INTRODUCTION

Given the complexity of health information and systems, health literacy has emerged as a vital field of study. Health literacy is defined as a person’s ability to understand, access, and use health information and resources in order to make informed health decisions [1–4]. Health literacy involves contextual factors, including the setting and people’s skills to navigate the situation [5]. In Canada, people who do not speak one of the official languages (English or French) and those with low English proficiency may be disadvantaged by the health system [6].

Immigrants to Canada may be at risk for low health literacy due to language and socio-cultural issues [3]. Immigrant families comprise 19.8% of Canada’s population [7]. According to the 2006 Census, 70.2% of the foreign-born population reports a mother tongue other than English or French [7]. Approximately 2% of the Canadian population report that they do not know either of the two official languages (English or French) and those with low English proficiency may be disadvantaged by the health system [6].

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Language challenges can heighten systemic and socio-cultural barriers to accessing health information and resources. The provision of enhanced culturally and linguistically sensitive services may support immigrant families in their caregiving role. Pediatric Blood Cancer © 2011 Wiley-Liss, Inc.

Background. Language is an important aspect of health literacy and plays a vital role in families’ ability to access and use health information and resources. Our study explored the role of communication and language in the healthcare experiences of immigrant parents of children with cancer living in Canada. Procedure. We used a grounded theory approach. Chinese and South Asian parents of children 6 months post-diagnosis were recruited from six Canadian pediatric oncology centers. Semi-structured interviews were conducted in Cantonese, Mandarin, Hindi, Punjabi, Urdu, or English. Questions relevant to communicating included: how parents navigated the healthcare system; nature of interpreter services and translated materials; and suggestions about how to improve services. Analysis involved line-by-line, focused and theoretical coding, and constant comparison. Results. Thirty-one (62%) parents reported no difficulty communicating with healthcare providers in English, while 13 (26%) parents struggled with English, and six (12%) parents could not communicate in English. Communication challenges influenced parents’ role in caring for their child and made it difficult to learn complex medical terminology. Interpreting services were sometimes inadequate or not accessible. Parents occasionally missed out on services and resources, reported limited availability of linguistically and culturally appropriate information, and experienced a lack of social integration in the healthcare process. Conclusion. Language ability played an essential role in parents’ healthcare experiences for pragmatic and social purposes. Language challenges can heighten systemic and socio-cultural barriers to accessing health information and resources. The provision of enhanced culturally and linguistically sensitive services may support immigrant families in their caregiving role. Pediatric Blood Cancer © 2011 Wiley-Liss, Inc.

Key words: caregiving; health literacy; immigrant health; language or communication; pediatric oncology; qualitative

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language in which information is presented. The aim of this study is to explore any special communication and language challenges faced by immigrant parents caring for their child with cancer.

METHODS

Design

This qualitative study adopted a constructive grounded theory approach described by Charmaz [22]. The approach is embedded in the interpretive paradigm, which promotes the understanding of participants’ perspectives through interacting with them in their natural surroundings [23]. This qualitative method is consistent with a growing body of literature in the social and health sciences where in-depth experiences of people are explored through naturalistic inquiry methods, including individual interviews. The aim of grounded theory is to develop theory from participants’ stories and experiences, which help to explain issues of importance to people.

Participants

This study is part of a larger study that explored the caregiving experiences of first generation Chinese and South Asian parents of children with cancer; this paper goes into greater detail regarding the experiences specific to communication and language ability. A purposive sample of 50 Chinese and South Asian immigrant parents were recruited from the following six Canadian pediatric oncology centers: BC Children’s Hospital (Vancouver), Stollery Children’s Hospital (Edmonton), Montreal Children’s Hospital (Montreal), Children’s Hospital of Eastern Ontario (Ottawa), Hospital for Sick Children (Toronto), and McMaster Children’s Hospital (Hamilton). Socio-demographic data were collected. Immigrant parents of children 0–18 years of age with any type of cancer were included if the following inclusion criteria were met: the child was at least 6 months post-diagnosis (or off-treatment up to 10 years) and not considered palliative; the parent was the child’s primary caregiver (i.e., most responsible for decision-making and day-to-day care) and spoke English, Mandarin, Cantonese, Hindi, Punjabi, or Urdu. Child characteristics varied for type of cancer (27 with leukemia, eight lymphoma, five sarcoma, four neuroblastoma, three brain, two Wilms’s tumour, and one liver), gender (34 male and 16 female), and current age (26 children were 0–9 years of age and 24 were 10–18 years). Ninety-four parents were invited to participate and 66 parents consented (70% response rate). Twenty-five of the 46 Chinese parents (54%) agreed compared with 41 of the 49 South Asian parents (84%). We interviewed all 25 Chinese parents who agreed to participate, and were able to purposively select parents from the South Asian participants to ensure a sample (n = 25) that varied by type of cancer.

Participants included seven recent (<4 years), 18 mid-term (4–10 years), and 25 long-term (>10 years) immigrants. Twenty-five parents were Chinese and 25 were South Asian. The 37 mothers and 13 fathers interviewed ranged from 29 to 52 years of age (mean = 41.3). Most participants were married and lived in two-parent households or in joint families with extended family. Seven parents were divorced or widowed. Twenty-three parents were university educated, nine were college educated, 11 had graduated from high school, and seven had less than high school education. Families’ annual household income ranged from $10,000 to $180,000 CAD (mean = $59,275). South Asian parents were of Hindu, Sikh, Muslim, or Christian faith. Sixteen Chinese families did not mention details about religion; the other Chinese families practiced Christian or Buddhist faith.

Procedure

Ethical approval was obtained from each center. Parents were recruited from December 2007 to December 2009. A research nurse, clinical research associate or pediatric oncologist invited parents to participate, and provided a letter explaining the study and a consent form in Chinese, Hindi, Punjabi, Urdu, or English. The research team was notified of any consenting parents, and these parents were called to schedule an interview at their convenience. Before conducting the interview, informed consent and parents’ agreement to the interview being audiorecorded was reconfirmed.

Data Collection and Analysis

Interviews were conducted in Mandarin, Cantonese, Hindi, Punjabi, Urdu, or English by multi-lingual qualitative researchers with a graduate degree (Master’s or PhD). All parents described language issues in relation to English rather than French. An interview guide with questions specific to language ability (see Table I) was used to facilitate the interview. Interviews ranged from 28 to 148 min (mean = 77) in duration. Most interviews were conducted face-to-face at the parent’s home or the hospital; eight were conducted over the telephone. English interviews were audio-recorded and transcribed verbatim with identifiable information removed. Interviews conducted in other languages were translated into English text making every effort to preserve the meaning. All transcripts were checked by a second person for accuracy.

Data collection and analysis occurred concurrently, which allowed the research team to revise the interview guide in order

TABLE 1. Sample Interview Questions Applicable to Communication and Language Ability

| 1. How did you navigate the healthcare system? | [Probe: How did you learn about the healthcare system, professionals (e.g., nurses, doctors, nutritionists, social workers and psychologists), organizations, community groups or healthcare resources? How have they been helpful or unhelpful?] |
| 2. How was the communication with healthcare professionals? | [If parent has difficulty speaking in English, then ask: Tell me how you communicate(d) with doctors, nurses and other healthcare providers? [Probe: Did you use an interpreter? Did you feel fully informed? Do you have any suggestions for improving services?]] |
| 3. Based on your experience, is there anything that could be done differently that might make it better or more helpful for immigrant families of children with cancer? | [Probe: What are your thoughts about talking with other families? Explore culturally sensitive care and resources, and receiving information in first or native language.] |
to gather data to refine emerging categories. Transcripts were discussed at team meetings. Analysis involved line-by-line coding of transcripts by two team members who worked independently and met to establish consensus. Focused and theoretical coding was used to examine initial codes, establish categories, and develop themes. Data analysis was inductive where no pre-defined categories or frameworks were applied to the data. Constant comparison was used to examine relationships within and across codes and categories. Interviewing continued until no new themes emerged. © QSR NVivo 8 [24] software was used to manage the data.

RESULTS

Thirty-one (62%) parents described no difficulty communicating with healthcare providers in English, while 13 (26%) parents struggled with English but could communicate, and six (12%) parents could not communicate at all in English. The main language(s) spoken by immigrant parents at home was as follows: Mandarin (12), Cantonese (14), Hindi (2), Punjabi (12), Urdu (6), English (5), and other languages (7). Immigrant parents used the following individuals to assist with interpretation when necessary: trained interpreter, healthcare provider, spouse/ex-spouse, child with cancer, sibling of child with cancer or a relative.

For most immigrant parents in our study, caring for a child with cancer was their first intensive experience with the healthcare system. The ability to communicate effectively verbally and non-verbally played an important role in immigrant parents’ healthcare experiences in both pragmatic (e.g., accessing health resources) and social ways (e.g., feeling integrated in the healthcare process). Five key challenges concerning communication and language were described by participants (Fig. 1) and are discussed below.

Parents’ Role in Caring for Their Child Being Affected

Parents’ were shocked to learn about their child’s cancer diagnosis. The nature of the cancer and treatment was often described to parents by healthcare providers at the hospital following the child’s diagnosis. The extent to which parents understood sensitive information, secondary to language barriers and their current state of mind, was questionable. The inability to fully comprehend and communicate with the healthcare team about their child’s condition and the treatment plan influenced parents’ ability to actively participate in discussions.

“[T]he hardest moment was the very beginning; I really wanted to know more about [child’s] situation, but because of this [language] aspect I couldn’t really understand. … [C]ouldn’t get the information that I wanted. … The hospital gave me all of the reports, and they also assigned an interpreter. But it’s myself who didn’t understand it.” (Chinese Parent, child with neuroblastoma)

Some parents seemed to have few options other than to fully trust healthcare providers, especially physicians, as they were helping to save their child. Parents were unlikely to complain about the care received or to ask questions about their child’s treatment or condition.

“[L]anguage, there is some barrier. Not like when I speak Chinese, so fluent. Sometimes I thought of some words, but I don’t know how to say it…” (Chinese Parent, child with sarcoma)

Difficulty speaking with healthcare providers made it challenging for some parents (14 of 50) to complete forms in English, advocate for their child, deal with misunderstandings, and prevent medical errors.

 “[There were] mistakes made in the hospital, even [if] they were unintentional … But at that time, if you didn’t really know English … [a]ll you could do was to stand there without a clue—what to say?” (Chinese Parent, child with leukemia)

Parents’ frustration increased when they had to struggle to communicate or be understood, especially in the emergency

Fig. 1. Overarching themes and sub-themes concerning language challenges

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department or during urgent matters. For some South Asian families, fathers often assumed the role of primary caregiver because they were able to communicate better in English than their spouses and were able to assist in emergency situations.

Many parents who were able to communicate in English were reluctant to leave their child alone in the hospital because parents had to assume the role of an interpreter for the child or were concerned about how non-English speaking family members would communicate with staff. This situation added to parental caregiving strain. The problem was further complicated when the child was young and unfamiliar with the context, and had limited exposure to interacting with people from diverse backgrounds.

“[The child] didn’t speak any English. So even when the cleaning lady would come [in the hospital room], she would look at her and she would start crying because she thought she was there to do something.” (South Asian Parent, child with leukemia)

Immigrant parents who were able to communicate fluently in English with the healthcare team often expressed that it helped to ease their sense of helplessness and uncertainty about their child’s condition and prognosis. These parents often discussed their child’s condition directly with healthcare providers with fewer reservations, including asking questions and seeking information. In addition, parents who spoke English readily acknowledged how difficult it appeared to be for immigrant parents with low English proficiency to navigate the cancer process when caring for their child.

Learning Unfamiliar and Complex Medical Terminology

Many parents (21 of 50) were unfamiliar with the term oncology and/or had no or very limited knowledge about childhood cancer.

“[W]hen they told me Hodgkin, I [said] to myself, ‘Okay what is a Hodgkin?’ So I didn’t take it very seriously because I say, ‘Okay it’s a Hodgkin Disease—it’s like a cough and cold or something.’ . . . Then when they [said] it’s one type of cancer, that’s when it hit me!” (South Asian Parent, child with Hodgkin Disease)

Parents highlighted the importance of learning this new medical language for the sake of their child’s health and to ensure that they understood the short- and long-term treatment process. Parents preferred when healthcare providers used simple language to explain complex medical issues (e.g., using the term blood cancer instead of leukemia) and some parents suggested the use of visual aids or diagrams to facilitate learning.

“[E]ven [the] most knowledgeable person who understands fully English, there are still medical terms [that] you don’t understand. You need to feel free to [be able to ask] . . . ‘Can you explain what that means?’ You know, in simple English. But sometimes I think they forget that they are talking in medical terms.” (South Asian Parent, child with leukemia)

Cancer information was not always easy to access or comprehend for most parents in our study. Some parents (11 of 50) also had to rely on relatives, people in their home countries and friends to explain complicated medical concepts. Regardless of their level of English proficiency, many parents found it challenging to understand complex medical information. Some parents also experienced difficulty locating culturally and linguistically appropriate health information in the hospital. Furthermore, the quality of information on the Internet varied and it proved challenging for parents to determine the relevance and accuracy of online information. The ability to understand and learn from information appeared to strengthen parents’ confidence and lessen their anxiety.

“[The] first [thing] [the doctor] told me was a big word, and then after that, he said he [would] try to use simple terms. And he did. . . . He actually explained as much as he could, so that helped. . . . I understood more than before. . . . So, actually [it] calmed me; it made you less nervous.” (Chinese Parent, child with Willm’s tumour)

Interpreting Services Being Inadequate or Not Readily Accessible

Twenty of the 50 parents utilized trained interpreter services at some time during their hospital visits. However, interpreters were not always readily available and sometimes they were not suitable (e.g., a Cantonese speaking parent was provided a Mandarin speaking interpreter). All hospitals in our study had contracts with external agencies to provide interpreting services, while three also had interpreting services onsite. Parents raised the following concerns about interpreting services: (i) parents were uncertain about the amount and range of information that could be discussed; (ii) parents were afraid of taking up too much of an interpreter’s time and of costing the system money; (iii) parents did not know how frequently interpreters could be used and how quickly they could be provided; and (iv) parents described discrepancies between the interpreter’s schedule, family needs and healthcare providers’ availability.

Given the perceived barriers to using formal interpreter services, parents with limited English proficiency also relied on informal translators to communicate, including healthcare providers, family members, friends, and the child with cancer. Many parents expressed a preference for using a healthcare provider (over formal interpreters) because they were familiar with their child’s condition and often more readily available.

“I would tell [the doctors] myself when I didn’t understand something, and they would say that we will call Dr. [name]—she is an Indian, Muslim doctor. . . . Speaks Punjabi and Urdu. . . . [S]he explains everything in our language, so that there is no misunderstanding left. . . . For me, it was very important because my English isn’t that good that I can understand every word.” (South Asian Parent, child with leukemia)

Of the parents that were considered by our research team to be fluent in English (31 of 50), some of these parents also preferred to be assisted with translation to ensure that they understood information correctly, especially during the early phase shortly after diagnosis and for important meetings with the healthcare team.

Both the age of the child and the child’s English proficiency was viewed as an advantage when communicating with hospital staff. Some older children (10 years of age or above) who were...
Parents of children with cancer typically learn about resources and services for families through a social worker who is a member of the pediatric oncology multidisciplinary team. Communication and language challenges contributed to parents’ lack of awareness about available services and resources, and improper understanding of how to access services. Some parents learned about support services and expenses that could be reimbursed through casual conversations with other parents in the hospital. However, by then, some parents had missed the deadlines to be reimbursed for medication or parking expenses.

“They didn’t give a [parking] pass then. At that time, we just parked the car on a side street. . . . After that, when some girl told us that like after [going] there (to the hospital) for five, six months—[then] we found out (regarding reimbursements).” (South Asian Parent, child with sarcoma)

There appeared to be limited availability of comprehensive and reliable translated and culturally sensitive material provided to parents by the hospital, community organizations, and online (e.g., information regarding diet/nutrition, basic information about cancer, and support services). Some parents expressed concern that translated written material was difficult to understand because of the complexity of cancer information or poor quality translation. One pediatric oncology center in our study provided parents with basic written information about cancer in English and the same information in parents’ first language in order to compare. Nevertheless, parents occasionally missed out on services due to language barriers or chose not to take advantage of supports that were available because they were not consistent with their socio-cultural preferences and language abilities.

“They gave me some information—somewhere that I can call to share experiences with each other or something. But I didn’t call because it’s all English-based.” (Chinese Parent, a child with leukemia)

**Lacking Social Integration**

The ability to communicate was often linked to addressing practical issues, including providing medical care to the child at home. However, parents also highlighted the social aspect associated with being able to communicate with people; an issue that was often overlooked by service providers when addressing communication or language issues. Parents, particularly those with poor English proficiency, found it more difficult to relate socially with other parents and staff in the hospital. Some parents expressed the desire for more social interaction with other families dealing with similar situations. Some parents expressed the desire to connect with other parents from their cultural background.

“I wish I can find [other parents] and they will have to be Chinese as well. Because, if it is Caucasians, I will have to think, I will have to translate what I think into English to say it, and they, you know, it’s like we do not have this resonance.” (Chinese Parent, child with leukemia)

Parents often longed to communicate in their native language, as this provided greater comfort and reassurance, the ability to express feelings more openly, and less reluctance to ask and respond to questions.

“If we were to express our feelings, our English proficiency might not be high enough. If they were all Chinese that would be better. . . .For those more emotional issues, sharing your feelings, you might feel that no matter how good your English was, you might still have trouble expressing them.” (Chinese Parent, child with leukemia)

Limited English proficiency and people’s lack of awareness about parents’ socio-cultural background appeared to contribute to the sense of loneliness experienced by some parents.

“When you are unfamiliar with the language, and you don’t find yourself surrounded by other people like yourself, like say you see all white people around you, or all Indian people around you, or all Chinese people around you, then the person feels very lonely. . . .So first of all, there should be support for language, and I guess that emotional support is the most important thing because when we move here from another country, we don’t feel belonged.” (South Asian Parent, child with Wilms’ tumour)

**DISCUSSION**

Cultural obstacles, including language barriers, can negatively impact pediatric care and patient—healthcare provider communication [19,25]. For many families living in large metropolitan cities, limited English proficiency seldom posed as an obstacle in day-to-day life. Thus, the length of time in Canada did not necessarily translate to immigrant parents having greater knowledge of the English language or the Canadian healthcare system. Our study identified both the practical and socio-cultural impact of communication and language challenges on immigrant parents’ caregiving role and healthcare experiences, and the implications for health services delivery, which are discussed below.

First, immigrant parents (6 of 50) in our study with low English proficiency experienced uncertainty, frustration, and helplessness when navigating the healthcare system, which affected their role in caring for their child with cancer. These parents often described being passive recipients in discussions with the healthcare team. Ethnic minority patients and their families tend to be less active participants in making decisions about their health care [26,27]. Patients who do not speak the same language as their health providers tend to report lower satisfaction with communication, rapport and quality of care.
Some parents in our study who were able to communicate with healthcare providers in their first language reported feeling more comfortable and understood. When there is language congruence, patients tend to have more opportunities for interpersonal contact and rapport building [9,12,13,29–32]. Parents in our study found it difficult to advocate for their child when language barriers existed. Limited English proficiency may impact parents’ management of child’s health needs [33].

Second, further strain was placed on immigrant parents’ (21 of 50) caregiving role when language ability made it difficult to learn complex medical terminology and treatment processes. Approaches suggested to help improve health literacy among immigrants include using simple language [4,21,34,35], good translation, and pictorials, theatre, and videos [4,36]. Similar approaches were suggested by immigrant parents in our study. The notion of culturally sensitive material and communication must go beyond translating information into multiple languages [37]. Translated material may be dismissed if it is not culturally relevant [30]. Some websites, including the Canadian Cancer Society [38], are providing simplified translated information about cancer. However, the quality of translated information requires further investigation.

Third, to address language barriers, immigrant parents’ (20 of 50) raised concerns about the limited availability and challenges with using interpreting services. Parents in our study were not always aware about how to make their interpretation needs known. It has been suggested that language difficulties are best addressed by trained interpreters who can facilitate high quality dialogue [39,40] and relationship building [16]. However, studies have shown that trained medical interpreters tend to be seldom used during hospital visits [40] due to difficulty coordinating and lack of awareness of interpreter services [29]. Immigrant parents in our study expressed concern over missing information and misunderstandings arising about the child’s illness if interpreting services were used. Parents in our study relied heavily on family to help interpret; Bowen [6] describes this as “make-do” solutions. Using untrained staff and family (‘ad hoc’ services) may be a convenient alternative, but may exacerbate the risk of clinical misunderstandings and malpractice suits [15,40,41]. Ad hoc interpretation has been linked to diminished trust in doctors, breach of confidentiality, inaccurate communication, inadequate treatment [11], and greater errors in translation [9,11,12,35,41]. Some immigrant parents in our study believed that older children and relatives were able to effectively translate information because they had better understanding about their socio-cultural background; while other parents were concerned about the sensitive information their child(ren) would learn if they acted as an interpreter. One study on Chinese and Vietnamese immigrant patients found that patients preferred trained interpreters over family members because relying on family created a power imbalance, caused discomfort, and created a role conflict between the parent–child [42]. Questions remain regarding the suitability and implications of using family to interpret information in hospitals and community settings (i.e., individuals may be unaware of ethical issues and medical interpretation). Further research is needed to explore issues of privacy and confidentiality in the midst of language barriers.

Fourth, people’s lack of familiarity with families’ socio-cultural background and the inability to adequately understand instructional material in English often resulted in immigrant parents’ missing out on services and resources that may have lessened caregiving strain (e.g., financial resources). Communication challenges made it difficult for immigrant parents in our study to understand, access and use services to meet their and their child’s needs. Our findings coincide with the account made by the Canadian Expert Panel on Health Literacy about access being “mediated by education, culture and language, by communication skills of professionals, by the nature of materials and messages, and by the settings in which health related supports are provided” [43]. Accessing services is often used interchangeably with the ability to use services; assuming that access may automatically lead to understanding and utilization of services. This ignores the complexity of the cultural, communication and language issues that may exist in the development, allocation and use of resources. A culturally competent healthcare setting should involve diverse healthcare providers and interpreters, cultural knowledge and language training for staff, and culturally and linguistically appropriate instructional material [44]. Immigrant parents in our study suggested that healthcare providers must work collaboratively with caregivers to ensure that health resources meet immigrant families’ needs.

Finally, many immigrant parents in our study expressed feeling lonely despite receiving adequate support in the hospital. Immigrant parents often expressed being highly satisfied with the quality of care their child received regardless of any communication and cultural barriers. The commitment of healthcare providers to children, the expertise of doctors, and the caring nature of staff appeared to compensate for language barriers that existed between families and staff in our study. However, immigrant parents’ sense of loneliness and lack of belonging indicates that there is limited awareness about how to effectively socially integrate immigrant families with language barriers in the healthcare process. Immigrant parents’ emphasized the importance to address communication and cultural barriers in order to ensure successful transition between services (e.g., family physicians, emergency departments and pediatric oncology centers) and more relevant support services; but also highlighted the importance of not ignoring parents’ need for greater social integration.

Pediatric cancer care involves a long-term relationship with the healthcare system, which is influenced by the ongoing effects of communication [25]. Communication is pivotal to the success of medical encounters [10,28,31], and for safety in health care [16]. There is variability in the interpreting services and translated material available at the six Canadian pediatric oncology centers presented in our study; currently, three centers have trained interpreter services available on site, one center has translated material about cancer, one center has information online to help immigrant families, and all centers have external or off-site translation services available on demand. This study supports the need to fund, implement, and evaluate such services and resources. There is growing concern that system level changes must also occur, including increasing the ethnic and linguistic diversity of healthcare staff and interpreters [9,12,26,42]. Attending to patients’ perspectives and the possible influence of culture may help to prevent the consequences of stereotyping and the risk of miscommunication [45].

A limitation of this study included not exploring participants’ expectations about the communication process with healthcare providers. This study did not focus on how immigrant parents
with varying degrees of English proficiency communicate about sensitive issues with their children. Further research might explore how to assist immigrant families in gaining confidence and control over navigating the healthcare system when communication barriers exist; and how immigrant families can approach communication barriers during emergency situations.

CONCLUSION

The results of this study indicate that communication, language ability, and culture can be important barriers to accessing, understanding, and using cancer-related information and the healthcare system. Language and communication challenges pose additional strain on immigrant parents caring for children with cancer in Canada. Healthcare providers should understand and acknowledge these factors as major determinants of health, and work to alleviate communication barriers to help immigrant families better manage their child’s care. The provision of enhanced culturally and linguistically sensitive services could help to support immigrant families in their caregiving role. Addressing specific aspects of health literacy, including communication and language, may assist in developing more practical and culturally appropriate responses to pediatric oncology services.

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REFERENCES


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