to think of stress as something that requires attention through mental health support services. This would suggest that more work needs to be done to reduce stigma around mental health in the Francophone community so that Francophone immigrants feel comfortable getting mental health support.

So far, we have only discussed the direct implications of these results on Francophone immigrant health. However, the results also have implications for Francophone immigrants to BC in general. While not associated with health in a statistically significant manner, 50% of respondents felt no connection or a weak connection to the Francophone community, and social connections are a determinant of health.

This is especially concerning given that sampling methods used to gather data favored immigrants who were already aware of one or more Francophone organisations. Combined with higher rates of poor health amongst immigrants who feel socially isolated, and do not see close family and friends very often, this may suggest that Francophone immigrants do not see the community as a means to meet their social needs. According to qualitative data from the survey and from interviews, those immigrants who do manage to connect with the community seem to be quite happy within it.

However, interview data suggests that the Francophone community can alienate some Francophone immigrants, especially non-European ones. The difference in demographics between Statistics Canada data on Francophone immigrants' countries of origin and the data from the survey also suggests that the community has a hard time reaching many segments of the French-speaking population in the province, especially with regard to health services. The Francophone community could benefit from shifting its perception of its role on in health from ensuring that Francophone immigrants find the health services they need in their language to using health as a way of bringing community members together to create social connections.

To accomplish this, the Francophone community needs to make the case to Francophone immigrants that 1) the Francophone community is there to support their health and 2) it can do a better job than anglophone services. As suggested in the literature on Francophone immigration, immigrant integration and retention rely on more than just providing settlement services. The Francophone community must ensure that immigrants have good experiences in a variety of sectors, and that they connect these good experiences to being part of a French-speaking community.

CONCLUSION AND RECOMMENDATIONS

As the Francophone minority in BC looks to immigration as a means to support its vitality, it must continue to support the work of all sectors that help Francophone immigrants to successfully integrate. Nowhere is this more important than health, as it is one of the first subjects considered by immigrants when they arrive.

The results of this study suggest that Francophone immigrants are generally in good health. However, compared to the results of other studies, the proportion of Francophone immigrants who are in good health is less than that of immigrants in general. Francophone immigrants also consider themselves in less good health than when they arrived in Canada, which suggests that they struggle to maintain the levels of health with which they arrived. These results are consistent with the "health immigrant effect" whereby immigrants' health declines after they arrive in Canada. However, the fact that a slightly smaller proportion of Francophone immigrants consider themselves in good health as compared to immigrants in general suggests that Francophones may be more vulnerable to this effect.

However, Francophone immigrants may not have the resources they need to maintain their good health as compared to their non-Francophone counterparts. In our data, Francophone immigrants were less likely to be satisfied by French-language health services they had used compared to the ones they had used in English. They were also only marginally satisfied with the degree of access they have to health services in French. As a result, here is a list of 9 high-level recommendations which could improve the experience Francophone immigrants have with regard to maintaining their health in BC.

Recommendation 1

Place more emphasis on population-health-based interventions in addition to interventions which focus on accessing health services and individual health behaviors.

Most health interventions in the Francophone community focus on providing information on health behaviours or services in French. The result is that the burden of maintaining good health for Francophone immigrants is placed squarely on individuals. However, the determinants of health framework suggest that the degree of control that individuals have over their health is relatively small, and that social and systemic factors play a much greater role. This is supported by the data in this study. Gender, income, employment, discrimination, and cultural sensitivity were all found to affect Francophone immigrant health. More emphasis needs to be placed on interventions within the Francophone community that account for these factors and help mitigate their effects.

Recommendation 2

Make gender and sexual orientation a centrepiece of programs and interventions. In particular, ensure that community members are knowledgeable about and sensitive to the particular health challenges that women and members of the LGBTQ+ community face.

Building on Recommendation 1, gender must be at the forefront of health programs within the Francophone community. The data from this study suggest that immigrant women are far more vulnerable to poor mental health than men and face greater stress and isolation than their male counterparts. Programs and interventions which consider the specific challenges that women face in the health sector, as well as the societal pressures placed on women with regard to gender roles, could provide Francophone immigrant women with the support they need to be in good mental health and to integrate more successfully in BC.

This is not to say that men's health needs do not require attention as well. Indeed, men may be less likely to engage in activities that are designed to support their health, but also have higher rates of unhealthy behaviors such as smoking and drinking. Men are also more likely to have problems with their weight than women. Special attention needs to be paid as to how to encourage Francophone immigrant men to participate in activities that support their health.

Finally, LGBTQ+ Francophone immigrants may be particular vulnerable to poor health. While not significantly represented in the survey, LGBTQ+ individuals already face greater challenges in society at-large. When paired with the pressures of immigration, as well as language barriers, these challenges can only be amplified. Francophone organisations need to ensure they are a safe space for these individuals.

Recommendation 3

Increase the number of programs which consider cultural views, attitudes, and expectations on health and health care. Encourage cultural sensitivity training amongst Francophone organisations and French-speaking health professionals. Develop print and web resources to help Francophone immigrants navigate healthcare in BC as a start.

One of the most frequently identified challenges in our data was cultural difference. Both European and non-European Francophone immigrants often do not know what to expect from the healthcare system in BC, and the gap between their expectations of the system and its reality can lead to a level of distrust that encourages Francophone immigrants to disengage. Francophone immigrants need more opportunities to learn about how the health system works, including what to expect from visits to health professionals, where to go for different health issues, how MSP works and what it covers, what kind of services are available for free and where to find them, and what kind of services are paid.

Non-European Francophone immigrants may also need information about adapting to Canadian lifestyles. Data from interviews and the focus group indicated that they may have different ideas about nutrition, exercise, and mental health. However, qualitative data suggest that this information is better delivered during other activities than workshops.

It was suggested that some of the more general information about the health system in BC could be easily delivered through infographics, showing what to do and where to go when confronted with a particular health challenge, or the steps to take when preparing for a visit to a health professional.

Recommendation 4

Increase initiatives supporting elderly Francophone immigrants and Francophone immigrant youth.

Both elderly Francophone immigrants and Francophone immigrant youth may face challenges maintaining good health for similar reasons. Namely, both of these populations are more likely to be isolated from the Francophone community, may face problems with income, and may live further away from Francophone services.
Programs which aim to increase the connection of these groups to the Francophone community and reduce social isolation could have a significant positive impact on their mental and physical health.

Recommendation 5

Invest more resources in mental health programs, particularly in stigma reduction.

Francophone immigrants have higher rates of poor mental health than general health, and face relatively high levels of stress and social isolation. While they desire more information on managing stress, their desire for information on mental health is less high.

Programs aimed at supporting positive mental health and decreasing stigma around mental health issues, along with programs for helping with stress management could positively impact Francophone immigrants. Programs which are aimed at creating community connections would also help.

Recommendation 6

Continue to look for better methods of engaging with Francophone immigrants. Try to reach Francophone immigrants that are not already connected to the community through partnerships with Anglophone organisations and advertising in locations such as community centres, public pools, and places of worship.

Francophone immigrants make up over 30% of the total Francophone population of the province. However, reaching them can be difficult, as indicated by the low response rate to the survey, and interview data suggesting that community organisations are not reaching them.
Interviewees indicated that Francophone community organisations need to look outside of their traditional areas to reach immigrants where they are. Francophone immigrants are less likely to engage with the community if they have to travel far to do so.

Recommendation 7

Rethink health programs as community-building activities rather than activities that are purely focused on health and implement programs oriented around this principle. Ensure that activities are accessible and not located too far away from where Francophone immigrants are living.

Interview data indicates that Francophone immigrants are less likely to attend events that are purely about topics related to health. This is likely because health comes after employment and income on immigrants' priority lists. By integrating health activities and information with other events, Francophone immigrants are less likely to feel they are spending time that could be better spent on something else.

In addition, integrating health information and activities into other events allows for health to be part of building community connections. As Francophone immigrants tend to be not very connected to the community and experience social isolation more frequently, this could be a way to improve mental health without specifically targeting it.

However, activities need to be closer to where Francophones immigrants live. Those who live outside of the City of Vancouver often do not want to travel into the city to participate in French-language activities. Holding events and activities in areas other than the City of Vancouver could not only positively impact Francophone immigrants' health but could increase their feeling of connection with the Francophone community.

In those communities where accessing Francophone health professionals and activities is more difficult due to distance, efforts should be made to ensure that Francophone immigrants have as much access as possible to services in their language. This could take the form of interpretation services or telehealth.

Recommendation 8

Continue and enhance partnerships with non-Francophone community stakeholders as well as government to support increase and improve service provision in French.

Francophone immigrants are only marginally satisfied with their ability to access services in French. However, they are also less satisfied with French-language services than English ones. The Francophone community requires more support from the federal and provincial governments as well as non-Francophone community stakeholders to ensure that Francophone immigrants have access to quality services in the official language of their choice. This is not only important for Francophone immigrants' health since being able to communicate with health professionals well is positively associated with health, but also for their satisfaction with their experience integrating to the Francophone community in BC.

However, increased and improved service provision also requires funding. Provincial and federal governments must ensure that francophone stakeholders have the financial resources necessary to undertake initiatives and programs that are responsive to the needs of their communities. Non-Francophone stakeholders should consider how they might include francophone stakeholders in their funding proposals and partner with them to design programs in both official languages.

Recommendation 9

Increase health advocacy on service accessibility and other issues impacting immigrants' health.

The Francophone community, especially in partnership with RésoSanté, should continue to advocate for increased capacity for health services in French, especially with regard to mental health. However, the results of this study demonstrate that there are other factors affecting Francophone immigrants' health that go beyond the ability to access services in French. The Francophone community should increase its advocacy for cultural sensitivity in the health system and within the Francophone community, sensitivity to LGBTQ+ issues in the health system and the Francophone community, and should ally itself with other organisations helping people to mitigate the impacts of the high cost of living in the province. RésoSanté should also lobby for French-language support workers that can help newcomers better navigate the health system.

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APPENDIX

Age Group	Health Status		Mental health		
	Poor	Good	Poor	Good	Total
18-19	0	3	0	3 (100%)	**3**
20-34	12	37	11 (22%)	38 (78%)	**49**
35-54	9	27	15 (42%)	21 (58%)	**36**
55-69	0	2	2 (100%)	0	**2**
70+	2	2	1 (25%)	3 (75%)	**4**
Total	**23**	**71**	**29**	**65**	**94**
Fisher's Exact Test (p-value)	0.67		0.05		

Age groups – decades	Mental health		
	Poor	Good	Total
18-19	0	3 (100%)	**3**
20-29	5 (22%)	18 (78%)	**23**
30-39	10 (23%)	34 (77%)	**44**
40-49	11 (65%)	6 (35%)	**17**
50-59	2 (67%)	1 (33%)	**3**
60-69	0	0	**0**
70-79	1 (33%)	2 (67%)	**3**
80+	0	1	**1**
Total	**29**	**65**	**94**
Fisher's Exact Test (p-value)	0.01		

Gender	Health Status		Mental health		
	Poor	Good	Poor	Good	Total
Male	5	11	2 (13%)	14 (83%)	**16**
Female	18	59	26 (34%)	51 (66%)	**77**
Other	0	1	1 (100%)	0	**1**
Total	**23**	**71**	**29**	**65**	**94**
Fisher's Exact Test (p-value)	0.65		0.07		
Odds Ratio			3.6		

Years in BC	Health Status		Mental health		
	Poor	Good	Poor	Good	Total
Less than a month	0	1	1	0	**1**
Less than 6 months	1	3	0	4	**4**
Less than a year	2	9	4	7	**11**
1-4 years	11	27	10	28	**38**
Subtotal	14 (26%)	40 (74%)	15 (28%)	39 (72%)	**54**
5-9 years	3	13	4	12	**16**
10+ years	6	16	10	12	**22**
Subtotal	9 (24%)	29 (76%)	14 (37%)	24 (63%)	**38**
Total	**23**	**69**	**29**	**63**	**92**
Fisher's Exact Test (p-value)	0.95		0.25		

Region of Origin	Health Status		Mental health		
	Poor	Good	Poor	Good	Total
Africa	3 (19%)	13 (81%)	4 (25%)	12 (75%)	**16**
North America	0	4 (100%)	0	4	**4**
South America	2 (100%)	0	1 (50%)	1 (50%)	**2**
Europe	18 (25%)	54 (75%)	24 (33%)	48 (67%)	**72**
Total	**23 (24%)**	**71(76%)**	**29 (31%)**	**65 (69%)**	**94**
Fisher's Exact Test (p-value)	0.10		0.47		

***Due to 0 cell counts, these results should be interpreted with caution*

Immigration Status	Health Status		Mental health		
	Poor	Good	Poor	Good	Total
Temporary	6 (30%)	14 (70%)	9 (45%)	11 (55%)	**20**
Economic	11 (27%)	30 (73%)	9 (22%)	32 (78%)	**41**
Refugees	0	3 (100%)	0	3 (100%)	**3**
Naturalized Citizens	6 (20%)	24 (80%)	11 (37%)	19 (63%)	**30**
Total	**23**	**71**	**29**	**65**	**94**
Fisher's Exact Test (p-value)	0.72		0.16		

Employment Satisfaction	Health Status		Mental health		
	Poor	Good	Poor	Good	Total
Not at all satisfied	1	0	0	1	**1**
Not satisfied	6	9	9	6	**15**
Subtotal	7 (44%)	9 (56%)	9 (56%)	7 (44%)	**16**
Satisfied	10	42	15	37	**52**
Completely satisfied	6	20	5	21	**26**
Subtotal	16 (21%)	62 (79%)	20 (26%)	58 (74%)	**78**
Total	**23**	**71**	**29**	**65**	**94**
Fisher's Exact Test (p-value)	0.13		0.03		
Fisher's Exact Test (p-value) with Binary Variable	0.06		0.03		
Odds Ratio	3.0		3.7		

Financial situation	Health status		Mental health		
	Poor	Good	Poor	Good	**Total**
Not enough money	8	13	11	10	**21**
Just enough money	8	21	10	19	**29**
Subtotal	16 (32%)	34 (68%)	21 (42%)	29 (58%)	**50**
Enough money	6	31	7	30	**37**
Lots of money	0	3	1	2	**3**
Subtotal	6 (15%)	34 (85%)	8 (20%)	32 (80%)	**40**
Total	**22**	**68**	**29**	**61**	**90**
Fisher's Exact Test (p-value)	0.23		0.06		
Fisher's Exact Test (p-value) with Binary Variable	0.09		0.04		
Odds Ratio	2.7		2.9		

Stress at work	Health status		Mental health		
	Poor	Good	Poor	Good	**Total**
Never	3	6	3	6	**9**
Rarely	4	28	3	29	**32**
Subtotal	7 (17%)	34 (83%)	6 (15%)	35 (85%)	**41**
Often	13	34	18	29	**47**
Always	3	3	5	1	**6**
Subtotal	16 (30%)	37 (70%)	23 (43%)	30 (57%)	**53**
Total	**23**	**71**	**29**	**65**	**94**
Fisher's Exact Test (p-value)	0.12		0.001		
Odds Ratio			4.5		

Stress at home	Health status		Mental health		
	Poor	Good	Poor	Good	**Total**
Never	2	9	2	9	**11**
Rarely	11	37	8	40	**48**
Subtotal	13 (22%)	46 (78%)	10 (17%)	49 (83%)	**59**
Often	9	25	18	16	**34**
Always	1	0	1	0	**1**
Subtotal	10 (29%)	25 (71%)	19 (54%)	16 (46%)	**35**
Total	**23**	**71**	**29**	**65**	**94**
Fisher's Exact Test (p-value)	0.43		0.001		
Odds Ratio			5.8		

General stress	Health status		Mental health		
	Poor	Good	Poor	Good	**Total**
Never	0	1	0	1	**1**
Rarely	8	34	5	37	**42**
Subtotal	8 (19%)	35 (81%)	5 (12%)	38 (88%)	**43**
Often	13	34	21	26	**47**
Always	2	1	3	0	**3**
Subtotal	15 (30%)	35 (70%)	24 (48%)	26 (52%)	**50**
Total	**23**	**70**	**29**	**64**	**93**
Fisher's Exact Test (p-value)	0.22		0.00		
Odds Ratio			7.0		

Ease with the Anglophone Community	Health status		Mental health		
	Poor	Good	Poor	Good	**Total**
Never	0	0	0	0	**0**
Rarely	8	14	12	10	**22**
Subtotal	8 (36%)	14 (64%)	12 (55%)	10 (45%)	**22**
Often	10	47	13	44	**57**
Always	4	8	2	10	**12**
Subtotal	14 (20%)	55 (80%)	15 (22%)	54 (78%)	**69**
Total	**22**	**69**	**27**	**64**	**91**
Fisher's Exact Test (p-value)	0.16		0.02		
Odds Ratio			4.32		

Frequency Seeing Friends	Health status		Mental health		
	Poor	Good	Poor	Good	**Total**
Less than once a year	2	3	4	1	**5**
At least once a year	7	10	9	8	**17**
Subtotal	9 (41%)	13 (59%)	13 (59%)	9 (41%)	**22**
At least once a month	5	26	8	23	**31**
At least once a week	8	23	5	26	**31**
Subtotal	13 (21%)	49 (79%)	13 (21%)	49 (79%)	**62**
Total	22	62	26	58	**84**
Fisher's Exact Test (p-value)	0.22		0.005		
Fisher's Exact Test (p-value) with Binary Variable	0.09		0.002		
Odds Ratio	2.6		5.4		

Frequency seeing close family

	Health status		Mental health		
	Poor	Good	Poor	Good	**Total**
Less than once a year	5	18	14	9	**32**
At least once a year	15	34	12	37	**49**
Subtotal	20 (28%)	52 (72%)	26 (37%)	46 (63%)	**71**
At least once a month	0	3	0	3	**3**
At least once a week	0	7	0	7	**7**
Subtotal	0	10 (100%)	0	10 (100%)	**10**
Total	20	62	26	56	**81**
Fisher's Exact Test (p-value)	0.31		0.002		
Fisher's Exact Test (p-value) with Binary Variable	0.11		0.03		

Satisfaction with health services in English

	Health status		Mental health		
	Poor	Good	Poor	Good	**Total**
Not at all satisfied	4 (80%)	1 (20%)	3	2	**5**
Not satisfied	2 (20%)	8 (80%)	2	8	**10**
Subtotal	6 (37%)	9(63%)	5 (33%)	10 (67%)	**15**
Satisfied	16 (31%)	35 (69%)	18	33	**51**
Completely satisfied	0	17 (100%)	3	14	**17**
Subtotal	16 (24%)	55 (76%)	21 (31%)	47 (69%)	**68**
Total	**22**	**61**	**26**	**57**	**83**
Fisher's Exact Test (p-value)	0.001		0.24		
Fisher's Exact Test with Binary Variables (p-value)	0.21				
Odds Ratio	2.3				

Respect for culture

	Health status		Mental health		
	Poor	Good	Poor	Good	**Total**
Never	7	16	8	15	**23**
Rarely	8	28	14	22	**36**
Subtotal	15 (25%)	44 (75%)	22 (37%)	37 (63%)	**59**
Often	5	17	3	19	**22**
Always	2	3	3	2	**5**
Subtotal	7 (26%)	20 (74%)	6 (22%)	21 (78%)	**27**
Total	**22**	**64**	**28**	**58**	**86**
Fisher's Exact Test (p-value)	0.77		0.09		
Odds Ratio			2.1		

Experienced discimination

	Health status		Mental health		
	Poor	Good	Poor	Good	**Total**
Never	14	48	14	48	**62**
Rarely	6	14	8	12	**20**
Subtotal	20 (25%)	62 (75%)	22 (27%)	60 (73%)	**82**
Often	2	3	3	2	**5**
Always	1	2	3	0	**3**
Subtotal	3 (38%)	5 (62%)	6 (75%)	2 (25%)	**8**
Total	**23**	**67**	**28**	**62**	**90**
Fisher's Exact Test (p-value)	0.62		0.01		
Odds Ratio			8.2		

Fruits and Vegetables Consumed in a week

	Health status		Mental health		
	Poor	Good	Poor	Good	**Total**
None	0	1	0	1 (100%)	**1**
1 to 2	11	26	16 (43%)	21 (57%)	**37**
3 to 4	11	30	8 (20%)	33 (80%)	**41**
Subtotal			24 (30%)	55 (70%)	**79**
5+	1	13	5 (36%)	9 (74%)	**14**
Total	**23**	**70**	**29**	**64**	**93**
Fisher's Exact Test (p-value)	0.38		0.10		

Smoking

	Heath status		
	Poor	Good	**Total**
I don't smoke	20	60	**80**
Less than once a week	0	4	**4**
A few times a week	0	4	**4**
Once a day	1	0	**1**
Multiple times a day	2	1	**3**
Total	**23**	**69**	**92**
Fisher's Exact Test (p-value)	0.08		

***Due to 0 cell counts, results should be interpreted with caution*

Weight

	Health status		
	Poor	Good	**Total**
Yes, I am a health weight	8 (16%)	42 (84%)	**50**
No, I am overweight	8 (30%)	19 (70%)	**27**
No, I am underweight	4 (67%)	2 (33%)	**6**
I don't know	2	5	**7**
Total	**22**	**68**	**90**
Fisher's Exact Test (p-value)	0.04		
	2.2	10.5	

Difficulties communicating with health professionals

	Health status		Mental health		
	Poor	Good	Poor	Good	Total
Never	3 (14%)	18 (86%)	7 (33%)	14 (67%)	**21**
Rarely	13 (24%)	42 (76%)	13 (24%)	42 (76%)	**55**
Subtotal	16 (21%)	60 (79%)	20 (26%)	56 (74%)	**76**
Often	4 (31%)	9 (69%)	6 (46%)	7 (54%)	**13**
Always	1 (50%)	1 (50%)	2 (100%)	0	**2**
Subtotal	5 (33%)	10 (67%)	8 (53%)	7 (47%)	**15**
Total	**28**	**63**	**21**	**70**	**91**
Fisher's Exact Test (p-value)	0.42		0.07		
Fisher's Exact Test with binary	0.32		0.06		
			3.2		

Feelings of social isolation

	Health status		Mental health		
	Poor	Good	Poor	Good	
Never	2 (25%)	6 (75%)	1 (13%)	7 (87%)	**8**
Rarely	10 (18%)	45 (82%)	7 (13%)	48 (87%)	**55**
Subtotal	12 (19%)	51 (81%)	8 (13%)	55 (87%)	**63**
Often	7 (28%)	18(72%)	15(60%)	10 (40%)	**25**
Always	4 (67%)	2 (33%)	6 (100%)	0	**6**
Subtotal	11 (35%)	20 (65%)	21 (68%)	10 (32%)	**31**
Total	**23**	**71**	**29**	**65**	**94**
Fisher's Exact Test (p-value)	0.07		0.00		
Fisher's Exact Test (p-value) with Binary Variable (p-value)	0.124		0.00		
	2.33		14.4		

Health status

	Mental health		
	Poor	Good	Total
Poor	12	11	**23**
Good	17	54	**71**
Total	**29**	**65**	**94**
Fisher's Exact Test (p-value)	0.02		
	3.5		

Mental health

	Health status		
	Poor	Good	Total
Poor	12 (41%)	17 (59%)	**29**
Good	11 (17%)	54 (83%)	**65**
Total	**23**	**71**	**94**
Fisher's Exact Test (p-value)	0.02		
	3.5		

Social Isolation

Gender			
	Infrequently	Frequently	Total
Male	14 (82%)	3 (18%)	**17**
Female	51 (63%)	30 (37%)	**81**
Other	1 (100%)	0	**1**
Total	**66 (67%)**	**33 (33%)**	**99**
Fisher's exact (p-value)	0.19		

Stress at work

Gender			
	Infrequently	Frequently	Total
Male	14 (74%)	5 (26%)	**19**
Female	32 (39%)	51 (61%)	**83**
Other	0	1 (100%)	**1**
Total	**46 (45%)**	**57 (55%)**	**103**
Fisher's exact (p-value)	0.01		

Stress at home

Gender			
	Infrequently	Frequently	Total
Male	19 (100%)	0	**19**
Female	44 (54%)	38 (46%)	**82**
Other	1 (100%)	0	**1**
Total	**64 (63%)**	**38 (37%)**	**102**
Fisher's exact (p-value)	0.00		

Stress at home

Gender			
	Infrequently	Frequently	Total
Male	17 (89%)	2 (11%)	**19**
Female	32 (40%)	49 (60%)	**81**
Other	0	1 (100%)	
Total	**49 (49%)**	**52 (51%)**	
Fisher's exact (p-value)	0.00		

Connection to the Francophone Community

	Health Status		Mental health		
	Poor	Good	Poor	Good	Total
No connection	0	2 (100%)	1 (50%)	1 (50%)	**2**
A weak connection	11 (24%)	34 (76%)	14 (31%)	31 (69%)	**45**
Subtotal	11 (23%)	36 (77%)	15 (32%)	32 (68%)	**47**
A strong connection	7 (23%)	23 (77%)	9 (30%)	21 (70%)	**30**
A very strong connection	5 (29%)	12 (71%)	5 (29%)	12 (71%)	**17**
Subtotal	12 (26%)	35 (74%)	14 (30%)	33 (70%)	**47**
Total	**23**	**71**	**29**	**65**	**94**
Fisher's Exact Test (p-value)	0.94		0.96		

Gender	Weight				
	Yes, I am a healthy weight	No, I am over-weight	No, I am under-weight	I don't know	**Total**
Male	8 (50%)	6 (38%)	1 (6%)	1 (6%)	**16**
Female	43 (57%)	21 (28%)	5 (7%)	6 (8%)	**75**
Total	**51 (56%)**	**27 (30%)**	**5 (5%)**	**6 (7%)**	**91**

Gender	Smoking					
	I don't smoke	Less than once a week	A few times a week	Once a day	Multiple times a day	**Total**
Male	11 (69%)	1 (6%)	1 (6%)	0	3 (19%)	**16**
Female	70 (91%)	3 (4%)	3 (4%)	1 (1%)	0	**77**
Other	1 (100%)	0	0	0	0	**1**
Total	**82 (87%)**	**4 (4%)**	**4 (4%)**	**1 (1%)**	**3 (3%)**	**94**

Mean drinks per day

	Observations	Mean	Standard Deviation	Mininum	Maximum
Male	16	0.78	1.12	0	4
Female	68	0.29	0.37	0	1.57
Other	1	0	N/A	0	0
Total	**85**	**0.38**	**0.61**	**0**	**4**