

**A population health approach to the health and healthcare of ethnocultural
minority older adults:**

An annotated and indexed bibliography



**Produced by the
Scoping Review Team
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Scoping Review Team

Jean Kozak & Sharon Koehn (lead investigators, Centre for Healthy Aging at Providence); Kelly Acker & Doni Eve (BC Ministry of Healthy Living and Sport); Karen Kobayashi (University of Victoria); Lynn Moran & Dora Replanski (Affiliation of Multicultural Societies and Service Agencies); Anne Kloppenborg (Social Planning; City of Vancouver); Sheila Neysmith (University of Toronto); Akber Mithani (Geriatric Psychiatry, Providence Health Care); Kelly McQuillen (Patients as Partners, BC Ministry of Health); Soma Ganesan (Vancouver Cross-cultural Psychiatry Clinic, Vancouver Coastal Health/UBC); Helen Leung (Carefirst Seniors & Community Services, Toronto)

Research Assistant: Hamish Khamisa

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Contact

Sharon Koehn, Ph.D.
Research Associate
Centre for Healthy Aging at Providence
4865 Heather St.
Vancouver, BC
V5Z 0B3
Canada

Tel: 604-876-7112 x605
Fax: 604-876-7113
skoehn@providencehealth.bc.ca

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1. What are the population health patterns (e.g., chronic illnesses, functional limitations and handicaps etc.) that characterize ethnocultural older adults as compared to older adults in general?

Chappell, N. L. (2003). Correcting cross-cultural stereotypes: aging in Shanghai and Canada. *J. Cross Cult. Gerontol.*, 18(2), 127-147.

This paper challenges common belief that the aging experience is primarily different for seniors in Asia and those in western cultures. The examination reveals that there are many differences in the life situation of seniors living in mainland China and those living in Canada, with Shanghais seniors living in much greater poverty, with much less education and typically not alone when compared to Canadian seniors whether they be of Chinese origin or not. The Shanghais are also in worse health and perceive themselves to be in worse health. However, when examining the predictors of subjective quality of life, life satisfaction, in both cultures it is social support and health that predict life satisfaction. The form that social support takes (the importance of sons is clearly evident in Shanghai, whereas spouses are more important in Canada) and the particular physical health problems that one might suffer from differ across cultures but it is social support and health that appear to be universal in their affects on our subjective quality of life. Similarly when examining caregivers there are many differences evident across the cultures but when examining subjective burden in both cultures it is the deteriorated health of the care receiver that is the major predictor of burden. The data suggest that there are cross-cultural universals, with particularistic forms.

Compared the experience of aging among older adults in Shanghai, China, with that of Chinese and non-Chinese older adults in Canada. Interviews were conducted with 250 adults aged 65 or older (mean age 82) in Shanghai in 1999. The Canadian data were derived from existing studies: a 1995 study of 830 Chinese adults aged 65 or older (mean age 76) in greater Vancouver and greater Victoria, British Columbia; a 1994 study of 1,278 non-Chinese older adults (mean age 74) in greater Victoria; a 1994 province-wide study of 1,614 caregivers of older adults in British Columbia; a 1998 study of 250 caregivers in Victoria; and national data on older adults (mean age 75) and caregivers from Statistics Canada's decennial census. It was found that older adults in Shanghai lived in very different housing situations, had fewer financial resources, were in worse health, and received fewer health services than older adults in Canada. The form of social support (generally from sons in Shanghai and from spouses in Canada) and particular physical health problems also differed across cultures. However, factors important for quality of life (life satisfaction for older adults and burden for caregivers) were strikingly similar in both countries. (AY) (AgeLine Database, copyright 2003 AARP, all rights reserved)

Durst, D. (2005). Aging amongst immigrants in Canada: Policy and planning implications.

In Canada, two interesting demographic trends have been underway: an aging population and a growth based upon immigration. These patterns combine to form a new group that seems to have evaded notice. Immigrants are older than the national average and almost 31% of the immigrants from Europe are over 65 years of age. Of the total senior population, 28.4% are immigrants (up from 16.9% in 1981) and 19.4% of all seniors are from Europe. One in twenty seniors in Canada are Asian. Overall, 7.2% of the senior's population is a visible minority (up from 6% in 1996). These patterns have implications for policy development and service delivery. As immigrants age in Canada, they will have very different expectations for services than non-immigrants and immigrants who aged in their home country. This paper presents the current statistical data and presents recent research under the Metropolis project on senior immigrants and integration. It offers recommendations for policy planners and service providers in health and social welfare services. This research contributes to the "forging of our social future."

Johnson, C. S., & Garcia, A. C. (2003). Dietary and activity profiles of selected immigrant older adults in Canada. *Journal of Nutrition for the Elderly*, 23(1), 23-39.

In Canada, the population of older adults is becoming ethnically diverse. However, our understanding of the health behaviors including diet and physical activity among this group is limited. The purpose of this study is to examine the dietary and physical activity profiles, and the factors that influence these behaviors, among older immigrants. The sample included 54 participants (mean age = 68 +/- 6 years) from Cambodian, Latin-American, Vietnamese and Polish groups. Measures included background questionnaire, nutrition screening tool, 24-hour dietary recall, and physical activity assessment. Results showed that 72.5% were at moderate to high risk for poor nutrition. Identified dietary issues were related to food preparation, nutrition management for diseases, and nutritional needs of the elderly. Although 83.3% reported to be physically active, the level was less than optimal, and barriers to physical activity were identified. The results are further discussed in light of health promotion and nutrition education among immigrant older adults

Lai, D. W. (2004). Impact of culture on depressive symptoms of elderly Chinese immigrants. *Canadian Journal of Psychiatry. Revue Canadienne De Psychiatrie*, 49(12), 820-827.

OBJECTIVES: The impact of culture on mental health has been inadequately researched. This study examines the effect of cultural factors on the depressive symptoms reported by elderly Chinese immigrants in Canada. **METHOD:** Data from 1537 elderly Chinese immigrants who took part in a cross-sectional multisite survey on the health and well-being of older Chinese-Canadians were used. Participants were identified through telephone screening of randomly selected telephone numbers listed with Chinese surnames. A structured questionnaire was used to conduct face-to-face interviews. A Chinese version of the 15-item Geriatric Depression Scale was used to assess depressive symptoms. **RESULTS:** Close to one-quarter of the elderly Chinese immigrants reported having at least a mild level of depressive symptoms. Having more cultural barriers and a higher level of identification with Chinese cultural values resulted in a higher probability of being depressive. **CONCLUSIONS:** The importance of the sociocultural determinants of mental health is demonstrated. The health delivery system should be more sensitive to the unique ethnic and cultural differences of older immigrants.

Lai, D. W. L. (2003). Health and Predictors of Health Among Older Chinese-Canadians in British Columbia: Why Do Older Chinese-Canadians in Victoria Enjoy a Better Health Status Than Their Counterparts in Vancouver? *BC Medical Journal*, 45(8)

In an aging and culturally diverse society, medical professionals need to understand the health status of ethnic minority older adults. Data collected by questioning 765 randomly selected older Chinese-Canadians in Vancouver and Victoria were extracted from a multisite study for further analysis. The results show that the older Chinese-Canadians in Vancouver were less healthy than their counterparts in Victoria. The health discrepancies may be associated with several factors, including more service barriers, lower level of self-rated financial adequacy, and a less positive attitude toward aging.

Lai, D. W. L., Tsang, K. T., Chappell, N., Lai, D. C. Y., & Chau, S. B. Y. (2007). Relationships between Culture and Health Status: A Multi-Site Study of the Older Chinese in Canada. *Canadian Journal on Aging*, 26(3), 171-183.

This study examined the relationships between culture and the health status of older Chinese in Canada. Data were collected through face-to-face interviews with a cross-sectional, randomly selected sample of 2,272 older Chinese between 55 and 101 years of age in seven Canadian cities. Health status was assessed by the number of chronic illnesses, by limitations in ADL and IADL, and by information on the Medical Outcome Study Short Form SF-36. Although cultural variables explained only a small proportion of variance in health status, having a stronger level of identification with traditional Chinese health beliefs was significant in predicting physical health, number of illnesses, and limitations on IADL. Other cultural variables, including religion, country of origin, and length of residence in Canada, were also significant in

predicting some health variables. Interventions to improve health should focus on strategies to enhance cultural compatibility between users and the health delivery system. (English) [ABSTRACT FROM AUTHOR]

Acharya, M. P. (2004). Constructing the meaning of "mental distress": coping strategies of elderly East Indian immigrant women in Alberta UMI Dissertation Services, ProQuest Information and Learning, Ann Arbor, MI.

This thesis explores how non-institutionalized English-speaking elderly (aged 60-74) East Indian immigrant women "define" mental distress. To understand the perceived meaning of mental distress of elderly East Indian immigrant women, this multiple case study employs a symbolic interactionist framework. A purposive, snowball sample of 21 elderly East Indian immigrant women from India living in Edmonton, Alberta were interviewed face to face. Transcripts from semi-structured interviews were analyzed using a thematic analysis. The findings suggest that East Indian immigrant women not only think that mental distress has negative effects on a person's emotional, mental, and physical self but also think that this negative experience can be prevented or minimized. The dominant theme for managing mental distress among the participants was "maximizing control over one's inner self." This management paradigm revolved around the Indian psychology of "staying busy," which includes 5 activities: engagement in family or household affairs (grhasta), religion and religious duties (dharma), acceptance of fate and action (karma), material well-being (artha), and living alone (sannyasin). Moreover, the integration of Indian tradition and spirituality/faith to cope with mental distress and enhance their living in old age has led the participants to describe their traditional culture as a "moral medicine." The thesis concludes with implications and limitations and suggests that this analysis of social construction of mental distress has offered a conceptual paradigm for future ethnogerontological health research that will be beneficial to professional and nonprofessional caregivers. (Author Abstract, used by permission) (AgeLine Database, copyright 2005 AARP, all rights reserved) Akber definitely, Dora Maybe

Lai, D. W. L. (2000). Prevalence of depression among the elderly Chinese in Canada. *Canadian Journal of Public Health*, 91(1), 64-66.

Examined the prevalence of depression among a sample of Chinese older adults in Canada. Telephone interviews were conducted in October 1998 with 96 randomly selected members of the Chinese senior center in Calgary, whose memberships account for more than 77 percent of the estimated total of the older Chinese population in the city. The respondents were aged 65-88 (mean age 71.7) and completed a Chinese version of the 15-item Geriatric Depression Scale. It was found that 9.4 percent of the respondents had mild depression, while 11.5 percent experienced moderate to severe depression. Women reported higher levels of depression than men: 28.8 percent of the female respondents reported mild to severe depression, while the prevalence rate for males was only 10 percent. The prevalence of depressive symptoms reported by the older Chinese is twice that of the estimated prevalence among the general older adult population in Canada. (MM) (AgeLine Database, copyright 2000 AARP, all rights reserved)

Lai, D. W. L., & Surood, S. (2008). Predictors of depression in aging South Asian Canadians. *Journal of Cross-Cultural Gerontology*, 23(1), 57-75.

Examined the prevalence and factors of depression among aging South Asians in Calgary, Canada, and whether higher levels of South Asian cultural values predicted mild levels of depression. A total of 210 South Asians aged 55-93 (mean age 65.8), all of whom were born outside of Canada, completed an adapted 15-item Geriatric Depression Scale and a 15-item Likert-scale questionnaire measuring cultural values of South Asian older adults. The cultural measure included questions concerning their children marrying a non-South Asian, the importance of the birth of a son, eating habits, and religiosity. A total of 21.4% of participants reported at least a mild level of depression. A stronger agreement with South Asian cultural values was significantly related to a higher probability of depression. Scoring one more unit higher in South Asian cultural values would increase the likelihood of depression by 2.9 times. Self-perceived health and physical health were the most significant factors after controlling for sociodemographic and culture-related factors. (TS) (AgeLine Database, copyright 2008 AARP, all rights reserved)

Marshall, V. W. (.). (1987). *Aging in Canada: social perspectives* Fitzhenry and Whiteside, Markham, Ontario, Canada.

Presents basic facts about age and aging and reviews major theoretical approaches that characterize social gerontological research in Canada. Offers research designs to help stimulate new research in the social aspects of aging. Lists principle sources of data that could be used in studying aging, such as survey data, material from archives, ethnographies, participant observation, vital statistics, and content analysis. Critically examines current social research, theory, methodology, and policy in the field of aging. Discusses aging among minority and ethnic groups, aging workers in the labor force, retirement and associated activities, family structure and social relationships, health and well-being in relation to age, health care, and the political, economic, and social implications of population aging in Canada. Includes chapter references and statistical tables. (JM) (AgeLine Database, copyright 1990 AARP, all rights reserved)

Penning, M. J. (1983). Multiple jeopardy: age, sex, and ethnic variations. *Canadian Ethnic Studies*, 15(3), 81-105.

Assessed the potential utility of a multiple-jeopardy perspective on quality of life issues, focusing on age, sex, and ethnic inequalities. Data were obtained on 2,253 individuals aged 30 and over contacted in 1977 in the Social Change in Canada survey. Quality of life was measured objectively in terms of income, and subjectively in terms of perceived economic security, self-assessed health status, and perceived overall well-being. The four age categories analyzed were young middle (30-49), old middle (50-64), young elderly (65-74), and old elderly (75 and over). Ethnicity was categorized as Canadian, American, British, North European, South European, East European or Russian, and other. Other independent variables employed were region of residence, employment status, education, religion, chronic illness, and marital status. The analyses offer preliminary support for the recognition of age, sex, and ethnic differentials, particularly with regard to the objective variable (income). (LS) (AgeLine Database, copyright 1985 AARP, all rights reserved)

Acharya, M. P., & Northcott, H. C. (Dec 2007). Mental Distress and the Coping Strategies of Elderly Indian Immigrant Women. *Transcultural Psychiatry*, 44(4), 614.

doi:<<http://dx.doi.org/10.1177/13634615007083901>>

This article explores how elderly English-speaking Indian immigrant women living in Edmonton, Alberta, Canada perceive and manage mental distress. With elders' consent, in-depth interviews were recorded, transcribed and transcripts were thematically analyzed. The findings suggest that these women believed that to lower the risk of mental distress it is critical for individuals to 'maximize control over inner self' by 'being busy.' The elder's busy behavior is framed within the Indian cultural and spiritual/faith matrix in dialogue with acculturation experiences in Canada. 'Staying busy' allows these elders to use culture as a 'moral medicine' to facilitate coping and adaptation.

Chan, K. B. (1983). Coping with aging and managing self-identity: the social world of the elderly Chinese women. *Canadian Ethnic Studies*, 15(3), 36-50.

Explores the social world of elderly Chinese-Canadian women and their patterns of coping with the problems of old age. Twenty-six elderly Chinese widows aged 56 to 88 living in rooming houses in Montreal, Canada, responded to a structured questionnaire; 10 of the women also participated in unstructured interviews. Interviews were also conducted with three community workers and with two Chinese physicians. Data were obtained on the women's immigration patterns and work histories, activities and social participation, service utilization and service needs, and family relationships. Analysis of the data revealed how the women managed to cope with their problems and how they worked to keep their sense of self-worth and personal efficacy intact in the face of difficulties. Challenges the myths that these women suffer more than older

whites because of the double jeopardy of age and ethnicity and that they are buffered somehow by the traditional Chinese values of filial piety. (LS) (AgeLine Database, copyright 1985 EBSCO Publishing, Inc., all rights reserved)

Chow, H. P. H. (2010). Growing old in Canada: physical and psychological well-being among elderly Chinese immigrants. *Ethnicity & Health*, , 1-12.

Objective. Immigrants are a vital component of the current and future ethnic aging population in Canada. This study was undertaken to explore the health status of elderly Chinese immigrants in a western Canadian city and to identify the major determinants of their physical and psychological well-being.

Method. Using a 50% random sample of elderly Chinese residing in three residential complexes occupied exclusively by individuals of ethnic Chinese origin located in downtown Calgary, a total of 147 Chinese seniors were interviewed in their homes by trained, bilingual interviewers using a structured questionnaire that covered a wide range of topics including health status, social network, living arrangements, use of health-related services, and socio-demographic information.

Data analysis. Descriptive and inferential analyses were conducted using the Statistical Package for the Social Sciences. A principal component factor analysis using varimax rotation was performed to explore the underlying factorial structure of the seven items measuring well-being. The internal consistency of all scales used was assessed by Cronbach's alpha reliability test. Two multiple ordinary least-squares (OLS) regression models were constructed to identify the major determinants of respondents' physical and psychological well-being.

Results. The findings revealed that a majority of the participants described their physical health as good or very good. Results of multiple OLS regression analysis demonstrated that education, country of origin, use of medications, physical mobility, and perceived financial needs were significantly associated with physical well-being, whereas sex, marital status, length of residence, education, and physical mobility were significantly related to psychological well-being.

Conclusion. Healthcare professionals, service providers, and policy-makers need to understand the significant impact of the various socio-demographic and background variables that contribute to the well-being of community-dwelling Chinese elderly immigrants. The provision of culturally sensitive and linguistically appropriate healthcare, social, and medical services is needed for the growing older Chinese population. Future studies should compare the health status of foreign-born Chinese seniors with those who were native-born, as well those co-residing with adult children.

LK <<http://www.informaworld.com/10.1080/13557850903418810>>

Chundamala, J., Matsuo, T., & Peng, I. (2006). Older Immigrant Women's Health: From the Triple Jeopardy Perspective to Cultural Competency

This literature review builds on an earlier report by Peng and Lettner (2004), which identified demographic aging among immigrant populations and its implications for health policy in Ontario. In the previous report the authors examined the changes in the demographic composition of older immigrant population in Ontario and Canada over the last several decades and its implications for health policy, highlighted five preliminary indicators related to immigrant women's health status - primary care, infectious disease, chronic disease, mental illness, and participation in clinical medical research - and pointed out research, policy, and program gaps.³ In particular, the report laid emphasis on the increasing diversity in the ethnic and cultural make up of Ontario's population, and a need to pay a special attention to the growing ethnic and cultural heterogeneity amongst the older population now and in the future. As the report points out, given the pattern of migration pattern in Canada and Ontario over the last few decades, "[w]e can anticipate greater diversity of health care issues and concerns among elderly immigrant population..." and that "[a]s many of the recent elderly immigrants come from countries other than Europe, we may [also] have to anticipate issues and concerns

that relate to cultural differences as well as and also linguistic barriers to health care.” (Peng and Lettner, 2004: 11).

Forbes, D. A. (2001). Enhancing mastery and sense of coherence: important determinants of health in older adults. *Geriatric Nursing*, 22(1), 29-32.

Assessed the determinants of health for community-dwelling older adults in Canada. Data from the Health Canada Supplement to the 1994/1995 National Population Health Survey (NPHS) were analyzed for 2,006 young-old individuals aged 65-79 and 406 old-old individuals aged 80 and older. The old-old group had significantly greater percentages of individuals who were women, immigrants, living alone, in the lowest or lower-middle income brackets, with lower education levels, and widowed, divorced, or separated. The NPHS incorporated the Sense of Coherence (SOC) Scale, Mastery Index, Self-Esteem Rosenberg Scale, and Health Utility Index Mark 3. In the young-old, SOC was positively related to marriage, income adequacy, education level, social support variables (perceived social support, social involvement, and frequency of contact), and other psychologic indicators. However, none of these variables were significantly related to SOC in the old-old. The young-old reported a greater mean self-esteem score than the old-old. Mastery scores for both age groups were similar. Hierarchical regression analyses revealed that mastery and SOC were strongly related to health status and perceived health. (AR) (AgeLine Database, copyright 2001 EBSCO Publishing, Inc., all rights reserved)

Griffiths, S. Y. (2001). Long-term adjustment after extremely challenging events in a sample of Vietnamese-Canadian seniors UMI Dissertation Services, ProQuest Information and Learning, Ann Arbor, MI.

The current study describes long-term outcomes in a sample of 64 Vietnamese-Canadian seniors related to the Vietnamese civil war, refugee migration, and life in Canada. Each participant completed questionnaires assessing: demographic features, civil war experiences, refugee experiences, protective factors (sense of preparation for the conflict, social support, and immigration experiences), and current distress (depression, anxiety, negative changes in outlook) and well being (life satisfaction, personal and familial happiness, positive changes in outlook) outcomes. Results revealed two general patterns of adjustment. The first pattern was characterized by a generally high level of current life satisfaction and current personal and familial happiness despite high levels of all types of civil war experiences. Additionally, being married, being older, and having more children in the family were associated with higher current happiness. Lower current happiness, on the other hand, was related to being single and reporting a smaller family size. The second general pattern of adjustment reflected witnessing and experiencing fewer civil war events, higher emotional distress during the war, more refugee experiences and higher current depression. Having fewer children in the family was also associated with higher current depression. Lower current depression was related to witnessing more war experiences and being older. These patterns of adjustment reflect the general well-being of this sample of Vietnamese-Canadians, while also accounting for the distress outcomes related to the extremely challenging process of refugee migration. The relationships between different demographic and protective factors and well being outcomes in the sample are also discussed. (Author Abstract, used by permission) (AgeLine Database, copyright 2004 EBSCO Publishing, Inc., all rights reserved)

Khan, N. A., Palepu, A., Norena, M., Ayas, N., Wong, H., Chittock, D., et al. (2008). Differences in hospital mortality among critically ill patients of Asian, Native Indian, and European descent. *Chest*, 134(6), 1217-1222.

BACKGROUND: It is unclear whether race/ethnicity influences survival for acute critical illnesses. We compared hospital mortality among patients of Asian (originating from Asia or Southeast Asia), Native Indian, and European descent admitted to the ICU. METHODS: Prospective cohort study of patients admitted to three ICUs (January 1999 to January 2006) in British Columbia, Canada. Multivariable analysis evaluated hospital mortality for each ethnic group, adjusting for age, sex, APACHE (acute physiology and chronic health evaluation) II score, hospital, median income, unemployment, and education. To account for differences in case mix, multivariable analysis was also restricted to those patients admitted for the five most

common ICU admission diagnoses (sepsis, pneumonia, brain injury, COPD, and ARDS) and adjusted for these diagnoses. RESULTS: Of 7,331 patients, 21% were Asian, 4% were Native Indian, and 75% were of European descent. Crude mortality was 33% for Asian, 30% for Native Indians, and 28% for patients of European descent. After adjusting for potential confounders, Native Indian descent was not associated with an increase in mortality compared to European descent. Asian descent was associated with a significantly higher mortality (odds ratio [OR], 1.22; 95% confidence interval [CI], 1.06 to 1.41; $p = 0.005$). After adjusting for case mix, this difference was no longer seen. For patients admitted for COPD exacerbation, Asian descent was associated with a substantial increase in mortality (OR, 4.5; 95% CI, 1.56 to 12.9; $p = 0.005$). There were no significant differences in mortality by race/ethnicity for patients who had any of the other common admitting diagnoses. CONCLUSION: Patients of Asian and Native Indian descent with acute critical illness did not have an increased mortality after adjusting for differences in case mix.

Lam, L. Self-assessment of health status of aged Chinese-Canadians Brill Academic Publishers. Examines factors relating to perceived health status of aged Chinese-Canadians in Toronto, Ontario. Demographic characteristics of 140 respondents in the study; Self-assessment of health status; Effect of changes in sociocultural milieu on health of aged Chinese-Canadians.

Menec, V. H., Shooshtari, S., & Lambert, P. (2007). Ethnic differences in self-rated health among older adults: a cross-sectional and longitudinal analysis. *Journal of Aging and Health*, 19(1), 62. The objectives of this study were to examine whether self-rated health differs among older adults of different ethnic backgrounds and to explore what factors may account for potential differences. The study was based on the 1983 and 1996 waves of the Aging in Manitoba study. A self-report measure of ethnic background was used to categorize participants into four groups: British/Canadian, Northern/Central European, Eastern European, and Other. In both 1983 and 1996, older Eastern European adults had significantly reduced odds of rating their health as good or excellent relative to British/Canadian adults. Controlling for demographic variables, socioeconomic status, language spoken, and health status attenuated but did not eliminate the difference. Global, subjective ratings of health are frequently used to measure health. The ethnic differences found here suggest, however, that ratings may be influenced by cultural factors, which may warrant some caution in making comparisons across ethnic groups.

Newbold, K. B. (2009). Health care use and the Canadian immigrant population. *International Journal of Health Services*, 39(3), 545-565. Set within the "determinants of health" framework and drawing on StatisticsCanada's longitudinal National Population Health Survey, this article explores health care utilization by Canada's immigrant population. Given the observed "healthy immigrant effect," whereby the health status of immigrants at the time of arrival is high but subsequently declines and converges toward that of the native-born population, does the incidence of use of health care facilities reflect greater need for care? Similarly, does the use of health care facilities by the native- and the foreign-born differ, and if so, are these differences explained primarily by socioeconomic, sociodemographic, or lifestyle factors, which may point to problems in the Canadian health care system? This study identifies trends in the incidence of physician and hospital use, the factors that contribute to health care use, and differences in health care use between the native- and foreign-born.

Veenstra, G. (2009). Racialized identity and health in Canada: Results from a nationally representative survey. *Social Science & Medicine*, 69(4), 538-542. This article uses survey data to investigate health effects of racialization in Canada. The operative sample was comprised of 91,123 Canadians aged 25 and older who completed the 2003 Canadian Community Health Survey. A "racial and cultural background" survey question contributed a variable that differentiated respondents who identified with Aboriginal, Black, Chinese, Filipino, Latin American, South Asian, White, or

jointly Aboriginal and White racial/cultural backgrounds. Indicators of diabetes, hypertension and self-rated health were used to assess health. The healthy immigrant effect suppressed some disparity in risk for diabetes by racial/cultural identification. In logistic regression models also containing gender, age, and immigrant status, no racial/cultural identifications corresponded with significantly better health outcomes than those reported by survey respondents identifying as White. Subsequent models indicated that residential locale did little to explain the associations between racial/cultural background and health and that socioeconomic status was only implicated in relatively poor health outcomes for respondents identifying as Aboriginal or Aboriginal/White. Sizable and statistically significant relative risks for poor health for respondents identifying as Aboriginal, Aboriginal/White, Black, Chinese, or South Asian remained unexplained by the models, suggesting that other explanations for health disparities by racialized identity in Canada - perhaps pertaining to experiences with institutional racism and/or the wear and tear of experiences of racism and discrimination in everyday life - also deserve empirical investigation in this context.

Wang, B. (2002). Geographical study on quality of life of Chinese seniors in the Toronto CM UMI Dissertation Services, ProQuest Information and Learning, Ann Arbor, MI.

There are two objectives of this project: to undertake a small-scale empirical study and compare the QOL of Chinese seniors in four Chinese Settlement Areas (CSA) in the Toronto CMA, and to critically evaluate four techniques that can be used to measure QOL, including the method developed by Brown et al. (1998), Simple Additive Weighting method (SAW), Decision Matrix Method (DMM), and DECisions on a FINITE set of alternatives (DEFINITE). In this project, a non-random sample of 80 Chinese individuals over 65 were asked to rate their importance and satisfaction level for 14 selected indicators related to QOL. The QOL scores of individuals were calculated and compared using the Brown et al. (1998) method, SAW method and DMM. The four CSAs were classified using their average QOL scores derived from the Brown et al. (1998) method and DEFINITE. This pilot project is a study of the QOL of Chinese seniors living in Toronto. (Abstract shortened by UMI.) (Author Abstract, used by permission) (AgeLine Database, copyright 2004 EBSCO Publishing, Inc., all rights reserved)

Nayar, K. E., & Sandhu, J. S. (2006). Intergenerational Communication in Immigrant Punjabi Families: Implications for Helping Professionals. *International Journal for the Advancement of Counselling*, 28(2), 139-152.

This paper is an extension of the primary author's post-doctoral research on the Sikh diaspora in Vancouver, Canada. Drawing upon the orality, literacy and 'analytics' (critical inquiry) paradigm, the paper delineates the distinctive communication patterns that characterize each of three generations in the Punjabi community in that location. A sample intergenerational dialogue in the counselling context is provided to demonstrate the nature of fluidity in communication, and the implications for helping professionals are discussed.

Elders, who for the most part are illiterate, maintain an oral or traditional mode of communication. Their thoughts express a collective orientation; their communication style involves telling stories, narrating traditions; and their knowledge is based on personal life experiences. On the other hand, immigrant parents and their children are, for the most part, able to read and write. The literacy mode of communication is a common characteristic of immigrant parents; it reflects some movement away from the collective and a shift toward differentiating the self from the collective. Knowledge is limited to personal life experiences and to concrete facts that have been learned. Lastly, the communication style maintained by the children of immigrant parents reflects an analytics mode, wherein self-orientation and critical inquiry are manifest. In addition to accumulating knowledge through personal experiences and learned facts, the children of immigrant parents also demonstrate a move toward a mode of communication that involves an explorative and inquisitive style, and in which abstract concepts are utilized to go beyond personal life experiences or the physical world.

Su, T. P. (2005). Prevalence and correlates of depressive symptoms in older immigrants (from Taiwan and mainland China) in Canada. *J.Chin.Med.Assoc.*, 68(3), 108-109.

Depression is common in the elderly, and is also the major reason for suicidal behavior in this age group.¹ Since worldwide migration has increased over the last few decades, the close relationship between immigrants and mental illness has attracted much attention. Health programs and strategies have been established to ensure that individuals in minority groups have access to appropriate health care services, and research into depression in immigrants has become very important.

Lai, D. W. L. (2005). Prevalence and correlates of depressive symptoms in older Taiwanese immigrants in Canada. *Journal of the Chinese Medical Association*, 68(3), 118-125.

Background: There is a lack of research regarding depression in older Taiwanese immigrants in North American countries. This study in Canada therefore examined the prevalence of depressive symptoms among older immigrants from Taiwan, and psychosocial factors as predictors of depressive symptoms reported by older Taiwanese immigrants.

Methods: Ninety-eight migrants (aged 55 years) from Taiwan to Canada, who were part of a multi-site study of health and well-being in a total of 2,272 older ethnic Chinese individuals in community dwellings, completed a face-to-face interview and answered questions in an orally administered questionnaire. Depressive symptoms were measured by a Chinese version of the Geriatric Depression Scale.

Results: Of the 98 migrants from Taiwan, 21.5% reported at least a mild level of depression. Predictive factors for depressive symptoms were a negative attitude towards aging, poor general physical health, single marital status, barriers in terms of gaining access to health care services, poor financial status, lower level of identification with Chinese health beliefs, and low income.

Conclusion: The prevalence of depressive symptoms in older Taiwanese immigrants in Canada was higher than that reported by older adults in the general Canadian population. Thus, implications for the delivery of health care services, and possible strategies to enhance the mental well-being of older Taiwanese immigrants, are discussed. [*J Chin Med Assoc* 2005;68(3):118-125]

2. What are the health risks and associated health outcomes currently faced by ethnocultural older adults as compared to older adults in general? Are there any related identified risks to the health system?

Assanand, S., Koehn, S., & Sethi, B. (2007). Workshop 2: Immigrant Status. Speaking to the Interface: A Symposium on Access to Care for Ethnic Minority Seniors, Surrey, B.C.

Busse, B. A. (2007). Access to Health Care for Ethnic Minority Seniors. Speaking to the Interface: A Symposium on Access to Care for Ethnic Minority Seniors, Surrey, B.C.

Chappell, N. L. (2007). Ethnicity and Quality of Life. In Heidrun, Mollenkopf & Walker (Eds.), *Quality of Life in Old Age - International and Multi-Disciplinary Perspectives* (). The Netherlands: Kluwer Academic Publishers.

Research on ethnicity and quality of life in old age includes a great diversity of ethnic groups located in a variety of countries. When interest focuses on a particular ethnic group (such as overseas Chinese, Punjabis, or Germans), there tends to be relatively little research on each group. Longitudinal research to examine causal relationships, specifically of the impact of ethnicity on quality of life, is even more scant. This paper focuses on subjective well-being indicators of quality of life. First it examines studies on ethnicity in old age that group ethnic groups as a special category, that is, not individual ethnic groups. There is much evidence that sub-cultural groups within developed nations are disadvantaged when compared with Whites in terms of objective societal indicators such as income and health. However, this objective disadvantage does not necessarily translate to the subjective level. Explanations for this discrepancy tend to refer to cultural notions of family embeddedness, social support and caring. Questions are raised concerning the extent to which these differences are driven by economic disadvantage or are culturally preferred. The studies of individual ethnic groups are examined in terms of whether involvement in ethnic sub-culture is advantageous or disadvantageous. Existing research suggests that it could be either, depending on the circumstances. The particular ethnic group of Chinese Canadian seniors are discussed in some detail. The paper ends with a comment on some of the methodological difficulties of insuring valid data when studying ethnic groups within developed societies.

Chappell, N. L., Lai, D., Lin, G., Chi, I., & Gui, S. (2000). International Differences in Life Satisfaction among Urban-Living Elders: Chinese and Canadian Comparisons. *Hallym International Journal of Aging*, 2(2), 105-118.

Compared the level and the predictors of life satisfaction among Chinese older adults living in Vancouver, Canada, and in 2 areas of China: Hong Kong and Shanghai. The sample was composed of persons aged 65 or older: 284 in Vancouver, 366 in Shanghai, and 231 in Hong Kong. Data were collected in face-to-face interviews lasting an average of 1 hour and 15 minutes in which the respondents were asked about chronic health conditions, level of functional ability, health symptoms, social support variables, and sources of income. Multiple regression analysis found that those living in Hong Kong showed the least satisfaction both for overall life satisfaction and for the majority of the domains. In every aspect of life satisfaction, those living in Vancouver were more satisfied than those living elsewhere. Older adults in Shanghai fell in the middle. In all of the cities, health, social support, and economic variables were predictive of life satisfaction. Overwhelmingly, these data point to the importance of location for quality of life and suggest that more research that focuses on comparisons in location is needed. (AS) (AgeLine Database, copyright 2001 AARP, all rights reserved)

Clarke, E. (2001). *Aging and caregiving in Canada*. Lewiston, NY: Edwin Mellen Press. Investigated cross-cultural patterns of social support between modern families in Canada and their older relatives in nursing homes, using a convergence of social exchange theory and symbolic interaction as a type of explanatory model. The sample, 218 long term care (LTC) residents, comprised 125 Anglo-Saxon Protestants (mean age 84) and 93 Italian Catholics (mean age 82). Data were collected in in-person interviews using a structured questionnaire on the participants' patterns of contact, feelings, and expectations between them and their younger relatives. The findings showed that most of the Italian Catholics reported being "very satisfied" with their family relationships, whereas most of the Anglo-Saxon Protestants said that they were "only satisfied." Both groups characterized their interactions with families as exchange relationships; however, Italian Catholics attached greater importance to children's returned help for past care. Anglo-Saxon Protestants, on the other hand, based their expectations for help from children on love rather than dutiful obligation. Individual chapters include discussion of the main assumptions of social exchange and symbolic interaction theories, the changing views about Canadian nursing homes from the past to the present, the concept of delayed reciprocity and its key role in sustaining interactions between LTC residents and their social network, conflicting role expectations among formal caregivers, the triadic exchange relationship among residents and formal and informal caregivers, communication problems that are common to nursing home settings, religious beliefs in relation to health, and the future of the Canadian health care industry, with special attention to implications for public policy. References and the study's interview questionnaire are included. (AS) (AgeLine Database, copyright 2002 AARP, all rights reserved)

Gee, E. M., Kobayashi, K. M., & Prus, S. G. (2004). Examining the Healthy Immigrant Effect in Mid- to Later Life: Findings from the Canadian Community Health Survey. *Canadian Journal on Aging Supplement*, 23, S61-S69.

Recent studies have established that a healthy immigrant effect operates in Canada-immigrants are generally healthier than Canadian-born persons-but that this effect tends to diminish over time, as the health of immigrants converges to the Canadian norm. Although this effect has been examined by place of birth, language, marital status, socio-economic status, charter-language ability, and category of immigrant status in Canada, less is known about the healthy immigrant effect at different stages of the life course, particularly in mid- to later adulthood, stages at which there is an increased likelihood of decline in physical and mental health status. This study examines how age at immigration affects the health of mid- to later-life immigrants, compared to Canadian-born persons, using data from the 2000-2001 Canadian Community Health Survey. These data indicate that the healthy immigrant effect applies to later mid-life immigrants; that is, new immigrants-those who immigrated less than 10 years ago-aged 45 to 64 have better health than their longer-term counterparts-those who immigrated 10 or more years ago-whose health status is similar to that of Canadian-born persons. Interestingly, a different picture emerges in old age (65 years and over), where recent immigrants have poorer overall health compared to Canadian-born persons. When a number of socio-demographic, socio-economic, and health behaviour factors are controlled, however, this disadvantage largely disappears. The findings are discussed in terms of their implications for Canadian health care policy and program planning for immigrants in the latter stages of the life course.

Lai, D. W. L. (2004). Health Status of Older Chinese in Canada. *Canadian Journal of Public Health*, 95(3), 193.

Lai seeks to examine the health status of the aging Chinese adults in Canada and compare it with the health status of the general aging population in Canada. Results of the study showed that older Chinese-Canadians reported better physical health than older adults in the Canadian population, while older Chinese in all age and gender groups scored lower on the mental component summary of the study.

Examined the health status of the older Chinese population in Canada and compared the health status of this group with that of the general aging population in Canada. Data were derived from the multisite Health and Well-Being of Older Chinese in Canada study (for 2,272 participants aged 55 or older) and the Canadian Multicentre Osteoporosis Study, which published Medical Outcomes Study 36-Item Short Form (SF-36) scores from the same age cohorts in the general Canadian population. Independent samples t-tests were used to compare the statistical significance of the Chinese and general population groups. Overall,

older Chinese Canadians reported better physical health than all older adults in the Canadian population. However, the older Chinese participants in all age and gender groups scored lower in the mental component summary, indicating poorer overall mental health in this population. Chinese women reported significantly poorer health than Chinese men in all of the 8 health domains. It is concluded that efforts to address the health needs of older Chinese Canadian women, the most vulnerable subgroup in this study, are essential, and interventions are also needed to address poor mental health status in this ethnic minority group overall. (KM) (AgeLine Database, copyright 2006 AARP, all rights reserved)

Pereira, I., Lazarowich, N. M., & Wister, A. (1996). Ethnic Content in Long-Term-Care Facilities for Portuguese and Italian Elderly. *CANADIAN ETHNIC STUDIES*, 28(2), 82-97.

Literature on the elderly often has not recognized socio-cultural differences between elderly ethnic groups or identified their housing needs and preferences. This study focuses on Toronto seniors of Portuguese and Italian descent living in two types of seniors' homes: ethnic homogeneous environments and ethnic heterogeneous environments. Fifty persons in each environment were interviewed to determine differences in well-being, satisfaction, involvement and perceived health. Theoretical models drawn from the environment and aging literature are applied to determine the effects of ethnic homogeneity on the quality of life. The results show that a homogenous long term care environment increases an ethnic elderly person's involvement in social activities. Type of residential environment does not appear to affect perceived health and well-being, and is the opposite direction for residential satisfaction. The findings support the contention that ethnic elderly should have the choice to live in culturally sensitive residential settings that are conducive to previous lifestyles. Several policy recommendations are presented in light of the findings.

Public Health Agency of Canada, Cornwell, L., Hendrickson, T., Lee, M., Lettner, M., Loli-Dano, L., et al. (2007). *Health Status and Health Needs of Older Immigrant Women: Individual, Community, Societal and Policy Links*. Ottawa: Public Health Agency of Canada.

EXECUTIVE SUMMARY

The study highlights these eight key findings about the health status, health trends, and health and social service-seeking behaviours of older immigrant women in Toronto, Ontario:

- The reality of gender, race/ethnicity, and age: triple jeopardy influences Ontario's health policy, service delivery, and clinical practice: The triple jeopardy of gender, race/ethnicity, and health, situated in the context of the reality of a determinants of health perspective, currently leads to a higher probability of health inequities and disparities for older immigrant women in Toronto because it influences health policy, service delivery, and clinical practice. In particular, older immigrant African women identify a striking lack of health, social, and community infrastructure, resources, providers, and services generally in their communities. Policy, service delivery, and clinical practice need to address the barriers raised by triple jeopardy and other determinants at an organizational or institutional level.
- Understanding what "health" means for older immigrant women is a compassionate, effective, and efficient approach to health policy, service delivery, and clinical practice: Continued inadequate understanding and resourcing of the impact of triple jeopardy on the health of older immigrant women in Toronto will lead to higher costs of care for these women as they continue to age and Toronto's ethnocultural and ethnoracial demographics continue to diversify. Socioeconomic stability and security - financial security, strong social supports, safe places for women to discuss their experiences and concerns, opportunities for women to work together to bring profile to their issues and solutions - clearly emerges as a key determinant of health for older immigrant women. In addition, creating space and a place for older immigrant women to talk with health providers about their experiences - in clinical settings and beyond - introduces the idea of client and provider as both learners and teachers with a shared goal of improving health service experiences.
- There is a critical lack of multidisciplinary research that directly addresses the interplay between the health needs of older immigrant women, particularly women of colour, and gaps in existing services designed to meet those needs, and that is situated in the real context of their lived experiences: Although older immigrant women experience many of the same health concerns as men, including mental, occupational and environmental health conditions, they experience them differently because of biological and social

considerations. Women are disproportionately vulnerable to gender-based violence, harmful practices, and inappropriate medical procedures, particularly those that are psychiatric.

• “Wisdom and advice” - six health-related areas for change to improve the health of older immigrant women: In the words of older immigrant women, these are the key, consistent, health-related areas for change that would, in turn, mean real change in their lives. It is clear that these areas are “health-related,” that is, that they are influenced by determinants of health that function outside the traditional definitions of health, health care, health policy, and clinical practices:

- Mental health
- Caregiving
- Immigration and resettlement
- Female-specific health concerns (e.g., breast and gynaecological cancers)
- Health care access and health promotion practices
- Illness management

• “Wisdom and advice” - six themes that inform the changes needed to improve the health of older immigrant women: These six themes consistently run through the data and inform directions for change in the six specific health related areas noted above:

1. Access to health services Access to health services, including the current three-month wait period for OHIP coverage in Ontario when women have no publicly funded health insurance (Ontario, British Columbia, New Brunswick and Quebec are the only provinces with a wait requirement. Quebec waives the wait period on request with proof of need.); and where, for older immigrant African women, “services” are defined broadly beyond “health” to include socio-economic infrastructure in underserved, under-resourced communities
2. Access to information Access to information, defined broadly as beyond “health” and beyond traditional “health information” to knowledge that supports determinants of health, citizenship, and human rights in a civil society
3. Role of language The critical role of language and its relationship to access to services and information, defined broadly as beyond interpretation and translation to the cultural competency of health providers
4. Role of social supports The critical role of “the social” - social support and connections - and its positive relationship to health
5. Relationships with family doctors The importance of relationships with family doctors as fundamental pathways to primary care
6. Access to publicly funded services The significance of access to services that are not publicly funded or have been delisted, e.g., alternative therapies, chiropractic, chiropody, dental, ophthalmologic, physiotherapy and certain drugs; and access to services for people with chronic illness who are not yet eligible for senior’s health coverage or income security (Ontario Works, Ontario Disability Support Program Old Age Pension, Guaranteed Income Supplement).

• Ontario’s health care delivery system - institutions, providers, policymakers, educators/trainers, funders - lacks a broad and inclusive understanding of cultural competency in health service delivery that affects the health outcomes of older immigrant women and, more broadly, individuals and communities at the margins: Community-based inclusion research data that informs an understanding and application of cultural competency in the Ontario context currently exists, along with the potential to expand that data. Developing stronger, interactive partnerships - partnerships that carry decision-making power - among health administrators, providers, policymakers, educators/trainers, and women would move this discussion forward to changes in clinical protocols, teaching models, human resource policies, and administrative policies that position and action health care service as connected to the diversity of Ontario’s cultural norms.

• While Community Health Centres (CHCs) provide much of the primary care to older immigrant women in Toronto and an active understanding of care based on community need, they are under resourced to provide the interdisciplinary, health promotion, community capacity-building/treatment, case coordination/management that they are mandated and actually deliver: Ontario’s CHCs are structured to play a holistic role in a broad understanding of “health” in their local communities, engaging at the individual, community, an system levels. They are also funded to provide health services to people who are not insured, have no or uncertain citizenship status in Canada, and who are otherwise vulnerable and disenfranchised. Their focus on interdisciplinary teams (e.g., physicians, nurses, nurse-practitioners, social workers, health promoters, dietitians, chiropodists, mental health counsellors, physiotherapists, community outreach workers), builds community capacity by creating connections of support “where people are at”,

action on civic engagement, and “upstream” work through population health approaches to health promotion and disease prevention.

- Health service capacity planning - specifically, current regionalization of health delivery in Ontario - needs to be better informed by basic data on the variations and differentiations in the health of older immigrant women: With the current regionalization of health service delivery in Ontario through the Local Health Integration Networks (LHINs) now underway, the data from this study points to the need and advisability of regional/local exploration and assessment of the health status, health trends, and health and social service seeking behaviours of older immigrant women in local planning areas. The data indicate strong variations and differentiations in service needs that are contingent on local geographic areas and local distributions of ethnocultural and ethnoracial communities. Specifically, the data indicate the urgent need to plan for the health status and health and social service needs of older immigrant women within Toronto’s diverse seniors’ communities. The data are a “first look” at these variations through the lens of CHCs, which provide an opportunity to hear older immigrant women speak about “service” needs that go beyond the definition of traditional “health services” and provide critical insight and context into the their lived experience and the reality of their lives. Developing stronger, interactive, inclusion-based partnerships among local health planners, providers, and women would benefit local capacity planning at both the regional and community levels and ensure that regionalization recognizes, respects, and acts on this lived experience; augments it with quantitative analysis of current and emerging service capacity needs; and develops a framework for health for older immigrant women grounded in the changing complexity of “need,” “equity” and “equitable outcomes” and therefore responsive to the care of individuals and communities at the margins.

Although this study does not look specifically and in depth at the impact of racism and discrimination, sexism, and the influence of class/socio-economic status as determinants of health, these themes crossed both the Literature Review and the research data from the focus groups and key informant interviews as influencing women’s mental health in multiple ways: through direct experience of racist or discriminatory treatment by others, either within or outside the health care system, with the expected negative impacts on self-image, self-esteem, sense of belonging, and inclusion; and through more indirect but still significant experience of unemployment, underemployment, lack of recognition of educational accreditation or work experience that creates marginalization/exclusion, financial instability, low income, and/or poverty. These determinants, bound together as another configuration of “triple jeopardy,” therefore act as significant stressors in the lives of older immigrant women.

Simmons, N. (2007). *Barriers, bridges and beyond: Understanding perspectives in linguistically and culturally diverse clinical interactions*. (Ph.D., The University of British Columbia (Canada)). , 270.

This study attempts to understand how monolingual English-speaking Speech-Language Pathologists (SLPs) and their Linguistically and Culturally Diverse (LCD) Indo-Canadian adult aphasic clients manage clinical interactions when they do not share the same language and/or culture. The specific objectives were to describe and explain participants' perspectives on the barriers they encountered, and the strategies they employed to overcome the barriers, and to develop a substantive theory that elucidates how SLPs manage such LCD clinical interactions. A symbolic interactionist theoretical perspective and grounded theory method were used to explore the clinical interaction experiences of eleven monolingual English-speaking SLPs, five adult Indo-Canadian aphasic clients, six family members, and five interpreters. Data were collected through interviews, observation, and field notes. Concurrent data collection and analysis was undertaken throughout the study. Constant comparative analysis, which included open, selective, and theoretical coding, was used to construct the substantive theory. The core category that emerged, 'coordinating communicative goals,' described the basic social process that was involved in clinician-client LCD interactions. This core category captured two stages and three conditions that participants encountered during clinical interactions. The two stages were 'encountering challenges in clinical interactions' and 'using strategies to overcome challenges.' The three conditions were 'linguistic barriers,' 'cultural barriers,' and 'involvement of family members and/or interpreters.' The two stages explained the processes used by participants during clinical interactions, and the three conditions were factors that impacted the stages. The findings indicate that participants coordinated their respective communicative goals in clinical interactions by going through an iterative process of confronting challenges and implementing strategies to overcome some of those challenges. The findings from this study have important implications for research, clinical practice, education, and policy aimed at helping SLPs provide linguistically and culturally appropriate services to LCD clients.

Smith, A. P., & Kobayashi, K. M. (2002). Making sense of Alzheimer's disease in an intergenerational context: The case of a Japanese Canadian nisei (second-generation)-headed family. *Dementia*, 1(2), 213.

An appraisal of cultural values and life history events is necessary to fully understand the ways in which family members interpret the significance of cognitive symptoms and make decisions about accessing clinical services for a relative in the early to moderate stages of dementia. This article presents a case study of a nisei (second-generation)-headed Japanese Canadian family in which the father was referred for clinical evaluation at a dementia clinic and diagnosed with Alzheimer's disease. This case study identifies the traditional issei (first-generation) Japanese Canadian values of filial obligation and shame and awareness of the father's life history as salient mediators in family members' interpretations of dementia symptoms. Furthermore, a discussion of the role of the clinical evaluation in arbitrating between divergent interpretations of the nature of the father's disruptive behavior among family members is included.

Aminzadeh, F., & Edwards, N. (1998). Exploring seniors' views on the use of assistive devices in fall prevention. *Public Health Nursing*, 15(4), 297-304. Examined the attitudes of older adults in Canada on the use of assistive devices, such as mobility aids and bathroom safety devices, in fall prevention. Four focus group interviews were conducted with a convenience sample of 30 community-dwelling older adults aged 61-86 (mean age 72.2) in Ottawa, Canada, including 17 Italian Canadians and 13 British Canadians. The interviews documented personal experiences with and the meaning of falls, aging, and assistive device use for older adults. The participants' comments revealed the potentially debilitating effects of falls and fear of falling on older adults' daily activities and quality of life. Participants acknowledged the many safety and functional gains of cane use, but also cited a range of attitudinal, normative, perceptual, and access barriers to cane use. Overall, participants had very favorable evaluations of bathroom safety devices, such as grab bars. Their comments suggested that, compared with canes, bathroom aids may be less frequently associated with aging and disability and more easily accepted and used by older adults. With few exceptions, Italian Canadians and British Canadians presented similar views on falls and barriers to preventive behaviors. (MM) (AgeLine Database, copyright 1999 AARP, all rights reserved)

Dorazio-Migliore, M. (2000). *Eldercare in context: narrative, gender, and ethnicity* UMI Dissertation Services, ProQuest Information and Learning, Ann Arbor, MI.

This study is an investigation of informal elder caregiving among Canadians of Italian, Japanese, and Anglo ancestry who have links to the Vancouver area of British Columbia, Canada. In this study, I explore the meanings attached to eldercare in the specific contexts of narrative, gender and ethnicity. In order to conduct the study, I analyzed transcripts generated in qualitative, in-depth interviews with 30 caregivers (24 women and 6 men). In addition, I employed interactive and observational techniques in care facilities, at support group meetings, during a course for caregivers, and in various community settings. I also wrote extensive fieldnotes and garnered information from academic sources, media reports, and popular culture. The collected information is used to show how personal meanings are expressed through mixed-genre, co-constructed, dialogical (in the Bakhtinian sense) eldercare narratives that generally focus on a senior care-recipient who is a parent or spouse, his/her need for care, and the caregiving experience itself. I argue that both differences and similarities occur in the meanings given to caregiving. Eldercare narratives are different yet similar. Each caregiver, care-recipient, and caregiving situation is unique, and each eldercare narrative reflects these unique differences. Yet there are also parallels and differences attributable to other factors.

These other factors include caregivers, situated involvements with a problem-fraught health care system, the social constructions of caregiving, ageing, gender, ethnicity, and class, and the character of narrative itself. My findings have policy and practice implications. They are particularly valuable for alerting us to how we should listen to and interpret what caregivers are telling us about their emotionally-charged, and often physically-draining, unpaid work. (Author Abstract, used by permission) (AgeLine Database, copyright 2004 AARP, all rights reserved)

Gee, E. M. (1999). Ethnic identity among foreign-born Chinese Canadian elders. *Canadian Journal on Aging*, 18(4), 415-429.

Examined the extent, determinants, and consequences of ethnic identification among older Chinese immigrants in British Columbia, Canada. At-home interviews were conducted during 1995-1996 with a random sample of 708 foreign-born Chinese adults aged 65 and older (median age 75) who were living in Greater Vancouver and Greater Victoria. Nearly one-half of the respondents (49.3 percent) reported that they thought of themselves as more Canadian than Chinese, 36.6 percent thought of themselves as more Chinese than Canadian, and 14.1 percent felt equally Chinese and Canadian. In logistic regression analyses, the strongest variable associated with the retention of Chinese ethnic identity was place of residence: respondents living in Victoria were nearly three times more likely to view themselves as more Chinese than were respondents in the Vancouver suburbs. Respondents who only spoke "some English" were nearly twice as likely to feel Chinese as those who spoke English well. Individuals who had a monthly income of more than \$1,000 were about twice as likely to identify as Chinese as those with a lower income. More recent immigrants and those aged 75 and older were also more likely to view themselves as more Chinese. In general, those who retained a Chinese ethnic identity assessed their lives, their social supports, and their health as lower than that of their counterparts who identified less as Chinese; this relationship was particularly strong among women. (AY) (AgeLine Database, copyright 2000 AARP, all rights reserved)

Gee, E. M. (2000). Living arrangements and quality of life among Chinese Canadian elders. *Social Indicators Research*, 51(3), 309-329.

Examined the role of living arrangements in the quality of life of community-dwelling Chinese older adults residing in Vancouver and Victoria, British Columbia. A random sample of 830 persons aged 65 and older (median age 74) completed interviews in their own homes in the language of their choice. Data were analyzed for married or widowed respondents: 235 married men (mean age 73.3), 181 married women (mean age 72.2), and 320 widows (mean age 80.3). Ordinary least squares regression analyses were performed on well-being and life satisfaction for the three groups, and comparisons were tested for significance by chi square and the Levene test. Few differences were found for married persons, especially women. For widows, living alone significantly reduced quality of life in a number of areas. Living arrangements were not a significant predictor of life satisfaction or well-being for married men or women. For widows, living arrangements determined well-being but not life satisfaction. Age, health status, and social support were better predictors of quality of life for older Chinese Canadians than were living arrangements. Findings highlight the importance of empirically distinguishing marital status and living arrangements in studying the quality of life of older adults, not homogenizing older Chinese Canadians with regard to living arrangements, and focusing on older Chinese widows who live alone as a group at risk of low well-being. (AR) (AgeLine Database, copyright 2000 AARP, all rights reserved)

Havens, B., & Chappell, N. L. (1983). Triple jeopardy: age, sex and ethnicity. *Canadian Ethnic Studies*, 15(3), 119-132.

Examines the triple-jeopardy concept of age, sex, and ethnicity in reference to the elderly (age 65 and over), community-living population in Manitoba, Canada. The data were drawn from the Aging in Manitoba Study conducted in 1971. To measure quality of life, one objective measure (mental health functioning) and two subjective measures (perceived well-being and perceived health) were employed. The ethnic groups investigated were North American, British, French, other European, and Polish/Russian/Ukrainian. Triple

jeopardy was very evident in mental functioning. Very elderly women of the Polish/Russian/Ukrainian ethnic group exhibited significantly worse mental health than did any of the comparison groups. Triple jeopardy was not confirmed, however, for perceived well-being and perceived health. (LS) (AgeLine Database, copyright 1985 AARP, all rights reserved)

Koehn, S. D. (1999). *Fine balance: family, food, and faith in the health-worlds of elderly Punjabi Hindu women* UMI Dissertation Services, ProQuest Information and Learning, Ann Arbor, MI.

The principal aim of this inquiry is to understand how elderly Hindu Punjabi women utilize and shape Ayurvedic knowledge in the broader context of their lives. Do these precepts constitute a way of knowing in the world as women, as seniors, as immigrants? Ayurveda furnishes a wealth of indigenous categories of understanding, which can function as epistemological tools, providing one means by which these elderly women are able to build more cohesive constructions of their selves and their current realities. While my interest lies in discerning health-related behaviours and beliefs, my research agenda reflects the scope and priorities of the women themselves who include in this domain a broad array of topics, most notably, family relations, food, and religion. So as to examine the continuity of constructions among the elderly subsequent to migration, the sample includes both elderly Punjabi Hindus who have migrated to Greater Vancouver, Canada ($n = 10$), as well as a comparable sample still residing in northwest India ($n = 10$). The methodology employed was a reflexive process which entailed a period of initial sensitization to relevant concepts (Hindi language training, participant observation), followed by a series of in-depth semi-structured interviews. While capable of eliciting more specific information on health and healing, this method simultaneously encouraged 'life story' constructions. The 'critical-interpretivist' stance (Scheper-Hughes and Lock) adopted for this study considers not only how people construct their worlds but the relations of power which constrain their choices. This paradigmatic position is articulated within a 'three bodies' framework which delineates the individual body, the social body, and the body politic. Other important theoretical influences include social science perspectives on emotion, selfhood and food. Profiles of two each of the women now living in India and Canada are presented so as to preserve the integrity of the women's stories which are otherwise fragmented by the subsequent analysis wherein all interviews are considered collectively according to common themes. The most predominant themes were (1) the socially-embedded nature of health and well-being which references especially, but not exclusively, relationships within the extended family; (2) the relationships drawn between particular foods, beverages, herbs and spices and one's mental, spiritual and physical health, (3) the all-pervasive idiom of balance; and (4) the complex interrelationships between that which is sacred, detached, and not confined to this life and more temporal concerns such as attachment, pride and so forth which ground people in this world. Evidence of a higher order category which unites all four themes--a recognition of the strong interrelationships between mind, body, and spirit--is apparent in every interview. So, too, however, is the competing ideology of the egocentric self coupled with an allopathic (dualistic) medical paradigm which seeks to separate spirit from mind, mind from body. A fifth theme is thus the accommodation of these two competing ideologies in the women's life-worlds. In sum, Ayurveda provides a rich metaphorical language according to which broadly conceived health concerns which are deemed to originate in familial concerns and other stressors such as loneliness can be readily discussed in terms of food. The ability to utilize this wealth of metaphor is most typically forsaken when religion is no longer integral to their lives in some form or another. The compartmentalization of religion appears to reflect a more dualist (allopathically influenced) world-view in which holistic conceptions of self and health are marginalized. (Author Abstract, used by permission) (AgeLine Database, copyright 2004 AARP, all rights reserved)

Lai, D. W. L. (2000). Depression among the elderly Chinese in Canada. *Canadian Journal on Aging*, 19(3), 409-429.

Investigated the prevalence of depression among older Chinese adults in Canada. Ninety-six randomly selected members aged 65-88 (mean age 71.74) of a senior center in Calgary completed a telephone survey. A 15-item Chinese version of the Geriatric Depression Scale was used as the depression measure. Results showed that among the respondents, 9.4 percent were mildly depressed and 11.5 percent were moderately to severely depressed. In Canada, the estimated prevalence rate of depression among the

general older population is close to 10 percent. Thus, even if those who were mildly depressed were excluded, the prevalence rate of 11.5 percent in this study is still slightly higher than the national estimate. It is concluded that contrary to the misconception that older Chinese adults have a lot of informal support and do not require professional services, the present results suggest that they have mental health needs similar to those of the general older population. (KM) (AgeLine Database, copyright 2000 AARP, all rights reserved)

Lai, D. W., & McDonald, J. R. (1995). Life satisfaction of Chinese elderly immigrants in Calgary. *Canadian Journal on Aging*, 14(3), 536-552.

Explored the life satisfaction of older Chinese immigrants living in a community in western Canada. Eighty-one respondents, 58 females and 23 males, aged 65-96 (mean age 76) were randomly selected from senior housing facilities for the Chinese in Calgary. Eighty of them had lived in Canada for 3 years or more, 61.7 percent were widowed, and 65.4 percent lived alone. Life satisfaction was measured by both the Life Satisfaction Index-A (LSI-A) and a single-item global measure of life satisfaction; both instruments were translated into Chinese. The LSI-A is a multidimensional measure assessing five components of life satisfaction: zest (versus apathy), resolution and fortitude, congruence between desired and achieved goals, positive self-concepts, and mood tone. Most respondents were rather satisfied with their life and scored high on the LSI-A; the mean score was 13.1 on a scale of 0-20. Activity level, general health, psychological health, social support, self-esteem, and sense of personal control were the significant variables associated with both satisfaction measures. Multiple regression analyses revealed that psychological health, social support, and sense of personal control were the strongest predictors of life satisfaction, with no significant difference observed between male and female respondents. It is concluded that to help older Chinese immigrants achieve a higher level of life satisfaction, adequate supportive resources should be developed and made accessible to them. (AR) (AgeLine Database, copyright 1995 AARP, all rights reserved)

Pacey, M. A. (2001). Living alone and living with children: living arrangements of Canadian and Chinese Canadian seniors UMI Dissertation Services, ProQuest Information and Learning, Ann Arbor, MI.

This thesis focuses on the living arrangements of Canadian seniors. These living arrangements impact on a wide range of public and private concerns, most particularly on issues of social support and need for formal services. As changes in the source of immigration to Canada have shifted, there has been an impact on the structure and distribution of these living arrangements, with Chinese Canadian and other Asian immigrants being much less likely to live alone and more likely to live with children. These impacts play out geographically as Chinese Canadians and other Asian immigrants are concentrated in the largest cities. In this thesis, Canadian seniors' living arrangements are explored from a variety of scales, from the nation to a focus on the cities of Vancouver and Toronto. Using seniors' data culled from the 1996 Canadian Census PUMF, National Population Health Survey, and General Social Survey Cycle 11, a series of logistic regression models are presented which emphasize the connection between demographic, economic, cultural and health-related factors and the living arrangements of Canadian seniors. The analysis of these data suggests that living arrangements are strongly conditioned by a mix of economic, cultural, demographic and health-related factors. These findings suggest that the heterogeneity of seniors needs to be taken into account in any policies involving the living arrangements of Canadian seniors. (Author Abstract, used by permission) (AgeLine Database, copyright 2004 AARP, all rights reserved)

Spitzer, D., Neufeld, A., Harrison, M., Hughes, K., & Stewart, M. (2003). Caregiving in transnational context: "my wings have been cut; where can I fly?". *Gender and Society*, 17(2), 267-286.

Explored the experiences of Chinese and South Asian immigrant women in Canada who were caring for family members with chronic health problems. Semistructured interviews were conducted with 18 Chinese (aged 29-71) and 11 South Asian (aged 40-75) female caregivers. In addition, 6 women provided a second interview and allowed researchers to observe them in the process of their routine of caregiving. Four focus group sessions, 2 with caregivers and 2 with health professionals and policymakers, were held to allow participants to discuss the program and policy relevance of the findings. Data were subject to theme and

content analysis. Responses were surprisingly similar despite differences in culture and length of residency in Canada. The women were regarded as natural and appropriate family caregivers who experienced significant strain juggling the competing demands of work and multiple generations of family in a new environment. Despite these pressures, the women rejected the notion of a caregiving burden, focusing instead on the rewarding aspects of caregiving obtained through cultural role fulfillment. In the interest of maintaining cultural values and identity, women did not want, nor were they able, to renegotiate their caregiving roles. These caregiving arrangements were more costly to the women in Canada than in their countries of origin. (AR) (AgeLine Database, copyright 2003 AARP, all rights reserved)

Tjam, E. Y., & Hirdes, J. P. (2002). Health, psycho-social and cultural determinants of medication use by Chinese-Canadian older persons. *Canadian Journal on Aging, 21*(1), 63-73.

Explored health, psychosocial, and cultural determinants of the use of traditional Chinese medicines (TCM) and Western medicines among Chinese Canadian older adults. One hundred six Chinese older adults living in Canada completed face-to-face interviews that included a Chinese version of the Minimum Data Set for Home Care and supplementary questionnaires. All medications including TCM, prescription, and over-the-counter medications were reviewed and recorded. Multivariate regression models found that those experiencing pain symptoms were almost 10 times more likely to use TCM than those without pain. The odds of using TCM for those that were hospitalized were 15 times greater than for those not hospitalized. A curvilinear association between use of TCM and health beliefs was found. Living with a child, physical health problems, and number of diseases were associated with Western medicine use. Both experiencing pain symptoms and previous hospitalization increased the odds of combined use of TCM and Western medicine. Living with a child was significantly associated with a reduced likelihood of combining TCM and Western medicines. Results suggest that targeting pain and social isolation, as well as an education program focusing on the importance of preventive health, will be important in helping Chinese Canadian older adults. (AR) (AgeLine Database, copyright 2002 AARP, all rights reserved)

Choudhry, U. K. (2001). Uprooting and resettlement experiences of South Asian immigrant women. *Western Journal of Nursing Research, 23*(4), 376-393.

The purpose of this descriptive qualitative study was to examine and understand the challenges faced by elderly women from India who immigrated to Canada. Ten women were interviewed about their experiences with immigration and resettlement. The analysis of interview data involved iterative process, through which four themes were identified. These themes were isolation and loneliness, family conflict, economic dependence, and setting in and coping. The participants experienced loss because of changes in traditional values and lack of social support. Because the participants could not manage resettlement on their own, personal independence was not very important. Interdependence for the attainment of emotional security and social rewards was more desirable. Health care professionals must take into account the nature of stress and impact of these experiences on health of older immigrant women.

Eapen, S., Bajpai, S., & Chiappa, A. (2002). *Ethnic Seniors and Healthy Aging: Perceptions, Practices and Needs*. Canadian Ethnocultural Council.

The Canadian Ethnocultural Council (CEC), with assistance from its project partners and national network of contacts, conducted a needs assessment study of ethnic seniors and healthy aging. Information for the study was gathered by using a well-defined questionnaire and by interviewing. In total, 352 seniors from 18 ethnic communities responded; 58.4% of the respondents were women and 41.6% men.

These seniors were questioned about their physical, mental, emotional, social and spiritual well-being. Data from the survey provide a broad overview of the perceptions, practices, and needs of seniors in ethnic communities.

Fornazzari, L., Fischer, C., Hansen, T., & Ringer, L. (2009). Knowledge of Alzheimer's disease and subjective memory impairment in Latin American seniors in the Greater Toronto Area. *International Psychogeriatrics*, 21(5), 966-969.

Background: This study examined knowledge levels of Alzheimer's disease (AD) in a sample of Latin American seniors attending AD educational sessions in a Canadian city; and investigated the relationship between knowledge of AD, demographic variables, education level, acculturation level (years living in Canada), subjective memory complaint and objective memory impairment. Methods: One hundred and twenty-five Spanish-speaking adults living independently in the Greater Toronto Area completed subjective and objective memory measures and completed a questionnaire on their knowledge of AD. Results: Knowledge of AD was very weakly correlated with level of education and years living in Canada. In addition, there were no correlations between knowledge level and gender or subjective memory complaints. Conclusions: The results suggest that Latin American seniors, in the Toronto community, are not knowledgeable about AD. In spite of showing subjective cognitive impairment the sample were not aware of the principal cause of their symptoms. Additional research is needed to develop better focused and specifically directed health promotion initiatives for the Latin American seniors living in the Toronto community. ABSTRACT FROM AUTHOR (Copyright of *International Psychogeriatrics* is the property of Cambridge University Press / UK and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use. This abstract may be abridged. No warranty is given about the accuracy of the copy. Users should refer to the original published version of the material for the full abstract.)

Garcia, A. C., & Johnson, C. S. (2003). Development of educational modules for the promotion of healthy eating and physical activity among immigrant older adults. *Journal of Nutrition for the Elderly*, 22(3), 79-96. Describes the development of teaching modules for nutrition education and physical activity, based on needs assessment and identified barriers, facilitators, and motivational factors among 4 groups of immigrant older adults in Canada. Fifty-four immigrants (mean age 68), including Cambodians, Latin Americans, Poles, and Vietnamese, attending health and education programs at a community health center in London, Ontario, completed an interview that included a nutrition screening checklist, 24-hour dietary recall form, and physical activity and demographic questionnaires. Based on the results, 73% of the participants were identified as at moderate to high nutritional risk. Barriers related to dietary needs included limited English skills, lack of cooking skills (among the men), illness, loneliness, bad weather, and unavailability of ethnic foods. Nutrition education modules based on the results focused on healthy eating, better nutrition for older adults, food safety, multicultural cuisine, exercise, how to exercise, types of activities, exercise options, weekly exercise schedules, and barriers to exercise. (MM) (AgeLine Database, copyright 2003 EBSCO Publishing, Inc., all rights reserved)

Ho, B., Friedland, J., Rappolt, S., & Noh, S. (2003). Caregiving for relatives with Alzheimer's disease: feelings of Chinese-Canadian women. *Journal of Aging Studies*, 17(3), 301-321.

Explored Chinese Canadian female caregivers' feelings about providing care for a relative with Alzheimer's disease (AD). Using an adapted version of the conceptual model of AD caregivers' stress by Pearlin and colleagues (1990), the authors conducted in-depth interviews in Cantonese with 12 caregivers aged 30-80. Qualitative analysis was inductive and done manually. Despite anticipating and accepting their caregiving role as a cultural obligation, these caregivers, like most caregivers, felt overwhelmed, anxious, and fearful of the future. Against their stated cultural and personal values, all caregivers had made applications to nursing homes, and 6 were ready to institutionalize their relatives when a place became available. While coping mechanisms and social support appeared to mediate their stress, participants' concerns about the influence of Western culture on traditional values and, in particular, intergenerational issues regarding caregiving provided an added burden. (KM) (AgeLine Database, copyright 2003 EBSCO Publishing, Inc., all rights reserved)

Hossem, A. (2009). The South Asian Older Adult Immigrant's Barriers to Accessing Health Services in Canada: What Do We Know? What Can We do? *Indian Journal of Gerontology*, 23(3), 328-342. The article discusses the barriers to health care access among South Asian elderly immigrants in Canada. It is stated that coronary health disease and diabetes increase their risk for morbidity and mortality, and domestic violence has been a major problem for them. It notes that the barriers to health care utilization include culturally inappropriate services, organizational barriers and discrimination. It also mentions that better health care delivery is needed to meet their special needs.

Meana, M., Bunston, T., George, U., Wells, L., & Rosser, W. (2001). Influences on Breast Cancer Screening Behaviors in Tamil Immigrant Women 50 Years Old and Over. *Ethnicity & Health*, 6(3), 179-188. Objective To investigate, using the Health Belief Model as a theoretical framework, the incentives and barriers to breast cancer screening in a recent immigrant group, older Tamil women from Sri Lanka. Method Tamil women who had had a mammogram and Tamil women who had never had a mammogram were compared on the following variables: socio-demographics, personal risk estimates for breast cancer, risk-reduction expectancies, beliefs and knowledge about breast cancer and screening recommendations, and acculturation. Results Groups differed significantly in terms of education, years living in North America, acculturation, and beliefs/knowledge about breast cancer. When education and acculturation were controlled, perceived barriers to mammography were most predictive of mammography utilization. Discussion Results are discussed with a view to developing culture-appropriate educational campaigns. [ABSTRACT FROM AUTHOR]; Copyright of *Ethnicity & Health* is the property of Routledge and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use. This abstract may be abridged. No warranty is given about the accuracy of the copy. Users should refer to the original published version of the material for the full abstract. (Copyright applies to all Abstracts.)

Meshefedjian, G., McCusker, J., Bellavance, F., & Baumgarten, M. (1998). Factors associated with symptoms of depression among informal caregivers of demented elders in the community. *Gerontologist*, 38(2), 247-253. Assessed variables associated with increased severity of depressive symptoms among informal caregivers of community-dwelling Canadians with dementia. Data were drawn from the Canadian Study of Health and Aging Working Group, 1994, for 321 caregivers aged 26-90 (mean age 61.5) of community-dwelling persons aged 65 and older (mean age 82.3) with dementia. Caregivers completed the Center for Epidemiologic Studies Depression Scale (CES-D), while patients completed the Activities of Daily Living questionnaire, Dementia Behavior Disturbance Scale, and MMSE. Multiple regression analyses indicated that a higher CES-D score was significantly associated with three caregiver characteristics (being a spouse or child of the patient, self-identified ethnicity other than English and French Canadian, and lower education) and two patient characteristics (greater behavioral disturbance and moderate to severe functional impairment). (AR) (AgeLine Database, copyright 1998 EBSCO Publishing, Inc., all rights reserved)

Rogers, M. E. (2004). Lifestyle acculturation and health among older foreign-born persons UMI Dissertation Services, ProQuest Information and Learning, Ann Arbor, MI. This thesis investigates the influence of acculturation, measured as duration of residence, on the health status of midlife and older foreign-born persons in Canada. Previous research has revealed a 'healthy immigrant effect,' which suggests that those who immigrate to Western nations initially have fewer health problems than the native-born population. However, this superior health status tends to diminish over time. Although many explanations have been proposed, none have been successful in fully explaining this phenomenon. It is hypothesized that lifestyle acculturation in the areas of smoking, physical activity, fruit and vegetable consumption, and body mass index will partially explain this increase in health conditions with longer residence duration. Since the observed health decline among foreign-born persons with longer stay in

Canada was not fully explained, a subanalysis was conducted to examine age interactions with residence status. Explanations for the observed age effects are discussed, including differential acculturation and varying circumstances around immigration between midlife and older immigrants. Also, several predictors of chronic health conditions for the foreign-born population aged 45 and older are identified. Results suggest a need for future studies to explore how the association between acculturation and health varies within particular age and ethno-cultural groups. (Abstract shortened by UMI.) (Author Abstract, used by permission) (AgeLine Database, copyright 2006 EBSCO Publishing, Inc., all rights reserved)

Shemirani, F. S., & O'Connor, D. L. (2006). Ageing in a Foreign Country. *Voices of Iranian Women Ageing in Canada. Journal of Women & Aging, 18(2), 73-90.*

Older Iranian women, who immigrated to Canada in later adulthood, experience unique issues as they age. In order to better understand this experience, in-depth, personal and semi-structured interviews were conducted with five immigrant/refugee Iranian women who immigrated to Canada in their later life. Analysis revealed that although each woman's story conveyed individual differences and idiosyncrasies, all the stories highlighted the critical interweaving of the aging experience and the immigration experience: neither experience could be understood in isolation of the other; each aspect gave meaning to the other experience. Two interrelated messages dominated the women's stories: first was the importance of each woman's immigration story for grounding her experience of the aging process in Canada. Second, each woman's personal story suggested that the immigration experiences were accorded priority for accounting for her experiences in Canada. Specifically, cultural identity (i.e., social class, education, religious affiliation and immigration status) offered a valuable cloak for overshadowing the force of the aging process and the aging process emerged as an elusive force that lurked in the background without ever being fully acknowledged or given power in their lives. The implications of these findings in relation to theory development on intersectionality and professional practice are discussed.

Tam, S., & Neysmith, S. (2006). Disrespect and isolation: elder abuse in Chinese communities. *Canadian Journal on Aging, 25(2), 141-151.*

Based on a qualitative study of home care workers, this paper aims to understand elder abuse of Chinese Canadians. The findings show disrespect is the key form elder abuse takes in the Chinese community. As a culturally specific form of abuse, disrespect remains invisible under categories of elder abuse derived from a Western cultural perspective. Applying a social exclusion framework to understand the dynamic of elder abuse, we argue that as a marginalized racial minority immigrant, an elderly Chinese person's vulnerability to abuse is increased under conditions of social isolation.

Wu, Z., & Hart, R. (2002). Social and Health Factors Associated With Support Among Elderly Immigrants in Canada. *Research on Aging, 24(4), 391.*

This article assesses determinants of social support among the foreign-born elderly in Canada. We draw cross-sectional data from the second cycle of the National Population Health Survey, conducted by Statistics Canada in 1996-1997, and use ordinary least squares models for our empirical analysis. We focus on three measures of social support: perceived social support, social involvement, and social contact. Generally, we find that poor physical and/or mental health is negatively associated with our measures of support.

Emotional problems, one of the most consistent predictors, erode social support. Also, social involvement declines with mobility problems but increases with self-reported health status, whereas social contact also increases with cognitive function. As with other studies, and consistent with relationships witnessed among the native-born population, our results indicate that the married/cohabiting are more likely than the separated/divorced or widowed to perceive social support. Further, we find that those with children experience greater perceived support. [ABSTRACT FROM AUTHOR]; Copyright of Research on Aging is the property of Sage Publications Inc. and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use. This abstract may be abridged. No warranty is given about the

accuracy of the copy. Users should refer to the original published version of the material for the full abstract. (Copyright applies to all Abstracts.)

Zhang, J., & Verhoef, M. J. (2002). Illness management strategies among Chinese immigrants living with arthritis. *Social Science & Medicine*, 55(10), 1795-1802.

The purpose of this qualitative study was to explore arthritis management strategies among Chinese immigrants in Calgary, Canada, and to assess factors, that impact on these strategies. Purposive sampling was used to select 19 Chinese immigrants living with arthritis. Data were collected by means of in-depth interviews. The interview data were analyzed according to the following steps: (1) transcribing interview materials, (2) developing codes, categories and themes, (3) theoretical coding, and (4) laying out the theoretical framework. The results of this study describe factors that impacted on illness management strategies. These include arthritic symptoms, beliefs about arthritis, beliefs about Western medicine based on treatment experience, beliefs about Chinese medicine, perceived barriers to using Chinese or Western medicine and social support. The emerging process of illness management shows that immigrants usually started using self-care remedies, followed by consulting Western physicians, consulting Chinese healers, and then returning to Western medicine. The results illustrate that disease management strategies among Chinese immigrants are impacted by disease, personal and cultural factors. These factors suggest helpful directions to providing culturally sensitive care, which can lead to greater satisfaction and well being for Chinese immigrants with arthritis.

Bagley, C. R. (1993). Mental health and social adjustment of elderly Chinese immigrants in Canada. *Canada's Mental Health*, 41(3), 6-10.

Lai, D. W. L. (2007). For Better or For Worse: Elderly Chinese Immigrants Living Alone in Canada. *Hallym International Journal of Aging*, 9(2), 107-123.

For many aging people, living alone leads to many positive and negative implications for their well-being. In Chinese culture, in which strong family ties and values are emphasized, elderly Chinese living alone is not a common phenomenon. This study examined the differences between elderly Chinese-Canadian immigrants living alone and those living with others, and the role of living alone in their health and well-being. The findings showed that those living alone reported fewer limitations in instrumental activities of daily living and received a higher level of social support than those living with others. Women living alone were less mentally healthy than their counterparts. Policies makers and practitioners need to address the mental health needs of the elderly immigrant women in this vulnerable group. Programs and interventions should address the gender and racial oppression, and culturally unique needs for stronger family support.

Newbold, K. B., & Danforth, J. (2003). Health status and Canada's immigrant population. *Social Science & Medicine* (1982), 57(10), 1981-1995.

Given the framework of the 1984 Canada Health Act, the health status of immigrants should be similar to average levels within whole of Canada. Yet, assuming equality of health status between immigrant and non-immigrants, or between immigrant groups is likely an unrealistic and simplistic assumption, given unseen barriers affecting accessibility, the restructuring of the Canadian health care system, and problems with the provision of health care resources to the immigrant population. Using the National Population Health Survey, this paper focuses upon the health status of the immigrant population relative to that of non-immigrants within Canada, with reference to diagnosed conditions, self-assessed health, and the Health Utilities Index Mark 3. Findings indicate that, with the exception of the most recent arrivals, immigrants experience worse health status across most dimensions relative to non-immigrants. Multivariate analysis reveals that age,

income adequacy, gender, and home ownership are dimensions upon which health status differs between the two groups.

National Advisory Council on Aging (Canada). (2005). *Seniors on the margins: Seniors from ethnocultural minorities*. Ottawa: Minister of Public Works and Government Services Canada.

Canada's population is not only aging, it is also becoming increasingly diverse: more than 200 ethnic groups were reported in the 2001 Census. Yet for the most part, aging-related programs and policies continue to treat the seniors population as a homogeneous group and the variety of needs, concerns and histories of ethnocultural minority seniors often go unrecognized. The purpose of this document is to examine the key challenges and disadvantages that ethnocultural minority seniors can face in terms of income, health, health care and family and community support, and to recommend policy directions to ensure that they have the same opportunity for health and well-being as other seniors in Canada.

Food for Life, & Koehn, S. D. (2001). *Food For Life/Back to the Table*. Unpublished final report. A joint project of the Vancouver/Richmond Health Board and Nutrition Neighbours. Funded by the B.C. Health Research Foundation

Koehn, S. D. (1997). *An In-depth Qualitative Study of English-Speaking Chinese Seniors in British Columbia*. Victoria, British Columbia: Centre on Aging.

A recent study of 830 Chinese seniors currently residing in Greater Vancouver and Greater Victoria (Chapell & Lai, 1996) found that health service utilization by this group is similar to that found among other groups of seniors in British Columbia and Canada as a whole. Predictors of service use were likewise parallel to that of other populations. Nonetheless, cultural factors were seen to be relevant insofar as traditional health care use was concerned. In order to explore these cultural facets of health care in greater depth, the Centre on Aging (out of which the original study was conducted) commissioned a much smaller qualitative study with an English-speaking subgroup of Chinese seniors from the same metropolitan areas. This report details the findings of this in-depth study.

First outlining the methodology used and characteristics of the sample, we go on to report findings in three broad, interdependent areas: (1) preventive health care; (2) local categories of disease etiology; and (3) treatment modalities. The themes reported under each section emerged from the data itself and into two broad domains (a) eating habits and (b) exercise and social activities. When asked to comment on causes of ill health, research participants again identified two main themes. The first of these details the relationship between mental and/or emotional distress - particularly as these relate to work and the family-and physical health. The second examines the nature of food - 'poisonous,' 'heating,' and 'cooling' - as identified in terms of the traditional Chinese concept of yin-yang. Finally, the section on health care looks at self care and professional care, each of which can be subdivided into 'Western' and traditional Chinese treatments. Here we further explore some tentative relationships between health care utilization patterns and behaviours identified in previous sections (e.g. relative adherence to yin-yang philosophy).

Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees. (1988). *After the door has been opened : mental health issues affecting immigrants and refugees in Canada*. Ottawa: Ottawa : Dept. of the Secretary of State of Canada, Multiculturalism Sector.

Executive Summary

Report of the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees

The 12-member Task Force was established by Health and Welfare Canada and Secretary of State, Multiculturalism to identify factors influencing the mental health of Canada's immigrants and refugees and to make recommendations regarding them. Over a two-year period, the Task Force carried out its mandate by reviewing the relevant academic literature, by inviting oral presentations and written submissions and by

preparing a final report, the recommendations of which are presented below.

The Task Force concluded that, while moving from one country and culture to another inevitably entails stress, it does not necessarily threaten mental health. The mental health of immigrants and refugees becomes a concern primarily when additional risk factors combine with the stress of migration.

In Canada, negative public attitudes, separation from family and community, inability to speak English or French, and failure to find suitable employment are among the most powerful predictors of emotional distress among migrants. Persons who are adolescent or elderly at the time of migration and women from traditional cultures are also more likely to experience difficulties during resettlement.

Canada can exert considerable control over these risk-inducing forces. It can provide the "ounce of prevention" needed to ensure that most newcomers will have as much chance as Canadian-born persons of maintaining their mental well-being, despite the stress of migration.

As preventive mental health measures, the Task Force recommends that:

1. The Canada Employment and Immigration Commission (CEIC) develop a multilingual series of pre-migration orientation programs in collaboration with immigrant service agencies and ethno-cultural organizations for distribution in refugee camps and at Canadian embassies abroad.
2. CEIC expedite changes in admission criteria to accommodate a broader definition of family, and changes in admission procedures to accelerate the family reunification process.
3. CEIC, Health and Welfare and Secretary of State provide core funding to immigrant service agencies to guarantee their operations on a long-term basis.
4. Health and Welfare and Secretary of State encourage and support the development of seniors' groups and programs in immigrant service agencies, general community service agencies, and ethno-cultural organizations.
5. Health and Welfare, Secretary of State, and Status of Women Canada develop and provide multilingual educational materials on women's rights and roles in Canada for discussion at immigrant service agencies, general community service agencies and ethno-cultural organizations.
6. Health and Welfare and Secretary of State work with their provincial counterparts to ensure that the curricula and environments of schools, pre-schools, and daycare facilities reflect the cultural diversity of the children attending them.
7. Secretary of State, in cooperation with provincial ministries of education, encourage and support school boards to adopt multicultural and race relations policies similar to those that have already proven successful in Canada.
8. CEIC, Ministry of Communications, and Secretary of State increase public education regarding the benefits of cultural pluralism, the contributions of immigrants to Canadian society, the difficulties faced by newcomers, and the effects of prejudice on both victim and perpetrator.
9. CEIC enable all immigrants and refugees to have equal access to official language education whether or not they are destined for the labour market. Basic training allowances must be available regardless of the immigration class of training applicants.
10. CEIC, in coordination with Secretary of State, expand and ensure the flexibility of official language training programs with respect to the level of mastery assumed, objectives of course content, duration of program, scheduling of instructional hours, and location of classes.
11. CEIC, Ministry of Labour and Secretary of State enter into negotiations with their provincial counterparts to provide criteria and guidelines for entry into professions and trades by persons trained outside of Canada. Regarding remedial measures, the Task Force concluded that when immigrants and refugees require mental health care in Canada, they tend to seek it outside the conventional system, according to their own cultural values and beliefs. Mental health services delivered to migrants, frequently emergency and acute care services, often prove ineffective. Language and culture differences between practitioner and patient are too great in many instances to achieve successful treatment. It is not feasible to create "parallel" mental health services for each language and cultural group in Canada, and it is not needed. With encouragement and leadership of the federal government, especially Health and Welfare, each province can provide cross-culturally accessible mental health services with existing resources and a minimum of new dollars. The Task Force recommends that:
12. Health and Welfare establish a national advisory body to coordinate and monitor social, health, and mental health services to ethnic minorities, with input from professional associations, service administration, and immigrant service agencies.
13. Health and Welfare invite requests for proposals on the development of cross-cultural training modules in education, family practice, nursing, psychiatry, psychology and social work.

14. Health and Welfare, Secretary of State and their provincial counterparts encourage institutions of higher learning to identify cross-cultural education as a priority, particularly for students of education, medicine, nursing, psychiatry, psychology and social work.

15. Health and Welfare and Secretary of State encourage all funders of social and health services to require that organizations applying for funds provide evidence of efforts to make their services to ethnic minorities accessible, and to provide evaluations of their effectiveness.

16. Health and Welfare identify immigrants and refugees as well as multicultural concerns among its priority areas for Health Promotion contributions, research and National Welfare grants, and other funded activities.

17. Health and Welfare, in collaboration with immigrant service agencies and ethnocultural organizations, develop multilingual educational materials on the psychological consequences of migration and the resources for mental health care. Health and Welfare should provide these materials to provincial ministries of health and immigrant service agencies for dissemination through front-line service providers and ethnic media.

18. Health and Welfare and its provincial counterparts encourage all social, health, and mental health service agencies to increase their hiring of ethnic minority staff by adopting equal employment opportunity policies.

19. Health and Welfare and Secretary of State encourage the admissions committees of social, health and mental health service training programs to recognize as assets fluency in a non-official language and the intention to work with clients who speak that language.

20. Health and Welfare encourage provincial mental health services to employ mental health practitioners at major immigrant service agencies.

21. Health and Welfare, in collaboration with provincial ministries of health and immigrant service agencies, develop a curriculum for training interpreters used by mental health services. Immigrant service agencies and provincial ministries of health should be provided with this curriculum for use in classes supported by Health and Welfare.

22. Health and Welfare support research and health promotion initiatives to define the psychological consequences of torture, and to develop effective treatment programs for torture victims and their families.

23. Health and Welfare encourage provincial mental health services to give special consideration to the funding of ethno-specific rehabilitation and reintegration facilities.

The Task Force recognizes that the cost effectiveness and ultimate success of any given preventive or remedial measure depends heavily on the knowledge and experience on which it is based. The need for accurate, empirical research findings, for controlled program evaluations, and for the coordinated monitoring of information and activity are noted throughout the report. It is therefore recommended that:

24. CEIC, Health and Welfare and Secretary of State establish at least three centres of excellence across Canada for research on issues affecting migrant mental health.

25. CEIC, Health and Welfare and Secretary of State establish at least three centres of excellence across Canada for cross-cultural training.

26. CEIC, Health and Welfare and Secretary of State establish a single, computerized information centre to collect, coordinate and disseminate the results of research and evaluations as well as descriptions of service and training programs directed to migrants and ethnic minorities in Canada.

27. Health and Welfare and Secretary of State create a national body to advise on and monitor the implementation of the Task Force recommendations.

In implementing these measures to address the mental health needs of immigrants and refugees, Canada will not only serve its own best interests; it will also affirm its status as a caring nation

3. What are the unmet health needs (and their extent) of ethnocultural older adults as compared to older adults in general?

Forster-Coull, L., & Koehn, S. (2001). 'Where's the dal?': Food and Nutrition Experiences of Ethnic Minority Seniors in Long-Term Care. Victoria, BC: Prevention and Health Promotion Strategies, BC Ministry of Health.

With few exceptions, seniors' residences and long-term care facilities in British Columbia cater to the dietary needs of Anglo-American seniors. In this review, we are particularly interested in the extent to which the dietary preferences and nutritional needs of seniors of minority ethnic backgrounds who are institutionalized in LTCFs organized by the dominant Anglo-/Franco-Canadian majority are met. A multidisciplinary literature review reveals a dearth of studies on the topic. The goal of this paper is threefold: (1) to examine the dietary options currently available to ethnic minority seniors in LTCFs and how they and their families cope with any shortcomings of the health system in meeting their needs; (2) to examine the literature on the meanings assigned to food, particularly as these pertain to immigrants and the elderly; and (3) to make suggestions as to the future directions that dietitians, nutritionists and health administrators might take in order to address identified shortcomings. Special attention is paid to Canada's South Asian population.

Growing Older, Gaining Strength: The Experience of Immigrant Seniors in Edmonton(2006).

There are thousands of immigrant seniors living in Edmonton who have their own stories. These people have experienced many difficulties in their new community. It is the intent of this paper to bring to light the very real issues facing our immigrant seniors. The desire is that immigrant seniors should have equitable access to services. Specific barriers often stand in their way; the community needs to address these issues so those seniors can appreciate the same level of services as their counterparts in mainstream culture. They are not passive recipients of resources; rather they are eager and able to participate richly to contribute to this community.

MacLean, M. J., & Bonar, R. (1983). Ethnic elderly in a dominant culture long term care facility. *Canadian Ethnic Studies*, 15(3), 51-59.

Much of the research on the elderly ethnic population in long-term care tends to focus on institutions where there is only one ethnic group. In a multi-ethnic society like Canada, there are many elderly ethnic people who are institutionalized in a long-term care facility organized by the dominant culture. This paper suggests that there are added difficulties for elderly ethnic individuals in this kind of institution. The three most significant issues for these ethnic elderly are loss of family, loss of culture and loss of community. Through a case study approach, this paper shows that these losses have a significant impact on some elderly ethnic individuals in an English-Canadian long-term care facility. Implications for research and practice are given in the interest of improving the life of elderly ethnic people in long-term care.

Sadavoy, J., Meier, R., & Ong, A. Y. (2004). Barriers to access to mental health services for ethnic seniors: the Toronto study. *Canadian Journal of Psychiatry. Revue Canadienne De Psychiatrie*, 49(3), 192-199.

OBJECTIVE: To identify and describe barriers to access to mental health services encountered by ethnoracial seniors. METHOD: A multiracial, multicultural, and multidisciplinary team including a community workgroup worked in partnership with seniors, families, and service providers in urban Toronto Chinese and Tamil communities to develop a broad, stratified sample of participants and to guide the study. This participatory, action-research project used qualitative methodology based on grounded theory to generate areas of inquiry. Each of 17 focus groups applied the same semistructured format and sequence of inquiry.

RESULTS: Key barriers to adequate care include inadequate numbers of trained and acceptable mental health workers, especially psychiatrists; limited awareness of mental disorders among all participants; limited understanding and capacity to negotiate the current system because of systemic barriers and lack of information; disturbance of family support structures; decline in individual self-worth; reliance on ethnospecific social agencies that are not designed or funded for formal mental health care; lack of services that combine ethnoracial, geriatric, and psychiatric care; inadequacy and unacceptability of interpreter services; reluctance of seniors and families to acknowledge mental health problems for fear of rejection and stigma; lack of appropriate professional responses; and inappropriate referral patterns. **CONCLUSIONS:** There is a clear need for more mental health workers from ethnic backgrounds, especially appropriately trained psychiatrists, and for upgrading the mental health service capacity of frontline agencies through training and core funding. Active community education programs are necessary to counter stigma and improve knowledge of mental disorders and available services. Mainstream services require acceptable and appropriate entry points. Mental health services need to be flexible enough to serve changing populations and to include services specific to ethnic groups, such as providing comprehensive care for seniors

Brotman, S. (2000). Institutional ethnography of elder care: understanding access from the standpoint of ethnic and "racial" minority women UMI Dissertation Services, ProQuest Information and Learning, Ann Arbor, MI.

The current study addresses the problematic of access for ethnic and "racial" minority elderly women through an examination of the working processes of a publicly-funded organization which provides elder care services in Ontario, from the standpoint of these women. Using Institutional Ethnography methodology, the study explicates how state ideologies become infused into the operating policies and guidelines of elder care ideologies become infused into the operating policies and guidelines of elder care organizations, shaping the actual way access is both conceptualized and operationalized and the subsequent interactions between workers and their elderly clients. Interviews conducted with 43 participants (elderly women, agency staff, community agency and institutional staff) explicate how actors both reproduce relations of oppression and counter or resist those relations. Several problematic constructions have been identified which highlight the disjunctures between older women's expressed desires regarding access and the way access to services are operationalized in elder care agencies. These include: family involvement in care; prolonged engagement as a means of facilitating access; the influence of acute health care models on eligibility for and delivery of care; and, a focus on cultural competence and language in the delivery of ethno-specific services. Program and practice implications are highlighted in order to shift the dominance of state-orchestrated ideologies which operate to shape the experience of women who are multiply situated on the margins and who have been and continue to be oppressed within elder care institutions. (Author Abstract, used by permission) (AgeLine Database, copyright 2004 AARP, all rights reserved)

Disman, M. (1991). Subjective experience of Alzheimer's disease: a sociocultural perspective. *American Journal of Alzheimer's Care and Related Disorders and Research*, 6(3), 30-34.

Considers sociocultural variations in the subjective experience of Alzheimer's disease. In Canada, data on important health indicators from sociocultural minority groups are not readily available, and the reasons for this unavailability include problems with defining and measuring ethnicity--in particular, concern that the sociocultural background of a person is private information, linked to concerns about potential violation of the Canadian Charter of Rights. Current research suggests that members of sociocultural minority groups, and especially seniors, may be neurologically vulnerable to the stresses associated with older age, particularly when compounded by stresses from immigration and from aging in an acquired culture. Cross-cultural psychology offers some guidance for studying Alzheimer's disease as an illness experience. In order to provide supportive environments for patients from sociocultural minority groups, some understanding is required of the cultural parameters for development of the self and of the influence of culture on personality. Therefore, research is urgently needed on the sociocultural variations in patients' response to Alzheimer's as well as on cultural variations in familial caretaking practices. A strategy for building support groups for family caregivers from the targeted population is presented as one example of an effective intervention. (WD) (AgeLine Database, copyright 1991 AARP, all rights reserved)

Filinson, R. (1992). Ethnic aging in Canada and the United States: a comparison of social policy. *Journal of Aging Studies*, 6(3), 273-287.

Compared research data and relevant social policy regarding ethnic aging in Canada and the United States. Although the organizing principles are different, the Canadian and U.S. systems are seen to be alike in perpetuating preretirement inequalities into old age, with ethnic elders particularly vulnerable to the disparities. Canadian research has focused on ethnic aging in terms of cultural variation rather than economic disadvantage. Canada has separated individual contributions from basic entitlements in health care and income maintenance systems using policies that steer clear of affirmative action programs benefiting individuals. Explicit policy on the treatment of ethnic groups in Canada is dictated by the Multicultural Act and related legislation that fosters a "multicultural mosaic" rather than a melting pot. It is suggested that rather than empowering ethnic groups, the system of grants creates competition for resources, depoliticizes inequalities, and attracts the most assimilated ethnics to come forward as representatives of their groups. The purity and autonomy of ethnic associations are diluted, and their goals are dictated by others. American research has addressed itself to the economic disadvantages accruing to ethnic elders. The United States it is argued, has taken a "much more proactive stance" on behalf of ethnic elders in the Older Americans Act and other programs by prioritizing groups with greatest economic or social needs--Indians, minorities, and those with limited English-language skills. Yet, this targeting occurs in a context in which health care and income maintenance are not universal. Although ethnic elders appear to fare better in Canada than in the U.S., the differences between the countries may be more ideological than practical. (UH) (AgeLine Database, copyright 1992 AARP, all rights reserved)

Guberman, N., & Maheu, P. (2003). Beyond cultural sensitivity: universal issues in caregiving. *Generations*, 27(4), 39-43.

Examines the place of culture and social structure in understanding caregiving in minority ethnic groups, using studies undertaken in Quebec, Canada, with Haitian, Italian, and Chinese families. Results indicate that practitioners should base their practice on the following principles: analyzing the caregiving dynamic within the context of specific values and beliefs of the family and their socioeconomic conditions and the general sociopolitical context, not overestimating the importance of cultural factors at the expense of structural factors in the assessment of needs, and focusing not only on cultural differences and specificities but also on what is similar for all families. It is argued that true cultural competence situates cultural differences within the socioeconomic context of the groups in question and within the larger picture of dominant social relations. It is concluded that if health care and social service practitioners do not adopt a more structural approach, they run the risk of reducing problems confronting caregivers of minority ethnocultural groups to "ethno-specific" problems and of excluding these groups when considering fundamental issues and problems facing all caregivers. (AY) (AgeLine Database, copyright 2004 AARP, all rights reserved)

MacLean, M. J., Siew, N., Fowler, D., & Graham, I. (1987). Institutional racism in old age: theoretical perspectives and a case study about access to social services. *Canadian Journal on Aging*, 6(2), 128-140. Assesses access to social and health services for older people of different ethnic groups at three community and social service centers (CLSCs) in Montreal, Canada. Reviews current perspectives on institutional racism in Canada and on institutional discrimination against ethnic elders. Presents data on the ethnic origin of Montreal's older population. Describes a case study that compared social services provided by CLSCs for older people in two ethnic communities (Portuguese and Chinese) with services for the elderly of the two dominant cultures (French-Canadian and English-Canadian). Data were collected in interviews with community workers, social workers, and a nurse. Older individuals from French-Canadian, English-Canadian, and Portuguese communities appeared to enjoy complete access to CLSC services. Older Chinese, on the other hand, did not have services or material about those services in their native language and did not have a firm commitment from the provincial government that services would continue from year

to year. Concludes that institutional racism is part of social and economic relations in Canada. (LS) (AgeLine Database, copyright 1988 AARP, all rights reserved)

Saldov, M., & Chow, P. (1994). Ethnic elderly in metro Toronto hospitals, nursing homes, and homes for the aged: communication and health care. *International Journal of Aging and Human Development*, 8(2), 117-135.

Examined the extent of communication problems the ethnic elderly face in metropolitan Toronto hospitals, nursing homes, and homes for the aged. Ethnic elders are aged 65 and older and speak neither English nor French; in 1986 they constituted 9 percent of the metropolitan Toronto population, and 66 percent were female. Ethnic elders face a "double jeopardy" when they come into a health care setting; already handicapped by losses in physical and cognitive functioning, they are unable to use their native language, which increases the risk of their health care needs being unmet. A total of 77 health care facilities serving 1,001 ethnic elders completed a research questionnaire with five categories of questions: the number of non-English-speaking patients, their needs (dietary, psychological, and communication, for example), the kind of interpreter services (IS) available, the institution's policies regarding meeting the communication needs of these individuals, and whether a budget for IS existed. A majority (83 percent) of the health care settings reported having some type of IS, although they were frequently informal, unprofessional, and ad hoc. Without IS, problems developed that were sometimes critical to the health care of the ethnic elderly; however, even with IS available, problems developed, suggesting that the services provided were not always effective. Few institutions had workshops or training to help staff understand ethnic variations on the perceptions of illness and health. The survey questionnaire developed by the authors is appended. (SW) (AgeLine Database, copyright 1994 AARP, all rights reserved)

Alagiakrishnan, K. (2008). Practice tips. Ethnic elderly with dementia: overcoming the cultural barriers to their care. *Canadian Family Physician*, 54(4), 521-522.

Brown, C. A. (2008). The implications of occupational deprivation experienced by elderly female immigrants. *Diversity in Health & Social Care*, 5(1), 65-69.

Canada's immigration policy favours family reunification, and many elderly parents follow their adult children into new lives in Canada. In particular, the population of elderly immigrant women living with adult children is growing rapidly. To date there are few theoretical models to guide research in this area although this subgroup of immigrants has been identified as having unique characteristics that warrant urgent research attention. The limited research that exists links immigration, acculturation and communication problems with negative physical and psychological health for immigrant women. One paradigm that holds promise for understanding and responding to the health needs of older immigrant women is that of occupational science. Occupational science proposes that 'human engagement is integral to everyday living as people of all ages plan, structure and use their time doing the things they need and want to do'. Occupational deprivation is a subconstruct of occupational science and refers to situations in which people's needs for meaningful and health-promoting occupations go unmet or are institutionally denied. Currently we do not understand the impact of occupational deprivation on the health of older immigrant women and how this influences their healthcare utilisation. It is probable that the needs of this unique, and growing, group of elderly women have important implications for health planning and resource utilisation that are only just beginning to be recognised. [

Leung, H. H., & McDonald, L. (2001). *Chinese Immigrant Women Who Care for Aging Parents*. Toronto, Ontario: CERIS.

Executive Summary

The purpose of this pilot study was to examine the experiences of a group of Chinese immigrant women who provided care to their aging parents and the experiences of the parents who received the care. The cultural dimensions and immigrant experiences of the care-giving dyad was explored. In particular, we examined the experiences of the dyads living in three generational household, a common practice in the Chinese culture. This study was based on in-depth interviews with nine care givers and recipients (18 respondents). We used a semi-structured interview schedule to explore the feelings and the challenges faced by the dyads in care-giving and how this was coloured by the immigration process.

Our findings indicated that the care-giving experience of women in three generational households can be a burden only when the care recipients are frail, and ill. Otherwise, the care-giving and receiving experience was not in one direction; rather it was reciprocal, this is especially so when the elderly parents were healthy and able. This reciprocal characteristic reflects the cultural traditions in the Chinese family system.

We also found that the mobility, independence, and the total life cycle of these elderly Chinese immigrants were affected by language barriers, transportation barriers, isolation, lack of culturally and linguistically sensitive health and social services, making care-giving especially challenging. The immigrant women who cared for frail elderly parents themselves faced additional challenges due to factors resulting from immigration, such as weak informal social networks, and the lack of culturally and linguistically sensitive health and social services.

On the other hand, the helping hands of the elderly parents lessened some of the struggles in settling in a new country mostly for the women and especially for those who had to participate in the work force to sustain the family. It was concluded that the inter-dependence between the generations assisted in the adaptation process to immigration for the whole family. Implications of the findings were discussed.

Neugebauer-Visano, R. (1995). *Aging and inequality: cultural constructions of differences* Canadian Scholars' Press, Toronto, Ontario, Canada.

Examines the impact of race and ethnicity on aging in Canadian society, focusing on inequalities and cultural constructions of differences. Discusses the ethnic dimensions of aging in Canada and aging from a historical and comparative perspective. Presents a minority-feminist perspective on women and aging and discusses modernization and aging in the Anicinabe context. Reviews black perspectives on aging and cultural factors affecting self-assessment of health satisfaction of Asian Canadian elderly. Examines the barriers of age, race, and ethnicity faced by women, along with strategies to change services for the ethnic elderly. Discusses social integration and institutionalization of older adults. Includes chapter references.

Puga-Pena, C. (2006). *Living conditions of older Latin American immigrants in Montreal (Quebec)* UMI Dissertation Services, ProQuest Information and Learning, Ann Arbor, MI.

During the 1970s and 1980s, a large number of South Americans and Central Americans immigrated to Quebec escaping from dictatorships and civil wars. Many aged here, while others, older, came later or are still coming today to join their family linked to their own cultural background, under special acceptance programs. Their reality in Canada is different to that of other older immigrants. Therefore, this study aims to examine the growing need to recognize and acknowledge Latin American cultures in the development of policies and services related to older people in Canada. In this thesis, the living conditions of older Latin American people in Montreal will be summarized and issues of intercultural communication specific to the Latin American context will be identified. Whether the development and delivery of services for older people living in Montreal support the unique cultural needs of older Latin American people will be discussed. Finally, suggestions for the development of improved services will be provided in order to emphasize the need to recognize and acknowledge Latin American cultures in the development of policies and services related to older people in Montreal.

Singh, A. (2008). *The Punjabi Diaspora in Canada: Listening to the Voices of the Diasporic Punjabi Seniors in Canada*. In K. Mehta, & A. Singh (Eds.), *Indian Diaspora: Voices of the Diasporic Elders in Five Countries* (pp. 13-54). Rotterdam, The Netherlands: Sense Publishers.

ABSTRACT

This chapter has two parts. The first part is designed to serve pedagogical and curriculum goals as outlined in Chapter one in this book. It reviews selected research in the area of social gerontology involving South Asian seniors in Canada, provides definitions of some key terms, discusses aspects of the South Asian Punjabi Sikh diaspora in Canada, provides statistical information on diasporic Punjabi seniors in Canada, and reviews studies done on them in Canada. Part II spotlights the voices of Punjabi seniors themselves. Research has shown (see endnotes) that the aged memoirist feels good when given the opportunity to express herself/himself about the joys and problems of aging. More recently, the concept of voice has been used as a tool for reflective personal and social transformation and empowerment (see Chapter one in this book). Building on these research based insights, Part II documents cultural themes that have emerged in the life stories of the diasporic Punjabi seniors now living in Canada (mostly in the Toronto area, but also in Atlantic Canada).* Punjabi diasporic seniors have many stories to tell to those whom they encounter daily at various sites. Among them are professional agencies which provide services to the seniors of different cultural backgrounds. This author and a team of other "cultural workers" have been interacting with the diasporic Punjabi seniors for more than two decades in formal and informal social settings - for example, at places of worship, weddings, social parties, shopping centers and various other sites - where routine activities of the everyday life of these seniors unfold in relations to others. What we have learned from them is that generally, diasporic Punjabi seniors often feel that many professionals and agencies who provide services to them do not fully know how to listen empathetically to the life histories of an older person with different cultural experiences. Further, the seniors claim that this is also the case with the younger members of their family; young folks often do not know how to listen to them respectfully. The voices of the seniors presented in the second part of this paper should be seen as an attempt on their part to produce cultural knowledge. This knowledge could be a learning resource both for the seniors and for those who are interested in their well-being. *Learning from the voices of the Punjabi seniors, the author concurs with them in concluding that programs and projects that provide safe sites for the diasporic seniors to voice their stories should be developed. Further, the professional service providers and families, friends, and relatives concerned with the well-being of these seniors need to understand the culture and history of the seniors they are trying to listen to in order to listen well.

I have organized this chapter in two parts. The first part presents a brief history mainly of the Sikh Punjabi diaspora in Canada and other related material. The material in this part should serve pedagogical goals (see Chapter One in this book). In the second part, I discuss my recent work with the Punjabi diasporic seniors in Canada. The concept of voice is an important one for this book (see Chapter One in this book) and this chapter. Therefore, in the first part, I try to allow the researchers to speak through their own writings. Hence, instead of completely paraphrasing their research on the Punjabi seniors, I present their direct voices. This I do by citing rather lengthy quotations from their work. In the second part, I give voice to the Punjabi diasporic seniors. This I do by listening to their stories carefully and, by creating conditions that enable them to freely narrate their stories. Finally, I add my own voice by way of making comments and framing the presentation of material in this chapter. It is my hope this chapter will enable both professional students and general readers to ask critical pedagogical questions (see Chapter One in this book) pertaining to the Indian diaspora, and the place of Indian seniors in it. Professional students, teachers, service providers, family members, and researchers may also reflect on their own locations and ask what role they can play in enhancing the well-being of diasporic Indian seniors and intergenerational relationships.

Taylor, L. E., Taylor-Henley, S., Newman, P., & Doan, L. (2003). *Resiliency and Well-Being: Reflections of Older Adults on Immigration and Integration*. Prairie Centre for Research on Immigration and Integration.

EXECUTIVE SUMMARY: *Resiliency and Well-Being: Reflections of Older Adults on Immigration and Integration*. This research project is a partnership involving the Faculty of Social Work, University of Manitoba, the School of Social Work, University of Windsor and the English as a Second Language (ESL) for Senior's Program of Age and Opportunity, Inc., Winnipeg MB. It has received two year funding from the Prairie Centre of Excellence for Research on Immigration and Integration.

The purpose of the project is:

(1) To explore how indicators of resiliency and social well-being are

reflected through lived stories of immigration and integration for ESL older adults;

(2) To determine how integration can be fostered for immigrants generally and for later-life immigrants particularly; and

(3) To make recommendations for policy and programme development based on the findings of this study.

For this project 139 stories written by ESL seniors who immigrated in later life were collected and analyzed using categorical/content and holistic/form narrative analysis.

A comparative secondary data analysis was conducted using 650 stories of Canadian war-brides who immigrated to Canada as young adults and can now reflect upon a life time of “immigrant” and “integration experience.”

From this analysis, four factors are identified as major contributors to the processes of integration for later-life immigrants and for young adult immigrants. As presented in our conceptual model, the four factors are: resiliency capacities, sense of social well-being, language competencies, and social literacy. ‘Social literacy’ a concept that emerged from our data analysis is ‘defined as the ability to recognize, to understand and to feel comfortable with social cues and behavioural expectations around activities of daily living and socialization found in the new culture’. The importance of ESL classes in the processes of integration is clearly discernible in our findings. The analysis of a “best practices” model for ESL seniors classes provides information for policy initiatives and programme development for later-life ESL immigrants.

The project identifies protective factors for resiliency as: being able to tell the immigration story; family re-unification; taking language classes that include social literacy skills; social well-being achieved by the many freedoms found in a democratic country and through the social safety net of the Canadian welfare system; the development of new social networks; and, developing an understanding of and knowledge about the new country and its customs.

The project also demonstrates the value of ESL classes for seniors and their gratitude for this opportunity to learn. A unique “best practices” ESL for Seniors programme which fosters community integration and eases the transition to Canada for many new ESL immigrants and refugees is described and successful programme components are identified. Although this project presents an ESL “best practices model”, we believe the findings are also relevant for French Second Language for seniors programmes.

Recommendations

The following recommendations for policy development and programme planning are suggested:

(1) that ESL classes be recognized as an important contributor to the processes of integration for later-life immigrants;

(2) that later-life immigrants need ESL learning to be tailored to their specific needs which involve a focus on conversational needs and social literacy;

(3) that as a matter of social justice, seniors should have access to free ESL classes;

(4) that integration is unlikely to occur without the development of competencies in the language(s) of “main-stream” society.

(5) that if we are to continue Family Re-unification policies in particular for later life immigrants, we need a national strategy for programme development and policy initiatives that: (i) commit resources to ESL classes, (ii) make ESL classes readily available; (iii) undertake a significant public relations campaign to raise awareness about ESL classes; (iv) provide adequate funding for ESL classes and training for ESL teachers; and (v) support research related to effective ESL teaching strategies, programme development, and programme evaluation.

Vucetic, M. (2006). Senior Immigrants From the Former Yugoslavia in Toronto: Access to Services and Community Connection. Toronto, Ontario: Ryerson University.

This paper concerns the availability and accessibility of support services for senior immigrants from the former Yugoslavia, and the nature of their social networks and community capacity. Interviews were held with 10 seniors from the former Yugoslavia looking into their experiences of accessing services, community involvement and social connectedness. Seniors from the former Yugoslavia belong to a community that is dispersed, small and lacking coordination and organized leadership. For these reasons, seniors face challenges accessing linguistically and culturally appropriate community support services due to a lack of information and limited English language skills. Politics and religion appeared more salient to earlier waves of immigrants from this region than to those who arrived in the 1990s.

Saldov, M. (1992). Communication needs of the ethnic elderly in hospitals and nursing homes. *Journal of Multicultural Social Work*, 2(2), 1-9.

The ethnic elderly (over 65 years of age and speak little or no English) enter our health care system at their peril. Many ethnic elderly have lived with their families or in ethno-specific communities, which does not prepare them for health care they receive in a predominantly anglophone health care system. Their age and associate disabilities combined with communication barriers result in a double jeopardy for ethnic elders. Faced with the tension between the communication-needs of the ethnic elderly in health care institutions and the absence of services which take into account language and cultural barriers, there is a role for social workers in helping to define these needs through research and to advocate for change through participation in the policy formulation process

Dorazio-Migliore, M., Migliore, S., & Anderson, J. M. (2005). Crafting a praxis-oriented culture concept in the health disciplines: conundrums and possibilities. *Health (London, England : 1997)*, 9(3), 339-360.

'Culture' is a key concept in the social sciences. It also figures prominently in health science discourses. Yet, it is an imprecise and politically charged term. Due to a variety of factors, health care professionals may tend to use notions of culture that can be easily applied. Dangers are posed when using simplified culture concepts, however, because they act as 'interpretive lenses' - lenses that may generate cultural stereotypes, lead health professionals to miss key interactions and processes in the provision of care, and simplify the cultural complexities surrounding the position(s) of both the health care providers and their clients. Two cases of eldercare are analysed to demonstrate the multi-layered intricacies of the concept of culture. The overall point is that 'culture' is a highly complex and dynamic term; the way in which it is conceptualized and used has enormous consequences for health care.

George, U., Tsang, K. T., Man, G., & Da, W. W. (2000). Needs Assessment of Mandarin-Speaking Newcomers Retrieved from <http://atwork.settlement.org/downloads/Needs_Mandarin_Speaking_Newcomers.pdf>

Executive Summary

This study started in September 1999 and was completed at the end of March 2000. It adopted a multi-method approach involving focus groups and individual interviews with Mandarin-speaking newcomers, interviews with service providers, and individuals who are knowledgeable about the community.

Data from the Mandarin-speaking newcomers were collected using focus group interviews and individual interviews. A total of 8 focus groups with 61 participants, and 21 individual interviews were conducted. The 82 Mandarin-speaking newcomers included people at different points of life cycle with gender and age variables: 23 youth, 21 adults without children, 19 adults with children and 19 seniors.

The sample of 82 Mandarin-speaking newcomers was highly educated. The majority of them had university or tertiary education. The study found that the newcomers experienced such settlement difficulties and needs as: linguistic and communication barriers, problems in obtaining employment, discrimination, familial conflicts, psychological adjustment problems, isolation, and housing problems. In terms of their access to social and community services, the newcomers reported inadequate access to information, accessible and appropriate ESL classes, health care, subsidized childcare, services for seniors, and youth activities. The

participants suggested programs to assist them in obtaining employment, recognition of their foreign credentials and employment experience, ESL classes for professional and highly skilled newcomers, accessible information on community and social services, specialized assistance for ESL students applying for university, increased services in the Mandarin and Mandarin-speaking newcomers.

Eight key informants from relevant community services and organizations were also interviewed. These service providers pinpointed some of the major difficulties they have confronted in providing services for the Mandarin-speaking newcomers. Lack of monetary or staff resources as a result of restructuring and budget cut have had drastic effect on service delivery to newcomers. Some service providers were frustrated by their inability to assist the newcomers in a concrete way due to structural barriers. The differences in organizational and cultural practices between China and Canada experienced by the newcomers, and the lack of language specific staff to provide services for the newcomers further compound the service providers' difficulties. The key informants' recommendations included: increased information regarding social services designed for Mandarin-speaking newcomers, orientation and job search workshops, escorting newcomers to government agencies, and the provision of adequate language specific services.

In addition, seven knowledgeable persons from established Chinese communities were interviewed. Apart from the difficulties mentioned by service providers, they identified language and cultural differences between Mandarin-speaking newcomers and service providers, poverty among the Mandarin-speaking newcomers, and the retraction of translation and interpretation services as a result of budget cuts and restructuring as some of the difficulties in providing services for Mandarin-speaking newcomers. The knowledgeable persons recommended more research data to be collected to reveal the needs of the newcomers, the training of more Mandarin-speaking social workers in community colleges and universities, increased academic support and after-school activities for Mandarin-speaking newcomer children, the re-establishment of translation and interpretation services in the schools, and the introduction of parenting classes and workshops to provide information for newcomer parents on language, assistance in obtaining appropriate housing, provision of practical information prior to their arrival to Canada, and programs to increase the opportunities for cultural exchange between Canadians parenting and communication skills with their children.

Based on the barriers and problems expressed by Mandarin-speaking newcomers, and views from service providers as well as knowledgeable and religious persons from the Chinese communities, the researchers have made some program recommendations for both the government and community service agencies serving new immigrants. The researchers recommend the implementation of programs related to initial settlement, ESL, housing, education and training; and for the community agencies, programs relevant to initial settlement, housing access, health and well-being, social integration, community services and employment are recommended.

Neysmith, S. M. (1999). *Critical Issues for Future Social Work Practice with Aging Persons* Columbia University Press.

A massive restructuring of health care in virtually all the wealthy nations of the West has offloaded services and costs from governmental responsibility into home care services and onto families -- a burden borne primarily by women. This restructuring has profoundly altered not only the practice of social work but also its representation in language and theory. As this volume demonstrates, many of the consequences social workers must face are made more difficult by the dominance of a market discourse that excludes a social justice framework.

The authors aim not to prescribe specific guidelines for practice but "to challenge current arrangements and explanations" in order to open the discourse and generate alternatives so that people receiving care might have fuller and more satisfying lives. Written by social work theorists and specialists from the U.S., Canada, and New Zealand, the chapters focus on topics of long-term care as they affect vulnerable groups -- women in particular -- as they age. Subjects include constructing community support, aging and caregiving in culturally diverse families, changing demographics of widowhood, and the new millennium's challenges for social work on aging and disability.

Stephenson, P. H. (1991). *The Victoria multi-cultural Health Care Research Project: Final Report*. Victoria, British Columbia: Secretary of State, Multiculturalism Canada.

Stephenson, P. H. (1995). Vietnamese refugees in Victoria, B.C.: an overview of immigrant and refugee health care in a medium-sized Canadian urban centre. *Social Science & Medicine* (1982), 40(12), 1631-1642.

This paper examines the manner in which Vietnamese refugees access the healthcare system in Victoria, British Columbia. A major theme of this study was the identification of barriers to health care access and provision as perceived by refugees and health care providers, as well as areas of overlap between the two sets of perceptions. The study was based on interview protocols developed with key informants followed by structured samples of 20 Vietnamese and 20 health care workers. The major issue identified by both groups was problematic interpretation of patient symptoms and health care provider recommendations. Lack of health care worker understanding of traditional remedies for common ailments was also identified as a barrier to health care access and utilization. The special problems of unemployment, depression, surviving torture and getting assistance are all made more difficult for refugees living in a smaller urban centre which lacks sufficiently large ethnic populations to assist in service provision. A number of suggestions are made which might ameliorate the difficulties of refugees living in smaller communities. These include municipally based client advocates and special translation training for existing hospital staff

Guruge, S., Kanthasamy, P., & Santos, J. E. (2008). Addressing Older Women's Health. In S. Guruge, & E. Collins (Eds.), *Working With Immigrant Women* (pp. 235-256). Toronto: Centre for Addiction and Mental Health.

We begin this chapter with a brief literature review on the key concerns of older immigrant women, paying particular attention to the diverse social, cultural, and economic forces that influence their mental health and well-being. We use the example of older Sri Lankan Tamil women in Canada to highlight general issues and concerns faced by older women immigrants.

Ethnicity and seniors : unity in diversity(1997). . Victoria: Victoria The Advisory Council.

Topics covered include definitions of cultural terminology, issues facing seniors as seen by ethnocultural organizations, culturally sensitive care in the community and in facilities, information and services for seniors in foreign languages, settlement services, senior citizen counsellors, health service delivery, social isolation, accessing resources to support multicultural or ethnic-specific programs and projects, partnerships with existing seniors' organizations, and literacy.

Canadian Ethnocultural Council. (2003). *Diabetes in older adults from Asian, Black and Hispanic Populations: Observations and Needs of Older Adults*. Canadian Ethnocultural Council.

Canadian Ethnocultural Council. (2003). *Information and programs to promote lifestyle changes for effective prevention and management of type 2 diabetes among ethnic seniors*. Ottawa, Ontario: Canadian Ethnocultural Council.

Lee, C., & Cheong, I. (1993). *Acculturation, aging & alienation - The voice of Indo-Canadian Seniors*. Orientation Adjustment Services for Immigrants Society.
The purpose of the study

The purpose of the study was twofold. The first and most important focus was to explore the dilemmas and research the needs of Indo-Canadian Seniors, age 55 and up, in the Municipality of Surrey/Delta. The second focus was to examine and assess existing services in terms of availability and appropriateness for the Indo-Canadian seniors. The outcome of the research would be to identify service gaps and make recommendations that would best meet the needs of this population.

Sanghera, G. S. (1991). *The Male Punjabi Elderly of Vancouver: Their Background, Health Beliefs, and Access to Health Care Services*. Unpublished Master of Social Work, University of British Columbia, Sanghera (1991:70) nonetheless reports very low rates of awareness of various types of services among the elderly Punjabi men of his Vancouver-based sample:

Only 16.5% [of male Punjabi elderly] knew of the existence of the Vancouver Health Department's office in South Vancouver, though none of them knew of the dental consultations facility in that office. Twenty percent know about homemaker services but none of them had heard of Long Term Care. Although all of them (120) had been visiting at least the Sunset Community Centre and Killarney Community Centre, only 8% had a superficial knowledge of other recreational and health related facilities. The possibility that these seniors do not know about additional services due to a lack of perceived need is rendered unlikely by the finding that "eighty per cent of the 120 subjects were dissatisfied with existing health services, including their own Punjabi speaking general practitioners" (1991:71). Of this sample, 20% had consulted their GP within the last month, while 27.5% said they had visited neither a GP nor any other health service during the past year. In parallel with Martyn (1991) and Koehn (1993), Sanghera (1991:76) identifies numerous barriers to attaining health care service for Punjabi seniors such as "general lack of information about the existence and availability of health services, . . . difficulties with . . . reception, filling out forms, language, interpretation, transportation, location of services, and the cultural appropriateness of some health services." Again, many of the problems that these seniors encounter in accessing health services could be addressed by modifications to the manner in which services are delivered.

Wood, M. I. (1991). *Access to social and health services by ethnic seniors in Vancouver*. Vancouver: Task Force to Review Availability and Accessibility of Health and Social Services to Diverse Ethnic Groups in Vancouver, Special Council Committee on Seniors, City of Vancouver.

Report of the National Workshop on Ethnicity and Aging, 21-24 February 1988, Ottawa, Ontario. --(1988). In Canadian Public Health Association (Ed.), . Ottawa, Ont.: Ottawa, Ont. : Canadian Public Health Association

4. To what extent and how do ethnocultural older adults make use of health care services (primary, secondary and tertiary) as compared to older adults in general?

Bowman, K. W., & Singer, P. A. (2001). Chinese seniors' perspectives on end-of-life decisions. *Social Science & Medicine*, 53(4), 455-464.

Making end-of-life decisions is a painful and difficult process; one that can be intensified by cultural differences between physicians and their patients. The objective of this study was to examine attitudes of Chinese seniors towards end-of-life decisions. We conducted a qualitative survey in a Chinese community centre in Toronto, Canada. Face-to-face interviews, in Cantonese, were conducted with 40 Chinese seniors 65 years of age or older. Respondents based their end-of-life decision making on the following factors: hope, suffering and burden, the future, emotional harmony, the life cycle, respect for doctors, and the Family. Respondents rejected advance directives. Respondents' attitudes toward end-of-life decision making can be understood through the lens of values from Confucianist, Buddhist and Taoist traditions. Health care workers can best achieve quality end-of-life care - and address the cultural differences that may arise - by focusing primarily on understanding the perspectives of patients and their families, and by continually striving for balanced and open communication at all stages of the caregiving process. (C) 2001 Elsevier Science Ltd. All rights reserved

Brotman, S. (2002). The Primacy of Family in Elder Care Discourse: Home Care Services to Older Ethnic Women in Canada. *Journal of Gerontological Social Work*, 38(3), 19-51.

Although public and institutional policy states that the presence of family to provide care should not limit older people's access to public services, it does occur in practice. When family members are perceived as being able to contribute to the care of their elderly relatives, the frequency and duration of public sector support diminishes. This reality is particularly important to address with respect to ethnic elders where the perception and expectation of increased family involvement by public sector workers is commonplace. This article reports on the findings of a qualitative study addressing the experience of access among ethnic minority elderly women. It highlights the primary role of families in the discourse of home care and the resulting pressures this places on older ethnic women and their families. Suggestions for improving services are also mentioned.

Chappell, N. L., & Lai, D. (1998). Health care service use by Chinese seniors in British Columbia, Canada. *Journal of Cross Cultural Gerontology*, 13(1), 21-37.

This paper assesses whether the same factors are predictive of health service utilization among this ethnic group as is true of the general population of seniors. The data suggest that the health of Chinese elders is just as bad as other seniors, and their utilization is very similar. They have a strong preference for Western over Chinese medicine and for Western trained doctors over Chinese practitioners, and use services with Chinese staff, probably because of language. Similarly, the predictors of service use are strikingly similar to predictors revealed in utilization studies throughout the industrialized world. Ability to speak English, immigration history, and country of origin are unrelated to the use of these services. However, approximately half of Chinese seniors also engage in traditional Chinese care. Religious beliefs and a preference for traditional Chinese medicine are strongly predictive of the use of traditional care. It would appear that distinctive culture is related to the use of traditional care, but not the use of the western health care system.

Investigated utilization of health care services by Chinese elders in British Columbia, Canada, and compared it with that of the general population of older adults in Canada. A random sample of 830 adults aged 65-102 (mean age 76) with Chinese surnames in the greater Victoria and greater Vancouver areas was interviewed, with the majority of interviews conducted in Cantonese. Service utilization was measured by asking the number of times respondents used a variety of services (physician, medical support and home

care services), their reasons for use, and whether Chinese practitioners were on staff at the service. Respondents were also asked about their use of traditional Chinese medical practices such as acupuncture or herbs. Need was measured in terms of health, illness, and disability, and sociodemographic data were collected. Almost half of the respondents spoke no English, and 73.2 percent reported their largest source of income as the old-age security payment and the guaranteed income supplement. The data suggest that Chinese elders have health that is similar to that of other older adults, and their utilization of services is similar to utilization figures for the general population. The vast majority see physicians, fewer than half use medical support services, and around 15 percent use home care services. Interestingly, they have a strong preference for western over Chinese medicine and for western-trained doctors over Chinese practitioners. However, they do tend to use services with Chinese staff, probably linked to the high proportion who do not speak or understand English. Similarly, the predictors of service use are strikingly similar to the predictors revealed in utilization studies throughout the industrialized world: ill health is the strongest predictor of use of physician services, while ill health and enabling and predisposing factors predict the use of both medical support services and home care services. Approximately half of the Chinese respondents also engage in traditional Chinese medical care. (SW) (AgeLine Database, copyright

Fung, J. (2006). Unpublished MSW, University of British Columbia, This paper examines the cultural appropriateness of the current service delivery practices in the Lower Mainland for the Chinese population, as Chinese seniors make up 40% of all visible minorities in Canada. The current service delivery practice is the person-centred approach. This paper examines the Western and Eastern cultural implications of personhood, the key concept in person-centred approach. A qualitative study conducted at S.U.C.C.E.S.S. Simon K. Y. Lee Care Home analyzed the experiences of health care professionals implementing a person-centred approach - Eden Alternative, is described. The study uses qualitative description to understand the meaning of the five participants' firsthand experiences. Three ideas emerged: 1) the Eden Alternative is appropriate to the Chinese population, 2) the implementation of Eden Alternative needs to be modified to cater to the Chinese culture, and 3) the Eden Alternative is a process no matter the culture. The two implications of the study are: 1) health care professionals need to focus on who the person is in order to be truly person-centred, and 2) the responsibility is on the health care professionals to figure out how to provide optimal care to each senior.

Hyman, I., Singh, M., Ahmad, F., Austin, L., Meana, M., George, U., et al. (2001). The role of physicians in mammography referral for older Caribbean women in Canada. *Medscape Women's Health* [Computer File], 6(5), 6.

BACKGROUND: Despite the fact that the proportion of immigrant and minority women who consult a general practitioner about their health is similar to that of their Canadian-born counterparts, studies suggest that they are less likely to be screened for breast cancer. This study examines physician characteristics associated with mammography referral and perceived barriers to mammography among family physicians serving the Caribbean community of Toronto. **METHODS:** The study consisted of a mail-back family physician survey. **RESULTS:** Among the 64 physicians who responded to the survey, over half reported that they were "very likely" to refer women for mammography during a regular preventive check-up. Among physician variables, only the amount of time spent on patient education was significantly associated with the likelihood of referral. Regarding perceived barriers, for male physicians, patient refusal and intervention causing patient discomfort were significantly associated with referral. For female physicians, only forgetting to provide service was identified as a significant barrier to referral. **INTERPRETATION:** An increased emphasis on patient education may help to increase screening referral among all physicians. Gender differences in perceived barriers to referral suggest that the gender of the physician is of major importance to the Caribbean community

Jones, D. C., & Amelvoort Jones, G. M. (1986). Communication patterns between nursing staff and the ethnic elderly in a long-term care facility. *Journal of Advanced Nursing*, 11(3), 265-272.

The purpose of this study was to examine verbal communication interactions between nursing staff and the elderly residents in a long-term care facility. Three groups of elderly were studied and compared. These were immigrant, Canadian-born, and Anglo-born elderly. Non-participant observation and tape recordings were the methods by which data were collected. Findings were transcribed and quantified under headings of 'words spoken', 'commands given', 'statements made', and 'questions asked and answered'. Significant differences in the observed interaction were found between groups. The findings indicate the need for nurses to be aware of the implications of ethnicity in caring for the elderly, and also for further communication studies in this area

Kinnon, D. (1999). *Canadian Research on Immigration and Health: An Overview* (catalogue No. Catalogue No. H21-149/1999E). Ottawa, Canada: Health Canada.

Koehn, S. (2006). *Ethnic Minority Seniors Face a Double Whammy in Health Care Access*. GRC News, 25(2), 1-2.

British Columbia is home to increasing numbers of seniors from ethnic minority (primarily Asian) backgrounds. Although health care providers commonly believe that family members usually provide care in the home for these seniors,¹ a new study suggests that this belief needs to be reconsidered. Ethnic minority seniors describe many barriers to accessing health care, such as conflicting family values, language barriers, immigration status, and lack of understandings of the roles of the health authority and of specific service providers. These problems are further confounded by the configuration and delivery of health services and the limited awareness among health care providers of the seniors' needs.

As a group, seniors have significantly greater health care needs than younger people and planning and delivery of health care services typically takes their needs into consideration. However, ethnic minority seniors face a double whammy - not only do they have greater health care needs, but they also have greater difficulty accessing health care. The barriers to care identified for ethnic minorities are especially acute for ethnic minority seniors. And the problem may intensify, since British Columbia's senior ethnic minority population is growing.

The research study, *Barriers to Access to Care for Ethnic Minority Seniors*, set out to identify barriers to the effective utilization and navigation of the continuum of care offered by the regional health authority, as well as strategies to overcome them. This article highlights the key themes that emerged from focus groups conducted with seniors and their families and health and multicultural service providers, as well as two workshops with all of these stakeholders. Strategies and policy changes that might help increase the navigability and effective utilization of services for this substantial group of B.C.'s seniors are also described.

Koehn, S. (2009). *Negotiating Candidacy: Access to Care for Ethnic Minority Seniors*. *Ageing & Society*, 29(4), 585-608.

The 'Barriers to Access to Care for Ethnic Minority Seniors' (BACEMS) study in Vancouver, British Columbia, found that immigrant families torn between changing values and the economic realities that accompany immigration cannot always provide optimal care for their elders. Ethnic minority seniors further identified language barriers, immigration status, and limited awareness of the roles of the health authority and of specific service providers as barriers to health care. The configuration and delivery of health services, and health-care providers' limited knowledge of the seniors' needs and confounded these problems. To explore the barriers to access, the BACEMS study relied primarily on focus group data collected from ethnic minority seniors and their families and from health and multicultural service providers. The applicability of the recently developed model of 'candidacy', which emphasises the dynamic, multi-dimensional and contingent character of health-care access to ethnic minority seniors, was assessed. The candidacy framework increased sensitivity to ethnic minority seniors' issues and enabled organisation of the data into manageable conceptual units, which facilitated translation into recommendations for action, and revealed gaps that pose

questions for future research. It has the potential to make Canadian research on the topic more coordinated.

Lai, D. W. (2004). Use of home care services by elderly Chinese immigrants. *Home Health Care Services Quarterly*, 23(3), 41-56.

Using the Anderson Service model, this study examined the level and predictors of using selected home care services by elderly Chinese immigrants in Canada. Data from 1,537 randomly selected Chinese immigrants aged 65 years and older were used. Only 5.2% of participants reported using home care services. Being older, living alone, having a post-secondary education, immigrating from Hong Kong or Southeast Asia, having a higher level of agreement with Chinese health beliefs, higher social support, and poorer physical and mental health were predictors for home care service use among elderly Chinese. The probability of using homecare services lessens with increased self-rated financial adequacy. These findings point to the need for service providers to address the gap in use of home care between elderly Chinese immigrants and overall elderly Canadians through promoting appropriate use of home care among elderly Chinese immigrants.

Examined the level and predictors of using selected home care services by older Chinese immigrants in Canada. Data were obtained on 1,537 Chinese immigrants aged 65 and older in regard to home care use, sociodemographic factors, Chinese health beliefs, social support, service barriers, and physical and mental health. It was found that 80 participants (5.2%, mean age 79.4) used home care services, while 1,457 (mean age 73.8) did not. Being older, living alone, having post-secondary education, immigrating from Hong King or Southeast Asia, having a high level of agreement with Chinese health beliefs, higher social support, and poorer physical and mental health were predictors of home care use. The probability of using home care services lessened with increased self-rated financial adequacy. The results point to the need for service providers to address the gap in home care use among Chinese immigrants in Canada compared with other Canadians through promotion of appropriate use of home care services. (MM) (AgeLine Database, copyright 2005 AARP, all rights reserved)

Majumdar, B., Browne, G., & Roberts, J. (1995). The prevalence of multicultural groups receiving in-home service from three community agencies in southern Ontario: implications for cultural sensitivity training. *Canadian Journal of Public Health. Revue Canadienne De Sante Publique*, 86(3), 206-211.

This survey assessed the ethnocultural proportion of clients (largely seniors) receiving services from three home care health agencies in Southern Ontario. Providers from the three agencies were asked to recall clients served in the previous two weeks and to describe them in terms of race, language, sex, age and disability status. White, English-speaking clients comprised 88.3% of the sample (N = 931). The remaining 11.7% of clients were white, non-English-speaking (7.8%), visible minority (2.8%), francophone (0.77%), indigenous (0.22%) and Hispanic (0.11%). Sixty-three percent of clients were women and 34% men. The majority (66.6%) of clients were over 65 years. The 11.7% of clients who were identified as multicultural in three home care agencies are an under-representation of the multicultural mix of population in the Southern Ontario region, which is 24%. Some recommendations have been offered for a system for ethnocultural data collection for the region and provision of cultural sensitivity training programs to enhance staff knowledge and skills

Masi, R., & Disman, M. (1994). Health care and seniors. Ethnic, racial, and cultural dimensions. *Canadian Family Physician*, 40, 498-504.

The profiles of Canadian seniors are changing. Racial, cultural, and social context is becoming increasingly important in the health care of seniors. This article discusses the interactions between physicians and seniors affected by ethnocultural variables and suggests a framework for cross-cultural care.

Wu, C. J. (2000). Cyclical migration among elderly immigrants: case of Taiwanese Canadians in Greater Vancouver (British Columbia) UMI Dissertation Services, ProQuest Information and Learning, Ann Arbor, MI. This thesis empirically examined cyclical migration among elderly immigrants--a phenomenon not addressed previously in the gerontological literature. 169 seniors who immigrated directly from Taiwan comprised the study sample (88 non-migrants and 81 cyclical migrants). They were interviewed to examine: (1) the pattern of, and reason for cyclical migration; (2) determinants of cyclical migration; and (3) the correlates of cyclical migration with health care utilization, social integration and socio-psychological well-being. A synthesis of Wiseman's behavioural model of elderly migration and Northcott's social demographic model of elderly mobility provided the theoretical basis for the research questions. The seasonal migration literature and cultural factors pertinent to the Taiwanese were also incorporated in formulating the research questions. Based on the findings, it is suggested that for elderly Taiwanese, cyclical migration acts as a way of fulfilling their socio-psychological, health care and economic needs after immigrating to Canada. It is recommended that emphasis be placed on culturally sensitive and accessible health care and social services for immigrant seniors, not necessarily to replace but not to supplement their personal resources. (Abstract shortened by UMI.) (Author Abstract, used by permission) (AgeLine Database, copyright 2004 AARP, all rights reserved)

Feser, L., & Bernard, C. B. (2003). Enhancing cultural competence in palliative care: perspective of an elderly Chinese community in Calgary. *Journal of Palliative Care*, 19(2), 133-139. Describes several projects designed to increase cultural competence within palliative care, focusing on the ethnic Chinese population in Calgary, Canada. A collaborative effort was undertaken with the Regional Palliative and Hospice Service within the Calgary Health Region, the Capital Health Area's Palliative Care Program, and the Calgary Chinese Elderly Citizens' Association to identify and translate commonly used assessments and other tools into languages used by the Chinese community. A community workshop was held to educate older Chinese about palliative care and hospice and to get their input on assessments and translation issues. The translated assessments and other documents included the Calgary Interagency Pain Assessment Tool, Edmonton Symptom Assessment Scale, a palliative care services brochure, a consumer questionnaire, and a consent form. Individual evaluation and group discussion of the translated documents by community members was positive and provided helpful feedback. (MM) (AgeLine Database, copyright 2004 AARP, all rights reserved)

Kobayashi, K. M. (2000). Nature of support from adult sansei (third generation) children to older nisei (second generation) parents in Japanese Canadian families. *Journal of Cross-Cultural Gerontology*, 15(3), 185-205. Investigated the cultural value of filial obligation affecting the nature of support from Japanese Canadian (JC) adult children to their older parents. One hundred second-generation JC older parents aged 55-80 and 100 of their adult children aged 30-50 completed personal interviews using an instrument with both qualitative and quantitative components. Data from the Canadian General Social Survey (GSS) were used for comparisons with the interview data. A total of 64% of the adult children had a high commitment to filial obligation; 51% felt more Japanese than Canadian. Filial obligation and ethnic identity were the only significant factors in predicting a JC adult child's emotional support for his or her older parent. Filial obligation also had a significant effect on the quality of emotional support provided by JC children to their parents. Parent's health and socioeconomic status had significant effects on children's provision of financial and service support. Child's availability was also a major determinant of financial support. In comparing JC adult children with their counterparts in the 1985, 1995, and 1996 GSS, both groups reported a high level of provision and quality of emotional support, with more assistance provided to mothers than to fathers. Although JC children provided a little more financial support than "other" matched Canadians, neither group provided much assistance in this domain. JC children were more likely to assist parents with general in-home services than their non-Japanese Canadian counterparts. Both groups were more likely to provide service help to mothers than to fathers. (AR) (AgeLine Database, copyright 2001 AARP, all rights reserved)

Lai, D. W. L. (2001). Use of senior center services of the elderly Chinese immigrants. *Journal of Gerontological Social Work*, 35(2), 59-79.

Examined the factors explaining different types of senior center service use among a random sample of older Chinese immigrants in Calgary, Canada, using the Andersen-Newman service utilization framework. The random sample of 97 Chinese immigrants aged 54-91 (mean age 69.3) who use Calgary's only Chinese senior center were interviewed in their native language about their general level of use of 19 types of services provided by the senior center, grouped into 4 categories (acculturation, recreation, task assistance, and support services). Predisposing factors were age, gender, marital status, education level, living arrangement, place of origin, and length of residency in Canada; enabling factors were financial status and social support; and need factors were mental health, negative affect, life satisfaction, and self-perceived health. Results show that most of the respondents visit the senior center regularly, although support services are substantially underutilized. Findings also show that the predictors of use vary for different types of senior center services. While the use of acculturation services is predicted by age of the users, the use of recreation services is better explained by place of origin and negative affect. The use of task assistance services is best explained by gender, satisfaction with services, and negative affect. The use of support services is predicted by living arrangement, satisfaction with services, and fewer mental health symptoms. (SW) (AgeLine Database, copyright 2002 AARP, all rights reserved)

Lai, D. W. L. (2004). Predicting factors for intention of use of long-term care facilities by aging Chinese-Canadians. *Journal of Social Work in Long-Term Care*, 3(2), 31-46.

Examined predictors of use of long term care (LTC) facilities among older Chinese in Canada. Data were obtained from the Health and Well-Being of Older Chinese in Canada study on 2,272 adults aged 55 and older living in 7 major metropolitan areas. Among the 2,249 participants who answered the question on whether they would consider living in an LTC facility if their health deteriorated, 920 (40.9%) indicated that they would. Significant predictors of intention to apply to an LTC facility were higher levels of dependence in instrumental activities of daily living, living alone, higher levels of social support, and higher levels of Chinese ethnic identity. Living alone increased the probability of having an intention to apply to an LTC facility by 2.37 times. (MM) (AgeLine Database, copyright 2005 AARP, all rights reserved)

This study examined the predictors of the elderly Chinese Canadians' intention of using long-term care facilities. The data for this study were collected as part of a larger research project, Health and Well Being of Older Chinese in Canada, which surveyed a total of 2,272 Chinese aged 55 and above. Among the 2,249 participants who answered the question on whether they would consider applying for long-term care facilities if their health deteriorated, 920 (40.9 percent) indicated that they would. The findings indicated that higher level of dependence in instrumental activities of daily living, living alone, higher level of social support, and higher level of Chinese ethnic identity were the significant predictors of intention to apply to a long-term care facility among older Chinese-Canadians. Implications for service providers are discussed.

Lai, D. W. L. (2005). Cultural factors and preferred living arrangement of aging Chinese Canadians. *Journal of Housing for the Elderly*, 19(2), 71-86.

Examined cultural factors and preferred living arrangements of aging Chinese in Canada. Data from a 2001-2002 national study of 2,272 Chinese Canadians aged 55 and older that included physical and mental health status, Chinese health beliefs and medicine, life satisfaction, and community support services were analyzed using logistic regression. Of the 2,053 respondents who indicated a living arrangement preference, 1,050 (mean age 69.7) preferred not living with adult children and 1,003 (mean age 70.0) preferred living with adult children. Potential predictors of preferred living arrangement were sociodemographic factors, health- and need-related factors (number of illnesses, functioning in basic and instrumental activities of daily living, physical and mental health, self-rated financial adequacy, and social support), and culture-related factors (religious affiliation, self-rated English competency, country of origin, length of residency in Canada, and identification with Chinese cultural values). When compared with those who preferred living with children, more who preferred not living with children were married, living alone, had a higher level of

education, had a lower level of identification with traditional Chinese cultural values, had a western religion, and were born in Canada. Among the health- and need-related variables, no significant differences were reported in number of illnesses, and physical and mental health between the 2 groups. However, those who preferred living with children reported a significantly higher level of dependency on others in activities of daily living. The findings suggest that culture-related factors were more important predictors of preferred living arrangement than health- and need-related factors. (SW) (AgeLine Database, copyright 2005 AARP, all rights reserved)

Racine, L. (2004). Meaning of home care and caring for aging relatives at home: Haitian Canadian primary caregivers' perspectives UMI Dissertation Services, ProQuest Information and Learning, Ann Arbor, MI. Providing nursing care in pluralist countries such as Canada remains a challenge for nurses. Little is known about the impact of 'race,' gender, and social class in mediating Haitian Canadian caregivers' ways of caring for aging relatives at home. This critical ethnography, informed by a postcolonial feminist theoretical approach, was directed at addressing two questions: What are the Haitian Canadian caregivers' ways of caring for an aging relative at home? and What are the contextual factors that might impinge on Haitian Canadian caregivers' access to public home care services? The study was carried out in Eastern Canada. A sample of convenience, composed of 16 Haitian Canadian primary caregivers, nineteen aging persons, and four home care nurses, was formed. Twelve out of sixteen participants were women--mostly daughters who were caring for aging mothers. Participant observation and open-ended interviews were used to collect data from primary caregivers. Fieldwork was carried out during two periods. The first part was from November 2000 to August 2001, during which 21 interviews and 15 sessions of participant observation at caregivers' home were conducted. The second part was from October 2001 to February 2002, during which 3 validity interviews were conducted with some participants to map out the data analysis. A postcolonial feminist framework guided data collection and analysis. A thematic content analysis was conducted. Results indicated that ways of caring are enmeshed in a complex nexus of social relations where power, race, gender, social class come into play to permeate each level of the caring commitment. Caring is a process of reciprocal growth. Ways of caring are structured by Haitian values, gendering of caring activities, immigration, social 'Othering,' health care reform, and cultural misunderstanding of mainstream health practitioners. These factors explain why this community tends to underutilize public home care programs. The study points to designing culturally safe nursing interventions and revising current neocolonial home care policies. The findings underline the need to redirect nursing cultural research to address racial, gendered, and social discrimination that influence the economic accessibility to home care support programs for low-income immigrant families in Canada, creating social inequities in our health care system. (Author Abstract, used by permission) (AgeLine Database, copyright 2005 AARP, all rights reserved)

van Dijk, J. (2004). Role of ethnicity and religion in the social support system of older Dutch Canadians. *Canadian Journal on Aging*, 23(1), 21-34. Examined the role of religion and ethnicity in providing social support for older Dutch Canadian Catholic and Calvinist parents and in establishing ethno-religious retirement and long term care (LTC) facilities. Continuity theory provides the theoretical framework for this study. Seventy-nine older Dutch Canadian immigrants (44 Calvinists, 35 Catholics) and 364 of their adult children (195 Calvinists, 169 Catholics) completed a 1995 postal survey that elicited information about demographic characteristics, ethnic and religious identities, living arrangements and social networks, family relationships, attitudes toward specific issues, and information about general issues, such as health, education, income, and occupation. Results showed differences between the Calvinist and Catholic groups in respondents' attitudes and commitments to the provision of and movement into ethnic and religious retirement residences or LTC facilities. When very old, the Calvinists tended to move into segregated housing built especially for them by their religious community. The Catholics did not have a cohesive Dutch community to support them as they aged and had to rely more heavily on their families or seek other accommodation. Second generation Dutch Calvinists have been busy establishing retirement and LTC facilities for the older Calvinist generation, while the Dutch Catholic Canadians have established very few facilities of this kind for their older members. (KM) (AgeLine Database, copyright 2004 AARP, all rights reserved)

Wasylenka, K. (2004). Visible minority seniors in long term care: not many and frail UMI Dissertation Services, ProQuest Information and Learning, Ann Arbor, MI.

Using an exploratory research design, this qualitative study examined the ways in which visible minority seniors in long term care facilities in the City of Regina remain connected to their culture. The number of visible minorities in Canada is increasing, along with an increase in the number who are age 65 and older. Little research in this area has been done in Canada, and no known research exists in Saskatchewan. Five owners/operators of personal care homes and 14 directors/senior staff from special care homes in the City of Regina participated, representing 14 facilities. The research was completed using the Social Inclusion Framework developed by Christa Freiler of the Laidlaw Foundation. Findings indicate that few visible minorities currently reside in long term care facilities in Regina. The research also indicates that connections to culture and traditions are influenced by the health of the resident, the availability of family members, and the ability of the facility to be flexible and adaptable. This research suggests that further research would be valuable in this area. (Author Abstract, used by permission) (AgeLine Database, copyright 2006 AARP, all rights reserved)

Lai, D. (2006). Predictors of use of senior centers by elderly Chinese immigrants in Canada. *Journal of Ethnic & Cultural Diversity in Social Work*, 15(1-2), 97-121.

This study examined the prevalence and predictors of use of senior centers by a random sample of 1,537 elderly Chinese immigrants in Canada. A service utilization model of Andersen and Newman (1973) was adopted as the theoretical framework to examine the predicting effects of predisposing, enabling, and need factors. The findings showed that 28.8% of the elderly Chinese immigrants reported using a senior center within the past year. Having a religion, living alone, having stronger Chinese ethnic identity and stronger social support were the significant predictors identified, as shown in the hierarchical logistic regression findings.

Lai, D., & Chau, S. (2007). Predictors of health service barriers for older Chinese immigrants in Canada. *Health & Social Work*, 32(1), 57-65.

Elderly people from ethnic minority groups often experience different barriers in accessing health services. Earlier studies on access usually focused on types and frequency but failed to address the predictors of service barriers. This study examined access barriers to health services faced by older Chinese immigrants in Canada. Factor analysis results indicated that service barriers were related to administrative problems in delivery, cultural incompatibility, personal attitudes, and circumstantial challenges. Stepwise multiple regression showed that predictors of barriers include female gender, being single, being an immigrant from Hong Kong, shorter length of residency in Canada, less adequate financial status, not having someone to trust and confide in, stronger identification with Chinese health beliefs, and not self-identified as Canadian. Social work interventions should strengthen support and resources for the vulnerable groups identified in the findings. Service providers should adjust service delivery to better serve elderly immigrants who still maintain strong Chinese cultural values and beliefs.

Elliott, S. J., & Gillie, J. (1998). Moving experiences: a qualitative analysis of health and migration. *Health & Place*, 4(4), 327-339.

This paper describes a qualitative analysis of the health and health care experiences of South Asian Fijian women now living in the lower mainland area of British Columbia, Canada. A particular focus is put on the health impacts of the migration experience. A thematic analysis of in-depth interviews informs the discussion of individual women's, as well as service providers', views of health meanings, physical and emotional health concerns, experiences with the health care system, and women's roles as care-givers. The findings have

implications for how health and illness are conceptualized, and how health services are provided to particular groups in particular places.

Kinch, J. L., & Jakubec, S. (2004). Out of the Multiple Margins: Older Women Managing Their Health Care. *Canadian Journal of Nursing Research*, 36(4), 90-108.

This feminist phenomenological study explores the meaning of older women's experiences as they negotiate health care. Several interviews with diverse groups of older women (immigrant, First Nations, and Japanese-Canadian women and those involved in community and social clubs) reveal that negotiating to have their health needs met was a challenging process requiring mutual support. Their health-care experiences were influenced by issues surrounding access to services, power, and poverty. For many participants, the conversational interview format served to inspire consciousness-raising, activism, and reflection. The findings suggest that such reflection may help other women to understand the "multiple margins" (being older, being a woman, being a member of a visible minority) that constrain and challenge their access to health care.

King, K. M., Khan, N. A., & Quan, H. (2009). Ethnic variation in acute myocardial infarction presentation and access to care. *The American Journal of Cardiology*, 103(10), 1368-1373.

Given the growing ethnic diversity in Canada, it is essential to recognize potential ethnic variability in acute myocardial infarction (AMI) symptoms to increase timely and effective treatment. We thus examined ethnic variation in symptom presentation and access to care of patients presenting to the emergency department (ED) with AMI. A random sample of 406 health records of Caucasian, Chinese, South Asian, Southeast Asian, and First Nations patients discharged from hospitals in the Calgary Health Region (Alberta, Canada) was audited. Measured variables were compared across ethnic groups and associations with classic AMI symptom profile and timely presentation to a hospital were examined. Chinese, South Asian, and Southeast Asian patients were 64% to 69% less likely than Caucasian patients to have a classic symptom profile reported and were less likely to speak English than their Caucasian and First Nations counterparts ($p < .05$). Chinese and South Asian patients were less likely to present to the ED within 12 hours of symptom onset; even in patients who presented with a classic symptom profile, South Asians were 70% less likely than Caucasians to report to the ED within 3 hours of symptom onset. Caucasians were significantly more likely to undergo angiography within 3 hours of presentation to the ED (42%, $p = 0.001$). In conclusion, explanatory variables associated with variability in symptom presentation and access to care associated with ethnicity require further exploration to ultimately develop effective strategies aimed at increasing timely presentation and care access.

Kobayashi, K. M. (2003). Do Intersections of Diversity Matter? An Exploration of the Relationship Between Identity Markers and Health for Mid- to Later-life Canadians. *Canadian Ethnic Studies*, 35(3), 85-98.

This paper explores the intersections of diversity, namely the identity markers of ethnicity, gender, age, and immigrant status, in the area of health and well-being. Based on findings from recent studies on the determinants of health status and health care utilisation patterns of immigrant and native-born Canadians in mid-to later life (Dunn and Dyck, 1998; Gliberman, 1998; Kopec, Williams, To and Austin, 2001; Perez, 2002), the paper examines issues of representation, inclusion, and access to health care services from both qualitative and quantitative perspectives. Specifically, the focus is on identifying and understanding the connections between ethnicity, gender, age, immigrant status, charter language ability, and health care accessibility and utilisation over the adult life course. A recent study, based on analyses from 1996-1997 National Population Health Survey data, examining the intersections between age, health, immigrant status, and language ability is highlighted. The paper concludes with a discussion on the implications of this research for policy and program development targeting specific intersection sub-groups (e.g., South Asian older adult women for screening tests). (English) [ABSTRACT FROM AUTHOR]

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

The authors examine the effects of service barriers on the health status of older Chinese immigrants in Canada. A survey was completed in seven Canadian cities by a random sample of 2,214 older Chinese immigrants age 55 years or older. Service barriers related to administrative problems, personal attitudes, and circumstantial difficulties were significant predictors of physical and mental health when controlling for the demographic factors. Empirically, the findings confirm that service barriers are detrimental to the health of older immigrants. The service barriers in the areas of ethnic, language, or cultural differences between the service providers or services themselves and the older Chinese clients also suggest that factors related to communication contribute to these older clients' perception of services or providers as culturally insensitive or unresponsive. Considering the individual, social, and economic costs incurred by adverse health consequences, barriers in service delivery must be addressed.

Lai, D. W. (2008). Intention of use of long-term care facilities and home support services by Chinese-Canadian family caregivers. *Social Work in Health Care, 47*(3), 259-276. One common myth about ethno-cultural minority family caregivers is that they do not use formal services. This study examined the intention of using home support and long-term care facilities by a random sample of 339 Chinese-Canadian family caregivers, using a modified version of the Andersen-Newman service utilization model. Filial piety, caregiving burden, care receivers, and health conditions are the common predictors identified. Filial obligation is most likely manifested through facilitating the care receivers to make use of the services needed, particularly for caregivers who reported a high level of caregiving burden.

Lai, D. W. L. (2010). Filial Piety, Caregiving Appraisal, and Caregiving Burden. *Research on Aging, 32*(2), 200-223. This study examined the effects of filial piety on the appraisal of caregiving burden by Chinese-Canadian family caregivers. A quantitative telephone survey was used as the research design for this study. A total of 339 randomly selected Canadian-Chinese family caregivers of elderly were interviewed by telephone. A hypothesized model denoting both the direct and indirect effects of filial piety on caregiving burden was tested using structural equation modeling. While stressors and appraisal factors reported direct predicting effects on caregiving burden, filial piety indirectly affected caregiving burden by altering appraisals of the caregiver role. Filial piety served as a protective function to reduce the negative effects of stressors and to enhance the positive effect of appraisal factors on caregiving burden.

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

Examined service barriers experienced by Chinese immigrant family caregivers in Canada and the predictors of different types of barriers. The 315 adults aged 18 and older providing care to 315 family members aged 65 and older (mean age 74.7) completed a telephone survey with a structured questionnaire regarding demographics, health status, caregiving tasks and burdens, impact of caregiving, depressive symptoms, caregiving rewards, caregiving attitudes, and service use and barriers. Age of caregivers was grouped into 7 categories ranging from 18-24 to 75 and older. Results of principle component and multiple regression analyses showed that financial factors significantly predicted the number and types of barriers reported by caregivers. Service barriers were grouped into 5 types: cultural incompatibility, administrative problems, circumstantial challenges, negative perception toward services, and personal attitude. Culture-related factors were significant in predicting the total number of access barriers and the different types of barriers experienced by the caregivers. The findings indicate the importance of culturally sensitive support for family caregivers to reduce the access barriers.

Lum, J. M., & Springer, J. H. (2004). *The Aging Experience of Chinese and Caribbean Seniors* No. 8). Toronto, Ontario: CERIS.

This paper documents varying patterns of support service use by Chinese and Caribbean seniors, living in social housing managed by the Toronto Community Housing Corporation (TCHC). It explores the factors that facilitate more extensive use of support services and programs critical for the continued independence and well-being of seniors. It argues that structural factors beyond individual characteristics affect patterns of support service use. These include:

?? A critical mass of tenants with a similar racial background living in the same building;

?? Closeness to a institutionally complete ethnoracial community; and

?? The intervention by social or community case workers.

The findings have broader policy implications for the pattern of support service use for other ethnoracial minority seniors in other metropolitan areas.

Matsuoka, A. K. (1999). Preferred Care in Later Life Among Japanese Canadians. *Journal of Multicultural Social Work*, 7(1), 127-148.

This paper explores preferences for care among minority seniors. Two generations of Japanese Canadians, those who came from Japan and those who were born in Canada as children of Japanese immigrants, participated. Vignettes are used to define situations of care and multidimensional scaling is employed for analyses. Care preferences differ by generation, marital status, Income and ethnic identity among these ethnic seniors. The findings suggest that preferences for care in later life are socially constructed and personally redefined. The study applies the double boundary theory of ethnicity and points out the importance of examining intra-ethnic group differences in care preferences which may bring a better understanding of culturally sensitive care provision.

Maurier, W. L., & Northcott, H. C. (2000). *Aging in Ontario: diversity in the new millennium*. Calgary, Alberta: Detselig Enterprises.

Examines the effects of the increasing diversity among older adults in Ontario, Canada, on the aging experience, focusing on the health and human service needs of diverse older adults. Presents demographic data on older adults in the province, including information on health status and health care utilization. Discusses the informal support provided by and to older adults and the formal support available for this population. Describes the types of long term care centers in Ontario, profiles the types of older adults residing in such facilities, and reviews their experiences with institutionalization. Examines federal and provincial programs for older adults, including income, housing, and health care, and issues related to intergenerational equity and sustainability. Concludes with an overview of how each element of diversity (age, gender, marital status, health, income, ethnicity, and regional differences) affects the health status, health care use, informal support, and institutionalization of older adults in Ontario. Includes references. (MM) (AgeLine Database, copyright 2001 AARP, all rights reserved)

Meana, M., Bunston, T., George, U., Wells, L., & Rosser, W. (2001). Older Immigrant Tamil Women and Their Doctors: Attitudes Toward Breast Cancer Screening. *Journal of Immigrant Health*, 3(1), 5-13.

Abstract Cultural beliefs have been hypothesized to be powerful barriers to breast cancer screening in minority women and physician recommendation is consistently reported to be the strongest incentive. This study investigated (1) beliefs regarding breast cancer and (2) the perception of barriers to mammography and clinical breast examination in a sample of immigrant Tamil women, as well as in a sample of primary care physicians. Three focus groups, each consisting of 10 immigrant Tamil women from Sri Lanka aged 50 years or over were conducted and 52 primary care physicians who serve this population completed mailed surveys. The most common barriers to screening reported by the women were (1) lack of understanding of the role of early detection in medical care, (2) religious beliefs and, (3) fear of social stigmatization.

Physicians reported the most common barriers to their screening recommendations for this group of women to be (1) women's episodic care, (2) unrelated presenting problems and, (3) women refusing to be screened.

Interventions to increase screening in this and other minority groups requires an elaborated understanding of utilization barriers for both women and their doctors

Motiwala, S. S. (2003). Socio-demographic determinants of place of death for seniors in Ontario UMI Dissertation Services, ProQuest Information and Learning, Ann Arbor, MI.

This study determined the place of death (hospital, long-term care facility or home) for seniors in Ontario who died in Fiscal Year 2001 (n = 59,871), and examined the relationship between socio-demographic factors--age, gender, comorbidities in the last year of life, county of residence, long-term care (LTC) and hospital bed availability in county of residence, socio-economic status (SES), ethnicity, and immigrant status--and place of death. 29,479 (49.24%) individuals died in hospital, 13,316 (22.24%) died in LTC facilities, and 17,076 (28.52%) died at home. Comorbidities in the last year of life, particularly psychosocial and major acute conditions, were the strongest predictors of place of death (p less than 0.0001), followed by age (p less than 0.0001) and gender (p less than 0.0001). Older individuals and women were less likely to die at home and more likely to die in LTC facilities. LTC and hospital bed availability, SES, ethnicity, and immigrant status were statistically significant predictors of place of death, but made a relatively small contribution to the final model. Our findings may guide policy and resource allocation decisions regarding palliative care in different settings. Research into other determinants of place of death and the costs and outcomes of palliative care in different care settings is recommended. (Author Abstract, used by permission) (AgeLine Database, copyright 2005 EBSCO Publishing, Inc., all rights reserved)

Mullings, D. V. (2006). Policy Needs of Older Caribbean-Canadian Women. *Caribbean Journal of Social Work*, 5, 143-158.

This paper explores the barriers to an enabling quality of life for older Caribbean-Canadian women who have aged in place. Increasingly, some of these women are forced, through social and financial circumstances, to use long-term care (LTC) residential facilities as an alternative to living in their communities. The article provides a brief description of the contemporary Canadian policy environment, social and historical position of Caribbean Canadians, including their experiences of sexual and racial discrimination, and describes some of the associated challenges that the women may encounter while residing in LTC residential facilities. Finally, suggestions for policy implementation are made to help improve the quality of life for older Caribbean Canadian women in LTC facilities. [ABSTRACT FROM AUTHOR]; Copyright of Caribbean Journal of Social Work is the property of ACSWE (Caribbean Journal of Social Work) and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use. This abstract may be abridged. No warranty is given about the accuracy of the copy. Users should refer to the original published version of the material for the full abstract. (Copyright applies to all Abstracts.)

Thomas, B. C., Carlson, L. E., & Bultz, B. D. (2009). Cancer patient ethnicity and associations with emotional distress--the 6th vital sign: a new look at defining patient ethnicity in a multicultural context. *Journal of Immigrant and Minority Health / Center for Minority Public Health*, 11(4), 237-248.

Variations in access to care, utilization of available resources and treatment outcomes in the context of ethnicity have been recognized, but very little research of this nature exists in the oncology context. The present paper is an in-depth analysis of data on a large representative sample of Canadian cancer patients with a focus on the role of 'ethnicity', its association to psychological distress, and its impact on the cancer experience. Because of a heterogeneous representation of ethnic self-identifications which were not easily grouped or classified, English as a second language was considered as a surrogate marker to ethnicity. People who self-reported to be from an English-speaking country were grouped together and compared to those hailing from countries which do not have English as a primary language. In a hierarchical logistic regression model (n = 2,402) the demographic and cancer-related variables associated with significant clinical distress in the first block were gender (male, except those with prostate cancer), age less than 68

years, less than a year since diagnosis, diagnosis of lung cancer, and recurrent disease. In the second block, after controlling for the influence of these factors, patient-reported ethnicity (being originally from a non-English speaking country) added significantly to the prediction of patient distress. Though compelling, there is a need to understand the relationship between the ethnic features and language (English versus non-English language). A hypothesis is presented as an attempt to understand an individual's 'ethnicity' within the framework of a multicultural society.

Ujimoto, K. V. (1987). Organizational activities, cultural factors, and well-being of aged Japanese Canadians. In C. M. Barresi (Ed.), *Ethnic dimensions of aging* (pp. 145-160) Springer, New York, NY. Examined generational differences in participation in organizational activities, differences in the retention of ethnic cultural factors, and the subjectively perceived well-being of elderly Japanese Canadians. A time-budget methodology was used to collect data on the frequency, duration, and sequence of various daily activities of 369 first- and second-generation Japanese Canadians. Respondents were members mainly of organizations and associations specifically for Japanese Canadians; actual participation in these organizations was rather limited, and membership seemed to be based on moral or social obligations and gratitude for past assistance in securing rights of citizenship and franchise privileges. Traditional cultural values deemed important for successful aging varied depending on generation and included perseverance, discipline, and filial obligations to respect elders. These factors were related to respondents' satisfaction with their financial situations and family relations. Cultural factors reported to hinder successful aging were reserve or restraint, lack of general aggressiveness, and false modesty. (KB) (AgeLine Database, copyright 1989 EBSCO Publishing, Inc., all rights reserved)

Wong, P. T. P., & Reker, G. T. (1985). Stress, Coping, and Well-Being in Anglo and Chinese Elderly. *Canadian Journal on Aging*, 4, 29-37.

Hwang, E. (2008). Exploring Aging-in-Place Among Chinese and Korean Seniors in British Columbia, Canada. *Ageing International*, 32(3), 205-218. British Columbia, Canada, has emerged as a popular settlement area for Chinese and Korean immigrants. Responding to the demographic trend, the goal of this study was to examine current characteristics of housing and neighborhoods and utilization of local amenities of Chinese and Korean seniors in BC in exploring the possibility of aging-in-place in their home and community. The data were collected using face-to-face interviews for 99 participants (50 for Chinese and 49 for Koreans). To compare group differences between Chinese and Koreans, chi-square and t tests were conducted. Results indicated that Chinese and Korean seniors stayed at current housing about 10 years and did not plan to move out in the next 3 years. However, Chinese seniors were more likely to live with their adult children and church was an important resource for Korean seniors. Local amenities created more resources and social support for both Chinese and Korean seniors, but Chinese seniors tended to actually use various local amenities more than Korean seniors. To Korean seniors, ethnic Korean church was an important source of community links. The role of housing should be discussed from a bigger context to enable the participants to remain in their familiar environment.

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

Over the past decade, policymakers and practitioners in the field of aging have been increasingly challenged to develop appropriate health and social services for elders from diverse ethnic communities. This has largely resulted from concerns regarding the significant barriers to care faced by disenfranchised elders. However, advances in the articulation of multicultural practice and policy dealing with ethnic communities have focused almost exclusively on developing competency skills based on individual communication and

understanding between formal service providers and clients rather than on exposing and altering institutional structures and power relations marked by racism. Indeed, antiracist agendas are rarely articulated in gerontological settings. This article reports on some of the central findings of a qualitative institutional ethnographic study on health care access among ethnic elderly women. It addresses the question of how multicultural programs and policies operate in elder care services and how they are experienced by ethnic elderly female clients and their service providers

Chappell, N. L., & Kusch, K. (2007). The gendered nature of filial piety--a study among Chinese Canadians. *Journal of Cross-Cultural Gerontology*, 22(1), 29-45.

This paper examines the modern face of filial piety enactment among Chinese families living away from their homeland. It empirically assesses filial piety practices among a random sample of diasporic Chinese Canadians, by studying the role of sons, daughters and spouses in providing assistance with basic activities of daily living, instrumental activities of daily living and perceptions of support; the relative contribution of the traditional Chinese caring unit (son plus daughter-in-law) with assistance provided; whether source of assistance changes when amount of care is taken into account, when the gendered nature of tasks is taken into account and when controlling for other factors in multivariate analyses. N = 2,272 Chinese seniors (age 55+) living in seven cities across Canada. The findings reveal that, among these diasporic Chinese, patterns found in other Chinese societies are evident in their tendency to live with children, even when the spouse is still living, and the involvement of sons and the son/daughter-in-law unit in providing care. However, similar to recent findings for China, daughters and spouses are involved in all 3 areas of support examined and importantly, their involvement increases as more assistance is provided while that from sons decreases, notably in terms of IADL. The participation of daughters-in-law tends to be lower than that of either sons or daughters. The involvement of spouses increases for perceived or emotional support. The findings suggest a blending of Chinese and Canadian patterns of care and are discussed in terms of the changing but still gendered nature of care.

Koehn, S. (1993). *Negotiating New Lives And New Lands: Elderly Punjabi Women in British Columbia*. University of Victoria, Victoria, B.C).

The medical literature reveals elevated patterns of GP utilization by "South Asian" immigrants in Britain and Canada, but provides few clues as to why this may be the case. A more critical examination of methodological inconsistencies between these studies reveals that oftentimes these figures cannot be attributed to ethnicity alone and that there exist considerable discrepancies among South Asian immigrants according to regional identification, religion, gender, and age. More in-depth examinations reveal, moreover, that while cultural beliefs influence health care utilization to some extent, structural barriers such as the organization of health care services and the attitudes of physicians toward their South Asian patients may be more salient.

Meadus, J. E., & Advocacy Centre for the Elderly. (2003). *Admission of Sponsored Immigrants Into Long-Term Care Facilities*. Unpublished manuscript. Retrieved 07/07/2006, from <<http://www.advocacycentreelderly.org/pubs/nursing/sponimm.pdf>>

The issue of the admission of sponsored immigrants into long-term care facilities is one which frequently arises. The following is information designed to assist in admitting sponsored immigrants to long-term care facilities to make sure that they receive the proper care to which they are legally entitled under our health-care system. In Ontario, long-term care facilities are defined as nursing homes, charitable homes for the aged, and municipal homes for the aged. Applications for such facilities are made through the local Community Care Access Centre which determines eligibility. Waiting lists are kept by the Community Care Access Centre and bed offers may be made either by the facility itself or by the Community Care Access Centre, depending on the arrangement with the facility. Residents of long-term care facilities are only required to pay for accommodation. If an applicant cannot afford the basic rate for ward accommodation, then the applicant can only apply for ward accommodation. It is not possible to have the accommodation rate reduced for private or semi-private accommodation. Should the senior's family wish to apply for semi-

private or private accommodation, they will be required to be responsible for the additional cost and the information contained herein does not apply. In order to be eligible for admission to a long-term care facility, the potential resident must have a valid health card. Certain immigrants on Minister's Permits are not entitled to health care in Canada and therefore may not apply to long-term care facilities. The applicant must also meet other eligibility criteria such as medical requirement and need for assistance with activities of daily living. (The eligibility criteria are not discussed in this paper.)

Meister, C., & Boyle, C. (1996). Perceptions of quality in long-term care: a satisfaction survey. *Journal of Nursing Care Quality*, 10(4), 40-47.

At a 387-bed geriatric hospital in Montreal, Canada, a cross-sectional satisfaction survey was conducted on random samples of patients, families, families of deceased patients, and nursing staff. Using the same pretested structured questionnaire, the subjects were asked to rank (assign importance to) and rate (assign a rate of success to) 15 indicators of quality care. Significant differences both between and within the four groups were found on the perceived importance and rate of success of many of the indicators, supporting the primary hypotheses. Ethnicity and several sociodemographic covariates influenced the importance and rate of success assigned to the key indicators. The article discusses survey methodology issues as well as the integration of a satisfaction survey into an overall quality improvement program

Neufeld, A., Harrison, M. J., Stewart, M. J., Hughes, K. D., & Spitzer, D. (2002). Immigrant women: making connections to community resources for support in family caregiving. *Qualitative Health Research*, 12(6), 751-768.

The purpose of this ethnographic study was to understand how immigrant women caregivers accessed support from community resources and identify the barriers to this support. The study included 29 Chinese and South Asian women caring for an ill or disabled child or adult relative. All experienced barriers to accessing community services. Some possessed personal resources and strategies to overcome them; others remained isolated and unconnected. Family and friends facilitated connections, and a connection with one community service was often linked to several resources. Caregivers who failed to establish essential ties could not initiate access to resources, and community services lacked outreach mechanisms to identify them. These findings contribute new understanding of how immigrant women caregivers connect with community resources and confirm the impact of immigration on social networks and access to support

Radcliffe, S., & Lundrigan, M. (1988). The Immigrant Seniors Project. *Canadian Journal of Public Health. Revue Canadienne De Sante Publique*, 79 Suppl 1, 11-15.

The Immigrant Seniors Project was an "action research" process in which two community surveys were conducted. The first survey focused on seniors: their attitudes to aging, their degree of socioeconomic and psychological dislocation, and the extent of their access to community services. A prime concern was the creation of an atmosphere of trust and relaxation in which seniors were encouraged to view themselves as the agents of change. The second survey focused exclusively on health concerns; it employed a more traditional methodology, encompassing all adult age cohorts in the target communities. The surveys were conducted in association with other community development activities including workshops, the production of information (subsequently translated), and the training of bicultural outreach workers

Keefe, J., Rosenthal, C., & Beland, F. (1993). The Impact of Ethnicity on Helping Older Relatives: Findings from a Sample of Employed Canadians. Montreal.

This study examines the relationship between ethnicity and the provision of assistance to older relatives. A sample of employed Canadians (N=2,753), a subsample of the CARNET Work and Family Survey, is used to explore how ethnicity influences the amount of assistance provided to older relatives. Findings from our study suggest that Asians, East Indians, and Southern Europeans provide higher levels of help than British

respondents. Filial obligation affects the amount of help provided but plays a similar role within each ethnic group. However, structural factors - in particular, living arrangement and age - are stronger predictors of the level of involvement in helping older relatives than are cultural factors of filial obligation and belonging to a particular ethnic group.

Molzahn, A. E., Starzomski, R., McDonald, M., & O'Loughlin, C. (2005). Indo-Canadian beliefs regarding organ donation. *Progress in Transplantation (Aliso Viejo, Calif.)*, 15(3), 233-239.

CONTEXT: There is concern that a disproportionately high number of people of South Asian origin await transplantation in Canada. The donation rate is low in this population, and it is difficult to obtain good tissue matches. OBJECTIVE: To explore the values and beliefs regarding organ donation among Indo-Canadian people living in British Columbia. DESIGN: A naturalistic qualitative study was designed. Individual interviews and focus groups were held to collect data pertaining to beliefs regarding organ donation. SETTING: Lower Mainland of British Columbia, Canada. PARTICIPANTS: A total of 40 Indo-Canadian persons participated; a wide range of ages, religions, and backgrounds were represented. RESULTS: The major themes that emerged from the data related to context (including family/community, religion, trust in the healthcare system, and knowledge about organ donation); and values and beliefs (including intergenerational considerations, death and dying, and the organ donation process). Participants noted that people from their community were reluctant to discuss death and related issues such as organ donation. Although there was recognition of the importance of individual decision making pertaining to organ donation, the participants believed that family and community members also should be involved. CONCLUSIONS: Beliefs varied considerably among participants, and one should not make assumptions about the beliefs of any one individual based primarily on that individual's membership in an ethnocultural community.

Canadian Ethnocultural Council. (2002). *Diabetes in Older Adults from Asian, Black, and Hispanic Populations: Opinions and Needs of Health Care Professionals*. Ottawa, Ontario: Canadian Ethnocultural Council.

Canadian Ethnocultural Council. (2000). *Use and misuse of drugs by seniors: A cross-cultural education model - Resource and training manual*. Ottawa, Ontario: Canadian Ethnocultural Council.

Martyn, C. (1991). *Hidden Faces: A Survey of Suburban Immigrant Seniors*. Burnaby, British Columbia: Burnaby Multicultural Society.

Over the past decade, municipalities around Greater Vancouver have witnessed an ever-increasing multicultural mix. This mix is evident in the school system, in municipal parks, and in local shopping centres. But the same multicultural representation is not evident in the clientele of many community services, for example services for seniors. This report describes findings from a study which examined suburban immigrant seniors' awareness and access to health and community services. The report also profiles other aspects of immigrant seniors lives and makes a number of recommendations for improving their quality of life. The study consisted of two hundred and fifty interviews, with 50 seniors (25 males and 25 females) from each of the Punjabi, Portuguese, Korean, Cantonese and German speaking communities. Participants were 55 years or older and were presently residents of Burnaby, New Westminister, Coquitlam, Port Coquitlam or Port Moody. The directive for the study was community development; thus, the report has been prepared with local organizations' needs and concerns in mind. For the same reason, the presentation of statistics in the body of the report has been minimized.

Replanski, D. (2006). *Promoting Health Living in BC's Multicultural Communities. The Affiliation of Multicultural Societies and Service Agencies of BC*.

5. To what extent and how do ethnocultural older adults engage in health promotion and disease prevention activities as compared to older adults in general?

Palmar, I., & Nascimento, O. (2002). Health Action Theatre by Seniors: community development and education with groups of diverse languages and cultures. *Generations*, 26(3), 65-67. Describes the Health Action Theatre by Seniors (HATS) project developed by St. Christopher House, a multiservice organization in Toronto's west end, an area with a high concentration of immigrants. The program employs an interactive theater model to address issues with diverse groups in multicultural and multilingual Canada, such as elder abuse, gambling, mental health, substance abuse, home and street safety, nutrition, environment, and caregiving. The troupes comprise older adults from a variety of linguistic and cultural backgrounds. The plays are primarily mimed, reducing barriers of language and literacy. Following each performance, a staff facilitator, aided by interpreters, encourages the audience to suggest ways to change how the performers have dealt with an issue in the play. (AY) (AgeLine Database, copyright 2003 AARP, all rights reserved)

Greaves, G., & Hill, G. (1997). Ethnicity, aging, and health: an interdisciplinary experience. *Educational Gerontology*, 23(7), 695-706. Describes the development and implementation of an undergraduate course about ethnicity, health, older adults, and interdisciplinary team care. The course was developed by the School of Nursing at Queen's University, Kingston, Ontario, Canada. An interdisciplinary advisory team, consisting of members from nursing, theology, sociology, psychology, occupational therapy, education, and human geography disciplines, guided the process of planning, implementing, and evaluating the course. Student participants were divided into six-person teams, with no more than two students from any one discipline per team. The primary learning activities involved review and presentation of case studies as an interdisciplinary student team, presentation and discussion of class topics through interdisciplinary faculty team role modeling, and two written assignments. The topics addressed reflected the course objectives and goals and content identified by the students. Students' postcourse questionnaires, class participation, and assignments suggested that the students enhanced their understanding of the culture and ethnicity of others and increased their appreciation for the views and practices of other disciplines. (KM) (AgeLine Database, copyright 1997 AARP, all rights reserved)

Rosenbaum, J. N. (1991). Health meanings and practices of older Greek-Canadian widows. *Journal of Advanced Nursing*, 16(11), 1320-1327. Analyzed the health meanings and practices of older Greek-Canadian widows. Twelve "key informants" (widows identified with the Greek culture, aged 50-81, widowed for 6 months or longer, and able to speak English) and 30 "general informants" (Greek-Canadian widows, community leaders, family, and friends) participated in the study. Interview inquiry guides, Leininger's Life History Health Care Protocol, and field journal recordings were used in data collection. Data were analyzed using Leininger's phases of analysis for qualitative data. Recurrent meanings and expressions were articulated: the state of the widow's health affected the extended family, there was an expectation that grown children would care for sick aging parents, a state of health was one of well-being and included the retention of cognitive abilities and self-esteem, a state of health allowed for the performance of daily role activities and expected behaviors, and physicians were visited and medications taken to avoid illness and pain. The Greek- and Turkish-born informants maintained the use of some folk remedies for illness, while relying primarily on professional caregivers. Health promotion beliefs and practices included maintenance of a balanced diet and moderation in eating. Nursing implications are discussed, particularly the need to incorporate family values and folk care practices into culturally relevant care. (UH) (AgeLine Database, copyright 1991 AARP, all rights reserved)

Wills, B. S. H. (2005). Responses of the elderly Chinese in Edmonton to the threat of SARS (Alberta) UMI Dissertation Services, ProQuest Information and Learning, Ann Arbor, MI.

Severe Acute Respiratory Syndrome (SARS) is considered the first virulent infectious disease of the 21st Century by medical professionals worldwide. Aided by international travel, SARS quickly spread to 32 countries in five continents within weeks of its outbreak in Southern China. There are still no definitive treatments for the disease at this time and the mortality rate of 50% for elderly over 65 years of age is a major concern for many elderly. Prevention is deemed the best strategy against SARS to date. It is of great importance to gain an understanding of the use of protective and preventive strategies among Chinese elderly living in Edmonton, as the Chinese are quickly becoming the largest visible minority of Canada. In this study, grounded theory was used to gain an understanding into the process of initiating preventive and protective strategies against SARS among Chinese elderly living in Edmonton. To fully address the cultural component of the study, specific ethnographic strategies were used. Retrospective individual interviews were conducted in Cantonese with 19 Chinese elderly who either lived by themselves, with family members or in a nursing home for Chinese elderly. Data analysis occurred concurrently with data collection. The researcher identified the core category of "Protecting self, family and others" using the constant comparison method of data analysis, and derived a theory consisting of 5 stages. (1) recognizing the threat of SARS, (2) becoming terrified, (3) initiating strategies against SARS, (4) resorting to higher power for comfort and extra protection, and (5) maintaining vigilance against SARS. The findings from this study suggest that while Chinese elderly were seized by the fear of SARS, they were knowledgeable about the different protective strategies against SARS. They initiated these strategies as a responsibility to their family and others in the community. These responsibilities were profoundly influenced by the concept of filial piety, which remains a salient factor in guiding the actions of Chinese elderly in Edmonton. Implications of this study include how health care professionals, especially those who work in the public health sector, could provide support and care for the elderly group in case of a re-emergence of SARS or other similar infectious diseases. (Author Abstract, used by permission) (AgeLine Database, copyright 2006 AARP, all rights reserved)

Majumdar, B. B. (1995). The effectiveness of a culturally sensitive educational programme of self-perception of health, happiness, self-confidence, and loneliness in Southeast Asian seniors. MICHIGAN STATE UNIVERSITY. , 181 p. (UMI Order PUZ9619862.)

Educational and Health care policies in Canada are based on the principle of universal accessibility. With this principle everyone has an equal right to access and receive educational and health services regardless of age and ethnicity. In spite of being part of the mainstream (dominant group), a large number of seniors suffer from ageism and have difficulty in accessing available services. Seniors from non-European backgrounds are confronted with double barriers: ageism and racism. Those seniors who are from non-European culture and non-English speaking are more vulnerable than any group of seniors. This study was aimed at exploring the effectiveness of a culturally sensitive, self-directed and self-supported educational programme for the selected population. The purpose of the programme was to increase self-confidence and alleviate social isolation among a selected group of senior, South-East Asian immigrants by providing a self-directed, self-supportive educational programme. In this study a descriptive design was employed: the independent variables include the subjects' gender, age, ethnic origin, marital status, language, education, income, financial status. The dependent variables were perception of health, self-confidence and loneliness, and ability to speak English. Participants included twenty seven seniors. They are all located in Hamilton, Ontario, and they immigrated from Vietnam within the last five years. All spoke Chinese and resided in apartment buildings in downtown Hamilton. Two questionnaires were developed and tested for face and content validity and reliability for this study. The health assessment questionnaire was developed to measure the perception of health, self-confidence, happiness and loneliness. Bader's (1983) oral language expression rating scale was modified to measure the seniors' ability to speak English. In addition, a weekly journal was kept to record the progress of individual seniors' ability to speak English and their group interaction. The demographic profile questions indicated respondents were: male 73%, married 73%, a low income earner--under \$500.00/month 65%, and Chinese origin 100%. Forty six percent of seniors had obtained an elementary school education (46%). Significantly, the seniors have created their roles as experts among the younger generation on maintaining cultural rituals and customs for the Canadian of

South East Asian origin. They have begun a self support group, independent of Provincial and Federal Government funding and started to take care of each other rather than depending on their children. [Scientific symbols modified where possible in accordance with CINAHL policy]

Reach Up Reach Out - Best Practices in Mental Health Promotion for Culturally-Diverse Seniors. Victorian Order of Nurses Canada. Retrieved from <http://www.von.ca/en/special_projects/docs/RR_manual.pdf>

VON Canada Eastern Region is the proponent of a national project entitled Reach Up, Reach Out: Best Practices in Mental Health Promotion for Culturally Diverse Seniors. The objectives of this project are to:

1. Establish collaborative relationships in order to identify best practices in mental health promotion for culturally diverse older adults, specifically through the establishment of a Project Advisory Committee (PAC) and Consulting Expert Panel (CEP).
2. Gather information on best practices and evidence of success for programs and strategies that foster the inclusion of diverse older adults through supportive networks and connections.
3. Develop guidelines for best practice in mental health promotion for culturally diverse seniors.
4. Develop a tool for community-based organizations and volunteer networks to use in developing culturally inclusive mental health promotion programs and strategies for older adults.
5. Implement best practices guidelines via pilot sites across Canada.
6. Educate stakeholders about the best practice guidelines and tool. The anticipated result of this project is increased capacity of community organizations to effectively respond to the mental health needs of culturally diverse older adults. These guidelines will also be of benefit to policy makers as they plan and develop services, programs, and policies that are culturally inclusive.

This document discusses best practices in mental health promotion for culturally diverse seniors. The best practices suggested here are collected from projects from around the world which share a focus on providing the tools needed to sustain and improve seniors' mental health.

These guidelines are derived from the project's literature review, environmental scan, evaluation review, focus groups and from interviews conducted for this project. The guidelines are designed to help VON providers engage in program development strategies to aid in the delivery of mental health outreach programming for ethno-cultural minority seniors. We have made every attempt to make these guidelines as extensive as possible, but it would not be possible for any such attempt to be entirely complete.

Choudhry, U. K. (1998). Health promotion among immigrant women from India living in Canada. *Journal of Nursing Scholarship*, 30(3), 269-274.

Purpose: To describe the health promoting practices of immigrant women from India and how cultural knowledge, norms, and values influence their behavior. Design: Descriptive using a small convenience sample. Method: Using ethnographic methodology, 20 women between the ages of 40 and 70 years living in Canada, 1995-1996, were interviewed individually using open-ended questions. Community get-togethers were also observed. Findings: The sample of women consistently reported that to remain healthy, a good diet, activity, and weight control were important. In addition, prayers, spiritual activities, and good relationships with families helped. Conclusions: Health professionals should be aware of the special needs of immigrant women to help them promote healthy lifestyles in their cultural context.

Choudhry, U. K., Jandu, S., Mahal, J., Singh, R., Sohi-Pabla, H., & Mutta, B. (2002). Health promotion and participatory action research with South Asian women. *Journal of Nursing Scholarship : An Official Publication of Sigma Theta Tau International Honor Society of Nursing / Sigma Theta Tau*, 34(1), 75-81.

PURPOSE: To examine South Asian immigrant women's health promotion issues and to facilitate the creation of emancipatory knowledge and self-understanding regarding health-promoting practices; to promote health education and mobilization for culturally relevant action. METHOD: The study was based on critical social theory; the research model was participatory action research (PAR). Two groups of South

Asian women (women from India and of Indian origin) who had immigrated to Canada participated in the project. The qualitative data were generated through focus groups. Reflexive and dialectical critique were used as methods of analyzing qualitative data. The data were interpreted through reiterative process, and dominant themes were identified. FINDINGS: Three themes that were extracted from the data were: (a) the importance of maintaining culture and tradition, (b) placing family needs before self, and (c) surviving by being strong. An issue for action was the risk of intergenerational conflicts leading to alienation of family members. Over a period of 3 years, the following action plans were carried out: (a) workshops for parents and children, (b) sharing of project findings with the community, and (c) a presentation at an annual public health conference. CONCLUSIONS AND IMPLICATIONS: The project activities empowered participants to create and share knowledge, which was then applied toward action for change. Health and health promotion were viewed as functions of the women's relationships to the world around them.

Dhaliwal, S. (2002). Dietary practices of older Punjabi women living in Canada UMI Dissertation Services, ProQuest Information and Learning, Ann Arbor, MI.

In Canada, little is known about the dietary beliefs and practices of the Asian Indian population which is among the top 3 ethnic groups in Toronto, Ontario. The nutritional health needs and disease risks of the Asian Indian population are different and often not well understood by western health care providers. Understanding the complex interaction of factors which influence the eating practices of this group is necessary to plan effective nutritional and health promotion programs for Asian Indian population. The purpose of this study was to describe the dietary practices of Punjabi immigrant older women who are living in Ontario, Canada, and how cultural knowledge, norms and beliefs, and practices influence their eating behavior. Using an ethnographic design, data were obtained through semi-structured interviews, and observations in the participant's homes. Nine Punjabi women, between the ages of 52 and 65, living west of Toronto with their families, from a rural background, and who prepared at least one main meal daily, participated in the study. (Abstract shortened by UMI.) (Author Abstract, used by permission) (AgeLine Database, copyright 2004 EBSCO Publishing, Inc., all rights reserved)

Singh, A., & Kinsey, B. (1993). Lay health and self-care beliefs and practices: Responses of the elderly to illness in four cultural settings in Canada and the United States. In R. Masi, L. Menshah & M. McLeod (Eds.), *Health and cultures: Policies, professional practices and education* (Vol. 1 ed., pp. 197-228). Oakville: Mosaic Press.

Taylor, L. E., Taylor-Henley, S., & Doan, L. (2005). Older immigrants: language competencies and mental health. *Canadian Journal of Community Mental Health (Revue Canadienne De Santé Mentale Communautaire)*, 24(2), 23-34.

Later-life immigration and a lack of dominant language competency present many challenges to mental health for older adults. English as a Second Language (ESL) classes for seniors, often regarded as the sole domain of ESL teachers, offer mental health professionals opportunities for mental health promotion and education. This paper examines some of the mental health issues that emerged from stories written by older adults in an ESL for Seniors program. The program is presented as an example of best practices in an ESL for Seniors program because of its specific development to meet the needs of ESL older persons.

Chappell, N. L. (2005). Perceived change in quality of life among Chinese Canadian seniors: the role of involvement in Chinese culture. *Journal of Happiness Studies*, 6(1), 69-91.

Although much gerontological literature is focused on subjective well-being, quality of life, and life satisfaction, we know little about this concept in old age among sub-cultural groups. This paper presents empirical data on subjective well-being among Chinese seniors (age 55 and over) living in seven cities in Canada. It asks whether and to what extent traditional Chinese culture, a culture in which seniors have been

historically valued as wise and contributing members to be respected, is related to their evaluation of whether or not life has improved in old age. Among a random sample of 2272 Chinese seniors, some but not all aspects of traditional Chinese culture were related to their valuation of old age. In particular, involvement in that traditional culture, return visits to the homeland, immigration due to family reunion, and ancestor worship were significant predictors but differentially depending on whether the overall scale or specific domains within that overall scale was the dependent variable. The fact that differential aspects of traditional culture contribute to a positive experience of aging suggests we must be careful in generalizing to traditional culture. Importantly, ethnocentric beliefs regarding Chinese culture were not related to any domain of quality of life.

Canadian Ethnocultural Council. (2003). Culturally appropriate best practice models for healthy aging. Ottawa, Ontario: Canadian Ethnocultural Council.

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