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

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Contents

Caregiving

Access to Services

This is where you can write your introduction.

Table of Contents

Section 1: Background

Section 2: Health Statuses and Determinants

Section 3: Socioeconomic Considerations

Section 4: Caregiving

Section 5: Access to Services

Section 6: Research, Practice and Policy Considerations

Chapter Summaries

The book is divided into six sections.

SECTION 1 provides context about the issues of aging and immigration 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 well-being, and (re)settlement and integration of older immigrants in Canada. She captures the role of key social determinants, such as how access to services, gender, and racism and discrimination affect the health and well-being 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, healthcare, and transportation.

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.

In Chapter 3,

SECTION 2 focuses on health and health issues of concern to older immigrants.

In Chapter 4, "Health Status and Health Determinants of Older Immigrant Women in Canada," Sepali Guruge, Kaveenaa Chandrasekaran, Nishana Chandrasekaran, and Madelaine Woo report on the health and health determinants of older immigrant women. They show that among older immigrant women, health is affected by the interplay of various social determinants including the physical and social environment, economic conditions, cultural beliefs, gendered norms, and the healthcare delivery system. Older immigrant women tend to have more health problems, to underutilize preventive services such as cancer screening, and to experience more difficulties in accessing healthcare services.

The aging population and immigration-based population growth in Canada necessitate research, practice, and policy focusing on mental health of older immigrants in Canada, which appears to deteriorate over time. In Chapter 5, "Mental Health Concerns of Older Immigrant Men," Sepali Guruge, Ernest Leung, and Souraya Sidani examine what is known about the social determinants of mental health among older immigrants in Canada and what barriers they face in accessing mental health services. They note that the key social determinants of mental health include culture, health services, and gender. They also show that older immigrants use fewer mental

health services than their Canadian-born counterparts as a result of cultural beliefs, lack of culturally and linguistically appropriate services, financial difficulties, and ageism. Finally, they conclude that regardless of subcategories within this population, older immigrants experience mental health inequities.

In Chapter 6, "Health Concerns of Older Immigrants," Souraya Sidani, Sepali Guruge, and Kandasamy Illanko explore the health profiles of long-term older immigrants who participated in the Canadian Longitudinal Study on Aging (CLSA). Baseline data obtained by the comprehensive cohort of the CLSA were analyzed with a sample of 4257 immigrant older adults. The results show that despite individual variability, on average this cohort of immigrants experience good physical, mental, and social health. However, older immigrant participants also report having chronic conditions, some of which may be attributed to their (new or old) health-related behaviours such as low levels of physical activity or alcohol use. On average, they report no depression or psychological distress and were satisfied with life. Their mental well-being may be associated with their perceived good physical health and their ability to maintain social connectedness. They report having large social networks with whom they frequently interact. These findings are encouraging, showing that in general, long-term older immigrants in Canada have been able to sustain good physical, mental, and social health.

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 and others. 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 7, "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 Spitzer, and Radamis Zaky explore the informal and formal social networks and social support that shape the lives of older adults, and propose strategies and programs that can be tailored to meet diverse experiences (pre-, during, and post-migration) to ensure 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, combined with racism, discrimination, and ageism. In Chapter 8, ""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 9, "Housing Insecurity and Homelessness Among Older Immigrants in Canada," Vibha Kaushik, Christine A. Walsh, and Jill Hoselton highlight housing insecurity and homelessness in Canada

among older immigrant adults, who 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 causes of homelessness among immigrant older adults who experience housing insecurity and homelessness, as well as systemic challenges in accessing housing services.

SECTION 4 focuses on caregiving.

In Chapter 10, "Conceptualizing Person-Centred Care for Ethnocultural Minority Residents in Long-Term Care Homes," Shreemouna Gurung, Atiya Mahmood, and Habib Chaudhary offer a conceptual framework for developing and implementing a person-centred care approach to meet the needs of ethno-racial individuals 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 the interrelated frameworks and empirical evidence.

In Chapter 11, "Chinese Family Members Caring for Older Adults in Private, Senior, and Long-Term Care Homes: A Mismatch of Needs and Culturally Appropriate Services," Charlotte Lee, Doris Leung, Jason Wong, Paige (Pei-Chun) Wen, Sammy Chu, Frank Ng, 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 show 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 access and policies that are culturally acceptable and match the shared financial capacity of the Chinese family member 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 not only vary between groups but also within them, and existential well-being 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 an individual's cultural beliefs and values. In Chapter 12, "The Diversity of Views About Death and Dying in Immigrants and Their Families: Implications for Helping Professionals," Hai Luo surveys 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 13, "Elder Abuse Risk Factors and Intervention Strategies: Emerging Perspectives of Older Korean 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 to 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 14, "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.

In Chapter 15, "Spatial and Language Discordance in Accessing Physicians Among Older Immigrants: Identifying Barriers, Facilitators, and Interventions," Lu Wang, Sepali Guruge, and Alexandra Wehr outline the barriers, facilitators, and interventions for older immigrants from Arabic- and Hindi-speaking communities in the Toronto area. The first phase of their project is a scoping review of general and group-specific barriers to and facilitators of access to primary care. The second phase involves surveys and focus groups and interviews with three groups of key stakeholders, revealing 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 and interventions.

Technology use can be beneficial for older adults in general, but many older immigrants remain excluded from the digital world. In Chapter 16, "Digital Divide Among Older Immigrants: A Literature Review and Reflection on Field Experience," Japleen Thind, Sepali Guruge, and Ernest Leung explore internet use among older immigrants: use of smartphones, tablets, tele-medicine, virtual public programs and services provided by the government and community agencies. The authors focus on technology use as it pertains to three specific issues: access to information, services, social networks, entertainment, and community activities; improved sense of independence and belonging to Canadian society; and maintaining and fostering transnational relationships. The authors also consider barriers to technology use in the context of how technology may enable older immigrants to preserve their ethnic

identities locally and transnationally. They conclude that technology should be considered as an enhancement to well-being rather than a replacement for in-person social interaction.

In Chapter 17, "Participant Recruitment 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. 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 18, "Aging in Third Places: Community Spaces and Social Infrastructure for Senior 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 can also empower them to participate more actively in public affairs and community advocacy.

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BACKGROUND

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

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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 the United Kingdom. In Canada, older immigrants now comprise a significant proportion of the population, and are expected to make up about 25 percent of the total population within the next 10 years (Guruge et al., 2019b). 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 social factors including immigration status, age, education, socioeconomic status, ability, gender identity, and sexual orientation. Another issue is that 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 well-being outcomes of older immigrants are affected by the intersecting influences of diverse racialized status, non-charter-language fluency, socioeconomic status, immigration status at arrival, and current immigration status.

Beyond these individual-level factors, all newcomers to Canada are affected by policy decisions. These macro-level factors can have considerable and negative effects on the lives of older immigrants. For example, Canadian 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, which is 3–5 years (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 well-being 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. Another issue is that this "healthy immigrant effect" is not applicable to all foreign-born individuals, for example, 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 and dietary practices can make newcomer older immigrants feel invisible and voiceless in terms of maintaining and promoting their good health, preventing illnesses, and addressing illnesses in a timely, efficient, and effective manner.

Health and well-being are strongly influenced by cultural and religious values, beliefs, attitudes, norms, customs, and knowledge. Some of these influences may change over time, for example through assimilation and acculturation upon arrival and over time in Canada. 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 non-charter languages, and healthcare providers and systems are not often equipped with paid translators and interpreters and 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, lack of culturally safe services, and discriminatory and racist practices embedded within service delivery (Badger and Koehn, 2015; Hanley et al., 2019; Hepburn et al., 2015). Older adults also underutilize shelters, hotlines, and social, health, and legal services (Guruge et al., 2019b) because of multiple intersecting factors: lack of familiarity with services; lack of culturally and linguistically appropriate services; lack of accessible, portable, and coordinated services; confidentiality concerns; and discriminatory and racist practices embedded within services and service delivery (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 (family, friends, neighbours, co-workers) and formal (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 and 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, are fluent in English or French, and/or are employed in paid work in Canada may be less isolated (Charpentier and Quéniart, 2017; Khan and Kobayashi, 2015; Jang et al., 2015).

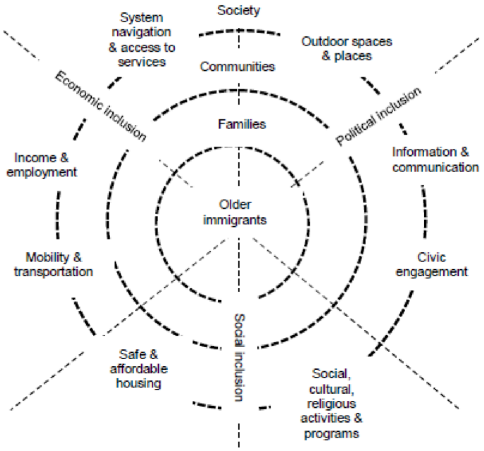
Social connectedness is also affected by the size and density of ethnic communities, the availability of ethno-specific resources and services, and ready access to reliable and accessible public transportation (Agrawal and Kurtz, 2019; Wang et al., 2019). For example, over the last 20 years more immigrants 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 well-being, 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 neighbourhoods 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, 2023), 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. Another significant factor is isolation, which can make older immigrants more vulnerable (Hepburn et al., 2015). Victims, families, and communities may hide abuse due to cultural values related to keeping 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).

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 racialized status, older age, 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 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 to 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 can also isolate newcomers, such as policies that disperse newcomers into different parts of the country. 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.

The diagram below (depicts some of the dimensions shaping the lives of older immigrants in Canada.



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 networks including social, infrastructural (e.g., transportation), and economic resources (Raymond et al., 2016; Shields et al., 2016). A mutual commitment is required between immigrants and their host country in order for them to feel a sense of belonging (Bilodeau, 2018). Immigrants also need to be able 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 et al., 2018; 2019), but a prerequisite to these types of engagements is that they feel included as valued citizens and community members.

Another important determinant of well-being 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 well-being 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, friends, 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 up-to-date and 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 38 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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References

Agrawal, S., & Kurtz, N. (2019). Ethnic Spatial Segmentation in Immigrant Destinations—Edmonton and Calgary. Journal of International Migration and Integration, 20(1), 199-222.

Avery, G. (2016). The state of seniors' health care in Canada. Canadian Medical Association.

Badger, M., & Koehn, S. (2015). Unpacking access to health services and health promotion programs and information for ethnocultural minority older adults. In S. Koehn, & M. Badger (Eds.), Health care equity for ethnic minority older adults (pp. 68-97). Vancouver, B.C.: Gerontology Research Centre, Simon Fraser University.

Baker, P. R., Francis, D. P., Hairi, N. N., Othman, S., & Choo, W. Y. (2016). Interventions for preventing abuse in the elderly. The Cochrane database of systematic reviews, 2016(8), CD010321. https://doi.org/10.1002/14651858.CD010321.pub2

Bilodeau, A., White, S., Turgeon, L., & Henderson, A. (2018). Belonging: Feelings of attachment and acceptance among immigrants in Canada (Working Paper No. 18-06). Canadian Network for Research on Terrorism, Security, and Society. Canadian: Vancouver, BC. Retrieved from https://www.tsas.ca/wp-content/uploads/2018/07/WP18-06_Bilodeau_Belonging_2018.pdf

Bogic M, Njoku A, Priebe S. Long-term mental health of war-refugees: a systematic literature review. BMC Int Health Hum Rights. 2015 Oct 28;15:29. doi: 10.1186/s12914-015-0064-9. PMID: 26510473; PMCID: PMC4624599.

Charpentier, M., Quéniart, A., & Lebreton, C. (2019). Vieillir au Québec pour des femmes aînées immigrantes : 'La liberté d'être soi, mais plus seule.' In F. LeBorgne (Ed) Vieillir en société. Une pluralité de regards sociologiques (pp. 181-192). Presses Universitaires de Rennes.

Charpentier, M., & Quéniart, A. (2017). Aging experiences of older immigrant women in Québec (Canada): From deskilling to liberation. Journal of women & aging, 29(5), 437-447.

Chu, J., & Leino, A. (2017). Advancement in the maturing science of cultural adaptations of evidence-based interventions. Journal of consulting and clinical psychology, 85(1), 45-57.

Curtis, J., & McMullin, J. (2016). Older workers and the diminishing return of employment: Changes in age-based income inequality in Canada, 1996–2011. Work, Aging and Retirement, 2(3), 359-371.

Ferrer, I. (2018). Seniors. Alberta Filipinos Leaders Conference. Retrieved from http://filipinosinalberta-ca.teknologybox.com/wp-content/uploads/2018/06/Seniors.pdf

Gómez, Limón, J. A., Vera-Toscano, E., & Rico-González, M. (2012). Measuring individual preferences for rural multifunctionality: the importance of demographic and residential heterogeneity. Journal of agricultural economics, 63(1), 1-24.

Gordon, D., Moos, M., Prayitno, K., Amborski, D., & Taylor, Z. (2018). THE FUTURE OF THE SUBURBS: POLICY CHALLENGES AND OPPORTUNITIES IN CANADA. University of Calgary. The School of Public Policy Publications. https://www.policyschool.ca/wp-content/uploads/2018/08/Canadas-Suburbs.pdf

Government of Canada. (2023). IRCC Minister Transition Binder 2023: Family Reunification. https://www.canada.ca/en/immigration-refugees-citizenship/corporate/transparency/transition-binders/minister-2023/family-reunification.html

Gulbrandsen, C., & Walsh, C. (2015). Aging and resilience: Older women's responses to change and adversity. Societies, 5(4), 760-777.

Guruge, S., Ford-Gilboe, M., Samuels-Dennis, J., Varcoe, C., Wilk, P., & Wuest, J. (2012). Rethinking social support and conflict: Lessons from a study of women who have separated from abusive partners. Nursing Research and Practice, 22(9), 1-10.

Guruge, S., Sidani, S., Wang, L., Sethi, B., Spitzer, D., Walton-Roberts, M., & Hyman I.

(2019b). Understanding social network and support for older immigrants in Ontario, Canada: A multi-methods study protocol. JMIR Aging, 2(1), e12616. doi:10.2196/12616

Guruge, S., Thomson, M. S., George, U., & Chaze, F. (2015). Social support, social conflict, and immigrant women's mental health in a Canadian context: A scoping review. Journal of Psychiatric and Mental Health Nursing, 22(9), 655-667.

Hanley, J., Ives, N., Lenet, J., Hordyk, S. R., Walsh, C., Ben Soltane, S. and Este, D. (2019). Migrant women's health and housing insecurity: an intersectional analysis, International Journal of Migration, Health and Social Care, 15(1), 90-106.

Harbison, J., Coughlan, S., Beaulieu, M., Karabanow, J., Vanderplaat, M., Wildeman, S., & Wexler, E. (2012). Understanding "elder abuse and neglect": A critique of assumptions underpinning responses to the mistreatment and neglect of older people. Journal of Elder Abuse & Neglect, 24(2), 88-103.

Hepburn, S., Matsuoka, A., Guruge, S., & Manuel, L. (2015). Intervention strategies to address abuse of ethnocultural minority older adults from different communities. In S. Koehn & M. Badger (Eds.), Health care equity for ethnic minority older adults (pp. 46-54). Vancouver, BC: Gerontology Research Centre, Simon Fraser University.

Hordyk, S. R., Hanley, J., & Richard, É. (2015). "Nature is there; its free": Urban greenspace and the social determinants of health of immigrant families. Health & place, 34, 74-82.

Jang, Y., Kim, K., Park, N. S., & Chiriboga, D. A. (2016). Emotional confidants in ethnic communities: Social network analysis of Korean American older adults. Journal of aging and health, 28(2), 324-340.

Jang, Y., Park, N. S., Chiriboga, D. A., Yoon, H., An, S., & Kim, M. T. (2015). Social capital in ethnic communities and mental health: A study of older Korean immigrants. Journal of Cross-Cultural Gerontology, 30(2), 131-141.

Khan, M. M., & Kobayashi, K. (2015). Optimizing health promotion among ethnocultural minority older adults (EMOA). International Journal of Migration, Health and Social Care, 11(4), 268-281.

Kim, B. J., Linton, K. F., & Lum, W. (2015). Social capital and life satisfaction among Chinese and Korean elderly immigrants. Journal of Social Work, 15(1), 87-100.

Koehn, S., Habib, S., & Bukhari, S. (2016). S4AC Case Study: Enhancing Underserved Seniors' Access to Health Promotion Programs. Canadian Journal on Aging, 35(1), 89-102. doi: 10.1017/S0714980815000586.

Koehn, S., Jarvis, P., K. Sandhra, S., K. Bains, S., & Addison, M. (2014). Promoting mental health of immigrant seniors in community. Ethnicity and Inequalities in Health and Social Care, 7(3), 146-156.

Li, C., Jiang, S., Li, N., & Zhang, Q. (2018). Influence of social participation on life satisfaction and depression among Chinese elderly: Social support as a mediator. Journal of Community Psychology, 46(3), 345-355.

Martin, S. (2017). Finding harmony in a multigenerational home. The Globe and Mail. https://www.theglobeandmail.com/life/parenting/finding-harmony-in-a-multigenerational-home/article35234637/

Michalski, C., Ragunathan, A., Foster, A., Pagalan, L., Chu, C., Diemert, L. M., Helliwell, J. F., Urajnik, D., Speidel, R., Malti, T., Fierheller, D., Fusca, L., Zenlea, I., McKean, S., & Rosella, L. C. (2023). Towards a community-driven definition of community wellbeing:

A qualitative study of residents. PloS one, 18(11), e0294721. https://doi.org/10.1371/journal.pone.0294721

Mitra, R., Siva, H., & Kehler, M. (2015). Walk-friendly suburbs for older adults? Exploring the enablers and barriers to walking in a large suburban municipality in Canada. Journal of Ageing Studies, 35, 10-19.

Patel, M. S., Benjamin, E. J., Volpp, K. G., Fox, C. S., Small, D. S., Massaro, J. M., Lee, J. J., Hilbert, V., Valentino, M., Taylor, D. H., Manders, E. S., Mutalik, K., Wang, W., & Murabito, J. M. (2017). Effect of a game-based intervention designed to enhance social incentives to increase physical activity among families: The BE FIT randomized clinical trial. JAMA internal medicine, 177(11), 1586-1593.

Preston, V., Weiser, N., King, K., Mandell, N., Kim, A. H., & Luxton, M. (2014). Worked to death: Diverse experiences of economic security among older immigrants. In D. M. Kilbride (Ed.), Immigrant integration: Research implications for future policy (pp. 67–81). Toronto: Canadian Scholars' Press.

Raymond, É., Grenier, A., & Lacroix, N. (2016). La participation dans les politiques du vieillissement au Québec: discours de mise à l'écart pour les aînés ayant des incapacités? Développement humain, handicap et changement social, 22(1), 5-21.

Sekhon, M., Cartwright, M., & Francis, J. J. (2017). Acceptability of healthcare interventions: an overview of reviews and development of a theoretical framework. BMC health services research, 17(1), 88.

Shields, J., Drolet, J., & Valenzuela, K. (2016). Immigrant settlement and integration services and the role of nonprofit service providers: A cross-national perspective on trends, issues and evidence. Ryerson Centre for Immigration and Settlement.

Statistics Canada. (2022). The Canadian census: A rich portrait of the country's religious and ethnocultural diversity. The Daily. https://www150.statcan.gc.ca/n1/daily-quotidien/221026/dq221026b-eng.htm

Thomson, M. S., Chaze, F., George, U., & Guruge, S. (2015). Improving immigrant populations' access to mental health services in Canada: a review of barriers and recommendations. Journal of immigrant and minority health, 17(6), 1895-1905.

Tong, H., Lai, D. W. L., & Walsh, C. (2019). Formal Social Participation and Utilization of Community-based Services among Urban Elderly Chinese Living Alone in Shanghai, China. Journal of Social Service Research, 45(4), 520-529.

United Nations. (2023). Addressing Gender-Based Violence in Older Age Policy, Law and Evidence-based Responses. https://www.un.org/en/observances/elder-abuse-awareness-day#:~:text=Elder%20abuse%20is%20a%20problem,and%20moral%20significance%20is%20obvious.

Walton-Roberts, M., Veronis, L., Wayland, S. V., Dam, H., & Cullen, B. (2019). Syrian refugee resettlement and the role of local immigration partnerships in Ontario, Canada. The Canadian Geographer/Le Géographe canadien, 63(3), 347-359.

Wang, L., Guruge, S., & Montana, G. (2019). Older Immigrants' Access to Primary Health Care in Canada: A Scoping Review. Canadian Journal on Aging/La Revue canadienne du vieillissement, 38(2), 193-209.

Wilcox, V., & Sahni, H. (2022). The Effects on Labor Supply of Living with Older Family Members Needing Assistance with Activities of Daily Living. Journal of family and

economic issues, 1–19. Advance online publication. https://doi.org/10.1007/s10834-022-09880-x

Williams, N. E., Thornton, A., & Young-Demarco, L. C. (2014). Migrant Values and Beliefs: How Are They Different and How Do They Change?. Journal of ethnic and migration studies, 40(5), 796–813. https://doi.org/10.1080/1369183X.2013.830501

Wu, Z., & Penning, M. (2015). Immigration and loneliness in later life. Ageing & Society, 35(1), 64-95.

Zhuang, Z. C. (2018). Toronto: Planning for Diversity, Inclusion, and Urban Resilience. Retrieved from http://citiesofmigration.ca/wp-content/uploads/2018/07/Building-Inclusive-Cities-Toronto-Case-Study_Final-Digital-Version-V2.pdf

Zhuang, Z. C. (2019). Cities of Migration: The Role of Municipal Planning in Immigrant Settlement and Integration. In Y. Samy & H. Duncan (Eds.) Canada Among Nations. Ottawa: Palgrave Macmillan.

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, Thomas, Kobayashi and Prus 2004; Kobayashi and Prus 2012), structural racism and institutional discrimination (Ferrer, Grenier, Brotman and Koehn 2017; Sahraoui 2020), and barriers in accessing care (Arora et al. 2018; Ciobanu and 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, and 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 and Keating 2012; Walsh et al. 2017).[2] Thinking about the importance of place and social

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.

networks, researchers focused on how the places one lives, in connection with social relations, could produce exclusion, particularly for poor and/or marginalized groups.

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 and 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 and 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 and Keating 2017; see also Grenier, Phillipson and 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, and Smith 2005; Walsh, Scharf, and 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

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 and 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, and Smith (2005) articulated five domains of exclusion (material resources; social relations; civic activities; basic services; and neighbourhood exclusion); Walsh, Scharf, and 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 and Guberman (2009)

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 and 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.

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, and 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 and 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).

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).

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 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

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
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

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 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 and Wiebe 2012; Guo 2015; Teelucksingh and Galabuzi 2010). Over the life course, this discrimination has health, financial and social implications (Ferrer, Grenier, Brotman and Koehn 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, and Lapshina 2014). Employers discriminate by dismissing

9. https://www.canada.ca/en/immigration-refugees-citizenship/services/visit-canada/parent-grandparent-super-visa.html

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, and 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, and 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 and Seifi 2015; Premji and 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 and 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 and 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, and 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 and 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 and 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 and 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 and 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% 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, and 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 well-being 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.

References

Arber, Sara. 2004. "Gender, Marital Status, and Ageing: Linking Material, Health, and Social Resources." Journal of Aging Studies 18, 1: 91–108.

Arora, Sanjana, Astrid Bergland, Melanie Straiton, Bernd Rechel, and Jonas Debesay. 2018. "Older Migrants' Access to Healthcare: A Thematic Synthesis." International Journal of Migration, Health and Social Care 14, 4: 425–38.

Ballet, Jérôme. 2001. L'Exclusion: Définitions et Mécanismes. Paris: L'Harmattan.

Berghman, Jos. 1995. "Social Exclusion in Europe. Policy Context and Analytical Framework." In Beyond the Threshold: The Measurement and Analysis of Social Exclusion, edited by Graham Room, 10–28. Bristol: Policy Press.

Billette, Véronique, Jean-Pierre Lavoie, Anne-Marie Séguin, and Isabelle Van Pevenage. 2012. "Réflexions sur L'Exclusion et L'Inclusion Sociale en Lien avec

le Vieillissement. L'importance des Enjeux de Reconnaissance et de Redistribution." Frontières 25, 1: 10–30.
Bohle, Philip, Claudia Pitts, and Michael Quinlan. 2010. "Time to Call It Quits? The Safety and Health of Older Workers." International journal of health services 40,1: 23–41.
Buffel, Tine, and Chris Phillipson. 2011. "Experiences of Place Among Older Migrants Living in Inner-City Neighbourhoods in Belgium and England." Diversité urbaine 11, 1: 13–37.
Burchardt, Tania, Julian Le Grand, and David Piachaud. 1999. "Social Exclusion in Britain 1991–1995." Social Policy and Administration 33, 3: 227–44.
Ciobanu, Ruxandra Oana, and Alistair Hunter. 2017. "Older Migrants and (Im)mobilities of Ageing: An Introduction." Population, Space and Place 23, 5: e2075.
Coloma, Roland Sintos, and Fritz Luther Pino. 2016. "'There's Hardly Anything Left": Poverty and the Economic Insecurity of Elderly Filipinos in Toronto." Canadian Ethnic Studies 48, 2: 71–97.
Côté, Daniel, Danielle Gratton, Sylvie Gravel, and Jessica Dubé. 2015. "Les enjeux de la santé-sécurité du travail et les conditions de l'inclusion." Vie économique 7, 1: 1-9
Creese, Gillian. 2010. "Erasing English Language Competency: African Migrants in Vancouver, Canada." Journal of International Migration and Integration/Revue de l'integration et de la migration internationale 11, 3: 295–313.
Creese, Gillian, and Brandy Wiebe. 2012. "'Survival Employment': Gender and Deskilling Among African Immigrants in Canada." International Migration 50, 5: 56–76
Dannefer, Dale, 2003. "Cumulative Advantage/Disadvantage and the Life Course: Cross-Fertilizing Age and Social Science Theory." The Journals of Gerontology Series B: Psychological Sciences and Social Sciences 58, 6: S327–S337.
Dolberg, Pnina, Sigurveig H. Sigurðardóttir, and Ursula Trummer. 2018. "Ageism and Older Immigrants." In Contemporary Perspectives on Ageism, 177–191. Cham: Springer.
Eid, P., 2012. "Les inégalités «ethnoraciales» dans l'accès à l'emploi à Montréal: le poids de la discrimination." Recherches sociographiques 53, 2: 415–450.
Esses, Victoria M., Caroline Bennett-AbuAyyash, and Natalia Lapshina. 2014. "How Discrimination Against Ethnic and Religious Minorities Contributes to the Underutilization of Immigrants' Skills." Policy Insights from the Behavioral and Brain Sciences 1, 1: 55–62
Ferrer, Ilyan. 2015. "Examining the Disjunctures Between Policy and Care in Canada's Parent and Grandparent Supervisa." International Journal of Migration, Health and Social Care 11, 4: 253–67.
Ferrer, Ilyan. 2017. "Aging Filipino Domestic Workers and the (In)adequacy of Retirement Provisions in Canada." Canadian Journal on Aging/La Revue canadienne du vieillissement 36, 1: 15–29
Ferrer, Ilyan, Shari Brotman, and Amanda Grenier. 2017. "The Experiences of Reciprocity Among Filipino Older Adults in Canada: Intergenerational, Transnational, and Community Considerations." Journal of Gerontological Social Work 60, 4: 313–27.
Ferrer, Ilyan, Amanda Grenier, Shari Brotman, and Sharon Koehn. 2017. "Understanding the Experiences of Racialized Older People Through an Intersectional Life Course Perspective." Journal of Aging Studies 41: 10–17.

Fournier, Geneviève, Hélène Zimmermann, Jonas Masdonati, and Christine Gauthier. 2018. "Job Loss in a Group of Older Canadian Workers: Challenges in the Sustainable Labour Market Reintegration Process." Sustainability 10, 7: 2245.

Gal, Sigalit, and Jill Hanley. 2012. Elder Abuse: Is Precarious Immigration Status a Factor? In Strangers in a New Homeland, edited by Michael Baffoe, 87–102. Cambridge: Scholars Press.

Gee, Ellen Margaret Thomas, Karen M. Kobayashi, and Steven G. Prus. 2004. "Examining the Healthy Immigrant Effect in Mid-to Later Life: Findings from the Canadian Community Health Survey." Canadian Journal on Aging/La Revue canadienne du vieillissement 23, 5: S55–S63.

Grenier, Amanda. 2021. Late Life Homelessness: Experiences of Disadvantage and Unequal Aging. Montreal: McGill Queens University Press.

Grenier, Amanda, and Nancy Guberman. 2009. "Creating and Sustaining Disadvantage: The Relevance of a Social Exclusion Framework. Health and Social Care in the Community 17, 2: 116–24.

Grenier, Amanda, Liz Lloyd, and Chris Phillipson. 2017. "Precarity in Late Life: Rethinking Dementia as a 'Frailed' Old Age." Sociology of Health and Illness 39, 2: 318–30.

Grenier Amanda, Chris Phillipson, and Richard Settersten, eds. 2020. Precarity and Aging: Understanding Changing Forms of Risk and Vulnerability in Later Life. Bristol: Policy Press.

Grenier, Amanada, Chris Phillipson, Debbie Laliberte Rudman, Stephanie Hatzifilalithis, Karen Kobayashi, and Patrik Marier. 2017. "Precarity in Late Life: Understanding New Forms of Risk and Insecurity." Journal of Aging Studies 43: 9–14.

Grenier Amanda, Chris Phillipson, and Richard Settersten, eds. 2020. Precarity and Aging: Understanding Changing Forms of Risk and Vulnerability in Later Life. Bristol: Policy Press.

Guo, Shibao. 2015. "The Colour of Skill: Contesting a Racialised Regime of Skill from the Experience of Recent Immigrants in Canada." Studies in Continuing Education 37, 3: 236–50.

Guruge, Sepali, Mary Susan Thomson, and Sadaf Grace Seifi. 2015. "Mental Health and Service Issues Faced by Older Immigrants in Canada: A Scoping review." Canadian Journal on Aging/La Revue canadienne du vieillissement 34, 4: 431–44.

Hossen, Abul. 2012. "Social Isolation and Loneliness Among Elderly Immigrants: The Case of South Asian Elderly Living in Canada." Journal of International Social Issues 1, 1: 1–10.

Hossen, Abul, and Anne Westhues. 2013. "Bangladeshi Elderly Immigrants in Southern Ontario: Perspectives on Family Roles and Intergenerational Relations." Journal of International Social Issues 2, 1: 1–15.

Immigration, Refugees and Citizenship Canada (IRCC). 2020. 2020 Report to Parliament on Immigration. https://www.canada.ca/en/immigration-refugees-citizenship/corporate/publications-manuals/annual-report-parliament-immigration-2020.html#permanent

Islam, Farah, Nazilla Khanlou, Hala Tamim, and Keya Saad-tengmark. 2015. "Exploring Women's Mental Health at the Intersections of Aging, Racialization, and Low Socioeconomic Status." In Women's Mental Health, 277–88. Cham: Springer.

Kobayashi, Karen M., and Steven G. Prus. 2012, "Examining the Gender, Ethnicity, and Age Dimensions of the Healthy Immigrant Effect: Factors in the Development of Equitable Health Policy." International Journal for Equity in Health 11, 1: 1–6.

Lavoie, Jean-Pierre, Hélène Belleau, Nancy Guberman, Alex Battaglini, Shari Brotman, Maria Montejo, and Karima Hallouche. 2007. "Prendre soin en contexte d'immigration récente. Les limites aux solidarités familiales à l'égard des membres de la famille avec incapacités." Enfances, familles, générations 6, printemps.

Levitas, Ruth. 2005. The Inclusive Society? Social Exclusion and New Labour. Houndmills: Palgrave Macmillan.

Levitas, Ruth, Christina Pantazis, Eldin Fahmy, David Gordon, E. Lloyd-Reichling, and Demy Patsios. "The multi-dimensional analysis of social exclusion." (2007). Public report. https://repository.uel.ac.uk/item/8666q

Lunt, Neil. 2009. "Older People within Transnational Families: The Social Policy Implications." International Journal of Social Welfare 18, 3: 243–51.

Martinson, Marty, and Meredith Minkler. 2006. "Civic Engagement and Older Adults: A Critical Perspective." The Gerontologist 46, 3: 318–24.

Matsuoka, Atsuko, Sepali Guruge, Sharon Koehn, Marie Beaulieu, and Jenny Ploeg. 2013. "Moving Forward: Prevention of Abuse of Older Women in the Post-migration Context in Canada." Canadian Review of Social Policy/Revue canadienne de politique sociale 2: 68–69 .

Ng, Eddy SW, and Alan Law. 2014. "Keeping Up! Older Workers' Adaptation in the Workplace after Age 55." Canadian Journal on Aging/La revue canadienne du vieillissement 33, 1: 1–14.

Oreopoulos, Philip. 2011. "Why Do Skilled Immigrants Struggle in the Labor Market? A Field Experiment with Thirteen Thousand Resumes." American Economic Journal: Economic Policy 3, 4: 148–71.

Premji, Stephanie. 2018. "'It's Totally Destroyed Our Life' Exploring the Pathways and Mechanisms Between Precarious Employment and Health and Well-being Among Immigrant Men and Women in Toronto." International Journal of Health Services 48, 1 (2018): 106–27.

Premji, Stephanie, and Yogendra Shakya. 2017. "Pathways Between Under/Unemployment and Health Among Racialized Immigrant Women in Toronto." Ethnicity and Health 22, 1 (2017): 17–35.

Premji, Stephanie, Yogendra Shakya, Megan Spasevski, Jessica Merolli, Sehr Athar, and Precarious Employment Core Research Group. 2014. "Precarious Work Experiences of Racialized Immigrant Women in Toronto: A Community-based Study." Just Labour 22: https://doi.org/10.25071/1705-1436.8.

Sahraoui, Nina. 2020. "From Everyday Racist Incidents at Work to Institutional Racism: Migrant and Minority-Ethnic Workers' Experiences in Older-Age Care." In Politics of (Dis)integration, 81–99. Cham: Springer.

Sakamoto, Izumi, Matthew Chin, and Melina Young. 2010. "Canadian Experience," Employment Challenges, and Skilled Immigrants A Close Look Through "Tacit Knowledge." Canadian Social Work 12, 145–51.

Scharf, Thomas, and Norah Christine Keating, eds. 2012. From Exclusion to Inclusion in Old Age: A Global Challenge. Bristol: Policy Press.

Scharf, Thomas, Chris Phillipson, and Allison E. Smith. "Social exclusion of older people in deprived urban communities of England." European Journal of ageing 2, no. 2 (2005): 76-87.

Silver, Hilary. 1994. "Social Exclusion and Social Solidarity: Three Paradigms." International Labour Review 133, 5-6: 531–78.

Statistics Canada. 2017. Focus on Geography Series, 2016 Census. Statistics Canada Catalogue no. 98-404-X2016001. Ottawa, Ontario. Data products, 2016 Census. https://www12.statcan.gc.ca/census-recensement/2016/as-sa/fogs-spg/Facts-can-eng.cfm?Lang=EngandGK=CANandGC=01andTOPIC=7

Statistics Canada Data tables, 2016 Census. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/dt-td/Rp-eng.cfm?TABID=2&Lang=E&APATH=3&DETAIL=0&DIM=0&FL=A&FREE=0&GC=0&GID=1341679&GK=0&GRP=1&PID=110563&PRID=10&PTYPE=109445&S=0&SHOWALL=0&SUB=0&Temporal=2017&THEME=120&VID=0&VNAMEE=&VNAMEF=&D1=0&D2=0&D3=0&D4=0&D5=0&D6=0

Teelucksingh, Cheryl, and Grace-Edward Galabuzi. 2010. "The Impact of Race and Immigrant Status on Employment Opportunities and Outcomes in Canada." In Health Promotion and Quality of Life in Canada: Essential Readings, edited by Dennis Raphael. Toronto: Canadian Scholars Press, 205-216.

Tong, Hongmei, Christine A. Walsh, Nathalie Bouchard, and Daniel WL Lai. 2020. "Social Inclusion and Immigrant Older Adults." In Handbook of Social Inclusion: Research and Practices in Health and Social Sciences, edited by Pranee Liamputtong, New York: Springer International Publishing, 1-22.

Torres, Sandra. 2012. "International Migration: Patterns and Implications for Exclusion in Old Age. In From Exclusion to Inclusion in Old Age: A Global Challenge, edited by Thomas Scharf and Norah Keating, 33–49. Bristol: Policy Press.

Van Regenmortel, Sofie, Liesbeth De Donder, Sarah Dury, An-Sofie Smetcoren, Nico De Witte, and Dominique Verté. 2016. "Social Exclusion in Later Life: A Systematic Review of the Literature." Journal of Population Ageing 9, 4: 3151–44.

Walker, Alan, and Carol Walker, eds. 1997. Britain Divided: The Growth of Social Exclusion in the 1980s and 1990s. London: Child Poverty Action Group (CPAG).

Walsh, Kieran, Thomas Scharf, and Norah Keating. 2017. "Social Exclusion of Older Persons: A Scoping Review and Conceptual Framework." European Journal of Ageing 14, 1: 811–98.

Williams, Fiona. 2010. "Migration and Care: Themes, Concepts and Challenges." Social Policy and Society 9, 3: 3851–96.

Zou, Ping, and Tony Fang. 2018. "Examination of Older Immigrants' Contributions to Canadian Society." Pathways to Prosperity.

Chapter 3. Perceptions of Health Aging in the Mandarin-speaking Community in Toronto

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HEALTH

Chapter 4. Health Status and Health Determinants of Older Immigrant Women in Canada

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Abstract

Increasing international migration in the context of aging populations makes a comprehensive understanding of older immigrant women's health status and determinants of their health particularly urgent. Using Arksey and O'Malley's framework, we conducted a scoping review to examine the available literature on the health of older immigrant women in Canada. We searched CINAHL, PsycINFO, Embase, Medline, and Cochrane databases for the period of 1990 to 2014 for Canadian-based, peer-reviewed studies on the topic. A total of 20 articles met the inclusion criteria. These articles were divided into six areas of focus: physical health; mental health; abuse; health promotion and chronic disease prevention; barriers to healthcare access and utilization; and health beliefs, behaviours, and practices. Our results show that the health of older immigrant women is affected by the interplay of various social determinants of health including the physical and social environment; economic conditions; cultural beliefs; gendered norms; and the healthcare delivery system. Our results also revealed that older immigrant women tend to have more health problems, underutilize preventive services, such as cancer screening, and experience more difficulties in accessing healthcare services.

Background

Aging and international migration are two prevailing global trends that have changed the age and ethnic composition of populations in countries worldwide, particularly Canada, the United States, the United Kingdom, and Australia. The global share of older people (aged 60 years or over) increased from 9.2% in 1990 to 11.7% in 2013 and will continue to grow, reaching 21.1% by 2050 [1]. Between 1990 and 2013, the number of older immigrants increased from 26 to 37 million worldwide [2]. This trend that is

1. Department of Economic and Social Affairs and Population Division, World Population Ageing 2013, United Nations, Department of Economic and Social Affairs, Population Division, 2013, http://www.un.org/en/development/desa/population/publications/pdf/ageing/WorldPopulationAgeing2013.pdf. See in References
2. Department of Economic and Social Affairs and Population Division, World Population Ageing 2013, United Nations, Department of Economic and Social

being observed in nearly all countries around the globe is the result of several factors including declining fertility rates as well as advances in medical care and technology and public health initiatives that have reduced mortality and morbidity rates for both chronic and acute illnesses [3]. These demographics demand changes in policies and service delivery systems that address the health and illness concerns of older immigrants [4].

The number of older women exceeds that of older men in most countries worldwide. In 2013, globally, there were 85 men per 100 women in the age group 60–79 years and 61 men per 100 women in the age group 80 years or older [5]. This phenomenon is referred to as the "feminization of aging" [6]. Older men and women have different health and illness experiences: women tend to experience more illnesses, more years of disability, and more stress than men, but they tend to live longer [7]. These gender disparities have been attributed partly to genetic predisposition, physiological and hormonal differences, and socioeconomic factors [8]. Research suggests that the family roles and responsibilities (such as caregiving) of older women often reduce their ability to make decisions regarding their own health and limit their access to and use of healthcare services [9]. Clarifying what is known about the health status of older women and the factors that affect their health is important to meet the health needs of this population. Building on our current and previous work, we focused on this topic in Canada.

Older adults are the fastest-growing age group in Canada. In 2011, an estimated 5.0 million individuals in Canada were 65 years or older, and this number is expected to double in the next 25 years to 10.4 million by 2036. By 2051, approximately one in four (25%) Canadians is expected to be 65 years or older [10]. The health of Canada's older immigrant population is of great interest to clinicians, health care managers, and policymakers because older immigrants' health is an important measure of population health and is directly related to issues, such as the cost and adequacy of the Canadian healthcare system [11]. For example, Gee et al. [12] reported that recent older immigrants are usually healthier than their Canadian-born counterparts or older immigrants who have been in Canada for many years, but over time their health may decline to a level that is worse than that of Canadian-born older adults. This phenomenon, the "healthy

Affairs, Population Division, 2013, http://www.un.org/en/development/desa/population/publications/pdf/ageing/WorldPopulationAgeing2013.pdf. See in References

3. Department of Economic and Social Affairs and Population Division, World Population Ageing 2013, United Nations, Department of Economic and Social Affairs, Population Division, 2013, http://www.un.org/en/development/desa/population/publications/pdf/ageing/WorldPopulationAgeing2013.pdf. See in References
4. A. M. Warnes, K. Friedrich, L. Kellaher, and S. Torres, "The diversity and welfare of older migrants in Europe," Ageing and Society, vol. 24, no. 3, pp. 307–326, 2004. View at: Publisher Site | Google Scholar See in References
5. United Nations, World Migration in Figures, 2013, http://www.oecd.org/els/mig/World-Migration-in-Figures.pdf. See in References
6. United Nations, World Migration in Figures, 2013, http://www.oecd.org/els/mig/World-Migration-in-Figures.pdf. See in References
7. C. B. Tannenbaum, L. Nasmith, and N. Mayo, "Understanding older women's health care concerns: a qualitative study," Journal of Women & Aging, vol. 15, no. 1, pp. 3–16, 2003. View at: Publisher Site | Google Scholar See in References
8. C. B. Tannenbaum, L. Nasmith, and N. Mayo, "Understanding older women's health care concerns: a qualitative study," Journal of Women & Aging, vol. 15, no. 1, pp. 3–16, 2003. View at: Publisher Site | Google Scholar See in References
9. E. M. T. Gee, K. M. Kobayashi, and S. G. Prus, "Examining the healthy immigrant effect in mid-to later life: findings from the Canadian Community Health Survey," Canadian Journal on Aging, vol. 23, no. 5, pp. 55–63, 2004. View at: Google Scholar See in References
10. Statistics Canada, Canadians in Context—Aging Population, Statistics Canada, Ottawa, Canada, 2011, http://well-being.esdc.gc.ca/misme-iowb/.3ndic.1t.4r@-eng.jsp?iid=33. See in References
11. J. T. McDonald and S. Kennedy, "Insights into the 'healthy immigrant effect': health status and health service use of immigrants to Canada," Social Science and Medicine, vol. 59, no. 8, pp. 1613–1627, 2004. View at: Publisher Site | Google Scholar See in References
12. E. M. T. Gee, K. M. Kobayashi, and S. G. Prus, "Examining the healthy immigrant effect in mid-to later life: findings from the Canadian Community Health Survey," Canadian Journal on Aging, vol. 23, no. 5, pp. 55–63, 2004. View at: Google Scholar See in References

immigrant effect," has also been documented in Australia[13], the United Kingdom[14], and the United States[15]. It has been reported that this deterioration applied only to "non-European" immigrants[16]. Overall, this topic has begun to receive attention from health sciences researchers.

We conducted a scoping review to examine the existing literature about the health of older immigrant women in Canada. Our objectives were to (1) summarize the current knowledge about the health status of older immigrant women in Canada; (2) identify gaps in the existing knowledge; and (3) highlight implications for research, practice, and policy.

Methods

We followed the five-stage process that was proposed by Arksey and O'Malley[17] for conducting a scoping review: to identify a research question; identify studies relevant to the research question; review and select a subset of studies for inclusion in the final review; chart the information and data for the selected studies; and collate, summarize, and present the results.

Our research question for the scoping review was as follows: what is known from the existing literature about the health of older immigrant women in Canada? With the help of an experienced librarian, we searched CINAHL, Embase, Cochrane, Medline, and PsycINFO databases from January 1990 to 2014 using the following combinations of keywords: old age OR senior, elder, and older; AND immigrant, refugees, precarious, ethnic minority, visible minority, racial, and racialized; AND health AND Canada, Canadian. Inclusion criteria for articles were (1) peer-reviewed research findings; (2) being published in English or French; (3) focusing on older immigrant women's health; and (4) being based on studies conducted in Canada.

In most developed countries, including Canada, an "older adult" is defined as someone aged 65 years or older[18]. However, in many low-income countries with relatively shorter life expectancies, this definition may be expanded to include individuals aged 55 years or older[19]. For the purposes of this scoping review, we defined older adults as individuals aged 55 and older, because this is the definition generally used among our target population, which consists of a large proportion of

13. N. Biddle, S. Kennedy, and J. T. Mcdonald, "Health assimilation patterns amongst Australian Immigrants," Economic Record, vol. 83, no. 260, pp. 16–30, 2007. View at: Publisher Site | Google Scholar See in References
14. S. Kennedy, J. T. McDonald, and N. Biddle, "The healthy immigrant effect and immigrant selection: evidence from four countries," Social and Economic Dimensions of an Aging Population Research Papers 164, McMaster University, 2006. View at: Google Scholar See in References
15. E. H. Stephen, K. Foote, G. E. Hendershot, and C. A. Schoenborn, "Health of the foreign-born population: United States, 1989-90," Advance Data, no. 241, pp. 1–12, 1994. View at: Google Scholar See in References
16. E. Ng, R. Wilkins, F. Gendron, and J. M. Berthelot, "Dynamics of immigrants' health in Canada: evidence from the National Population Health Survey," Healthy Today, Healthy Tomorrow? Findings from the National Population Health Survey, Statistics Canada, Ottawa, Canada, 2005. View at: Google Scholar See in References
17. H. Arksey and L. O'Malley, "Scoping studies: towards a methodological framework," International Journal of Social Research Methodology, vol. 8, no. 1, pp. 19–32, 2005. View at: Publisher Site | Google Scholar See in References
18. WHO, Definition of Older or Elderly Person, World Health Organization, Geneva, Switzerland, 2011, http://www.who.int/healthinfo/survey/ageingdefnolder/en/index.html. See in References
19. C. Spencer and G. Gutman, Sharpening Canada's focus, Developing an Empirical Profile of Abuse and Neglect Among Older Women and Men in the Community, Human Resources and Social Development, Ottawa, Canada, 2008. See in References

older immigrants from low- and middle-income countries. We included studies that did not focus primarily on older women if their sample mean or median age range was 55 years or older and if at least half of the participants were women and separate results were available for this group. We defined "immigrants" as individuals who were born outside Canada (to non-Canadian parents), at some point, 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.

A total of 6622 (CINAHL: 1261; Embase: 2223; Cochrane: 312; Medline: 1923; and PsycINFO: 903) records were generated through database searches. Of these, 1453 duplicates were removed and the abstracts of remaining 5169 articles were read for the inclusion criteria. After removing 4304 articles that did not focus on older immigrants, full text of 835 articles was read to determine if they focused on the health of older immigrant women. Twenty articles met our inclusion criteria and were included in the scoping review (see Figure 1).

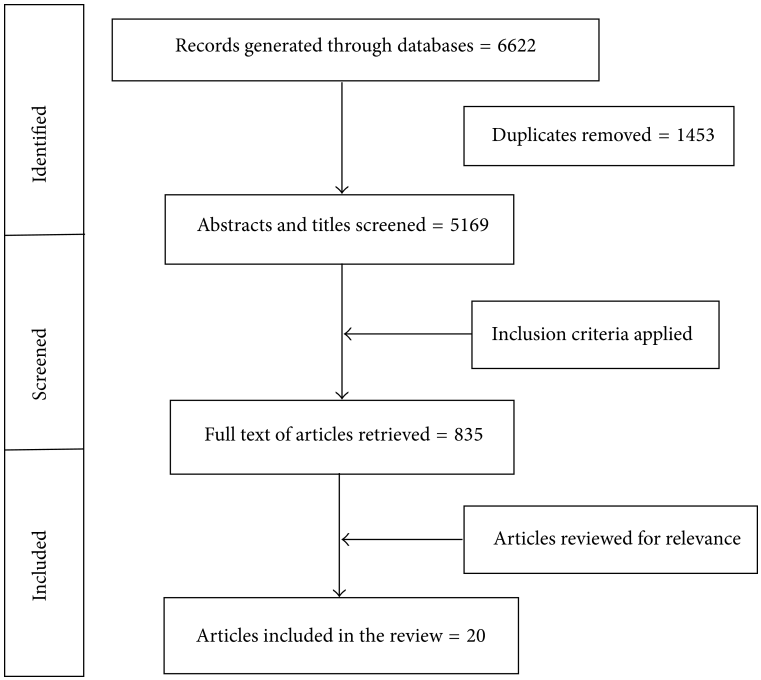

Figure 1: Flowchart of literature search and selection.

As per Arksey and O'Malley[20], scoping reviews are undertaken to map the extent, range, and nature of literature, so we did not assess the quality of studies included in the review. We charted the 20 articles in Microsoft Excel 2011 using the following headings: Author/s, Name of Journal, Year of Publication, and Title; Aim of the Study, Focus Area; Ethnicity or Country/Continent of Origin, Age, Sample Size, and Study Setting; Study Method, Study Design, Data Collection, and Data Analysis; and Major Findings (see Table 1).

20. H. Arksey and L. O'Malley, "Scoping studies: towards a methodological framework," International Journal of Social Research Methodology, vol. 8, no. 1, pp. 19–32, 2005. View at: Publisher Site | Google Scholar See in References

Table 1: Summary of charted data

Author information	Sample information	Research design	Focus area
Lai (2004) [15]	*Ethnicity or country/continent of birth/ origin*: Mainland China *Age*: 65 years *Sample size*: 444 *Location*: Victoria, Vancouver, Calgary, Edmonton, Winnipeg, Toronto, and Montreal	*Method*: mixed *Design*: cross-sectional *Collection*: face-to-face interview *Analysis*: bivariate association using Mann-Whitney test, Kruskal-Wallis test, and Spearman's correlation test	Mental health
Chau and Lai (2011) [16]	*Ethnicity or country/continent of birth/ origin*: Mainland China *Age*: 55 years *Sample size*: 2,272 *Location*: Victoria, Vancouver, Calgary, Edmonton, Winnipeg, Toronto, and Montreal	*Method*: mixed *Design*: cross-sectional *Collection*: face-to-face interview *Analysis*: hierarchical multiple regression analysis	Physical and mental health
Lai (2011a) [17]	*Ethnicity or country/continent of birth/ origin*: China *Age*: 65 years *Sample size*: 151 *Location*: Calgary	*Method*: mixed *Design*: cross-sectional *Collection*: telephone survey *Analysis*: multiple regression analysis	Mental health
Lai (2011b) [18]	*Ethnicity or country/continent of birth/ origin*: Mainland China, Hong Kong, Taiwan, Vietnam, and other Southeast Asian countries *Age*: 55 years *Sample size*: 2,272 *Location*: Victoria, Vancouver, Calgary, Edmonton, Winnipeg, Toronto, and Montreal	*Method*: mixed *Design*: cross-sectional *Collection*: face-to-face interview *Analysis*: hierarchical logistic regression analysis	Abuse

Lai and Surood (2009) [19]	*Ethnicity or country/continent of birth/ origin*: Mainland China, Hong Kong, Taiwan, Vietnam, and other Southeast Asian countries *Age*: 55 years *Sample size*: 2,272 *Location*: Victoria, Vancouver, Calgary, Edmonton, Winnipeg, Toronto, and Montreal	*Method*: mixed *Design*: cross-sectional *Collection*: face-to-face interview *Analysis*: multiple stepwise regression analysis	Health beliefs
MacEntee et al. (2012) [20]	*Ethnicity or country/continent of birth/ origin*: China, Hong Kong *Age*: 65 years *Sample size*: 51 *Location*: Vancouver and Melbourne	*Method*: qualitative *Design*: cross-sectional *Collection*: focus groups *Analysis*: thematic analysis	Health beliefs
Tieu et al. (2010) [21]	*Ethnicity or country/continent of birth/ origin*: China *Age*: 55–87 years *Sample size*: 53 *Location*: Calgary	*Method*: mixed *Design*: cross-sectional *Collection*: interview *Analysis*: multiple chi-square analyses	Health beliefs
Lai et al. (2007) [22]	*Ethnicity or country/continent of birth/ origin*: Mainland China, Hong Kong, Taiwan, Vietnam, and other Southeast Asian countries. *Age*: 55 years *Sample size*: 2,272 *Location*: Victoria, Vancouver, Calgary, Edmonton, Winnipeg, Toronto, and Montreal	*Method*: mixed *Design*: cross-sectional *Collection*: face-to-face interview *Analysis*: hierarchical multiple regression using stepwise method	Health beliefs
Jette and Vertinsky (2011) [23]	*Ethnicity or country/continent of birth/ origin*: China *Age*: 65 *Sample size*: 15 *Location*: Vancouver	*Method*: qualitative *Design*: cross-sectional *Collection*: in-depth semistructured interviews *Analysis*: thematic analysis	Health behaviour

Green et al. (2010) [24]	*Ethnicity or country/continent of birth/ origin*: European and Asian *Age*: 50 years *Sample size*: 1,996 *Location*: British Columbia	*Method*: mixed *Design*: cross-sectional *Collection*: phone-administered survey *Analysis*: multivariate logistic regression	Health behaviour
Johnson and Garcia (2003) [25]	*Ethnicity or country/continent of birth/ origin*: Cambodian, Latin-American, Vietnamese, and Polish *Age*: mean age = 68 ± 6 years *Sample size*: 54 *Location*: London, Ontario	*Method*: qualitative *Design*: cross-sectional *Collection*: questionnaire and questionnaire-guided interviews *Analysis*: descriptive analysis using SPSS	Health behaviour
Fornazzari et al. (2009) [26]	*Ethnicity or country/continent of birth/ origin*: Latin America *Age*: 55 years *Sample size*: 125 *Location*: Greater Toronto Area	*Method*: mixed *Design*: cross-sectional *Collection*: questionnaires and scales *Analysis*: descriptive analysis using SPSS	Health beliefs
Sun et al. (2010) [27]	*Ethnicity or country/continent of birth/ origin*: Asia *Age*: 50–69 years *Sample size*: 508 *Location*: Canada	*Method*: mixed *Design*: cross-sectional *Collection*: data from the Canadian Community Health Survey cycle 2.1 (2003) *Analysis*: multivariate logistic regression analyses	Health promotion and chronic disease prevention
Todd et al. (2011) [28]	*Ethnicity or country/continent of birth/ origin*: China *Age*: 50 years (mean 63.61) *Sample size*: 103 *Location*: Ontario	*Method*: mixed *Design*: cross-sectional *Collection*: interviews *Analysis*: Fisher's exact tests and independent sample tests, multivariate logistic regression	Health promotion and chronic disease prevention

Donnelly (2006) [29]	*Ethnicity or country/continent of birth/ origin*: Vietnam *Age*: 49–78 years *Sample size*: 15 *Location*: Western Canadian city	*Method*: qualitative *Design*: cross-sectional *Collection*: interviews; semistructured questionnaire using open-ended questions *Analysis*: qualitative data/thematic analysis	Health promotion and chronic disease prevention
Lofters et al. (2010) [30]	*Ethnicity or country/continent of birth/ origin*: 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 *Age*: 50–66 years (mean 56.2) *Sample size*: 88,447 *Location*: Ontario	*Method*: quantitative *Design*: population-based cohort study *Collection*: Landed Immigrant Data System *Analysis*: multivariate Poisson regression	Health promotion and chronic disease prevention
Choudhry et al. (2002) [31]	*Ethnicity or country/continent of birth/ origin*: South Asian *Age*: 58 and 68 years and 40 and 60 years *Sample size*: 13 *Location*: in and around Toronto	*Method*: qualitative *Design*: cross-sectional *Collection*: focus group discussions *Analysis*: reflexive and dialectical critique	Health promotion and chronic disease prevention
Lai and Chau (2007) [32]	*Ethnicity or country/continent of birth/ origin*: Mainland China, Hong Kong, Taiwan, Vietnam, and other Southeast Asian countries. *Age*: 55 years *Sample size*: 2,272 *Location*: Victoria, Vancouver, Calgary, Edmonton, Winnipeg, Toronto, and Montreal	*Method*: mixed *Design*: cross-sectional *Collection*: face-to-face interview *Analysis*: multiple regression analysis	Healthcare access

Lai and Kalyniak (2005) [33]	*Ethnicity or country/continent of birth/ origin*: Mainland China, Hong Kong, Taiwan, Vietnam, and other Southeast Asian countries. *Age*: 55 years *Sample size*: 2,272 *Location*: Victoria, Vancouver, Calgary, Edmonton, Winnipeg, Toronto, and Montreal	*Method*: mixed *Design*: cross-sectional *Collection*: face-to-face interview *Analysis*: hierarchical logistic regression analysis	Healthcare utilization
Ballantyne et al. (2011) [34]	*Ethnicity or country/continent of birth/ origin*: China, Hong Kong, Vietnam, and Portugal *Age*: 65 years *Sample size*: 30 *Location*: Toronto	*Method*: qualitative *Design*: cross-sectional *Collection*: interview *Analysis*: inductive content analysis	Healthcare service utilization

Results

3.1. Characteristics of the Studies Included

Among the 20 articles selected for analysis, seven (35%) were based on data collected for one study that was conducted in seven major cities of Canada: because these articles focused on different aspects of health of older immigrant women in Canada, we included them all. The characteristics reported here, therefore, are for the 14 studies (upon which the 20 articles are based). Their sample sizes ranged from 15 to 88,447. Most studies were based in Ontario (n = 6; 43%), British Columbia (n = 4; 29%), or Alberta (n = 2; 15%). Two were secondary analyses based on large sets of data across multiple provinces. The place of origin of immigrant women was operationalized in different ways across the studies: "country of origin," "country of birth," "continent of birth," or "ethnicity." With the exception of three articles, all (n = 18; 90%) included participants from Mainland China, Hong Kong, Taiwan, and Vietnam. With the exception of one (longitudinal) study, all studies used a cross-sectional design. Most (n = 7; 50%) used mixed methods combining qualitative and quantitative methods, six (n = 6; 43%) used qualitative methods, and one (n = 1; 7%) used a quantitative method. We did not find any articles written in French that met our inclusion criteria.

3.2. Summary of the Studies

We organized the 20 articles into six focus areas: physical health (n = 1; 5%), mental health (n = 3; 15%), abuse (n = 1; 5%), health beliefs/behaviour/practices (n = 8; 40%) and health promotion and chronic disease prevention (n = 5 ; 25%), and barriers to

healthcare access and utilization (n = 3; 15%). One paper addressed both physical and mental health.

3.2.1. Physical Health

Chau and Lai [21] investigated the relationship between the size of Chinese communities and the health of older Chinese immigrants in Canada. Older Chinese immigrants residing in communities with a smaller Chinese population reported better physical health than older Chinese immigrants residing in communities with a larger Chinese population. Also, in this particular study, older men tended to score higher than older women did on physical health status scales.

3.2.2. Mental Health

Lai [22] categorized the predictors of depressive symptoms among older Chinese immigrants into three types: physical health factors, circumstantial factors, and psychosocial factors. Physical health factors included general physical health; circumstantial factors included finances, length of residency in Canada, barriers to services, and living arrangement; and psychosocial factors included ethnic identity, life satisfaction, and attitudes toward aging. Lai [23] also reported that older immigrants often encounter additional service barriers, making the transition from their homeland to their life in Canada stressful. Lai [24] later reported that, compared to their male counterparts, Chinese older immigrant women are often more vulnerable, more financially disadvantaged, have fewer resources, and are less healthy physically and mentally and stressed the need for improved support services aimed at older immigrant women. Chau and Lai [25] reported that the size of a Chinese community was a significant predictor of mental health status. As is the case with physical health above, participants residing in cities with a larger Chinese population scored lower on mental health scales. Social support was not a significant predictor of mental health in larger Chinese communities.

21. S. Chau and D. W. L. Lai, "The size of an ethno-cultural community as a social determinant of health for Chinese seniors," Journal of Immigrant and Minority Health, vol. 13, no. 6, pp. 1090–1098, 2011. View at: Publisher Site | Google Scholar See in References
22. D. Lai, "Depression among elderly Chinese-Canadian immigrants from Mainland China," Chinese Medical Journal, vol. 117, no. 5, pp. 677–683, 2004. View at: Google Scholar See in References
23. D. Lai, "Depression among elderly Chinese-Canadian immigrants from Mainland China," Chinese Medical Journal, vol. 117, no. 5, pp. 677–683, 2004. View at: Google Scholar See in References
24. D. W. L. Lai, "Perceived impact of economic downturn on worry experienced by elderly Chinese immigrants in Canada," Journal of Family and Economic Issues, vol. 32, no. 3, pp. 521–531, 2011. View at: Publisher Site | Google Scholar See in References
25. S. Chau and D. W. L. Lai, "The size of an ethno-cultural community as a social determinant of health for Chinese seniors," Journal of Immigrant and Minority Health, vol. 13, no. 6, pp. 1090–1098, 2011. View at: Publisher Site | Google Scholar See in References

3.2.3. Abuse

Lai[26] reported that 4.5% of the study sample (N = 2,272) had experienced at least one incident of "maltreatment" or "neglect" within the past year: the most common forms of abuse included "being scolded, yelled at, treated impolitely, and ridiculed" (p. 338).

3.2.4. Health Beliefs, Behaviours, and Practices

Lai and Surood[27] reported that the health beliefs of older Chinese adults involve beliefs about "traditional" health practices (such as "Chinese exercise"), traditional Chinese medicine, and preventive diet. MacEntee et al.[28] focused on how acculturation in Canada influenced dental beliefs and behaviours among older Chinese immigrants: they found participants used "western dentistry" in addition to traditional remedies but it was difficult for them to get relevant information about oral health care: the two main barriers to accessing western-based dental care were language and financial costs. Tieu et al.[29] compared beliefs about treatment, etiology, and prognosis about depression among older Chinese immigrants and Canadian-born participants of the same age. They found that older Chinese immigrants would benefit from health education about the symptoms of depression, its etiology, and effective treatments.

Lai et al.[30] reported that participants who identified more strongly with Chinese cultural values and beliefs reported less favourable physical health and more illnesses. Jette and Vertinsky[31] explored how older Chinese immigrant women understood and took up western biomedical beliefs about health and physical activity. They found that the health practices of participants were not influenced by the western narratives of health, rather strongly tied to cultural beliefs. Green et al.[32] assessed the use of vitamin D supplements among older adults and found that 60% of older British Columbians, including those of "Asian ethnic origin," were using a vitamin D supplement. They also found that older women were more likely than older men to take a supplement containing vitamin D. Having a healthcare practitioner recommend a vitamin D supplement doubled the likelihood of supplement use among older immigrants, demonstrating the importance of healthcare practitioners in influencing positive health behaviours. Johnson and Garcia[33] collected dietary and physical activity profiles and

26. D. W. L. Lai, "Abuse and neglect experienced by aging Chinese in Canada," Journal of Elder Abuse & Neglect, vol. 23, no. 4, pp. 326–347, 2011. View at: Publisher Site | Google Scholar See in References
27. D. W. L. Lai and S. Surood, "Chinese health beliefs of older Chinese in Canada," Journal of Aging and Health, vol. 21, no. 1, pp. 38–62, 2009. View at: Publisher Site | Google Scholar See in References
28. M. I. MacEntee, R. Mariño, S. Wong et al., "Discussions on oral health care among elderly Chinese immigrants in Melbourne and Vancouver," Gerodontology, vol. 29, no. 2, pp. e822–e832, 2012. View at: Publisher Site | Google Scholar See in References
29. Y. Tieu, C. Konnert, and J. Wang, "Depression literacy among older Chinese immigrants in Canada: a comparison with a population-based survey," International Psychogeriatrics, vol. 22, no. 8, pp. 1318–1326, 2010. View at: Publisher Site | Google Scholar See in References
30. D. W. L. Lai, K. T. Ka, N. Chappell, D. C. Y. Lai, and S. B. Y. Chau, "Relationships between culture and health status: a multi-site study of the older Chinese in Canada," Canadian Journal on Aging, vol. 26, no. 3, pp. 171–183, 2007. View at: Publisher Site | Google Scholar See in References
31. S. Jette and P. Vertinsky, "'Exercise is medicine': understanding the exercise beliefs and practices of older Chinese women immigrants in British Columbia, Canada," Journal of Aging Studies, vol. 25, no. 3, pp. 272–284, 2011. View at: Publisher Site | Google Scholar See in References
32. T. J. Green, S. I. Barr, and G. E. Chapman, "The majority of older British Columbians take vitamin D-containing supplements," Canadian Journal of Public Health, vol. 101, no. 3, pp. 246–250, 2010. View at: Google Scholar See in References
33. C. S. Johnson and A. C. Garcia, "Dietary and activity profiles of selected immigrant older adults in Canada," Journal of Nutrition For the Elderly, vol. 23, no. 1, pp. 23–39, 2003. View at: Publisher Site | Google Scholar See in References

explored the factors that influenced these profiles. They found that older immigrants are at a high level of nutritional risk and identified contributing factors, such as inadequate dietary consumption, tooth and mouth problems, the presence of chronic conditions that require dietary modifications, multiple medications, eating alone, and limited financial resources. Fornazzari et al.[34] reported low levels of knowledge about Alzheimer's disease among a sample of older Latin-American immigrants resulting in both normalization (as a "normal part of aging") and stigmatization (e.g., belief that it is contagious) that may act as a barrier to timely access to health care services.

3.2.5. Health Promotion and Chronic Disease Prevention

Sun et al.[35] reported lower rates of mammography screening among older Asian immigrant women in Canada as compared to Canadian-born women. They found that language differences were a key barrier to mammography screening. Todd et al.[36] explored the predictors of colon and breast cancer screening among older Chinese immigrant women and found that physician recommendation, self-efficacy, and adequate English-language proficiency affected the likelihood of cancer screening. Donnelly[37] explored the processes by which older Vietnamese immigrant women decided to engage in regular breast and cervical cancer screening: key findings were that decision-making should be shared by the patient and the physician, and outreach materials should be provided in a language that is understood by and accessible to this population. Lofters et al.[38] compared the prevalence of cervical cancer screening among older immigrant women from various countries and among Canadian-born women and found that screening rates were much lower among older women from South Asia than among Canadian-born women. Their findings suggested that income and cultural differences contributed significantly to the differences in screening rates between the two groups of women. Choudhry et al.[39] focused on health promotion among South Asian immigrant women and reported that the participants found it important to "maintain culture and tradition," placed family needs before themselves, and survived by "being strong."

34. L. Fornazzari, C. Fischer, T. Hansen, and L. Ringer, "Knowledge of Alzheimer's disease and subjective memory impairment in Latin American seniors in the Greater Toronto Area," International Psychogeriatrics, vol. 21, no. 5, pp. 966–969, 2009. View at: Publisher Site | Google Scholar See in References
35. Z. Sun, H. Xiong, A. Kearney et al., "Breast cancer screening among Asian immigrant women in Canada," Cancer Epidemiology, vol. 34, no. 1, pp. 73–78, 2010. View at: Publisher Site | Google Scholar See in References
36. L. Todd, E. Harvey, and L. Hoffman-Goetz, "Predicting breast and colon cancer screening among English-as-a-second-language older Chinese immigrant women to Canada," Journal of Cancer Education, vol. 26, no. 1, pp. 161–169, 2011. View at: Publisher Site | Google Scholar See in References
37. T. T. Donnelly, "The health-care practices of Vietnamese-Canadian women: cultural influences on breast and cervical cancer screening," Canadian Journal of Nursing Research, vol. 38, no. 1, pp. 82–101, 2006. View at: Google Scholar See in References
38. A. K. Lofters, S. W. Hwang, R. Moineddin, and R. H. Glazier, "Cervical cancer screening among urban immigrants by region of origin: a population-based cohort study," Preventive Medicine, vol. 51, no. 6, pp. 509–516, 2010. View at: Publisher Site | Google Scholar See in References
39. U. K. Choudhry, S. Jandu, J. Mahal, R. Singh, H. Sohi-Pabla, and B. Mutta, "Health promotion and participatory action research with South Asian women," Journal of Nursing Scholarship, vol. 34, no. 1, pp. 75–81, 2002. View at: Publisher Site | Google Scholar See in References

3.2.6. Barriers to Healthcare Access and Utilization

Lai and Chau [40] reported that older Chinese immigrants find accessing health services difficult due to communication barriers such as language differences, lack of cultural competence among service providers, and logistical problems in the service delivery system. Lai and Kalyniak's [41] study of predictors related to accessing annual physical examinations among older Chinese immigrants revealed that, in addition to lack of knowledge about healthcare coverage and service availability, the low rates of accessing healthcare could be related to a lack of understanding about the importance and benefits of preventive annual physical examinations. Ballantyne et al. [42] investigated medication use among a diverse group of older immigrants and found that older immigrants from China, Hong Kong, Vietnam, and Portugal often avoided discussing their self-care and alternative healthcare practices with their physicians; they also found that the participants often disagreed with the assessment and the recommended treatment and sought out and tried alternative treatments.

Discussion

This scoping review summarizes the current literature on the health status of older immigrant women in Canada and the multiple and intersecting factors that affect this population's health. The review makes a significant contribution to the health science literature as it collates the relevant research on the topic.

Many of the studies used narrow recruitment strategies (e.g., telephone surveys) and small samples. Most also focused on one ethnic group and did not compare the results with other immigrant groups or individuals born in Canada. Other limitations of the original studies included potential loss of cultural nuances during translation and interpretation of data; lack of culturally and linguistically relevant data collection instruments; and lack of information about premigration health statuses.

In spite of these limitations, these studies revealed that older immigrant women experience health disadvantages due to intersecting factors such as social isolation, poverty, gender- and generational-specific roles, and other factors linked to the social determinants of health. The World Health Organization defines the Social Determinants of Health as the conditions in which people are born, grow, live, work, and age,

40. D. W. L. Lai and S. B. Chau, "Effects of service barriers on health status of older Chinese immigrants in Canada," Social Work, vol. 52, no. 3, pp. 261–269, 2007. View at: Publisher Site | Google Scholar See in References

41. D. W. L. Lai and S. Kalyniak, "Use of annual physical examinations by aging Chinese Canadians," Journal of Aging and Health, vol. 17, no. 5, pp. 573–591, 2005. View at: Publisher Site | Google Scholar See in References

42. P. J. Ballantyne, R. M. Mirza, Z. Austin, H. S. Boon, and J. E. Fisher, "Becoming old as a 'pharmaceutical person': negotiation of health and medicines among ethnoculturally diverse older adults," Canadian Journal on Aging, vol. 30, no. 2, pp. 169–184, 2011. View at: Publisher Site | Google Scholar See in References

including the health system[43]. The social determinants of health are a key element of Canada's framework for improving the health of its population[44].

The social determinants of health can be depicted using three circles to show how each determinant is contextually related to the others[45]. The familial and biologic context is at the centre of Figure 2, reflecting the social determinants of genetic and biological endowment, health practices and coping skills, and healthy child development. The structural context at the next level reflects socially created categories of "identity," which affect individual and group status and, in turn, suboptimal versus optimal health. The socioeconomic and political context, depicted at the outermost level, refers to the structuring of communities and the availability of community-specific resources needed to support health. The three levels are interdependent, but the social determinants of health related to the socioeconomic and political context have the strongest influence on the health and wellbeing of individuals[46]. As is the case with all Canadians, the health priorities and experiences of older immigrant women in Canada are inherently linked to the social determinants of health. Our scoping review has identified six social determinants that strongly affect the health of older immigrant women: physical environment, social environment, economic conditions, cultural beliefs, gendered norms, and the healthcare service delivery system.

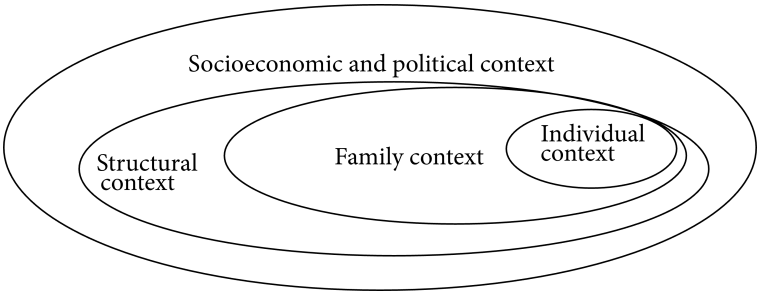

Figure 2: Social determinants of health

4.1. Socioeconomic and Political Context

Physical environment is an important determinant of health. Within the built

43. Commission on Social Determinants of Health, Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health, World Health Organization, 2008, http://www.who.int/social_determinants/en/. See in References
44. Public Health Agency of Canada, "What makes Canadians healthy or unhealthy?" 2011, http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php. View at: Google Scholar See in References
45. K. Edmunds and J. A. Samuels-Dennis, "Immigrant Canadians," in Fundamentals: Perspectives on the Art and Science of Canadian Nursing, D. Gregory, C. Seniuk, L. Patrick, and T. Stephen, Eds., Lippincott Williams & Wilkins, Toronto, Canada, 2014. View at: Google Scholar See in References
46. K. Edmunds and J. A. Samuels-Dennis, "Immigrant Canadians," in Fundamentals: Perspectives on the Art and Science of Canadian Nursing, D. Gregory, C. Seniuk, L. Patrick, and T. Stephen, Eds., Lippincott Williams & Wilkins, Toronto, Canada, 2014. View at: Google Scholar See in References

environment, factors related to housing, the design of communities, and transportation systems can significantly influence the physical and psychological wellbeing of older immigrants[47]. Lack of or limited transportation is known to be a significant barrier for older immigrant women, in particular, in terms of access to health services[48] as well as access to supermarkets and/or "ethnic food stores"[49]. Weather has also been identified as a barrier to physical activity among older immigrant women[50].

Support from families, friends, and communities is associated with better health[51]. Lai and Kalyniak[52] identified social support as a significant enabling factor in gaining adequate access to services. Perceived social support was also associated with positive mental health outcomes in older Hispanic immigrants living in the United States[53]. Further, the size of ethnic communities also affects health and wellbeing. For example, Chau and Lai[54] found that older Chinese immigrants living in larger ethnic communities in Canadian cities reported poorer health status as compared with those living in smaller ethnic communities. They gave several possible explanations for this observation. The first involves segregation of the older Chinese immigrants from individuals of other ethnicities: the large Chinese population in major cities may mean they are unlikely to be integrated into "mainstream" Canadian society, resulting in increased "social distance" from the Canadian-born counterparts and a subsequent decline in health. Members in smaller ethnic communities tend to have stronger social bonds that lead to psychological wellbeing. Also, because smaller communities pose less "less of a threat" to the dominant group, members of smaller ethnic communities may be perceived and treated more positively. Finally, members of smaller ethnic communities may be more resilient in dealing with negative experiences, resulting in better health and functioning.

Lai and Chau[55] found that older Chinese immigrants reported difficulties in accessing services because of lack of knowledge about existing health services, communication barriers, lack of cultural competence on the part of service providers, and administrative problems in the service delivery system. Language was a significant barrier to effective communication with a physician and mammogram use among

47. Public Health Agency of Canada, "What makes Canadians healthy or unhealthy?" 2011, http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php. View at: Google Scholar See in References
48. M. I. MacEntee, R. Mariño, S. Wong et al., "Discussions on oral health care among elderly Chinese immigrants in Melbourne and Vancouver," Gerodontology, vol. 29, no. 2, pp. e822–e832, 2012. View at: Publisher Site | Google Scholar See in References
49. C. S. Johnson and A. C. Garcia, "Dietary and activity profiles of selected immigrant older adults in Canada," Journal of Nutrition For the Elderly, vol. 23, no. 1, pp. 23–39, 2003. View at: Publisher Site | Google Scholar See in References
50. C. S. Johnson and A. C. Garcia, "Dietary and activity profiles of selected immigrant older adults in Canada," Journal of Nutrition For the Elderly, vol. 23, no. 1, pp. 23–39, 2003. View at: Publisher Site | Google Scholar See in References
51. Public Health Agency of Canada, "What makes Canadians healthy or unhealthy?" 2011, http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php. View at: Google Scholar See in References
52. D. W. L. Lai and S. Kalyniak, "Use of annual physical examinations by aging Chinese Canadians," Journal of Aging and Health, vol. 17, no. 5, pp. 573–591, 2005. View at: Publisher Site | Google Scholar See in References
53. S. C. Brown, C. A. Mason, A. R. Spokane, M. C. Cruza-Guet, B. Lopez, and J. Szapocznik, "The relationship of neighborhood climate to perceived social support and mental health in older hispanic immigrants in Miami, Florida," Journal of Aging and Health, vol. 21, no. 3, pp. 431–459, 2009. View at: Publisher Site | Google Scholar See in References
54. S. Chau and D. W. L. Lai, "The size of an ethno-cultural community as a social determinant of health for Chinese seniors," Journal of Immigrant and Minority Health, vol. 13, no. 6, pp. 1090–1098, 2011. View at: Publisher Site | Google Scholar See in References
55. D. W. L. Lai and S. B. Chau, "Effects of service barriers on health status of older Chinese immigrants in Canada," Social Work, vol. 52, no. 3, pp. 261–269, 2007. View at: Publisher Site | Google Scholar See in References

older Asian immigrant women[56]. Sun et al.[57] reported that older Asian immigrant women who spoke one of the official languages were almost three times more likely to have ever had a screening mammogram. Similarly, studies based in the United States[58] have found language as a significant barrier to access to healthcare services. Publicly insured healthcare and drug benefits reportedly increase the willingness of older immigrant women to regularly consult or attend appointments with a physician and to use "western medicines"[59]. However, more research is needed to clarify the factors affecting the health of older immigrant women, especially their access to and use of healthcare services

4.2. Structural Context

Our findings highlight the negative impact of socioeconomic barriers on health care utilization. Similar findings have been reported in other studies based in the United States[6061]. Lai[62] found that being financially stable is important to the physical and mental health of older immigrants: older immigrant women are particularly vulnerable because they have access to fewer resources. In a study of cervical cancer screening use among urban immigrants, older South Asian immigrant women with lower incomes had lower rates of screening[63]. Financial constraints have also been identified as a major barrier to healthy eating practices among older immigrants[64].

The health choices of older immigrants are influenced by their cultural beliefs and values. For example, older Chinese immigrants reportedly believed that mental health problems can be addressed without professional help, which may be one reason for their underutilization of mental health services compared with their non-Chinese counterparts[65]. Lai et al.[66] also reported that older Chinese immigrants who identify more strongly with "traditional" Chinese cultural values and beliefs have less favourable health outcomes in the postmigration context and provided two possible explanations

56. D. W. L. Lai and S. B. Chau, "Effects of service barriers on health status of older Chinese immigrants in Canada," Social Work, vol. 52, no. 3, pp. 261–269, 2007. View at: Publisher Site | Google Scholar See in References
57. Z. Sun, H. Xiong, A. Kearney et al., "Breast cancer screening among Asian immigrant women in Canada," Cancer Epidemiology, vol. 34, no. 1, pp. 73–78, 2010. View at: Publisher Site | Google Scholar See in References
58. G. Flores, "Language barriers to health care in the United States," The New England Journal of Medicine, vol. 355, no. 3, pp. 229–231, 2006. View at: Publisher Site | Google Scholar See in References
59. P. J. Ballantyne, R. M. Mirza, Z. Austin, H. S. Boon, and J. E. Fisher, "Becoming old as a 'pharmaceutical person': negotiation of health and medicines among ethnoculturally diverse older adults," Canadian Journal on Aging, vol. 30, no. 2, pp. 169–184, 2011. View at: Publisher Site | Google Scholar See in References
60. F. M. Gany, A. P. Herrera, M. Avallone, and J. Changrani, "Attitudes, knowledge, and health-seeking behaviors of five immigrant minority communities in the prevention and screening of cancer: a focus group approach," Ethnicity and Health, vol. 11, no. 1, pp. 19–39, 2006. View at: Publisher Site | Google Scholar See in References
61. A. S. O'Malley, J. Mandelblatt, K. Gold, K. A. Cagney, and J. Kerner, "Continuity of care and the use of breast and cervical cancer screening services in a multiethnic community," Archives of Internal Medicine, vol. 157, no. 13, pp. 1462–1470, 1997. View at: Publisher Site | Google Scholar See in References
62. D. W. L. Lai, "Perceived impact of economic downturn on worry experienced by elderly Chinese immigrants in Canada," Journal of Family and Economic Issues, vol. 32, no. 3, pp. 521–531, 2011. View at: Publisher Site | Google Scholar See in References
63. A. K. Lofters, S. W. Hwang, R. Moineddin, and R. H. Glazier, "Cervical cancer screening among urban immigrants by region of origin: a population-based cohort study," Preventive Medicine, vol. 51, no. 6, pp. 509–516, 2010. View at: Publisher Site | Google Scholar See in References
64. C. S. Johnson and A. C. Garcia, "Dietary and activity profiles of selected immigrant older adults in Canada," Journal of Nutrition For the Elderly, vol. 23, no. 1, pp. 23–39, 2003. View at: Publisher Site | Google Scholar See in References
65. D. W. L. Lai, K. T. Ka, N. Chappell, D. C. Y. Lai, and S. B. Y. Chau, "Relationships between culture and health status: a multi-site study of the older Chinese in Canada," Canadian Journal on Aging, vol. 26, no. 3, pp. 171–183, 2007. View at: Publisher Site | Google Scholar See in References
66. D. W. L. Lai, K. T. Ka, N. Chappell, D. C. Y. Lai, and S. B. Y. Chau, "Relationships between culture and health status: a multi-site study of the older Chinese in Canada," Canadian Journal on Aging, vol. 26, no. 3, pp. 171–183, 2007. View at: Publisher Site | Google Scholar See in References

for this finding. First, those with stronger cultural values and beliefs may find it more difficult to adapt to Canadian values and beliefs about health, health practices, and service access. Second, older immigrants often face service barriers, such as language difficulties during encounters with healthcare practitioners. Culture also appears to play a key role in neglect and abuse: Lai and Surood [67] reported that older Chinese immigrants who were more "traditional" were more likely to experience neglect or abuse. But these findings need careful examination in the context of marginalization, stigmatization, loss or devaluation of language and culture, and lack of access to culturally appropriate and safe healthcare and services [68][69][70].

Gender refers to the various socially determined roles, attitudes, behaviours, values, relative power, and influence that society ascribes to women and men on a differential basis [71]. Many health issues can be ascribed to gender-based social status or roles [72]. For instance, a literature review on older Asian immigrants in North America found that depression was more prevalent among older Asian women than older Asian men [73]. The intersection of gender with other social identities had a significant effect on the health outcomes. For example, being older, female, single, and poor were all associated with negative influences on health [74]. Older women's access to health services may be related to factors such as the family's financial situation and employment concerns [75]. Often, making time for themselves at the cost of their family's needs is not an option for older immigrant women [76].

4.3. Social Determinants of Health Not Addressed in the Literature

One area of focus absent from the existing body of health research is how employment and working conditions affect the health of older immigrant women. The recent removal of the mandatory retirement age and anecdotal evidence that older women are remaining in the workforce longer indicate the importance of assessing how work and work environments influence the health of older immigrant women. We also did not find studies that assessed literacy and education as a determinant of older immigrant women's health or those that linked child development and the childhood environment

67. D. W. L. Lai and S. Surood, "Chinese health beliefs of older Chinese in Canada," Journal of Aging and Health, vol. 21, no. 1, pp. 38–62, 2009. View at: Publisher Site | Google Scholar See in References
68. K. Edmunds and J. A. Samuels-Dennis, "Immigrant Canadians," in Fundamentals: Perspectives on the Art and Science of Canadian Nursing, D. Gregory, C. Seniuk, L. Patrick, and T. Stephen, Eds., Lippincott Williams & Wilkins, Toronto, Canada, 2014. View at: Google Scholar See in References
69. S. Guruge, P. Kanthasamy, J. Jokarasa et al., "Older women speak about abuse & neglect in the post-migration context," Women's Health and Urban Life, vol. 9, no. 2, pp. 15–41, 2010. View at: Google Scholar See in References
70. B. C. H. Kuo, V. Chong, and J. Joseph, "Depression and its psychosocial correlates among older Asian immigrants in North America: a critical review of two decades' research," Journal of Aging and Health, vol. 20, no. 6, pp. 615–652, 2008. View at: Publisher Site | Google Scholar See in References
71. Public Health Agency of Canada, "What makes Canadians healthy or unhealthy?" 2011, http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php. View at: Google Scholar See in References
72. Public Health Agency of Canada, "What makes Canadians healthy or unhealthy?" 2011, http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php. View at: Google Scholar See in References
73. B. C. H. Kuo, V. Chong, and J. Joseph, "Depression and its psychosocial correlates among older Asian immigrants in North America: a critical review of two decades' research," Journal of Aging and Health, vol. 20, no. 6, pp. 615–652, 2008. View at: Publisher Site | Google Scholar See in References
74. D. W. L. Lai, K. T. Ka, N. Chappell, D. C. Y. Lai, and S. B. Y. Chau, "Relationships between culture and health status: a multi-site study of the older Chinese in Canada," Canadian Journal on Aging, vol. 26, no. 3, pp. 171–183, 2007. View at: Publisher Site | Google Scholar See in References
75. T. T. Donnelly, "The health-care practices of Vietnamese-Canadian women: cultural influences on breast and cervical cancer screening," Canadian Journal of Nursing Research, vol. 38, no. 1, pp. 82–101, 2006. View at: Google Scholar See in References
76. U. K. Choudhry, S. Jandu, J. Mahal, R. Singh, H. Sohi-Pabla, and B. Mutta, "Health promotion and participatory action research with South Asian women," Journal of Nursing Scholarship, vol. 34, no. 1, pp. 75–81, 2002. View at: Publisher Site | Google Scholar See in References

with the health statuses of older immigrant women in Canada. No studies addressed genetic predispositions and health statuses of older immigrant women in Canada.

Strengths and Limitations of This Review

Scoping reviews are, particularly, useful for topics that have not been reviewed comprehensively before[77], as is the case of health of older immigrant women in Canada. Our review focused on social determinants of health and mirrors the current political trends that guide many health programs in Canada. The factors that shape older immigrant women's health are of importance to key stakeholders around the globe. Thus, our findings can inform practice and policy changes in this area. The findings can also inform future research on the topic.

Our review has several limitations. We excluded grey literature, which can include important research conducted by community organizations. Our literature search also did not include social science databases and thus potentially miss some relevant articles. We also did not search the reference lists of the articles included in the review.

Most of the studies included in our review included immigrants from (South, East, and Southeast) Asia, in general, and Chinese immigrants, in particular. However, the Chinese are the second-largest racialized immigrant group, making up 21% of the racialized population and 4% of the total Canadian population[78], and the findings help to clarify the health issues faced by the (diverse groups of) Asian immigrants in the country. Also, Asians constitute close to 50% of immigrants to most English-speaking countries[79], thus making our findings possibly transferable beyond the Canadian context to other countries with similar rates of Asian immigrants.

Implications

6.1. Implications for Research

There is an urgent need for more research on various aspects of older immigrant women's health (see Table 2). Studies involving cross-cultural groups would help reveal the degree to which findings are unique to older immigrant women from a specific ethnocultural group or common across immigrant communities. Research in different regions of Canada and different countries of the world would help clarify how

77. H. Arksey and L. O'Malley, "Scoping studies: towards a methodological framework," International Journal of Social Research Methodology, vol. 8, no. 1, pp. 19–32, 2005. View at: Publisher Site | Google Scholar See in References

78. Statistics Canada, Immigration and Ethnocultural Diversity in Canada, 2011, http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-010-x/99-010-x2011001-eng.cfm. See in References

79. G. Hugo, "The new international migration in Asia: challenges for population research," Asian Population Studies, vol. 1, no. 1, pp. 93–120, 2005. View at: Publisher Site | Google Scholar See in References

geographic locations and healthcare contexts in different regions may affect older immigrant women's health and access to care and services. Studies with a longitudinal design would help delineate and track health changes, the aging process, and sociocultural changes among older immigrant women and their access to services over time. Other methodological issues to consider in future research include more emphasis on comparative research, larger sample sizes, inclusion of older immigrants from different immigration categories (such as refugee, precarious status and family sponsored), and more comprehensive recruitment strategies. An intersectionality approach[80] to examine the interactions of migration, gender, race, ethnicity, and other dimensions of social identity with health could also help further address the knowledge gap.

80. S. Guruge and N. Khanlou, "Intersectionalities of influence: researching the health of immigrant and refugee women," Canadian Journal of Nursing Research, vol. 36, no. 3, pp. 32–47, 2004. View at: Google Scholar See in References

Table 2: Key implications from selected studies

List of studies	Key implications
Lai (2004) [15]	Adequate community support services and networks
Chau and Lai (2011) [16]	Further research to examine the residual confounding effects of the socioeconomic and political environment related to racism and various forms of discrimination in large urban centres
Lai (2011a) [17]	Further research on the influence of cross-cultural differences on health
Lai (2011b) [18]	Community education
Lai and Surood (2009) [19]	Longitudinal studies to clarify the effects of aging and acculturation on health values and beliefs
Tieu et al. (2010) [21]	Mental health education integrated into supports and services
Lai et al. (2007) [22]	Service delivery with attention to individuals' cultural health practices, using an approach that is respectful and nonjudgmental
Johnson and Garcia (2003) [23]	More research about adequate dietary intake and regular physical activity of older immigrants
Fornazzari et al. (2009) [26]	Longitudinal studies about health promotion initiatives
Sun et al. (2010) [27]	Culturally and linguistically appropriate education programs about breast cancer risk and mammography screening and the role of the physician in influencing older immigrant women's mammography screening behaviours
Donnelly (2006) [29]	Research about the influence of culture, social, political, historical, and economic background on cancer screening
Lofters et al. (2010) [30]	Research about cultural barriers to cancer screening
Lai and Chau (2007) [32]	Local health agencies and community health practitioners working more closely to design culturally appropriate methods for health information and promotion activities
Lai and Kalyniak (2005) [33]	Family physicians' proactive engagement in health promotion and local health regions and with community health practitioners

6.2. Implications for Practice

Overall, our findings suggest that the Canadian healthcare system fails to respond to the health and illness concerns of older immigrant women (see Table 2). First, it lacks holistic and supportive programs that could help older immigrant women cope with postmigration and (re)settlement challenges and achieve a sense of health and wellbeing. Second, services must incorporate community values and strengths, recognize social inequities, and implement new models of collaborative and integrated care. The healthcare and social service sectors need to work together to address the health needs of older immigrant women. There is a need for innovative community outreach strategies that engage key community leaders, to help clarify the barriers in accessing healthcare services. Healthcare practitioners need ongoing training to develop their cross-cultural communication and counselling skills. It is also important to strengthen the curricula of health professions to ensure that graduates in practical disciplines such as nursing are well equipped with the cross-cultural communication skills required for working with culturally diverse older immigrants. Also, with an increasingly aging population, demand for workers to provide care for the elderly population will increase. However, increasing the supply of healthcare providers alone is not a solution; there has to be a key focus on preventive healthcare.

6.3. Implications for Policy

Policy and systematic changes are needed to overcome many health and social challenges faced by older immigrant women (see Table 3). When policy recommendations were made, most articles referred to income security as a way to ensure the health of older immigrant women. A number of articles recommended policy changes that would allow for adequate access to a monthly income, rental/mortgage supplements, and extended health benefits, such as dental care. Some referred to the need for resource distribution policies to target the development of formal social support networks, because being surrounded by a large immigrant community does not always translate to social connectedness. One recommendation that was common to several articles was to promote social inclusion of older immigrant women to encourage their physical and social involvement in community life. Addressing abuse of older immigrant women should also be a key policy focus which must address the larger socioeconomic and cultural contexts that contribute to the vulnerability of older immigrant women[81]. Public policies, programs, and services for older immigrant women should extend beyond the health sector and involve collaboration with other sectors, and approaches should be multipronged to incorporate education, awareness-raising, and community-based initiatives.

81. A. Matsuoka, S. Guruge, S. Koehn, M. Beaulieu, and J. Ploeg, "Moving forward: prevention of abuse of older women in the post-migration context in Canada," Canadian Review of Social Policy, vol. 2, no. 68–69, pp. 107–120, 2012. View at: Google Scholar See in References

Table 3: Overview of the policy recommendations offered by selected studies.

List of studies	Key implications
Lai (2004) [15]	*Policy focus*: income security among Chinese immigrants (i) 17.3% of the older Chinese from Mainland China had an inadequate monthly income (<$500/mth) that, in turn, negatively affected all aspects of their health. (ii) Current sponsorship regulation restricts access to government pension benefits within the first ten years after their arrival in Canada. *Recommendation*: policies have to be instituted to help older immigrants access and/or maintain an adequate level of financial stability to protect society from the probable social and fiscal cost of physical and mental health problems that are a direct result of poverty.
Chau and Lai (2011) [16]	*Policy focus*: social support and networks (i) The presence of a larger ethnic community size does not necessarily enhance individual health and wellbeing. (ii) Older immigrants from ethnically diverse populations cannot rely solely on their immediate and community social networks for support to meet their health and wellbeing needs. *Recommendation*: the development of formal social support networks that can attend in culturally safe ways to the needs of ethnically diverse groups is essential to the health and wellbeing of older immigrant women.
Lai (2011a) [17]	*Policy focus*: income security among older Chinese immigrants *Recommendation*: there is a need for policies that will extend income security benefits to realistically account for the nutritional and rent/mortgage supplement needs of older immigrant women.
Lai (2011b) [18]	*Policy focus*: abuse of older immigrants Length of residency in Canada is a significant correlate of neglect and abuse, with long-term immigrants more likely to experience greater levels of abuse and neglect. *Recommendation*: practice policies should evolve to extend screening for abuse and neglect among older immigrant women. There is a need for policies that will support the development of shelters for older immigrant women who may be exposed to various forms of family and even community violence.
MacEntee et al. (2012) [20]	*Policy focus*: income security and dental health *Recommendation*: there is a need for policies that will increase access to routine and emergency dental care particularly among older immigrant women.

Lai et al. (2007) [22]	*Policy focus*: income security *Recommendation:* there is a need for policies that strategically focus on enhancing the health of older immigrant women who are unmarried and who are living in poverty.
Sun et al. (2010) [27]	*Policy focus*: health promotion and illness prevention *Recommendation:* practice and resource distribution policies that target breast cancer prevention need to address culturally safe ways to recruit and treat Asian immigrant women.
Lofters et al. (2010) [30]	*Policy focus*: health promotion and illness prevention *Recommendation:* practice and resource distribution policies that target cervical cancer screening need to address culturally safe ways to recruit and treat older immigrant women living in the lowest-income neighborhoods where service may be absent or where acculturation is likely to affect service uptake.
Lai and Chau (2007) [32]	*Policy focus*: health service access and effectiveness *Recommendation:* enduring and productive changes to improve racialized communities' experience with the healthcare system require the development of equitable and culturally competent systems that respect the rights of culturally diverse populations. Policies that attend to structural changes are needed to ensure that older immigrants are served in a way that prioritizes cultural safety social equity versus equality.

Conclusion

The socioeconomic and political context in which older immigrant women live, work, and grow old has significant implications for their health and wellbeing. This scoping review suggests that older immigrant women, when compared with Canadian-born women, are more vulnerable to poor health, more financially disadvantaged, and face a greater number of barriers when accessing the services needed to maintain and/or promote their health. The findings of this review suggest that Canada's health service system is ill equipped to address the health and illness concerns of this population. Specifically, our findings suggest the need to develop healthcare service delivery approaches that account for the cultural, generational, and gender-based norms of this population. Additionally, improving older immigrant women's health will require innovative community outreach strategies that engage older immigrant women, key community leaders, family members, and other stakeholders across sectors to address barriers to social inclusion, income security, stable housing, healthy relationships, and resources to access health care which will lead to individual transformation, community development, and policy change.

Conflict of Interests

The authors declare that there is no conflict of interests regarding the publication of this paper.

References

Department of Economic and Social Affairs and Population Division, *World Population Ageing 2013*, *United Nations*, Department of Economic and Social Affairs, Population Division, 2013, http://www.un.org/en/development/desa/population/publications/pdf/ageing/WorldPopulationAgeing2013.pdf.

A. M. Warnes, K. Friedrich, L. Kellaher, and S. Torres, "The diversity and welfare of older migrants in Europe," *Ageing and Society*, vol. 24, no. 3, pp. 307–326, 2004.

View at: Publisher Site | Google Scholar

United Nations, *World Migration in Figures*, 2013, http://www.oecd.org/els/mig/World-Migration-in-Figures.pdf.

C. B. Tannenbaum, L. Nasmith, and N. Mayo, "Understanding older women's health care concerns: a qualitative study," *Journal of Women & Aging*, vol. 15, no. 1, pp. 3–16, 2003.

View at: Publisher Site | Google Scholar

E. M. T. Gee, K. M. Kobayashi, and S. G. Prus, "Examining the healthy immigrant effect in mid-to later life: findings from the Canadian Community Health Survey," *Canadian Journal on Aging*, vol. 23, no. 5, pp. 55–63, 2004.

View at: Google Scholar

Statistics Canada, *Canadians in Context—Aging Population*, Statistics Canada, Ottawa, Canada, 2011, http://well-being.esdc.gc.ca/misme-iowb/.3ndic.1t.4r@-eng.jsp?iid=33.

J. T. McDonald and S. Kennedy, "Insights into the 'healthy immigrant effect': health status and health service use of immigrants to Canada," *Social Science and Medicine*, vol. 59, no. 8, pp. 1613–1627, 2004.

View at: Publisher Site | Google Scholar

N. Biddle, S. Kennedy, and J. T. Mcdonald, "Health assimilation patterns amongst Australian Immigrants," *Economic Record*, vol. 83, no. 260, pp. 16–30, 2007.

View at: Publisher Site | Google Scholar

S. Kennedy, J. T. McDonald, and N. Biddle, "The healthy immigrant effect and immigrant selection: evidence from four countries," *Social and Economic Dimensions of an Aging Population Research Papers* 164, McMaster University, 2006.

View at: Google Scholar

E. H. Stephen, K. Foote, G. E. Hendershot, and C. A. Schoenborn, "Health of the foreign-born population: United States, 1989-90," *Advance Data*, no. 241, pp. 1–12, 1994.

View at: Google Scholar

E. Ng, R. Wilkins, F. Gendron, and J. M. Berthelot, "Dynamics of immigrants' health in Canada: evidence from the National Population Health Survey," *Healthy Today*, *Healthy*

Tomorrow? Findings from the National Population Health Survey, Statistics Canada, Ottawa, Canada, 2005.

View at: Google Scholar

H. Arksey and L. O'Malley, "Scoping studies: towards a methodological framework," *International Journal of Social Research Methodology*, vol. 8, no. 1, pp. 19–32, 2005.

View at: Publisher Site | Google Scholar

WHO, *Definition of Older or Elderly Person*, World Health Organization, Geneva, Switzerland, 2011, http://www.who.int/healthinfo/survey/ageingdefnolder/en/index.html.

C. Spencer and G. Gutman, *Sharpening Canada's focus, Developing an Empirical Profile of Abuse and Neglect Among Older Women and Men in the Community*, Human Resources and Social Development, Ottawa, Canada, 2008.

D. Lai, "Depression among elderly Chinese-Canadian immigrants from Mainland China," *Chinese Medical Journal*, vol. 117, no. 5, pp. 677–683, 2004.

View at: Google Scholar

S. Chau and D. W. L. Lai, "The size of an ethno-cultural community as a social determinant of health for Chinese seniors," *Journal of Immigrant and Minority Health*, vol. 13, no. 6, pp. 1090–1098, 2011.

View at: Publisher Site | Google Scholar

D. W. L. Lai, "Perceived impact of economic downturn on worry experienced by elderly Chinese immigrants in Canada," *Journal of Family and Economic Issues*, vol. 32, no. 3, pp. 521–531, 2011.

View at: Publisher Site | Google Scholar

D. W. L. Lai, "Abuse and neglect experienced by aging Chinese in Canada," *Journal of Elder Abuse & Neglect*, vol. 23, no. 4, pp. 326–347, 2011.

View at: Publisher Site | Google Scholar

D. W. L. Lai and S. Surood, "Chinese health beliefs of older Chinese in Canada," *Journal of Aging and Health*, vol. 21, no. 1, pp. 38–62, 2009.

View at: Publisher Site | Google Scholar

M. I. MacEntee, R. Mariño, S. Wong et al., "Discussions on oral health care among elderly Chinese immigrants in Melbourne and Vancouver," *Gerodontology*, vol. 29, no. 2, pp. e822–e832, 2012.

View at: Publisher Site | Google Scholar

Y. Tieu, C. Konnert, and J. Wang, "Depression literacy among older Chinese immigrants in Canada: a comparison with a population-based survey," *International Psychogeriatrics*, vol. 22, no. 8, pp. 1318–1326, 2010.

View at: Publisher Site | Google Scholar

D. W. L. Lai, K. T. Ka, N. Chappell, D. C. Y. Lai, and S. B. Y. Chau, "Relationships between culture and health status: a multi-site study of the older Chinese in Canada," *Canadian Journal on Aging*, vol. 26, no. 3, pp. 171–183, 2007.

View at: Publisher Site | Google Scholar

S. Jette and P. Vertinsky, "'Exercise is medicine': understanding the exercise beliefs and practices of older Chinese women immigrants in British Columbia, Canada," *Journal of Aging Studies*, vol. 25, no. 3, pp. 272–284, 2011.

View at: Publisher Site | Google Scholar

T. J. Green, S. I. Barr, and G. E. Chapman, "The majority of older British Columbians take vitamin D-containing supplements," *Canadian Journal of Public Health*, vol. 101, no. 3, pp. 246–250, 2010.

View at: Google Scholar

C. S. Johnson and A. C. Garcia, "Dietary and activity profiles of selected immigrant older adults in Canada," *Journal of Nutrition For the Elderly*, vol. 23, no. 1, pp. 23–39, 2003.

View at: Publisher Site | Google Scholar

L. Fornazzari, C. Fischer, T. Hansen, and L. Ringer, "Knowledge of Alzheimer's disease and subjective memory impairment in Latin American seniors in the Greater Toronto Area," *International Psychogeriatrics*, vol. 21, no. 5, pp. 966–969, 2009.

View at: Publisher Site | Google Scholar

Z. Sun, H. Xiong, A. Kearney et al., "Breast cancer screening among Asian immigrant women in Canada," *Cancer Epidemiology*, vol. 34, no. 1, pp. 73–78, 2010.

View at: Publisher Site | Google Scholar

L. Todd, E. Harvey, and L. Hoffman-Goetz, "Predicting breast and colon cancer screening among English-as-a-second-language older Chinese immigrant women to Canada," *Journal of Cancer Education*, vol. 26, no. 1, pp. 161–169, 2011.

View at: Publisher Site | Google Scholar

T. T. Donnelly, "The health-care practices of Vietnamese-Canadian women: cultural influences on breast and cervical cancer screening," *Canadian Journal of Nursing Research*, vol. 38, no. 1, pp. 82–101, 2006.

View at: Google Scholar

A. K. Lofters, S. W. Hwang, R. Moineddin, and R. H. Glazier, "Cervical cancer screening among urban immigrants by region of origin: a population-based cohort study," *Preventive Medicine*, vol. 51, no. 6, pp. 509–516, 2010.

View at: Publisher Site | Google Scholar

U. K. Choudhry, S. Jandu, J. Mahal, R. Singh, H. Sohi-Pabla, and B. Mutta, "Health promotion and participatory action research with South Asian women," *Journal of Nursing Scholarship*, vol. 34, no. 1, pp. 75–81, 2002.

View at: Publisher Site | Google Scholar

D. W. L. Lai and S. B. Chau, "Effects of service barriers on health status of older Chinese immigrants in Canada," *Social Work*, vol. 52, no. 3, pp. 261–269, 2007.

View at: Publisher Site | Google Scholar

D. W. L. Lai and S. Kalyniak, "Use of annual physical examinations by aging Chinese Canadians," *Journal of Aging and Health*, vol. 17, no. 5, pp. 573–591, 2005.

View at: Publisher Site | Google Scholar

P. J. Ballantyne, R. M. Mirza, Z. Austin, H. S. Boon, and J. E. Fisher, "Becoming old as a 'pharmaceutical person': negotiation of health and medicines among ethnoculturally diverse older adults," *Canadian Journal on Aging*, vol. 30, no. 2, pp. 169–184, 2011.

View at: Publisher Site | Google Scholar

Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*, World Health Organization, 2008, http://www.who.int/social_determinants/en/.

Public Health Agency of Canada, "What makes Canadians healthy or unhealthy?" 2011, http://www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php.

View at: Google Scholar

K. Edmunds and J. A. Samuels-Dennis, "Immigrant Canadians," in *Fundamentals: Perspectives on the Art and Science of Canadian Nursing*, D. Gregory, C. Seniuk, L. Patrick, and T. Stephen, Eds., Lippincott Williams & Wilkins, Toronto, Canada, 2014.

View at: Google Scholar

S. C. Brown, C. A. Mason, A. R. Spokane, M. C. Cruza-Guet, B. Lopez, and J. Szapocznik, "The relationship of neighborhood climate to perceived social support and mental health in older hispanic immigrants in Miami, Florida," *Journal of Aging and Health*, vol. 21, no. 3, pp. 431–459, 2009.

View at: Publisher Site | Google Scholar

G. Flores, "Language barriers to health care in the United States," *The New England Journal of Medicine*, vol. 355, no. 3, pp. 229–231, 2006.

View at: Publisher Site | Google Scholar

F. M. Gany, A. P. Herrera, M. Avallone, and J. Changrani, "Attitudes, knowledge, and health-seeking behaviors of five immigrant minority communities in the prevention and screening of cancer: a focus group approach," *Ethnicity and Health*, vol. 11, no. 1, pp. 19–39, 2006.

View at: Publisher Site | Google Scholar

A. S. O'Malley, J. Mandelblatt, K. Gold, K. A. Cagney, and J. Kerner, "Continuity of care and the use of breast and cervical cancer screening services in a multiethnic community," *Archives of Internal Medicine*, vol. 157, no. 13, pp. 1462–1470, 1997.

View at: Publisher Site | Google Scholar

S. Guruge, P. Kanthasamy, J. Jokarasa et al., "Older women speak about abuse & neglect in the post-migration context," *Women's Health and Urban Life*, vol. 9, no. 2, pp. 15–41, 2010.

View at: Google Scholar

B. C. H. Kuo, V. Chong, and J. Joseph, "Depression and its psychosocial correlates among older Asian immigrants in North America: a critical review of two decades' research," *Journal of Aging and Health*, vol. 20, no. 6, pp. 615–652, 2008.

View at: Publisher Site | Google Scholar

Statistics Canada, *Immigration and Ethnocultural Diversity in Canada*, 2011, http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-010-x/99-010-x2011001-eng.cfm.

G. Hugo, "The new international migration in Asia: challenges for population research," *Asian Population Studies*, vol. 1, no. 1, pp. 93–120, 2005.

View at: Publisher Site | Google Scholar

S. Guruge and N. Khanlou, "Intersectionalities of influence: researching the health of immigrant and refugee women," *Canadian Journal of Nursing Research*, vol. 36, no. 3, pp. 32–47, 2004.

View at: Google Scholar

A. Matsuoka, S. Guruge, S. Koehn, M. Beaulieu, and J. Ploeg, "Moving forward: prevention of abuse of older women in the post-migration context in Canada," *Canadian Review of Social Policy*, vol. 2, no. 68-69, pp. 107–120, 2012.

View at: Google Scholar

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Chapter 5. Health Status and Health Determinants of Older Immigrant men in Canada: Gaps in Literature and Considerations for Future Research

SEPALI GURUGE; ERNEST LEUNG; AND SOURAYA SIDANI

Chapter 6. Health Profile of Older Immigrants: Analyzing the Canadian Longitudinal Study on Aging

SOURAYA SIDANI; SEPALI GURUGE; AND KANDASAMY ILLANKO

SOCIOECONOMIC CONSIDERATIONS

Chapter 7. 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

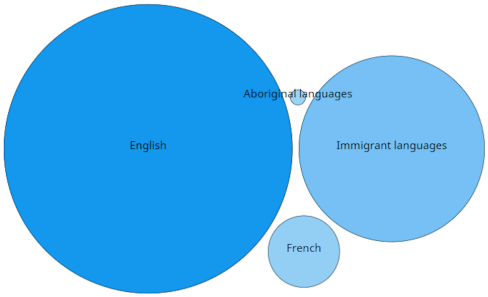
Social supports and social networks are critical to health and well-being (Stewart et al. 2008), but research has confirmed that for immigrants, familial and other social networks are segmented – if not severed – across borders (Spitzer et al. 2003). Migration to countries including as Canada may necessitate 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
https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/dv-vd/lang/index-eng.cfm

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 and 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 well-being. 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 and 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, and Keating 2015; Salma and Salami 2020; Salma et al. 2018). Health problems and low income are also associated with social isolation and loneliness (Salma and 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, and 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, and 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 and 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 and 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 and 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 and 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 and 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 well-being; (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 interviewed	**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 — interviewed				
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

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.

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

Sample

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 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 (in years)							
6 to 10	4	4	8	2	1	3	11
11 to 15	3	6	9	0	2	2	11
16 to 20	0	2	2	0	4	4	6
21 or more	1	2	3	4	3	7	10
First official language — Most proficient (second official language spoken not included in this table)							
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 — I live with:							
Alone	1	3	4	2	3	5	9
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 the 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 well-being 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 well-being. 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 well-being.

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 well-being, 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.

References

Bernt, M., L. Colini (2013). Exclusion, Marginalization and Peripheralization: Conceptual concerns in the study of urban inequalities, Working Paper, No. 49, Leibniz-Institut für Regionalentwicklung und Strukturplanung (IRS), Erkner. http://nbn-resolving.de/urn:nbn:de:101:1-2013052811489

Bowen, S . The Impact of Language Barriers on Patient Safety and Quality of Care. Société Santé en français; 2015.

Brenner N., N. Theodore (2005). Neoliberalism and the urban condition, London et.al.: Taylor & Francis.

Cox K.R. (1997). Spaces of Globalization: Reasserting the Power of the Local, New York: Guilford Press.

De Jong Gierveld, J., S. Van der Pas, and N. Keating (2015). "Loneliness of Older Immigrant Groups in Canada: Effects of Ethnic-Cultural Background." Journal of Cross-Cultural Gerontology 30: 251-268. DOI: 10.1007/s10823-015-9265-x.

De Moissac, D., J. Savard, S. Savard, F. Giasson, & L.-A. Kubina (2020). Management strategies to improve French language service coordination and continuity for official language Francophone seniors in Canada. Healthcare Management Forum, 33(6), 271–276. https://doi.org/10.1177/0840470420931115

Engels, B., G. J. Liu (2011). Social exclusion, location and transport disadvantage amongst non-driving seniors in a Melbourne municipality, Australia. Journal of Transport Geography. Volume 19, Issue 4, Pages 984-996, ISSN 0966-6923. https://doi.org/10.1016/j.jtrangeo.2011.03.007.

Fingeld-Connett, D. (2005). "Clarification of Social Support." Journal of Nursing Scholarship 37(1): 4-9.

Fischer, A. (2011) 'Reconceiving Social Exclusion', BWPI Working Paper 146, Brooks World Poverty Institute, Manchester.

Holgersson, J. et al. (2021). "Cybersecurity and Digital Exclusion of Seniors: What Do They Fear?" Human Aspects of Information Security and Assurance, 2021, p. 12–, doi:10.1007/978-3-030-81111-2_2.

Johnson, S, J.; Bascu, T.; McIntosh, B.; Jeffery, and N. Novik (2018). "Social Isolation and Loneliness Among Immigrant and Refugee Seniors in Canada: A Scoping Review." International Journal of Migration, Health and Social Care 15(3): 177-190. DOI: 10.1108/1HMHSC-10-2018-0067.

Levitas, R., C. Pantazis, E. Fahmy, D. Gordon, E. Lloyd, & D. Patsios (2007). The Multi-Dimensional Analysis of Social Exclusion.

Makwarimba, E., M. J. Stewart, Z. Jones, K. Makumbe, E. Shizha, and D. L. Spitzer (2010). "Senior Immigrants' Support Needs and Preferences of Support Intervention Programs." In Diversity in Aging Among Immigrant Seniors in Canada, edited by D. Durst and M. Maclean, pp. 205-226. Calgary: Detselig Enterprises, Ltd.

Ohtani, A, T. Suzuki, H. Takeuchi, H. Uchida (2015) Language barriers and access to psychiatric care: a systematic review. Psychiatr Serv. 66(8):798–805.

Piketty, T. (2014). Capital in the Twenty-First Century. Cambridge and London: Harvard University Press.

Salma, J., and B. Salami (2020). "'Growing Old is Not for the Weak of Heart': Social Isolation and Loneliness in Muslim Immigrant Older Adults in Canada." Health and Social Care in the Community 28: 615-623. DOI: 10.1111/hsc.12894.

Salma, J., Keating, N., L. Ogilvie, and K. Hunter (2018). "Social Dimensions of Health Across the Life Course: Narratives of Arab Immigrant Women Ageing in Canada." Nursing Inquiry 25 (e12226): 1-8. DOI: 10.1111/nin.12226.

Silver, H. (1994) Social Exclusion and Social Solidarity: Three Paradigms', In: International Labour Review, Vol. 133. 5-6, 531-578.

Spitzer, D. L., A. Neufeld, M. Harrison, K. Hughes, and M. J. Stewart (2003). "Caregiving in Transnational Perspective: 'My Wings Have Been Cut, Where Can I Fly'" Gender & Society 17(2): 267-286.

Statistics Canada (2021). Census Profile, 2016 Census. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=CSD&Geo2=PR&Code2=01&SearchType=Begins&SearchPR=01&TABID=1&B1=All&type=0&Code1=3506008&SearchText=ottawa Accessed 3 September 2021.

Stewart, M.J., J. Anderson, E. Makwarimba, A. Neufeld, L. Simich, and D. L. Spitzer (2008). "Multicultural Meanings of Social Support Among Immigrants and Refugees." International Migration 46(3): 123-159.

Swyngedouw E. (1997). Neither global nor local: 'glocalization'and the politics of scale, New York: Guilford Press.

Thoits, P. (1995). "Stress, Coping and Social Support Processes: Where Are We? What Next?" Journal of Health and Social Behaviour 35(extra): 53-79.

UN (1998), United Nations Economic and Social Council. Statement of commitment for action to eradicate poverty adopted by administrative committee on coordination. May 20, 1998.

Voyer, J-P. (2004). "Foreward." Journal of International Migration and Integration 5(2): 159-164.

Wu, Z. and R. Hart (2002). "Social and Health Factors Associated with Support Among Elderly Immigrants in Canada." Research on Aging 4: 391-412.

Yoshikawaa, K, B. Bradyb, M. A. Perryd, H. Devand (2020). Sociocultural factors influencing physiotherapy managementin culturally and linguistically diverse people with persistentpain: a scoping review. Physiotherapy 107, 292–305.

Zhao, Y, N. Segalowitz, A. Voloshyn, E. Chamoux, AG. Ryder (2019). Language barriers to healthcare for linguistic minorities: the case of second language-specific health communication anxiety. Health Community 1–13. doi:10.1080/10410236.2019.16924.

Chapter 8. "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 and Hanley 2012; Walsh and 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 well-being. 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 and 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 and Bernhard 2009; Hanley and 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 and 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 and 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 and Thorpe 2015; Da and 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 and Chau 2007a; 2007b) and policy barriers such as sponsorship regulations (Koehn, Spencer and 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) (IRCC 2013; Dempsey 2005). 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 and 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, and 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, and Hwang 2010). Language barriers are often a main reason for social isolation among older immigrants (Tam and Neysmith 2006), while childcare and other forms of daytime domestic labour often isolate minority older adults from services and communities (Rittman, Kuzmeskus, and Flum 1998). Surprisingly, even Chinese older adults living in large Chinese communities can experience high degrees of social isolation (Chau and Lai 2011). Finally, weakened cultural values and loss of independence and status can lead to social isolation and intergenerational conflict (Northcott and Northcott 2010).

With regard to *service* barriers, older immigrants often report low levels of social participation (Fong and 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 and Lopez 1998). Overreliance on family and kin can lead to reluctance to use local formal services (Northcott and 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 and Chau 2007). The complicated logistics of accessing service delivery can also reduce confidence in using them (Lai and 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 and Lopez 1998) and engage in community education and training in cross-cultural communication skills (Lai and 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 well-being 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 well-being.

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 and 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	$40–60, 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 and 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 and 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 and 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, and 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 and 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% 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 and 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, and 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.

References

Brotman, S. (1998). The incidence of poverty among seniors in Canada: Exploring the impact of gender, ethnicity and race. Canadian Journal on Aging, 17, 166-185.

Brotman, S. (2003). The limits of multiculturalism in elder care services. Journal of Aging Studies, 17(2), 209-229.

Canada. (2001). Immigration and Refugee Protection Act. Ottawa: Citizenship and Immigration Canada.

Chau, S., and Lai, D. W. (2011). The size of an ethno-cultural community as a social determinant of health for Chinese seniors. Journal of Immigrant and Minority Health, 13(6), 1090-1098.

Chen, X., and Thorpe, S. X. (2015). Temporary families? The parent and grandparent Sponsorship Program and the Neoliberal regime of immigration governance in Canada. Migration, Mobility, and Displacement, 1(1).

Cranswick, K., and Dosman, D. (2008). Eldercare: What We Know Today (Vol. Catalogue no. 11-008-X). Ottawa: Statistics Canada.

Da, W.-W., and Garcia, A. (2015). Later life migration: Sociocultural adaptation and changes in quality of life at settlement among recent older Chinese immigrants in Canada. Activities, Adaptation and Aging, 39(3), 214-242.

Dempsey, C. (2005). Elderly Immigrants in Canada: Income Sources and Self-Sufficiency. Paper presented at the 2005 Economic Conference, Ottawa.

Durst, D. (2005). More snow on the roof: Canada's Immigrant seniors. Canadian Issues/ Themes Canadienne, 34-37.

Ferrer, I. (2015). Examining the disjunctures between policy and care in Canada's Parent and Grandparent Supervisa. International Journal of Migration, Health and Social Care, 11(4), 253-267.

Fong, E., and Ooka, E. (2006). Patterns of Participation in Informal Social Activities among Chinese Immigrants in Toronto1. International Migration Review, 40(2), 348-374.

Gal, S., and Hanley, J. (2012). Elder Abuse: Is Precarious Immigration Status a Factor? . In M. Baffoe (Ed.), Strangers in a New Homeland. Cambridge: Cambridge Scholars Press.

Goldring, L., Berinstein, L., and Bernhard, J. (2009). Institutionalizing precarious migratory status in Canada. Citizenship Studies, 13(3), 239-265.

Gui, T., and Koropeckyj-Cox, T. (2016). "I am the only child of my parents:" Perspectives on future elder care for parents among Chinese only-children living overseas. Journal of Cross-Cultural Gerontology, 31(3), 255-275.

Hanley, J., and Shragge, E. (2009). Economic Security for Women with Precarious Immigration Status: Enforcing Labour Rights for All. In J. Pulkingham and M. Griffin Cohen (Eds.), Imagining Public Policy to Meet Women's Economic Security Needs. Toronto: University of Toronto Press.

Immigration, Refugees and Citizenship Canada (IRCC). 2011. Ministerial Instruction regarding the Parent and Grandparent Super Visa. Ottawa: IRCC. Available at: https://www.canada.ca/en/immigration-refugees-citizenship/corporate/mandate/policies-operational-instructions-agreements/ministerial-instructions/parent-grandparent-super-visa.html

Immigration, Refugees and Citizenship Canada (IRCC). 2013. Backgrounder — Action Plan for Faster Family Reunification: Phase II. Ottawa: IRCC. Available at: https://www.canada.ca/en/immigration-refugees-citizenship/news/archives/backgrounders-2013/action-plan-faster-family-reunification-phase.html

Immigration, Refugees and Citizenship Canada (IRCC). 2018a. Applying for Visitor Visa. Ottawa: IRCC. Available at: https://www.canada.ca/en/immigration-refugees-citizenship/services/application/application-forms-guides/guide-5256-applying-visitor-visa-temporary-resident-visa.html%23incometables#5256E2

Immigration, Refugees and Citizenship Canada (IRCC). 2018b. Tell us you want to sponsor your parents and grandparents. Ottawa: IRCC. Available at: https://www.canada.ca/en/immigration-refugees-citizenship/services/immigrate-canada/family-sponsorship/sponsor-parents-grandparents/tell-us-you-want-sponsor-parent-grandparent.html?_ga=2.260764101.995196272.1524752620-1503106283.1521194770

Koehn, S., Spencer, C., and Hwang, E. (2010). Promises, Promises: Cultural and Legal Dimensions of Sponsorship for Immigrant Seniors. In D. Durst and M. MacLean (Eds.), Diversity and Aging among Immigrant Seniors in Canada (pp. 79-102). Calgary, Alberta: Detselig Enterprises Ltd.

Kuo, B. (2010). Predicting Cultural Adaptation of Seniors Chinese Immigrants Within a Bidirectional Model of Acculturation: Canadian Acculturation and Chinese Identification. In D. Durst and M. MacLean (Eds.), Diversity and Aging among Immigrant Seniors in Canada (pp. 409-428). Calgary, Alberta: Detselig Enterprises Ltd.

Labov, W., and Waletzky, J. (2003). Narrative analysis: Oral versions of personal experience. University of Washington Press.

Lai, D. W., and Chau, S. B. (2007a). Effects of service barriers on health status of older Chinese immigrants in Canada. Social Work, 52(3), 261-269.

Lai, D. W., and Chau, S. B. (2007b). Predictors of Health Service Barriers for Older Chinese Immigrants in Canada. Health and Social Work, 32(1), 57.

Lai, D. W., and Surood, S. (2009). Chinese health beliefs of older Chinese in Canada. Journal of Aging and Health, 21(1), 38-62.

Northcott, H. C., and Northcott, J. L. (2010). Integration Outcomes for Immigrant

Seniors in Canada: A review of Literature 2000-2007. In D. Durst and M. MacLean (Eds.), Diversity and Aging among Immigrant Seniors in Canada (pp. 37-57). Calgary, Alberta: Detselig Enterprises Ltd.

Padgett, D. (2008). Qualitative methods in social work research (Vol. 36): Sage.

Rittman, M., Kuzmeskus, L., and Flum, M. (1998). A Synthesis of Current Knowledge on Minority Elder Abuse. In T. Tatara (Ed.), Understanding Elder Abuse in Minority Populations (pp. 221-238). Philadelphia, PA: Brunner/Mazel – Taylor and Francis Group.

Scotti, M. (2017). Immigration sponsorship lottery draws nearly 100k applications. Global Online News. 27 April 2017.

Statistics Canada. (2007). The Chinese Community in Canada. In Statistics Canada (Ed.), (Vol. Catalogue no. 89-621-XWE). Ottawa: Statistics Canada.

Statistics Canada. (2011). Visible Minority Groups (15), Immigrant Status and Period of Immigration (9), Age Groups (10) and Sex (3) for the Population of Canada, Provinces, Territories, Census Metropolitan Areas and Census Agglomerations, 2006 Census – 20% Sample Data (Vol. Catalogue no. 97-562-XCB2006011). Ottawa: Statistics Canada.

Statistics Canada. (2017a). Canada [Country] and Canada [Country] (table). Census Profile. 2016 Census. Statistics Canada Catalogue no. 98-316-X2016001. Ottawa. Released November 29, 2017. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E (accessed May 2, 2018).

Statistics Canada. (2017b). Montréal [Census metropolitan area], Quebec and Quebec [Province] (table). Census Profile. 2016 Census. Statistics Canada Catalogue no. 98-316-X2016001. Ottawa. Released November 29, 2017. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E (accessed May 2, 2018).

Tam, S., and Neysmith, S. (2006). Disrespect and isolation: Elder abuse in Chinese communities. Canadian Journal on Aging, 25(2), 141-152.

Troung, L. (2006). Chinese Seniors Survey. Toronto: Chinese Canadian National Council, Toronto Chapter.

Tsai, D. T., and Lopez, R. A. (1998). The use of social supports by elderly Chinese immigrants. Journal of Gerontological Social Work, 29(1), 77-94.

Walsh, C., and Hassanali, S. (2010). Elder abuse: Perspectives in the Chinese-Canadian community. In D. Durst and M. MacLean (Eds.), Diversity and aging among immigrant seniors in Canada: Changing faces and greying temples (pp. 251-268). Calgary, AB: Detselig Enterprises Ltd.

Wellesley Institute. (2008). Citizenship Matters : Re-examining Income (In)Security of Immigrant Seniors. Toronto: Wellesley.

Wolf, R. S., Bennett, G., and Daichman, L. (2003). Abuse of Older People. In F. L. Green, M. L. Friedman, J. T. V. M. de Jong, S. D. Soloman, T. M. Keane and J. A. Fairbank (Eds.), Trauma Interventions in War and Peace: Prevention, Practice and Policy (pp. 105-128). New York: Kluwer Academic/Plenum Publishers.

Chapter 9. Housing Insecurity and Homelessness Among Older Immigrants in Canada

VIBHA KAUSHIK; CHRISTINE WALSH; AND JILL HOSELTON

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% of the total recent immigrant population) followed by Africa (13.4%) (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%) 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, and 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, and 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, and 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 and Wood 2017). Individuals experiencing homelessness are also less likely to access preventative services, which are key determinants for reducing poor health outcomes (Stafford and 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 and 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 and 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 and 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 experiencing homelessness 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 and 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 and Wood 2017). Forchuk et al. (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, and 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.

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 (Ro et al. 2014; Hacker and Rehm 2020). 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 and Lu 2017). As discussed below, chronic low income is strongly linked with homelessness. (cite)

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 and 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, and 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, and 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, and 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, and 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 (Ciobanu, Fokkema, and Nedelcu 2017; Brotman, Ferrer, and Koehn 2020). 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 and Westhues 2013; Kim et al. 2013; McDonald, Dergal, and 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, and Harding 2006; Kushel 2020; Rota-Bartelink and Lipmann 2007). The correlation between homelessness and poorer health levels is stronger among older people (Fajardo-Bullon et al. 2019; Garibaldi Conde-Martel, and 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, and 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 and Wallace 2019). Older immigrant women are more vulnerable to poorer health compared to older immigrant men (Guruge, Birpreet, and 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.

[Insert here: Figure 1. Multi-layered complexities of housing insecurity and homelessness among older immigrants. Please see attached document with image.]

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 and 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, and 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 and Dobbs 2014; Ng and 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 and Tang 2017; Luhtanen 2009; Ng and Northcott 2015; Preston et al. 2011; Um and 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.

References

Barken, R. Amanda Grenier, Brian Budd, Tamara Sussman, David Rothwell, and Valerie Bourgeois-Guérin. 2015. "Aging and Homelessness in Canada: A Review of Frameworks and Strategies. Gilbrea Centre for Studies on Aging, McMaster University, Hamilton, ON.

Bhui, Kamaldeep, Lisa Shanahan, and Geoff Harding. 2006. "Homelessness and Mental Illness: A Literature Review and a Qualitative Study of Perceptions of the Adequacy

of Care." International Journal of Social Psychiatry 52 (2): 152–65. https://doi.org/10.1177/0020764006062096.

Brotman, Shari, Ilyan Ferrer, and Sharon Koehn. 2020. "Situating the Life Story Narratives of Aging Immigrants within a Structural Context: The Intersectional Life Course Perspective as Research Praxis." Qualitative Research 20 (4): 465–84. doi.:10.1177/1468794119880746.

Burholt, Vanessa, and Christine Dobbs. 2014. "A Support Network Typology for Application in Older Populations with a Preponderance of Multigenerational Households." Ageing and Society 34 (7): 1142–69. doi: 10.1017/S0144686X12001511.

Canadian Observatory on Homelessness. 2021. "About Homelessness: Causes of Homelessness." Assessed on 5 August 2021. https://www.homelesshub.ca/about-homelessness/homelessness-101/causes-homelessness

Canham, Sarah L., Lupin Battersby, Mei Lang Fang, Mineko Wada, Rebecca Barnes, and Andrew Sixsmith. 2018. "Senior Services that Support Housing First in Metro Vancouver." Journal of Gernotological Social Work 61 (1): 104-25. https://doi.org/10.1080/01634372.2017.1391919.

Ciobanu, Ruxandra Oana, Tineke Fokkema, and Mihaela Nedelcu. 2017. "Aging as a Migrant: Vulnerabilities, Agency and Policy Implications." Journal of Ethnic and Migration Studies 43 (2): 164–81. doi:10.1080/1369183X.2016.1238903.

Dolberg Pnina, Sigurveig H. Sigurðardóttir, Ursula Trummer. 2018. "Ageism and Older Immigrants." Contemporary Perspectives on Ageism 19: 177–91. doi: 10.1007/978-3-319-73820-8_12.

Fajardo-Bullón, Fernando, Igor Esnaola, Isobel Anderson, and Lars Benjaminsen. 2019. "Homelessness and Self-Rated Health: Evidence from a National Survey of Homeless People in Spain." BMC Public Health 19 (1): 1081–81. doi:/10.1186/s12889-019-7380-2.

Gaetz, S., C. Barr, A. Friesen, B. Harris, C. Hill, K. Kovacs-Burns, B. Pauly, B. Pearce, A. Turner, and A. Marsolais. 2012. "Canadian Definition of Homelessness." Toronto: Canadian Observatory Press. Accessed on September 3, 2021. https://www.homelesshub.ca/sites/default/files/COHhomelessdefinition.pdf

Gaetz, Stephen, Jesse Donaldson, Tim Richter, and Tanya Gulliver. 2013. "The State of Homelessness in Canada 2013." The Homeless Hub. Assessed 5 August 2021. https://www.homelesshub.ca/sites/default/files/SOHC2103.pdf

Garibaldi, Brian, Alicia Conde-Martel, and Thomas P O'Toole. 2005. "Self-Reported Comorbidities, Perceived Needs, and Sources for Usual Care for Older and Younger Homeless Adults." Journal of General Internal Medicine 20 (8): 726–30. doi:10.1111/j.1525-1497.2005.0142.x

Gee, Ellen M., Karen M. Kobayashi, and Steven G. Prus. 2004. "Examining the Healthy Immigrant Effect in Mid- to Later Life: Findings from the Canadian Community Health Survey." Canadian Journal on Aging 23 (5): 55–63.

Giannini, Alice. 2017. "An Intersectional Approach to Homelessness: Discrimination and Criminalization." Marquette Benefits and Social Welfare Law Review 19 (1): 27–42.

Gonyea, Judith G., Kelly Mills-Dick, and Sara S. Bachman. 2010. "The Complexities of Elder Homelessness, a Shifting Political Landscape and Emerging Community Responses." Journal of Gerontological Social Work 53 (7): 575–90. doi:10.1080/01634372.2010.510169.

Government of Canada. 2017. "Who's at Risk and What Can Be Done About It? A Review of the Literature on the Social Isolation of Different Groups of Seniors." Last updated 26 April 2017. https://www.canada.ca/en/national-seniors-council/programs/publications-reports/2017/review-social-isolation-seniors.html#h2.6-h3.3)

Government of Canada. 2021. "Social Isolation of Seniors: A Focus on New Immigrant and Refugee Seniors in Canada." Accessed 18 August 2021. https://www.canada.ca/en/employment-social-development/corporate/seniors/forum/social-isolation-immigrant-refugee.html

Government of Canada. 2021. "The National Shelter Study — Emergency Shelter Use in Canada 2005 to 2016." Accessed 18 August 2021. https://www.canada.ca/en/employment-social-development/programs/homelessness/publications-bulletins/national-shelter-study.html

Grenier, Amanda, Rachel Barken, Tamara Sussman, David Rothwell, Valérie Bourgeois-Guérin and Jean-Pierre Lavoie. 2016. "A Literature Review of Homelessness and Aging: Suggestions for a Policy and Practice-Relevant Research." Canadian Journal on Aging / La Revue canadienne du vieillissement 35 (1): 28–41. doi:10.1017/S0714980815000616.

Grenier, Amanda, Tamara Sussman, Rachel Barken, Valerie Bourgeois-Guérin, and David Rothwell. 2016. "'Growing Old' in Shelters and 'On the Street': Experiences of Older Homeless People." Journal of Gerontological Social Work 59(6): 458–77. https://doi.org/10.1080/01634372.2016.1235067.

Gubernskaya, Zoya, and Zaqun Tang. 2017. "Just Like in Their Home Country? A Multinational Perspective on Living Arrangements of Older Immigrants in The United States." Demography 54: 1973–98. doi: 10.1007/s13524-017-0604-0.

Guruge, Sepali et al. 2021. "Elder Abuse Risk Factors: Perceptions Among Older Chinese, Korean, Punjabi, and Tamil Immigrants in Toronto." Journal of Migration Health 4. 100059. doi: 10.1016/j.jmh.2021.100059.

Guruge, Sepali, Birpreet Birpreet, and Joan A. Samuels-Dennis. 2015. "Health Status and Health Determinants of Older Immigrant Women in Canada: A Scoping Review." Journal of Aging Research. doi: 10.1155/2015/393761.

Haan, Michael. 2011. "Does Immigrant Residential Crowding Reflect Hidden Homelessness?" Canadian Studies in Population 38 (1–2): 43–59. https://doi.org/10.25336/P6331B.

Hacker, Jacob S., and Phillip Rehm. 2020. "Reducing Risk as Well as Inequality: Assessing the Welfare State's Insurance Effects." British Journal of Political Science First View: 1–11 doi: 10.1017/S0007123420000034.

Hossen, Abul, and Anne Westhues. 2013. "Bangladeshi Elderly Immigrants in Southern Ontario: Perspectives on Family Roles and Intergenerational Relations." Journal of International Social Issues 2 (1): 1–15.

Hwang, Stephen W., Maritt J. Kirst, Shirley Chiu, George Tolomiczenko, Alex Kiss, Laura Cowan, and Wendy Levinson. 2009. "Multidimensional Social Support and the Health of Homeless Individuals." Journal of Urban Health 86 (5): 791–803. doi: 10.1007/s11524-009-9388-x.

Ichou, Mathieu, and Matthew Wallace. 2019. "The Healthy Immigrant Effect: The Role of Educational Selectivity in the Good Health of Migrants." Demographic Research 40 (4): 61–94. doi: 10.4054/DemRes.2019.40.4.

Kei, Wendy, Marc-David L. Seidel, Dennis Ma and Marjan Houshmand. 2019. "Results from the 2016 Census: Examining the Effect of Public Pension Benefits on the Low Income of Senior mmigrants." Assessed 11 August 2021. https://www150.statcan.gc.ca/n1/pub/75-006-x/2019001/article/00017-eng.htm

Kim, Bum Jung, Erica Auh, Yeon Jung Lee, and Joonhee Ahn. 2013. "The Impact of Social Capital on Depression Among Older Chinese and Korean Immigrants: Similarities and Differences." Aging and Mental Health 17 (7): 844–52. doi:10.1080/13607863.2013.805399.

Kim, Mimi M., Julian D. Ford, Daniel L. Howard, and Daniel W. Bradford. 2010. "Assessing Trauma, Substance Abuse, and Mental Health in a Sample of Homeless Men." Health and Social Work 35 (1): 39–48. doi:10.1093/hsw/35.1.39.

Kushel, Margot. 2020. "Homelessness Among Older Adults: An Emerging Crisis." Generations Summer 2020. Assessed 19 August 2021. https://generations.asaging.org/homelessness-older-adults-poverty-health

Luhtanen, Ethel. 2009. "Including Immigrant and Refugee Seniors in Public Policy." A discussion paper for the Calgary Immigrant Seniors "Speak Out" Forum. Assessed 1 September 2021. https://www.calgary.ca/csps/cns/seniors/speak-out-forum.html

Magesan, Arvind. 2017. "New Fingures Show Just How Big Canada's Immigrant Wage Gap Is." MacLean's. Assessed 5 August 2021. https://www.macleans.ca/news/canada/new-figures-show-just-how-big-canadas-immigrant-wage-gap-is/

McDonald, Lynn. 2010. "Theorizing about Aging and Immigration." In Diversity and Aging Among Immigrant Seniors in Canada: Changing Faces and Greying Temples, edited by Douglas, Durst and Michael MacLean, 59–78. Calgary: Detselig Enterprises Ltd.

McDonald, Lynn, Julie Dergal, and Laura Cleghorn. 2007. "Living on the Margins." Journal of Gerontological Social Work 49 (1–2): 19–46. doi.:10.1300/J083v49n01_02

Ng, Edward. 2021. "COVID-19 Deaths Among Immigrants: Evidence from the Early Months of the Pandemic." StatCan COVID-19: Data to Insights for a Better Canada. Accessed 10 September 2021. https://www150.statcan.gc.ca/n1/en/pub/45-28-0001/2021001/article/00017-eng.pdf?st=xALpsQO4

Ng, Cheuk Fan, and Herbert C. Northcott. 2015. "Living Arrangements and Loneliness of South Asian Immigrant Seniors in Edmonton, Canada." Ageing and Society 35 (3): 552–75. doi:10.1017/S0144686X13000913.

Older Adult Council of Calgary. 2018. "Older Adults and Homelessness." Assessed 27 August 2021. https://www.calgary.ca/content/dam/www/csps/cns/documents/seniors/older-adults-and-homelessness.pdf

Perri, Melissa, Naheed, Dosani, Stephen, W. Hwang. 2020. "Covid-19 and People Experiencing Homelessness: Challenges and Mitigation Strategies." Canadian Medical Association Journal (CMAJ). 192 (26): 716–19. https://doi.org/10.1503/cmaj.200834.

Picot, Garnett, and Yuqian Lu. 2017. "Chronic Low Income Among Immigrants in Canada and its Communities." Statistics Canada: Analytical Studies Branch Research Paper Series. https://www150.statcan.gc.ca/n1/pub/11f0019m/11f0019m2017397-eng.htm

Ploeg, Jenny, Lynda Hayward, Christel Woodward, and Riley Johnston. 2008. "A Case Study of a Canadian Homelessness Intervention Programme for Elderly People."

Health and Social Care in the Community 16 (6): 593–605. doi:10.1111/j.1365-2524.2008.00783.x.

Preston, Valerie, Robert Murdie, Silvia D'Addario, Prince Sibanda, and Ann Marie Murnaghan, with Jennifer Logan and Mi Hae Ahn. 2011. "Precarious Housing and Hidden Homelessness Among Refugees, Asylum Seekers, and Immigrants in the Toronto Metropolitan Area." CERIS Working Paper no. 87. Assessed 1 2021. https://refugeeresearch.net/wp-content/uploads/2016/11/Preston-et-al-2011-Precarious-housing-for-newcomers-in-Toronto.pdf

Pruegger, Valerie J., and Alina Tanasescu. 2007. "Housing Issues of Immigrants and Refugees in Calgary." Assessed 27 August 2021. https://www.homelesshub.ca/sites/default/files/attachments/r5qrpj1a.pdf

Reynolds, Christopher. 2019. "Immigrant Wage Gap Costing Canada $50 Billion a Year in GDP: Report." The Globe and Mail, 17 September. Assessed 5 August2021. https://www.theglobeandmail.com/business/article-immigrant-wage-gap-costing-canada-50-billion-a-year-in-gdp-report/

Reynolds, Kristin A., Corinne A. Isaak, Tracy DeBoer, Maria Medved, Jino Distasio, Laurence Y. Katz, and Jitender Sareen. 2016. "Aging and Homelessness in a Canadian Context." Canadian Journal of Community Mental Health 35 (1): 1–13. https://doi.org/10.7870/cjcmh-2015-016.

Rota-Bartelink, Alice, and Bryan Lipmann. 2007. "Causes of Homelessness Among Older People in Melbourne, Australia." Australian and New Zealand Journal of Public Health 31 (3): 252–58. doi:10.1111/j.1467-842X.2007.00057.x.

Seegert, Liz. 2016. "Homeless Get 'Older' at Younger Ages than their Peers, Research Says." Association of Health Care Journalists. Assessed 27 August 2021. https://healthjournalism.org/blog/2016/04/homeless-get-older-at-younger-ages-than-their-peers-research-says/

Setia, Maninder Singh, Amelie Quesnel-Vallee, Michal Abrahamowicz, Pierre Tousignant, and John Lynch. 2012 "Different Outcomes for Different Health Measures in Immigrants: Evidence from a Longitudinal Analysis of the National Population Health Survey (1994–2006)." Journal of Immigrant and Minority Health 14 (1): 156–65.

Stafford, Amanda, and Lisa Wood. 2017. "Tackling Health Disparities for People Who Are Homeless? Start with Social Determinants." International Journal of Environmental Research and Public Health 14 (12): 1–12. https://doi.org/10.3390/ijerph14121535.

Statistics Canada. 2017a. "Census in Brief: Linguistic Integration of Immigrants and Official Language Populations in Canada." Accessed 5 August 2021. https://www12.statcan.gc.ca/census-recensement/2016/as-sa/98-200-x/2016017/98-200-x2016017-eng.cfm

Statistics Canada. 2017b. "Immigration and Ethnocultural Diversity: Key Results from the 2016 Census." Last updated 1 November 2017. https://www150.statcan.gc.ca/n1/daily-quotidien/171025/dq171025b-eng.htm?indid=14428-1&indgeo=0

Statistics Canada. 2020. "Demographic Estimates by Age and Sex, Provinces and Territories." Last updated on 2 December 2020. https://www150.statcan.gc.ca/n1/pub/71-607-x/71-607-x2020018-eng.htm

Stewart, Miriam, Edward Shizha, Edward Makwarimba, Denise Spitzer, Ernest N Khalema, and Christina D. Nsaliwa. 2011. "Challenges and Barriers to Services for

Immigrant Seniors in Canada: "You Are Among Others but You Feel Alone." International Journal of Migration, Health and Social Care 7 (1): 16–32. doi: 10.1108/17479891111176278.

The World Bank. "Life Expectancy at Birth, Total (Years)— Canada." Accessed 11 September 2021. https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=CA

Torres, Sandra. 2006. "Elderly Immigrants in Sweden: 'Otherness' Under Construction." Journal of Ethnic and Migration Studies 32 (8): 1341–58. doi: 10.1080/13691830600928730.

Trypuc, Bri and Jeffery Robinson. 2009. "Homeless in Canada: A Funder's Primer in Understanding the Tragedy on Canada's Streets." Charity Intelligence Canada. Accessed 10 September 2021. http://www.charityintelligence.ca/images/Ci-Homeless-in-Canada.pdf

Um, Seong-gee, and Naomi Lightman. 2017. "Seniors' Health in the GTA: How Immigration, Language, and Racialization Impact Seniors' Health." Wellesley Institute: Advancing Urban Health. Assessed 1 September 2021. https://www.wellesleyinstitute.com/wp-content/uploads/2017/05/Seniors-Health-in-the-GTA-Final.pdf

Wilkes, Rima, and Cary Wu. 2019. "Immigration, Discrimination, and Trust: A Simply Complex Relationship." Frontiers in Sociology 4: 32–32. doi:10.3389/fsoc.2019.00032.

Woolrych, R., N Gibson, J Sixsmith, and A Sixsmith. 2015. ""No Home, No Place": Addressing the Complexity of Homelessness in Old Age Through Community Dialogue." Journal of Housing for the Elderly 29 (3): 233–58. https://doi.org/10.1080/02763893.2015.1055024.

World Health Organization. 2021. "Social Determinants of Health." Accessed 3 September 2021. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

CAREGIVING

Chapter 10. Conceptualizing Person-Centred Care for Ethnocultural Minority Residents in Long-Term Care Homes: Adaptation of the 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 and 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 and 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 and Flesner 2003). In theory, PCC enables LTC residents to live more meaningful lives with an improved quality of life and overall well-being (Brownie and 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% of the total older adult population aged 65 and over in Canada, and racialized minorities made up 22% 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 well-being, 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 and 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 and 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 well-being, 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 well-being 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 and 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.

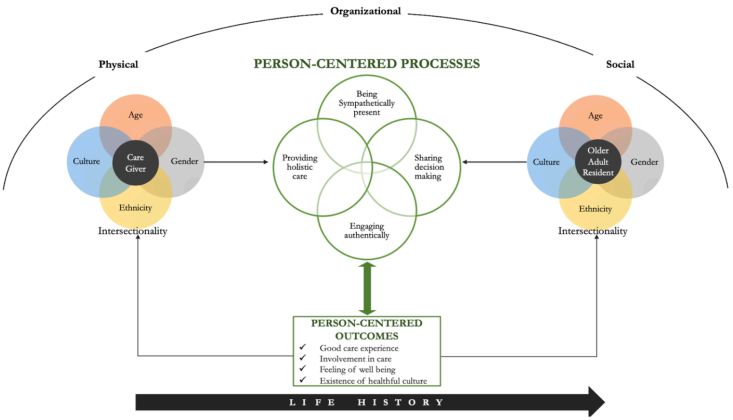
A New Conceptual Framework: PCC for Ethnocultural Minority Older Adults in LTC Homes

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 and 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 well-being, and a healthy environment (McCormack and McCance 2017). Bi-directional links between person-centred processes and outcomes represent the interrelationships between them.

*Figure 9.1 SEQ Figure * ARABIC 1. Diagram of the Proposed Conceptual Framework*



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 and 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 and 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 and 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 well-being 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.

References

Brownie, Sonya, and Susan Nancarrow. 2013. "Effects of person-centered care on residents and staff in aged-care facilities: a systematic review." Clinical interventions in aging 8: 1-10. doi:10.2147/CIA.S38589

Bunjun, Benita. 2010. "Feminist organizations and intersectionality: Contesting hegemonic feminism." Atlantis 34, no. 2: 115-126.

Chappell, Neena L. 2003. "Correcting cross-cultural stereotypes: aging in Shanghai and Canada." Journal of cross-cultural gerontology 18, no. 2: 127-47. doi:10.1023/a:1025156501588

Collins, Patricia Hill. 1990. Black feminist thought: Knowledge, consciousness, and the politics of empowerment. New York: Routledge.

Crenshaw, Kimberly W. 2009. "A Primer on Intersectionality." Accessed July 1, 2021. https://www.racialequitytools.org/resourcefiles/african.pdf

Elder, Glen H. 2000. "Life course theory." In Encyclopedia of Psychology, edited by Alan E Kazdin, 50-52. American Psychological Association.

Ferrer, Ilyan, Amanda Grenier, Shari Brotman, and Sharon Koehn. 2017. "Understanding the experiences of racialized older people through an intersectional life course perspective." Journal of Aging Studies 41:10-17. https://doi.org/10.1016/j.jaging.2017.02.001

Hankivsky, Olena. 2014. "Intersectionality 101." Accessed July 5, 2021.https://bccampus.ca/wp-content/uploads/2020/07/Hankivsky-Intersectionality101-2014.pdf

Hankivsky, Olena, Daniel Grace, Gemma Hunting, Melissa Giesbrecht, Alycia Fridkin, Sarah Rudrum, Olivier Ferlatte, and Natalie Clark. 2015. "An intersectionality-based policy analysis framework: Critical reflections on a methodology for advancing equity." International Journal for Equity in Health 13: 1-16. https://doi.org/10.1186/s12939-014-0119-x

Kitwood, Tom. 1997. Dementia Reconsidered: The Person Comes First. Open University Press, Milton Keynes.

Lee, Mo Yee, and LeeAnn Mjelde-Mossey. 2004. "Cultural dissonance among generations: a solution-focused approach with East Asian elders and their families." Journal of marital and family therapy 30, no. 4: 497-513. doi:10.1111/j.1752-0606.2004.tb01258.x

Leibing, Annette. 2008. "Entangled Matters–Alzheimer's, interiority, and the 'unflattening' of the world." Culture, medicine and psychiatry 32, no.2: 177-93. doi:10.1007/s11013-008-9091-5

Li, Junxin, and Davina Porock. 2014. "Resident outcomes of person-centered care in long-term care: a narrative review of interventional research." International journal of nursing studies 51, no.10: 1395-415. doi:10.1016/j.ijnurstu.2014.04.003

McCall, Leslie. 2005. "The complexity of intersectionality." Journal of Women in Culture and Society 30, no. 3:1771-180

McCormack, Brendan, and Tanya McCance. 2017. "The Person-centered Practice Framework". In Person-Centred Practice in Nursing and Health Care: Theory and Practice, edited by Brendan McCormack and Tanya McCance, 36-64. Chichester, West Sussex: John Wiley & Sons Inc.

McGilton, Katherine S, Hazel Heath, Charlene H Chu, Anne-Marie Boström, Christine Mueller, Veronique M Boscart, Barbara McKenzie-Green, Rola Moghabghab, and Barbara Bowers. 2012. "Moving the agenda forward: a person-centred framework in long-term care." International journal of older people nursing 7, no. 4: 303-9. doi:10.1111/opn.12010

Merleau-Ponty, Maurice. 1989. Phenomenology of Perception. London: Routledge.

Nolan, Mike R, Sue Davies, Jayne Brown, John Keady, and Janet Nolan. 2004. "Beyond 'person-centred' care: a new vision for gerontological nursing." Journal of Clinical Nursing 13, no. 3a:45-53. doi:10.1111/j.1365-2702.2004.00926.x

Rantz, Marilyn J and Marcia K. Flesner. 2003. Person-centered Care: A Model of Nursing Homes. Washington DC: American Nurses Association.

Sabat, Steven R. (2002). "Surviving Manifestations of Selfhood in Alzheimer's Disease: A Case Study." Dementia 1, no.1: 25-36. https://doi.org/10.1177/147130120200100101

Santana, Maria J, Kimberly Manalili, Rachel J Jolley, Sandra Zelinsky, Hude Quan, and Mingshan Lu. 2017. "How to practice person-centered care: A conceptual framework." Health Expectation 21, no.2: 429-40. doi: 10.1111/hex.12640

Statistics Canada. 2018a. "150 years of immigration in Canada." Accessed July 5, 2021. https://www150.statcan.gc.ca/n1/pub/11-630-x/11-630-x2016006-eng.htm

Statistics Canada. 2018b. "Ethnic Diversity and Immigration." Accessed July 5, 2021. https://www150.statcan.gc.ca/n1/pub/11-402-x/2011000/chap/imm/imm-eng.htm

Statistics Canada. 2019. "Results from the 2016 Census: Examining the effect of public

pension benefits on the low income of senior immigrants." Accessed July 5, 2021. https://www150.statcan.gc.ca/n1/pub/75-006-x/2019001/article/00017-eng.htm

Torres, Sandra. 2015. "Expanding the gerontological imagination on ethnicity: conceptual and theoretical perspectives." Aging & Society 35, no. 5:935-960. doi:10.1017/S0144686X14001330

Ujimoto, Victor K. 1995. "Ethnic Dimensions of Aging in Canada." In Aging and Inequality: Cultural Constructions of Difference, edited by Robynne Neugebauer-Visano, 3-29. Toronto: Canadian Scholars' Press.

Van Herk, Kimberley Anne, Dawn Smith, and Caroline Andrew. "Identity matters: Aboriginal mothers' experiences of accessing health care." Contemporary nurse 37, no. 1: 57-68. doi:10.5172/conu.2011.37.1.057

Weisman, Gerald, Habib Chaudhury, and Keith Diaz Moore. 2000. "Theory and Practice of Place: Toward an Integrative Model." In The Many Dimensions of Aging, edited by Robert L Rubinstein, Miriam Moss, and Morton H Kleban, 1-22. New York, NY: Springer Publishing Company Inc.

Chapter 11. 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, people are living longer and as a result more families are caring for older adults at home. Caregiving at home involves both benefits and challenges, but scholars have noted that it can reduce the number of deaths occurring in hospitals, which can have huge cost-saving potential (Bone et al. 2018; Martens et al. 2018; Cohen et al. 2019). Many studies have explored the idea of "aging in place," meaning that people can stay in their homes as long as possible and can have some independence while receiving some support (Vanleerberghe et al. 2017; Chum et al. 2020; Martens et al. 2018).

Aging in place involves many assumptions about access to support, including ability to access health and social services (Bone et al. 2018). In reality, the home environment may not be conducive to older adults' declining health status, and may even contribute to increasing social isolation (Chum et al. 2020). Older adults who are relatively healthy, autonomous, and independent can benefit from continuing support from families – financially or otherwise (Chum et al. 2020). However, this can stigmatize and exclude other older adults who are less able to engage with the community and also lack support from family (Chum et al. 2020). Caregiving by family members is a complicated issue, and few studies have explored the extent of family involvement among older immigrants and how this can influence quality of life as they age in place (Vanleerberghe et al. 2017).

Family caregivers, also known as informal caregivers or care partners, are any family member or self-identified significant other who provides unpaid care to an older adult who has chronic conditions and/or disabilities (Cohen et al. 2019). These family caregivers can affect quality of life in many ways because they have so much control over the home environment (Bandura 1999). One important issue is that family caregivers can ensure more access to formal care – but their informal care can also reduce access to formal care, to the detriment of the older family member (Huxhold et al. 2014).

Key factors related to the agency of caregivers include who they are (family or friend) and the quality of their relationship (Huxhold et al. 2014). Ideas about caregiving also vary by ethnicity and socioeconomic status, both between and within groups (Cohen et al. 2019). Among family caregivers who identify as ethnic minorities, social

locations are distinguished by culture-specific expectations and social norms (Cohen et al. 2019). Other important intersections include gender disparities in the distribution and caregiving intensity: women tend to spend more time in the role and to report more burden and depression, as well as poorer physical health, than men in caregiving roles (Cohen et al. 2019). More work is needed to explore all of these issues among older immigrants; the following discussion explores caregiving among Chinese families in the Greater Toronto Area.

Chinese Family Caregiving in the Greater Toronto Area: A Mismatch of Needs and Community Services

Caregiving patterns reflect underlying differences in cultural values, beliefs, and attitudes; among immigrants, another factor is generational acculturation in the new/host country. Chinese socio-historical cultural attitudes stem from Confucian ideals and stress filial piety, meaning the obligation to respect and care for older immigrant family members and to value family reciprocity (Liu et al. 2021; Miyawaki 2016). Caregiving for aging parents is a social obligation, so the most common caregiving relationship is that of the parent/parent-in-law and adult child. Chinese caregivers also tend to use more informal supports than formal supports because of cultural beliefs and/or taboos about using outside formal services; for example, they may seek to preserve family harmony by using passive coping strategies such as forgiveness, tolerance, or contentment, rather than by seeking formal social supports and help (Liu et al. 2021). These socio-cultural dispositions can be even more pronounced in a new country when the older immigrant and/or family members do not speak the host country language (Miyawaki 2016). Caregivers who are working to assimilate or integrate into a host societies may be open to the idea of using formal caregiver services as an alternative way of fulfilling filial piety, but cultural expectations of filial responsibility may supersede and hinder others becoming involved. For example, Miyawaki (2016) found that Chinese immigrants in the US continue to practise filial piety regardless of historical acculturation or the availability of Chinese community services (churches, service agencies targeting older immigrants, and in-home caregiving services and care homes). As a result, Chinese caregivers may experience more emotional and psychological distress (e.g., risk of depression, loneliness, and suicidal ideation) than their non-Asian counterparts (ibid.).

How Social Location Affects Caregivers' Access to Community-based Services in the Greater Toronto Area

We explored caregiving among Chinese families in the Greater Toronto Area (GTA), which has a population of about 6.8 million (PopulationU.com 2021) and the most diverse and highest proportion of visible minorities (63%) in Canada (Yee Hong Centre

for Geriatric Care 2013). In 2021, the GTA had 700,705 people of Chinese descent (PopulationU.com 2021). In 2011, 10.5 percent of those identifying as Chinese were aged 65 or older, and more than 97 percent were immigrants (Zhang 2019).

Fifty percent of the older immigrants living in the GTA have low incomes ($10 to $30 K per year), and those who are visible minorities have much lower median incomes than their nonminority counterparts (Toronto City Hall 2016). Nearly 15 percent of visible minority older immigrants do not speak English, and 29 percent do not use the Internet every day (ibid.). Many older immigrants find it difficult to accessing the city's more than 40 services targeting older immigrants (City of Toronto 2018), and many are also excluded from social programs due to a ten-year waiting period for program eligibility (Yee Hong Centre for Geriatric Care 2013). Together, these issues increase their risk of vulnerability to poverty and isolation (Toronto City Hall 2016).

Methods

Critical Realism

Our qualitative study was informed by critical realism, a post-positivistic methodology first developed by Bhaskar in 1975 (Elder-Vass 2010). Elder-Vass (2010) depicted critical realism as three pyramid-shaped layers. The top layer consists of "empirical" evidence of what we tell each other happened. The middle is the "actual" and consists 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 structures that are not measurable but may cause events or experiences.

Figure 10.1. Philosophical underpinnings of critical realism.

Within this framework, an individual's agency (with oneself or with others) is exercised through mechanisms (e.g., a sense of responsibility), which are 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). Social structures are created through interactions within and between social groups that influence the occurrence or non-occurrence of events or experiences. Mechanisms and structures can be internalized and thus exert pressure on individuals (e.g., peer pressure), in turn causing some individuals to endure in certain contexts or under certain conditions.

Research Team

All research team members identify as visible minorities: four identify as female and one as male, and all originate from Asian families who immigrated to Canada one to four generations ago. All team members tried to suspend their own personal

"inside" knowledge of the subject and to position themselves as co-creators of data and centring the voices of participants. Five team members have PhDs in nursing, one in architecture, and one is an MD; all were trained in research informed by critical realism. The other authors confirmed the findings using their clinical and research expertise in immigrant health and social services.

Participant Recruitment and Sampling

Participants were recruited from communities with large Chinese memberships in person, by email, and using snowball strategies. One research team member supported recruitment at their workplace using purposive sampling of potential participants, but was not involved in the consent procedure or data collection. Inclusion criteria were: individuals who self-identify as Chinese, 18 years or older, and consider themselves to be a primary caregiver to an older Chinese adult (aged 65 or older). Exclusion criteria were: not providing informed consent or declining to be recorded via handwritten notes or audio recorder. In total, 31 potential participants were approached: three declined because of discomfort with being recorded, for a total of 28 participants.

Ethical Considerations

The research ethics boards of the participating universities and community organizations approved the study protocol before any work began. We answered any questions from participants before they provided verbal and/or written consent. We also redacted any identifiable information (i.e., names, places) during transcription and prior to data analysis. All electronic data were password protected on researchers' computers and in cloud storage. In all publications, participants are identified only by assigned numbers. All participants were assured that they could withdraw at any time and that their participation would not affect in any way the care their family member received.

Data Collection

Participants were interviewed by one of three research team members. Interviews ranged from 45 minutes to 1.5 hours and began with the collection of socio-demographic data, followed by experiences. Interviewers drew out personal examples using semi-structured questions that were pilot tested with the first three participants. Analysis of this pilot testing led to one revision: we added a question about the meanings given to caregiving responsibility.

Participants chose their preferred language for interviews: English, Cantonese, or Mandarin. Given public health restrictions due to the COVID-19 pandemic, all interviews were conducted via Zoom or by phone in their homes. Interviews were

audio-recorded with the exception of one, in which content was manually written verbatim by two research assistants. In all but three interviews, a research assistant observed to assist with writing field notes. Older immigrants receiving care were present in two interviews. No repeat interviews were conducted. Prior to analysis, interviews conducted in Cantonese or Mandarin were translated to English and subjected to back-and-forth verification by two researchers fluent in both languages.

Data Analysis and Interpretation

Drawing from Elder-Vass's (2010) work on critical realism, we analyzed data in four steps: comprehension, synthesis, theorization, and reconceptualization. In the first step, two researchers open-coded transcripts of the first 10 interviews independently. This open coding corresponds to the empirical level of critical realism. NVivo12 software facilitated organization and management of data (QSR International 2021). After the first step (comprehension), team members met to discuss, refine, and reach consensus on the code names, producing an initial code list. This second step (synthesis) also involved discussion of codes and possible inferences of patterns (i.e., subcategories). All new codes were confirmed through discussions with at least one other research team member to reach consensus.

In the third step, theorization involved visual mapping of codes and subcategories; abstraction of patterns required working through inferential reasoning to explain patterns (Elder-Vass's "empirical" level). These patterns were used to make deductive inferences that were then explored by the research team with the data to clarify how events and experienced were actualized (the "actual" level). Finally, 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 a team consensus.

Trustworthiness

We strived to meet four trustworthiness criteria: credibility, plausibility, transferability, and authenticity for readers (Elo et al. 2014). To ensure credibility, all interviews lasted at least 45 minutes while the research team recorded reflective field notes. 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. The plausibility of the preliminary results was also confirmed by research team members with expertise in the subject matter. To ensure transferability and utility, we balanced description of the findings with examples from the raw data. To ensure authenticity, we followed the Consolidated Criteria for Reporting Qualitative Research for transparency and comprehensiveness in research reporting.

Results

In total, 28 Chinese caregivers participated: 61 percent were female, 57 percent were aged 55–75 years, and 39 percent were aged 18–54 years. Most reported high levels of education (75% university); 68 percent were children of older immigrants, and 18 percent were partners. Slightly more than half (57%) lived in a household separate from their care recipient, while 43 percent lived in the same household. All were Canadian citizens: 50 percent had lived in Canada more than 30 years, and 97 percent were immigrants to Canada.

Table 10.1. Socio-demographic data of the Chinese caregivers.

	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 Gender		
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, the perceived needs of Chinese caregivers, and the expectations of their older family member. Most Chinese caregivers reported that they needed to care for their family member at all levels of the socio-ecological model of health (Figure 1). This was most prominent among those providing care for older adults in a private home, compared to those in assisted-living or long-term care facilities. We theorized that a mismatch between care needs and culturally appropriate services forced caregivers to tolerate increasing burdens as older adults transitioned from their own homes to assisted-living facilities or long-term care facilities.

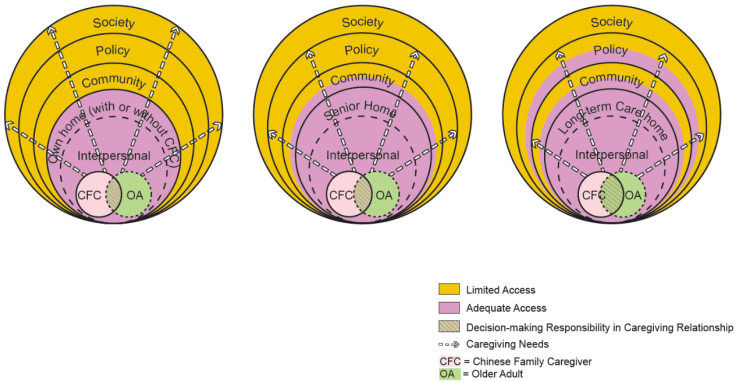
Different Locations of Care for Older Adults by Chinese Caregivers

Figure 10.2 presents a three-part model we developed based on our interpretation of how agency and place intersect, drawing from a socio-ecological model of older adults' health in age-friendly cities (Van Hoof et al. 2018). We found that the narratives of Chinese caregivers included interpretations of what their care recipients desired or expected, so we conceptualized each caregiver and care recipient as a dyad with shared resources. Figure 10.2a depicts both members of the dyad living in their own home(s) in close physical proximity. In this location, caregivers referred to the need to access all levels of structure (white arrows); some reported having access to a few layers of support (shaded in pink), but did not have access to many areas of community, policy, or societal resources (shaded in yellow).

Figure 10.2b depicts an assisted-living facility location, where the caregiver and recipient do not live in the same household or even necessarily close by. In this location, caregivers expressed less need to access all layers of resources (white arrows) and reported access to more layers of resources (shaded in pink).

Figure 10.2c depicts a long-term care facility location, where the caregiver and recipient do not live in the same household or even necessarily close by. In this location, caregivers reported the need to access the fewest layers of resources (white arrows) and reported having access to the most layers of resources (shaded in pink).

In all three figures, caregivers' access to health and social services for their care recipient depended on community access and policies that matched the capacity of caregivers, the financial circumstances of care recipients, and the availability (or lack) of culturally acceptable care.



Chinese Caregivers in Private Households (Figure 10.2a)

Caregivers caring for an older family member in the same or different private household (usually in close proximity) expressed the most challenges negotiating access to help (informal and formal), and feared disruptions in caregiving. For example, one 60-year-old woman who was caring for her father in her own home spoke about her ongoing worry about whether she could handle her father's needs, in part because of her own age: "At my age, sometimes I have the intentions but I don't have enough energy to accomplish them … There are many times you may think that it is okay, but actually you can't handle it."

These concerns were magnified after her father fell out of bed when trying to get 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.

Caregivers living separately from their care recipient referred to perceived barriers to accessing instrumental support (from personal support workers) and government financial support resulting from institutional policies (nursing or long-term-care home) that limited when and how much support was available to them:

> Actually morning is the worst time. I actually asked the personal support worker company manager if they can just come to mom's place 7 to 8 am, whatever, but unfortunately no one wants to come at that time, especially in the winter time.

> Their window is two hours. We can't wait for that long. (60-year-old woman caring for her mother in a separate household)
>
> Anytime they [personal support workers] can leave. But I just let it go.[1] 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. (72-year-old woman caring for her mother)

One 63-year-old woman caring for her mother in a long-term care facility reflected on her multiple past attempts to get formal home care for her mother in her same household, commenting that 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.

The majority of caregivers reported resistance from social structures of institutional policy (i.e., municipal services) when seeking formal help, and also felt that provincial policies related to access to assisted-living facilities or long-term care facilities were overwhelming. One 78-year-old man caring for his spouse said, "If private it's [assisted-living or long-term care facility], then you'll have to wait 8 or 10 years, and it still might not be available."

A 62-year-old woman caring for both of her parents reported that access to an assisted-living facility for her parents appeared to happen by chance, rather than as a systematic process of being placed on the local health system wait list:

> I was lucky that the social worker knows my case, [and] knows that I am a cancer survivor caring for two older immigrants who have very challenging problems … [so] my mom and dad can go into the nursing home.

One 39-year-old caregiver felt that the financial cost of transferring her mother to an assisted-living or long-term care facility was too high, and anticipated early retirement as the only option to take care of her:

> So financially I think there's a big problem [in transferring OA 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." (woman caring for mother in separate household)

1. She used a Chinese expression that translates as "I open half an eye and close the other half;" this has a similar meaning to the English expression "I let it go."

Caregivers Caring for Older Adults in Assisted-living Facilities (Figure 10.2b)

When their care recipient lived in an assisted-living facility, caregivers generally reported partial access to services in the community, but limited access to services and Chinese cultural practices (e.g., food or leisure) that could help caregivers meet cultural expectations to care for their aging family member. For example, a 50-year-old man caring for in-laws in their home said he had visited several assisted-living facilities only to find that, while some had Cantonese speakers, none served Mandarin speakers: "I saw some retirement homes are Cantonese, but I didn't see much for Chinese local mainland [people]."

One 71-year-old man caring for a mother with dementia living in an assisted-living facility was grateful for the health and social services she received, but also described gaps in needed services resulting from provincial policy changes and funding cuts:

> My mom lives in an older immigrants' apartment taken care of by XXX services. So, every morning the personal support workers 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 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 five days to two days, due to funding.

The majority of caregivers with older immigrants in assisted-living facilities continued to report significant concern for long wait times and barriers to accessing culturally inclusive long-term care facilities in their communities. For example, one 63-year-old woman caring for her mother referred to the barriers related to "few choices" prior to her mother being transferred after a three-year wait:

> "Like we had choices—I mean the Community Care Access Centre, 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 ZZ, 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.

Caregivers Caring for Older Adults in Long-term Care Facilities (Figure 10.2c)

Care recipients in a long-term care facility had more access to community and health system supports, as well as transportation needed for various healthcare appointments (e.g., medical care, rehabilitation). However, caregivers commented that financial subsidies for day programs were inadequate, as was staffing:

> Since the government provides them [long-term 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." (63-year-old woman caring for her mother in a long-term care facility)

In all three locations of care, the agency of caregivers was shared and interdependent with that of their care recipient as the trajectory of illness changed. As family members became more dependent on their caregivers and less able to make decisions, caregivers spent more time and effort on caregiving and less time and effort on their own self-care and the needs of their immediate family.

Discussion

In building our socio-ecological model of health, we found that Chinese caregivers who lived with or close to the older family member they cared had considerable difficulties accessing health and social services in the community. Of the three locations (private households, assisted living facilities, or long-term care facilities) caregivers providing care in private households were the least supported by public policies and institutional practices (e.g., access to personal support workers). We theorized that a mismatch between the needs of caregivers and the lack of culturally appropriate services forced caregivers to tolerate increasing burdens as their older family members became increasingly dependent, and their ability to meet cultural expectations about caregiving decreased.

Our findings are consistent with previous research suggesting that provincial governments in Canada need to bolster their budgets and change practices for older immigrants wanting to age in place in the communities (Béland and Marier 2020). However, to date no studies have focused on assumptions about the agency of family caregivers in Canada in terms of supervising and supplementing care; this kind of agency can prevent older family members from having to enter institutions such as assisted-living or long-term care facilities. Some empirical evidence from outside Canada suggests variability in terms of agency among Chinese caregivers. For example, Wand and colleagues (2020) conducted a study of 13,781 elders in 22 provinces of China and found that those who were primarily cared for by sons and daughters-in-law tended to be institutionalized much later than those who received care from their spouses. They also found that elders who relied on care from other relatives and friends, from domestic helpers, and those with no caregivers also tended to be institutionalized much earlier than those who received cared from their spouses.

Regardless of whether Chinese caregivers live in China or are immigrants or descendants of Chinese immigrants, our findings and those reported by others suggest that they tend to view formal care not as a substitute for family caregiving but as a supplement (Lin 2019). Filial piety continues to be a key cultural expectation for Canadian descendants of Chinese immigrants, but this expectation is weakening even in China because most young people are unable to fulfill it (Lin 2019). China's healthcare system is based on a patrilineal society and Confucian ideals, but filial piety is

unsustainable with the growing population over the age of 75, rapid urbanization, and the fact that many adult children now live far from their parents (Lin 2019).

Choy and colleagues (2021) conducted a systematic review of immigrant acculturation primarily to North American or European countries, and found that immigrants reported significantly more anxiety and depression than their native-born counterparts. They concluded that this is likely caused by 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). The higher risk of depressive symptoms appeared to be a result of interactions that reduced the agency of older 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. The authors also reported that the level of acculturation appears to be 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 more financial hardship and less preservation of cultural traditions.

Differing forms of 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 US can affect whether older Chinese immigrants want to live in the same household as their caregiver, and whether the caregiver benefits from this arrangement. One study conducted in Shanghai revealed that caregivers living apart from their older immigrant relatives were more depressed than those who co-resided (Miyawaki 2020). In contrast, Liu and colleagues (2021) found that among Chinese caregivers in the US, females who lived apart from their care recipients were more resilient, likely due to lower caregiving demands and more social support from families, friends, and community sources. The authors concluded that despite the strong cultural expectations about family caregiving, Chinese caregivers in the US require more infrastructure to support them in accessing public health resources, and more policies that broaden their options.

Martens and colleagues (2018, 8) argued that enabling older adults to age in place requires "partnerships between individual and public responsibility." Our findings suggest that the most vulnerable Chinese family caregivers are those living with their care recipient. This is consistent with previous findings that caregiving commitments have negative effects on employment, especially when the caregiver is a married woman with young children (Cohen et al. 2019). Liu and colleagues (2021) found that among Chinese family caregivers in New York, the most frequent challenge was physical and emotional exhaustion, followed by limited knowledge of the family member's medical condition, navigating the healthcare system, and limited time for self-care/development (Liu et al. 2021).

In Canada, as in other countries, agency to be healthy is heavily influenced by social determinants including employment and housing. Drummond and colleagues (2020, 5) noted that while "health is not a federal responsibility, many of the socioeconomic determinants of health are heavily influenced by federal policy." Although we found that all Chinese caregivers were committed to caring for their older relative, they need more federal and provincial funding and resources to help them develop a sense of mastery

– and more access to formal and informal support to achieve resilience in caregiving (Drummond et al. 2020; Liu et al. 2021).

Future Directions

In Canada and elsewhere, aging in place requires a greater range of accessible continuing care services (Drummond et al. 2020) and more emphasis on building culturally reflexive options. Putting culture in context (Aronowitz et al. 2015) requires creating culturally sensitive interactions with older immigrants, regardless of their location of care. The goal is to help them access formal care that meets communication needs, provides assistance with daily needs, and includes supports such as daycare for older immigrants, caregiver respite, and other elements of supportive living as needs evolve (Miyawaki 2020). In Canada, as in the US, there is an urgent need to extend the agency of Chinese family caregivers, for example by training interprofessional teams to accommodate culturally specific assisted-living, as well as long-term care facilities that respond to characteristics of acculturation (e.g., limited English-language proficiency) and preserve cultural diet and lifestyles (Miyawaki 2020).

As a first step, we support the recommendations made by Backman and colleagues (2018): more meaningful conversations during discharge planning when older immigrants leave hospitals, and interprofessional teams to assist with navigating the healthcare system to prevent systematic barriers in care transitions. We also suggest promoting cultural reflexivity, paying close attention to the structurally situated way that healthcare practices exert pressure on social interactions. This can help identify both contradictions of culture and external conditions that "enable, constrain, and transform local cultural arrangements" (Aronowitz et al. 2015, S405).

Reducing barriers to care transitions from home to institutional care requires partnerships between community interprofessional teams and informal caregivers – family, friends, and neighbours – to navigate barriers encountered in municipal and provincial policies. Choi and Park (2021) suggested that healthcare professionals, such as nurse-led teams, could be integrated into the community at all levels: they could collaborate in multiple locations in the community, including in homes. This would also require the inclusion of community health leaders, community care administrators, and local services providers (Flaherty and Bartels 2019). Integrated care professionals could help agencies collaborate in providing community-based care for older immigrants. This kind of system could foster the accountability of personal support workers in providing assistance, for example for follow-up appointments with specialists, coordination of care by healthcare professionals, and timely access to primary care (Backman et al. 2018).

Several previous studies have stressed the need to look beyond immediate family members: non-kin networks such as friends and peers can help maintain happiness among older immigrants (Huxhold et al. 2014). This kind of non-kin network can be particularly beneficial in the later stages of life. For example, Watanabe (2021) found that among individuals aged 75 or older in Japan, close friend and neighbourhood

networks increased life satisfaction among both men and women. We found that dyads of Chinese family care providers and their care recipients have the interpersonal agency to "age well in place." However, each dyad is affected by both their local cultural communities and associated policies, along with government policies related to equity for entitlements and choices beyond health to social determinants of health.

Strengths and Limitations

Our study had strengths and limitations, both methodological and contextual. All of our participants were immigrants or descended from immigrant families, but all were Canadian citizens that had lived in Canada for more than 10 years and were fluent in English. Therefore, we were unable to theorize how acculturation and integration within this group may have influenced aging in place. Additionally, our study population, both caregivers and care recipients, included older individuals. Our results may not accurately reflect the experiences of younger family caregivers who may have fewer resources (e.g., financial, housing) to manage the needs of older family members (Lai and Surood 2008). Finally, our results represent only the perspectives of Chinese family caregivers, not their care recipients, although our data clearly reflect an entanglement of the two as dyads.

Conclusion

We found that Chinese family caregivers tolerate an increasing burden when they are unable to access culturally appropriate social structures for their aging family members. For example, they may have difficulty accessing personal support, transportation, peer support, or assisted-living and long-term care facilities in the community. A shift is currently occurring in healthcare, with a move toward integrated team-based care. Many institutions in North America are beginning to create more accessible services for older immigrants and their families where they live (Drummond et al. 2020; Flaherty and Bartels 2019). However, limited cultural sensitivity within health and social services leads to barriers for Chines family caregivers. Lack of self-efficacy and lack of support create barriers for collaboration across intersections of the socioecological environment. More interprofessional care is needed to extend the agency of Chinese family caregivers beyond their households and to address societal attitudes about aging in place – whether in private homes, assisted-living facilities, or long-term care facilities.

References

Aronowitz, R., Deener, A., Keene, D., Schnittker, J., & Tach, L. (2015). Cultural reflexivity in health research and practice. American journal of public health. 105 Suppl 3(Suppl 3), S403–S408. https://doi.org/10.2105/AJPH.2015.302551

Backman, C., Stacey, D., Crick, M., Cho-Young, D., & Marck, P. B. (2018). Use of participatory visual narrative methods to explore older adults' experiences of managing multiple chronic conditions during care transitions. BMC health services research. 18(1), 1-10. https://doi.org/10.1186/s12913-018-3292-6

Bandura, A. (1999). Social cognitive theory: An agentic perspective. Asian Journal of Social Psychology. 2(1): 21–41. doi:10.1111/1467-839X.00024

Béland, D., & Marier, P. (2020). COVID-19 and Long-Term Care Policy for Older People in Canada, Journal of Aging & Social Policy. 32:4-5, 358-364, DOI: 10.1080/08959420.2020.1764319

Bone, A. E., Gomes, B., Etkind, S. N., Verne, J., Murtagh, F. E., Evans, C. J., & Higginson, I. J. (2018). What is the impact of population ageing on the future provision of end-of-life care? Population-based projections of place of death. Palliative medicine. 32(2), 329-336. DOI: 10.1177/0269216317734435

Canadian Institutes of Health Research. (2017). Infographic: Canada's seniors population outlook: Uncharted territory. Available at: https://www.cihi.ca/en/infographic-canadas-seniors-population-outlook-uncharted-territory.

Choi, E. J., & Park, M. H. (2021). Preparing for the Trend of Aging in Place: Identifying Interprofessional Competencies for Integrated Care Professionals. Journal of Korean Gerontological Nursing. 23(3), 273-284. https://doi.org/10.17079/jkgn.2021.23.3.273

Choy, B., Arunachalam, K., Gupta, S., Taylor, M., & Lee, A. (2021). Systematic Review: Acculturation strategies and their impact on the mental health of migrant populations. Public Health in Practice. 2, 100069. https://doi.org/10.1016/j.puhip.2020.100069.

Chum, K., Fitzhenry, G., Robinson, K., Murphy, M., Phan, D., Alvarez, J. & McGrath, C. (2020). Examining community-based housing models to support aging in place: A scoping review. The Gerontologist. 142, https://doi.org/10.1093/geront/gnaa142

Cohen, S. A., Sabik, N. J., Cook, S. K., Azzoli, A. B., & Mendez-Luck, C. A. (2019). Differences within differences: Gender inequalities in caregiving intensity vary by race and ethnicity in informal caregivers. Journal of cross-cultural gerontology. 34(3), 245-263. https://doi.org/10.1007/s10823-019-09381-9

City of Toronto (2018). Toronto Senior Strategy. Available at: https://www.rgptoronto.ca/toronto-seniors-strategy-2-0-approved/https://www.msn.com/en-ca/feed

Drummond, D., Sinclair, D., Bergen, R., as part of the COVID-19 Health Policy Working Group. (2020). Aging Well. School of Policy Studies, Queen's University. Available at: https://www.queensu.ca/sps/sites/webpublish.queensu.ca.spswww/files/files/Publications/Ageing%20Well%20Report%20-%20November%202020.pdf

Flaherty, E., & Bartels, S. J. (2019). Addressing the community-based geriatric healthcare workforce shortage by leveraging the potential of interprofessional teams. Journal of the American Geriatrics Society. 67(S2), S400-S408. doi.org/10.1111/jgs.15924

Huxhold, O., Miche, M., Schüz, B. (2014, May) Benefits of Having Friends in Older Ages: Differential Effects of Informal Social Activities on Well-Being in Middle-Aged and Older Adults, The Journals of Gerontology: Series B. 69 (3), 366- 375, https://doi.org/10.1093/geronb/gbt029

Kasper, J. D., Wolff, J. L., & Skehan, M. (2019). Care arrangements of older adults: What they prefer, what they have, and implications for quality of life. The Gerontologist. 59(5), 845-855. doi:10.1093/geront/gny127

Lai, D. W., & Surood, S. (2008). Service barriers of CFCPs in Canada. Journal of Gerontological Social Work. 51(3-4), 315-336.

Leung, K.-M.; Ou, K.-L.; Chung, P.-K.; Thøgersen-Ntoumani, C. (2021). Older Adults' Perceptions toward Walking: A Qualitative Study Using a Social-Ecological Model. Int. J. Environ. Res. Public Health. 18, 7686. https://doi.org/10.3390/ ijerph18147686

Lin, W. The relationship between formal and informal care among Chinese older adults: based on the 2014 CLHLS dataset. BMC Health Serv Res. 19, 323 (2019). https://doi.org/10.1186/s12913-019-4160-8

Liu, J., Lou, Y., Wu, B., & Mui, A. C. Y. S. (2021). "I've been always strong to conquer any suffering:" challenges and resilience of Chinese American dementia caregivers in a life course perspective. Aging & Mental Health. 25(9), 1716-1724. https://doi.org/10.1080/13607863.2020.1793900.

Manuel, T. (2007). Envisioning the possibilities for a good life: Exploring the public policy implications of intersectionality theory. Journal of Women, Politics & Policy. 28(3-4), 173-203. https://doi.org/10.1300/J501v28n03_08

Martens, C. T. (2018). Aging in which place? Connecting aging in place with individual responsibility, housing markets, and the welfare state. Journal of Housing for the Elderly. 32(1), 1-11. DOI: 10.1080/02763893.2017.1393483

Miyawaki, C. E. (2020). Caregiving attitudes and needs of later-generation Chinese-American family caregivers of older adults. Journal of Family Issues. 41(12), 2377-2399.

National Institute of Health/Telus Health Report. (2021). Pandemic Perspectives on Long-Term Care: Insights from Canadians in Light of COVID-19. Available at: https://www.cma.ca/sites/default/files/pdf/Activities/National-Institute-on-Ageing-CMA-Report-EN.pdf

Toronto City Hall. (2016). Mapping the Ethnicity of Toronto's Elders. Presentation by the Social Development, Finance & Administration Division, City of Toronto, to the Toronto Council on Aging's Age Friendly Toronto Forum. Ryerson University. Available at: https://www.toronto.ca/wp-content/uploads/2017/11/9045-Toronto-Council-on-Aging-03192016-Ethnic-Ancestry.pdf

PopulationU.com (2021). Toronto Population. Available at: https://www.populationu.com/cities/toronto-population

Vadivelan, K., Sekar, P., Sruthi, S. S., & Gopichandran, V. (2020). Burden of caregivers of children with cerebral palsy: an intersectional analysis of gender, poverty, stigma, and public policy. BMC public health. 20, 1-8. doi.org/10.1186/s12889-020-08808-0

Van Hoof, J., Kazak, J. K., Perek-Białas, J. M., & Peek, S. (2018). The challenges of urban ageing: Making cities age-friendly in Europe. International Journal of Environmental Research and Public Health. 15(11), 2473. ; doi:10.3390/ijerph15112473

Vanleerberghe, P., De Witte, N., Claes, C., Schalock, R. L., & Verté, D. (2017). The quality

of life of older people aging in place: a literature review. Quality of Life Research. 26(11), 2899-2907. DOI 10.1007/s11136-017-1651-0

Xiao, L. D., De Bellis, A., Habel, L., & Kyriazopoulos, H. (2013). The experiences of culturally and linguistically diverse family caregivers in utilising dementia services in Australia. BMC Health Services Research. 13(1). https://doi.org/10.1186/1472-6963-13-427

Watanabe, D. (2021). Understanding diversity in later life and a new culture of aging: Sociology of aging in Japan. International Sociology. 36(2), 243-253. DOI: 10.1177/02685809211005355

Yee Hong Geriatric Centre, in partnership with University of Toronto Factor-Inwentash Faculty of Social Work. (2013). The Changing Needs of Chinese Seniors in the Greater Toronto Area. Retrieved Nov. 18, 2021 at: https://www.yeehong.com/centre/publications/needs-study-download/report/

Yiu, H. C., Zang, Y., & Chau, J. P. C. (2020). Barriers and facilitators in the use of formal dementia care for dementia sufferers: A qualitative study with CFCPs in Hong Kong. Geriatric Nursing. 41(6), 885-890.

Zhang, W. (2019). Perceptions of elder abuse and neglect by older Chinese immigrants in Canada. Journal of Elder Abuse & Neglect. 31(4-5), 340-362. https://doi.org/10.1080/08946566.2019.1652718.

Zhou, M. (2014). Segmented assimilation and socio-economic integration

of Chinese immigrant children in the USA, Ethnic and Racial Studies. 37(7), 1172-1183, https://doi.org./10.1080/01419870.2014.874566.

Chapter 12. The Diversity of Views About Death and Dying in 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 well-being of those who are dying and their families.

The needs of dying persons and their families range from physical and mental comfort to spiritual well-being. Dying individuals may experience crises of meaning, and existential and spiritual well-being can be more important than physical and psychological well-being. 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%) 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 and 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 and 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 and 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; Solomon et al. 2004; Pyszczynski, Greenberg, and Solomon 1999). 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, and Faucher 2010; Tam 2013; Solomon, Greenberg, and Pyszczynski 1991).

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 and Strickland 2020; Novak, Northcott, and 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 and 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, and 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 and Nathaniel 2015). The "right to know" has become a crucial element in contemporary Western medicine (DeSpelder and 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, and 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, and 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 and 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%; ibid.) 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, and 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 and 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 and 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 and 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 well-being, 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 and 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, and 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 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.

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

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, and 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, and 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

References

Advance Care Planning Canada. 2019. New Poll Shows That Most People in Canada Think it is Important to Do Advance Care Planning but Only Few Did. Retrieved from https://www.advancecareplanning.ca/news/advance-care-planning-canada-releases-new-national-poll-2019/

Alvarado, Katherine A., Donald I Templer, Charles Bresler, and Shan Thomas-Dobson. 1995. "The Relationship of Religious Variables to Death Depression and Death Anxiety." Journal of clinical psychology 51, (2): 202–204.

Andrews, Tom and Alvita Nathaniel. 2015. "Awareness of Dying Remains Relevant after Fifty Years." The grounded theory review 14, (2): 3-10.

Ariès, Philippe. 1974. Western attitudes towards death: From Middle Ages to the present. Baltimore. John Hopkins University Press.

Ariès, Philippe. 1981. The hour of our death 1st American ed. New York: Knopf.

Baile, Walter F, Robert Buckman, Renato Lenzi, Gary Glober, Estela A Beale, and Andrzej P Kudelka. 2000. "SPIKES—A Six-Step Protocol for Delivering Bad News: Application to the Patient with Cancer." The oncologist (Dayton, Ohio) 5, (4): 302–311.

Van Brussel, L., and Nico Carpentier. 2014. “Introduction”. In Leen van Brussel & Nico Carpentier (Eds.), The social construction of death: Interdisciplinary perspectives. New York, NY: Palgrave MacMillan.

Burge, Fred, Beverley Lawson, Grace Johnston, Yukiko Asada, Paul F McIntyre, Eva Grunfeld, and Gordon Flowerdew. 2014. “Bereaved Family Member Perceptions of Patient-Focused Family-Centred Care During the Last 30 Days of Life Using a Mortality Follow-Back Survey: Does Location Matter?” BMC palliative care 13, (1): 25–25.

Burke, Brian L, Andy Martens, and Erik H Faucher. 2010. “Two Decades of Terror Management Theory: A Meta-Analysis of Mortality Salience Research.” Personality and social psychology review 14, (2): 155–195.

Burr, Vivien. 2003. Social constructionism, second edition. London and New York: Routledge.

Byock, Ira. 1997. Dying well: Peace and possibilities at the end of life. New York: Riverhead Books.

Carver, Courtney. 2018. “The Fear of Dying: A Case Study Using the SPIKES Protocol.” Families in society 99, (4): 333–337.

Caswell, Glenys, Kristian Pollock, Rowan Harwood, and Davina Porock. 2015. “Communication Between Family Carers and Health Professionals About End-of-Life Care for Older People in the Acute Hospital Setting: A Qualitative Study.” BMC palliative care 14, (1): 35–35.

DeSpelder, Lynn Ann, and Albert Lee Strickland. 2020. The Last Dance: Encountering Death and Dying, eleventh edition. New York: McGraw Hill Education.

Dresser, Norine, and Fredda Wasserman. 2010. Saying Goodbye to Someone You Love: Your Emotional Journey through End of Life and Grief. New York: Springer Publishing Company.

Elias, Norbert, and Edmund. Jephcott. 1985. The Loneliness of the Dying. Oxford, Ox., UK ;: B. Blackwell.

Erikson, Erik H. 1982. The Life Cycle Completed: A Review 1st ed. New York: Norton.

———. 1993. Childhood and Society. New York: Norton.

Gardner, Daniel S, Meredith Doherty, Gleneara Bates, Aliza Koplow, and Sarah Johnson. 2018. “Racial and Ethnic Disparities in Palliative Care: A Systematic Scoping review.” Families in Society: The Journal of Contemporary Social Services 99, (4): 301–316.

Gire, James. 2014. How Death Imitates Life: Cultural Influences on Conceptions of Death and Dying. Online Readings in Psychology and Culture, 6, (2): 1-22.

Glaser, Barney G., and Anselm L. Strauss. 1965. Awareness of Dying. Chicago: Aldine Publishing.

Greenberg, Jeff, Tom Pyszczynski, Sheldon Solomon, Abram Rosenblatt, Mitchell Veeder, Shari Kirkland, and Deborah Lyon. 1990. “Evidence for Terror Management Theory II: The Effects of Mortality Salience on Reactions to Those Who Threaten or Bolster the Cultural Worldview.” Journal of personality and social psychology, 58(2): 308–318.

Hobart, Katharine R. 2002. “Death and Dying and the Social Work Role.” Journal of gerontological social work 36, (3-4◈: 181–192.

Hsu, Chiung-Yin, Margaret O'Connor, and Susan Lee. 2009. "Understandings of Death and Dying for People of Chinese Origin." Death studies, 33(2): 153–174.

Kearl, Michael C. 1989. Endings: a Sociology of Death and Dying New York: Oxford University Press.

Kierkegaard, Soren. 1957. The concept of dread. Princeton, NJ: Princeton University Press. (Original work published 1844)

Kübler-Ross, Elisabeth. 1969. On Death and Dying London: Macmillan.

———. 1974. Questions and Answers on Death and Dying 1st Macmillan pbk. ed. New York: Macmillan.

Loddon Mallee Regional Palliative Care Consortium. 2011. An Outline of Different Cultural Beliefs at the Time of Death. Retrieved from https://lmrpcc.org.au/admin/wp-content/uploads/2011/07/Customs-Beliefs-Death-Dying.pdf

Lokker, Ineke, Lia Zuylen, Laetitia Veerbeek, Carin Rijt, and Agnes Heide. 2012. "Awareness of Dying: It Needs Words." Supportive care in cancer 20, (6): 1227–1233.

Morris, Gareth J, and Tina McAdie. 2009. "Are Personality, Well-Being and Death Anxiety Related to Religious Affiliation?" Mental health, religion & culture 12, (2): 115–120.

Novak, Mark W., Herbert C. Northcott, and Lori D. Campbell. 2018. Aging and Society: Canadian Perspectives Eighth edition. Toronto, Ont: Nelson Canada.

Parsuram, Ameeta & Maya Sharma. 1992. "Functional relevance of belief in life-after-death." Journal of Personality and Clinical Studies, 8(1-2): 97–100.

Pyszczynski, Tom, Jeff Greenberg, and Sheldon Solomon. 1999. "A Dual-Process Model of Defense Against Conscious and Unconscious Death-Related Thoughts: An Extension of Terror Management Theory." Psychological review, 106(4): 835–845.

Rose, Brigid M, and Michael J O'Sullivan. 2002. "Afterlife Beliefs and Death Anxiety: An Exploration of the Relationship Between Afterlife Expectations and Fear of Death in an Undergraduate Population." Omega: Journal of Death and Dying 45, (3): 229–243.

Roshdieh, Simin, Donald I Templer, W. Gary Cannon, and Merle Canfield. 1999. "The Relationships of Death Anxiety and Death Depression to Religion and Civilian War-Related Experiences in Iranians." Omega: Journal of Death and Dying 38, (3): 201–210.

Seale, Clive. 1995. "Heroic Death." Sociology (Oxford) 29, (4): 597–613.

———. 1998. Constructing Death: The Sociology of Dying and Bereavement. Cambridge University Press.

———. 2002. Media and Health. London: Sage.

Solomon, Sheldon., Jeff Greenberg, & Thomas A. Pyszczynski. 1991. "A terror management theory of social behavior: The psychological functions of self-esteem and cultural worldviews". In M. Zanna (Ed.), Advances in experimental social psychology, 24 (pp. 93-159). San Diego, CA: Academic Press. https://www.sciencedirect.com/science/article/abs/pii/S0065260108603287?via%3Dihub

———. 2004. "Lethal consumption: Death-denying Materialism". In T. Kasser, & A. D. Kanner (Eds.), Psychology and consumer culture: The struggle for a good life in a materialistic world. (pp. 127-146). Washington, DC: American Psychological Association.

Somerville, Margaret A. 2014. Death Talk: the Case Against Euthanasia and Physician-Assisted Suicide Second edition. Montreal, Québec: McGill-Queen's University Press.
Steen, R. Grant. 2007. The evolving brain: The known and the unknown. Amherst, NY: Prometheus Books.
Steinberg, Maurice D., and Stuart J. Youngner. 1998. End-of-Life Decisions: A Psychosocial Perspective 1st ed. Washington, DC: American Psychiatric Press.
Tam, Kim-Pong. 2013. "Existential Motive Underlying Cosmetic Surgery: A Terror Management Analysis: Existential Motive Underlying Cosmetic Surgery." Journal of applied social psychology 43, (5): 947–955.
Van Brussel, Leen. 2014. "A discourse-theoretical approach to death and dying." Leen van Brussel & Nico Carpentier (Eds.), The social construction of death: Interdisciplinary perspectives. New York, NY: Palgrave MacMillan.
Virdun, Claudia, Tim Luckett, Patricia M Davidson, and Jane Phillips. 2015. "Dying in the Hospital Setting: A Systematic Review of Quantitative Studies Identifying the Elements of End-of-Life Care That Patients and Their Families Rank as Being Most Important." Palliative Medicine 29, (9): 774–796.
Walter, Tony. 1994. The Revival of Death. London: Routledge.
Wink, Paul. 2006. "Who Is Afraid of Death? Religiousness, Spirituality, and Death Anxiety in Late Adulthood." Journal of religion, spirituality & aging 18, (2-3): 93–110.

ACCESS TO SERVICES

Chapter 13. Elder Abuse Risk Factors and Intervention Strategies: Emerging Perspectives of Older Korean 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 and 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 provide assistance in care. However, adult children themselves are working immigrants who are often 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 elders (Guruge, Tiwari, and Lucea 2010). Unresolved cultural differences and misunderstandings can lead to family conflict and feelings of neglect, helplessness, and isolation.

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 well-being facilitated help-seeking behaviours among older Chinese immigrants experiencing abuse. Moon and Benton (2000) reported that Korean immigrants tend to be more tolerant of abusive behaviours and less likely to report to abuse to the authorities or use the available programs and resources. In the Canadian context, some researchers have assessed potential interventions to address issues such as, social isolation, loneliness, and neglect (Johnson et al. 2019; Zhang 2019). However, the body of Canadian research

on the prevention of elder abuse in immigrant communities is limited, especially with regard to the relatively recent and small Korean community.

The Korean immigrant community in Canada is the fifth largest Korean diaspora globally, after the United States, China, and Japan (Bergsen and Choi 2004). 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, older Korean immigrants face many acculturation and settlement challenges that increase their risk of abuse. We explored the risk factors for elder abuse in the Korean immigrant community in the Greater Toronto Area (GTA). Our specific aims were to: (1) identify risk factors and the pathways through which they create situations involving elder abuse, and (2) explore potential interventions that are relevant, appropriate, and acceptable to the community.

Theoretical Framework

This study was informed by an intersectionality framework (Guruge and Khanlou 2004) and an ecosystemic framework (Heise 1998; Waller, 2001). By integrating both frameworks, we were able to clarify how an individual's multiple social locations are influenced by family (micro), community (meso), and social (macro) systems, and how multiple factors at these different levels intersect to create situations involving elder abuse. An ecosystemic model 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 and Khanlou, 2004). An intersectionality lens also helps to contextualize each individual's unique perceptions of risk factors and potential intervention strategies in relation to their social identities.

Methods

We used a mixed-method study design. In Phase 1, we used a quantitative approach to explore 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 in previous research and asked them to rank these on a scale of 0–4 in terms of importance and frequency of occurrence. 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 effective to prevent elder abuse in the Korean community. Participants were asked to rate (on a scale of 0–4) the potential effectiveness 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, as well as ways to alter potential interventions to make them more appropriate for Korean older adults.

After obtaining research ethics approval from Toronto Metropolitan University and York University, we recruited older women and men who met the following criteria: 60 years or older, living in Canada for 20 years or more, self-identifying as belonging to the Korean community, and personal experience of elder abuse or know others in the community who have experienced it. Participants were recruited using word of mouth and/or referral through our community connections. Phase 1 was conducted in 2018, and Phase 2 from 2019–2020 in the GTA, where 70 percent of older adults are immigrants (Wang et al. 2019). 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 consent from all participants and then asked each participant to complete a brief socio-demographic questionnaire. Next, the research assistants asked participants to rate the frequency and importance of thirteen risk factors for elder abuse (in Phase 1) and the effectiveness of fourteen intervention strategies (in Phase 2), and finally to engage in group interviews to discuss their ratings and rationales.

Data Analysis

Demographic information and rankings on the risk factor and intervention questionnaires 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 and intervention in terms of frequency and importance.[1]

Audio-recordings of group interviews were transcribed and translated into English, and the transcriptions were analyzed thematically. The transcripts of each group interview were analyzed separately, and then the themes across interviews were examined across groups and genders using an intersectionality lens (Guruge and Khanlou 2004) and ecosystemic framework (Heise 1998; Waller 2001).

Phase 1 Results

In total, 49 older men and women completed the rankings and participated in seven semi-structured group interviews. Most of them had arrived in Canada before 2000, and more than 75% had children residing in Canada. All spoke Korean as their first

1. Independent sample T-tests were used to compare mean scores between the ratings 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.

language. The following sections present the quantitative findings along with excerpts from group interviews.

Quantitative Findings: Risk Factor Ratings

In Phase 1, participants were asked to rate thirteen risk factors on a five-point scale from 0–4, based on how they perceive each factor's frequency of occurrence and importance in contributing to elder abuse. Table 12.1 lists the ratings for the frequency of occurrence. 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, the effects of these gender-based differences were minimal, and these risk factors were not rated as very frequent.

Importance ratings were similar to frequency ratings. Table 12.2 lists the ratings for the 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.

Qualitative Findings: Risk Factors for Elder Abuse

Based on the thematic 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/intergenerational differences.

Factors Important to Older Women

Language Barrier

> 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/support in critical situations because of the language barrier.

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

> Being unable to speak and understand English makes me feel tragic, because it is one of the factors that make 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. Older women expressed disappointment that their sacrifice for their children was often not reciprocated and reported feeling neglected by their children's individualistic mindsets.

Financial Vulnerability

Older women also felt helpless upon experiencing abuse (mainly in the form of financial exploitation and neglect) because they did not want to report abuse to authorities to protect the family's reputation.

> The longer your residence in Canada, the more you embrace the Canadian culture. You no longer have the sentiment of a Korean parent who sacrifices everything for their children. Eventually you realize that even if you do things for your children, they don't realize how much it had cost [parents] to do the things that they did; they don't appreciate or even sympathize with you.

Korean immigrants often bring assets with them, and our older participants worried about their finances being taken away by family members.

> People 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 if they wanted to. 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 many of the government-funded benefits designed to help older persons during their retirement. Without adequate language skills, they felt helpless and unable find employment. Some 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.

> 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. Whether in Canada or Korea, the senior parents living in a multigenerational family are basically the housekeeper.

Pressure to provide childcare fuelled disputes within multigeneration families, especially between mothers and daughters-in-law regarding the unspoken distribution of domestic responsibilities. Some older women reported that their adult children saw them as a burden once they could no longer contribute to the household. Cultural interpretation of what constitutes abuse played an important role in help-seeking behaviours. Many older women noted that they avoided reporting abuse by a family member due to the stigma and shame that comes from disclosing personal matters to authorities.

Social Isolation

Older adults tend to have limited options to socialize as they age, and older women shared their desire for more culturally accessible services and programs. Many stressed the need for long-term care facilities with Korean-speaking staff within the GTA.

> Until we go to visit, they are basically "left alone" in a vulnerable state, and they live in a great belittlement and discrimination. Older immigrants living in this nursing home feel 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.
>
> 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 and find their lives in senior homes very difficult to accept and adapt to.

Our participants noted that they relied heavily on their children (often their abusers) as their main source of social connection and to navigate support resources. Without culturally appropriate housing options for older persons, participants were forced to remain with their adult children with full-time jobs, and some noted that their children feared for their parents' safety when left unsupervised. Many of our participants 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. Some participants actively sought places to socialize and make meaningful connections despite their limitations. For example, some older women counteracted social isolation by volunteering in the local Korean immigrant community.

Legacy of Patriarchy

Older Korean men tend to have a patriarchal mindset, which further compromised the financial independence of older women. The lack of accessible social services for older immigrants also limited their options to live elsewhere.

> Most women in our generation often just submit to their husbands and think of themselves as the dependents.
>
> I am not getting everything. Just a partial payment for the old age pension. Anyhow, so I told my husband to give me the bank account so I can take out some money. But he confronted me why I need the money. This is a significant stress factor because 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 the government-sponsored benefit programs for older immigrants as they relied heavily on this federal assistance for some guaranteed income, apart from what their husbands gave them.

The limited ability of participants to understand and speak English, coupled with a lack of financial security, diminished their ability to navigate the community and build meaningful social connections, leaving them isolated and lonely. Declining physical and mental health further exacerbated this problem and increased their dependency on others for navigating support resources. Together, these risk factors created a cascade effect that made them vulnerable to elder abuse in the context of constant tension that arose from cultural and intergenerational differences.

Factors Important to Older Men

Diminishing Authority

The transition from a patriarchal society in Korea to the somewhat more egalitarian society in Canada was a source of conflict between older men and their spouses, as well as their adult children who viewed them as no longer contributing to the family. Older men reported feeling that their authority diminished with age.

Many older men experienced conflicts with their spouses related to gender role reversal. Retired 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 isolation even within their own homes. Limited English skills and inability to advocate for themselves also exposed them to experiences of racism and diminished their social status outside their homes.

Language Barrier and Declining Health

> Toronto is a multicultural city, and to be able to at least greet your neighbours 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, it 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.

> I've been in Canada for thirty years and still counting. From what I hear, 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.

Distribution of Inheritance

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 supporting 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. Many participants shared stories of their adult children taking their retirement money and later neglecting them.

Social Isolation

One male participant commented that indifference toward older people can sometimes be even worse than abuse. Some referred to the detrimental effects of feeling neglected and indifference from others on their sense of social connectedness, linking this experience with the onset of depression, and ultimately affecting their sense of self. The fragile emotional state resulting from feeling socially isolated could make them more 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 … But also, people around them could label them as being mentally sick or hostile— and treat them accordingly. As older immigrants become more exposed to such negative interactions with their family members or close circle of friends, they will eventually be at a higher risk for elder abuse and other negative consequences.

Due to fears about stigma and shame surrounding elder abuse, few of our male participants reported being neglected by their adult children or others. Participants also pointed out that their definitions of abuse could be very different from how the Canadian justice system defines elder abuse, and this conflicting interpretation led to confusion and frustration. Some noted that Korean culture stresses collectivism – where harmony with others is considered more important than self-protection – and

therefore feared reporting domestic disputes that might bring harm to their family members.

Patriarchal Legacy from the Perspective of Older Men

Korean culture is strongly rooted in patriarchy, and our male 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.

Phase 2 Results

In Phase 2, 36 older women and men completed the rankings and participated in six semi-structured group interviews. More than three-quarters 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.

Quantitative Findings: Intervention Strategy Ratings

Participants were asked to rate fourteen potential elder abuse interventions on a five-point scale from 0–4 based on four criteria: how effective the intervention is in preventing elder abuse in the Korean immigrant community; how effective it is in improving the well-being of those who experienced abuse; how appropriate it is for the community; and how risky it is.

Overall, social support intervention, information about outreach programs, case management, and psychoeducation emerged as the most effective interventions. In contrast, ESL training was perceived as the least effective.

Ratings Based on Overall Effectiveness

Table 12.3 lists the ratings of interventions based on overall effectiveness. Participants rated social support intervention, information about outreach programs, education, community outreach programs, case management, and referral to psycho-social counselling or support as the most effective interventions to prevent elder abuse. In contrast, ESL training was perceived as the least effective.

Results from the independent sample T-test and Cohen's test reveal some gender-

based differences. In general, the ratings of older men indicated that they perceived referral to psycho-social counselling or support, multi-component intervention, and community outreach as highly effective, while older women perceived the same interventions as fairly ineffective.

Appropriateness for the Korean Community

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

Qualitative Results: Effective Intervention Strategies to Prevent Elder Abuse

Interventions Preferred by Older Women

Our female participants favoured 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 among friends and worry among children.

Some female 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 promote healthy relationships.

> Korean culture can be somewhat patriarchal. Back in the days, some men would beat up their wives. However, 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 intimate partner violence is a form of abuse.

However, some referred to concerns about the availability of Korean professionals, as well as ability to access this kind of program:

> There are many who really want mental health support. There is a lot of aging Korean immigrant population in Toronto. Can't find the service providers [who

> can speak Korean]. We wouldn't even know where to go to find these individuals. We can't find them.

Thus, although psychoeducation was seen to have positive advantages, there was some hesitancy about implementation and buy-in. Still, this program was one of the most favoured because of access to communicating with a Korean professional and educational opportunities to learn about elder abuse.

Our female participants also felt that a community outreach program would be effective. This kind of program would assist older immigrants with daily living activities with the support of bilingual Korean outreach workers. 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, so the community outreach program was very popular.

> 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."

One of the 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 PSWs arrived, and her English also improved.

> She needs assistance at her home so she had to become friends with her 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.

> Probably through church. 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.

Interventions Preferred by Older Korean Men

Most male participants felt that ESL classes – defined as informal settings to learn conversational English – would be a good intervention to help reduce elder abuse in the community. They felt ESL classes would be effective and realistic for their age group, and some commented that the 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? 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, when do you get to breathe in that Canadian fresh air people are talking about? … 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 favoured 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.

> Many assume that the first-generation Korean Canadians speak English quite well. 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 a lot of education because we were busy putting food on the table. However, I think 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. Interestingly, one male participant commented that his children dismissed the available help from programs for seniors, because it would make it look as though the children do not care for their parents.

Finally, male participants 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 felt 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.

One said he would prefer having a younger volunteer:

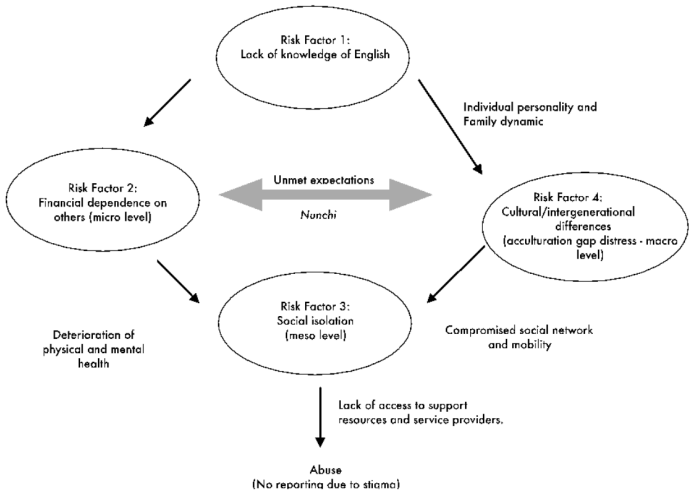
> I think it is a lot better for the younger people to volunteer. I think peer volunteers can be a bit awkward, am I not right? You may feel a bit down because you see a peer who is healthy and more mobile than you are. You may feel inferior.

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

Discussion

Figure 12.1 presents a model that integrates the significant findings and anchors the four risk factors within individual, micro, meso, and macro levels of the ecosystemic framework. Limited language proficiency (an individual-level factor), financial dependence (a micro-level factor), social isolation (a meso-level factor), and cultural/intergenerational differences (macro-level factors) emerged as the most salient risk factors for elder abuse.

Figure 12.1. Elder abuse risk factors identified by members of the Korean immigrant community



Our findings confirm that lack of English increases dependence on caregivers, especially financial dependence: family disputes over the distribution of inheritance were a particularly 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. Unfortunately, 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

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 for their grandchildren.

Most participants expressed frustration and helplessness related to navigating the growing distance between different members of the family resulting from cultural and intergenerational differences. They also commented on the limited places to socialize outside of their homes: increasingly vulnerable older immigrants eventually lose their social capital and became isolated, compromising their ability to access support and services outside their homes. 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 abusers were usually their adult children who sponsored them to come to Canada. The cultural stigma of bringing shame to the family further outweighed the need to protect themselves, and 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 (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; they also affect the abuser's sense of their own actions and the consequences. For example, upon accusation, an abuser may become and resist interventions. 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. Our participants reported that much of the family conflict they experienced was related to inheritance and financial dependence on others, and identified these as significant risk factors for elder abuse.

As immigrants age, they face challenges reconciling cultural differences between their old and new countries (Kim, Kim, and Hurh 1991). Expectations about aging can differ depending on place of origin. In Korea, elders in the family are usually treated with the utmost respect and frequently consulted on important family matters (Chung 2016). Our participants often remarked on how individualistic and spoiled their children were, especially the second generation, commenting 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 – many felt they could not assert heir authority freely and could not get their family members to treat them with respect.

Family is a vital element of Korean culture. Even when experiencing abuse, older immigrants typically remain silent because it is considered shameful to complain about or report one's own family members (Lee and Eaton 2009). Family conflict is considered

a private matter and rarely discussed with healthcare providers or those outside of the trusted inner circle. Against this cultural backdrop, there is 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). In her essay collection, Minor Feelings: An Asian American Reckoning, Hong (2020) noted that Koreans are expected to process trauma internally and quietly, which in turn can increase the feeling of han. 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: lack of knowledge of English (an individual-level factor), financial dependence on others (a micro-level factor), social isolation (a meso-level factor), and cultural differences (a macro-level factor) 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, communal, and societal levels. Proactive 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. Previous research has confirmed that government funding has not reflected the actual needs of many immigrant-serving agencies, many of which are NGOs that rely on government assistance programs to survive (Evans and Shields 2014). Providing strategic and concerted support to community-based agencies will be an important step toward addressing elder abuse.

References

Armstrong, C. K. (2021). Korean History and Political Geography. https://asiasociety.org/education/korean-history-and-political-geography

Bergsen, F. C., & Choi, I. (2003). Korean Diaspora in the Making: Its Current Status and Impact on the Korean Economy.

Burnes, D., MacNeil, A., Nowaczynski, A., Sheppard, C., Trevors, L., Lenton, E., ... & Pillemer, K. (2021). A scoping review of outcomes in elder abuse intervention research: The current landscape and where to go next. Aggression and Violent Behavior, 57, 101476.

Hong, C. P. (2020). Minor Feelings: An Asian American Reckoning. One World.

Chang, B. W. (2016a). Health, health service use and informal caregiver distress among older Korean home care clients in Canada and Korea.

Chang, M. (2016b). Experience of elder abuse among older Korean immigrants. Journal of elder abuse & neglect, 28(2), 76-94.

Chang, M. (2019). Comparative Study on Subjective Experience of Elder Abuse Between Older Korean Immigrants in the United States and Older Koreans in Korea. The International Journal of Aging and Human Development, 88(2), 187-210.

Choi, Y., He, M., & Harachi, T. W. (2008). Intergenerational cultural dissonance, parent–child conflict and bonding, and youth problem behaviors among Vietnamese and Cambodian immigrant families. Journal of youth and adolescence, 37(1), 85-96.

Chung, A. Y. (2016). Saving face: The emotional costs of the asian immigrant family myth Rutgers University Press.

Cohen, J. (1992). A power primer. Psychological bulletin, 112(1), 155.

Dong, X., Chang, E. S., Wong, E., & Simon, M. A. (2014). Perceived barriers and facilitators to implement elder abuse intervention for victims and perpetrators: views from US Chinese older adults. The Journal of Adult Protection.

Evans, B., & Shields, J. (2014). Nonprofit engagement with provincial policy officials: The case of NGO policy voice in Canadian immigrant settlement services. Policy and Society, 33(2), 117-127.

Guruge, S., & Khanlou, N. (2004). Intersectionalities of influence: researching the health of immigrant and refugee women. Canadian Journal of Nursing Research Archive, 32-47.

Guruge, S., Tiwari, A., & Lucea, M. B. (2010). International perspectives on family violence. Springer, New York, NY, USA,.

Guruge, S., Sidani, S., Matsuoka, A., Man, G., & Pirner, D. (2019). Developing a comprehensive understanding of elder abuse prevention in immigrant communities: a comparative mixed methods study protocol. BMJ open, 9(1), e022736.

Heise, L. L. (1998). Violence against women: An integrated, ecological framework. Violence against women, 4(3), 262-290.

Johnson, M. A. (2007). The social ecology of acculturation: Implications for child welfare services to children of immigrants. Children and Youth Services Review, 29(11), 1426-1438.

Johnson, S., Bacsu, J., McIntosh, T., Jeffery, B., & Novik, N. (2019). Social isolation and loneliness among immigrant and refugee seniors in Canada: a scoping review. International Journal of Migration, Health and Social Care 15(3), 177-190.

Kim, E. (2019, May 20). There's a uniquely Korean word for rage and regret. So why had I never heard of it?. Canadian Broadcasting Company. https://www.cbc.ca/radio/docproject/there-s-a-uniquely-korean-word-for-rage-and-regret-so-why-had-i-never-heard-of-it-1.5118989

Kim, K. C., Kim, S., & Hurh, W. M. (1991). Filial piety and intergenerational relationship in Korean immigrant families. The International Journal of Aging and Human Development, 33(3), 233-245.

Kim, S. S. H. C. (2017). Korean" Han" and the Postcolonial Afterlives of" The Beauty of Sorrow". Korean Studies, 253-279.

Koehn, S., Neysmith, S., Kobayashi, K., & Khamisa, H. (2013). Revealing the shape of

knowledge using an intersectionality lens: Results of a scoping review on the health and health care of ethnocultural minority older adults. Ageing and Society, 33(3), 437.

Lee, H. Y., & Eaton, C. K. (2009). Financial abuse in elderly korean immigrants: Mixed analysis of the role of culture on perception and help-seeking intention. Journal of Gerontological Social Work, 52(5), 463-488.

Lee, H. Y., Yoon, H. S., Shin, N., Moon, J. Y., Kwon, J. H., Park, E. S., ... & Park, K. H. (2011). Perception of elder mistreatment and its link to help-seeking intention: A comparison of elderly Korean and Korean American immigrants. Clinical Gerontologist, 34(4), 287-304.

National Initiative for the Care of the Elderly. (2015). Into the Light: National Survey on the Mistreatment of the Older Canadians. http://www.eapon.ca/wp-content/uploads/2017/04/Into-The-Light.pdf?_ga=2.65992302.1592451391.1638829641-1052945392.1638829641

United Nations Department of Economic and Social Affairs, Population Division (2020). World Population Ageing 2020 Highlights: Living arrangements of older persons (ST/ESA/SER.A/451).

Walsh, C. A., Olson, J. L., Ploeg, J., Lohfeld, L., & MacMillan, H. L. (2010). Elder abuse and oppression: Voices of marginalized elders. Journal of Elder Abuse & Neglect, 23(1), 17-42.

Wang, L., Guruge, S., & Montana, G. (2019). Older immigrants' access to primary health care in Canada: A scoping review. Canadian Journal on Aging/La Revue canadienne du vieillissement, 38(2), 193-209.

Waller, M. A. (2001). Resilience in ecosystemic context: Evolution of the concept. American Journal of orthopsychiatry, 71(3), 290-297.

Yan, E., Lai, D. W., Daoust, G. D., & Li, L. (2014). Understanding elder abuse and neglect in aging Chinese immigrants in Canada. The Journal of Adult Protection.

Zhang, W. (2019). Perceptions of elder abuse and neglect by older Chinese immigrants in Canada. Journal of elder abuse & neglect, 31(4-5), 340-362.

Chapter 14. 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 now about 18 percent (Statistics Canada 2020), and estimates suggest that almost one in four Canadians – 23 percent – will be 65 years or older by 2030 (Employment and Social Development Canada 2014). Canada is somewhat unique in that a substantial proportion of its older adults have a migration background.[1] Older immigrants face the general challenges associated with old age; they can also experience increased risk of income insecurity, discrimination, and difficulties in accessing and utilizing the services that are necessary during old age. Previous research has revealed that older immigrants – and particularly new immigrants and refugees – are especially vulnerable to social isolation, which increases their risk of suffering poor health and poor quality of life (Employment and Social Development Canada 2018, 3).[2]

The "Aging Well" project was recently launched to clarify the social needs, networks, and supports of older immigrants in Ontario and how best to foster their capacity, resilience, and independence. This large-scale research project was funded by the Social Sciences and Humanities Council of Canada (see Guruge et al. 2019 for more details).[3] It 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, which is located about 100 kilometres west of Toronto and encompasses the cities of Cambridge, Kitchener, and Waterloo. As of 2019, its population was estimated at 617,870.[4] This mid-sized region is growing and dynamic, home to two large universities and a vibrant manufacturing

1. Note that about 30 percent of older adults in Canada were foreign born (Employment and Social Development Canada 2018, 8).
2. 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).
3. Aging Well Among Immigrants in Canada, https://www.agingwell-immigrants.com/.
4. Population, Region of Waterloo. https://www.regionofwaterloo.ca/en/regional-government/population.aspx

sector. As of 2016, 22.6 percent of its residents were immigrants: this is 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 65 older Spanish-speaking and Mandarin-speaking older adults.[5] Participants were also asked to fill out a questionnaire about social supports. Eleven family members and seven community leaders were also 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 social support services that are available in their community." In this context, we are referring to formal supports, meaning healthcare, legal, educational, social, and/or settlement services.[6] To conduct thematic analysis to assess service awareness, we read through the transcripts of focus groups, identified emerging themes, and analyzed then in the larger context of the municipality, e.g., community composition and structure, available services, etc. This helped reveal how familiar respondents were with formal supports, specifically what information respondents had about services, how they had learned about these programs and services, and how 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).

To benefit from the available formal services, older immigrants must first be aware of their existence – but they must also be able to access them. Ensuring access to services is a vital element of fostering social embeddedness among older immigrants in Canadian cities, and can also mitigate the often overlooked but very serious and growing epidemic of social isolation. We made an effort to amplify the voices of older immigrants in order to convey what these residents had to say about their service awareness. The goal was not to concentrate on the perspectives of service providers, social workers, or community leaders, nor it was to explore their efforts to raise service awareness. Rather, we were interested in the opinions of older adults themselves.[7] 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

Many 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 as well as community commitment to meet them. Service availability is also dependent on the characteristics of each individual city/municipality,

5. Respondents were 60 or older and had been living in the Waterloo region for 20 years or less.
6. The Aging Well study differentiated between informal social support (help with daily tasks from families, friends) and formal social supports (healthcare, legal, educational, social, settlement services).
7. We recognize that our positionality is influenced by our own world views and reflects our personal biases.

and especially 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). Another issue is effective coordination between agencies, service providers, and other stakeholders; Xie and colleagues (2020) noted that ensuring the inclusion of vulnerable populations may not require new interventions, but instead requires coordinated implementation.[8] The availability and delivery of quality information is another crucial element; older immigrants need to be aware of the available community supports in order to access them. Many Canadian studies have focused on topics including the quality of information about formal services available in particular communities, awareness of these services among older, and the communication strategies used by service providers, but few have focused specifically on older immigrant adults.

Some Canadian studies have explored how service providers of all sorts can increase their visibility in the communities and be more effective in terms of communication, information dissemination, and outreach methods. For example, Deville-Stoetzel and colleagues (2021) recently recommended using a series of strategies to increase attendance at cardiovascular health awareness program meetings by older adults who live in subsidized housing in Quebec: recommendations 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 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. Many service providers, umbrella organizations, and different levels of government have compiled lists of "best practices" to optimize outreach strategies (see Ontario Age-Friendly Communities 2021; Edmonton Seniors Coordinating Council 2010; Public Health Agency of Canada 2010).

In contrast, some studies have focused on the perspectives of older adults themselves and the degree to which they are informed about the available support in their communities. Tindale and colleagues (2011) investigated studied the social determinants of awareness of community support services among older adults in Hamilton, Ontario. Also in the Canadian context, Denton and colleagues (2008) reported high levels of perceived need but low levels of awareness of available support. Employment and Social Development Canada (2018) has 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 being socially isolated.

8. In their paper, Xie and colleagues (2020) recommend following a series of both digital and nondigital strategies to deliver adequate information to older adults, their family members, and their caregivers in the context of the COVID-19 pandemic.

Diversity of Perspectives

As we began to analyze our dataset, we noticed a clear diversity of perspectives. We identified general differences between members of the Spanish- and the Chinese-(Mandarin) speaking communities at large,[9] but interestingly, also observed significant differences among the older adults within each of these communities. Factors including gender, educational level, socioeconomic status, and residency status all clearly influenced what information older immigrants had about the available social support services in the region of Waterloo. We also found that factors 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. Based on these findings, we became aware of the need for nuanced analysis. For example, some broad concepts and terms (e.g., "Spanish-speaking older immigrants") are valuable in specific contexts, but it is important to be aware that older immigrants are a heterogenous group with significant differences among individuals. They all have diverse life courses, personal circumstances, and different experiences of aging, which in turn influence their independence, capacities, resilience, and long-term care needs.

One example of this wide diversity is the broad range of familiarity regarding 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 provided for them in the region of Waterloo, whether as clients or volunteers. Their familiarity with these services 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 more socially connected.

Other respondents were moderately aware, and tended to feel that there is a general lack of awareness among the members of their communities. One said, "There is a lack of awareness … Not everybody knows about the available programs and services."[10] 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." Most of our less connected and less active respondents had at least some degree of awareness of the supports available in the community.[11] However, some focus group participants indicated that this was the first they had heard about many of the available supports. Some older immigrants are not connected at all, and continue to be difficult to reach.[12] Previous studies have reported the problem of underutilization of

9. In terms of how aware they were about the available services, their concerns, etc.
10. All focus groups were conducted in the first languages of participants and then translated.
11. This may have affected sampling.
12. The COVID-19 pandemic has made scholars, and society more broadly, more mindful about the situation facing isolated adults in Canadian communities (Belza, Souza, and Sadak 2020).

services among older immigrants,[13] and lack of awareness about social supports is one important cause.

In some cases, being informed is not the problem; certain services and programs may simply not be available in medium and small cities. Larger cities like Toronto tend to have higher proportions of foreign-born residents, and immigrant communities 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. This does not mean that living in larger cities is best for older immigrants (for example, larger cities can be less affordable and involve transportation challenges), but large cities tend to have the capacity to offer more services.

Aspirations and Experiences

Members of both communities generally hoped to enter a language-specific long-term-care facility, or at least to have access to services provided in their native tongue. Some ethno-specific care facilities are available in Toronto (Wellesley Institute 2016); the region of Waterloo provides some services in German, but few institutions/services are provided in Spanish or Mandarin. The Chinese-speaking community was particularly vocal about the need for ethno-specific care, probably partly due to language issues, but also food preferences. To a lesser degree, Spanish-speaking participants had similar hopes, but far fewer reported feeling uneasy about care facilities in Canada or being concerned about price or quality.[14]

With regard to the provision of health care, the region of Waterloo has several health professionals who speak Spanish or Mandarin, but respondents felt more were needed. Some commented that they rarely visited a doctor for this reason, while others noted they were reluctant to go to a hospital because nursing staff may not speak their native language.[15] Instead, many said they tried to manage on their own, e.g., by self-medicating. Lack of English proficiency is a significant barrier to health care, especially in 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 are places of care, identity, and connection: they play crucial roles in service provision and fostering awareness about available supports. However, the Spanish-speaking community in the region of Waterloo still lacks its own cultural centre.[16]

We also found that while a relatively large proportion of the older immigrants were

13. See Guruge (2019) for more details.
14. This complex discussion is beyond the scope of this chapter but involves many factors (e.g., reputation, different expectations, and cultural models of care).
15. 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.
16. Churches play a very important role for Spanish-speaking older adults, but may not be as inclusive as an ethno-cultural association.

aware of available support services, many were unable to access them for a number of reasons. Cultural centres and churches were located far from the homes of some participants, so one main barrier to access was transportation. Some participants could no longer drive or did not have a license. Despite some access to public transit or senior-specific accessible buses, our respondents were concerned about fares (e.g., in many parts of China, older residents do not pay to use local buses) and lack of convenience (schedules, routes, time spent commuting, low temperatures in the winter, slippery roads).

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 referred to price 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 referred to disappointing experiences with service providers that made them reluctant to seek help).

Users also had different conceptions of public space. For example, Chinese elders tend to be relatively physically active and prioritize physical exercise (e.g., dancing, 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 is that awareness of a service (e.g., legal assistance) does not always guarantee that one will 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 different cultures and certain topics (e.g., sexuality, mental health) might not be handled adequately or appropriately; cultural differences can also make some programs targeted at older adults inapplicable or boring for older immigrants. In addition, some existing programs struggle to stay afloat because they are underfunded.

One issue requiring more research is fragmentation – especially lack of trust – within some communities. Financial scams, intracommunity dynamics, and issues can make older immigrants more guarded and less proactive in reaching out.[17] Some respondents reported discriminatory incidents and other difficulties preventing them from fully integrating into local culture.

Finally, engagement with sociocultural programs is related to simple personal preferences: some elders were simply not interested in the activities offered or have grown too accustomed to their current routines. There is usually more room for better advertisement strategies, but service providers can do only so much when the target population is not interested. One excerpt from a conversation illustrates this kind of apathy:

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

[person 1]"I have noticed that this information is featured in the bulletins but people…"

[person 2]"Maybe they don't read them"

[P3]"They don't read them"

[P1]"And they carry them by the hand!"

Overall, many of our respondents felt the available supports were efficient, fair, fostering equality, and lacked corruption. Still, more work is needed to engage with older immigrants and consider their feedback to optimize existing community supports. We found that most respondents were grateful for the opportunity to take part in our study and learn more about the issues. Although recruitment was initially challenging, participants were eager to be better informed and actively participate in the community. More work is needed to build this momentum and avoid apathy, for example by 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. One commented, "One more thing that I want to suggest [is] based on what I have learned about the policies practiced in Switzerland." Others wanted to make meaningful contributions, with comments including, "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, although we observed 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, friends, cultural centres, and churches for information. A few said they had seen advertising (bulletins, magazines, posters etc.), but questioned their effectiveness (see Choi and Smith 2014). Some reported accessing information from the internet or messaging apps such as WeChat. Overall, there seemed to be a consensus that better information-dissemination strategies are needed. In 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 the flow of information could be improved.

With regard to improving the flow of information, some participants felt family doctors could play a more active role in facilitating information about support groups or activities such as workshops; others said social workers or pharmacists could do the same. Some Spanish-speaking participants noted that churches serve as crucial

nodes in communication networks and can very effectively disseminate information of interest. To our knowledge, the churches and priests in the region of Waterloo community were informed and active to an extent, but may not be aware of all available institutional supports. Some participants suggested that a hotline with employees who spoke their native language might be a valuable source of information. Others commented on the need for more coordination between local service providers. Overall, improving dissemination strategies will be essential to ensure that the available social supports are well known among target populations. Addressing this barrier will be much more effective in the short term than attempts to address 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; services can help them age well and benefit broader society by addressing the increasing challenge of social isolation – and optimizing existing services requires listening to older immigrants themselves.

Therefore, we engaged in thematic content analysis based on the transcripts of a series of focus groups conducted for the larger "Aging Well" project. We found that some older immigrants were familiar with the available formal supports, but not all – especially those who were most isolated. Moreover, being informed was not enough to guarantee access: participants identified the need to services and activities that are not offered/available in the region of Waterloo, such as ethno-specific long-term-care options. In some cases, access to services was affected by barriers including transportation, limited English-language skills, and costs.

We found that many participants were eager to actively participate in the community and wanted to be better informed about the available supports. It will be vital to build on this momentum. We also explored where older immigrants received their information and found that most relied on friends, family, cultural centres, and churches. Other dissemination strategies could be adopted to facilitate service access. This issue requires more investigation, because implementing more efficient strategies will be more effective in the short term than efforts to address more complex factors such as income insecurity. Finally, in all future research, it will be crucial to recognize the diversity and heterogeneity among "older immigrants" – not just across communities, but also within each community.

References

Belza, B., Souza, A., & Sadak, T. (2020). Reaching out to isolated older adults is essential during coronavirus – here are 7 specific things you can do, just for starters. The Conversation. https://theconversation.com/reaching-out-to-isolated-older-adults-

is-essential-during-coronavirus-here-are-7-specific-things-you-can-do-just-for-starters-134221

Cantor, M. H. (1989). Social care: Family and community support systems. The Annals of the American Academy of Political and Social Science, 503(1), 99-112.

Choi, N. G., & Smith, J. (2014). Reaching out to racial/ethnic minority older persons for elderly nutrition programs. Journal of Nutrition for the Elderly, 24(1), 89-104.

Denton, M., Ploeg, J., Tindale, J., Hutchison, B., Brazil, K., Akhtar-Danesh, N., ... & Boos, L. (2008). Where would you turn for help? Older adults' awareness of community support services. Canadian Journal on Aging/La Revue canadienne du vieillissement, 27(4), 359-370.

Deville-Stoetzel, N., Kaczorowski, J., Agarwal, G., Lussier, M. T., & Girard, M. (2021). Participation in the Cardiovascular Health Awareness Program (CHAP) by older adults residing in social housing in Quebec: Social network analysis. BMC Health Services Research, 21(1), 1-13.

Edmonton Seniors Coordinating Council (2010). Helping Seniors Age in Place: A strategic Framework to Improve Outreach to Edmonton's Isolated and/or At-Risk Seniors. https://www.seniorscouncil.net/uploads/files/Outreach%20report%20Helping%20seniors%20age%20in%20place.pdf

Employment and Social Development Canada (2014). Action for Seniors Report. https://www.canada.ca/en/employment-social-development/programs/seniors-action-report.html

Employment and Social Development Canada (2018). Social Isolation of Seniors: A Focus on New Immigrant and Refugee Seniors in Canada. https://www.canada.ca/content/dam/canada/employment-social-development/corporate/seniors/forum/social-isolation-immigrant-refugee/social-isolation-immigrant-refugee-seniors-EN.pdf

Guruge, S., Sidani, S., Wang, L., Sethi, B., Spitzer, D., Walton-Roberts, M., & Hyman, I. (2019). Understanding social network and support for older immigrants in Ontario, Canada: protocol for a mixed-methods study. JMIR aging, 2(1), e12616.

Hawkley, L. C., & Cacioppo, J. T. (2010). Loneliness matters: A theoretical and empirical review of consequences and mechanisms. Annals of behavioral medicine, 40(2), 218-227.

Kei, W., Seidel, M. D. L., Ma, D., & Houshmand, M. (2019). Results from the 2016 Census: Examining the effect of public pension benefits on the low income of senior immigrants. Statistics Canada= Statistique Canada.

MacLeod, A., Skinner, M. W., Wilkinson, F., & Reid, H. (2016). Connecting socially isolated older rural adults with older volunteers through expressive arts. Canadian Journal on Aging/La Revue canadienne du vieillissement, 35(1), 14-27.

Ontario Age-Friendly Communities, (2021). Building Connections: Promising Practices to Reduce Older
Adult Social Isolation for Age-Friendly Community Initiatives. https://bc.healthyagingcore.ca/sites/default/files/2021-05/Building-Connections-April-2021.pdf

Public Health Agency of Canada, (2010). Age-Friendly Communication: Facts, tips and ideas. https://www.phac-aspc.gc.ca/seniors-aines/alt-formats/pdf/publications/public/various-varies/afcomm-commavecaines/AFComm-Commavecaines-eng.pdf

Region of Waterloo, (2019). Waterloo Region Immigration Profile. June 2019. https://www.regionofwaterloo.ca/en/regional-government/resources/Reports-Plans–Data/Public-Health-and-Emergency-Services/WR_ImmigrationProfile_2019.pdf

Statistics Canada (2020). Canada's population estimates: Age and sex, July 1, 2020. https://www150.statcan.gc.ca/n1/daily-quotidien/200929/dq200929b-eng.htm

Tindale, J., Denton, M., Ploeg, J., Lillie, J., Hutchison, B., Brazil, K., ... & Plenderleith, J. (2011). Social determinants of older adults' awareness of community support services in Hamilton, Ontario. Health & social care in the community, 19(6), 661-672.

Wellesley Institute (2016) "The cost of waiting for care: Delivering Equitable long term care for Toronto's diverse population." http://www.wellesleyinstitute.com/wp-content/uploads/2016/04/The-Cost-of-Waiting-For-Care.pdf

Xie, B., Charness, N., Fingerman, K., Kaye, J., Kim, M. T., & Khurshid, A. (2020). When going digital becomes a necessity: Ensuring older adults' needs for information, services, and social inclusion during COVID-19. Journal of Aging & Social Policy, 32(4-5), 460-470.

Chapter 15. Spatial and Language Discordance in Accessing Physicians Among Older Immigrants in Toronto: Identifying Barriers, Facilitators, and Interventions

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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, about 17 percent of Canada's total population was classified as older adults (65+ years) (Statistics Canada 2017a) and by 2036, this figure is expected to increase to almost 25 percent (Turcotte and Schellenberg 2007). This demographic transformation will continue to increase demand for existing healthcare services, many of which are unevenly distributed across communities, neighbourhoods, and cities.

Immigrants in Canada can 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 neighbourhoods. Recent trends including the suburbanization of older immigrants (Channer, Hartt, and 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 and 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 and Rosenberg 2014).

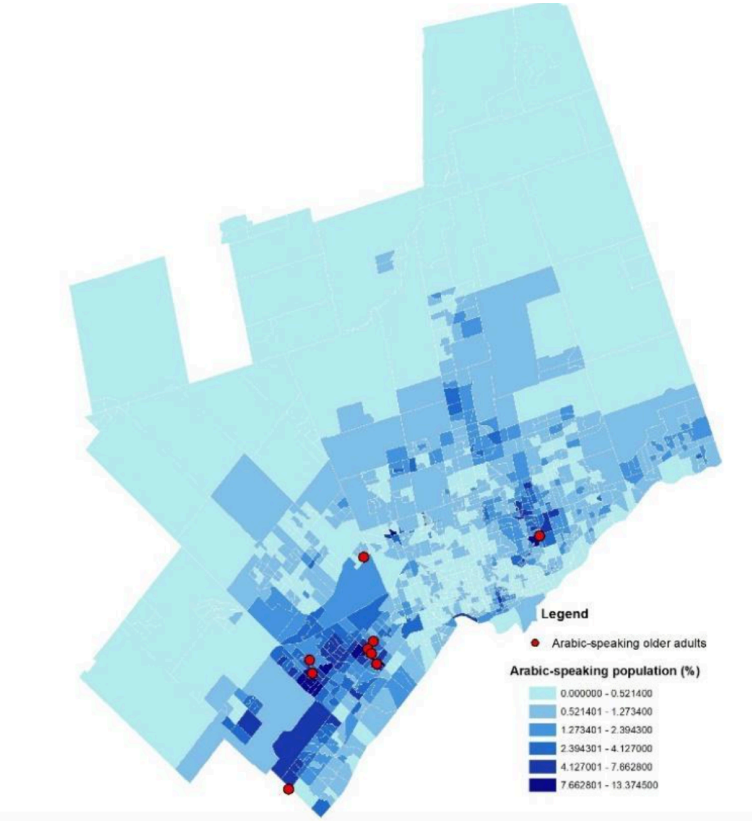
This chapter presents the results of an ongoing study investigating the barriers and facilitators to accessing primary health care among older immigrants, with the goal of informing policies and improving access through translation services, joint efforts with community agencies, and other community-based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

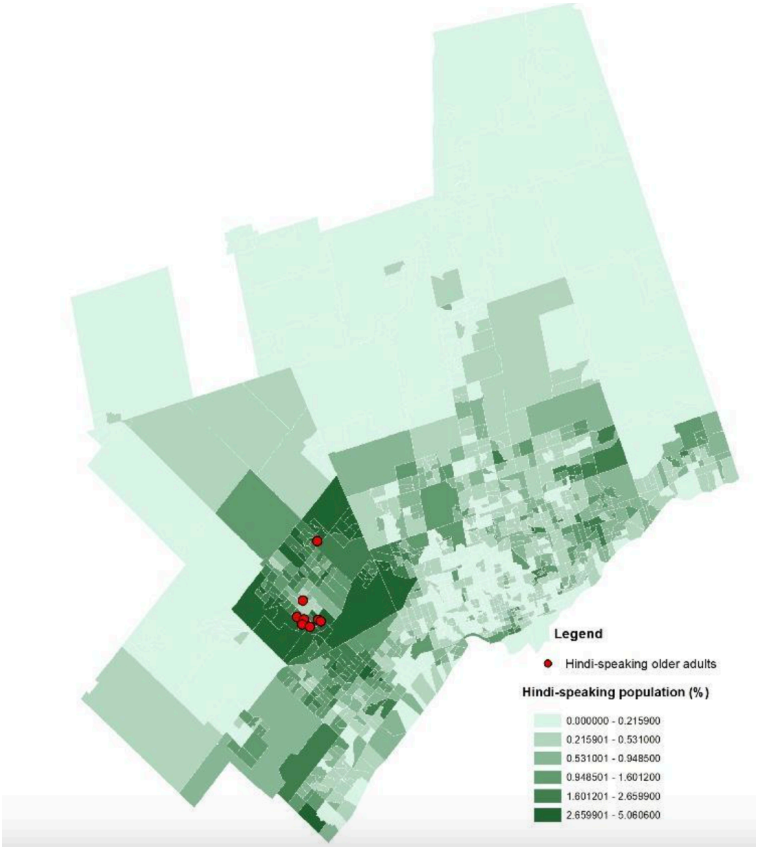
The Project

This four-phase project is focused on older immigrants (aged 65+ years) in Canada. Phase 1 involved compiling and analyzing the relevant literature for a scoping review. For Phase 2, we recruited participants from three stakeholder groups: older immigrant community members (Arabic- and Hindi-speaking), 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 5,862,850, including 2,705,550 immigrants (Statistics Canada 2017b). Of these immigrants, 460,940 (about 17 percent) are classified as older adults (65+ years) (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 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 (StatsCan 2016 ?). As with other immigrants, both of these groups face settlement challenges and barriers in accessing health care (citation). 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 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, and 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 and Lai 2010); Afro-Caribbean, former Yugoslavian, and Spanish (Stewart et al. 2011); and Chinese (Chow 2012; Lai and 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 and Chappell 2006; Lai and 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 and 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 and 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 (ref). 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, and Bukhari 2016; Todd, Harvey, and Hoffman-Goetz 2011; Todd and 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 and 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 and 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, and 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, and 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 and Surood 2013). A study conducted in Calgary revealed that only 11.4 % of older Chinese adults could correctly identify depression, compared with 74 % of the general population (Tieu, Konnert, and 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: older immigrants, representatives from community organizations, and healthcare practitioners. Our goal was to explore how these stakeholders felt about primary care and access to services. We interviewed [and surveyed?] older immigrant community members from Arabic-speaking and Hindi-speaking language groups in their preferred language. We also interviewed [and surveyed?] representatives from community organizations (Access Alliance, Family Service Toronto, the Arab Community Centre of Toronto [ACCT], CultureLink Settlement and Community Services, and the Brampton Multicultural Community Centre [BMC]), as well as healthcare practitioners serving these language groups. Research approval was granted by the Research Ethics Board at Ryerson University in accordance with formal ethical standards (Tri-Council Policy Statement). We recruited the older immigrants 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 previous projects.

Data were cleaned and organized, and then analyzed using descriptive analysis for survey data and thematic analysis for interviews (Braun and 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 on 14 June 2019 at Toronto Metropolitan University and brought together a range of stakeholders including students, professors, health, social and settlement service providers, and representatives from analytics firms.

The event included a number of key presentations and many opportunities to collaborate. Dr. Lu Wang (the first author of this chapter) delivered a keynote presentation outlining the project background, objectives, and methodology. This project focused specifically on Arabic-speaking and Hindi-speaking older immigrants, but Dr. Wang also spoke about Mandarin-speaking and Cantonese-speaking older immigrants – both large immigrant communities within the Greater Toronto Area – commenting that older Chinese immigrants are well-represented among secondary data such as the Canadian Community Health Survey.

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, and 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 discussion 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. Discrimination in health care was another important area of discussion, and 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 trave 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 is 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. She outlined the demographics and factors affecting the health and well-being of older South Asian adults. In the following discussion, 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.

Peizhong P. Wang presented his unpublished research on healthcare access among

recent older adult Chinese immigrants. About 50% of his study participants were able to walk to their doctors, and most were in Markham and Richmond Hill, Ontario. The following 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 research project, because it is helping to disseminate our findings. Together, the four research phases 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 in the four phases 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 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. We will use a mixed-methods approach combining quantitative and qualitative analyses, and will collect additional data sourced from the experiences

of stakeholders. We also expect to identify supplementary funding opportunities with engaged stakeholders.

References

Ahmad, Farah and Donna E. Stewart. 2004. "Predictors of Clinical Breast Examination Among South Asian Immigrant Women." Journal of Immigrant Health 6, no. 3: 119–26. doi: 10.1023/b:joih.0000030227.41379.13

Amankwah, Ernest, Emmanuel Ngwakongnwi, and Hude Quan. 2009. "Why Many Visible Minority Women in Canada Do Not Participate in Cervical Cancer Screening." Ethnicity & Health 14, no. 4: 337–49. doi: 10.1080/13557850802699122

Asanin, Jennifer and Kathi Wilson. 2008. "'I Spent Nine Years Looking for a Doctor': Exploring Access to Health Care Among Immigrants in Mississauga, Ontario, Canada." Social Science & Medicine 66, no. 6: 1271–83. doi: 10.1016/j.socscimed.2007.11.043

Braun, Virginia and Victoria Clarke. 2006. "Using Thematic Analysis in Psychology." Qualitative Research in Psychology 3, no. 2: 77–101. doi: 10.1191/1478088706qp063oa

Braun, Virginia and Victoria Clarke. 2014. "What Can 'Thematic Analysis' Offer Health and Wellbeing Researchers?" International Journal of Qualitative Studies in Health and Well-being 9: 26152. doi: 10.3402/qhw.v9.26152

Bryant, Toba, Ivan Brown, Tara Cogan, Clemence Dallaire, Sophie Laforest, Patrick McGowan, Dennis Raphael, Lucie Richard, Loraine Thompson, and Joyce Young. 2004. "What Do Canadian Seniors Say Supports Their Quality of Life? Findings from a National Participatory Research Study." Canadian Journal of Public Health 95, no. 4: 299–303. doi: 10.1007/BF03405136

Canadian Institute for Health Information. 2011. Health Care in Canada, 2011: A Focus on Seniors and Aging. Ottawa: Canadian Institute for Health Information. https://secure.cihi.ca/free_products/HCIC_2011_seniors_report_en.pdf

Channer, Natalie S., Maxwell Hartt, and Samantha Biglieri. 2020. "Aging-in-Place and the Spatial Distribution of Older Adult Vulnerability in Canada." Applied Geography 125, no. 1: 102357. doi: 10.1016/j.apgeog.2020.102357

Chow, Henry P.H. 2012. "Health Care Service Needs and Correlates of Quality of Life: A Case Study of Elderly Chinese Immigrants in Canada." Social Indicators Research 106, no. 2: 347–358. doi: 10.1007/s11205-011-9810-0

Crawford, Joanne, Angela Frisina, Tricia Hack, and Faye Parascandalo. 2015. "A Peer Health Educator Program for Breast Cancer Screening Promotion: Arabic, Chinese, South Asian, and Vietnamese Immigrant Women's Perspectives." Nursing Research and Practice 947245. doi: 10.1155/2015/947245

Dorkenoo, Selasi. 2019. "Accessing Informal and Formal Social Supports Among Older Immigrants in Toronto: A Mixed-Methods Approach." Master's thesis, Ryerson University. https://digital.library.ryerson.ca/islandora/object/RULA%3A9446

Durbin, Anna, Rahim Moineddin, Elizabeth Lin, Leah S. Steele, and Richard H. Glazier. 2015. "Mental Health Service Use by Recent Immigrants from Different World Regions

and by Non-Immigrants in Ontario, Canada: A Cross-Sectional Study." BMC Health Services Research 15, no. 1: 336–51. doi: 10.1186/s12913-015-0995-9

Gesink, Dionne, Alanna Mihic, Joan Antal, Brooke Filsinger, C. Sarai Racey, Daniel F. Perez, Todd Norwood, Farah Ahmad, Nancy Kreiger, and Paul Ritvo. 2014. "Who are the Under- and Never-Screened for Cancer in Ontario: A Qualitative Investigation." BMC Public Health 14, no. 1: 495–505. doi: 10.1186/1471-2458-14-495

Kirmayer, Laurence J., Morton Weinfeld, Giovani Burgos, Guillaume Galbaud du Fort, Jean-Claude Lasry, and Allan Young. 2007. "Use of Health Care Services for Psychological Distress by Immigrants in an Urban Multicultural Milieu." Canadian Journal of Psychiatry 52, no. 5: 295–304. doi: 10.1177/070674370705200504

Koehn, Sharon, Sanzida Habib, and Syeda Bukhari. 2016. "S4AC Case Study: Enhancing Underserved Seniors' Access to Health Promotion Programs." Canadian Journal on Aging 35, no. 1: 89–102. doi: 10.1017/S0714980815000586

Lai, Daniel W.L. and Neena Chappell. 2006. "Use of Traditional Chinese Medicine by Older Chinese Immigrants in Canada." Family Practice 24, no. 1: 56–64. doi: 10.1093/fampra/cml058

Lai, Daniel W.L. and Shireen Surood. 2010. "Types and Factor Structure of Barriers to Utilization of Health Services Among Aging South Asians in Calgary, Canada." Canadian Journal on Aging 29, no. 2: 249–58. doi: 10.1017/S0714980810000188

Lai, Daniel W.L. and Shireen Surood. 2013. "Effect of Service Barriers on Health Status of Aging South Asian Immigrants in Calgary, Canada." Health & Social Work 38, no. 1: 41–50. doi: 10.1093/hsw/hls065

Lai, Daniel W. L. and Shirley B.Y. Chau. 2007. "Predictors of Health Service Barriers for Older Chinese Immigrants in Canada." Health & Social Work 32, no. 1: 57–65. doi: 10.1093/hsw/32.1.57

Lofters, Aisha K., Rahim Moineddin, Stephen W. Hwang, and Richard H. Glazier. 2010. "Low Rates of Cervical Cancer Screening Among Urban Immigrants: A Population-Based Study in Ontario, Canada." Medical Care 48, no. 7: 611–18. doi: 10.1097/MLR.0b013e3181d6886f

McDonald, James T. and Steven Kennedy. 2007. "Cervical Cancer Screening by Immigrant and Minority Women in Canada." Journal of Immigrant and Minority Health 9, no. 4: 323–34. doi: 10.1007/s10903-007-9046-x

Newbold, Bruce K. 2009. "Health Care Use and the Canadian Immigrant Population." International Journal of Health Services 39, no. 3: 545–565. doi: 10.2190/HS.39.3.g

Ng, Edward, Claudia Sanmartin, Jack Tu, and Doug Manuel. 2014. "Use of Acute Care Hospital Services by Immigrant Seniors in Ontario: A Linkage Study." Health Reports 25, no. 10: 15–22. https://pubmed.ncbi.nlm.nih.gov/25317755/

Sadavoy, Joel, Rosemary Meier, and Amoy Y.M. Ong. 2004. "Barriers to Access to Mental Health Services for Ethnic Seniors: The Toronto Study." Canadian Journal of Psychiatry 49, no. 3: 192–99. doi: 10.1177/070674370404900307

Schreier, Margrit. 2012. Qualitative Content Analysis in Practice. London: Sage.

Setia, Maninder S., John Lynch, Michal Abrahamowicz, Pierre Tousignant, and Amelie Quesnel-Vallee. 2011. "Self-rated Health in Canadian Immigrants: Analysis of the Longitudinal Survey of Immigrants to Canada." Health & Place 17, no. 2: 658–70. doi: j.healthplace.2011.01.006

Chapter 15. Spatial and Language Discordance in Accessing Physicians Among Older Immigrants in Toronto: Identifying Barriers, Facilitators, and

Statistics Canada. 2017a. “Census Profile, 2016 Census – Canada (Country) and Canada (Country).” Statistics Canada. Government of Canada. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E

Statistics Canada. 2017b “Focus on Geography Series, 2016 Census – Toronto (CMA), Ontario.” Statistics Canada. Government of Canada. https://www12.statcan.gc.ca/census-recensement/2016/as-sa/fogs-spg/Facts-cma-eng.cfm?LANG=Eng&GK=CMA&GC=535&TOPIC=7

Stewart, Miriam, Edward Shizha, Edward Makwarimba, Denise Spitzer, Ernest N. Khalema, and Christina D. Nsaliwa. 2011. “Challenges and Barriers to Services for Immigrant Seniors in Canada: ‘You are Among Others but You Feel Alone.’” International Journal of Migration, Health and Social Care 7, no. 1: 16–32. doi: 10.1108/17479891111176278

Subedi, Rajendra P. and Mark W. Rosenberg. 2014. “Determinants of the Variations in Self-Reported Health Status Among Recent and More Established Immigrants in Canada.” Social Science and Medicine 115: 103–10. doi: 10.1016/j.socscimed.2014.06.021

Sun, Zhuoyu, Hui Xiong, Anne Kearney, Jin Zhang, Wei Liu, Guowei Huang, and Peizhong P. Wang. 2010. “Breast Cancer Screening Among Asian Immigrant Women in Canada.” Cancer Epidemiology 34, no. 1: 73–78. doi: 10.1016/j.canep.2009.12.001

Surood, Shireen and Daniel W.L. Lai. 2010. “Impact of Culture on Use of Western Health Services by Older South Asian Canadians.” Canadian Journal of Public Health 101, no. 2: 176–80. doi: 10.1007/BF03404367

Thomson, Mary S., Ferzana Chaze, Usha George, and Sepali Guruge. 2015. “Improving Immigrant Populations’ Access to Mental Health Services in Canada: A Review of Barriers and Recommendations.” Journal of Immigrant and Minority Health 17, no. 6: 1895–905. doi: 10.1007/s10903-015-0175-3

Tiagi, Raaj. 2016. “Access to and Utilization of Health Care Services Among Canada’s Immigrants.” International Journal of Migration, Health and Social Care 12, no. 2: 146–56. doi: 10.1108/IJMHSC-06-2014-0027

Tieu, Yvonne, Candace Konnert, and Jian L. Wang. 2010. “Depression Literacy Among Older Chinese Immigrants in Canada: A Comparison with a Population-Based Survey.” International Psychogeriatrics 22, no. 8: 1318–1326. doi: 10.1017/S1041610210001511

Todd, Laura, Erin Harvey, and Laurie Hoffman-Goetz. 2011. “Predicting Breast and Colon Cancer Screening Among English-as-a-Second-Language Older Chinese Immigrant Women to Canada.” Journal of Cancer Education 26, no. 1: 161–69. doi: 10.1007/s13187-010-0141-7

Todd, Laura and Laurie Hoffman-Goetz. 2011. “A Qualitative Study of Cancer Information Seeking Among English-as-a-Second-Language Older Chinese Immigrant Women to Canada: Sources, Barriers, and Strategies.” Journal of Cancer Education 26, no. 2: 333–40. doi: 10.1007/s13187-010-0174-y

Turcotte, Martin and Grant Schellenberg. 2007. A Portrait of Seniors in Canada. Ottawa: Statistics Canada. https://www150.statcan.gc.ca/n1/pub/89-519-x/89-519-x2006001-eng.pdf

Vahabi, Mandana. 2011. “Knowledge of Breast Cancer and Screening Practices Among Iranian Immigrant Women in Toronto.” Journal of Community Health 36, no. 2: 265–273. doi: 10.1007/s10900-010-9307-9

Wang, Lu, Sepali Guruge, and Gelsomina Montana. 2019. “Older Immigrants’ Access to Primary Health Care in Canada: A Scoping Review.” Canadian Journal on Aging 38, no. 2: 193–209. doi: 10.1017/S0714980818000648

RESEARCH, PRACTICE, & POLICY CONSIDERATIONS AND INTERVENTIONS

Chapter 17. Participant Recruitment for Research: Opportunities and Challenges

MELISSA NORTHWOOD; ERNEST LEUNG; SOURAYA SIDANI; AND SEPALI GURUGE

It is critical to include older immigrants in research in order to generate a representative evidence base and prevent health inequalities that may arise from excluding this group. Immigration patterns are now leading to more linguistic, ethnic, social, and religious diversity in many countries (Sethi, Guruge, and 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 and Harrison 2017). Other challenges include mistrust of research projects, especially among older immigrants (Arean et al. 2003). As a result, despite the increasing numbers of older immigrants, little is known about their health and social conditions to inform clinical and community practices. Researchers are now recognizing the imperative to design inclusive recruitment strategies.

Effective recruitment involves disseminating information about a study to the target population: 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 and Braden 2021). For qualitative studies, sample sizes may differ depending on the method, but the goal is generally to generate a credible description of the phenomenon of interest (Thorne 2018). 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 features including those related to health, socio-economic or ethno-racial background, or experiences of the phenomenon under investigation (Sidani and Braden 2021).

Recruitment strategies can be categorized as active or passive. Active strategies involve direct contact between the recruiters and members of the target population; contact may take the form of informal or formal presentations to individuals or groups at relevant locations and events. Passive strategies involve the use of various media, such as 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

The following subsections briefly describe some of the known challenges when attempting to recruit 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 and 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 literature 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 no or little English or French language proficiency (Wang, Guruge, and 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, religion, and (dis)advantages etc., all of which can negatively affect effective communication (Resch and 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 strongly influence their ability or desire to participate in research – either 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, inconsistent culturally sensitive care, and inappropriate assessment tools (Waheed et al. 2015).

Trust and Mistrust

Historical mistrust of both research/researchers and healthcare systems are significant barriers to recruitment of some older 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). For example, the process of signing an informed consent document may pose concerns for individuals who have experienced situations of war and other forms of civil unrest etc that can raise suspicion regarding the requirement of a signature (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, and Csiernik 2021). Older immigrants may be living with multiple chronic conditions or may be homebound, and therefore may feel especially vulnerable to potential exploitation (Hughson et al. 2016; McHenry et al. 2015).

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.

State of the Evidence: Recruiting 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 recruitment strategies to reach 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 and 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 and Froelicher 2007; Zou 2017). Face-to-face recruitment activities occurred in a variety of settings including peer-support groups, 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 and Froelicher 2007; Zou 2017).

The articles specific to older Chinese immigrants (Li et al. 2016; Taylor-Piliae and Froelicher 2007) also identified several useful passive strategies for recruiting participants for clinical trials, in addition to active strategies mentioned previously: advertisements in Chinese newspapers, television, and radio, and circulation of bilingual flyers and posters. The reason for this difference is unclear but may be related to the socio-educational and financial status of the Chinese immigrant community, 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 and 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 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 community visibility and interaction (Bistricky et al. 2010).
- Communicating information about the study in the preferred language of potential participants (Taylor-Piliae and 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 extend the current state of knowledge from the literature on effective strategies for recruiting older immigrants by sharing 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 supports received by older immigrants (Guruge et al. 2019; Guruge et al. 2019). 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 participants at the intersection of aging and immigration.

Snowball Sampling and Social 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 study samples. 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 covering the costs of parking, transportation, and the time required to take part in the study are effective incentives to recruitment. In contrast, honoraria such as gift cards are not as valued.

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 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 media and at 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, and no one responded. In contrast, we have 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 or recruiters. 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 similarities . 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 they understand and trust the research team, they are also more likely to help share information about the study with their peers. 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. This approach also helped us obtain consent from all study participants to be contacted again for subsequent phases of our longitudinal research study.

Implications for Research

Older immigrants to 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 and Hankivsky 2011; Sethi, Guruge, and 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 of a particular 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 and Hodgetts 2018). The onus is on the research community, not on older immigrants themselves, 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 target population: 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 target immigrant community, 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.

References

Arean, Patricia A., Jennifer Alvidrez, Rowena Aery, Carroll Estes, and Karen Linkins. "Recruitment and retention of older minorities in mental health services research." The Gerontologist 43, no. 1 (February 2003): 36-44.

Barata, Paula C, Enza Gucciardi, Farah Ahmad, and Donna E. Steward. (2006). "Cross-cultural perspectives on research participation and informed consent." Social Science and Medicine 62, no. 2 (January 2006): 479-490.

Bistricky, Steven. L, Scott R. Mackin, Joyce P. Chu, and Patricia A. Arean. "Recruitment of African Americans and Asian Americans With Late-Life Depression and Mild

Cognitive Impairment." American Journal of Geriatric Psychiatry 18, no. 8 (August 2010): 734-742.

Burns, Dorothy, April C.M. Soward, Anne H. Kelly, Jennifer Leeman, and John Carlson. "Effective recruitment and retention strategies for older members of rural minorities." The Diabetes Educator 34, no. 6 (2008): 1045-1052. http://doi.org/10.1177/0145721708325764.

Choi, Eunsuk, Grace Jeongim Heo, Youngshin Song, and Hae-Ra Han. "Community Health Worker Perspectives on Recruitment and Retention of Recent Immigrant Women in a Randomized Clinical Trial." Family and Community Health 39, no. 1 (2016): 53-61. http://doi.org/10.1097/FCH.0000000000000089

Commodore-Mensah, Yvonne, Ruth-Alma Turkson-Ocran, Nwakaego A. Nmezi, Manka Nkimbeng, Joycelyn Cudjoe, Danielle S. Mensah, Sarah York, et al. "Commentary: Engaging African Immigrants in Research Experiences and Lessons from the Field." Ethnicity and Disease 29, no. 4 (2019): 617-622.

Feldman, Susan, Harriet Radermacher, Colette Browning, Steve Bird, and Shane Thomas. "Challenges of recruitment and retention of older people from culturally diverse communities in research." Ageing & Society 28, no. 4 (2008): 473-493.

Fete, Margaux, Josephine Aho, Magalie Benoit, Patrick Cloos, and Valery Ridde. "Barriers and recruitment strategies for precarious status migrants in Montreal, Canada." BMC Medical Research Methodology 19, no. 41 (2019). https://doi.org/10.1186/s12874-019-0683-2.

Forsat, Noah D., Andriko Palmowski, Yannick Palmowski, Maarten Boers, and Frank Buttgereit. "Recruitment and Retention of Older People in Clinical Research: A Systematic Literature Review." Journal of American Geriatric Society 68, no.12 (2020): 2955-2963.

Guruge, Sepali, Souraya Sidani, Atsuko Matsuoka, Guida Man, and Diane Pirner. Developing a comprehensive understanding of elder abuse prevention in immigrant communities: a comparative mixed methods study protocol. BMJ Open, 9, no.1 (2019), e022736. https://doi.org/10.1136/bmjopen-2018-022736

Guruge, Sepali, Souraya Sidani, Lu Wang, Bharati Sethi, Denise Spitzer, Margaret Walton-Roberts, and Ilene Hyman. Understanding Social Network and Support for Older Immigrants in Ontario, Canada: Protocol for a Mixed-Methods Study." JMIR Aging 2, no.1 (2019),e12616. https://doi.org/10.2196/12616

Hughson, Jo-anne, Robyn Woodward-Kron, Anna Parker, John Hajek, Agnese Bresin, Ute Knoch, Tuong Phan, and David Story. "A review of approaches to improve participation of culturally and linguistically diverse populations in clinical trials." Trials 17, no.263 (2016).

Markle-Reid, Maureen, Rebecca Ganann, Jenny Ploeg, Gail Heald-Taylor, Laurie Kennedy, C. McAiney, and Ruta Valaitis. (2021). "Engagement of older adults with multimorbidity as patient research partners: Lessons learned from a patient-oriented research program." Journal of Multimorbidity and Comorbidity, 11 (2021). http://doi.org/10.1177/2633556521999508.

McHenry, Judith C., Kathleen C. Insel, Gilles O. Einstein, Amy N. Vidrine, Kari M. Koerner, and Daniel G. Morrow. "Recruitment of Older Adults: Success May Be in the

Details." The Gerontologist 55, no.5 (2015): 845-853. https://doi.org/10.1093/geront/gns079

Njie-Carr, Veronica P.S., Bushra Sabri, Jill T. Messing, Allison Ward-Lasher, Crista E. Johnson-Agbakwu, Catherine McKinley, Nicole Campion, Saltanat Childress, Joyell Arscott , and Jacquelyn Campbell. "Methodological and Ethical Considerations in Research with Immigrant and Refugee Survivors of Intimate Partner Violence." Journal of Interpersonal Violence 36, no.19-20 (2021): NP10790–NP10808. http://doi.org/10.1177/0886260519877951

Ontario SPOR Support Unit. "Fairness is Excellence: The Ontario SPOR SUPPORT Unit's Equity Framework." Accessed November 1, 2021. https://ossu.ca/resources/equity-framework/

Samuel, Tonya. "Standardizing a Process to Engage African Americans in Health Research: The Community Research Outreach Workers' Network (CROWN)." Progress in Community Health Partnerships-Research Education and Action 8, no.1 (2014): 109-116. http://doi.org/10.1353/cpr.2014.0003

Sethi, Bharati, Sepali Guruge, and Rick Csiernik. Understanding the Refugee Experience in the Canadian Context. Newcastle: Cambridge Scholars Publishing, 2021.

Sidani, Souraya, and Carrie Jo Braden. Nursing and health interventions: Design, evaluation and implementation (2nd ed.). London: Wiley (2021).

Taylor-Piliae, Ruth E., and Erika Sivarajan Froelicher. "Methods to optimize recruitment and retention to an exercise study in Chinese immigrants." Nursing Research 56, no.2 (2007): 132-136. http://doi.org/10.1097/01.NNR.0000263971.46996.14

Thorne, Sally. Interpretive Description: Qualitative Research for Applied Practice (2nd ed.). New York: Routledge (2016).

Waheed, Waquas, Adwoa Hughes-Morley, Adrine Woodham, Gill Allen, and Peter Bower. "Overcoming barriers to recruiting ethnic minorities to mental health research: a typology of recruitment strategies." BMC Psychiatry 15, (2015). https://doi.org/10.1186/s12888-015-0484-z

Wang, Lu, Sepali Guruge, and Gelsomina Montana. "Older immigrants' access to primary health care in Canada: A scoping review." Canadian Journal on Aging, 38, no.2 (2019), 193-209. http://doi.org/10.1017/S0714980818000648

Zou, Ping. "Recruitment process of a Chinese immigrant study in Canada." Applied Nursing Research 36, (2017): 84-87.

Chapter 18. Aging in Third Places: Community Spaces and Social Infrastructure for Senior Immigrants

RYAN LOK AND ZHIXI ZHUANG

According to the 2016 Canadian Census, seniors (aged 65+) accounted for 21 percent of the total population of Canada, and almost one-third (30%) 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 and 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 and 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 (Van Hees et al. 2017; Pani-Harreman et al. 2020). 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 well-being (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 2015, 2019; Zhuang and Chen, 2017), 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 and Gallant 2019). Although studies tend to consider the importance of third places as a form of beneficial social infrastructure, studies that focus on seniors broadly (Campbell 2017; Alidoust et al. 2019; 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 well-being (Mand 2006; Koehn et al. 2016; Park et al. 2020; Jang et al. 2015; Kim 2013). More specifically, they have identified the valuable role of ethnic community centres (Chung and Seo 2017; Kim and Silverstein 2021; Cerin et al. 2019), religious institutions including churches (Heikkinen 2011; Kim et al. 2012; Wright-St.Clair and Nayar 2019), or temples (Slade and Borovnik 2018), and community gardens (Li et al. 2010; Hartwig and Mason 2016) (that enhances well-being 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 percent 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 and 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 and 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; Lai et al. 2019; Kim and Silverstein 2021).

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 and 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 and 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 and 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 well-being 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.

References

Alidoust, S. Bosman, C., & Holden, G. (2019). Planning for healthy ageing: how the use of third places contributes to the social health of older populations. Ageing and Society, 39(7), 1459-1484.

Asanin, J., & Wilson, K. (2008). "I spent nine years looking for a doctor": Exploring access to health care among immigrants in Mississauga, Ontario, Canada. Social Science & Medicine, 66(6), 1271-1283.

Berry, J. W. (1997). Immigration, Acculturation, and Adaptation. Applied Psychology: An International Review, 46(1), 5-68.

Berry, J. W. (2005). Acculturation: Living successfully in two cultures. International Journal of Intercultural Relations, 29(6), 697-712.

Berry, J. W., & Hou, F. (2016). Immigrant Acculturation and Wellbeing in Canada. Canadian Psychology, 57(4), 254-264.

Berry, J. W. & Hou, F. (2021). Immigrant acculturation and wellbeing across generations and settlement contexts in Canada. International Review of Psychiatry, 33(1-2), 140-153.

Boldy, D., Grenade, L., Lewin, G., Karol, E., & Burton, E. (2011). Older people's decisions regarding 'ageing in place': A Western Australian case study. Australasian Journal on Ageing, 30(3), 136-142.

Campbell, N. (2017). There's no place like third place: starting to generalize the qualities and value of third places. Housing & Society, 44(3), 157-172.

Caxaj, C. S., & Gill, N. K. (2017). Belonging and Mental Wellbeing Among a Rural Indian-Canadian Diaspora: Navigating Tensions in "Finding a Space of Our Own." Qualitative Health Research, 27(8), 1119-1132.

Cerin, E., Nathan, A., Choi, W. K., Ngan, W., Yin, S., Thornton, L., & Barnett, A. (2019). Built and social environment factors influencing healthy behaviors in older Chinese immigrants to Australia: a qualitative study. International Journal of Behavioral Nutrition and Physical Activity, 16(1), 1-15.

Chau, S., & Lai, D. W. L. (2011). The Size of an Ethno-Cultural Community as a Social Determinant of Health for Chinese Seniors. Journal of Immigrant Minority Health, 13(6), 1090-1098.

Chung, J., & Seo, J. Y. (2017). Using the socioecological model to explore factors affecting

health-seeking behaviours of older Korean immigrants. International Journal of Older People Nursing, 13(2), e12179-n/a.

Curtin, A., Martins, D. C., Gillsjo, C., & Schwartz-Barcott, D. (2017). Ageing out of place: The meaning of home among hispanic older persons living in the United States. International Journal of Older People Nursing, 12(3),e12150-n/a.

Finlay, J., Esposito, M., Kim, M. H., Gomez-Lopez, I., & Clarke, P. (2019). Closure of 'third places'? Exploring potential consequences for collective health and wellbeing. Health & Place, 60, 102225-102225.

Fong, P., Haslam, C., Cruwys, T., & Haslam, S. A. (2020). "There's a Bit of a Ripple-effect": A Social Identity Perspective on the Role of Third-Places and Aging in Place, Environment and Behavior, 53(5), 540-568.

Government of Ontario. (2021). Ontario population projections. Retrieved from https://www.ontario.ca/page/ontario-population-projections#:~:text=The%20number%20of%20seniors%20aged,22.2%20per%20cent%2C%20by%202046.&text=The%20number%20of%20children%20aged,to%203.0%20million%20by%202046.

Guo, M., Stensland, M., Li, M., Dong, X., & Tiwari, A. (2019). Is Migration at Older Age Associated with Poorer Psychological Well-Being? Evidence from Chinese Older Immigrants in the United States. The Gerontologist, 59(5), 865-876.

Hartwig, K. A., & Mason, M. (2016). Community Gardens for Refugee and Immigrant Communities as a Means of Health Promotion. Journal of Community Health, 41(6), 1153-1159.

Heikkinen, S. J. (2011). Exclusion of Older Immigrants from the Former Soviet Union to Finland: The Meaning of Intergenerational Relationships. Journal of Cross-Cultural Gerontology, 26(4), 379-395.

Hepburn, S. (2018). Residential selection at retirement: A visual ethnography exploring the later life mobilities of Jamaican Canadian Transmigrants, ProQuest Dissertations Publishing.

Huber, A., & O'Reily, K. (2004). The construction of Heimat under conditions of individualised modernity: Swiss and British elderly migrants in Spain. Ageing & Society, 24(3), 327-351.

Hug, E., Stewart, G., Thorne, J. (2013). Enabling Positive Change. OPPI Journal, 1-3.

Hutchinson, S. L., & Gallant, K. A. (2016). Can senior centres be contexts for aging in third places, Journal of Leisure Research, 48(1), 50-68.

Jang, Y., Park, N-S., Chiriboga, D. A., Yoon, H., An, S., & Kim, M. T. (2015). Social Capital in Ethnic Communities and Mental Health: A Study of Older Korean Immigrants, Journal of Cross-Cultural Gerontology, 30(2), 131-141.

Jang, Y., Kim, K., Park, N-S., & Chirboga, D. A. (2016). Emotional Confidants in Ethnic Communities: Social Network Analysis of Korean American Older Adults, Journal of Aging and Health, 28(2), 324-340.

Johnson, S., Bacsu, J., McIntosh, T., Jeffery, B., & Novik, N. (2019). Social isolation and loneliness among immigrant and refugee seniors in Canada: a scoping review. International Journal of Migration, Health, and Social Care, 15(3), 177-190.

Kim, Y. S. (2013). Ethnic Senior Schools, Religion, and Psychological Well-Being Among

Older Korean Immigrants in the United States: A Qualitative Study. Educational Gerontology, 39(5), 342-354.

Kim, C. K., Hong, P. Y. P., Treering, D. J., & Sim, K. (2012). The Changing Map of Characteristics and Service Needs Among Korean American Immigrants in Chicago: A GIS-Based Exploratory Study. Journal of Poverty, 16(1), 48-71.

Kim, J. H. & Silverstein, M. (2021). Are Filial Piety and Ethnic Community Engagement Associated With Psychological Wellbeing Among Older Chinese American Immigrants? A Cultural Resource Perspective. Research on Aging, 43(2), 63-73.

Klinenberg, E. (2018). "Introduction: The Social Infrastructure." Palaces for the people: how social infrastructure can help fight inequality, polarization, and the decline of civic life. New York, NY: Broadway Books.

Klok, J., van Tillburg, T. G., Suanet, B., Fokkema, T., & Huisman, M. (2017). National and transnational belonging among Turkish and Moroccan older migrants in the Netherlands: protective against loneliness? European Journal of Ageing, 14(4), 341-351.

Koehn, S., Habib, S., & Bukhari, S. (2016). S4AC Case Study: Enhancing Underserved Seniors' Access to Health Promotion Programs, Canadian Journal on Aging, 35(1), 89-102.

Koehn, S., Ferrer, I., & Brotman, S. (2020). Between loneliness and belonging: narratives of social isolation among immigrant older adults in Canada. Ageing & Society, First View, 1-21. https://www.cambridge.org/core/journals/ageing-and-society/article/abs/between-loneliness-and-belonging-narratives-of-social-isolation-among-immigrant-older-adults-in-canada/0F13457CBEF2B0C5B8F600D918F86A2D

Lai, D. W. L., Li, J., Lee, V. W. P., & D. X. (2019). Environmental Factors Associating with Chinese Older Immigrants' Social Engagement. Journal of American Geriatrics Society, 67(3), 571-576.

Lee, Y. M. (2007). The immigration experience among elderly Korean immigrants. Journal of Psychiatric and Mental Health Nursing, 14(4), 403-410.

Lewis, D. C. (2009). Aging Out of Place: Cambodian Refugee Elders in the United States. Family and Consumer Sciences Research Journal, 37(3), 376-393.

Li, W. W., Hodgetts, D., & Ho, E. (2010). Gardens, Transitions and Identity Reconstruction among Older Chinese Immigrants to New Zealand. Journal of Health Psychology, 15(5), 786-796.

Li, W. L., McLaughlin, S. J., & Zhang, J. (2020). Healthy Aging in Older Chinese Americans: Associations with Immigrant Experiences, Journal of Aging and Health, 32(9), 1098-1108.

Lo, L., Preston, V., Anisef, P., Basu, R., & Wang, S. (2015). "Chapter 3: Vulnerability in York Region." Social Infrastructure and Vulnerability in the Suburbs. University of Toronto Press.

Logan, J. & Murdie, R. (2016). Home in Canada? The Settlement Experiences of Tibetans in Parkdale, Toronto. Journal of International Migration and Integration, 17(1), 95–113.

Mand, K. (2006). Social Relations Beyond the Family? Exploring elderly South Asian women's friendships in London. Community, Work and Family, 9(3), 309-323.

Mao, W., Wu, B., Chi, I., Yang W., & Dong, X. (2020). Neighborhood Cohesion and Oral Health Problems Among Older Chinese American Immigrants; Does Acculturation Make a Difference? The Gerontologist, 60(2), 219-228.

Nyashanu, M., Mbalinda, S. N., Mushawa, F., & Ekpenyong, M. S. (2020). Exploring perceptions and attitudes of black Sub-Sahara African (BSSA) migrants towards residential care in England. International Journal of Migration, Health and Social Care, 16(3), 307-315.

Oldenburg, R. (1999). The great good place: Cafes, coffee shops, bookstores, bars, hair salons and other hangouts at the heart of a community. Cambridge, MA: Da Capo Press.

Pani-Harreman, K. E., Bours, Gerrie. J. J. W., Zander, I., Kempen, Gertrudis. I. J. M., & van Duren, Joop. M. A. (2021). Definitions, key themes and aspects of 'ageing in place': a scoping review. Ageing & Society, 41(9), 2026-2059.

Parekh, R., Maleku, A., Fields, N., Adorno, G., Schuman, D., & Felderhoff, B. (2018). Pathways to age-friendly communities in diverse urban neighborhoods: Do social capital and social cohesion matter? Journal of Gerontological Social Work, 61(5), 492-512.

Park, N. S., Jang, Y., Chiriboga, D. A., & Chung, S. (2020). Profiles of Social Engagement and Their Association With Loneliness and Self-Rated Health Among Older Korean Immigrants, Research on Aging, 42(9-10), 300-3011.

Sadarangani, T. R. & Jun, J. (2014). Newly Arrived Elderly Immigrants: A Concept Analysis of "Aging Out of Place." Journal of Transcultural Nursing, 26(2), 110-117.

Salma, J., Keating, N., Ogilvie, L., & Hunter, K. F. (2018). Social dimensions of health across the life course: Narratives of Arab immigrant women ageing in Canada. Nursing Inquiry, 25(2), e12226-n/a.

Seo, Y. K., & Mazumdar, S. (2011). Feeling at home: Korean Americans in senior public housing. Journal of Aging Studies, 25(3), 233-242.

Slade, N. & Borovnik, M. (2018). 'Ageing out of place': Experiences of resettlement and belonging among older Bhutanese refugees in New Zealand. New Zealand Geographer, 74(2), 101-108.

Statistics Canada. (2017). Table 1: Geographic distribution of immigrants and recent immigrants and their proportion within the population of census metropolitan areas, Canada, 2016. Retrieved from https://www150.statcan.gc.ca/n1/daily-quotidien/171025/t001b-eng.htm

Statistics Canada. (2021). Social isolation of seniors: A Focus on New Immigrant and Refugee Seniors in Canada. Retrieved from https://www.canada.ca/en/employment-social-development/corporate/seniors/forum/social-isolation-immigrant-refugee.html#h2.2

Stewart, M., Shizha, E., Makwarimba, E., Spitzer, D., Khalema, E. N., & Nsaliwa, C. D. (2011). Challenges and barriers to services for immigrant seniors in Canada: "you are among others but you feel alone." International Journal of Migration, Health, and Social Care, 7(1), 13-32.

Tiamzon, T. J. (2013). Circling Back: Reconstituting Ethnic Community Networks Among Aging Filipino Americans. Sociological Perspectives, 56(3), 351-375.

Vanleerberghe, P., Witte, N. D., Claes, C., Schalock, R. L., & Verte, D. (2017). The quality of life of older people aging in place: a literature review. Quality of Life Research, 26(11), 2899-2907.

Van Hees, S., Horstman, K., Jansen, M., & Ruwaard, D. (2017). Photovoicing the

neighbourhood: understanding the situated meaning of intangible places for ageing-in-place. Health & Place 48, 11–19.

Van Hees, S, Horstman, K, Jansen, M and Ruwaard, D. (2018). Meanings of 'lifecycle robust neighbourhoods': constructing versus attaching to places. Ageing & Society, 38(6), 1148–1173.

Wang, Q., & Zhan, H. J. (2019). The making of a home in a foreign land: understanding the process of home-making among immigrant Chinese elders in the U.S. Journal of Ethnic and Migration Studies, 47(7), 1539-1557.

Wear, A. (2016). Planning, Funding, and Delivering Social Infrastructure in Australia's Outer Suburban Growth Areas. Urban Policy and Research, 34(3), 284-297.

Wessendorf, S., & Farrer, J. (2021). Commonplace and out-of-place diversities in London and Tokyo: migrant-run eateries as intercultural third places. Comparative Migration Studies, 9(1), 1-17.

Wright-St Clair, V. A., & Nayar, S. (2019). Resettling amidst a mood of loneliness: later life Chinese, Indian and Korean immigrants in New Zealand. Ageing & Society, 40(11), 1-17.

Zhuang, Z. C. (2015). Construction and reconstruction of ethnicity in retail landscapes: case studies in the Toronto area. Journal of Urban Design, 20(5), 677-697.

Zhuang, Z. C., & Chen, A. X. (2017). The role of ethnic retailing in retrofitting suburbia: case studies from Toronto, Canada. Journal of Urbanism: International Research on Placemaking and Urban Sustainability, 10(3), 275-295.

Zhuang, Z. C. (2019), Ethnic Entrepreneurship and Placemaking in Toronoto's Ethnic Retail Neighbourhoods. Journal of Economic and Human Geography, 110(5), 520-537.Zhuang, Z. C. (2021). The Negotiation of Space and Rights: Suburban Planning with Diversity. Urban Planning, 6(2), 113-126.

Authors' Bios

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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

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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

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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

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Ryan Lok is a PhD student 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 migration: migrant settlement and integration, migrant acculturation and well-being, multicultural and intercultural integration, and the built and social environments of smaller Canadian cities.

Hai Luo focuses on social and health issues among older adults of diverse cultural backgrounds and their implications for social theory and social work practice. Her research interests include cross-cultural aging, Indigenous aging, sexuality and older adults, gambling among older adults, elder abuse, and social capital and social support for older adults. She is currently involved in local and international projects investigating how the COVID-19 pandemic affected long-term care facilities and Indigenous older adults, as well as cross-cultural active aging, Indigenous older adults in economic development, mental health and substance abuse in older adults, and transformation of nursing homes. She also engages with gerontological education in higher education and international teaching and research collaboration. She co-founded and facilitates the Gerontological Social Work Group for local social workers and graduate students and the International Network for Indigenous Aging for international scholars and practitioners.

Atiya Mahmood is an associate 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

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Melissa Northwood is an assistant professor with the School of Nursing at McMaster University and a certified gerontological nurse. Her research addresses health- and social-care system integration for older adults with multiple chronic conditions and their caregivers. She has practised in acute care in geriatric rehabilitation and geriatric medicine, complex continuing care, and home and community care.

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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.

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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 is a PhD candidate at the Institute of Feminist and Gender Studies, University of Ottawa. His research interests include activism among Arab and Muslim women in the Middle East and within diasporic communities in Canada. He is a 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. She is the founder and director of the DiverCityLab (www.divercitylab.com), and her research focuses on the increasing urban diversity and how city-builders can instill the values of equity and inclusion into planning policies and practices. She explores how the intersections of individual characteristics affect lived experiences in cities and how

diversity and differences can shape communities and cities, specifically how immigrant and racialized communities have made long-lasting marks in urban and suburban landscapes. She uses mixed-method and arts-informed research (e.g., Photovoice, interviews, focus groups, surveys, documentary, demographic and policy analysis) to engage immigrant community members and city-building professionals and gain a holistic perspective on immigrant integration, place-making, civic engagement, and inclusive policy-making. Her research also explores how global migration affects local governance and inclusive community-building, as well as equity-based approaches to planning and design with diversity.

This is where you can add appendices or other back matter.