Intersections of Aging and Immigration: The Promise and Paradox of a Better Life

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Dedication

This book is dedicated to my father (Don) and to the memory of my mother (Leela) who, as older immigrants in Canada, experience(d) the many challenges this book attempts to capture. Yet they live(d) each day with hope and resilience, and share(d) so much love and kindness with everyone around them.

This book is also dedicated to my husband, Illanko (PhD in Electrical and Computer Engineering), who set aside his academic dreams to help mine come true, and to my daughter, Apsara, who brings joy to my life every day.

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I would also like to acknowledge SSHRC and CIHR funding that helped me collaborate with many practice and policy partners across the country to build a program of research at the intersections of aging and immigration.

Table of Contents

Chapter Summaries

The book is divided into six sections.

SECTION 1 provides a context within which intersections of aging and immigration is considered in this book in order to help readers (re)think about what it means to age well in Canada.

In Chapter 1, "Aging Well: Critical Issues of Concern for Older Immigrants in Canada," Sepali Guruge introduces key issues of concern in relation to health and wellbeing, and (re)settlement and integration of older immigrants and refugees in Canada. She captures the role of social determinants, such as access to services, gender, and racism and discrimination in shaping the health and wellbeing of older adults in order to provide a context for issues related to aging and immigration in Canada. She stresses the need to understand the social determinants of health and how multiple institutional and structural elements create inequities in basic need areas for older immigrants, including housing, employment, transportation, and healthcare.

In Chapter 2, "Social Exclusion: A Lens for Understanding Aging in the Context of Migration," Amanda Grenier and Jill Hanley explore the merits of thinking through social exclusion as a conceptual framework to better understand the experience of aging within the context of migration, in terms of the structural, organizational, and relational issues at the intersections of aging and migration and how they affect the lives of older migrants. Using composite examples at micro, meso, and micro levels of community-based practice, they illustrate dimensions of social exclusion in action, and how these affect the experiences of older migrants in the contexts of family sponsorship, dependency, and care. The authors underscore the need for a critical agenda that links the analysis of social exclusion with mechanisms for inclusion through advocacy and political change.

Mandarin-speaking older immigrants represent about 25 percent of the older adult population in Toronto, yet there is limited knowledge on their perspectives of aging in Canada. In Chapter 3: Perceptions of Healthy Aging among Mandarin-Speaking Immigrant Older Adults in Toronto, Sepali Guruge, Robert Ta, Ernest Leung, and Souraya Sidani report the results of their study that involved 36 Mandarin-speaking older immigrants in Toronto. They highlight that the older adults' access to information and community-based programs, as well as formal and informal support for their care needs, were key factors contributing to healthy aging in this community. The authors call for a strength-based approach for mobilizing members of the Mandarin-speaking community to promote the cultural values of caring for older adults, and in involving service providers in enhancing accessibility to health care and social services that are essential to maintaining older adults' wellbeing.

SECTION 2 focuses on health statuses and health determinants of older immigrants.

Based on a scoping review that included a sample of 47 articles, in Chapter 4, "Health Statuses and Health Determinants of Older Immigrant Women in Canada," Sepali Guruge, Kaveenaa Chandrasekaran, Nishana

Chandrasekaran, and Madelaine Woo report that older immigrant women in Canada experience decline in some aspects of their physical and mental health. They also underutilize preventive services such as cancer screening, and experience difficulties in accessing healthcare services. The authors report language, cultural differences, and digital literacy, among others, as key barriers to healthcare access and utilization. The authors highlight the need for culturally safe and linguistically tailored health services and health information, as well as consistent funding to ensure community-based social and settlement services to facilitate the health needs of older immigrant women in Canada.

The aging population and immigration-based population growth in Canada necessitate research, practice, and policy focusing on older immigrants' health, which appears to deteriorate over time. In Chapter 5, "Health Status and Health Determinants of Older Immigrant Men in Canada," Sepali Guruge, Kaveenaa Chandrasekaran, Ernest Leung, Tobert Ta, and Souraya Sidani examine what is known about the older immigrant men's health, social determinants of health, and barriers to access to health services. Based on the analysis of the results of the 25 articles that were included in their scoping review, the authors report that the key social determinants of health include culture, religion, gender, and access to health services. They also highlight that older immigrant men use fewer health services than their Canadian-born counterparts as a result of cultural beliefs, lack of culturally and linguistically appropriate health services, financial difficulties, and ageism. The authors conclude that regardless of subcategories within this population, older immigrant men experience considerable health inequities.

SECTION 3 focuses on socioeconomic considerations for older immigrants' wellbeing in Canada.

Multiple factors, including moving to a new country, can result in the loss of informal and formal social networks, leading to social isolation for older adults. The quantity and quality of lost (and sometimes gained) networks and support can shape where and how newcomers build their lives and participate in cultural and political life in Canada. In Chapter 6, "Loneliness Kills: Social Support and Social Interactions as Determinants of Aging Well and Inclusion Among Arabic- and Spanish-Speaking Senior Immigrants in Ottawa," Paola Ortiz Loaiza, Denise L. Spitzer, and Radamis Zaky explore the informal and formal social networks and social support that shape the lives of immigrant older adults, and propose strategies and programs that can be tailored to meet diverse experiences (pre-, during, and post-migration) to ensure their effective uptake, implementation, and sustainability.

Exclusionary practices can affect the participation of older immigrants in the labour force; these include lack of recognition of overseas education, training, and skills, alongside of racism, discrimination, and ageism. In Chapter 7, "I helped them to help the country": Lack of State Support for Precarious-Status Older Chinese Immigrants, Fanyuan Zhang, Jill Hanley, and Christina Klassen discuss the importance of recognizing the older immigrants' everyday contributions in private homes and the broader community and society, and examine the exclusionary practices and policies that force older immigrants into poverty and housing insecurity and expose them to abuse.

Homelessness is increasing in Canada, and the proportion of older people who are homeless is also increasing. Studies on this population point to their unique health and service needs, which require special attention. In Chapter 8, "Housing Insecurity and Homelessness Among Older Immigrants in Canada," Vibha

Kaushik, Christine A. Walsh, and Jill Hoselton highlight that older immigrant adults may have unique psychosocial vulnerabilities. The authors examine the issue through an intersectional lens, with a focus on the various factors associated with aging, housing insecurity, and homelessness among immigrant older adults who experience a range of systemic challenges in accessing housing-related services.

SECTION 4 focuses on caregiving.

In Chapter 9, "Conceptualizing Person-Centred Care for Ethnocultural Minority Residents in Long-Term Care Homes," Shreemouna Gurung, Atiya Mahmood, and Habib Chaudhury offer a conceptual framework for developing and implementing a person-centred care approach to meet the needs of ethnic and racialized individuals living in long-term care homes. They focus on integrating the concept of intersectionality into a person-centred practice framework alongside secondary evidence and key constructs from gerontology. Their framework is based on a multidisciplinary literature review on person-centred care and ethno-specific long-term case settings. The authors also identify future research directions based on the gaps in related frameworks and empirical evidence.

In Chapter 10, "Chinese Family Members Caring for Older Adults in Private, Senior, and Long-Term Care Homes," Charlotte Lee, Doris Leung, Jason Wong, Paige (Pei-Chun) Wen, Sammy Chu, Frank Ng, Luna (Jiayue Fan), Lisa Seto Nielsen, Daphne Cheung, and Sepali Guruge examine the agency of family care partners who support older immigrants. This issue has been generally overlooked to date, and it is not yet clear whether, how, and when caregivers access resources. Based on their qualitative study involving 28 Chinese family care partners living with or near relatives in their private homes, assisted-living facilities, or long-term care facilities in the Greater Toronto Area, the authors explore dimensions of caregiving agency across intersections with the environment, including a mismatch between the needs of Chinese family caregivers and the available supports. They report that the mismatch is worst for Chinese family caregivers whose relatives live with them or nearby. Access to health and social services for their care recipient depends on the availability of community-based services that are culturally appropriate and match the shared financial capacity of the older adult and their caregiver.

Culture, religion, and society shape how individuals conceive of death, and strongly influence the process of dying. Views about death and dying vary between groups and also within them, and existential wellbeing may become much more important than physical and psychological health. The meaning of death (and life), and choices and decisions made in the processes of dying and bereavement are usually rooted in cultural values and beliefs. In Chapter 11, "The Diversity of Views About Death and Dying among Immigrants and Their Families" Hai Luo examines views of death and dying in contemporary Western societies and their theoretical foundations, followed by an overview of how various cultural and religious groups think about life and death, practices at the time of and after death, and bereavement and mourning processes.

SECTION 5 focuses on access to services.

In Chapter 12, "Elder Abuse Risk Factors and Intervention Strategies: Perspectives of Korean Older Immigrants," Sepali Guruge, HeeJin Zhou, Ernest Leung, Souraya Sidani, and Tharsiny Thavarasa examine growing concerns about elder abuse in the newcomer Korean community. The first phase of their mixed-

methods study with older Korean women and men in Toronto focuses on limited language proficiency, financial dependence, social isolation, and the lack of appropriate health, social, and settlement services as the most salient elder abuse risk factors. The second phase focuses on peer support, community outreach, and information about community outreach programs, psychoeducation, and English language classes as potentially effective interventions to prevent elder abuse.

Timely access to appropriate services is a key requirement for aging well, but older immigrants tend to underutilize social, settlement, health, and legal services, often due to intersecting barriers related to housing, employment, income, transportation, language, and problems with the services/service provisions themselves. In Chapter 13, "Awareness of Formal Social Supports Among Older Immigrants in Mid-Sized Urban Communities: The Case of Waterloo, Ontario," Hector Goldar Perrote and Margaret Walton-Roberts discuss how eligibility for services is determined not by the individual seeking help nor the service provider, but rather by the interaction between the two, which can be affected by racist, ageist, and gendered policies. They use the candidacy model as a framework of engagement at the micro, meso, and macro levels to explore the intersecting oppressions experienced by older immigrants and how these might be addressed in terms of service access, use, and provision.

Based on a 4-phase project, in Chapter 14, "Spatial and Language Discordance in Accessing Physicians Among Older Immigrants in Toronto," Lu Wang, Sepali Guruge, and Alexandra Wehr outline the barriers, facilitators, and interventions for Arabic- and Hindi-speaking older immigrants in the Greater Toronto area. The first phase is a scoping review of general and group-specific barriers to and facilitators of access to primary care. The second phase involves surveys, focus groups, and interviews with three groups of key stakeholders, that revealed gaps in systemic access to specialists and privatized health care, availability of culturally relevant educational resources, and utilization of mental health services. The third phase is a symposium bringing together stakeholders to share knowledge and explore new possibilities. The fourth and final phase focuses on synthesizing and sharing the co-created knowledge.

SECTION 6 focuses on research, practice, and policy considerations.

In Chapter 15, "Recruiting Older Immigrant for Research: Opportunities and Challenges," Melissa Northwood, Ernest Leung, Souraya Sidani, and Sepali Guruge critically explore how to engage in community-based research that is respectful, ethical, and useful for older immigrant adults and their communities. The inclusion of older immigrants in research is critically important to generate a representative evidence base and prevent health inequalities that may arise from exclusion to participation. Part of the community can include physical, psychological, historical, linguistic, economic, cultural, political, social, and spiritual spaces, so the authors examine key issues related to fieldwork in research on the intersections of immigration and aging, such as recruiting older immigrants, ethical considerations for working with vulnerable populations, and the strengths and limitations of community-based research involving older immigrants, their families, and communities.

The processes of social, economic, and political inclusion among immigrants are fundamentally embedded in space and place, so it is imperative to understand the spatial needs and social lives of senior immigrants within the context of the public realm. In Chapter 16, "Aging in Third Places: Community Spaces and

Social Infrastructure for Older Immigrants," Zhixi Zhuang and Ryan Lok discuss the role of third places – social spaces outside of the home and workplace – and how they may mitigate social isolation and promote connectedness among older immigrants. The findings of their mixed-method project involving secondary data, ethnographic observations, and case studies reveal that third places provide a space for older immigrants to build community bonding through routine social, economic, and physical activities – and also empower them to participate more actively in public affairs and community advocacy.

SECTION 1: BACKGROUND

Chapter 1. Aging Well: The Critical Issues of Concern for Older Immigrants in Canada

SEPALI GURUGE

The global population continues to age, and in conjunction with increases in international migration, the average ages and ethnic compositions of populations in many countries are rapidly changing. This is particularly true of countries in the Global North such as Canada, the United States, and England. In Canada, older immigrants now comprise a significant proportion of the population (Statistics Canada, 2022). Canada's immigration policies have changed over time with regard to sponsorship criteria and countries of origin, and these changes have shaped the numbers and diversity of older residents in terms of ethno-cultural, religious, and racialized statuses. Historically, many immigrants to Canada originated in Europe, but more adults have been arriving from Asia and Africa in recent years. Canada's responses to global emergencies, such as the Syrian and Ukrainian humanitarian crises, have also led to an influx of refugees, including older adults. At present, Canada has residents from more than 200 ethnic groups and more than 200 language groups, and 30 percent of all older adults in Canada were born outside the country, with many concentrated in large metropolitan cities such as Toronto, Vancouver, and Montreal (Statistics Canada, 2022).

Older immigrants in Canada can be loosely classified into two main groups: those who came to Canada at a younger age and those who arrived later in life. Their backgrounds are diverse, and their heterogeneous identities and lives are very much shaped by multiple and intersecting factors including immigration status, age, education, socioeconomic status, ability, gender identity, and sexual orientation. The meaning of aging itself can differ within and between groups. For example, age is not dichotomous, and older individuals may be classified as young-old adults, mid-old adults, and old-old adults. In Canada, older adult status is generally conferred to those 65 and older. In the context of older immigrant populations, some researchers draw from WHO guidelines to include those over the age of 60 or even 55. This is because lower- and middle-income countries usually have a lower life expectancy due to socioeconomic and other life factors that put residents at morbidity and mortality risks from a younger age. After arrival in Canada, the health and wellbeing outcomes of older immigrants are affected by the intersecting influences of diverse racialized status, English/French language fluency, socioeconomic status, immigration status at arrival, and current immigration status, among others.

Beyond these individual-level factors, all newcomers to Canada are affected by policy decisions. These macro-level factors can have considerable negative effects on the lives of older immigrants. For example, Canadian immigration policies related to the Super Visa program have reduced the numbers – and rights – of older adults who arrive in Canada as permanent residents. Another example is the Family Reunification program: many newcomer older adults arrive through this policy, but recent changes to Canadian immigration policy now require that the sponsoring relative guarantee financial and social support for the older adult for a period of 20 years (much longer than that of any other age group in the Family

Class) (Government of Canada, 2023), during which time the sponsored older immigrant is prohibited from accessing many social programs, including Old Age Security. This policy often results in multi-generational co-residence (Martin, 2017). Many older newcomer adults become isolated at home, unable to find paid employment due to various structural barriers including ageism and racism, while also not qualifying for Old Age Security. They often engage in unpaid household activities such as cooking, cleaning, laundry, grocery shopping, and caring for grandchildren. Some also engage in volunteer work and other community activities that benefit other older adults and the broader community, but many of their contributions are ignored, even though the literature is clear that most immigrants arriving as sponsored relatives make significant socioeconomic contributions to their families and the communities, and by extension, to Canadian society. Essentially, Canadian society benefits from the unpaid labour carried out by older immigrants, which can even constitute a form of elder abuse.

These daily responsibilities can affect the general health and wellbeing of older immigrants over time. All immigrants undergo medical checks to qualify for admission to Canada: most arrive in better health than their Canadian-born counterparts, but this health status tends to worsen the longer they are in Canada. This "healthy immigrant effect" however is not applicable to all foreign-born individuals, for example, to refugees who may have left war-torn countries or other disasters. Many refugees have high levels of resilience, but they may also face considerable physical and mental health consequences (Bogic et al. 2015). Very few studies have explored the health of older immigrants and refugees, so it is not clear whether the healthy immigrant effect applies equally to this population or whether their health status is poorer than or equal to their Canadian-born counterparts. The lack of research attention to the health of older immigrants reflects the preference of Canada's immigration policy for younger economic-stream applicants, as well as the general expectation within Canadian society for immigrants to acculturate and assimilate. The reality is that language differences, lack of familiarity with the Canadian healthcare system, and the loss of familiar health, physical activity, and dietary practices can make it nearly impossible for newcomer older immigrants to maintain and promote their health, prevent illnesses, and address illnesses in a timely, efficient, and effective manner.

Health and wellbeing are strongly influenced by cultural and religious values, beliefs, attitudes, norms, customs, and knowledge. Some of these influences may change over time in Canada, for example through assimilation and acculturation. Language fluency and cultural and religious differences create unique challenges and opportunities for healthcare, social, and settlement services providers. Older adults who are refugees face seemingly insurmountable barriers to health-related support, advice, and information, so they are a key priority for the Canadian healthcare system. However, very limited information about health and healthcare services is available in other languages, healthcare providers are not often equipped with paid translators and interpreters, and healthcare systems have not implemented measures to provide culturally safe care.

Beyond issues related to language-specific services and programs, older immigrants tend to underutilize social, settlement, health, and legal services due to intersecting factors related to housing, employment and income, transportation, unfamiliarity with services, and discriminatory and racist practices embedded within service delivery (Badger & Koehn, 2015; Hanley et al. 2019; Hepburn et al. 2015). Older adults also underutilize shelters, hotlines, and other such services (Guruge et al. 2019b) because of multiple intersecting

factors such as lack of familiarity with services; lack of accessible, portable, and coordinated services; and confidentiality concerns (Hepburn et al. 2015). Together, all of these factors can work to the disadvantage of older immigrants who may or may not have access to their customary social networks and support.

Migration disrupts the social networks and support available to immigrants, affecting their ability to age well, independently, and with dignity (Guruge et al. 2015; Jang et al. 2016). Older immigrants report higher levels of social isolation than individuals born in Canada (Charpentier et al. 2019; Wu & Penning, 2015). Social networks – both informal (e.g., family, friends, neighbors, co-workers) and formal (e.g., healthcare providers, settlement workers) – can facilitate the settlement process, foster a sense of belonging, promote resilience and capacity, improve access to information and services, and reduce the effects of discrimination and racism (Ferrer, 2018; Gulbrandsen & Walsh, 2015; Walton-Roberts et al. 2019). Social inclusion is known to be associated with life satisfaction among older immigrants (Kim et al. 2015; Li et al. 2018; Tong et al. 2019), especially among those without ties to an established community (Jang et al. 2015). Individuals who arrive at a younger age, often become fluent in English or French, and/or are employed in paid work in Canada, and as such may be less isolated (Charpentier & Quéniart, 2017; Jang et al. 2015; Khan & Kobayashi, 2015).

Social connectedness is also affected by the size and density of ethnic communities, the availability of ethno-specific resources and services, and ready access to reliable and accessible public transportation (Agrawal & Kurtz, 2019; Wang et al. 2019). For example, over the last 20 years more immigrants in Canada have moved into suburban areas instead of downtown cores, but this change has not been reflected in funding, service, and resource allocation, resulting in extensive unmet social support needs (Gordon et al. 2018). While it is long known that place affects wellbeing, few studies have explored how living in small, mid-sized, and large cities affect older immigrants and their access to social networks. For example, life in ethnic neighborhoods in larger cities might be different from that in small cities where pressure to conform to cultural and religious values and beliefs may increase the risk of elder abuse (Guruge et al. 2012).

Rates of elder abuse are underreported globally (United Nations, 2023). Post-migration values, beliefs, expectations, and conditions are changing in many immigrant communities. These changes can alter social supports, gender roles, and socio-economic statuses in the context of other stressors, such as, language differences, discrimination, and racism (Williams et al. 2014). More daughters and daughters-in-law are now participating in the paid labour market, which is normalizing the expectation that older adults will care for grandchildren (Wilcox & Sahni, 2022), and can also prevent older immigrants from receiving 'traditional' elder care. Alongside such changes, older adults' forced reliance on family, due to immigration and other policies, can lead to conflict (Hepburn et al. 2015). Another significant risk factor is isolation, which can make older immigrants more vulnerable to abuse. Victims, families, and communities may hide abuse to keep shameful family matters private (Baker et al. 2016). When adequate and appropriate resources are available, older immigrants may not be as reliant on family for support (Avery, 2016; Jang et al. 2015), and perhaps leave their abuser(s).

Access to financial resources and continued involvement in paid work are important aspects of feeling included in society and aging well in general. As noted above, most older immigrants in Canada experience economic difficulties related to factors including ageism, racism, and policy barriers, and many are financially dependent on their children. Research has revealed that the income gap between older

immigrants and their Canadian-born counterparts can be as large as 50 percent (Curtis & McMullin, 2016; Preston et al. 2014). Although (as noted earlier) many older immigrants contribute to society through unpaid domestic labour and caregiving work, paid work, and volunteering, these contributions are rarely acknowledged by policymakers (Harbison et al. 2012). Some scholars have suggested that recognition of their contributions, and implementation of policies to enable such recognition, can help older immigrants age well (Avery, 2016). Economic support in the form of pensions and other benefits would also enable older immigrants to live independently of their children and avoid the tension and conflicts inherent in cohabitation. Policy is a particularly important issue: refugee policies and delays in processing claims can leave people without citizenship, making them feel socially disconnected from the recipient society and lonely because they cannot visit family members without a passport. Other policies, such as those that disperse newcomers into different parts of the country, can also isolated newcomers, and in doing so, reduce their chances of access to timely health, social, and settlement services. Most insidiously, many new immigrants and refugees are excluded from full participation in society due to racialization and its many intersections, e.g., with ageism, Islamophobia, sexism, and xenophobia.

One indicator of a healthy and inclusionary social system is political participation and civic engagement among immigrants. This kind of participation requires that immigrants can access political resources as well as social, infrastructural (e.g., transportation), and economic resources (Raymond et al. 2016; Shields et al. 2016). A mutual commitment is required between immigrants and Canadian society at large in order for them to feel a sense of belonging (Bilodeau, 2018). Immigrants must be given opportunities to cultivate a voice that reflects their needs. Community agencies, municipal offices, religious institutions, and multiethnic organizations are important sites of political and civic engagement (Zhuang, 2019). Immigrants can contact public officials, join community groups, volunteer, and vote (Zhuang, 2021; 2019), but a prerequisite to these types of engagements is that they feel included as valued citizens and community members.

Another important determinant of wellbeing is geospatial inclusion and place-making. All individuals, including older immigrants, need to feel a sense of belonging, feel accepted and valued within their communities, have spaces and places to actively take part in preferred social activities, and be able to form intimate social relationships (Koehn et al. 2014; 2016). Community growth and individual wellbeing require places and resources that promote community engagement (Michalski et al. 2023) and cooperation among individuals and institutions (Gomez et al. 2012). More research is now focusing on steps to fostering 'age-friendly cities' (Hordyk et al. 2015; Mitra et al. 2015). However, this emerging body of scholarship has largely neglected the specific needs of older immigrants. Some emerging evidence suggests that interventions are most effective (in terms of promoting uptake, implementation, and sustainability) if they are tailored to the specific needs, beliefs, and values of immigrant communities (Chu & Leino, 2017; Patel et al. 2017; Sekhon et al. 2017; Thomson et al. 2015).

The phenomenon of transnational aging has led to new challenges but also new opportunities. Recent advances in technologies have created new spaces to address challenges related to 'aging in place.' Older immigrants in Canada need more access to these technologies and training so that they can be more connected to their family and friends who live in Canada or in their countries of origin, and they also need

more access to appropriate and necessary services. Overall, this population requires urgent attention in terms of policy, practice, and research that recognizes both their vulnerabilities and resiliencies.

This book presents an in-depth analysis of these critical issues faced by older immigrants in Canada, along with transferable knowledge, collaborative approaches, and innovative solutions to address those challenges. In doing so, the chapters examine aging at the intersection of immigration and (re)settlement. The hopes and dreams of older immigrants (including refugees) are discussed in juxtaposition to their challenges and struggles.

The volume's 40 contributors draw from research on health, social, and settlement experiences of older immigrants in Canada through critical analyses and reconceptualization of theory, policy, and practice within the Canadian context to highlight the resiliency and agency of older immigrants in responding to the challenges of aging in this country. Contributors engage the readers in appreciating the shared and distinct migration and (re)settlement experiences of older immigrants. Chapters capture a diverse range of issues that are important to older immigrants and other stakeholders, with a focus on health, socioeconomic considerations, caregiving, access to services, and considerations for research, practice, and policy from a broad range of geographic, theoretical, and professional perspectives. Discussions related to policy, research, and practice implications are interwoven throughout the book, and we pay attention to how the resilience and strengths of older adults could be incorporated when developing programs and policies, and/or building community capacity.

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Chapter 2. Social Exclusion: A Lens for Understanding Aging in the Context of Migration

AMANDA GRENIER AND JILL HANLEY

Migration is a relatively recent consideration in social gerontology, and migration studies often overlook aging (Torres, 2012). Despite the important presence of im/migrants[1] across the country (StatsCan, 2017), relatively few studies have focused on aging and migration. Existing literature finds that older im/migrants experience health disparities (Gee et al. 2004; Kobayashi & Prus, 2012), structural racism and institutional discrimination (Ferrer et al. 2017; Sahraoui, 2020), and barriers in accessing care (Arora et al. 2018; Ciobanu & Hunter, 2017). Im/migrants also have higher rates of insecure employment and poverty than the Canadian-born population. It is safe to assume that this trend persists or even becomes more pronounced among aging im/migrants (Grenier, Phillipson, & Settersten, 2020). Aging is structured and experienced differently, and unequally, at the intersections of migration and aging. Discrepancies correspond with policy structures and institutional practices related to income, health, housing, and care.

We explore the merits of thinking through social exclusion as a conceptual framework to better understand the experience of aging within the context of migration. It can help to situate the analysis of structural, institutional/organizational, and relational issues as they affect the lives of older im/migrants. The concept serves as a critical analytic framework to identify key issues and discrepancies, inform directions for advocacy, and suggest policies and practices that promote and facilitate the meaningful inclusion of older im/migrants and their communities.

Definitions and Approaches: Social Exclusion among Older People and in Late Life

The study of older people's social exclusion began in the late 1990s, spurred by demographic trends on aging, shifting family forms, neighbourhood and community change, and the impacts of increasing individualization and austerity measures (Scharf & Keating, 2012; Walsh et al. 2017).[2] Thinking about the importance of place and social networks, researchers focused on how the places one lives, in connection with social relations, could produce exclusion, particularly for poor and/or marginalized groups.

1. In this chapter, we use the term "migration" to refer to international mobility, and "migrant" to refer to people who are either in the process of moving or in Canada on a temporary basis (ex. SuperVisa, migant worker, refugee claimant). We use "immigration" or "immigrant" to refer to refer to Canadian policies (in line with the Department of Immigration, Refugees and Citizenship Canada (IRCC)) or those who have become Permanent Residents. We use the term "im/migration" when a statement refers to both Permanent Residents and those with temporary status.
2. Social exclusion and older people have been on the policy agenda since the early 2000s, mainly in the UK and Canadian province of Quebec.

Although the concept of social exclusion was traditionally concerned with issues of economic disadvantage (Levitas, 2007; Silver, 1994), it is now better understood as a multi-dimensional concept that includes barriers and/or poor access to social and material resources, as well as persistent poverty, social inequalities, unequal health and social outcomes, and the nonrealization of civil, social, and political rights (Arber, 2004; Ballet, 2001; Berghman, 1995; Burchardt et al. 1999; Martinson & Minkler, 2006).[3] In social gerontology, social exclusion is a framework to identify risks experienced by older people across the life course, as well as disadvantage over time as one ages (Dannefer, 2003). The study of exclusion explores how disadvantage and/or unequal aging vary according to age, socioeconomic status, gender, race and/or ethnicity, disability, health conditions, and place (e.g., urban deprived or rural remote) (Scharf & Keating, 2012).

Walker and Walker define exclusion as "the dynamic process of being shut out, fully or partially, from any of the social, economic, political, and cultural systems which determine the social integration of a person in society" (1997, 8). Walsh and colleagues outline how "old age exclusion involves interchanges between multi-level risk factors, processes and outcomes" that are "amplified by old-age vulnerabilities, accumulated disadvantage … and constrained opportunities" (2016, 93). They highlight how social exclusion leads to "inequities in choice and control, resources and relationships, and power and rights" across a range of domains, and finally, that social exclusion "implicates states, societies, communities and individuals" (Walsh et al. 2017, 93). Three additional features of social exclusion are relevant to older im/migrants' experience: 'First, that exclusion can be accumulated over people's lives, contributing to increased prevalence of social exclusion in later life; second, that mechanisms and dimensions of social exclusion serve as tipping points for precarity, as well as opportunities to get out of exclusion; and third, that some groups are more susceptible to social exclusion than others' (Walsh, Scharf, & Keating, 2017; see also Grenier, Phillipson, & Settersten, 2020).

Social exclusion is relative to the society and time within which people live. It can change over time and may have effects that reach across generations (Scharf, Phillipson, & Smith, 2005; Walsh, Scharf, & Keating, 2017). Although slight differences exist between the leading models in gerontology, domains of social exclusion genereally consist of exclusion from material and financial resources, social relations and/or negative cultural constructs, civic activities and participation, institutional or political processes, basic services and/or amenities, meaningful relations, and neighbourhoods (see footnote for further detail).[4] Three sources drive older people's social exclusion: structural drivers that operate at a national or supranational level; environmental drivers related to living environments; and individual drivers, including low socioeconomic status in early life, disruptions to personal and social networks, and/or migration (Scharf & Keating, 2012). We explore examples of the individual (micro), organizational/institutional (mezzo), and structural (macro) processes and dynamics that create and sustain social exclusion among im/migrant older people. Although we do not provide direct examples of the environmental or place-based processes, we assume that they operate in the background context of each story.

3. Silver refers to social exclusion as a "multidimensional process of progressive social rupture, detaching groups and individuals from social relations and institutions and preventing them from full participation in the normal, normatively prescribed activities of the society within which they live" (Scharf & Keating, 2012, 4). Levitas and colleagues define it as the "lack or denial of resources, rights, goods and services, and the inability to participate in the normal relationships and activities available to the majority of people in a society" (2005, 25).
4. Scharf, Phillipson, & Smith (2005) articulated five domains of exclusion (material resources; social relations; civic activities; basic services; and neighbourhood exclusion); Walsh, Scharf, & Keating (2017) investigated six domains of exclusion (neighbourhood and community; social relations; services, amenities and mobility; material and financial resources; socio-cultural aspects; and civic participation); and Grenier & Guberman (2009) and the VIES team in Montreal employed seven forms of analysis of social exclusion to understand the experiences of older people (symbolic; identity; socio-political; institutional; economic; meaningful relations; and territorial) (also see Billette et al. 2012; Van Regenmortel et al. 2016).

Identifying Social Exclusion among Older Im/migrants: Examples from the Macro, Mezzo and Micro levels

We have created composite cases to illustrate social exclusion in action. They reflect trends and components of life stories that reveal the challenges that older im/migrants encounter with systems and structures. The examples correspond with the macro, mezzo, and micro levels, and for each level of interaction, we begin with a fictionalized vignette to situate the discussion. We have chosen one main issue to highlight at each level, but of course, there are others.

Macro Level Example: Ageism in Canada's Immigration Policy

> Elena is a graphic artist working for a marketing firm in Argentina. At 47, she has never had children of her own. She has spent the past 10 years caring for her aging father. As an only child, her "family" is a close network of friends, most of whom emigrated to Canada because of the successive economic shocks in the country. When her father passed away last year, Elena decided to join her friends in Canada. However, despite her skills and her plan to work for at least another 20 years, her age means that she cannot accumulate enough points to immigrate, so she is separated from those most important to her.

Canada has followed international trends that institutionalize ageism by excluding older adults from independent migration (Dolberg, Sigurðardóttir, & Trummer, 2018), assigning them the cultural stigma of social burden (i.e., the idea that older people are a financial drain on the system) (Zou & Fang, 2018). Canada's immigration system is overwhelmingly weighted toward recruiting immigrants who will make economic contributions through either major investment or, more often, participation in the labour force as a skilled worker (Guo, 2015).

Since 1967, Canada has assessed potential immigrants using a complex "points system" that takes into account factors known to influence an immigrant's success in the labour market: language ability; college or university education; work experience in an in-demand field; temporary experience as a student or worker in Canada; and pre-existing family connections in the country.[5] Chronological age is used as a crucial eligibility criterion. A person aged 18-35 years is accorded the maximum 12 points, after which they lose a point every year until they get 0 after age 47. Given that a successful application requires 67 out of a possible 100 points, the likelihood of being selected as an immigrant declines sharply from the age of 40 onward. Quebec's age weighting is even more severe, with 0 points accorded at age 43.[6] The emphasis on age and "employability" thus renders immigration for people over age 40 extremely difficult.

> Aadi's daughter left Mali to do a master's degree in Canada and became a Permanent Resident after her graduation. She recently married, and is excited to have children. She worries, though, about

5. https://www.canada.ca/en/immigration-refugees-citizenship/services/immigrate-canada/express-entry/eligibility/federal-skilled-workers/six-selection-factors-federal-skilled-workers.html
6. https://www.immigration-quebec.gouv.qc.ca/publications/fr/divers/Grille-synthese.pdf

being able to handle the care of her future children when both she and her husband have to work to make ends meet. She wonders if her father would agree to join them in Canada as a sponsored parent. Aadi, aged 50, is healthy and active and loves the idea of coming to Canada to help look after his grandchildren. With 28 years' service in Mali's public sector, he will soon be eligible for a pension that would allow him to live modestly and comfortably in Mali. However, the pension will not go far in Canada and he is worried about becoming a financial burden to his daughter or losing autonomy over his spending decisions.

Unable to independently immigrate to Canada, older migrants with children or grandchildren in Canada may use the family reunification stream to join their family members as permanent residents.[7] This requires that Canadian citizen or permanent resident children commit to family sponsorship, which entails the child submitting the application for their parent's immigration and a legal commitment to provide for them financially, backed up by proof of a relatively high income (e.g., a family of four seeking to sponsor one parent or grandparent must show tax returns with around $70,000 income a year for three years prior to the sponsorship).[8] Upon arrival, the sponsored older immigrant has all the rights of a permanent resident except for last-resort income security (i.e., welfare or social assistance) for 10 years in Quebec and 20 years in the rest of Canada. Should something happen to the sponsored older person's family financial support — the family's breadwinner becomes unable to work, or sponsorship breaks down because of elder abuse, for example — they would be forced to sue their family before accessing welfare or else their sponsor would be indebted for any welfare they received.

To make matters worse, Canada has severely restricted access to this program in the past decade (Ferrer, 2015), admitting only 22,000 in 2019, leaving 43,000 families waiting (IRCC, 2020). Instead, older migrants are encouraged to access the SuperVisa for parents and grandparents, a 10-year tourist visa that allows older migrants to come and go from Canada relatively freely (maximum 2 years consecutively in Canada) but without providing access to any social benefits such as public health insurance (private insurance being prohibitively expensive for many families), the right to work, or access to income security.[9]

Canadian immigration policy is clearly based on the assumption that older migrants are a burden to our social welfare system, particularly in terms of health and income security. Older migrants' contributions in the labour force, as community members, or within their families as caregivers, emotional supports, or household managers are dismissed.

Mezzo Level Example: Implications of Discrimination, Deskilling and Low Wages for Older Im/migrants

Duy graduated near the top of his nursing class in Vietnam and expected to continue his career in Canada. But life was so expensive when he immigrated that he could not afford to invest in the process to be recognized as a nurse here. To make ends meet, he took a job as a personal care

7. https://www.canada.ca/en/immigration-refugees-citizenship/services/immigrate-canada/family-sponsorship/sponsor-parents-grandparents.html
8. https://www.cic.gc.ca/english/helpcentre/answer.asp?qnum=1445&top=14
9. https://www.canada.ca/en/immigration-refugees-citizenship/services/visit-canada/parent-grandparent-super-visa.html

worker and has struggled to support his family this way for the past 25 years. As he approaches his sixties, he finds this job increasingly physically difficult. His back aches all the time and he has emotional challenges related to a recent workplace incident of violence by a patient with high level care needs. He's worried about retirement because, as a low-wage earner, his pension will be meagre and he won't get the full OAS because he has not lived in Canada long enough. His kids are starting university, so he wants to keep working to support them, but he wonders how much longer he can hack it.

Despite Canada's stringent selection of skilled workers, many newcomers find that the job market does not recognize or value their training, skills, and experience once they arrive. Needing to quickly find employment to support their families, too many skilled im/migrants find themselves trapped in manual labour positions that do not reflect their capacities, and in ways that are heavily racialized and gendered (Creese & Wiebe, 2012; Guo, 2015; Teelucksingh & Galabuzi, 2010). Over the life course, this discrimination has health, financial and social implications (Ferrer et al. 2017).

While there are structural aspects to im/migrants' difficulties in the Canadian labour market, such as the difficulties of having international training or experience recognised by Canadian professional orders, employers' behaviour remains an issue (Esses, Bennett-AbuAyyash, & Lapshina, 2014). Employers discriminate by dismissing job applicants with "foreign-sounding" names (Eid, 2012). Employers dismiss or discount international education and experience in search of candidates with Canadian training and/or experience (Esses, Bennett-AbuAyyash, & Lapshina, 2014). Language is another major barrier — employers discriminate against spoken accents or insist on perfect written English or French even when it is really not necessary for the job (Creese, 2010; Oreopoulos, 2011). One of the most insidious forms of discrimination occurs when employers seek a candidate who "fits in" with the existing team. This often veils racism and xenophobia, with employers unwilling to work across diversity (Sakamoto, Chin, & Young, 2010).

The result is that im/migrant workers find themselves disproportionately in low-wage, precarious, and physical work, for example, in factories or as caregivers. Im/migrants, often with high levels of education and unused to such physical labour, have higher rates of workplace injury when they take on such jobs (Bohle et al. 2010; Côté et al. 2015). As they age in Canada, workers in these jobs often accumulate physical strains and injuries, making them physically unwell at younger ages than people engaged in less strenuous work (Premji et al. 2014; Premji, 2018). For im/migrants who expected professional and financial advancement by moving to Canada, there are also the physical and mental health effects of the weight of heavy disappointment, even shame, related to their drop in socio-professional standing (Guruge, Thomson, & Seifi, 2015; Premji & Shakya, 2017).

Lorena worked as an accountant in the Philippines but after immigrating, found that Canadian employers weren't willing to hire her. When she was 28, she was hired by a sock factory and, although the pay was not great, the job was steady and the employer was decent. After she had worked there for 23 years, the factory owner suddenly died, and his son took over. The son wants to modernize operations, which mostly means increasing production quotas and harassing workers who didn't meet them. Lorena can't keep up, and feels like these unreasonable quotas are a veiled way to push older workers – who apart from working at a somewhat slower pace, also get paid

slightly more than new hires – to quit. She and her "old timer" colleagues are resisting the changes. She's not enjoying her job anymore, but she knows that as a 51-year-old, her prospects on the job market are slim. Not only is her professional training far behind her, but she's considered too old to do manual labour.

In a labour market where, at least in the past 20 years, there has always been another newcomer in line to take up such a job, earning a slightly higher salary and asserting rights can pose a risk to one's employment. Despite one's skill and knowledge, insisting on taking breaks and resisting unreasonable production quotas can lead older workers to be squeezed out so that unscrupulous employers can hire cheaper, less assertive new recruits. Unfortunately, older workers in general, and especially those in the manual labour market, have a very hard time finding employment after age 45 (Fournier et al. 2018). Canada's pension regime already leaves many im/migrants facing retirement and old age in poverty (Coloma & Pino, 2016; Ferrer, 2017) but if im/migrant workers find themselves laid off or fired in later life, they may find themselves permanently unemployed at a time when they need immediate income and would benefit from continued contributions to their pensions. Such economic exclusion is also associated with other challenges such as first-time homelessness (Buffel & Phillipson, 2011; Grenier, 2021; Lunt, 2009). For im/migrants who arrive in later life, for example, sponsored parents and grandparents, finding employment can be near impossible even if they are still below retirement age, leaving them completely economically dependent on their sponsors.

Micro Level Example: Family Dynamics Shaped by Dependent Migration

After Greece's financial crash when she was 67, Dimitra's private pension lost almost all value. She found herself in a very difficult financial situation at the same time that her son, who had emigrated to Canada some years ago, started to have children. Dimitra's son sponsored her to immigrate to Canada. She sold her house for what she could and gave the money to her son for a down payment on a bigger home in the suburbs. Now that she's in Canada, she looks after her son's three children before and after school while her son and daughter-in-law work. Things are going well with her son's family, but sometimes she feels trapped. Without any income of her own, the possibility of going home to visit friends and other family seems like an imposition on her son's family. She resents that she has to ask them for pocket money.

The macro and mezzo levels of social exclusion can have implications for the dynamics within im/migrant families. Many older im/migrants are deeply involved in providing care to their younger family members, looking after young children, and cooking and cleaning while their adult children work outside the home (Ferrer, Brotman, & Grenier, 2017). They may find themselves financially dependent on their children while their role as an older person and their lifetime of knowledge are often discounted within the Canadian context (Gal & Hanley, 2012). If they im/migrated as older adults, they are often socially isolated due to language, cultural, and information barriers (Tong et al. 2020).

While many older im/migrants cherish close relationships with their grandchildren, sometimes the sheer weight of caregiving responsibilities socially isolates them from those outside the family. Grandchildren

growing up in Canada do not always speak their heritage language and there can be communication barriers with grandparents. In the worst scenarios, Canadian-born family members may even judge older relatives for their accents, and assume their less-than-fluent English or French indicates lack of education or knowledge. There can also be a cultural clash between older im/migrants and younger relatives raised in Canada (Hossen, 2012). Taking the older im/migrant's caregiving role for granted can be another source of hurt or conflict.

In many cultures, older people are respected as knowledge holders, but when an older adult joins a child in Canada, the expected roles of authority can be reversed, with the child having more knowledge and experience of the local context than their parent. This change can create tensions and conflict in a family (Hossen & Westhues, 2013). Unfortunately, when older im/migrants have precarious status that depends on their family members, it may be hard for them to express their feelings for fear of repercussion.

> *Amar, 62, runs a small* family business in Egypt and enjoys more free time as he slowly turns the business over to his older daughter. Since his son immigrated to Canada, Amar misses him a lot so he wants to visit more often and maybe even retire in Canada. The family applied for Amar to have a SuperVisa so that he could travel back and forth more freely. Unfortunately, on one of his longer trips to Canada, Amar had a stroke, and the care he needs went above what is covered by his medical insurance. He is too unwell to travel back to Egypt. As his medical bills grow, his son in Canada is held financially responsible for them. Amar is deeply ashamed that he needs his children's financial support, and Amar's son and his siblings in Egypt are fighting about the financial burden of Amar's health care.

Apart from exclusion from public health insurance, older migrants on SuperVisas face additional restrictions (Ferrer, 2015): They cannot legally work, they are ineligible for any type of income security, and they do not qualify for housing subsidies. They are even excluded from many formal services that are organized for im/migrant groups, including settlement services and/or language classes. This complex web of exclusion combines so that older migrants on SuperVisas are especially vulnerable to social isolation, without the language skills to speak to people outside their community or the knowledge or resources to take advantage of what services do exist.

In the worst-case scenario, an older im/migrant's dependence on a family member can lead to situations of elder abuse, whether financial, physical, emotional, or forced labour (Gal & Hanley, 2012). While it is always difficult for an older person to confront and/or escape elder abuse, an im/migration background can add extra layers of difficulty to potential recourse (Matsuoka et al. 2013). Facing language or cultural barriers with service providers, the older im/migrant might not have sufficient financial resources to live independently and their lack of an extended family or social network locally might make the prospect of leaving the family home untenable. In the case of a SuperVisa or family sponsorship, the breakdown of relationship with the sponsor can even put the older im/migrant at risk of losing their right to remain in Canada.

Social Exclusion as a Basis for Change: Moving to Meaningful Inclusion

The vignettes reveal how social exclusion affects the lives of older im/migrants and their families and kin networks. They also demonstrate how immigration policies and related organizational and institutional practices can affect older im/migrants and their families' everyday lives. Older im/migrants experience contradictory social and cultural expectations, precarity, and cumulative disadvantage.

Contradictory Social and Cultural Expectations

The discourse of a "better life" at the heart of government programs and personal expectations is limited by a range of social exclusion processes. This is particularly evident in how im/migrants are blocked from access (or excluded) from social programs as well as their challenges entering the labour market according to their level of experience (and the levels of experience for which they were recruited).

At the level of care, whether access to elder care for older im/migrants themselves or grandparents' provision of care to children, for example, aging and migration expose the contradictions that affect older im/migrants' lives (Williams, 2010). Canadian policies locate care in the family and market domains, and public resources are limited to those only in the greatest need. While a Canadian frameworks and programs express a strong moral imperative of family and kin care, the policies under which many im/migrants come to Canada may prevent them from being with their families or kin for the purposes of receiving or providing care. In other cases, immigration policies permit older migrants to come to Canada to provide care, but exclude them from necessary health or income programs or resources that would ensure their wellbeing and/or meaningful participation in civil society.

Older im/migrants' lives are constructed in contradictory ways across a continuum that includes being the "the ideal carers" (recruitment for programs such as live-in-caregiver), "having strong family ties" (and thus perceived as family reliant and not needing public services) (Lavoie et al. 2007), and only as "carers and grandparents" (sponsored without consideration of their own meaningful lives) (Ferrer, 2015). The framing of older im/migrants' lives differs from the cultural constructions of Canadian-born lives, and in doing so, reveal how older older im/migrants become, using Walker and Walker's definition of exclusion, "shut out, fully or partially, from… the social, economic, political, and cultural systems which determine social integration" (1997, 8) through policies and institutional practices.

Precarity and Cumulative Disadvantage

The vignettes of older im/migrants and their families also reveal how trajectories of disadvantage and inequality continue to accumulate and deepen as people age, and over time (Dannefer, 2003). Grenier, Lloyd, and Phillipson (2017) argue that one of the features that distinguishes precarity in later life from earlier periods of the life course, is that precarity may worsen at the moment of needing care, and becomes particularly acute for those relying on public services. Our examples related to employment demonstrate how precarious employment affects older im/migrants through workplace discrimination in access to jobs,

injury over time. Insecurity mounts as older workers age and may experience further discrimination related to being older (Ng & Law, 2014) and needing their own care. Excluded from full eligibility for pensions, older im/migrants are structured into poverty. Excluded from the protections of retirement intended to offer people reprieve from continued work in later life, they are rendered financially insecure, which may lead them to having little choice but to work into later old age. A history of precarious employment can leave older im/migrants at increased risk of having to rely on public care (if they are indeed eligible) or to rely solely on their own, often very modest, individual resources in the private market.

The example of chronological age as a basis for the point system is a striking example of social and systemic exclusion. Older people who im/migrated to Canada after age 40 are often structured into poverty as a result of not having accumulated enough work experience to qualify for full pension (if indeed they were eligible) (Grenier et al. 2017). The intersections of aging, racialization and low socio-economic status are known to affect women in earlier periods of the life course (Islam et al. 2015). Older women are known to be over-represented in terms of poverty in later life (Arber, 2004), and the relationship between gender, im/migration and/or racialization, and poverty is more pronounced in late life. In Canada, data tables from the 2016 census reveal that 16.8 percent of visible ethnic minority women over the age of 65 live in poverty (Statistics Canada, 2016). It is difficult to judge the extent to which decisions about the point system were connected to the composition of the pension structure, but when we pair the exclusion of immigration policy with retirement policy we see how older im/migrants, who would later be "structured into poverty" are simply excluded (or cut off) at the front end — through the point system. This raises important questions about the youth-based emphasis in immigration policy and how the emphasis on work overlooks the longer-term impacts of systems and structures over time. It ignores how mitigating later-life poverty relies on access to stable full-time employment across the life course, as well as schemes that compensate for needing care.

Policy Intersections

Older im/migrants' lives are structured by social policies, and through institutional and organizational practices in policy spheres of im/migration, health, income, housing, and care. The effects of one policy have spin-off effects in other policy spheres or over time as disadvantage accumulates. This problem is often acknowledged in the popular rhetoric of eliminating policy silos. However, such thinking overlooks how the solution is not only a question of working across policies but of identifying and addressing the systematic exclusion that happens relationally between policy structures, and in the lives of older im/migrants and their families. In thinking about late life, this includes, for example, how the types of im/migration pathways affect income security in later life (through employment and pension) and, thus, later, access to care (whether by family or state).

Our analysis of social exclusion and examples from community-based practice reveal the importance of creating mechanisms for meaningful inclusion across the life course and into late life. Social exclusion provides a framework to expose the systemic forms of exclusion and discrimination that affect people from im/migrant backgrounds across the life course. The illustrations reveal some of the complex ways that social exclusion can affect older im/migrants. Migration is one of the risk factors that drive exclusion

through unequal access to employment, income security, health, and care. We now need to determine how the drivers and risk factors may be similar or different for those with im/migrant backgrounds—how particular im/migrant groups may experience social exclusion.

One of the next steps is to better understand the experiences of social exclusion from within the social location of im/migration— from the voices and experiences of older people with im/migrant backgrounds. Here, for example, an allied concept of precarity suggests how im/migration may be accompanied by greater risks for exclusion, and that the culmination of features such as low income, employment trajectories, and care policies may have particular impacts on im/migrant groups as they begin to need care in systems where the care may be expensive or inaccessible for a number of structural, cultural, or personal reasons (Grenier et al. 2017; Grenier, Phillipson, & Settersten, 2020). Where some of the multiple and varying trajectories that can lead into social exclusion in later life are relatively well known, we know less about how these may change over time, and in later life. This includes how time, aging, and the need for care may alter experiences of social exclusion that have been well-documented in earlier periods of the life course. Older im/migrants' experiences of social exclusion will differ based on immigration policy, work and retirement benefits, institutional eligibility, as well as family patterns of care.

Where social exclusion provides an analytic framework to better understand aging among im/migrant groups, social inclusion and the elimination of discrimination are concepts that can be used to develop and assess policy and practice outcomes. The analysis of social exclusion needs to be paired with action to include older people from im/migrant groups, to eliminate discrimination into late life, and to promote wellbeing and justice. This would entail examining and challenging the assumptions and contradictions that exist between cultural discourses about aging, im/migration, and life-course pathways of older im/migrants; the elimination of disadvantage over time; and ensuring that policies do not create harm or injury. Achieving true social inclusion of older im/migrants requires addressing the system issues and conditions that cause risk and insecurity to accumulate as people age, and over time.

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Chapter 3. Perceptions of Healthy Aging among Mandarin-Speaking Immigrant Older Adults in Toronto

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As the older adult population in Canada grows, it is also becoming more culturally diverse: In Canada, 30 percent of all older adults are foreign-born (Government of Canada, 2022). A large portion of older immigrants in Canada live in Ontario (Wang et al. 2019), and about 70 percent of all older adults in Toronto are immigrants (Um & Lightman, 2017). In 2021, Chinese older adults represented 28 percent of all racialized older adults in Canada (Ferreira, 2023). In 2021, 679,255 Mandarin speakers resided in Canada, with almost half living in Toronto (Government of Canada, 2022).

The lives of many Mandarin-speaking immigrants are based on a family structure that builds on respect for one's elders and filial piety, whereby older adults are accorded higher status within the family (Yang & Zheng, 2019). Decisions made by older adults are respected and considered to better the family unit, creating an incentive for younger generations to care for older adults later in life (Li et al. 2018). However, values about family hierarchy and the importance of collective wellbeing may change after settling in a Western country such as Canada, where the prevailing ideology centres on the individual, personal fulfillment, and self-reliance over community needs (Kotlaja, 2018). In addition, younger family members may be consumed with their own family, educational, employment, and other responsibilities, leaving older adults to care for themselves. Language barriers often prevent older immigrants from accessing important services and programs (Ahmed et al. 2016; Kalich et al. 2016; Pandey et al. 2021; Pot et al. 2018), and as a result, older immigrants may find it difficult to navigate the aging process.

The World Health Organization (WHO) has stressed the need to support healthy aging by helping people develop and maintain a level of functional ability that enables wellbeing (WHO, 2017). The WHO's 2015 World Report on Aging and Health emphasized the importance of mental health supports for older adults and their caregivers. In addition to mental health status, factors associated with healthy aging include resilience, use of technology, and cognitive functionality (Kwong et al. 2015; Reynolds et al. 2022). Some scholars have explored these factors in the Canadian context (Gu et al. 2020; Jeffery et al. 2018; Waldbrook, 2015), and some have focused on how they relate to older adults from diverse ethno-cultural backgrounds, acknowledging that healthy aging is defined differently across ethnocultural groups (Shooshtari et al. 2020). For example, Salma and Salami (2020) found that among older Muslim immigrants in Alberta, healthy aging is linked to a combination of individual, community, and societal factors. The following discussion focuses on the perceptions of aging among Mandarin-speaking older immigrants living in Toronto, Ontario. It contributes to much-needed scholarship exploring healthy aging among diverse older immigrant groups in Canada.

Methods

This chapter draws from a larger mixed-methods study that explored experiences of aging among Mandarin-, Arabic-, and Spanish-speaking immigrants, along with their access to services in four cities (London, Ottawa, Toronto, and Waterloo) in Ontario. The project included four different stakeholder groups: older women, older men, family members of older immigrants, and community leaders. Data collection sessions were held separately with each stakeholder group to maximize comfort and encourage dialogue. This article focuses on the qualitative data from Mandarin-speaking immigrant older adults in Toronto.

After obtaining approval from the research ethics boards at participating universities, we used a combination of convenience and snowball sampling strategies to recruit potential study participants. The inclusion criteria were: 60 years of age or older, spoke Mandarin as their primary language, and had lived in Canada less than 20 years (to ensure relatively recent immigrant status). The recruitment process began at community centres where older immigrants and their families gather for social activities; community partners also shared information about the project with their service users; and participants were also asked to share study information with others. All interested participants were asked to contact the study's research assistants.

At the initial contact, research assistants asked participants a few questions to ensure they met the inclusion criteria. If eligible, the research assistants provided more information about the study, answered participants' questions about the study, and then invited them to take part in a group interview. Those who agreed were asked to arrive at a scheduled group interview session 30 minutes before the start time to provide informed consent. Group interviews were held in various locations in Toronto that were familiar and convenient for participants such as community centres, community organizations, and churches.

Individuals who provided consent completed a socio-demographic questionnaire and then participated in a group interview, that lasted between 1.5 and 2 hours. Two research assistants moderated each group interview: the primary moderator was responsible for guiding the discussion, and the assistant moderator helped collect paperwork, took fieldnotes, and paid close attention to group dynamics and intervened if needed. Interview questions included: What does healthy aging mean to you? How do you see aging in Canada in relation to what you would have experienced or expected back home? Who do you rely on, day to day, for support and connection? What constraints or barriers do you face in coping with personal or health problems? What formal supports and services have you accessed or need?

All interviews were audio-recorded with consent and transcribed verbatim; all identifying names and places were removed. Data analysis was informed by the ecosystemic theoretical framework to understand the key factors at micro (personal/familial), meso (community), and macro (societal) levels that shape participants' perceptions of healthy aging.

Socio-demographic profile of the study participants

Four group interviews were conducted (two with older women and two with older men), for a total of 36 participants (19 women and 17 men). Their average age was 72.14 (σ = 5.537); most (35) were born in China and one was born in Thailand. Most (29) were married, three were single, and four were divorced. With regard to immigration status, most (29) were permanent residents who had been sponsored as a parent/grandparent, four were Canadian citizens, two were dependents of a skilled worker, and one was a temporary resident. In terms of education, 14 participants had a bachelor's degree, 10 had completed high school, and 6 held a college diploma. Most indicated that they lacked proficiency in English (28) or French (31). They reported major sources of income as: savings (11), wages or salaries (7), or a pension (4). Five participants indicated that they did not have their own source of income. Not all participants answered all demographic questions.

Findings

Seeing Aging in a Positive Light

Several participants suggested that healthy aging is achieved by maintaining an optimistic perspective on their circumstances as aging individuals. They mentioned that this helped them better manage their physical health and led to less anxiety over uncertainties about aging:

> When you are 60 to 80, that's a golden age. Right? Because you have less burden, there is no stress. That is good. If you are pessimistic, your body gets worse, your health gets worse.... We should be active and optimistic (8, older men FG1)

> Once you have a healthy mind, you have a healthy body, then everything else is healthy too. Then, you no longer feel old. That's how I feel (1, older women FG1)

> Aging is unstoppable. You shouldn't fear it. My physical status is really good, and I don't drink or smoke. I can still take care of many things at home. I help with my children's construction business. But I do realize that there are certain things I can't do by myself anymore. I feel that I'm doing less than I want to. Sometimes, I get discouraged, but my wife always tells me not to compare myself to younger people. After all, you're old! (5, older men FG2)

These statements demonstrate the importance of maintaining a positive attitude toward aging. This mindset may arise from the belief that aging is simply a phase of life.

A number of participants provided more context about how they had realized the need to stay optimistic during the aging process. For example, one participant described how he came to realize the importance of learning to mentally adapt to the challenges of aging while facing the inevitable deteriorations of his physical health:

> Actually, many things are different. For example, my body is changing. Now I have high blood pressure, diabetes, and high cholesterol; a lot of challenges. However, to think from a different angle, since I'm close to retirement, I will have more time to worship God, as I belong to a religious community. I will have more time to serve my friends and my community. This is more meaningful to me. I used to be busy with my own things, now I can help others. So, how you see aging is up to you. It will happen and complaining is useless. (4, older men FG2)

As this participant explained, aging changes one's intrinsic capacities over time. By changing his outlook about the inevitability of aging, he moved from focusing on physical deteriorations to the benefits brought about by aging, such as having more time to do what he values.

The Importance of Family in Aging Well

Many participants referred to the importance of family, both in terms of older adults' own responsibility in making meaningful contributions to their family unit and also the family's responsibility to support older adults' healthy aging. They noted that strong family bonds make them happy by providing them with a sense of purpose, especially when their physical functioning declines and external environmental factors can prevent them from accessing public services outside the home. The following excerpts capture some of these ideas:

> You're not just taking care of yourself. You have the responsibility for your entire family. It makes you look forward to still supporting your family. (7, older men FG2)

> Life isn't easy for the young generation either… Our responsibility is to take care of their home. Conflicts are always there, so we need to learn to resolve them. (3, older women FG1)

Study participants reported feeling obligated to help around the house in any capacity they could, such as supervising their grandchildren, cooking, or cleaning. Many said their family members were grateful for help, which made our participants feel happy and experience a sense of purpose.

Some participants also referred to how much they are relying on their families for general support as well as specific support for their health and wellbeing, and in doing so placing a lot of burden on their children.

> We can't always rely on our children because they need to work. The Canadian government should provide friendly and reasonable supports and facilities. You can't expect us to wait for 8, 10, or 20 years [to qualify for services] – we may not live that long. (5, older women FG2)

> When you cannot take care of yourself, you feel bad. When you reach that age, you need your children. They will bring you to see a doctor. We look for doctors that speak Chinese. But when you need to go to hospital for an emergency, unlike in China, you can't do anything. The doctors don't understand us, and we don't understand them. (4, older men FG1)

Participants said that they felt pressured to compromise their own wellbeing by staying home rather than asking family members or seeking services for help. Some commented on the problems that can arise when they ask for help and support from their adult children who are already struggling to balance taking care of their own children while also taking on eldercare responsibilities. In this context, the participants commented about wanting to access external supports to help manage pressure within the family which in turn help improve family dynamics.

Importance of Connections and Support in the Community

Participants identified access to a support network as an important factor that shapes the aging process. Support networks identified included health, social, and settlement service providers who are integral in assisting older adults manage the physical and psychological effects of aging in a new/relatively new country. In general, these networks can provide support when needed and connect older adults with others on a regular basis, all of which can foster a sense of belonging in older adults. However, many participants expressed frustration with the lack of or limited support available to them beyond their immediate family, and in particular, with the general lack of Mandarin-speaking services and activities. Participants' comments included:

> Especially in Toronto, older people are living a tough life. We don't drive, don't speak English, and can't hear and listen well. I feel the kind of confusion I get is different between here and back in China. (6, older women FG1)

> I only know some simple phrases, and I don't understand many things [in English]. There's no real communication with neighbours and community members. This bothers me, and I don't think it's healthy for aging. (2, older women FG2)

These statements demonstrate how the lack of community-level services in Mandarin prevents these older adults from engaging in meaningful connections and accessible activities, potentially leading to, or accelerating physical and mental health problems.

Structural Barriers to Health Aging

The lack of language specific services was a considerable structural barrier to healthy aging identified by study participants. Many of our participants said that because of the language barrier, they were only able to access services provided in Mandarin or those with an interpreter. Not all neighbourhoods in Toronto are equipped with culturally or linguistically accessible services. For example, one participant commented that libraries in north Toronto do not provide Chinese books and resources, forcing older immigrants to access libraries in other neighbourhoods using public transit. This involves its own challenges, as Mandarin-speaking older immigrants may find it difficult to access public transit due to language issues as well as physical challenges related to long trips during the winter months.

The lack of reliable public transportation combined with a lack of proximity to services were identified by many of our participants as a significant barrier to reach the health, social, and settlement services they needed.

> There are almost no social services in the community here. We have to walk a long time to get to the nearest one. Social infrastructure does not catch up. There is not even a library nearby. (4, older men FG1)

> For transport, the buses are not too safe for older adults. Also, if you are close to public transport, that's good. But if you live far away from public transport, you have to walk far, which is very inconvenient. (7, older men FG1)

> High transportation costs were also a recurring macro-level factor that concerned many participants: many did not drive and relied on public transportation to go around the neighbourhood and access resources. The following excerpts capture their sentiments:

> I'm not asking them to make public transportation free; just lower the cost. More people will actually want to take public transportation if it's cheaper. (7, older men FG2)

> Buses are too expensive. In China, if you are above sixty years of age, you can take the bus for free. But here, if you want to take the bus, you have to pay at least three dollars one way. That's six dollars round trip. So sometimes I don't go out (1, older men FG 1)

Like this last participant, others also commented that the lack of access to safe, affordable public transportation deterred them from going out to access public resources and health and social services. They also noted that the resulting isolation from the community had negative effects on their aging process.

Another macro-level factor identified by study participants was the lack of affordable and accessible Mandarin-speaking treatment and medication options. Many participants commented that the process of aging is naturally accompanied by declining physical and mental health. They noted that the changes that accompany aging are worsened by the wait times to see medical specialists and to have diagnostic procedures, which are much longer in Canada than they were accustomed to in China:

> It is not good for older adults who have chronic illness to live in Canada. For example, the wait time in hospital is just so long. When I had to have a medical scan for my eyes before surgery, they made me wait for three months. In China, if you request, they get things done for you on the same day. For older people, seeing doctors is a big issue. Canada needs to improve the efficiency of their medical system. (7, older men FG 2)

> There are many organizations out there that are designated to serving Chinese immigrants. But they all charge high fees. This isn't helping us because we don't have much money. Many of us are too

> old to wait for the government's financial aid to come. The aid used to come in 10 years after you immigrate, but now it's 20 years (1, older men FG 2)

The changes to government aid regulations noted by this last participant are forcing new immigrants to wait longer to receive pension and other benefits making reliance on the public system challenging. Participants noted that many of the organizations and companies with programs for Mandarin-speaking older adults are beyond their financial means.

Discussion

Declining physical and mental health were commonly noted as a 'natural' part of the aging process by our study participants. They also discussed the importance of maintaining an optimistic perspective on their circumstances as aging individuals. The effects of health decline on people's perceptions of aging are well documented (Li et al. 2018; Wang & Dong, 2018) and are considered in the WHO's 2015 guidelines on maintaining intrinsic capacity (World Health Organization, 2017). Other research also highlights positive perceptions of aging as a key predictor of good quality of life among older adults (Ingrand et al. 2018). Historically, healthy aging has been equated with being physically healthy (Jang & Kim, 2020) or with the ability to perform daily activities (Velaithan et al. 2023). This means that conceptions about physical health remain strongly correlated with general musculoskeletal health (McPhee et al. 2016), with many studies focusing on reducing the rates of age-associated morbidities and frailty. For example, Liu and colleagues (2021) proposed that a daily walking regimen is correlated with lower morbidity rates. While this research shows the importance of focusing on improving physical health and managing chronic illness and/or the ability to engage in daily activities, doing so does not always lead to meaningful activities and engagement with others.

Our results demonstrate the need to shift focus from an individual's physical health problems and limitations to a more family and community perspective. Many of our participants positively connected their aging to a continued sense of obligation to their family and the community, and a desire to contribute to society through activities in which they could take part. Many sympathized with their children who are tasked with unpaid eldercare and childcare responsibilities in Canada. They criticized the fact that older immigrants are expected to wait for 20 years before being eligible for government benefits, which is forcing many to be dependent on their children for financial support. This may create feelings of guilt for burdening their children, as well as force them to engage in unpaid household work, all of which can hinder their ability to prioritize their needs associated with healthy aging.

Our findings reveal that meaningful connections with individuals beyond one's immediate family and accessible services in the community are important to ensuring healthy aging. Kim and colleagues (2015) noted that culturally meaningful activities had positive effects on older Korean immigrants to the United States. Similarly, Li and colleagues (2018) found that regular access to community networks is linked to resilience among Chinese older immigrants in the U.S. and advocated for more access to affordable social services. Wahl and colleagues (2012) also advocated for an environment-oriented model of aging where older adults are able to effectively interact with their community and build a sense of agency. Our findings

indicate that many older immigrants rely on public transportation for such interactions, thus highlighting the importance of reliable, safe, and affordable public transportation to promote healthy aging. This calls for more investment in community infrastructure to assist older adults in healthy aging.

Societal views on aging influence government spending, with profound consequences for healthy aging. More financial support in the form of government funding would ensure older adults have more access to activities and services; the provision of more capital for family members who provide care would also give them more freedom to interact with their older family members in more fulfilling ways. Older adults who feel they are a burden to those around them because of a lack of caregiver support are likely to feel the passage of time and the effects of age more strongly.

Recent research into the accessibility of Canada's current old age security program has revealed marked disadvantages for older immigrants. Curtis and colleagues (2017) investigated the barriers to old age security and found that older immigrants were less likely than their Canadian-born counterparts to receive any benefits, and that older Mandarin-speaking immigrants were the least likely to receive benefits of any amount. This last finding is particularly relevant because having access to financial supports and high-quality social services will promote healthy self-perception and reduce the likelihood that older adults will view themselves as an encumbrance on their families. Having access to supports and services (such as timely and accessible transportation and resources in their own language) would help improve quality of life for older adults and foster a healthy perception of self as older adults.

Accessibility of resources is particularly important for ethnic groups whose first language is not English, as with the Mandarin-speaking older adults in this study. Language plays a significant role in accessibility to services and other supports. Language barriers may prevent Mandarin-speaking and other older immigrants from accessing information about supports that are available, and from accessing services and supports not offered in their first language. Support workers can facilitate access by increasing the number of community referrals to services such as Meals on Wheels, day programs, deliveries from the pharmacy, library services, and supports and groups that are offered in the older adult's first language. Our study participants would benefit from service promotion through pamphlets, posters, and telephone calls in Mandarin to clarify which supports are available. Connecting with these would increase older adults' opportunities to interact with others and form social bonds, thereby contributing to a positive outlook. Our findings also suggest that accessibility of social services can increase the sense of agency among older Mandarin-speaking adults and decrease feelings of loneliness and isolation.

Limitations

The study participants were primarily recruited via convenience and snowball sampling strategies. Additional recruitment strategies could have helped recruit a more diverse study sample. The inclusion of Mandarin-speaking older adults from other Ontario cities would enable a richer understanding of the topic. Another limitation is that (as part of a larger mixed methods study) we utilized a group interview format which is much more structured than a more traditional focus group discussion; The latter would likely have provided more in-depth information on the topic.

Conclusions and Implications

Healthy aging requires a focus beyond physical health, and is shaped by factors at micro, meso, and macro levels. As immigrants from collectivist cultures, Mandarin speaking older adults believed in the importance of maintaining close family connections, contributing to their lives, and not being a burden on them. Our study participants identified the importance of more financial resources dedicated to caregivers assisting their elderly family members at home

Our findings clearly indicate the importance of allocation of funding for community infrastructure to help older adults develop connections outside their families, access community supports, and engage in a range of activities in the neighbourhood. Our study participants identified a lack of accessible Mandarin-speaking services. Our findings reveal a need for more community centres and health services in areas with dense Mandarin-speaking populations. The provision of more accessible supports and services may improve perceptions about aging well, rather than focusing on limitations and constraints.

While it would be helpful to mobilize members of the Mandarin-speaking community to promote the cultural values of caring for older adults, this may be an impossible task in the context of lack of accessible health, social, and settlement services and supports at the community level. Community level investments for aging immigrants can help Mandarin-speaking older adults age well and continue to participate as active community members. Investing in healthy aging among all older immigrant populations should be a key priority for stakeholders. Access to primary care, as well as community-level programs and services are essential to maintain wellbeing of aging immigrants. Policymakers must reexamine the ageist and racist policies to ensure equitable and timely access to and investment in all aging adults in Canada.

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SECTION 2: HEALTH STATUSES AND DETERMINANTS

Chapter 4. Health Statuses of and Health Determinants among Older Immigrant Women in Canada: A Scoping Review

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Background

Aging and migration are two factors that continue to significantly shape population trends worldwide (United Nations, 2022). The number of individuals aged 65 years and older is growing more rapidly in comparison to those in younger age groups, and the global percentage of those aged 65 years and above is projected to rise from 10 percent in 2022 to 16 percent in 2050 (United Nations, 2022). This trend is the result of various factors including diminished fertility rates, advanced medical care, and socioeconomic development, all of which have helped lower levels of mortality and morbidity (Cheng et al., 2020; United Nations, 2019).

The global population of older women exceeds that of older men (Davidson et al., 2011; United Nations, 2019). According to the United Nations (2019), women outlive men by 4.8 years, and in 2022, women accounted for 55.7 percent of people aged 65 or older worldwide (United Nations, 2022). This phenomenon is known as the "feminization" of aging (Sousa et al. 2018). Previous research has demonstrated that older men and women experience different health statuses. Evidence suggests that because women generally live longer, they are at an increased risk of experiencing age-related disability and functional limitations (Crimmins et al. 2019; Rapp et al., 2022; Scommegna, 2019). Women are also more likely than men to survive the death of their spouse and live alone (Carr & Bodnar-Deren, 2009). This can increase social isolation, which can have detrimental effects on their health and wellbeing (Zheng & Yan, 2024). Women also tend to have more obligations related to family caregiving and domestic chores, which can limit their time to engage in health promoting activities and seek care in a timely manner, ultimately affecting their long-term health.

Alongside the above-noted age-related demographic changes, the number of immigrants aged 65 years of age and older has continued to increase in the major immigrant receiving countries (Krzyż & Lin, 2024). In Canada, immigrants constitute about 30 percent of Canada's population aged 65 years and older (Statistics Canada, 2022). Factors such as language barriers, cultural differences, geographical location, and socioeconomic status impede their access to healthcare services, and place them at an elevated risk for compromised health. Older immigrant women and older immigrant men may have different settlement experiences and challenges. This chapter reports on findings from a scoping review we conducted to comprehensively map and examine research that has analyzed the health of older immigrant women in Canada.

Our review was guided by the following research question: What can be known from the existing literature about the health of older immigrant women in Canada?

Method

We used the JBI method that is outlined in the 27-item Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA) checklist (Peters et al., 2015).

Eligibility Criteria

Articles were included if they: 1) were peer-reviewed; 2) reported results of primary research; 3) were published in English or French; and 4) examined the health of older immigrant women in Canada.

The United Nations (2019) defines an "older adult" as someone aged 60 or 65 years and older. However, in many low-income countries with relatively shorter life expectancies, this definition may be expanded to include individuals aged 55 and older (Spencer & Gutman, 2008). Because many older immigrants to Canada arrive from low- and middle-income countries, we adopted the definition of older adults as individuals aged 55 or older. We also included studies that did not focus primarily on older women as long as a) their sample mean or median age range was 55 years or older, b) at least half of the participants were women, and c) separate results were available for older women. We defined "immigrants" as individuals who were born outside Canada (to non-Canadian parents) and permanently relocated to Canada. If a study included both immigrant and Canadian-born older adults, we included it only if at least half of the study sample was born outside Canada and separate results were available for this group.

Information Sources and Search

We searched four electronic databases: CINAHL, PsychINFO, Embase, and Medline. A subject librarian was consulted to ensure our search strategy was comprehensive in identifying relevant literature, and to develop a list of the most applicable search terms and strategies.

Separate searches were conducted for the four databases with the last search conducted in May 2024. The search in CINAHL used Medical Subject Headings (MeSH) terms: "old age" OR "senior" OR "elder" OR "older" AND "immigrant" OR "refugee" AND "health" AND "Canada," following which the keywords and search strategies were tailored to each remaining database source. Boolean operands OR/AND were incorporated throughout the search terms. To produce a comprehensive map of the existing literature on this topic, no time limitations were included. Although the term "health" was deemed an important keyword by the subject librarian and the research team to guide the search and answer the research question, it limited the results. Therefore, we also screened the literature identified by each search without using the term health

to ensure that we included all available studies that evaluated the health or determinants of health among older immigrant women in Canada.

The reference lists of all included articles located through the electronic database searches were also reviewed. All additional articles that were identified through reference list searching were entered into the screening process beginning with Stage 1 screening (see below). A saturation point was reached where no new literature was being identified.

Selection of Sources of Evidence

We used a reference management software (Rayyan) to organize the articles from the four electronic database searches and to manage the review process. A two-stage screening process was conducted to select the sources of evidence. First, the titles and abstracts were read to remove any studies that were clearly irrelevant. If the study appeared to meet the eligibility criteria, or if it was not clear whether the article was relevant, it was advanced to the second stage screening, which involved assessing the full text of the article. The screening process was conducted by two of the co-authors independently of each other. Discrepancies on article inclusion or exclusion were resolved through research team discussions. The PRISMA flowchart shown in Figure 1 presents the numbers of articles excluded at each level, along with the reasons for exclusion.

Data Items and Charting Process

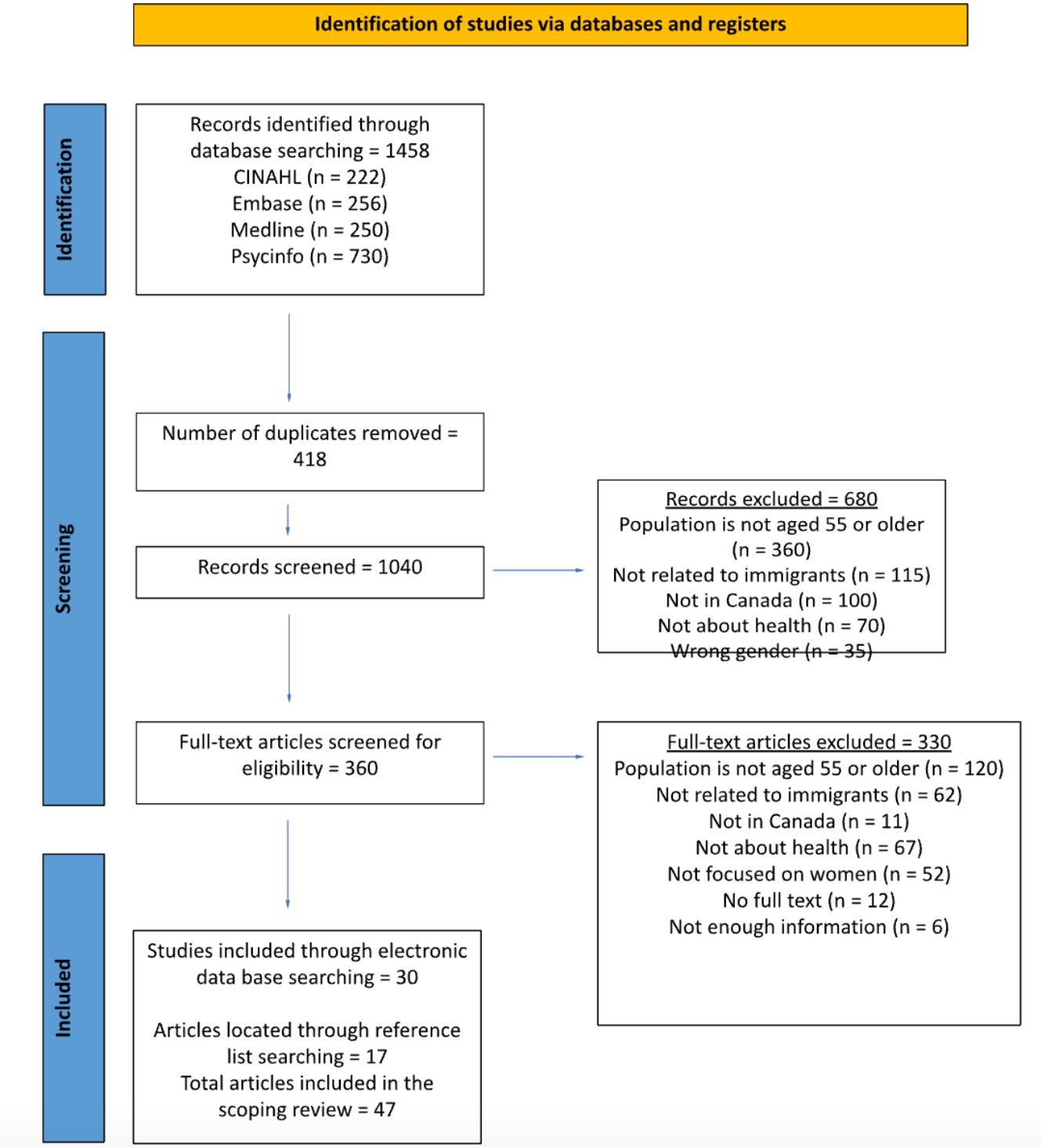
The data charting process was also performed by two co-authors. Key information was extracted from all eligible articles and inputted into a data extraction tool. The information collected included author(s), year, title, journal, purpose, design, date, location or context, target population/sample, procedures/measures, relevant findings/themes/concepts, limitations, and implications. Table 4.1 presents the extracted data.

Synthesis of Results

Following the data charting process, we conducted a narrative synthesis, which was informed by the approach outlined by Popay and colleagues (2006) consisting of four elements: (1) selecting a theoretical framework; (2) developing a preliminary synthesis of the findings; (3) exploring relationships within and between all included studies; and (4) assessing the robustness of the synthesis. As this scoping review was exploratory, with the goal of mapping the existing literature on this topic, we did not utilize a particular theory, and instead we prioritized the identification of key concepts, themes, and factors that emerged across the literature. The preliminary synthesis consisted of extracting key details from all included articles that were relevant to the scoping review question. A tabulation tool was used to organize the data visually into labelled columns in tables. This helped us identify patterns and compare and contrast the results between included articles. We then used a modified thematic analysis to identify concepts, patterns, and themes across the included studies.

We did not engage in critical appraisal of the included literature because our objective was to map the existing evidence on the topic under investigation. However, to ensure the robustness of the data synthesis process, we adhered to the PRISMA-ScR guidelines, and provided a clear audit trail that is illustrated in the PRISMA flow chart (Figure 4.1).

Figure 4.1 PRISMA Flow Chart



Results

Characteristics of Articles

We identified 47 relevant cross-sectional studies. Ten studies used a quantitative design, 20 used a qualitative design, and 17 used a mixed-method design. The characteristics of each article can be reviewed in Table 4.1.

Summary of the Studies

We organized the 47 articles into six focus areas: physical health (n=1), mental health (n=13), abuse (n=3), health beliefs (n=14), health behaviours and practices (n=8), and barriers to healthcare access and utilization (n=22). It is important to note that the focus areas presented in this scoping review identify recurring patterns, themes, or findings and therefore, some articles focused on more than one theme.

Physical Health

Only one study reported on physical health, and it focused on the influence of workplace environment on the physical health of older immigrant women (Choi et al., 2014a). Choi and colleagues (2014a) conducted a qualitative cross-sectional study involving 15 Korean women to explore their experiences of health after retirement. Their participants described experiencing various physiological symptoms while being employed, such as weight loss, loss of appetite, and headaches, which they attributed to their everyday working environment. A significant number of the participants worked as labourers, cooks, and housekeepers, which exposed them to demanding working conditions. The authors concluded that labouring in such demanding working conditions contributed to a range of health ailments, ultimately predisposing these women to the development of acute or chronic diseases (Choi et al., 2014a).

Mental Health

Thirteen studies reported on the mental health of older immigrant women (Acharya & Northcott, 2007; Ahmad et al., 2021; Alvi & Zaidi, 2017; Lai, 2010; Jo et al., 2018; Lai, 2004a; Lai, 2004b; Lai et al., 2020; Mackinnon et al., 1996; Madhavi et al., 2014, Salma & Salami, 2020; Su et al., 2022; Wu & Hart, 2002). Eight reported on the experiences of social isolation and loneliness among older immigrant women (Ahmad et al., 2021; Alvi & Zaidi, 2017; Jo et al., 2018; Lai et al., 2020; Mackinnon et al., 1996; Madhavi et al., 2014, Salma & Salami, 2020; Su et al., 2022). For example, participants in Mackinnon and colleagues' (1996) qualitative cross-sectional study described feelings of loneliness and emotional isolation caused by factors including language barriers and limited access to transportation. Jo and colleagues (2018) conducted a cross-sectional mixed-methods study to explore how a cultural community program affected overall wellbeing among 79 older Korean immigrants, which included 61 older women (77 % of the sample). They found that all

participants experienced a sense of belonging when they could communicate and maintain connections with other older Korean immigrants.

Three studies reported on experiences of mental distress, such as depression among older immigrant women (Acharya & Northcott, 2007; Jo et al., 2018; Lai, 2004b). Acharya and Northcott (2007) conducted a qualitative cross-sectional study to explore the strategies that older immigrant women utilize to cope with mental distress. Their participants emphasized the importance of keeping occupied with personal, familial, and social obligations as a means of preventing mental distress, and also noted that religious rituals during times of stress helped contribute to a stronger sense of control over their internal emotional state. Jo and colleagues (2018) found that maintaining relationships and connections with other older immigrants from similar cultures provided enhanced feelings of emotional support when experiencing depression. Lai (2004b) conducted a quantitative cross-sectional study with 1537 older Chinese immigrants that showed that less financial adequacy, diminished levels of social support, and cultural barriers increased the likelihood of experiencing depressive symptoms.

Experience of abuse

Three studies reported on abuse against older immigrant women (Alvi & Zaidi, 2017; Lai, 2011; Souto et al., 2016). Two studies explored intimate partner violence, experienced by older immigrant women. Souto and colleagues (2016) conducted a qualitative study to explore intimate partner violence among 10 older Portuguese female immigrants in the Greater Toronto Area; Alvi and Zaidi (2017) conducted a qualitative study to explore experiences of abuse among 10 older South Asian immigrant women in Southern Ontario. Both studies reported a range of abusive behaviours towards older immigrant women by their intimate partners, including daily threats, isolation, humiliation, and experiences of financial, verbal, and sexual abuse (Alvi & Zaidi, 2017; Souto et al., 2016). Lai (2011) conducted a cross-sectional study to explore abuse among a random sample of 2272 aging Chinese immigrants in seven Canadian cities and found that the most common forms of abuse included being scolded, yelled at, treated impolitely, and ridiculed.

Women in each study reported various experiences with regard to reporting their experiences of abuse. Souto and colleagues (2016) reported that their participants had experienced supportive and favourable encounters with legal agencies. More specifically, their participants referred to challenges in reporting their experiences of abuse in their home country, Portugal, where reports were often encountered with disbelief or dismissal; in contrast, they noted that in Canada they were able to obtain the social and legal supports they needed to end the ongoing intimate partner violence (Souto et al., 2016). This was in contrast to participants' experiences in the other two studies. Participants in other studies described unsatisfactory experiences with authorities (Alvi & Zaidi, 2017) or instances where abuse remained undisclosed indefinitely (Alvi & Zaidi, 2017; Lai, 2011). Participants in Alvi and Zaidi's (2017) study referred to challenges disclosing their experiences of abuse to authorities due to structural discrimination, including a lack of knowledge or understanding of their legal rights as well as language barriers. Some of these participants feared potential repercussions to their families, which stemmed from perceptions of political bias or racism among authorities, as well as stereotyping based on ethnicity, race, and cultural background (Alvi & Zaidi, 2017). With regard to underreporting of abuse, older immigrant women in both studies expressed apprehensions

about reporting due to feelings of guilt and loss of respect among other family members (Alvi & Zaidi, 2017; Lai, 2011).

Health Beliefs

Fourteen studies reported on the health beliefs that influenced the utilization of healthcare services among older immigrants (Acharya & Northcott, 2007; Choi et al., 2014b; Fornazzari et al., 2009; Jette & Vertinsky, 2011; Lai, 2004b; Lai & Hui, 2007; Lai & Kalyniak, 2005; Lai et al., 2007; Lai & Surood, 2009; MacEntee et al., 2012; Su et al., 2022; Tieu et al., 2010; Tjam & Hirdes, 2002; Zou, 2019).

Of these, 11 explored how older Chinese immigrants in Canada combine traditional Chinese health practices with Western health practices (Jette & Vertinsky, 2011; Lai & Hui, 2007; Lai & Kalyniak, 2005; Lai, 2004b; Lai et al., 2007; Lai & Surood, 2009; MacEntee et al., 2012; Su et al., 2022; Tieu et al., 2010; Tjam & Hirdes, 2002; Zou, 2019). Participants from across the 11 studies referred to preferring traditional Chinese health approaches over Western approaches. Three studies reported that older immigrants who followed Chinese philosophical and religious values, as opposed to Western religions or no religion at all, identified more with Chinese health beliefs (Lai, 2004b; Lai et al., 2007; Lai & Surood, 2009). Lai and Surood (2009) found that older Chinese immigrants from mainland China reported higher levels of traditional health beliefs and the use of traditional Chinese medicine.

In contrast, Acharya and Northcott (2007) found that the South Asian cohort in their study viewed their cultural beliefs as supplementary to maintaining their health rather than as a substitute for Western medicine. Participants in their multiple case study included 21older South Asian immigrant women who noted that their beliefs – including having faith in God, performing religious rituals, and attending religious institutions – were essential to maintaining health and wellbeing (Acharya & Northcott, 2007). The authors concluded that traditional beliefs related to "dharma" (fulfilling one's duties to perform well in life) were empowering, and that their participants leveraged these as resources for health promotion and illness prevention. Their participants also referred to using religiously oriented self-talk, such as worship, prayer, and meditation, as an especially important non-clinical resource to avoid mental distress, with some describing it as therapy or medicine (Acharya & Northcott, 2007). Overall, participants felt that their religious rituals and activities were better than medication to treat mental and physical health problems, especially when they did not perceive the health problem as life-threatening.

Health Behaviours and Practices

Eight studies reported on the health behaviours and practices of older immigrants (Choi et al., 2014a; Choudhry et al., 2002; Johnson & Garcia, 2003; Lai & Surood, 2009; Salma et al., 2020; Tong et al., 2019; Tong et al., 2018; Zou, 2019).

Six explored levels of physical activity among older immigrant women (Choi et al., 2014a; Johnson & Garcia, 2003; Lai & Surood, 2009; Salma et al., 2020; Tong, et al., 2019; Tong et al., 2018). Salma and colleagues (2020) conducted a qualitative cross-sectional study involving 58 older immigrants (74% of whom were women) to

analyze what barriers may prevent them from engaging in physical activity. Female participants specifically described chronic or intermittent pain during physical exertion that significantly impeded their capacity to engage in physical activities and noted that they were unfamiliar with ways to modify their activity to accommodate and manage this pain (Salma et al., 2020). Tong and colleagues (2019) explored how gender affects physical activity in a mixed-methods cross-sectional study involving 18 older immigrant women. Their participants referred to the necessity of prioritising household chores, such as cooking and cleaning over exercising within their daily routine (Tong et al., 2019). These authors also reported that engaging in culturally familiar activities appears to be a powerful motivator to engaging in outdoor physical activity; many of their participants noted they enjoyed going outside to shop at culturally familiar stores, such as those in their local Chinatown (Tong et al., 2019).

Three studies reported on nutritional and dietary habits among older immigrants in Canada (Johnson & Garcia, 2003; Lai & Surood, 2009; Zou, 2019). The authors found that women were more likely than men to take a vitamin D supplement due to their belief in its benefits for their own health and wellbeing. Johnson and Garcia (2003) conducted a mixed-methods cross sectional study on the health and dietary profiles of older adult immigrants in Canada, and found that the dietary intake of fibre, vitamin A, calcium, and vitamin D were insufficient. Two studies reported on the barriers that influenced healthy eating behaviours among older immigrant women (Johnson & Garcia, 2003; Zou, 2019). Zou (2019) conducted a qualitative cross-sectional study to explore barriers to healthy eating among 30 older Chinese Canadians. Participants noted that living a busy, fast-paced life hindered their ability to eat healthily and referred to time limitations that prevented them from cooking at home, which affected the quality of the food they consumed. In particular, they referred to frequent meals at restaurants, which made it difficult to manage their salt intake (Zou, 2019). Johnson and Garcia (2003) conducted a mixed-methods cross-sectional study to analyze the dietary profiles of older immigrants and found that financial constraints, transportation, illnesses (e.g., dental conditions), and eating alone on an everyday basis were barriers to healthy eating.

Barriers to Healthcare Access and Utilization

Twenty-two studies examined the barriers older immigrants face when attempting to access or utilize health care (Ahmad et al., 2011; Alvi & Zaidi, 2017; Ballantyne et al., 2011; Brotman, 2003; Brual et al., 2023; Charpentier & Quéniart, 2016; Chau & Lai, 2010; Donnelly, 2006; Lai, 2004b; Lai & Chau, 2007; Lai & Hui, 2007; Lai & Kalyniak, 2005; Lofters et al., 2010; McWhirter et al., 2011; Salma et al., 2020; Salma & Salami, 2019; Salma & Salami, 2020; Su et al., 2022; Sun et al., 2010; Todd et al., 2010; Todd & Hoffman-Goetz, 2010a; Todd & Hoffman-Goetz, 2010b). Of these, eight identified language barriers as a challenge for older immigrant women attempting to access healthcare services in Canada (Ahmad et al., 2011; Ballantyne et al., 2011; Brual et al., 2023; Chau & Lai, 2010; Lai & Chau, 2007; Lai & Kalyniak, 2005; Salma & Salami, 2020; Todd & Hoffman-Goetz, 2010b).

Ballantyne and colleagues (2011) conducted a qualitative study on the use of medications among older immigrants and found that participants had difficulty communicating with Western doctors due to limited English language proficiency. This was noted specifically when attempting to understand the health information or treatment recommendations provided by doctors and reading the English-language

instructions on prescriptions (Ballantyne et al., 2011). Todd and Hoffman-Goetz (2010b) found that while some of the older Chinese immigrant women in their study spoke fluent English as a second language, most indicated that speaking in Chinese is more comfortable. Some even reportedly preferred obtaining health information directly from mainland China, rather than translating between English and Chinese. Participants noted that translating medical terminology is particularly challenging because there is not always a Chinese equivalent for the English terms, or the terms are not commonly used in their immigrant community (Todd & Hoffman-Goetz, 2010b). Lai and Chau (2007) also reported that older Chinese immigrants experienced challenges when attempting to access healthcare services due to communication barriers such as limited English proficiency and service providers lacking cultural competence; these factors may result in negative perceptions of service providers and the healthcare system in Canada (Lai & Chau, 2007).

Three studies reported on cultural barriers faced by older immigrant women when attempting to access the Canadian healthcare system (Lai, 2004b; Lai & Chau, 2007; Salma & Salami, 2020). Salma and Salami (2020) conducted a qualitative cross-sectional study to explore social isolation and loneliness among Muslim older immigrants; they observed a lack of cultural and religious sensitivity as participants attempted to access continuing care facilities, as evidenced by the lack of provision of ethnic foods, designated prayer spaces, cultural activities, and privacy measures (Salma & Salami, 2020). Lai and Chau's (2007) survey on the effects of service barriers on the health of older Chinese immigrants found a lack of culturally sensitive services, as well as interaction styles between service providers and users that are culturally dissimilar. Lai (2004b) conducted a qualitative study analyzing the effects of culture on depressive symptoms among older Chinese immigrants, and also reported cultural barriers to accessing healthcare services in Canada, specifically a lack of understanding of Chinese culture among healthcare professionals and health services that are not tailored to meet the needs of Chinese clients.

Two studies reported on the challenges faced by older immigrants when attempting to access virtual healthcare services including the fact that some older immigrants lack access to technological devices (Brual et al., 2023; Su et al., 2022). Brual and colleagues (2023) conducted a repeated cross-sectional analysis on the use of virtual care among older immigrant adults in Ontario during the COVID-19 pandemic. They found that older immigrants not only lacked access to technological devices, but also reported challenges in acquiring and utilizing digital skills. The authors concluded that many of the communication difficulties experienced by patients who are unable to speak the dominant language during in-person encounters are likely exacerbated during virtual care (Brual et al., 2023).

Two studies reported that older immigrants' access to healthcare services can be hindered by financial barriers (Charpentier & Quéniart, 2016; Salma & Salami, 2020). Salma and Salami (2020) found that older immigrants desired more financial support, including for medication costs. These authors reported that women who stayed home to act as caregivers and did not participate in the workforce were under significant financial strain during older age. Another issue is that Canadian immigration policies mandate that immigrant families financially support sponsored parents and grandparents for 20 years from the arrival date to Canada; one of their participants referred to finding it difficult to ask their children for constant assistance. The authors concluded that being financially dependent on younger family members, who had their own families to care for, took away the dignity of older immigrants (Salma & Salami, 2020).

Nine studies reported on accessing healthcare services, including preventive care and screening among older immigrants in Canada (Ahmad et al., 2011; Donnelly, 2006; Lai & Hui, 2007; Lai & Kalyniak, 2005; Lofters et al., 2010; Sun et al., 2010; Todd & Hoffman-Goetz, 2010a; Todd & Hoffman-Goetz, 2010b; Todd et al., 2010). Lofters and colleagues (2010) conducted a quantitative cross-sectional study to explore cervical cancer screening among older urban immigrant and Canadian-born women. They found that screening rates were notably lower among South Asian older women compared to Canadian-born women: only 21.9 percent of older South Asian women who lived in the lowest-income neighbourhoods had been appropriately screened. Similarly, Donnelly (2006) found that lower income and socioeconomic status made it difficult for older Vietnamese immigrant women to access breast and cervical cancer screenings. Ahmed and colleagues (2011) conducted a cross-sectional mixed-methods study exploring mammography access among South Asian immigrant women aged 50 years and older and found that 85 percent of their participants had never had a screening mammogram due to barriers related to language, transportation, and lack of health knowledge. Lastly, Todd and Hoffman-Goetz (2010b) conducted a qualitative cross-sectional study and found that older Chinese immigrants obtained cancer-screening information from physicians, community centres, family and friends, and written pamphlets or books, but reported difficulties understanding cancer information and complex medical terminology due to language barriers.

Discussion

We assessed the available literature exploring the health status and determinants of health for older immigrant women in Canada. One study reported physical inactivity to be attributed to chronic or intermittent pain during physical exertion (Salma et al., 2020). Physical inactivity among older adults in general is known to be associated with poor health and wellbeing; for example, sedentary behaviour has been found to increase the risk of early mortality, and is correlated with common chronic diseases such as type two diabetes, obesity, and mental health disorders (Le Roux et al., 2021). One possible explanation reported in other research for the low levels of physical activity reported in the studies included is a fear of movement can decrease levels of physical activity among older adults, and that women are more likely than men to experience fear of movement and subsequent declines in physical activity (Atıcı et al., 2022).

Three studies focused on factors that hindered older immigrant women from having an adequate dietary intake (Johnson & Garcia, 2003; Lai & Surood, 2009; Zou, 2019). These studies make an explicit link to the report by Statistics Canada (2015) that found that women are more likely to be at nutritional risk than men. More specifically, women are more likely than men to be on medication, which can affect their appetite or the absorption and metabolism of food; women are also more likely to experience pain and depression, which is associated with a decline in appetite and eating (Statistics Canada, 2015).

Two studies reported that environmental factors can negatively affect the health of older immigrant women (Choi et al., 2014a; Tong et al., 2019). Other studies have reported that immigrants are more likely to engage in more physically demanding employment and to have poor working environmental conditions, putting them at increased risk for occupational injuries (Drydakis, 2021). In particular, Choi et al. (2014) reported older immigrant women who labour in demanding working conditions to report experiencing a range of

health ailments. This aligns with previous research which has also found immigrant women tend to report higher rates of workplace absences due to illness and often retire earlier than their counterparts (Akhavan, 2007).

Social isolation and loneliness among older immigrant women and its effect on their mental wellbeing was a common theme in the studies we reviewed. Other research has shown that the degree to which an older adult experiences social isolation, and its effects on their psychological wellbeing, are dependent on their personality, social network, and ability to cope (Akhavan, 2007). Older immigrants are particularly vulnerable to social isolation for many reasons including language barriers and lack of knowledge regarding available services (Drydakis, 2021). Similar to the studies we reviewed here, Perkins and colleagues (2016) reported that being widowed is also associated with worse health outcomes such as psychological distress and reduced cognitive ability, especially among women.

This scoping review also found older immigrant women reported experiences of mental distress, such as depression, which was attributed to factors such as lower levels of social support. Religious rituals were a coping mechanism among older immigrant women in many of the studies we reviewed. Mental distress and depressive symptoms among older immigrant women in Canada are a significant issue. In a literature review that analyzed gender differences and depression among the general older adult population, Girgus and colleagues (2017) found a lack of social support is known to be related to depression, and women are at increased risk for depression because they are more likely than men to feel they have less social support. Previous literature has also found that religious beliefs and practices to help individuals cope with stressful situations and contribute to a sound mental health (Chireshe, 2024). More specifically, among women, engaging in religious prayers and a sense of closeness to God has been reported to provide them with a sense of hope (Chireshe, 2024).

The three studies we reviewed focusing on abuse against older immigrant women primarily discussed victimization by intimate partners (Alvi & Zaidi, 2017; Lai, 2011; Souto et al., 2016). However, previous research focusing specifically on elder abuse has revealed that older immigrant women may experience abuse in relationships with children, grandchildren, sons-in-law, and daughters-in-law (Mehdi et al., 2022). Guruge and colleagues (2021) conducted a quantitative cross-sectional study of elder abuse risk factors among older immigrants in Toronto, and found living together in a multi-generational household to be a risk factor to abuse. Cultural obligations like filial piety can make older adults dependent on family members such as their children for advice and support, due to social, financial, language, and transportation barriers; ultimately, this dependence may make them more vulnerable to abuse (Guruge et al., 2021). Moreover, older immigrant women who were raised in households with strong patriarchal values may be more likely to remain in abusive relationships to continue providing care to their aging spouse (Roger et al., 2014).

Studies we reviewed showed that health beliefs tied to culture and religion affected the utilization of healthcare services among older immigrants in Canada (Lai, 2004b; Lai & Chau, 2007; Salma & Salami, 2020). A review of the literature by Iwamasa and Hilliard (1999) that examined depression and anxiety among older Asian American adults reported that views about traditional Chinese medicine along with cultural beliefs about psychology and physiology may influence how older Asian immigrants experience depression; they may not express emotions readily and internalize their feelings, in comparison to younger Asians

who are more likely to follow Western health beliefs (Iwamasa & Hilliard, 1999). Lai and colleagues (2007) theorized about how each culture has a health care system, arguing that the symbolic meanings, values, and behavioural norms associated with different illnesses are culturally unique; they also found that those suffering from a serious illness tend to prefer treatments that are rooted in familiar cultural beliefs and ideas (Lai et al., 2007). Ultimately, it is imperative to adjust the Canadian healthcare system to provide tailored care that can meet the unique needs of immigrants and refugees (Lane and Vatanparast, 2022).

According to the studies we reviewed, barriers faced by older immigrant women when trying to access and utilize healthcare services include: language barriers (Ahmad et al., 2011; Ballantyne et al., 2011; Brual et al., 2023; Chau & Lai, 2010; Lai & Chau, 2007; Lai & Kalyniak, 2005; Salma & Salami, 2020; Todd & Hoffman-Goetz, 2010b), cultural barriers (Lai & Chau, 2007; Lai, 2004b; Salma & Salami, 2020), technological barriers (Brual et al., 2023; Su et al., 2022), financial barriers (Charpentier & Quéniart, 2016; Salma & Salami, 2020), and preventative care and screening barriers (Ahmad et al., 2011; Donnelly, 2006; Lai & Hui, 2007; Lai & Kalyniak, 2005; Lofters et al., 2010; Sun et al., 2010; Todd & Hoffman-Goetz, 2010a; Todd & Hoffman-Goetz, 2010b; Todd et al., 2010). Among immigrants in general, language is considered a key barrier to the uptake of health promotion practices (Kobayashi & Khan, 2021). For example, few translator services are available in Canada, resulting in poor-quality interactions between patients and doctors. Another problem is the limited availability of health promotion pamphlets printed in other languages, which may prevent the uptake of health promotion practices (Kobayashi & Khan, 2021). Coombs and colleagues (2022) examined 12 healthcare providers from diverse training backgrounds to explore barriers to healthcare access in the patient populations they care for; their participants emphasized the need for cultural humility in care to enhance their access to healthcare services. Technological barriers can include limited technical skills, difficulties with a specific device, software updates, complex platforms, digital literacy, and concerns about privacy and security (Lin et al., 2023; Pang et al., 2022). Older immigrants who lack digital literacy are at a particularly significant disadvantage, as they may struggle to perform essential tasks such as online health management and social interaction with their support networks. Being unable to access important information and services that are primarily provided online may increase their feelings of social exclusion and disconnectedness from society (Lin et al., 2023).

Determinants of Health not Addressed in the Literature

Several determinants of health were not sufficiently addressed in the literature we reviewed including education, genetic predispositions, and early childhood development. Only two studies (Charpentier & Quéniart, 2016; Tong et al., 2018) reported on education as a determinant of older immigrant women's health. Education is known to be an important determinant of longevity because it affects various factors including employment opportunities, income level, and access to information, which in turn influence the adoption of healthier lifestyle decisions (Aris et al., 2024). None of the studies we reviewed addressed genetic predispositions among older immigrant women in Canada, even though genetic factors can lead to an inherited predisposition to a wide range of health-related issues (Public Health Agency of Canada, 2011). Finally, none of the studies included in this scoping review reported on early childhood development. A child's development and environment are extremely important: experiences in the first six years can become physiologically imprinted and affect outcomes throughout life, both positively and negatively (Likhar et al.,

2022). Likhar and colleagues (2022) found that disruptions during the early years can have a major influence on behaviour and adult health consequences, and also that a healthy diet and being vaccinated can have long-term benefits including on physical, social, and emotional development.

Strengths and Limitations

We performed this scoping review to understand the state of knowledge on the health status and health determinants of older immigrant women in Canada. To ensure the rigour of our scoping review (Peters et al., 2015), we utilized the JBI methodology, including the PRISMA-ScR checklist. There are several limitations to our review. We did not search grey literature because it can vary in terms of quality, rigour, and relevance. Since the focus of the scoping review was on health, we did not search social science databases. We excluded literature that was not written in English, studies that did not take place in Canada, and any studies in which fewer than half of participants were older immigrant women. These decisions may have excluded studies with important findings on the health and experiences of older immigrant women. In spite of these limitations, our scoping review identified important findings that have research, practice, and policy implications related to the health of older immigrant women in Canada.

Implications

Implications for Research

The vast majority of studies reviewed were conducted in urban settings such as the Greater Toronto and Metro Vancouver Areas. Further research is needed across various geographical regions in Canada to clarify how the physical environment and specific healthcare settings affect health status and access to services among older immigrant women. Only one study in this scoping review (Lai et al., 2020) included a longitudinal design. More longitudinal studies would help clarify health, social, and economic changes, as well as the aging process over time for older immigrant women and how these affect their health and access to services over time. Future research exploring the health of older immigrant women should also place more emphasis on comparative research, larger sample sizes, and the inclusion of older immigrants from various immigration categories, including refugees and others with precarious status, and family-sponsored immigrants. Finally, more research utilizing an intersectionality approach would help address knowledge gaps by clarifying the interactions between health and immigration, gender, race, and ethnicity, along with other elements of social identity.

Implications for Practice

Overall, our findings suggest that the Canadian healthcare system has been ineffective for older immigrant women. Older immigrant women face unique stressors, including trauma, isolation, and acculturation challenges, and it is imperative to ensure they have access to affordable and comprehensive healthcare in

Canada. Holistic programs and services that address older immigrant women's social determinants of health can help them overcome challenges and adjust to their lives post-migration. Healthcare providers must give attention to health education, that includes information on the significance of physical activity, nutrition, and preventive care, as well as different programs and services they can utilize to improve their overall health and wellbeing. Moreover, healthcare providers must be trained to provide culturally competent care to understand and respect the differences in cultural values, beliefs, and backgrounds among older immigrant women. This includes being cognisant of language barriers and the use of medical jargon, and using translation services whenever necessary.

Implications for Policy

Policy changes are urgently needed to address the various health and social concerns encountered by older immigrant women. For example, it is vital to ensure timely access to and effectiveness of health services for older immigrant women. Policies should be developed based on the awareness that each older immigrant woman is an individual with unique needs, while promoting their access to resources that are culturally safe including language interpretation services, as needed, to overcome such barriers. To address abuse among older immigrant women, it is imperative to look at personal experiences and insights provided by women themselves to better inform service providers and policymakers in designing service aid programs. It is also important to implement policies regarding education for nurses and other healthcare professionals, such as integrating multicultural content into curricula.

Conclusions

This scoping review provided an overview of the health status and determinants of health for older immigrant women in Canada. Studies reported on the influence of the environment on physical health; mental health with respect to social isolation, feelings of loneliness, and depressive symptoms; experiences of abuse; and the influence of cultural and religious beliefs, health behaviours, and health practices on health outcomes. The scoping review highlighted numerous barriers that older immigrant women face when accessing healthcare services in Canada, underlining an urgent need to reformulate healthcare delivery systems to address their needs. Stakeholders can draw from these findings to implement tailored interventions to improve the health and wellbeing of older immigrant women in Canada. For example, the government could adapt current policies to address the unique needs of older immigrant women, such as improving access to adequate language interpretation services, and providing more education to healthcare providers to ensure culturally competent care. More research is needed to analyze social determinants of health that were not addressed in the literature, such as how education, income, genetic predispositions, and early childhood development influence the health of older immigrant women.

Data Extraction Table (Table 4.1)					
In-Text Citation	**Study Purpose**	**Method**	**Setting**	**Sample**	**Focus Area**
(Acharya and Northcott 2007)	This article explores how elderly English-speaking Indian immigrant women living perceive and manage mental distress.	Qualitative; Cross-sectional	Edmonton, Alberta, Canada; 200 to 2002	21 older immigrant Indian women	Mental Health; Health Beliefs
(Ahmad et al. 2011)	The study aimed to understand South Asian older immigrant women's experiences and beliefs about barriers to screening mammography, and their perspective on ways to increase mammography uptake and retention.	Mixed-Method; Cross-sectional	Toronto, Ontario, Canada; 2009	60 South Asian older immigrant women	Barriers to Healthcare Access and Utilization
(Ahmad, Sathiya-moorthy, and Othman 2021)	To explore the dynamics of social inclusion among older Tamil immigrants in Canada through identifying facilitators and barriers that they consider central to their social inclusion. Another aim was to identify factors that they consider possible to change at the community service level.	Mixed-Method; Cross-sectional	Toronto, Ontario, Canada; June to October, 2017	27 older Tamil immigrants	Mental Health
(Alvi and Zaidi 2017)	To explore the relationship between the wellbeing and quality of life of South Asian elderly immigrant women.	Qualitative; Cross-sectional	Southern Ontario	10 older South Asian immigrant women	Mental Health; Experience of Abuse; Barriers to Healthcare Access and Utilization
(Ballantyne et al. 2011)	To understand how immigrants navigate prescribed-medication use within the context og aging.	Qualitative; Cross-sectional	Toronto, Ontario, Canada	30 immigrants from China, Hong Kong, Vietnam, and Portugal	Barriers to Healthcare Access and Utilization
(Brotman 2003)	This study aims to understand the experience of access among ethnic minority elderly women.	Qualitative; Cross-sectional	Ontario; 1998 to 1999	10 older ethnic women and 3 family members, 16 staff of the organization Eldercare, where the study was undertaken, and 14 people who worked in the community	Barriers to Healthcare Access and Utilization
(Brual et al. 2023)	This study aims to understand the virtual care use in older immigrant populations residing in Ontario, Canada.	Quantitative; Cross-sectional	Ontario Canada; January 2018 to March 2021	Older immigrants	Barriers to Healthcare Access and Utilisation
(Charpentier and Quéniart 2016).	This study aims to understand living conditions marked by both professional deskilling and a certain degree of economic independence, and also freedom, i.e., possibilities for women to further their personal development.	Qualitative; Cross-sectional	Montreal, Quebec, Canada to 2012-2014	83 elderly women from different ethnocultural backgrounds (Arab, African, Haitian, Japanese, Chinese, Portuguese, and Romanian)	Barriers to Healthcare Access and Utilisation
(Chau and Lai 2010)	To examine the link between the sizes of the Chinese community to the health of Chinese seniors in Canada.	Mixed Method; Cross-sectional	Victoria, Vancouver, Calgary, Edmonton, Winnipeg, Toronto, and Montreal	2,272 immigrants from Mainland China	Barriers to Healthcare Access and Utilization
(Choi et al. 2014a)	To explore the health experiences of immigrant women after retirement.	Qualitative; Cross-sectional	Western Canada	15 older immigrant Korean women	Physical Health; Health Behaviours and Practices
(Choi et al. 2014b)	To examine midlife and older Korean immigrant women's experiences following their immigration to Canada.	Qualitative; Cross-sectional	Western Canada	15 older immigrant Korean women	Health Beliefs

(Choudhry et al. 2002)	To examine South Asian immigrant women's health promotion issues.	Qualitative; Cross-sectional	Toronto, Ontario, Canada	13 South Asian immigrant women	Health Behaviours and Practices
(Donnelly 2006)	To explore the participation of Vietnamese-Canadian women in screening for breast and cervical cancer.	Qualitative; Cross-sectional	Western Canadian city	15 Vietnamese immigrant women	Barriers to Healthcare Access and Utilization
(Fornazzari et al. 2009)	To examine the knowledge levels of Alzheimer's disease (AD) in a sample of Latin American seniors attending AD educational sessions in a Canadian city.	Mixed Method; Cross-sectional	Greater Toronto Area	125 Latin American immigrants	Health Beliefs
(Jette and Vertinsky 2011)	To examine how Western biomedical beliefs around exercise and related health practices compare and contrast with traditional Chinese medicine conceptions of health and exercise.	Qualitative; Cross-sectional	Vancouver, British Columbia, Canada	15 Chinese immigrants	Health Beliefs
(Johnson and Garcia 2003)	To examine the dietary and physical activity profiles, and the factors that influence these behaviours, among older immigrants.	Qualitative; Cross-sectional	London, Ontario	54 Cambodian, Latin-American, Vietnamese, and Polish immigrants	Health Behaviours and Practices
(Jo et al. 2018)	To evaluate the impact of CESC in improving the health-related quality of life of older adults.	Mixed-Method; Cross-sectional	Greater Toronto Area, Ontario, Canada	79 Korean older adults	Mental Health
(Lai and Hui 2007)	To examine the predictors for elderly Chinese immigrants' use of dental care services.	Quantitative; Cross-sectional	Seven Canadian cities; Summer 2001 to Spring 2002	2,272 Chinese older adults	Health Beliefs; Barriers to Healthcare Access and Utilization
(Lai 2004a)	To examine the prevalence of depressive symptoms among elderly immigrants from Mainland China to Canada and the impact of various psychosocial factors.	Mixed-Method; Cross-sectional	Victoria, Vancouver, Calgary, Edmonton, Winnipeg, Toronto, and Montreal	444 immigrants from Mainland China	Mental Health
(Lai 2004b)	To examine the effect of cultural factors on the depressive symptoms reported by elderly Chinese immigrants in Canada.	Quantitative; Cross-sectional	7 major Canadian cities; June 2001 and March 2002	2272 older Chinese immigrants	Mental Health; Health Beliefs; Barriers to Healthcare Access and Utilization
(Lai 2010)	To examine the effects of the economic downturn on elderly Chinese immigrants.	Mixed-Method; Cross-sectional	Calgary, Alberta, Canada	Immigrants from China	Mental Health
(Lai 2011)	To examine the incidence of abuse and neglect and the associated correlates among aging Chinese immigrants.	Mixed-Method; Cross-sectional	Victoria, Vancouver, Calgary, Edmonton, Winnipeg, Toronto, and Montreal	2,272 immigrants from Mainland China, Hong Kong, Taiwan, Vietnam, and other Southeast Asian countries	Experience of Abuse
(Lai and Chau 2007)	To examine the effects of service barriers on the health status of older Chinese immigrants in Canada.	Mixed Method; Cross-sectional	Victoria, Vancouver, Calgary, Edmonton, Winnipeg, Toronto, and Montreal	2,272 immigrants from Mainland China, Hong Kong, Taiwan, Vietnam, and other Southeast Asian countries	Barriers to Healthcare Access and Utilization
(Lai and Kalyniak 2005)	To identify the predictors of use of annual physical examination by aging Chinese Canadians.	Mixed Method; Cross-sectional	Victoria, Vancouver, Calgary, Edmonton, Winnipeg, Toronto, and Montreal	2,272 immigrants from Mainland China, Hong Kong, Taiwan, Vietnam, and other Southeast Asian countries	Health Beliefs; Barriers to Healthcare Access and Utilization

(Lai et al. 2007)	To examine the relationships between culture and the health status of older Chinese in Canada.	Mixed Method; Cross-sectional	Victoria, Vancouver, Calgary, Edmonton, Winnipeg, Toronto, and Montreal	2,272 immigrants from Mainland China, Hong Kong, Taiwan, Vietnam, and other Southeast Asian countries	Health Beliefs
(Lai et al. 2020)	To examine the effectiveness of a peer-based intervention in reducing loneliness, social isolation, and improving psychosocial wellbeing with a sample of aging Chinese immigrants.	Quantitative; Cross-sectional	Canada	60 older Chinese immigrants	Mental Health
(Lai and Surood 2009)	To examine the cultural health beliefs held by older Chinese in Canada	Mixed Method; Cross-sectional	Victoria, Vancouver, Calgary, Edmonton, Winnipeg, Toronto, and Montreal	2,272 immigrants from Mainland China, Hong Kong, Taiwan, Vietnam, and other Southeast Asian	Health Beliefs; Health Behaviours and Practices
(Lofters et al. 2010)	To compare the prevalence of appropriate cervical cancer screening among screening-eligible immigrant women from major geographic regions of the world and native-born women.	Quantitative; Cross-sectional	Ontario	88,447 immigrants from East Asia and Pacific, Eastern Europe and Central Asia, Latin America and Caribbean, Middle East and North Africa, South Asia, Sub-Saharan Africa, USA, Australia and New Zealand, and Western Europe	Barriers to Healthcare Access and Utilization
(MacEntee et al. 2012)	To explore how elderly Chinese immigrants value and relate to how acculturation influences oral health and subsequent service use.	Qualitative; Cross-sectional	Vancouver and Melbourne, British Columbia, Canada	51 older immigrants from China and Hong Kong	Health Beliefs
(Mackinnon, Gien, and Durst 1996)	To describe the experience of Chinese elders who are dependent on their adult children, and explore the potential physical and mental health outcomes associated with this.	Qualitative; Cross-sectional	Atlantic Canada; August 1996	Older Chinese immigrants	Mental Health
(Madhavi et al. 2014)	To explore the experience of loneliness of older Sinhalese immigrant women in Toronto, Canada.	Qualitative; Cross-sectional	August 2014; Toronto, Canada	Two Sinhalese women, 65 years or older, living in Canada, able to use verbal and written communication to understand the intent of the study, able to provide written consent	Mental Health
(McWhirter, Todd, and Hoffman-Goetz 2011)	To compare older ESL Chinese immigrant women's performance on a written assessment of health literacy (Cloze test) to performance on an oral assessment of health literacy (Teach Back) and to compare performance on colon cancer-specific measures (Cloze and Teach Back) to a general measure of health literacy (Short Test of Functional Health Literacy for Adults, S-TOFHLA).	Quantitative; Cross-sectional	Ontario, Canada; October 2009 to February 2010	29 older Chinese immigrant women	Barriers to Healthcare Access and Utilization
(Salma and Salami 2020)	To highlight the experiences and needs of older adults in immigrant Muslim communities in Alberta and identify recommendations for future policy and service provision.	Qualitative; Cross-sectional	2017-2018; Edmonton, Alberta, Canada	67 older adults were being a community-dwelling individual, who was 55 years of age or older, who self-identified as Muslim, and who was an immigrant to Canada. The inclusion criterion for stakeholders was being a community member, religious leader, or service provider who had in-depth experience working with Muslim older adults (49 women, 18 men)	Mental health; Barriers to Healthcare Access and Utilization

(Salma and Salami 2019)	To understand the experiences of healthy ageing in Muslim communities in an urban centre in Alberta. A central focus of the study that emerged in consultation with Muslim communities related to understanding and addressing social isolation and loneliness in older community members.	Qualitative; Cross-sectional	2017-2018; Edmonton, Alberta, Canada	67 older adults were community-dwelling individuals, 55 years of age or older, and self-identified as Muslim. Stakeholders were community members, religious leaders and community service workers who had extensive experience working with Muslim communities (51 Muslim older adults, 16 stakeholders)	Barriers to Healthcare Access and Utilization
(Salma et al. 2020)	To discuss experiences of and barriers to physical activity from the perspective of South Asian, Arab, and African Muslim immigrant communities in an urban Canadian center in Alberta.	Qualitative; Cross-sectional	2017-2018; Edmonton, Canada	68 older adult Muslim immigrants and stakeholders who were community members with extensive knowledge and interactions with older community members (52 older adults, 16 stakeholders)	Health Behaviours and Practices; Barriers to Healthcare Access and Utilization
(Souto et al. 2016)	To build on previous research but with a specific focus on the unique context of Portuguese older immigrant women living in Canada who have experienced IPV.	Qualitative; Cross-sectional	July-October 2013; Portuguese community center in the Greater Toronto Area, Canada	10 women living in the Greater Toronto Area who were older than 60 years, Portuguese-speaking, immigrants or refugees, and were experiencing or had experienced IPV	Experience of Abuse
(Sun et al. 2010)	To examine the pattern of breast cancer screening among Asian immigrant women aged 50-69 years and compare it with corresponding non-immigrant women in Canada.	Mixed Method; Cross-sectional	Canada	508 older immigrant women from Asia	Barriers to Healthcare Access and Utilization
(Su et al. 2022)	To (1) examine the effects of loneliness or social support on psychological wellbeing, as indexed by the global emotional wellbeing and life satisfaction of older Chinese immigrants in Canada during the pandemic; and (2) explore the moderating effects of acculturation.	Quantitative; Cross-sectional	Greater Toronto Area, Montreal, Edmonton; September-November 2020;	168 older Chinese immigrants (aged 65-89, 106 women)	Mental health; Health Beliefs; Barriers to Healthcare Access and Utilisation
(Tieu, Konnert, and Wang 2010)	To investigate depression literacy among older Chinese immigrants in Canada.	Mixed Method; Cross-sectional	Calgary, Alberta, Canada	53 older immigrants from China	Health Beliefs
(Tjam and Hirdes 2002)	To explore health, psychosocial and cultural determinants of use of TCM and Western medicines among Chinese-Canadian older persons. Three patterns of medication use were examined; namely, what predicts the use of; 1) TCM alone, 2) TCM and Western medicines combined, and 3) Western medicines alone in Chinese-Canadian older persons?	Quantitative; Cross-sectional	Kitchener /Waterloo, Ontario, Canada; 2002	106 Chinese-Canadian older adults	Health Beliefs
(Todd, Harvey, and Hoffman-Goetz 2010)	To explore predictors of colon and breast cancer screening in this population, 103 Mandarin- and Cantonese-speaking immigrant women ages 50 years and older were recruited.	Mixed Method; Cross-sectional	Ontario, Canada	103 older immigrants from China	Barriers to Healthcare Access and Utilization
(Todd and Hoffman-Goetz 2010a)	To examine basic health literacy among older Chinese immigrant women in Canada, predicators of health literacy, and how colon cancer prevention information presented in one's first versus second language affects health literacy.	Quantitative; Cross-sectional	Southern Ontario, Canada; October 2009-February 2010	106 immigrants aged 50 years or older, and have Cantonese or Mandarin as their first language and English-as-a-second-language (ESL), and can read English	Barriers to Healthcare Access and Utilization

(Todd and Hoffman-Goetz 2010b)	To (1) describe the self-reported cancer information seeking behaviours of older ESL Chinese immigrant women in Canada, including preferred sources of information and experiences accessing and using this information and (2) examine whether cancer information seeking preferences and experiences reflect differences in their health literacy.	Qualitative; Cross-sectional	Ontario, Canada; October 2009-February 2010	50 female immigrants to Canada, aged 50 years and older, with Cantonese or Mandarin as their first language, and are able to read English	Barriers to Healthcare Access and Utilization
(Tong et al. 2019)	To determine: (a) What factors facilitate physical activity amongst FBOAs? and (b) How do gender, culture, and personal biography affect participants' physical activity and mobility?	Mixed-method; Cross-sectional	South Vancouver, British Columbia, Canada; May-June 2013	18 foreign born visible minority older adults, aged 65 years and above	Health Behaviours and Practices
(Tong, Sims Gould and McKay 2018)	To challenge the assumption that FBOAs are less active than their nonimmigrant peers and confirm the key role of "nonexercise" and low activity, rather than moderate to vigorous, in older adults' PA acquisition.	Mixed-method; Cross-sectional	South Vancouver, British Columbia, Canada; May-June 2013	49 foreign born visible minority older adults, aged 65 years and above	Health Behaviours and Practices
(Wu and Hart 2002)	To assess determinants of social support among the foreign-born elderly in Canada.	Quantitative; Cross-sectional	Canada; 1996-1997	3009 elderly immigrants (1737 women; 1272 men)	Mental Health
(Zou 2019)	To determine the facilitators and barriers influencing healthy eating behaviours among aged Chinese-Canadians with hypertension.	Qualitative; Cross-sectional	Canada; January 2019	30 aged Chinese Canadians with stage one hypertension	Health Beliefs; Health Behaviours and Practices

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Chapter 5. Health Statuses and Health Determinants of Older Immigrant Men in Canada

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In 2020, an estimated 727 million persons worldwide were aged 65 years or older (United Nations, 2020). This number is expected to more than double within the next 30 years, reaching 1.5 billion older persons in 2050. Throughout most of the world, including Canada (Statistics Canada, 2022) older women outnumber older men: in 2020, 13.7 percent of women and 10.2 percent of men were aged 65 and older (UN Migration, 2020). Older men and women have different health and illness experiences (Chang, Simon, & Dong, 2016; Salami et al. 2017). Globally, men tend to have lower life expectancies and worse health outcomes than women (Etienne & Carissa, 2018; Weiner & Salib, 2020). These gender disparities are the result of complex factors including genetic predispositions and patriarchal systems that can deter men from seeking medical care, taking time off from work when they are ill, and recognizing signs of illness (Smith, Braunack-Mayer, & Wittert 2006).

Evidence suggests that foreign-born status confers a health advantage (Vang et al. 2016), known as the Healthy Immigrant Effect, wherein newly arrived immigrants tend to be healthier than their Canadian-born counterparts. However, this health status is known to change over time and may not be consistent for all immigrants. For example, Um and Lightman (2017) found that recently arrived immigrant older adults tend to report poorer physical and mental health than Canadian-born older adults. The authors also found that older adults whose first language was not English reported poorer health than those whose mother tongue was English. Wang, Guruge, and Montana (2019) found that older immigrants tend to experience physical health problems in the first six months to two years after arrival, often due to migration and settlement challenges including stress related to cultural differences, discrimination, environmental adaptation, dietary changes, and/or difficulties with the healthcare system.

Difficulties with the healthcare system include barriers to access due to language differences and lack of transportation, among others (Koehn et al. 2019; Lai & Chau, 2007; Wang, Guruge, & Montana 2019). Social isolation, which itself can negatively affect the health of older immigrants (de Jong Gierveld, van der Pas, & Keating 2015; Salma & Salami, 2020), has also been identified as a barrier for older immigrants' access to healthcare services. New immigrants tend to receive information about available services and where and how to find them through their social contacts. Often these contacts are from the same or similar immigrant communities. Lack of such connections can make it difficult to learn about and access healthcare services.

To effectively meet the needs of older immigrant men and women, it is vital to clarify what is known about their health statuses and the factors that affect their health. A growing body of literature has focused on the health status of older immigrant women in Canada, as illustrated by the scoping review conducted by

Guruge, Birpreet, and Samuels-Dennis (2015) as well as the recent scoping review included in Chapter 4 of this book. By contrast, fewer studies have focused on older immigrant men's health in Canada.

Objective

This chapter captures the range and scope of evidence on the health and wellbeing of older immigrant men in Canada and identifies gaps in knowledge to inform future research. The literature review was guided by the following research question: What is known in the literature about the health statuses and health determinants of older immigrant men in Canada?

Table 5.1 Population, Concept, and Context (PCC) Framework

Framework Component	Criteria
Population	Older immigrant men, aged 55 years and older
Concepts	Health, health determinants
Context	Canada

Methods

The review was conducted using the Joanna Briggs Institute (JBI) methodology outlined in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) checklist (Peters et al. 2015). The population, concepts, and context (PCC) framework was used in developing the research question and eligibility criteria that guided this scoping review, which is outlined in Table 5.1.

We included articles based on the following criteria: published in English; peer-reviewed; based on studies conducted in Canada; and focused on older immigrant men's health. We defined "older adults" as individuals who are 55 years of age or older. We defined "immigrants" as individuals who were born outside of Canada and who at some point permanently relocated to Canada. To capture as many studies as possible, we included those that sampled both men and women as long as they provided separate results for older immigrant men's health. We also included studies that focused on both immigrant older men and Canadian-born older men, as long as they provided separate results for immigrant older men.

The search was conducted using RULA (Toronto Metropolitan University Libraries' academic search tool that is designed to capture most scholarly databases) as well as Google Scholar. The search focused on literature published between 1990 and 2024, and used a combination of the following keywords: senior, elder, older; immigrant, emigrant, migrant, transient, refugees, ethnic, cultural, visible minority, racial, racialized; health; and Canada, Canadian. Boolean operands OR/AND were incorporated through the search terms. Zotero, a reference management software, was used to organize and manage the articles. The eligibility screening process was conducted at two levels. At the first level, the titles and abstracts were read. If an article met (or was unclear regarding) the eligibility criteria, it was moved to the next (second)

level, which entailed reading of the full text. Those that were found to be relevant were subjected to data extraction and charting. Table 5.2 presents the extracted data. A critical appraisal of the included studies was not performed because the aim of this scoping review was to gain an understanding of the scope and range of the studies on the topic. The narrative synthesis approach outlined by Popay and colleagues (2006) was used in synthesizing the data.

Results

The initial search yielded a total of 724 articles. All identified citations were uploaded onto Zotero, and 67 duplicates were removed. The remaining 657 articles were subjected to two-level eligibility screening process noted earlier, following which, 25 articles were identified as relevant. Of these, only four reported on studies that solely focused on older immigrant men (Bedi et al. 2008; Oliffe et al. 2010; 2009; 2007); the remaining 21 articles were based on mixed-gender articles. Most of the studies focused on Chinese older immigrants (n = 10) or Punjabi older immigrants (n = 6); all four studies that focused only on older immigrant men included Sikh participants only. Of the studies specifying location, most were conducted in Alberta (n = 8), followed by British Columbia (n = 7), and Ontario (n = 7); three were multi-site studies. One study was published before 2000, 14 were published between 2000 and 2010, and the remaining 10 were published from 2011 onwards.

We summarized the relevant information from the 25 articles under the following broad topic areas: physical health, mental health, elder abuse, access to health care, social connectedness, and altered lifestyle. Of note is that some topics received minimal research attention, and in some cases, only one study was found on the whole topic. Where available, we have presented comparative information pertaining to these topics.

Physical Health

Five articles focused on physical health (Chau & Lai, 2010; Kobayashi & Prus, 2012; Lai et al. 2007; Lemus 2013; Oliffe et al. 2009). Of these, four articles analyzed physical health status among older immigrant men and older immigrant women in Canada (Chau & Lai, 2010; Kobayashi & Prus, 2012; Lai et al. 2007; Lemus, 2013), whereas Oliffe and colleagues (2009) solely focused on older immigrant men.

In general, immigrant older men tended to report health problems similar to those experienced by older adults, in general. For example, older immigrant men in Lemus' (2013) qualitative cross-sectional study reported diminished eyesight and bodily aches and pains in their hands, backs, and knees.

Of the four articles that included both older immigrant women and men, two articles from the same study compared the health status of older immigrant men and women (Chau & Lai, 2010; Lai et al. 2007). In Chau and Lai's (2010) quantitative cross-sectional study conducted with 2,272 older Chinese immigrants, higher physical health scores were reported by men compared to their female counterparts. In an earlier publication from the same study, Lai and colleagues (2007, 178) found that "compared with the females, males

reported better physical health, fewer chronic illnesses, and a lower level of limitation in IADL" (instrumental activities of daily living).

One study conducted by Kobayashi and Prus (2012) compared the health status of older immigrant men to that of their Canadian-born counterparts. These authors expanded upon previous research on the healthy immigrant effect in Canada using the 2005 Canadian Community Health Survey data. More specifically, the study compared midlife (45–64 years) and older (65+ years) immigrant men with their Canadian-born counterparts. The authors found that the healthy immigrant effect was applicable only to immigrant men in midlife who had come to Canada within 10 years of the data collection, and that it was especially apparent among racialized, recently immigrated men in their midlife. They further noted that this group was 85 percent less likely to report poor/fair health compared to Canadian-born men in midlife (Kobayashi & Prus, 2012). The authors noted that older immigrant men (65+ years) did not exhibit the healthy immigrant effect, and that recently immigrated, racialized older men "may actually have increased needs for services due to poor health status at migration" (Kobayashi & Prus, 2012, 4) and might have been developing illnesses as they migrate to Canada, and therefore be more likely to self-report a lower health status.

Mental Health

Seven articles focused on mental health (Bedi et al. 2008; Chow, 2010; Durbin et al. 2015; Kuo, Chong, & Joseph, 2008; Lai & Surood, 2008; Lai & Yeun, 2005; Oliffe et al. 2007). Of these, five compared mental health status between older immigrant women and older immigrant men in Canada (Chow, 2010; Durbin et al. 2015; Kuo, Chong, & Joseph, 2008; Lai & Surood, 2008; Lai & Yuen, 2005). In Lai and Surood's (2008) study on the mental health status among 210 older South Asian immigrants in Calgary, men reported symptoms of depression less frequently than women. Others reported similar trends in Chinese immigrant communities (Durbin et al. 2015; Kuo, Chong, & Joseph, 2008; Lai & Yuen, 2005). For example, Lai and Yuen (2005) examined the mental health status of 96 older Chinese immigrants using the Geriatric Depression Scale, and found that older men scored significantly lower for depression than older women. Specifically, only 10 percent of the older male participants self-reported experiencing depression compared with 28.6 percent of the older immigrant women. In contrast, in Chow's study (2010) with older Chinese immigrants in Calgary (100 women and 26 men), men reported worse mental health than their female counterparts.

Religion and spirituality emerged as an important facilitator for good mental health status. Oliffe and colleagues' study (2007, 229) with older Sikh men in British Columbia found "strong linkages between spirituality and health." The authors reported that many participants considered illnesses to be the result of kismet (destiny), and "accepted the inevitability of death and conceptualized it as a journey to another life or state of being" (229). Bedi and colleagues (2008, 221) observed related findings among older Sikh men in Calgary, who perceived their physical health problems as part of "God's plan."

Elder Abuse

Two studies reported on elder abuse among older immigrant men and women (Ploeg, Lohfeld, & Walsh, 2013; Tyyskä et al. 2013). Ploeg, Lohfeld, and Walsh (2013, 410–411) reported that older Punjabi men were found to

remain silent on the topic of what constitutes elder abuse and instead focused only about financial, physical, and emotional abuse. Although participants were aware of cases where adult children stole their pension checks, they insisted this did not take place within their community. Rather, participants revealed detailed events where older immigrants were verbally or physically attacked. The participants attributed the latter to racist attitudes and prejudice, and reported that older members of their community were targeted because they were most vulnerable. A qualitative cross-section study conducted by Tyyskä and colleagues (2013, 69) found that older immigrant men's mistrust of service providers and police was identified as a barrier that restricted their ability to report experiences of abuse.

Access to Healthcare Services

Two studies reported that language barriers are a key factor that hinder access to healthcare services among older immigrant men in Canada (Bedi et al. 2008; Oliffe et al. 2007). Bedi and colleagues' (2008) grounded theory study examined the barriers to addressing coronary heart disease risks among older Sikh men in Calgary. The authors reported that many of their participants were unable to obtain appropriate health information because this information was commonly written in English and not often translated into the Punjabi language. The authors noted that without adequate health information, some older immigrant men did not even know that they required medical attention. For some older Sikh men in their sample, interpreters were their only point of contact for receiving health information and accessing healthcare services. Oliffe and colleagues' (2007) study on the health of older South Asian Sikh immigrant men found that many of their participants were hesitant to access medical care even if they had family members to translate for them. The participants were much more open to medical care and treatment if they were recommended by a Punjabi doctor.

Other barriers to accessing healthcare services identified by Oliffe and colleagues (2007) included transportation, long wait times, and cost. These authors reported that older immigrant men often rely on their children for transportation, but that most younger people are busy working during the day. The lack of transportation and ability to travel independently limited older immigrant men's access to healthcare, and especially to those services provided by healthcare professionals who speak their own language, which may be located far from home. The authors also found that many older immigrant men had to wait for a long time prior to being seen. Interestingly, some older immigrant men associated long wait times with doctor incompetence. Some reported going back to India and paying out of their own pocket for surgery in order to avoid the long wait period in Canada. Those with limited savings and/or low income had no alternatives but to endure the long wait time. Additionally, some older men reported taking prescribed medication less frequently than advised or not taking medication at all because not all prescribed medications were covered by the Canadian healthcare system.

Two studies (Gopaul-McNicol, Benjamin-Dartigue, & Francois, 1998; Oliffe et al. 2009) reported that religion was an important factor in determining whether older immigrant men seek healthcare services, suggesting that older immigrant men with religious beliefs are less likely to access medical treatment if they believe it will conflict with their beliefs. In Oliffe and colleagues' (2009) study of 36 older Sikh men, one participant reported that "he did not need to go for a checkup" because "God will take care, whatever is meant to happen

will happen" (229). Gopaul-McNicol, Benjamin-Dartigue, and Francois (1998) reported that an older male immigrant from Haiti, who was a devout Catholic, was hesitant to access help for mental illness because he felt that a psychologist would devalue his religious and spiritual beliefs.

One study (Oliffe et al. 2007) with older Sikh men in British Columbia reported that personal beliefs, values, and/or pre-migration experiences also affected some older male immigrants' use of healthcare services. In this study, participants reported avoiding healthcare services because they did not deem their health problem as serious enough. Many had grown up in regions where it was difficult to access healthcare services, so they tended to access healthcare services only in life-threatening situations – and many continued this habit after moving to Canada.

Social Connectedness

Eight articles reported on living arrangements and social connectedness among older immigrants Canada (Gee, 2000; Lai & Leonenko, 2007; Luo, 2015; Luo & Menec, 2018; Ng, Northcott, & Abu-Laban, 2007; Oliffe et al. 2007; Oliffe et al. 2009; Wu & Hart, 2002). Six of these articles included both older immigrant women and men (Gee, 2000; Lai & Leonenko, 2007; Luo, 2015; Luo & Menec, 2018; Ng, Northcott, & Abu-Laban, 2007; Wu & Hart, 2002), and two articles from the same study reported specifically on social connectedness among a sample of older immigrant men (Oliffe et al. 2007; Oliffe et al. 2009). For example, Gee's (2000) study compared (N = 2500) married older Chinese immigrant men in Canada who were living with their spouse only with those living with their children and grandchildren together with their spouse. They found that living arrangements were related to the health and wellbeing of older married Chinese men. Compared to married men living with their spouse only, married men living intergenerationally were less satisfied with their health and wellbeing. Gee (2000) also noted that while living intergenerationally was negatively correlated with Chinese older immigrant men's health, their ability to see their children as often as they wanted was significantly related to wellbeing among this population.

Two studies reported that older immigrant men are more likely to live alone (Lai & Leonenko, 2007; Ng, Northcott, & Abu-Laban, 2007). For example, Lai and Leonenko's (2007) study with 660 older Chinese immigrants in Canada found that the majority of the individuals living alone were men. Similarly, a study conducted by Ng and colleagues (2007) that analyzed housing and living arrangements among 161 South Asian immigrants in Edmonton found that among participants without a spouse, men were more likely to live alone compared to women who were more likely to live with extended family. They also compared the living arrangements of older women and men who were single, and found that 37 percent of single men lived alone, compared to only 3 percent of single women. The authors of both studies noted that acculturation is an important factor related to older men being more likely to live alone.

One study (Oliffe et al. 2007) reported that some older immigrant men obtained social support from places of worship. The authors noted that for older Sikh men in British Columbia, temples served as a place to socialize and engage in community service (sewa). The latter involved "freely giving their time to help others and making financial contributions to the temple" (229). Temples provided older men with a sense of belonging and connections with other people through activities, helping them feel part of a community.

Five studies reported on older immigrants' participation in social activities and implications on their physical and mental wellbeing (Chow, 2010; Luo, 2015; Luo & Menec, 2018; Oliffe et al. 2009; Wu & Hart, 2002). Oliffe and colleagues (2009) found that older South Asian immigrant men in British Columbia organized physical activities and walking groups among themselves to stay healthy. Wu and Hart (2002) conducted a cross-sectional analysis of the National Population Health Survey undertaken by Statistics Canada in 1996–1997. They analyzed data related to 1737 older immigrant women and 1272 older immigrant men and found that male respondents were less likely to perceive the availability of social support and maintain a greater number of social contacts outside the home (Wu & Hart, 2002). Older immigrant men tend to have relatively lower levels of social involvement and report lower health status. Chow (2010) reported that older immigrant men might have lower levels of mental health wellbeing because they do not have the same level of social networks as their female counterparts.

It is important to note that two studies (Luo, 2015; Luo & Menec, 2018) reported findings with respect to social networks. Luo and Menec (2018) examined the relationship between social capital and health among 101 older Chinese immigrants in Winnipeg and reported that the level of social participation was significantly negatively correlated with older immigrant men's physical health status. In a study of 30 older Chinese men in Winnipeg, Luo (2015) found that the level of social participation was significantly negatively correlated with overall physical health, but not mental health.

Altered Lifestyle and health behaviours

Altered lifestyle and health behaviors were discussed in six articles (Bedi et al. 2008; Da & Garcia, 2015; Jarvis et al. 2011; Oliffe et al. 2009; Oliffe et al. 2010; Zhou, 2012). Of these, three articles specifically examined older immigrant men (Bedi et al. 2008; Oliffe et al. 2009; Oliffe et al. 2010).

Oliffe and colleagues (2009) found that some older Punjabi men in their sample had been farmers before coming to Canada. Lack of access to farmland and/or inability to secure employment on Canadian farms prevented them from maintaining their prior lifestyle in Canada so they were forced to adopt a more sedentary lifestyle, with negative effects on their health. Many older Punjabi men in their study also reported preferring a hotter climate because they felt it was more conducive to maintaining their physical wellbeing, specifically because they believe that the heat keeps blood vessels open, and sweating is a way to cleanse. Some of their participants also commented that a hotter climate would allow them to perform physical work such as farming, which is a good form of exercise (Oliffe et al. 2009).

Immigration to Canada was also reported to influence diet and eating habits. In a later publication of the same ethnographic study, Oliffe and colleagues' (2010) found that their participants, especially former farmers, had developed specific eating habits that they continued in Canada even when they knew it might not be healthy. For example, in Punjabi culture, dairy products are seen as symbols of wealth. The relatively low cost and easy access to these foods in Canada meant that many Punjabi older men consumed considerable fat and sugar even if they understood these may not be good for their health (Oliffe et al. 2010). This may be contributing to high rates of diabetes and cardiovascular disease among older Punjabi

immigrant men in Canada (Oliffe et al. 2010; Bedi et al. 2008). Oliffe and colleagues (2010) also reported that masculine ideals that are deeply rooted in culture may be contributing to their consumption of alcohol. However, a few study participants reported altering their dietary practices after acquiring new health information in Canada. For example, instead of serving sweets to his guests, one participant described serving fresh fruit.

Four studies suggested that older men may feel a loss of power within their family after moving to Canada (Da & Garcia, 2015; Jarvis et al. 2011; Oliffe et al. 2009; Zhou 2012). Within patriarchal cultures, men are considered the head of household and enjoy decision-making powers (Da & Garcia, 2015). After moving to Canada, the role of older men tends to change from being the leader of the family to being dependent on their adult children (Oliffe et al. 2009). Their sense of power might further diminish because older women typically become the main caregiver to children and grandchildren, while older men take on a supportive role (Da & Garcia, 2015; Zhou, 2012). For example, a qualitative study by Zhou (2012) found that although elderly couples tend to work as a team to share care work and housework, women often are the primary caregiver, while men tend to provide peripheral assistance, such as playing with grandchildren, picking grandchildren up from kindergarten or school and snow shoveling. Overall, many older immigrant men report feeling less respected after moving to Canada, which can affect their mental wellbeing (Jarvis et al. 2011).

The article by Oliffe and colleagues (2009) on physical activity among 36 older male Punjabi immigrants in British Columbia reported that walking outdoors was the most popular physical activity among the study participants because this type of exercise is accessible, familiar, and feasible. Physical limitations and cold weather emerged as important barriers to exercise. Physical health problems, such as knee pain, limited the type of exercise that they could engage in. The authors also noted that many older Punjabi men were concerned that too much exercise might lead to more bodily pain such as “aching joints and bones” (Oliffe et al. 2009, 388). Many chose not to participate in winter sports including skiing, skating, and snowshoeing due to age, lack of interest, the cold, and the expenses associated with such sports. Individuals living in multigenerational households reported lacking adequate space at home to exercise indoors during the winter (Oliffe et al. 2009). Facilitators of physical activity included the opportunity to socialize while exercising. Members of walking groups informally shared health-related information and lived experiences with each other an in doing so acquired additional health information (Oliffe et al. 2009). Participants in this study reported that their sense of masculinity was disappearing because they felt less capable of carrying out daily tasks as they aged, and being able to discuss their past accomplishments with each other while walking helped them remain positive and regain a sense of self. These benefits encouraged many older immigrant men to participate in walking groups (Oliffe et al. 2009).

Discussion

This scoping review is the first we are aware of to focus on the health of older immigrant men in Canada. Some research suggests that older immigrant men generally experience better physical and mental health than older immigrant women (Chau & Lai, 2010; Lai et al. 2007; Durbin et al. 2015). Some studies noted that this may be related to older immigrant men’s higher degree of acculturation than their female counterparts

(Lai & Leonenko, 2007; Ng, Northcott, & Abu-Laban, 2007). Older immigrant men usually have higher educational attainment, better language skills, and higher income or more savings than older immigrant women; as a result they tend to be more independent and are better able to access information, and consequently report better health status (Ng, Northcott, & Abu-Laban, 2007). Yet, this may be a double-edged sword because the higher degree of acculturation among immigrant men means that they are also more likely to live alone and to therefore receive less social support (Ng, Northcott, & Abu-Laban, 2007).

Chow (2010) suggested that older Chinese men report lower mental health status because they are less socially connected. Some immigrant men also struggled with their post-migration identity, such as loss of power; as a result of being dependent on their children (Jarvis et al. 2011).

Access to healthcare services is a key issue for older immigrant men. Scholars have called for more research on health and health status among older immigrant men. For example, Wang and colleagues (2019) reviewed studies on access to primary healthcare services among older immigrants in Canada and found that no studies between 2002 and 2017 focused specifically on men. Based on the limited studies available, our results suggest that older men face challenges when accessing healthcare services including language barriers, transportation, and financial constraints. These challenges are, however, not unique to older immigrant men; Guruge and colleagues (2010) have reported similar results for older women.

Overall, our findings point to a problematic gap in the existing literature: very few Canadian studies have focused specifically on the health of older immigrant men. Of the 25 articles we reviewed, only four focused specifically on older immigrant men. Moreover, in the few studies that included both older immigrant men and women, men were usually the minority, often representing about one-third of the total sample. As a result, unique health problems facing older immigrant men are not well known. Another issue is the limited geographical coverage of research on older immigrants: most studies exploring the health of older immigrant men have been conducted in British Columbia, Alberta, and Ontario. Finally, most relevant studies to date have focused predominantly on the Punjabi and Chinese immigrant communities. It is imperative to engage in research that focus on the health of older immigrant men from diverse ethnic backgrounds in order to inform the development of future health promotion strategies in Canada.

Future research is needed to focus on the intersection of social, cultural, political, geospatial, and economic factors that influence their health, health behaviours, and health outcomes. By examining factors, such as, accessibility to healthcare services, the impact of acculturation, and social connectedness among this under-studied and vulnerable population, we can tailor health promotion strategies to address their unique health needs. This can improve their overall health and wellbeing, thus reducing health disparities experienced by older immigrant men and promoting health equity in Canada.

Conclusions

Migration brings significant changes to the lives and wellbeing of older immigrant men in Canada. However, research dedicated to older immigrant men's physical and mental health is scarce. Although we did not include grey literature and may therefore have missed articles that could have provided additional insights

into the health and wellbeing of older immigrant men in Canada, we were able to identify several key areas of concern related to their health wellbeing. Some of the available literature provides contradictory results, which may be related to differences between studies in terms of the immigrant community of focus, participants' length of stay in Canada, study sample size, measures of health and wellbeing, health behaviors, and social connectedness. More research is urgently needed to clarify the health statuses of older immigrant men to inform practice and policy efforts to ensure they remain healthy after coming to Canada.

Data Extraction Table (Table 5.2)					
In-Text Citation	**Study Purpose**	**Method**	**Setting**	**Sample**	**Focus Area**
(Bedi et al. 2008)	To describe the gender- and ethnoculturally based influences associated with the process that Sikh men undergo when faced with managing coronary artery disease risk.	Qualitative Grounded theory	Calgary	10 older immigrant Sikh men	Mental health; Access to healthcare services; Altered Lifestyle and Health Behaviours
(Chau and Lai 2010)	To examine the influence of ethnic group density on health by studying the effect of the size of the Chinese community on the health of Chinese older adults in Canada	Quantitative	Between summer 2001 and spring 2002; Victoria, Vancouver, Calgary, Edmonton, Winnipeg, Montreal, and Toronto	2,272 Chinese older adults (55.8% female, 44.2% male)	Physical health
(Chow 2010)	To explore the health status of older adult Chinese immigrants in a western Canadian city and to identify the major determinants of their physical and psychological wellbeing.	Quantitative	Calgary	126 Chinese older adults (100 women, 26 men)	Mental health; Social connectedness
(Da and Garcia 2015)	To explore and gain insights into the settlement experience of recent older Mandarin-speaking Chinese immigrants.	Qualitative	2007, 2008 & 2010; London, Ontario	31 older Chinese immigrants (20 women, 11 men)	Altered Lifestyle and Health Behaviours
(Durbin et al. 2015)	To examine mental health service use by immigrants from the full range of regions in a large, diverse province with a single payer health care system.	Quantitative	April 1st, 1993 and March 31st, 2007; Ontario	912,114 immigrants (422,373 men, 489,741 women)	Mental health

(Gee 2000)	To examine the role of living arrangements in the quality of life among Chinese Canadian older adults in urban southern British Columbia.	Quantitative	1995-96; Vancouver	830 older Chinese adults (64% women, 46% men)	Social connectedness
(GoPaul-McNicol, Benjamin-Dartigue and Francois 1998)	To analyze how cultural factors impact the treatment of Haitian families in mental health services	Qualitative	1998	2 case studies of Haitian Canadian families	Access to Healthcare Services
(Jarvis et al. 2011)	To explore if and how the social and economic determinants of mental health for Punjabi-speaking seniors were addressed by community programs	Qualitative	2010; South Fraser region of British Columbia, Canada	52 Punjabi seniors (28 women and 24 men)	Altered Lifestyle and Health Behaviours
(Kobayashi and Prus 2012)	To analyze the effects of both immigrant and visible minority status on self-rated health	Quantitative	2005; Canada	59,786 Canadians (28,609 men, 31,177 women)	Physical Health
(Kuo, Chong and Joseph 2008)	To systematically summarize the literature on depression and its psychosocial correlated among older Asian immigrants in North America	Quantitative literature review	1985-2006; Canada and the United States	24 depression studies on older Asian immigrants in North America	Mental Health
(Lai and Loenenko 2007)	To analyze living alone among the older adult Chinese in Canada	Quantitative cross-sectional	Summer 2001 and Spring 2002; Seven major Canadian cities	660 single Chinese older adult immigrants (82% women)	Social Connectedness
(Lai and Surood 2008)	To investigate the socio-cultural specific characteristics of depressive symptoms in aging South Asians	Quantitative	August 2004 and July 2005; Calgary	210 older South Asians (56.2% men)	Mental Health

(Lai et al. 2007)	This study examines the effects of culture and related variables on the health of the older Chinese in Canada.	Quantitative	Summer 2001 to Spring 2002; Victoria, Vancouver, Calgary, Edmonton, Winnipeg, Montreal, and Toronto	2,272 older Chinese adults (44.2% men)	Physical Health
(Lai and Yuen 2003)	To analyze the effects of gender and physical limitation on depression among Chinese older adults	Quantitative	Calgary	96 Chinese-Canadians older adults (58.3% women)	Mental Health
(Lemus 2013)	To examine factors affecting the retirement planning of Salvadorian immigrants	Qualitative	Southwest Ontario	10 Salvadorian immigrants (5 men, 5 women)	Physical Health
(Luo 2015)	To understand the challenges related to healthy aging faced by Chinese seniors living in a cultural and social context different from their home countries.	Quantitative	April-June 2013; Winnipeg	101 Chinese immigrant seniors (36 men, 65 women)	Social Connectedness
(Luo and Menec 2018)	To examine the relationship between social capital and health among Chinese immigrants	Quantitative cross-sectional	April-June 2013; Winnipeg	101 Chinese immigrant seniors (64.4% women)	Social Connectedness
(Ng, Northcott and Abu-Laban 2007)	To examine differences in housing and living arrangements among South Asian older adults who immigrated at different life stages.	Qualitative	Edmonton	161 older South Asian immigrants (80 men, 81 women)	Social Connectedness
(Oliffe et al. 2007)	To describe the connections between masculinity, culture, and health among South Asian immigrant men.	Qualitative	2005; British Columbia lower mainland	14 South Asian immigrant men	Mental Health; Access to Healthcare Services; Social Connectedness
(Oliffe et al. 2009)	To better understand how masculinity informs and influences men's physical activity	Qualitative	2009; British Columbia	36 older Punjabi-Sikh men	Physical Health; Social Connectedness; Altered Lifestyle and Healthcare Behaviours

(Oliffe et al. 2010)	To explore how varying gendered ideals influence the practices of senior Punjabi-Sikh Canadian immigrant men	Qualitative	British Columbia	36 older Punjabi-Sikh men	Altered Lifestyle and Healthcare Behaviours
(Ploeg, Lohfeld and Walsh 2013)	To explore perceptions of older adult abuse among marginalized groups such as Aboriginal persons, immigrants, refugees, and lesbians	Qualitative	February 2003- July 2005; Hamilton and Calgary	87 older adults part of marginalized groups (77% female)	Elder Abuse
(Tyyskä et al. 2013)	To explore the perspectives of victims and service providers on abuse of older adults in Tamil and Punjabi families	Qualitative	May – September 2007; September 2007 – October 2008; Toronto	11 Tamil and Punjabi older adult immigrants (5 male, 6 female)	Elder Abuse
(Wu and Hart 2002)	To assess determinants of social support among the foreign-born older adults in Canada.	Quantitative	1996- 1997; Canada	3,009 older adults immigrants (1,737 women and 1,272 men)	Social Connectedness
(Zhou 2012)	To examine the impacts of Chinese grandparents' transnational experiences on three interconnected dimensions – spatial, temporal and cognitive – of aging.	Qualitative	Canada	70 Chinese-Canadian immigrants: 36 grandparents (31 women, 5 men) and 34 skilled immigrant women	Altered Lifestyle and Healthcare Behaviours

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SECTION 3: SOCIOECONOMIC CONSIDERATIONS

Chapter 6. Loneliness Kills: Social Support and Social Interactions as Determinants of Aging Well and Inclusion Among Arabic- and Spanish-Speaking Senior Immigrants in Ottawa

PAOLA ORTIZ LOAIZA; DENISE L. SPITZER; AND RADAMIS ZAKY

> The most important thing is that when the person gets older – don't live alone. Loneliness kills whether you are a man or a woman. The person shouldn't be alone; the person should have company. The type of company doesn't matter – a spouse, a daughter, a brother. Each one should have company in order to age well.
>
> —Arabic-speaking older immigrant

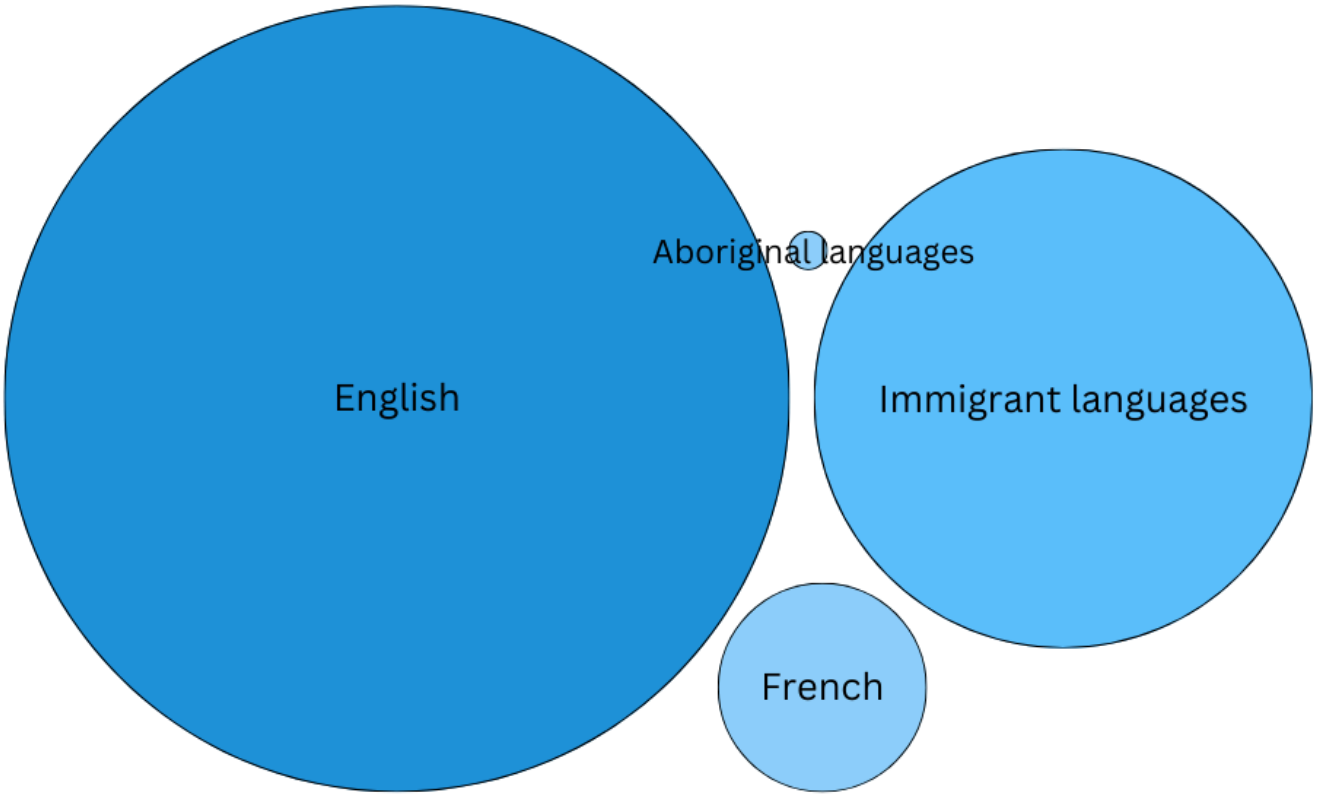
Social supports and social networks are critical to health and wellbeing (Stewart et al. 2008), but research has confirmed that for immigrants, familial and other social networks are segmented – if not severed – across borders (Spitzer et al. 2003). Migration to countries including as Canada may necessitate changes in support-seeking strategies. Older immigrants facing barriers accessing social support, whether formal or informal, can become lonely and excluded. The United Nations defines poverty as a "denial of choices and opportunities, a violation of human dignity" (UN Statement, 1998), expanding the definition from simply economic deprivation to incorporate the concept of exclusion. Fischer (2011) found that individuals can be excluded on the basis of factors including socioeconomic class, racialized status, age, and gender. The following discussion explores social interactions and social supports among older immigrants in Ottawa, the challenges and barriers they face to overcome isolation and exclusion, and how they negotiate changing needs and create resilience strategies, and – when possible – generate new networks and sources of support in their new location.

Context

Ottawa is Canada's national capital and has a population of approximately one million, about 23 percent of whom are foreign born (Statistics Canada, 2021). Nearly 10 percent of the foreign-born population immigrated at age 45 or older. According to Statistics Canada, 1.5 percent of Ottawa's population speak neither English nor French (2021) – immigration laws exempt adults aged 55 and older from any language requirements and compliance with "Canadian Language Benchmarks" to immigrate to Canada and obtain citizenship (Immigration, Refugees and Citizenship Canada, 2021). Census results from 2016 reveal that 32,295 Ottawa residents spoke Arabic as their first language (45 percent of whom were women), while 11,985 had Spanish as a mother tongue (55 percent of whom were women): these two groups represent 3.7

and 1.3 percent of the local population, respectively (Statistics Canada, 2021). These two linguistic groups are among the three largest language communities in Ottawa, after Chinese (Mandarin and Cantonese) (Statistics Canada, 2021).

Figure 6.1. Ontario: Immigrant Languages and Official Languages



Source: Census 2016, Proportion of mother tongue responses for various regions in Canada

Social Support as a Determinant of Health

Traditionally, social support has been framed as a coping resource – a "social 'fund' from which people may draw when handling stressors" (Thoits, 1995, 64). Social supports can be broadly categorized as: emotional (e.g., empathy, humour, social activities), instrumental (e.g., services, financial and material aid), informational (e.g., knowledge), and affirmational (e.g., positive feedback, praise) (Fingeld-Connett, 2005; Makwarimba et al. 2010; Stewart et al. 2008; Wu & Hart, 2002). Social supports can be embedded in social relations, networks, and the roles that individuals enact (Thoits, 1995). Fingeld-Connett noted that social support "is an advocative interpersonal process that is centred on the reciprocal exchange of information and is context specific" (2005, 5). Here, context refers to the social and cultural environment in which meanings, shape, and expectations of social support are produced. The ways that migrants – for the purposes of this discussion, defined as all foreign-born persons – and other members of ethnic minority

communities conceptualize social supports may be affected by their experiences in their respective homelands. For example, Somali refugees in Canada generally have an expansive definition of social support that emphasizes reciprocity and interdependence, which differs from the focus on formal support services promoted in Canada (Stewart et al. 2008).

Social supports have positive effects on health and wellbeing. Research has confirmed that emotional and affirmational supports mitigate the negative effects of stressors and foster coping strategies and healthy behaviours (Makwarimba et al. 2010; Stewart et al. 2008; Thoits, 1995). Conversely, chronic poor health status may result in reduced social interaction and subsequently less access to social supports (Wu & Hart, 2002). When support needs and expectations are not met, social isolation can follow (Stewart et al. 2008).

Globally, older immigrants find their social networks truncated, which increases vulnerability to social isolation (Johnson et al. 2018). Loneliness and social isolation are major challenges for this sector of the population, particularly for women and racialized minorities – even those who have resided in Canada since youth (De Jong Gierveld, Van der Pas, & Keating, 2015; Salma & Salami, 2020; Salma et al. 2018). Health problems and low income are also associated with social isolation and loneliness (Salma & Salami, 2020). Deskilling and lack of recognition of foreign credentials and work experience is common for non-European migrants, resulting in a disproportionate concentration of immigrants with lower socioeconomic status (Voyer, 2004). These patterns reflect trends in health status, with racialized (non-European) immigrant women reporting poorer health than their European and Canadian-born counterparts (De Jong Gierveld, Van der Pas, & Keating, 2015).

Social isolation and loneliness have been associated with a variety of health problems including coronary heart disease, dementia, depression, poor nutrition, and increased risk of unhealthy behaviours and mortality (De Jong Gierveld, Van der Pas, & Keating, 2015; Johnson et al. 2018). Conversely, social supports – in the form of engagement in social activities with friends and community and financial assistance (if required) – can help older immigrant women mitigate the effects of chronic illness and other stressors (Salma et al. 2018; Salma & Salami, 2020).

Socio-Political Inclusion and Exclusion

Few studies have explored social supports and connections as they relate to social and political exclusion. Social supports (formal and informal) are especially important when older immigrants face barriers related to language, access to information and technology, and mobility. For example, language and sociocultural barriers affect accessibility, safety, and quality of healthcare services, including psychiatric, physiotherapeutic , and urgent care among others (Bowen, 2015; De Moissac et al. 2020; Ohtani et al. 2015; Yoshikawa et al. 2020; Zhao et al. 2019). Lack of information, including challenges in accessing and/or hesitancy in using technology and services, can also lead to exclusion from healthcare and other supportive programs (Holgersson et al. 2021). Limited mobility (including limited access to public or private transport) contributes to isolation and poverty (Engels & Liu, 2011). Social connections and both formal and informal networks are fundamental channels for older immigrants to receive information and mediation to access services and opportunities that they cannot obtain on their own.

Social exclusion can be defined as "the lack or denial of resources, rights, goods and services and the inability to participate in the normal relationships and activities available to the majority of people in a society" (Levitas et al. 2007, 9). Social inclusion implies acceptable access to resources, participation, and quality of life; all of these can be related to class, racialized status, gender, and language. According to Bernt and Colini, scholars generally agree that exclusion can be defined as "both a process and condition, one resulting from a combination of intertwined forms of social, economic and power inequalities and leading to disadvantage, relegation and the systematic denial of individuals' or communities' rights, opportunities and resources" (2013, 6). Exclusion is also framed as failure of the capitalist system or the market (Brenner & Theodore, 2005; Cox, 1997) in terms of redistributing wealth and welfare (see Piketty, 2014) and thereby creating uneven development through interdependent geographies (global, national, regional, urban, and micro local levels) (Bernt & Colini, 2013; Swyngedouw, 1997). Despite the various definitions used, inclusion and exclusion are complex processes with relational natures; for example, social and political exclusions are closely linked with economic factors.

Silver (1994) analyzed exclusions based on three paradigms (republicanism/solidarity, liberalism/specialization, and social democracy/monopoly) and proposed that within a solidarity paradigm, exclusion refers to the rupture of social ties – and the state has a fundamental role in providing assistance to repair the lack of social support. In the monopoly paradigm, exclusion results from the interplay of "class, status and political power" between the excluded and the included – serving the interests of the included. In this case, inclusion would occur through granting "formal rights such as citizenship and extension of membership" by the dominant group (see Bernt & Collini, 2013, 7) — emphasizing political inclusion.

The following discussion presents some of our findings from our work with Arabic- and Spanish-speaking older immigrants in Ottawa, which was informed by the following assumptions: (1) Social supports and social networks counteract isolation and their negative implications for health and wellbeing; (2) Exclusions result from lack of access (or denial) to resources, rights, goods and services — including a paucity of or limited participation in the relationships and activities that are available to the majority of non-immigrant elders.

The Study

We explored the main causes and implications of social isolation, loneliness, and exclusion affecting the lives of older immigrants in Ottawa, as well as the main barriers they face in accessing formal and informal social support and the mechanisms they use to overcome those barriers. This work was part of a province-wide project designed to clarify informal networks (e.g., friends, family, and other social relationships) as well as formal social services (e.g., organized settlement, health, legal, and other programs) available to older immigrant immigrants in four cities. The cities were chosen for their different sizes and immigrant populations: London, Ottawa, Toronto, and Waterloo.

The research in Ottawa focused on two communities: Arabic-speaking and Spanish-speaking older immigrants. Our approach was exploratory and qualitative. Aided by a community advisory committee of representatives from cultural communities, immigrant-serving agencies, and academia, two bicultural

graduate student research assistants who are fluent in Spanish and Arabic recruited participants and collected and analyzed data.[1] Participants included foreign-born Ottawa residents aged 60 or older, whose first language was Spanish or Arabic, and who had lived in Canada for less than 20 years. Family members, community leaders, and service providers also contributed, but the following discussion focuses specifically on focus groups involving foreign-born older immigrants (N = 38).

Table 6.1 Sample and Focus Groups in Ottawa				
Older immigrants	**Focus group discussions #**	**Men**	**Women**	**Total participants**
Arabic	5	8	14	22
Spanish	4	6	10	16
Total	**9**	**14**	**24**	**38**
Family members who provide care				
Arabic	1	3	1	4
Spanish	1	0	6	6
Total	**2**	**3**	**7**	**10**
Service Providers				
Arabic	1	6	1	7
Spanish	1	2	8	10
Total	**2**	**8**	**9**	**17**

We hosted focus group discussions using a semi-structured interview guide informed by academic and grey literature and recorded them with consent. Transcripts of focus group sessions were translated from Spanish or Arabic into English and anonymized by the research assistants who conducted them. The research team used an intersectional approach to explore similarities, differences, and nuances between and among the two language communities, considering gender, national origin, language, and economic variables. They independently coded transcripts and met regularly to reach agreement on codes and subcodes. Analyses explored social dimensions (e.g., gender, culture, meaning of aging, language, length of stay in the country, extended family co-residence); actual/preferred size and composition (gender, culture, age, location) of informal networks; and types and frequency of supports, reciprocity, expectations, conflict, and formal social support services (e.g., police, legal, employment, education, ESL, housing and transportation). After analysis at individual and group levels, data were integrated across gender and language communities to reveal common and unique themes.

Each participant also completed a comprehensive questionnaire that collected contextual information about demographics, health, living arrangements, economic situation, sense of belonging, and physical and emotional needs. These data were coded and analyzed for comparison between communities. Given the

1. We especially thank the Latin American Women's Organization (LAZO), Immigrant Women's Services Ottawa/ Services pour femmes immigrantes d'Ottawa, Club Casa de los Abuelos, Ottawa Local Immigration Partnership / Partenariat Local d'immigration d'Ottawa, and Dr. Martine Lagacé for their valuable support and advice.

limited number of focus group participants, survey data complemented and contextualize the qualitative findings from focus groups.

We analyzed the focus group discussions involving 38 older immigrants: 22 from the Arabic-speaking community and 16 from the Spanish-speaking community. Analyses were triangulated with questionnaires, as well as comments by family members and service providers who were also interviewed in a different set of focus groups (held in Spanish, Arabic, and English).

Table 6.2 lists characteristics of the study population, including gender, age, length of stay in Canada, marital status, first official language spoken, and living arrangements.

Table 6.2 Demographic Characteristics of Older Immigrants Interviewed

Category	Men Arabic-speaking	Women Arabic-speaking	Arabic Total	Men Spanish-speaking	Women Spanish-speaking	Spanish Total	Total
Total sample	8	14	22	6	10	16	38
Age							
60–65	2	3	5	4	4	8	13
66–70	1	2	3	0	4	4	7
71–75	0	4	4	2	0	2	6
76–80	3	1	4	0	1	1	5
81–85	0	3	3	0	0	0	3
86 and older	2	0	2	0	1	1	3
N/A	0	1	1	0	0	0	1
Length of stay							
6 to 10 years	4	4	8	2	1	3	11
11 to 15 years	3	6	9	0	2	2	11
16 to 20 years	0	2	2	0	4	4	6
21 years or more	1	2	3	4	3	7	10
First official language							
Excellent English	1		1	1	3	4	5
Excellent French	1		1	1		1	2

Very good English	1	3	4	3	5	8	12
Some English	3	4	7		2	2	9
Poor English	1	6	7				7
Poor French	1		1				1
No English/No French		1	1	1		1	2
Marital status							
Divorced		3	3		5	5	8
Married	7	7	14	4	2	6	20
Separated				1		1	1
Single				1	1	2	2
Widow/ widower	1	4	5		2	2	7
Living arrangements							
Lives alone	1	3	4	2	3	5	9
Live with mother/ father (elderly)					1	1	1
Daughter/ son (and grandkids)		4	4		3	3	7
Husband/ wife	5	6	11	2	2	4	15
Husband/ wife and son/ daughter	2	1	3	2		2	5
N/A					1	1	1

Voices of Older Immigrants: Analyzing Data

During focus group discussions, older immigrants from both communities frequently mentioned loneliness as a major challenge, but responses varied between communities and individuals.

Loneliness and Isolation

Many participants referred to loneliness in terms of living alone, having no family nearby, and difficulties in meeting and interacting with others to create long-lasting friendships. Others referred to the challenges of adapting to a new country and a different culture. Some complained of being lonely most of the time because family members worked all day and did not have time to share, eat, and talk with them. This loneliness may be more acute when no neighbours or friends are nearby. One Arabic-speaking woman commented, "Loneliness kills. There should be more activities to increase the older immigrants' self-esteem and activities that make older immigrants don't feel that they are isolated and lonely. They have someone to check on them and to take care of them." Another said:

> My family lives far from me. I don't find kindness and support and … it is very hard to deal with the doctors because of the language … We study English a lot but we forget it as elders' memory is not good. Loneliness is the most difficult thing to any human being. Living far from the family is very hard even if your children live here. They are very busy and the day is very short here.

Some participants perceived their neighbours as distant or unapproachable, or question their own ability to interact in the new context. One Arab-speaking man commented: "My problem here is that I can't make friends. I used to have a lot of friends in my country of origin. I have been here in Canada for four years and … I failed to make friends." Another said:

> I feel so lonely here. There is no social life here. Even here in the church people don't socialize enough— we only see each other on Sundays and then everyone go home. Unlike Egypt, people here don't have strong emotional connections to each other. I don't know why. Even Canadians themselves are having the same problem.

This excerpt illustrates the challenges older immigrants face with regard to language and culture – but also their need to relate to others who understand their experiences and cultural context. One Spanish-speaking man said:

> And about the world of sentiments and affections, I think this is something very important, especially for immigrant communities, because sometimes we have lived very hard things in our countries, or exile or something—we have friends who are political refugees or others with really hard life stories and to manage all that world of emotions is sometimes so hard.

He was referring not only to experiential and cultural differences, but also to mental health challenges faced by some older immigrants face, depending on their former life conditions and circumstances of migration (or expulsion) to Canada. Reasons for immigration are heterogeneous and can lead to much different social and economic circumstances.

A few Spanish-speaking older immigrants said they can enjoy their solitude and independence as long as

they have health, resources, and mobility – especially if they have someone to lean on when needed. One Spanish-speaking man said:

> I have a family … with many friends in Peru … there were too many people there! And here, the good thing is that here one can choose if you want to be with people or without people, or if you want to be alone! It is to say, that solitude/loneliness is not necessarily something negative. I see solitude as something positive. You have time to read, to watch the programs you want, and I see solitude as something good when you can abandon it whenever you want! And then you can go and meet someone, right? I see solitude/loneliness as something that has positive aspects and negative aspects!

Culturally Different Expectations and Needs for Social Support

Many participants felt that the culture in their country of origin was warmer and more welcoming to older individuals than Canada. This sentiment affected how they perceived their treatment by formal service providers. It also led to a sense of loss of relevance among participants in both language groups, and some noted that older persons are traditionally seen as a source of wisdom and authority in their communities but they were not valued in the same way in Canadian society. One commented:

> There is a sense of loss for a lot of parents and even grandparents who used to be either matriarchs or patriarchs to the family. Losing all that power, and having to find out: "OK, what is my role here, what's my purpose in this country?" … Especially depending on the culture you come from … we give older immigrants a lot of praise and they have such important roles there! But here in Canada it is not like that. We … put them in a home and that is enough! In our culture … when you live with your parents you take them in — you don't put them in a home where they are going to be alone, and they feel that they've been left behind.

This feeling of exclusion from the structures and dominant values of Canadian society was also reflected in comments about interactions with the healthcare system. For example, one Spanish-speaking woman noted that the structure of the healthcare system and behaviour of healthcare practitioners contrasted with her expectations, and that this can contribute to the challenges faced by older immigrants when trying to access formal services.

> The problem is that the physicians here … they treat us so distant. They do not treat us with that care/love, "how have you been?" at least! … Hi! And that is all, and then you have to sit down! "What is happening to you? How can I help you?" that is the word! [all laughing] "May I help you?" [phrase in English] and that is all! [the rest of the participants laugh out loud] What for will I come here, then? [emotional-angry] they just tell you and tell you … But tell me, is it like that or not?
>
> All participants: [Different voices overlapping] yes, YES, it is like that!

The need to be heard is even more problematic for those who do not speak either of Canada's official

languages. Some participants said that this problem may be overcome with a translator or interpreter in formal services, but even these services involve challenges. For example, interpreters are often not available at the appointment site, so service providers may ask older immigrants to bring a family member to interpret for them – in many cases, this prevents older immigrants from expressing their real needs or feelings. Moreover, even when a formal interpreter is provided, older immigrants may find it difficult to express their problems to a stranger who is not a physician – while also being forced to trust that this person will explain their real needs – especially when they are trying to explain a delicate or confidential situation. One Spanish-speaking woman noted:

> The same way, the social worker feels limited when she talks to us. They tell us that there are interpreters, but they are very scarce. And so, they tell you that you better bring your friend or your son, or sometimes there are five-year-old kids helping their parents, that is the biggest barrier that exists for the older people, and to age, right? One who has gotten here younger, even if he/she doesn't speak English, he/she is able to defend his/herself and keeps moving forward.

Sense of Belonging and Autonomy

Despite all the challenges, Arabic-speaking older immigrants appear to have a stronger sense of belonging to the local community than their Spanish-speaking counterparts. All of the Arabic speakers responded that their sense of belonging to their community was strong or very strong, while only eight of the 16 Spanish speakers felt a strong or very strong belonging.

In this context, "local community" may refer to their language-speaking community or their neighbourhood or Ottawa. No specific or single variables appear to explain this sense of strong or weak belonging to the community; a complex mix of variables is at play. For example, most of the interviewed Arab-speaking older immigrants (18 out of 22) were married and/or lived with other family members, which may help explain their stronger sense of belonging to family or community.

For the Spanish-speaking community, belonging to a community referred primarily to the city of Ottawa or their own neighbourhoods, which was different from the Arabic-speaking community.

> We know what Latin America is like. There is a different quality of life there, the presence of the people. Hugs flow there, it is very easy to touch and express care and love! Here we can't—everything is prohibited, everything is harassment! The relationships are colder, and they are supposed to be like that. It is evident due to the existent ethnocentrism, right? … We are part of the few couples who do not have a family. We don't have anybody here—no children, no siblings, no uncles, no grandkids, nothing! I am her husband, she is my wife, and there is nobody else! … Well, I do have an assimilated family which are my friends, you and you. Our friends begin to be like our family. I think that is what is missing, to migrants in general, Latinos in particular, when we come here. The huge family that we have in our countries is reduced or null.

Spanish-speaking participants also described having limited spaces and moments to interact; some women noted that accessing meetings and activities required extra effort, time, and resources. One commented:

> It is easier and naturally pleasant to get older in our countries than here. And that is why I think it is so important that here exist groups like this one [organization named], because we have to, artificially … — in the best sense of the word—create support networks because in our countries that network is the neighbours from across the street, from next door!

The idea of autonomy is closely linked with the sense of belonging and feeling part of a family, network, or community, as well as other variables such as language and mobility. The research team identified several elements related to financial and family related autonomy. Relatively more Spanish-speaking participants were divorced (six of 16 were divorced or separated) compared to Arab-speaking participants (three of 22). With a single exception, all Spanish-speaking women were financially independent and had some source of income (mainly wages/salary). In contrast, only seven of 14 Arabic-speaking women reported having a source of income: Arabic-speaking women depended more on their husbands and children, were less independent, and were mostly responsible for unpaid house labour. However, the fact that most Spanish-speaking women (and men) were still depending on wages raises other questions about pensions, survival, and life quality in the elderly years. Gender and socioeconomic status were important determinants for both communities.

The data also suggest that women tend to have a stronger sense of belonging if they are married or live with their family, compared with those living alone or working to support themselves or their families. Despite having a weaker sense of belonging, Spanish-speaking women were very active organizing activities in their communities (e.g., community groups, celebrations, and meals). This reveals the importance – and also the fragility – of social networks for immigrants, who depend on close family and friends to overcome isolation and develop a sense of belonging. In general, loneliness and isolation appear to become more pronounced during the winter months when it is more difficult to organize or attend other community activities.

> Well, here we have to create community, and in our countries maybe not, because there is already a community: you grew up there, you know the people, and you move around. You don't have to create those connections. Then here if you isolate yourself and you stay alone at home, you isolate yourself and do not make those connections. Those things that over there you don't have to look for … they are already given, because you are there, isn't this true? Then here, if we don't make an effort to go out and look for those connections, we isolate ourselves, and maybe because we have known each other, and we are here in this group, then we don't feel that lonely, but there are people who… feel alone and they are not here because they have not been able to connect.

With regard to income patterns, similar patterns emerged for male older immigrants. Five of six Spanish-speaking men reported having some source of income, while only two of eight Arab-speaking men reported having any source of income. Some of the Spanish-speaking interviewees were still working (full-time, part-time, or self-employed) to support their families because they had no access to a pension. However, some participants reported having good pensions or family savings or investments. Both language communities were very heterogeneous in terms of economic situations, which varied based on education, profession,

living arrangements, reasons for immigration, and length of stay in Canada. Arabic-speaking participants referred to socioeconomic challenges; one commented: "Yes, I have some obstacles, like I don't receive pension. This is an obstacle. I transfer my pension from my home country and it is only $200. This is not enough money to live. I have to pay rent; I have to buy food, I have to buy medications." Another said:

> Unfortunately, I couldn't find any job. I also decided to take a career shift and find a job as an office manager, however, I couldn't find a job. I am so concerned and worried not to be able to live well, even after I start to get the Old Age Pension after I become sixty-five. How much money will I get? 300 or 400? and also, I'm not sure if I will be able to get it. Even if I got it, can I live with dignity with this amount of money?

Barriers to Participation and Access to Services

In most cases, loneliness is very closely related to language, mobility, technology literacy, and economic barriers, all of which limit access to services and participation in other activities. One Spanish-speaking man said, "it is very difficult to establish a relationship with anyone while I don't have the language." Limited language proficiency in at least one of Canadas two official languages is one of the most fundamental barriers to full independence and wellbeing among older immigrants in Ottawa. This single variable alone is not responsible for determining sense of belonging to the community, but language proficiency affects opportunities for a range of activities and is further implicated in social inclusion or exclusion. Ability to interact with others is strongly related to independence in terms of economic resources, health, physical mobility, and ability to navigate. Literacy – including technological literacy and access to information (particularly on-line resources) – was clearly identified.

Poor health and aggravated health conditions (e.g., hearing/sight loss, mobility problems) are also significant barriers to connecting with the community and with necessary formal services. One older immigrant woman who was caring for her elderly mother noted:

> Fortunately, I have a mother who is very open, very independent since youth. She has been independent and takes risks! Now she is ageing. Well, now physically her sight is preventing her from many things, but she can adapt herself. She has even adapted already — she is 88 now—she migrated to Canada at 80 years of age!

Some participants also noted that mobility was further challenged by Ottawa's hard and long winter. One said:

> Back home you can go see family, you can go do social activities, you can go visit things around. But here … they don't really either have the time to see anyone or other people don't have time for them … They are just sitting home doing the normal things which I feel like—after they get to the older immigrant years, they are just dying the slow death … Maybe the weather is not helping with it but at the same time I just feel like, living for them [older immigrants] in Canada is just like a locked place. They are just going to live in this house for the rest of their lives.

Conclusion

Older immigrants in Ottawa reported feeling socially excluded because of language and socioeconomic barriers and being deprived of meaningful work. They referred to challenges to physical and social mobility related to climate and declining health status. These compounding issues furthered their inability to access certain social programs. Loneliness, lack of social interaction, and a sense of lost relevance were major obstacles to aging well in Canada. Another major issue is that older immigrants –many who live alone – have been aging in the context of the COVID-19 pandemic, which has had acute effects on isolation and health. However, many older immigrants tried to overcome challenges by seeking out informal connections with members of their own cultural communities: this helped some of them overcome language barriers, remain physically and mentally active, and maintain their health and wellbeing. However, some "younger" older immigrants who are still economically active do not consider themselves older immigrants: they struggle to adapt and support themselves and their families. Overall, older immigrants in Canada face persistent challenges as they age, and much more work is required to explore how age, gender, and language are related to their wellbeing.

Implications for Policy and Practice

Based on our findings, we have developed several recommendations with implications for program, practice, and policy development. Older immigrants would benefit from the creation of safe and accessible spaces to gather and interact informally, as well as to access low-cost or free further education programs, preferably in their own languages (e.g., Spanish or Arabic), such as English as an additional language, computer training, and physical fitness. Information about these programs and registration forms should be provided in their own language, because older immigrants find it difficult to navigate in English or French. Another option is to provide more interpreters and translators.

Older immigrants also want more access to social programs including pensions, as well as linguistically and culturally compatible health and social services; female care providers in particular wanted access to care programs to support families. Many older immigrants also want opportunities to find remunerative and meaningful employment.

Although our study population included many professional and highly educated older immigrants, those who faced language and economic barriers needed extra support to access low-cost and safe transportation in their language to facilitate mobility and thus enable participation in other activities. Notably, many sought access to linguistically and culturally appropriate training and literacy programs and ways to navigate the system: how and where to ask for information in their language, how to access information online, how to find a route and map for the public transport system, and how to ask for help. Some relied on family for support, including information, but family members may not have the time or the most accurate or up-to-date information to pass along.

Overall, addressing loneliness and isolation among older immigrants will require ensuring they have access

to services, activities and other members of their communities. It will also require providing economic and material support, which are both fundamental in terms of preventing unhealthy dependencies and elderly abuse. By strengthening connections with family and friends and promoting wellbeing, it will be possible to foster inclusion (belonging to a community) and mitigate social (and political) exclusion. Finally, older immigrants who are aging in a new country may have different ideas about the meaning of social support and social inclusion, so all services should be inclusive and culturally appropriate.

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Chapter 7. "I helped them to help the country": Lack of State Support for Precarious-Status Older Chinese Immigrants

FANYUAN ZHANG; JILL HANLEY; AND CHRISTINA KLASSEN

Canada and other immigrant-seeking countries are currently recruiting working-age individuals who can make a direct contribution to the economy through the labour force. Meanwhile, the older parents of immigrants often stay behind in their countries of origin, either by choice or because of the difficulties in obtaining immigration status. Canada has long allowed individuals with permanent status to apply to sponsor for their parents, but the program was criticized for the high income required of sponsors and the extreme dependence the status imposed on their parents (Gal & Hanley, 2012; Walsh & Hassanali, 2010). Parents often come to Canada to be reunited with their children, but also to help them by providing childcare for grandchildren and performing household tasks (Ferrer, 2015). Chinese parents are acutely aware that their contributions enable their children to study or work, indirectly contributing to Canada's economic and social wellbeing. However, rhetoric and policy around the sponsorship of parents and grandparents frame them as burdens on the Canadian health and social service system (IRCC, 2013).

The already-limited sponsorship program was "paused" in November 2011: instead of applying for permanent residency under the family sponsorship program, parents of Canadian permanent residents or citizens can now come to Canada only as long-term tourists on the so-called "Super Visa," a two-year tourist visa renewable for up to 10 years (Chen & Thorpe, 2015; IRCC, 2011). The program was reinstituted in January 2014 under an annual quota system: the first 10,000 applications received each year are processed. Additionally, the sponsorship period (during which sponsored individuals are excluded from government income-security programs) was increased to 20 years instead of 10 throughout Canada with the exception of Quebec (IRCC, 2013). Under this system, many families rushed to complete their applications, only to miss out on the annual quota and a massive backlog was created (Ferrer, 2015). In January 2017, the sponsorship program was changed to operate on a lottery system that randomly selects 10,000 potential sponsors from eligible applicants, who are then invited to submit a full application (IRCC, 2018b). Almost 100,000 families apply annually to sponsor their parents or grandparents, so these quotas fall critically short of demand (Scotti, 2017). As a result, families are separated and struggle to maintain relationships and provide care.

To be allocated a Super Visa, parents or grandparents must convince immigration officers that they will leave Canada willingly at the end of the visa: this typically requires demonstrating ongoing ties to the home country, the temporary nature of their trip, adequate family finances to cover all needs while in Canada, and the "overall economic and political stability of [their] home country" (IRCC, 2018a). Their adult child/children must also demonstrate that they meet a minimum income threshold (equivalent to the low-income cut-off for the family size, including the parents arriving on a visa) to support their parents while they are excluded from income-security programs. One important difference between sponsorship and the

Super Visa is exclusion from Medicare: parents must demonstrate that they have purchased private medical insurance for the duration of their visit, and affirm their good health through a medical exam (IRCC, 2018a).

In this context, migrants including parents and grandparents have a "precarious immigration status" – their legal status denies them the permanent right to stay in Canada and often enforces dependence on a third party (e.g., an employer or family members) (Goldring, Berinstein, & Bernhard, 2009; Hanley & Shragge, 2009). Canada's Immigration and Refugee Protection Act (C.a.I. Canada, 2001) thus creates a continuum of precarious statuses from the most insecure – undocumented migrants (those smuggled or trafficked into the country or having overstayed a legal visa), refugees (claimants, accepted or refused), and temporary residents (e.g., student and temporary foreign worker visas) to the most secure – sponsored family members (permanent residents whose status depends on their sponsor). This chapter focuses on older Chinese adults, who often fall into the categories of sponsored family members and long-term visitors.

Canadian policies have important repercussions for the immigrant Chinese community (Chen & Thorpe, 2015). Given China's one-child policy, many young Chinese adults emigrating to Canada leave their parents behind without any direct support for them, as many do not have siblings to help support their parents back home (Gui & Koropeckyj-Cox, 2016). This particular confluence of Canadian immigration policy with Chinese family policy creates a situation in which the stakes for family reunification between adult children and older adult parents are particularly high. The lack of settlement and social support for precarious-status older adult migrants (whether sponsored, on Super Visas, or undocumented) – in contrast to those available to younger immigrants heading into the paid job market – suggests an underappreciation of their contributions to Canadian society, whether in terms of family caregiving, household support, or community contributions (Chen & Thorpe, 2015; Da & Garcia, 2015).

People of Chinese origin make up the second-largest racialized population in Canada: as of 2016, about 5 percent of the Canadian population was of ethnic Chinese origin (StatsCan, 2017a). In 2016, Metropolitan Montreal had a Chinese population of 108,755, or about 2.7 percent of the city's total population (StatsCan, 2017b). The following discussion focuses on the experiences of Chinese older adults living with precarious immigration status in the West Island, a suburban area of Montreal. Based on the 2006 census, this area had a large population (n = 1050) of Chinese persons aged 55 or older; this is about 13 percent of the total population of older Chinese persons living in Montreal (StatsCan, 2011). We examined how precarious immigration status intersects with the experiences of older Chinese persons as family caregivers.

Chinese Older Immigrants in Canada

Northcott and Northcott (2010) identified six main barriers facing Chinese older adults when accessing health, social, and settlement services in Canada: language, cultural, economic, transportation, social, and weather. Other scholars have identified other barriers including service barriers (Lai & Chau, 2007a; 2007b) and policy barriers such as sponsorship regulations (Koehn, Spencer, & Hwang, 2010). Together, these interwoven barriers lead to high levels of social isolation and affect quality of life among older Chinese immigrants. In our broader study, we explored language, cultural, transportation, and weather barriers;

the discussion in this chapter focuses specifically on the themes most directly relevant to precarious immigration status: economic, social, and service barriers.

Among economic barriers, Northcott and Northcott (2010) identified several subthemes: poverty, lack of employment, lack of access to certain social benefits due to immigration status, and high financial dependence on children. Dempsey (2005) found that sponsored parents have a low incidence of being employed and a high incidence of receiving Old Age Security (OAS) and the Guaranteed Income Supplement (GIS) upon completion of the sponsorship period (10 years in Quebec and since 2013, 20 years in the rest of Canada) (Dempsey, 2005; IRCC, 2013). During the 10-year waiting period for access to OAS, older immigrants who are unable to work are therefore completely economically dependent on their children, and this is a common situation among older Chinese immigrants (Brotman, 1998; Da & Garcia, 2015). The problem is compounded if relationships break down: compared to older immigrants in general, older Chinese immigrants are known to have high rates of poverty (Dempsey, 2005), with length of residency in Canada having no correlation to poverty level (Troung, 2006). Access to OAS and ability to overcome language and other barriers to employment have the strongest effects in terms of reducing poverty and dependence on their children (Koehn, Spencer, & Hwang, 2010; Troung, 2006). Moreover, when older adults have less economic dependency, they feel they are making more of a contribution to their family (Wellesley Institute, 2008).

Northcott and Northcott defined *social* barriers as "social isolation, lack of 'weak ties,' familial roles, and relationships which function as either a facilitator or a barrier to integration, lack of support for family caregivers, and systemic racism, sexism, and ageism" (2010, 41). Even when living with their families, sponsored older immigrants may feel extremely lonely and isolated from much-needed services and support (Koehn, Spencer, & Hwang, 2010). Language barriers are often a main reason for social isolation among older immigrants (Tam & Neysmith, 2006), while childcare and other forms of daytime domestic labour often isolate minority older adults from services and communities (Rittman, Kuzmeskus, & Flum, 1998). Surprisingly, even Chinese older adults living in large Chinese communities can experience high degrees of social isolation (Chau & Lai, 2011). Finally, weakened cultural values and loss of independence and status can lead to social isolation and intergenerational conflict (Northcott & Northcott, 2010).

With regard to *service* barriers, older immigrants often report low levels of social participation (Fong & Ooka, 2006). Among Chinese older adults, family and kin are often the most immediate and main resource for support; those who live with their adult children tend to access formal services less (Tsai & Lopez, 1998). Overreliance on family and kin can lead to reluctance to use local formal services (Northcott & Northcott, 2010). Older Chinese immigrants often report a lack of professionals who speak their language as a main reason for not accessing formal services (Lai & Chau, 2007). The complicated logistics of accessing service delivery can also reduce confidence in using them (Lai & Chau, 2007).

To address such service barriers, Northcott and Northcott (2010) emphasizes the need to develop culturally safe and linguistically appropriate services, including hiring practitioners from the ethnic community and providing culturally and linguistically appropriate informational materials. For example, clinicians and service providers serving older Chinese immigrants should assess the acculturation level of each client and their knowledge of the local system before providing services (Kuo, 2010). Practitioners should also

collaborate with supportive family members (Tsai & Lopez, 1998) and engage in community education and training in cross-cultural communication skills (Lai & Chau, 2007b). However, while measures of cultural competency are important, the current emphasis on language barriers and solutions in services for ethnic minority older adults can neglect issues related to underlying racism (Brotman, 2003).

Documenting the Lives of Suburban Chinese Older Adults

Montreal's West Island has gradually become a hub for the Chinese population, which is drawn to the area's anglophone public life. However, the West Island is located far from the traditional Chinatown neighbourhood in downtown Montreal, which has two well-known Chinese health and social service organizations: the Montreal Chinese Hospital and Chinese Family Services of Greater Montreal. For some older Chinese adults, especially newcomers with significant language barriers, the West Island can seem very far away, and travelling to Chinatown by public transportation often takes up to an hour and a half and involves multiple transfers from bus to metro.

This area and its understudied population required a needs assessment, so we collected first-hand information about the particular needs of this population on the West Island. Our study population included eight Chinese older adults (55 and older) with no health problems impeding communication, precarious immigration status (sponsored or visitors), and who had arrived in the last ten years (minimum six months in Canada). We also included three adult children living with their immigrant older parents. We included both older immigrants and older long-term visitors because they are likely to experience similar challenges. Three interviewees were visitors in the process of applying for sponsorship through their children.

We recruited study participants through resources within the West Island Chinese community: an immigration consulting company, social gatherings of Chinese older adults in a public park, the home of one older adult, two schools, a community organization, and a local soccer club. We arranged individual meetings with directors, activity organizers, and team leaders to explain the research subject, objectives, and procedures. We also asked community leaders to share a flyer about the study with their contacts (verbally at activities or by e-mail) and to include the information in newsletters and on information boards. Community partners played an important role in encouraging their members to overcome any hesitation or distrust to participate in the interviews, and also provided useful suggestions in revising the interview format and wording of questions, as well as adding essential information to the consent form.

Data Collection

Older adults and adult children each participated in one semi-structured qualitative interview (about one hour each) to collect demographic information and used open-ended questions to explore psychosocial wellbeing and quantitative questions to explore opinions on health and social services. The following sections discuss the responses to open-ended questions exploring: (a) living arrangements; (b) difficulties and changes compared to life in China; (c) caregiving responsibilities; (d) social participation; (e) transportation; (f) conflicts with adult children and coping methods; and (g) psychological wellbeing.

Given the low level of English proficiency among most respondents, interviews with older adult participants were conducted by the first author entirely in Chinese, and those with adult children were conducted primarily in Chinese. English was used only for certain terms without Chinese equivalents.

Data Analysis

Transcribing from another language into English can be problematic because it requires two filters: translation and transcription (Padgett, 2008). To reduce inaccuracy caused by filters, the first author designed all questions in Chinese to prioritize understanding by Chinese participants, instead of translating them from English to Chinese. A translated version together with the Chinese version was shared with the other authors and for ethics approval.

When coding and analyzing, we paid special attention to four of the six elements of narrative approach provided by Labov and Waletzky (2003): *abstract*, *orientation*, *complicated action*, and *evaluation*. We summarized each interviewee's life story chronologically, framed by interview questions. To ensure coding accuracy, the research team coded the interviews twice with a one-week interval between coding. No major differences emerged between the two rounds of coding. After coding and summarizing were completed, we reorganized the themes into different categories (main themes) and levels (subthemes).

Limitations

Due to the limited number of interviewees, we were unable to thoroughly explore the influence of gender on provision of care to family members. The results would have been more generalizable if more male older participants and younger adult participants were included. Additionally, because of our focus on a specific geographical area, the results may not be applicable to other areas with significant concentrations of older Chinese immigrants – even within the greater Montreal area.

Intersecting Identities among Caregivers on the West Island

Language, transportation, economic dependence, social isolation, and access to social services all emerged as important interview themes, but these have already been explored thoroughly in the literature. Therefore, we focused on the themes most directly related to precarious immigration status and the main reason these Chinese older adults came to Canada: to support their children and grandchildren. The following discussion explores the themes of *heavy daily tasks*, *intergenerational conflict*, and *self-identification.*

Table 7.1 summarizes the demographic profiles of all participants. While levels of education varied greatly, seven of the eight older adults had no English or French at all, and personal incomes were very low: from $0 to a maximum of $15,000 per year. Among the eight older adults, only one earned an income

in Canada through Old Age Security; the rest received income from China, either their pension or small business income. The individual with the highest income ($15,000) received an annual gift from their son as compensation for contributions to the family. Half of the older participants had an annual income of about $3600. All but one of the older adults were living with their son or daughter and their family, with no clear preference with regard to gender. All three adult children interviewed were male, while the eight older interviewees included six females and two males. Previous research has revealed that the majority of immigrant older adults are female (Durst, 2005) and that women are more likely to provide caregiving in Canada (Cranswick & Dosman, 2008).

Table 7.1 Demographic Summary of the 11 Participants

Participant	Gender	Age	Immigration Status	Time in Canada	English or French Capacity	Education	Annual Income	Living with	Use of public transport	Spouse in Canada
Older imm 1	F	69	Visitor, applying for sponsorship	18 months	None	High School	$3,600	Son's family	No	No
Older imm 2	M	72	Visitor to sponsored immigrant	18 months	None	College	$12,000	Son's family	Yes	Yes
Older imm 3	F	59	Visitor, applying for sponsorship	9 months	None	Elementary	$3,600	Son's family	No	No
Older imm 4	F	65	Visitor, applying for sponsorship	12 months	None	Junior high school	$3,600	Daughter's family	No	No
Older imm 5	F	61	Visitor to sponsored immigrant	9 years	None	None	$15,000 (from his son)	Son's family	Yes	Widow
Older imm 6	M	64	Skilled worker	10 years	Basic English	College	$10,000	Alone	Yes	Yes
Older imm 7	F	73	Sponsored immigrant	10 years	None	University	$3,600	Daughter's family	Yes	Yes
Older imm 8	F	70	Sponsored immigrant	6 years	None	College	$0	Daughter's family	Yes	Yes
Adult child 1	M	41	Skilled worker	10 years	Fluent English	Bachelor's degree	$80,000	Parents from both sides		Yes
Adult child 2	M	34	Skilled worker	8 years	Fluent English	Master's degree	$65,000	Mostly mother-in-law		Yes
Adult child 3	M	32	Skilled worker	4 years	Fluent French	Master's degree	$40,000 – $60,000	Parents from both sides		Yes

Heavy Daily Tasks

The extended family structure is central within Chinese culture. Many visiting parents lived under the

same roof with their children and grandchildren to enjoy a sense of family happiness and the love of being reunited (Tian lun zhi le, ◇◇◇◇). In accordance with cultural expectations of maintaining the household and taking care of grandchildren (Rittman et al. 1998), most older participants said it was natural for them to take over many daily tasks. All participants but one – who had immigrated as a business immigrant and raised his children in Montreal – reported that they had some role in caring for the families of their adult children. Daily tasks included babysitting, cooking, cleaning, grocery shopping, and gardening, and most felt these were their responsibility. Often, long-term stays in Canada began after their daughter or daughter-in-law became pregnant. One participant described a typical day as follows:

> After getting up, I have to warm up milk and prepare breakfast for the baby. I drop her off at the daycare at 8:30 am and pick her up at around 4:00 pm. After coming back from the daycare in the morning, I wash the dishes and do the laundry every three days. I prepare the three meals for the whole family every day. I go to my [Chinese] neighbour's home about two to three times per week. I go to IGA and dollar store etc. Around 2 pm, everything [preparation for supper] is ready. I read Chinese newspaper for a while. I take a shower in the afternoon, as I won't have too much time in the evening. Before picking up the baby, the supper is ready. I keep it warm. I only have to cook a soup before the supper. (Participant # 4, Female older immigrant)

As illustrated by this excerpt, this participant was so busy with daily tasks that she was unable to take a shower at a time convenient to her. Another older woman participant commented on the length of her day: "I got up at 7 am. It will last until 7 pm." Babysitting was common and participants reported that this caregiving work was most intensive before the child began going to daycare. Comments from older adults included having "to take care of the baby from opening my eyes in the morning till closing my eyes at night" or "taking care of kids, every day of 365 days." Despite their busy schedule and long hours, almost all older participants also reported positive aspects of these roles, such as responsibility, joy, and happiness. One said:

> To take care of kids is tiring. But at its essence, it is enjoyment and happiness. It is also responsibility. I feel the responsibility is on top of the other two … I feel I got lots of joys when I accompanied my granddaughter acting out cartoon stories and dancing together. But responsibility is still the top principle. Sometimes you have tiredness and even painfulness following the joys. I have to admit that it is more tiring to look after a child than to do real work. (Participant # 2, Male older immigrant)

Koehn, Spencer, and Wang (2010) found that Chinese older adults enjoyed such responsibilities for a number of reasons: they love their grandchildren, it keeps them busy, and/or it allows them to fulfill a role that they value. Our results were consistent with these findings, and one interviewee noted that she "was brought up with little sense of family ties … had never thought about being exempted from the work of taking care of kids." However, she also commented that the more she helped, the more her son and daughter-in-law were spoiled, so she was careful to not overdo it. Sometimes the parents of both adult children in a couple took turns visiting Canada to share these heavy responsibilities, and sometimes older adults came with their spouse and shared the tasks. For example, one husband would take a walk with the grandchild while the wife cooked or did laundry.

Because of their heavy daily task load, interviewees often reported that they did not get enough personal

time. A few reported a fixed hour-by-hour daily schedule of household and childcare tasks, commenting that their personal time was squeezed into a short period of time, either after lunch or after supper before sleep:

> [I worked] until 6:30 when my son comes back. We will say, "Finally you are back." (I am) very tired. A two-year-old baby is the most tiring. In the evening (after the baby goes to bed), I have my own time … I have thought about having some of my own time. For example, every Thursday I started to plan my weekend. (Participant # 2, Male older immigrant)

> I don't have much time for myself now. It is impossible to sit to read for two hours. (Participant # 4, Female older immigrant)

Of these two participants, the older man seemed to have a bit more time for himself, at least during the weekend; he focused more on playing with his grandchild and taking her for walks, while his wife prepared food and cleaned the house. This reflects the general trend that women are more likely to do housekeeping tasks than men, and the gendered nature of the distribution of caregiving tasks between men and women in Canada (Cranswick & Dosman, 2008).

Interviews with adult children revealed that they were aware of the heavy load borne by their parents; some they tried to compensate for this by taking parents out on weekends and arranging for activities:

> I don't accompany them out too often. Sometimes, when I go to do shopping, I will bring them with me. (Participant # 9, adult child)

> I have tried to look for some activities for her. I arranged some travelling, for example to Gaspé. But she prefers to wait for her husband and travel together in the future. She does not want to travel too far. For other occasions, we bring her to friends and have a dinner there. (Participant # 4, adult child)

> [My mother] does not have too much time for herself … I accompany her out at least twice a week. On Saturday or Sunday, we often go out. (Participant # 11, adult child)

Intergenerational Conflict

Older immigrants are known to experience intergenerational conflict (Northcott & Northcott, 2010). One of our participants commented, "it happens in every family" and others described it as "unavoidable." We found that older participants felt lonely and isolated as a result of different living habits, different life circles, and lack of integration in the host society. All of these factors were mentioned as causes of intergenerational conflict:

> There is always a generation gap existing. For example, the work and rest schedule is quite different.

> The choice of food and the health ideology are more or less different. (Participant # 2, Male older immigrant,)

> For the leftovers, when we saw they wanted to throw away, we told them that we could eat them. Then my son questioned "How much money would you be able to save? If you are getting sick, how much more would you spend?" Obviously, he is right. But I just didn't feel happy. I was doing something good for you, while you gave me this attitude. It hurt my dignity. There is no right or wrong, but the difference between two different living habits.... (Participant # 2, Male older immigrant)

Most older immigrant participants seemed unwilling to give up the parental authority that they would normally have in China. Northcott and Northcott (2010) described similar situations in which older immigrants experience an erosion of the power and authority that they would exercise within the "traditional" family structure in their countries of origin.

Money, or attitudes about saving money, emerged as common cause of intergenerational conflict. Older participants tended to worry more about "wasting" money than the younger generation:

> After I came, my son-in-law insisted on buying private health insurance for me. I don't want to buy. It is too expensive. It is not worth it. I won't be sick. But he insisted that it would cost more in case I fell or got sick here. (Participant # 4, Female older immigrant)

Many of the older adults questioned why they should "waste" money on health insurance, especially when they are always at home. They did not want to spend money on something they did not feel was necessary. In contrast one older immigrant felt her daughter-in-law cared too much about money:

> My daughter-in-law kept complaining to my son, "For the Internet, I have already said so many times [switch to a cheaper plan]. I am too tired of this life." I told her that if she talked about money so much, I would leave. I told her, "If you are tired of the marriage, get divorced ... In my factory in 1980, our salary was about $80/month. One watch was $120. A colleague lost his watch. His wife told him that it was OK and she should not feel pain for it since it was gone." I found her to be more understanding and mature after my intervention. (Participant # 3, Female older immigrant)

On one hand, older adults expected their adult children not to waste or overspend money; on the other, they wanted the younger generation to check whether they had enough money and to have a certain financial independence. One commented:

> I have a good relationship with my daughters-in-law, both here and the one in China. The one here is very smart. She won't care how much money I spend ... If there is not enough, they will give me. (Participant # 5, Female older immigrant)

All participants agreed that some degree of intergenerational conflict was unavoidable, but referred to different levels of intensity and coping mechanisms. One important coping mechanism was communicating

when conflict arises. One older man referred to trying to initiate communication while also maintaining his traditional authority.

> For this situation (of conflict), we talk it out. I tell them I am right and you are wrong. In my heart, I believe they are right. (Participant # 2, Male older immigrant)

Avoiding and *ignoring* were also common techniques in dealing with conflict; these might be related to the often vulnerable positions of older adults within their child's home. Female participants reported avoiding and/or ignoring more often than males:

> Conflicts are unavoidable. My daughter is very anxious. When there is a conflict, I just ignore it. For the biggest conflict that I ever had with her, I just did not talk to her for two days. After that, we were ok. (Participant # 7, Female older immigrant)

Fighting back was another coping method. Two participants reported fighting back: they both had strong personalities and were living alone with their child's families because their spouses had either passed away or lived in China:

> I will fight. I will blame and scream at them. They will leave and go to their own bedroom. They don't want to fight back. But I follow to their bedroom and continue to fight. (Participant # 5, Female older immigrant)

> I only hit you hard once [a big fight between the older immigrant and her daughter-in-law] and make you wake up and understand life. (Participant # 3, Female older immigrant)

When conflict arose between older adults and daughters-in-law or sons-in-law, an intervention by their own child seemed effective:

> My daughter-in-law used the cloth to clean the table. I told her not to use that particular one. She was not happy. She raised her voice. My son intervened and asked her to apologize. I did not expect that. I would have let it go if she did not come up to me. They are educated. It won't affect the relationship between the son and her. She apologized to me. I thought she was very nice and civilized. (Participant # 1, Female older immigrant)

> We have a good relationship with parents. Both sides have tolerance. (…)We have a good dynamic. I deal with the conflict with my own parents. She does with her parents. Your own parents would never slap you. (Participant # 9, Adult child)

Despite these "unavoidable" intergenerational conflicts, all participants denied having any experience of abuse.

Self-identification

This section explores how older adults self-identified their own roles to clarify how and why they handled issues in particular way: the results provide a solid basis for developing required services.

Self-identification As a Helper and/or Caregiver

Interviews with older adults revealed that most took responsibility for nearly all caregiving and housekeeping tasks motivated by the goal of contributing to the family and avoiding being a burden. Chinese culture values making sacrifices for and prioritizing the younger generation (Gui & Koropeckyj-Cox, 2016). Collective thinking about one's contribution to society – similar to the concept of prioritizing collective welfare over individual benefits – is common among older adults who lived for years under China's socialist system (Wolf, Bennett, & Daichman, 2003). One interviewee framed herself as an indirect contributor to Canada through her support of her children's family:

> I feel happy when my children come back with a happy face. I help them to help the country. I reduce the burden for the country. I take care of the kids. I tell stories to the kids. When my children are concentrating on my work, I am kind of helping Canada government. (Participant # 1, Female older immigrant)

Another commented that her household and caregiving contributions allowed her adult children to "focus more on contributing to the Canadian society."

Financial factors are another reason why some older adults remain in the caregiver role. Many older immigrants prefer to contribute to the family financially rather than feel like a burden on them (Wellesley Institute, 2008). However, Koehn, Spencer, and Hwang (2010) stressed that older adults do not always choose to come to Canada themselves. Several of our participants said they had no choice about taking responsibility as a helper:

> Taking care of babies, I have no other choice. (My adult children) pay so much tax … They won't have time to take care of the kids. (Participant # 8, Female older immigrant)

> I don't mean I don't like here. I have no choice. It does not matter if I like it here or not. Both of my children are outside in another country. I have nobody in China. (Participant # 8, Female older immigrant,)

We found that older parents viewed themselves as helpers for the whole family; this is somewhat different from perceptions among their adult children, who made comments like "the main goal of the parents' visit is to help (take care of) the grandchildren." However, adult children also noted that that help from the older generation provided them with "lots of time and the convenience of learning something else." All adult children emphasized that it is "a good chance for the kids to live with their grandparents" or for

"the grandparents not being far away from their grandchildren." These views were in contrast with the observations of their older immigrant parents:

> They are very educated, but they do not have enough life experience. They took things for granted. (Participant # 3, Female older immigrant)

> I vent out my bad feeling by screaming at my son. I told him, "I am not a babysitter or maid. I am your mother." He said "I never asked you to be a maid." (Participant # 5, Female older immigrant,)

Lack of recognition about how adult children personally benefitted from their parents' contributions became more obvious during conflict.

Self-identification as an Outsider

Some older immigrants described being an outsider to their children's family. One older woman said, "I reserve some opinions when we have different opinions on educating children. I always listen to them, as it is their family" (Participant # 1). Not all adult children felt this way, but interviews revealed that parents were considered a kind of burden:

> It is very obvious that they do give us extra burden. They have their own pension in China. But everything here is on my shoulder. (Participant # 9, Adult child)

> Sometimes, I do feel there is a burden when they live with us. Especially when there is a conflict—we have thought that it would have been better if they did not live with us. (Participant # 11, Adult child)

Some older adults viewed themselves as outsiders because they were living with a daughter's family rather than a son's family. In Chinese culture, it is mostly the son's responsibility to exercise filial piety toward his parents – an indication of the traditional cultural value of men's power and authority over women (Lai & Surood, 2009). One older immigrant who had no sons and lived with her daughter's family did not have a strong sense of being part of her son-in-law's family: "It is my daughter's home. It is not my home. It is another home under another family name (the son-in-law's name)" (Participant # 8, Female older immigrant).

Another issue related to feeling like an outsider involves Canadian society: most older adult participants reported not having a strong sense of belonging to Canadian society. One said, "I feel that I am only a guest for Canada. Here is only a hotel for me. Eventually, I have to leave … I am not a Canadian … I feel like I am locked here." We observed similar findings among both precarious-status visitors and sponsored immigrant participants, and found that those who had been in the country for a shorter time reported feeling less of a sense of belonging to Canada. This finding is in contrast to previous research indicating that 76 percent of the overall Chinese population of all ages report a strong sense of belonging to Canada (StatsCan, 2007).

Discussion

Interviews with the precarious immigrant older adults revealed that they have a very demanding life and experience three notable emotions: a sense of pride and satisfaction in contributing both to their families (and indirectly to Canadian society); a sense of happiness and love in being able to share their lives with their children and grandchildren; and a sense of frustration and sometimes anger that their heavy responsibilities leave them little time for themselves and leave them tired and isolated. Immigration status can impose financial dependence on children, and access to health, social, and community services can be very limited. We focused specifically on Chinese immigrants, but similar results are to be expected in other immigrant communities. Precarious status among older immigrants is an issue that merits more scholarly and policy attention.

Demographically, the West Island of Montreal has a comparatively large older (55+) Chinese population, which is likely higher than the 1050 reported in 2006 due to annual increases in new arrivals under family-class sponsorship and the aging of Chinese individuals who entered Canada as economic immigrants. In addition, many older Chinese visitors stay with their adult children for at least six months, including those waiting to be processed for family-class sponsorship. Our interviews with older Chinese immigrants in the West Island revealed a combination of challenges including language problems, high levels of isolation together with feelings of loneliness, helplessness, sadness, transportation barriers, low income and economic dependence, and intergenerational conflict. All these issues affect their quality of life in Canada, and existing formal services cannot address all of these needs.

Precarious immigration status is clearly not the only challenge faced by older Chinese adults, but it affects everyday life and contributes to other challenges including a heavy burden of daily tasks and intergenerational conflict. It also affects how older adults self-identify themselves and their roles within the family and Canada. Fundamentally, precarious immigration status creates a situation of legal dependency on adult children. The legal right of older adults to be present in Canada is tied to their children's legal sponsorship – while this same sponsorship denies them any access to the kind of income security enjoyed by other Canadian residents. Cultural values encourage older adults to accept the heavy burden of family caregiving and housekeeping, but this leads to a sense of not having much choice about being in Canada, not having any real possibilities to earn independent income, and having to compensate for the "burden" they pose to their children through economic dependency. This kind of dependency is not helpful in managing the "unavoidable" intergenerational conflict. While such tensions are common, total dependency makes for difficult situations – and if abusive situations arise, a precarious-status older immigrant is ill-placed to resist (Gal & Hanley, 2012). Finally, precarious status reinforces a person's sense of being an "outsider." Previous research has confirmed a sense of exclusion from Canadian society among precarious-status migrants (Goldring, Berinstein, & Bernhard, 2009), but in the case of sponsoring immigrant older adults, this sense of being an "outsider" can extend into the family. Parents of adult children often experience a sense of being in someone else's home when they live with an adult child. Under conditions of sponsorship, this feeling of being an outsider is underpinned by the knowledge that their children have little choice but to continue living with them, facing stiff financial penalties should the older immigrant parents leave and try to access public income security.

Overall, the experiences of Chinese older adults living in Montreal with precarious immigration status reflect a transnational dynamics of care. Many decided to come to Canada to join their adult children and grandchildren. Their adult children want to support their parents, but also need their parents' support to care for their own children. The decision to migrate in later life is difficult, and many of our interviewees did not necessarily see migration as permanent; some were trying to travel back and forth between Canada and China. Finally, we found that older adults frame themselves as helping both their adult children and Canada: by helping their adult children support their employment by providing childcare and other household tasks, they feel they are helping Canada by reducing demands on the welfare state. This finding may extend beyond the Chinese community to other immigrant groups.

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Chapter 8. Housing Insecurity and Homelessness Among Older Immigrants in Canada

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Older adults are increasingly represented in the homeless population in Canada and other Western countries (Canham et al. 2018; Grenier et al. 2016; Woolrych et al. 2015). The rise in homelessness among older adults can be attributed to population aging, shifting age structure, and the added consequences of poverty, economic volatility, lack of affordable and subsidized housing, decreased social programs and social assistance benefits, and increased rates of mental health issues and substance use (Grenier et al. 2016; Reynolds et al. 2016; Woolrych et al. 2015). One under-researched demographic within the older adult homeless population is older immigrants.

Older immigrant adults are likely to face additional risk factors in addition to the known age-related challenges associated with the risk and experiences of homelessness, but very few scholars have explored the experiences of older immigrants facing homelessness. The following discussion explores the existing literature and debates surrounding the topic of housing insecurity and homelessness among older immigrants in Canada; we used an intersectional lens to investigate what is known about these issues in Canadian academic literature and public policy statements with the goal of fostering discourse that will inform future research, housing strategies, community services, and public policies for older immigrants in Canada facing housing insecurity and homelessness.

Who Are Older Immigrants in Canada?

Approximately 300,000 new immigrants arrive in Canada annually. According to the most recent census data, 1.2 million new immigrants settled permanently in Canada between 2011 and 2016 (Statistics Canada, 2017b). The immigrant population now accounts for almost 22 percent or one-fifth of Canada's population, with Asia (including the Middle East) being the top region of origin (about 61.8 percent of the total recent immigrant population) followed by Africa (13.4 percent) (Statistics Canada, 2017b). More than half of the immigrant population currently lives in large urban centres including Toronto, Montreal, and Vancouver (Statistics Canada, 2017b). The 2011 National Household Survey reported that 4.5 million older adults in Canada were born outside the country: most immigrated to Canada at a young age; few (3.3 percent) immigrated to Canada around the age of retirement (Government of Canada, 2017).

Early- and late-age migration are two distinct experiences that shape the lives of older immigrants and reflect the complexities inherent to aging and immigration (McDonald, 2010). For example, an older

immigrant who has lived in Canada for 30 years is likely to be competent and perhaps fluent in at least one of the two official languages and to understand Canadian culture better than an older immigrant who arrives in Canada at a later life stage. Some researchers have argued for the benefits of immigrating at a younger age (McDonald, 2010), while others have explored the hardships faced even by those who come to Canada at an early age, including racism and economic and social discrimination that can compound over many years (Brotman, Ferrer, & Koehn, 2020). The life-stage of any immigrants arriving in Canada distinctly shapes their experiences, but all immigrants encounter a diverse range of challenges.

Scholars working in the field of ethno-gerontology have identified multiple layers in the older immigrant experience: factors including race, ethnicity, national origin, and culture all affect the individual and the broader aging immigrant population (McDonald, 2010). The available literature offers important insights into the lived experiences of older immigrants, but it can also simplify intergroup differences and neglect to address important nuances that can offer a more accurate portrayal of the structural forces that lead to inequality among older immigrants (Brotman, Ferrer, & Koehn, 2020). Examples of structural inequities include income and poverty, education, the effects of having a minority status, social capital, the physical environment one lives in, access to resources, and immigration status (Brotman, Ferrer, & Koehn, 2020).

Understanding Homelessness

Homelessness is defined differently depending on the research, practice, or policy context (Grenier et al. 2016). Gaetz and colleagues defined homelessness as "the situation of an individual, family, or community without stable, safe, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it" (2012, par. 1). They further organized homelessness in a typology as follows:

> 1) Unsheltered, or absolutely homeless and living on the streets or in places not intended for human habitation; 2) Emergency Sheltered, including those staying in overnight shelters for people who are homeless, as well as shelters for those impacted by family violence; 3) Provisionally Accommodated, referring to those whose accommodation is temporary or lacks security of tenure, and finally, 4) At Risk of Homelessness, referring to people who are not homeless, but whose current economic and/or housing situation is precarious or does not meet public health and safety standards. It should be noted that for many people homelessness is not a static state but rather a fluid experience, where one's shelter circumstances and options may shift and change quite dramatically and with frequency. (Gaetz et al. 2012, par. 2)

Scholars focusing on homelessness among older adults tend to explore two main trajectories: chronic homelessness (experienced throughout life and into the older adult years) and late-life homelessness (becoming homeless for the first time as an older adult) (Grenier et al. 2016). Another experience of homelessness, among the Canadian-born or immigrant population, is sometimes called "hidden homelessness." This term refers to "people who are homeless but have not yet resorted to the shelter system (the 'abjectly homeless'), though they are at high risk of ending up there—or, even worse, on the streets" (Haan, 2011, 44). Many individuals at risk of homelessness reside with their social support networks, resulting

in residential overcrowding, meaning households with more residents than what is considered optimal according to the size, value, tenure, and crowding characteristics of the dwelling (Haan, 2011).

Homelessness has well-documented health consequences including shorter life expectancy and high morbidity (Stafford & Wood, 2017). Individuals experiencing homelessness are also less likely to access preventative services, which are key determinants for reducing poor health outcomes (Stafford & Wood, 2017). As a result, those experiencing homelessness have a higher prevalence of later-stage diseases, tend to neglect manageable conditions such as diabetes or hypertension, and have an increased occurrence of preventable conditions such as skin and respiratory issues, leading to more hospitalizations (Stafford & Wood, 2017).

Indeed, the health risks and consequences associated with homelessness are such that they have changed the age parameters for who is defined as an older adult. The standard age that marks entry into older adulthood in Canada is 65 (typically the age of retirement and eligibility for government-sponsored pensions); in contrast, in the context of homelessness, age 50 is considered the benchmark for this life transition (Grenier et al. 2016). Older adults (65+) now account for six percent of the visibly homeless population in Canada and older adults (55+) account for nine percent. These statistics indicate that older adults are a minority within the homeless population, but this could be in part because of higher mortality rates among people who are homeless (Barken et al. 2015; Hwang et al. 2009). The average life expectancy among the homeless population is 39 years (Trypuc & Robinson, 2009), compared with 82 years among the broader Canadian population (The World Bank, 2021). Older adults currently compose about 18 percent of the total population of Canada (Statistics Canada, 2020).

Recent studies have found that both the homeless population and immigrant populations are particularly vulnerable due to a range of factors. Perri, Dosani and Hwang (2020) reported that homeless shelters promote disease transmission because these communal spaces have such a high turnover and are often overcrowded. The homeless population is also susceptible to numerous chronic health conditions that increase the risk of poor health outcomes (Perri, Dosani, & Hwang, 2020). Immigrants, particularly new immigrants, often have lower incomes, which can force them into overcrowded living spaces and multigenerational households, also increasing the risk of disease transmission (Ng, 2021). To date no studies have focused specifically on the effects of the COVID-19 pandemic on older immigrants in Canada, but the vulnerabilities to risk among both the homeless population and the immigrant population suggest that older immigrants who are homeless are at greater risk of heightened mortality rates as a result of COVID-19.

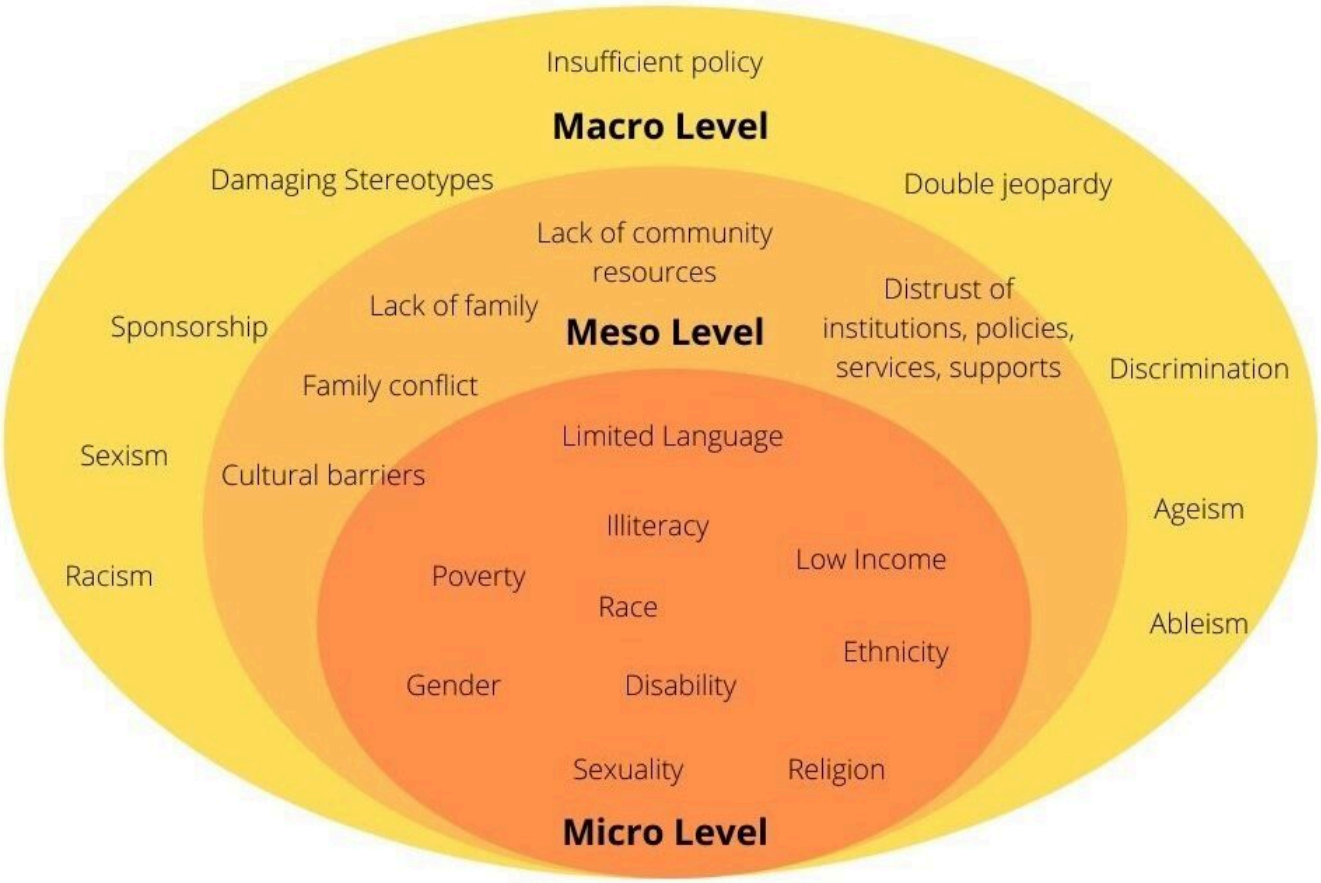
The high morbidity and mortality rates among the homeless population reflect the significance of access to shelter and housing as a basic social determinant of health and a fundamental human right (Barken et al. 2015; Stafford & Wood, 2017; World Health Organization, 2021). The World Health Organization defines the social determinants of health as “the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age and the wider set of forces and systems shaping the conditions of daily life” (2021, par. 1). In addition to housing, social determinants of health include unemployment and job insecurity, working life conditions, food insecurity, and discrimination that is directly or indirectly connected to housing insecurity. The condition of homelessness is socially determined, so it is futile to treat the symptoms of homelessness (such as poor health outcomes) without also addressing

the root problems of homelessness, including social, economic, and relational issues, as well as family dysfunction (Stafford & Wood, 2017). Forchuk and colleagues (2022) assert that it is necessary to focus on measures that prevent homelessness as opposed to investing in strategies to manage homelessness. Possible prevention measures could include efficient social assistance processes and regulations; safer and more desirable housing conditions; affordable housing; increased access to permanent housing; and increased awareness building of social services that can support individuals and families at risk of homelessness (Forchuk et al. 2022).In the context of older immigrants and homelessness, this will require addressing the unique challenges that older immigrants face in Canada.

Multi-Layered Complexities

Understanding complex issues like housing insecurity and homelessness among older immigrants necessitates careful examination of the interactions and interconnections among factors at micro, meso, and macro levels. These, in turn, shape the vulnerabilities of older immigrants, influence their capacity for dealing with adverse life situations (Ciobanu, Fokkema, & Nedelcu, 2017), and create pathways that can force older immigrants into homelessness. Use of an intersectional perspective can help reveal the complex interactions among factors that contribute to homelessness among older adults, including older immigrants.

Figure 8.1 Multi-layered complexities of housing insecurity and homelessness among older immigrants



Micro-level: Poverty, Income Insecurity, and Financial Instability

At the micro (individual) level, poverty, low income or income insecurity, and financial instability create a state of precarity that becomes the main driver of homelessness. Low-income individuals experience more income volatility and financial instability even after factoring the effects of taxes and public transfers (Hacker & Rehm, 2020; Ro et al. 2014). Relatively short periods of low income may not lead to negative effects such as homelessness; in contrast, long durations of low income may be defined as chronic low income: a financial state in which combined family income remains under the regional low-income cut-off (LICO) for at least five consecutive years (Picot & Lu, 2017). As discussed below, chronic low income is strongly linked with homelessness.

A dominant theme in immigration debates is the fact that immigrants earn less than Canadian-born workers, and even Canadian citizens born to immigrant parents earn less than Canadians who have been here for many generations (Magesan, 2017; Reynolds, 2019; Statistics Canada, 2017a). According to the Government of Canada's Longitudinal Immigration Database for the period 1993–2012, 30 percent of all older immigrants in Canada over the age of 65 were classified as having chronic low income and more than 50 percent of recent older immigrants (i.e., immigrants who arrived in Canada 5–10 years previously) were classified as having chronic low income rates. This is roughly three times the rate among immigrants aged 25–54, roughly twice that among immigrants aged 55–64, and is in sharp contrast to the low rates of chronic low income rate among their Canadian-born counterparts: about two percent (Picot & Lu, 2017).

Poverty and chronic low income are the strongest predictor of homelessness (Canadian Observatory on Homelessness, 2021), and most persons experiencing homelessness have limited or no financial resources. People who are living on the threshold of poverty or with high levels of income volatility are often only one "trigger event" (e.g., loss of paycheque; death of/dispute with spouse or family member who provides financial security) away from living on the streets (Canadian Observatory on Homelessness, 2021; Gaetz et al. 2013; Gonyea, Mills-Dick, & Bachman, 2010; Grenier et al. 2016).

In Canada, older adults are guaranteed income security through the Canadian Old Age Security (OAS) program, in which a monthly benefit is paid to all Canadians or permanent residents aged 65 and older. Low-income OAS pension recipients also receive a supplementary monthly non-taxable benefit: the Guaranteed Income Supplement (GIS). Access to OAS/GIS pensions significantly reduces low-income rates and minimizes the risk of chronic low income among older adults. However, recent older immigrants in Canada are often not eligible for these programs because an eligible person must have lived in the country for at least 10 years since age 18 to qualify. Older immigrants often have short employment and residence histories in Canada, meaning that they may have minimal access to the Canadian public pension system (Kei et al. 2019; McDonald, Dergal, & Cleghorn, 2007). Another issue is that older immigrants who arrive from a country lacking a social security agreement with Canada are more likely to have a low income, because their period of contributions and residence in their country of origin cannot be added to their public pension benefits in Canada (Statistics Canada, 2016). Some scholars have linked the lower pension contributions of older immigrants to the increased likelihood of poverty, which, in turn, is linked to housing insecurity and the overrepresentation of older immigrants in Canada's homelessness population (McDonald, Dergal, & Cleghorn, 2007).

Unique Needs, Vulnerabilities, and Experiences

Government data reveal that increasing numbers of immigrants and other newcomers to Canada (e.g., refugees) are becoming homeless and ending up in shelters (Government of Canada, 2021). Research has confirmed that various demographic markers create unique challenges for marginalized populations when they live on the streets (Giannini, 2017). Therefore, it is important to understand the needs and vulnerabilities of older immigrants in the context of their overall experiences. These individuals have experienced a discontinuity in their life course as they leave behind the sociocultural contexts of their places of origin, which once provided them with meaningful support in difficult situations (Ciobanu, Fokkema, & Nedelcu, 2017). They may have unfavourable health conditions, have limited English/French language and technological literacy, limited family and social networks, and may experience family conflict, disability, cultural barriers, discrimination based on race, ethnicity, gender, sexuality, and/or religion, all of which add layers of complexities to the already vulnerable subpopulation of persons experiencing homelessness (Brotman, Ferrer, & Koehn, 2020; Ciobanu, Fokkema, & Nedelcu, 2017). For example, older adults including immigrants tend to experience difficulties navigating government services and may not receive the full extent of government assistance for which they qualify (Ploeg et al. 2008). Older immigrants must also navigate through communication challenges as they try to access social support resources and services including housing support and services for persons experiencing homeless (Hossen & Westhues, 2013; Kim et al. 2013; McDonald, Dergal, & Cleghorn, 2007).

The Government of Canada's (2021) demographic profile of older immigrants in Canada provides further insights into this issue: about 63 percent of older immigrants (65+) who arrived in Canada between 2012 and 2016 reported being unable to speak either of the two official languages, and older immigrant women were less likely than their male counterparts to speak either official language. This lack of fluency not only creates challenges in accessing services but also serves as a huge barrier to becoming aware of housing support programs and services. Stewart and colleagues (2011) also noted the connection between lack of competency/fluency in official languages and limited employment opportunities, also increasing the risk of low income and poverty.

Homelessness has also been attributed to declines in physical and/or mental health, and persons experiencing homelessness are more likely to have poor health outcomes (Bhui, Shanahan, & Harding, 2006; Kushel, 2020; Rota-Bartelink & Lipmann, 2007). The correlation between homelessness and poorer health levels is stronger among older people (Fajardo-Bullon et al. 2019; Garibaldi, Conde-Martel, & O'Toole, 2005; Kim et al. 2010; Seegert, 2016). Upon arrival in Canada, older immigrants tend to be healthier than their Canadian-born counterparts or older immigrants who have been in Canada for many years. However, over time the health of older immigrants tends to decline, especially among those from non-European countries, and their health can become worse than their Canadian-born counterparts (Gee, Kobayashi, & Prus, 2004; Setia et al. 2012). This phenomenon is known as the "healthy immigrant effect" and has been well documented in several immigrant-receiving countries (Ichou & Wallace, 2019). Older immigrant women are more vulnerable to poorer health compared to older immigrant men (Guruge, Birpreet, & Samuels-Dennis, 2015). People who experience poor physical or mental health tend to lose their ability to perform daily biological, psychological, or social activities and tasks that are normally expected of other individuals of the

same age, and are at greater risk of homelessness (Older Adult Council of Calgary, 2018). Together, older age and the poorer health outcomes of older immigrants have implications for their housing outcomes, putting them at a greater risk of homelessness.

Systemic Challenges and Barriers

Experiences of discrimination have also emerged as a major systemic challenge for vulnerable older immigrants (Stewart et al. 2011). When an older person's immigrant status intersects with other identities such as ethnicity, race, cultural background, gender, language competencies, and socioeconomic status, this creates additional layers of disadvantages with cumulative effects on experiences and perceptions of discrimination and marginalization (Pruegger & Tanasescu, 2007). Together, these can have implications for housing outcomes, especially over time. The experiences of discrimination and perceived discrimination are salient predictors of trust: individuals who experience discrimination or who feel they are being discriminated against are never sure when or where those experiences may occur again and therefore find it difficult to trust institutions, policies, services, and supports (Wilkes and Wu, 2019). However, it is not yet clear to what extent this situation prevents older immigrants from accessing the services and supports needed to mitigate challenges including housing challenges.

The limited welfare options for older immigrants present additional disadvantage related to their status in the country, lack of policy or insufficient policies specifically targeted at older immigrants, and the risk of being portrayed as a social problem (Dolberg, Sigurðardóttir, & Trummer, 2018). One review of Swedish studies on older immigrants who are "less privileged" found that policies related to older immigrants are framed with the assumption that older immigrants have "special needs" and that planners and providers must consider "the problems that they might pose" (Torres, 2006, 1341–42). Ciobanu, Fokkeman, and Nedelcy (2017) raised similar concerns, noting that researchers tend to consider older immigrants a "monolithic group" and to focus solely on age and experiences of migration – when in fact older immigrants are an "analytical category" with high levels of heterogeneity related to many various factors influencing aging and migration.

Other Factors

Numerous factors can influence the housing situations of older adults, but older immigrants can be considered victims of double jeopardy when it comes to housing insecurity and homelessness. For example, many older immigrants live in multigenerational households (Burholt & Dobbs, 2014; Ng & Northcott, 2015). This may suggest strong family connections and housing security, but it may also increase the risk of social isolation and emotional dependency (Government of Canada, 2021; Guruge et al. 2021). Many older immigrants are sponsored by their adult children, which can make them financially dependent on their children; they may have few housing options because they rely on their children to house them (Government of Canada, 2021; Preston et al. 2011). The dynamics related to sponsorship can create pressure and financial hardship for the sponsor and the older adult being sponsored, and can lead to family conflict. Previous research has confirmed that homelessness can be one outcome when financial and family problems become

insurmountable (Canadian Observatory on Homelessness, 2021; Government of Canada, 2021). Although multigenerational living is highly valued in some immigrant groups, its sustainability has been questioned, and it is sometimes even considered a form of hidden homelessness (Gubernskaya & Tang, 2017; Luhtanen, 2009; Ng & Northcott, 2015; Preston et al. 2011; Um & Lightman, 2017).

Conclusion

Effective responses to homelessness among older adults, including subpopulations of older immigrants, must be based on a clear understanding of their needs and the challenges they face. These usually involve a variety of micro-, meso-, and macro-level factors. For example, it is vital to be aware of experiences of marginalization across the life course, and particularly in later life. Every person's journey is unique, and older immigrants may face many risk factors that can negatively affect housing outcomes. The population of older immigrants in Canada is expected to rise, which is likely to be accompanied by more situations of housing insecurity or homelessness.

Few studies have explored the housing crisis facing this vulnerable subpopulation, so scholars have a limited knowledge base, making the development of effective policies and practices very precarious. This chapter has explored the intersections of older age, immigrant status, and homelessness with the goal of informing policy – and especially more targeted research to fill this important research gap. The research community has generally neglected the urgent need to document the current state of homelessness among older immigrants in Canada, and much more work is needed to prepare for future trends. Any research focusing on this vulnerable population should involve listening to the voices of those older immigrants who are at risk – those who are experiencing or have experienced housing insecurity or homelessness.

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SECTION 4: CAREGIVING

Chapter 9. Conceptualizing Person-Centred Care for Ethnocultural Minority Residents in Long-Term Care Homes: Adaptation of a Person-Centred Practice Framework

SHREEMOUNA GURUNG; ATIYA MAHMOOD; AND HABIB CHAUDHURY

Within long-term-care (LTC) settings, the needs and concerns of ethnocultural minority older adults are often ignored and unmet. Many of these individuals receive substandard care, reinforcing the common perception that life in LTC settings is lonely, boring, and helpless (Li & Porock, 2014, 1396). Person-centred care (PCC) has been widely recognized as a fundamental way to promote a more humanistic approach: policies, programs, and services incorporating elements of PCC can foster a better quality of care for older adults and create a more supportive LTC setting promoting autonomy, independence, and dignity (Rantz & Flesner, 2003).

PCC approaches to improve quality of life and resident experience can enable public, private, and non-profit sectors to deliver improved care and services for all residents of LTC settings, including ethnocultural minority older adults. For example, PCC centres the individual needs of older residents by shifting the focus of healthcare providers from task-oriented activities to person-oriented activities (McGilton et al. 2012; Rantz & Flesner, 2003). In theory, PCC enables LTC residents to live more meaningful lives with an improved quality of life and overall wellbeing (Brownie & Nancarrow, 2012). However, few studies have explored how the principles of PCC can be effectively translated into care practices that are appropriate for ethnocultural minority older adults.

The term "ethnocultural minority older adults'" refers to older individuals whose culture, ethnicity, race, and/or religion differ from those of mainstream Canadians (Statistics Canada, 2018b). It includes older individuals who immigrated to Canada in later life, as well as immigrants who may have arrived as children and have aged in Canada (Statistics Canada, 2018b). In 2016, older immigrants represented 31 percent of the total older adult population aged 65 and over in Canada, and racialized minorities made up 22 percent of Canada's population (Statistics Canada, 2019). Canada's immigration patterns have been changing, with a shift away from European immigrants to more immigrants from Africa, Asia, and Middle East, making Canada more ethnoculturally diverse (Statistics Canada, 2018a). The heterogenous nature of their experiences, based on the intersection of gender, race, class, and other social identities, shape their health and wellbeing, as well as their aging and care expectations.

Research suggests that changes in cultural values, combined with work and life demands, make it challenging for the family members of ethnocultural minority older adults to take on the role of primary caregiver (Chappell, 2003; Lee & Mjelde-Mossey, 2004; Ujimoto, 1995). As a result, many ethnocultural

minority older adults must depend on LTC services. More research efforts are now focusing on the experiences of ethnocultural minority older adults in LTC homes as they relate to cultural changes, as well as the provision of innovative types of housing and care, but very few studies have focuses on PCC as it related to minority older adults living in LTC settings.

The COVID-19 pandemic has brought concerns about quality of care in LTC settings to the forefront. More research is needed, especially given the increasing populations of ethnocultural minority older adults in LTC settings. Specifically, a careful examination is needed to assess the relevance and application of PCC approaches in LTC settings, and how PCC approaches can be effectively incorporated into practice, policy, and programs. This chapter presents a conceptual PCC framework that can provide a comprehensive perspective. It draws from McCormack and McCance's (2017) person-centred practice framework (PCPF), complemented with elements from intersectionality, life course theory, and integrative model of place. The guiding research question is: How can PCC models be adopted and implemented to meet the needs of ethnocultural minority residents in LTC settings?

Person-centred Care

The core concepts of PCC are personhood and person-centredness. Kitwood defined personhood as "a status that is bestowed upon one human being by others, in the context of relationship and social being. It implies recognition, respect and trust" (1997, 8). Personhood represents the inner feeling individuals have that guides them as persons; each individual has a unique inner perspective that shapes their being in the world (Leibing, 2008). Sabat (2002) argued that personhood is linked to three different understandings of "the self": Self 1 involves personal identity and is autobiographical in nature, focusing on how individuals relate to their being in the world; Self 2 involves the physical and mental characteristics of individuals (height, weight, beliefs, religion); and Self 3 involves the various social identity that individuals form in different circumstances.

McCormack and McCance (2017) suggested that person-centredness includes four central means of being: being in relation, being in a social world, being in place, and being with self. Being in relation involves significant relationships and interpersonal practices that have healing benefits. Being in social context aligns with Merleau-Ponty's (1989) theory of how individuals are interconnected with their social world, continuously reconstructing meaning through being in the world. Being in place refers to the importance of built environment and its influences on care experiences: places are strongly linked with each individual's memories, emotions, and histories. Being with self emphasizes the need for individuals to be self-aware: they must recognize their own values and beliefs in order to engage in authentic relationships that stimulate person-centred practices. Research about person-centredness and its elements is constantly evolving (McCormack & McCance, 2017), so procedures and processes intended to foster quality of life in LTC settings necessitate continuous monitoring, re-evaluation, and revision.

Person-centred Practice Framework

McCormack and McCance's (2017) developed their PCPF based on empirical research in a nursing context; it serves as a practical guide to foster PCC in healthcare settings. Its philosophical underpinning is rooted in the human sciences, and it consists of four main interrelated domains: prerequisites, care environment, care processes, and person-centred outcomes. Successful person-centred outcomes require first addressing prerequisites, followed by the care environment, and then by person-centred processes. This framework also recognizes influences occurring at the macro level.

The first domain, prerequisites, involves ensuring that healthcare providers can deliver effective PCC. For example, healthcare providers must be professionally competent, have interpersonal skills, be self-aware of their own beliefs and values, and be committed to their job. All of these attributes are important and indicative of a PCC provider who can successfully handle the challenges of a frequently changing environment. The second domain, the care environment, refers to the context in which care is being delivered: the facilitation of PCC is contingent on the care environment regardless of the healthcare provider attributes stated in the prerequisites. The provision of care is closely linked with the third domain, person-centred processes, which involve a series of activities that operationalize person-centred practice. Activities may include working with the individual's beliefs and values, sharing decision-making, engaging authentically, being sympathetically present, and providing holistic care.

Person-centred processes lead to the fourth domain, person-centred outcomes. Successful person-centred outcomes include good care experience, involvement in care, feeling of wellbeing, and a healthy environment and culture within the healthcare setting. Good care experience entails both objective evaluations of the care provided and the subjective views of the care received. Involvement in care speaks to the decision-making process where individuals are active contributors in planning and monitoring their own care. Feelings of wellbeing entail both the care recipient and the care providers feeling valued. Finally, a healthy environment supports collaboration among staff members, pioneering practices, shared decision-making, and transformative leadership. These PCC outcomes are about more than just accomplishing the goals and tasks related to the individual's medical needs: they promote collaborative care, shared decision-making, and an individualized approach to care.

Strengths and Limitations of the Person-centred Care Framework

McCormack and McCance's (2017) PCPF expands on their earlier theoretical model and functions as a guide to cultivate practical knowledge about person-centred approach, transforming PCC from philosophy to practice. As a theoretical framework, it offers a clear description of PCC's core concepts and their synergistic relationship, which informs research and contributes to further theory development. Person-centred outcomes detailed in this framework are informed by evidence and provide direct targets for evaluating PCC approach by including the perspectives of care professionals, individuals receiving care, and their family members. This framework also recognizes the significance of the care environment and other contextual components (e.g., attitudes and moral beliefs of involved parties), which are fundamental in implementing and fostering PCC.

However, while the PCPF stresses the importance of considering each individual's beliefs and values, the care environment, and other contextual components, the complexity of person-centred practice, and the implications of attributes among care professionals (McCormack & McCance, 2017; Santana et al. 2017), it does not explicitly include the perspectives of diverse individuals and communities such as ethnocultural minority older adults in LTC settings. Personal attributes extend beyond values, beliefs, and personality, and a broader perspective is needed to include the influences of characteristics such as age, gender, ethnicity, and culture, all of which affect person-centred processes and outcomes. Life history and experiences also shape how both healthcare professionals and residents foster connections and engagements that facilitate PCC. Moreover, the PCPF stresses the role of staff (e.g., nurses) in the implementation of person-centred practice, which can understate the mutually inclusive relationship between care professionals and residents that is imperative for achieving person-centred outcomes. The next section explores how to address these gaps and conceptualize PCC for ethnocultural minority residents in LTC settings, by incorporating complementary theories and concepts such as intersectionality, the life course, and the integrative model of place.

Complementary Theories and Concepts: Intersectionality, the Life Course, and the Integrative Model of Place

Many scholars have drawn from intersectionality to highlight the important relationships between multiple social positions, e.g., race, gender, age, ethnicity, religion, and class (Crenshaw, 2009). The concept of intersectionality stems from post-structuralist feminist debate, feminist critical movements, and political movements (e.g., Black feminisms). Post-colonial, Latina, queer, and Indigenous scholars have contributed to scholarly discussions on the multi-dimensional processes that influence human lives (Bunjun, 2010; Collins, 1990; Hankivsky, 2014; Van Herk et al. 2011). The nature of intersectionality remains open for discussion among scholars: it has been interpreted as a theory, a methodological approach, and a practice (Hankivsky, 2014), but these are not mutually exclusive.

McCall (2005) identified three approaches to address the complexity of intersectional analysis: anti-categorical (rejecting categories and advocating for inclusion and exclusion mechanisms); intra-categorical (examining intersecting categories to identify the social location of a disadvantaged group); and inter-categorical (supporting the strategic use of analytical categories). Other scholars have stressed the importance of considering the collective influence of many social locations, because oppression and inequities are not the outcomes of single isolated elements, but rather result from the intersections of social positions, power relations, and experiences (Crenshaw, 2009; Hankivsky et al. 2015). Intersectionality can complement the PCPF by capturing and exploring multiple identity markers – of ethnocultural minority older adults and healthcare providers – and thus facilitating a person-centred approach.

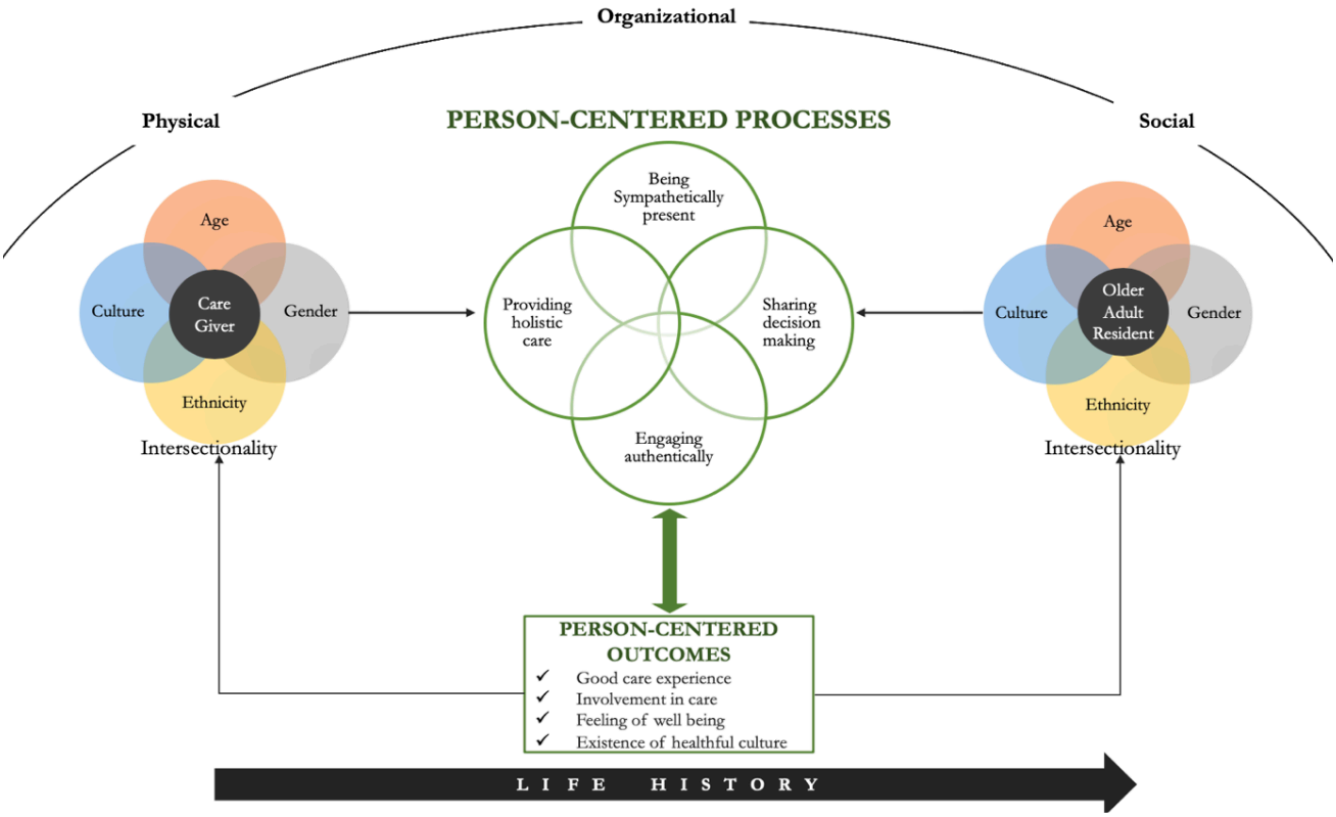
The concept of the life course, or life history, originates from Elder's (2000) work on the diverse dimensions that influence an individual's life from birth to death. It integrates cultural, social, and historical factors and highlights four paradigmatic principles that play a critical role in shaping the life course of each individual: lives in time and place, timing of lives, linked lives, and human agency in choice making and actions. It can be

used as a method to collect data, specifically a chronology of events and activities. Life history can provide valuable information on LTC residents; for example, information about birth, marriage, education, work, family, and retirement can be gathered through archival documents or interviews involving a life calendar or age-event matrix.

The integrative model of place draws from work by Weisman, Chaudhury, and Moore (2000). For example, the multifaceted and dynamic relationship between an older resident and a LTC setting is influenced by numerous contextual factors including organizational, sociological, architectural, and psychological systems.

A New Conceptual Framework: PCC for Ethnocultural Minority Older Adults in LTC Homes

Figure 9.1 presents a novel framework to help conceptualize the implementation of PCC to best serve the needs of ethnocultural minority residents in LTC settings. It draws from McCormack and McCance's (2017) PCPF, complemented by the incorporation of concepts including intersectionality, the life course, and the integrative model of place. It acknowledges the multiple attributes and experiences of both residents (ethnocultural minority older adults) and caregivers (care aides and nurses) and elucidates a set of care processes that are necessary to ensure PCC and positive care outcomes. It is rooted in person-centred processes and outcomes, while incorporating Weisman, Chaudhury, and Moore's (2000) integrative model of place to acknowledge the contextual factors of LTC settings that affect overall PCC processes and outcomes.



The new framework offers a clear description of the activities that operationalize PCC, along with desired outcomes; it can be used to assess whether effective person-centred practices have been achieved. Activities related to person-centred processes include sharing decision-making, engaging authentically, being sympathetically present, and providing holistic care (McCormack & McCance, 2017). These activities interrelate with one another and can function simultaneously to foster person-centred outcomes including good care experience, involvement in care, feeling of wellbeing, and a healthy environment (McCormack & McCance, 2017). Bi-directional links between person-centred processes and outcomes represent the interrelationships between them.

Person-centred processes involve activities that require ongoing collaboration between care practitioners and older adults in LTC settings. The conceptual framework clearly identifies caregivers and residents to illustrate the interactions – and personal attributes – that can affect care processes and outcomes (McCormack & McCance, 2017). This focus on interactions aligns with the main tenets of relationship-centred care, which should involve engagement between a group of care professionals, the older resident, and those who are significant to the older resident (McCormack & McCance, 2017; Nolan et al. 2004). Partnerships are at the core of person-centred processes, and person-centred outcomes can in turn influence and inform caregivers, residents, and broader PCC processes.

McCormack and McCance's (2017) framework includes working with each individual's beliefs and values as one of many processes. In contrast, our framework centres this as a guiding principle that overlaps with all of the activities happening in the care processes, ultimately affecting person-centred outcomes. In addition to centring the beliefs and values of individuals, our conceptual framework incorporates the attributes of both caregivers and residents. By drawing from elements of intersectionality, care providers can start to understand the multiple social positions of an ethnocultural minority resident (age, gender, ethnicity, and culture) and how these affect their values and beliefs. Caregivers can learn to utilize strategies that allow differences between and within groups, and do not diminish individuals to a single category (Crenshaw, 2009; Torres, 2015). This can help prevent 'othering' and generalizing individuals who share similar identity markers.

Another important component of our framework is life history, which complements the intersectionality lens because it helps healthcare providers understand how life experiences over time (e.g., pre-, during, and post-migration) affects identity, interests, and what is important to each individual (Elder, 2000; Ferrer et al. 2017). For example, the values and beliefs of an older Southeast Asian adult who immigrated to Canada in the later stages of life will likely be different from an older Southeast Asian adult who arrived in Canada as a child and grew older in Canada: these individuals share the same ethnicity but may require very different care approaches. This example helps demonstrate the interplay among life history and social identity markers such as age, gender, culture, and ethnicity, and how cultural values, beliefs, and lifestyle are unique to each individual. An intersectional and life course approach acknowledges the interactions between various identity markers and life events and can be utilized to customize and sensitize care practices in LTC homes. It is also important to recognize the various identity markers of healthcare providers, because their values and beliefs strongly affect their ability to facilitate PCC (McCormack & McCance, 2017). It is also important to note that while our conceptual framework specifies identity markers such as age, gender, culture, and

ethnicity, other identity markers may apply to ethnocultural minority residents and healthcare providers and should be incorporated as necessary, e.g., religion, disability, race, nationality, and sexual orientation.

Finally, our conceptual framework illustrates how social, organizational, and physical factors can affect healthcare providers and residents, as well as overall PCC processes and outcomes. The theoretical framework developed by Weisman and colleagues (2000) serves as useful guide to illustrate how the quality of care practices and quality of life among LTC residents are influenced by contextual environmental factors. Social factors refer to the overall social setting: how residents, various staff groups, and other involved parties interact and affect the care practices and social relations within in the LTC setting. Organizational factors refer to internal and external components and influences that shape processes and practices within the LTC setting: internal factors might include the values, culture, and policies at the LTc, and external factors might include funding, staffing models, and regional policies/regulations. Physical environmental factors are defined by the geographic area of the care home and its built environmental features. The interplay of organizational, social, and physical environmental factors affect how person-centred practices are facilitated in LTC settings for all residents, including ethnocultural minority residents.

Conclusion

Our novel conceptual framework offers new insights into how PCC processes are influenced by various attributes and experiences of diverse individuals, healthcare providers, and communities. We drew from McCormack and McCance's (2017) PCPF and incorporated elements from intersectionality, the life course, and the integrative model of place to develop a helpful theoretical model for exploring how practices related to PCC can contribute to the overall wellbeing of the ethnocultural minority aging population. Limited research has focused on the implications of PCC for ethnocultural minority older adults, and this framework provides a starting point to conceptualize the person-centred approach in ways that can meet the unique needs of ethnocultural older adults in LTC settings. In addition to contributing to theory, this framework will extend opportunities to develop a research agenda to identify, implement, and facilitate person-centred processes for ethno-specific older adults in LTC homes.

Our new framework was designed for the LTC context, but it can be modified to accommodate other healthcare settings. It is not intended to be a one-size-fits-all approach, as the dimensions and context of care will vary. More empirical research will be necessary to validate, adapt, and refine our framework to serve the evolving nature of theory and practice related to person-centred care.

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Chapter 10. Chinese Family Members Caring for Older Adults in Private, Senior, and Long-Term Care Homes: A Mismatch of Needs and Culturally Appropriate Services

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Globally, in developed countries, the proportion of people living longer is growing, requiring families to be caregivers for older adults in private homes. This trend contributes to a decline in hospital deaths (Bone et al. 2018), and a cost-saving potential (Martens et al. 2018) of approximately $221 and $642 billion in the USA annually, which would otherwise be spent on formal care and/or institutionalization (Cohen et al, 2019). "Aging in place" refers to "the option where people can stay in their homes as they age" (Vanleerberghe et al. 2017, p. 2899), with some level of independence (Chum et al. 2020); as long as they receive "support to remain" (Martens et al. 2018, p. 5) in their private homes, though the concept of home lacks specific boundaries (same or different households), except those defined by the families' themselves (Martens et al. 2018).

Aging in place holds many assumptions about access to support, which has yet to be addressed. Older adults are assumed to be enabled to access health and social services that allow them to die well at home (Bone et al. 2018), with estimates of up to 85% preferring to "age in place" (Lantz & Fenn, 2017, cited by Chum, 2020). Further, in theory, the "process of deinstitutionalizing care increases the sustainability of care systems and enhances the users' quality of life" (Vanleerberghe, 2017, p. 2899). Yet, housing-specific characteristics (i.e., spatial capital) and ones' neighborhood infrastructure (e.g., transportation, proximity of health and social services) appear to pose barriers, rather than create paths to ensure older adults' quality of lives (Chum et al. 2020).

Indeed, according to Chum and colleagues (2020), the environment may not be conducive to older adults' declining health status and as a consequence, contribute to increasing social isolation. Paradoxically, healthier peers may stigmatize and intentionally exclude those older adults that do not have ability to engage in the greater community (Chum et al. 2020). Alternatively, residents, who are more autonomous and independent to access select services or activities may benefit from continuous control and development of their self-fulfillment; all of which is assumed to be supported (financially or otherwise) by families (Chum et al. 2020). Moreover, preferences of older adults of location of care, including their desire and degree of family involvement varies by socio-economic and cultural demographics (Kasper et al. 2019).

In light of our recent COVID-19 pandemic in Canada, results of a National Institute of Ageing/ Telus Health National Survey (2021) reported that "91% of Canadians of all ages, and almost all those age 65 years and

older plan on supporting themselves to live safely and independently in their own home as long as possible" (p. 3). The assumption is that family caregivers will be primary partners in caring for older adults at home, or else hire help to do so, until this is no longer possible. In this regard, few studies report on the extent of involvement of family caregivers, or how this influences older adults' quality of life, as it relates to aging in place (Vanleerberghe, 2017). Further, a literature review by Martens and colleagues (2018) stated that aging in place policies entail joint individuals and families, and public responsibility for caregiving, including housing. This raises questions about the agency of family caregivers, particularly the racialized immigrants who experience barriers to access to health and social services (Lai & Surood, 2008; Xiao et al. 2013; Yiu et al. 2020).

A brief review of literature on immigrant family caregiving of older adults

Family caregivers, also known as informal caregivers or care partners of older adults are defined as any family or self-identified significant other who provide unpaid care to an older adult (65 years of age or older), with chronic conditions, and/or disabilities (Cohen et al. 2019). In relation to the older care recipient, family caregivers may influence their access to formal care. On the one hand, studies have shown that families involved in older adults' care improve outcomes for individuals with dementia and schizophrenia (Flaherty & Bartels, 2019); but on the other hand, informal care may lessen older adults' access to formal care and support in the community (Huxhold et al. 2014).

In other words, family caregivers can both help or hinder older adults' wellbeing, depending on the family caregivers' individual agency; that is, their capability to exercise control over their own or others' actions (Bandura, 1999). Key factors of a caregiver's agency include who they are (e.g., family or friend), and the quality of their relationship that enable them to enact their role (Huxhold et al. 2014). Further, caregiving varies by ethnocultural backgrounds and socioeconomic status, both between individuals within a demographic group, and between groups, which has important implications for research into caregivers and related caregiver health and quality of life (Cohen et al. 2019).

To understand how family caregivers perceive the choices they have, in response to public policy of aging in place, we propose that intersectionality can help explain dimensions of caregivers' agency across their environment (Cohen et al. 2019). According to Manuel (2007, p. 174-175), intersectionality is a key concept that "suggests our lives and the choices we make are best understood as a consequence of our social location" in reference to "the intersections of race [or ethnicity], gender, class, and other forms of identity and distinction." These intersections of social markers of identity and difference do not function independently but, rather, "act in tandem as interlocking or intersectional phenomena" (p. 175) to shape individual agency.

For family caregivers who identify as ethnic minorities, social locations are distinguished by culture-specific expectations and social norms (Cohen et al. 2019). For example, a study of Mexican informal caregivers in the USA demonstrated that the complexity of language and culture including attitudes, beliefs, and motivations that were unique to certain subpopulations of Hispanic/Latino caregivers (Cohen et al. 2019). Other important intersections include gender disparities in the distribution and caregiving intensity: more

often women are assigned to the role, and spend more time in caregiving, and report greater levels of caregiver burden and depression, as well as poorer physical health than men in caregiving roles (Cohen et al. 2019).

In the next section, we will describe the socio-ecological model of health to guide "mapping" one's social location to aging in different places/locations.

The socio-ecological model of health to map social locations of aging in place

Figure 10.1 Socio-ecological model of older adults' health in age-friendly cities

The socio-ecological model, originating from Bronfenbrenner in 1989, aims to identify and explain major dimensions of individual psychosocial burden across intersections with the environment, whether older adults (Leung et al. 2021) or caregivers of children with disabilities (Vadivelan et al. 2020). The socio-ecological model of health assumes interactive influences across individual, social, and physical-environmental levels, which shape choices and responses to healthcare policy (Van Hoof et al. 2018). For this chapter, we interpreted and applied Van Hoof and colleagues' (2018) criteria for "age-friendly cities" to the socio-ecological model of health to 'map' how each level intersects and potentially determines the older adults' capacity to age in place. (See Figure 10.1).

We used the socioecological model to analyze how the different locations of care (i.e., family caregivers and older adults living in the same or separate households, older adults living in older adults (assisted living) homes, and in long-term care facilities) and how location of care influenced caregivers' access to services in each environment.

Chinese family caregiving in the Greater Toronto Area, Canada: An exemplar study of the mismatch of needs and community services

In the USA and Canada, there exists diverse heterogeneity in patterns of ethnic minority caregiving (Lai & Surood, 2008; Miyawaki, 2016) that reflect underlying differences in ethnocultural values, beliefs, and attitudes, as well as in generational acculturation to their (host) country. However, regardless of generation, in the USA, compared to non-ethnic counterparts, East Asian and Hispanic caregivers appear to access respite care the least, spend the most caregiving hours per week, and report the longest caregiving duration; demonstrating commitments to respect socio-historical cultural attitudes, regardless of level of acculturation (Miyawaki, 2016).

Chinese socio-historical cultural attitudes towards the care of older adults are largely shaped by Confucian philosophy, and refer to the practice of filial piety (Liu et al. 2021; Miyawaki, 2016). Filial piety is defined as the notion of respect and care for older adult family members and to uphold beliefs of family reciprocity (Miyawaki, 2016). Caregiving for aging parents is a social obligation, and the most common caregiving relationship in Chinese families is that of the parent/parent-in-law and adult child (Miyawaki, 2016). Chinese caregivers tend to use more informal than formal support due to cultural beliefs and/or taboos to use outside formal services (Miyawaki, 2016). In part, this may be because of a tendency to nurture social connections in extended families as alternative caregivers among Chinese (84% to 93%), as compared to their White counterparts (80% to 82%) (Miyawaki, 2016). Additionally, many Chinese family care partners tend to use passive coping strategies, such as forgiveness, tolerance, or contentment, rather than seeking social support and help, to maintain family harmony (Liu et al. 2021). These socio-cultural dispositions are even more pronounced when language barriers (Miyawaki, 2016).

In the U.S., non-Asian majority in general perceive Asian immigrants as "model minority" (Zhou, 2014). This can shape how Asians themselves perceive behaving as citizens, and their choices of and use of health and social services (Liu et al. 2021). For Chinese family care partners these predispositions may create a sense of burden as well as a barrier to meeting filial expectations of aging-parent care (Liu et al. 2021). Whilst

caregivers may be open to the idea of using formal caregiver services as an alternative way of fulfilling filial piety; the cultural expectation of filial responsibility may supersede and hinder involving others in caregiving (Miyawaki, 2016). For example, in the U.S., strong patterns to upholding filial piety appears to hold true for Chinese immigrants, regardless of historical acculturation or the number of Chinese community services (i.e., churches, senior service agencies, and in-home caregiving services and care homes) (Miyawaki, 2020). Little is known about this topic in Canada.

Research question

How does the social location of Chinese family care partners of older adults shape caregivers' access to community-based health and social services in the Greater Toronto Area?

Study Setting

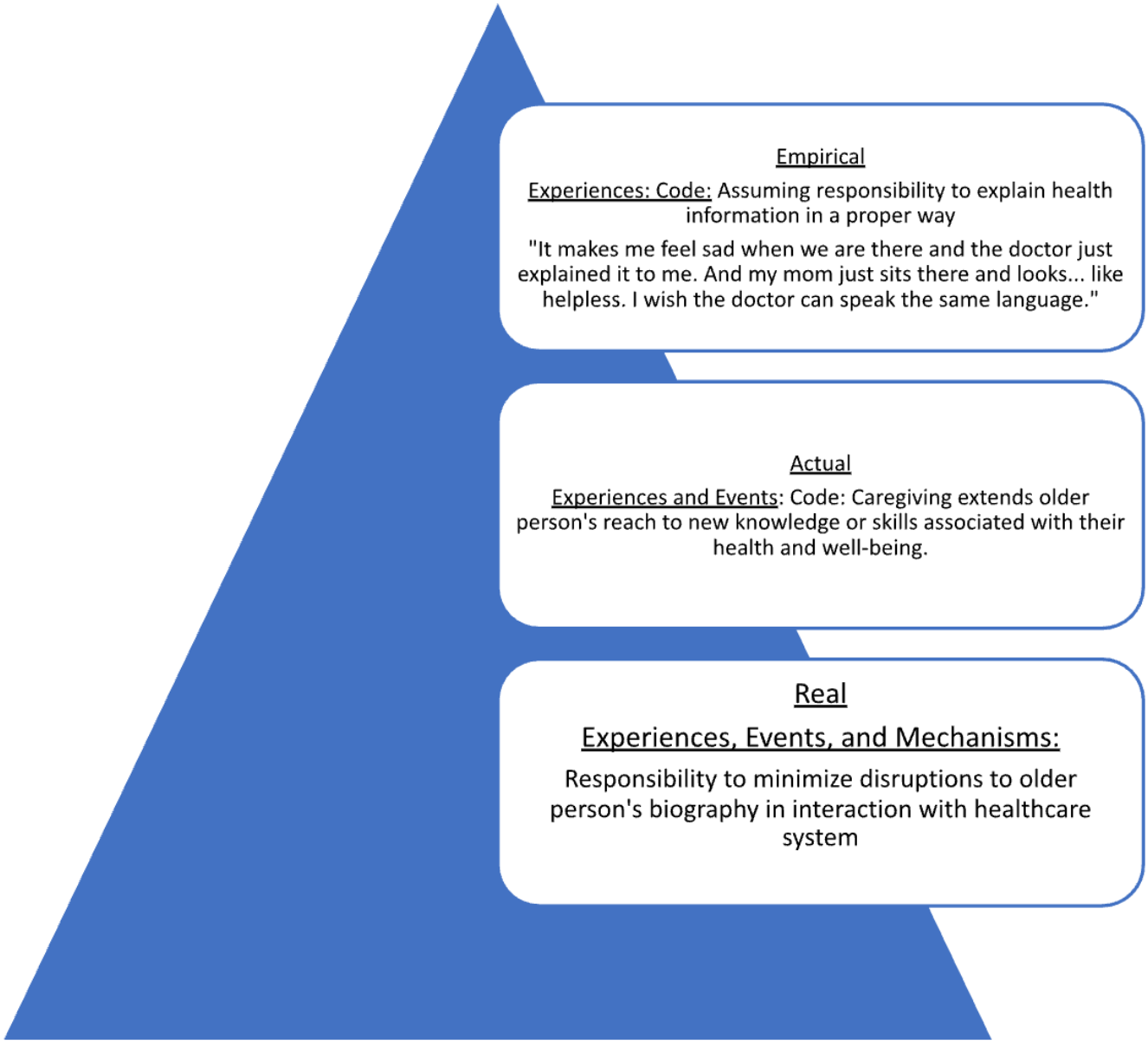
The study took place in the Greater Toronto Area, Canada, with a population of about 6.8 million in 5,903 sq km (PopulationU.com, 2021), which has the most diverse and highest proportion of racialized individuals (63%) in Canada (Yee Hong Centre for Geriatric Care, 2013). In 2021, there were 700,705 people of Chinese descent in Toronto, Canada (PopulationU.com, 2021), of which 10.5%, in 2011, identified as age 65 and over and 97% were immigrants (Zhang, 2019).

Older adults in Toronto are not a homogenous group, yet they are among the most vulnerable groups, as 50% have low incomes ($10K to $30K per year) and those who are racilized have much lower median incomes, than their non-minority counterparts (Toronto City Hall, 2016). Of older adults, who are racialized, nearly 15% do not speak English, and 29% do not use the internet everyday (Toronto City Hall, 2016). Additionally, consultations with older adults reflect difficulty accessing the city's more than 40 senior services (City of Toronto, 2018), as many older immigrants are excluded from social programs due to a 10-year waiting period for program eligibility (Yee Hong Centre for Geriatric Care, 2013). Altogether, these characteristics suggest the potential for Chinese immigrant older adults to be vulnerable to poverty and isolation (Toronto City Hall, 2016).

Methods

This qualitative study was informed by critical realism that was developed by Roy Bhaskar, a British Philosopher in 1975 (Elder-Vass, 2010). According to Elder-Vass (2010), critical realism consists of three layers, in the shape of a pyramid: The top layer, the "empirical" consists of evidence of what we tell each other happened. The middle is the "actual" and consists of evidence of what is tangible, regardless of whether we are aware of it. The bottom and largest layer is the "real" and consists of "mechanisms" and (social) "structures" that are not measurable but may generate events or experiences to occur (or not occur) for individuals (Elder-Vass, 2010). Please see examples in Figure 10.2.

Figure 10.2 Philosophical underpinnings of critical realism



One's agency is exercised through mechanisms (e.g., a sense of responsibility), made up of factors, such as one's insights, disposition, habitual routines, and expectations. These mechanisms shape the production and reproduction of social structures (e.g., stigma) (Elder-Vass, 2010). Social structures are created through interactions within and between social groups that influence the occurrence or non-occurrence of events or experiences (Elder-Vass, 2010). Mechanisms and structures can be internalized, and thus exert pressure on individuals (e.g., peer pressure), in turn, generating some individuals to endure in certain contexts or under certain conditions (Elder-Vass, 2010).

Participant Recruitment and Sampling

Participants were recruited in-person, through email, and snowball strategies from communities with large Chinese memberships. Inclusion criteria were: Individuals who self-identify as Chinese, 18 years or older, and consider themselves as primary caregivers (care partners) to a Chinese older adult (65 years of age or older). Altogether, 31 people were approached, three declined due to expressed discomfort with being recorded, and no participants withdrew, yielding a total of 28 participants.

Ethical considerations

Prior to study commencement, research Ethics Boards of the participating universities and community organizations provided approval for the study. Each participant provided verbal or written consent. Redaction of identifiable information (such as, names and places) occurred during transcription of the audio-recorded interviews, prior to data analysis. All electronic data were password protected on researchers' computers and in cloud storage. Potential participants were assured that their (non)participation would not affect in any way the services they received or would receive. In all dissemination activities, participants are only identified by assigned numbers.

Data collection

Participants were interviewed by one of the research team members. Interviews lasted between 45 mins to 1.5 hours, and began with collecting participants' socio-demographic data, followed by eliciting their' storied experiences. The latter was guided by semi-structured questions, which were pilot tested with the first three participants. Analysis of the pilot interview data led to one revision: adding a question about meanings given to the responsibility of caregiving.

Participants chose a language of their preference for interviews: English, Cantonese or Mandarin (the latter two are common Chinese dialects). Given public health restrictions due to COVID-19, all interviews were conducted via the Zoom internet platform or by phone in their homes. Interviews were audio-recorded or in one case, content was manually written verbatim by two research assistants, for transcription. In all but three cases, a second research assistant assisted with writing field notes. In two interviews, the older adult care recipient was present. No repeat interviews were conducted. Prior to analysis, Chinese interviews were translated to English through verification by two researchers fluent in the dialect and English.

Data analysis and interpretation

The researchers analysed data in four steps (comprehension, synthesis, theorization, and reconceptualization) to immerse themselves in the data and to facilitate data interpretation informed by Elder-Vass' (2010) version of critical realism. In the first step, two researchers engaged in open coding of the first 10 interviews independently. This open coding corresponds to the empirical level of critical realism, used to answer the research question. NVivo12 software facilitated organization and management

of data (QSR International Pty Ltd, 2018). They then met to discuss and reach consensus on the code names, producing an initial code list. (Second step). Discussion of codes also generated theoretical memos about possible inferences of patterns for synthesis and theorization; all confirmed by future reference to data. In the third step, the second author led theorization and reconceptualization, through visual mapping of codes and subcategories, strategically laid out to answer the research question. Abstraction of patterns for theorization required working through inferential reasoning to explain patterns (Elder-Vass' (2010) empirical level). These patterns were used to make deductive inferences that were then explored by the research team, to understand how events and experienced were actualized (the actual level). Last, the research team identified how events and experiences interacted to produce epistemic patterns of mechanisms and structures (the real level). This process continued until all interviews were analyzed and preliminary findings were confirmed by discussion to reach consensus by the research team.

Trustworthiness

We engaged in the following steps to ensure trustworthiness (credibility, plausibility, transferability and authenticity) of the work (Elo et al. 2014). To ensure credibility, prolonged engagement of participants in interviews (minimum 45 minutes) and taking reflective field notes were used. Further, theoretical saturation of patterns appeared after the 25th interview, whereby no new codes were found in analysis of three additional interviews. To ensure plausibility, the research team achieved consensus about the coding scheme. Further, the plausibility of preliminary results was confirmed by research team members who had expertise in the subject matter. To ensure transferability and utility, we balanced description of the findings with raw-data examples in this book chapter. To ensure authenticity, we followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) for transparency and comprehensiveness in research reporting (Tong et al. 2007).

Results

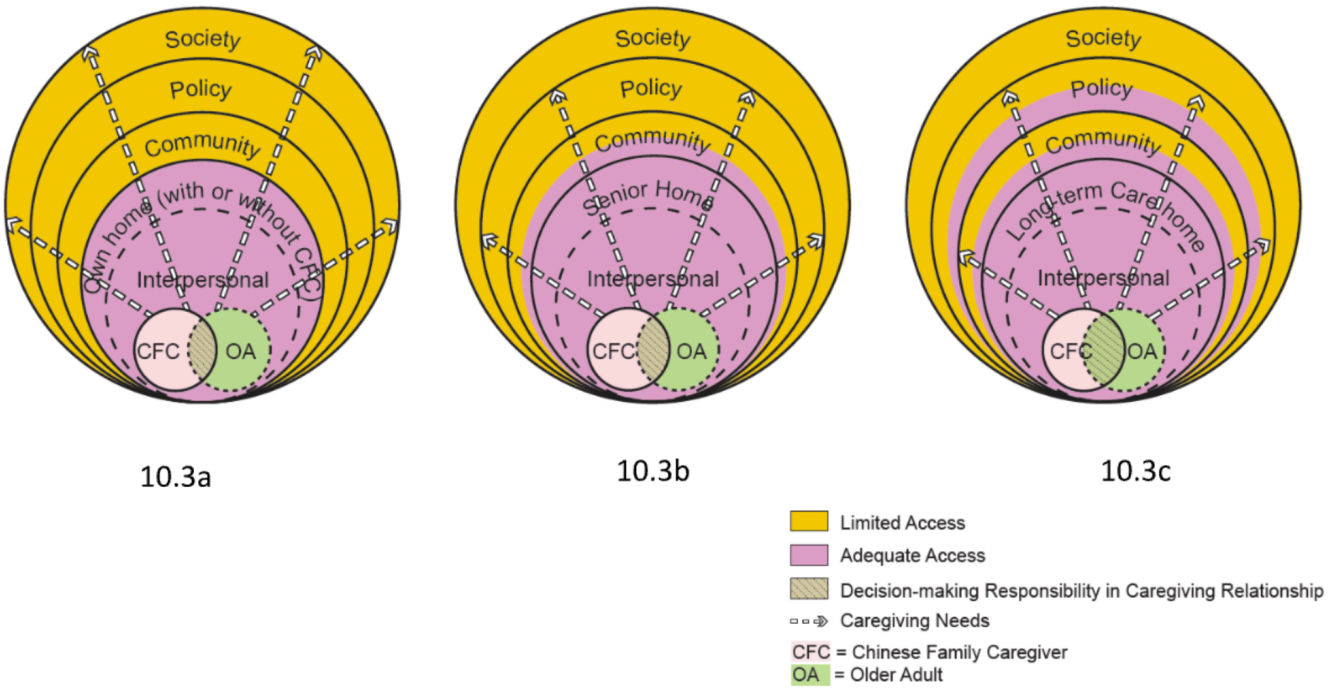
Twenty-eight (28) Chinese family care partners participated, 61% of whom were female, 57% of whom were 55 to 75 years old, and 39% of whom were 18 to 54 years old. Most 75% reported having university level education, and 68% were children of older adults, while 18% were partners. A bit more than half (57%) of Chinese family care partners lived in separate households from their older care recipients, whereas 43% lived in the same household. All reported to be Canadian citizens; 50% lived in Canada for more than 30 years, and 97% were immigrants to Canada. (See Table 10.1 for detailed characteristics.)

Table 10.1 Socio-demographic data of the Chinese family care partners		
	Caregivers (N=28)	
	Frequency (n)	**Percentage %**
Age		
18 to 54 years old	11	39
55 to 75 years old	16	57
Prefer not to say	1	4
Self-Identified Center		
Female	17	61
Male	11	39
Citizenship Status		
Canadian citizen	28	100
Permanent resident	0	0
Relationship with Older Adult		
Spouse/Partner	5	18
Child	19	68
Grandchild	2	7
In-laws	2	7
Education		
High school	2	7
College	5	18
University	21	75
Living with Older Adult		
Yes	12	43
No	16	57

The main theme we found was a cultural mismatch between available resources and the perceived needs of Chinese family care partners and their older care person's expectations. Chinese family care partners reported their needs to care for their aging recipients at all levels of the socio-ecological model of health (Figure 10.1). This mismatch was perceived most prominently among Chinese family care partners of older adults who resided in their own (private) homes, as compared to assisted-living or long-term-care facilities. We theorized that a mismatch of culturally appropriate services forced Chinese family care partners to tolerate increasing burdens as older adults transitioned from their own homes, to assisted-living facilities, to long-term care facilities. Figure 10.3 (below) presents the three-part model we developed, based on our interpretation of how agency and place intersect in Van Hoof and colleagues' (2018)'s socio-ecological model of older adults' health in age-friendly cities. To note, Chinese family care partners' narratives included

interpretations of what the care recipients/older adults desired or expected; hence, the Chinese family care partners and older adults were conceptualized as a dyad, with shared resources.

Figure 10.3. Socio-ecological model of health for the different locations of care by Chinese family care partners (CFCPs): 3a. Older adults' (OAs) or Chinese family care partners' homes, 3b. Assisted living facilities, and 3c. Long-term-care facilities.



Socio-ecological model of health for the different locations of older adults' care by Chinese family care partners

Figure 10.3a depicts Chinese family care partners and older adult /care recipient living in own home(s) in close physical proximity. In this location, Chinese family care partners expressed needs to access all levels of structure (white arrows). While Chinese family care partners reported having access to a few layers of support (shaded in pink), they (the Chinese family care partners and older adult) did not have access to many areas of community, policy, or societal resources (shaded in yellow). **Figure 10.3b** depicts the assisted-living facility location, where Chinese family care partners and older adult did not live in the same household nor necessarily close by. In this location, the Chinese family care partners expressed less need to access all layers of resources (white arrows) and reported access to more layers of resources (shaded in pink). **Figure 10.3c** depicts older adults in long-term care facilities, whereby the Chinese family care partners and older adults did not live in the same household, nor necessarily close by. In these locations, Chinese family care partners expressed needs to access in the lowest number of resource layers (white arrows), and they reported access to the most layers of resources (shaded in pink).

In all three figures, Chinese family care partners' access to health and social services for their care recipient depended on community access and policies that matched the shared capacity of Chinese family care partners' and older adult's financial circumstances, and the availability (or lack) of culturally acceptable care.

Next, we describe in detail the situation of Chinese family care partners in each of the three locations presented in Figure 10.3

Chinese family care partners caring for older adults in private households (Figure 10.3a)

Chinese family care partners who cared for older adults in the same or different private households (usually in close proximity) appeared to express the most challenges negotiating access to help (informal and formal), and feared disruptions in caregiving. For example, Participant 10 (60-year-old woman, caring for father living with her) talked about her ongoing worry not knowing or fearing about whether she can "handle" her father's needs, in part due to her own aging:

> At my age, sometimes I have the intentions but I don't have enough energy to accomplish them. It was like this. There are many times you may think that it is okay, but actually you can't handle it.

For herself and others, her worry was magnified after her father fell out of bed when he got up to use the bathroom:

> You know, when the elders get up and go to restroom at night, you need to know it… I worry about if he would fall down. That was torturing. You don't know how to deal with it. Then I asked my sister to come here. Then we took turns. We took turns to get up at night. You know, we don't know how to deal with such a situation.

Indeed, participants living separately from the relative they cared for perceived barriers to accessing instrumental support (from personal support workers) and government financial support due to institutional (nursing home or long-term care home) policies that limited when and how much support was available to them:

> Actually, morning is the worst time, I actually asked the Personal Support Worker (PSW) company manager if they can just come to mom's place from 7 to 8am, but unfortunately no one wants to come at that time especially in the wintertime. Their window is 2 hours. We can't wait for that long. (Participant 15, 60+ year old woman caring for mother in separate household)

> Anytime they [PSWs] can leave. But I just let it pass. We can't worry much about it. [I: Yes, yes, yes, with a laugh]. If I ask for one hour and half, they might stay longer. But if their boss doesn't allow it, then there's nothing we can do. (Participant 20, 72-year-old woman caring for her mother)

In a contrasting case, Participant 19 (63-year-old woman caring for mother in a long term care facility) reflected on her multiple past attempts to get formal home care with caring for her mother in her same household. She was met with resistance from home care administrators:

> In the beginning, there was no help. I had to keep telling them, "My mom won't shower, so what should I do?" They were very reluctant and eventually said 'There is nothing I can do, but maybe I can send a person to come once a week.' That's all.

Not only did the majority of Chinese family care partners report resistance from social structures of institutional policy (i.e., municipal) when they sought formal help, they felt that provincial policies concerning access to assisted-living facilities or long-term care facilities were overwhelming:

> If it's [assisted-living or long-term care facility] private, then you'll have to wait 8 or 10 years, and it still might not be available. (Participant 14, 78-year-old male, caring for spouse)

Indeed, this concern appeared validated by Participant 24 (62-year-old woman caring for parents) when she reported that access to an assisted-living facility for her parents appeared to happen by chance, rather than a systematic process of being placed on the local health system wait list:

> I was lucky that the social workers know my case, [and] know that I am a cancer survivor caring for two seniors that have very challenging problems. ...[so] my mom and dad can go into the nursing home.

In a contrasting case, one Chinese family care partners considered the financial cost of transferring her mother to an assisted-living or long-term care facility too high, and anticipated early retirement as the only option to take care of her mother:

> So, I financially. I think there's a big problem [in reference to transferring older adult to assisted-living facility] because I am not working. I need to retire early, forced to retire early because of caregiving... so I just ask for caregiver tax credit. But then, it's hard. (Participant 7, 39-year-old woman, caring for mother in separate household)

Chinese family care partners caring for Older Adults in assisted-living facilities (Figure 10.3b)

When older adults were located in assisted-living facilities, Chinese family care partners reported partial access to services in the community, but limited access to services and Chinese cultural practices (e.g., food or leisure) that can help Chinese family care partners meet cultural expectations to care for their aging parents. For example, Participant 26 (50-year-old male, caring for in-laws in their different private household) visited several assisted-living facilities only to find that, while there were some for Cantonese speakers, they did not serve Mandarin speakers:

> I saw some retirement homes is Cantonese, but I didn't see much for like Chinese local mainland [people].

In another example, Participant 25's mother with dementia lived in an assisted-living facility and though he expressed gratitude for the health and social services his mother received, he described gaps in needed services, due to provincial policy changes and funding cuts:

> My mom lives in a senior apartment taking care of by XXX Services. So, every morning the Personal support workers (PSWs) will come to serve her with prescribed medication, and then help her to dress… If there is any problems, my mom pushes the panic button and they (PSWs) come down immediately to check on her… I wish there was more cleaning services, and more day care services, as this was reduced for mom from 5 days to 2 days, due to funding. (71 year old male participant)

The majority of participants with older adults in assisted-living facilities continued to report a prominent concern for long wait times and barriers to accessing culturally-inclusive LONG-TERM CARE facilities in their communities. Participant 19 (63-year-old woman, caring for her mother) exemplified the barriers when she spoke of "few choices" prior to her mother being transferred after a three year wait:

> Like we had choices, I mean the Community Care Access Centre (CCAC), they gave us choices. Certainly, my mom had language barrier problems. So, because of that, there weren't that many choices, it was just a few like XX and XX, and others. There were a few that had mixed ethnicity people, but still there were quite a few Chinese people. However, in terms of food, they didn't serve Chinese food.

Chinese family care partners caring for older adults in long-term care facilities (Figure 10.3c)

When older adults were placed in a LONG-TERM CARE facility, community services, reflecting community and health system support were more accessible, as was transportation arranged when needed for various healthcare (e.g., medical care, rehabilitation). However, financial subsidies for day programs and adequate staffing were not deemed enough:

> Since the government provides them [LONG-TERM CARE facility] funding, why does it seem like they [the government] don't care, like the programs, fees, etc. It's as though it's not part of their responsibility. (Participant 19, 63-year-old woman, caring for her mother in a LONG-TERM CARE facility)

In all three locations of care, the agency of Chinese family care partners was shared and interdependent with the older care recipients as their trajectory of illness changed. As the older adults became more dependent on Chinese family care partners and less able to make decisions, the Chinese family care partners' time and

effort spent caregiving increased and their agency towards their own self-care and their immediate families lessened.

Discussion

In building our socio-ecological model of health, we found that Chinese family care partners who lived with, or were close to the older adults they cared for, reported pronounced difficulties accessing health and social services in the community. Of Chinese family care partners in the three locations (the other two having relatives living in assisted living or long-term care facilities), those in private households were the least supported by public policies and institutional practices (e.g., accessibility to Personal Support Workers). We theorize that a mismatch between Chinese family care partners' needs and a lack of culturally appropriate services forced Chinese family care partners s to tolerate increasing caregiving burdens as the older adults they cared for became increasingly dependent on them and their ability to meet their culture's caregiving expectations lessened.

Our study results reflect previous literature in Canada that suggests provincial governments need to bolster their budgets and change practices for older adults wanting to remain in place in their communities (Béland, & Marier, 2020); however, previous studies do not address continuing assumptions of family caregivers' agency to supervise and supplement care, and in doing so will prevent older persons from having to enter institutions (assisted living or long-term care facilities). Indeed, empirical evidence suggests variability in the agency of Chinese family care partners. For example, in a study of 13,781 elders in 22 provinces of China (Wang et al. 2023), those who were primarily cared for by sons and daughters-in-law tended to be institutionalized much later than those who were cared for by their spouses. Additionally, elders who relied on care by other relatives and friends, by domestic helpers, and those with no caregivers tended to be institutionalized much earlier than those who were cared for by their spouses (Wang et al. 2023).

Irrespective of whether Chinese family care partners live in China or are immigrants from China to Canada or descendants of Chinese immigrants, our study, and previous literature (Lin, 2019) supports a tendency for Chinese family care partners to view formal care, not as a substitute for family caregiving, but as a supplement. Having said that, while filial piety continues to be a key cultural expectation for Canadian descendants of Chinese immigrants, even in China this expectation is weakening, due to the inability of most young people to fulfill it in historical ways (Lin, 2019). Although China's healthcare system is based on patrilineal society with Confucian beliefs, filial piety is unsustainable with the growing population over 75 years old, rapid urbanization, and adult children s who tend to live far from their parents (Lin, 2019).

In a systematic review (Choy et al. 2021) of immigrant acculturation (i.e., process of adaptation to a new culture) primarily to a North American or European country, immigrants were significantly reporting more anxiety and depression, due to a combination of intrinsic and extrinsic stressors that increased a sense of marginalization (i.e., the rejection of both the new and their own cultures). A higher risk of depressive symptoms appeared to be a result of interactions that reduced the agency of individuals when they reported: a perceived cultural gap between themselves and their adult children, family dysfunction, poor family relationships, fewer number of children living in proximity, limited assistance from adult children, and

ineffective social support (Choy et al. 2021). Moreover, the level of acculturation was reported as a function of interactions, both intrinsic (e.g., lower levels of host language proficiency, female gender, low education) as well as extrinsic social factors of reported greater financial hardships, and less preservation of cultural traditions (Choy et al. 2021).

The differing spatial capital (i.e., type of housing, and its geographic proximity to health and social services), social networks, and cultural norms in Canada and the United States can alter whether Chinese older adults' desire and Chinese family care partners benefit from residing in the same households. A study in Shanghai, China reported that Chinese family care partners living apart from older adult relatives felt more depressed than those who co-resided (Miyawaki, 2020). In contrast among American Chinese family care partners, higher resilience was interpreted in narratives of female caregivers who lived apart from care recipients; the latter was in conjunction with lower caregiving demands, and availability of social support from families, friends, and community sources (Liu et al. 2021). The authors contend that, despite the strong value of family caregiving, American Chinese family care partners require more infrastructure to support them in accessing public health resources, and policies that broaden their choices (Liu et al. 2021).

Martens and colleagues (2018) assert that enabling older adults to age in place requires "partnerships between individual and public responsibility" (p. 8). Our study suggests that the most vulnerable Chinese family care partners are those whose older adult relatives live with them. According to literature, these are most often C Chinese family care partners PARTNERSs encountering a negative impact to their employment, in order to juggle commitments of caregiving, as well as married women with young children (Cohen et al. 2019). For example, Chinese family care partners in New York reported the most frequent challenge was physical and emotional exhaustion, followed by limited knowledge of the older adults' medical conditions, navigating the healthcare system, and limited time for self-care/development (Liu et al. 2021). Indeed, in Canada, one's agency to be healthy is heavily influenced by social determinants, such as employment, and housing; and while "health is not a federal responsibility, many of the socioeconomic determinants of health are heavily influenced by federal policy" (Drummond et al. 2020, p.5). So, while all Chinese family care partners expressed commitment to older adults' caregiving, more federal and provincial funding and resources are required to assist them to develop a sense of mastery and access to formal and informal support to achieve resilience in caregiving (Drummond et al. 2020; Liu et al. 2021).

Future Directions

Recommendations from this study suggest that in Canada, and elsewhere, such as the USA, aging in place requires a greater range of accessible continuing care services (Drummond et al. 2020) and a greater emphasis to build culturally-reflexive options, defined as putting culture in context (Aronowitz et al. 2015). This refers to creating culturally sensitive interactions with older adults, irrespective of their location of care, to enable accessing formal care that meets communication needs, formal daily assistance, senior daycare, caregiver respite, and various forms of supportive living as the older adults' needs evolve (Miyawaki, 2020). Moreover, in Canada, as in the USA, there is an urgent need to extend the agency of Chinese family care partners, through training inter-professional teams to accommodate culturally-specific assisted-living and LONG-TERM CARE facilities reflexive of characteristics of acculturation (e.g., limited English-language

proficiency), and to being enabled to preserve ones' cultural diet and lifestyles (Miyawaki, 2020). To begin this process, we support Backman, and colleagues' (2018) Canadian study that recommends more meaningful conversations during discharge planning of older adults from hospitals; advocating inter-professional teams assist with navigating the healthcare system to prevent systematic barriers in care transitions. To do this, we suggest cultural reflexivity that pays close attention to the structurally situated way that healthcare practices exert pressure on social interactions, and identify contradictions of culture, and external conditions that "enable, constrain, and transform local cultural arrangements" (Aronowitz et al. 2015, p. S405).

In our study, reducing barriers to care transitions from home to institutional care require partnerships between community inter-professional teams and informal caregivers (family, friends, and neighbors) to navigate barriers encountered in municipal and provincial policies. Choi and Park (2021) suggest that healthcare professionals, such as nurse-led-team collaboration, integrated into the community at all levels of the socio-ecological model could collaborate in multiple locations in one's community, and work across different levels, in contributing to policy, and with individuals in their homes. Further, this would necessarily include community health leaders, community care administrators, and local services providers (Flaherty & Bartels, 2019). Indeed, integrated care professionals might help agencies collaborate in providing community-based older adult care. This could enhance accountability of personal support workers (PSWs) to provide assistance, for follow-up specialists' appointments, for coordination of healthcare professionals' care, and for timely access to primary care (Backman et al. 2018).

Several studies also confirm the necessity to look beyond immediate family members for beneficial effects of non-kin networks (i.e., friends or peer networks) for maintaining older adults' happiness (Huxhold et al. 2014). For example, an effect of such non-kinship networks has been identified as beneficial particularly in the later stages of life. In a study of people aged 75 or older in Japan, close friend networks and neighborhood networks increased the life satisfaction of men and women, respectively (Watanabe, 2021). Hence, we contend that the dyad of Chinese family care partners' with their care recipients' have interpersonal agency to together "age well in place." Together, they are affected by both their local cultural communities and associated policies, along with the government leaders' inclusion of preferences that demonstrate equity for entitlements and choices beyond health to social determinants of health.

Strengths and Limitations

The study has strengths and limitations, which were methodological and contextual. While all participants were immigrants, they were Canadian citizens, and most had lived in Canada for more than 10 years, and were fluent in English. Thus, we were unable to theorize how acculturation and integration, within the diversity of the group, may have influenced their aging in place. Further, while our participants did reflect a group of older caregivers and adults being cared for (aged 75 years and older) in Canada (Canadian Institutes of Health Research, 2017), our results may not reflect the experiences of younger family caregivers, who are theorized to have less resources (e.g., financial, housing) to manage older adults' needs (Lai & Surood, 2008). Last, our results represent only Chinese family care partners perspectives, and not their care recipients,

though data clearly reflect an entanglement of the two, as dyads (Chinese family care partners and older adults).

Conclusion

We found that Chinese family care partners tolerate an increasing burden when culturally appropriate social structures are limited in their access to older adults (e.g., personal support, transportation, peer support, assisted-living and long-term care facilities) in their community. A shift in health care to integrated team-based care is emerging, with many institutions in North America creating more accessible services for older adults and their families where they live in the community (Drummond et al. 2020; Flaherty & Bartels, 2019). However, we assert that limited cultural sensitivity in health and social services generates barriers for Chinese family care partners to collaborate across intersections of the socioecological environment, due to lack of self-efficacy and support. Hence, we advocate for better interprofessional care, which extend Chinese family care partners' agency beyond their households to encompass federal social determinants of health, shaping provincial policy and funding, and society's attitudes to aging in place, whether in private homes, assisted living homes, or long-term care.

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Chapter 11. The Diversity of Views About Death and Dying among Immigrants and Their Families: Implications for Helping Professionals

HAI LUO

Death is the only certainty in life, but perceptions of death vary widely. Culture, religion, and society shape how individuals conceptualize death, with significant influences on the dying process. Views about death and dying can also vary within groups, and overgeneralization and assumptions among helping professionals about how individuals perceive death and their preferences about dying can hinder the wellbeing of those who are dying and their families.

The needs of dying persons and their families range from physical and mental comfort to spiritual wellbeing. Dying individuals may experience crises of meaning, and existential and spiritual wellbeing can be more important than physical and psychological wellbeing. Perceptions of death (and life) and decisions made during the processes of dying and bereavement are usually grounded in cultural beliefs and values, but helping professionals are often unaware of these. A national poll (Advance Care Planning Canada, 2019) revealed that most Canadians (80 percent) appreciate conversations with family and friends about end-of-life issues, but fewer than 20 percent have implemented an advance care plan.

Another issue is that although immigrants are now a significant proportion of the Canadian population, considerable gaps exists in the literature on access to and use of health care, palliative care, and end-of-life care services among immigrants (e.g., DeSpelder & Strickland, 2020; Gardner et al. 2018). Much more research is needed to explore views of death and dying among the Canadian population, including among the rapidly growing immigrant population.

Conceptions of Death

The process of death is more complicated than simple cessation of life. Traditionally, the absence of cardiac and respirational functions were viewed as indicators of death (Novak, Northcott, & Campbell, 2018). More recent Western medical definitions of death include at least eight criteria:

- absence of spontaneous response to any stimuli;
- completely unresponsive to even the most painful stimuli;
- lack of spontaneous respiration for at least one hour;
- absence of postural activity, swallowing, yawning, or vocalizing;
- no eye movements, blinking, or pupil responses;

- a flat electroencephalogram (EEG) for at least ten minutes;
- a total absence of motor reflexes; and
- these conditions do not change if tested again after twenty-four hours (Gire, 2014).

Some argue that brain death must include the cessation of brain activity in both the cortex (which controls consciousness and cognition) and the brainstem (which is responsible for functions such as breathing) (DeSpelder & Strickland, 2020; Gire, 2014). A person in a vegetative state with no hope of regaining consciousness with life sustained as merely "an artifact of modern technology" (Gire, 2014, 4) may be considered dead, but under the standard of whole brain death, this person is still considered to be alive (Steen, 2007). Overall, biomedical definitions of death represent the materiality of death encompassing the object (the dying individual and/or the body) and the materiality of practices (healthcare and ritual practices). However, the social and cultural constructions of death and dying play a critical role in how people make sense of it (van Brussel & Carpentier, 2014).

Awareness of death is one characteristic distinguishing humans from animals. Humans and animals instinctive engage in self-preservation to avoid death, but humans are aware of the inevitability of death (Greenberg et al. 1990; Pyszczynski, Greenberg, & Solomon, 1999; Solomon et al. 2004). Philosophers such as Kierkegaard (1844/1957) argued that knowing one is alive is tremendously uplifting, but that anxiety and terror can emerge from the tension of self-preservation and ultimate vulnerability and helplessness caused by the inevitability of death. Much human behaviour is motivated by anxiety about death, as illustrated by consumer behaviour, plastic surgery, and beliefs and practices related to death and dying (Burke, Martens, & Faucher, 2010; Solomon, Greenberg, & Pyszczynski, 1991; Tam, 2013).

Van Brussel and Carpentier (2014, 3) noted that "society – and all objects and subjects functioning therein – is the outcome of continuous processes of meaning-making" (2014, 3). They described two broad perspectives: a macro-oriented social constructionist perspective that addresses the collective construction of death and dying within a society, culture, or religion; and a micro-oriented constructivist perspective that focuses on agency and an individual's meaning-making process. Scholars working in the field of thanatology – the study of death and dying – study both, for example popular media, literature, and artifacts pertaining to death and dying, and how individuals construct meanings related to the ultimate loss for themselves and others (Burr, 2003). The meaning-making process, and the meanings attached to death, involve active interactions at the macro and micro levels, so any attempt to simplify views about death and dying is certain to result in misunderstandings and misinterpretations of the needs, wants, and wishes of dying persons and their families, and in turn, the delivery of inappropriate or unwanted services.

Ariès (1974, 1981) argued that death was considered "tamed" well into the early Middle Ages, but that Western attitudes about death have shifted: familiarity with death began changing to denial of death at the turn of the 20th century with the advent of modernization and industrialization (1981). As more deaths took place in medical institutions, death and dying became hidden and invisible from the private sphere. Elias and Jephcott commented: "Never before, have people died so noiselessly and hygienically as today" (1985, 85). Death and dying can now be considered a bureaucratic process, symbolized by a death certificate and

institutional medical intervention (van Brussel, 2014). From a medical-rationalist perspective, death is no longer a "tamed" part of life, but an extreme of illness where modern medicine fails (Seale, 1995).

Conceptions of the Dying Process

Death is inevitable, and humans have long wondered about what makes a good death and how to have one. However, conceptions of a "good death" have varied over time and across cultures (DeSpelder & Strickland, 2020; Novak, Northcott, & Campbell, 2018). A traditional romanticized notion of the dying process might be dying quickly and painlessly at home surrounded by loved ones (Hobart, 2002). In more modern times, the dying process became more medicalized, and a good death "was foremost a death that happened without the patient noticing it, such as dying quietly in one's sleep" (van Brussel, 2014). In contemporary Western societies, an "appropriate death" generally includes lack of pain, ability to recognize and resolve residual conflicts, satisfying realistically possible wishes, and yielding control to trusted others (Steinberg & Youngner, 1988, 13). Other thanatologists (e.g., Byock, 1997) have broadened the conditions of dying well to include end-of-life growth. Overall, the conditions for a good death now include:

- completing one's worldly affairs
- coming to closure in personal and professional relationships
- learning the meaning of one's life
- loving oneself and others
- accepting the finality of life
- sensing a new self and surrendering to the unknown.

The topic of death and dying still evokes discomfort in most people, but practitioners working with dying people stress that the process of dying is a natural part of life. "We depathologized the concept of pregnancy and birth, saying it was not a disease but a part of healthy living. Similar things can be said about the end of life; we need not pathologize people in order to acknowledge their mortality" (Hobart, 2002, 183).

Kübler-Ross developed a five-stage model to describe attitudes about one's own process of death: denial ("Not me"), anger ("Why me?"), bargaining ("Yes, me, but …"), depression and mourning, and finally acceptance ("It's okay") (1969, 1974). The model is not rigid: some individuals may not experience all stages; some may move back and forth between several stages; some may have overlapping stages; and others do not appreciate their grief being confined by this kind of model and reject it entirely (Novak, Northcott, & Campbell, 2018).

Glaser and Stauss (1965) conducted a six-year study of dying experiences occurring in hospitals, hospices, and nursing homes with the care of healthcare professionals (i.e., virtual strangers, as opposed to the family members who would have been present in pre-industrialized times), and identified four main types of awareness related to dying in institutions:

- **Closed awareness.** The dying persons are kept from the truth of their health condition and thus unaware of their impending death. Healthcare workers and families cooperate to conceal the information. Believing that they will recover, the dying persons are deprived of full closure with regard to life and loved ones.
- **Suspicion awareness.** The dying persons suspect death is near, although healthcare providers and family keep the information from them. Tension may arise when the dying persons try to confirm their suspicions and others deny or ignore the reality with dispassionate, impatient, or abrupt responses, or fake cheerfulness.
- **Mutual pretense.** All concerned individuals are aware that the person is dying, but pretend they do not know. Everyone tries to avoid unintentional slips of tongue by maintaining conversations on safe topics, but the noticeable physical deterioration eventually makes pretense difficult and even impossible.
- **Open awareness.** The dying person, healthcare providers, and family all acknowledge the fact that death is approaching, although details such as the mode and time of death may be concealed with mutual pretense.

"To tell or not to tell" a dying person has been long debated among care providers and families. Many care providers find open awareness preferable because it allows the dying person an opportunity to bring closure to their lives, in term of both personal thoughts and their relationships with relatives and friends. Care providers may also benefit from comforting the dying person with affection and compassion without needing to pretend otherwise (Andrews & Nathaniel, 2015). The "right to know" has become a crucial element in contemporary Western medicine (DeSpelder & Strickland, 2020). It can be articulated using two sets of concepts, control and autonomy and awareness and heroism (van Brussel, 2014). Postmodernists believe that individuals have the right "to make their own decisions about what remains of their lives, they must be told the truth about their condition" (Walter, 1994, 31). Contemporary medical science makes control and autonomy possible by allowing the dying person to control the dying process to a certain degree. Within the dominant individualistic discourse, deprivation of truthful information to enable the dying person to make decisions is considered equivalent to a violation of basic human rights (Kearl, 1989; Novak, Northcott, & Campbell, 2018). However, the interpretation of control and autonomy is not homogenous.

The field of end-of-life care involves at least two main movements, which are not mutually exclusive: those focusing on the right to die and those focusing on palliative care (Table 11.1). Those promoting the right-to-die stress control and autonomy, including the practice of euthanasia (currently under the umbrella of Medical Assistance in Dying) by which the dying person has great control over the time and form of their own death. Some scholars have argued that the need for self-control during the dying process is rooted in attitudes related to deep fear and denial of death (i.e., Somerville, 2014), but many others feel that autonomy in dying enhances human dignity (i.e., the Dying with Dignity movement in Canada https://www.dyingwithdignity.ca/). In postmodern society, dignity is often related to independence, self-determination, and control, as well as "a civilised body discourse that values self-mastery and self-care" (van Brussel, 2014, 21). Even so, practitioners in the palliative care or hospice movement do not always support the "right to die." Instead, most focus on controlling pain and symptoms to provide comfort to

the dying person during the "natural" dying process, however long it may be, without active interference. The palliative care and hospice movement emphasizes facilitating the dying person in fulfilling their wishes (except for the wish to die) and assuring comfort (e.g., pain management, symptom management), rather than providing assistance in dying. The key difference between palliative care and regular medical intervention is that in palliative care, aggressive active treatment is withdrawn, but interventions with pain management and comfort remains. Control and autonomy in the dying process are less stressed in the palliative care and hospice sphere. Hobart (2002) identified three levels of control and autonomy over death: (1) voluntary active euthanasia, or clinician-administered medical assistance in dying (MAiD); (2) self-administered MAiD; and (3) sedation death (palliative care physicians ensure the dying person is free of pain to the point of sedation when death occurs) (Hobart, 2002). The decision between forgoing treatment but maintaining pain management until death occurs, versus hastening death in grievous and irremediable medical conditions to shorten inevitable (physical) suffering, is highly personal, contextual, and cultural.

Awareness and heroism are another set of concepts currently used in discourse about death. Western cultures tend to value open awareness, which involves at least three levels of conduct. First, the dying person is explicitly and accurately informed about their health condition. Second, they are informed about available options for medical intervention and care support so that they can make their own decisions or at least be part of the decision-making process. Third, they can evaluate their relationships with loved ones and determine whether, how, and when to tell others, reconcile with some, express affection, or make confessions (van Brussel, 2014). A dying person may continue or engage in a life review by which they assess their life: whether it has had meaning and purpose, tie up loose ends, reach acceptance, and prepare for death (Novak, Northcott, & Campbell, 2018). This idea of life review is closely related to Erikson's theory of ego development (1982, 1993) according to which eight stages of psychosocial development define a person's entire life. The last stage (age 65 to death) can involve feelings of integrity and a sense of accomplishment and fulfillment (acceptance, a sense of wholeness, lack of regret, feeling at peace, a sense of success, and feelings of wisdom and acceptance), or despair and feelings of regret (bitterness, ruminating over mistakes, feeling that life was wasted, feeling unproductive, depression, and hopelessness). Ideally, a life review will help the dying person achieve acceptance of life lived and the anticipated death.

Seale's theory of the heroic death (1995, 1998) built on Erikson's notion of ego development and integrity. He referred to a journey of emotional labour that involves both the dying person and people around them and described the "inner-directed heroics of the self" – meaning the action of gathering "support from family and friends and mak[ing] emotional progress in the process of denying, fighting, and accepting death" (Seale, 2002, 185). In this way, a dying person can be viewed as a "hero" who is forced to face a dangerous tragedy alone and must move through inner struggles at different phases of death awareness – shock, fear, anxiety, anger, and depression – while demonstrating great bravery and dignity in the final stage (van Brussel, 2014). Both the dying person and others view this life as completed without regret when death finally occurs (Dresser & Wasserman, 2010). The characteristics of a heroic death align with the palliative care and hospice movement: personal growth in the face of ultimate deterioration of the body as the goal, with a focus on the needs and wants of the dying person and their family and friends. The right-to-die movement also recognizes the importance of personal growth of both the dying person and others in the process – but also stresses that the care of others may not be sufficient to counterattack the suffering in late stages of terminal

illnesses (Seale, 1995). From this perspective, heroic death and integrity may not be complete unless the dying person is provided with and actualizes the right to die (van Brussel, 2014).

Table 11.1 Diversity in views of death awareness

	Control and Autonomy	Awareness and Heroism
Palliative care and hospice movement	The dying person focuses on fulfilling wishes, closure, and comfort. Do not hasten death in any circumstance.	The focus is personal growth, emotional development, and ego integrity of the dying person and others.
Right-to-die movement	The dying person decides the time and manner of death. MAiD is a basic human right.	The dying person should be allowed personal growth and be able to decide the time and manner of death.

(Adapted from van Brussel, 2014)

Diversity in Views on Death and Dying

Canadian practitioners working in the fields of healthcare and social services frequently work with individuals of diverse cultural and faith backgrounds. As discussed above, open awareness of death has been considered a basic human right, and research has confirmed that patients who engage in open awareness are more likely to die in peace (Lokker et al. 2012). However, empirical evidence indicates that many (38–49 percent) dying patients in the hospital are unaware of their imminent death in the last days of life (Burge et al. 2014; Caswell et al. 2015). Practitioners have identified effective communication about the dying person's condition, along with shared decision-making responsibilities and efficient professional care in the last days of life, as crucial to the quality of end-of-life care (Gardner et al. 2018; Virdun et al. 2015). However, some practitioners find it challenging to reveal the news to the dying person and/or their family. They can become more comfortable communicating with the dying person and family if they understand perceptions of death and dying within various cultural and religious contexts. For example, they need to be equipped with knowledge about different cultural interpretations of choice, preference, and behaviours in the dying process.

Religiosity is probably one of the most extensively examined among all cultural factors (Gire, 2014). Culture and religion are highly complex topics and change continually, so it is impossible to generate a complete, accurate, and detailed summary of all those existing in contemporary Canadian society. The following discussion explores some of the beliefs within some cultural and faith groups.

Buddhist

Many newcomers to Canada from East, Southeast, and some parts of South Asia are Buddhists. Among the many denominations, sects, and movements within Buddhism, most Buddhists believe in reincarnation: the dead are reborn, but not necessarily in human form. The ultimate goal of Buddhist practice is to escape the cycle of death and rebirth and achieve nirvana, a state of perfect peace and completion. Buddhists are taught to not fear death because it leads to the beginning of a new life. They believe that the spirit leaves

the body when death occurs and lingers in a spirit world before it enters a new body, and that the dying person's state of mind determines the state of rebirth. The body is cleaned, dressed, and prepared for the funeral by the family (if the person died at home). Funerals vary by the type of Buddhism and the cultural context of the deceased. Generally, Buddhists are not attached to any one form of disposing the body (e.g., cremation or burial); this is personal preference because the spirit is much more important and is already living on (Hsu, O'Conner, & Lee, 2009; Loddon Mallee Regional Palliative Care Consortium, 2011). Buddhism has no explicit rituals in memory of the deceased, but many Buddhism-influenced cultures practice in their own traditional ways. For example, Chinese Qingming Festival (Tomb Sweeping Day, held in late March or early April) is considered a memorial day during which Chinese people around the world conduct rituals to pay respect to their deceased loved ones, regardless of their religious beliefs.

Hindu

Most Hindus also believe in reincarnation. Rituals may begin in the last days or hours before death and can include praying, reciting scriptures, singing holy songs, and tying a sacred thread around the neck and wrist of the dying person. The deceased is usually cleansed by the family and dressed in traditional clothing, e.g., traditional Indian attire. Usually, the eldest son or an older male from the family will lead prayers and mourning for the spirit of the deceased. Hindus often choose cremation as they believe the creator, Brahma, represented by fire, releases the spirit from the body to attain nirvana. The body is considered to be unclean, so after the funeral a priest usually burns incense and spices at the deceased's home, and mourners change their clothes after the funeral. The family usually conducts semi-formal memorial events in the years following the death (DeSpelder & Strickland, 2020; Loddon Mallee Regional Palliative Care Consortium, 2011).

Christian

Christianity includes many denominations. Most Christians believe that the person or spirit will meet God in Heaven or will wait in the spirit world for a final judgment before attaining eternal life in Heaven, joining their ancestors, and later being joined by their offspring. Clergy may visit dying persons and their families to provide comfort and support, at home or at an institution. At the time of death, a minister or priest may conduct certain rituals, such as lighting candles or saying prayers. The body is cleaned, dressed, and prepared for the funeral – sometimes by the family, if the person died at home. The funeral or mass may take place in a church, cemetery, or a funeral home. Disposal of the body varies by denomination: Protestants may choose cremation or burial, but cremation is generally forbidden or discouraged in Orthodox and Mormon religions (DeSpelder & Strickland, 2020; Loddon Mallee Regional Palliative Care Consortium, 2011).

Jewish

Jewish beliefs also vary by denomination. Most Jews believe they will join God in Olam HaEmet (the World of Truth) after death. A rabbi may offer comfort and prayers to the dying person, who is usually surrounded by family members. After death and before the funeral, a relative is expected to be with the body at all times. A special group of volunteers from the Jewish community usually prepares the body for the funeral. Cremation

is usually not encouraged. Shivah is held at the family's home after the funeral. This is a seven-day mourning ritual: friends and extended family prepare meals for those attending Shivah; some families cover all mirrors in the house and tear their clothes as an expression of mourning; and many guests talk about the deceased loved one, offering sympathies to the family by sharing positive memories (Loddon Mallee Regional Palliative Care Consortium, 2011).

Muslim

Muslims believe that after burial, the body remains in the grave and the spirit/soul continues to exist. On Judgement Day, Allah (God) will decide whether they go to Heaven or Hell. One of the reasons for Muslim daily prayers to prepare for death at any time. When a Muslim is dying, relatives and elders from the community, or any Muslim in the absence of family, surround them to pray from the Koran, their holy book. Support services that are not grounded in Islam may not be welcome and may be considered intrusive to the rituals. After death, the family will prepare the body for the funeral, including arranging the head facing Mecca (the holy city). Non-Muslims are not allowed to touch the body without wearing gloves, and those who are helping prepare the body must be of the same sex as the deceased. Cremation is not permitted in Islam, and burial usually takes place in a graveyard with prayers and readings from the Koran. Following the funeral, family and friends usually gather for three days to remember the deceased. Other family memorial activities may last for a year (DeSpelder & Strickland, 2020; Loddon Mallee Regional Palliative Care Consortium, 2011).

Cultural and Religious Influence in Coping with Death Anxiety

Some people find comfort in religions based on the idea of an afterlife. Gire (2014) found that those from cultures with these religious beliefs have less anxiety about death than others. However, even individuals from these cultures differ in terms of level, quantity, and quality of religious involvement, and the nature of religious activities. Research suggests that the higher the degree of certainty in an afterlife, the lower the level of death anxiety (Alvarado et al. 1995; Wink, 2006). Parsuram and Sharma (1992) conducted a cross-religious study comparing death anxiety among Hindus, Muslims, and Christians in India, and found that Hindus had the highest level of belief in an afterlife and reported the lowest level of death anxiety. Roshdieh and colleagues (1999) engaged in a study with 1176 Muslims in Iran, and found that those with stronger religious beliefs had lower levels of death anxiety, even in the face of war. Morris and McAdie (2009) reported that Christians had less death anxiety than Muslims, but that both Christians and Muslims had significantly less death anxiety than their nonreligious counterparts. However, not all empirical findings are consistent; for example, Rose and O'Sullivan's (2002) results did not confirm any association between levels of death anxiety and religious belief in an afterlife.

Overall, intertwining structural and individual factors create numerous types of beliefs, which in turn affect choices and decisions around death and dying. Therefore, healthcare and social service practitioners should never make assumptions about a dying person's wants and preferences based on their language and ethnicity, or assume that all people within one culture or religion share the same ritual practices and beliefs.

Many aspects of social, cultural, and religious behaviours around death, such as funerals and expressions of sorrow, involve complex sociological, social, and psychological elements.

Practitioners also need to be aware of atheist (explicit denial of a deity's existence) and agnostic (belief that such existence is unknown) views about death and dying. Based on her experience caring for thousands of dying individuals, Kübler-Ross (1974) reported that steadfast atheists demonstrated peaceful mindsets when facing death, just like others with religious beliefs. She noted that individuals with stronger beliefs, regardless of faith, experienced less death anxiety. Religious beliefs contain explicit, though not always consistent, descriptions of life after death, but followers may develop their own ideas about afterlife based on this ideological foundation. Thus, personal and contextual variables play critical roles in shaping level of faith. Anxiety about death can affect mental and spiritual wellbeing, especially among older adults and people experiencing a fatal illness. Healthcare and social service practitioners should try to offer effective interventions and support to dying persons and families from diverse backgrounds by being inclusive and respectful.

Practitioners' Roles in End-of-life Care

Healthcare and social service practitioners who frequently work with older adults, individuals with fatal illnesses, and patients or residents in institutions, should be aware of the obstacles that individuals and their families of diverse cultural and religious backgrounds face in accessing appropriate palliative care and end-of-life services. They should advocate to reduce disparities in healthcare and supporting programs. They should also try to advance the quality of end-of-life care by understanding different ideas about death and dying. The goal is to ensure "a good death." Practitioners may provide end-of life care during three main stages, as described below.

Pre-end-of-life stage. Individuals in this stage may not have developed a clear understanding of the dying process and may engage in conscious or unconscious denial of death, for example saying "If I die …" as opposed to "When I die." At this stage, practitioners should help the patient by educating them (DeSpelder & Strickland, 2020). They might also give presentations on views of death and dying and advance directives as part of community outreach and public education for various audiences including students, paramedic and fire station staff, and older immigrants. An advance directive helps healthcare practitioners and family members understand the dying person's wishes regarding medical intervention, for example in case of critical conditions when they are unable to communicate and medical decisions must be made (Novak, Northcott, & Campbell, 2018). It is impossible to predict every situation, so a proxy (usually a family member or a friend) may be assigned to make decisions based on the advance directive.[1]

End-of-life stage. At this stage, death is expected to occur in months, weeks, or days. This is not a medical "problem" requiring a "solution" (Carver, 2018); the goal for practitioners is to support the dying person and

1. Resources for death and dying, and advance directives, are provided at the end of this chapter.

help them have the best possible quality of life in their final days. Baile and colleagues (2000) developed the six-step SPIKES model to effectively support a dying person and their family, as presented below.

1. Set up: Set up the initial interview. The practitioner sets up a time to meet the patient; the timing should not disrupt treatment, visits, or rest.
2. Perception: Assess the patient's perception. After the patient is comfortable, the practitioner might ask if they understand what is happening and their awareness of their diagnosis. The practitioner should invite the patient to reflect on what they have learned, heard, observed, thought, and felt, while listening attentively and responding with empathy. This step is critical as it will strengthen rapport and also provide the practitioner with more information to better adjust intervention strategies.
3. Invite: The practitioner should respectfully invite the patient to hear more about their condition.
4. Knowledge: After receiving consent, the practitioner should share their knowledge with the patient, telling the patient explicitly and empathetically that they are dying. Patients in this stage have frequently heard comments about their condition like "no more treatment is available" or "we've run out of options" – this may be the first time the patient is really informed of the news. They may react strongly and exhibit common reactions such as denial, anger, and bargaining.
5. Empathy: The practitioner must address all of the patient's responses with empathy. The patient may elaborate on the reasons for their reactions, which may relate to family relationships, personal dreams, concerns about the dying process, and fear of death. Emotional support, attentive listening, and empathic responses are appropriate, and a gentle touch on the hand may be comforting to some patients.
6. Strategize and summarize. Some practitioners, often social workers, can help the patient plan for the best quality of life under the circumstances. Some patients may want to conduct a life review, reconnect with relatives or friends, or complete a directive or other documents. Some may want counselling with a spiritual or religious person, or to discuss information on medical assistance in dying.

The SPIKES protocol can be useful for physicians, nurses, social workers, and palliative care workers when helping individuals go through the dying process; and the six steps can be applied multiple times to evaluate emerging needs and wants, and then adjust supporting strategies accordingly.

Grief and bereavement. This final stage involves the survivors and friends of the deceased, as well as the professionals who have treated and cared for them. Grief refers to the personal emotional reactions to a loss (e.g., sorrow, depression, anger, and guilt), while bereavement is the recent experience of the loss of a loved one (Gire, 2014; Novak, Northcott, & Campbell, 2018). Practitioners may assist grieving persons in any of the four stages of mourning: acknowledging the reality of the loss; coping with and processing the pain of grief; adjusting to a world without the deceased; and finding a way to stay connected with the deceased when ready to move on (Gire, 2014). Providing support to grieving individuals requires long-term commitment, and structured organization can assure sustainability and dependability. Many not-for-profit and for-profit agencies provide various programs to address this need including counselling, spiritual counselling, support groups, and visits or conversations with volunteers.

Overall, when assessing the end-of-life wishes of patients, practitioners need to be sensitive to the specific needs of each patient. For example, patients will want to have different levels of control over the dying process: some may want medical assistance in dying (in Canada, only clinician-assisted MAiD is available, as opposed to self-administered death); others may choose a sedation death under palliative care. Both of these choices may involve explicitly rejecting active medical treatment and life extension. It is vital that practitioners avoid making assumptions about a dying person; instead, they should invite each patient to guide them in the provision of appropriate support to maximize quality of life during the final days (Gardner et al. 2018; Hobart, 2002; Hsu et al. 2009; Novak, Northcott, & Campbell, 2018).

Conclusion

Culture and religion are important elements in making meaning of the dying process, but some cultural and religious groups remain under-researched, meaning that practitioners may have limited information when working with dying individuals and their families. More research is needed to filling the gaps in certain areas of thanatology and end-of-life practice. Specifically, more research is needed to explore the social determinants affecting the quality of end-of-life care, in addition to cultural and religious factors. This body of work will provide a more comprehensive picture of how Canadians with diverse backgrounds view death and dying and end-of-life care, and thereby inform practitioners how best to meet their needs.

Useful Links and Resources

Five Regrets of the Dying https://bronnieware.com/blog/regrets-of-the-dying/

When Death Is Near https://www.virtualhospice.ca/en_US/Article/Final+Days/When+Death+is+Near.aspx

What Really Matters at the End of Life https://www.ted.com/talks/bj_miller_what_really_matters_at_the_end_of_life#t-265047

Documenting Her Wife's Death on Social Media https://www.newyorker.com/video/watch/documenting-her-wifes-death-on-social-media

Living My Culture: Views of death and dying and palliative care in diverse cultures (First Nations, Inuit, Metis, Chinese, Ethiopian, Filipino, Indian, Iranian, Italian, Pakistani, and Somali) in different languages (English, Amharic, Cantonese, Farsi, Hindi, Mandarin, Tagalog, Punjabi, Italian, Urdu, and Af Soomaali). https://livingmyculture.ca/culture/

Embracing Cultural Diversity in Palliative Care https://www.youtube.com/watch?v=_pSEni3LqEY

The Role of Culture in Palliative Care https://www.youtube.com/watch?v=PhFCJ_ZSWGY

Cultural Sensitivity in Palliative Care https://www.youtube.com/watch?v=z7YHMekqmok

Finding Meaning and Purpose During a Health Crisis https://www.virtualhospice.ca/en_US/Main+Site+Navigation/Home/Topics/Topics/Spiritual+Health/Finding+Meaning+and+Purpose+during+a+Health+Crisis.aspx

Rituals to Comfort Families https://www.virtualhospice.ca/en_US/Main+Site+Navigation/Home/Topics/Topics/Spiritual+Health/Rituals+to+Comfort+Families.aspx

Spirituality and Life-Limiting Illness https://www.virtualhospice.ca/en_US/Main+Site+Navigation/Home/Topics/Topics/Spiritual+Health/Spirituality+and+Life_Limiting+Illness.aspx

Personal Directive — Alberta https://www.alberta.ca/personal-directive.aspx

Advance Care Planning — British Colombia https://www2.gov.bc.ca/gov/content/family-social-supports/seniors/health-safety/advance-care-planning

Healthcare Directive — Ontario https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2017/healthcare-directives-what-you-really-need-to-know

Health Care Directive — Manitoba https://www.gov.mb.ca/health/livingwill.html

Advance Medical Directives — Quebec https://www.quebec.ca/en/health/health-system-and-services/end-of-life-care/advance-medical-directives

Advance Care Directive (Living Will) — Saskatchewan https://www.saskatoonhealthregion.ca/patients/Pages/Advance-Care-Directive.aspx

Health Care Directives in the US https://www.virtualhospice.ca/en_US/Main+Site+Navigation/Home/Topics/Topics/Decisions/Health+Care+Directives.aspx

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SECTION 5: ACCESS TO SERVICES

Chapter 12. Elder Abuse Risk Factors and Intervention Strategies: Perspectives of Korean Older Immigrants

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The percentage of older people is increasing worldwide (United Nations, 2020), and concerns about elder abuse are also growing. The WHO (2017, par. 4) defines elder abuse as "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person. Elder abuse can take the form of financial, physical, psychological, and sexual abuse, or be the result of intentional or unintentional neglect." In Canada, the prevalence of elder abuse is about 7.5 percent (National Initiative for the Care of the Elderly, 2015). However, elder abuse in immigrant communities remains largely underreported (Moon & Benton, 2000).

Previous studies have identified a range of factors that contribute to elder abuse. With age, many people are vulnerable to physical, mental, and cognitive health challenges, including decreasing mobility and declining general health, all of which increase the demand for health care and social services (Walsh et al. 2010). Immigrant older adults with language barriers often rely on others, primarily family members, to access required services and/or to receive assistance in care. However, adult children themselves are often working immigrants who may be struggling to adjust to Canada's culture and lifestyle, making it difficult for them to access the services and resources required to help their aging parents (Chung, 2016). For some immigrants, acculturation may involve additional challenges, specifically related to reframing the collectivistic mindset to accommodate a more individualistic way of life (Chung, 2016). Some scholars have observed intergenerational differences in cultural expectations regarding filial piety and treatment of elderly parents and grandparents (Guruge, Tiwari, & Lucea, 2010). Unresolved cultural differences and misunderstandings can lead to family conflicts and situations of neglect.

Some studies have developed intervention strategies to address elder abuse (Burnes et al. 2021; Ploeg et al. 2009). Some of these have included immigrants; for example, Dong and colleagues (2014) found that increasing psychological wellbeing facilitated help-seeking behaviours among older Chinese immigrants experiencing abuse. However, the body of Canadian research on elder abuse risk factors and prevention strategies in immigrant communities is limited, especially with regard to the relatively recent and small Korean community.

The Korean immigrant community in Canada is the fourth largest Korean diaspora globally, after the United States, China, and Japan (Bergsen & Choi, 2003). It shares the broader Confucian tradition with other East Asian immigrant communities, but it also has a distinct history and customs, norms, beliefs, and values (Armstrong, 2021), all of which may influence perspectives on elder abuse. Similar to other immigrant counterparts in Canada, Korean older adults face many settlement challenges that increase their risk of

experience of abuse. We explored the risk factors for elder abuse in the Korean immigrant community in the Greater Toronto Area. Our specific aims were to: (1) identify most frequent and important risk factors that create situations of elder abuse as perceived by older Korean immigrants, (2) explore interventions that aim to prevent abuse and are appropriate to the community, and (3) examine gender differences in the perception of risk factors and appropriateness of the interventions.

Theoretical Framework

This study was informed by an intersectionality framework (Guruge & Khanlou, 2004) and an ecosystemic framework. The ecosystemic model (Heise, 1998; Waller, 2001) can help clarify how individuals are situated within and influenced by individual-, micro-, meso- and macro-systems, and how elder abuse is affected by the dynamic interplay of multilevel influences (Guruge & Khanlou, 2004). An intersectionality lens also helps to contextualize each individual's unique perceptions of risk factors and appropriate interventions in relation to their social identities.

Methods

We used a mixed-method study design.

In Phase 1, we used a quantitative approach to identify what risk factors were perceived as most frequent and important in leading to elder abuse in the Korean community. Specifically, we provided older participants with a list of thirteen elder abuse risk factors that we had identified from previous research and asked them to rate the factors, on a scale of 0–4, based on how they perceive each factor's frequency of occurrence and importance in contributing to elder abuse. Next, participants engaged in semi-structured group interviews to discuss the rationale for their choices.

In Phase 2, we used a quantitative approach to identify what interventions were perceived as appropriate in preventing elder abuse in the Korean community. Participants were given a description of each intervention that highlighted what the intervention is about and how it is delivered. Then, participants were asked to rate (on a scale of 0–4) the appropriateness (i.e., suitability) to the community, of fourteen interventions: eight targeting older immigrants and six targeting abusers. Next, participants engaged in semi-structured group interviews to discuss the rationale for their choices.

After obtaining research ethics approval from all affiliated universities, we recruited older women and men who met the following criteria: 60 years or older, born outside of Canada, self-identifying as belonging to the Korean community, and personal experience of elder abuse or know other Korean older adults who have experienced it. Participants were recruited using word of mouth and/or referral through our community connections. The group interviews were held in private rooms, at times and locations that were convenient for participants, such as a university, recreational centre, or church.

Bilingual research assistants obtained informed written or verbal consent from all participants and then

asked each participant to complete a brief socio-demographic questionnaire. Next, the research assistants asked each participant to rate the frequency and importance of thirteen risk factors for elder abuse (in Phase 1) and the appropriateness of fourteen intervention strategies (in Phase 2), and then to engage in a group interview to discuss their ratings and rationales.

Demographic information and rankings on the risk factors and interventions were analyzed using SPSS. We used descriptive statistics (frequency, measures of central tendency, and dispersion) to analyze demographic information, and mean scores for each risk factor in terms of frequency and importance and for perceived appropriateness of interventions. Independent sample T-tests were used to compare mean rating of older women and men. Additional Cohen's d tests were performed to determine the effect sizes of gender-based differences in risk factor ratings.

Audio-recordings of group interviews were transcribed and translated into English. The transcripts of each group interview were analyzed separately, and then the emerging results were compared and contrasted across groups and genders using an intersectionality lens and an ecosystemic framework.

Phase 1 Results

In total, 49 older men and women completed the rankings and participated in seven semi-structured group interviews. Most had arrived in Canada before 2000, and more than 75% had children residing in Canada. All spoke Korean as their first language. The following sections present the quantitative findings along with excerpts from group interviews.

Risk Factor Ratings

Table 12.1 lists the ratings for the perceived frequency of occurrence for each factor. Overall ratings hovered around the low-to-moderate spectrum of the scale. In general, older women and men identified social isolation, lack of English knowledge, financial dependence, and racialized, cultural, or ethnic group status as risk factors that occur frequently in situations of elder abuse. Women tended to rate advanced age, physical dependence on others, and emotional dependence on caregivers as risk factors that occur frequently. However, these gender-based differences were minimal, and these risk factors were not rated as very frequent.

Table 12.2 lists the ratings based on the perceived importance of risk factors. Participants identified social isolation, lack of English knowledge, and financial dependence as the most important risk factors. Gender-based differences were more apparent in importance ratings compared to frequency ratings. For example, compared to older men, older women rated physical dependence on others and emotional dependence on caregivers as important risk factors.

Table 12.1 Perceived frequency of risk factors						
Risk factor (rated 0–4) 0 indicates the least frequent and 4 indicates the most frequent	**Older women (n=26) mean (SD)**	**Older men (n=23) mean (SD)**	**Combined rating mean (SD)**	**t(47)**	**p**	**Cohen's D**
Advanced age	1.88 (1.11)	1.35 (1.11)	1.63 (1.13)	1.689	.098	.48
Gender	1.68 (1.25)	1.43 (0.99)	1.56 (1.13)	.756	.131	.22
Length of time in Canada	1.92 (1.26)	1.48 (1.08)	1.71 (1.19)	1.328	.191	.37
Sponsorship status	1.35 (1.16)	1.26 (1.05)	1.31 (1.10)	.269	.789	.08
Lack of English knowledge	2.46 (1.18)	2.09 (1.28)	2.28 (1.23)	1.035	.306	.30
Income	2.12 (1.09)	2.04 (1.30)	2.08 (1.18)	.220	.827	.07
Employment	1.62 (1.06)	1.48 (0.99)	1.55 (1.02)	.467	.643	.14
Physical dependence on others	2.23 (0.95)	1.74 (1.21)	2.00 (1.10)	1.563	.126	.45
Emotional dependence on caregiver	2.23 (1.03)	1.74 (1.10)	2.00 (1.08)	1.611	.114	.46
Financial dependence	2.38 (1.13)	2.17 (1.19)	2.29 (1.16)	.631	.531	.18
Multi-generational co-residence	1.92 (1.09)	1.52 (0.95)	1.73 (1.04)	1.377	.175	.39
Social isolation	2.58 (0.99)	2.22 (1.24)	2.41 (1.18)	1.112	.272	.32
Racialized, cultural, or ethnic group status	2.31 (1.16)	1.96 (1.30)	2.14 (1.23)	.995	.325	.29

Table 12.2 Perceived importance of risk factors						
Risk factor (rated 0–4) 0 indicates the least important and 4 indicates the most important.	**Older women mean (SD)**	**Older men mean (SD)**	**Combined rating mean (SD)**	**t(47)**	**p**	**Cohen's D**
Advanced age	2.46 (1.10)	1.96 (1.19)	2.22 (1.16)	1.536	.131	.44
Gender	2.04 (1.39)	1.74 (0.86)	1.90 (1.78)	.912	.367	.26
Length of time in Canada	1.65 (0.89)	1.91 (1.13)	1.78 (1.01)	-.886	.381	-.26
Sponsorship status	1.62 (1.02)	1.57 (1.12)	1.59 (1.06)	.163	.871	.05
Lack of English knowledge	2.48 (1.09)	2.39 (1.03)	2.44 (1.05)	.290	.773	.08
Income	2.40 (0.91)	2.35 (1.15)	2.38 (1.02)	.173	.864	.08
Employment	2.00 (1.06)	1.87 (0.97)	1.94 (1.01)	.451	.654	.13
Physical dependence on others	2.69 (0.79)	1.87 (1.18)	2.31 (1.07)	2.832	.007*	.93*
Emotional dependence on caregiver	2.62 (0.64)	2.13 (1.18)	2.39 (0.95)	1.758	.088	.53

Financial dependence	2.62 (0.85)	2.35 (0.94)	2.49 (0.89)	1.042	.303	.30
Multi-generational co-residence	2.19 (0.90)	1.74 (0.92)	1.98 (0.92)	1.747	.087	.49
Social isolation	2.88 (0.77)	2.52 (1.08)	2.71 (0.94)	1.339	.188	.39
Racialized, cultural, or ethnic group status	2.58 (0.99)	2.04 (1.22)	2.33 (1.13)	1.665	.103	.49
*Denotes statistically significant values.						

Qualitative results: Risk Factors for Elder Abuse

Based on our analysis, the top four risk factors for elder abuse in the Korean immigrant community were: communication challenges and language barriers, financial vulnerability, social isolation, and cultural and intergenerational differences.

Factors Important to Older Women

Communication challenges and language barriers:

Language limitations prevented Korean older women from accessing resources and building social connections, and significantly compromised their independence and ability to advocate for themselves.

> It really is a systemic abuse against older immigrants who cannot speak English. Without this, we cannot fully access the services that are available for all Canadians. We would not be able to receive help and support in critical situations because of the language barrier.

> Being unable to speak and understand English makes me feel tragic, because it makes me inferior in the society. Lacking English knowledge and skills puts me at risk for being treated with disrespect.

At the micro level, the Korean custom of nunchi (in which needs are not explicitly mentioned but are expected to be met) frequently led to miscommunication and misunderstanding between caregivers and older immigrants and reported feeling neglected by their children's 'individualistic mindsets.' Many of our participants noted that they had difficulty accessing professional support services due to lack of awareness, as well as inadequate language skills to complete the application process for available programs.

Financial vulnerability:

Older women spoke about their experiences of and worry about financial exploitation and neglect. Korean

immigrants often bring assets with them, and our participants were worried about their finances being taken away by family members or others. The following excerpts capture some of these ideas.

> We have seen many incidents where older immigrants' pension gets taken away by their children or grandchildren. In fact, anyone who is close to the older immigrants can fool them and take their money. When you become too old, your ability to manage your own finances declines. These things really frighten me, as my children do not live in Canada.

Some participants who had been sponsored by their adult children experienced even more financial vulnerability, because they were typically not eligible to receive government-funded benefits designed to help older persons. Without adequate language skills and limited finances, some participants felt enormous pressure to provide childcare which fueled disputes within multigeneration families, especially between mothers/-in laws and daughters/-in-law regarding the unspoken distribution of domestic responsibilities.

> If you live with your children and grandchildren, you have to look after the grandchildren twenty-four hours a day. You can't just ignore them. For example, when your daughter-in-law comes home from a long day of work, you can't just sit there and do nothing. You at least have to prepare dinner before she comes.

Some older women reported that their adult children saw them as a burden once they could no longer contribute to the household.

Social isolation:

Some participants wished to be closer to their grandchildren, but some older women did not want to live with family, fearing that they would be automatically expected to provide free childcare for the grandchildren and take on all domestic responsibilities while their adult children worked full-time. Participants also shared their desire for more culturally and linguistically accessible services and programs. Many stressed the need for long-term care facilities with Korean-speaking staff within the Greater Toronto Area.

> Older immigrants living in this nursing home say that they are being neglected and abused because the staff will pretend not to understand when the attempt to express their needs in broken English. Until we go to visit, they are basically "left alone" in a vulnerable state, so they live in great belittlement and discrimination.

> The food that the senior homes serve may not be the type of food that they are familiar with. They also have a difficult time communicating because of their inability to speak English. Even after being admitted to senior homes, it does not solve all their problems. They still struggle with isolation and find their lives in senior homes very difficult to accept and adapt to.

Overall, our participants noted that they relied heavily on their children (who may be their abusers) as

their main source of social connection and to navigate formal social support resources. Without culturally appropriate housing options for older persons, participants were forced to remain with their adult children who often have multiple or full-time jobs.

Patriarchal beliefs, values, and attitudes:

Participants reported that patriarchal beliefs and values shape older men and women's lives, which increase the vulnerability of older women:

> Most women in our generation often just submit to their husbands and think of themselves as the dependents.

> I am not getting [the total amount]. Just a partial payment from the old age pension. I asked my husband to give me access to the bank account so I can take out some money. But he confronted me why I need the money. I always have to ask for his "approval" for my portion of the money.

At the macro level, many of our female participants were grateful for any government-sponsored benefit programs they were able to access as they relied heavily on such assistance for some guaranteed income, apart from what their husbands gave them.

Factors Important to Older Men

Language barrier:

Most participants reported the impact of their lack of fluency in English as a significant factor contributing to many aspects of their lives which contribute to situations of elder abuse. These aspects ranged from social isolation to dependency on others to manage their declining health.

> Toronto is a multicultural city, and to be able to at least greet your neighbors every morning, you need to speak English. Because communication isn't possible, they can't get into in-depth conversations with one another. These things can't be helped. Having aged, it's really not easy.

Participants shared their concerns over increasing dependency on others to navigate support resources and programs due to limited English proficiency and declining physical and mental health, as well as broader ageism.

Financial vulnerability:

Our participants noted that many of their first-generation children struggled as they settled in Canada and often asked parents to support them financially with their retirement savings from Korea. Parents who

agreed to support their children tended to suffer from financial vulnerabilities such as being unable to afford rising healthcare costs and other support services needed in later life.

> I've been in Canada for thirty years and counting. Canada is one of the top prosperous countries, where people can live the best lifestyle. But at the same time, there's a huge disparity. Not everyone is so well off to enjoy that kind of a lifestyle. Older immigrants who are very old and not financially well off, there's blatant disregard for them.

They reported that the restrictions regarding old age benefits and the sponsorship expectations of financial dependency on their children were significant barrier to their independence from their children.

Social isolation:

Some participants commented on the detrimental effects of people's indifference towards older people's social isolation, linking this experience with the onset of depression. The fragile emotional state that results from feeling socially isolated was noted as resulting in increase in vulnerable to abuse.

> With this indifference towards older immigrants, the older immigrants lose their ability to interact with others and become less empowered due to loneliness and isolation. The more their independence falters, they eventually develop depression. They would lose the power to react the way any logical person would, to those who perpetrate elder abuse against them— because they are so weakened from the isolation and indifference…

Several participants reported being neglected by their adult children or others. They also noted that Korean culture stresses the importance of collectivism – where harmony with others is considered more important than self-protection – and therefore, feared reporting abuse that might bring harm to their family members.

Patriarchal legacy:

Our participants referred to tasks that are traditionally managed by men, such as asset management. Unequal distribution of inheritance among children was noted as creating tension within the family unit. Many participants emphasized the importance of retirement planning and preparing a safety net for the later years to protect against becoming financially dependent on children, commenting that being burdensome can overwhelm caregivers, which in turn can lead to elder abuse. Older men reported feeling that their authority diminished with age and as a result of the transition from a life in Korea to one in Canada. Many older men experienced conflicts with their spouses related to gender role reversal. Older men without an income became completely dependent on their wives and children to cook and take care of them, resulting in low self-esteem and diminished authority at home. Limited English skills and inability to advocate for themselves also exposed them to experiences of racism and diminished their social status outside their homes.

Phase 2 results

A total of 36 older women and men participated in Phase 2. More than three-quarter of these participants had come to Canada prior to 2000: most had come to Canada as either skilled workers, dependents of skilled workers, or as sponsored parents/grandparents. The following sections present the quantitative results along with excerpts from the group interviews.

Intervention Strategies Ratings

Participants rated the appropriateness of fourteen elder abuse interventions to the Korean community. The mean score for women and men as well as the total sample are Table 12.3.

Community outreach programs, information about outreach programs, social support interventions, case management, and psychoeducation (social support interventions) emerged as the most appropriate interventions. Significantly more gender-based differences were observed in the ratings for appropriateness: older women rated psychoeducation, information about outreach programs, family mediation, and referral to psycho-social counselling or support as much less effective compared to older men.

Table 12.3 Ratings of interventions based on appropriateness for the Korean community

Interventions (rated 0–4) **0 indicates the least effective and 4 indicates the most effective.**	**Older women (n=21)** **mean (SD)**	**Older men (n=15)** **mean (SD)**	**Combined rating** **mean (SD)**	**t(47)**	**p**	**Cohen's D**
Interventions targeting older women and men						
Psycho-education	2.19 (.98)	3.13 (.83)	2.58 (1.03)	-3.11	.005	1.02
Social support intervention	2.45 (.83)	2.87 (.92)	2.63 (.88)	-1.65	.11	.48
ESL teacher training	1.81 (.93)	2.20 (.78)	1.97 (.88)	-1.37	.18	.45
Information about outreach programs	2.33 (.86)	3.14 (.66)	2.66 (.87)	-3.14	.004	1.03
Peer support program	2.24 (.83)	2.60 (.91)	2.39 (.87)	-1.22	.23	.42
Case management	2.48 (1.03)	2.80 (.56)	2.61 (.87)	-1.21	.24	.37
Advocacy	2.40 (.68)	2.60 (.91)	2.49 (.82)	-.68	.51	.26
Community outreach program	2.67 (1.07)	2.80 (.86)	2.72 (.97)	-.41	.68	.13
Interventions targeting elder abuse perpetrators						
Education	2.38 (.92)	2.80 (.68)	2.56 (.84)	-1.57	.13	.51
Cultural context support	2.24 (.83)	2.73 (.88)	2.44 (.88)	-1.70	.10	.58
Family mediation	1.90 (1.00)	2.80 (.78)	2.28 (1.00)	-3.03	.005	.98
Referral to psycho-social counselling or support	2.05 (.81)	3.00 (.66)	2.44 (.88)	-3.91	<.001	1.26

Multi-component intervention	1.90 (1.02)	2.67 (1.11)	2.23 (1.11)	-2.09	.05	.73
Community outreach	2.19 (.93)	2.93 (.88)	2.50 (.97)	-2.44	.02	.81

Qualitative Results: Interventions to Prevent Elder Abuse

Interventions Preferred by Older Women

Our female participants favored psychoeducation because it would provide opportunities to speak with a professional about healthy aging, risks that lead to abuse, and assistance with navigating resources within the community. Most indicated they would feel more comfortable sharing personal information with a professional rather than with a friend or their children, noting that they expected a high level of advice from a professional – and also that seeing a professional would prevent judgement and worry that would often come from friends and children.

Some participants said that in their generation it was normal for husbands to abuse their wives, and that this kind of program would be useful to educate the population on what elder abuse is, and how to promote healthy relationships.

> Korean culture can be somewhat patriarchal. Some men would beat up their wives, and these women would just accept that this is the way it is and not make a big deal out of it. But through educational workshops like this, we can become aware that this is abuse.

Although psychoeducation was seen to have advantages, some participants noted concerns about the availability of Korean professionals to deliver such programs, as well as older adults' ability to access them:

> There are many who really want mental health support. There is a lot of aging Korean immigrant population in Toronto who can't find the service providers [who can speak Korean]. We wouldn't even know where to go to find these individuals.

Our study participants also felt that a community outreach program would be effective in assisting older immigrants with daily living activities if bilingual Korean outreach workers can be available. One of the younger participants mentioned that she was in a "sandwich generation" because she could speak English, and noted that many people mistakenly think that younger Korean Canadians who speak English do not need outreach workers who speak Korean. Language emerged as a prominent barrier across all focus groups.

> I think the best feature of this intervention is the bilingual outreach worker. The fact that you can speak your needs to someone in the language you feel comfortable with can be very helpful.

> It develops trust through in-person interaction during visitations. I think many lonely older immigrants appreciate people visiting them.

Based on their different beliefs, upbringing, and the language barrier, our participants were concerned about their limited relationships with their children and grandchildren. They saw the community outreach program as an opportunity to interact with the younger generation. One commented that "when younger people visit older adults, they can learn from one another and benefit mutually."

Another (relatively younger) participants vouched for the effectiveness of this kind of program despite the outreach workers not being Korean. She noticed that her elderly mother become more enthusiastic when her personal support workers (PSWs) arrived, and her English also improved.

> She needs assistance at her home so she had to become friends with her personal support workers (PSWs). They visited her every day. Koreans tend to keep their house very clean. They don't like to have strangers coming into their house either. However, for my mom, she cannot get by without the help of PSWs. I even witnessed my mom's English improved after receiving regular support from her PSWs. My brother and I cannot see her everyday as we have our own work.

Our female participants also stressed the need for more information about outreach programs to help increase access. Most felt that church served as a central hub for information sharing and that any information shared outside of church was confusing.

> Korean immigrants belong to some immigrant church, even if they are not Christians. Korean churches are where you can obtain information and network to find out more about what's available.

Most of our female participants had limited knowledge of English, so having a list of services made it much easier to navigate resources to meet their needs.

> If we could speak English, we can seek help ourselves. Anywhere. Because of this language barrier, we feel isolated. If I were younger, I will go out and learn English. But now I am aged and everything becomes that much harder physically and emotionally. We become more vulnerable ourselves to abuse.

I think having translated information for older immigrants would be very helpful, especially for those of us who struggle with English.

Participants highlighted the importance of addressing the language barriers across all intervention strategies.

Interventions Preferred by Older Korean Men

Most male participants felt that English as a Second Language (ESL) classes would be a good intervention

to help reduce elder abuse in the community. They felt ESL classes would help address the communication gap with their grandchildren, and thereby improve their relationship.

> My grandchildren were embarrassed to have me in front of their English-speaking friends. We were eating watermelon. My grandson came over with his friends and told me to go back in the room. This is a sad reality.

Some commented that learning English would also empower them to do daily activities on their own.

> It is really embarrassing that sometimes I get overwhelmed ordering a simple cup of coffee at a coffee shop. They ask me so many questions about what to include and I do not understand.

Some commented that they had worked hard when they first arrived in Canada, so they had very little opportunity to learn English: being a financial provider was a trade-off for bettering their social conditions later in life.

> You are stuck in your convenience store all day [many first-generation Korean immigrants run convenience stores]. When do you get to breathe in fresh Canadian air people are talking about? I don't understand. All I could breathe in was beverage fridge cooling air and run the cash register. At the end of the day, I would see my nose snot that turned black due to dust. Seriously, this is the reality for the first-generation Korean immigrants. So when do you have the time to learn proper English?

As with female participants, male participants also favored a community outreach program, stressing the need for translated lists of information for those with language barriers. Some commented that this would allow them to be more independent – and that they would not have to annoy their children for information.

> They look down at us by saying, "You lived here for more than forty years. You don't even understand something like this?" This kind of treatment really discourages us from asking our children for help with translation. I rather ask strangers but not my children.

Another commented that this kind of program would make it easier to access information and ensure privacy when seeking help.

> Most community-dwelling older immigrants these days have access to a cell phone. We can receive texts and make phone calls. So, mobile apps can be a safe place to receive continuous updates on available resources in Korean. This method … is accessible to anyone who has access to a working cell phone.

Some participants stressed the need to learn basic English and computer skills to access websites.

> We could not have much education because we were busy putting food on the table. However, we

> can learn simple English phrases used in everyday life, as well as master basic computer skills like sending and receiving emails. Having these essential skills would protect one from becoming abused.

The majority of participants felt that inadequate English skills leads to a lack of knowledge about human rights, as well as dependence on children for information, both of which put elders in a vulnerable position.

Male participants also liked the idea of a peer-support program in which older immigrants sign up to volunteer and receive training on how to check on the needs of other older immigrants and socialize with them. One commented that this program could help protect mental health, especially for those who are socially isolated:

> If you do not have regular conversation with people, your brain deteriorates as you age. If you live alone, it's detrimental. Living alone is worse than dying. … Even if there is a risk of you falling on the street, older people should get out and be socially active. If you do nothing, you become sedentary. This is why older people must have friends as they age.

Some participants said that they preferred younger volunteers rather than peer-support:

> I think it is a lot better for the younger people to volunteer. I think peer volunteers can be a bit awkward, am I not right? You may feel a bit down because you see a peer who is healthy and more mobile than you are. You may feel inferior.

Many of our participants also noted that they felt distant from the younger generation, and this kind of peer-support program could connect them with younger Koreans.

Discussion

Limited language proficiency, financial dependence, social isolation, and cultural and intergenerational differences emerged as the most salient risk factors for elder abuse.

Our study participants confirmed that lack of English language skills increased dependence on caregivers, especially financial dependence: family disputes over the distribution of inheritance were a noteworthy risk factor. Cultural differences, coupled with differences across three generations (grandparents, parents, grandchildren), increased the potential for elder abuse due to the inevitable miscommunications and unmet expectations among family members living together with different worldviews. Family conflicts were also fueled by significant life stresses, such as financial hardship experienced by the adult children of older immigrants. The Korean custom of nunchi, where one's needs are not explicitly stated but are expected to be met by others, further complicated the situation. Cultural misunderstandings and miscommunications were significant sources of conflict, especially between mothers/in-law and daughters/-in-law regarding role expectations at home. Our female participants felt that they were expected to fulfill domestic responsibilities and provide free childcare and household work.

Most participants expressed frustration and helplessness related to the growing distance between different family members that result from cultural and intergenerational differences. They also commented on the limited places to socialize outside of their homes. Older immigrants were seen as vulnerable to loss of their social capital as well as social isolation. Their ability to access support and services outside their homes was often limited. Our participants also noted they were experiencing deteriorating health, both physically and mentally, as well as reduced mobility. They rarely reported experiencing abuse because the stigma of bringing shame to the family outweighed the need to protect themselves. Those experiencing abuse were unable to access support systems due to language barriers and cultural dissonance when trying to find help.

From an intersectionality perspective, the acculturation gap, individual differences in language proficiency, education level, and income status can all shape how abusive situations are interpreted and experienced (Chang, 2016a). From an ecosystemic perspective, interpretations of abuse are influenced by individual differences and their relationship with the social, cultural, economic, and political environment (Heise, 1998). Subjective and nuanced cultural interpretations of elder abuse influences perceptions and experiences of abuse and its consequences, and what intervention strategies are perceived as acceptable, appropriate, and potentially effective. Lee and colleagues (2011) reported that older Korean immigrants in the United States perceived only physical abuse as a reportable offence, compared to older adults in Korea who viewed other types of abuse such as emotional abuse to be equally worthy of reporting to authorities.

As immigrants age, they face challenges reconciling cultural differences between their old and new countries (Kim, Kim, & Hurh, 1991). Expectations about aging can differ depending on place of origin. In Korea, elders in the family are usually treated with respect and frequently consulted on important family matters (Chung, 2016). Our participants often remarked that the younger generation was heavily influenced by "Western values" and did not know how to respect elders. Moreover, because of language barriers, many of our participants had to rely on their English-speaking children to navigate social-support systems and resources – and access to their grandchildren. This reversed the customary family hierarchy, creating unsettling cognitive dissonance for many older immigrants.

Family conflict is rarely discussed with those outside of the trusted inner circle (Lee & Eaton, 2009). This creates a sense of deep-seated resentment and indignation about elder abuse; This emotion is similar to the Korean concept of "han," which can be defined as "an internalized feeling of deep sorrow, resentment, grief, regret, and anger" (Kim, 2019). This concept reflects complex emotions that may be related to suppressed trauma among Korean people, who have suffered from a long history of foreign invasion, oppression, and colonialism (Kim, 2017). Many of our participants felt disappointed and frustrated at not being able to seek justice while witnessing or experiencing abuse, but they often felt that sharing such trauma with service providers and authorities violated the cultural norm for how to handle these issues.

Conclusion

We identified four predominant elder abuse risk factors at micro, meso, and macro-levels: lack of knowledge of English language, financial dependence on others, social isolation, and cultural differences that intersect

to increase the risk of abuse. Public health practices and policies intended to address elder abuse should consider the dynamics of intersectionality at individual, community, and societal levels. Intervention strategies must be culturally and linguistically responsive to maximize their effectiveness. Given the importance of community-based agencies such as churches, more consistent and structured support should be provided for agencies serving immigrant populations. Providing strategic and concerted support to community-based agencies will be an important step toward addressing elder abuse.

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Chapter 13. Awareness of Formal Social Supports Among Older Immigrants in Mid-Sized Urban Communities: The Case of Waterloo, Ontario

HECTOR GOLDAR PERROTE AND MARGARET WALTON-ROBERTS

The proportion of older adults (aged 65 and over) in Canada is currently about 18 percent (Statistics Canada, 2020). Estimates suggest that by 2030, nearly one in four Canadians – 23 percent – will be 65 years or older (Employment and Social Development Canada, 2014). Canada is somewhat unique in that a substantial proportion of its older adults have a migration background. These older immigrants face general challenges associated with aging and also contend with heightened risks such as income insecurity, discrimination, and difficulties in accessing and utilizing necessary services later in life. Previous research has revealed that older immigrants – particularly new immigrants and refugees – are especially vulnerable to social isolation, which in turn increases their risk of experiencing poorer health outcomes and a lower quality of life (Employment and Social Development Canada, 2018, 3).[1]

In response to these challenges, the "Aging Well" project was conducted to clarify the social needs, networks, and support of older immigrants in Ontario and to determine how best to foster their capacity, resilience, and independence. This large-scale research initiative was funded by the Social Sciences and Humanities Council of Canada (Guruge et al. 2019). The project drew from an intersectionality perspective and an ecological model, and employed a collaborative, community-based, mixed-methods approach. Surveys, focus groups, and interviews were conducted across four cities in Ontario: Toronto, Ottawa, Waterloo, and London. Participants included service providers, community leaders, older immigrant adults, and their families. The research team focused specifically on Arabic, Mandarin, and Spanish-speaking communities.

This chapter explores a subset of the data gathered for the Aging Well study, specifically data collected in the Region of Waterloo. Located about 100 kilometres west of Toronto, the region encompasses the cities of Cambridge, Kitchener, and Waterloo. As of 2019, its population was estimated at 617,870 (Population, Region of Waterloo, n.d). This growing, mid-sized region is home to two large universities and a still relatively important manufacturing sector. As of 2016, 22.6 percent of its residents were immigrants – the third-highest proportion of immigrants in Canada outside of the Greater Toronto Area (Region of Waterloo, 2019, 5). The Waterloo component of the Aging Well study involved eight focus group sessions with a total of

1. Social isolation can be defined as a "situation in which someone has infrequent and/or poor quality contact with other people" (Employment and Social Development Canada, 2018, 3). Social isolation is somewhat different from loneliness, which Hawkley and Cacioppo defined as "the distressing feeling that accompanies the perception that one's social needs are not being met by the quantity or especially the quality of one's social relationships" (2010, 1).

65 older Spanish-speaking and Mandarin-speaking older adults who are 60 years of age or older and had lived in the Waterloo region for 20 years or less. The participants were also asked to fill out a questionnaire about social support. All focus groups were conducted in the first languages of the participants. Additionally, eleven family members and seven community leaders were either interviewed individually or participated in dedicated focus groups.

The following discussion explores these primary data with a specific focus on service awareness, which we define as the knowledge that older immigrants have about the formal supports to include healthcare, legal, educational, social, and settlement services that are available in their community. To assess service awareness, we conducted a thematic analysis. We read through the focus group transcripts, identified emerging themes, and analyzed them within the larger context of the municipality (e.g., community composition and structure, available services). This approach helped reveal how familiar the study participants were with the available formal supports, what information they had about these programs and services, how they had learned about them, and how both services and communication about services might be improved. Our discussion and analysis drew from the social determinants of health approach and from Cantor's theory of "social care" (1989).

Ensuring access to services is vital for fostering social embeddedness among older immigrants in Canadian cities and can also mitigate the often overlooked but serious and growing epidemic of social isolation. That said, older immigrants can only benefit from available formal services if they are aware of their existence. In this chapter, we aimed to amplify the voices of older immigrants in order to convey their perspectives on service awareness. Our focus did not center on the viewpoints of service providers, or community leaders, nor on their efforts to raise service awareness. Instead, we concentrated on capturing the perspectives of older adults themselves. Our hope was that this discussion would reveal valuable insights, identify place-specific gaps and vulnerabilities, and potentially help stakeholders in Waterloo and beyond optimize the provision of formal supports in their municipalities.

Research on Service Awareness

Several factors affect the reach and effectiveness of formal supports for older immigrants. First, services and programs must be available, which itself requires the recognition of specific needs and a community commitment to meet them. Service availability is also dependent on the characteristics of each individual city/municipality, particularly funding. In Ontario, funding cuts over the past decade have reduced both the quality and the availability of services for immigrants at large (Guruge et al. 2019, 2). Effective coordination between agencies, service providers, and other stakeholders is another factor. Xie and colleagues (2020) noted that ensuring the inclusion of vulnerable populations may not always require new interventions but rather coordinated implementation.

Furthermore, the availability and delivery of quality information are crucial. Older immigrants need to be aware of the available community supports to be able to access them. Several Canadian studies have explored this and other related topics in detail, including the quality of information about formal services available across different communities, awareness levels among older adults, and communication strategies

employed by service providers. However, there remains a gap in research specifically focusing on older immigrant adults themselves. Some Canadian studies have aimed to understand how service providers across various sectors can increase their visibility in local communities and be more effective in terms of their communication, information dissemination, and outreach methods. For example, Deville-Stoetzel and colleagues (2021) recommended using a series of strategies to increase attendance at cardiovascular health awareness program meetings by older adults living in subsidized housing in Quebec. Their suggestions included improving confidentiality, relying on community peer networks to enhance recruitment, engaging opinion leaders and other types of "bridging" individuals, and pairing attendees to increase the likelihood of participation. MacLeod and colleagues (2016) found that innovative programs, such as the one they helped design in Ontario with the help of volunteers interested in the expressive arts, can help reach isolated older adults living in rural areas. Additionally, numerous service providers, umbrella organizations, and different levels of government have compiled lists of "best practices" to optimize outreach strategies (see Edmonton Seniors Coordinating Council, 2010; Ontario Age-Friendly Communities, 2021; Public Health Agency of Canada, 2010).

Other studies have focused on the perspectives of older adults themselves more specifically and the degree to which they are informed about the available supports in their communities. Tindale and colleagues (2011), for instance, studied the social determinants that influence awareness of community support services among older adults in Hamilton, Ontario. Denton and colleagues (2008) reported high levels of perceived need but low levels of awareness of available support. Employment and Social Development Canada (2018) also identified lack of awareness of community programs as a significant risk factor for the increasing numbers of new immigrants and refugee older adults who are at risk of social isolation.

Diversity of Perspectives

As we began to analyze our dataset, we noticed a clear diversity of perspectives among older immigrants within the Spanish and Mandarin-speaking communities in the Region of Waterloo in terms of their awareness of the available services and their related concerns. Significant differences were also evident among individuals from the same community. Factors including gender, educational level, socioeconomic status, and residency status all clearly influenced the information older immigrants had about available social support services in the Region of Waterloo. Our findings also revealed that additional variables such as personality and extraversion, energy levels, degree of connectedness, interests, and hobbies – which tend to be overlooked in academic analyses – also played significant roles in this respect.

These findings highlighted the importance of nuanced analysis. While broad concepts and terms such as "Spanish-speaking older immigrants" are valuable in some contexts, it is important to acknowledge that older immigrants are a heterogeneous group with significant differences among individuals. They all have diverse life courses, personal circumstances, and varying experiences of aging, all of which influence their independence, capacities, resilience, and long-term care needs.

As noted, we identified varying levels of familiarity with the available social supports in Waterloo. Some respondents were very well connected and embedded in the social matrix of the community. Typically, they

were younger, and many were women. They tended to participate actively in social programs and activities in the Region of Waterloo, whether as clients or volunteers. Their engagement had a positive cascading effect: these residents were quite knowledgeable about the available formal supports in their community, which, in turn, made them more resourceful and socially connected. Other respondents were moderately aware and felt that there was a general lack of awareness among their community members. One participant said, "There is a lack of awareness … Not everybody knows about the available programs and services." This sentiment was echoed by other respondents who made comments such as, "Yes. Definitely. There is that lack of information … it seems that most of us don't know these kinds of supports." Some, who were relatively dependent on their children, mentioned "we are not sure of what is out there – what is available and not. Everything is done by others, not us." Even the least connected and least active respondents had some degree of awareness of the supports available in the community. However, some focus group participants indicated that this was the first they had heard about many of the available supports. Our research also revealed that some older immigrants were not connected at all and that they remained difficult to reach. Previous studies have reported the problem of underutilization of services among older immigrants[2], with lack of awareness being a significant contributing factor.

It is important to note that, in some cases, lack of information is not the main problem; certain services and programs may simply not be available in medium and small cities. Larger cities, such as Toronto, tend to have a higher proportion of foreign-born residents, and immigrant communities in these cities tend to be better organized, have community centres of their own, and more able to offer programs and services targeting older immigrants. Given the relatively short distance between the Region of Waterloo and the Greater Toronto Area, comparisons are inevitable. However, living in larger cities may not always be the best option for older immigrants. For example, larger cities can be less affordable and present challenges related to transportation. Typically, though, they have the capacity to offer more services compared to smaller cities and towns.

Aspirations and Experiences

Members of both communities generally hoped to enter a language-specific long-term-care facility if needed, or at least to have access to services provided in their mother tongue. The Region of Waterloo provided some services in German, but few institutions offered services in Spanish or Mandarin. The Mandarin-speaking community was particularly vocal about the need for ethno-specific care, partly due to language barriers and food preferences. To a lesser degree, Spanish-speaking participants had similar hopes. Several respondents from both communities reported feeling uneasy about care facilities in Canada, citing concerns about affordability and quality.[3]

With regard to the provision of health care, the Region of Waterloo had several health professionals who spoke Spanish or Mandarin, but respondents felt there was a need for more. Some mentioned that they rarely visited their doctor for this reason, while others noted they were reluctant to go to hospitals due to

2. See Guruge (2019) for more details.
3. This complex discussion is beyond the scope of this chapter but involves many factors (e.g., reputation, different expectations, and cultural models of care).

potential language barriers with nursing staff[4], and tried to manage their health problems on their own, (e.g., by self-medicating). The lack of English proficiency posed a significant barrier to their access to healthcare, especially during emergencies.

With regard to social/educational programs, participants commented that some of the activities they wanted (e.g., Zumba) were not offered at local community centres or were offered exclusively in English (e.g., yoga.) Ethno-cultural groups and associations serve as places of care, identity, and connection, playing crucial roles in service provision and fostering awareness about available supports. However, at the time of writing, the Spanish-speaking community in the Region of Waterloo lacked its own cultural centre.[5]

We also found that while a relatively large proportion of the older immigrants were aware of available support services, many were unable to access them. One main barrier was *transportation*, as cultural centres and churches were often far from the homes of some participants. Others could no longer drive or did not have a license. Despite some access to public transit or senior-specific accessible buses, respondents expressed concern about fares. For instance, in many parts of China, older residents do not pay to use local buses. Additionally, issues, such as, inconvenient schedules,routes, commuting time, and hazardous winter conditions hindered access.

Another important issue is *lack of adequate English-language skills*: Waterloo is becoming more multicultural, but most services continue to be offered predominantly in English. Some respondents also highlighted *affordability* as a significant barrier, referring not only to the costs of activities and services (e.g., theatre, courses at community centres, dental care), but also the associated costs (e.g., course materials). Many older immigrants in Canada have modest incomes (Kei et al. 2019): one of our respondents stated simply: "it's the money; it is not enough." Financial insecurity among older immigrants can have many consequences: from poor nutrition to difficulties finding appropriate housing, to increased risk of social isolation.

Disability and limited mobility were also identified as challenges, and some older immigrants spoke about disappointing experiences with service providers in some settings, which made them reluctant to seek assistance. Participants also had *different conceptions of public space*. For example, Chinese older adults tended to be relatively physically active and prioritized physical activities such as dancing and tai-chi. However, without a dedicated place of their own, some had received complaints about being "very loud" when using public spaces or even their own residential spaces.

Another issue worth noting is that awareness of a service (e.g., legal assistance) does not always guarantee that individuals will be able to benefit from it. Some participants commented that *they did not know how to obtain satisfactory information* about certain services. Others noted that some available programs did not consider *cultural differences*, and that certain topics (e.g., sexuality, mental health) were not handled appropriately. As a result, some programs that focus on older adults become inapplicable or uninteresting

4. Some – but not all – immigrants may have family members or friends who can translate. Larger hospitals (e.g., in Toronto) are likely to employ more multilingual employees. Another issue is transnational healthcare: many immigrants seek medical care when they return home for more personalized treatment, faster results, convenience, etc.
5. Churches play a very important role for Spanish-speaking older adults but may not be as inclusive as an ethno-cultural association.

to some groups or individuals. In addition, some programs struggled to stay afloat because they were *underfunded*.

One issue requiring more research is fragmentation, especially the *lack of trust* within some communities. Financial scams, intracommunity dynamics, and other issues can make older immigrants more guarded and less proactive in reaching out[6]. Some respondents reported discriminatory incidents and other difficulties preventing them from fully integrating into local culture.

Finally, engagement with sociocultural programs is influenced by *personal preferences*. Some older adults were simply not interested in the activities offered or had grown too accustomed to their routines. Overall, there was room for better advertisement strategies, but service providers could do only so much when a segment of the target population is not interested. One excerpt from a conversation illustrates this kind of apathy:

> [Person 1] "I have noticed that this information is featured in the bulletins but people…"
> [Person 2] "Maybe they don't read them"
> [Person 3] "They don't read them"
> [Person 1] "And they carry them by the hand!"

Overall, many of our respondents perceived the available supports as efficient, fair, fostering equality, and free from corruption. Still, more work is needed to engage with older immigrants and consider their feedback to optimize existing community supports. In spite of the initial recruitment challenges, respondents were grateful for the opportunity to participate in our study and learn more about these topics. They showed eagerness to stay informed and actively contribute to the community. To maintain this momentum and avoid apathy, there is a need for fine-tuning systems. One participant said, "What would be good now is that, since you know about that [service], you [go] tell the secretary here about it so that she can inform us all about these things."

We observed relatively high levels of political engagement among participants: Many were proactive, informed, and curious about the state of affairs in other cities and countries. For instance, one participant commented, "One more thing that I want to suggest [is] based on what I have learned about the policies practiced in Switzerland." Others expressed their desire to make meaningful contributions, with statements such as, "even after retiring, we have continued to contribute. In return, we hope that the local government does more practical things for us." Respondents were eager to engage with other cultures and learn from others, which speaks to their resilience, ability to adapt, and eagerness to contribute and to belong. We also identified differences in terms of willingness to participate more actively in the community and become better informed; these differences were influenced by personal preferences, lifestyle and routines, and narratives of self-reliance.

With regard to optimizing services and facilitating access in the future, we found that most older immigrants relied on word of mouth to obtain information about formal supports. Many reported relying on family,

6. This has repercussions in terms of advocacy: stronger communities tend to mobilize and advocate for their needs more efficiently.

friends, cultural centres, and churches for information. A few said they had seen advertisements in bulletins, magazines, and posters, but questioned their effectiveness (see Choi & Smith, 2014). Others reported accessing information from the internet or messaging apps such as WeChat. Overall, there seemed to be a consensus that better information-dissemination strategies were necessary. During one focus group, the moderator asked "What are we lacking here? What do you miss? What do you think could be improved when talking about institutional services?" Respondents replied with comments including: "communication," "more [information] about all these services," and "regarding advertisement, there is not enough diffusion, other than the posters that they hang in the lobbies at these community centres." Clearly, participants felt that there was room for improvement in the flow of information.

With regard to improving the flow of information, some participants reported that family doctors could play a more active role in facilitating information about support groups or activities such as workshops. Other participants mentioned that social workers or pharmacists could fulfill a similar function. Spanish-speaking participants noted that churches served as crucial nodes in communication networks that effectively disseminate information of interest. To our knowledge, the churches and priests in the Region of Waterloo were informed and active to an extent but they may not have been aware of all available institutional supports. Some participants suggested that a hotline staffed by employees who spoke their native language might be a valuable source of information. Other\s commented on the need for more coordination between local service providers. Overall, improving dissemination strategies will be essential to ensure that available social supports are well known among target populations. Addressing this barrier will be much more effective in the short term than attempts to tackle more complex issues such as income insecurity among older immigrants.

Conclusion

Service awareness is a key factor in the provision of quality care and services for older immigrants. These services can not only help them age well but also benefit broader society by addressing the increasing challenge of social isolation. To optimize existing services, it is essential to listen to older immigrants themselves. Our thematic analysis of the transcripts from a series of focus groups conducted with older immigrants in the Region of Waterloo, show varying levels of familiarity with formal supports among the study participants. Many were aware of the available services in the region. However, a significant proportion did not have access to such information. Moreover, being informed was not sufficient to guarantee access to services. Barriers such as transportation issues, limited English proficiency, and financial constraints hindered access to services for many respondents. The study participants identified a need for ethno-specific long-term care options. We found that many respondents were eager to actively participate in their community and wanted to be better informed about the available supports. Harnessing this enthusiasm will be crucial for future practice and policy efforts. Most participants relied on information from friends, family, cultural centres, and churches, which can be potential avenues for service dissemination. Efforts to enhance service access should prioritize more efficient strategies, recognizing the heterogeneity among older immigrants both across and within communities.

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Chapter 14. Spatial and Language Discordance in Accessing Physicians Among Older Immigrants in Toronto: Identifying Barriers, Facilitators, and Interventions

LU WANG; SEPALI GURUGE; AND ALEXANDRA WEHR

The Canadian population is aging rapidly, reflecting global trends. Low birth rates, increased life expectancies, and the aging of the baby boom generation have resulted in a shift toward a larger proportion of older adults (Canadian Institute for Health Information, 2011). In 2016 and 2021, about 17 percent and 19 percent of Canada's total population were classified as older adults (65+ years) (Statistics Canada, 2017a; 2022), and by 2036, this figure is expected to increase to almost 25 percent (Turcotte & Schellenberg, 2007). This demographic transformation will continue to increase demand for existing healthcare services, many of which are unevenly distributed across communities, neighborhoods, and cities.

Immigrants in Canada experience disparities in health and access to primary care compared with their Canadian-born counterparts, and these disparities can be even more pronounced for older immigrants living with chronic conditions (Canadian Institute for Health Information, 2011). Geographical variations in health can be explained by both compositional effects resulting from individual differences and contextual effects related to the differing physical and social attributes of neighborhoods. Recent trends including the suburbanization of older immigrants (Channer, Hartt, & Biglieri, 2020) and the spatial clustering of physicians speaking ethno-specific languages within urban areas have resulted in spatial–language discordance, further challenging older adults with limited mobility, access, and social support. Another issue affecting older immigrants is the influence of interconnected social determinants of health including class, race, and gender (Bryant et al. 2004; Subedi & Rosenberg, 2014). Finally, the health of older immigrants may be affected by length of residency and exposure to the Canadian healthcare system. For example, newly arrived immigrants tend to have better health than non-immigrants, but their health status tends to decline with length of residence (Newbold, 2009; Setia et al. 2011; Subedi & Rosenberg, 2014).

This chapter presents the results of an ongoing study investigating the barriers and facilitators to accessing primary health care among older immigrants, with the goal of informing policies and improving access through translation services, joint efforts with community agencies, and other community-based practices.

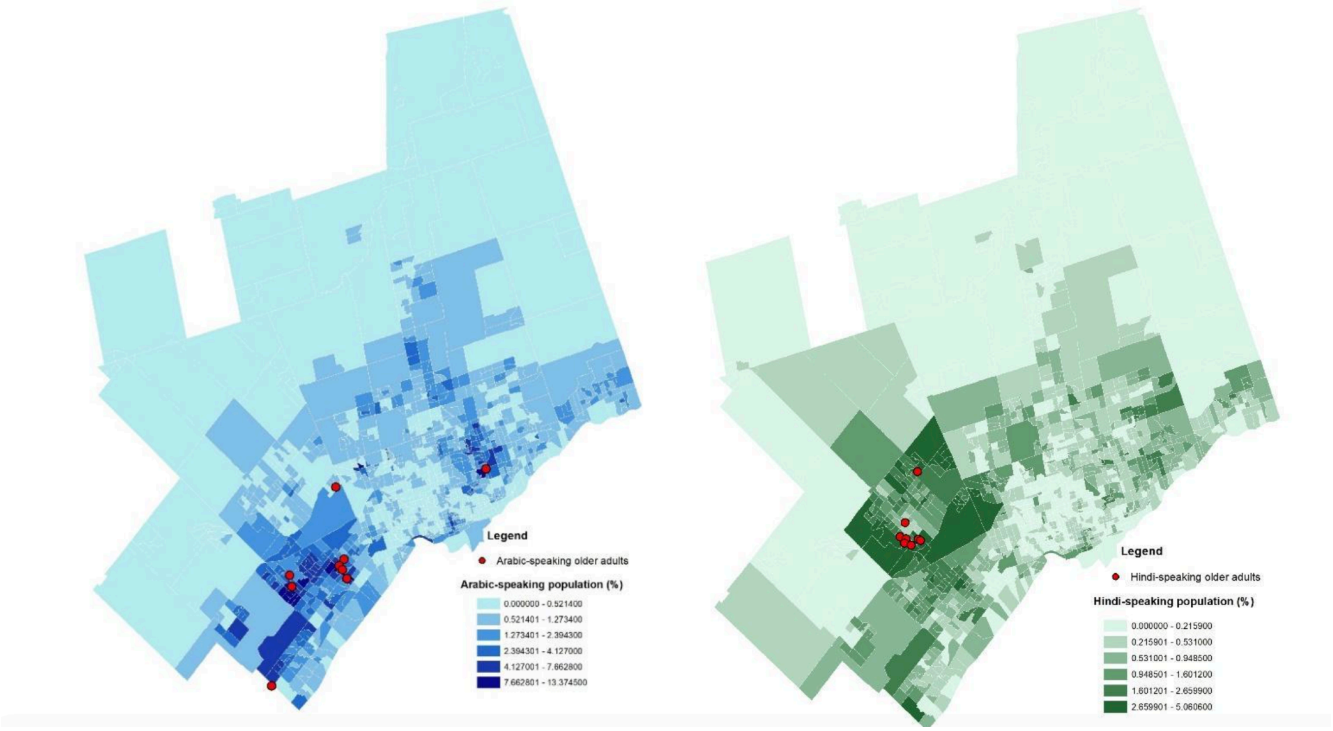
The Project

This four-phase project is focused on older immigrants (aged 65+ years) in Canada. Phase 1 involved a

scoping review of the relevant literature. For Phase 2, we recruited participants from three stakeholder groups: Arabic- and Hindi-speaking older immigrants, representatives from community organizations, and healthcare practitioners. Phase 3 involved a symposium that took place in June 2019. The project is currently in Phase 4: knowledge synthesis and dissemination.

All project activities were set within the Toronto Census Metropolitan Area (CMA) in Ontario. According to the most recent census, its total population was 6,202,225 in 2021 (5,862,850 in 2016), including 2,862,850 (2,705,550 in 2016) immigrants (Statistics Canada, 2017b; 2021). Of these immigrants, 460,940 (about 17 percent) are classified as older adults (65+ years) in 2016 (Statistics Canada, 2017b). We focused specifically on Arabic- and Hindi-speaking older immigrants. Canada has a long history of immigration from South Asia, including Hindi speakers, while the Arabic-speaking immigrant population is relatively more recent. About 1.5 and just under 1 percent of the total population of the Toronto CMA lists Arabic and Hindi as their first language, respectively (Statistics Canada, 2016). Both of these groups face settlement challenges and barriers in accessing health care (Gulati et al. 2012; Woodgate et al. 2017). In general, Arabic-speaking older immigrants tend to cluster in the suburb of Mississauga, while Hindi-speaking older immigrants tend to cluster in the suburb of Brampton (see Figure 14.1).

Figure 14.1. Arabic-speaking and Hindi-speaking populations in Toronto CMA at a census tract level



Phase One: Exploring the Literature

We conducted a scoping review on access to primary health care among older immigrants in Canada (Wang, Guruge, & Montana, 2019). Specifically, we utilized Arksey and O'Malley's five-stage framework to examine

31 peer-reviewed articles, focusing on three main areas: access and use of primary care, health promotion and cancer screening, and use of mental health services. The review revealed intersecting factors affecting access to health care, including health literacy, language and cultural barriers, health beliefs, spatial access, and structural barriers.

Access and Use of Primary Care

Family physicians are on the front lines, providing primary care for older immigrants who may have various chronic health problems. Our literature review included articles focusing on healthcare access among older immigrants from multiple ethnic and racialized groups including South Asian (Surood & Lai, 2010); Afro-Caribbean, former Yugoslavian, and Spanish (Stewart et al. 2011); and Chinese (Chow, 2012; Lai & Chau, 2007). Healthcare access may be influenced by a lack of culturally appropriate services and health information, personal and traditional beliefs, and spatial factors such as available modes of transportation (Lai & Chappell, 2006; Lai & Surood, 2010; Thomson et al. 2015). One main barrier is the lack of translated health information, especially for older immigrants. In primary care settings with limited language options, older immigrants may use improvised sign language, or have friends or family translate, or utilize paid interpreters (Stewart et al. 2011; Surood & Lai, 2010).

Immigrants are less likely than their Canadian-born counterparts to depend on a family physician. When access to a family physician is limited, older immigrants may seek access to primary care through hospital emergency rooms and walk-in clinics; this appears to be more common among recent immigrants compared to more established immigrants (Tiagi, 2016). One study reported that in Mississauga, older immigrants from China, India, Pakistan, and Romania attributed their reliance on emergency rooms and walk-in clinics to the inability of family physicians to accommodate new patients (Asanin & Wilson, 2008). Another issue is mobility: the unavailability of nearby family physicians is a major barrier to accessing healthcare among older immigrants with limited mobility (Wang et al. 2019). One study also reported that recently arrived older immigrants had lower rates of hospitalization compared with more established immigrants and Canadian-born counterparts (Ng et al. 2014).

Health Promotion and Cancer Screening

Older immigrants who receive preventative care services, such as cancer screening and general health promotion strategies, generally obtain them from family physicians. Major barriers to accessing preventative care services include differences in culture and language, unavailability of local practitioners, and challenges related to mobility and access to transportation (Gesink et al. 2014; Koehn, Habib, & Bukhari, 2016; Todd, Harvey, & Hoffman-Goetz, 2011; Todd & Hoffman-Goetz, 2011). Some studies have explored breast and cervical cancer screening among immigrants in various regions of Canada, and have found that older immigrants seeking these services face challenges related to unmet language and cultural needs, inadequate education about screening practices and methods, and inability to access a family physician (Ahmad & Stewart, 2004; Vahabi, 2011).

Breast cancer screening rates among Arab, Chinese, South Asian, and Vietnamese immigrants are also

affected by the preference for, and availability of, female physicians (Crawford et al. 2015). Asian immigrant women also appear to use mammogram services less, partly due to their lack of ability to speak English or French in a primary care setting (Sun et al. 2010). Rates for cervical cancer screening methods such as Pap tests are lower among immigrant women than their Canadian-born counterparts, but rates tend to increase with length of residency (McDonald & Kennedy, 2007). Ontario-based research has revealed that cervical cancer screening rates are lower among older women who are recent immigrants, racialized, and/or living in low-income neighbourhoods (Amankwah, Ngwakongnwi, & Quan, 2009; Lofters et al. 2010).

Use of Mental Health Services

Relatively few studies have focused on access to mental health services among older immigrants. The limited research evidence suggests that older immigrants generally underutilize mental health services (Kirmayer et al. 2007; Thomson et al. 2015) but rates may vary based on length of residency, as well as ethnic and racialized background. For example, rates of access to mental health services were lower among recent immigrants compared to established immigrants and Canadian-born community members, and rates were lowest among immigrants from Asia and the Pacific (Durbin et al. 2015).

One study conducted in Toronto, revealed that older Chinese and Tamil adults are limited by a general lack of mental health workers providing services to specific language groups, discrepancies in knowledge of mental illnesses, and cultural stigma that encourages a private approach to mental health problems (Sadavoy, Meier, & Ong, 2004). Another study involving South Asian immigrants also reported that access may be affected by traditional beliefs and attitudes about mental health and illness (Lai & Surood, 2013). A study conducted in Calgary revealed that only 11.4 percent of older Chinese adults could correctly identify depression, compared with 74 percent of the general population (Tieu, Konnert, & Wang, 2010). Interventions to improve access rates should involve culturally relevant health promotion efforts to reach specific immigrant groups.

Phase Two: Stakeholder and Community Voices

The second phase of this project involved three stakeholder groups to explore how these they felt about primary care and access to services. We interviewed and surveyed Arabic-speaking and Hindi-speaking older immigrants (in their preferred language). We also interviewed and surveyed representatives from community organizations, as well as healthcare practitioners serving these language groups. Research approval was granted by the Research Ethics Board at Toronto Metropolitan University. We recruited the older immigrant stakeholders through community outreach, using flyers and other media posted in community hubs. Representatives from community organizations were recruited through contacts with our existing community partners; we also asked these community organizations to share information about the project with their older immigrant clients. We recruited healthcare practitioners through word-of-mouth, as we have worked with them in the past on other projects.

Data were cleaned and organized, and then analyzed using descriptive analysis for survey data and thematic

analysis for interviews (Braun & Clarke, 2006, 2014; Schreier, 2012). As discussed in the following sections, four key themes emerged related to access to primary care by older immigrants: systemic gaps in levels of care; gaps in communication and education; service access gaps and privatization; and mental health gaps, stigma, and fear.

Systemic Gaps in Levels of Care

> By the time they get to see a specialist, their health is deteriorated more. What if they do not even survive until then?
> — Older immigrant

Several systemic gaps were identified by Arabic-speaking older immigrants; these were echoed by representatives from community organizations as well as healthcare practitioners. Older immigrants noted that they generally accessed family physicians as their primary point of care, and most were satisfied with the services they received from these practitioners. However, they considered the long wait times, language barriers, and costs associated with seeing a specialist to be prohibitive, noting that specialists were often unable to accommodate their health needs (e.g., monitoring illness progression, and extended care), and that seeing a specialist involved communication challenges and financial stresses. Healthcare practitioners also identified the need for consistent care, and follow-up when referring patients to other avenues of health care, including specialists.

Hindi-speaking community members also reported many of the same problems when navigating the healthcare system beyond their usual family physicians. They referred specifically to the problem of long wait times for specialist care when a health problem was serious and required urgent care. This situation was exacerbated by the inability of most specialists and emergency care providers to speak Hindi. The healthcare practitioners serving these older immigrants noted that they do have some employees who speak the necessary languages, but that trained translators and certified translation services are desperately needed.

Gaps in Communication and Education

> Sometimes the doctor doesn't have time to listen to the patients.
> — Older immigrant

Both Arabic-speaking and Hindi-speaking older immigrants identified communication and education-related gaps. Representatives from community organizations reported that they often assist with translation, transportation, and the completion of medical forms. Despite this, older immigrants commented on issues including a lack of ongoing communication between patients and physicians, lack of information about the Canadian healthcare system's structure for recent immigrants, and the need for older immigrants' voices to be genuinely heard when addressing their health issues.

The language barriers between older immigrants and certain healthcare providers (specialists, emergency

attendants, and others apart from family physicians) increase the risk for misdiagnoses. Representatives from community organizations interacting with Arabic-speaking older immigrants also stressed the need for access to spaces of safe communication (e.g., religious spaces such as mosques or other community settings); they also reported that follow-up from doctors helps make older immigrants feel valued.

Representatives from organizations working with Hindi-speaking older immigrants noted that patients tend to be embarrassed by their inability to communicate effectively in English. Many older immigrants rely on their children and other caregivers to take them to appointments and relay medical information, and the representatives associated this reliance with frequent misunderstandings of diagnoses, especially related to technical medical terminology. Healthcare practitioners stressed that peer support is important: some noted that Arabic-speaking older immigrants had difficulty with follow-up appointments and taking medication regularly; others noted that Hindi-speaking older immigrants required more community-based education and outreach.

Service Access Gaps

> Eye treatments are too expensive, and dentists are too expensive as well.
>
> — Older immigrant

Arabic-speaking older immigrants commented on the long distances between their homes and doctors, although most also said that they would undertake the journey to see doctors who speak their language. Strikingly, one community member lives in Burlington but sees a family doctor in Mississauga: this is a significant distance for an older immigrant facing additional structural and institutional challenges.

Hindi-speaking older immigrants commented that physiotherapy services are often difficult to access and pay for. Similarly, the high costs of dental and eye care were cited as major issues for both language groups struggling with financial hardships. Representatives from community organizations explained that transportation systems (Toronto Transit Commission, MiWay transit system in Mississauga, and Brampton Transit) are complicated for older immigrants in both language groups, especially when they must travel long distances. Healthcare practitioners confirmed these transportation difficulties for their Arabic-speaking and Hindi-speaking older immigrant patients and also emphasized the importance of prevention for health issues that would require privatized care services.

Mental Health Gaps and Stigma

> I just want to say that we do not know how much longer we are going to live in this world. God knows what other problems await us.
>
> — Older immigrant

Older immigrant participants from both language groups commented on long wait times for access to mental health professionals. Hindi-speaking older immigrants cited fears of deteriorated mental health while waiting to see a specialist. Representatives from community organizations were quick to note that

many Arabic-speaking older adults had recently immigrated from conflict zones and may therefore have serious mental health challenges requiring care from mental health specialists.

Representatives from organizations working with Hindi-speaking older immigrants commented that recent immigrant older adults suffer culture shock and anxiety, while long-term older immigrants may experience family-related stresses that can lead to depression and isolation. Service provider participants also noted that there is stigma surrounding mental illness in the South Asian community, as in many others, and that many individuals who need mental health services are told that their issues are "all in their heads." Healthcare practitioners working with Arabic-speaking patients also commented that social workers should be more involved in care. One practitioner working with Hindi-speaking older immigrants noted that the families of older immigrants, and even other healthcare providers, tend to use that "reality" against them to exert control over their lives.

Phase Three: A Collective Exchange of Ideas

The third phase of this project involved planning and hosting a symposium to facilitate communal knowledge sharing. This symposium was held at Toronto Metropolitan University and brought together a range of stakeholders including students, faculty members, health, social and settlement service providers, and representatives from analytics firms.

The event included a number of key presentations and provided opportunities to collaborate. Dr. Lu Wang (the first author of this chapter) delivered a keynote presentation outlining the project background, objectives, and methodology. While this project focused specifically on Arabic-speaking and Hindi-speaking older immigrants, Dr. Wang also spoke about Mandarin-speaking and Cantonese-speaking older immigrants – both large immigrant communities within the Greater Toronto Area – commenting that older immigrants are not well-represented among secondary data sets such as the Canadian Community Health Survey based data.

In the discussion that followed Dr. Wang's presentation, guests noted that those who know how best to navigate the healthcare system benefit the most. They also commented that immigrants require more support in terms of health advocacy, and that community health centres enable better syntheses of services: they may send a patient to a specialist immediately, while going to a private or family practice may create additional barriers. Points of privilege emerged as a central theme: some older immigrants do not have the means to pay for privatized health services or insurance, and services covered by the Ontario Health Insurance Plan may be too far away to access.

Gelsomina Montana was a co-author of the scoping review conducted for the first phase of this project (Wang, Guruge, & Montana, 2019), and spoke about the key themes of access and use of primary care, health promotion and cancer screening, and use of mental health services. Guests attending this session discussed screening patterns among immigrants and identified differences based on Ontario Health Insurance Plan coverage, misinformation among older immigrants, and general lack of awareness of the services. Some participants commented that patients felt uncomfortable in waiting rooms and with doctors who did

not speak their languages. Community health centres were identified as sources of culturally sensitive service provision, although these also involve difficulties. For example, social workers might ask patients to travel significant distances to reach appropriate services and/or treatment, which is problematic if the patient lacks access to transportation. This discussion period revealed that older immigrants require holistic approaches to health access: approaches that frame access as multifaceted and "whole."

Selasi Dorkenoo presented a paper based on a mixed-methods study she had conducted as part of her Master's thesis on access to language-specific services for Arabic-, Mandarin-, and Spanish-speaking communities in Toronto (Dorkenoo, 2019). Guests commented on the importance of alternative methods of transportation and services that could be improved to address systemic access gaps (e.g., WheelTrans and 55+ Rideshare in Toronto). They also referred to the need for more awareness about these issues.

Samya Hasan the Executive Director of the Council of Agencies Serving South Asians, a social justice umbrella agency promoting research advocacy and attempting to influence policy for South Asian populations in Canada) outlined the demographics and factors affecting the health and wellbeing of older South Asian adults. In the discussion that followed, guests commented on the intergenerational divide in mental health understanding and care for South Asian immigrants, and the need for narrative-based intervention based on life experience. Guests also identified the general need for culturally based healthcare practices that integrate community and family support, rather than "simply prescribing medication and using a medical lens that tends to exclude other supports and intervention." Some guests commented on the importance of addressing domestic violence within the community, along with mental health supports to improve self-empowerment of victims and complement existing interventions such as law enforcement.

Dr. Peizhong P. Wang from Memorial University presented his unpublished research on healthcare access among recent older adult Chinese immigrants. About 50 percent of his study participants were able to walk to their doctors, and most were in Markham and Richmond Hill, Ontario. The subsequent discussion began with a conversation about transnational medicine. Guests noted that discrimination and other systemic barriers lead to trust issues with healthcare providers in Canada, especially among older immigrants who are often dismissed, minimized, and told that health issues are simply "a part of being old." Guests also noted that immigrant women are more at risk of medical misconduct as a result of ingrained racist, patriarchal, and colonial practices. One commented that "the general public needs to help educate doctors on how to practise" when the health outcomes of immigrant women are involved.

Phase Four: Synthesizing and Disseminating Knowledge

This chapter is a key component of the final phase of our study, because it is helping to disseminate our findings. Together, the four phases of the study are helping to clarify the current state of practice and evidence-based knowledge related to access and use of primary health care among older immigrants, including barriers. The work done has helped reveal similarities among older immigrants from various regions and with differing residential locations, language skills, lengths of residency in Canada, and socioeconomic conditions. In particular, the primary data collected in Phase 2 helped clarify the barriers and facilitators related to delivering culturally appropriate health care to older immigrants. We found that

Arabic and Hindi-speaking older immigrants face barriers including communication, lack of paid and trained translation services, long wait times, transportation, mobility issues, high costs related to eye and dental care, and stigma of mental illness. These are consistent with the key findings from the scoping review in Phase 1, and similar issues were discussed by the symposium attendees from community organizations and the health sector. Together, our findings provide evidence-based insights that can inform the development of initiatives and policy interventions. Healthcare delivery to older immigrants can be improved in four key areas: enhancing communication and providing timely and appropriate translation; providing assistance in transportation to access care including preventive care; providing additional coverage and support for eye care, dental care, and mental health care; and education for older immigrants through collaborative efforts among community organizations, community health centres, social workers, and other relevant interest groups.

Moving Forward

In our future research, we plan to further explore primary and secondary data, including Census data of different years. We will use a mixed-methods approach to collect additional data from the stakeholders. We also expect to identify supplementary funding opportunities with engaged stakeholders to further explore the barriers and facilitators for older immigrants of different backgrounds in healthcare access to develop interventions and to inform policy.

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SECTION 6: RESEARCH, PRACTICE, AND POLICY CONSIDERATIONS

Chapter 15. Recruiting Older Immigrants for Research: Opportunities and Challenges

MELISSA NORTHWOOD; ERNEST LEUNG; SOURAYA SIDANI; AND SEPALI GURUGE

Including older immigrants in research is critical to generate a representative evidence base and prevent health inequalities that may arise from excluding this group. Changes to the immigration patterns over the last few decades have resulted in more linguistic, ethnic, social, and religious diversity in many countries (Sethi, Guruge, & Csiernik, 2021). This is also the case in Canada: more immigrants are now coming from Asia and Africa, unlike the historical patterns of European immigration (Immigration, Refugees and Citizenship Canada, 2020). Immigration now accounts for about 80 percent of Canada's annual population increase (Immigration, Refugees and Citizenship Canada, 2020). Despite their large numbers in Canada and elsewhere, immigrants have historically been excluded from research for reasons related to language and access (Hughson et al. 2016; Smart & Harrison, 2017). Other challenges include mistrust of research projects, especially among older immigrants (Arean et al. 2003). As a result, little is known about their health and social conditions that shape their health and wellbeing in Canada. Researchers are now recognizing the imperative to design inclusive recruitment strategies.

Effective recruitment involves disseminating information about a study to the population of focus: the goal is to raise awareness and encourage enrollment to obtain a sufficient sample size. For quantitative studies, the sample size should be adequate to reach valid conclusions regarding the relationships among concepts or the intervention's effects, while minimizing the chances of type I error (false conclusion that there is a relationship or the intervention is effective) and type II error (false conclusion that there is no relationship or the intervention is ineffective) (Sidani & Braden, 2021). For qualitative studies, sample sizes may differ depending on the method, but the goal is to generate a credible description of the phenomenon of interest (Thorne, 2016). Recruitment strategies must also yield a sample that is adequate in composition based on the study method and design, meaning that it must represent all of the various groups making up the target population. These groups may be defined by aspects including those related to health, socio-economic or ethnic and racialized background, or experience of the phenomenon under investigation (Sidani & Braden, 2021).

Recruitment strategies can be categorized as active or passive. Active strategies involve direct contact between the recruiters and members of the population of focus; contact may take the form of informal or formal presentations to individuals or groups at relevant locations and events. Passive strategies include advertisements on social media or in newspapers. The information shared with potential participants may include the study's purpose and general eligibility criteria, the main research activities, and how to contact the research staff to learn more about the study. All types of recruitment involve challenges, most of which can be overcome. The following discussion summarizes the current state of research evidence related to effective recruitment strategies for older immigrants; we also augment this evidence with our own experiences in recruiting older immigrants for a range of research projects.

Challenges in Recruiting Older Immigrants

Inequitable Research Practices

All researchers should prioritize equity in their work and recruitment practices. However, historically many have used exclusionary research practices, such as requiring participants to speak and write in English or French, often due to the costs of interpretation and translation of research materials (Smart & Harrison, 2017). In extreme cases, inequitable research practices were applied because of lack of interest in equity in research endeavors. Even when researchers actively try to prioritize equity, recruitment challenges may be hampered by a lack of research evidence about practical strategies to overcome challenges (Feldman et al. 2008).

Communication Barriers

Some older immigrants have low levels of education, limiting their ability to read and write, even in their first language. Many newcomer older immigrants have little or no English or French language proficiency (Wang, Guruge, & Montana, 2019). Research practices that privilege English and French and written materials create communication barriers to participation. Another issue is that study materials may simply be too complicated or too lengthy (Forsat et al. 2020). Moreover, even when researchers or research assistants share a language with the older immigrants being recruited, they do not necessarily have shared life experiences, religions, and (dis)advantages etc., all of which can negatively affect effective communication (Resch & Enzenhofer, 2018).

Cultural Barriers

Some older immigrants may come from cultural backgrounds that do not value research highly, or they might mistrust researchers, especially those working in the medical field (Barata et al. 2006; Burns et al. 2008; Choi et al. 2016). Family and community can influence older adults' ability or desire to participate in research by encouraging or prohibiting it. Furthermore, data collection processes and assessment measures may be unsuited to the target communities (Hughson et al. 2016). Cultural barriers can also limit engagement in activities outside their household and ethnic community, which may limit their participation in research activities (such as, interviews or focus groups) outside the home. Older immigrants also face barriers to accessing healthcare services and facilities where information about research studies may be shared. Some of the barriers include underrepresentation of racialized healthcare providers, lack of translation services, lack of culturally safe care, and inappropriate assessment tools (Waheed et al. 2015).

Trust and Mistrust

Historical mistrust of research/researchers and healthcare systems are significant barriers to recruitment

of older adults from some immigrant communities (Barata et al. 2006; Commodore-Menash et al. 2019; Fete et al. 2019; Forsat et al. 2020; Hughson et al. 2016; Samuel, 2014; Waheed et al. 2015). The process of signing a consent form may pose concerns for some individuals (Hughson et al. 2016). Much of this mistrust is legitimate and may be amplified among older refugees who have lived through war, civil unrest, or political or religious persecution (Njie-Carr et al. 2021; Sethi, Guruge, & Csiernik, 2021).

Views of Health and Illness

Older adults – especially older immigrants – may perceive their own health and illness in ways that differ from the perceptions of researchers. For example, some older immigrants and their families may consider some health problems, such as depression, as normal age-related changes and therefore not requiring research and intervention (Arean et al. 2003; Bistricky et al. 2010). Another issue is that older immigrants may be concerned about sharing information about their mental health or changes in cognition (Arean et al. 2003) for fear of bringing shame to their families. Older immigrants may be living with multiple chronic conditions and may be homebound, and therefore may feel especially vulnerable to potential exploitation (Hughson et al. 2016; McHenry et al. 2015), thus not engage in conversations with unknown people (such as researchers).

State of the Evidence: Strategies to Recruit Older Immigrants

Together, these multiple and interacting challenges make it critical that researchers design and implement effective recruitment strategies. We searched for strategies identified as effective using relevant databases (CINAHL, Medline, PsycINFO, Embase, Sociological Abstracts) and forward citation searches (using Web of Science). Of the 76 articles focusing on the effectiveness of strategies to recruit older adults, immigrants, or persons of diverse ethnic backgrounds, only four focused on older immigrants, and these were specifically focused on Chinese and African-American immigrants (Arean et al. 2003; Li et al. 2016; Taylor-Piliae & Froelicher, 2007; Zou 2017).

All four articles reported that active recruitment strategies were more effective than passive strategies. Specific strategies included face-to-face recruitment in neighbourhoods where older immigrants lived and participated in social and recreational activities; involving community members or bilingual research staff as recruiters; and referrals from sources trusted by older immigrants like primary healthcare teams and community centre staff (Arean et al. 2003; Li et al. 2016; Taylor-Piliae & Froelicher, 2007; Zou, 2017). Face-to-face recruitment activities were conducted in a variety of settings including peer-support group settings, the homes of older immigrants, religious organizations, community centres, English-language classes, libraries, physical activity classes, restaurants, shopping malls, healthcare facilities serving immigrants, health fairs, and social clubs (Arean et al. 2003; Li et al. 2016; Taylor-Piliae & Froelicher, 2007; Zou, 2017).

The articles specific to older Chinese immigrants (Li et al. 2016; Taylor-Piliae & Froelicher, 2007) also identified several useful passive strategies for recruiting participants for clinical trials: advertisements in Chinese newspapers, television, and radio, and circulation of bilingual flyers and posters. The reason for

the usefulness of the passive recruitment strategies is unclear but may be related to the socio-educational and financial status of the Chinese immigrants in their city/neighbourhood, as well as their technological literacy. A synergistic effect may also have emerged, where potential participants saw advertisements and were also directly approached by recruiters, thus raising the profile of the research study (Taylor-Piliae & Forelicher, 2007).

Together, the four articles focusing on the recruitment of older immigrants identified four general principles or approaches that may be helpful:

- Building trust and considering gender and cultural concordance of recruiter and target group, cultural competence of recruiter, and common experiences of recruiter with the target group (Arean et al. 2003). Heterogeneity within groups may render this strategy ineffective, so recruiter competence and experience may become more important (Arean et al. 2003).
- Forming a community advisory board to advise on recruitment plans, including feedback to ensure recruitment materials and consent forms are relevant to the cultural beliefs of older immigrants (Arean et al. 2003).
- Ensuring interaction with and visibility in the community (Bistricky et al. 2010).
- Communicating information about the study in the preferred language of potential participants (Taylor-Piliae & Forlicher, 2007).

Overall, a combination of active and passive strategies is recommended. Active strategies appear to be more effective than passive strategies, but more research is needed to confirm these findings.

Insights from Fieldwork: Recruiting Older Immigrants

In this section, we share insights from our own program of research (led by Guruge). One study involving older immigrants was focused on developing preventive strategies to address elder abuse; another investigated the formal and informal social support received by older immigrants (Guruge et al. 2019a; Guruge et al. 2019b). These studies included participants from Chinese, Korean, Punjabi, Tamil, and Arabic immigrant communities. Recruitment was conducted in collaboration with community partners, using several active and passive recruitment strategies that were relevant to each community. The following discussion details our experiences, and which strategies were effective in recruiting older immigrant participants for our studies.

Snowball Sampling and Group Participation

Snowball sampling (word of mouth) is one of the most useful strategies for recruiting older people from diverse immigrant communities. It was very effective in our study on the risk factors contributing to elder abuse in immigrant communities. Many older immigrants (including those who were not eligible) forwarded information about the study to their contacts, and as a result, we were able to recruit sufficient participants

for our studies. Many of these older immigrants were willing to participate because the study provided a social space for them to connect with people of the same language and culture. Our participants told us that they wanted to remain socially active as they aged, but that their participation was limited due to lack of English-language skills. Therefore, snowball sampling may be particularly helpful for newer immigrants who do not speak English/French and are therefore not aware of, or lack access to, other recreational activities and programs available in their community.

Tailored Incentives

As with research participants in other age categories, offering meaningful incentives can be useful when recruiting older immigrant participants. Some of our participants commented that the costs associated with transportation were a barrier to participation. They wanted to contribute to Canadian society and regarded research participation as part of this contribution. However, most had not lived in Canada long enough to be eligible for a pension, and as a result, they relied on their own savings, a pension from their home country, or their children for financial support. We have found that providing cash to cover the costs of parking, transportation, and the time required to take part in the study is an effective incentive to recruitment. In contrast, honoraria such as gift cards were not as appreciated.

Flexible Interview Locations

Providing a variety of interview location options is another key strategy for optimizing study participation. We have worked with community partners to identify potentially appropriate locations for older immigrants. One effective method was scheduling interviews after regular activities of older immigrants, for example, after they had attended churches or temples. We also worked with community partners to help book a meeting room in convenient locations (such as nearby libraries or places of worship) so that older immigrants were familiar with the location/building, or they did not need to make an additional trip to participate in the study. We were aware that some elements of this method might make older immigrants worry that their relationships with the community partners would be affected if they declined to participate. To mitigate this risk, we stressed the voluntary nature of the study participation and that the community partners would not know about their decision to participate (or not), nor would they have access to any of the participants' responses.

Online Recruitment Advertisements

One passive strategy we have used is posting printed recruitment flyers in different locations frequently visited by older immigrants, such as ethnic grocery stores, community centres, churches, and temples. For example, we posted flyers at a Korean ethnic grocery store and a community agency serving older Arabic-speaking immigrants. However, this strategy was ineffective (no one responded). In contrast, we found that posting recruitment ads online is an effective way to recruit older immigrants. We posted flyers in the form of an electronic image file on our social media platforms and on various social media networks, such as Kakao Talk to reach out to the Korean community, and WeChat, a messaging application used by the Chinese

community. We have also used WhatsApp and Facebook to share recruitment information, because we have found that many older immigrants use multiple instant-messaging applications to stay connected. An added benefit of online flyers is that older immigrants can enlarge the image file with their devices, if needed, to compensate for poor vision. While the online advertisements generally targeted older immigrants with higher digital literacy, they helped amplify our reach by sharing the electronic flyers with others in their networks who were more likely to open an attachment from a friend.

Hiring bilingual and bicultural research assistants

It is critical to establish trust between potential participants and researchers/research assistants. One key strategy we have used to build trust with older immigrants is to hire bilingual and bicultural research assistants. Older immigrants are more willing to participate in research if the research assistants share the same language and/or cultural backgrounds. They can learn more about the study in their preferred language and directly interact with the research assistants (i.e., without a translator), which fosters comfort and trust. If older immigrants understand and trust the person recruiting and interviewing them, they are also more likely to help share information about the study with others (such as, their peers) as well. Awareness and attention to cultural nuances also help the research assistants build trusting relationships with older immigrants.

Direct contact with potential participants

Another effective strategy involves the active recruitment strategy of direct contact with potential participants during community activities. For example, we found that it was very effective to have Tamil research assistants directly contact older Tamil immigrants, most of whom had come to Canada after the civil war and were wary of figures of authority. This personal contact, especially before or after a community event, helped older immigrants get to know the research assistants who would later conduct the research interviews, reducing feelings of uncertainty who might be interviewing them. This approach also helped us obtain consent from all study participants to be re-contacted for subsequent phases of our longitudinal research study.

Implications for Research

Older immigrants in Canada are a heterogeneous group. When recruiting older immigrants for research, it is important to consider the intersections of various social identities (such as, ethnicity, culture, gender, age, disability, migration status, and religion), as well as systems of oppression (e.g., racism, sexism, ageism, colonialism) that can create health and social inequities (Dhamoon & Hankivsky, 2011; Sethi, Guruge, & Csiernik, 2021). Experiences of aging and dealing with aging-related health and social concerns require thoughtful consideration and tailored support: recruitment strategies that are effective for one older immigrant group may not be effective for all groups – or even all members within one group. Researchers should consider features such as community dynamics, length of time in Canada, and previous experiences

with research when attempting to recruit study participants, as well as within-group diversity related to acculturation, ethnicity, socioeconomic status, and gender.

Researchers should also work in consultation with the community of focus, and be flexible and responsive to changes as recruitment progresses, to ensure the inclusion of older participants (Chamberlain & Hodgetts, 2018). The onus is on the research community, not on older immigrants, to create the necessary conditions for inclusion. For example, researchers can employ study designs that foster citizen engagement, such as participatory action research or the use of citizen advisory boards (Markle-Reid et al. 2021). An effective recruitment plan will include multiple and synergistic active and passive recruitment strategies based on knowledge of the population of focus: this plan should be monitored and evaluated, and will likely be adapted over the course of recruitment based on feedback and observations.

Given the lack of research evidence on effective recruitment of older immigrants, we recommend that researchers document both effective and ineffective recruitment strategies for groups at various intersections of social identity. By documenting these in publications and knowledge translation activities, it will be possible to improve practical knowledge among researchers seeking to recruit older immigrants. This will also help raise awareness of the importance of employing inclusive research practices. Ideally, researchers will include an assessment of the effectiveness of recruitment strategies as part of the study design, and report this information as part of their methods or results. More research is needed to explore and understand effective recruitment strategies at the intersections of age and immigration, as well as other social locations such as those involving older refugee women or older immigrants with disabilities.

Conclusion

A thoughtfully constructed recruitment plan is necessary to ensure the inclusion of older immigrants in research, to generate a representative evidence base, and to promote health equity in research as well as in healthcare and social settings. We recommend a multifaceted approach to recruitment that is informed by the immigrant community of focus, including both active and passive recruitment strategies at the community level, with the overall goal of building and establishing trusting relationships between older immigrant communities and researchers.

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Chapter 16. Aging in Third Places: Community Spaces and Social Infrastructure for Older Immigrants

ZHIXI ZHUANG AND RYAN LOK

According to the 2016 Canadian Census, seniors (aged 65+) accounted for 21 percent of the total population of Canada, and almost one-third (30 percent) of the total senior population were immigrants (Statistics Canada, 2021). By 2046, the senior population is expected to make up about 20 percent of the total population in the Greater Toronto Area (GTA), an increase from about 15 percent in 2020. Moreover, the senior population in suburban regions of the GTA is expected to increase by 97 percent (Government of Ontario, 2021). The GTA has attracted the largest share of immigrants to Canada, and more than 56 percent of immigrants have settled in suburban areas (Vézina & Houle, 2017). Given the intersecting processes of aging, migration, integration, and suburbanization, senior immigrants experience social isolation differently than their Canadian-born senior counterparts (Sadarangani & Jun, 2014).

Some scholars working in the field of gerontology have explored social isolation among senior immigrants, including challenges related to sense of loss, living arrangements, dependence, and family conflict (Johnson et al. 2019;). These studies have primarily focused on social, economic, and political factors ranging from acculturation to interpersonal relationships with family and within the home. Scholars tend to neglect the important roles of space and place and how they may contribute to social isolation, especially among senior immigrants. For immigrants, social, economic, and political inclusion processes are fundamentally embedded in space and place, so it is imperative to understand the spatial needs and social lives of senior immigrants within the context of the public realm, and how places affect their experiences of social isolation and connectedness.

Gerontological studies of the senior population have focused on “aging in place” – referring to seniors living and aging at home rather than moving into a long-term care centre (Vanleerberghe et al. 2017). Many scholars view “aging in place” as reinforcing the autonomy of seniors within the home environment (Boldy et al. 2011). However, some scholars are now starting to conceptualize “aging in place” in conjunction with a senior’s attachment to their environment outside the home. Some seniors feel at home in their surrounding social and physical environments; these familiar environments can be physically functional, supportive, and networked, and socially and emotionally imbued with memories and experiences (Pani-Harreman et al. 2021; Van Hees et al. 2017). However, some seniors are less familiar and comfortable in their surrounding environments. Sadarangani and Jun (2014) explored how senior immigrants can experience “aging out of place,” specifically due to the physical and emotional experiences of aging in foreign environments and the associated challenges such as limited language proficiency, financial constraints, and acculturative stress.

Individuals who immigrate at an older age tend to have more depressive symptoms in their new

environment, which leads to poorer psychological wellbeing (Guo et al. 2019). Senior immigrants also have different cultural needs in terms of space, care, and services, and face challenges including limited mobility and interactions with others, poor access to culturally appropriate foods, different cultural values and norms regarding aging and death, and lack of community inclusivity (Nyashanu et al. 2020). More research is needed to investigate the intersectional experiences of senior immigrants and their relation to space and place beyond the home.

This chapter explores the role of third places and community spaces as forms of social infrastructure. Oldenburg (1999) defined third places as places outside of the home and workplace that are conducive for social interaction and engagement. To date, most studies have explored the importance of third places in facilitating and promoting social connectedness and community-building. Relatively few have focused on ethnic third places that meet diverse cultural needs (Zhuang, 2017), and specifically how senior immigrants experience social spaces outside of the home and workplace as a way to combat social isolation and foster connectedness.

The following discussion draws from secondary data, ethnographic observations (including two organized walking tours), and previous case studies of third places conducted via interviews and shopper intercept surveys to explore two research questions in the context of the GTA: (1) What are the ethnic-oriented third places that provide community spaces and social infrastructure for senior immigrants? (2) Considering the role of a third place in shaping the aging experiences of senior immigrants, what are the implications for municipalities building culturally appropriate social infrastructure to support senior immigrants' social connectedness? We begin by discussing previous research about third places that can help senior immigrants combat social isolation and build connectedness, followed by four case studies. We conclude with policy implications for municipalities to help them (re)invest in ethnic third places that can foster a supportive and inclusive environment for healthy aging.

Third Places: Presence of Community Spaces and Social Infrastructure for Senior Immigrants

Third places are spaces in the community beyond the home (a first place) and workplace (a second place) that are conducive for social interaction (Oldenburg, 1999). They can include coffee shops, restaurants and pubs, public squares, shopping centres, and libraries; they are community spaces that provide a public or semi-public (e.g., commercial establishments) venue for people to engage in civic conversations and the building of social and cultural connections. Third places support the development of social infrastructure, meaning physical spaces, services, institutions, or programs, for example public libraries, schools, playgrounds, parks, athletic centres, and swimming pools, as well as sidewalks, courtyards, community gardens, community organizations, and commercial establishments (Klinenberg, 2019).

Scholars have confirmed the value of investment in social infrastructure because of its role in mitigating forms of social and urban inequalities (Klinenberg, 2019). However, Lo and colleagues (2015) stressed that growth of vulnerable populations in GTA suburbs is outpacing the capacity for establishing social infrastructure, which is consistent with empirical evidence from other places such as Australia (Wear, 2016).

Given the growing trends of aging and processes of immigrant settlement in suburban areas (Li, 2009; Zhuang & Chen, 2017; Zhuang, 2015, 2019), more research is needed to explore the implications of (or the lack of) social infrastructure in suburban areas and how these affect the social connectedness of senior immigrants in the public realm.

Previous research has confirmed that third places provide health benefits through space and place (Campbell, 2017; Finlay, 2019). Having a space outside of the home, such as at senior centres, builds and bridges social interaction through third places (Hutchinson & Gallant, 2016). Although studies tend to consider the importance of third places as a form of beneficial social infrastructure, studies that focus on seniors broadly (Alidoust et al. 2019; Campbell, 2017; Fong et al. 2020), as opposed to a focus on senior immigrants, may overlook processes of acculturation.

Aging in third places has been discussed in the broad sense (Alidoust et al. 2019; Campbell, 2017; Fong et al. 2020), but few studies have investigated use of a third place among senior immigrants or and how it shapes their aging experiences (Cerin et al. 2019). More research and policymaking is needed to promote culturally relevant social infrastructure for immigrant seniors (Johnson et al. 2019). To date, most scholars have not conceptualized public and semi-public spaces used by older immigrants as third places, but some studies have explored and evaluated the implications of these spaces. Many scholars have found noted that organized meeting spaces can encourage community participation among senior immigrants and thus foster wellbeing (Jang et al. 2015; Kim, 2013; Koehn et al. 2016; Mand, 2006; Park et al. 2020). More specifically, they have identified the valuable role of ethnic community centres (Cerin et al. 2019; Chung & Seo, 2017; Kim & Silverstein, 2021), religious institutions including churches (Heikkinen, 2011; Kim et al. 2012; Wright-St.Clair & Nayar, 2019), or temples (Slade & Borovnik, 2018), and community gardens (Hartwig & Mason, 2016; Li et al. 2010) (that enhances wellbeing and mitigates loneliness and isolation. These and other places such as health services, libraries, grocery stores/supermarkets, recreational facilities, and affordable public transport serve as important public spaces to promote "regular engagement in physical activity, healthy eating and socialising" among senior immigrants (Cerin et al. 2019, 1). Together, these findings reveal the vitally important role of third places in shaping sense of belonging for senior immigrants at the local scale – and should motivate governments to develop more inclusive and supportive social infrastructure for senior immigrants.

The following discussion presents four case studies in the City of Toronto and its inner and outer suburbs. It explores the role of ethnic-oriented third places in shaping the aging experiences of senior immigrants, focusing on functional and physical spaces in both urban and suburban contexts and how they are imbued with social and cultural meanings and promote a sense of belonging by serving the needs of senior immigrants.

Case Studies: Ethnic-Oriented Third Places in Urban and Suburban Contexts

Scarborough: Suburban Chinese Shopping Malls Where Daily Senior Group Activities Promote Healthy Living

Scarborough is one of Toronto's inner suburbs; it has long served as a landing pad for generations of immigrants. According to the 2016 Census, immigrants in Scarborough accounted for 56.6% of the local population (vs. 51.2% city average). The influx of immigrants to the area has brought new forms of retail developments, especially Chinese indoor shopping malls. The Agincourt neighbourhood in Scarborough is the epicentre for Chinese retail developments: the first Chinese restaurant and grocery opened in 1979, and the first Chinese indoor mall in North America (the Dragon Centre) opened in 1984 (Dragon Centre Stories, 2022). Since then, approximately 20 Chinese indoor malls have transformed the conventionally homogenous suburban landscapes and catered to the growing needs of Chinese (45.8%) and other Asian (22.6%) populations in the Agincourt area (Zhuang, 2019).

Suburban indoor shopping malls are not new and for some time have been considered informal public spaces or the "'new main street'" (Oldenburg, 1999). However, Chinese indoor malls are designed and developed differently from mainstream malls. Typically, a Chinese mall features small independent Asian-oriented businesses that anchor restaurants or grocery stores rather than department stores. Many of them provide a mix of retail (e.g., clothing, kitchenware, jewellery, giftware), food-oriented businesses (e.g., grocery, bakery, coffee/bubble tea shop, restaurant, takeout), and personal and professional services (e.g., health clinic, hair and beauty, banking, law offices, accounting, travel, immigration, education and training) (Zhuang & Chen, 2017).

These indoor shopping spaces provide not only a large variety of options for cultural goods, foods, and services, but also needed social spaces for senior immigrants to interact and bond with each other and promote healthy living. It is not uncommon to observe regular senior group exercises taking place inside Chinese malls, such as fan dancing, tai chi, and line dancing. One of the organized senior groups is the Hong Kai Fitness and Dance Club, which was founded in 1997. It has more than 1000 members and has been in operation in 11 locations (mainly in Chinese malls and one community centre) across the GTA. The founder emigrated from Hong Kong with her family but had to stay home alone while her husband and children were at work during the day. She did not speak English well and felt distressed in the early days after her arrival. After she began to dance with other Chinese seniors in an Agincourt park, she was inspired to found a non-for-profit fitness and dance club for other Chinese senior immigrants, many of whom speak only Cantonese or Mandarin. She now organizes group exercises in Chinese shopping malls, and finds that it helps remove language barriers and makes older adults feel comfortable and welcomed. We interviewed her after she had begun leading group dance sessions with about 150 members at the Oriental Centre in Agincourt. This Chinese mall has allocated the lobby and hallway spaces on both floors for the senior group to use five days a week. The organizer explained the physical, personal, familial, and societal benefits of joining group exercises for senior immigrants.

> The benefit of doing group exercise is that we are not only becoming healthier, but are also changing our mindsets. We no longer see things negatively and we tend to help out each other … It's also worry free for our children. Otherwise, they would worry about how we spend the day while they are at work. Now they don't need to worry at all because [they know] we have friends to take care of each other … Some senior immigrants had health problems when they first arrived in Canada, but after doing regular exercise [with us], the symptoms were gone. So I said to them, "It's very good that you helped save the government's health spending. It's a charitable deed." … Joining the club makes us a family and we help each other like family members.

A club member shared similar sentiments as she witnessed her own body change and overall health improvement:

> I've greatly benefited from being a club member over the past years because it significantly helped me improve my health. Before that, my body was very weak. But after doing the regular exercise, I've become much healthier, physically and mentally … [Without joining the club] these seniors had to face the four walls at home every day. Here, they feel happy because they can talk to their friends and go for dim sum [and shopping] together [after the exercise].

Both interviewees commented that club members have good relationships and often share information, organize social events, and celebrate birthdays and Chinese and Canadian holidays. Because of their familiarity with the languages spoken in the Chinese malls, the business components, and the cultural practices, this environment is conducive to developing a sense of belonging and integrating into the local community socially, economically, and culturally. These privately owned shopping malls have now become vital semi-public spaces in the suburbs that facilitate and support social interaction and community bonding among senior immigrants.

In addition to group dancing and exercises, which tend to be more appealing to female seniors, we observed other individual and group senior activities during multiple field observations. Many seniors come to the malls regularly; they tend to arrive early in the morning and enjoy breakfast or coffee/tea in the food court, reading Chinese newspapers or watching TV news from Hong Kong or Mainland China. Several senior shoppers who participated in intercept surveys said they come alone or with their spouses or friends and often do window shopping or run errands in the mall – with more frequent visits in the winter time because of Canada's cold climate and the lack of year-round outdoor spaces. Small groups of senior men are often found playing Xiangqi (Chinese chess) in food courts, attracting spectators who may offer tips to the winners. Overall, the semi-public spaces in these malls have promoted spontaneous interactions between seniors and created a familiar environment for them to develop a sense of belonging and ownership. Oldenburg (1999, 16) suggested that these types of third places are "inclusively sociable" by "hosting regular, voluntary, informal, and happily anticipated gatherings."

Brampton East: Mixed-use Ethnic Retailing, Places of Worship, and Community Centres Help Promote Social Connectedness for South Asian and Caribbean Seniors in a Suburban Periphery

Brampton is an outer suburb of Toronto that has experienced rapid demographic growth in the past few decades. It is now richly multicultural: as of the 2016 Census, immigrants and racialized groups represented 52.3 percent and 73.3 percent of the population, respectively, with South Asians (44.3%), Blacks (13.9%), and Filipinos (3.4%) the top three minority groups. In this context, suburban developments represent the growing demographics and diversity. One example is the Brampton East subdivision along the Gore Road corridor at the city's periphery.

The area was mainly farmland until 30 years ago, when a Hindu temple was relocated after governmental expropriation. Since then, the area has flourished and turned into a mixed-use community. The subdivision has attracted about 18,000 residents and more than 400 South Asian and Caribbean businesses clustering in four retail plazas adjacent to each other. This one-kilometre-long corridor has now become a complete community, with places of worship, community facilities, and cultural institutions, including two Hindu temples (that also serve as community centres) for East Indians and one for West Indians, one Islamic service centre, one gurdwara, two banquet halls for weddings and cultural events, and one Sikh private school. The proximity of the plaza to the surrounding residential areas provides local residents, especially seniors, with easy access to ethnic food, retailing, and services, promoting active transportation on foot or by bicycle. Several South Asian and Caribbean seniors who took part in shopper intercept surveys commented on the convenience of access, noting they often walk or cycle to the plazas for shopping, to meet friends, pray, and participate in seniors' programs offered by their religious institutes, such as yoga, cooking, English classes, games and sports, and sightseeing trips. These community spaces also serve as third places and are very popular among senior immigrants. One religious leader commented:

> The temple offers a lot of language classes. It's not only for the second generation — it's for the seniors. They are retirees from India or Southeast Asia. We offer them English-as-a-second-language classes. We arrange their free trips to Niagara Falls and other places in Canada so they can see other part of the world, not just babysit at home with their grandchildren.

A small heritage school house located directly across from one of the retail plazas has been transformed into a shared community centre. One of the groups it serves Punjabi men, and a group of about 30–40 Punjabi senior men have been using it to gather on a daily basis. Most walk, cycle, or come by wheelchair to cook meals together in the kitchen, play cards, or sit and chat about everything from politics to their families. In essence, they have brought into Canada the tradition of a Saath (meaning "togetherness" or "support"), a social gathering that normally happens in a village square, under a big tree, or in a park back home. This community centre provides an important space for these Punjabi seniors to build social connectedness through traditional cultural practices. Recognizing the spatial and cultural needs of the community, the City of Brampton has waived the venue-rental fees for this group of seniors to ensure they have free access to the space and the facility. The centre is also shared by other groups for various programs and services including senior yoga, children's arts and crafts, and Sunday services for a church group.

This case study demonstrates the importance of a third place in supporting social interaction and connectedness among senior immigrants. In a suburban context, accessibility is key to ensuring the activation of third places and effective uses of social infrastructure. Suburban planning policies and design interventions must address the needs of senior immigrants and prioritize investments and solutions for active transportation, mixed uses, and culturally sensitive programming.

Parkdale: Community Garden Returns Tibetan Senior Refugees to their Agricultural Roots

Parkdale is a dense urban neighbourhood in the inner city of Toronto with high-rise apartment buildings, a busy main street with streetcars operating, and mixed residential, commercial, and institutional uses including a variety of amenities and services. Because of the large stock of rental apartments in the area and the convenient access to urban amenities, Parkdale has also long been an entry point for immigrants, who accounted for 43.2 percent of the population in 2016. Parkdale differs from other urban neighbourhoods in Toronto because it has a high concentration of Tibetan refugees who have transformed the area into an unofficial "Little Tibet." Numerous Tibetan food and retail establishments, decorated storefronts, apartment window displays, and cultural events commemorate this cultural community's history and heritage. Toronto is now home to about 6000 people in the Tibetan diaspora from India and Nepal, one-third of whom have settled in the Parkdale area (Logan & Murdie, 2016).

Many senior Tibetan refugees came from farming settlements in rural India or Nepal. They did not speak English and many took adult ESL classes provided by the Parkdale Public Library. When the librarian who taught the classes found out that these seniors could not afford to buy fresh vegetables, she took the initiative to acquire a vacant private property adjacent to the library and turned it into the Milky Way Community Garden together with her Tibetan students, including many seniors (Parkdale Neighbourhood Land Trust, 2022).

In 2018, we took a walking tour organized by senior Tibetan farmers, who shared how important land and nature are to them in daily life and expressed joy and pride of growing their own fresh and healthy vegetables from scratch; they are able to apply their farming and gardening skills and develop urban agriculture within the community. They associated the garden with "home" and felt satisfied with this connection to their cultural roots. In another walking tour organized by a Tibetan legal worker who was raised in the area and has been serving the Tibetan community for many years, we heard how the community garden has become a thriving communal space that makes the seniors feel comfortable, included, and engaged. The garden has since been acquired by a community land trust and is now a community-owned property that will continue to connect newcomers (including seniors) through healthy food, learning, and skills development opportunities (Parkdale Neighbourhood Land Trust, 2022). Community gardens allow senior immigrants to reflect and reconnect with their previous life experiences, while providing a physical and social space to help them cultivate new connections with their new community. Li and coauthors (2010, 794) wrote, " gardens can be essential places for migrants to develop and maintain a new sense of self and belonging … Gardens weave together nature, thought, memory and daily practice in culturally loaded ways … Much like the display of personal objects such as family portraits, vegetables can symbolize what is important to growers."

Thorncliffe Park: Empowering Senior Immigrant Women through Public Space Enhancement Projects in an Apartment Tower Neighbourhood

About 500,000 people in Toronto (20% of the total population) live in a unique stock of more than 1000 high-rise apartment buildings constructed during the postwar boom (Hug et al. 2013). Despite the poor building conditions and the lack of services and amenities, these apartment-tower neighbourhoods have been landing places for newcomers for decades. Thorncliffe Park is one of these tower neighbourhoods located in the inner city of Toronto, and is home to over 20,000 residents: 63.7 percent are immigrants and 79.2 percent are visible minorities (vs. 51.2% and 51.5% city average respectively). It is one of 31 Neighbourhood Improvement Areas designated by the city that aim to strengthen the social, economic, and physical conditions in local communities y investing in people, services, programs, and facilities (City of Toronto, 2018b). With very limited public spaces in the neighbourhood, many newcomers – especially women and seniors – found it very challenging to access information, resources, and services.

Recognizing the needs of immigrant women in particular, the Thorncliffe Park Women's Committee was founded in 2008. The committee also includes many senior members and has led a series of initiatives to improve public spaces, create local economic development opportunities, and empower immigrant women, seniors, and youth to champion community building. One local community leader told us, "the intention of [creating public spaces and public amenities] is to provide a space for women to share information, as they need more than a green space." Over the last decade, the committee has revitalized the central park in the neighbourhood, successfully lobbied local politicians and planning authorities for new park amenities (including the first outdoor tandoori oven in Canada), created a year-round cafe converted from a shipping container, and hosted seasonal events like Arts in the Parks, community markets, and winter carnivals. All actions were locally driven, firmly rooted in community consultation, and built upon a collaborative relationship with the city. Through continued conversations with the community, the committee has identified needs and opportunities related to economy, social interaction, and community building for all ages and cultural backgrounds.

Considering the large South Asian population in the area, the committee has prioritized the cultural and economic needs of women and seniors. One community leader interviewee explained, "We have a large [South Asian] immigrant population in Thorncliffe Park. Their clothing, jewellery and other items from home countries are generally not available from retailers." With this in mind, the committee organized a community market in the revitalized central park for local residents to sell these items on Fridays. They also built an outdoor tandoori oven for cooking events in the park – a unique way for the South Asian community to celebrate that represents their culture and heritage. They needed to convince city planning staff of the need for these spaces and amenities, which were immediately popular. Volunteers working at the Friday market (mostly women and seniors) quickly expanded from 5 to 100, and the market now helps immigrant women and seniors connect to their community and earn supplemental income for their families. It is also a means for intercultural knowledge exchange. The year-round cafe in the park also helps address the challenges of seasonality with the other events, prolongs public activity, and provides employment, catering, and food-handling training opportunities for local women, senior, and youth members.

The success of the Women's Committee initiatives stems from their comprehensive understanding of

community needs, especially those of immigrant youth, women, and seniors. Many immigrant women and seniors see their children and family as their first priority and themselves the last. Their needs for social space and employment or entrepreneurship opportunities are often unmet: many immigrant women and seniors run home-based or informal businesses from their homes (e.g., beauty spas, hair salons, child care, catering, family kitchens, school pick-up/drop-off). However, most immigrants have limited resources and lack matching skills. Existing agencies tend to provide only traditional settlement services for immigrants, and not entrepreneurship opportunities. The Women's Committee understands the different interests and needs of immigrant women and seniors: many want income, but are fearful to lose social benefits and are not looking for full-time jobs. They also want to balance family life, so they need flexible entrepreneurial and employment opportunities. The market and the cafe in the neighbourhood park have created opportunities beyond economic benefits. One woman told us:

> When the space is being used by local people and local entrepreneurs, it will become good social space for women, for seniors. They will be able to find that space to socialize, to gather, to meet new friends, and to avoid isolation. A social space is important as it addresses mental health issues.

This kind of meaningful community engagement under the leadership of the Women's Committee has helped immigrants including seniors to develop a sense of belonging and ownership, and a strong desire to engage in bottom-up initiatives, encouraging proactive and collective actions to challenge the status quo while cultivating strong working relationships with city staff.

Discussion

Activating Third Places: Ethnic Concentration and the Effects on Senior Immigrants

The four case studies presented above reflect how third places can be activated in both urban and suburban contexts. Third places like parks, markets, gardens, malls, places of worship, and community centres can enable senior immigrants to socialize, interact, and connect with their peers. They can help build and maintain social supports and integration, with strong positive effects on social connectedness and mitigating isolation. Our findings confirm previous research suggesting that third places can provide beneficial ethnic, cultural, religious, social, and linguistic support for senior immigrants who face challenges related to acculturation and aging (Jang et al. 2015, 2016; Kim & Silverstein, 2021; Lai et al. 2019).

By supporting the establishment of ethnic-oriented social infrastructure – manifested as shops, gardens, places of worship, markets, and traditional practices involving tandoori ovens and other food-related practices, Saath, and Tai chi – third places can help senior immigrants feel at home in a new and often unfamiliar environment. Consistent with the notion of familiarity (Koehn et al. 2020; Lewis, 2009; Slade & Borovnik, 2018), our findings suggest that the ethnic-oriented third places and social infrastructure help people maintain social contact with members of the community, especially those who share similarities in ethnocultural, linguistic, and religious backgrounds. Unfamiliarity with the new environment can exacerbate

a sense of isolation and fear among older migrants in new settings, particularly in "ethnically mixed environments" (Lewis, 2009).

Our findings also confirm the importance of accessibility and spatial proximity to both physical and social infrastructure in the context of ethnic concentration. The third places in the four case studies provide senior immigrants with convenient access to ethnic-oriented foods, services, amenities, and programs. A co-ethnic community also provides social support that helps mitigate the sense of isolation and loneliness for senior immigrants (Tiamzon, 2013). These ethnically dense areas allow for social interaction and contact with others sharing similarities in ethnicity, language, and culture (Wang & Zhan, 2013).

Previous studies of social isolation among senior immigrants in the Canadian context have primarily focused on large metropolitan centres, with limited attention to the broader geographic contexts of aging and migration (Johnson et al. 2019). This is not surprising given that immigrant settlement has primarily concentrated in larger cities – and more recently, as illustrated by the case studies, in the suburban communities surrounding large metropolitan centres. However, suburbs were conventionally designed and developed with segregated land uses and are centred around automobiles. As a result, acculturation barriers are embedded in space and place. It is crucial to consider how geographic and spatial dynamics affect acculturation and aging. Based on our results, it is imperative to promote mixed uses, intensification, and spatial proximity and accessibility to third places and social infrastructure. As illustrated by the cases of Brampton and Scarborough, these in turn will create more walkable, age-friendly, and inclusive places to effectively provide senior immigrants with needed public spaces, amenities, and services that are often underdeveloped in conventional suburbs (Zhuang, 2019).

Developing a Sense of Belonging to the Local Community

What constitutes a community for senior immigrants can be subjective (Huber & O'Reilly, 2004). For example, senior immigrants who rely more on transnational ties as a form of social capital or a connection with their country of origin may feel more isolated and lonely in the host community (Heikkinen, 2011; Hepburn, 2018; Klok et al. 2017; Salma et al. 2018). The case studies presented above highlight the importance of third places in supporting the social construction of community and belonging. Senior immigrants engaged in bottom-up and community-based initiatives to convert vacant land into a community garden, revitalize a run-down public park into a thriving community space, organize group exercises to promote healthy living, and utilize community amenities to shop, learn, pray, and socialize. These actions demonstrate civic engagement and advocacy through their negotiations with city authorities, which is essential to developing a sense of connection and wellbeing among senior immigrants.

Conclusion

Our findings highlight the role of ethnic-oriented third places as a form of social infrastructure that provides accessible, familiar, engaging, and interactive community spaces for social, economic, and civic

participation for senior immigrants. They also provide a space for empowerment and engagement of senior immigrants in civic affairs and community advocacy.

These findings have important policy implications for municipalities and policymakers. Despite community efforts, we observed a lack of municipal involvement or policy intervention that could facilitate and maintain these ethnic-oriented and age-friendly third places. Much of this is due to insufficient understanding and acknowledgement of the needs of senior immigrants. Despite ad hoc municipal involvements such as supporting the revitalization of public spaces in Thorncliffe Park or waiving fees for Punjabi senior men at Brampton's community centre, we found that immigrant communities had to proactively lobby authorities to negotiate spaces, or had to develop partnerships with community organizations and the private sector to have their needs met. As a result, ethnic-oriented third places have been created, promoted, and enhanced through bottom-up community-based initiatives, rather than through pre-emptive municipal interventions. Municipalities should take more proactive actions to form community partnerships, acknowledge and prioritize the needs of senior immigrants, and develop explicit policies that address aging in third places. A first step would be to engage in asset mapping of the existing physical and social infrastructure to clarify local needs and challenges and opportunities facing senior immigrants.

More research is also needed to critically consider the role of third places as a form of social infrastructure. How can they cultivate social connectedness for senior immigrants in the context of aging, migration, suburbanization, and community planning? Municipalities play an important role in facilitating and supporting the needs of senior immigrants by providing physical and social infrastructure. Through appropriate actions, they can help mitigate social isolation and disconnectedness and foster the social, economic, and political inclusion of senior immigrants.

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About the Editor

Dr. Sepali Guruge is an international expert on the complex intersections between health, immigration, gender relations, and aging. Her research foregrounds resilience, agency, and the significance of compounded vulnerabilities in addressing the health and wellbeing of immigrant women and older adults. She has led complex, multidisciplinary, multisector projects in several low-, middle-, and high-income countries.

In Canada, Dr. Guruge has partnered with hundreds of immigrant-serving agencies across the country, and co-designed research projects to address health inequities. The evidence-based interventions she has developed in collaboration with health, social, and settlement sectors, and affected individuals have helped improve the health of immigrants and refugees, their families, and broader communities. Government ministries/agencies have developed meaningful policies based on Dr. Guruge's research related to mental health, gender-based violence, and aging in immigrant communities.

To ensure local researchers, educators, practitioners, and policymakers can access her findings, Dr. Guruge often publishes in local journals and newspapers, in local languages. Her community-based knowledge translation efforts encompass presentations at libraries, health fairs, cultural and religious organizations, and at annual general meetings of social and settlement agencies. Dr. Guruge has also completed 300+ refereed publications and conference presentations.

In recognition of her work, Dr. Guruge has received numerous awards and honours, some of which include the Registered Nurses' Association of Ontario (RNAO) Leadership Award in Nursing Research (2011); inaugural membership in the Royal Society of Canada's College of New Scholars, Artists and Scientists (2014); fellowship in the Canadian Academy of Nursing (2021); and fellowship in the Canadian Academy of Health Sciences (2022).

Other books co-edited by Dr. Sepali Guruge:

Guruge, S., & Collins, E. (Eds.). (2008). Working with Immigrant Women: Issues and Strategies for Mental Health Professionals. Toronto, ON: Centre for Addiction and Mental Health (CAMH).

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Further information about Dr. Guruge's work can be found at:
www.ImmigrantHealthResearch.ca

Authors' Bios

Kaveenaa Chandrasekaran graduated from the Bachelor of Science of Nursing program in 2021 and from the Master of Nursing program at Toronto Metropolitan University in 2024. Her Master's thesis is titled "The Health Implications of Social Isolation and Loneliness Among Older Adults During the COVID-19 Pandemic: A Scoping Review." She is currently working as a project manager for the Inclusive Communities for Older Immigrants, a multidisciplinary, multi-sector, multi-province research project that aims to generate knowledge on social isolation and connectedness among older immigrants. Kaveenaa is a registered nurse who is trained to work in a wide range of clinical settings, including general medicine, rehabilitation, palliative, and acute care.

Nishana Chandrasekaran is a first-year undergraduate nursing student and research assistant at Toronto Metropolitan University. She has clinical experience as a nursing student, providing care to older immigrants from diverse ethnic backgrounds in a rehabilitation medicine unit. Her research interests and passions include immigrant, refugee, and older adult health.

Habib Chaudhury is chair and professor in the Department of Gerontology at Simon Fraser University. His research and consulting work focuses on the physical environment for people with dementia in long-term care facilities, memories of home and personhood in dementia, community planning and urban design for active aging, and dementia-friendly communities. His published books include Environments in an Aging Society: Autobiographical Perspectives in Environmental Gerontology (Annual Review of Gerontology and Geriatrics, Vol 38, 2018; co-edited with F. Oswald), Remembering Home: Rediscovering the Self in Dementia (Johns Hopkins University Press, 2008), and Home and Identity in Later Life: International Perspectives (Springer, 2005; co-edited with G. Rowles). He is affiliated with the Centre for Research on Personhood in Dementia at the University of British Columbia and Alzheimer Catalonia, Barcelona, Spain, and is currently editor-in-chief of the Journal of Aging and Environment.

Daphne Cheung is an associate professor at the School of Nursing, Hong Kong Polytechnic University. She is a gerontological nursing scientist with extensive clinical and research experience focusing on dementia care, related symptom management, and dementia caregiver support. She is also working with international interdisciplinary research teams to develop interventions to address the physical and psychosocial needs of older adults, such as frailty, loneliness, dementia, caregiver stress, and anticipatory grief. Her team has recently introduced technology into elder care research.

Sammy Chu is a research assistant and fourth-year undergraduate nursing student at Toronto Metropolitan University. She also has a Bachelor of Science degree from Western University. Her research interests include health issues related to women, East Asian immigrants, family caregivers, and aging.

Luna (Jiayue) Fan is a research assistant and a graduate of the Daphne Cockwell School of Nursing at Toronto Metropolitan University. She is a recent immigrant and enjoys working with patients from diverse cultural backgrounds. Her research interests include health promotion and health equity issues among

visible minorities as well as the provision of culturally sensitive care, such as health interventions targeting new immigrants.

Amanda Grenier is a professor and the Norman and Honey Schipper Chair in Gerontological Social Work at the University of Toronto and Baycrest Hospital. Prior to this, she was the inaugural director of the Gilbrea Centre for Studies in Aging and Gilbrea Chair at McMaster University, and an associate professor at the McGill School of Social Work. Her research focuses on aging and inequality and has included topics such as life course transitions, social constructs of frailty, aging with a disability, social isolation, late-life homelessness, and precarity and aging (SSHRC, ESDC, CIHR). Her books include Transitions and the LifeCourse (Policy Press), Precarity and Late Life (co-edited; Policy Press), and Late Life Homelessness (MQUP).

Sepali Guruge, RN, is a professor at the Daphne Cockwell School of Nursing at Toronto Metropolitan University. She has 30 years of experience in community-based, collaborative, and interdisciplinary research focusing on immigration and settlement. She has worked closely with academic, public, and not-for-profit service sectors, advocacy groups, and ethno-cultural communities. She has focused on the intersections of aging and immigration for more than 15 years and her research findings have been disseminated in more than 15 languages. She has received numerous awards in recognition of her contributions to nursing and social sciences; examples of her work can be accessed at: www.ImmigrantHealthResearch.ca

Shreemouna Gurung is a PhD candidate in the Department of Gerontology at Simon Fraser University. Her research is focused on person-centred care for ethnically diverse older adults in long-term care homes. She also engages in community-based participatory research related to aging in the right place for older adults experiencing homelessness, as well as qualitative research on health and quality of life of people with spinal cord injury.

Jill Hanley is a professor at the McGill School of Social Work where she teaches social policy, community development, and migration. She is also scientific director of the SHERPA University Institute, mandated by the Quebec Ministry of Health and Social Services to conduct applied research and training on access to care for migrants and ethno-racial minority groups. Her research focuses on access to social rights (housing, labour, health) for precarious-status migrants, as well as their individual, family, and collective strategies to defend their rights. She is co-founder of the Immigrant Workers Centre, where she has been actively involved for more than 20 years.

Jill Hoselton is a registered social worker in Alberta and a PhD student at the University of Calgary. Her research interests include intersectionality, discourse analysis, critical whiteness studies, and anti-racist and anti-colonial social work. Jill holds both Bachelor and Master of Social Work degrees and currently works as a graduate research assistant on the Aging in the Right Place project.

Kandasamy Illanko has a BSc in electronic engineering and a MASc and PhD in electrical and computer engineering. He obtained his MASc from the University of Toronto as a Commonwealth Scholar, and then worked for more than 15 years in the software industry. He completed his PhD at Toronto Metropolitan

University, and has since been with the Department of Electrical, Computer, and Biomedical Engineering as a lecturer and research associate. His research interests include neural networks and deep learning.

Vibha Kaushik is the director of research and policy development at Immigrant Services Calgary. Her research centres on newcomer settlement and integration, diversity and intersectionality, welcoming communities, social development, and linguistic challenges of non-native speakers. Her most recent work examines the settlement and integration needs of skilled immigrants in Calgary. She is a registered social worker and holds a PhD and a master's degree in social work and a master's degree in German.

Christina Klassen currently works with complex cross-cultural cases of children in out-of-home care in the Australian foster care system. She is a former MA student at McGill University in the Division of Social and Transcultural Psychiatry and completed her BA, Joint Honours, in Linguistics and Psychology. In her SSHRC- and FRSQ-funded research, under the supervision of Drs. Mónica Ruiz-Casares and Cécile Rousseau, she investigated how the migration and resettlement experiences of Syrian refugee mothers influence their well-being, parenting practices, and family relationships. She has also worked with the SHERPA University Institute in Montreal to explore caregiving and community support in the context of migration, as well as translation and interpretation services during crisis events. Her research privileges the voices of participants, and her findings have informed clinical practice and policymaking, particularly in contexts of migration and cultural complexity.

Charlotte Lee is an associate professor at the Daphne Cockwell School of Nursing, Toronto Metropolitan University. She focuses on health services evaluation and collaboration in healthcare, and is particularly interested in understanding how interpersonal relationships affect teamwork processes and healthcare outcomes within a diverse population. She is also a certified oncology nurse working on health services issues associated with cancer care, such as role definition for specialty oncology nurses, work environment issues, and knowledge translation from research to clinical settings.

Doris Leung graduated with a BScN in 1987 from Western University. As a registered nurse, she worked in various facets of mental health for 10 years, including general psychiatry, emergency psychiatry, ambulatory care for special needs children, and at a psychiatric day hospital. In 1997, she obtained her Master of Nursing at the Lawrence S. Bloomberg Faculty of Nursing, and was a nurse educator for a mental health inpatient unit for a community hospital in Toronto. In 2010, she obtained her PhD in philosophy from the Lawrence S. Bloomberg Faculty of Nursing, University of Toronto, where she then became an assistant professor. After moving to Hong Kong in 2013, she worked as a teaching fellow at the School of Nursing, Hong Kong Polytechnic University. Since returning to Toronto in 2020, she has held the title of adjunct assistant professor at the Hong Kong Polytechnic University, School of Nursing. She engages in qualitative research related to family caregiving, palliative end-of-life care, and cultural competencies in health and social science education and practice.

Ernest Leung is an MA student in the joint Communication and Culture program at York University and Toronto Metropolitan University. His research interests include comedy studies, political economy of media, and cultural studies. He is a recipient of the Canada Graduate Scholarship and is currently working on his MA thesis, exploring the use of stand-up comedy to address anti-Asian racism in North America during

the COVID-19 pandemic. He is an associate at the York Centre for Asian Research and the Robarts Centre for Canadian Studies. He has an honours bachelor of arts in English from the University of Toronto, and is currently working as a research assistant at Toronto Metropolitan University.

Paola Ortiz Loaiza holds a PhD in international development from the University of Ottawa, where she also worked on the Aging Well project. Her research interests include the political economy of equity and inclusion, and she has analyzed political and economic empowerment among women and Indigenous and racialized communities in Canada and Latin America.

Ryan Lok is a PhD Candidate in the School of Planning at the University of Waterloo. He holds a Master of Planning in Urban Development from Toronto Metropolitan University and a Bachelor of Arts in Urban Studies with a Minor in Sociology from the University of Calgary. His research interests include the intersection of planning and immigration, including topics of cultural diversity, place, and belonging.

Hai Luo is an Associate Professor in the Faculty of Social Work, University of Manitoba and a registered social worker. Her research addresses social and health issues of older adults of diverse cultural backgrounds and the implications to social theory and practice. Her publications include global Indigenous aging, cross-cultural aging, mental health and substance abuse in older adults, long-term care, sexuality and older adults, gambling in older adults, elder abuse, social capital of older adults, and social work leadership. Dr. Luo is active in gerontological education and international collaboration (Finland, Taiwan, and China). She currently is the Chair of the Human Research Ethics Board 1 and a research affiliate of the Centre on Aging at the University of Manitoba.

Atiya Mahmood is a professor in the Department of Gerontology at Simon Fraser University. Her postsecondary education in architecture focused on the relationships between environment and behaviour, and her postdoctoral training was in environmental gerontology. She has received funding from the Social Science and Humanities Research Council, Canada (SSHRC); Canadian Institutes of Health Research (CIHR); Canada Mortgage and Housing Corporation (CMHC); Human Resource and Social Development, Canada (HRSDC); and Accessibility Canada. Her research interests include urban design, mobility, and social participation of older adults and persons with disabilities; social engagement in multi-unit buildings; housing insecurity and aging in the right place, neighbourhood environments and active living; and linkage of innovative housing and support services to age-friendly communities and aging in place.

Franco Ng is a research assistant and a graduate of the Bachelor of Science in Nursing program at Toronto Metropolitan University. His professional experience includes working at long-term care facilities, palliative care settings, as well as serving on the executive of the Asian Student's Association. His research interests include aging and health among immigrants and the well-being of their family caregivers. He also focuses on East Asian culture, youth mentorship, and immigrant health, and has presented nationally about East Asian alternative therapies and their implications for nursing practice.

Melissa Northwood is an assistant professor with the School of Nursing at McMaster University and a certified gerontological nurse. She is an applied health services researcher and previous CIHR Health System Impact Fellow, who conducts collaborative research in partnerships with older adults and health and

social care providers to improve the well-being of older adults. Her research program seeks to enhance care quality, the culture of the practice environment, and health system transformation through a learning health system. Melissa had a lengthy practice career across health care sectors from acute care to home care, with a focus on older adults with multiple chronic conditions.

Hector Goldar Perrote holds a master's degree in human geography from Wilfrid Laurier University and the University of Waterloo. He is currently a PhD candidate in the Department of Social Work at the Norwegian University of Science and Technology. His previous work explored immigration policy, aging populations, and the connections between them, and before joining the Norwegian University of Science and Technology he was a Blue Book trainee at the European Commission.

Lisa Seto Nielsen is an associate professor at the School of Nursing, York University. She completed her doctorate at the Lawrence S. Bloomberg Faculty of Nursing, University of Toronto. Her research integrates the areas of palliative care, death and dying, home care, caregiving, vulnerable groups, racialized immigrants, and the healthcare system. Her approach to research is informed by critical social theory, such as postcolonialism and intersectionality, and critical qualitative methodologies. Her current work focuses on the cancer and palliative care experiences of undocumented immigrants who often lack health insurance and have precarious employment and limited social and legal protections, and how the intersections of these dynamics affect marginalized populations.

Souraya Sidani is an experienced quantitative research methodologist. As principal and co-investigator, she has received funding for more than 125 studies (totalling more than $45 million). Her work focuses on the design and evaluation of health and patient-centred interventions, patient-centred care, self-report measures for assessing different concepts (e.g., intervention acceptability, satisfaction and preferences, self-care ability), and the refinement of research methods and measures for determining the clinical effectiveness of interventions. She has authored several books on the design, implementation, and evaluation of health interventions and has published more than 250 peer-reviewed articles.

Denise L. Spitzer is a professor in the School of Public Health at the University of Alberta and an adjunct professor in the Institute of Feminist and Gender Studies at the University of Ottawa, where she was the Canada Research Chair (2005–2015) in Gender, Migration and Health and a principal scientist at the Institute of Population Health. She is a critical feminist anthropologist and engages in participatory research with migrant communities around the world to explore how global processes, mediated through intersectionality, relate to health and well-being.

Robert Ta graduated from the Honours Biomedical Science program at Trent University in 2024. He has experience working with older adults from diverse ethnic backgrounds in retirement-community settings. His research interests include immigrant and older adult health.

Tharsiny Thavarasa received her MPH at Western University in 2018. Her research focuses on improving health outcomes and reducing health disparities. She leverages her public health background, along with her data analytics skills, to address public health issues. She has also worked on a sustainable diets policy for Scottish National Health Services as part of their initiative to reduce greenhouse gas emissions by 2030.

Christine A. Walsh is a professor in the Faculty of Social Work at the University of Calgary. Her research explores violence across the lifespan. Her community- based, arts-informed, and action-oriented research involves collaborations with populations affected by social exclusion, poverty, and homelessness, including people with histories of incarceration, immigrants, and older adults.

Margaret Walton-Roberts is a professor in the Geography and Environmental Studies program at Wilfrid Laurier University and is affiliated with the Balsillie School of International Affairs. Her research focuses on migration-related themes with a focus on South Asian migration, gender, and skilled migration. She has published more than 40 book chapters and 50 journal articles, as well as co-edited books including Diasporas, Development and Governance (Springer Global Migration Series), The Human Right to Citizenship: A Slippery Concept (University of Pennsylvania Press), A National Project: Canada's Syrian Refugee Resettlement Experience (McGill-Queens University Press), and Global Migration, Gender and Health Professional Credentials: Transnational Value Transfers and Losses (forthcoming, University of Toronto Press).

Lu Wang is a professor in the Department of Geography and Environmental Studies program at Toronto Metropolitan University. Her research areas include geography of health and healthcare; spatial epidemiology; the COVID-19 pandemic; spatial mobility and risk perception; transnational healthcare; and ethnic retailing. Her research has been funded by a range of sources including SSHRC (Social Science and Humanities Research Council), CIHR Operating Grant/COVID-19 Rapid Response, CIHR Planning and Dissemination Grant, and the RBC Immigrant, Diversity and Inclusion Project. She has published widely and has also contributed chapters to several edited books including A Research Agenda for Migration and Health (Elgar), Immigrant Experiences in North America (Canadian Scholars' Press), Immigrants in US and Canadian Cities (Oxford), and Wal-Mart World: The World's Biggest Corporation in the Global Economy (Routledge).

Alexandra Wehr holds a master's (MASc) degree from the Environmental Applied Science and Management program at Toronto Metropolitan University. Her research focuses on spatial accessibility to neighbourhood amenities and natural environmental features, health among older adults, and GIS analysis.

Paige (Pei-Chun) Wen graduated from the University of Leuven, Belgium in 2014 with a PhD in architecture, focusing on landscape urbanism. She is the author of several book chapters, journal articles, and a book based on her PhD thesis: Water Urbanism: Water Conflicts and the Interplay of Production Landscapes and Settlements: Chia-Nan Plain, Taiwan. She was a lecturer and studio teacher on housing design at National Cheng-Kung University in Taiwan and Peking University in China for bachelors and masters students focusing on housing designs. Her research interests include housing typology, the movement of new infill housings across North America, and related emerging issues such as aging in place. She moved to Toronto in 2015 and is currently pursuing her architecture license while she works as an intern architect on commercial and residential projects.

Jason Wong is a staff radiation oncologist at the Stronach Regional Cancer Centre and at the University of Toronto.

Madelaine Woo is a fourth-year undergraduate student in the journalism program at Toronto Metropolitan University (formerly Ryerson University). She is also pursuing a minor in English. Madelaine has published articles on Project Protech and Fashion Art Toronto, as well as co-authored a scoping review on COVID-19 vaccine hesitancy in Toronto. As a third-generation immigrant, she has a strong interest in using her voice to help racialized immigrants.

Radamis Zaky holds a doctorate in Women's Studies from the Institute of Feminist and Gender Studies at the University of Ottawa. His research focuses on activism among Arab and Muslim women in the Middle East and within diasporic communities in Canada. Additionally, he is an active member of the Arab Canadian Research Group at the University of Ottawa.

Fanyuan Zhang came to Canada as an international student in 2004. He obtained a bachelor's degree in social work in 2006 and a master's degree in social work in 2012, both from McGill University. He has worked for community organizations and government agencies in Montreal, serving vulnerable populations including the elderly, people with mild intellectual disabilities, immigrants, and youth at risk. His academic interests focus on immigrants (particularly Chinese) and gerontology. He has personal experience with sponsoring and supporting his parents, and leverages this in his work on ensuring access to appropriate services and support for elderly Chinese in Montreal. His goal is to open a non-profit organization for Chinese elderly in need, providing them with culturally sensitive services.

HeeJin Zhou completed the Master of Health Science Education program at McMaster University in 2015 and has worked for McMaster University's Faculty of Health Sciences and McMaster Children's Hospital, coordinating various research projects in program development and evaluation. She recently worked on a research project at Toronto Metropolitan University focusing on elder abuse among immigrant communities. She is currently pursuing a social service work diploma at Sheridan College, bridging her passion for understanding individual and collective resilience-building at the clinical front lines while promoting greater access and system navigation support for marginalized communities.

Zhixi Zhuang is a registered professional planner and an associate professor at the School of Urban and Regional Planning, Toronto Metropolitan University. As the Academic Director of the Toronto Metropolitan Centre for Immigration and Settlement and Founder and Director of DiverCityLab (www.divercitylab.com), her research explores the intersection of immigrant settlement, urban landscapes, and municipal policies in topics related to building welcoming infrastructure in non-traditional gateway cities, immigrant entrepreneurship and city building, ethnic place-making in 'third places,' migration and suburban transformation, and the role of municipal planning in immigrant settlement and integration. She has conducted mixed-method, arts-informed, and community-based research, effectively engaging immigrant community members and city building professionals to gain a holistic perspective on immigrant integration, place-making, civic engagement, and inclusive policy-making.

How to Cite the Book

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