MEETING THE CHALLENGE OF DIVERSITY IN HEALTH: THE NETWORKING AND PARTNERSHIP APPROACH OF QUEBEC'S ENGLISH-SPEAKING MINORITY

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> *"One of the most important challenges facing modern societies,*
> *and at the same time one of our most significant opportunities,*
> *is the increase in ethnic and social heterogeneity"*
>
> —Putnam, R.D. (2007)

Abstract

The diverse English-speaking minority communities of Quebec provide an opportunity to consider the challenges and opportunities embedded in the linguistic and socio-cultural dimensions of public health care access in a globalizing Canada. This article draws from the Statistics Canada 2011 *National Household Survey* to review similarities and differences among the immigrant and Canadian-born within Quebec's English and French-speaking communities regarding key socio-economic characteristics. The community development approach practiced by Quebec's Community Health and Social Services Network (CHSSN) is assessed among prevailing efforts being made to provide linguistic and culturally appropriate health assessment, prevention and treatment to heterogeneous populations. It is argued that the community development approach is distinct in its (1) capacity to align with the history and tradition of the collective it targets, (2) in its reach in building a continuum of care that extends beyond formal medical settings and (3) in its promotion of community impact at the level of health service planning.

Résumé

La diversité des communautés minoritaires d'expression anglaise au Québec fournit l'occasion d'étudier les opportunités et les défis enchâssés dans les dimensions linguistiques et socioculturelles en matière d'accès aux services de santé publics dans un Canada mondialisé. Cet article se base sur l'Enquête nationale auprès des ménages de Statistique Canada en 2011 pour faire le point sur les similitudes et les différences des caractéristiques socio-économiques entre les populations immigrantes et celles nées au Canada au sein des communautés d'expression anglaise et française

au Québec. L'approche de développement communautaire du Community Health and Social Services Network (CHSSN) (Réseaux communautaires de santé et de services sociaux) est évaluée dans le cadre des efforts importants faits dans le but d'offrir des évaluations, de la prévention et des traitements en matière de santé et tenant compte des aspects culturels et linguistiques de ces populations hétérogènes. L'article soutient que l'approche de développement communautaire se distingue par (1) sa capacité de s'aligner avec l'histoire et les traditions des collectivités visées; (2) sa façon de construire un continuum de soins qui va au-delà des environnements médicaux officiels; et (3) sa promotion des impacts communautaires en matière de planification de services de santé.

Introduction

Access to health care is among the social determinants cited by health organizations around the world as essential to the health of individuals and vitality of communities (Mikkoven and Raphael, 2010). Barriers to access contribute to health inequalities. Access is measured not only by the geographic distance to service facilities but also by linguistic and socio-cultural factors that shape the quality of engagement citizens have with their public health and social service system. The effective engagement of citizens with their health institutions not only promises to improve their health status - it also contributes to the increased social participation that flows from a sense of cultural safety and from trust in responsive "host" institutions (Kirmayer, 2012; Allen, 2008; Brown et al. 2009; Brascoupe and Waters, 2009).This article explores the situation of a culturally heterogeneous minority community with respect to their engagement of Quebec's public health and social service institutions.

Part 1 of the article introduces Quebec's minority language community and the legislative/policy background that underlies the relation of community members with their public health institutions. Aside from their language use, Quebec's English-speaking communities[1] have long been understood as distinct from the French-speaking majority of the province, and from official-language minority communities located in other Canadian provinces, by virtue of their cultural diversity. The same comparisons also reveal a high level of socio-economic vulnerability, high levels of community sector participation and research demonstrates that English-speakers display an overall low representation among Quebec's health occupations.

Part 2 draws primarily on the 2011 *National Household Survey* (NHS) (Statistics Canada 2011) to detail the differences and similarities

among immigrant and Canadian born as well as visible minority groups that compose Quebec's English-speaking and French-speaking communities. To highlight, Quebec's English-speaking immigrants are less bilingual than those who are Canadian-born, they are more likely to have high levels of high educational attainment and they also have higher rates of unemployment. Whether English-speaking or French-speaking, whether residing inside or outside of urban Montréal[2], Quebec's immigrant citizens are less likely to have full-time, stable employment compared to the non-immigrant group.

With respect to Quebec's English-speaking visible minority population, 33.2% are living below the low income cut-off compared to 17% of the non-visible minority group. In the Montréal region, 37.7% are living in these straitened circumstances. Among age groups, youth and young adults 25–44 years of age represent the largest proportion of the English-speaking visible minority population.

Part 3 introduces the case of English-speaking Quebec as an occasion to explore the challenges and opportunities embedded in the linguistic and cultural dimensions of health care access in a globalizing Canada. Here, the community development approach exemplified by the Networking and Partnership Initiative (NPI) of the Community Health and Social Services Network (CHSSN)[3] has the potential to address cultural challenges even as they are compounded by the low socio-economic status of the minority group and the small proportion of health workers drawn from their ranks. The role of community sector networks that mobilize to secure and improve the access of a multi-cultural citizenry to health and social services organized primarily around the reality of the dominant cultural group, is examined and contrasted with more institutionally-centred strategies. From the case of CHSSN we learn that the community development approach is distinguished from prevailing strategies in its capacity to align with the history and tradition of the collective it targets; in its reach in building a continuum of care that extends beyond formal medical settings; and, in its promotion of community impact at the level of health service policy and planning. In network terms, bridging and linking connections as well as bonding (Putnam, 2007; Dale and Onyx, 2005).

Part 1: Who are Quebec's English-speaking Minority Communities?

Distinguishing characteristics of the provincial collective as well as both inter-regional and intra-regional differences distributed across its territories are important considerations in meeting the health challenges posed by the diversity of the English-speaking population.

Aside from provincial and regional findings, comparison is drawn between English-speaking and French-speaking communities of the urban Montréal area and the "rest of Quebec." These features coupled with the unique language policy of Canada and Quebec, particularly its implementation in the health sector, set the boundaries of strategies to secure access to linguistic and culturally appropriate care for Quebec's language minority.

Demographic variance between and within regional communities

In terms of both land mass and population, Quebec is the second largest of Canada's provinces. This means that while numbers for the province are substantial, English-speaking communities are dispersed across a large territory and live in varying social circumstances. There are more than one million English speakers who comprise 13.5% of Quebec's population. Among Official-Language Minority Communities (OLMC) in Canada, Quebec's English-speaking population is the largest followed by Ontario and New Brunswick's Francophone populations and second only to New Brunswick Francophones in terms of its share of the provincial population (Canadian Heritage, 2015b).

According to the 2011 *Census of Canada*, regional English-speaking communities range from more than 600,000 on the island of Montréal and large population counts in nearby Montérégie (159,515) and Laval (82,078) to tiny populations in areas such as Bas-Saint-Laurent (1,135), Saguenay Lac-Saint-Jean (1,798) and Centre-du-Québec (2,635) (Canadian Heritage, 2015b).

Overall, 9 in 10 of Quebec's English speakers are living in cities. Yet despite this urban character, a number of regional English-speaking communities show high proportions of community members living in rural situations. This is the case in Northern Quebec (100%)[4], Gaspésie – Îles-de-la-Madeleine (97%), Abitibi-Témiscamingue (52%), Estrie (49%) and Bas-Saint-Laurent (45%) (Canadian Heritage, 2015b). Another demographic variance to be considered is the highly clustered nature of populations in Montréal and Laval and the highly dispersed populations on the North Shore and the Gaspé and Magdalen Island regions.

The reality of geographic isolation from major population centres is an important dimension of community life in regions such as the North Shore, Gaspé and the Magdalen Islands, Abitibi-Témiscamingue and Northern Quebec and one that can be overlooked by some of the standard strategies to improving access to linguistically and culturally appropriate health care. Institution-centric approaches to improvement, for example, may inadvertently narrow attention and investment to communities where population density warrants

medical centres and a stable pool of health practitioners who can be trained in linguistic skills and cultural sensitivity.

Heterogeneous composition

In terms of population diversity, one-third (33.6%) of Quebec's English speakers are immigrants and more than one-quarter (27.9%) are members of visible minority groups. These levels are much higher than the levels found among Quebec's Francophone majority wherein immigrants represent 8.8% of the population and visible minority populations represent 7.8 % (CHSSN, 2015). In four of Quebec's regions, individuals who claim an aboriginal identity comprise 25% or more of the English-speaking population (CHSSN, 2015).

When we use the 2011 *National Household Survey* (Statistics Canada) to look across the regions of the province and compare language groups, we find that the proportion of immigrants within Quebec's English-speaking communities substantially outweighs the proportion in the majority language group in every region. The highest concentrations of immigrants who use English as their first official language are located in the urban regions of Montréal (40.4%) and Laval (38.2%) followed closely by Montérégie (27.4%) and Capitale-Nationale (26.7%) *(see Table 1)*.

When we consider place of birth of English-speakers, we note that nearly half (45%) of English speakers were incomers to the province with their place of birth located either outside Canada or in another Canadian province. In some regions, such as the Outaouais at 67% and Saguenay Lac-Saint-Jean at 56%, more than half of English speakers were born outside the province where they now reside. (Canadian Heritage, 2015b:51).

Socio-economic Vulnerability

Using a composite indicator for socio-economic status (SES) developed by the Department of Canadian Heritage, we note that there is a prevalence of low SES among the English-speaking communities of Quebec (Canadian Heritage, 2015a). This is a health risk factor and points to a population that may be reliant on public health services not only due to a greater rate of illness but also because they cannot cover the expense of private care. After New Brunswick Francophones, Quebec's English-speaking populations display the greatest socio-economic vulnerability when aspects such as low education levels, unemployment and labour force participation and low income tendencies are analyzed. Relative to the Francophone majority of Quebec, English speakers show much higher unemployment rates. This gap has grown in recent decades and is more marked among

		English speakers			French speakers		
Immigrants, by Language Group **Quebec and its Administrative Regions, 2011**							
region	Total population	total	Non-Immigrants	Immigrants	total	Non-Immigrants	Immigrants
Gaspésie - Iles-de-la-Madeleine	91,955	9,406	9,084	263	82,516	81,984	518
Bas-Saint-Laurent	192,455	841	685	88	191,581	189,235	2,128
Capitale-Nationale	682,120	12,656	8,889	3,381	668,281	639,374	26,411
Chaudière - Appalaches	400,760	3,113	2,330	636	397,558	392,320	4,916
Estrie	302,810	22,576	19,003	3,314	279,466	267,818	10,874
Centre-du-Québec	227,435	2,508	1,953	536	224,618	220,168	4,286
Montérégie	1,417,490	155,623	111,504	42,708	1,255,223	1,179,034	74,043
Montréal	1,844,500	610,703	341,565	246,665	1,190,468	825,900	336,670
Laval	392,725	82,260	50,305	31,395	303,860	241,680	60,840
Lanaudière	464,970	11,572	8,921	2,597	452,612	436,106	16,197
Laurentides	549,575	34,673	28,240	6,234	513,478	495,505	17,394
Abitibi - Témiscamingue	142,585	4,909	4,609	241	137,619	136,379	1,051
Mauricie	255,495	2,876	2,243	543	251,986	247,243	4,213
Saguenay - Lac-Saint-Jean	268,100	1,536	1,248	223	266,531	264,053	2,253
Côte-Nord	92,980	5,093	4,968	100	87,258	86,378	760
Quebec	7,732,520	1,046,493	668,813	351,495	6,618,178	5,998,878	581,300
Canada	32,852,325	24,719,000	18,778,338	5,648,868	7,593,070	6,851,848	695,468
Gaspésie - Iles-de-la-Madeleine		100.0%	96.6%	2.8%	100.0%	99.4%	0.6%
Bas-Saint-Laurent		100.0%	81.5%	10.5%	100.0%	98.8%	1.1%
Capitale-Nationale		100.0%	70.2%	26.7%	100.0%	95.7%	4.0%
Chaudière - Appalaches		100.0%	74.8%	20.4%	100.0%	98.7%	1.2%
Estrie		100.0%	84.2%	14.7%	100.0%	95.8%	3.9%
Centre-du-Québec		100.0%	77.9%	21.4%	100.0%	98.0%	1.9%
Montérégie		100.0%	71.7%	27.4%	100.0%	93.9%	5.9%
Montréal		100.0%	55.9%	40.4%	100.0%	69.4%	28.3%
Laval		100.0%	61.2%	38.2%	100.0%	79.5%	20.0%
Lanaudière		100.0%	77.1%	22.4%	100.0%	96.4%	3.6%
Laurentides		100.0%	81.4%	18.0%	100.0%	96.5%	3.4%
Abitibi - Témiscamingue		100.0%	93.9%	4.9%	100.0%	99.1%	0.8%
Mauricie		100.0%	78.0%	18.9%	100.0%	98.1%	1.7%
Saguenay - Lac-Saint-Jean		100.0%	81.3%	14.5%	100.0%	99.1%	0.8%
Côte-Nord		100.0%	97.5%	2.0%	100.0%	99.0%	0.9%
Quebec		100.0%	63.9%	33.6%	100.0%	90.6%	8.8%
Canada		100.0%	76.0%	22.9%	100.0%	90.2%	9.2%

Source: JPocock Research Consulting, based on data from the 2011 National Household Survey, Statistics Canada, 100% sample. Language concept is First Official Language Spoken with multiple responses distributed equally.

Table 1: Immigrants by Language Group

younger workers age 25–44 than for the older workers in the 45–64 age group (Canadian Heritage, 2015c:40.).

On a regional basis, very high levels of socio-economic vulnerability are observed in Gaspésie – Îles-de-la-Madeleine, Nord-du-Québec[5], Abitibi-Témiscamingue, Côte-Nord and Estrie when these key socio-economic indicators are considered. As the accompanying table illustrates, these regions are ranked among the top ten in terms of the measure for socio-economic vulnerability among all OLMCs across Canada *(see Table 2).*

OLMC Populations with Low Socio-economic Status, Canada, 2011			
composite indicator for socio-economic status		Region	OLMC population
quintile	rank		
1	2	Quebec (province)	1,058,250
1	1	Gaspésie - Iles-de-la-Madeleine (QC)	9,950
1	2	Nord-du-Québec (QC)	20,645
1	3	Abitibi - Témiscamingue (QC)	5,378
1	4	Côte-Nord (QC)	5,335
1	5	Cariboo (BC)	1,940
1	6	Estrie (QC)	23,440
1	7	Cape Breton (NS)	5,095
1	8	Campbellton - Miramichi (NB)	97,338
1	9	Interlake (MB)	1,430
1	10	Hamilton - Niagara Peninsula (ON)	33,143

Source: Research Team, Official Languages Branch, Department of Canadian Heritage, based on data from the 2011 National Household Survey, Statistics Canada.
Notes: The composite measure weighs 8 scores which are based on the rankings of the 4 socio-economic variables (low education rates, low income rates, unemployment and out of the labour force rates) as well as the minority-majority indices for each variable. The ranking and quintiles present the relative socio-economic status of Official-Language Minority Communities in the 76 economic regions across Canada (referred to as administrative regions in Quebec). For this analysis, only the 69 regions with at least 500 OLMC individuals are included so the rankings in the second column are based on 69 territories.

Table 2: OLMC Populations with Low Socio-economic Status

The Legislative and Policy Context

Quebec's English-speaking communities find themselves in a complex legislative and policy context. The Government of Canada, through the *Charter of Rights and Freedoms* and the *Official Languages Act*, confers certain rights on English speakers in Quebec and recognizes them as one of Canada's official-language minority communities, along with Francophones living outside Quebec. In the health sector, this commitment is delivered through the Health Canada Official Languages Health Contribution Program which features a three-pronged strategy aimed at integrating health professionals from OLMCs, strengthening local health networking capacity and promoting health services access and retention programs. The Official Languages Program of the Department of Canadian Heritage offers generalized support to community-based organizations which work to support the vitality of OLMCs[6].

At the provincial level, as set out in the *Charter of the French Language*, French is recognized as the sole official language in the province and the government has the legislative and policy objective of making it "the normal and everyday language of work, instruction, communication, commerce and business" in Quebec[7]. In recognition

of the historical presence of English-speaking communities, the *Charter of the French Language* refers to a commitment to pursue the objective "in a spirit of fairness and open-mindedness, respectful of the institutions of the English-speaking community of Québec, and respectful of the ethnic minorities, whose valuable contribution to the development of Québec it readily acknowledges[8]."

Access to educational services in English is described in detail in the *Charter of the French Language*, as are certain legal rights which are enshrined in Canada's *Charter of Rights and Freedoms*. However, the Quebec Charter is largely silent on the right to receive health and social services in English which perhaps explains the English-speaking community's campaign in the 1980s to see legislative recognition of their rights. This culminated in the adoption of Bill 142 in 1986 which amended Quebec's *Health and Social Services Act* to provide a qualified right for English speakers to receive services in English. Key elements of the revised legislation included the requirement for regional planning authorities to develop access programs for services in English, subject to the resources of the institutions in each region and for the designation of certain institutions which would be permitted to offer their range of services in English (Carter, 2008; Silver, 2000).

In the years since the adoption of Bill 142, English-speaking communities have worked with the government of the day to implement the commitments set out in the legislation but have been buffeted by political, administrative and fiscal conditions which have seen successive governments place a great emphasis on the promotion of French, invoking the right of health system employees to work in French as taking primacy over the client's right to receive services in English, while others have forced the merger of institutions which has led to the disappearance of many of the designated institutions.

Part 2: What is the situation of English-speaking immigrants and visible minority members?

English-speaking Immigrants: Period of Immigration for those born outside of Canada
While the initial period of re-settlement for first generation newcomers is a time of challenges on many fronts causing high levels of distress, research shows that it is later generations who are in fact sicker. Population studies find that the health of more newly arrived immigrants tends to be better than that of the general population in receiving countries. However, over time, the health of immigrants tends to worsen to match that of the host population (Kirmayer et al., 2011:E960-961). For example, certain types of mental illness show higher rates among second generation migrants, even more specifically

among those coming from a developing country or area where most of the population is black, suggesting a link to racism and discrimination in the receiving country (Kirmayer et al., 2011:E961) *(see Table 3)*.

Immigrants, by Period of Immigration and Language Group
Quebec, 2011

Period	French-speakers (immigrants)	English speakers (immigrants)
2001 to 2011	43.7%	32.0%
1991 to 2000	20.0%	20.3%
1981 to 1990	13.1%	13.4%
Before 1981	23.2%	34.3%

□ French-speakers (immigrants)
■ English speakers (immigrants)

Source: JPocock Research Consulting, based on data from the 2011 National Household Survey, Statistics Canada. Language concept is First Official Language Spoken, with multiple responses distributed equally among declared languages.
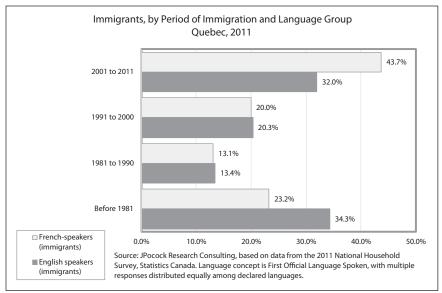
Table 3: Immigrants, by Period of Immigration and Language Group

When we consider the period in which immigrants arrived in Canada, we find that a much higher share of English-speaking immigrants (34.3%) arrived in the period prior to 1981 than was the case for French-speaking immigrants (23.2%). Conversely, a much higher proportion of French-speaking immigrants are recent immigrants (arrived between 2001 and 2011) than is observed in the English-speaking immigrant population (43.7% compared to 32%).

Bilingualism and Immigrant Status

Linguistically restricted services are a post-migration factor to be considered along with racism and other forms of discrimination in assessing the quality of reception and support by the host country and its institutwions (Whitley, Kirmayer and Groleau, 2006; Cook, Alegria, Lin, and Guo, 2009). Language barriers may discourage engagement with public agencies, contribute to lack of information and invite avoidance and delay of diagnosis and treatment (Bowen, 2001). Quebec's Institut national de santé publique (INSPQ) considers language "a determinant of health status or as a factor acting on other determinants" (INSPQ, 2012:3) *(see Table 4)*.

According to the *2011 National Household Survey* (Statistics Canada), in terms of linguistic competence, English speakers, whether

Bilingualism Rate, by Language and Immigrant Status, Montreal CMA, Rest of Quebec and Quebec, 2011

Category	immigrants	non-immigrants
French speakers (rest of Quebec)	45.1%	30.1%
French speakers (Montreal CMA)	53.7%	51.0%
French speakers (Quebec)	52.3%	38.2%
English speakers (rest of Quebec)	59.9%	61.1%
English speakers (Montreal CMA)	54.0%	78.3%
English speakers (Quebec)	54.5%	73.9%

Source: JPocock Research Consulting, based on data from the 2011 National Household Survey, Statistics Canada. Language concept is First Official Language Spoken, with multiple responses distributed equally among declared languages.
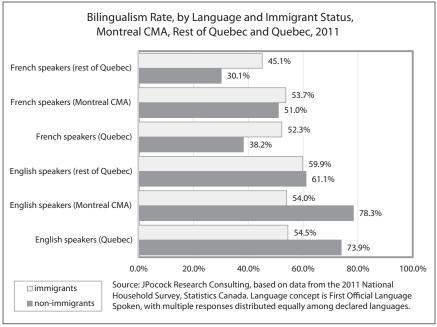
Table 4: Bilingualism Rate, by Language and Immigrant Status

immigrant or non-immigrant, report higher levels of bilingualism than their Francophone counterparts, both in Montréal CMA and across the rest of Quebec. The immigrants of Quebec's English-speaking communities tend to be much less English-French bilingual than their non-immigrant counterparts (54.5% compared to 73.9%) making the lack of linguistically accessible services more of a risk factor to their well-being. They are more likely to be bilingual than the immigrants who claim French as their first official language but they form a numerically smaller group, and the more unilingual Francophone group show a higher tendency to be working in a health occupation.

Educational Attainment
Provincially speaking, Quebec's English-speaking immigrants are less likely (16.6%) than the Canadian-born group (18.1%) to have low levels of education (no high school leaving certificate). When compared to Anglophones, the French-speaking population has a greater proportion of immigrants as well as non-immigrants without high school leaving *(see Table 5)*.

The greatest proportion of individuals who have not graduated from high school (28.1%) is found among Canadian-born English-speakers living outside of Montréal, followed by French-speaking Canadian born living in the same territory (23.1%). This contrasts sharply with
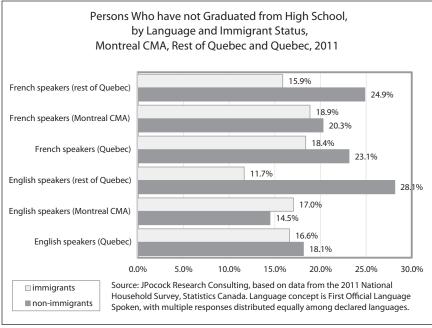
Persons Who have not Graduated from High School,
by Language and Immigrant Status,
Montreal CMA, Rest of Quebec and Quebec, 2011

French speakers (rest of Quebec)	15.9% / 24.9%
French speakers (Montreal CMA)	18.9% / 20.3%
French speakers (Quebec)	18.4% / 23.1%
English speakers (rest of Quebec)	11.7% / 28.1%
English speakers (Montreal CMA)	17.0% / 14.5%
English speakers (Quebec)	16.6% / 18.1%

□ immigrants
■ non-immigrants

Source: JPocock Research Consulting, based on data from the 2011 National Household Survey, Statistics Canada. Language concept is First Official Language Spoken, with multiple responses distributed equally among declared languages.

**Table 5: Persons Who have not Graduated from High School
by Language and Immigrant Status**

immigrant English-speakers living in the same territory (11.7%). In the CMA of Montréal, the situation among English-speakers is reversed such that immigrants (17.0%) are more likely than non-immigrants (14.5%) to be without a high school leaving certificate and the variance between the two groups is much smaller.

Immigrants in Quebec are more likely to have a university B.A or higher than Canadian-born regardless of their language and of whether they are living within or outside Montréal in the regions that comprise the rest of Quebec *(see Table 6)*.

When Quebec's language groups are considered by immigrant status and territory, the group that show the greatest proportion of immigrants with high levels of educational attainment are the English-speaking communities outside of Montréal (38.8%). The greatest gap between immigrant (38.8%) and Canadian-born (14.4%) citizens when it comes to high educational attainment is located among English-speakers residing outside of Montréal. This is followed by French-speakers residing outside of Montréal where the level of university degree holders is much higher among immigrants (32%) than among non-immigrants (13.2%).
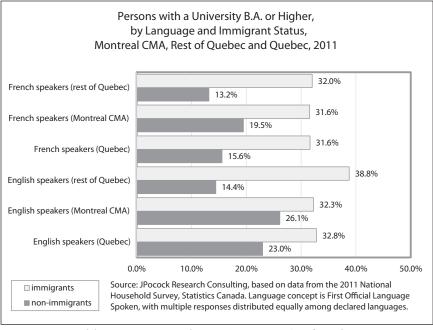
Persons with a University B.A. or Higher,
by Language and Immigrant Status,
Montreal CMA, Rest of Quebec and Quebec, 2011

French speakers (rest of Quebec) 32.0%
13.2%

French speakers (Montreal CMA) 31.6%
19.5%

French speakers (Quebec) 31.6%
15.6%

English speakers (rest of Quebec) 38.8%
14.4%

English speakers (Montreal CMA) 32.3%
26.1%

English speakers (Quebec) 32.8%
23.0%

0.0%   10.0%   20.0%   30.0%   40.0%   50.0%

☐ immigrants
■ non-immigrants

Source: JPocock Research Consulting, based on data from the 2011 National
Household Survey, Statistics Canada. Language concept is First Official Language
Spoken, with multiple responses distributed equally among declared languages.

**Table 6: Persons with a University B.A. of Higher,
by Language and Immigrant Status**

Labour Force Status

Labour force participation is an important measure not only for determining level of income but also for access to bridging and linking network opportunities that extend outside the family and socio-cultural group *(See Part 3 for network types)*. Inequalities in socio-economic status within a population tend to be predictors of health risk and reduced capacity for community mobilization.

According to the 2011 *National Household Survey* (Statistics Canada), the provincial rate of unemployment is higher for immigrant English-speakers than among Canadian-born English-speakers (10.2% compared to 8.6%). The unemployment deficit for immigrants is more pronounced in the French-speaking population (11.5% for immigrants compared to 6.3% for non-immigrants) than in the English-speaking population *(see Table 7)*.

Despite higher levels of education, Canadian-born citizens living in Quebec are more likely to report full-time and year-round employment compared to immigrants. This is true regardless of their language and regardless of whether they are living within Montréal or within the regions that comprise the rest of Quebec *(see Table 8)*.
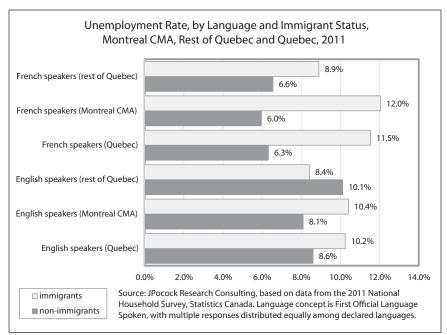
Unemployment Rate, by Language and Immigrant Status, Montreal CMA, Rest of Quebec and Quebec, 2011
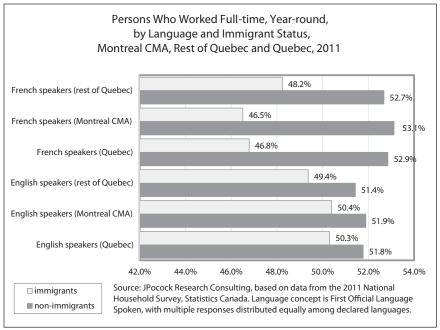
Category	immigrants	non-immigrants
French speakers (rest of Quebec)	8.9%	6.6%
French speakers (Montreal CMA)	12.0%	6.0%
French speakers (Quebec)	11.5%	6.3%
English speakers (rest of Quebec)	8.4%	10.1%
English speakers (Montreal CMA)	10.4%	8.1%
English speakers (Quebec)	10.2%	8.6%

Source: JPocock Research Consulting, based on data from the 2011 National Household Survey, Statistics Canada. Language concept is First Official Language Spoken, with multiple responses distributed equally among declared languages.

Table 7: Unemployment Rate, by Language and Immigrant Status

Persons Who Worked Full-time, Year-round, by Language and Immigrant Status, Montreal CMA, Rest of Quebec and Quebec, 2011

Category	immigrants	non-immigrants
French speakers (rest of Quebec)	48.2%	52.7%
French speakers (Montreal CMA)	46.5%	53.1%
French speakers (Quebec)	46.8%	52.9%
English speakers (rest of Quebec)	49.4%	51.4%
English speakers (Montreal CMA)	50.4%	51.9%
English speakers (Quebec)	50.3%	51.8%

Source: JPocock Research Consulting, based on data from the 2011 National Household Survey, Statistics Canada. Language concept is First Official Language Spoken, with multiple responses distributed equally among declared languages.

Table 8: Persons Who Worked Full-Time, Year-round, by Language and Immigrant Status

Health Occupations

Both Canadian-born and immigrant Francophones are more likely to be employed in health occupations than are their English-speaking counterparts. In both cases, immigrants are more likely to be employed in health occupations compared to non-immigrants. Canadian-born English speakers living in the greater Montréal region are the least likely to be working in health professions (4.5%) while French-speaking immigrants in the greater Montréal area are the most likely to be so employed (8.1%) *(see Table 9)*.

Persons Employed in Health Occupations,
by Language and Immigrant Status,
Montreal CMA, Rest of Quebec and Quebec, 2011

Category	immigrants	non-immigrants
French speakers (rest of Quebec)	7.1%	6.7%
French speakers (Montreal CMA)	8.1%	6.2%
French speakers (Quebec)	7.9%	6.5%
English speakers (rest of Quebec)	4.9%	4.6%
English speakers (Montreal CMA)	5.8%	4.5%
English speakers (Quebec)	5.8%	4.5%

Source: JPocock Research Consulting, based on data from the 2011 National Household Survey, Statistics Canada. Language concept is First Official Language Spoken, with multiple responses distributed equally among declared languages.

**Table 9: Persons Employed in Health Occupations,
by Language and Immigrant Status**

English-speaking Visible Minorities

According to the 2011 *National Household Survey* (Statistics Canada), socio-economic inequalities are revealed when Quebec's language populations are explored through a visible minority lens.

Among the English-speaking visible minority population of Quebec, 33.2% live below the low income cut-off compared to 17% of the English-speaking non-visible minority population and 13.8% of the French-speaking non-visible minority. In the urban Montréal region noted for high levels of ethno-cultural diversity, visible minority English speakers living in poverty represent a substantial 37.7% of the visible minority group. Close to 40 percent (39.7%) of Montréal's English-speaking black community are living below the low income cut-off *(see Table 10)*.

Age Structure of Visible Minority Populations in Linguistic Groups Quebec						
English speakers, numbers	**Total**	**0-14**	**15-24**	**25-44**	**45-64**	**65+**
Total English speakers	1,046,495	158,640	145,520	316,405	287,855	138,070
visible minorities	292,480	46,820	44,955	114,190	67,335	19,180
Chinese	43,065	5,130	6,565	18,690	10,320	2,355
South Asian	59,855	10,785	9,005	22,285	14,020	3,755
Black	53,845	11,635	8,135	16,625	11,590	5,865
Filipino	28,765	5,120	3,550	10,385	7,860	1,850
Latin American	27,090	2,815	4,790	13,545	5,255	685
Southeast Asian	17,530	2,205	2,635	6,685	5,150	845
Arab	32,450	3,555	5,510	14,290	7,015	2,080
West Asian	11,655	1,195	1,760	5,435	2,730	535
Korean	4,000	590	775	1,490	825	320
Japanese	2,430	380	210	1,160	410	265
other	3,730	685	570	1,335	870	275
multiple	8,070	2,720	1,465	2,265	1,295	330
not visible minority	754,010	111,820	100,565	202,220	220,525	118,880
English speakers, percentages	**Total**	**0-14**	**15-24**	**25-44**	**45-64**	**65+**
Total English speakers	100.0%	15.2%	13.9%	30.2%	27.5%	13.2%
visible minorities	100.0%	16.0%	15.4%	39.0%	23.0%	6.6%
Chinese	100.0%	11.9%	15.2%	43.4%	24.0%	5.5%
South Asian	100.0%	18.0%	15.0%	37.2%	23.4%	6.3%
Black	100.0%	21.6%	15.1%	30.9%	21.5%	10.9%
Filipino	100.0%	17.8%	12.3%	36.1%	27.3%	6.4%
Latin American	100.0%	10.4%	17.7%	50.0%	19.4%	2.5%
Southeast Asian	100.0%	12.6%	15.0%	38.1%	29.4%	4.8%
Arab	100.0%	11.0%	17.0%	44.0%	21.6%	6.4%
West Asian	100.0%	10.3%	15.1%	46.6%	23.4%	4.6%
Korean	100.0%	14.8%	19.4%	37.3%	20.6%	8.0%
Japanese	100.0%	15.6%	8.6%	47.7%	16.9%	10.9%
other	100.0%	18.4%	15.3%	35.8%	23.3%	7.4%
multiple	100.0%	33.7%	18.2%	28.1%	16.0%	4.1%
not visible minority	100.0%	14.8%	13.3%	26.8%	29.2%	15.8%
French-speakers, numbers and pct.	**Total**	**0-14**	**15-24**	**25-44**	**45-64**	**65+**
Total French-speakers	6,618,175	1,074,695	828,165	1,706,705	2,039,415	969,190
visible minorities	516,545	144,020	80,205	182,210	89,405	20,705
not visible minority	6,101,630	930,680	747,960	1,524,500	1,950,005	948,485
Total French-speakers	100.0%	16.2%	12.5%	25.8%	30.8%	14.6%
visible minorities	100.0%	27.9%	15.5%	35.3%	17.3%	4.0%
not visible minority	100.0%	15.3%	12.3%	25.0%	32.0%	15.5%
Source: JPocock Research Consulting, based on data from the 2011 National Household Survey, Statistics Canada. Language concept is first official language spoken, with dual responses distributed equally.						

Table 10: Age Structure of Visible Minority Populations in Linguistic Groups, Quebec

The largest proportion of Quebec's English-speaking visible minority group are located in the 25–44 age group (39%) and the smallest proportion at 6.6% are located in the 65+ age range. This may reflect, in part, the fact that since the 1960's there has been a shift away from Europe as a country of origin with increased immigration originating from Asia, Africa, and Central and South America (Statistics Canada, 2013). Among all age groups, Quebec's visible minority citizens aged 25–44 represent a larger proportion of their communities, regardless of language, compared to their non-visible minority counterparts *(see Table 11)*.

Part 3: The Case of Community Health and Social Services Network (CHSSN) and the Networking and Partnership Initiative (NPI)

Culture and Inequalities in Access to Health Provisions

A major challenge for health institutions in the context of diverse populations arises from linguistic and cultural differences that pose difficulties for the communication and trust between service workers and users that is essential for the effective prevention, diagnosis and treatment of illness. Aside from variance in linguistic proficiency, cultural background can influence styles of emotional expression, interpretation and reaction to symptoms, patterns of coping and seeking help and adherence to treatment (Helman, 2007). Fear of stigma and anxiety around communication failure and inability to negotiate treatment are among the factors which may hinder access to the health and social service system for Quebec's culturally marginal users. In the context of diversity, the socio-cultural match between health practitioners or social workers and their patients is problematic (Kirmayer, 2012:151) and herein lies the opportunity for innovation.

Cultural Competence

Not surprisingly, much of the discussion around culturally appropriate health care in the context of globalizing populations is focused upon the issue of the linguistic and cultural competence of care providers. Prevailing strategies seek to develop the linguistic competence and cultural sensitivity of care providers as an important feature of their medical expertise and to improve the "receptivity" of public health institutions as "hosts" of the ethno-culturally diverse groups they serve (Kirmayer et al., 2011; Allen, 2008). The promotion of "cultural safety" generally refers to reducing barriers to open, reciprocal and safe places in clinical services (Brown et al., 2009; Brascoupe & Waters, 2009) and is considered to be a means to improve the rapport of health practitioner and patient and thus improve treatment outcomes. The

Low-income cut-off Status (LICO) of Visible Minority Populations in Linguistic Groups Quebec			
English speakers, numbers	**Total population**	**Less than lico**	**At or above lico**
Total English speakers	1,046,495	225,520	802,375
visible minorities	292,480	97,125	195,290
Chinese	43,065	13,805	29,255
South Asian	59,855	20,380	39,450
Black	53,845	18,430	35,405
Filipino	28,765	6,375	22,385
Latin American	27,090	9,490	17,595
Southeast Asian	17,530	5,420	12,100
Arab	32,450	12,640	19,805
West Asian	11,655	5,330	6,325
Korean	4,000	1,590	2,415
Japanese	2,430	595	1,835
other	3,730	1,225	2,505
multiple	8,070	1,840	6,225
not visible minority	754,010	128,400	607,085
English speakers, percentages	**Total population**	**Less than lico**	**At or above lico**
Total English speakers	100.0%	21.6%	76.7%
visible minorities	100.0%	33.2%	66.8%
Chinese	100.0%	32.1%	67.9%
South Asian	100.0%	34.0%	65.9%
Black	100.0%	34.2%	65.8%
Filipino	100.0%	22.2%	77.8%
Latin American	100.0%	35.0%	65.0%
Southeast Asian	100.0%	30.9%	69.0%
Arab	100.0%	39.0%	61.0%
West Asian	100.0%	45.7%	54.3%
Korean	100.0%	39.8%	60.4%
Japanese	100.0%	24.5%	75.5%
other	100.0%	32.8%	67.2%
multiple	100.0%	22.8%	77.1%
not visible minority	100.0%	17.0%	80.5%
French-speakers, numbers and pct.s	**Total population**	**Less than lico**	**At or above lico**
Total French-speakers	6,618,175	1,015,805	5,583,175
visible minorities	516,545	174,305	342,155
not visible minority	6,101,630	841,495	5,241,020
Total French-speakers	100.0%	15.3%	84.4%
visible minorities	100.0%	33.7%	66.2%
not visible minority	100.0%	13.8%	85.9%
Source: JPocock Research Consulting, based on data from the 2011 National Household Survey, Statistics Canada. Language concept is first official language spoken, with dual responses distributed equally.			

Table 11: Low-income Cut-off Status (LICO) of Visible Minority Populations in Linguistic Groups, Quebec

cultural match of health practitioner and patient has become more difficult to achieve but remains the goal. Within this framework, community organizations and networks are acknowledged but largely as peripheral resources for health and social service practitioners seeking to identify and mobilize extra-institutional, bonding support for their patients.

Community Development

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

The community development approach does not aspire to *replace* efforts to enhance the cultural competence of health professionals and receptivity of public health institutions and agencies. However, as we shall see below, the case of Quebec's CHSSN does suggest that in redefining the role of minority language community organizations the scope and impact of promoting culturally appropriate care is enhanced. For long-standing citizens and newcomers alike, community organizations assist patients in identifying social support networks and trajectories for treatment at the local level but not without working towards their ongoing representation in the decision-making of "their" public institutions.

What is the Networking and Partnership Initiative?

Through the Community Health and Social Services Network (CHSSN)[9] and Health Canada's official language strategy[10], 20 community networks are supported across Quebec's territory as focal points for addressing the priorities of English-speaking communities with respect to the health and social service system. Many of these are housed within regional community organizations[11] that have a long tradition in the lives of English speakers reflecting the dedication to the community sector that is a distinguishing characteristic of Quebec's minority language group. Indicators of community sector participation such as high levels of volunteerism (CHSSN, 2006a) as well as tendency to rely on community organizations for health and social service information and as a source of support in the event of illness (CHSSN, 2006a; 2011) point to community as a value and a pattern of conduct that distinguishes Quebec's minority language group from the majority.

With CHSSN as the "hub" and its 20 "network nodes," the network approach offers the flexibility to connect with demographically diverse communities across Quebec's territory and to empower them to strategically mobilize according to their unique profile of health needs and resources. Importantly, the NPI networks are not only responsive to geographically delimited populations but they also recognize ethno-cultural identities and support inter-cultural collaboration to improve access to public health services. For example, the NPI of the African Canadian Development and Prevention Network (ACDPN) serving the English-speaking black community collaborate with Batshaw Youth and Family Centres of Montréal to address the gap in linguistically appropriate psychosocial, rehabilitation and social integration services for children and their families and with other NPI participants across the province. Through the network REISA[12], an NPI located in the historical English-speaking Italian neighborhood of Montréal, has found common ground with an NPI, Coasters Association, on the more isolated Lower North Shore and they have exchanged models for initiatives to improve access to health and social services for their very different populations. The network has brought together AGAPE, situated in the ethno-culturally diverse Laval region, and CASA[13] serving the widely dispersed, English-speaking and more ethnically homogenous communities of the Gaspé coast who find common cause in mobilizing to develop a sense of belonging and social support networks in the midst of social fragmentation and low-income (CHSSN, 2013a).
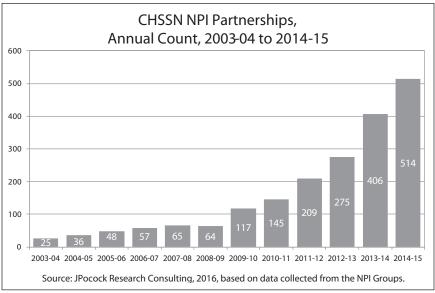
CHSSN NPI Partnerships, Annual Count, 2003-04 to 2014-15

25	36	48	57	65	64	117	145	209	275	406	514
2003-04	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15

Source: JPocock Research Consulting, 2016, based on data collected from the NPI Groups.

Table 12: CHSSN NPI Partnerships, Annual Count, 2003-04 to 2014-15

Growing Partnerships

Through CHSSN, NPI networks are trained in community consultation and in the use of an evidence-base that profiles the situation of their local English-speaking communities in terms of key health determinants[14], socio-demographic features and health and social service access. Information that is tailored to the level of CSSS[15] (health clinic) territory and captures the diverse ethno-cultural background and social environment of the patient population lays the foundation for establishing partnerships with public health authorities and influencing policy promoting linguistic and culturally appropriate care. These include partnering with health and social service centers delivering primary level care as well as regional planning authorities who, in turn, integrate this knowledge within their action plans. The accompanying figure demonstrates the rate of growth of NPI partnerships with public health agencies between 2003 and 2015[16] (see Table 12).

Community Networks as Connectors

Quebec's NPI partnerships with public agencies have given rise to a myriad of innovative practices designed to increase timely and culturally appropriate engagement between health care institutions and Quebec's minority language population. Both the community development approach and the model promoting the cultural competence of health experts hold the overall objectives of increased

institutional engagement and improved treatment success but their different tactics lend the former the advantage of an impact that reaches a wider range of implicated players. An example that underscores this difference is the emergence of health professionals who move beyond the medical domain to engage patients in a setting provided by their community network. In the words of NPI leaders themselves[17]:

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

The impact of these visiting experts or "boundary crossers" touches many dimensions along the continuum of care. For the doctors and nurses, entering the "turf" of the patients' community and speaking their language is, in itself, training in their culture. Becoming familiar with existing communities and their style of organization can help health practitioners identify and mobilize informal support and other resources. Research has shown that increased contact with health practitioners outside of medical settings can result in improved patient disclosure of the psychosocial stressors that help explain illness (Kirmayer et al., 2011:E963).

For the patient community, knowledge concerning health conditions and treatment procedures is transferred in a familiar, small-scale setting while in the company of supportive others. The stigma of lacking language skills is reduced in a community setting as well as the pressure to process information in the limited time allotted in a doctor's office or clinical setting. Research underscores the importance of the cultural community organizations and religious institutions of the receiving country as welcoming connectors that can buffer the effects of health risk factors like poverty and discrimination (Kirmayer et al., 2011:E964) and guide entry into the broader society.

Whether newcomer to a disease, or to Canada, social support within the patients' culturally safe milieu is identified and isolation is reduced. Successful knowledge transfer and improved trust ultimately results in improved patient engagement of public health and social services. For community organizations, the sessions mentioned

above by NPI coordinators allow them to monitor the needs of the patient community and astutely advise the health and social service authorities, particularly the access committees[18], with whom they partner.

Mobilization and Empowerment in Health

> *"…we need to work toward bridging as well as bonding."*
> —Putnam, R.D. (2007)

Social Capital Dimensions of Networks

Bonding: This refers to networks between people who share a "common bond" and are cohesive in their interests (i.e. a tight-knit rural community, or a family).

Bridging: These relations bring different groups together. They are outward looking and encompass people across social divides. They generate broader identities and links to assets more than bonding.

Linking: These are connections which tend to work vertically along a social hierarchy. This kind of network forges relations between groups who are unequal in terms of access to power such as a marginalized group and the decision-makers responsible for social policy *(Dale, 2005).*

In his work on the challenges and opportunities of diversity, Putnam observes that successful immigrant societies have overcome fragmentation by "creating new, cross-cutting forms of social solidarity" (Putnam, 2007:137). He points out that locally based programs that reach out to minority communities are a powerful tool for mutual learning and uses the example of religious institutions and ethnically defined organizations that have historically played a major role in incorporating new immigrants. Still, he cautions that the inclusive lines of in-group bonding ought not to preclude work toward the bridging relations that expand a people's life chances and offer an enlarged sense of belonging (Putnam, 2001:165).

In the interest of reducing health inequalities and improving the quality of engagement of Quebec's minority language communities with their health and social service institutions, the CHSSN networks of NPI nodes cross-cut territorial and sectoral boundaries as well as forge vertical links that amplify the voice of English-speaking communities among health authorities. For example, the collaboration of the NPI

network with the regional hospital located in Sept-Îles has resulted in interpretation services that serve not only the nearby minority language community but also the communities dispersed along Quebec's extensive Côte-Nord. Taken together, one quarter of NPI partners in 2011–2012 were located in the education sector (schools, school boards and universities) and served to broaden the scope of linguistically appropriate health promotion and prevention offerings, including knowledge of services, for the very diverse English-speaking youth population (CHSSN, CLC and LEARN, 2014). Aside from their partnerships with over 40 health and social service centres delivering primary care, they also partner with 12 of the 16 agencies responsible for regional planning (CHSSN, 2013a:5). NPI networks have also collaborated in mobilizing their diverse communities to participate in province-wide consultations to determine the health and social service priorities for Quebec's heterogeneous English users (CHSSN, 2013b).

Conclusion

The heterogeneous composition of English-speaking Quebec, as revealed when immigrant and visible minority status are explored, debunks any notion of reference to a group coalescing around a single ethnic origin, religious affiliation or racial background. The vigilance of community networks with respect to the legislative guarantees that protect access to English language services, and the institutional mechanisms for their implementation, are misconstrued when identified as efforts to maintain the privileged status of an old colonial power. They are more like the voice within Quebec's health and social service institutions sounding the alert when standardization and efficiency undermines the priority mission of improving health and well-being and prolonging life. Work that reduces linguistic and cultural barriers surrounding access to situations of healing opens the doors to the positive social connection that research demonstrates is of crucial importance to health, well-being and, indeed, the survival of humanity (Seppala, Rossomando and Doty, 2013). In this sense, the impact of networking and partnering is not limited to a specific constituency but in fact benefits all system users.

> In the end it is about creating the opportunity for people to feel supported and to feel cared for. It is about quality of life and connection between people – not just services. Our NPI partnerships bring the sense of community back to the public system for Anglophones and Francophones as well. We all have vulnerable people who we want to have quality of life. (CHSSN, 2013a)

The case of CHSSN NPI offers evidence that local support networks among Quebec's diverse minority language population can play a key

role in the health of Quebec citizens and their engagement with their public health and social services. With their partnering, they have the potential to lay the ground for a local and collaboratively formed trajectory that connects their communities with health practitioners employed in medical settings that are organized primarily around the majority group. The success of networks in nurturing trust in these institutions, along with their cross-territorial scope and inter-sectoral focus, opens the opportunity for a greater sense of cultural safety in negotiating other public agencies and globalizing societies, such as Quebec, in general. From the point of view of health practitioners, who, too, struggle with the conditions of their work, the network offers the support they need to be effective care providers and compassionate healers to their patients. Aside from improving access to services by identifying linguistic and cultural barriers, actions that reduce the distress and fear of those with poor health status are in themselves the needed medicine for an array of physical and mental health symptoms.

ENDNOTES

1. The language concept used throughout this article is First Official Language Spoken which is derived from three census questions: knowledge of official languages, mother tongue, and home language. The terms "English speakers" and "Anglophones" are used interchangeably here as are "French speakers" and "Francophones."

2. Unless otherwise stated, mentions of "the Montréal region" refer to the Census Metropolitan Area (CMA) of Montréal, which includes the island of Montréal coupled with those neighbouring municipalities which are considered to be part of the metropolitan area based on the 2011 *National Household Survey* (Statistics Canada) of commuting patterns between places of residence and places of work.

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

4. It should be noted that the population of Northern Quebec is primarily Cree and Inuit.

5. It should be noted that the population of Northern Quebec is primarily Cree and Inuit.

6. For a description of their support programs, go to http://www.pch.gc.ca/eng/1266413216352.

7. *Charter of the French Language*, CQLR c C-11, <http://canlii.ca/t/526jl> retrieved on 2015-11-22.

8. *Preamble*, Charter of the French Language, CQLR c C-11, *http://canlii. ca/t/526jl*, retrieved on 2015-11-22.

9. For further description of the CHSSN and its Networking and Partnership Initiative, see the CHSSN *Baseline Data Report http:// www.chssn.org/En/pdf/2013_Baseline_Data_Report_final_En.pdf*, p.1–8. For a map with NPI network locations, see *http://chssn.org/chssn- programs-and-projects/networking-and-partnership-initiative/.*

10. For further description of Health Canada's strategy, go to *http://www. hc-sc.gc.ca/ahc-asc/branch-dirgen/rapb-dgrp/pd-dp/olcdb-baclo-eng.php*. The views expressed herein do not necessarily reflect the official policies of Health Canada.

11. Some of these are funding recipients of the Canadian Heritage official language support program.

12. REISA is the French acronym for Réseau de l'Est pour les services en anglais.

13. CASA is the acronym for Community for Anglophone Social Action.

14. See Mikkoven, J and Raphael, D. (2010) *Social Determinants of Health: The Canadian Facts. http://www.thecanadianfacts.org/* and WHO, Social Determinants of Health website *http://www.who.int/social_ determinants/en/* .

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

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

17. These are the words from interviews with NPI coordinators reported by the author with their permission.

18. In each region of Quebec, the government agency responsible for public health and social services must create an "access program." The program must be approved by two committees representing the English-speaking population.

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